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Law

Colorado's New Proxy Law Allowing Physicians to Serve as Proxies: Moving from Statute to Guidelines

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ABSTRACT

In 2016, the Colorado legislature passed an amendment to Colorado's medical proxy law that established a process for the appointment of a physician to act as proxy decision maker of last resort for an unrepresented patient (Colorado HB 16-1101: Medical Decisions For Unrepresented Patients). The legislative process brought together a diverse set of stakeholders, not all of whom supported the legislation. Following passage of the statutory amendment, the Colorado Collaborative for Unrepresented Patients (CCUP), a group of advocates responsible for initiating the legislative process, coordinated a unique effort to engage these stakeholders in the creation of a set of voluntary guidelines to assist facilities and individual careproviders in the implementation of policies and procedures enabled by the statute. This article delineates the questions and concerns of stakeholders, describes how those issues were addressed within the guidelines, and proposes additional opportunities for research to assess the impact of the legislation in Colorado.

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INTRODUCTION

Decision making for unrepresented patients is an increasingly common dilemma in healthcare settings, with these patients at risk for under treatment, over treatment, and delayed testing and treatment.¹ Despite much exploration of the topic for the past 25 years, a 2016 position statement by the American Geriatrics Society points to a continued lack of consensus on both legal and clinical practice standards for making medical decisions on behalf of this vulnerable population.² The result is a patchwork of approaches across the United States, which may or may not be supported by the diverse range of state laws and very limited research that confirms the numbers of unrepresented patients and investigates the timeliness and procedural fairness of those approaches in practice.

In 2016, the Colorado Collaborative for Unrepresented Patients (CCUP), consisting of healthcare professionals, attorneys, and ethicists, worked together to successfully amend the proxy law in Colorado to include a mechanism to make more timely healthcare decisions for patients who are unrepresented.³ Amending legislation wasn't the first choice of the members of CCUP, who originally worked to include medical decision making in a public guardianship pilot program that was proposed, but not funded, in 2014. Still committed to better address-

ing the needs and care of unrepresented patients, the members of CCUP turned to the expansion of Colorado's otherwise good proxy statute to include a provision that was specific to unrepresented patients, which allows for the appointment of a physician as the proxy of last resort.

Throughout the process of passing legislation to amend the proxy statute to include physicians as proxies, CCUP leaders navigated a variety of legal, ethical, practical, and political dimensions, some of which were directly addressed in the body of the statute.⁴ However, it was not strategic to address every detail in the statute, so the CCUP leadership promised to coordinate the development of a set of guidelines to help stakeholders with the practical logistics of implementing the statute in their facility. They initiated additional communications with stakeholders and convened a large meeting of stakeholders in order to create a set of community-generated guidelines for implementation. This unique approach to the practical implementation of enabling legislation should be of interest to other states considering similar solutions to the dilemma of unrepresented patients.

The final elements of Colorado HB 16-1101, Concerning Medical Decisions for Unrepresented Patients (hereafter, HB 16-1101), reflected the option of a volunteer physician-proxy of last resort with safeguards to protect the very vulnerable population of unrepresented patients. The key provisions of the amendment are listed in table 1. The full bill can be located at the state website.⁵

STAKEHOLDERS' INPUT

The original CCUP was composed of colleagues from multiple disciplines and healthcare settings who then reached out to colleagues in both rural and metropolitan settings in order to obtain the most feedback on issues from the widest array of different perspectives. What to do about medical decision making for unrepresented patients was an ongoing topic at the annual meeting of the Colorado Healthcare Ethics Forum, and its members were a valuable source of feedback. As the legislative process progressed, an extensive list of stakeholders was created. Active stakeholders included representatives of the Colorado Hospital Association, large hospital systems, the major liability carrier, the Colorado Medical Society, the Colorado Nurse Association, the Colorado Bar Association, the long-term care community, and the disabilities community. Following passage of the legislation in the spring of 2016, this list was used in late summer of 2016 to

re-engage the stakeholder community in the development of the promised guidelines to address the appointment, termination, and scope of physician-proxies, the role of ethics committees, and other aspects of protecting unrepresented patients.

DEVELOPMENT OF THE GUIDELINES

Throughout the initial process of gathering stakeholders' input and support, CCUP leaders kept the legislative amendment deliberately vague to try to garner maximum support from a wide array of institutions and to try to insure that willing institutions could fashion policies and procedures that best fit their individual contexts when using a physician as a proxy decision maker. Based on feedback from stakeholders before and during the legislative process, the leaders of CCUP were already aware of many of the ethical, legal, and practical concerns that would remain once the legislation passed, that might hinder facilities and individual careproviders from making use of the new law. In fact, the FAQ (frequently asked question) document that was developed during the legislative process served as the starting point for the guidelines, intended to help institutions that were willing to adopt the processes that were outlined in the legislation.

It should be noted that the concept of community-generated guidelines was preferred to regula-

TABLE 1. Highlights of Colorado HB 16-1101, Concerning Medical Decisions for Unrepresented Patients

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- Appointment of a physician as proxy decision maker of last resort for an unrepresented patient
 - Proxy as physician is separate from patient's attending physician, and assignment is voluntary
 - Ethics committee involvement is required for choice of physician as proxy and consensus with treatment decisions that need written consent and for end-of-life decisions
 - Independent decisional capacity determination by second careprovider
 - Documentation requirements in medical record
 - Physician as proxy to be involved in all decisions that would normally require informed consent
 - Special end-of-life provisions involve an attending and a second consultant physician, a physician-proxy, and the ethics committee of the institution
 - Protection from liability for physician acting as proxy
 - Processes for when the role of physician as proxy ends
 - Applicable in all healthcare facilities, including hospitals, nursing homes, and hospices
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tions, since guidelines are voluntary and can be generated via the community itself, while they can also be easily amended with subsequent experience. Unlike the case with Colorado's statute regarding cardiopulmonary resuscitation—which specifically directed the Colorado State Department of Public Health and Environment (CDPHE) to promulgate regulations—the amended proxy statute that allows a physician to serve as a proxy is voluntary, and the DPHE has never tried to implement a regulation regarding any part of the proxy process. Therefore, neither state statute nor regulation provide specific details on how to implement the basic process outlined in the statute. However, in creating community-generated guidelines, careful language was required in discussions with stakeholders so as not to commit to too much by referring to them as “standards of care” or “best practices.” There was a thin line between wanting to capture and encourage practices that would enhance the care of unrepresented patients and setting a required standard that was beyond the scope of CCUP's efforts, could not be applied in some settings, and made legal colleagues nervous.

In the absence of specific regulations, and even though the guidelines are voluntary, their development was essential. Most importantly, the guidelines helped address specific concerns about the use of physicians as proxies that might well have prevented some careproviders and facilities from using the legislation. In addition, the development of community-generated guidelines presented an opportunity to improve practice for unrepresented patients and make it more predictable and consistent across the state. A final benefit of the guidelines was simply the opportunity to educate both individual careproviders and facilities regarding the larger proxy statute itself.

Ultimately, the goal of the legislation was to improve the timeliness, consistency, and fairness of decision making for unrepresented patients as a matter of justice. Passing the legislation was a step in that direction, but not enough, in and of itself, to promote its effective use in practice. Therefore, using the FAQ document as a starting point, an initial set of guidelines for the use of physicians as proxies was drafted and distributed to a small group of volunteer reviewers. Based on their support for the document, the draft was then distributed to the full set of stakeholders who had expressed interest during the legislative process, and a meeting was convened in September of 2016. Based on the extensive feedback gathered during and after this meeting, a guidelines document was finalized and widely

distributed later in 2016. CCUP leaders continue to be contacted with questions and requests for education regarding the legislation or assistance with policy development.

THE CONTENT OF THE GUIDELINES

The document, “Decision Making for Unrepresented Patients Who Lack Capacity: Guidelines for Health Care Facilities in Colorado” (hereafter, the Guidelines), which was widely distributed, begins with a preamble to give some context and a summary of the amended proxy law that allows physicians to serve as proxies.⁶ It then expands on the intentionally general provisions of the law to provide more detailed descriptions of options and recommendations to operationalize the law in some of the widely differing healthcare sites around Colorado. An outline of the multiple components of HB 16-1101 covered in the Guidelines is provided in table 2; the key issues within each of the topics are discussed below.

1. Identification of an Unrepresented Patient

Assessment of Decisional Capacity. Significant variability exists in how institutions determine if a patient has or lacks decision-making capacity. Criteria have been proposed in prior literature.⁷ Some of the CCUP members had been involved in developing policies and processes at their own institution. But such criteria are not widely understood or used. An appendix to the Guidelines was added to demonstrate one version of a tool for documenting the elements of decision-making capacity.

“Reasonable Effort” to Find a Healthcare Proxy. There is considerable confusion about and variability in determining the amount of “due diligence” that is required to determine whether a given person is indeed unrepresented. This determination remains one of the least uniform processes at healthcare institutions. In response, a list of suggested sources of potential family, close friends, or others was added to the Guidelines. The appendices include a tool for suggesting and documenting sites that might need to be researched by a facility prior to considering using a physician-proxy. The scope of due diligence clearly depends on the time and urgency of the decisions that need to be made to care properly for a patient. In the first hours and days of an acute turn that requires interventions needing informed consent, the search is necessarily less comprehensive. For patients who have longer stays, institutions need to continue to search for less obvious sources of information. This persistence in

attempting to locate “interested persons”—as the Colorado proxy statutes describes—is difficult for institutional staff to sustain, but is important to the integrity of the process that allows for a physician to serve as proxy only after no other proxies are found. In addition, documentation of due diligence is often needed when presenting a request for guardianship before a judge.

2. Ethics Committee Roles and Responsibilities

As stated in HB 16-1101, an institution’s ethics committee is required to be notified when a potentially unrepresented patient is identified and the use of a physician to serve as a proxy might be necessary. Ethics committees have clear consultative responsibilities that are outlined in the law, and the Guidelines again outline procedures for oversight, review, and documentation, some of which depend

on the nature of individual cases. The Guidelines remind institutions that ethics committees should not serve in the proxy role, although ethics committees have additional policy and education responsibilities around the use of a physician-proxy, in keeping with the three common roles for ethics committees articulated in the literature.⁸

Since 1992, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO—now known as the Joint Commission) has mandated that healthcare institutions have a “mechanism for considering ethical issues.”⁹ While the existence of ethics committees has surged since the JCAHO mandate, a small minority of healthcare institutions in Colorado and elsewhere are not accredited, may lack an ethics committee, and may not be linked to a system with ethics consultation resources. In addition, there are disparities in the functionality of eth-

TABLE 2. Issues addressed in the Guidelines

| Elements of the Guidelines | Topics addressed | Particularly difficult issues |
|--|---|--|
| 1. Identification of unrepresented patient | <ul style="list-style-type: none"> • Assessment of decisional capacity • “Reasonable effort” to find a healthcare proxy | <ul style="list-style-type: none"> • Lack of common legal standard and wide variation in practice |
| 2. Ethics committee roles and responsibilities | <ul style="list-style-type: none"> • Roles, responsibilities, and problem solving if no ethics committee | <ul style="list-style-type: none"> • No committee or available alternative • Minimally active committee • Limited committee resources/funding • Lack of committee training |
| 3. Appointment and the role and responsibilities of a physician who assumes the proxy role | <ul style="list-style-type: none"> • Process of appointment • Role and responsibilities of the physician who agrees to serve as proxy | <ul style="list-style-type: none"> • Perceived conflict of interest • Willing and available physicians |
| 4. Requirements when using a physician as proxy | -- | <ul style="list-style-type: none"> • Coordination and authority |
| 5. Decision-making standards and conflict resolution | <ul style="list-style-type: none"> • Types of decisions • Decision-making standards in hierarchical order • Conflict resolution | <ul style="list-style-type: none"> • Legal concerns • Resolving conflict |
| 6. Guardianship | -- | <ul style="list-style-type: none"> • Might not use when appropriate |
| 7. No willing proxy, termination of physician who is the proxy, and transitions of care | <ul style="list-style-type: none"> • Process for requesting a guardian • No willing proxy • Physician who is the proxy resigns • Patient recovers decisional capacity or a suitable proxy is located • Patient discharge or transition of care | <ul style="list-style-type: none"> • Coordination • Continuity of care |
| 8. Appendices | <ul style="list-style-type: none"> • Glossary of Terms • Summary of Bill • Decision Making Capacity (DMC) Assessment Tool (and Pearls) • Checklist for Reasonable Efforts to Find a Proxy • Resources for Ethics Consultation • FAQs for Physicians Serving as Proxy Decision Makers for Patients without any Surrogate | |

ics committees varies widely across Colorado and the U.S.

Approaches to making decisions for patients without surrogates vary widely across Colorado and across the U.S.¹⁰ In Colorado, the Medical Treatment Decisions Act was amended in 2010 to provide that “the assistance of a healthcare facility’s medical ethics committee shall be provided” when a proxy or potential proxy is considering withdrawing or withholding medical treatment. It also states that, if there is no medical ethics committee at the healthcare facility, an outside referral may be used for consultation or assistance.¹¹

The requirement for an ethics role is met in different ways by healthcare institutions. Recognizing this, the Guidelines suggest several different ways in which an ethics committee’s response can occur, including: oversight by the entire institutional ethics committee with identification of a lead consultant, delegation of ethics responsibilities to a more nimble representative subgroup of persons who are experienced in ethics consultation, the use of system resources for small rural institutions that are part of a larger system, the use of another nearby healthcare facility’s resources, or consultation with one of the key ethics organizations in the state. Our disabilities communities strongly encouraged that a patient advocate, ideally with experience with disabled persons, be at the table.

3. Appointment and the Role and Responsibilities of a Physician Who Assumes the Proxy Role

Process of Appointment. The process of appointment of a physician who agrees to be a proxy is clearly outlined in HB 16-1101. In particular, the attending physician can appoint another physician as a proxy, in collaboration with an ethics committee; however, the attending physician cannot directly serve as a proxy. This restriction raised concerns for many institutions regarding how to locate a willing physician to serve as a proxy who would not also be likely to attend as the patient’s physician during the patient’s healthcare stay. The use of a colleague who is, for instance, a part of the hospitalist or geriatrics group could present a potential conflict of interest. Avoiding the appearance of a conflict of interest is particularly problematic in small institutions, where only one group of physicians may serve. An ethics committee is required to approve the proposed “willing physician,” and, in several locations, it has become clear subsequently that a “stable” of potential physician-proxies might benefit from inclusion of physician-administrators or retired physicians at the

discretion of the institution or system. In addition, the Guidelines discourage the use of resident physicians and fellows due to the potential lack of independence.

Role and Responsibilities of the Physician Who Agrees to Serve as a Proxy. It has been difficult for potential physician-proxies to understand that their role is one of an advocate speaking on behalf of a patient, not that of a consultant and not as part of the medical team. Education from an ethics committee is required to be sure that this role is clear. For instance, a physician-proxy only has access to a patient’s medical chart through institutional policies, in the same way that any other proxy does. Clearly, a physician’s medical knowledge facilitates an understanding of the nature of the treatment decisions that need to be made, but this should be no greater than that of any other proxy who also has a medical background. The Guidelines contain an appendix to help give guidance to potential physician-proxies.

4. Requirements When Using a Physician as Proxy

The guidelines indicate the types of decisions in which a physician-proxy will need to participate. In general these include interventions for which informed consent would be required, according to an institution’s normal policies and procedures. Special procedures are required under the legislation when end-of-life decisions need to be considered, as with potentially nonbeneficial treatments and withholding or withdrawing life-sustaining treatments. For these decisions, a concurring assessment from a second consulting physician is required, as well as consensus by the ethics committee and consent from the physician-proxy representing the patient.

5. Decision Standards and Conflict Resolution

Types of Decisions. Several institutions asked what kind of treatment decisions would require utilization of a physician-proxy. The interventions can be roughly divided into three levels. (1) Routine treatments that are within broadly accepted standards of medical practice that present a low level of risk to a patient do not require informed consent. Such decisions can be made by an attending physician without proxy consent. This includes such care as blood draws, routine x-ray imaging, and initiating antibiotics. (2) Interventions that normally require a patient’s or surrogate’s consent would require review and consent by a physician-proxy. Such interventions would include surgery, major procedures

that carry some risk to a patient, such as initiating chemotherapy, placement of a pacemaker, *et cetera*, or treatments for which personal, social, or religious values are expected to differ.

(3) A third and distinct level of consent and consideration is end-of-life management. The legislators involved in HB 16-1101 made it clear that they felt these decisions required special oversight and confirmation. Those stipulations are discussed above. In addition to the three levels of treatment decisions, physicians serving as proxies would be expected to participate in transition and transfer decisions. The controversial issue of organ donation was resolved by consent only in the face of a patient's known wishes (driver's license or other documentation), since there was concern by some legislators that this was the ulterior motivation for this amendment to the proxy law.

Decision-Making Standards in Hierarchical Order. The Guidelines reference accepted standards for surrogate decision making, according to the following hierarchy: a patient's known wishes, substituted judgment, the best interests of the patient.¹² The Guidelines suggest that several factors should be taken into account when a physician who is serving as a proxy considers making decisions using the best interest standard. Institutions are reminded of the vulnerability of unrepresented patients and the need to focus on respect for these patient and their ability to cooperate with any proposed treatments.

Conflict Resolution. The Guidelines encourage mediation internally or through outside referral in the event of an inability to reach consensus among ethics committee representatives, or between a physician-proxy and ethics committee members.

6. Guardianship

The 2016 amendment to Colorado Revised Statutes Title 15, Article 18.5, "Proxy Decision-Makers for Medical Treatment and Surrogate Decision-Makers for Health Care Benefit Decisions," that allows for a physician to serve as a proxy of last resort, is not the ideal resolution to the problem of unrepresented patients. The authors consider this amendment a bridge solution to the need for a robust guardianship program that would allow a dedicated decision maker across institutions and through a life span of medical treatments, if needed. Therefore, a section reminding institutions and ethics committees of definitions and the process of requesting a guardian in Colorado was included in the Guidelines. Appointment of a guardian terminates the responsibilities of a physician who is serving as a proxy.

7. No Willing Proxy, Termination of the Physician Who Is the Proxy, and Transitions of Care

No Willing Proxy. Since a physician serving as a proxy is a volunteer, there will be times when no accepting and acceptable physician-proxy can be found. In such a case, the patient is in the same limbo as he or she would be without this new amendment. Options include appointment of a guardian *ad litem* to assess the situation and perhaps expedite the appointment of a guardian, or to seek a volunteer guardian from the community.

Physician Who Is the Proxy Resigns. A physician serving in the proxy role is a volunteer. The physician-proxy can step aside at any point if the physician feels unable or unwilling to fulfill the role. The Guidelines reiterate the conditions and recommend a process when an appointed physician is unable or declines to continue, to replace a physician serving in the proxy role, or when a patient transitions back to being unrepresented.

Patient Recovers Decisional Capacity or a Suitable Proxy Is Located. Both of these circumstances normally relieve a physician who is the proxy of his/her appointment. When it appears that a patient may have regained enough decisional capacity to resume medical decision making, the ethics committee and attending physician should conduct and document another functional assessment of capacity. A suitable proxy may still need or wish support from the ethics committee. A patient who regains capacity should be encouraged to appoint a decision maker for future times when capacity is lost, and a clarification of values and wishes to inform future decision makers should be carefully documented.

Patient Discharge or Transition of Care. Since one of the most difficult types of decision making involves patient placement, it is very helpful if nursing homes, hospices, and other non-acute-care settings utilize the physician-as-proxy amendment, as these facilities face similar challenges. Access to ethics committee support may be more difficult, and physicians who serve as proxies in one setting often will want to step aside when a patient moves to another setting. The Guidelines reinforce the concept that a new search for a proxy or a physician to serve as a proxy is usually needed at each site of care.

WILL IT WORK? FUTURE RESEARCH AND RESEARCH CHALLENGES

The stakeholder process used to develop the community-generated Guidelines for the implemen-

tation of legislation allowing physicians to serve as proxy decision makers was a unique approach to informing and educating the community, retaining stakeholders' support for the process, and attempting to standardize practice for the benefit of both patients and care teams. The process of drafting the Guidelines was greatly enhanced by reconvening stakeholders, some of whom had actually opposed the legislation for much of the legislative process, but were now ready and willing to assist with its implementation.

However, the passage of the legislation and the community-generated Guidelines constitute only the beginning of a journey to effectively address the specific needs of unrepresented patients and the larger, more general issue of the lack of available guardianship options for this vulnerable population. There is an obvious need for follow-up research to assess the effectiveness of both the legislation and the Guidelines in order to determine what additional steps or resources are needed for successful implementation of the legislation statewide, and the ongoing standardization of the unrepresented patient experience. Among the questions that should be investigated, the following would be good places to start:

- How many facilities, and of what type, have policies and processes in place that allow a physician to serve as a proxy?
- Of the facilities that have policies, how many are actively using those policies?
- Of the facilities that do not have policies, why have they chosen not to implement the legislative option? What are the specific concerns or barriers?
- What alternative process are these facilities using with this patient population?

Once the general use of the physician-as-proxy amendment has been determined, the next area of investigation should be the issues of effectiveness and appropriateness, which raise another more complex set of questions:

- How should effectiveness and appropriateness be defined?
- Should measures of effectiveness be different in different settings?

There are many potential measures that could be considered. Basic descriptive measures could include the number of unrepresented patients identified, the number of patients who needed a proxy and couldn't get one, the number of patients who were assigned a physician to serve as a proxy, the

number of physicians willing to volunteer as proxies, earlier and more consistent involvement of ethics committees with unrepresented patients, and the estimated cost savings of receiving more timely and appropriate care and placement via shorter stays or lower overall facility charges. Somewhat more qualitative measures of effectiveness might include reductions in avoidable patient harm and moral distress among care team members. Measures of appropriateness should address the intent of the legislation that allows physicians to serve as proxies and the integrity of the process. For example, are facility ethics committees providing appropriate levels of coordination and consensus?

Finally, and secondary to effectiveness of the legislation itself, the usefulness of the Guidelines should be evaluated:

- To what extent were the Guidelines helpful in developing the policies and processes for using physicians as proxies of last resort?
- How closely do existing policies and processes align with the Guidelines?
- How can the Guidelines be expanded, clarified, or adapted to better reflect community practice and to assist facilities in using the legislation?

To illustrate the potential for research presented by the Guidelines, it is helpful to consider what little we currently know about the initial implementation of the legislation allowing for physicians to serve as proxies. As the Guidelines were being developed, the most engaged stakeholders were hospitals, and specifically the large hospital systems in the Denver Metro area; at least one of these systems extended across the entire state. These systems began developing and implementing policies during the fall of 2016 following the bill's effective date. A year into the legislation, anecdotal evidence is that the policy is being used in at least some acute inpatient settings with success, although the frequency of its use seems to vary widely. However, no definitive data have been collected at this point to determine how extensively it has been used or the barriers to use that remain.

Even less clear is its application in other health-care settings. For example, there is no available evidence on whether or not smaller and rural hospitals are actively using the statute. Likewise, a recent meeting with one of the major long-term care providers suggests that long-term care settings are having a hard time with the practical logistics set out by both the bill and the subsequent community Guidelines. At one level, this difficulty should not be surprising, given the primarily acute-care expe-

rience of the drafters of the Guidelines and the involvement of mostly acute-care providers in the stakeholder process. However, most of the barriers are deeper than simple participation in the Guidelines process, and were anticipated even as the bill itself was being drafted.

The feedback from one of our long-term care providers illustrates the issues that had been anticipated for the use of physicians as proxies in rural and long-term care settings. First is the general concern regarding the unfunded 24/7 time commitment by both the physician-proxy and the ethics committee for every individual case. The majority of ethics committees in Colorado are unfunded and rely predominantly on the volunteer membership of both facility employees and community members, who often find themselves attending meetings on their day off or who may carry a 24-hour pager without compensation. While this issue is present in nearly all acute-care settings, there are simply more options and available human resources upon which to draw in larger settings. The same dynamic is true for the number of physicians who are willing and available to assume the proxy role.

Other concerns include the facts that many smaller hospitals and long-term care (LTC) facilities don't have an ethics committee, or, if they do, the members of the ethics committee receive minimal training and often lack the expertise and other institutional support needed to fully comply with the statute itself, or with the community Guidelines. Another concern that was anticipated was the question of the continuity of physicians serving as proxies, and the transfer of care when a patient moves from one setting to another.

All of these issues warrant further investigation; however, access to the necessary data is a considerable barrier to conducting research, and there is no mandate to track or assess the use of the amended statute. As was experienced during the legislative process, definitive data on something as simple as the number of unrepresented patients, the "patient days" they represent in acute care, and the total charges they incur are simply not available due to a combination of the difficulty in identifying these patients after the fact and competing priorities in facilities that hesitate to dedicate resources to setting up a tracking system. An informal survey of nearly 100 LTC facilities, which the authors conducted with the Colorado Health Care Association (CHCA) prior to introducing the legislation, yielded widely varying data regarding the number of both unrepresented patients who lack capacity and those residents who are immediately at risk of becoming

unrepresented and lacking capacity. Presently, the active engagement of an ethics committee, in every case, may ease some of these barriers to information, at least in the facilities that are using the legislation, via the ethics committees' own internal tracking of their activities.

A final development worth mentioning and celebrating is that the successful passage of this legislation allowing physicians to serve as proxies of last resort emboldened its legislative sponsors to run a bill the following year to establish a limited pilot project to study an office of public guardianship. Unfortunately, the budget process did not allow for an appropriation for the study; rather, the study was approved under the caveat that its five-year funding be based on grants, gifts, and donations. A Public Guardianship Commission has been appointed; it is currently working on strategies to collect the initial funds to launch the study. The unrepresented patient legislation in Colorado was never intended to solve the larger scope of guardianship issues for these patients, and there is still a great deal of support among the stakeholder community that came together to address unrepresented patients for the establishment of a public guardianship program in Colorado. However, research into the prevalence and costs, both human and fiscal, associated with this vulnerable population could well be a critical factor in garnering both donor and eventual legislative support for public guardianship.

While the call by the American Geriatrics Society for model legal standards and standardized, systematized methods of decision making for unrepresented patients is reasonable, it is probably not practical in the short term, given the current wide variation in legal codes and actual practice. However, the development of community-generated guidelines for policy and process development by individual facilities, based on existing state statutes, may provide an intermediate step in obtaining consensus on the most workable approaches. In addition, a concerted effort to generate data on measurable outcomes would greatly enhance the discussion, much of which remains more theoretical than practical or evidence based. Recent publications by Courtright and colleagues and Moye and colleagues are heartening examples of efforts to investigate and assess actual practice.¹³

NOTES

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