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Changes to Idaho Health Care Consent Law

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Effective July 1, 2012, amendments to Idaho's health care consent statutes, Idaho Code § 39-4501 *et seq.*, take effect. The changes resolve some concerns, but raise others. The following summarizes the more significant changes.

1. Application of consent statutes. The amended statute expressly confirms that it applies to all forms of health care, not just medical or dental care. (I.C. § 39-4503).

2. Capacity to consent. As amended, "any person who comprehends the need for, the nature of and the significant risks ordinarily inherent in" the contemplated health care may consent to or refuse their own care. (I.C. § 39-4503). The change removes the additional condition that the person must have "ordinary intelligence and awareness", which created ambiguity and potentially unwarranted discrimination in applying the standard.

3. Surrogate decision makers. The amendment clarifies the authority of "surrogate decision makers" to make health care decisions for persons who lack capacity to make their own decisions. Surrogates may make decisions for minors and other persons who are not capable of giving consent. As amended, the statute establishes the following hierarchy for surrogates:

1. A court-appointed guardian of the patient.
2. A person named in a living will or durable power of attorney, but only if the conditions in the living will or power of attorney that authorized the agent to act have been satisfied.
3. The spouse of the patient.
4. An adult child of the patient.
5. A parent of the patient.
6. A person named in a delegation of parental authority executed per I.C. § 15-5-104.
7. Any relative of the patient who represents himself or herself as appropriate to act under the circumstances.
8. Any other competent person who represents himself or herself as responsible for the patient's health care.

(I.C. § 39-4504(1)). Importantly, the amendment clarifies that the surrogate decision maker must themselves have sufficient capacity under § 39-4503 to make their own health care decisions before they can make decisions for others. In addition, the surrogate cannot trump the prior wishes of the patient expressed while the patient was competent, e.g., through a POST,

advance directive, or other method. (I.C. § 39-4504(1)).

4. Responsibility for obtaining consent. The amendment confirms that the health care provider upon whose order or at whose direction the contemplated care is rendered is responsible for ensuring that sufficient consent is obtained, either by themselves or by their agents. (I.C. § 39-4508).

5. Advance directives. The old statute contemplated certain forms of advance directives, e.g., a living will, durable power of attorney for health care, or physician's orders for scope of treatment ("POST"). Questions sometimes arose concerning other forms of advance directives, or the validity of a directive that did not contain the statutory elements required for a living will, durable power of attorney, or POST. The amended statute confirms that any advance directive ought to be honored, including any "document which represents a competent person's authentic expression of [the] person's wishes concerning his or her health care." (I.C. § 39-4502(8); *see also* I.C. §§ 39-4509(3) and 39-4514(6)).

6. POSTs. The amended statute broadens the availability of POSTs. The former statute made POSTs "appropriate" if the patient had an incurable or irreversible injury, disease, illness or condition, or if such conditions were anticipated. The amended statute removes that condition, making POSTs possible for all patients. (*See* I.C. § 39-4512A). The amended statute also expands the persons who may execute a POST. In addition to physicians, the new statute allows advanced practice nurses or physician assistants to execute POSTs on behalf of the provider. (I.C. § 39-4512A). Similarly, in addition to the patient, the new statute allows surrogate decision makers to execute POSTs on behalf of the patient so long as the POST is not contrary to the patient's last known expressed wishes. (I.C. § 39-4512A(1)). The amendment allows a provider or person to suspend a POST for a period of time, although such suspension is not automatic. (I.C. § 39-4512A(2)). For example, contrary to some providers' belief, POSTs and other advance directives are not automatically suspended during surgery.

7. DNRs. When enacted, the former version of the statute removed the laws that authorized "do not resuscitate orders" ("DNRs"), apparently intending POSTs to replace DNRs. The amended statute expressly allows hospitals and other health care providers to continue to use DNRs, provided that if the patient presents a POST, they must accept the POST and not require a separate DNR to validate the POST. (I.C. §§ 39-4512B(3) and 39-4514).

8. Withdrawal or denial of treatment. A new section was added to limit a provider's ability to withdraw or deny certain forms of treatment requested by the patient or surrogate. As amended, assisted feeding or artificial nutrition and hydration may not be withdrawn or denied if such care is requested by the patient or surrogate decision maker. Other forms of treatment cannot be withdrawn or denied if requested by the patient or surrogate decision maker unless the treatment that medically is inappropriate or futile. (I.C. § 39-4514(3)). Unfortunately and unlike other amendments, this section is poorly drafted and may inappropriately limit a

provider's professional judgment. For example, under both the former and amended law, the consent statute shall not be construed "to require medical treatment that is medically inappropriate or futile"; however, the new law expressly states that this limitation "does not authorize any violation" of the new withdrawal of care provisions described above, *i.e.*, the requirement that requested treatment must be provided unless futile. (I.C. § 39-4514(3) and (6)). The limitation on withdrawal or denial of care does not reference medically inappropriate treatment. (I.C. § 39-4514(3)). The net effect appears to be that a provider may not withdraw or deny requested treatment even if medically inappropriate unless the treatment is also futile, which result defies logic and cannot be what was intended. At the very least, the amendment creates ambiguity concerning the proper response to treatment that is requested but is medically inappropriate.

9. Futile care. As amended, the statute only permits the withdrawal or denial of requested treatment if the treatment is futile. The statute now defines "futile care" as a course of treatment:

1. For a patient with a terminal condition, for whom, in reasonable medical judgment, death is imminent within hours or at most a few days whether or not the medical treatment is provided and that in reasonable medical judgment will not improve the patient's condition; or
2. The denial of which in reasonable medical judgment will not result in or hasten the patient's death.

(I.C. § 39-4514(6)). This definition of "futility" only considers the length of a patient's life without considering qualitative factors, including the pain or suffering that an incompetent patient may be forced to endure simply to preserve life or the fact that a patient may be in a permanent comatose state. It is inconsistent with Idaho's "Baby Doe" regulations which also factor in the humanity of a patient's care. (*See* IDAPA 16.06.05.004.10). In some cases, the provider may deem continued treatment to be unethical or unconscionable if not "futile" as defined in the statute, in which cases the provider's alternative is to withdraw as the treating provider after making a good faith effort to transfer care to another provider pursuant to I.C. §§ 39-4513(2) or 18-611. That may be a viable alternative for a physician or other individual health care provider, but it is more difficult for a hospital or other health care facility. The practical effect is that it is even more important for providers and facility ethics committees to come to an agreement with patients or surrogate decision makers concerning the appropriate course of treatment or withdrawal thereof.

10. Minor consents. The amended statute does not explicitly resolve whether mature minors may consent to their own care. Section 39-4503 states that "any person" with sufficient comprehension may consent to their own care, not any "adult" person. Similarly, § 39-4509 was amended to define "competent person" to mean any person who meets the standard in § 39-4503, not just adults or emancipated minors. On the other hand, § 39-4504(1) states that surrogate decision makers may consent for minors. Until clarified by a court, the conservative approach would be to require surrogate consent for minors unless another statute grants the minor authority to make their own health care decisions or the minor is clearly

deemed to be emancipated under Idaho law.

Conclusion. The amended consent statute resolves some of the concerns that have bothered providers in recent years; however, the new "withdrawal of treatment" provisions may prove problematic in some cases. Redlined copies of the amended statute may be accessed at http://www.legislature.idaho.gov/legislation/2012/S1294E1.pdf and http://www.legislature.idaho.gov/legislation/2012/S1348E1.pdf.

If you have questions concerning these or other legal issues, please contact Kim Stanger at kcstanger@hollandhart.com or (208) 383-3913, or visit Holland & Hart's website at www.hollandhart.com

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