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Law

Legal Briefing: The Unbefriended: Making Healthcare Decisions for Patients without Surrogates (Part 1)

Thaddeus Mason Pope and Tanya Sellers

ABSTRACT

This issue's "Legal Briefing" column covers recent legal developments involving medical decision making for unbefriended patients. These patients have neither decision-making capacity nor a reasonably available surrogate to make healthcare decisions on their behalf. This topic has been the subject of recent articles in *JCE*.¹ It has been the subject of major policy reports.² Indeed, caring for the unbefriended has even been described as the "single greatest category of problems" encountered in bioethics consultation.³ Moreover, the scope of the problem continues to expand, especially with rapid growth in the elderly population and with an increased prevalence of dementia.

Unfortunately, most U.S. jurisdictions have failed to adopt effective healthcare decision-making systems or procedures for the unbefriended. "Existing mechanisms to address the issue of decision making for the unbefriended are scant and not uniform."⁴ Most providers are "muddling through on an *ad hoc* basis."⁵ Still, over the past several months, a number of state legislatures have finally addressed the issue. These developments and a survey of the current landscape are grouped into the following 14 categories.⁶ The first two define the problem of medical decision making for the un-

befriended. The remaining 12 categories describe different solutions to the problem. The first six of these solutions are discussed in this article (Part 1). The last eight solutions will be covered in the Summer 2012 issue of *JCE* (Part 2).

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1. WHO ARE THE UNBEFRIENDED?

Patient autonomy is highly valued in the United States. Patients with capacity can make their own healthcare decisions. And patients retain the right of self-determination even when they lose the capacity to make healthcare decisions for themselves. The law has devised several tools to promote "prospective autonomy," the right to control one's future medical treatment in the event one loses decision-making capacity. One mechanism is the instructional advance directive or living will. But most of us do not write such directives. Another mecha-

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nism is the proxy directive or durable power of attorney for healthcare, designating another person, a surrogate, to direct the course of our medical treatment upon our incapacity. But most of us do not appoint surrogates. Therefore, the most common mechanism by which our prospective autonomy is protected and promoted is through the informal selection of surrogates based on statutory priority lists. These “default” surrogates are the most common type of surrogate.⁷

The unbefriended are incapacitated individuals who cannot be helped by any of these standard legal mechanisms that protect and promote prospective autonomy. They have not left an instructional advance directive (a living will).⁸ They have not appointed or have no available healthcare agent (power of attorney); they have no available friends or family to make medical decisions as “default” surrogates.⁹ These unbefriended patients may have outlived, lost contact with, or been abandoned by family members. Or they may be loners who have spent much of their lives disconnected and in social isolation. Whatever the reason, the unbefriended are incredibly vulnerable because “no one cares if they live or die.”¹⁰ Many different terms have been used to describe this group: “adult orphans,”¹¹ “friendless patients,”¹² “unrepresented patients,”¹³ “patients alone,”¹⁴ “solo citizens,”¹⁵ “patients without a surrogate decision maker,”¹⁶ “patients without proxies,”¹⁷ “patients for whom no surrogate is identified as reasonably available, willing, or competent to act.”¹⁸ This article will use the term “unbefriended,” as it seems to have the most currency in the bioethics, medical, and legal literature.¹⁹

The majority of the unbefriended are believed to live in hospitals and nursing homes. The landmark study on the unbefriended in the U.S., from 2003, estimated that these individuals make up about 3 to 4 percent of the nursing home population.²⁰ A more recent study found that 16 percent of patients admitted to an intensive care unit (ICU) were unbefriended.²¹ A Minnesota nursing facility survey identified an unbefriended rate of just under 2 percent.²² Social services staff from Minnesota Volunteers of America estimate they handle approximately 250 calls a year regarding end-of-life decisions

about people who have impaired decision-making capacity with no legally designated decision maker.²³ Another study found that 45 percent of incapacitated patients’ next of kin could not be reached to make treatment decisions.²⁴ These are significant numbers, and they continue to grow. Most of these unbefriended individuals are elderly. The 2010 U.S. Census indicates there were approximately 400,000 people over the age of 65 living in the U.S., 13 percent of the total population.²⁵ This is a 15 percent increase in that age group since 2000. It is one of the fastest growing age groups. Moreover, the 65 and older age group will continue to grow at unprecedented rates because the boomer generation (born between 1946 and 1964) is one of the largest generations in U.S. history.²⁶

While the elderly are the largest group of unbefriended, they are not the only group who may be adversely affected by a lack of a surrogate (or a “reasonably available” surrogate).²⁷ There are five other key populations of unbefriended individuals: minors, the homeless, the mentally disabled, individuals in same-sex relationships, and individuals who have family or friends but who are nevertheless unbefriended due to a plethora of legal and other reasons.

First, minors, because of their legal status, may be unbefriended. With a few limited exceptions, individuals under the age of majority (typically 18) may not legally consent to medical treatment. Consent must be given by a parent, guardian, or other legally authorized adult. Typically, a parent will attend doctors’ appointments with minor children, but children often present to a medical facility without an adult. In the absence of an adult who is able to legally consent, physicians are urged to refrain from treating minors in non-emergency situations.²⁸ Physicians who provide care without proper consent may be subject to civil liability. There are many reasons why parents or guardians might not be available. Family living arrangements vary greatly, and many children reside with an adult who is not a legal guardian, such as a grandparent, aunt, uncle, or stepparent.²⁹ Alternatively, children may be brought to medical facilities by a child care provider. It is increasingly common for both parents to work, resulting in children spending large amounts

of time with child care providers. Such providers are not legal guardians, and, therefore, do not have legal authority to consent to treatment. Other times, children may be traveling out of state without a parent when a need for treatment arises. In certain states, noncustodial parents may not consent to medical treatment. A significant number of children live in foster homes, and for many, no one has asked the court to appoint a legal guardian. Furthermore, despite the enhanced communication available in today's culture, many hospitals and emergency personnel find it difficult or impossible to achieve real-time contact with parents or guardians, as many facilities do not have adequate systems in place to achieve this.³⁰

The homeless are another group likely to be unbefriended. Many times it is difficult or impossible to identify homeless patients, and when a patient cannot be identified, it is difficult to identify a surrogate.³¹ Even when the person can be identified, many homeless individuals do not have family or friends who are willing/able to make decisions on their behalf.³²

A third category of unbefriended are those with a mental disability. This category typically includes two populations: the developmentally disabled—people with conditions such as mental retardation, autism, cerebral palsy, or epilepsy; and people who are mentally ill—people with conditions such as schizophrenia, manic-depressive disorder, and serious depression. While these populations often overlap significantly within the homeless population, many others are served by special institutions. Because mentally disabled patients are often easily identifiable and are especially vulnerable, many laws and programs have been developed specifically for their benefit and protection.³³

Patients who are in same-sex relationships often have someone available and willing to make treatment decisions on their behalf, but, because of legalities, they may become unbefriended. Same-sex marriages are not legally recognized in the majority of states,³⁴ and so same-sex partners are often not recognized as a patient's "spouse" for purposes of healthcare decision making, unless the spouse was appointed a surrogate in an advance directive.³⁵ A few states have specifically added "domestic

partners" to surrogate statutes,³⁶ and some states allow "close friends" to act as a proxy. However, many other states have not amended their statutes to address such situations, and the statutes still require that the surrogate be a family member, either through blood or marriage, unless appointed in an advance directive.

Finally, like same-sex couples, some patients, despite the *existence* of family or friends, are unbefriended. Family or friends may exist, but they are *unavailable* to make treatment decisions, for any number of reasons, including legalities, identification, willingness, personal time constraints, or physical location. For example, homeless, institutionalized, or migratory individuals may lack access to appropriate witnesses to complete an advance directive.³⁷

2. THE RISKS AND PROBLEMS OF THE UNBEFRIENDED

Unbefriended patients are vulnerable to many undesirable, and possibly dangerous or life-threatening, situations. They often have multiple chronic conditions such as Alzheimer's disease, cancer, heart problems, diabetes, and kidney failure.³⁸ With no available formal decision-making mechanism, their healthcare providers are left in a quandary;³⁹ on the one hand, they might treat the patient without consent; on the other hand, providers might refuse to treat until they can obtain valid consent. Providers in the U.S. take both approaches, exposing the patients to significant risks.⁴⁰ In short, the unbefriended are exposed to two main types of risks: overtreatment and undertreatment.

The unbefriended are often overtreated. The absence of an authorized surrogate may result in "maximum medical intervention, whether or not a medical 'full court press' is clinically and ethically warranted."⁴¹ The unbefriended receive unnecessary or unwanted treatment for various reasons, including physicians' fears of civil liability for failure to treat, institutional fear of regulatory sanctions, physicians' economic incentives to treat, and physicians' interventionistic philosophy of medicine.⁴² All of these reasons are illegitimate. Instead, to the extent that a patient's preferences and values can be ascertained, treatment decisions should

be determined through substituted judgment; otherwise, they should be consistent with the patient's best interests.

Not only are the unbefriended overtreated, they are undertreated. Many physicians refuse to provide any type of treatment without informed consent, and so important decisions may be "dangerously deferred, or forgone altogether."⁴³ Instead, some physicians will wait until an emergency, and then consent is implied, and therefore there is no need for a surrogate to authorize treatment.⁴⁴ However, waiting for emergency situations may result in longer periods of suffering and indignity and increases the chance of morbidity to the patient.⁴⁵ In short, the absence of a surrogate can "stymie decision-making and possibly leave . . . patients to linger in pain and discomfort."⁴⁶

Furthermore, physical harm is not the only type of risk posed to the unbefriended. A serious affront to individual self-determination is also a threat. Whether overtreated or undertreated, the unbefriended are susceptible to treatment decisions that do not conform to their personal values, morals, or beliefs. For instance, several studies report that physicians often make decisions based upon their own preferences.⁴⁷ They may not know the patient, or may not be willing and/or able to take the time to learn the patient's preference. A treatment decision that is not based upon a patient's own preferences and values is particularly offensive in a society that places a premium on personal autonomy.

3. PREVENTION: ADVANCE CARE PLANNING, DILIGENT SEARCHING, AND CAREFUL CAPACITY ASSESSMENT

Before examining special decision-making mechanisms for the unbefriended, it is important to note that using established autonomy-protective strategies can often preclude the need to resort to "alternative" decision-making mechanisms. In other words, there are ways to prevent a patient from being unbefriended in the first place. Three key preventative strategies are advance care planning, diligent searching for surrogates, and careful capacity assessments.

First, all individuals are strongly encouraged

to engage in advance care planning. Even isolated individuals who are unable to appoint a family member might be able to appoint a friend or a "professional" surrogate. A recently completed Minnesota program nicely illustrates the use of advance care planning to prevent at-risk individuals from becoming unbefriended. From 2008 to 2011, supported in part by a grant from the Minnesota Department of Human Services, the Volunteers of America Minnesota (VOAMN) ran a program called "The Unbefriended Elders: Matching Values with Decisions."⁴⁸ The program served elderly residents of certain counties who had no written healthcare directive on file and who were at risk of guardianship proceedings because of the absence of any available default surrogate. The program consisted of local volunteers who were trained to identify and work with the unbefriended before they became incapacitated. The volunteers helped the at-risk elderly to complete healthcare directives and identify, locate, and support potential surrogate decision makers. Evaluations of the project indicate 62.5 percent of those served completed healthcare directives and 80 percent named an agent;⁴⁹ 78 percent of those who completed the directive had follow-up conversations with their physician. The program evaluators concluded it is very feasible to serve this vulnerable population, and that there is a growing need for training and education regarding their unmet needs. The grant that funded the project expired and the program has formally ended. But the Care Management and Consultation branch of the VOAMN still provides assistance for the unbefriended and those caring for them.

Even if a patient has not engaged in advance care planning before admission to a hospital or long-term care facility, it may not be too late. Clinicians should, at least at that point, clarify the patient's preferences about who should serve as surrogate in the event the patient loses capacity. Indeed, such inquiries are legally mandated by both state law⁵⁰ and by the Patient Self Determination Act.⁵¹ Furthermore, some have suggested that electronic POLST (physicians' orders for life-sustaining treatment) registries can help track the wishes of the unbefriended.⁵² In short, if patients leave adequate guidance about their post-capacity treatment, they can

avoid the risks of being unbefriended.

Advance care planning is one proven strategy; a second is diligent searching. For many individuals initially thought to be unbefriended, a diligent search often turns up an available surrogate.⁵³ The search should be, and is often legally required to be, aggressive and rigorous.⁵⁴ Facility staff should contact nursing homes, neighbors, and relevant service agencies. They should attempt to (legally) gain access to a patient's home or apartment.⁵⁵ They should construct a genogram (a graphic of a person's family relationships and medical history) and an eco-map (a graphic of the systems at play in an person's life).⁵⁶ Staff should examine patients' personal effects, health records, and other records such as benefits and pension plans. In this way, surrogates were found for nearly half of those who were initially thought to be unbefriended.⁵⁷ Therefore, before reverting to special mechanisms for the unbefriended, many states first require a very careful documentation of efforts to locate "natural" surrogates.⁵⁸

Of course, there is not always time to engage in these efforts. But even if the identification of a surrogate is not possible, prior health-care providers and others may have information about a patient's history, past relationships, wishes, values, and/or priorities. Even if a surrogate cannot be found, careproviders may still be able to gather "scattered bits and pieces of information, clues from a patient's past."⁵⁹ In short, even an unsuccessful search can be valuable, because clinicians may gather evidence that clarifies a patient's values relating to health-care, and preferences regarding treatment under different circumstances.⁶⁰ This is important, because whoever makes the treatment decision should exercise substituted judgment. An ongoing lawsuit in Washington, D.C., alleges that the D.C. government consented to elective surgeries for mentally disabled residents without considering their wishes.⁶¹ Similarly, a January 2012 decision of the Appeals Court of Massachusetts reversed a lower court's order authorizing an abortion and sterilization of a 32-year-old mentally ill woman. While incapacitated, the woman clearly and consistently had expressed her opposition to an abortion.⁶²

In addition to advance care planning and

diligent searching, a third prevention strategy is careful capacity assessment. With support, time, and good communication, seemingly unbefriended individuals may be able to make decisions that at first blush appear not to be possible. Individuals might not actually be unbefriended, because but for a diagnostic or assessment error, they have capacity to make treatment decisions.⁶³ Many bioethicists are concerned that unbefriended individuals are more likely to be the victim of an incorrect determination of incapacity by a physician.⁶⁴ Indeed, patients often present to a hospital with an initial appearance of incapacity that later "dissipates under scrutiny." In one reported case, an elderly woman who entered Massachusetts General Hospital for a heart condition found herself just days later declared mentally ill and transferred involuntarily to a nursing home. Her hearing in Suffolk Probate Court lasted about two minutes. A subsequent, more detailed evaluation convinced the original judge to void the guardianship and restore her freedom.⁶⁵

Capacity is not all-or-nothing. While nearly half of long-term-care residents may lack capacity, a quarter still had partial capacity.⁶⁶ For example, although patients may lack the capacity to make complex treatment decisions, they may have sufficient capacity to appoint a surrogate.⁶⁷ The VOAMN program found that even though half of its clients had a cognitive impairment, they still had sufficient capacity to complete an advance directive. An unbefriended patient might still have capacity to share what she thinks "about death, life, her current living situation, and her hopes for the future."⁶⁸ The unbefriended should be allowed to participate in making decisions to extent that they can.⁶⁹

4. DECISION-MAKING MECHANISMS FOR THE UNBEFRIENDED

There is significant disagreement about how to handle decision making for the unbefriended. For example, the American Medical Association recommends that when there is no surrogate, an ethics committee should be consulted, and judicial intervention should be the last resort.⁷⁰ In contrast, the Ethics Committee of the American Geriatrics Society maintains that the

patient's team of treating providers should make a decision.⁷¹ The American College of Physicians posits that a court-appointed guardian should be utilized in each and every case.⁷²

Just as medical associations disagree about the best way to make treatment decisions for the unbefriended, so do state legislatures. A variety of laws and statutes have been developed for the benefit of this vulnerable group of individuals. This article will focus on the following 10 decision-making mechanisms: (1) the emergency exception to informed consent; (2) expanding statutory default surrogate lists to include close friends; (3) authorizing private guardians; (4) authorizing volunteer guardians; (5) authorizing public guardians; (6) authorizing temporary and emergency guardians; (7) authorizing attending physicians; (8) authorizing other clinicians, individuals, and entities; (9) authorizing institutional committees; and (10) authorizing external committees. Through whichever of the mechanisms treatment decisions are made for an unbefriended patient, the decision-making standards are approximately the same. These standards are usually specified in state statutes in the U.S., and there is substantial uniformity across the country. There is generally a two-step hierarchy; surrogates should apply these standards sequentially: substituted judgment and then best interest.

Under the substituted judgment standard, surrogates must engage in some speculation and "infer" patients' wishes from prior statements and conduct. Laws across several states are substantially similar. Alabama, for example, states a surrogate must make decisions "that conform as closely as possible to what the patient would have done or intended under the circumstances." Surrogates must take into account "any evidence of the patient's religious, spiritual, personal, philosophical, and moral beliefs and ethics."⁷³ There is often no reliable evidence of the unbefriendeds' expressed wishes, values, or preferences. When this is the case, surrogates cannot apply the substituted judgment standard, and therefore must apply the best interest standard. Surrogates must shift focus from the patient's autonomy to the patient's welfare. In the absence of subjective evidence about a patient's wishes, a surrogate must rely on more objective

grounds, on an outcome that best promotes the patient's well-being. Typically, these factors are used to guide the application of the best interest standard: (1) the patient's present level of physical, sensory, emotional, and cognitive functioning; (2) quality of life, life expectancy, and prognosis for recovery with and without treatment; (3) the various treatment options and the risks, side-effects, and benefits of each; (4) the nature and degree of physical pain or suffering resulting from the medical condition; (5) whether the medical treatment being provided is causing or may cause pain, suffering, or serious complications; (6) the pain or suffering to the patient if the medical treatment is withdrawn; and (7) whether any particular treatment would be proportionate or disproportionate in terms of the benefits to be gained by the patient versus the burdens caused to the patient.⁷⁴

5. EMERGENCY EXCEPTION TO INFORMED CONSENT

In emergency situations, decision making for the unbefriended is reasonably straightforward: the patient lacks capacity to consent, there is no reasonably available surrogate, and consent to treatment is implied.⁷⁵ Emergency situations are typically defined as those in which, according to competent medical judgment, proposed surgical or medical treatment or procedures are reasonably necessary, and a delay in treatment could reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impaired faculties.⁷⁶ The emergency makes it necessary, or apparently necessary, for providers to act *before* there is opportunity to obtain consent.⁷⁷

For example, a pending 2011 Missouri bill provides that healthcare may be provided to an unbefriended patient without consent if "in the reasonable medical judgment of the attending physician or other healthcare professional responsible for the care of the patient, the delay occasioned by attempting to locate an authorized person or by continuing to attempt to locate an authorized person presents a substantial risk of death, serious permanent disfigurement, or loss or impairment of the functioning of a bodily member or organ, or other serious

threat to the health of the patient.”⁷⁸ The law in every other state is substantially similar.⁷⁹ The law concerning treatment decisions in emergency situations is reasonably well settled. Therefore, the challenges primarily concern non-emergency treatment. The remaining decision-making mechanisms focus on how treatment decisions are made for unbefriended patients in non-emergency situations.

6. EXPANDED DEFAULT SURROGATE LISTS: CLOSE FRIENDS

Most individuals have either not completed or not effectively implemented advance directives appointing healthcare agents or durable powers of attorney. In response, most states have enacted “default statutes”⁸⁰ specifying a hierarchy of surrogates to consent to treatment on behalf of incapacitated individuals. Surrogates do not need to be designated or appointed; rather, they are automatically designated, based on their familial, or otherwise defined, relationship to the incapacitated individual. U.S. statutes normally provide a list in order of priority. Most give spouses the highest priority and typically also include, in various sequences, parents, siblings, adult children, and grandparents.

With a broader statutory list of authorized surrogates, it is more likely surrogates can be found, and thus less likely that patients will be unbefriended.⁸¹ Accordingly, many states have amended their laws to allow “close friends,” or some variation of “interested adult,” to make decisions when no family member is available.⁸² For example, New Mexico permits “an adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values and who is reasonably available” to act as a surrogate when no family member listed in the statutory hierarchy is available.⁸³ Similarly, Pennsylvania allows “an adult who has knowledge of the principal’s preferences and values, including, but not limited to, religious and moral beliefs, to assess how the principal would make healthcare decisions.”⁸⁴ The Veterans Health Administration includes “close friend” in its surrogate list.⁸⁵

Over the past two years, several additional states have added “close friends” as authorized

surrogates in their default statutes.⁸⁶ In 2010, a Georgia bill added “adult friends” to its list of default surrogates. This new category includes an “adult who has exhibited special care and concern for the patient, who is generally familiar with the patient’s health care views and desires, and who is willing and able to become involved in the patient’s health care decisions and to act in the patient’s best interest.”⁸⁷

In 2010, New York also added “close friend” as its ultimate default surrogate or “decision maker of last resort.”⁸⁸ Under the New York Family Health Care Decisions Act, “close friend” includes an individual “who has maintained such regular contact with the patient as to be familiar with the patient’s activities, health, and religious or moral beliefs, and who presents a signed statement to that effect to the attending physician.”⁸⁹ In 2011, New Jersey introduced legislation, closely patterned after the New York act, which would authorize the patient’s close friend as the ultimate default surrogate,⁹⁰ but the New Jersey bill has not yet been scheduled for a vote on the floor of the state assembly.

Tennessee has an interesting variation on the statutory default priority list that places the physician in a powerful position. A recent Tennessee court case held that despite existing custom, a patient’s next of kin is not automatically authorized to make healthcare decisions upon the patient’s incapacity.⁹¹ If a patient has not appointed an agent and a court has not appointed a guardian, then the treating physician is authorized to appoint a decision maker.⁹² The statutory default list is not a mandate, only a guideline. Physicians do not mechanically follow the sequence in the statute; instead, physicians must choose “an adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, who is reasonably available, and who is willing to serve.”⁹³ Physicians may consider family members or next of kin, but are not bound to do so. They may choose any adult, as long as the person satisfies the listed criteria.⁹⁴ West Virginia similarly gives attending physicians or advanced nurse practitioners discretion to select the best qualified surrogate, even if the person is lower in a common ranking of surrogates.⁹⁵

Colorado and Hawaii have a similar varia-

tion on the default priority list, but which leaves the physician with less discretion than in Tennessee and West Virginia. After determining that a patient is incapacitated, the attending physician may initiate proceedings to nominate a surrogate decision maker to act on behalf of the patient. The physician seeks out as many interested persons as possible, including the patient's spouse, family, and close friends.⁹⁶ There is no hierarchy. Instead, all interested parties must meet and decide amongst themselves who will be the decision maker. Hopefully, the group will choose the person who is most familiar with and most likely to honor the patient's wishes and values. The nominated individual is then legally authorized to make decisions for the patient and should make decisions based on the substituted judgment or best interest standard. The nominated Colorado surrogate, like default surrogates in several other states, may elect to withhold or withdraw artificial nourishment or hydration only under certain conditions. Two physicians (the attending and a second, independent physician) must certify such care is only "prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."⁹⁷ The statute requires that the healthcare facility provide the assistance of its medical ethics committee to any surrogate decision maker who is deciding to withhold or withdraw treatment.

Finally, the Delaware Health Care Decisions Act purports to include close friends as default surrogates. When no family member is available, the statute authorizes "an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values and who is reasonably available" to make medical treatments. But the statute awkwardly authorizes a close friend only if the chancery court appoints that person as a guardian.⁹⁸ Commentators often write that Delaware includes close friends as default surrogates,⁹⁹ but since the close friend cannot be informally designated by a careprovider, close friends are not really part of Delaware's default priority list.

In sum, close friend laws offer protection to the unbefriended by expanding the categories of authorized default surrogates. Even patients who have no available family may have a close

friend. Still, close friend laws are of little value to patients who do not have any known or reasonably available close friends. Many times, patients have meaningful interactions only with careproviders. But providers are almost always prohibited from serving as surrogates, even if they would otherwise qualify as close friends.¹⁰⁰

CONCLUSION

Most authors addressing the strengths and weaknesses of existing healthcare decision-making mechanisms for the unbefriended invoke the language of balance and equilibrium. Muriel Gillick, for example, writes, "a balance must be struck between the need to protect [the unbefriended] from caregiver bias and institutional self-interest, on the one hand, and a stranger's excessive distance on the other."¹⁰¹ Diane Meier writes that the decision maker must be "responsive yet independent."¹⁰² This is an appropriate way to frame the question. On the one hand, we want a decision-making process that is accessible, quick, convenient, and cost-effective. On the other hand, we want a process that provides the important safeguards of expertise, neutrality, and careful deliberation.¹⁰³

Part 2 of this "Legal Briefings" column on the unbefriended will begin with a discussion of the main officially authorized decision-making mechanism for the unbefriended: guardianship. Specifically, it reviews four types of guardianship: private, volunteer, public, and emergency guardians. The formal court-supervised guardianship process helps assure neutrality, impartiality, and public accountability. But serious concerns over cost, speed, competence, and the availability of guardians have led most commentators to view guardianship as an option of last resort. Instead, significant effort has been devoted to the development of extrajudicial mechanisms. Part 2 of this article reviews the four main models that give decision-making authority to attending physicians, other clinicians, institutional committees, and external committees.

NOTES

1. I. Hyun et al., "When Patients Do Not Have a

Proxy: A Procedure for Medical Decision Making When There Is No One to Speak for the Patient,” *The Journal of Clinical Ethics* 17, no. 4 (2006): 323-30; D.M. Bartels et al, “Dignity Matters: Advance Care Planning for People Experiencing Homelessness,” *The Journal of Clinical Ethics* 19, no. 3 (2008): 214-22.

2. N. Karp and E. Wood, *Incapacitated and Alone: Healthcare Decision Making for Unbefriended Older People* (Washington, D.C.: American Bar Association, 2003); *When Others Must Choose: Deciding for Patients without Capacity*, (Albany, N.Y.: New York State Task Force on Life and the Law, March 1992), chapter 10; J.E.B. Ortiz, *Advocating for the Unbefriended Elderly: An Informational Brief* (Washington, D.C.: National Consumer Voice for Quality Long-Term Care, August 2010), http://www.ltombudsman.org/sites/default/files/ombudsmen-support/training/Informational-Brief-on-Unbefriended-Elders_0.pdf, accessed 27 January 2012; Center for Advocacy for the Rights and Interests of the Elderly (CARIE), *White Paper: Meeting the Needs of Persons with Alzheimer's or Other Dementia When No Informal Support is Available*, October 2010, <http://www.carie.org/alzheimers-white-paper/>, accessed 27 January 2012.

3. See Karp and Wood, note 2 above, p. 1 (quoting Nancy Dubler). The issue has also been described as “one of the most difficult problems in medical decision-making,” *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Briarcliff Manor, N.Y.: Hastings Center, 1987).

4. M.J. Quinn, *Guardianships of Adults: Achieving Justice, Autonomy, and Safety* (New York: Springer, 2005): 112. “Only a few states specify a procedure [for a] patient without a surrogate.” American Medical Directors Association, “White Paper on Surrogate Decision-Making and Advance Care Planning in Long-Term Care, 2003, http://www.amda.com/governance/whitepapers/surrogate/decisionmaking_hierarchy.cfm, accessed 27 January 2012; J Sacco, “Incapacitated, Alone, and Treated to Death,” *New York Times*, 7 Oct. 2008.

5. M.B. Kapp, “The ‘Voluntary’ Status of Nursing Facility Admissions: Legal, Practical, and Public Policy Implications,” *Criminal and Civil Confinement* 24, no. 1 (1998): 1-35; M.B. Kapp, “Editorial—Surrogate Decision-Making for the Unbefriended: Social and Ethical Problem, Legal Solution?” *Journal of Ethics, Law, and Aging* 1, no. 2 (1995): 83-85.

6. This briefing does not address some related issues. First, it does not address decision-making mechanisms for special and extraordinary medical situations such as sterilization and the administration of psychotropic medication. Additional protec-

tions are usually required in such situations. E.g. Fla. Stat § 765.113. Second, this briefing does not address the situation in which the incapacitated unbefriended patient “objects” to treatment. Third, while this briefing focuses on healthcare decision making, such decisions are often intertwined with those concerning finances. For example, it might be necessary to authorize someone to sell a patient’s property so that she or he can qualify for Medicaid and long-term care placement. Fourth, this briefing does not address the participation of the unbefriended in biomedical research.

7. T.M. Pope, “Legal Fundamentals of Surrogate Decision Making,” *Chest* 141 (2012): in press.

8. While many unbefriended patients are individuals who have lost decision-making capacity, some are individuals who never had capacity.

9. Sometimes, a patient’s unbefriended status is a factor not so much due to the *non-existence* of a surrogate, but to the *unavailability* of a surrogate at the relevant time. For example, an unbefriended patient might have relatives, but those relatives may be unresponsive, uninvolved, or incapable of making treatment decisions for the patient.

10. N. Karp and E. Wood, “Incapacitated and Alone: Healthcare Decision Making for Unbefriended Older People,” *Human Rights* 31, no. 2 (2004): 20-4.

11. Minnesota Commission on End-of-Life Care, “Final Report,” January 2002, p. 54, <http://www.mnhpc.org>, accessed 27 January 2012.

12. C. Frank, “Surrogate Decision-Making for ‘Friendless’ Patients,” *Colorado Lawyer* 34, no. 4 (April 2005): 71-6; California Law Review Commission, “Memorandum 98-63: Health Care Decisions: Comments on Tentative Recommendation,” (18 September 1998): 9, www.clrc.ca.gov/pub/1998/M98-63.pdf, accessed 27 January 2012.

13. V. Kind, *The Caregiver's Path to Compassionate Decision Making* (Austin, Tex: Greenleaf Book Group, 2010): 46-8.

14. L.F. Post, J. Blustein, and N.N. Dubler, *Handbook for Healthcare Ethics Committees* (Baltimore, Md.: Johns Hopkins University Press, 2007): 205-8; American Health Decisions, “The Patient Alone: Making Health Care Choices for Patients without Surrogates,” 6-7 May 2008, http://www.ahd.org/Presentations_%26_Faculty.html, accessed 27 January 2012.

15. See Karp and Wood, note 2 above, p. 31 (citing an unpublished paper: C. Downing, “Temporary Medical Treatment Guardians: Procedural Considerations”).

16. D.B. White et al., “Life Support for Patients without a Surrogate Decision Maker: Who Decides?”

Annals of Internal Medicine 147, no. 1 (2007): 34-40; D.B. White et al., "Decisions to Limit Life-Sustaining Treatment for Critically Ill Patients Who Lack Both Decision-Making Capacity and Surrogate Decision-Makers," *Critical Care Medicine* 34, no. 8 (2006): 2053-9; S.J. Baumrucker et al., "A Cognitively Impaired Patient without a Surrogate: Who Makes the Decision?" *American Journal of Hospice and Palliative Medicine* 28, no. 8 (2011): 583-7; American Medical Directors Association, see note 4 above.

17. C. Griggins, "Patients without Proxies: What's Happening in Other States?" *Mid-Atlantic Ethics Committee Newsletter* (Summer 2010): 7-9; A. Robichaud and C. Griggins, "Patients without Proxies: Medical Decision-Making for Patients without Advocates," PowerPoint presentation for Cleveland State University, 18 Nov. 2010, http://wapps.csuohio.edu/campusmailbag/forum_posts.asp?TID=6308, accessed 10 February 2012.

18. N.J. A.B. 4098, 214th Legis. (2011) (Conaway).

19. E.D. Isaacs and R.V. Brody, "The Unbefriended Adult Patient," *San Francisco Medicine* (July/August 2010): 25-6; M. Varughese et al., "Ethics and Clinical Practice Guided by the Family Health Care Decisions Act," *NYSBA Health Law Journal* 16, no. 1 (2011): 75-82; R.M. Gibson, "IDT Decision-Making in California Long-Term Care Facilities," *California Association of Long-Term Care Medicine* (December 2011), <http://calctcm.org/news/dec2011/idt>, accessed 27 January 2012; C.P. Sabatino, *Advance Directives and Advance Care Planning: Legal and Policy Issues* (Washington, D.C.: U.S. Department of Health and Human Services, 2007), <http://aspe.hhs.gov/daltcp/reports/2007/adacplpi.pdf>, accessed 27 January 2012; M.J. Gorbien and A.R. Eisenstein, "Elder Abuse and Neglect: An Overview," *Clinics in Geriatric Medicine* 21, no. 2 (2005): 279-92; M.B. Kapp, "Medical Decision Making for Older Adults in Institutional Settings: Is Beneficence Dead in an Age of Risk Management," *Issues in Law and Medicine* 11, no. 1 (1995): 29-46; M.A. Williams, "Unbefriended," *Neurology* 67, no. 11 (2006): 2088. The term was apparently coined in a symposium of the *Journal of Ethics, Law and Aging* 1, no. 2 (1995). One article attributes the term to Joanne Lynn. T.E. Finucane, R.D. Elon, and J.M. Keenan, "The Medical Director in Non-Institutional Long-Term Care Programs," *Clinics in Geriatric Medicine* 11, no. 3 (1995): 391-402.

20. See Karp and Wood, note 2 above; M.R. Gillick, "Medical Decision-Making for the Unbefriended Nursing Home Resident," *Journal of Ethics, Law and Aging* 1, no. 2 (1995): 87-92; T. Miller and A.M. Cugliari, "Withholding and Withdrawing

Treatment: Policies in Long-Term Care Facilities," *Gerontologist* 30, no. 4 (1990): 462-8.

21. See White et al., note 16 above.

22. D. Silverman, "Serving the Unbefriended Elder Population: Trends, Challenges, and Successes," PowerPoint presentation, 2011 Minnesota Age & Disabilities Odyssey, Mayo Civic Center, Rochester, Minn., 21 June 2011 (citing a study by Andrea Palumbo, Elder Justice Scholar, William Mitchell College of Law), <http://www.mnodyssey.org>, accessed 27 January 2012.

23. See Minnesota Commission on End-of-Life Care, note 11 above, p. 54.

24. A. Fader, S. Gambert, M. Nash, and K. Gupta, "Implementing a Do-Not-Resuscitate Policy in a Nursing Home," *Journal of the American Geriatrics Society* 37, no. 6 (1989): 544-8.

25. L.M. Howden and J.A. Meyer, "Age and Sex Composition: 2010," United States Census Bureau, May 2011, <http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf>, accessed 27 January 2012.

26. N. Karp and E.F. Wood, "Guardianship Monitoring: A National Survey of Court Practices," *Stetson Law Review* 37, no. 1 (2007): 143-97.

27. See Silverman, note 22 above.

28. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine and Committee on Bioethics, "Consent for Emergency Medical Services for Children and Adolescents," *Pediatrics* 128, no. 2 (2011): 427-33.

29. J.E. Berger and American Academy of Pediatrics, Committee on Medical Liability, "Consent by Proxy for Nonurgent Pediatric Care," *Pediatrics* 112, no. 5 (2003): 1186-95.

30. See AAP, note 28 above, p. 431.

31. For example, Michelle Bateman, a 43-year-old woman, remained unconscious in University of Pennsylvania hospital for four months before she was identified and her family located. She went into cardiac arrest on 13 August 2010, was brought to an area hospital, and later transferred to Penn, but never regained consciousness. Because no one could determine her identity and no family members were immediately present, the hospital absorbed all costs of treatment and presumably all decisions relating to the treatment. Her family placed missing person reports and made phone calls, and the hospital ran nationwide fingerprint checks and asked for help from local TV stations and newspapers. Four months later, in December 2010, a friend recognized her picture in the newspaper and contacted her family. D. Sapatkin, "Family Identifies Unconscious Woman," *Philadelphia Inquirer*, 14 December 2010.

32. For further reading on studies of treatment and the advance care of the homeless, see: D.M.

Bartels et al., see note 1 above; J.J. O'Connell, "Raging Against the Night: Dying Homeless and Alone," *The Journal of Clinical Ethics* 16, no. 3 (Fall 2005): 262-6; J. Song, E.R. Ratner, and D.M. Bartels, "Dying While Homeless: Is It a Concern When Life Itself Is Such a Struggle?" *The Journal of Clinical Ethics* 16, no. 3 (Fall 2005): 251-61; W.M. Norris, E.L. Nielsen, R.A. Engelberg, and J.R. Curtis, "Treatment Preferences for Resuscitation and Critical Care among Homeless Persons," *Chest* 127, no. 6 (2005): 2180-7.

33. See "14. External Committees," on authorizing "external committees" to make treatment decisions in Part 2 of this column in *JCE* Summer 2012.

34. M. Stiff, *Breaking Down Barriers: An Administrator's Guide to State Law and Best Policy Practice for LGBT Healthcare Access* (Washington, D.C.: Human Rights Campaign, 2009). Effective in 2012, a new Delaware statute provides that "parties to a civil union . . . shall have all the same rights, protections and benefits . . . as are granted to, enjoyed by or imposed upon married spouses." Del. S.B. 30, 146th Gen. Assembly (2011) (Sokola), *codified*, at 13 Del. Code §§ 201-216.

35. See note 7 above; K. Tucker, "Elder Law: Counseling Clients Who Are Terminally Ill," *William Mitchell Law Review* 37, no. 1 (2010): 117-31.

36. T.M. Pope, "Comparing the FHCDA to Surrogate Decision Making Laws in Other States," *NYSBA Health Law Journal* 16, no. 1 (2011): 107-11; Wash. Rev. Code Ann. § 7.70.065.

37. L.S. Castillo et al., "Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care," *Annals of Internal Medicine* 154, no. 2 (2011): 121-8.

38. Karp and Wood, note 2 above, p.15.

39. *Ibid.*, 32.

40. R.N. Swidler, "New York's Health Care Decisions Act: The Legal and Policy Background, Key Provisions, and Emerging Issues," *NYSBA Health Law Journal* (June 2010): 18-27.

41. See Kapp, note 5 above, p. 22.

42. Volunteers of America—Minnesota, "Unbefriended Elders: Matching Values with Decisions," 30 April 2010, <http://www.mnvero.org/downloads/UnbefriendedElders.pdf>, accessed 27 January 2012.

43. See Kapp, note 5 above, p. 22.

44. See the section, "5. Emergency Exception to Informed Consent," in this column, above.

45. See Kapp, note 5 above, p. 18; Volunteers of America—Minnesota, see note 42 above.

46. A. Meisel and K.L. Cerminara, *The Right to Die: The Law of End of Life Decisionmaking*, 3rd ed. (suppl.) (New York: Aspen, 2010), § 3.16[F].

47. See Norris et al., note 32 above; T.E. Miller, C.H. Coleman, and A.M. Cugliari, "Treatment Deci-

sions for Patients without Surrogates: Rethinking Policies for a Vulnerable Population," *Journal of the American Geriatrics Society* 45, no. 3 (1997): 369-74, 370. ("Without a surrogate, decisions may be less open, less clearly articulated, and more susceptible to judgments about the patient's social and individual worth.")

48. M. Bornang, "Unbefriended Elders: Matching Values in Decisions," *NAELA Bulletin*, 25 August 2009; Volunteers of America—Minnesota, "Volunteers of America—Minnesota Wins Grant to Help Unbefriended Elders Convey Healthcare Preferences," 27 August 2008, <http://www.voamn.org/About-Us/Press-Room/2008-News-Archive/Unbefriended-Elders-Grant>, accessed 27 January 2012.

49. Volunteers of America—Minnesota, "Unbefriended Elders Project," PowerPoint Presentation, <http://www.voamn.org/Learn-About-our-Services/Senior-Services/Protective-Services/Unbefriended-Elders-Project>, accessed 27 January 2012. Public and private "next-of-kin registries" may also be useful in identifying and locating potential surrogates, <http://www.nokr.org/>, accessed 27 January 2012.

50. N.Y. Pub. Health Code § 2994-g(1) ("Within a reasonable time after admission as an inpatient to the hospital of each adult patient, the hospital shall make reasonable efforts to determine if the patient has appointed a health care agent or has a guardian. . . . With respect to a patient who lacks capacity, if no such health care agent, guardian or potential surrogate is identified, the hospital shall identify, to the extent reasonably possible, the patient's wishes and preferences, including the patient's religious and moral beliefs, about pending health care decisions, and shall record its findings in the patient's medical record.")

51. 42 U.S.C. § 1395cc(f)(1); 42 C.F.R. §§ 482.13(b)(3) & 489.102(a)(4).

52. J. Duncan, "Physician Order for Life Sustaining Treatment: Developing a POLST Registry," <http://www.naphsis.org>, accessed 27 January 2012.

53. D. Sapatkin, "Nearly Four Months Later, Woman at HUP Still Unidentified," *Philadelphia Inquirer*, 11 December 2010.

54. E.g. Tex. Health & Safety Code § 313.005(b).

55. L.M. Peterson, "Clinical Decision Making for the Unbefriended Patient," *Lahey Clinic Journal of Medical Ethics* (Fall 2010): 3.

56. S.F. Cohn and M.H. Rieff, "Care Management Challenges in Serving Un-Befriended Older Adults with Compromised Cognitive Capacity," ASA/NCOA Conference, 29 April 2011, http://www.jarvie.org/docs/Unbefriended_Elder_with_Cogn_Impairment_presentation.pdf, accessed 27 January 2012.

57. See Griggins, note 17 above, p. 8.
58. Fla. Stat. § 765.401(h).
59. See Karp and Wood, note 2 above, p. 18.
60. *Ethical Aspects of the Relationship between Clinicians and Surrogate Decision Makers* (Washington, D.C.: National Ethics Committee of the Veterans Health Administration, 2007). The policy at Brigham and Women's Hospital suggests "weaving these fragments of experience and knowledge together produces a 'synthetic judgment' of the patient's preferences." N. Sadovnikoff and M. Jurchak, "Substituted Judgment in the Absence of Surrogates," *Critical Care Medicine* 35, no. 10 (2007): 2467-8; M. Jurchak, "Creating a Voice for Absent or Inadequate Surrogates," ASBH Annual Meeting, 19 October 2007, <http://asbh.confex.com/asbh/2007/techprogram/P6154.HTM>, accessed 27 January 2012.
61. *Does I to III v. District of Columbia*, No. 01-2398 (HHK) (D.D.C. 30 September 2011) (order granting motion to file second amended complaint).
62. *In re Moe*, 81 Mass. App. Ct. 136, 2012 WL 104915 (17 January 2012).
63. See Karp and Wood, note 2 above, p. 47; M. Church and S. Watts, "Assessment of Mental Capacity: A Flow Chart Guide," *Psychiatrist* 31 (2007): 304-07 (reviewing "properly supported processes" sufficient to enable the patient to make the decision in question, such as: multiple learning trials with corrected feedback and enhanced structure using computer-based presentations).
64. M.S. Chin and V.A. Brown, "The Dilemma of Capacity: Respecting Patient Wishes and Preferences and Decision Making Ability," *Journal of Hospital Ethics* 2, no. 1 (2010).
65. "Old, Sick, and Unbefriended" editorial, *Boston Globe*, 18 January 2008.
66. See Miller et al., note 47 above.
67. See Gillick, note 20 above.
68. See Baumrucker et al., note 16 above. The concept of the "least restrictive alternative" is a centerpiece of guardianship reform.
69. In states that utilize the traditional process, substantial efforts are underway to develop practical alternatives and guardian prevention methods. D.P. Smith and S.B. Gardner, "Complex Family Matters in Guardianship, Advanced Elder Law and Advanced Guardianship," in *Advanced Guardianship Course 2009* (Houston, Tex.: State Bar of Texas, 2009), chapter 11. For instance, the Texas legislature recently mandated the development of an additional program to assist those individuals with mental disabilities and no guardian in making decisions. The statute requires the Health and Human Services Commission to develop and evaluate two Volunteer Supported Decision-Making Advocate Programs. Tex. H.B. 1454 (2009); Texas Council for Developmental Disabilities, "Alternatives to Guardianship: Volunteer Supported Decision-Making Advocate Pilot #2010-06," http://www.txddc.state.tx.us/grants_projects/rfp2010-06.asp, accessed 27 January 2012. The programs will assist these individuals in making life decisions such as where to live and with whom and where to work.
70. AMA Council on Ethical and Judicial Affairs, "Selection of Health Care Decision-Making Surrogates," CEJA Report 3-A-04, <http://www.ama-assn.org/resources/doc/ethics/3a04.pdf>, accessed 27 January 2012.
71. Ethics Committee of the American Geriatrics Society, "Making Treatment Decisions for Incapacitated Older Adults without Advance Directives," *Journal of the American Geriatrics Society* 44, no. 8 (1996): 986-7.
72. L. Snyder, "American College of Physicians Ethics Manual, Sixth Edition," *Annals of Internal Medicine* 156, no. 1 (2012): 73-104.
73. Ala. Code § 22-8A-11(c).
74. T.M. Pope, "The Best Interest Standard: Both Guide and Limit to Medical Decision Making on Behalf of Incapacitated Patients," *The Journal of Clinical Ethics* 22, no. 2 (2011): 134-8.
75. Ariz. Rev. Stat. § 36-512; Cal. Bus. & Prof. Code § 2397; Cal. Health & Safety Code § 1418.8(h); Cal. Prob. Code § 3210(b); Colo. Rev. Stat. § 15-18.6-104(3); 16 Del. Code § 2510(a)(4); Idaho Code § 49-4504(g); Ind. Code § 16-36-3-3; Miss. Code § 41-41-7; Mo. Rev. Stat. § 27- 431.063; N.C. Gen. Stat. Ann § 90-21.13(c1); N.Y. Pub. Health Code § 2994-q(2); S.C. Code § 44-66-40(A) ("Health care may be provided without consent to a patient who is unable to consent if no person authorized . . . is available immediately, and in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the patient, the delay occasioned by attempting to locate an authorized person, or by continuing to attempt to locate an authorized person, presents a substantial risk of death, serious permanent disfigurement, or loss or impairment of the functioning of a bodily member or organ, or other serious threat to the health of the patient.").
76. Ga. Code § 31-9-3(a).
77. *Restatement (Second) Torts* § 892D; *Stewart-Graves v. Vaughn*, 170 P.3d 1151 (Wash. 2007); *Miller v. HCA, Inc.*, 118 S.W.3d 758 (Tex. 2003).
78. Mo. H.B. 392 § 191.1304, 96th Gen. Assembly (2011) (White).
79. E.g. Ga. Code § 31-9-3(b) ("In addition to any instances in which a consent is excused or implied, at law, a consent to surgical or medical treat-

ment or procedures suggested, recommended, prescribed, or directed by a duly licensed physician will be implied where an emergency exists.”).

80. See Meisel and Cerminara, note 46 above; C.P. Sabatino, “The Evolution of Health Care Advance Planning Law and Policy,” *Milbank Quarterly* 88, no. 2 (2010): 211-39.

81. Some states, like Delaware, also have comparatively shorter lists of eligible relatives. 16 Del. Code § 2507. In contrast, other states include, near the bottom of the list, “nearest living relative” or “close adult relative.” E.g. D.C. Code § 21-2210; Fla. Stat. Ann. § 765.401. The shorter the list, the more likely patients will be unbefriended.

82. Alaska Stat § 13.52.030(d); Ariz. Stat. § 36-3231(A)(6), Colo. Rev. Stat. § 19a-571; D.C. Code § 21-2210; Fla. Stat. § 765.401(g); Ga. Code § 31-9-2(7); Haw. Rev. Stat. § 327E-2; Idaho Code § 39-4503; 755 Ill. Cons. Stat. § 40/25(a)(7); 18-A Me. Rev. Stat. § 5-805; Md. Health-Gen. Code Ann. 5-605(a)(2); Miss. Code Ann. 41-41-203; N.M. Stat. Ann. 24-7A-5; N.Y. Pub. Health Code § 2994-d(1)(f), N.C. Gen. Stat. § 90-322; N.C. Gen. Stat. § 90-21.13(c)(7); N.D. Cent. Code § 23-12-13; Ore. Rev. Stat. § 127.635(2)(g); 20 Pa. Stat. Ann. § 5461; S.D. Codified Laws § 34-12C-1; Tenn. Code Ann. § 68-11-1806(c)(3); Utah Code Ann. § 75-2-108; Va. Code § 54.1-2986(A)(7); W. Va. Code Ann. § 16-30-8; Wisc. Stat. Ann. § 50.06; Wyo. Stat. § 35-22-406. Delaware includes “close friend,” but only if appointed as guardian. 16 Del. Code § 2507.

83. N.M. Stat. § 24-7A-5(c) However, the statute further dictates that a surrogate “may not be an owner, operator or employee of a health-care institution at which the patient is receiving care.” N.M. Stat. § 24-7A-5(j).

84. 20 Pa. Cons. Stat. Ann. § 5461.

85. 38 C.F.R. § 17.32(e)(4); “Informed Consent for Clinical Treatments and Procedures,” *VHA Handbook* § 1004.01(14), 14 August 2009, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2055, accessed 27 January 2012.

86. Close friends are also included in health-care decisions statutes of many foreign jurisdictions. E.g. New South Wales [Australia] Guardianship Act of 1987 § 33A(4)(d).

87. Ga. S.B. 367 (2009), codified at Ga. Code Ann. § 31-9-2(a)(7).

88. N.Y. Pub. Health Code § 2994-d(1)(f). Like most state statutes, this act contains certain restrictions on who may serve as a surrogate, even if the individual would otherwise qualify as a close friend. In particular, healthcare providers typically cannot qualify as close friends.

89. N.Y. Pub. Health Code § 2994-a(4).

90. N.J. A.B. 4098, 214th Legis. (2011) (Conaway). The bill was reintroduced in the next legislative session. N.J. A.B. 1835, 215th Legis. (2012) (Conaway).

91. *Barbee v. Kindred Healthcare Operating Inc.*, No. W2007-00517-COA-R3-CV (Tenn. App. 20 Oct. 2008).

92. Tenn. Code Ann. § 68-11-1806(c). The Tennessee Department of Health provides an “Appointment of Surrogate Form,” <http://health.state.tn.us/AdvanceDirectives/Surrogate.pdf>, accessed 10 February 2012.

93. Tenn. Code Ann. § 68-11-1806(c)(2).

94. Tenn. Code Ann. § 68-11-1806(c)(3).

95. W. Va. Code § 16-30-8(b). The West Virginia Center for End-of-Life Care has developed a useful “Checklist for Surrogate Selection,” <http://www.wvendoflife.org/MediaLibraries/WVCEOLC/Media/public/Surrogate-Selection-with-demographic-info.pdf>, accessed 10 February 2012.

96. Colo. Rev. Stat. § 15-18.5-103; Haw. Rev. Stat. § 327E-5(c)-(d). A 2006 roundtable meeting of the Elder Law Section of the Colorado Bar addressed that this statute needs to be amended to provide for an isolated individual with no close family or friends. Elder Law Section of the CBA, Meeting Minutes, 19 January 2006, http://www.cobar.org/repository/Inside_Bar/Elder/01.19.06%20min..pdf?ID=2157, accessed 27 January 2012.

97. Colo. Rev. Stat. § 15-18.5-103(6)

98. 16 Del. Code § 2507(b)(3).

99. ABA Commission on Law and Aging, “Default Surrogate Consent Statutes,” http://www.americanbar.org/content/dam/aba/migrated/aging/PublicDocuments/famcon_2009.authcheckdam.pdf, accessed 27 January 2012.

100. E.g. N.M. Stat. § 24-7-A-5 (c); N.Y. Pub. Health Code § 2994-d(2) (“An operator, administrator, or employee of a hospital or a mental hygiene facility from which the patient was transferred, or a physician who has privileges at the hospital or a health care provider under contract with the hospital may not serve as the surrogate for any adult who is a patient of such hospital, unless such individual is related to the patient by blood, marriage, domestic partnership, or adoption, or is a close friend of the patient whose friendship with the patient preceded the patient’s admission to the facility.”).

101. See Gillick, note 20 above, p. 91.

102. D. Meier, “Editorial—Voiceless and Vulnerable: Dementia Patients without Surrogates in an Era of Capitation,” *Journal of the American Geriatrics Society* 45, no. 3 (1997): 375-77; Kapp, note 5 above.

103. See Karp and Wood, note 2 above, p. 48; Hyun et al., note 1 above, p. 329.