

Recommendation for Establishing Policy on
Health Care Decisions for Incapacitated Patients Without Surrogates

Santa Clara County Medical Association
San Jose, California
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I. Purpose Statement

To provide procedural mechanisms whereby health care decisions can be made for patients who lack health care decision-making capacity and for whom no surrogate exists.

II. Background

A. This policy represents a consensus among the medical and legal professionals of the Ethics Committee of the Santa Clara County Medical Association about the most appropriate manner in which to make medical decisions on behalf of incapacitated patients who lack surrogate decision-makers. Despite their incapacity, such patients are entitled to have appropriate medical decisions made on their behalf and to have these decisions made in their best interest, respecting their wishes and values as much as they can be known. The procedures set forth here are intended to meet these goals. This policy is considered necessary since no clear-cut legal guidelines exist that cover these circumstances. As a consequence, unrepresented patients tend to be managed inconsistently and on an *ad hoc* basis, which often confounds and delays medical decisions. Finally, this policy and its procedural protections were considered especially important for the irreversible decisions to forgo life-sustaining treatment for unrepresented patients.

B. This policy is procedural in nature and applies to all medical decisions for which informed consent is usually required.

C. This policy is meant to support the institution's underlying consent policy.

D. Goals to be achieved

To make and effect health care decisions in accordance with a patient's best interest, taking into consideration the patient's personal values and wishes to the extent that these are known.

To establish uniform procedures to implement appropriate health care decisions for unrepresented patients. Appropriate healthcare decisions include both the provision of needed and wanted medical treatment and the avoidance of nonbeneficial or excessively burdensome treatment. Appropriate health care decisions are also those that are based on sound medical advice and made without the influence of material conflicts of interest.

E. Circumstances where policy is not applicable or is applied only with additional considerations

This policy does not apply in emergency medical situations.

This policy does not apply in situations where, using sound medical judgment, a physician makes a bedside decision to cease attempts at cardio-pulmonary resuscitation of a patient.

If the Public Guardian is appointed, the Public Guardian must be involved in medical decision-making under this policy. Medical circumstances will dictate when medical providers can delay decision-making in order to include the Public Guardian.

Hospital legal counsel should be consulted if a decision to withdraw treatment is likely to result in the death of the patient and the situation arises in any of the following circumstances:

- The patient's condition is the result of an injury that appears to have been inflicted by a criminal act
- The patient's condition was created or aggravated by a medical accident
- The patient is pregnant
- The patient is a parent with sole custody or responsibility for support of a minor child

F. Application: The patient's age, sex, religion, ethnic or social status, the ability to pay for healthcare services, or avoidance of burden to family or to society shall not be used to bias considerations about the appropriateness of any health care decision under this policy.

III. Who Is An Incapacitated Patient Who Lacks A Surrogate?

A. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) to lack capacity to make health care decisions. Capacity means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision.

B. No agent, conservator, or guardian has been designated to act on behalf of the patient.

C. No dispositive individual health care instruction is in the patient's medical record.

D. No surrogate decision-maker can be selected or the surrogate is not reasonably available. For the purpose of this policy, a surrogate can be an adult family member. Also, an individual with a close personal relationship to the patient can serve as a surrogate. Any surrogate needs to have shown care and concern for the patient's welfare and must have some familiarity with the patient's activities, health, religious beliefs, and values. There must be medical record documentation (such as by a social service worker) that this surrogate has been interviewed and satisfies the above criteria to serve as a surrogate decision-maker.

Efforts to establish whether or not a surrogate is reasonably available should be diligent and can include contacting the facility from which the patient was referred, and contacting public health or social service agencies known to have provided treatment for the patient.

IV. Referral To Ethics Committee

If no surrogate can be located, medical decisions on behalf of incapacitated patients will be made using the following procedures.

A. Medical decisions for which informed consent is required

An ethics consultant (one or more people) will provide advice about the process of medical decision-making. This consultant will come from the facility's Ethics Committee or, if there is none, the consultant will possess appropriate skill and experience in ethical medical decision-making. The consultant will ensure that treatment decisions are made consistent with this policy. In this process, the consultant will make all reasonable efforts to learn about the patient's medical treatment preferences. The consultant should contact others for expanded advice should the circumstances warrant.

B. Medical decisions about withholding or withdrawing life-sustaining treatment

a. The medical team will obtain a second opinion about the decision from an independent physician with relevant medical qualifications.

b. The Chair of the Ethics Committee will appoint a sub-committee to act as surrogate decision-maker and review the proposed decision to ensure that the decision was based on sound medical advice and made in conformity with this policy.

c. Composition of Sub-Committee: The sub-committee will consist of multidisciplinary medical personnel capable of independently appreciating the medical consequences of the healthcare decision. At least one non-medical member of the Ethics Committee will be named to the sub-committee. If the patient is in a long-term care facility, the sub-committee will include an ombudsman as a member. All members will be asked whether they have any material conflict of interest, real or apparent, in the matter and, if so, will be excused from the sub-committee.

d. Conduct and Standards of Review by Sub-Committee: The sub-committee will advocate on behalf of the patient. The sub-committee will interview the relevant medical treatment providers and anyone else closely involved with the patient. The sub-committee will inquire about the process to determine the decision-making capacity of the patient, the attempts made to learn about the patient's medical preferences and to locate a surrogate decision-maker, the medical basis for the conclusion that medical treatment should be withheld or withdrawn, and about the other available medical options and their likely outcomes. The sub-committee will consider the patient's cultural, ethnic or religious perspectives, if known. If possible, someone of the patient's cultural, ethnic or religious background should be consulted

to determine if it is likely that these factors would influence what treatment the patient would prefer. The sub-committee will also inquire about the likelihood of restoring the patient to an acceptable quality of life. The patient's quality of life will be considered from the perspective of the patient and not from that imposed by any sub-committee member. The sub-committee will weigh and balance all of the above considerations, keeping in mind that the best interest of the patient do not require that life support be continued in all circumstances, such as when the patient is terminally ill and suffering, where there is no hope of recovery of cognitive functions, or where treatment is otherwise nonbeneficial.

e. Decision-making by Sub-Committee: The sub-committee will assure itself that there were adequate safeguards to confirm the accuracy of the diagnosis and that the medical decision was made in good faith, was based on sound medical advice, and is in the patient's best interest according to this policy. The sub-committee can ask for further medical opinions to verify the primary conclusions. The sub-committee can also ask that further investigations be made about the availability of surrogates, the patient's treatment preferences, or other relevant matters. After this investigation is completed, the sub-committee will then make an independent finding about the proposed decision.

f. Subsequent Action: If the sub-committee is in general agreement about the proposed decision, the decision can be implemented by the primary treating physician. If the sub-committee cannot reach a general agreement or if it disapproves of the medical decision, the Chief of Staff or his/her designee will be included in the decision-making process to assist in resolving any disagreements. In any case where a medical decision to withhold or withdraw life-sustaining treatment will be implemented under this policy, the Chief of Staff must approve of the decision. Irresolvable conflicts can be referred to court for legal resolution with the understanding that a legal remedy should only be sought in extreme circumstances. Any implementation of a decision to withhold or withdraw life-sustaining medical treatment will be the responsibility of the primary treating physician.

V. Record Keeping

Signed and dated medical record progress notes will be written for the following:

- a. The findings used to conclude that the patient lacks medical decision-making capacity,
- b. The finding that there is no durable power of attorney for healthcare, no conservator or guardian, and no medical instructions,
- c. The attempts made to locate surrogate decision-makers and the results of those attempts,
- d. Any interviews of individuals with a close personal relationship to the patient willing to serve as surrogate and facts to substantiate their qualifications under this policy,
- e. The medical bases for the decision to withhold or withdraw life-sustaining treatment and the likely outcome if the decision is implemented, and
- f. Any findings and conclusions by the ethics consultant, the appointed ethics sub-committee, or the Chief of Staff.

VI. References

- (1) Veterans Health Administration, Department of Veterans Affairs, Informed Consent, VHA Directive 1004, February 21, 1996, pages5-7.
- (2) Kirschner, M. and Michel, V., Guideline Addendum, The April 2, 1990 LACMA Physician guidelines for Foregoing Life-Sustaining Treatment for Adult Patients. Supplement: Patient's without decision-making capacity who lack surrogates, *LACMA Physician*, July 12, 1993.
- (3) 22 CCR 70707
- (4) JCAHO Patient Rights and Organizational Ethics, RI.1
- (5) California Probate Code § 3200 *et seq*
- (6) Health Care Decisions Law (California Probate Code § 4600), specifically, Part 2, Uniform Health Care Decisions Act (California Probate Code §§ 4670, 4735)

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