

A Preface to the  
Santa Clara County Medical Association Ethics Committee  
Model Policy on  
Health Care Decisions for Patients Without Surrogates  
Developed by the Task Force on Decision-Making for  
Unbefriended and Conserved Patients

The Santa Clara County Medical Association recently approved a model Policy on Health Care Decisions for Patients Without Surrogates. The Policy was adopted because the recently enacted California Health Care Decisions Law,<sup>1</sup> which provides legal guidance for the medical management of patients who lack medical decision-making ability, contained no provisions concerning medical decisions for patients who also lack a surrogate decision-maker. The failure of the new law to address this aspect of medical care is regrettable given the vulnerability of these patients to inconsistent and *ad hoc* practices of medical treatment decision-making. This issue is especially important when the medical decision involves withholding or withdrawing life-sustaining treatments. Despite their incapacity, these 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 these can be known. However, there exists in the County no set standard of practice for accomplishing these goals. The Ethics Committee determined, therefore, that there is a need for standard setting and this Policy is intended to create processes to manage medical decision-making for incapacitous unrepresented patients.

To create this Policy, a 27- member Task Force of the Ethics Committee was formed, comprised of physicians, medical and elder law attorneys, members of the Offices of the Court Investigator, County Counsel, and Public Guardian, Long Term Care Ombudsman and a private conservator. All of these individuals were either members of local medical ethics committees or they dealt with unrepresented patients as part of their professional duties. The Policy was developed after a process of literature review, canvassing the hospitals in the County concerning local practice, and receiving input from various local hospital ethics committees. Also, two existing documents served as resources for the Task Force—the Veteran’s Health Administration Directive on informed consent and the Addendum to the Guidelines on Foregoing Life-sustaining Treatment for Adults published by the Joint Committee on Biomedical Ethics of the Los Angeles County Medical and Bar Associations.<sup>2, 3</sup> In addition to developing this Policy, the Task Force reviewed current procedures within the Office of the Public Guardian regarding medical decision-making for conserved adults and San Andreas Regional Center protocol for decision-making regarding their clients.

---

<sup>1</sup> California Probate Code § 4600-4805, 1999 Cal. Stat. ch.685, AB 891.

<sup>2</sup> Veterans Health Administration, Department of Veterans Affairs, Informed Consent, VHA Directive 1004, February 21, 1996, pages 5-7.

<sup>3</sup> 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.

This Policy was approved by a majority of the members of the Ethics Committee after extensive discussion of the pros and cons of its implementation. It was then approved by the Santa Clara County Medical Association for potential adoption by hospitals and nursing facilities.

Among the perceived benefits of the Policy was that it provides for a process of objective review of medical decisions made on behalf of unrepresented patients. This review process was believed to promote the interests of patients and also to relieve treating physicians from what can be the conflictual role of sole medical decision-maker. Secondly, if the Policy is generally adopted, it could create both a medical and legal standard of practice and eliminate inconsistency in medical decision-making for these patients. Problems associated with adoption of the policy were related to variance in local ethics consultation practices. For instance, some health care institutions, such as nursing homes and federal hospitals, need to adhere to regulations that may be inconsistent with this Policy. Also, some ethics committees may not have sufficient staff to manage the work required to review the medical care of all unrepresented patients. Ethics committees may also have their own internal decision-making processes that conflict with the process specified in this Policy. However, despite such variances in ethics committee practice, it is hoped that the medical facilities in the County could adopt the fundamentals of the Policy as much as possible without altering effective internal practice.

Another aspect of the Policy deserves special attention. It was recognized that this Policy creates an alternative role for most medical ethics committee members who normally serve as advisors only and not as participants in medical decision-making. Under this Policy, for decisions to withhold or withdraw life-sustaining treatment for unrepresented patients, a small group of ethics committee members would serve as surrogate decision-makers. This new role is an attempt to provide a meaningful and practical solution to the difficult problem of selecting the most appropriate and reasonably available persons to serve as surrogates for these patients. Treating physicians and employees of the health care institution can be perceived as having a conflict of interest in the matter since the physicians and the institution receive compensation (or sometimes they do not) for providing medical care for the patient. This is one reason why the California Health Care Decisions Law provides that, in most circumstances, neither the supervising health care provider nor an employee of the health care institution where the patient is receiving care can act as surrogate decision-maker for the patient. To compound the problem, independent public or private conservators or guardians are not often reasonably available to serve these patients. And judicial intervention is openly disfavored under the Health Care Decisions Law. For these reasons, it was believed that a small multi-disciplinary group of experienced ethics consultants available to the medical institution offered the best alternative. Using members of several disciplines, including a non-medical member, was intended to prevent bias based on the perspective of any particular discipline. A committee would also ensure that no one interested person would control the medical fate of the patient. It is also common for medical ethics committees to

include members who are not employees of the facility and these members, if qualified, would be excellent candidates for the sub-committee surrogate work.

Finally, both the Veterans Administration and the Los Angeles County Medical and Bar Associations endorsed the use of institutional ethics committees to review physician decisions to withhold or withdraw life-sustaining medical treatment for unrepresented incapacitous patients. One reason, however, that the VA Directive and Los Angeles County Guidelines were not adopted *in toto* was that they contained no provision for a patient surrogate. Consequently, these documents provided that medical decisions to withhold or withdraw life-sustaining treatment were ultimately made by either the Chief of Staff or the attending physician. Inclusion of a surrogate in this process preserves the accepted role of the physician to recommend and provide medical treatment after having obtained the consent of the patient or surrogate and, as much as is practicable, preserves the right of the incapacitous patient to have a surrogate weigh the risks and benefits of foregoing life-sustaining treatment and make the decision based on the patient's desires, if known, or based on the patient's best interests.

It is hoped that this Policy provides a reasonable and workable standard for the ethical treatment of incapacitous patients who lack surrogates so that the Policy will be adopted as accepted practice by the medical facilities in Santa Clara County. It is also hoped this Policy will be considered outside of this county.

\*\*\*\*\*

The Task Force was chaired by Serl Zimmerman, MD, JD and Doris E. Hawks, Esq., Elder Law Attorney.

Primary drafter of the Model Policy was Margaret Eaton of the Ethics Committee at Stanford Hospital. Members of the Sub-Committee on Health Care Decisions for Patients without Surrogates were: Susan Branch, Esq., Allan Hikoyeda, Esq., Stan Ulrich, Esq. and Serl Zimmerman, MD.

The Sub-committee on Decision-making by the Public Guardian and for developmentally disabled adult individuals included: Les Lindop, Sharon O'Neill, Ron Willsey, and Ann Hubrich, LCSW.

Other members of the Task Force included: Beverly Chan, Esq., Sidney Chapman, Thomas Dailey, MD, Donna Di Minico, Allen Fleishman, Esq., Stephen Henry, MD, Steve Jackson, MD, Tamara Lopez, Esq., Sandra Mangiapia, MD, Elizabeth Menkin, MD, Marilyn Regan, MFT, Elisabeth Ryzen, MD, Edna Smyth, MSW, Gary Steinke, MD, LouAnn Trent, ACSW, Cheryl Walsh, Esq., and Sheldon Zitman, MD.