

Law

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Legal Briefing: The Unbefriended: Making Healthcare Decisions for Patients Without Surrogates (Part 2)

Thaddeus Mason Pope and Tanya Sellers

ABSTRACT

This issue's "Legal Briefing" column continues coverage of 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 cat-

egories define the problem of medical decision making for the unbefriended. The remaining 12 describe different solutions to the problem. The first six categories were covered in Part 1 of this article;⁷ the last eight categories are covered in this issue (Part 2).

1. Who are the unbefriended?
2. Risks and problems of the unbefriended
3. Prevention: advance care planning, diligent searching, and careful capacity assessment
4. Decision-making mechanisms and standards
5. Emergency exception to informed consent
6. Expanded default surrogate lists: close friends
7. Private guardians
8. Volunteer guardians
9. Public guardians
10. Temporary and emergency guardians
11. Attending physicians
12. Other clinicians, individuals, and entities
13. Institutional committees
14. External committees

7. PRIVATE GUARDIANS

Guardianship is a legal relationship that is created by state courts when a judge determines that an individual is incapacitated and unable to make decisions on her or his own behalf. The court creates a relationship in which the guardian is given legal authority to make decisions for an incapacitated individual—referred to as the *ward*—regarding that person and/or her or

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his property. Every state provides for guardianship. Indeed, most states provide no other healthcare decision-making mechanism for the unbefriended. So, in most states, guardianship is the *only* officially recognized decision-making mechanism.⁸

On the surface, this might appear to be entirely appropriate and adequate. The formal judicial process helps to assure neutrality, impartiality, and public accountability. The procedural due process afforded by the courts helps to assure that all perspectives and alternatives are aggressively pursued, and it provides important protections against improper decision making.⁹ While the courts may lack expertise in healthcare decision making, they can draw on the advice and recommendations of treating and independent clinicians. Consequently, guardianship might appear to be a mechanism ideally suited to protecting vulnerable unbefriended patients.

Nevertheless, despite the widespread utilization of the guardianship procedure, commentators generally believe that the disadvantages of guardianship significantly outweigh its advantages.¹⁰ The four main deficiencies concern speed, cost, competence, and the availabilities of guardians. In terms of *speed*, court proceedings are problematic, because they are very time consuming, and, in these situations, time is of the essence. Guardianship proceedings regularly take at least six to eight weeks,¹¹ and they frequently take much longer than that. A 2010 study noted the lack of data describing how decisions are made for patients while they are awaiting a court-appointed guardian. The study revealed that, in many cases, a treatment decision was necessary prior to the appointment of a guardian.¹²

In terms of *cost*, guardianship proceedings require a significant investment.¹³ A facility must pay medical experts to assess the patient's capacity, and must pay an attorney to prepare and argue the petition. It must often pay for a guardian *ad litem* (another attorney or an independent evaluator) to represent the interests of the ward,¹⁴ and the facility must pay filing fees and other court costs. All of these expenses will likely total \$5,000 to \$8,000.¹⁵

In terms of *competence*, in the majority of guardian situations, the guardian does not know the patient and is unable to make decisions based on the patient's morals and values. Guardians are poorly trained, and, given very high case load, they are often unable to properly supervise their wards.¹⁶ In short, it is unclear that guardians can or do make better decisions for unbefriended patients than other potential surrogates, such as attending physicians and ethics committees.¹⁷

Finally, in terms of *availability*, both typically and ideally, an appointed guardian is a willing family member or friend.¹⁸ For families who can afford it, there are also companies that provide professional guardianship services.¹⁹ "The task of caring for an elderly or a disabled family member can be overwhelming. . . . Having a third party administer the daily tasks of financial and medical management frees family members to focus on their relationships with the loved one."²⁰ However, neither of these options is viable for unbefriended individuals who do not have family, friends, or resources. Courts are forced to find other alternatives, such as volunteer guardians and public guardians;²¹ unfortunately, as described in the next two sections, even these resources are usually inadequate to meet the need.

Encouragingly, there are ongoing efforts to improve the guardianship system. In the U.S. in 2011, at least 27 states passed new guardianship legislation.²² The Third National Guardianship Summit, convened by 10 national organizations in October 2011, resulted in 43 standards for the performance of guardians and 21 recommendations for action by courts and legislatures.²³ At the federal level, the proposed 2011 Guardian Accountability and Senior Protection Act would provide funding for state courts to assess and improve handling of proceedings relating to adult guardianship.²⁴

Even if enacted tomorrow, the impact of reform is years away. The current guardianship situation is not generally perceived as effective for the unbefriended. It is encumbered with "onerous formalities"²⁵ that are "untenable most of the time."²⁶ Consequently, guardianship is generally viewed as an option of last resort.²⁷

The U.S. guardianship system is not the only one in need of reform. Israel also utilizes a guardianship approach to caring for its unbefriended.²⁸ A recent study identified several shortcomings of the Israeli guardianship appointment procedure.²⁹ For example, guardians are not required to take into account the desires or wishes of the ward. The controlling statute does not provide any alternatives or less restrictive means. No training is provided to the guardians. And while the act requires guardians to provide financial reports, it does not require reports regarding the care and social welfare of the ward. In 2007, officials considered creating a unit to monitor the guardians' care of health and personal affairs of the wards, but no such program has yet been established.

Finally, it is noteworthy that, in 2011, the Supreme Court of India addressed the issue of the unbefriended and determined the removal of life-support measures for incapacitated patients may *only* be approved by the High Court. The court decided its approval is necessary to best protect patients, doctors, relatives, next friends of patients, and even the public.³⁰ The case centered around Aruna Shanbaug, an unbefriended individual who became incapacitated after she was brutally attacked 37 years ago.³¹ Since the attack, Shanbaug has lived in a persistent vegetative state in an Indian hospital.³² Immediately after the attack, her family and fiancé visited her, but her parents are now deceased, and other visits stopped many years ago. Thus, she was left to the care of the hospital.³³ Shanbaug had one friend, Pinky Virani, who visited on occasion and even wrote a book about the tragic situation.³⁴ Virani, on behalf of Shanbaug, filed a petition asking the Supreme Court to direct the facility to stop feeding Shanbaug and allow her to die peacefully.³⁵ The hospital opposed the petition. Prior to the attack, Shanbaug was a nurse employed at the same hospital. The nursing staff, who had taken exceptional care of Shanbaug, was extremely fond of her. The hospital argued that its staff love and care for Shanbaug, that she is responsive to them, loves music and certain foods, and she is very much alive.³⁶ The court refused to recognize Virani as Shanbaug's "next friend."³⁷

Moreover, the court decided it is the *court's* responsibility to decide whether it is in the best interest of an incapacitated patient to withhold treatment.³⁸ The family, next friend, or the medical team of an incapacitated patient may petition the court to discontinue life support, but the ultimate decision is left to the judiciary.³⁹

8. VOLUNTEER GUARDIANS

Even if a treating facility engages in the cumbersome, lengthy guardianship process for an unbefriended patient, there is often yet another obstacle: a shortage of available guardians. The unbefriended patient has no family or friends to serve, and professional guardians are unwilling to serve unless they will be compensated (usually from the patient's estate). In response, some states have developed volunteer programs to overcome the lack of available guardians. For example, the Colorado Guardianship Alliance (the Alliance) developed a program to recruit volunteers to serve as court appointed guardians for the unbefriended.⁴⁰ It screens all potential guardians and requires them to go through a training program, free of charge. When a medical facility or nursing home has an incapacitated patient, it calls the Alliance, which provides a volunteer guardian, when possible. The guardian may determine where the ward should live, make medical treatment decisions, and see that daily needs such food, clothing, and shelter are met. The guardian provides annual reporting to the Alliance as well as to the court.

As in Colorado, citizens in Indiana forged a statewide initiative to create and fund volunteer guardianship programs.⁴¹ The Indiana Adult Guardianship Services Project (IAGSP) was formed in 2008 and is heavily involved in this initiative. Its stated purpose is to "build a framework of community-based adult guardianship services projects/programs across the state."⁴² IAGSP sponsors research projects to further explore the ethics, standards, and regulations surrounding guardianships.⁴³ Currently, IAGSP is working to implement pilot guardianship programs in six counties across the state. It has convened a multidisciplinary task force to support development of these programs.⁴⁴

Indiana law provides that the court may appoint a volunteer advocate for a senior or incapacitated adult.⁴⁵ These guardians can consent to medical care or other treatment needs for an incapacitated adult.⁴⁶ As a result of the state-wide initiative, Wishard Health Services has begun funding a volunteer guardianship program that has experienced success: there are approximately 30 trained volunteers serving as court-appointed guardians of unbefriended patients in Marion County, Indiana, hospitals and nursing homes. Program consultants report seeing fewer unbefriended patients re-admitted, and greater Medicaid reimbursement to hospitals, due to the guardians who assist patients with the application process.⁴⁷

9. PUBLIC GUARDIANS

Recognizing that the general guardianship situation is poor, most U.S. states have implemented variations of traditional guardianships. Notable among these variations are “public guardianship” programs. These programs follow four different models. Most public guardians are either publicly funded social service organizations or county government public officials.⁴⁸ For instance, in Colorado, Mr. Yeager was an unbefriended individual.⁴⁹ His physician concluded that attempting resuscitation would be futile. The court affirmed the right of Morgan County Department of Human Services to authorize a do-not-resuscitate (DNR) order and granted it unlimited authority to make medical decisions on behalf of Yeager. A minority of states have taken a different approach, instead establishing public guardians as either officials of the court or as employees of an independent state office within the executive branch of government. Unfortunately, however they have been established, public guardianship services suffer from serious problems. First, they are generally overburdened, understaffed, and underfunded.⁵⁰ Consequently, most states have significant unmet needs for public guardianship. At the same time, some jurisdictions give guardians ridiculously high numbers of clients, far above the recommended 1:20 ratio. Second, education and training requirements vary con-

siderably. Only 15 states have licensing, certification, or regulation systems. Third, public guardians often have—or at least perceive that they have—limited authority regarding decisions around life-sustaining treatment.⁵¹

The U.S. is not the only country in which public guardians are used to make treatment decisions for the unbefriended. For example, in Ontario, if no appointed agent or statutory default surrogate is available, then “the Public Guardian and Trustee shall make the decision to give or refuse consent.”⁵² Similarly, in New South Wales, while not needed for “urgent” or “minor” treatment, a public guardian can consent to “major” medical treatment.⁵³

10. TEMPORARY AND EMERGENCY GUARDIANS

Yet another variation on traditional guardianship is to allow for temporary and emergency guardianships.⁵⁴ Such petitions are filed with the court when there is no time to conduct normal “plenary” or full guardianship hearings, which may take several weeks or months.⁵⁵ These procedures are neither as cumbersome nor as expensive as full guardianship.⁵⁶ Temporary and emergency guardians are authorized to make one or a series of decisions, but do not have unlimited or ongoing decision-making powers. They are appointed to make the immediate treatment decisions only, and then their authorization ends. For instance, Indiana provides for emergency guardian appointments when an adult needs immediate attention and there is no known person who can consent to treatment.⁵⁷ A temporary guardian is appointed for a maximum of 60 days, or until a permanent guardian is appointed.

In 2010, Georgia gave hospitals and other healthcare facilities the right to petition the court for expedited appointment of a temporary guardian to make medical decisions. The statute provides: “In the absence, after reasonable inquiry, of any [other surrogate] to consent for the patient, a hospital or other healthcare facility or any interested person may initiate proceedings for expedited judicial intervention to appoint a temporary medical consent guard-

ian.”⁵⁸ But the law restricts the guardian from withdrawing life-sustaining procedures unless specifically authorized by the court.⁵⁹

11. ATTENDING PHYSICIANS

Some commentators have suggested that the need to engage the cumbersome guardianship appointment process could be avoided if default surrogate statutes included healthcare providers on the statutory priority list of authorized surrogates.⁶⁰ After all, even when there is no available family member or close friend, there is almost always an available physician. Indeed, there is evidence that some patients actually prefer physicians over guardians as surrogate decision makers.⁶¹ Responsive to these considerations, 12 states authorize attending physicians, either unilaterally or with a concurring opinion, to make treatment decisions for the unbefriended.⁶²

For example, in South Carolina, healthcare services may be provided without the consent of the patient or surrogate if, “in the reasonable judgment of the attending physician or other healthcare professional, the healthcare is necessary for the relief of suffering or restoration of bodily function or to preserve the life, health, or bodily integrity of the patient.”⁶³ The healthcare provider is not liable for providing, in good faith, healthcare without consent unless the provision of care is negligent.⁶⁴ A 2011 Missouri bill is virtually identical.⁶⁵

With respect to life-sustaining treatment, North Carolina provides: “If none of the [surrogates] is reasonably available then at the discretion of the attending physician the life-prolonging measures may be withheld or discontinued upon the direction and under the supervision of the attending physician.”⁶⁶ Oregon’s law is virtually identical.⁶⁷ Connecticut law oddly provides that the physician need only “consider” the patient’s wishes and need only “consult” the surrogate.⁶⁸

But these six states authorizing attending physicians to unilaterally make treatment decisions are in the minority.⁶⁹ Seven other states limit the authority of physicians. There are longstanding and well-grounded concerns that giv-

ing physicians unilateral authority to make treatment decisions is risky due to both conflicts of interest and personal bias.⁷⁰ Accordingly, while these seven states authorize attending physicians to make treatment decisions on behalf of the unbefriended, they require some confirmation or “double-check” on clinical decision making.⁷¹ This additional review is widely perceived as an important safeguard.⁷² This review normally takes one of three forms: (1) concurrence of a second physician, (2) concurrence of an institutional committee, or (3) concurrence of an external committee. The first model is described here, and the second two are described in following sections.

For example, in Tennessee, if no family or close friend is reasonably available, the treating physician is then authorized to make medical decisions, but only after obtaining concurrence from a second independent physician.⁷³ Texas law similarly provides that if no surrogate is available, then a treatment decision “must be concurred in by another physician who is not involved in the treatment of the patient or who is a member of an ethics or medical committee of the healthcare facility.”⁷⁴ Likewise, in North Carolina, “the patient’s attending physician, in the attending physician’s discretion, may provide healthcare treatment without the consent of the patient or other person authorized to consent for the patient if there is confirmation by a physician other than the patient’s attending physician of the patient’s condition and the necessity for treatment.”⁷⁵ Arizona similarly provides: “If the health care provider cannot locate any of the [surrogates], the patient’s attending physician may make health care treatment decisions for the patient after the physician consults with . . . a second physician who concurs with the physician’s decision.”⁷⁶

New York’s 2010 Family Health Care Decisions Act (FHCDA), on which a pending New Jersey bill is closely patterned, also authorizes physicians to make healthcare decisions for unbefriended patients. But the discretion of the attending physician narrows as the invasiveness or burden of the treatment rises.⁷⁷ Specifically, the FHCDA divides treatment into three categories: (1) routine medical treatment, (2) major

medical treatment, and (3) life-sustaining treatment.⁷⁸ *Routine medical treatment* includes those treatments, services, and procedures for which providers do not ordinarily seek specific consent. Examples of such treatment include drawing blood for tests or providing medication for high blood pressure. These interventions involve little or no risk to patients and are clearly beneficial.⁷⁹ An attending physician is authorized to unilaterally decide about the provision of routine medical treatment for unbefriended patients.⁸⁰

Major medical treatment includes those treatments, services, and procedures that involve the use of general anesthesia; any significant risk to the patient; or any significant invasion of bodily integrity requiring an incision, producing significant pain, or having a significant recovery period. Examples of such treatment include lumbar puncture, colonoscopy, and hernia repair. Such decisions carry greater risks and burdens and incorporate important nonmedical considerations. Accordingly, the decision-making process is more extensive. First, the attending physician must consult with the staff directly responsible for the patient's care (nurses, social workers, nurse aids). Second, the attending physician must obtain an independent concurring determination from a second physician.⁸¹

Life-sustaining treatment includes the use of any medical device or procedure to sustain a vital bodily function. Typical treatments include cardiopulmonary resuscitation, mechanical ventilation, dialysis, and clinically assisted nutrition and hydration.⁸² Decisions to withhold or withdraw life-sustaining treatment are subject to the closest scrutiny. An attending physician may make such decisions only if she or he determines, with the concurrence of an independent physician, that the treatment either "would violate accepted medical standards" or "offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided." Otherwise, withholding or withdrawing life-sustaining treatment requires judicial approval.⁸³

The Veterans Health Administration (VHA) follows a process very similar to that outlined

in the New York FHCDA. For those treatments or procedures that involve minimal risk, practitioners can make a decision after attempting to explain the nature and purpose of the proposed treatment to the patient.⁸⁴ For procedures that require signature consent, both the attending physician and the chief of service (or his or her designee) must indicate approval of the treatment decision in writing. In the VHA, as in New York, decisions to withhold or withdraw life-sustaining treatment require a more elaborate process. They must be reviewed by a multidisciplinary committee appointed by the facility director. The committee functions as the patient's advocate and may not include members of the treatment team. The committee must submit its findings and recommendations in a written report to the chief of staff, who must note his or her approval of the report in writing. After reviewing the record, the facility director may concur with the decision to withhold or withdraw life support or request further review by regional counsel.

Like New York and the VHA, some foreign jurisdictions also follow a tiered approach. In New South Wales, for example, medical treatment for unbefriended patients may be carried out without consent so long as it is "minor."⁸⁵ But for "major" treatment, consent must be obtained from a Guardianship Tribunal.⁸⁶

12. OTHER CLINICIANS, INDIVIDUALS, AND ENTITIES

While professional decision making for the unbefriended is usually vested primarily with physicians, it is sometimes vested with other clinicians, individuals, and entities. In Florida, for example, the ultimate surrogate in the default priority list is "a clinical social worker . . . selected by the provider's bioethics committee and . . . [not] employed by the provider."⁸⁷ While these social workers have the authority to consent to major medical treatment, "decisions to withhold or withdraw life-prolonging procedures will be reviewed by the facility's bioethics committee." Some Florida social workers have formed companies to serve these surrogate functions.⁸⁸

In Texas, if no other surrogate is reasonably available and willing to consent to treatment on behalf of a patient, treatment decisions may be made by “a member of the clergy.”⁸⁹ In 2011, Texas extended this surrogate decision-making process not only to patients in hospitals, nursing homes, and home care, but also to inmates in county or municipal jails.⁹⁰ Several other states authorize clergy as “surrogates of last resort,” but these states require that the clergy know the patient.⁹¹

Since 1993, Oregon has had a mechanism for making life-sustaining treatment decisions for the unbefriended.⁹² But it has had no mechanism for making decisions regarding major medical treatment. So, in 2011, Oregon enacted a new law permitting a hospital “to appoint a health care provider . . . who has received training in health care ethics.”⁹³ If the appointed provider is the patient’s attending physician, then that individual must obtain a second opinion from another healthcare provider.

In Mississippi, “consent may be given by an owner, operator or employee of a residential long-term health-care institution at which the patient is a resident if there is no advance health-care directive to the contrary and a licensed physician who is not an owner, operator or employee of the residential long-term health-care institution at which the patient is a resident has determined that the patient is in need of health care.” But this power to consent is limited to those healthcare services determined necessary by the physician. And it does not include the power to consent to “withholding or discontinuing any life support, nutrition, hydration or other treatment, care or support.”⁹⁴

In West Virginia, the surrogate of last resort can include “any other person or entity, including, but not limited to, public agencies, public guardians, public officials, public and private corporations and other persons or entities which the Department of Health and Human Resources [DHHR] may from time to time designate.”⁹⁵ In a 2003 regulation, the West Virginia DHHR designated three categories of individuals and entities as eligible surrogates for patients in DHHR facilities: (1) any organization authorized under state or federal laws, or under contract with

the DHHR, to advocate for individuals in DHHR facilities; (2) any organization authorized under federal or state laws, or under contract with DHHR, to provide surrogacy, guardianship, or conservator services for persons in DHHR facilities; and (3) any DHHR employee who was not otherwise precluded from serving as a surrogate.⁹⁶

13. INSTITUTIONAL COMMITTEES

Whether or not authorized by law, many treatment decisions for the unbefriended are made by physicians without institutional or judicial review, and even without the concurring opinion of another physician.⁹⁷ In other words, much decision making is informal and *ad hoc*. Many commentators and policy makers have expressed concern with leaving treatment decisions solely in the hands of individual physicians or other facility employees. One concern is that such decision makers suffer from a conflict of interest, given their own and/or their facility’s financial incentives. Another concern is that these decision makers may be too influenced by their own personal values and biases.

To address these concerns, the American Medical Association (AMA) has recommended a more thorough process to better ensure accountability, objectivity, and independence. Specifically, the AMA recommended consulting “an ethics committee to aid in identifying a surrogate decision-maker or to facilitate sound decision-making.”⁹⁸ A committee has some advantages over a single decision maker.⁹⁹ With an individual decision maker, there is always a concern that the decision will be based upon financial incentives or the biases of that person.¹⁰⁰ A committee, on the other hand, can better offer various perspectives and can utilize a multifaceted array of both medical and ethical considerations.¹⁰¹ A committee is more likely to view a patient as an individual, considering, in addition to the medical benefits and burdens, any known moral or personal values and the nature of a patient’s previous life style.¹⁰² At the same time, committees provide quicker, more easily accessible, and more personalized decisions than the court system.

However, committees are sometimes impractical because of the necessary logistics; it often takes too much time to convene a committee, thoroughly evaluate patients and their treatment options, collectively deliberate, and issue a decision. Patients in need of medical care often do not have this much time. Decisions must be made quickly. In addition, these committees may face the same problems as public and private guardianship programs. They are usually burdened with under-funding, understaffing, and problems associated with properly training members. On the other hand, treatment decisions for the unbefriended are sometimes reviewed by just a subgroup, which is more easily convened.¹⁰³

Several states have enacted statutes allowing institutional committees to guide decision making for the unbefriended. Most of the statutes call for a physician, in conjunction with an ethics committee, to make decisions. In Alabama, for example, decisions may be made by “a committee composed of the patient’s primary treating physician and the ethics committee of the facility where the patient is undergoing treatment or receiving care, acting unanimously.”¹⁰⁴ If there is no ethics committee, then decisions can be made

by unanimous consent of a committee appointed by the chief of medical staff or chief executive officer of the facility and consisting of at least the following: (i) the primary treating physician; (ii) the chief of medical staff or his or her designee; (iii) the patient’s clergyman, if known and available, or a member of the clergy who is associated with, but not employed by or an independent contractor of the facility, or a social worker associated with but neither employed by nor an independent contractor of the facility.

In Georgia, with respect to DNR orders, “an attending physician may issue an order not to resuscitate” for a patient, provided that three conditions are satisfied. First, the physician must determine with the concurrence of a second physician, in writing in the patient’s medical record, that such patient is a candidate for nonresuscitation. Second, “an ethics commit-

tee or similar panel” must concur in the opinion of the attending physician and the concurring physician that the patient is a candidate for nonresuscitation. Third, the patient must be receiving inpatient or outpatient treatment from, or is a resident of, a healthcare facility other than a hospice or a home health agency.¹⁰⁵

In California, long-term care facilities can establish “interdisciplinary teams” (IDTs), sometimes known as “Epple committees,” to make decisions for unbefriended residents.¹⁰⁶ An IDT must include “the resident’s attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident’s needs, and, where practicable, a patient representative, in accordance with applicable federal and state requirements.”¹⁰⁷ Looking to this IDT model, California considered a “surrogate committee” for other, non-long-term-care patients. But none was enacted as part of the 1999 Health Care Decisions Act.¹⁰⁸

Some states prefer, but do not strictly require, ethics committee review. In Arizona, for example, an attending physician may make a treatment decision after consulting and obtaining the recommendation of an institutional ethics committee. But the statute recognizes that may not always be possible. If it is not possible, the statute alternatively allows a physician to make the treatment decision after consulting with and obtaining the concurrence of a second physician.¹⁰⁹

As discussed above, many states authorize attending physicians to make decisions regarding routine medical treatment. But safeguards typically increase proportionately with the gravity of the treatment. These safeguards often include the approval of an ethics committee.¹¹⁰ For example, in the VHA, ethics committees are utilized for decisions involving withholding or withdrawal of life-sustaining treatment. Such decisions by an ethics committee must be approved by a multidisciplinary committee acting as the patient’s advocate.¹¹¹

Finally, even when not given a formal decision-making role, ethics committees are often given at least a consulting role in treatment decisions for the unbefriended. For example, a

2011 Oregon statute expressly provides that a healthcare facility may appoint an ethics committee to “participate in making decisions.”¹¹²

In addition to these decision-making processes specifically authorized by state or federal law, it is important to note that many facilities in other U.S. states authorize institutional committees to make treatment decisions for the unbefriended, even though not expressly authorized by law.¹¹³ For example, the California Health Care Decisions Act fails to address medical decision making for the unbefriended. Nevertheless, the Santa Clara County Medical Association wanted a less cumbersome and more immediately responsive decision-making process than guardianship.¹¹⁴ So, in 2001, it developed a model policy for facilities in the county.¹¹⁵ It has since been adopted not only by institutions in Santa Clara, but also by institutions in other parts of California.

One hospital that adopted the model policy noted that it wanted to make “appropriate healthcare decisions” for unbefriended patients in “a timely and transparent manner.”¹¹⁶ Here, basically, is how it works. Once a patient is determined to be unbefriended, the policy calls for the physician of record to ask the chair of the ethics committee to appoint and chair a “multidisciplinary committee” to make treatment decisions. The policy recommends, but does not require, that a community member and a representative of the patient’s cultural, ethnic, or religious community serve on the committee. The attending physician is a nonvoting member of the committee. Consensus is required, and in cases of withholding and withdrawing treatment, the approval of the hospital’s medical director is also required.

14. EXTERNAL COMMITTEES

Review by an institutional committee provides more accountability than review by an attending physician alone. But some are concerned that such a process is still too much of an “inside job.”¹¹⁷ Ethics committees are, after all, primarily comprised of individuals who are economically dependent upon the facility.¹¹⁸ Responsive to this concern, New York, Texas,

and Iowa have enacted statutes that authorize extra-institutional, “external” surrogate committees to make treatment decisions for certain unbefriended persons. While the Iowa committees serve all unbefriended patients, the New York and Texas committees serve only certain residents and former residents of facilities for the mentally disabled.

In 1985, the New York legislature determined that the judicial process to appoint a guardian was not meeting the needs of its mentally disabled citizens.¹¹⁹ So, it enacted legislation establishing a “statewide quasi-judicial surrogate decision-making process.”¹²⁰ At the heart of this process is the Surrogate Decision Making Committee (SDMC). The SDMC consists of volunteers appointed by the state Commission on Quality of Care and Advocacy. These volunteers come from four distinct categories: (1) physicians, nurses, psychologists, or other healthcare professionals; (2) family or advocates of a mentally disabled person; (3) New York attorneys; and (4) other individuals with “recognized expertise” in the treatment of mentally disabled persons. Sitting in panels of four, these volunteers make treatment decisions for the unbefriended patient.

An SDMC must first determine, through clear and convincing evidence, that a patient lacks capacity. The committee then decides whether the proposed treatment is in the best interest of the patient. In making its decision, the SDMC fully considers any evidence of the patient’s previously expressed desires. A decision by an SDMC is legally valid consent, as if the person had made a capacitated decision on her or his own behalf. But the SDMC’s decision is valid only for the specifically proposed treatment presented, not for any future medical care.¹²¹ And certain designated individuals, including staff at the patient’s residential facility, may appeal the decision to court.¹²² The use of SDMCs became statewide in 2001.¹²³

The program boasts that it is superior to judicially appointed guardians because it is inexpensive, expeditious, and ethical. First, there is no cost for training or hearings. There are no court costs or attorneys’ fees. Second, an average decision takes only 14 days, and expedited

hearings are available. Hearings are held statewide at the convenience of the individuals involved. Third, the committees utilize a person-centered approach to medical decision making. In 2009, the regulations governing SDMCs were amended to conform the program to recent statutory amendments which expanded the jurisdiction of the program.¹²⁴ SDMCs are now available to a wider range of individuals served by the New York Office of Mental Retardation and Developmental Disabilities. For example, individuals who receive home or community based care, or who are only provided with case management or service coordination services, are now eligible for SDMC services. Similarly, individuals who have been discharged from mental hygiene facilities into nursing homes or the community are now eligible to have SDMC decisions made on their behalf. Lastly, the SDMCs are now authorized, subject to very specific safeguards, to make decisions to withhold or withdraw life-sustaining treatment.

Texas has also implemented a surrogate decision-making committee program to make decisions on behalf of its unbefriended citizens who suffer from mental retardation and related conditions.¹²⁵ The committees are appointed by the Texas Department of Aging and Disability Services and consist of three to five volunteers.¹²⁶ Volunteers must attend a four-hour training. When a committee is convened, it reviews written documentation as well as oral testimony from the patient, the provider, and any other interested person. It then decides if the proposed treatment is in the best interest of the individual. In 1999, proposed Texas legislation would have authorized similar “surrogate decision making committees” for patients in hospitals and nursing homes.¹²⁷ The bill called for the Texas Board of Human Services to adopt rules regarding the appointment of such committees to, among other things, “ensure the independence of each committee member” and “govern the minimum number” of members. Unfortunately, the bill died in committee.

Iowa also has external surrogate committees. But in contrast to the external committees in New York and Texas, external committees in Iowa are not limited to any specific population

of unbefriended patient.¹²⁸ Iowa law provides that counties may establish “local substitute medical decision-making boards.” These boards “may act as a substitute decision maker for patients incapable of making their own medical care decisions if no other substitute decision maker is available to act.”¹²⁹ But they may not consent to stopping life-sustaining treatment.¹³⁰ Agency regulations require local substitute medical decision-making boards include one or more members from three categories: (1) physicians, nurses, or psychologists; (2) attorneys or social workers; and (3) other individuals with “recognized expertise or interest in” the unbefriended.¹³¹

In March 2012, the Iowa Department of Public Health adopted amendments to the requirements and procedures for local substitute medical decision-making boards. The changes remove references to a “statewide” substitute medical decision-making board that was repealed by the legislature in 2010.¹³² Unfortunately, the local committees have not fared much better. Only seven of 99 Iowa counties ever developed committees. And while state regulations still authorize any Iowa county to establish a committee, there has not been a local committee for more than 10 years.¹³³ Iowa is now looking to revive its Office of the Substitute Decision Maker, an analog of public guardianship programs in other states.¹³⁴

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 that “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.”¹³⁵ Diane Meier writes that the decision maker must be “responsive yet independent.”¹³⁶

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.¹³⁷ In striking the balance, we can take guidance from the sliding-scale approach taken in New York and in the VHA that provides oversight proportionate to consequences of the decision. Data must be gathered and reviewed to assess how these and other currently implemented processes are working. The status quo is unacceptable. The majority of states must legally authorize workable decision-making mechanisms. Failing that, facilities should follow the model of facilities in Santa Clara and Cleveland, and seriously consider adopting policies and processes on their own.

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: Achiev-*

ing 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): 83-5.

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 protections 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 and T. Sellers, "Legal Briefing: The Unbefriended: Making Healthcare Decisions for Patients Without Surrogates," *The Journal of Clinical Ethics* 23, no. 1 (Spring 2012): 84-96.

8. A.K. Dayton, T.H. Guare, L.M. Mezzullo, and M.M. Wood, *Advising the Elderly Client* (St. Paul, Minn., West, 2011), § 34:10.

9. A. Meisel and K.L. Cerminara, *The Right to Die: The Law of End of Life Decisionmaking*, 3rd ed. (suppl.) (New York: Aspen, 2010), § 3.26[A][2]. L.M. Beauregard, "Ethics in Electrophysiology: Who Speaks for this Man?" *Pacing and Electrophysiology* 35, no. 5 (May 2012): 564-6.

10. See Quinn, note 4 above; E.J. Larson and T.A. Eaton, "Limits of Advance Directives: A History and Assessment of the Patient Self Determination Act," *Wake Forest Law Review* 32, no. 2 (1997): 249-94.

11. See Meisel and Cerminara, note 9 above at § 3.26[c]; *Rains v. Belshe*, 38 Cal. Rptr. 2d 185, 189 (App. 1995) (seven-month delay in obtaining judi-

cial decision authorizing treatment).

12. P.B. Teaster et al., *Public Guardianship: In the Best Interest of Incapacitated People?* (Santa Barbara, Calif.: ABC-CLIO, 2010).

13. See Kapp, note 5 above, p. 19; see Meisel and Cerminara, note 9 above, at § 3.26[E]-[F].

14. L.A. Frolik and R.L. Kaplan, *Elder Law in a Nutshell*, 5th ed. (St. Paul, Minn.: West, 2010): 251-2.

15. Recently proposed legislation would provide a tax credit for legal expenses paid with respect to establishing guardianship. H.R. 878, 112th Cong., 1st Sess. (2011) (Deutch, D-Fla.).

16. The *Boston Globe* published an article discussing the dire guardianship situation in Massachusetts. The article notes that there are no prerequisite training requirements to become a guardian. The article discusses how “guardianship businesses” open up, but the compensation is so low that, in order to survive, the businesses take on too many wards to adequately monitor all of them. The wards become neglected and ignored, some receiving only two visits a year from their guardian. The article notes that courts are too overburdened to properly monitor the guardians and fail to demand the filing of required paperwork. For instance, guardians in Massachusetts are required to file an inventory of property and an annual accounting. But in one county, 262 of the 308 guardian cases in the probate court had no filing at all. J. Kelly, M. Kowalski, and C. Novak, “Courts Strip Elders of their Independence,” *Boston Globe*, 13 January 2008.

17. See *When Others Must Choose*, note 2 above, p. 159.

18. See Quinn, note 4 above, pp. 73-81.

19. *Ibid.*, 86-95.

20. Alternate Decision Makers, <http://altdecisionmakers.com/>, accessed 27 January 2012.

21. See Quinn, note 4 above, pp. 95-104.

22. ABA Commission on Law and Aging, “State Guardianship Legislation: Directions for Reform 2011,” http://www.americanbar.org/content/dam/aba/uncategorized/2011/2011_aging_gship_elss_2010.authcheckdam.pdf, accessed 27 January 2012.

23. <http://www.guardianshipsummit.org/>, accessed 27 January 2012.

24. S.1744, 112th Cong., 1st Sess. (2011) (Klobuchar, D-Minn.).

25. C. Frank, “Surrogate Decision-Making for ‘Friendless’ Patients,” *Colorado Lawyer* 34, no. 4 (April 2005): 71-6.

26. C. Griggins, “Patients without Proxies: What’s Happening in Other States?” *Mid-Atlantic Ethics Committee Newsletter* (Summer 2010): 7-9.

27. L. Nerenberg, “Unbefriended Elders Receive Court Protection in California,” *Aging Today* 27, no. 3 (2006): 10, 15; Cal. Prob. Code § 4650(c) (“[A] court is normally not the proper forum in which to make healthcare decisions, including decisions regarding life-sustaining treatment.”).

28. The Legal Capacity and the Guardianship Act, 5722-1962. The country established the Legal Capacity and Guardianship Act in 1962, and has made no significant amendments since that time.

29. C. Shay, “Guardianship in Israeli Law—Need for Revisions,” *ABA Bifocal* 31, no. 5 (2010): 101, 104-7.

30. *Shanbuag v. Union of India*, Item No. 1A, Court 6, Section 10 (3 July 2011).

31. *Ibid.*, 4.

32. *Ibid.*, 23.

33. *Ibid.*, 29.

34. *Ibid.*, 34.

35. *Ibid.*, 6.

36. *Ibid.*, 28.

37. *Ibid.*, 34.

38. *Ibid.*, 95.

39. *Ibid.*, 26, 128.

40. Guardianship Alliance of Colorado, “Guardianship Alliance Programs and Services,” <http://guardianshipallianceofcolorado.org/programs.html>, accessed 27 January 2012.

41. *Guidelines for Emergency Guardianships of Adults in Marion County* (Marion County, Ind.: Bureau of Quality Improvement Services, Division of Developmental Disabilities and Rehabilitative Services, Indiana Family and Social Services Administration, March 2008).

42. <http://www.arcind.org/index/iags/project-mission-and-goals.asp>, accessed 27 January 2012.

43. “Adult Guardianship Issues & Needs,” symposium, Indiana Adult Guardianship Services, 12 May 2009, Indianapolis, Ind.

44. The task force consists of various organizations and state agencies, including the Indiana State Guardianship Association (ISGA). The ISGA is a non-profit organization formed to strengthen guardianship and related services through networking, education, and tracking, and commenting on legislation. Among other events, this group conducts annual educational conferences, the most recent being held on 14 June 2011, <http://indianaguardian.org/about>, accessed 27 January 2012.

45. Ind. Code § 29-3-8-5-1.

46. Ind. Code § 29-3-8.5-4.

47. E-mail from Robin Bandy, JD, MA, NCG President, Indiana State Guardianship Association.

48. Teaster et al., see note 12 above; P.B. Teaster,

"The Wards of Public Guardians: Voices of the Unbefriended," *Family Relations* 51, no. 4 (2002): 344-50.

49. *In re Yeager*, 93 P.3d 589 (Colo. App. 2004).

50. See Karp and Wood, note 2 above, pp. 27-9; P.B. Teaster, E.F. Wood, W.C. Schmidt, and S.A. Lawrance, *Public Guardianship after 25 Years: In the Best Interests of Incapacitated People* (Washington, D.C.: ABA, 2007), apps.americanbar.org/aging/docs/Guard_report_Exec_Summ.pdf, accessed 27 January 2012.

51. E.g. Minn. Admin. Rule 9525.3055(2); *In re Shirey*, No. 98005210-DD (Mich. Prob. Ct., Montorency Cty., 17 Oct. 2005).

52. Ontario Health Care Consent Act of 1996 § 20(5).

53. NSW Guardianship Act of 1987, Section 36.

54. Related to these are "single court transactions," where the judge directly makes the treatment decision. See Quinn, note 4 above, p. 112; Va. Code § 37.2-1101 (as amended by S.B. 371 in 2012).

55. Cal. Prob. Code § 3200; Fla. Prob. R. 5.900; Ga. Code Ann. § 31-36A-1 (placement only); Ind. Code Ann. § 16-36-1-8; N.J. Court R. 4:86-12 (special medical guardian); S.D. Cod. L. § 34-12C-4; VA Code Ann. § 37.2-1101, formerly cited as Va. Code § 37.1-134.21.

56. See Karp and Wood, note 2 above, pp. 29-32; *In re JM*, No. P-036-10 (N.J. Sup. Ct., Chancery Div., Bergen Cty., 2 July 2010).

58. Ga. Code Ann. § 31-9-2(a1). Sample petition forms for the appointment of a temporary medical consent guardian are available at <http://www.gaprobate.org/forms/forms10/pdf/11GPCSF%2036.pdf>, accessed 27 January 2012. The implementation of this act is being studied. Georgia Appleseed Center for Law and Justice, "Safeguarding Seniors: Informed End of Life Decision Making," <http://www.gaappleseed.org/initiatives/elder/>, accessed 27 January 2012.

59. Ga. Code Ann. § 29-4-18(i).

60. E. Phipps and R. Allman, "Potential Impact of Advance Directive Law Act 169 of Decisions and Care for Patients at End of Life: Reflections of Ethics Consultants," <http://jdc.jefferson.edu/cgi/viewcontent.cgi?article=1538&context=hpn>, accessed 27 January 2012.

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. Many states specifically prohibit healthcare providers or employees of a facility to which a patient has been admitted from serving as a patient's surrogate unless they are re-

lated to the patient or are a close friend whose friendship preceded the patient's admission. 16 Del. Code § 2503(h).

62. Sometimes physicians are given far narrower roles with respect to the unbefriended. For example, in Utah, physicians may "complete and sign new Life with Dignity Orders for individuals with prior forms who no longer have capacity to complete new orders, and who do not have a surrogate/guardian to authorize the new order." Utah Admin. Code § R432-31-11(3).

63. S.C. Code Ann. § 44-66-50.

64. S.C. Code Ann. § 44-66-70(D).

65. Mo. H.B. 392 §§ 191.1306 & 191.1310(4), 96th Gen. Assembly (2011) (White).

66. N.C. Gen. Stat. Ann § 90-322(b).

67. Or. Rev. Stat. Ann. § 127.635(3).

68. Conn. Gen. Stat. § 19a-571(a).

69. Several years ago, in Michigan, a physician was treating 97-year-old Hazel Wagner, a heart attack victim with no chance of recovery. The patient was screaming to the physician, "Help me Jesus!" The physician petitioned the court to end life-support efforts, but the court denied the petition. The court ruled that the petition would have to come from the patient's guardian and that a physician's role was not to advocate, but simply advise. B. Booth, "Doctor's Request to End Patient's Care Denied," *American Medical News*, 12 June 2006; J. Agar, "Judge Rules Lawton Woman's Life Must Be Preserved," *Kalamazoo Gazette*, 25 April 2006.

70. See Larson and Eaton, note 10 above, p. 289; N. Sadovnikoff and M. Jurchak, "Substituted Judgment in the Absence of Surrogates," *Critical Care Medicine* 35, no. 10 (2007): 2467-8; D.B. White, A. Jonsen, and B. Lo, "Ethical Challenge: When Clinicians Act as Surrogates for Unrepresented Patients," *American Journal of Critical Care* 21, no. 3 (2012): 202-7.

71. See Meisel and Cerminara, note 9 above, at § 3.25[A][3][a].

72. T.E. Miller, C.H. Coleman, and A.M. Cugliari, "Treatment Decisions for Patients without Surrogates: Rethinking Policies for a Vulnerable Population," *Journal of the American Geriatrics Society* 45, no. 3 (1997): 371.

73. Tenn. Code Ann. § 68-11-1806(c)(5) (alternatively allowing confirmation from an ethics committee).

74. Tex. Health & Safety Code §§ 166.039(e) & 166.088(f) ("If there is not a qualified relative available . . . an out-of-hospital DNR order must be concurred in by another physician who is not involved in the treatment of the patient or who is a represen-

tative of the ethics or medical committee of the health care facility in which the person is a patient.”).

75. N.C. Gen. Stat. Ann § 90-21.13(c1).

76. Ariz. Rev. Stat. § 36-3231(B). The statute prefers that the attending physician consult with and obtain the recommendations of an institutional ethics committee. But if this is not possible, then concurrence of second physician is sufficient.

77. 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.

78. A fourth category of medical treatment is emergency treatment, discussed in Part 1, section 5 of this article, “Emergency Exception to Informed Consent,” see note 7 above. For decision-making purposes, some even identify a fifth category: futile treatment. See Karp and Wood, note 2 above, p. 17; *In re a Patient*, 2011 NSWSC 432.

79. The New York State Health Facilities Association has developed model forms that help assure compliance with the statute. “Model Nursing Home Forms for the Family Health Care Decisions Act,” <http://www.nyshfa.org/Downloads/FHCDAForms.doc>, accessed 27 January 2012.

80. N.Y. Pub. Health Code 2994-g(3)(B); N.J. A.B. 4098 § 3(a)(1), 214th Legis. (2011) (Conaway). In these cases, pursuant to its institutional policy that is not expressly authorized by Ohio law, the Cleveland Clinic also requires a “social work consultation” to locate surrogates, to assess whether guardianship is appropriate, and to confirm that the patient’s best interests are being served. Cleveland Clinic, “Policy on Medical Decision-Making for Patients Lacking Decision-Making Capacity Who Do Not Have a Surrogate Decision-maker,” http://my.clevelandclinic.org/Documents/Bioethics/Policy_on_Patients_without_Surrogates.pdf, accessed 27 January 2012.

81. N.Y. Pub. Health Code § 2994-g(4)(B); N.J. A.B. 4098 § 3(a)(2), 214th Legis. (2011) (Conaway). In facilities other than general hospitals, the medical director shall make the independent determination that the recommendation is appropriate. In these cases, the Cleveland Clinic also requires a “social work consultation” and a “consultation by the ethics consult service.” See note 80 above.

82. N.Y. Pub. Health Code §§ 2994-a(19), 2994-g(3)(A) & 2994-g(4)(A); N.J. A.B. 4098 § 1, 214th Legis. (2011) (Conaway).

83. N.Y. Pub. Health Code § 2994-g(5); N.J. A.B. 4098 § 3(b), 214th Legis. (2011) (Conaway). The Cleveland Clinic does not have a substantive rule

like New York. Instead, it requires both a “concurring medical opinion” and approval of a “multidisciplinary subcommittee of the Ethics Committee.” See note 80 above. Before the June 2010 enactment of the FHCDA, New York authorized attending physicians to write DNR orders for unbefriended patients when resuscitation would be medically futile. N.Y. Pub. Health Code § 2966.

84. 38 C.F.R. § 17.32(f); *VHA Handbook* 1004.01(14)(c). Still, treatment must not be provided indefinitely without review of the treatment plan at least every six months by the attending practitioner of record and the service chief, or designee, to ensure that clinical objectives are being met and the treatment plan is in the best interests of the patient.

85. NSW Guardianship Act of 1987, § 37(2)-(3).

86. NSW Guardianship Act of 1987, § 36(1)(b).

87. Fla. Stat. § 765.401(h).

88. See Karp and Wood, note 2 above, p. 150 (noting that a “burgeoning number of not-for-profit and for-profit agencies has developed to serve the at-risk, unbefriended population”). It is increasingly important to carefully examine the qualifications and incentives of these and other professional guardians. L.A. Frolic, “Aging and the Law,” paper presented at the 2012 Annual Meeting of the American Association of American Law Schools on 6 January 2012 in Washington, D.C. The authors thank Carol S. Huffman, owner of a Florida-based surrogate service, Social Work Advantage, for a telephone interview, 12 January 2012. They thank Ken Goodman for a telephone interview, 3 February 2012.

89. Tex. Health & Safety Code § 313.004(a)(5). The original Consent to Medical Treatment Act was limited to patients in a nursing facility or hospital. In 2007, the legislature added “home and community support services.” Tex. H.B. 3473, 80th Legis. (2007) (Delisi). The scope of consent does not include life-sustaining treatment. Tex. Health & Safety Code § 313.003(b).

90. Tex. H.B. 1128, 82nd Legis. (2011), enacted, Tex. L. ch. 253.

91. D.C. Code § 21-2210(a)(5a); Ind. Code Ann. § 16-36-1-5(a)(3); Ind. Code § 16-36-4-13(g)(7); Tex. Health & Safety Code § 313.004(a)(5).

92. Or. Rev. Stat. § 127.635(3) (“If none of the persons described in subsection (2) of this section is available, then life-sustaining procedures may be withheld or withdrawn upon the direction and under the supervision of the attending physician.”).

93. Ore. S.B. 579 § 2(a), 76th Legis. Assembly (2011) (Johnson), enacted, 2011 Ore. Laws Ch. 512. The authors thank Barbara Glidwell, the longtime patient advocate at Oregon Health Sciences Univer-

sity, for her generous telephone interview, 27 September 2011.

94. Miss. Code Ann. § 41-41-215(9).

95. W. Va. Code Ann. § 16-30-8(a)(7).

96. W. Va. Admin. Rule 64-86-4.

97. 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.

98. AMA, *Code of Medical Ethics* § 8.081.

99. Just as a committee may offer more perspectives and greater deliberation than an individual decision maker, some jurisdictions require the involvement of additional individuals. While not authorized as surrogates, these individuals do provide some oversight of and support for those making the treatment decisions. See Karp and Wood, note 2 above, pp. 37-38. One example is the long-term care ombudsperson (patient advocate). Another is the "independent mental capacity advocate" required by the U.K. Mental Capacity Act of 2005.

100. 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): 375-7.

101. See Hyun et al., note 1 above.

102. *Ibid.* This article cites two case examples of patients without a surrogate. Mr. T was an older gentleman and his physician recommended that a feeding tube be inserted, due in part to Mr. T's poor nutrition. A committee was convened, and after discussion with the patient and the nursing home where he had been living, the committee advised against the tube. They noted that eating was one of his only remaining pleasures, and the life-extending benefits to Mr. T were unimpressive. In contrast, Mr. A's physician also recommended a feeding tube, due to Mr. A's poor nutrition. But Mr. A was much younger and had better prospect for an improved quality of life. The committee noted that the feeding tube was very effective for short-term nutrition, and recommended the tube for Mr. A. These decisions exemplify how committees can evaluate medical decisions subjectively, based on the individual characteristics of each patient, as opposed to simply the objective medical benefits.

103. See Griggins, note 26 above.

104. Ala. Code § 22-8A-11(d)(7). "In the event a surrogate decision is being made by an ethics committee or appointed committee of the facility where

the patient is undergoing treatment or receiving care, the facility shall notify the Alabama Department of Human Resources for the purpose of allowing the department to participate in the review of the matter."

105. Ga. Code Ann. § 31-39-4(e).

106. R.M. Gibson, "IDT Decision-Making in California Long-Term Care Facilities," *California Association of Long-Term Care Medicine* (December 2011), <http://caltcm.org/news/dec2011/idt>, accessed 27 January 2012. IDTs are sometimes known as "Epple Committees" because they are named after California State Assemblyman Bob Epple, who sponsored the legislation that created them. Cal. A.B. 3209 (1992).

107. Cal. Health & Safety Code § 1418.8(e). *Rains v. Belshe*, 38 Cal. Rptr. 2d 185 (Ct. App. 1995).

108. The original bill, A.B. 891 (1999) (Alquist), proposed new Probate Code sections 4720 to 4725, which would have addressed decision making for the unbefriended. Indeed, the problem of the unbefriended was an original and key motivation for the entire Health Care Decisions Act. But these provisions were politically controversial. They were removed so that the rest of the bill could move forward. California Law Review Commission, Memo 99-39 (6 October 1999), <http://www.clrc.ca.gov/pub/1999/M99-39.pdf>, accessed 27 January 2012; California Law Review Commission, *2000 Health Care Decisions Law and Revised Power of Attorney Law* (March 2000), <http://www.clrc.ca.gov/pub/Printed-Reports/Pub208.pdf>, accessed 27 January 2012.

109. Ariz. Rev. Stat. § 36-3231(B).

110. *DeKalb*, 655 S.E.2d at 825; *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*, see note 3 above, § II(3)(c)(3).

111. 38 *C.F.R.* § 17.32(f)(2); "Informed Consent for Clinical Treatments and Procedures," *VHA Handbook* 1004.01(14) (14 August 2009). The chief of staff and the facility director must approve the withdrawal of any life sustaining treatment. The patient's record must be documented accordingly. The treating physician is not permitted to be a member of the committee. The committee must use the substituted judgment standard, if possible, and, if not, must decide based on the best interest of the patient. The committee should seek input from the patient's religious, ethnic, or cultural groups.

112. Ore. S.B. 579 § 2(b), 76th Legis. Assembly (2011) (Johnson).

113. E.D. Isaacs and R.V. Brody, "The Unbefriended Adult Patient," *San Francisco Medicine* (July/August 2010): 25-6 (describing the process at San Francisco General Hospital); White et al., note

97 above. This is what Karp and Wood refer to as “flying below the radar screen.” See Karp and Wood, note 2 above, pp. 38-40; Kapp, note 5 above, p. 22 (noting physicians act as “de facto surrogates . . . covertly and with hesitation”). Isaacs and Brody argue that it is unclear that a more elaborate process does or would produce better results. For example, judges usually follow the medical recommendation. Because the New York SDMC votes to go forward with the medical procedure in 96 percent of cases, some have observed that this review “may not substantially improve decisions.” See Miller, note 73 above; *In re Browning*, 543 So. 2d 258, 273 (Fla. App. 1989) (“Until we see evidence of some abuse by an informal forum, we believe its advantages outweigh its disadvantages.”); Karp and Wood, note 2 above, p. 41 (describing concerns about “the due process-ization of medical decision-making”); Kapp, note 5 above, p. 34 (arguing that requiring legally authorized surrogates may reduce beneficent behavior on the part of facility staff who often “functioned in essence in the role of family for the resident who had no one else”). On the other hand, the prospect of accountability matters. T.M. Pope, “Multi-Institutional Healthcare Ethics Committees: the Procedurally Fair Internal Dispute Resolution Mechanism,” *Campbell Law Review* 31, no. 2 (2009): 257-331; White et al., see note 70 above.

114. See Karp and Wood, note 2 above, pp. 35-36; <http://www.sccma-mcma.org>, accessed 27 January 2012. While not specifically authorized in California law, the Santa Clara policy has received judicial endorsement and deference.

115. “Ethics Subcommittee Surrogate for Patients,” *Medical Ethics Advisor*, 1 September 2004.

116. Santa Clara Valley Medical Center, “Administrative Policies and Procedures Manual, VMC 301.14, Healthcare Decisions for Incapacitated Patients without Surrogates,” 18 January 2011.

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