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The Idaho Medical Consent Act: Recent Amendments

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The Idaho legislature has amended Idaho's Medical Consent Act. The redlined changes are shown here. Effective July 1, 2023, the rules for medical consents in Idaho are as follows:

1. Need for Informed Consent. As a general rule, a healthcare provider or entity must have informed consent from a competent patient or their authorized surrogate decision-maker to provide healthcare. Failure to obtain sufficiently informed consent may subject the provider to liability for civil, administrative, and potentially criminal penalties. In addition to malpractice, assault, or other common causes of action, Idaho recognizes a specific tort cause of action for lack of informed consent.[1]

2. Patient's Capacity to Consent or Refuse Care. As amended, I.C. § 39-5303 sets forth the standard for determining whether a patient has capacity to consent to or refuse their own healthcare[2]:

> Any person … who comprehends the need for, the nature of, and the significant risks ordinarily inherent in any contemplated health care services is competent to consent thereto [or refuse such care] on his or her own behalf. Any health care provider may provide such health care and services in reliance upon such a consent [or refusal of consent].[3]

The former version of the statute stated,

> Any health care provider may provide such health care and services in reliance upon such a consent **if the consenting person appears to the health care provider securing the consent to possess such requisite comprehension at the time of giving the consent**.

(Emphasis added). Unfortunately for healthcare providers, the amendment arguably but unintentionally[4] changed the test from the provider's subjective belief concerning the patient's capacity to an objective test, thereby offering less protection to the provider. Fortunately, however, § 39-4504(3) continues to state, “No health care provider who, in good faith, obtains consent from a person pursuant to … section 39-4503 … shall be

subject to civil liability therefor." The "good faith" language may continue to provide some protection to providers.

Note that the capacity test in § 39-4503 applies to "[a]ny person"; it is not expressly limited to "any **adult** person"; however, the next section, § 39-4504, confirms that, as a general rule, unemancipated minors may not consent to their own healthcare unless a specific statute allows minors to consent to their own care. For more information about a minor's consent for treatment, read our recent legal update.

3. Patients Who Lack Capacity: Advance Directives. If a patient currently lacks capacity to make his or her own decisions, healthcare providers should first determine whether the patient expressed his or her healthcare wishes while competent or executed an advance directive. Per the statute, a healthcare provider may render care consistent with the patient's "advance care planning document or wishes expressed by the person while the person was capable of consenting to his or her own health care services."[5] Providers who act in good faith reliance on an advance directive are immune from liability for actions taken consistent with the advance directive.[6]

a. ACPDs. Significantly, the amendments replaced living wills and durable powers of attorney with "advance care planning documents."

> "Advance care planning document," "advance directive," "directive," or "health care directive" means a document that:
> (a) Substantially meets the requirements of [I.C. § 39-4510(1)];
> (b) Is a POST form; or
> (c) Is another document that represents a competent person's authentic expression of such person's wishes concerning health care services.[7]

Under § 39-4510,

> Any competent person aged eighteen (18) years or older may execute an advance care planning document (ACPD). Such document must contain the mandatory elements set forth in this section. Any provisions of an ACPD that are left blank by a person executing the document shall be deemed intentional and shall not invalidate the document…. To be considered a valid ACPD, a document must include:
> (a) The person's name, date of birth,

telephone number, and mailing address;
(b) The signature of the person for whom the ACPD is created or the authorized agent of such person; and
(c) The date on which the document was signed.[8]

b. POSTs. The statutes continue to recognize Physicians Orders for Scope of Treatment (POST) forms, which allow "licensed independent practitioners" (*i.e.*, physicians, physician assistants and advance practice registered nurses[9]) and patients or their surrogate decision-makers to complete orders governing the patient's care in any care setting.[10] The amendments removed the obligation for practitioners to periodically review the POST form with the patient.[11]

c. Authentic Expressions. Despite the statutory requirements for ACPDs and POST forms, the statutes also confirm that no formal document is required to implement the patient's prior expressed wishes and no technical defect in an advance directive (including an ACPD) should nullify its clear intent. Thus, while the statute recognizes ACPDs and POST forms as ways to document the patient's wishes, they are **not** intended as "the only effective means for such communication…";[12] instead, any "document that represents a competent person's authentic expression of such person's wishes concerning health care services" constitutes a valid advance directive[13] and "[a]ny authentic expression of a person's wishes with respect to health care services should be honored."[14] Providers relying on such advance directives or prior expressed wishes will want to document the facts or communications that affirm the patient's wishes and justify the provider's reliance.

d. Revocation, Suspension or Termination. Once executed, an ACPD or advance directive remains in effect until revoked, suspended or terminated by its maker, *i.e.*, the patient or the surrogate decision-maker.[15] Contrary to common belief, advance directives do not automatically suspend during surgery; instead, the patient or surrogate must affirmatively take action to suspend the advance directive.[16] The maker of an ACPD may suspend, revoke or terminate an advance directive by "any … action that clearly manifests the maker's intent to revoke the ACPD."[17] Providers are not liable for failure to comply with an ACPD or act on the termination, suspension or revocation of an ACPD unless the provider has actual knowledge of such.[18] Providers may disregard a POST if they believe the POST has been revoked; to avoid oral or physical confrontations; or if ordered to do so by a licensed independent practitioner.[19]

4. Patients Who Lack Capacity and Minors: Surrogate Decision-Makers. If a person (i) "is not then capable of giving such consent" per the standard in I.C. § 39-4503; or (ii) the person "is a minor" (*i.e.*, less than 18

years old[20]), then the following persons ("surrogate decision-makers") may consent to or refuse care in the following order of priority:

> (a) The court-appointed guardian of such person;
> (b) The person named in another person's advance care planning document … if the conditions in such advance care planning document for authorizing the agent to act have been satisfied;
> (c) If married, the spouse of such person;
> (d) An adult child of such person;
> (e) A parent of such person;
> (f) The person named in a delegation of parental authority executed pursuant to section 15-5-104, Idaho Code;
> (g) Any relative of such person;
> (h) Any other competent individual representing himself or herself to be responsible for the health care of such person.[21]

The authority of surrogate decision-makers is subject to a couple of important limitations. First, "the surrogate decision-maker shall not have authority to consent to or refuse health care services contrary to [the patient's] advance care planning document or wishes expressed by [the patient] while the [patient] was capable of consenting to his or her own health care services."[22] Second, the surrogate decision-maker must "have sufficient comprehension as required to consent to his or her own health care services pursuant to the provisions of section 39-4503."[23]

Although the general rule is that minors may not consent to their own healthcare in Idaho, there are several exceptions. For example, emancipated minors may generally consent to their own care. Also, several Idaho statutes allow minors to consent to their own care or allow healthcare providers to render care without consent. For more information about minor consents in Idaho, look for our forthcoming alert this week.

If the patient has not communicated his or her wishes and there is no readily available surrogate decision-maker, then the attending healthcare provider may render appropriate emergency care. The relevant statute states:

> If the person presents a medical emergency or there is a substantial likelihood of his or her life or health being seriously endangered by withholding or delay in the rendering of health care services to such person and the person has not communicated and is unable to communicate his or

> her wishes, the attending health care provider may, in his or her discretion, authorize or provide such health care services, as he or she deems appropriate, and all persons, agencies, and institutions thereafter furnishing the same, including such health care provider, may proceed as if informed valid consent therefor had been otherwise duly given.[24]

The statute also creates a presumption in favor of consent to cardiopulmonary resuscitation (CPR) unless:

> (a) CPR is contrary to the person's advance care planning document;
> (b) The person's surrogate decision-maker has communicated the person's unconditional wishes not to receive CPR;
> (c) The person's surrogate decision-maker has communicated the person's conditional wishes not to receive CPR and those conditions have been met;
> (d) The person has a proper POST identification device pursuant to section 39-4502 …; or
> (e) The licensed independent practitioner has executed a DNR order.[25]

As the patient consent, "[n]o health care provider who, in good faith, obtains consent from a [surrogate decision-maker] pursuant to … § 4504(1) … shall be subject to civil liability therefor."[26]

5. Mental Holds. If a patient is gravely disabled due to mental illness, Idaho does allow law enforcement or hospital LIPs to initiate a "mental hold" and provide appropriate care pending competency proceedings without patient or surrogate decision-maker consent.[27] Similarly, in the case of minors experiencing a serious emotional disturbance, Idaho allows law enforcement and/or hospitals to initiate a protective hold to care for a minor pending notice to the parents or guardians.[28] For more information concerning mental holds or protective holds, see our article.

6. Sufficiency of Consent. To be effective, consent must be sufficiently informed. Idaho Code§ 39-4506 sets forth the applicable standard:

> SUFFICIENCY OF CONSENT. Consent, or refusal to consent, for the furnishing of health care services shall be valid in all respects if the person giving or refusing the consent is sufficiently aware of pertinent facts

> respecting the need for, the nature of, and the significant risks ordinarily attendant upon such a person receiving such services, as to permit the giving or withholding of such consent to be a reasonably informed decision. Any such consent shall be deemed valid and so informed if the health care provider to whom it is given or by whom it is secured has made such disclosures and given such advice respecting pertinent facts and considerations as would ordinarily be made and given under the same or similar circumstances.

Prior to the amendment, the last sentence read,

> Any such consent shall be deemed valid and so informed if the health care provider to whom it is given or by whom it is secured has made such disclosures and given such advice respecting pertinent facts and considerations as would ordinarily be made and given under the same or similar circumstances **by a like health care provider of good standing practicing in the same community. As used in this section, the term "in the same community" refers to that geographic area ordinarily served by the licensed general hospital at or nearest to which the consent is given**.

(Emphasis added). Thus, the amendment makes the applicable standard less certain and may invite attempts to apply consent standards from outside the relevant community, although one would think that a court should still apply a community standard to the issue.

For more information about the sufficiency of consent, see our article.

7. Form of Consent. In Idaho, valid consent need not be written to be effective. The relevant statute states:

> FORM OF CONSENT. It is not essential to the validity of any consent for the furnishing of health care services that the consent be in writing or any other specific form of expression.[29]

However, written consent comes with benefits. First, a signed consent form helps document and prove that consent was obtained. Second, under the statute, written consent carries a presumption of its validity:

> [W]hen the giving of such consent is recited or documented in writing and expressly authorizes the health care services to be furnished, and when such writing or form has been executed or initialed by a person competent to give such consent for himself or another, such written consent, in the absence of convincing proof that it was secured maliciously or by fraud, is presumed to be valid for the furnishing of such health care services, and the advice and disclosures of the attending licensed independent practitioner or dentist, as well as the level of informed awareness of the giver of such consent, shall be presumed to be sufficient.[30]

As the statute suggests, simply signing a consent form does not necessarily mean that informed consent has been obtained. Informed consent requires the exchange of relevant information and understanding by the patient. A consent form may help inform the patient and document consent, but if relevant facts have not been communicated in the form or otherwise, or if the patient does not understand the form or relevant facts relating to the risks and benefits of the care, then no effective consent has been obtained. For more information about consent forms, see our article.

8. Responsibility for Consent. The statute confirms that the health care provider under whose order the care is rendered is responsible for ensuring that informed consent is obtained:

> RESPONSIBILITY FOR CONSENT AND DOCUMENTATION. Obtaining sufficient consent for health care services is the duty of the attending licensed independent practitioner upon whose order or at whose direction the contemplated health care services are rendered; provided however, a licensed hospital and any employee of a health care provider, acting with the approval of such an attending licensed independent practitioner or other individual health care provider, may perform the ministerial act of documenting such consent by securing the completion and execution of a form or statement in which the giving of

> consent for such care is documented by or on behalf of the person. In performing such a ministerial act, the hospital or health care provider employee shall not be deemed to have engaged in the practice of medicine or dentistry.[31]

9. Refusal or Withdrawal of Care. A patient with sufficient capacity to consent to his or her own care generally has the right to refuse care.[32] Similarly, an authorized surrogate decision-maker may generally refuse proposed care for a patient so long as such action is not contrary to the patient's prior expressed wishes.[33] If such refusal of care constitutes child neglect or vulnerable adult neglect, the healthcare provider is obligated to report such neglect to the appropriate authorities.[34] If a surrogate decision-maker refuses necessary life-sustaining care for a child, healthcare providers may seek emergency authorization from the court to render such care,[35] although it is usually easier for the provider simply to report the neglect to the state and let state authorities assume responsibility for the child and authorize needed care. Idaho's "Simon's Law" imposes additional conditions if a surrogate decision-maker wants a "do not resuscitate" (DNR) order for an unemancipated minor.[36] In the case of a developmentally disabled person, additional steps must be satisfied before life-sustaining care may be withdrawn or withheld.[37]

If a patient or authorized surrogate decision-maker requests life-sustaining treatment or comfort care, a healthcare provider may not withdraw or deny such care unless it is "nonbeneficial medical treatment."[38] As amended,

> "Nonbeneficial medical treatment" means treatment:
> (a) For a patient whose death, according to the reasonable medical judgment of a licensed independent practitioner, is imminent within hours or a few days regardless of whether the treatment is provided: or
> (b) That, according to the reasonable medical judgment of a licensed independent practitioner, will not benefit the patient's condition.[39]

Conclusion. The foregoing summarizes key elements of Idaho consent law as amended. Additional state or federal laws may apply in certain cases. For example, state licensure statutes generally require providers to obtain effective consent. Federal regulations may also impose additional requirements for certain provider types. Knowing and navigating applicable consent law is critical for effective patient care, protecting the patient's rights, and defending against claims by disgruntled patients.

[1] *See, e.g., Foster v. Traul*, 141 Idaho 890, 894, 120 P.3d 278, 282 (2005); *Anderson v. Hollingsworth*, 136 Idaho 800, 804, 41 P.3d 228, 232 (2001); *Shabinaw v. Brown*, 131 Idaho 747, 751, 963 P.2d 1184, 1188 (1998);

Sherwood v. Carter, 119, Idaho 246, 251, 805 P.2d 452, 457 (1991).

[2] "'Consent to treatment' means the agreement an individual makes to receive health care services. Consent to treatment also includes refusal: (a) Refusal to consent to care and/or withdrawal of care treatment; and (b) Consent to withholding or withdrawal of health care services." (I.C. § 39-4501(8)).

[3] I.C. § 39-4503.

[4] Based on my discussions with those who drafted the amendment, they did not intend to change the standard and did not realize the effect the change might have.

[5] I.C. § 39-4504(1).

[6] I.C. § 39-4513(1).

[7] I.C. § 39-4502(1).

[8] I.C. § 39-4510(1).

[9] I.C. § 39-4502(13)).

[10] I.C. § 39-4512A.

[11] *See* § I.C. 39-4512A.

[12] I.C. § 39-4509(3).

[13] I.C. § 39-4502(1)(c).

[14] I.C. § 39-4509(3).

[15] I.C. § 39-4512.

[16] I.C. § 39-4511B.

[17] I.C. § 39-4511A(1) and 39-4511B(1).

[18] I.C. § 39-4511A(2)-(3); 39-4511B(2)-(3).

[19] I.C. § 39-4513(5)).

[20] *See* §I.C. 39-4516(3).

[21] I.C. § 39-4504(1).

[22] I.C. § 39-4504(1).

[23] I.C. § 39-4504(1).

[24] I.C. § 39-4504(1)(i).

[25] I.C. § 39-4514(5). "'Cardiopulmonary resuscitation' or 'CPR' means

measures to restore cardiac function and/or to support ventilation in the event of cardiac or respiratory arrest." (I.C. 39-4502(6)).

[26] I.C. § 39-4504(3).

[27] I.C. § 66-326.

[28] I.C. § 16-2411.

[29] I.C. § 39-4507.

[30] I.C. § 39-4507.

[31] I.C. § 39-4508.

[32] I.C. § 39-4503.

[33] I.C. § 39-4504(1); *see also* I.C. 39-4514(3).

[34] I.C. § 16-1605 and 39-5303.

[35] I.C. § 16-1627.

[36] I.C. § 39-4516.

[37] I.C. § 66-405(8).

[38] I.C. § 39-4514(3).

[39] I.C. 39-4502(14).