Clinical Ethics and Law: Overlapping Concepts and Distinct Disciplines

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Article

I. Introduction

Clinical ethics and law are disciplines with overlapping concepts, yet each discipline has unique parameters and a distinct focus. For example, the ethics concept of respect for autonomy is expressed in law as individual liberty. Each of these disciplines has its forums and authority; however, law may ultimately "resolve" a clinical ethics dilemma with a court order.

To better understand the relationship between ethics, law and risk management, these materials will briefly review:

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II. Understanding relationships: clinical ethics, law & risk management

A. Definitions and sources of authority

In the course of practicing medicine, a range of issues may arise that lead to consultation with a medical ethicist, a lawyer, and/or a risk manager. The following discussion will outline key distinctions between these roles.

- *Clinical ethics* may be defined as: a discipline or methodology for considering the ethical implications of medical technologies, policies, and treatments, with special attention to determining what ought to be done (or not done) in the delivery of health care.
- *Law* may be defined as: established and enforceable social rules for conduct or non-conduct; a violation of a legal standard may create criminal or civil liability.
- *Risk Management* may be defined as: a method of reducing risk of liability through institutional policies/practices.

Many health care facilities have in-house or on-call trained ethicists to assist health care practitioners, caregivers and patients with difficult issues arising in medical care, and some facilities have formally constituted institutional ethics committees. In the hospital setting, this ethics consultation or review process dates to at least 1992 with the formulation of accreditation requirements that mandated that hospitals establish a "mechanism" to consider clinical ethics issues.[1]

Ethics has been described as beginning where the law ends. The moral conscience is a precursor to the development of legal rules for social order. Ethics and law thus share the goal of creating and maintaining social good and have a symbiotic relationship as expressed in this quote:

> [C]onscience is the guardian in the individual of the rules which the community has evolved for its own preservation. *William Somerset Maugham*[2]

The role of lawyers and risk managers are closely linked in many health care facilities. Indeed, in some hospitals, the administrator with the title of Risk Manager is an attorney with a clinical background. There are, however, important distinctions between law and risk management. Risk management is guided by legal parameters but has a broader institution-specific mission to reduce liability risks. It is not uncommon for a hospital policy to go beyond the minimum requirements set by a legal standard. When legal and risk management issues arise in the delivery of health care, ethics issues may also exist. Similarly, an issue originally identified as falling within the clinical ethics domain may also raise legal and risk management concerns.

To better understand the significant overlap among these disciplines in the health care setting, consider the sources of authority and expression for each.

Ethical norms may be derived from**:**

- Law
- Institutional policies/practices
- Policies of professional organizations
- Professional standards of care, fiduciary obligations

Note: If a health care facility is also a religious facility, it may adhere to religious tenets. In general, however, clinical ethics is predominantly a secular professional analytic approach to clinical issues and choices.

Law may be derived from**:**

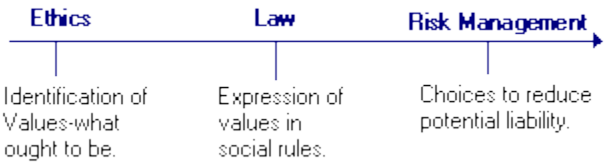
- Federal and state constitutions (fundamental laws of a nation or state establishing the role of government in relation to the governed)
- Federal and state statutes (laws written or enacted by elected officials in legislative bodies, and in some states, such as Washington and California, laws created by a majority of voters through an initiative process)
- Federal and state regulations (written by government agencies as permitted by statutory delegation, having the force and effect of law consistent with the enabling legislation)
- Federal and state case law (written published opinions of appellate-level courts regarding decisions in individual lawsuits)
- City or town ordinances, when relevant

Risk Management may be derived from law, professional standards and individual institution's mission and public relations strategies and is expressed through institutional policies and practices.

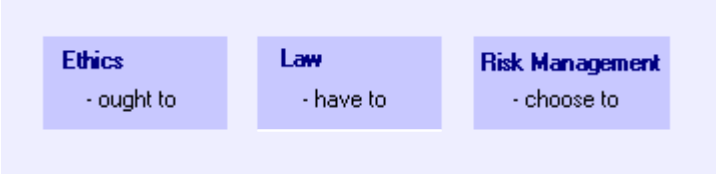
B. **Conceptual Models**

Another way to consider the relationship among the three disciplines is through conceptual models:

1. **Linear**



2. **Distinctions**



3. **Interconnectedness**

III. Orientation to law for non-lawyers

A. Potential legal actions against health care providers

There are two primary types of potential civil actions against health care providers for injuries resulting from health care: (1*) lack of informed consent*, and (2) *violation of the standard of care*. Medical treatment and malpractice laws are specific to each state.[3]

1. Informed Consent. Before a health care provider delivers care, ethical and legal standards require that the patient provide informed consent. If the patient cannot provide informed consent, then, for most treatments, a legally authorized surrogate decision-maker may do so. In an emergency situation when the patient is not legally competent to give informed consent and no surrogate decision-maker is readily available, the law implies consent on behalf of the patient, assuming that the patient would consent to treatment if he or she were capable of doing so.[4]

Information that must be conveyed to and consented to by the patient includes: the treatment's nature and character and anticipated results, alternative treatments (including non-treatment), and

the potential risks and benefits of treatment and alternatives. The information must be presented in a form that the patient can comprehend (i.e., in a language and at a level which the patient can understand) and that the consent must be voluntarily given. An injured patient may bring an informed consent action against a provider who fails to obtain the patient's informed consent in accordance with state law. [5]

From a clinical ethics perspective, informed consent is a communication *process,* and should not simply be treated as a required *form* for the patient's signature. Similarly, the legal concept of informed consent refers to a state of mind, i.e., understanding the information provided to make an informed choice. Health care facilities and providers use consent forms to document the communication process. From a provider's perspective, a signed consent form can be valuable evidence the communication occurred and legal protection in defending against a patient's claim of a lack of informed consent. Initiatives at the federal level (i.e., the Affordable Care Act) and state level (e.g., Revised Code of Washington § 7.70.060) reflect approaches that support shared decision-making and the use of patient decision aids in order to ensure the provision of complete information for medical decision-making.

2. Failure to follow standard of care. A patient who is injured during medical treatment may also be able to bring a successful claim against a health care provider if the patient can prove that the injury resulted from the provider's failure to follow the accepted standard of care. The duty of care generally requires that the provider uses reasonably expected knowledge and judgment in the treatment of the patient, and typically would also require the adept use of the facilities at hand and options for treatment. The standard of care emerges from a variety of sources, including professional publications, interactions of professional leaders, presentations and exchanges at professional meetings, and among networks of colleagues. Experts are hired by the litigating parties to assist the court in determining the applicable standard of care.

Many states measure the provider's actions against a national standard of care (rather than a local one) but with accommodation for practice limitations, such as the reasonable availability of medical facilities, services, equipment and the like. States may also apply different standards to specialists and to general practitioners. As an example of a statutory description of the standard of care, Washington State currently specifies that a health care provider must "exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the State of Washington, acting in the same or similar circumstances."[6]

B. The litigation process: a brief summary

There are essentially three distinct phases to the litigation process: (1) initiation, (2) pre-trial, and (3) trial and post-trial. The possibility that the parties will reach an agreement about the legal claims before or during trial, known as a *settlement*, means that the vast majority of initiated claims do not go through all three phases. An understanding of the litigation process and its accompanying vocabulary can be helpful in providing a fuller understanding of the intersection of law, clinical ethics, and risk management.

1. Initiation phase: A lawsuit will begin when the *plaintiff* (an allegedly injured patient) files a *complaint* (claim) with the court. The plaintiff is obligated to legally notify (*serve)* the *defendant(s)* (e.g., the health care provider) with a *summons* and the complaint on the defendant. Medical malpractice lawsuits frequently include more than one defendant and may be made against more than one provider, institution, and manufacturer of medical equipment and/or pharmaceutical companies. In the complaint, the plaintiff presents the facts that are the basis for the lawsuit. The defendant is required to file an *answer* (written response) with the court, and to also provide the plaintiff with a copy within a specified period of time.

2. Pre-trial phase: After filing a lawsuit and before trial, both sides (plaintiff and defendant) gather information using various methods known as *discovery*. Discovery methods used may include *interrogatories*, which are written questions that the opposing side must answer under oath. *Requests for production* require the opposing side to provide documents to the other side. *Requests for admissions* require the opposing side to state that some facts are true before trial. Witnesses can be required to answer questions in person under oath, known as a *deposition,* and may also be required to bring documents to the deposition. Although the information collected during discovery prepares the parties for trial, it also can be used as a basis for settlement. Indeed, most civil lawsuits, including actions against health care providers, are settled and never go to trial before a judge or jury.[7] Some cases are resolved by *summary judgment,* in which the court decides in favor of one party based on information derived during the discovery process. To encourage the parties to find a resolution to a health care dispute before trial, a few states require the parties to submit to *mediation*.[8]

3. Trial and post-trial phase. Cases involving injuries in health care are typically decided by a jury. However, cases involving federal health care facilities (and their employees), such as the Veterans Health Administration, are decided by a judge.[9] A trial in front of a jury will involve the following, in this order: jury selection; opening statements by both parties; plaintiff's trial testimony; defendant's trial testimony; closing arguments; *jury instructions* (argued by legal counsel to the judge, determined by the judge, and designed to guide the jury in decision-making); jury deliberation; and, verdict. Even after a jury verdict, there may be post-trial motions to the judge which could alter the outcome of the case.

C. How and where to find the law on a particular topic[10]

Law is dynamic—it is constantly evolving and changing, and this is particularly true in health law. Courts and legislatures respond to new issues and technologies by creating new laws or applying and interpreting existing laws. The changing nature of the law prompts a caveat to legal researchers: material obtained through general legal searches may not be current and the state of the law should be confirmed with a practicing lawyer before relying upon it. The internet offers many helpful resources to orient non-lawyers to locating relevant law, several of which are described below.

- The American Association of Law Libraries offers a practical guide for non-lawyers on researching a legal problem: American Association of Law Libraries *"How to Research a Legal Problem: A Guide for Non-Lawyers*" (revised 2022): How to Research a Legal Problem: A Guide for Non-Lawyers - AALL (aallnet.org).
- Another online resource on legal research for the non-lawyer audience is available through Nolo Press: Laws and Legal Research (updated 4 June 2024) http://www.nolo.com/legal-research/.
- For a basic outline of the structure of the American legal system, FindLaw has prepared a guide titled "*The U.S. Legal System*" by Mark F. Radcliffe and Diane Brinson of the law firm DLA Piper (2008): The U.S. Legal System - FindLaw

In addition, a number of useful resources are available in hard-copy or eBook format, two of which are mentioned below.

- *Law 101: Everything You Need to Know About the American Legal System*, 3d ed. (Oxford University Press, 2018). Available at University of Washington School of Law Library in eBook or hard copy (KF387.F45 2018 in Classified Stacks).
- *American Law: An Introduction* (Oxford Univ. Press 2017). eBook available through University of Washington School of Law Library. Earlier hard copy editions are also available (KF387.F74 1998 at Classified Stacks).

Reference librarians at law schools, particularly at public institutions, may be helpful in locating specific documents or orienting an interested person to the law. Specific statutes, regulations or case law may also be available on official government websites. In addition, medical journals (available on the internet or in medical school libraries) frequently have articles on clinical ethics or policy issues in health care which often address relevant legal authority.

IV. Common clinical ethics issues: medical decision-making and provider-patient communication

There are a number of common ethical issues that also implicate legal and risk management issues. Briefly discussed below are common issues that concern medical decision-making and provider-patient communication.

If a patient is capable of providing informed consent, then the patient's choices about treatment, including non-treatment, should be followed. This is an established and enforceable legal standard and also consistent with the ethical principle of respecting the autonomy of the patient. The next two sections (Surrogate decision-making; Advance directives) discuss how this principle is respected from a legal perspective if a patient lacks capacity, temporarily or permanently, to make medical decisions. The third section briefly introduces the issue of provider-patient communication, and highlights a contemporary dilemma raised in decisions regarding the disclosure of medical error to patients.

A. Surrogate decision-making

The determination as to whether a patient has the *capacity* to provide informed consent is generally a professional judgment made and documented by the treating health care provider. The provider can make a determination of temporary or permanent incapacity, and that determination should be linked to a specific decision. The legal term *competency* (or *incompetency*) may be used to describe a judicial determination of decision-making capacity. The designation of a specific *surrogate decision-maker* may either be authorized by court order or is specified in state statutes.

If a court has determined that a patient is incompetent, a health care provider must obtain informed consent from the court-appointed decision-maker. For example, where a guardian has been appointed by the court in a guardianship action, a health care provider would seek the informed consent of the guardian, provided that the relevant court order covers personal or health care decision-making.

If, however, a physician determines that a patient lacks the capacity to provide informed consent, for example, due to dementia or lack of consciousness, or because the patient is a minor and the minor is legally proscribed from consenting, then a legally authorized surrogate decision-maker may be able to provide consent on the patient's behalf. Most states have specific laws that delineate, in order of priority, who can be a legally authorized surrogate decision-maker for another person. While these laws may vary, they generally assume that legal relatives are the most appropriate surrogate decision-makers. If, however, a patient has previously, while capable of consenting, selected a person to act as her decision-maker and executed a legal document

known as a *durable power of attorney for health care* or *health care proxy,* then that designated individual should provide informed consent.

In Washington State, a statute specifies the order of priority of authorized decision-makers as follows, with some conditions: guardian, holder of durable power of attorney; spouse or state registered partner; adult children; parents; adult brothers and sisters; adult grandchildren; nieces and nephews; aunts and uncles; and an adult that has exhibited special care and concern for the patient. If the patient is a minor, other consent provisions may apply, such as: court authorization for a person with whom the child is in out-of-home placement; the person(s) that the child's parent(s) have given a signed authorization to provide consent; or, a competent adult who represents that s/he is a relative responsible for the child's care and signs a sworn declaration stating so.[11] Health care providers are required to make reasonable efforts to locate a person in the highest possible category to provide informed consent. If there are two or more persons in the same category, e.g., adult children, then the medical treatment decision must be unanimous among those persons.[12] A surrogate decision-maker is required to make the choice she believes the patient would have wanted, which may not be the choice the decision-maker would have chosen for herself in the same circumstance. This decision-making standard is known as *substituted judgment.*[13] If the surrogate is unable to ascertain what the patient would have wanted, then the surrogate may consent to medical treatment or non-treatment based on what is in the patient's *best interest.*[14]

Laws on surrogate decision-making are beginning to catch up with social changes. Non-married couples have not traditionally been recognized in state law as legally authorized surrogate decision-makers. This lack of recognition has left providers in a difficult legal position, encouraging them to defer to the decision-making of a distant relative over a spouse-equivalent unless the relative concurs. Washington law, for example, recognizes spouses and domestic partners registered with the state as having the same priority status, and also recognizes the potential decisionmaking authority of an adult who has "exhibited special care and concern for the patient" and is "familiar with the patient's personal values," subject to specified conditions.[15]

Parental decision-making and minor children. A parent may not be permitted in certain situations to consent to non-treatment of his or her minor child, particularly where the decision would significantly impact and perhaps result in death if the minor child did not receive treatment. Examples include parents who refuse medical treatment on behalf of their minor children because of the parents' social or religious views, such as Jehovah's Witnesses and Christian Scientists. The decision-making standard that generally applies to minor patients in such cases is known as the *best interest* standard. The substituted judgment standard may not apply because the minor patient never had decision-making capacity and therefore substituted judgment based on the minor's informed choices is not able to be determined. It is important to note that minors may have greater authority to direct their own care depending on their age,

maturity, nature of medical treatment or non-treatment, and may have authority to consent to specific types of treatment. For example, in Washington State, a minor may provide his or her own informed consent for treatment of mental health conditions, sexually transmitted diseases, and birth control, among others. Depending on the specific facts, a health care provider working with the provider's institutional representatives could potentially legally provide treatment of a minor under implied consent for emergency with documentation of that determination,[16] assume temporary protective custody of the child under child neglect laws, or if the situation is non-urgent, the provider could seek a court order to authorize treatment.

B. Advance directives

The term *advance directive* refers to several different types of legal documents that may be used by a patient while competent to record future wishes in the event the patient lacks decision-making capacity. The choice and meaning of specific advance directive terminology is dependent on state law. Generally, a *living will* expresses a person's desires concerning medical treatment in the event of incapacity due to terminal illness or permanent unconsciousness. A *durable power of attorney for health care* or *health care proxy* appoints a legal decision-maker for health care decisions in the event of incapacity. An *advance health care directive* or *health care directive* may combine the functions of a living will and durable power of attorney for health care into one document in one state, but may be equivalent to a *living will* in another state. The *Physician Orders for Life Sustaining Treatment* (*POLST) form*, also referred to as *Portable Orders for Life Sustaining Treatment,* is a document that is signed by a physician and patient which summarizes the patient's wishes concerning medical treatment at the end of life, such as resuscitation, antibiotics, other medical interventions and artificial feeding, and translates them into medical orders that follow patients regardless of care setting. It is especially helpful in effectuating a patient's wishes outside the hospital setting, for example, in a nursing care facility or emergency medical response context. Programs may operate under different names: POST (Physician or Portable Orders for Scope of Treatment), MOST (Medical Orders for Scope of Treatment), MOLST (Medical Orders for Life-Sustaining Treatment), and COLST (Clinician Orders for Life-Sustaining Treatment). The simple one-page treatment orders follow patients regardless of care setting. Thus, it differs from an advance directive because it is written up by the clinician in consultation with the patient and is a portable, actionable medical order. The POLST form is intended to complement other forms of advance directives. For example, Washington State recognizes the following types of advance directives: the health care directive (living will), the durable power of attorney for health care, and the POLST form.[17] Washington also recognizes another legal document known as a *mental health advance directive*, which can be prepared by individuals with mental illness who fluctuate between capacity and incapacity for use during times when they are incapacitated. [18]

State laws may also differ on the conditions that can be covered by an individual in an advance directive, the procedural requirements to ensure that the document is effective (such as the number of required witnesses) and the conditions under which it can be implemented (such as invalidity during pregnancy).

Advance directives can be very helpful in choosing appropriate treatment based upon the patient's expressed wishes. There are situations, however, in which the advance directive's veracity is questioned or in which a legally authorized surrogate believes the advance directive does not apply to the particular care decision at issue. Such conflicts implicate clinical ethics, law and risk management.

C. Provider-patient communications: disclosing medical error

Honest communication to patients by health care providers is an ethical imperative. Excellent communication eliminates or reduces the likelihood of misunderstandings and conflict in the health care setting, and also may affect the likelihood that a patient will sue.

One of the more contentious issues that has arisen in the context of communication is whether providers should disclose medical errors to patients, and if so, how and when to do so. Disclosure of medical error creates a potential conflict among clinical ethics, law and risk management. Despite a professional ethical commitment to honest communication, providers cite a fear of litigation as a reason for non-disclosure. Specifically, the fear is that those statements will stimulate malpractice lawsuits or otherwise be used in support of a claim against the provider. An increase in malpractice claims could then negatively affect the provider's claims history and malpractice insurance coverage.

There is some evidence in closed systems (one institution, one state with one malpractice insurer) that an apology coupled with disclosure and prompt payment may decrease either the likelihood or amount of legal claim. In addition, a number of state legislatures have acted to protect provider apologies, or provider apologies coupled with disclosures, from being used by a patient as evidence of a provider's liability in any ensuing malpractice litigation.[19] The impact of those laws on the size or frequency of medical malpractice claims in multiple settings is a subject of ongoing evaluation. [20] For this reason and others, it is advisable to involve risk management and legal counsel in decision-making regarding error disclosure.

V. Case studies highlighting the interplay between clinical ethics, legal & risk management issues

The three cases below are examples of fact patterns that may arise in practice. The facts are derived from actual cases which have been modified to allow further exploration of the intersection of the law with clinical ethics and risk management. Each situation is unique, and the cases are not intended to be authority for any specific application.

Case 1: Disagreement among surrogate decision-makers and with advance directive/end of life/futility

A 72-year-old woman was admitted to the Neurological Intensive Care Unit following a cerebral hemorrhage which left her with severe brain damage and ventilator dependent. One year before this event, the patient and her husband had drawn up "living wills" with an attorney. She was diagnosed by her treating physician as being in a permanent unconscious condition. The patient's living will specified that the patient did not want ventilator support or other artificial life support in the event of a permanent unconscious condition or terminal condition.

The patient's husband is her legal next of kin and the person with surrogate decision-making authority. When the living will was discussed with him, he insisted that the patient had not intended for the document to be used in a situation like the present one. Further discussion with him revealed that he understood that the patient would not be able to recover any meaningful brain function, but he argued that the living will did not apply because her condition was not imminently terminal. He further indicated that he did not consider his wife to be in a permanent unconscious condition. The immediate family members (the couple's adult children) disagreed with their father's refusal to withdraw life support.

The treatment team allowed a week to pass to allow the husband more time to be supported in his grief and to appreciate the gravity of his wife's situation. Nevertheless, at the end of this time, the husband was unwilling to authorize withdrawal of life support measures consistent with the patient's wishes as expressed in her living will.

What should be done? What are the ethical and legal parameters?

Discussion of Case 1: The ethical and legal parameters in Case 1 are informed consent, surrogate decision-making and the patient's ability to direct her care - expressed in law as a liberty or privacy right and in clinical ethics as respect for patient autonomy. While the details of each case will determine the advice provided, the difficult issues raised in Case 1 prompt consideration of several clinical ethics and legal issues.

<u>Specific clinical ethics and legal issues:</u>

The patient is unable to provide informed consent for medical care. Informed consent means making a medical treatment choice and includes the choice of non-treatment. What is known about the patient's wishes for continued medical treatment under her current circumstances?

Her providers, referencing intuitional policy, thought ventilator support and CPR were medically futile. A provider's determination of medical futility means that treatment is highly unlikely to provide overall benefit to the patient. Such determinations are case-specific and should be thoroughly discussed with surrogate decision-makers. While providers may not be obligated to provide medically futile interventions, depending upon circumstances, the patient may be transferred to another facility. Institutional policies are crafted to provide guidance to providers within the context of clinical ethics and the relevant laws and should guide decision-making in this area. In Washington State for example, decisions to withdraw or withhold medical treatment are partially governed by the Washington Natural Death Act which currently requires that the patient be in a permanent unconscious or terminal condition. [21] There are other circumstances in which a surrogate will be able to make choices on behalf of the patient.

The patient's advance directive is strong evidence and significant in determining what the patient would want for substituted judgment. Since the patient's husband (her legal surrogate) only made vague statements as to why he thought she would want continued care under these circumstances and the husband's perspective was contradicted by their adult children, it appears the situation requires further communication efforts, e.g., patient care conference, clinical ethics consultation, potential consult with institutional risk manager and/or attorney. The services of a hospital chaplain may also be helpful since the husband had indicated that his religious beliefs played some role in his perspective of his wife's situation.

If these additional communication efforts fail to resolve the impasse, one possible legal/risk management approach would be to consider pursuing withdrawal of life support after multiple steps and ongoing consultation. Possible actions might include the following.

The content of the patient's advance directive should be verified to be consistent with a decision to forego further life-sustaining measures. Those persons who were present when she prepared and signed the document should be contacted to gather further information about the patient's intentions.

The requisite clinical determination(s) ("terminal" or "permanent unconscious" conditions) to activate the patient's advance directive should be confirmed and documented in the patient's chart.

Consensus among the medical team should be confirmed regarding: the clinical determinations; the appropriateness of withdrawing life support as in the patient's best interests; and, that withdrawal is consistent with her advance directive. The applicability of the institutional futility or withholding and withdrawal policy should be reviewed and, if applicable, documented in the patient's chart.

A patient care conference with the family members should be scheduled to review the patient's prognosis with the family once again. Assuming that the medical team is in consensus about

withdrawal, they can communicate their decision to withdraw care at a specific future date and time. With this advance notice of planned future action, the patient's husband is provided an opportunity to seek judicial review or arrange for a transfer of care to another medical facility before the withdrawal of care. At any time throughout this process, it may be possible to break the stalemate of the patient's situation and allow a resolution.

It is anticipated that in such a complex medical and emotionally charged circumstance that there would be ongoing communications and multiple opportunities with hospital staff, care providers, and the patient's surrogate and immediate family members about what the patient would want and or what is in her best interest. This situation underscores the importance of communication with the surrogate throughout the resolution process. A clinical ethicist or palliative care consultant can assist in this process.

Case 2: Surrogate decision-maker with potential conflict of interest

A 32-year-old woman was admitted to the Trauma Intensive Care Unit following a motor vehicle accident; she had multiple injuries and fractures, with several complications which continued to develop over the first couple of weeks. The patient rapidly developed Adult Respiratory Distress Syndrome, was on a ventilator, and was continuously sedated. Shortly after the patient's admission, her parents were contacted and remained vigilant at her bedside. The parents reported that the patient was one month away from having her divorce finalized. The patient's husband was reportedly physically and emotionally abusive to her throughout their five years of marriage. The parents had not notified this man of the patient's hospitalization, and reported that a visit by him would be distressing to the patient if she were aware of it. The patient's soon to be ex-husband is her legal next of kin.

Should the husband be responsible for treatment decisions which the patient cannot make?[22] *What are the ethical and legal parameters?*

Discussion of Case 2: Some key clinical ethics and legal issues raised by Case 2 are informed consent and surrogate decision-making. While the details of each case will determine the advice provided, this case raises a number of issues.

Specific clinical ethics and legal issues:

As mentioned above,[23] implied consent is permitted by law for provision of "emergency" medical treatment. However the relevant state's law does not define the term "emergency."[24] Each institution should have a policy that defines emergency in accordance with state law and lays out institutional documentation requirements so that providers are guided in their decision-making.[25] Thus, if a medical emergency exists and implied consent is relied on by the health

care providers, it should be documented in the patient's medical record in accordance with legal and institutional standards.

The patient may have provided her own consent to treatment either at the time of her admission or earlier in her hospitalization. At that time, she may have expressed her ongoing wishes for care. The patient's own previous statements/consent may therefore be the basis for continued consent for her ongoing care. If there is a need for informed consent for a new treatment decision on behalf of the patient, the patient's previously expressed wishes may still be relevant to her legally authorized surrogate decision-maker and her treatment plan.

If the patient has already filed for divorce, it is likely that there is a temporary court order in effect and this order may affirmatively remove the patient's estranged husband from making medical decisions for her. Also, divorce paperwork may have mutual restraining orders which prevent both spouses from contacting each other. The patient's parents should be asked to provide the name of her divorce attorney. Hospital staff may contact the patient's attorney to request information and to obtain copies of the relevant legal papers, which can then be placed in the legal section of the patient's medical record. Obtaining information is not a violation of patient confidentiality. It is also permissible for an attorney to provide information that is contained in public records, such as documents filed with a court. With the husband thus removed as her surrogate decision-maker, it appears the patient's parents would become the highest-level class of surrogate decision-maker and could provide informed consent for her care if the patient is unable to do so.

Even if the patient's husband remains as her legal surrogate decision-maker, his decisions on the patient's behalf are constrained by clinical ethics and legal standards. First, a surrogate is legally required to provide "substituted judgment" on behalf of the patient. This means that the surrogate must act in accordance with the patient's wishes. If substituted judgment is not possible (i.e., unknown what the patient would want under the current medical circumstances), then the law requires the surrogate to act in the patient's "best interest." Since the medical team has significant input about what would medically be in the patient's best interest, a decision by a surrogate which does not adhere to this standard should not be automatically followed and may need to be reviewed by a clinical ethics consultant or committee, risk management, or legal counsel.

The patient's husband may be willing to waive his role as surrogate decision-maker. If this occurs, then he would agree to remove himself from the list of potential surrogate decision-makers and the next highest level surrogate decision-maker(s) would be contacted as necessary to provide informed consent for the patient.

Another option may be for the patient's parents to file in court to become the patient's legal guardians for health care decision-making.

Case 3 – Minor patient/Jehovah's Witness/non-treatment against medical advice

A 17-year-old young woman is diagnosed with acute lymphocytic leukemia. The patient and her family are practicing Jehovah's Witnesses. Based on their religious beliefs, the patient and her parents do not want the medical treatment to include any blood transfusions or blood products. All non-blood alternatives had been attempted or deemed inadequate. The standard of care would require the use of blood products, to which the patient and her parents will not consent. There is sub-optimal treatment available which does not include transfusion support that the patient and her parents are willing to consent to receive. The physicians estimate that the difference in receiving sub-optimal treatment is that the minor's chances for cure are probably diminished by at least 50%.

Can the 17-year-old patient be deemed sufficiently mature to make her own medical treatment choices? Who has authority to make this determination?

Are the patient's parents, as her legally authorized surrogate decision-makers, entitled to make a choice for their daughter? If so, would the parents be bound to use a "substituted judgment" or a "best interest" standard when making a decision on behalf of their minor child?

Discussion of Case 3: The legal and clinical ethics parameters in Case 3 concern: (a) whether a minor can provide informed consent for her own treatment (which includes non-treatment) that may have fatal consequences; (b) what surrogate decision-making authority do parents have for a mature minor; and (c) the health care providers' ability to accept non-treatment choices that greatly diminish the likelihood of successful treatment. The patient's ability to direct her care is expressed in law as a liberty or privacy right and in clinical ethics as respect for patient autonomy. Case 3 implicates a number of clinical ethics and legal issues.

<u>Specific clinical ethics and legal issues:</u>

The 17-year-old patient is a minor under state law. [26] A key question in this case is whether or not the patient should be treated as capable of providing her own informed consent. The treatment team held a series of meetings with the patient, her parents, and her younger sibling to discuss the patient's diagnosis, its implications and treatment availability. The patient was also separately counseled by medical staff to ascertain whether she was freely and voluntarily expressing her preferences or if she may have felt pressured by her family or church members.

Jehovah's Witnesses have beliefs which forbid the acceptance of blood transfusions and blood products due to an interpretation of certain biblical text. With the exception of this treatment modality, Jehovah's Witnesses are generally willing to accept medical treatment. This belief is not generally shared by others in our society. As such, this belief may appear unacceptable and irrational to others, including health care providers. Even if the patient is deemed competent to make medical treatment decisions, if the patient rejects potentially life-saving treatment based on an uncommon belief, this may cause distress to the patient's health care providers who may view such an act as not being in the patient's best interest.

The patient was capable of articulating her personal beliefs and preferences and was believed to be mature by the hospital staff. In some instances, physicians have documented clinical observations that support a conclusion that the minor was mature and capable of making medical decisions in light of the nature of the condition and treatment choices. This type of clinical determination of ability to provide mature reasoned decision-making for health care has been recognized in state law, e.g., in Washington State. The court has identified certain factors as relevant in considering whether a minor is "emancipated" including: age, maturity, intelligence, training, experience, economic independence, and freedom from parental control.[27] Additional state laws have expanded the ability of minors to provide consent for particular types of health care, such as abortion, birth control, sexually transmitted infections and mental health treatment.[28]

In this particular situation, since the refusal of the blood transfusion had potential fatal consequences, from an institutional risk management perspective, the option of a court review and judicial determination of emancipation was a preferred choice. The hospital's legal counsel initiated a legal process to allow the patient and her family to request the local superior court for a court determination of emancipation so that the patient would be deemed an adult for making her own treatment choices.

In this particular case, ultimately a court proceeding was held at the hospital. The patient, her parents, her sibling, church members of the family, the church's attorney, the treating physician, the hospital's attorney, and the judge were present. Testimony was taken and the judge also spoke with the patient in private (the judge later gave a summary of the conversation for the record). There was also evidence in the form of an affidavit signed by Children's Protective Services that this would not be a situation in which that state agency would file a petition and seek a court order for treatment of the minor. The physician supported that the patient was emancipated and should be permitted to make her own informed consent. The court entered an order of emancipation.

The effect of this court order of emancipation put the minor patient on equal consent footing as an adult. Emancipation, in and of itself, does not alter the requirement that the patient provide informed consent, i.e., be able to understand and weigh the risks and benefits of the recommended medical treatment and other treatment options, including non-treatment.

While this particular set of facts resolved with minimal or no conflict, other situations involving patients with differing social or religious beliefs regarding specific treatments may have greater conflict.

[1] Sharon E. Caulfield, Health Care Facility Ethics Committees: New Issues in the Age of Transparency, ABA Human Rights Magazine, *Fall 2007 Vol. 34, No. 4* Available at: https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/human_rights_vol34_2007/fall2007/hr_fall07_caulfi/. Accessed 22 August 2024.

[2] W. Somerset Maugham, *The Moon and Sixpence* (New York: Grossett & Dunlap Publishers, 1919), 80.

[3] Where relevant, Washington state law will be referenced as an example in this discussion. See, generally, Revised Code of Washington, Chapter 7.70, http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.

[4] Each institution should have a policy that defines "emergency" in accordance with state law and lays out institutional documentation requirements so that providers are guided in their decision-making. Where there is no definition of "emergency" in state law or institutional policies, institutions and courts may be guided by the definition found in the federal Emergency Medical Treatment and Active Labor Act (EMTALA, also referenced as COBRA) which provides:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

42 U.S.C 1395dd(e)(1).

[5] See Revised Code of Washington § 7.70.050, http://apps.leg.wa.gov/RCW/default.aspx?cite=7.70.050. Accessed 22 August 2024.

[6] See Revised Code of Washington § 7.70.040, http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.040. Accessed 22 August 2024.

[7] "Among jurisdictions that provided totals for both trial and non-trial general civil dispositions in 2005, trials collectively accounted for about 3% of all tort, contract, and real property dispositions in general jurisdiction courts." LYNN LANGTON & THOMAS H. COHEN, CIVIL BENCH AND JURY TRIALS IN STATE COURTS, 2005, at 1 (2008), *available at https://bjs.ojp.gov/content/pub/pdf/cbjtsc05.pdf*. Accessed 22 August 2024.

[8] Florence Yee, *Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis*, 7 CARDOZO J. CONFLICT RESOL. 393, 432-33 (2006).

[9] A federal health facility and its employees would be subject to the Federal Torts Claims Act (FTCA). 28 U.S.C. § 2402. Lawsuits against the United States under the FTCA are tried without a jury. Lester Jayson, *Handling Federal Tort Claims: administrative and judicial remedies* § 16.08 (Mathew Bender and Company 2011).

[10] The authors gratefully acknowledge the research support of the Reference Librarians at the University of Washington School of Law in drafting this section.

[11] Revised Code of Washington § 7.70.065 (2) (a), http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.065. Accessed 15 November 2011.

[12] See Revised Code of Washington § 7.70.065, http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.065. Accessed 22 August 2024.

[13] See, for example, in Washington State the case *In re Ingram*, 102 Wn.2d 827, 689 P.2d 1363 (1984). This Washington Supreme Court decision establishes in state law the substituted judgment standard and articulates the countervailing interests of the State in weighing whether an incapacitated patient's choice for treatment or non-treatment may be overridden. Under substituted judgment, a court directs the course of medical treatment for an incompetent by determining the treatment the incompetent would choose if he were competent to make the decision and weighing that determination against any compelling State interests, including: preservation of life, protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession.

[14] Revised Code of Washington § 7.70.065 (1)(c), http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.065. Accessed 22 August 2024.

[15] See Revised Code of Washington § 7.70.065(1)(a)(iii), http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.065. Accessed 22 August 2024.

[16] See Discussion of Case #2. For example, Washington State law provides for "implied consent" for emergency treatment situations: If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his or her consent to required treatment will be implied. Revised Code of Washington § 7.70.050(4), http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.050. Accessed 22 August 2024. However, the hospital policy may be more specific and include an institutional documentation standard.

[17] See Revised Code of Washington Chapter 70.122, http://apps.leg.wa.gov/rcw/default.aspx?cite=70.122. Accessed 22 August 2024. Non-married individuals may also wish to complete a hospital authorization form in advance to ensure that they are permitted to visit a patient as a family member regardless of hospital policy.

[18] See Revised Code of Washington, Chapter 71.32, http://apps.leg.wa.gov/RCW/default.aspx?cite=71.32. Accessed 22 August 2024.

[19] See e.g., Mastroianni A., Mello M, Sommer S, Hardy M. Gallagher T. 2010. **"**The Flaws in State 'Apology' And 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits," *Health Affairs* 29(9): 1611-19.

[20] See e.g., Benjamin J. McMichael, R. Lawrence Van Horn & W. Kip Viscusi. "Sorry" Is Never Enough: How State Apology Laws Fail to Reduce Medical Malpractice Liability Risk, 71 Stan. L. Rev. 341 (2019). https://review.law.stanford.edu/wp-content/uploads/sites/3/2019/02/McMichael-71-Stan.-L.-Rev.-341-2019.pdf. Accessed 22 August 2024.

[21] Washington's Natural Death Act currently defines the terms "terminal condition," "permanent unconscious condition" and "life-sustaining treatment," Revised Code of Washington, Chapter 70.122, http://apps.leg.wa.gov/rcw/default.aspx?cite=70.122. Accessed 22 August 2024.

[22] Washington law, for example, allows designated classes of persons to provide informed consent on behalf of an incompetent patient in the following order of priority: 1. guardian with authority to make health care decisions; 2. holder of Durable Power of Attorney with authority to make health care decisions; 3. Spouse or registered domestic partner; 4. adult children; 5. parents; and 6. adult brothers and sisters, followed by several other categories of persons. See Revised Code of Washington § 7.70.065, http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.065. Accessed 22 August 2024. If there are two or more persons in the same class listed above (e.g., adult children), then the decision must be unanimous among all available persons in that class.

[23] See III.A.1. above ("Informed Consent") and accompanying notes.

[24] See, for example, Revised Code of Washington § 7.70.050(4) http://apps.leg.wa.gov/rcw/default.aspx?cite=7.70.050. Accessed 22 August 2024.

[25] For example, the University of Washington's policy provides that the definition of emergency "would clearly include treatment that is necessary to preserve life or to prevent serious disability. It also may include other types of treatment that cannot be delayed without risking unacceptable deterioration or aggravation of the patient's condition." Informed Consent Manual, UW Medicine, 40 at pp. 22-22 (revision date June 2019).

[26] In Washington State, see Revised Code of Washington, § 26.28.010, https://apps.leg.wa.gov/RCW/default.aspx?cite=26.28.010 . Accessed 22 August 2024.

[27] See, e.g., in Washington State, *Smith v. Seilby,* 72 Wn.2d 16, 431 P.2d 719 (1967).

[28] See, e.g., in Washington State*, State v. Koome*, 84 Wn.2d 901, 530 P.2d 260 (1975); Informed Consent Manual, UW Medicine, 55 at pp. 29-31 (revision date June 2019).