

Who Should Make Medical Decisions for Incompetent Adults? A Critique of RCW 7.70.065

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I. INTRODUCTION

Advances in medical technology give us a better chance of surviving a serious accident or illness than ever before. On a daily basis, heart attack victims, accident victims, and cancer patients are treated with new techniques and technologies that keep them alive longer.¹ Survival, however, does not mean that we will be able to communicate our wishes or be competent enough to make decisions about our medical treatment. Who, then, should make decisions such as whether we should undergo surgery or be taken off life support systems?

Many Washington residents may be surprised to learn that if they are not competent to make medical decisions for themselves, a parent seen only at Christmas-time every few years may be called on to make medical decisions for them, or that their significant other may be prevented from making medical decisions for them regardless of how long they have lived together. These situations, and several others, are described more fully in this Comment in the context of the need to amend Revised Code of Washington (RCW) 7.70.065, Washington's medical decision-making statute. To show why the statute should be rewritten, this Comment discusses: (1) the importance of autonomy and self-determination in medical decision-making; (2) the purpose of proxy medical decision-making statutes; (3) Washington's proxy

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1. See, e.g., M. Saklayen et al., *In-Hospital Cardiopulmonary Resuscitation: Survival in 1 Hospital and Literature Review*, 74 MED. BALTIMORE 4, 163 (1995) (stating that CPR has been used extensively since its introduction three decades ago); J. Adolfsson, *Radical Prostatectomy, Radiotherapy or Deferred Treatment for Localized Prostate Cancer?* 23 CANCER-SURV. 141, 141 (1995) (discussing technological advancements in the treatment of prostate cancer and resulting survival rates).

decision-making statute; and, (4) current family demographics. This Comment concludes by proposing a new medical decision-making statute for Washington.²

In crafting medical decision-making statutes, state legislatures have tried to answer the question of who should make medical decisions for incompetent patients by looking to the principle of personal autonomy.³ Personal autonomy, a principle rooted in Western philosophy, has strongly influenced American law and bioethics.⁴ Because the principle of autonomy requires that a patient make medical decisions for him or herself, legislatures have struggled to find ways of effectuating an incompetent patient's wishes.⁵

The Washington legislature, in addressing this problem, has created a statutory priority list of proxy decisionmakers who are authorized to make medical decisions for an incompetent patient.⁶ Incompetence is defined as mental illness, developmental disability, habitual drunkenness, excessive use of drugs or other mental incapacity.⁷ Under Washington's proxy decision-making statute, the first two decisionmakers on the priority list are a court-appointed guardian, followed by any person to whom the incompetent patient has given his or her durable powers of attorney for health care.⁸ Because most incompetent individuals have neither a court appointed guardian, nor a durable power of attorney for health care decisions, these first two classes of decisionmakers will rarely apply.⁹

The classes that follow guardian and a person with durable power of attorney are most relevant to the majority of people who become incompetent. Those classes of decisionmakers are, in the order of priority, spouse, adult children, parents, and adult siblings.¹⁰ No person outside these four classes of decisionmakers is legally authorized

2. The proposed medical decision-making statute is not modeled after any other state statute. Rather, it was written by the author to address the specific problems with Washington's statute.

3. See discussion *infra* Part II.

4. See discussion *infra* Part II.

5. See discussion *infra* Part II.

6. WASH. REV. CODE § 7.70.065(1) (1996).

7. WASH. REV. CODE § 11.88.010(1)(e) (1996).

8. WASH. REV. CODE § 7.70.065(1)(a)-(b).

9. Robert A. Pearlman et al., *Advance Care Planning: Eliciting Patient Preferences for Life-Sustaining Treatment*, 26 PATIENT EDUC. & COUNSELING 353, 355 (1995) (estimating that only between 9% and 23% of U.S. citizens have executed a formal written advance directive). See also Jeffrey S. Janofsky, M.D. & Barry Rovner, M.D., *Prevalence of Advance Directives and Guardianship in Nursing Home Patients*, 6 J. GERIATRIC PSYCHIATRY & NEUROLOGY 214, 214 (1993) (stating that between 4% and 17.5% of adults have advance care directives).

10. WASH. REV. CODE § 7.70.065(1)(c)-(f).

to make decisions for the incompetent patient.¹¹ Additionally, no person in one of the authorized classes may make medical decisions for the incompetent patient if a person in a higher class can be located.¹² The belief underlying the statute is that these classes of decision-makers, in the order set out by the Washington legislature, will know and make the same decision that the incompetent patient would make, were he or she competent.

However, this Comment will demonstrate that the statute and its exclusive hierarchy of decisionmakers may fail to effectuate an incompetent patient's wishes for as many as one-third of Washington residents.¹³ The statute's priority list of proxy decisionmakers assumes that all families consist of two legally married individuals and their children. As U.S. Census Bureau statistics show, this married-two-parent family is not the reality for many Washington residents.¹⁴ Family members who are not classified as members of this unit, such as grandparents, aunts, uncles, and cousins, or unmarried partners and close friends are prevented from acting as proxy decisionmakers under the statutory hierarchy. Furthermore, even among the family members who are included in the statutory hierarchy, the statute's rigidity does not allow a family member who is lower on the priority list, though a more appropriate decisionmaker for the incompetent patient, to be appointed if a higher priority family member can be contacted.¹⁵ The statute's appointment of proxy decisionmakers based on the degree of consanguinity or legal relationship rather than the decisionmakers' demonstrated closeness to or concern for the incompetent patient can result in the appointment of decisionmakers who have no idea what the patient would decide were he or she competent. Conversely, people who may be most likely to know what the incompetent patient would decide may be excluded from the decision-making process. Thus, the statute should be rewritten.

11. WASH. REV. CODE § 7.70.065(1) (1996).

12. WASH. REV. CODE § 7.70.065(2) (1996).

13. See *infra* p. 593 and note 74.

14. See *infra* p. 593 and note 74.

15. WASH. REV. CODE § 7.70.065(2)(a) (1996).

II. THE IMPORTANCE OF AUTONOMY AND SELF-DETERMINATION IN MAKING MEDICAL DECISIONS

The belief that every person has the right to autonomy and self-determination is deeply rooted in the western philosophical tradition.¹⁶ Because the dominant culture and belief system of the United States is shaped by this philosophical tradition, the importance of personal autonomy and self-determination is evident in many facets of our society, including making medical decisions. This section briefly shows how the principles of autonomy and self-determination have influenced American case law and legislation pertaining to medical decision-making.

The principle of personal autonomy has not always affected a patient's right in determining what medical treatment he or she will or will not receive. As long ago as ancient Greece, and as recently as the nineteenth century, patients' participation in medical decision-making was minimal because doctors were expected to inspire confidence in their own medical judgment and maintain patients' hope for a cure.¹⁷ By the early part of the twentieth century, however, the notion that personal autonomy requires informed consent for medical treatment became ingrained in American tort law.¹⁸

In 1891, the United States Supreme Court recognized the right of personal autonomy.¹⁹ In response to a defendant's request that the plaintiff in a personal injury action submit herself to a physical examination, the Court stated, "no right is held more sacred or is more carefully guarded by the common law, than the right of every individual to the possession and control of her own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."²⁰ Thus, the Court affirmed that every person has a right to control his or her own body.

Justice Cardozo, of the New York Court of Appeals, took the principle that every person has a right to control his or her own body one step further. He is widely credited with originating the legal requirement that the right of personal autonomy mandates that a

16. See generally BARRY R. FURROW ET AL., *BIOETHICS: HEALTH CARE LAW & ETHICS*, 4-24 (1991).

17. BARRY R. FURROW ET AL., *HEALTH LAW CASES, MATERIALS AND PROBLEMS*, 322 (2d ed. 1991).

18. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 32, at 189-92 (5th ed. 1984).

19. *Union Pac. R. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

20. *Id.*

medical practitioner must obtain a patient's consent to medical treatment.²¹ In *Schloendorff v. Society of New York Hospital*, Justice Cardozo wrote:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.²²

Thus, not only does one have a right to control his or her own body, but if someone else tries to exert control over another's body, the person exerting unauthorized control over another's body may be sued.

The right of personal autonomy in medical decision-making has been recognized by state legislatures as well as courts. For example, the preamble of Washington's Natural Death Act,²³ which permits terminally ill patients to legally refuse life-sustaining treatment, states that "adult persons have the fundamental right to control the decisions relating to the rendering of their own health care."

In medical decision-making, it is not just the patient's consent that is required, but the patient's informed consent.²⁴ As American tort law has developed, doctors are required to give their patients sufficient information so that the patient can make an informed and intelligent decision on whether to submit to a particular medical treatment.²⁵ A doctor's responsibility to inform his or her patient of the risks involved in a particular medical treatment is considered the legal standard of professional conduct under American tort law.²⁶ Consequently, a doctor's failure to obtain informed consent gives rise to a cause of

21. A.D. Nieuw, *Informed Consent*, 12 MED. & L. 125, 125 (1993).

22. *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

23. WASH. REV. CODE § 70.122.010 (1996).

24. KEETON, *supra* note 18, at 190.

25. *Id.*

26. *See* Nieuw, *supra* note 21, at 125-26.

'Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body and he may, if he be sound of mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary, but the law does not permit him to substitute his own judgment by any form of artifice or deception. The law requires that the inroads made upon a person's body take place only with informed voluntary consent of the person. The patient is entitled to full disclosure of risks, benefits and alternative treatments to any proposed procedure, both in therapy and in medical experimentation, except in emergencies or when the patient is incompetent, in which case proxy consent is required.'

Id. at 125 (quoting *Natanson v. Kline*, 350 P.2d 1093, *reh'g denied*, 354 P.2d 670 (Kan. 1960)).

action for negligence.²⁷ Therefore, when a patient is incompetent and unable to give informed consent, doctors are in a quandary: How can doctors provide the patient with the needed medical treatment, preserve the patient's right of autonomy, and protect themselves from a suit for negligence for treating the patient without the patient's consent?²⁸

III. THE PURPOSE OF PROXY MEDICAL DECISION-MAKING STATUTES

State legislatures, including Washington's, have sought to resolve this quandary by enacting proxy decision-making statutes.²⁹ Proxy decision-making statutes serve to protect medical practitioners from liability for treating an incompetent patient and to preserve patient autonomy, even when the patient is incompetent. Proxy decision-making statutes protect doctors from liability for treating a patient in the absence of the patient's informed consent by allowing someone besides the incompetent patient to give informed consent. As mentioned above, a doctor's failure to obtain consent from a patient would give rise to an action for negligence.³⁰ Proxy decision-making statutes also are intended to preserve the principle of autonomy by authorizing an individual who is most likely to know what decisions the incompetent patient would make to give informed consent on behalf of the incompetent patient.

Generally, the family is deemed to be the most appropriate proxy decisionmaker for the incompetent patient.³¹ The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommends that the family be designated as proxy decisionmaker for three reasons:

- (1) The family is generally most concerned about the good of the patient;
- (2) the family will also usually be most knowledgeable about the patient's goals, preferences, and values;

27. KEETON, *supra* note 18, at 190.

28. It should be noted that under the common law doctors may act in an emergency without informed consent. Judith Areen, *The Legal Status of Consent Obtained From Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. AM. MED. ASS'N 229, 229 (1987) (citing *Cobbs v. Grant*, 502 P.2d 1, 10 (1972)).

29. *Id.*

30. *See supra* Part II.

31. *In re Hamlin*, 102 Wash. 2d 810, 818, 689 P.2d 1372, 1377 (1984).

(3) the family deserves recognition as an important social unit to be treated, within limits, as a single decisionmaker in matters that intimately affect its members.³²

The common law in many states, including Washington, also requires doctors to look to the incompetent patient's family to obtain consent for medical treatment.³³

Some doctors and ethicists are critical of proxy decision-making because they believe that proxy decision-making does not actually effectuate the patient's wishes.³⁴ After conducting studies, some doctors and ethicists concluded that there is not a strong enough correlation between the decision a family believes the incompetent patient would make and the decision the patient would make for him or herself.³⁵

In examining these studies, however, one may draw the opposite conclusion: There is, in fact, a high correlation between the patient and proxy decisions. Which conclusion one draws depends on how one analyzes the data and the credence one gives the statistical theory used. To begin with, although the authors of these studies claim that there is not a "high" correlation rate, they fail to define high correlation in any of the studies.³⁶ In almost every study, there was at least a seventy percent correlation between the choice the patient said that he or she would choose and the choice that the proxy believed the patient would make.³⁷ However, the studies' authors did not believe that correlation rates of at least seventy percent were high.³⁸

The authors who argue that there is not a high correlation between the decisions a patient would make and those made by their

32. Paul B. Solnick, M.D., *Proxy Consent for Incompetent Non-Terminally Ill Adult Patients*, 6 J. LEGAL MED. 1, 19-20 (1985) (citing PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS 182-83 (1982)).

33. For example, in *Grannum v. Berard*, 70 Wash. 2d 304, 306, 422 P.2d 812, 814 (1967), the Washington Supreme Court found that consent to surgical treatment for an incompetent patient must be obtained from a "near relative capable of giving consent."

34. See Linda L. Emanuel, M.D. et al., *Advance Directives for Medical Care - A Case for Greater Use*, 324 NEW ENG. J. MED. 889, 894-95 (1991).

35. See *id.* See also Jan Hare et al., *Agreement Between Patients and Their Self-selected Surrogates on Difficult Medical Decisions*, 152 ARCHIVES INTERNAL MED. 1049, 1049-54 (1992); Allison B. Seckler et al., *Substituted Judgment: How Accurate Are Proxy Predictions?*, 115 ANNALS INTERNAL MED. 92, 92-97 (1991); Richard F. Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY M115, M115-21 (1988).

36. See sources cited *supra* note 35.

37. Hare, *supra* note 35, at 1049 (agreement on treatment occurred only 70% of the time); Seckler, *supra* note 35, at 94 (agreement between patients and family members on the two vignettes was 88% and 68%); Uhlmann, *supra* note 34, at M119 (Table 4A) (agreement between patients and their spouses ranged from 60.7% to 90% depending on the vignette).

38. See sources cited *supra* note 35.

proxies drew their conclusions based on the kappa coefficient,³⁹ which discounts for chance, and not the raw data that showed a seventy percent correlation. Thus, if one does not base one's conclusion on the kappa coefficient, but on the raw data, there is actually a high correlation (at least seventy percent) between patient and proxy decisions.

There are two other important conclusions from these studies. First, the studies that compared physician and patient decisions found that there was a much lower correlation rate between the physician-patient decisions than the family member-patient decisions.⁴⁰ This is further evidence that those closest to the patient should be proxies for the incompetent patient.

Second, when there was a discrepancy between the treatment the patient said he or she would select and that which the proxy believed he or she would select, the discrepancy was due to the surrogate overestimating the patient's preference to be resuscitated.⁴¹ In other words, the proxies selected by the patient erred on the side of preserving the patient's life. By contrast, the physicians erred on the side of removing life support.⁴² Because physicians erred on the side of removing life support, or not resuscitating, and more frequently made errors about what the patient's actual desires were, the need to appoint a proxy who is closest to the patient and most likely to know the patient's wishes is further reinforced.

Rather than showing that proxy decision-making fails to effectuate an incompetent patient's wishes, these studies show that at least seventy percent of the time the incompetent patient's wishes are effectuated. These studies also illustrate one way to improve the correlation rate: Ensure that the proxy is someone who knows the incompetent patient well. Doctors, who presumably did not know the patients as well as the family members knew the patients, failed to effectuate the patient's wishes more often than did the family members.

39. There are many methods of statistical analysis. The conclusion of these particular studies—that there is not a high correlation between patient and proxy decisions—is based on the statistical theory and methodology used, which, in brief, requires that a certain percentage of the answers be attributed to chance. The statistical number used to represent the correlation between patient and proxy decisions discounted by chance is called the kappa coefficient.

40. Seckler, *supra* note 35, at 94 (59% to 72% correlation for patient/physician decisions compared to 68% and 88% for family/patient decisions); Uhlmann, *supra* note 35, at M119 (Tables 4A and 4B) (correlation for five vignettes was 66.3%, 60%, 51.2%, 75.6%, 89.5% and 53.5% for physicians compared to 75.5%, 70.8%, 53.4%, 61.8%, 90%, and 60.7% for family members).

41. Seckler, *supra* note 35, at 95; Uhlmann, *supra* note 35, at M117.

42. See sources cited *supra* note 35.

This observation goes to the heart of this Comment's thesis: Because Washington's proxy decision-making statute fails to effectuate the incompetent patient's wishes, it must be revised to ensure that the person who is appointed proxy for the incompetent patient knows the patient well.

IV. WASHINGTON'S PROXY DECISION-MAKING STATUTE: RCW 7.70.065

In assessing why Washington's proxy decision-making statute may fail to effectuate many incompetent patients' wishes, this section analyzes the language and structure of the statute and the decision-making process that the statute creates. It also includes illustrations of family situations in which the person who is most likely to know the incompetent patient's wishes is excluded from the decision-making process.

A. *Analysis of RCW 7.70.065*

In exploring the complicated issue of who should make medical decisions for the incompetent patient, the Washington Supreme Court stated that the legislative, rather than the judicial, process was the appropriate forum for resolving such complex legal, medical, social, moral, and ethical issues.⁴³ The Washington legislature addressed this question in 1987 by enacting RCW 7.70.065. In reading the statute, the reader should focus on the following: the hierarchy of decisionmakers, the requirement of unanimity when parents or siblings are proxies, and the type of relationship one must have with the incompetent patient to act as the patient's proxy.

RCW 7.70.065 Informed Consent—Persons authorized to provide for patients who are not competent—Priority.

(1) Informed consent for health care for a patient who is not competent, as defined in RCW 11.88.010(1)(b), to consent may be obtained from a person authorized to consent on behalf of such patient. Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent shall be a member of one of the following classes of persons in the following order of priority:

43. *Hamlin*, 102 Wash. 2d at 821-22, 689 P.2d at 1378-79.

- (a) The appointed guardian of the patient, if any;
 - (b) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
 - (c) The patient's spouse;
 - (d) Children of the patient who are at least eighteen years of age;
 - (e) Parents of the patient; and
 - (f) Adult brothers and sisters of the patient.
- (2) If the physician seeking informed consent for proposed health care of the patient who is not competent to consent makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:
- (a) If a person of higher priority under this section has refused to give such authorization; or
 - (b) If there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.
- (3) Before any person authorized to provide informed consent on behalf of a patient not competent to consent exercises that authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

While there are several important aspects of the statute, this section highlights the benefits and problems particular to each class of decisionmakers under the statute. The first priority decisionmaker is a court-appointed guardian.⁴⁴ If a guardian is appointed by the courts, the courts can then intercede in circumstances such as the following: (1) there is a conflict between family members within the same class under the statute so that, as the statute directs, none of the family members may give consent; (2) a family member who disagrees with the proxy decisionmaker files a petition for guardianship to have the court appoint a different decisionmaker; (3) the hospital or treating

44. WASH. REV. CODE § 7.70.065(1)(a) (1996).

physician believes that the statutory decisionmaker is acting contrary to the patient's wishes or interests; or (4) none of the statutory decisionmakers are available or competent to give consent for the incompetent patient's treatment.

While guardianship proceedings may effectively resolve some conflicts, guardianship proceedings require the family members to seek legal advice, incur legal costs, and go through cumbersome legal guardianship proceedings.⁴⁵ Thus, cost or lack of knowledge about the legal system may preclude many people from using guardianship proceedings. Additionally, guardianship proceedings are not likely to resolve some of the problems with the statute, such as the exclusion of certain family members, unmarried partners or lifelong friends. The reason that guardianship proceedings are unlikely to remedy these problems is that judges are likely to rely on traditional notions of family and the statute itself in determining who should be appointed guardian.⁴⁶

The second priority decisionmaker under the statute is any individual to whom the patient has given a durable power of attorney for health care.⁴⁷ Although this is the ideal method for preserving patient autonomy, very few people have written a durable power of attorney for health care. According to one estimate, only between nine and twenty-three percent of Americans have executed any kind of formal, written advance directive.⁴⁸ However, even if someone has written a durable power of attorney, it may not be valid. There are strict statutory requirements for a durable power of attorney for health care to be effective under Washington law.⁴⁹ For example, the

45. See, e.g., WASH. REV. CODE § 7.70.065(1)(a) (1996). Ironically, one of the reasons that the Washington legislature enacted the statute was to enable the incompetent patient's family to avoid costly guardianship proceedings. *Floor Notes on H.B. 763*, 50th Leg., Reg. Sess. (Wash. 1987) (stating that "[t]he bill would eliminate the need for appointing a guardian in most cases. This would facilitate quicker medical treatment for the patient. It would also save the family court costs associated with the court appointment of the guardian.").

46. Areen, *supra* note 28, at 229; see also Amy Brown, Note, *Broadening Anachronistic Notions of "Family" in Proxy Decisionmaking for Unmarried Adults*, 41 HASTINGS L.J. 1029, 1057-59 (1990) (discussing *In re Guardianship of Kowalski*, 382 N.W.2d 861 (Minn. Ct. App. 1986). Sharon Kowalski was rendered incompetent after being hit by a drunk driver. The court refused to appoint Sharon's lesbian partner as guardian despite testimony from the treating nurses that Sharon was communicating that she wanted her partner to care for her. Instead, the court appointed Sharon's father guardian even though he called gays and lesbians fruits and queers and barred Sharon's partner from seeing her.)

47. WASH. REV. CODE § 7.70.065(1)(b) (1996).

48. Pearlman, *supra* note 9, at 355.

49. WASH. REV. CODE § 11.94.010(1) (1996). The durable power of attorney must either state "[t]his power of attorney shall not be affected by disability of the principal," or "[t]his power of attorney shall become effective upon the disability of the principal," or must include "similar

durable power of attorney instrument must clearly state that the instrument is to be effective during the patient's disability.⁵⁰ The absence of this language renders the durable power of attorney invalid.⁵¹

Additionally, if the person who is given the patient's durable power of attorney for health care is not on the statute's priority list, and is the patient's physician, an employee of the physician, or an owner, administrator, or employee of the health care facility where the patient resides or receives care, the durable power of attorney for health care is void.⁵² In other words, if an individual gives his or her durable power of attorney to a significant other, the couple is not married, and the significant other is a doctor or even a cafeteria worker in the patient's hospital, the durable power of attorney is invalid. Thus, even those individuals who take steps to preserve their autonomy by drafting durable powers of attorney may not have their wishes followed because of strict or outdated statutory requirements.

Furthermore, for each of the classes set out within the statute's family priority list in which there may be more than one person in the class (e.g., parents, children, and siblings), there must be unanimous agreement among that class of individuals.⁵³ If unanimity does not exist, no one is authorized to give consent under the proxy decision-making statute.⁵⁴ As discussed below, the requirement of unanimity may prevent an entire class of potential proxies, whether siblings or parents, from making decisions for the incompetent patient because a unanimous decision cannot be reached.

Finally, the person who is appointed as proxy must seek to determine what decision the patient would have made if he or she were competent.⁵⁵ The statute does not specify what efforts must be made or who should be questioned in making this determination.⁵⁶ If the proxy decisionmaker cannot determine what decision the incompetent patient would make, the proxy decisionmaker may make the decision according to "the best interests" of the patient.⁵⁷ The less the proxy

words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the principal's disability." *Id.*

50. *Id.*

51. There are no studies of which the author is aware that document the number of power of attorneys held invalid because of a failure to comply with the statutory requirements.

52. WASH. REV. CODE § 11.94.010(3) (1996).

53. WASH. REV. CODE § 7.70.065(2)(b) (1996).

54. *Id.*

55. WASH. REV. CODE § 7.70.065(3) (1996).

56. *Id.*

57. *Id.*

decisionmaker knows the incompetent patient, the more likely the proxy will resort to "the best interests" test, which may not comport with the decision that the patient would have made. Under such circumstances, the statute's purpose of preserving the patient's autonomy will not be carried out.

Several legal scholars, ethicists, and medical practitioners, though not analyzing this particular statute, have made general observations about proxy decision-making. These authors have discussed both the problem with limiting proxy decisionmakers to immediate family members and the problem with legislating a hierarchy of decisionmakers.⁵⁸ Noted family law professor Judith Areen has written that reliance on families as proxy decisionmakers is not without problems because the family may not include the most knowledgeable proxy decisionmaker.⁵⁹ Other legal scholars and doctors writing about proxy decision-making echo the concerns raised by Areen. In some circumstances, the most appropriate decisionmaker will be excluded because that person is lower in priority or not designated in the statute at all, there will be no close family member, or there may be a conflict of interest between the incompetent patient and family members.⁶⁰ In such cases, as one ethicist points out, flexibility is desirable.⁶¹

Some ethicists go a step further and argue that imposition of a hierarchical arrangement, a particular vision of how families ought to be, in and of itself negates personal and family autonomy. A legal hierarchy of proxy decisionmakers may fail to effectuate patient autonomy because "families and close others do not necessarily or even very commonly come in the neat prearranged hierarchical order envisioned by legislators."⁶²

These general criticisms of hierarchical decision-making statutes are applicable to RCW 7.70.065 because the statute imposes a rigid hierarchy of decisionmakers. This hierarchical arrangement of family members in proxy decision-making statutes, as these authors argue and the hypotheticals above illustrate, does not reflect current reality.

58. See Areen, *supra* note 28, at 233-34; Dan W. Brock, *Surrogate Decision Making for Incompetent Adults: An Ethical Framework*, 58 MT. SINAI J. MED. 388, 390 (1991); Erich H. Loewy, *Furthering the Dialogue on Advance Directives and the Patient Self-Determination Act*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 405, 407-08 (1994); Solnick, *supra* note 32, at 22.

59. See Areen, *supra* note 28, at 233-34.

60. See Brock, *supra* note 58, at 390; Solnick, *supra* note 32, at 22.

61. Brock, *supra* note 58, at 390.

62. See Loewy, *supra* note 58, at 407.

Consequently, statutes such as RCW 7.70.065 impose a decision-making structure that negates personal autonomy.

B. Illustrations of Family Members Excluded by RCW 7.70.065

Up until this point, the discussion of the statute's shortcomings has been focusing on theory rather than on the people who are adversely affected by the statute. The discussion thus far has focused on the priority of potential decisionmakers in the statute, the requirement of unanimity, and the infrequent use of durable powers of attorney. However, who is actually affected by the statute's shortcomings? The following hypotheticals illustrate the range of family members and intimate relations who are excluded from the decisionmaker hierarchy of the statute.⁶³

Illustration 1

Derrick is twenty-nine years old and is incompetent due to a rare genetic disorder. His parents were divorced when he was three. Derrick's mother was his primary caretaker and has cared for Derrick as his condition has deteriorated over the last three years. Derrick's father rarely paid the required child support as Derrick was growing up and only saw Derrick about once every year or two. Derrick's doctors believe that Derrick is a good candidate for an experimental treatment, which, if successful, may enable Derrick to lead a fairly normal life, but if unsuccessful will likely result in Derrick's death. Derrick had often indicated to his mother that he would take any risk if by doing so he might be cured. The doctors are obligated to obtain permission from both parents under the statute. Derrick's father refuses to consent to the treatment.

Illustration 2

Jasmine and Charlie have lived together as significant others for six years. Both of Charlie's parent's are deceased, though he has a younger brother to whom he has never been particularly close. When Charlie is critically injured in a car accident, the hospital seeks consent for certain surgical procedures from his brother, rather than Jasmine, because an unmarried partner cannot give consent for treatment under the current version of the statute.

63. See *infra* Part V, which uses U.S. Census Bureau Statistics to show the number of Washington residents represented by each of these hypotheticals.

Illustration 3

Monique is twenty-one years old. She has lived with her grandmother who has raised her since Monique was three years old. Monique's mother is a substance abuser and has been in and out of Monique's life depending on whether she is clean and sober or on a substance binge. Monique is shot at a party after a fight breaks out between two individuals standing near Monique. Because grandparents are excluded from the statute's hierarchy, the hospital is legally obligated to consult with Monique's mother to gain consent for Monique's treatment.

Illustration 4

Richard and Doug, who consider themselves to be life partners, have been together for twelve years. Doug, dying from complications due to AIDS, has had infrequent contact with his family over the past fifteen years. He has never come out to his family because he believes they would condemn him because of his homosexuality. Doug has not written out a medical durable power of attorney. He has, however, told Richard, emphatically, that he does not want to be maintained on a respirator or other life support systems. When Doug becomes incompetent, the hospital contacts his parents in Ohio, because Richard may not legally give consent to Doug's treatment. Doug's parents are shocked and outraged when they find out that Doug is gay and is dying from complications due to AIDS. Over Richard's objections, Doug's parents order the hospital to maintain Doug on a respirator.

Illustration 5

Kathryn lives in a wealthy suburb of Seattle with her four children, ages twelve to five. She and her husband have been separated, though not legally, for nearly a year. Kathryn's parents, who live in the same city, have been tremendously supportive of her in her struggle to put her life back together. When Kathryn is rendered incompetent due to a car accident, the statute requires that the hospital first seek consent from her husband for nonemergency surgery. Kathryn's parents are excluded from decision-making because if there is someone available from a higher priority class, here a spouse, the lower priority class may not be consulted.

Illustration 6

Diane, aged thirty-three, is an only child. Her father passed away when she was six and her mother passed away just last year. Diane and her cousin Sharon have been like sisters their whole lives. After

feeling ill for over a month, Diane is diagnosed with leukemia and her condition degenerates very quickly. Within six weeks she is incompetent. Sharon has been at her side continuously. Diane, refusing to believe that she was dying, would not fill out a medical durable power of attorney. After Diane becomes incompetent, Diane's doctors may not turn to Sharon to make decisions, because cousins are not listed in the statute.

Illustration 7

Eileen McCafferty has lived in the same eastern Washington community for all of her seventy-two years. She has one child, Mike, who she sees about once a year. She speaks to him on the phone about once every two or three months. Mrs. McCafferty and Etta Jones have been each other's closest friend since the two women graduated from high school together in 1936. Each morning Eileen and Etta walk the one mile trail around the lake and then have coffee at Etta's house. One morning Eileen collapses and never regains consciousness. Although Etta knows Eileen better than anyone, the hospital must seek consent from Eileen's son, Mike, for Eileen's medical treatment.

In each of the illustrations above, the person or persons who are most likely to know what the incompetent patient's wishes would be are precluded from making medical decisions for the incompetent patient by RCW 7.70.065. Conversely, in each illustration an individual who has had little contact with the incompetent patient and is unlikely to know the incompetent patient's wishes is the designated decisionmaker from whom a doctor must obtain consent.

The reasons that the statute may preclude those most likely to know the patient's wishes from making medical decisions for the incompetent patient are twofold. First, as discussed below, the statute makes certain presumptions about families that prove to be erroneous. For instance, it seems to presume that one is always married to his or her significant other. Also, it operates under the assumption that both parents are equally aware of what decisions their adult child would make should the adult child become incompetent.

The second reason the statute may lead to relying on a family member unfamiliar with the incompetent patient's wishes is the statute's rigid hierarchy. For example, in Illustration 5, the parents, rather than the spouse, are the more appropriate decisionmakers under the statute. However, the statute does not allow for any flexibility.

V. DEMOGRAPHIC PROFILE OF THE FAMILY

The assertion that this traditional configuration of the family does not reflect current reality is supported by U.S. Census Bureau statistics on the family.⁶⁴ These statistics illustrate that the traditional family, a married couple living with their children, is no longer a reality for millions of Americans. As the tables below illustrate, there has been a dramatic decline in the number of two-parent families, a larger percentage of the population has never married than in previous decades, more people live alone than ever before, and there has been a sharp rise in what the census bureau labels "nonfamily households."⁶⁵ Additionally, there are important differences in how family is defined among different ethnic groups.⁶⁶ Therefore, as the statistics discussed below illustrate, the family hierarchy used in the statute does not reflect current reality.

A. Rise in Single-Parent Families

Table 1 illustrates that there has been an 18% decline in the percentage of U.S. households with children that are comprised of two parents residing with their children (87% in 1970 to 69% in 1994). Conversely, there has been an 18% increase in the number of single-parent households over this same time period. Numerically, there were 141,964 single-parent households in Washington in 1990, according to the 1990 census.⁶⁷

64. U.S. DEPT. OF COMMERCE, BUREAU OF THE CENSUS, CENSUS OF POPULATION AND HOUSING, WASHINGTON, Summary Tape File 3A (1990).

65. The U.S. Census Bureau does not define "nonfamily household." However, every household that does not meet the Census Bureau's definition of "family household" is a nonfamily household. Family, according to the U.S. Census Bureau, consists of a householder and one or more other persons living in the same household who are related to the householder by birth, marriage or adoption. *See id.* at Appendix B-15.

66. *See infra* Part V(D).

67. *See* CENSUS OF POPULATION AND HOUSING, *supra* note 64 at 7.

Table 1
Family Household Composition, 1970-1994
(percent distribution)^a

	1970	1980	1990	1994
Two Parent Family Groups	87	79	72	69
One Parent Family Groups	13	22	28	31
Maintained by Mother	12	19	24	27
Maintained by Father	1	2	4	4

- a. U.S. Department of Commerce, Bureau of the Census, *Table No. 71. Family Groups with Children Under 18 Years Old, by Race and Hispanic Origin: 1970 to 1994*, Statistical Abstract of the United States, at 61 (1995).

The significance of a large percentage of children growing up in single family households, for the purposes of the proxy decision-making statute, is that when a young, unmarried person is rendered incompetent, the statute directs that consent be obtained from the "parents of the patient."⁶⁸ The statute apparently assumes that parents, plural, will have knowledge of the incompetent patient's wishes.

Illustration 1, in which Derrick's absentee father refused to give permission for Derrick's treatment, is one scenario in which a parent may have no knowledge of an adult child's wishes, in marked contrast to the other parent. The statute requires that reasonable efforts be made to locate both parents and, if both parents are located, the statute is clear that both parents must agree to the treatment.⁶⁹ Therefore, the parents, irrespective of the tenuousness of their relationship with

68. WASH. REV. CODE § 7.70.065(1)(e) (1996).

69. WASH. REV. CODE § 7.70.065(2)(b) (1996). No person listed in the statutory hierarchy may give consent if "there are two or more individuals in the same class and the decision is not unanimous among all available members of the class." *Id.*

the incompetent patient, or with each other, must agree to the treatment. In addition, there is no requirement that each parent have had frequent, or even any, contact with the incompetent patient. If no agreement is reached between the parents, the treating physician must look to the courts to appoint a guardian. The family, therefore, will have to incur legal costs, miss work, undergo the stress of a legal proceeding and, in all probability, wind up with the primary caretaker parent being appointed as guardian.

In addition to the problem of the unanimity requirement, the prevalence of single-parent families also illustrates the problems within the mandatory hierarchy of family decisionmakers. The statute imposes a blanket rule that consent must be sought from a parent over and above other family members, regardless of the various family members' demonstrated concern for the patient and knowledge of the patient's wishes. Therefore, when the parent who had been the primary caretaker is deceased or incompetent herself, a parent who has been predominantly an absentee parent of the incompetent adult patient must give consent to treatment for the incompetent patient.⁷⁰ In this case, adult siblings, who may have a much closer relationship with the incompetent patient than the absentee parent, may be more appropriate decisionmakers. Siblings, however, are precluded from being decisionmakers if there is a parent who can be contacted.⁷¹ Grandparents and other relatives are not even considered in the statute.

It is evident that in enacting RCW 7.70.065, the legislature assumed that all families are comprised of two-parent households, and that both parents are close enough to their adult children to know what treatment their child would choose if competent. However, Census Bureau statistics show that two-parent families are not a reality for 141,964 households in Washington. While these statistics do not show how many of these single-family households have a parent not residing in the household who nevertheless is active in his or her children's lives, for many people raised in single-parent families, the statute may fail to effectuate their wishes by requiring consent from both parents, regardless of whether or not both parents were active in their lives.

B. Decline in Number of People Who Marry

Just as the statute erroneously assumes that both parents have been active in their children's lives, it also wrongly assumes that the patient is married. It ignores the possibility of a significant other.

70. See WASH. REV. CODE § 7.70.065 (1996).

71. WASH. REV. CODE § 7.70.065(2)(a) (1996).

Under the statute's hierarchy, the spouse is the first priority of the family decisionmakers.⁷² By placing the spouse as the first priority medical decisionmaker for an incompetent patient, the statute assumes that a person's significant other (i.e., spouse) will be most knowledgeable of the patient's wishes. Though that assumption may indeed be correct, the statute wrongly assumes that all people are married to their significant others.

As Table 2 illustrates, the percentage of the population over age eighteen that has never married has increased from 16.2% in 1970 to 23.3% in 1994. In Washington, 923,372 people over age fifteen have never married.⁷³

Table 2

Marital Status of Individuals 18 Years Old and Over
(percent)^a

	1970	1980	1990	1994
Never Married	16.2	20.3	22.2	23.3
Married	71.7	65.5	61.9	60.6
Widowed	8.9	8.0	7.6	7.0
Divorced	3.2	6.2	8.3	9.2

- a. U.S. Department of Commerce, Bureau of the Census, *Table No. 58. Marital Status of the Population, by Sex, Race, Hispanic Origin: 1970 to 1984*, Statistical Abstract of the United States, at 52 (1995).

However, many of these individuals who have never married do live with other individuals. As illustrated by Table 3, nearly a third of the population lives in "nonfamily households."

72. WASH. REV. CODE § 7.70.065(1)(c) (1996).

73. See CENSUS OF POPULATION AND HOUSING, *supra* note 64, at 8.

Table 3
Comparison of Family and Nonfamily Households
(percent)^a

	1970	1980	1990
Family Households	81.1	73.7	70.8
Nonfamily Households ^b	18.9	26.3	29.1
Male Householder ^c	6.4	10.9	12.4
Female Householder	12.4	15.3	16.7
One Person ^d	17.1	22.6	24.6

- a. Derived from U.S. Department of Commerce, Bureau of the Census, *Table 65. Households, Families, Subfamilies, Married Couples, and Unrelated Individuals: 1960 to 1994*, STATISTICAL ABSTRACT OF THE UNITED STATES 57 (1995).
- b. Nonfamily households are divided into either households with a male householder (head of house) or female householder.
- c. Householder: one person in each household is designated as the householder. In most cases, this is the person, or one of the persons, in whose name the home is owned, being bought, or rented and who is listed in column 1 of the census questionnaire. U.S. Department of Commerce, Bureau of the Census, *1990 Census of Population and Housing, Summary Social, Economic and Housing Characteristics Washington*, at Appendix B-15 (1990).
- d. One person households are a subset of nonfamily households and include both male and female householders who live alone.

In Washington, there were 599,281 nonfamily households counted in the 1990 Census (32% of all Washington households).⁷⁴ Of these nonfamily households, 86,772 households identified themselves as "unmarried partner households." Thus, at least 173,544 people in Washington live with someone in an intimate relationship, though those intimate partners are invisible in Washington's medical decision-making hierarchy. Consequently, as shown by Illustration 2, Jasmine and Charlie, an unmarried couple who live together, and

74. See *id.* at 7.

Illustration 4, Doug and Richard, a gay couple, the statute may not effectuate the wishes of incompetent patients because it excludes unmarried partners from the statutory hierarchy of decisionmakers. Thus, for this sizable group of people, the statute does not achieve its purpose.

C. Numbers of Washington Families Living With Extended Family

Even among "family" households, as Table 4 illustrates, people often live with individuals who are not immediate family members. In Washington in 1990, 44,584 children lived with a grandparent present in the house. The statistics do not show if the grandparent is the head of the household or if the child's parents are also present in the household. Even if the grandparent has been the child's primary caretaker, RCW 7.70.065 makes no provision for grandparents to be proxy decisionmakers.⁷⁵ These families are represented by Illustration 3, in which Monique's grandmother is not able to consent to Monique's treatment even though she has raised Monique.

Additionally, as Table 4 also illustrates, 97,358 Washingtonians live with relatives other than their spouse, children or grandchildren. Even though tens of thousands of Washington residents live with grandparents, aunts, uncles and cousins, who may well know what treatment these Washington residents would choose for themselves, if they were able to do so, these family members are excluded from RCW 7.70.065's list of decisionmakers.

75. WASH. REV. CODE § 7.70.065(1) (1996).

Table 4
Washington Population by Household Type^a

Relationship to Family Householder	Number
Number of Family Households ^b (number of householders)	1,276,227
Spouse	1,045,661
Child	
Natural	1,344,689
Stepchild	89,886
Grandchild	44,584
Other Relatives	97,358
Nonrelatives	88,969

- a. U.S. Department of Commerce, Bureau of Census, *Census of Population and Housing, 1990, Washington, Summary Tape File 3* (1990).
- b. All categories of people in this table are listed by their relationship to the householder (head of house). For example, spouse represents the householder's spouse, child represents the householder's child(ren).

D. Cultural Differences in the Definition of Family

The current legal hierarchy for proxy decisionmakers also does not take into account how cultural differences between different racial or ethnic groups affect who should make life or death decisions and how they should be made. For example, "family" is often defined in much broader terms in ethnic groups than in the dominant culture. "Play" relatives within the African-American community refer to individuals who have become members of a family through their close relationship and commitment to the family rather than through blood or marriage.⁷⁶ One may have "play" sisters, aunts, uncles and

76. Robin Terrell Tucker, *Patient Self-Determination Act: An African American Perspective*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 417, 418 (1994).

cousins.⁷⁷ These "play" family members are considered as much a part of the family as people related by blood or marriage.⁷⁸

In sum, the concept of family underlying RCW 7.70.065 does not reflect the reality of many families in Washington or in current U.S. society as a whole. Nearly a third of Washington's population lives in "nonfamily households."⁷⁹ More than a quarter of family households are maintained by single parents.⁸⁰ People are marrying less often and divorcing more frequently. Tens of thousands of Washingtonians live with members of their extended families.⁸¹ There are differences among ethnic groups as to who is considered family. Therefore, it should not be presumed or legislated that those who best know an incompetent patient's wishes are only the immediate family members in the following order: spouse, adult children, parents, and adult siblings.

VI. SOLUTIONS

As Part V of this Comment illustrates, no single definition of "family" currently describes all families. Nor does a family relationship mean that one will know the wishes of a family member who becomes incompetent. Therefore, RCW 7.70.065, which is based on a single definition of "family" and the presumption that only those family members will know what decision an incompetent person would make, should be revised to reflect the reality of families today.

Specifically, four changes should be made to Washington's proxy medical decision-making statute. First, general practitioners should be required to discuss advance directives and medical durable powers of attorney with their patients. This can be accomplished by enacting a new statute designed to encourage the use of durable powers of attorney and other advance care directives.

Second, the definition of "family" in RCW 7.70.065 should be amended to include relatives other than immediate family members. This change should be made to reflect the current reality of what "family" is for tens of thousands of Washington's citizens. In addition, close friends should be allowed to act as surrogate decision-makers in appropriate circumstances.

77. *Id.*

78. *Id.*

79. *See supra* Table 3.

80. *See supra* Table 1.

81. *See supra* Table 4.

Third, the hierarchy in RCW 7.70.065 should be eliminated by amending Washington's statutes on proxy decision-making and durable powers of attorney. Fourth, hospital ethics committees, rather than the courts, should be a first resort for families having difficulty deciding the appropriate proxy. This change also can be accomplished by amending the proxy decision-making statute.

Although each of these proposed amendments eliminates some of the problems discussed above, new problems or uncertainties may arise from the newly formulated statute. However, the benefits of the proposed new statutory scheme far outweigh its potential problems. Each of these proposed changes, as well as sample language for the proposed statutes, is discussed in detail in the following section.

A. *Requiring General Practitioners to Discuss Advance Directives and Durable Powers of Attorney With Their Patients*

Currently, the federal Patient Self-Determination Act requires caregivers to ask a patient entering any hospital, hospice, nursing home, managed care organization, or home health care organization that receives Medicare or Medicaid funds if the patient has an advance care directive.⁸² Additionally, the physician must inform a patient of any state laws that pertain to medical durable powers of attorney and living wills.⁸³ The patient's directives must then be documented in the patient's medical record.⁸⁴

Unfortunately, not all patients are capable of engaging in these discussions when entering a hospital. The patient may already be incompetent. If a patient has already discussed his or her wishes about care with a physician while the patient was still healthy, the patient's wishes would be known by the physician in the event the patient becomes incompetent. To eliminate the problem of having the required discussion about advance care directives occur too late in the patient's treatment, that is, after the patient is already incompetent, these discussions should be required at an earlier point in the patient's medical treatment. A revision to Washington law should require that general practitioners discuss advance directives and medical decision-making with their patients during routine examinations and document

82. 42 U.S.C. § 1395cc(f) (1995); see also P.V. Caralis et al., *The Influence of Ethnicity and Race on Attitudes Toward Advance Directives, Life-Prolonging Treatments, and Euthanasia*, 4 J. CLINICAL ETHICS 155, 155 (1993).

83. *Id.*

84. *Id.*

the patients' decisions in their medical records.⁸⁵ Furthermore, there should be a requirement that these discussions reoccur every five to ten years.

Doctors, health care facilities, and insurers may be concerned about the cost of doctors' time for discussing these issues with patients. Some would argue that fifteen minutes spent with every patient on the patient's first visit and then at five-year intervals thereafter will be costly. That doctors, insurers, health maintenance organizations and, ultimately, patients, will have to bear the cost of the doctors' time spent discussing advance care directives and medical durable powers of attorney is undeniable.

However, one study that examined the time it would take for doctors and patients to discuss these issues and fill out a form found that the time required was minimal.⁸⁶ This study found that the discussion could be coupled with the use of documents, such as medical directives, which most patients were able to finish in fifteen minutes or less.⁸⁷ The authors of the study believed that the visit involves a small amount of time that is well-justified by the physician's ethical duty to inform the patient and preserve patient autonomy.⁸⁸ Therefore, as this study concludes, the concern about excessive costs associated with requiring physicians to discuss advance care directives or medical durable powers of attorney with their patients is outweighed by the benefit.

Furthermore, spending fifteen minutes with a patient explaining a durable power of attorney and other medical directives could save the physician and third-party payers time and money if and when the patient becomes incompetent. Currently, when a patient is incompetent, the physician must make reasonable efforts to locate family members and determine who under the statutory scheme is the appropriate proxy.⁸⁹ If a patient already has a durable power of attorney for health care in his or her medical records, the time the physician must expend to find the appropriate decisionmaker if a patient becomes incompetent is lessened considerably.

85. Linda L. Emanuel, M.D. & Ezekiel S. Emanuel, M.D., *The Medical Directive: A New Comprehensive Advance Care Document*, 26 J. AM. MED. ASS'N 3288, 3291 (1989) (discussing patients' end of life decisions with them has long been considered part of a physician's ethical responsibility).

86. Emanuel, *supra* note 34, at 895.

87. *Id.*

88. *Id.*

89. WASH. REV. CODE § 7.70.065(2) (1996).

Another concern that might be raised in requiring physicians to discuss advance directives and durable powers of attorney with their patients is that fifteen minutes with a physician will not allow a patient enough time to make weighty decisions such as (1) who do I want to have my medical durable power of attorney, or (2) do I want to be resuscitated should the need arise? The author of this Comment has found no study examining the question of whether decisions made in fifteen minutes concerning durable powers of attorney or advance directives comport with decisions a patient would make given more time. Common sense, however, leads to the conclusion that if a patient has thought about these issues, though has never filled out the proper documents, then fifteen minutes would be sufficient. But, if a patient has never thought about advance directives or durable powers of attorney, fifteen minutes is probably insufficient to make such weighty decisions.

To alleviate this problem, a patient could be prompted to think about advance directives or medical durable powers of attorney prior to his or her first visit during which the physician will discuss these issues. The physician or health maintenance organization should send a pamphlet, written in easily understandable language describing the function of advance care directives and medical durable powers of attorney and the medical situations in which these documents would be used. Thus, although a fifteen minute discussion with a physician may be insufficient for some patients, the patient can be prompted to think about advance directives or medical durable powers of attorney by being sent an information pamphlet prior to the patient's first visit with the physician.

In order to ensure that physicians will send their patients information pertaining to advance care directives and medical durable powers of attorney and that physicians discuss this information with their patients, physicians should be required by statute to carry out these two tasks. The following proposed statute, modeled after the federal Patient Self-Determination Act,⁹⁰ would ensure that a larger percentage of Washingtonians have durable powers of attorney or medical directives, thereby preserving their autonomy.

90. 42 U.S.C. § 1395cc(f) (1995).

Proposed Washington Patient Self-Determination Act

(1) Every physician licensed by the State of Washington shall provide written information to all adult individuals to whom that physician provides medical care concerning an individual's rights under Washington law (whether statutory or as recognized by the courts of Washington) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives under RCW 70.122.030 and the right to appoint a medical durable power of attorney under RCW 11.94.010.

(2) Every physician shall provide the written information described in section (1) to the patient prior to the patient's first visit with the physician.

(3) Every physician shall document in the medical records of each patient when they treat the patient

(a) whether or not the patient has executed a living will;

(b) whether or not the patient has executed a durable power of attorney for health care;

(c) if the patient has executed a living will or durable power of attorney, the physician shall ask the patient to send a copy of such document(s) to the physician and the physician shall place such document(s) in the patient's medical record;

(d) if the patient already has a living will or durable power of attorney in his or her medical records, the physician shall ask the patient if the directive(s) are still current and note the patient's response in the medical records. If the directive(s) are not current, the doctor shall have the patient change the directive(s) to make them current, and have the patient initial the changes.

B. Broadening the Definition of Family and Including Close Friends in the List of Potential Proxy Decisionmakers

Although the increased use of durable powers of attorney for health care and other advance directives will decrease the need for a statute to authorize proxy decisionmakers, not all Washingtonians who become incompetent will have completed durable powers of attorney for healthcare.⁹¹ Consequently, the need for statutory proxies will persist. In order to carry out the purpose of a statute for proxy

91. Janofsky & Rovner, *supra* note 9, at 214 (between 4% and 17.5% of adults have advance care directives); Pearlman, *supra* note 9, at 355.

decisionmaking, i.e., appointing a proxy that is most likely to know the incompetent patient's wishes, the current statute for proxy decision-making should be amended. The statute should reflect the fact that at least one-third of Washington residents do not live within a traditional family unit.⁹² Specifically, Washington's statute for proxy decisionmaking should include unmarried partners, relatives other than immediate family members, and close friends who are, in effect, considered "family" by the incompetent patient. These changes will ensure that those who are closest to the patient, and therefore those most likely to know the patient's wishes, will not be excluded from the proxy decision-making process.

Opposition to amending the definition of family under RCW 7.70.065 may be voiced by those who believe that a majority of Washingtonians live in a traditional nuclear family and that broadening the definition of "family" will contribute to the breakdown of the traditional family. First, critics may argue that there is no point in changing the definition of family because for the majority of Washingtonians, the current definition of family fits: that is, a majority of Washingtonians live in the traditional nuclear family.⁹³ However, this argument ignores the fact that for as many as one-third of Washington residents, the current definition of family under RCW 7.70.065 does not fit.⁹⁴ The effect of this lack of fit is that life and death decisions may be made by a family member who has little or no idea of what decision the incompetent individual would make for him or herself.

A decision such as whether or not an incompetent patient should be resuscitated while hospitalized is too important to be made by someone who is unfamiliar with the patient's wishes, particularly when someone who knows the patient's wishes may be available to make that decision instead. Therefore, the argument that the statute probably works for up to two-thirds of Washingtonians is too simplistic in the face of the importance of the decisions being made by the proxy. Because the definition of "family" under RCW 7.70.065 can be amended to encompass more than simply a majority of Washington families, the statute should be amended to increase its effectiveness.

A second argument raised in opposition to broadening the definition of "family" is that doing so will contribute to the breakdown of the traditional family. This argument erroneously focuses on one

92. See *supra* Part V.

93. See *supra* Part V.

94. See *supra* Part V.

of the symptoms of the decline of the traditional family, rather than the cause of the decline. That is, some family members will not know the wishes of an incompetent family member because of a breakdown in the traditional family. Just as the current definition of "family" does not keep families together, a broadened definition of "family" will not tear families apart. The statute's definition of "family" should merely reflect reality.

It is important for the definition of "family" to reflect reality because the purpose of the statute is to select a proxy decisionmaker who is familiar with the incompetent patient's wishes, thereby preserving the personal autonomy of the incompetent patient. Thus, RCW 7.70.065 should be amended because broadening the definition of "family" and permitting close friends who are considered "family" to be proxy decisionmakers will preserve patient autonomy for a greater number of Washingtonians.

C. *Eliminating the Hierarchy Under RCW 7.70.065*

Broadening the definition of "family" under RCW 7.70.065, however, will not resolve all of the problems with the statute. In many circumstances, there are family members who are equally close to the incompetent patient, and, therefore equally capable of knowing or figuring out what the incompetent patient's wishes would be, yet are not included in the legal hierarchy of decisionmakers. To elaborate, an incompetent patient's parents and spouse might know equally well what decision an incompetent would make for himself or herself. Or, for example, the parents and siblings might be equally familiar with the incompetent patient's wishes.

Consequently, the statute should encourage family members to discuss what the incompetent patient would want and to come to a consensus about the decision that the incompetent patient would make, were he or she competent. The family's shared knowledge of the patient's values, wishes, and past statements may make it more likely that the treatment decision that is made by the family will accurately reflect the patient's wishes.

D. *Utilizing the Hospital Ethics Committee*

Under some circumstances, it will not be possible for the family to reach a consensus about the medical treatment that the incompetent patient would choose. In these circumstances one person will have to

be appointed as proxy decisionmaker.⁹⁵ Rather than resorting to the cumbersome, slow, and expensive legal guardian proceedings, an alternative exists. Hospital ethics committees provide a ready-made forum for resolving disputes concerning medical ethics and treatment decisions.⁹⁶ These committees are frequently made up of a lawyer, a member of the community, a physician (who is not the treating physician), a nurse, a social worker and a hospital administrator. The hospital ethics committee could be a valuable tool in resolving the dispute over which family member is the most appropriate proxy decisionmaker.

The benefits of having a hospital ethics committee make the initial determination as to the most appropriate proxy are that it is quicker and less expensive than going through a guardianship proceeding and some of the members of the committee, such as the social worker, bring special professional expertise in understanding and evaluating family or other interpersonal relationships. An additional benefit is that the hospital ethics decision is appealable and any family member who is dissatisfied with the decision can file a legal guardianship petition with the courts at any time. Further, having a hospital ethics committee determine who should be appointed as the proxy decisionmaker alleviates the concern that if the family does not agree on a treatment decision, the physician will select as a proxy the family member who agrees with the physician's treatment choice.⁹⁷

Some may argue that having the hospital ethics committee involved in helping the family resolve any disputes over the most appropriate proxy is merely another hoop for the family to jump through in making a decision for the incompetent patient. However, mediation has been recognized as an effective tool in resolving disputes inexpensively, while at the same time preserving the relationships among the parties that might otherwise be damaged through the adversarial process. While requiring that families first attempt mediation through the hospital ethics committee will be another hoop for families if the mediation fails, for families where the mediation is successful, family relationships will be preserved and the dispute will be resolved more quickly. Because the benefits of preserving family relationships at the difficult time when a loved one becomes incompetent far outweigh the several hours spent in mediation, the hospital

95. See WASH. REV. CODE § 7.70.065 (1996).

96. Areen, *supra* note 28, at 234; Solnick, *supra* note 32, at 44-46.

97. Solnick, *supra* note 32, at 42-43.

ethics committee should be involved in resolving disputes over the appropriate proxy decisionmaker.

The statute can mandate that in choosing the proxy the committee consider the following factors: (1) with whom the incompetent patient resided before becoming incompetent; (2) who of the eligible decisionmakers was in close contact with the incompetent patient over the years immediately prior to the patient becoming incompetent; (3) who shared an intimate relationship with the patient; (4) who has discussed the patient's wishes concerning medical treatment with the incompetent patient before the patient became incompetent; and, (5) who has cared for and will continue to care for the incompetent patient.

E. Proposed Proxy Decision-Making Statute

The following amended version of RCW 7.70.065 addresses the concerns discussed in this Comment by broadening the class of potential proxies, eliminating the hierarchy of potential decisionmakers, encouraging discussion among family members, and using hospital ethics committees to resolve disputes over who should be appointed proxy in the event that the family (including close friends) is not able to make that decision.⁹⁸

Proposed Proxy Decision-Making Statute

(1) Definitions:

(a) family: for the purposes of this statute shall include any person related to the incompetent patient by blood, marriage or adoption, the unmarried partner of the incompetent patient, and any person who has demonstrated a sincere, long-standing interest in the welfare of the patient.

(b) hospital ethics committee: for the purposes of this statute is a committee formed by a hospital that, at a minimum, includes the following members: a lawyer, a member of the community, a physician (who is not the treating physician), a nurse, a social worker and a hospital administrator.

(c) unmarried partner: for the purposes of this statute shall include a person over the age of eighteen with whom the incompetent person, immediately prior to becoming incompetent, shared a committed, intimate relationship.

98. These proposed changes necessitate amending RCW 11.94.010(3), the durable power of attorney statute. A discussion of why amendments are necessary follows *infra*.

Evidence of such a relationship may include documentation of commitment; whether the couple commingles funds, owns property together, lives together; parents children together; have named each other as beneficiaries in wills, pension plans or insurance policies; whether they hold themselves out to the community as a couple.

(2) Informed consent for health care for a patient who is not competent, as defined in RCW 11.88.010(1)(b), to consent may be obtained from a person authorized to consent on behalf of such patient. Persons authorized to provide informed consent to health care on behalf of a patient who is not competent shall be a member of one of the following classes of persons in the following order of priority:

- (a) The appointed guardian of the patient, if any;
- (b) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
- (c) A relative or friend who is age eighteen or older and who has demonstrated a sincere, long-standing interest in the welfare of the incompetent patient.

(3) The treating physician seeking informed consent must make reasonable efforts to contact (1) the patient's spouse or unmarried partner; (2) one of the patient's parents; and (3) any person who has presented him or herself at the hospital and who may be an eligible decisionmaker under the criteria in section (1)(c).

(4) The treating physician shall request that the family reach a consensus about the treatment decision that the incompetent patient would have made were he or she competent.

(5) If the family is not able to reach consensus within a reasonable time, usually within twenty-four hours for a nonemergency treatment decision, the hospital ethics committee shall meet with family members or speak with concerned family members via telephone and the hospital ethics committee shall decide who of the eligible decisionmakers shall be the proxy decisionmaker.

(6) If the patient's condition, in the opinion of the treating physician, requires that a medical decision be made sooner than twenty-four hours, the treating physician shall set a shorter time period for the family's decision-making process. The physician shall inform the hospital ethics committee of the need for the shorter time period.

(7) The hospital ethics committee shall consider the following criteria in determining who the proxy decisionmaker should be:

- (a) with whom the incompetent patient resided before becoming incompetent;
 - (b) who of the eligible decisionmakers was in close contact with the incompetent patient over the last few years;
 - (c) who shared an intimate relationship with the patient;
 - (d) who has discussed the patient's wishes concerning medical treatment with the incompetent patient before the patient became incompetent;
 - (e) if applicable, who has cared for and will continue to care for the incompetent patient.
- (8) Before any person authorized to provide informed consent on behalf of a patient not competent to consent exercises that authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

By broadening the definition of "family," permitting close friends to be proxy decisionmakers when appropriate, eliminating the hierarchy of decisionmakers, and requiring that the hospital ethics committee mediate disputes, the proposed proxy decision-making statute will preserve patient autonomy for a greater number of Washington residents. However, to effectuate all the changes under the proposed proxy decision-making statute, RCW 11.94.010(3) also must be amended.

F. Necessary Amendments to RCW 11.94.010(3)

Because encouraging people to draft medical durable powers of attorney for health care is a valuable tool in preserving patient autonomy, the durable powers of attorney statute must also reflect current reality. Additionally, because the individual to whom the incompetent patient has given his or her durable power of attorney is one of the potential decisionmakers under the proposed RCW 7.70.065, these two statutes must be consistent with each other.

Currently, RCW 11.04.010(3), the statute authorizing durable powers of attorney, excludes as potential decisionmakers anyone who is affiliated with the health care facility where the incompetent patient is being treated, unless that person is the incompetent patient's spouse, adult child, brother or sister. Curiously, parents are not exempted. Consequently, if the incompetent patient has given a durable power of attorney to a parent or anyone other than the three classes listed above,

and that person is a nurse, physician, administrator, janitor, secretary in the marketing department or any other employee of the facility where the incompetent patient is being treated, the durable power of attorney is void.

The intent of RCW 11.94.010(3) is, obviously, to preserve patient autonomy by allowing the patient to give someone close to them their durable power of attorney while at the same time preventing conflicts of interest between the health care provider and the patient. Similar to RCW 7.70.065, the pool of close "family" members who are likely to be considered close family members by the incompetent patient is limited to spouse, children and siblings.⁹⁹ To correct this erroneous assumption, RCW 11.94.010(3) should be amended in the following way:

Revisions to RCW 11.94.010(3) Power of Attorney Designation
(3) A principal may authorize his or her attorney-in-fact to provide informed consent for health care decisions on the principal's behalf. Unless he or she is qualified to serve as a proxy decisionmaker under RCW 7.70.065(2)(c) [proposed version], none of the following persons may act as the attorney-in-fact for the principal: Any of the principal's physicians, the physicians' employees, or the owners, administrators, or employees of the health care facility where the principal resides or receives care. This authorization is subject to the same limitations that apply to a guardian under RCW 11.92.040(3)(a) through (d).

G. Application of the New Statutes to the Illustrations

Having outlined a new statutory release for proxy decisionmaking, this section of the Comment returns to the illustrations and examines the results under the proposed proxy decision-making statute and the proposed Washington Patient Self-Determination Act.

To begin with, if the proposed Washington Patient Self-Determination Act were to be enacted, physicians would be required to discuss a patient's right to formulate an advance care directive or the patient's right to appoint a medical durable power of attorney. Furthermore, physicians would be required to (1) document in the patient's medical records whether the patient has executed an advance care directive or medical durable power of attorney and (2) request that the patient send a copy of this document to the physician so that the document could be included in the patient's medical records. As a result of these

99. WASH. REV. CODE § 11.94.010(3) (1996).

requirements, some of the individuals in the seven illustrations may have executed an advance care directive or medical durable power of attorney prior to becoming incompetent. If any of the individuals in the illustration had executed an advance care directive or medical durable power of attorney, the individual's choice of proxy decision-maker or choice of treatment would have been documented. The individual's autonomy would have been preserved and the situations, discussed in the illustrations, of a family member who was unfamiliar with the patient's wishes being appointed as proxy would not have arisen.

It is possible that some of the individuals in the illustration may never have visited a physician prior to becoming incompetent or that, despite receiving the information on advance care directives or medical durable power of attorney, the individual may not have executed either document. If no advance care directive or medical durable power of attorney were executed, the proxy medical decision-making statute would determine who made decisions for the patient. Each of the seven illustrations is revisited in the paragraphs below to show the differing results in who is appointed proxy decisionmaker under the old and new statutes.

In Illustration 1, Derrick was twenty-nine and incompetent because of a rare genetic disorder. His mother, who had been his primary caretaker, wanted to authorize an experimental treatment which was risky, but the only chance of saving Derrick's life. Derrick's express wish had been to utilize any treatment that might possibly save his life. Derrick's father refused to consent to the treatment. Because the current version of the proxy medical decision-making statute requires both parents' consent, consent was not obtained for the treatment. Derrick's mother's next step would have to be to seek appointment as Derrick's guardian. Under the proposed proxy decision-making statute, the physician would have referred the case to the hospital ethics committee when the parents could not achieve consensus. The hospital ethics committee would probably have appointed Derrick's mother as proxy because she had been Derrick's primary caretaker and because she was following Derrick's express wishes. During the course of the discussions with the hospital ethics committee, Derrick's father may also have changed his mind and have agreed that the treatment was appropriate. However, only one parent's consent would have been necessary under the proposed proxy decision-making statute. If Derrick's father remained strongly opposed to the treatment, he could seek to be appointed as guardian for Derrick. Thus, in this illustration, the inclusion of the hospital ethics

committee in selecting a proxy decisionmaker would give an independent committee the opportunity to assess which parent was more likely to know Derrick's wishes. Furthermore, the additional step of requiring the family to work with the hospital ethics committee may have created consensus among the family members. That would have avoided the costly step of seeking guardianship.

In Illustration 2, Jasmine and Charlie were unmarried partners. Because unmarried partners are not permitted to be proxies under the current proxy decision-making statute, Jasmine could not make medical decisions for Charlie. Under the proposed proxy decision-making statute, Jasmine could be a proxy medical decisionmaker for Charlie.

In Illustration 3, twenty-one-year-old Monique had been raised by her grandmother. Under the current proxy decision-making statute, Monique's grandmother could not make medical decisions for Monique when Monique became incompetent. Rather, doctors had to rely on Monique's absentee mother to make medical decisions. Under the proposed proxy medical decision-making statute, Monique's grandmother could legally make medical decisions for Monique. Thus, under the proposed statute someone who had raised and had known Monique all of Monique's life could make medical decisions for Monique, rather than someone who though a closer blood relation, did not know Monique as well.

In Illustration 4, under the current statute, Doug's life partner, Richard, could not make medical decisions for Doug when Doug became incompetent due to AIDS. Under the proposed proxy medical decision-making statute, Richard, Doug's partner, could become Doug's proxy decisionmaker.

In Illustration 5, under the current statute, physicians would have had to have turned to Kathryn's estranged husband to obtain consent for Kathryn's medical treatment. Under the proposed proxy decision-making statute, because the hierarchy of family decision makers would be eliminated, Kathryn's parents could make medical decisions for Kathryn. If both Kathryn's estranged husband and Kathryn's parents wished to be the proxy decisionmaker, the doctor would ask the family members to try to reach a consensus about Kathryn's treatment. If consensus were not achieved, the hospital ethics committee would select as proxy the person who the committee felt best knew Kathryn's wishes. Whoever was not selected as proxy could petition the court to be appointed as guardian for Kathryn, as is currently the case. Under the current proxy medical decision-making statute's hierarchy, Kathryn's parents could not be Kathryn's proxy decisionmakers and Kathryn's estranged husband would automatically become Kathryn's

proxy. Under the proposed statute it is quite likely that Kathryn's parents would become her proxy medical decisionmaker, after the hospital ethics committee assessed whether Kathryn's parents or Kathryn's estranged husband was more likely to know Kathryn's wishes.

In Illustration 6, Diane's cousin, her closest living family member, could not be appointed proxy under the current proxy medical decision-making statute because cousins are not listed in the statutory hierarchy. Under the proposed proxy medical decision-making statute, Diane's cousin would be permitted to act as Diane's proxy medical decisionmaker.

Similar to Illustration 6, in Illustration 7, Eileen's close friend of forty years could not be appointed as a proxy decisionmaker for Eileen under the current proxy decision-making statute, because close friends are not listed in the statutory hierarchy. However, under the proposed proxy decision-making statute, Eileen's lifelong friend could be Eileen's proxy because people who have "demonstrated a sincere, long-standing interest in the welfare of the incompetent patient" may act as proxies.

In sum, as each of the recaps for the illustrations shows, by eliminating the hierarchy in the proxy medical decision-making statute and by broadening the definition of family in the statute, people who are closer to the incompetent patient and, thus, more likely to know the patient's wishes will be appointed proxy. Furthermore, by encouraging people to draft advance care directives or medical durable power of attorney, more people will choose their own proxy or articulate their own wishes for medical treatment prior to becoming incompetent. As a result of encouraging people to make medical decisions for themselves prior to becoming incompetent and by making the proxy medical decision-making statute more flexible, the incompetent patient's autonomy will be preserved.

VII. CONCLUSION

Although Washington's proxy decision-making statutes are intended to preserve patient autonomy by allowing those who are closest to the patient to make medical decisions for the incompetent patient, the statute may achieve the opposite result for as many as one-third of Washington's residents. For individuals whose family does not mirror the family structure in RCW 7.70.065, their closest family members are excluded from the proxy statute. It is unlikely that the legislature intended this effect. However, because RCW 7.70.065 relies on a concept of family that is a reality for some, but not all

Washingtonians, the statute fails to preserve patient autonomy for many Washington residents.

Washington's proxy decision-making statute is intended to preserve patient autonomy by identifying people who are likely to be close enough to the incompetent patient to know the incompetent patient's wishes. It is not a referendum on the meaning of family. To achieve the statute's intended purpose, the statutory framework should be broadened and amended to include the people who are actually likely to be closest to the incompetent patient, and, therefore, most likely to effectuate the incompetent patient's wishes.

These changes should include: (1) requiring physicians to discuss advance care directives and medical durable powers of attorney with their patients, (2) amending RCW 7.70.065 to broaden the statute's definition of family, to permit close friends who are considered family to be proxy decisionmakers, to eliminate the statute's hierarchy of decisionmakers, and to require families to mediate disputes about proxy decision-making through a hospital ethics committee, and (3) amending RCW 11.94.010(3), the durable powers of attorney statute, so that it reflects reality and is consistent with RCW 7.70.065.