

IDAHO LAW REVIEW

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CONSENT FOR HEALTHCARE UNDER IDAHO LAW: A PRIMER

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I. INTRODUCTION

*"Every human being of adult years and sound mind has a right to determine what shall be done with his own body"*¹

*"A physician . . . has no more right to needlessly and rudely lay hands upon a patient against her will than has a layman."*²

The right of competent persons to make their own healthcare decisions is fundamental in our society.³ The patient's right of self-

1. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *abrogated on other grounds* by *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

2. *Inderbitzen v. Lane Hosp.*, 12 P.2d 744, 747 (Cal. Dist. Ct. App. 1932).

3. The right has, at various times, been recognized as part of our constitutional rights of liberty and privacy or a common law right of self-determination. *See generally* Alice G. Gosfield et al., *Health Care Decision-Making, Patient Autonomy and Professional Responsibility*, in 1 HEALTH L. PRAC. GUIDE §§ 8.3–8.7 (2007) (offering the right to privacy, the right

determination trumps healthcare provider (provider) paternalism, thereby allowing patients to choose whether to receive or refuse treatment even if their decisions are not, medically speaking, in their own best interests. To facilitate rational decision making, individuals have the right to receive sufficient information from their providers so that they may weigh the facts and likely consequences of their decisions.⁴ This article summarizes Idaho law and offers suggestions for obtaining and documenting valid informed consent and, its corollary, the refusal of treatment.⁵

II. LIABILITY FOR FAILURE TO OBTAIN INFORMED CONSENT

Few, if any, providers would knowingly treat a patient contrary to the patient's express objections; however, treatment without valid consent may arise in less obvious ways, including situations in which the practitioner:

- Treats a patient who lacks capacity to consent to his own care (e.g., the patient is impaired due to intoxication or medication, is underage, or is unconscious);⁶
- Ignores the patient's prior wishes or decisions concerning treatment (e.g., the practitioner provides life-sustaining treatment contrary to the patient's advance directive);
- Continues treatment even though the patient has objected to the treatment or withdrawn his consent (e.g., a nurse inserts a catheter even though the quadriplegic patient objects to the action);
- Provides treatment that exceeds the scope of the consent;⁷ or
- Fails to inform the patient of relevant information that is reasonably necessary to enable the patient to make an informed decision, thereby negating the patient's consent.⁸

to religious freedom, the common law right of self-determination, and other fundamental bases for the right to decide).

4. See, e.g., *Foster v. Traul (Foster II)*, No. 33537, 2007 WL 4472262 (Idaho Dec. 24, 2007).

5. This article provides an overview of some of the more relevant statutes, laws, and regulations at the time of publication. Other laws and regulations may apply, particularly in the mental healthcare context. In addition, the statutes and regulations seem to be subject to constant change. The reader should review the current status of the law and regulations. This article does not establish an attorney-client relationship between the authors and the reader and does not constitute the giving of legal advice.

6. See, e.g., *Shabinaw v. Brown (Shabinaw II)*, 131 Idaho 747, 749, 963 P.2d 1184, 1186 (1998) (arguing the physician did not obtain informed consent to conduct surgery because the patient was heavily medicated on Demerol at the time the risks were disclosed).

7. See, e.g., *Shannahan v. Gigray*, 131 Idaho 664, 666, 962 P.2d 1048, 1050 (1998) (alleging that the physician only gained consent to conduct surgery on the patient's toenail rather than the entire toe).

Anytime a practitioner provides treatment without the valid consent of the patient or statutory authority to provide care in the absence of consent, the practitioner is exposed to civil, administrative, and, in egregious cases, criminal liability.

Patients may sue physicians for treatment without consent under several tort theories. The failure to obtain consent may violate the standard of care, giving rise to a malpractice claim.⁹ In addition, "[c]ivil battery [is any] intentional, unpermitted contact upon the person of another which is either unlawful, harmful, or offensive."¹⁰ To be liable for battery, a practitioner need only intend the act; the practitioner may be liable even though there is neither intent to harm nor actual physical injury.¹¹ Practitioners may be liable for false imprisonment if they seclude, restrain, or otherwise restrict the patient without his consent.¹² Practitioners may also be liable for fraudulent misrepresentation if they know of facts concerning their patients' conditions which are material to their patients but fail to disclose the information.¹³

Significantly, informed consent is either a valid defense or negates the elements required to establish these claims; hence, it is critical to obtain the patient's informed consent before treating him.

In addition to common law torts, Idaho courts recognize a statutorily based cause of action against healthcare providers for the failure to obtain informed consent.¹⁴ Under sections 39-4501 to 39-4515 of the Idaho Code,¹⁵ physicians and other healthcare providers have a duty to disclose risks of injury that might result from a proposed course of treatment.¹⁶ A provider may be liable to the patient for failing to obtain informed consent even though the provider was not negligent in the ac-

8. See, e.g., *Rook v. Trout*, 113 Idaho 652, 653, 747 P.2d 61, 62 (1987) (alleging that the physician failed to adequately disclose risks attendant to surgery and alternative courses of treatment), *overruled on other grounds by Sherwood v. Carter*, 119 Idaho 296, 805 P.2d 452 (1991); *Shabinaw II*, 131 Idaho at 749, 963 P.2d at 1186 (alleging that the physician failed to adequately disclose the risks of surgery and failed to provide any treatment alternatives).

9. See *Shabinaw II*, 131 Idaho 747, 963 P.2d 1184.

10. *Neal v. Neal*, 125 Idaho 617, 622, 873 P.2d 871, 876 (1994) (citing *White v. Univ. of Idaho*, 118 Idaho 400, 797 P.2d 108 (1990)).

11. *Id.*; see also *White*, 118 Idaho at 401-02, 797 P.2d at 109-10.

12. See, e.g., *Kenner v. N. Ill. Med. Ctr.*, 517 N.E.2d 1137, 1139 (Ill. App. Ct. 1987) (alleging that physician, by administering Valium without consent, deprived patient of control over his body that resulted in false imprisonment).

13. *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1054 (Ohio Ct. App. 1984).

14. See *Foster v. Traul (Foster I)*, 141 Idaho 890, 894, 120 P.3d 278, 282 (2005); *Anderson v. Hollingsworth*, 136 Idaho 800, 804, 41 P.3d 228, 232 (2001); *Shabinaw II*, 131 Idaho 747, 751, 963 P.2d 1184, 1188 (1998); *Shabinaw v. Brown (Shabinaw I)*, 125 Idaho 705, 708, 874 P.2d 516, 519 (1994); *Sherwood v. Carter*, 119 Idaho 246, 251, 805 P.2d 452, 457 (1991).

15. See *infra* Part II.C.

16. See also *Foster I*, 141 Idaho at 894, 120 P.3d at 282; *Sherwood*, 119 Idaho at 251-52, 805 P.2d at 457-58.

tual treatment of the patient.¹⁷ To establish a claim for lack of informed consent, the patient must prove three elements: (1) nondisclosure, (2) causation, and (3) injury.¹⁸

To establish nondisclosure, the patient must establish that the practitioner failed to meet the objective, medical community-based standard for informed consent.¹⁹

To establish causation:

[T]he plaintiff must show by a preponderance of the evidence that a prudent person in the patient's position would not have consented to the proposed procedure had full and adequate disclosure of the significant risks been made at the time consent was originally given.

Thus, in order to prove causation [the plaintiff] must show by a preponderance of the evidence that 'a reasonable person would have chosen no treatment or a different course of treatment had he or she been adequately informed by the physician.'²⁰

To establish injury:

[T]he plaintiff must prove his injuries were a direct and proximate cause of the defendant's failure to disclose risks and alternatives to the patient. The injury must be as a result of the undisclosed material risk, rather than some unrelated risk, such as falling off of the operating table or faulty work on the part of medical personnel not involved in [the relevant] care.²¹

The patient's common law right of self-determination is also reflected in laws, regulations, licensing, and accreditation standards; the failure to comply with such laws and standards may subject the health-care provider to loss of licensure or participation in government programs. For example, federal regulations governing hospitals' participation in Medicare confirm that "[t]he patient has the right to participate in the development and implementation of his or her plan of care."²² Furthermore,

The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or

17. See, e.g., *Foster I*, 141 Idaho at 894, 120 P.3d at 282; *Shabinaw I*, 125 Idaho at 709, 874 P.2d at 520.

18. E.g., *Foster v. Traul (Foster II)*, No. 33537, 2007 WL 4472262, at *3 (Idaho Dec. 24, 2007); *Sherwood*, 119 Idaho at 257, 805 P.2d at 463.

19. See *infra* Part II.C.

20. *Anderson v. Hollingsworth*, 136 Idaho 800, 805, 41 P.3d 228, 233 (2001) (internal citations omitted) (quoting *Sherwood*, 119 Idaho at 259, 805 P.2d at 465).

21. *Foster II*, 2007 WL 4472262, at *6.

22. 42 C.F.R. § 482.13(b)(1) (2007).

her health status, being involved in care planning and treatment, and being able to request or refuse treatment.²³

III. REQUIREMENTS FOR INFORMED CONSENT

Theoretically, all healthcare treatment requires valid, informed consent. Practically, proper informed consent ranges from general, implied consent for routine, non-invasive treatment on the low side to specific, detailed informed consent for serious, high-risk procedures on the high side: the more serious the procedure and potential consequences, the greater the need to obtain specific, documented informed consent.

For example, one would likely not expect or require a physician to go through a lengthy explanation of the risks and benefits associated with taking a patient's blood pressure or obtain a written consent before placing the sphygmometer around the patient's arm; instead, the patient's act in extending his arm and cooperating with the test constitutes implied consent. On the other hand, the treating healthcare provider will want to ensure that he has obtained and documented truly informed consent consistent with the principles described below before performing open-heart surgery.

Unlike most states, Idaho codifies the relevant principles of informed consent for healthcare.²⁴ In general, effective consent requires that (1) the patient must have sufficient competency; (2) if the patient is incompetent, consent must be obtained from another authorized person; (3) the provider must give sufficient information to allow the patient to make an informed decision; and (4) the consent must be voluntary.²⁵ Although Idaho Code section 39-4501 expressly applies to "hospital, medical, dental or surgical care,"²⁶ the statutory requirements are consistent with common law principles and presumably would be applied to the provision of other types of healthcare.

A. Competency

To consent to or refuse their own care, a person must have "ordinary intelligence and awareness sufficient for him or her generally to comprehend the need for, the nature of and the significant risks ordinarily inherent in, any contemplated [medical] care."²⁷ Given the importance of individuals' fundamental right to make their own decisions, the

23. *Id.* § 482.13(b)(2).

24. Medical Consent and Natural Death Act, IDAHO CODE ANN. §§ 39-4501-4515 (Supp. 2007).

25. *Id.* §§ 39-4503-4504, 39-4506-4507.

26. *Id.* § 39-4501(1)(a).

27. *Id.* § 39-4503; see also *id.* §§ 66-317(8) (2007) (discussing capacity to consent for one's own hospitalization for the mentally ill), 16-2403(9) (Supp. 2007) (discussing a parent's capacity to consent for hospitalization or treatment of a child for mental health services in juvenile proceedings).

phrase "ordinary intelligence"²⁸ should not be construed to exclude persons who may have some limited impairment, mild mental illness, or developmental disability so long as they otherwise have understanding and awareness "sufficient . . . generally to comprehend the need for, the nature of and significant risks"²⁹ associated with the contemplated care.³⁰

Unless the patient has been through a judicial competency proceeding, the determination of competency is generally left to the front-line, treating healthcare provider. Idaho Code section 39-4503 states: "Any health care provider may provide . . . health care and services in reliance upon [an individual's] consent if the consenting person appears to the health care provider securing the consent to possess such requisite intelligence and awareness at the time of giving consent."³¹

Providers who obtain and act on such consent in good faith are generally immune from civil liability for issues relating to the patient's competency to give consent.³² If there is any question concerning the patient's competency, the healthcare provider should carefully consider and document in the patient record the factors supporting the healthcare provider's conclusion, whether for or against competency. If the circumstances allow, the provider may want to delay any treatment until the patient becomes competent or a more certain determination of competency may be made. In appropriate cases, the provider may want to consult with experts, family members, or others concerning competency, although the final determination rests with the treating healthcare provider.

B. Authority

If a person is not capable of consenting for himself under the standard set forth in Idaho Code section 39-4503 due to mental, physical, or legal incompetence, then consent must be obtained from a competent person with authority to consent on the patient's behalf. Idaho Code section 39-4504(1) establishes a hierarchy of persons (surrogates) who may give or refuse consent for healthcare on behalf of persons who are "minors or incompetent" as follows, in descending order of priority:

28. *Id.* § 39-4503.

29. *Id.*

30. *See, e.g.,* *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986) ("[I]nvoluntarily committed mental patients [have] the fundamental right to refuse antipsychotic medication."); *In re Quackenbush*, 383 A.2d 785, 790 (Morris County Ct. N.J. 1978) (holding that "constitutional and decisional law" require that a seventy-two year old patient be allowed to refuse amputation of his gangrenous legs); *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197 (Tenn. Ct. App. 1978) (holding that a seventy-two year old patient may "exercise her right for control over her own destiny" by refusing amputation of her gangrenous feet).

31. § 39-4503.

32. *Id.* § 39-4504(3).

1. Legal Guardian

A legal guardian tops the hierarchy.³³ Although not defined, "legal guardian" is presumably a person who has been appointed by a court as the patient's legal guardian.³⁴ It may also include a conservator if no legal guardian has been appointed because, by statute, conservators have the same power as guardians if there is no guardian.³⁵ Guardians may authorize medical or professional care or treatment of their wards.³⁶ "A guardian is not liable by reason of this consent for injury to the ward resulting from the negligence or acts of third persons unless it would have been illegal for a parent to have consented."³⁷ The guardian of a minor or incapacitated person may delegate his duties to another competent person for a period of up to six months by a properly executed power of attorney,³⁸ except in the case of a developmentally disabled person.³⁹ As discussed more fully below, a guardian's authority to refuse care may be limited in certain circumstances.⁴⁰

2. Persons with Durable Power of Attorney

If there is no legal guardian, then a person named in a living will or durable power of attorney (DPOA) for healthcare pursuant to Idaho Code section 39-4510 (or a similar document authorized by Idaho Code sections 39-4501 to 39-4515), may make the healthcare decision.⁴¹ Importantly, the person so named would only have authority to make healthcare decisions if the patient is incompetent under Idaho Code section 39-4504 and, presumably, if all other preconditions set forth in the DPOA have been satisfied. Similarly, the scope of the surrogate's authority should be limited according to the terms and conditions of the DPOA.⁴²

3. Spouse

If there is no legal guardian or person with a DPOA and the patient is married, then the spouse may make the decisions for the patient.⁴³ "Spouse" is not defined in the statute, but presumably refers to the spouse from a legal marriage. Idaho generally does not recognize com-

33. *Id.* § 39-4504(1)(a).

34. *See id.* § 15-1-201(21).

35. *Id.* § 15-5-424(a) (2001).

36. *Id.* § 15-5-209(c); *see also id.* § 66-405(6)-(7) (2007) (providing that a guardian may authorize medical or professional care or treatment of a developmentally disabled person and setting forth limitations to this authority).

37. *Id.* § 15-5-209(c) (2001).

38. *Id.* § 15-5-104 (Supp. 2007).

39. *Id.* § 66-405(10)(c).

40. *See infra* Part III.B.

41. § 39-4504(1)(b) (Supp. 2007).

42. *See id.* § 39-4510.

43. *Id.* § 39-4504(1)(c).

mon law marriage, nor does it give spousal rights to co-habitants.⁴⁴ The spouse's authority ends upon divorce, but not necessarily upon separation.⁴⁵

4. Parent

If there are no persons with higher authority, then a parent of the patient is the authorized decision maker.⁴⁶ While not defined, "parent" presumably means the birth or adoptive parent, not a stepparent. The statute does not give one parent greater authority than the other; thus, where treatment is in the child's best interest, a practitioner may rely on the consent given by one parent even if the other parent refuses. Absent some court order to the contrary, a non-custodial parent may consent to the child's care despite the parents' divorce; generally, divorced parents share joint legal custody over their children, which includes the right to make medical decisions for the children.⁴⁷ As with guardians, parents may delegate their authority for a period of up to six months by a properly executed power of attorney.⁴⁸ As discussed more fully below, a parent may be liable for failing to consent to necessary care for his or her child.⁴⁹

5. Relatives

If no spouse, parent, or other person with greater authority is available, then "[a]ny relative representing himself or herself to be an appropriate, responsible person to act under the circumstances" may consent to or refuse care for the patient.⁵⁰ The statute does not define the requisite degree of familial relationship, but would certainly include adult offspring, grandparents, siblings, or the like. It is not clear whether it would extend to relations by marriage (e.g., stepparents, stepchildren, or in-laws). Similarly, the statute does not prioritize authority among relatives (e.g., adult children compared to adult siblings). As a practical matter, practitioners are probably justified in acting at the direction of those with the closest familial and emotional ties to the patient, especially if those directions are consistent with the patient's best interests.

44. *Id.* § 32-201 (2006) (denying recognition to unlicensed, unsolemnized marriages after January 1, 1996).

45. *See id.* § 32-601 (providing that a marriage is dissolved only upon death or decree of divorce).

46. *Id.* § 39-4504(1)(d) (Supp. 2007).

47. *Cf. id.* § 32-717A (2006) (stating that a non-custodial parent has the right to access a child's medical records). It must be noted that "joint legal custody" is indicated as opposed to "joint physical custody." *See id.* § 32-717B.

48. *Id.* § 15-5-104 (Supp. 2007).

49. *See infra* Part III.B.

50. § 39-4504(1)(e).

6. Other Persons

If no other person in the hierarchy is available, then “[a]ny other competent individual representing himself or herself to be responsible for the healthcare of such person” may consent to or refuse care.⁵¹ This catch all provision might include persons such as day care providers, babysitters, teachers, coaches, or the like who have a temporary responsibility to watch over the patient. One might suppose that it includes operators of certain healthcare entities who are responsible for the patient’s care (e.g., a nursing home operator); however, this result would appear inconsistent with statutes that limit such persons’ ability to serve as surrogate decision makers.⁵²

7. Attending Physician or Dentist

If the patient “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 [medical] care,” then the attending physician or dentist may authorize or provide care or both as they deem appropriate.⁵³ In this case, the physician should document the emergent circumstances that triggered the physician’s authority, including the circumstances that prevented the physician from seeking authority from parents or other surrogates or the physician’s good faith efforts to obtain such authorized consent.

8. General Rules for Surrogates

Several principles apply to surrogate decision makers. First, surrogates may make healthcare decisions only if, and to the extent that, the patient is legally or mentally incompetent; statutory authority is inapplicable if the patient is competent and capable of making their own healthcare decisions under the standard set forth in Idaho Code section 39-4503.⁵⁴

Second, the known wishes or directives of a competent patient should trump the decisions of surrogates, and the surrogates should not act inconsistently with the known directives of a competent patient, including the patient’s refusal of treatment.⁵⁵

51. *Id.* § 39-4504(1)(f).

52. *See, e.g., id.* § 39-4510 (disqualifying treating healthcare providers, operators of community care facilities, and their non-relative employees from being designated as the agent in a DPOA).

53. *Id.* § 39-4504(1)(g); *see also id.* §§ 66-405(7) (2007) (regarding emergency treatment of a developmentally disabled patient if the guardian refuses to give consent), 56-1015 (Supp. 2007) (granting immunity from civil liability to healthcare providers who render treatment in emergency situations where they are unable to obtain the patient’s consent due to incapacity).

54. *Id.* § 39-4504(1) (Supp. 2007).

55. *See id.* (“[The surrogate consent statute] shall not be deemed to authorize any person to override the express refusal by a competent patient to give such consent himself . . .

Third, to be able to make healthcare decisions for another person, the proposed surrogate must be competent to make healthcare decisions, presumably under the standard set forth in Idaho Code section 39-4503.⁵⁶ Obviously, if a person is incompetent to make decisions for their own healthcare under Idaho Code section 39-4503, they should not be making healthcare decisions for others under Idaho Code section 39-4504.

Fourth, Idaho Code section 39-4504 lists surrogate decision makers in descending order of priority. If there is time, healthcare providers should make a reasonable effort to obtain consent or refusal from, and defer to the decisions of, those who are higher in the chain of priority.⁵⁷

Fifth, the statutory hierarchy is by no means perfect and may lead to counter-intuitive results. For example, under Idaho Code section 39-4504, the parents of an incompetent patient would appear to have higher priority than the patient's adult children. Similarly, relatives—perhaps distant relatives—of an incompetent patient probably take priority over the patient's stepparent or unmarried “significant other” who lived with and cared for the patient for years.⁵⁸ Nevertheless, the hierarchy establishes some order to practitioners' attempts to identify the proper surrogate decision makers. Patients may avoid problems simply by making their treatment wishes known in advance to their practitioner or by executing appropriate advance directives, for example, a living will/DPOA or physician orders for scope of treatment (POST).⁵⁹

Finally, surrogates who give or refuse consent in good faith consistent with the requirements of Idaho Code section 39-4504, and healthcare providers who rely in good faith on such consent, are generally immune from civil liability relevant to the surrogate's authority.⁶⁰ Surrogate decision makers—primarily parents or guardians—may still be liable for failing to consent to or for refusing necessary care in certain circumstances. For example, as explained below, parents, guardians, and other caretakers may be liable for neglect or abuse if they fail to provide for necessary medical care for children or vulnerable adults in their care.⁶¹

.”); *id.* §§ 39-4509(3) (“Any authentic expression of a [patient’s] wishes with respect to health care should be honored.”), 39-4510 (requiring DPOA agents to “make health care decisions that are consistent with [the principal’s] desires as . . . made known to [the] agent.”).

56. *See id.* §§ 16-2403(7), 39-4504(1)(f).

57. *See id.* § 56-1015.

58. *See id.* § 39-4504.

59. *See infra* Part IV.

60. § 39-4504(3).

61. *See infra* note 94 and accompanying text.

C. Information

It is not enough for a healthcare provider to obtain consent; to be valid, the consent must be informed, that is "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 patient receiving such care, as to permit the giving or withholding of such consent to be a reasonably informed decision."⁶²

In general, practitioners should inform the patient of (1) the need for treatment; (2) the nature of the treatment; (3) the reasonably probable benefits; (4) the significant risks, side effects, and potential consequences; (5) treatment alternatives, with their associated benefits and risks; and (6) the names of providers who will perform significant aspects of the treatment.⁶³ A few cases from other jurisdictions suggest that a practitioner must also disclose information about their own personal factors that might affect their ability to treat the patient (e.g., the practitioner's alcohol abuse or surgical success rate).⁶⁴ However, these cases appear to be unique and, at present, probably do not represent the law in Idaho, especially under the community standard described below. Professional associations, licensing agencies, accreditation bodies, professional liability insurers, or third party payors may require specific information to be included in informed consents.

In evaluating the sufficiency of the information provided, Idaho courts will apply an objective community standard test.

Any such consent shall be deemed valid and so informed if the physician or dentist 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 physician or dentist [or other like healthcare 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 such consent is given.⁶⁵

62. *Id.* § 39-4506 (Supp. 2007); *see also id.* §§ 16-2403(7) (regarding informed consent for minor's mental health treatment), 18-602(h), 18-604(7) (addressing informed consent for abortion); *Foster v. Traul (Foster II)*, No. 33537, 2007 WL 4472262, at *6 (Idaho Dec. 24, 2007) ("The doctrine of informed consent is the general principle of law that a physician has a duty to disclose to his patient those risks of injury which might result from a proposed course of treatment." (citing *Sherwood v. Carter*, 119 Idaho 246, 251, 805 P.2d 452, 457 (1991))).

63. *See* § 18-604(7); *see also Shabinaw v. Brown (Shabinaw II)*, 131 Idaho 747, 963 P.2d 1184 (1998) (addressing some of the information listed under Idaho Code section 18-604(7) that must be disclosed by practitioners).

64. *See, e.g., Hidding v. Williams*, 578 So. 2d 1192 (La. Ct. App. 1991).

65. § 39-4506.

Significantly, the standard depends on what a similarly situated practitioner in the community would have disclosed; it *does not* depend on what a particular patient would have liked to receive, or specific information that a patient claims would have affected his decision.⁶⁶ Applying the “community standard” test to the sufficiency of informed consent is appropriate and should accommodate differences in practitioner types and factual circumstances while avoiding complaints based on a patient’s subjective preferences. However, practitioners may take only guarded comfort in the standard because it is inherently prone to hindsight: when called into question, it is easy for a testifying expert to look back and conclude that omitted information should have been given. As a result, practitioners should remain familiar with the community norms for providing information for specific treatment, and, when in doubt, disclose more than less.

Courts from other jurisdictions have recognized the so-called “therapeutic privilege,” which allows healthcare providers to withhold information from the patient if the healthcare provider determines that doing so would be in the patient’s best interest.⁶⁷ The privilege is incorporated in the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, which allow healthcare providers to deny a patient access to his own protected health information if the provider determines that disclosing the information could result in substantial harm to the patient or others.⁶⁸ There does not appear to be any Idaho cases expressly adopting the therapeutic privilege, but the privilege would likely be encompassed by Idaho’s “community standard” test; if other like healthcare providers would not have disclosed the information, then the provider should not be liable for failing to disclose the same.⁶⁹ Nevertheless, given the significant risk that the decision will be second-guessed, practitioners should err on the side of full disclosure. In the rare case that relevant information is withheld, the practitioner should (1) confirm that non-disclosure is truly required for therapeutic reasons, and not simply because the practitioner fears that the patient will make a treatment decision with which the practitioner disagrees; (2) document the basis for the practitioner’s decision, including the practitioner’s observations of the patient, information that was and was not withheld, and specific reasons for withholding the information; and (3) consult with one or more other qualified healthcare providers to help ensure that withholding the information is consistent with the community standard and document the consultation.

66. *Sherwood v. Carter*, 119 Idaho 246, 256, 805 P.2d 452, 462 (1991).

67. *See, e.g., Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972) (holding that “a physician is armed with a privilege to keep . . . information from [a] patient” when disclosure would unnecessarily cause the patient a detriment).

68. *See* 45 C.F.R. § 164.524(a)(2)–(3) (2007).

69. *See* § 39-4506.

As suggested by the following chart, a consent form is not and cannot substitute for informed consent.

Informed consent = Communication	Consent form = Documentation
<ul style="list-style-type: none"> • Practitioner communicates information relevant to treatment. • Patient understands the material facts, including the benefits, risks, and likely consequences of the proposed treatment and alternatives. • Patient makes an informed decision, either to consent to or refuse care. 	<ul style="list-style-type: none"> • Supplements the oral or other information given by the practitioner. • Documents that the process of informed consent took place, for example, that the practitioner communicated relevant information to the patient and the patient made a voluntary, informed decision.

Informed consent is the result of effective communication of relevant facts between the healthcare provider and the patient or the patient's surrogate decision maker. A consent form may supplement the practitioner's oral communication and document that the communication occurred, but it should rarely be used in lieu of effective direct discussion between the practitioner and the patient. To ensure effective communication takes place, the practitioner should consider taking the following steps.

First, evaluate whether the patient is mentally and emotionally competent to process the information given. Although the patient may hear the words, stressors or distractions may inhibit the patient's ability to comprehend their meaning or apply them rationally to the patient's situation. In such situations, the practitioner may need to postpone the discussion until a more appropriate time.

Second, speak at the patient's level of understanding. "The [practitioner] must provide the information in terms which can be understood by the person making the decision, with consideration of age, level of maturity and intellectual capacity."⁷⁰ Most patients are not trained in the multi-syllabic medical or technical terminology or frequent acronyms employed by healthcare professionals. Some patients have only limited education or experience to utilize in processing the provider's information. In such cases, the practitioner may need to simplify or step down to the patient's level of understanding or supplement with pictures or other resources to ensure that the information given is understood.

70. *Id.* § 18-604(7) (Supp. 2007) (providing the definition of "informed consent" for abortions).

Third, beware of language barriers, for example, if the patient does not understand English or has a hearing or vision impairment. Federal and state laws generally prohibit discrimination against such persons and require most healthcare providers to take reasonable steps to accommodate non-English speaking or physically impaired patients.⁷¹ Depending on the provider's circumstances and the patient's limitations, the healthcare provider may need to communicate through a qualified interpreter, translate key documents, or employ other means to ensure effective communication.⁷² Healthcare providers often grumble about the cost of regulatory compliance; however, such actions are often necessary for effective communication, which in turn is essential to valid, informed consent and quality healthcare.

Fourth, supplement the oral communication with written or visual material and documentation. The written information may cover items that were overlooked or omitted during the oral communication, and will provide information the patient may review and consider without time constraints or distractions that may be present in oral communication. It will also help document that sufficient information was given.

Finally, give the patient an opportunity to ask questions and receive answers. This will not only ensure that the patient understands the treatment options with associated risks and benefits (thereby achieving truly informed consent) but may also provide the practitioner with information that may be relevant to treatment.

D. Voluntary

To be valid, informed consent must be voluntary; it may not be coerced, given under duress, or obtained by fraud.⁷³ The failure to provide material information may vitiate otherwise voluntary consent.⁷⁴ Although it is unlikely that a practitioner would ever knowingly force a patient into treatment against his will, practitioners must understand that many patients are intimidated by practitioners or circumstances or both. Unless a practitioner is sensitive to the circumstances—including the patient's mental state and the timing—a patient may later complain

71. See, e.g., Rehabilitation Act of 1973, 29 U.S.C. § 794 (2000 & Supp. 2005); Civil Rights Act of 1964, 42 U.S.C. § 2000d-2000d-7 (2000 & Supp. 2004); Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (2000 & Supp. 2004); Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (LEP Guidelines), 68 Fed. Reg. 47,311 (Dep't of Health & Hum. Servs. Aug. 8, 2003) (notice); Idaho Human Rights Act, IDAHO CODE ANN. §§ 67-5901-5912 (2006).

72. See LEP Guidelines, 68 Fed. Reg. 47,311.

73. IDAHO CODE ANN. § 39-4507 (Supp. 2007) (discussing informed consent for medical treatment generally); see also *id.* § 18-604(7) (requiring informed consent for abortions).

74. See *id.* § 39-4506 (requiring that a patient be "aware of pertinent facts").

that he was brow beaten into the treatment without adequate time to consider and decide.

E. Form of Consent

Idaho does not require any specific form for valid consents; valid consent may be oral, written, or implied.⁷⁵ Of course, written consents are easier to prove. Moreover, under Idaho law, written consents carry a statutory presumption that they are valid and sufficient:

[W]hen the giving of . . . consent is recited or documented in writing and expressly authorizes the care, treatment or procedures 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 care, treatment or procedures, and the advice and disclosures of the attending physician or dentist, as well as the level of informed awareness of the giver of such consent, shall be presumed to be sufficient.⁷⁶

The statutory presumption may be overcome by a showing of malice, fraud, duress, or failure to provide sufficient information.⁷⁷

Practitioners should identify and establish policies for securing written, informed consent from the patient or authorized surrogate decision maker. An initial, general consent should be obtained upon initiating care. The general consent should identify and cover basic treatment activities that may be employed (that is, physical exams, basic medications, diagnostic tests, laboratory or pathology tests, or the like). However, the general consent may not be sufficient for high-risk procedures or treatment methods that require specific, in-depth discussion and information to establish truly informed consent. Accordingly, specific, detailed consent should be obtained and documented for such treatment. Practitioners usually have detailed, pre-published consent forms that they utilize for specific types of procedures. These forms often contain relevant information and long lists of associated risks, side effects, and treatment alternatives. Although appropriate and helpful, practitioners should not rely on such forms alone to secure informed consent, and should periodically review the forms to ensure that they still reflect current knowledge and practices. Moreover, the physician should always

75. § 39-4507. *But see id.* § 16-2403(7) (stating that informed consent for a minor's mental health treatment must be "evidenced in writing").

76. *Id.* § 39-4507.

77. *Id.*; *see also* *Rook v. Trout*, 113 Idaho 652, 655, 747 P.2d 61, 64 (1987), *overruled on other grounds by* *Sherwood v. Carter*, 119 Idaho 246, 805 P.2d 452 (1991) (overruling portions of *Rook v. Trout* which held that Idaho's informed consent statute "merely provides alternative defenses to a claim of lack of informed consent, and which held that the statute provides for a subjective patient-based standard of disclosure for informed consent.").

document in the patient's medical record that the elements for valid consent have been obtained (that is, document the patient's competency or competency of the surrogate decision maker, note the discussion of the risks and benefits of the treatment, etc.).

Although a patient or surrogate decision maker may orally or impliedly consent in person or by phone, the practitioner should still document in the patient's chart that such informed consent was obtained if the treatment involves any significant risk. Practitioners may want to have another person (1) witness any oral discussion in which consent was obtained, especially if the patient or the surrogate is not able to complete a consent form then (2) document the consent in the patient's medical record or in a separate form.

F. Scope and Duration

Consent is generally limited to the specific procedure or course of treatment for which consent is given and any incidental, included procedures. Consent generally *does not* extend to additional or different procedures outside the scope of treatment to which consent was given.⁷⁸ A new consent or reaffirmation of the prior consent should be obtained if any of the facts relevant and material to the consent or refusal have changed, including: (1) changes that impact the risk, (2) changes in the method or treatment, (3) changes in whom will provide treatment, or (4) a significant lapse of time.

However, an exception to general consent rules applies if, in the course of treatment, a physician or other healthcare provider discovers a new condition that needs to be addressed, but the provider cannot reasonably obtain informed consent (that is, a surgeon discovers unanticipated, additional, emergent problems during surgery).⁷⁹ In those cases, the practitioner should be permitted to take appropriate steps to address the problem consistent with the patient's best interests and the prior direction from the patient or authorized decision maker.⁸⁰

G. Timing

Informed, voluntary consent generally requires sufficient time for the patient to consider and decide on his healthcare alternatives. Accordingly, if circumstances permit, the communication with the patient resulting in informed consent should take place sufficiently in advance of the treatment to enable the patient to deliberate, but not so far in advance that circumstances are likely change before the treatment. The consent discussion should be delayed if the patient is sedated, suffering

78. See, e.g., *Shannahan v. Gigray*, 131 Idaho 664, 962 P.2d 1048 (1998).

79. See *infra* Part V.B.

80. See IDAHO CODE ANN. §§ 39-4504(1)(g), 56-1015 (Supp. 2007).

from severe pain, or if there are other circumstances that might affect the patient's ability to make a voluntary, informed decision.⁸¹

H. Responsibility for Obtaining Consent

Informed consent should be obtained by the practitioner responsible for performing or supervising the treatment. "Obtaining consent for health care is the duty of the attending physician or dentist or of another physician or dentist acting on his or her behalf or actually providing the contemplated care, treatment or procedure"⁸² The treating practitioner has the education, training, and license necessary to diagnose the condition; evaluate the circumstances; explain relevant facts, potential results, and associated risks; and answer questions from the patient. Accordingly, the treating practitioner may be held accountable if he fails to obtain informed consent or to ensure that informed consent is obtained.

Although the treating practitioner has the responsibility to obtain informed consent, the practitioner may utilize others to assist in providing information or documenting the consent.

[A] licensed hospital and any medical or dental office employee . . . 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 patient.⁸³

It is common practice for healthcare providers to use such persons to help obtain and document informed consent; however, the ultimate duty still rests on the treating provider to ensure that informed consent is obtained. In *Foster v. Traul (Foster I)*, for example, the patient sued both a physician and a hospital for failing to obtain informed consent.⁸⁴ The Idaho Supreme Court affirmed dismissal of the claims against the hospital because, under Idaho Code section 39-4306 (the precursor to current section 39-4508), "the duty to inform and to disclose facts is not the duty of the hospital;" instead, it is the practitioner's duty.⁸⁵

Although Idaho places the duty to obtain informed consent on the treating practitioner, state and federal laws or regulations may require that other healthcare providers ensure that such consent is obtained or maintained in the patient charts. Per *Foster I*, the other provider may not be liable to the patient for failing to obtain consent, but they may still face licensing, accreditation, or payment problems if they fail to ensure that such documentation is maintained.

81. See, e.g., *Shabinaw v. Brown (Shabinaw II)*, 131 Idaho 747, 963 P.2d 1184 (1998) (alleging consent was invalid because patient was on Demerol at the time).

82. IDAHO CODE ANN. § 39-4508 (Supp. 2007).

83. *Id.*

84. 141 Idaho 890, 120 P.3d 278 (2005).

85. *Id.* at 894, 120 P.3d at 282.

I. Withdrawal or Revocation

A competent patient generally has the right to withdraw his consent or refuse further treatment at anytime.⁸⁶ Practitioners must address the patient's objections or questions that arise during the treatment to ensure that consent remains effective.

IV. REFUSAL OF TREATMENT

A. Patient's Right to Refuse Treatment

A competent patient's right to determine his own healthcare includes the right to refuse care or withdraw from care or both.⁸⁷ Absent a court order or statute to the contrary, other persons—including family members or healthcare providers—generally cannot override a competent patient's refusal of treatment.⁸⁸

As with informed consent, patients (or their surrogate decision makers) are entitled to sufficient information to make informed decisions to refuse consent; absent such information, practitioners may be liable for resulting damages. To protect themselves, practitioners should take appropriate steps to document a patient's refusal and, if appropriate, document that the action is taken "against medical advice." Thus, a practitioner should (1) inform the patient of the relevant facts and consequences of refusing treatment (essentially the same information that would be required for informed consent, as discussed above); (2) document in the chart the patient's competency, the practitioner's attempt to obtain the patient's informed consent (including the discussion of the risks and benefits associated with the refusal), and the patient's voluntary, informed refusal; and (3) obtain a written release from a competent patient or person authorized to refuse treatment on the patient's behalf. As with informed consent, a proper release form should (1) confirm that the practitioner has explained the risks and benefits of the treatment; (2) confirm that, notwithstanding the practitioner's efforts, the patient has knowingly and voluntarily refused the treatment against the practitioner's advice; and (3) be signed by the patient or by a person authorized to refuse treatment on behalf of the patient.⁸⁹

86. See IDAHO CODE ANN. § 39-4511 (Supp. 2007) (allowing patient to revoke advance directives at anytime).

87. See *id.* § 39-4502(6); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 270 (1990) ("The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."); 42 C.F.R. § 482.13(b) (2007).

88. § 39-4504(1).

89. See, e.g., 42 C.F.R. § 489.24(d)(3), (5) (2007) (documenting elements required if patient refuses treatment or transfer required under the Emergency Medical Treatment and Active Labor Act (EMTALA)).

If there is uncertainty as to whether the patient has refused treatment or is competent to refuse treatment, the practitioner should discuss the matter with those persons who are authorized to consent to treatment. If the patient's competency is in doubt, a practitioner would probably not face significant liability so long as he provides treatment that is in the best interests of the patient after obtaining consent from an authorized representative. Alternatively, the practitioner may seek court involvement, for example, a temporary injunction allowing the practitioner to take appropriate action or appointing a temporary guardian who will act in the best interests of the patient.⁹⁰

B. Surrogate's Authority to Refuse Treatment

In the case of incompetent patients, authorized surrogate decision makers generally have the right to refuse treatment,⁹¹ but that authority is subject to important limitations.

Parents and guardians generally must provide necessary medical care for children or vulnerable adults in their charge; failure to do so may constitute neglect.⁹² If a parent's or guardian's failure to provide or consent to care amounts to neglect, practitioners must report the circumstances to law enforcement or the Department of Health and Welfare (DHW).⁹³ In the case of a neglected child, law enforcement officers have the authority to remove the child from the home or dangerous situation and, if treatment is needed, authorize treatment for the child.⁹⁴ Healthcare providers are generally immune from civil liability if they make such reports in good faith; however, they may be liable if they make a report in bad faith, which may include overstating or misrepresenting the facts relevant to the determination of neglect or necessary treatment.⁹⁵

Although Idaho Code section 39-4504 allows competent surrogates to refuse care for incompetent persons, practitioners may feel ethically, if not legally, obligated to take appropriate action if such decision is not in the patient's best interests. Nevertheless, given the current state of the law, practitioners should be very careful about acting against an authorized surrogate decision maker's decision absent specific statutory authority or judicial support for the practitioner's action. Courts are willing to review such situations and, in many cases, authorize care if necessary for the incompetent person's best interests. On the other

90. Cf. IDAHO CODE ANN. § 16-1627 (Supp. 2007).

91. *Id.* § 39-4504(1).

92. For the laws on child neglect, see *id.* § 16-1602(25) (defining child neglect), and *id.* § 18-401(2) (2004) (criminal sanctions for child neglect). For the laws on vulnerable adult neglect, see *id.* § 39-5302(8) (2002) (defining vulnerable adult neglect), and *id.* § 18-1505 (Supp. 2007) (criminal sanctions for vulnerable adult neglect).

93. *Id.* §§ 16-1605 (Supp. 2007), 39-5303 (2002).

94. See *id.* § 16-1608 (Supp. 2007); see also *Mueller ex rel. Mueller v. Aufer*, No. CV-04-399-S-BLW, 2007 WL 627620 (D. Idaho Feb. 26, 2007).

95. §§ 16-1606-1607 (Supp. 2007), 39-5303(5)-(6).

hand, if the patient suffers from a terminal illness or is being sustained on artificial life support systems, greater deference is given to the parent's or guardian's decision to refuse or end treatment.⁹⁶

Idaho has established a process that allows practitioners or other interested persons to petition a court for an order authorizing medical or surgical care for a child if (1) "the parent, guardian or other custodian refuses or fails to consent" to care, and (2) "[a] physician informs the court orally or in writing that in his professional opinion, the life of the child would be greatly endangered without certain treatment."⁹⁷ If time allows and the child's life will not be jeopardized thereby, the court will grant the parent, guardian, or custodian an "informal hearing."⁹⁸ If there is no such time, the court may simply act on the information provided by the physician and orally authorize the physician or hospital to provide necessary care.⁹⁹

No physician or hospital nor any nurse, technician or other person under the direction of such physician or hospital shall be subject to criminal or civil liability for performance of care or treatment in reliance on the court's authorization, and any function performed thereunder shall be regarded as if it were performed with the child's and the parent's authorization.¹⁰⁰

This process provides quick and efficient means for obtaining the necessary consent for a child if the parent or guardian refuses; however, at present, there does not appear to be a similar process under Idaho law for obtaining authorization to provide urgent care to an incompetent adult. Presumably, the best option would be for the provider to report the situation pursuant to the vulnerable adult statutes, thereby involving the DHW.

Parents and guardians are not required to consent to care if doing so would violate the religious beliefs of the parents or the patient.¹⁰¹ Similarly, a parent's or guardian's decision to treat a child "by prayers through spiritual means alone in lieu of medical treatment" does not

96. See, e.g., *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633 (Mich. Ct. App. 1992); *In re Quinlan*, 355 A.2d 647 (N.J. 1976); cf. IDAHO CODE ANN. §§ 66-405(7) (2007) (implying that a practitioner must respect a refusal of treatment when the patient has a terminal condition or is facing imminent death), 39-4501-4515 (Supp. 2007).

97. IDAHO CODE ANN. § 16-1627(1)(b) (Supp. 2007). The process also applies if "[a] parent, legal guardian or custodian is not immediately available and cannot be found after reasonable effort" to provide consent. *Id.* § 16-1627(1)(a). However, in that situation, the emergency process for court approval would rarely be necessary because Idaho Code sections 39-4504(1)(g) and 56-1015 authorize healthcare providers to render emergency care. *Id.* §§ 39-4504(1)(g), 56-1015.

98. *Id.* § 16-1627(2).

99. *Id.* § 16-1627(5).

100. *Id.*

101. *Id.* § 39-4501(3).

constitute neglect so as to make the parent criminally liable.¹⁰² A court must consider the parents' or guardian's religious beliefs before authorizing necessary care pursuant to Idaho Code section 16-1627.¹⁰³ Despite the parents' religious beliefs, however, the state may still intervene in appropriate cases to protect the well-being of a child.¹⁰⁴ As the United States Supreme Court stated, "Parents may be free to become martyrs themselves. But [they cannot] make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."¹⁰⁵

Applying the foregoing principles in the heat of the moment may be difficult; however, the practical net effect of these principles for practitioners appears to be as follows:

First, parents or guardians generally have the right to refuse care that is not necessary for the child's well-being.¹⁰⁶ Practitioners should usually honor the parent's or guardian's wishes and should not provide care without statutory or judicial authorization.

Second, if a parent or guardian refuses necessary care, the practitioner should seek authorization from the government. If the refusal amounts to neglect and there is time, the practitioner should consider reporting the matter to law enforcement, Child Protective Services, or DHW and then let the appropriate government agency assume responsibility. In appropriate situations, the government may initiate shelter care proceedings and authorize the necessary care. Alternatively, the practitioner may petition the court directly for authorization to provide emergency treatment for a child pursuant to Idaho Code section 16-1627. In either event, the practitioner should be protected from liability so long as he acts in good faith and documents the bases for his decisions.

C. Developmentally Disabled Persons

Idaho law imposes additional protections for persons with developmental disabilities. If a guardian is appointed for a developmentally disabled person, physicians or caregivers may not "withhold or withdraw [necessary] treatment for a [developmentally disabled person] whose condition is not terminal or whose death is not imminent," as described below.¹⁰⁷ "If the physician . . . cannot obtain valid consent for medically necessary treatment from the guardian," the statute requires

102. *Id.* § 16-1602(25) (regarding the Child Protective Act); *see also id.* § 18-401(2) (2004) (regarding criminal liability for child desertion and nonsupport).

103. *Id.* § 16-1627(3).

104. *See id.* (requiring only that the court "take into consideration" the religious beliefs of the parent or guardian).

105. *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

106. *See* IDAHO CODE ANN. § 39-4504(1) (Supp. 2007).

107. *Id.* § 66-405(7) (2007).

the physician to “provide the medically necessary treatment without such consent.”¹⁰⁸

As for the guardian,

No guardian [of a developmentally disabled person] shall have the authority to refuse or withhold consent for medically necessary treatment when the effect of withholding such treatment would seriously endanger the life or health and well-being of the person with a developmental disability.¹⁰⁹

“[W]ithhold[ing] or attempt[ing] to withhold such treatment shall constitute neglect . . . and [justify] removal of the guardian.”¹¹⁰

Notwithstanding the foregoing, “a guardian . . . may consent to withholding or withdrawal of artificial life-sustaining procedures” for developmentally disabled persons when the developmentally disabled person has one of the following conditions:

(a) an incurable injury, disease, illness or condition, certified by [his] attending physician and at least one (1) other physician to be terminal such that the application of artificial life-sustaining procedures would not result in the possibility of saving or significantly prolonging the life of the respondent, and would only serve to prolong the moment of the respondent's death for a period of hours, days or weeks, and where both physicians certify that death is imminent, whether or not the life-sustaining procedures are used; or

(b) [a] diagnos[is] by [his] attending physician and at least one (1) other physician as being in a persistent vegetative state which is irreversible and from which the respondent will never regain consciousness.¹¹¹

It is not clear whether these limitations apply if no guardian has been appointed.

D. Disabled Infants (Baby Doe Regulations)

State and federal regulations also limit a parent's or guardian's ability to refuse care for infants with certain disabilities.¹¹² Hospitals and other healthcare providers who are obligated to report child neglect under Idaho Code section 16-1601 must report to the DHW if they be-

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.* § 66-405(8).

112. As part of the Child Abuse Prevention and Treatment Act, the federal government requires states to impose reporting requirements (Baby Doe Regulations) as a condition to obtaining certain federal funds. See Child Abuse and Neglect Prevention and Treatment, 45 C.F.R. § 1340.10–15 (2006).

come aware of any instances of “withholding of medically indicated treatment from disabled infants with life-threatening conditions.”¹¹³ Upon receipt of the report, DHW will initiate an investigation into the potential neglect of the child. The statute defines “withholding of medically indicated treatment” as:

The failure to respond to the infant’s life-threatening conditions by providing treatment, including appropriate nutrition, hydration and medication which, in the treating physician’s reasonable medical judgment, will most likely be effective in ameliorating or correcting all such conditions.¹¹⁴

However, the term does not apply to:

[T]he failure to provide treatment, other than appropriate nutrition, hydration, or medication, to an infant when, in the treating physician’s reasonable medical judgment, any of the following circumstances apply:

- i. The infant is chronically and irreversibly comatose; or
- ii. The provision of such treatment would merely prolong dying, would not be effective in ameliorating or correcting all of the infant’s life-threatening conditions, or would otherwise be futile in terms of the survival of the infant; or
- iii. The provision of such treatment would be virtually futile in terms of the survival of the infant, and the treatment itself under such circumstances would be inhumane.¹¹⁵

Thus, as a practical matter, the regulations may prevent parents or guardians from withholding necessary care for infants with disabilities unless the care would be futile or inhumane.

E. Euthanasia

Although competent people may refuse otherwise life-saving treatment, healthcare providers may not affirmatively take steps to help them end their life. Like most states, Idaho does not allow euthanasia, mercy killing, or assisted suicide.¹¹⁶

113. IDAHO ADMIN. CODE r. 16.06.05.020.01 (2007).

114. *Id.* r. 16.06.05.004.10(a).

115. *Id.* r. 16.06.05.004.10(b).

116. IDAHO CODE ANN. § 39-4514(2) (Supp. 2007) (replacing IDAHO CODE ANN. § 56-1022 (2002)) (“This chapter does not make legal, and in no way condones, euthanasia, mercy killing, or assisted suicide or permit an affirmative or deliberate act or omission to end life, other than to allow the natural process of dying.”); *see also id.* § 18-4014 (2004) (“Every person who, with intent to kill, administers or causes or procures to be administered, to another, any poison or other noxious or destructive substance or liquid, but by which death is not caused, is punishable by imprisonment in the state prison not less than ten (10) years, and the imprisonment may be extended to life.”).

V. ADVANCE DIRECTIVES

Patients are generally entitled to issue “advance directives” expressing their treatment preferences and directions if the patient becomes incompetent or incapacitated. The federal Patient Self-Determination Act requires hospitals and certain other healthcare facilities to advise patients of their rights under state law to consent to or refuse care and to execute advance directives.¹¹⁷ Hospitals must establish policies concerning advance directives and document them in the patient’s chart.¹¹⁸

Idaho law allows patients to execute the following advance directives. Importantly, these advance directives only apply if the patient is incompetent or otherwise unable to communicate his treatment wishes; they do not apply if the patient is otherwise competent and capable of making his own healthcare decisions.

A. Living Wills/Durable Power of Attorney

A living will is a document executed by the patient through which the patient may authorize or decline certain artificial life-saving treatment in the event that the patient becomes incompetent and has a terminal, irreversible condition.¹¹⁹

A durable power of attorney (DPOA) is a document through which the patient (principal) appoints someone (the agent) to make healthcare decisions for the principal if the principal becomes incompetent or is unable to communicate his treatment wishes.¹²⁰

In 2005, Idaho published a statutory form that combines a living will and a DPOA into one document.¹²¹ Patients are not required to use the statutory form, although there may be a greater chance that the living will/DPOA will be honored when the statutory form is used because practitioners will, presumably, be more familiar with the statutory form.¹²² Living wills/DPOAs may be executed by any competent adult.¹²³ Healthcare providers are generally immune from liability for providing care consistent with the living will/DPOA.¹²⁴

117. See 42 U.S.C. § 1395cc(f) (Supp. 2004); 42 C.F.R. § 482.13(a)(1), (b)(3) (2007).

118. 42 C.F.R. § 482.13(b)(3).

119. See IDAHO CODE ANN. § 39-4510 (Supp. 2007).

120. *Id.*

121. Medical Consent and Natural Death Act, ch. 120, § 2, 2005 Idaho Sess. Laws 380, 384–89 (codified as amended at IDAHO CODE ANN. § 39-4510 (Supp. 2007)).

122. § 39-4510.

123. *Id.*

124. *Id.* § 39-4513(1).

B. Physician Order for Scope of Treatment (POST)

In 2007, Idaho authorized a new form of advance directive, the physician order for scope of treatment (POST).¹²⁵ The POST was intended to replace “do not resuscitate” (DNR) orders and Idaho’s “comfort ONE/DNR”¹²⁶ program as the standard physician order directing the use of artificial life-sustaining healthcare such as CPR if the patient is incompetent or unable to communicate his treatment wishes.¹²⁷ The POST is a standardized form prepared by and available through the DHW.¹²⁸ Any competent adult patient (or, if the patient is incompetent, his personal representative) may have a POST form executed by the patient’s physician.¹²⁹ Upon the patient’s request, the attending physician must give the patient a POST form, discuss its ramifications, and help the patient complete the form.¹³⁰ The physician has an ongoing responsibility to review and update the form.¹³¹

Unlike DNRs or comfort ONEs, the POST is portable and valid in any healthcare setting.¹³² In general, all healthcare providers must accept and comply with a properly executed POST; providers may not require additional or alternative forms before honoring the patient’s wishes expressed in the POST.¹³³

Healthcare providers and emergency medical services personnel may disregard the POST form or a POST identification device:

- (a) If they believe in good faith that the order has been revoked; or
- (b) To avoid oral or physical confrontation; or
- (c) If ordered to do so by the attending physician.¹³⁴

Nothing in the POST statute requires a healthcare provider to pursue treatment considered medically inappropriate or futile.¹³⁵ If a provider cannot or is unwilling to honor the POST directives due to ethical or professional reasons, the provider should make a good faith effort to assist the patient in transferring the patient’s care to another provider before withdrawing from the case.¹³⁶

125. *See id.* §§ 39-4512A–4515.

126. *See generally* IDAHO DEPT OF HEALTH & WELFARE, COMFORT-ONE: DO NOT RESUSCITATE (DNR), http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/DNR_Brochure.pdf (last visited Feb. 19, 2008).

127. *See id.* § 39-4512B(2).

128. *Id.* § 39-4512A(6).

129. *Id.* § 39-4512A.

130. *Id.* § 39-4512A(3).

131. *Id.* § 39-4512A(4).

132. *Id.* § 39-4514(8).

133. *Id.*

134. *Id.* § 39-4513(5).

135. *Id.* § 39-4514(5).

136. *Id.* § 39-4513(2).

According to the statute, if there is a conflict between the POST and the patient's expressed directives, the directions of a personal representative, or the directions of the person identified in a DPOA, the POST controls.¹³⁷ This section is a bit curious in that the POST purportedly trumps the patient's expressed directives; however, as a general rule, healthcare providers should always follow a competent patient's expressed directives.¹³⁸ Idaho Code section 39-4509(3) expressly states that healthcare directives, including a POST, "shall [not] impair or supersede any legal right . . . which a person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. Any authentic expression of a person's wishes with respect to healthcare should be honored."¹³⁹ As a practical matter, a patient's subsequent directives (whether oral or otherwise) that conflict with the POST should be construed as a revocation of the POST, thereby enabling the healthcare professional to comply with a competent patient's subsequent wishes.¹⁴⁰ As with a living will and DPOA, the maker of a POST may revoke it at anytime by expressing his intent verbally, in writing, or by destroying the form.¹⁴¹

Healthcare providers are generally immune from liability for actions taken in reliance on what appears to be a facially valid POST.¹⁴² Similarly, providers are generally immune from liability for failing to act on a revocation unless the provider had actual knowledge of the revocation.¹⁴³

C. "Do Not Resuscitate" Orders and Other Advance Directives

Like the POST, DNRs are orders written by physicians directing how the patient's care is to be handled if the patient otherwise requires life-sustaining care and the patient is unable to communicate his wishes. Because the POST was intended to replace DNRs in Idaho, the Idaho Legislature repealed Idaho's former DNR statute when the new POST law was enacted.¹⁴⁴ The POST law expressly states that DNRs issued before July 1, 2007—the date the POST law took effect—are still valid so long as they complied with the former law when executed.¹⁴⁵ Similarly, directives from other states are valid in Idaho so long as they "substantially comply" with Idaho's POST requirements.¹⁴⁶

137. *Id.* § 39-4512A(2).

138. *See id.* §§ 39-4503–4504(1).

139. *Id.* § 39-4509(3).

140. *See id.* § 39-4511(1).

141. *Id.*

142. *Id.* §§ 39-4511(3), 39-4513.

143. *Id.* § 39-4511(3).

144. Act of Mar. 27, 2007, ch. 196, § 18, 2007 Idaho Sess. Laws 579, 594 (repealing IDAHO CODE ANN. § 56-1020 (2002)).

145. IDAHO CODE ANN. § 39-4514(6) (Supp. 2007).

146. *Id.*

Given the repeal of the DNR statute, the status of DNRs executed after July 1, 2007 is somewhat uncertain; however, the better argument is that DNRs (and other advance directives) may still be executed, so long as a provider does not require a DNR in addition to or in lieu of a POST. Idaho Code section 39-4509 states that “the laws of [Idaho] shall recognize the right of a competent person to have his or her wishes for medical treatment and for the withdrawal of artificial life-sustaining procedures carried out even though that person is no longer able to communicate with the physician.”¹⁴⁷ Furthermore, the legislature declared that living wills/DPOAs and POSTs *are not*:

the only effective means of such communication, and nothing in [the general consent statute], shall impair or supersede any legal right or legal responsibility which a person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. *Any authentic expression of a person's wishes with respect to health care should be honored.*¹⁴⁸

This language appears to authorize not only DNRs, but any other advance directive that constitutes the “authentic expression” of a person’s wishes, whether or not it complies with the technical requirements for living wills/DPOAs or POSTs.

D. Declarations for Mental Health Treatment

Idaho law also allows a competent adult to make a declaration containing his directives for certain types of mental health treatment and to designate an agent to make mental health decisions.¹⁴⁹ The declaration is the mental health equivalent of a living will/DPOA. The declaration becomes effective only if the patient becomes incompetent as declared by “a court, two (2) physicians that include a psychiatrist, or a physician and a professional mental health clinician.”¹⁵⁰

VI. EXCEPTIONAL AND PROBLEM CASES

So far, this article has discussed general principles and statutes governing informed consent or refusal of treatment; however, there are always exceptions. The following summarizes rules that may apply in exceptional cases.

A. Minors

Under Idaho law, persons under age eighteen (minors) generally lack the maturity and legal capacity to consent to or refuse their own

147. *Id.* § 39-4509(2).

148. *Id.* § 39-4509(3) (emphasis added).

149. *Id.* §§ 66-601–613 (2007).

150. *Id.* § 66-613(1).

healthcare, and therefore consent must be obtained from an authorized surrogate decision maker.¹⁵¹ There are exceptions to the general rule, however.

1. Emancipation

Minors may consent to their own care if they are emancipated.¹⁵² Although there are no Idaho cases or statutes defining “emancipation” in the context of medical consent, minors will likely be deemed emancipated under Idaho law and authorized to consent to their own care in the following circumstances:

- A court has entered an order that declares the minor to be emancipated;¹⁵³
- The minor is married or has been married, even if the minor is no longer married;¹⁵⁴
- The minor has rejected the parent-child relationship, is living on his own, and is self-supporting. For example, the minor has his own job, pays his own bills, etc.;¹⁵⁵ or
- The minor is serving in the armed forces.¹⁵⁶

Contrary to common belief, pregnancy does not appear to be an emancipating event under Idaho law. Accordingly, Idaho’s abortion statute generally requires parental consent before an abortion may be performed on a minor unless certain emergency or judicial bypass conditions are satisfied.¹⁵⁷ Idaho Code section 18-609A uses the term “pregnant unemancipated minor.”¹⁵⁸ The legislature’s conclusions with regard to the abortion statute would presumably apply to other healthcare decisions; thus, it would appear that pregnant minors generally lack capacity to consent to their own care unless another statute or exception provides otherwise.

151. *Id.* § 39-4504 (Supp. 2007); *see also id.* §§ 18-604(9), 18-609A, 39-4509(4); *cf. id.* §§ 32-101 (2006), 15-1-201(29) (Supp. 2007).

152. *See id.* §§ 16-2403(1), 39-4509(4).

153. *See id.* § 16-2403(1).

154. *Id.* § 18-604(3); *see also id.* §§ 32-101(3) (2006), 66-402(6) (2007), 15-1-201(15), 16-2403(1).

155. *See id.* § 66-402(6). For cases addressing emancipation for child support purposes, *see Ireland v. Ireland*, 123 Idaho 955, 855 P.2d 40 (1993), and *Embree v. Embree*, 85 Idaho 443, 380 P.2d 216 (1963).

156. *See* § 18-604(3); *Embree*, 85 Idaho at 448, 380 P.2d at 219 (“[A] mother cannot compel payments of support money for children whose dependency upon her has ceased by reason of . . . service in the Armed Forces of the United States” (quoting *Ditmar v. Ditmar*, 293 P.2d 759, 760 (Wash. 1956))); *Swenson v. Swenson*, 227 S.W.2d 103 (Mo. Ct. App. 1950).

157. IDAHO CODE ANN. § 18-609A (Supp. 2007)

158. *Id.*

Parenthood is more problematic (in more ways than one). Idaho Code section 39-4504 expressly allows parents to make decisions for minor children; it does not expressly exclude parents who are also minors.¹⁵⁹ This would appear to be consistent with other statutes, such as Idaho Code section 16-1504(6), which allows a minor parent to consent to his or her own child's adoption.¹⁶⁰ If a minor parent may consent to his or her child's adoption, one would assume that he or she may also consent to his or her child's healthcare. And if a minor parent may consent to his or her child's healthcare under Idaho Code section 39-4504, then the minor parent should be able to consent to the minor parent's own healthcare. Nevertheless, as discussed above, Idaho Code section 39-4504 probably only applies to surrogates (including parents) who are themselves competent, that is, they have sufficient intelligence and awareness to understand and appreciate the consequences of their decision.¹⁶¹ Until the statutes are amended or the seeming contradictions are resolved by a court, practitioners are probably justified in deferring to the decisions of the minor parent so long as the minor parent satisfies the competency standard set forth in Idaho Code section 39-4503.

2. Statutes Granting Minors Authority to Consent

Certain statutes allow minors to consent to their own care or otherwise protect practitioners who treat minors without parental consent. For example:

- According to the Interpretive Guidelines issued by the Center for Medicare and Medicaid Services (CMS), the Emergency Medical Treatment and Active Labor Act (EMTALA) allows minors to consent to their own emergency medical screening examination and, if an emergency condition is detected, stabilizing treatment by hospitals.¹⁶²
- Physicians and certain other licensed practitioners may provide "examinations, prescriptions, devices, and informational materials" regarding contraception if the physician deems the patient to have sufficient intelligence and maturity to understand the nature and significance of the treatment.¹⁶³
- Minors age fourteen or older may consent to their own testing or treatment for certain infectious or communicable

159. *See id.* § 39-4504(1)(d).

160. *Id.* § 16-1504(6).

161. *See id.* § 39-4503.

162. CTRS. FOR MEDICARE & MEDICAID SERVS. (DEP'T OF HEALTH & HUMAN SERVS.), INTERPRETIVE GUIDELINES—RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES § 489.24(a) (2004), available at http://www.cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pdf [hereinafter INTERPRETIVE GUIDELINES].

163. IDAHO CODE ANN. § 18-603 (2004).

diseases.¹⁶⁴ Parents are not liable for payment of such care given without the parent's consent.¹⁶⁵

- Minors age fourteen or older may consent to their own hospitalization for observation, diagnosis, evaluation, and treatment for their own mental condition.¹⁶⁶ The treating facility must notify the parents.¹⁶⁷
- Minors may consent to their own drug treatment or rehabilitation.¹⁶⁸ If the minor is age sixteen or older, the practitioner shall not notify the parents without the minor's consent.¹⁶⁹
- Minors age seventeen or older may consent to donate blood in a voluntary, noncompensatory blood program.¹⁷⁰

3. Mature Minor Doctrine

In many states, minors may consent to their own care if they have sufficient maturity and understanding to appreciate the consequences of their healthcare decisions.¹⁷¹ This "mature minor" doctrine is premised on the fundamental right of mentally competent persons to make their own healthcare decisions and the recognition that a person's eighteenth birthday is a relatively arbitrary date on which to base a person's competency to make such decisions.¹⁷²

It is not clear whether Idaho will adopt the mature minor doctrine; however, a strong argument exists that it applies in Idaho. First, Idaho's

164. *Id.* § 39-3801 (2002); *see also* IDAHO ADMIN. CODE r. 16.02.10.015.11(c) (2007).

165. IDAHO CODE ANN. § 39-3801.

166. *Id.* § 66-318(1)(b) (2007).

167. *Id.*

168. *Id.* § 37-3102 (2002).

169. *Id.*

170. *Id.* § 39-3701.

171. *See, e.g.*, *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337-38 (Kan. 1970); *Bishop v. Shurly*, 211 N.W. 75 (Mich. 1926); *Bakker v. Welsh*, 108 N.W. 94 (Mich. 1906); *Lacey v. Laird*, 139 N.E.2d 25 (Ohio 1956); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 837 n.12 (W. Va. 1992); *see also Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941) (declining to apply doctrine to particular facts and thus impliedly agreeing with the premise that the doctrine exists). *But see Novak v. Cobb County-Kennestone Hosp. Auth.*, 849 F. Supp. 1559 (N.D. Ga. 1994) (finding by negative implication that Georgia does not recognize the mature minor exception because, under Georgia's consent statute, the general rule is that a minor's consent is not effective and the mature minor exception is not among the several explicit statutory exceptions to this rule).

172. *See Belcher*, 422 S.E.2d at 837 n.12 ("It has been observed: 'Children today are more 'streetwise' and knowledgeable than children were even a few decades ago. Some children of very tender years exposed to continuous types of care are able to give or refuse consent. They may be far more skilled at discussing the pros and cons, the risks and benefits of bone marrow transplants or chemotherapy than a first-year medical student.'" (quoting FAY A. ROZOVSKY, CONSENT TO TREATMENT § 5.2.2, at 265 (2d ed. 1990))).

general consent statute, Idaho Code section 39-4503, states that “[a]ny person of ordinary intelligence and awareness sufficient for him or her generally to comprehend the need for, the nature of and the significant risks ordinarily inherent in, any contemplated [medical] treatment or procedure” may consent to his own care.¹⁷³ Significantly, the statute does not limit the statute’s application to any *adult* person.¹⁷⁴

Second, draft legislation was submitted in 2006 and 2007 that would have limited Idaho Code section 39-4503 to any “any adult person,” but the proposed amendment was rejected at the urging of health-care provider organizations who recognized the logic of the mature minor doctrine. Although Idaho Code section 39-4509 was amended to define “competent person” as “any emancipated minor or person eighteen (18) or more years of age who is of sound mind,” that definition was expressly limited to the statutes dealing with advance directives, not the general consent rules found in Idaho Code sections 39-4503 and 39-4504.¹⁷⁵ The legislature’s repeated rejection of the proposed change suggests that Idaho Code section 39-4503 codifies the mature minor doctrine.

Third, the mature minor doctrine is consistent with Idaho Code section 39-4503 as well as other Idaho laws. For example, Idaho Code section 18-603 allows certain practitioners to “provide examinations, prescriptions, devices and informational material” regarding contraception if the physician deems the patient to have sufficient intelligence and maturity to understand the nature and significance of the treatment.¹⁷⁶ Likewise, Idaho Code section 18-609A(2)(a) allows a judge to authorize a minor’s abortion if he determines that “[t]he pregnant minor is mature and capable of giving informed consent to the proposed abortion.”¹⁷⁷

Despite the foregoing, the fact remains that Idaho Code section 39-4504 still lists those who may make decisions for a “minor or incompetent person.”¹⁷⁸ Based on this language, a court might still conclude that Idaho Code section 39-4504 prevents minors from consenting to their own care unless another statute expressly authorizes such consent. Accordingly, practitioners should generally require parental consent in the case of unemancipated minors unless a statute expressly grants the minor the authority to consent on his own behalf. If a practitioner decides to rely on Idaho Code section 39-4503 and the mature minor doctrine to allow minors to consent to their own care, the practitioner is doing so at his own risk. At the very least, the practitioner should carefully consider and document appropriate factors relevant to his decision,

173. IDAHO CODE ANN. § 39-4503 (Supp. 2007) (emphasis added).

174. *See id.*

175. *Id.* § 39-4509 (stating that the definition of “competent person” in Idaho Code section 39-4509(4) is solely “[f]or purposes of sections 39-4509 through 39-4515”).

176. IDAHO CODE ANN. § 18-603 (2004).

177. *Id.* § 18-609A(2)(a) (Supp. 2007).

178. *Id.* § 39-4504.

including: (1) the age of the minor, because the decision is more easily justified if the minor is close to age eighteen; (2) the intelligence, awareness, understanding, and maturity of the minor; and (3) the nature of the care or treatment, because there is less risk to the provider and a minor may more easily understand the consequences associated with routine, low-risk procedures than with a serious, high-risk procedure.

The decision to allow minors to consent to their own healthcare may have unexpected side effects. In such cases, for example, HIPAA may preclude practitioners from disclosing information to the minor's parents without the minor's consent, or at the very least, without giving the minor patient the chance to object to such disclosure.¹⁷⁹ This may also make it more difficult to collect for the care rendered to the minor (especially if the care is not necessary) since minors generally lack the capacity to enter into binding contracts.

B. Emergencies

In emergency situations involving incapacitated patients, healthcare providers may not have time to obtain consent from an authorized representative. Accordingly, Idaho authorizes certain healthcare providers (namely physicians, dentists, hospitals, and emergency responders) to treat a patient if (1) the practitioner determines that there is a substantial likelihood that the patient's life or health may be seriously endangered without immediate treatment, that is, the patient faces a medical emergency; (2) neither the patient nor any other authorized person is readily available or competent to give consent; and (3) the practitioner acts in good faith without knowledge of facts suggesting that consent would be contrary to a competent patient's directions, for example, a do not resuscitate (DNR) order.¹⁸⁰ Idaho law protects physicians, hospitals, and certain emergency services personnel who render such care without consent:

No [emergency services personnel], or physician or hospital licensed in this state shall be subject to civil liability, based solely upon failure to obtain consent in rendering emergency medical, surgical, hospital or health services to any individual regardless of age where that individual is unable to give this consent for any reason and there is no other person reasonably available who is legally authorized to consent to the providing of such care, provided, however, that such person, physician, or hospital has acted in good faith and without knowledge of facts negating consent.¹⁸¹

179. See 45 C.F.R. §§ 164.504(g)(2), 164.510 (2007).

180. See IDAHO CODE ANN. §§ 39-4504, 56-1015 (Supp. 2007).

181. § 56-1015.

EMTALA provides authority on a federal level. If an individual presents at a hospital with an emergency department and requests examination or treatment of a medical condition, then EMTALA generally requires that the hospital provide an emergency medical screening examination to determine if the patient has an emergency medical condition.¹⁸² If the screening exam reveals an emergency medical condition, the hospital must either provide stabilizing treatment within the hospital's capability or transfer the patient to another facility.¹⁸³ EMTALA does not expressly preempt or negate state law requirements for informed consent. To the contrary, EMTALA is limited to situations in which a request is made for the patient's care or such consent may be inferred.¹⁸⁴ EMTALA recognizes the individual's right to refuse care and excuses healthcare providers from compliance if such refusal is documented so long as the healthcare provider gives certain information to the patient so as to allow the patient to make an informed decision.¹⁸⁵ Nevertheless, the statute probably excuses healthcare providers from obtaining consent from a surrogate decision maker before initiating emergency treatment.¹⁸⁶

An emergency situation does not give a healthcare provider *carte blanche*, however. The statutory authority would appear to be limited to the treatment necessary to address and resolve the emergency condition. Accordingly, practitioners should not provide treatment beyond the scope of the emergency and should seek consent from a surrogate decision maker as soon as reasonably possible. To protect themselves, practitioners should (1) document the existence and nature of the emergency (for example, the absence of immediate treatment would result in a serious threat to the person's health);¹⁸⁷ (2) document the practitioner's efforts to obtain consent from a person authorized to give consent, or note the circumstances that prevented the practitioner from obtaining such consent;¹⁸⁸ and (3) take reasonable steps to ensure there is no advance directive relevant to the emergency care (e.g., a living will, POST, DNR, or comfort One identification).

Health care providers and emergency medical services personnel shall make reasonable efforts to inquire as to whether the patient has completed a [POST] form and inspect the patient for a POST identification device when presented with a situation calling for artificial life-sustaining treatment not caused by severe

182. 42 U.S.C. § 1395dd(a) (2000 & Supp. 2004); 42 C.F.R. § 489.24(a)(1)(i) (2006).

183. 42 U.S.C. § 1395dd(a); 42 C.F.R. § 489.24(a)(1)(i).

184. See 42 C.F.R. § 489.24.

185. *Id.* § 489.24(d)(3).

186. See, e.g., INTERPRETIVE GUIDELINES, *supra* note 166.

187. IDAHO CODE ANN. § 39-4504 (Supp. 2007); see also *id.* § 16-2403(6) (defining "emergency" in mental health cases); 42 U.S.C. § 1395dd(e)(1) (2000 & Supp. 2004) (defining "emergency medical condition" for purposes of EMTALA).

188. § 39-4504 (Supp. 2007).

trauma or involving mass casualties and with no indication of homicide or suicide.¹⁸⁹

C. Involuntary Mental Health Treatment

Under certain circumstances, healthcare providers may involuntarily detain and treat patients who may be suffering from mental illness or emotional disturbance.

1. Twenty-Four-Hour “Mental Holds”

A physician who is a medical staff member of a hospital may, on behalf of the hospital, detain a person against the person’s will for observation, diagnosis, evaluation, care, or treatment of mental illness if:

the person presented or was brought to [the hospital] to receive medical or mental health care [and the] physician . . . has reason to believe that the person is gravely disabled due to mental illness or the person’s continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm.¹⁹⁰

The purpose of the detention is to hold and protect the person (and, perhaps, to protect the public) while a judicial proceeding is initiated to determine whether the patient should be hospitalized for mental illness.¹⁹¹ Within that twenty-four-hour period, the court may issue an order extending the time to hold the person while a mental health examination is conducted and, if appropriate, a commitment hearing takes place.¹⁹² If the court fails to issue the temporary order, the hospital’s authority to hold the patient expires and the hospital must release the patient or obtain consent from an authorized decision maker to continue caring for the individual.¹⁹³ Physicians who act in good faith consistent with the requirements of the statute and without gross negligence are immune from civil liability.¹⁹⁴

Significantly, the statute only applies to hospitalization for mental healthcare; if the patient requires medical care, then the general rules

189. *Id.* § 39-4512C.

190. *Id.* § 66-326(1) (2007). “Gravely disabled” is defined as “a person who, as the result of mental illness, is in danger of serious physical harm due to the person’s inability to provide for any of his basic needs for nourishment, or essential medical care, or shelter or safety.” *Id.* § 66-317(13). “Mentally ill” is defined as “a person, who as a result of a substantial disorder of thought, mood, perception, orientation, or memory, which grossly impairs judgment, behavior, capacity to recognize and adapt to reality, requires care and treatment at a facility.” *Id.* § 66-317(12).

191. *Id.* § 66-326(1).

192. *See id.* § 66-326.

193. *See id.*

194. *Id.* § 66-341.

for medical consent as set forth in Idaho Code sections 39-4501 to 39-4515 should be followed, including the standards for determining the patient's capacity to give valid consent for medical care¹⁹⁵ and the authority for others to consent on behalf of incompetent patients.¹⁹⁶

The "mental hold" laws only apply to persons who are mentally ill. They do not apply or allow detention of an individual who:

(1) has epilepsy, a developmental disability, a physical disability, mental retardation, is impaired by chronic alcoholism or drug abuse, or aged, unless in addition to such condition, such person is mentally ill;

(2) is a patient under treatment by spiritual means alone, through prayer, in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof and who asserts to any authority attempting to detain him that he is under such treatment and who gives the name of a practitioner so treating him to such authority; or

(3) can be properly cared for privately with the help of willing and able family and friends, and provided, that such person may be detained or involuntarily admitted if such person is mentally ill and presents a substantial risk of injury to himself or others if allowed to remain at liberty.¹⁹⁷

2. Seventy-Two-Hour Administrative Holds

Administrators in mental health facilities may place patients who seek to leave the facility on an involuntary seventy-two-hour administrative hold while an appropriate examination is conducted to determine if commitment proceedings should be initiated.¹⁹⁸ In general, to initiate the seventy-two-hour administrative hold (1) the hospital must be licensed or otherwise in a position to admit patients for voluntary mental healthcare (e.g., be a psychiatric hospital),¹⁹⁹ (2) the hospital must have actually admitted the patient as a voluntary patient under Idaho Code section 66-318, and (3) the patient must request to leave the facility.²⁰⁰

3. Emergency Mental Health Treatment for Minors

Idaho allows a peace officer to take a child into protective custody and transport him to a treatment facility for emergency evaluation and

195. *See id.* § 39-4503 (Supp. 2007).

196. *See id.* § 39-4504.

197. *Id.* § 66-329(l) (2007).

198. *Id.* § 66-320(a)(3).

199. *See id.* § 66-317(7).

200. *Id.* § 66-320(a).

care if (1) the officer determines that an emergency²⁰¹ mental health situation exists, (2) the officer has probable cause to believe that the child “is suffering from serious emotional disturbance as a result of which he is likely to cause harm to himself or others or is manifestly unable to preserve his health or safety with the supports and assistance available to him,” and (3) “immediate detention and treatment is necessary to prevent harm to the child or others.”²⁰² “[T]he treatment facility may administer necessary medications or other treatment, except electroconvulsive treatments, to a child, consistent with good medical practice without the [parents’] informed consent . . . if it is not possible to obtain such consent.”²⁰³ Such treatment must be for the child’s emotional disturbance; consent for medical or surgical care must be obtained by the normal consent process.²⁰⁴

D. Abortions

Idaho recently amended its abortion statute after portions were deemed unconstitutional by federal courts.²⁰⁵ Under Idaho’s current abortion statute, Idaho Code sections 18-601 to 18-615, physicians must obtain informed consent from the pregnant patient, or, in the case of incompetent patients, from a person authorized to give consent for medical or surgical care.²⁰⁶ In the case of unemancipated minors, the physician must also obtain the consent of one of the minor’s parents or the minor’s guardian or conservator,²⁰⁷ unless (1) the minor obtains authorization from a court to have the abortion,²⁰⁸ (2) the minor certifies that pregnancy resulted from rape or incest,²⁰⁹ or (3) there is no time to obtain parental consent or a court order because of a medical emergency.²¹⁰ A court may authorize an abortion without parental or guardian consent if it determines that (1) the pregnant minor is mature and

201. “Emergency” is defined as:

a situation in which the child’s condition, as evidenced by recent behavior, poses a significant threat to the health or safety of the child, his family or others, or poses a serious risk of substantial deterioration in the child’s condition which cannot be eliminated by the use of supportive services or intervention by the child’s parents, or mental health professionals, and treatment in the community while the child remains in his family home.

Id. § 16-2403(6) (Supp. 2007).

202. *Id.* § 16-2411(1) (2001).

203. *Id.* § 16-2423(1) (Supp. 2007).

204. *Id.* § 16-2423(4).

205. See *Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908 (9th Cir. 2004).

206. IDAHO CODE ANN. § 18-609(1), (5) (Supp. 2007).

207. *Id.* § 18-609A(1).

208. *Id.* § 18-609A(2).

209. *Id.* § 18-609A(7)(a).

210. *Id.* § 18-609A(7)(b).

capable of giving informed consent to the proposed abortion,²¹¹ or (2) the abortion would be in her best interest.²¹² A pregnant woman may refuse an abortion regardless of her age or competence, and such refusal trumps any surrogate consent that may have otherwise been given.²¹³ Physicians and others who violate the detailed abortion laws may face professional, civil, and criminal sanctions.²¹⁴

E. Sterilization

Traditionally, a married person could not undergo sterilization procedures without his or her spouse's consent.²¹⁵ Under Idaho law, however, a competent patient may consent to his or her own sterilization; spousal consent is not required.²¹⁶ If the patient is incompetent, the court must authorize sterilization following a hearing.²¹⁷ The judicial process does not apply if sterilization is the result of an otherwise therapeutic procedure.²¹⁸

F. Tests Requested by the Court or Law Enforcement

As a general rule, law enforcement officers do not have authority to compel tests or treatment by healthcare providers—they cannot compel a patient to undergo certain tests, and they cannot compel a healthcare provider to perform such tests or treatment.²¹⁹ In most cases, providers should decline to perform tests or treat patients unless the patient consents and cooperates. There are limited exceptions, however.

By statute, persons who drive or are in physical control of an automobile in Idaho are deemed to have consented to evidentiary testing for intoxication (e.g., blood tests, urine tests, saliva tests, etc.).²²⁰ If requested by a police officer, certain qualified providers²²¹ may draw blood for evidentiary testing even though the driver objects. Importantly,

211. *Id.* § 18-609A(2)(a).

212. *Id.* § 18-609A(2)(b).

213. *Id.* § 18-610 (2004).

214. *Id.* §§ 18-606 (2004), 18-605 (Supp. 2007).

215. *Cf.* *Ponter v. Ponter*, 342 A.2d 574 (N.J. Super. Ct. Ch. Div. 1975) (recognizing that, although many physicians require spousal consent to sterilization procedures, many state statutes requiring the same have been invalidated and thus New Jersey will not require spousal consent).

216. *See* IDAHO CODE ANN. § 39-4503 (Supp. 2007).

217. *Id.* §§ 39-3901–3904.

218. *Id.* § 39-3914 (“Nothing in this chapter shall be construed so as to prevent sterilization of persons subject to this chapter as part of emergency medical treatment or the voluntary sterilization of a person competent to give his or her consent.”).

219. *See id.* § 39-4502(6) (“Consent to care’ includes refusal to consent to care and/or withdrawal of care.”).

220. *Id.* § 18-8002(1) (Supp. 2007).

221. *Id.* § 18-8003(1) (2004). The statute only applies to “a licensed physician, qualified medical technologist, registered nurse, phlebotomist trained in a licensed hospital or educational institution or other medical personnel trained in a licensed hospital or educational institution.” *Id.*

while the statute *allows* the specified providers to draw the blood, it *does not require* that a provider do so.²²² As a practical matter, most providers will decline to perform the test out of a legitimate concern for the safety of the patient and the provider if the patient objects or refuses to cooperate in the testing. A practitioner who agrees to perform the test is immune from civil or criminal liability relating to the test, unless the practitioner fails to exercise the community standard of care.²²³

Law enforcement may compel a healthcare provider to assist with testing in very limited circumstances. If a police officer has reasonable cause to believe the person has committed certain crimes (e.g., aggravated DUI or vehicular manslaughter), the officer may order a qualified provider to withdraw a blood sample for testing.²²⁴ The blood draws must be conducted by a physician, qualified medical technologist, registered nurse, phlebotomist, or other properly trained individual.²²⁵ The provider may delay or terminate the blood draw if the provider determines that withdrawal of the blood sample (1) “may result in serious bodily injury to hospital personnel or other patients,”²²⁶ or that the withdrawal (2) “is contraindicated because of the medical condition of the suspect or other patients.”²²⁷ If ordered to participate in such a test, the provider should document the relevant facts, including the officer’s name and instructions. If possible, the provider may want to have the officer sign a statement confirming (1) that the officer has reasonable cause to suspect a covered crime and (2) that the officer ordered the test.

G. Prisoners and Detainees

Just as any other patient, prisoners generally have the right to consent to or refuse treatment.²²⁸ The practitioner should not treat the patient without the patient’s consent unless authorized by a court order or a specific statute. For example, Idaho Code section 39-604 requires that prisoners, certain detainees, and persons charged with certain crimes be examined and treated for venereal diseases, HIV, and hepatitis.²²⁹ Such tests should be conducted by or at the direction of the relevant law enforcement or corrections agency.

222. *See id.*

223. *Id.* § 18-8002(6).

224. *Id.* § 18-8002(6)(b).

225. *Id.* § 18-8003(1) (2004).

226. *Id.* § 18-8002(6)(e)(i) (Supp. 2007).

227. *Id.* § 18-8002(6)(e)(ii).

228. *See, e.g.,* *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir. 1990) (holding that prisoners have the right to refuse treatment but that the right is limited and the state can force treatment in certain situations).

229. IDAHO CODE ANN. § 39-604(1)–(4) (2002).

H. "Safe Haven" Care

"Safe haven" practitioners (including hospitals, physicians, physician assistants, and advance practices nurses) who take temporary physical custody of infants under Idaho's safe haven law are authorized to "[p]erform any act necessary, in accordance with generally accepted standards of professional practice, to protect, preserve, or aid the physical health and safety of the child during the temporary physical custody

.....²³⁰

I. Potential Exposure to Disease or Virus

A physician may order tests of a patient's blood or other bodily fluids to determine the presence of blood or bodily-fluid-transmitted diseases without the patient's consent if (1) emergency or medical service providers have been exposed or are likely to face a significant exposure which could transmit a virus or disease, and (2) the patient is unconscious or incapable of giving informed consent and the physician is unable to obtain consent from a surrogate decision maker under Idaho Code section 39-4504.²³¹ The statute imposes limits on disclosures that may be made of test results.²³²

J. Treatment of Newborns

Idaho generally mandates certain testing or treatment for newborns. For example, physicians and midwives must instill a germicide into the eyes of newborns to prevent ophthalmia neonatorum (certain blindness).²³³ Hospitals are required to administer certain tests to newborns, including tests for phenylketonuria (PKU).²³⁴ These requirements do not apply if the minor's parent or guardian objects to the care "on the grounds that it conflicts with the tenets or practices of a recognized church or religious denomination" of which the parent or guardian is a member.²³⁵

K. Anatomical Gifts

Idaho recently passed new laws in regard to anatomical gifts to coincide with the 2006 Revised Uniform Anatomical Gift Act.²³⁶ Idaho allows competent adults and emancipated minors to consent to anatomical gifts. Specifically, a person eighteen or older or an emancipated minor may execute a document consenting to or refusing to consent to ana-

230. *Id.* § 39-8203(2)(a) (Supp. 2007).

231. *Id.* § 39-4505(1)(a)-(b).

232. *Id.* § 39-4505(3)-(4).

233. *Id.* § 39-903 (2002).

234. *Id.* § 39-909.

235. *Id.* § 39-912.

236. *Id.* §§ 39-3401-3425 (Supp. 2007).

tomical gifts for himself.²³⁷ The person's consent or refusal to consent may be documented on his drivers license.²³⁸ The person may revoke his consent for an anatomical gift by complying with certain statutory prerequisites;²³⁹ however, the consent becomes irrevocable upon the person's death and thereafter does not require the consent of family members or others.²⁴⁰

In addition, absent an unrevoked refusal, certain persons may consent to an anatomical gift on behalf of the decedent. Such persons include, in order of priority: the holder of a durable power of attorney, spouse, adult child, parent, adult sibling, adult grandchild, grandparent, or guardian.²⁴¹ Consent must be recorded and may be revoked by any person of higher priority.²⁴²

Unemancipated minors sixteen years of age or older may consent to make an anatomical gift so long as a parent or an adult guardian also consents in writing in the presence of the donor.²⁴³ Even though consent generally becomes irrevocable at death, a parent or adult guardian may revoke or amend an anatomical gift of the minor's body or part.²⁴⁴ If an unemancipated minor signs a refusal to consent to an anatomical gift and the minor dies, a parent or adult guardian may revoke the minor's refusal.²⁴⁵

L. Research, Experimental Treatments, and Investigational Drugs

Federal regulations set forth detailed requirements for consent to medical research involving human subjects and investigational drugs, devices, and tests.²⁴⁶ Practitioners engaging in such research should consult the regulations.

VII. SUMMARY: SUGGESTIONS FOR OBTAINING INFORMED CONSENT

In summary, to obtain an effective consent, practitioners should consider the following:

1. Remember that consent is a continuum: the more invasive the procedure, the greater the need for detailed, procedure-specific informed consent.

237. *Id.* §§ 39-3401-3418.

238. *Id.* § 39-3405(1)(a).

239. *See id.* § 39-3406.

240. *See id.* § 39-3408(1).

241. *Id.* § 39-3409(1)(a)-(g).

242. *Id.* § 39-3409(3).

243. *Id.* § 39-3404(1)(b).

244. *Id.* § 39-3408(7).

245. *Id.* § 39-3408(8).

246. *See* 45 C.F.R. § 46 (2007); *see also* 21 C.F.R. §§ 50, 56, 312, 812 (2007).

2. The physician or other principal practitioner should discuss the treatment with the patient. Others may perform ministerial tasks to document consent, but they should notify the principal practitioner if the patient has questions, objections, or otherwise indicates that he is not giving an informed, voluntary consent.

3. Obtain written consent where possible to prove that consent was obtained.²⁴⁷ However, use consent forms carefully, especially when it comes to serious, invasive procedures. In such cases, written forms only supplement and document consent discussions—they cannot replace them. Moreover, specific forms may not fit particular circumstances and may become outdated as circumstances, knowledge, and accepted treatments change.

4. For all consents, whether written or oral, do the following:

- Use plain language that can be understood by the patient.²⁴⁸ This may require the services of an interpreter.
- Confirm that the patient has the competency and capacity to consent.²⁴⁹ Make sure that the patient is not sedated, upset, or otherwise impaired. Document the patient's capacity.
- If the patient lacks capacity, obtain consent from a person who has authority to consent.²⁵⁰ Obtain proper confirmation that the person has authority to consent (e.g., guardianship papers). Include the evidence in the patient's chart.
- For incompetent or incapacitated patients, confirm that there are no POSTs, DNRs, living wills, or other advance directives. References to such documents should be included in patient charts.
- Inform the patient or person giving consent about the treatment, including: (1) the patient's diagnosis and prognosis that necessitates the treatment; (2) the nature, risks, and benefits of the proposed treatment, including any incidental procedures (e.g., if a procedure is exploratory, confirm that the consent extends to procedures or actions that may occur during the procedure); and (3) the nature, risks, and benefits of any alternatives to the recommended treatment.
- Identify the practitioners who will provide care, including those who may assist or who may cover the call or provide substitute services.
- Give the patient the chance to ask questions and receive answers. Confirm that the patient has had any questions answered to his satisfaction.

247. See IDAHO CODE ANN. § 39-4507 (Supp. 2007).

248. See *id.* § 39-4506.

249. See *id.* § 39-4503.

250. *Id.* § 39-4504.

- Confirm that consent is given voluntarily, without duress or coercion.
- Confirm the date and time of the consent to document it was obtained before the relevant treatment.
- Do not guarantee results.
- Consider using a competent witness to confirm the consent.

5. Even if a form is used, document the foregoing in the patient's chart. In addition, if consent was given by a surrogate decision maker, document the circumstances that justified such consent (e.g., the incompetency of a patient and efforts to locate someone with higher priority). If consent was not obtained, document the circumstances that justified such action and efforts taken to obtain consent (e.g., the incompetency of a patient, the existence of an emergency, and the inability to find surrogate decision maker).

6. For written consents, obtain the patient's signature or the signature of the authorized representative. State the representative's authority.

7. If the practitioner obtains consent via telephone, the practitioner should verify the identity and authority of the person giving the consent, and document the conversation in the chart. The practitioner might consider sending a follow-up letter confirming the consent.

8. If the practitioner obtains consent via fax, the practitioner should still verify the identity and authority of the person giving consent, and document the conversation concerning the treatment in the chart.

9. Beware of consents obtained by others. They may not have covered the necessary items, thereby exposing subsequent practitioners to potential liability. Furthermore, general practitioners may lack the expertise necessary for specific procedures, and therefore the specialist should obtain informed consent.

10. If a practitioner relies on a prior consent, ensure that the treatment and the practitioner are within the scope of the prior consent.

