

**GUARDIANSHIPS
&
CONSENTS:
FROM WOMB TO TOMB**

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Consent Required?



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**I. GUARDIANSHIPS &
DURABLE POWERS
OF ATTORNEY**

How do they relate to consent
issues?

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Definitions

- **Competent Adult** – An individual who has reached the age of 18 and who is able to understand his or her medical condition and proposed treatment, its risks and benefits
- **Patient Advocate** – Person 18 or older of sound mind and designated in writing to exercise power over the patient
- **Legal Guardian** – Parent of a minor child or a court appointed guardian for an incompetent adult
- **Emancipated Minors** – Legally recognized as an adult when: married; on active duty in armed forces; or by court order

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WHAT IS STATUTORY LAW IN MICHIGAN?

- Generally, there are three individuals authorized by Michigan statutory law to make health care decisions on behalf of a patient (in order of preference):
 - The patient
 - A designated patient advocate
 - Legal guardian

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GENERAL RULE

- Where a patient is presently competent, or in the instance where the patient was previously competent and expressed his or her health care wishes in a document such as a Durable Power of Attorney for Healthcare (with a named Patient Advocate), the patient's wishes will be given priority.

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GENERAL RULE (con't)

- In the absence of competency or a designated Patient Advocate in a Durable Power of Attorney for Healthcare, a legal guardian may make health care decisions on behalf of a patient.

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WHAT'S THE DIFFERENCE BETWEEN A GUARDIANSHIP AND A DURABLE POWER OF ATTORNEY FOR HEALTHCARE?



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DURABLE POWER OF ATTORNEY FOR HEALTHCARE

- Signed by individual 18 years old or older;
- Individual must have been competent at the time of the signing of the document;
- Witnessed by at least two disinterested, competent adults;
- Patient Advocate must accept in writing (no attestation required);
- Patient need not be competent at the time service is rendered.

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LEGAL GUARDIANSHIP

- Patient is determined by a judge to be a Legally Incapacitated Individual (L.I.I.) at the time of the hearing;
- Letters of Guardianship are issued by the Court and signed by a judge;
- Letters/Order of Guardianship name a court-appointed person to make decisions on behalf of the ward;
- Legal Guardianship is in effect until terminated by a judge.

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DO NOT CONFUSE A GUARDIANSHIP WITH A CONSERVATORSHIP!!!



- A Conservator is appointed by a judge for business and financial purposes only!
- A Guardian and a Conservator may (but need not necessarily be) the same person.
- DO NOT ASSUME!

MICHIGAN LAW

- Michigan statutory law provides that, except as limited by a Durable Power of Attorney for Healthcare executed prior to the Guardianship Order, "a legally incapacitated individual's guardian is responsible for the ward's care, custody, and control."
- Statutory law further states whenever meaningful communication is possible, the guardian should consult with the L.I.I. prior to making a major decision affecting that individual.

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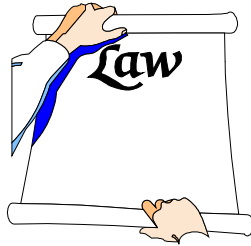
II. Who can give consent?

- Competent Adult Patient
- Legal Guardian
- Patient Advocate/Durable Power of Attorney for Health Care
- Parent of minor child
 - custodial parent
- Next of kin:
 - spouse
 - child of majority age
 - parent
 - sibling of majority age

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HOW DOES THIS APPLY TO SERVICES AT YOUR FACILITY?

- The statute states, “[a] guardian may give the consent or approval that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service.”



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ARE GUARDIANS OR THOSE EXERCISING POA FOR INCAPACITATED PATIENTS AUTHORIZED TO MAKE LIFE ENDING DECISIONS ON BEHALF OF THE PATIENT?

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**PATIENT ADVOCATE
STATUTORY**

“[a] patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient’s death.”

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LEGAL GUARDIANSHIP

NON-STATUTORY, FACT-SPECIFIC

➤ Generally, Michigan law supports public policy preference that courts play a minimal role in issues surrounding life ending decisions, and that judicial intervention is only employed where affected parties disagree.

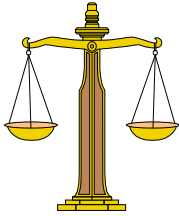
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**In re Rosebush, 195 Mich. App.
675 (1992).**

- Two separate legal standards exist to guide decision maker for life ending decisions:
- Where patient is a minor or has never been competent, “best interest” standard applies
- Where a patient was previously competent or is a minor of mature judgment, the subjective standard of “substitute judgment” is used.

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**In re Rosebush, 195 Mich. App.
675 (1992). (CON'T)**



Rosebush's "best interest" standard also applies when the issue of whether a surrogate or guardian can decide to refuse medical treatment (not necessarily life ending) on behalf of a minor who has never been competent.

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**GUARDIAN'S ABILITY TO
REFUSE MEDICAL
TREATMENT ON BEHALF OF A
FORMERLY COMPETENT
INCAPACITATED PATIENT**

- In re Martin, 450 Mich. 204 (1995).
Narrow holding – Guardian must present clear and convincing evidence that the particular patient would have refused treatment under the circumstances involved.

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Express vs. Implied Consent

- Express Consent: Patient Gives you consent directly
- Implied Consent: Emergency – patient presents at the ER
- Always try to obtain written consent to avoid disputes as to whether consent has been given – w/o consent can be assault/battery.

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Patient's Right to Make An Informed Decision

- Michigan Statute:
"A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the facility, information about his or her medical condition, proposed course of treatment, and prospects for recovery in terms that the patient or resident can understand, unless medically contradicted as documented by the attending physician in the medical record."
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Consent to Treat vs. Informed Consent

- Consent to Treat: Obtained upon admission to the entity allowing general treatment of the patient by the health care provider.
 - Informed Consent: Specific consent given after complete explanation/disclosure from a health care provider as to:
 - risks of the procedure
 - nature of the procedure and
 - probable outcome.
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Informed Consent Does Not Extend to Other Treatment

- If a Patient gives Informed Consent for Procedure A and Surgeon performs Procedure A and B, Procedure B becomes a Battery unless it was an unexpected emergency and unable to wait for consent.
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Who is Responsible for Obtaining Informed Consent?

- The physician is ultimately liable and thus must be the one to obtain the informed consent. If given by a non-physician, the increased possibility for incorrect or incomplete information exists which increases the physician's liability. *Lincoln v. Gupta*, 142 Mich.App. 615, 370 N.W.2d 312 (1985).
- Communication must be clear and understandable for the patient

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Elements of Informed Consent

- A clear, concise, factual discussion of each of the following constitutes informed consent
 - Diagnosis/Nature of Illness being Treated
 - Nature of the Proposed Treatment
 - Risks and Consequences
 - Probability/Likelihood of Successful Outcome
 - Feasible Treatment Alternatives

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III. Special Circumstances with Consent Revocation of Consent

- Patient has the legal right to revoke consent or refuse to give consent. The patient's revocation should be documented and the reasons noted in the patient's chart.

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Refusal of Treatment



- A competent adult may refuse treatment and shall be informed of the consequences of that refusal.
 - Obtain signature of patient acknowledging decision to refuse treatment if possible.
 - Document in the patient's chart

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Capacity to Consent - Incompetent

- Legal Guardian or patient advocate is the only one with authority to give consent.
- Consent from an incompetent patient is invalid.
- Emergency exception applies.

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Capacity to Consent - Minors

- General Rule: Must have consent of custodial parent or legal guardian for treatment unless emancipated or for certain procedures/circumstances except in an emergency.



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Special Issues - Minors

- May obtain treatment for their minor children.
- Note: If the minor obtains treatment without parental consent, except for emergency care, parent cannot be held responsible for payment.

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What is an Emancipated Minor?

- Emancipated minor defined by law:
 - Validly married per State of Michigan
 - On Active Military Duty
 - Ordered Emancipated by the Court
 - In custody of Law Enforcement for purposes of non-emergency, non-surgical care where impractical to contact parents
MCLA 722.4

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Emancipated Minor

- Emancipated minor is considered an adult and is permitted to consent in all circumstances the same as an adult
- In case of an emancipated minor, must have her consent to share information with parents or anyone else
- Require documentation from the patient confirming emancipation status and place in chart

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Minors-Exceptions

- **Minor who is not emancipated may seek treatment without parent's consent in the following circumstances:**
 - **Treatment for sexually transmitted disease (for medical reasons, parents may be informed without the patient's consent) MCLA 333.5127**

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Minors-Exceptions

- **Prenatal and Pregnancy related care for the wellbeing of the fetus - before providing care the minor Must be informed that alleged father, minor's spouse, or parent may be notified of treatment MCLA 333.9132**
- **Minor may not consent to termination without consent of parent or court order**
- **Clearly document in the chart that minor advised of potential notification to others before treatment commences**

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Minors – Exceptions

- **May also consent to:**
 - **contraception**
 - **alcohol or other drug abuse or addiction**
 - **examination for victims of sexual assault**
 - **outpatient mental health counseling for child over age 14 for a maximum of 12 (twelve) treatment sessions over a period of no more than four months**

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Who has the Consent Power?

- If emancipated minor confirmed, then the Physician **must** get consent from the patient to relay medical information to the parents, others (HIPAA, Michigan patient/doctor privilege statute) **Minor has the Power**
- If “excepted” minor, then get consent from minor but **may** contact parents if necessary
- In all other circumstances, **must** get consent from the parents/legal guardian for treatment of minor

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Special Issues - Prisoners

- A prisoner (a person convicted of a crime and sentenced to state custody) may be treated at the request of the authorities, without consent, including medical clearance screening and examinations.
- This does NOT apply to a person under arrest. Such individuals must consent to the treatment or a court order/search warrant must be obtained for procedures – including drawing blood, etc.

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Special Circumstances Requiring Informed Consent in Michigan

- AIDS Test: An AIDS test may not be performed without first obtaining the written, informed consent of the test subject.
 - 1 Exception – Occupational Exposure; then patient need only be informed of test
- Abortion: Physician shall not perform an abortion otherwise permitted by law without providing informed consent, oral and in writing, not less than 24 hours before the procedure.

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IV. Unique Issues regarding
Parental Rights, OB, and
Neonatal Issues

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Context of occupation will present
several critical issues regarding:

- Care and treatment given to particular mothers & neonates with questionable prognosis
- Required/optional management decisions, and informed consent discussions with parents
- Documentation of the neonates condition and the treatment discussions/decisions

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Careful analysis and consideration must
be taken of the following:

- the parent's status and authority
- proper consent, especially if parent wants no code
- neonate's gestational age (<24 weeks)
- neonate's probable outcome/terminal outcome
- neonate's immediate condition at birth
- benefits and risks to treatment
- legality of action or inaction

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Above all, good documentation practices must be observed regarding all of these things!

Parents often change their mind after a poor outcome and the realization of long term care consequences

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Issue #1: Resuscitation of the “vigorous” neonate at 23 weeks

- If parents want code, all measures - then full and aggressive management is required.
- What to do when the parents don't want to resuscitate?
 - Parents don't want disabled child
 - Or, simply don't want a child

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Evolution of 'Guidelines' to Resuscitation of Low Birth Weight

- < 1986 - At many hospitals, no attempts to resuscitate <750 gm
- 1986 - Some surviving 750 gm infants, thus some attempts at resuscitation
- 1989 - More aggressive attempts at resuscitation, but no increase in survival rates (steroids/surfactant - increased use - better outcomes) (Hack & Fanaroff, Outcomes of Extremely Low Birth Weight Infants Between 1982-1988, N Engl J Med 1989;321:1642-7)
- **Now** - some use 10-20 min. guideline - **Is this too long? (Apgar of 1 at 20 minutes?)**

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Key is to be Prepared - Discussion and Documentation

- **Must have discussion, agreement , and plan in place between obstetrical and neonatal teams - Write it Down before Delivery**
- **Must “warn” parent who wants no-code that there is an ethical responsibility to attempt initial resuscitation in a baby who appears vigorous at delivery!**

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Case Example

- **Twin premies, 23 weeks, mom is bleeding and dilating**
- **Labor briefly arrested, MFM expects delivery in less than 7 days - steroids given**
- **Decision to terminate, Twin A vigorous, (B dies) Neonatal Resuscitation of Twin A**
- **After the fact note by Neonatologist documenting discussion with parents re: code vigorous baby**
- **Grade 3-4 IVH, no post IVH discussion as to removal of aggressive management**
- **Parents Sue MFM and Neonatologist**

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Case Example

- **Lawsuit based on:**
 - **MFM should have killed babies before delivery**
 - **Neonatologist should have warned parents of code in advance**
 - **Neonatologist should have recommended withdrawal of life support when condition deteriorated in the nursery**
 - **Damages claimed = cost of long term care for child (millions of dollars) - Court denied motion to strike claim for wrongful life**

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The Discussion

- **Must have detailed discussion with parents prior to delivery:**
 - What constitutes viable vs. nonviable; vigorous vs. non-vigorous
 - Prognosis - Death, Damage, and “*Long Term Care*”
 - Tell them Gestational age is not always exact- doesn't always tell viability of baby (e.g. 23 week U.S.)
 - Physician cannot ignore the possible rights of the baby and ignore vigorous signs - Tell Them!
 - Discuss plan for delivery room and subsequent care
 - Document parental understanding even if they disagree or still want a no-code

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Remember

- You cannot state with certainty what the outcome will be at delivery - general stats
- Be careful when discussing this with parents, including:
 - That you cannot determine whether the child might be viable until delivery has taken place
 - That a baby can only be properly evaluated at the time of birth for vigor and possible viability
 - That in an emergency situation, must provide initial life sustaining treatment to the minor child who is vigorous/non-terminal

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The Written Word

- **Document the specifics regarding the discussion-**
 - Survival and morbidity rates
 - What is viable/vigorous
 - Statistics regarding long term outcome/care
 - When resuscitation will/will not be implemented
 - What resuscitation will be done if the condition is X, Y, or Z
 - Parental understanding
 - Post Delivery management

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Legal Issues

➤ **Gestational Age - Viability**

- Roe v Wade = 24 weeks viable by law, but **states can determine viability at earlier gest. ages** = Open question
- **Legal Duty** - If baby **appears viable** at delivery (whether a termination or delivery), baby should be resuscitated unless death is inevitable - **must document in advance or upon discovery at delivery**
- **Failure to resuscitate** can potentially result in criminal/civil action (e.g. Messenger case) - Courts have not decided these issues clearly, however, **consider yourself at risk**

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American Academy of Pediatrics Committee on Bioethics issued guidelines on "foregoing" life sustaining medical treatments:

- "Best interests for the child"
- **Must assess:**
 - chance therapy will succeed and to what degree
 - risks, pain, and discomfort involved with treatment vs. nontreatment
 - anticipated quality of life with vs. without treatment (Pres. Comm. Report on Deciding to Forego Life Sustaining Trmt; also Pediatrics 1994; 93:532-6)
- These issues are usually unclear at delivery, therefore, resuscitate and follow for possible treatment withdrawal

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Issue #2: What is your obligation with a known anomalous neonate?

Delivery Decisions and Code Situations

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Do you have to offer a c/section if you know the child is going to be damaged after birth?

- What is “Damaged?”- Determine what the probable outcome and long term prognosis would be for child
- E.g., anencephalic, Downs, mental retardation, cerebral palsy, hydrocephalus
- Does the C-Section offer benefit - Maternal or Fetal?

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Benefit/Risks

- Look at the risk to the mother - i.e., Physical Trauma - same obstetrical rules apply as to normal baby
- If baby is going to die shortly after birth, is there any benefit (anencephaly)?
- If baby will survive for 1-2 years with deteriorating genetic syndrome (Krabbes disease), is there a benefit to avoid possible hypoxia in labor?

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Benefit/Risk

- Remember that the mother’s “body” is paramount to the baby
- A mother can refuse a C-section regardless of the fetal condition
- Therefore, advise and document discussion with parent as to potential outcomes - if the mother sees no significant benefit, mother often will agree with physician
- If there is absolutely no benefit, then C-section is not warranted regardless of patient desire

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Are you required to give heroic measures to a known terminal infant?

- **GENERALLY NO** - It is acceptable, but not required when there is no benefit to infant
- **Must document “no benefit” every time you withhold heroic measures**
- **Compare “immediately” terminal condition to “gradual deterioration” over months - this will involve a more detailed discussion with parents - Would hypoxic injury cause hastening of the inevitable death?**

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“Nemo Ad Inutile Tenatur”

i.e. No One is Bound to Use an Ineffective or Useless Treatment

Most treatments carry some Risk
Do not treat only to cause Risk

Therefore the no benefit, but risk rule permits withholding or withdrawing treatment

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Issue #3: What if the neonate is afflicted with Spina Bifida, Down’s syndrome or other genetic anomaly?

What neonatal treatment options do I have? What is required?

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Post Delivery Care

- Again, must determine what type of anomaly or “damage” is expected - Downs syndrome vs. anencephaly, Trisomy 18, etc.
- Duty to repair anomalies?
 - Required if Benefit, regardless of Parental wishes
 - Any procedure must be justified by a realistic expectation of prolonged benefit. If such an outcome cannot be anticipated, then no justification for intervention
- Continued Ventilation? - Must offer withdrawal if condition presents grave prognosis (i.e., Severe IVH in premie)

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If the baby is going to potentially have a “bad outcome”, can you forgo ventilatory support?

- NO - Cannot no code and let baby die on basis of “possible risk of damage”, unless: current condition suggests severe insult already to extent you can predict severe neuro outcome/terminal - May withdraw heroic measures - comfort only
- Must provide resuscitation and ventilatory support, unless a known futile situation
 - e.g. anencephalic infant = inevitable death (versus Spina Bifida, Down’s syndrome infant = *quality of life* issues)

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Infant Doe Regulations from Dept. Of Health & Human Services

- Designed to prevent discrimination or denial of medical treatment to handicapped neonates
- Does not require futile therapies which merely temporarily prolong the process of a dying infant born terminally ill (Report of the Surgeon General’s Workshop on Children With handicaps 7 Their Families, U.S. Dept. of HHS, 1982)
- Highly dependant on how you document the condition

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Thank you for your kind
attention!

QUESTIONS?



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