Better Healthcare Decision Making for Incapacitated Patients without Surrogates

3rd Annual WINGS Minnesota Guardianship Summit

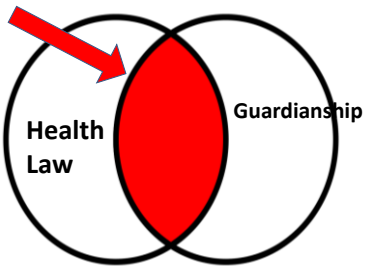
February 3, 2017

Thaddeus Mason Pope, JD, PhD
Mitchell Hamline School of Law

Health law

Bioethics

Not guardianship



Increasingly **common** situation

Minnesota hospitals & LTC **challenged**

Patient **needs** treatment

BUT

No capacity

No surrogate

Patient **cannot** consent

Nobody else to consent

Various terms

"unrepresented"

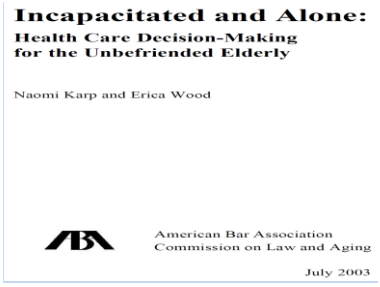
"adult orphan"

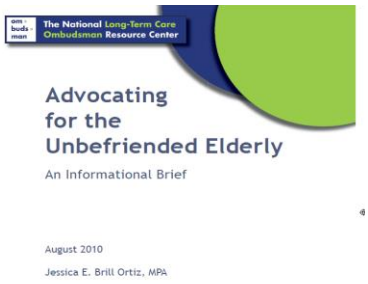
Patient w/o proxy

Incapacitated & alone

I use

"unbefriended"





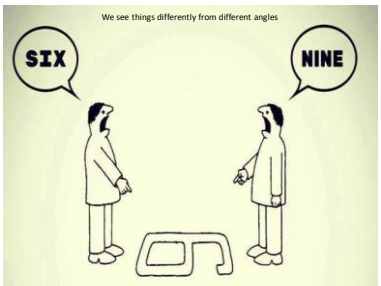

AGS Position Statement: Making Medical Treatment Decisions for Unbefriended Older Adults

Timothy W. Farrell, MD, AGSF,[1,2] Eric Widera, MD,[3,4] Lisa Rosenberg, MD,[5] Craig D. Rubin, MD, AGSF,[6] Amand D. Naik, MD,[7,8] Ursula Braun, MD, MPH,[7,8] Alexia Torke, MD, MS,[9] Ina Li, MD,[10] Caroline Vitale, MD, AGSF,[11,12] Joseph Shega, MD,[13,14] for the Ethics, Clinical Practice and Models of Care, and Public Policy Committees of the American Geriatrics Society

November 22, 2016

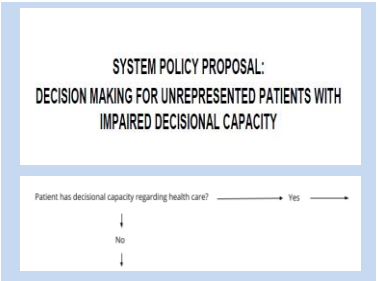
My

Perspective



I am a **law** professor.

But I often speak and write directly to **clinicians**


SYSTEM POLICY PROPOSAL:
DECISION MAKING FOR UNREPRESENTED PATIENTS WITH IMPAIRED DECISIONAL CAPACITY

Patient has decisional capacity regarding health care? → Yes →
↓
No
↓

Fairview Lakes Medical Center
Fairview Northland Medical Center
Fairview Ridges Hospital
Fairview Southdale Hospital
Maple Grove Hospital
Univ. Minnesota Masonic Children's Hospital
University of Minnesota Medical Center
Fairview Range Medical Center

Perspective today – from the **clinician**

Who?

Roadmap

5 parts

1 Substitute decision making

2 **Who** are the unbefriended

3 **Risks** to patient safety

4 Prevention measures

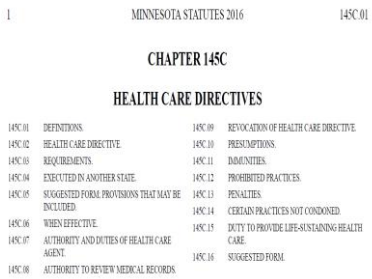
5 Decision making mechanisms

Unit 1 of 5

Substitute Decision Making

How to make healthcare decisions for patients **without** capacity

Capacity



1 MINNESOTA STATUTES 2016 145C.01

CHAPTER 145C

HEALTH CARE DIRECTIVES

145C.01	DEFINITIONS.	145C.09	REVOCATION OF HEALTH CARE DIRECTIVE.
145C.02	HEALTH CARE DIRECTIVE.	145C.10	PRESUMPTIONS.
145C.03	REQUIREMENTS.	145C.11	IMMUNITIES.
145C.04	EXECUTED IN ANOTHER STATE.	145C.12	PROHIBITED PRACTICES.
145C.05	SUGGESTED FORM; PROVISIONS THAT MAY BE INCLUDED.	145C.13	PENALTIES.
		145C.14	CERTAIN PRACTICES NOT CONDONED.
145C.06	WHEN EFFECTIVE.	145C.15	DUTY TO PROVIDE LIFE-SUSTAINING HEALTH CARE.
145C.07	AUTHORITY AND DUTIES OF HEALTH CARE AGENT.	145C.16	SUGGESTED FORM.
145C.08	AUTHORITY TO REVIEW MEDICAL RECORDS.		

Ability to **understand** the significant benefits, risks and alternatives to proposed health care

Ability to **make and communicate** a decision

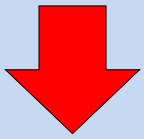
If decision not impaired by cognitive or volitional defect, providers **must respect** decision

Not honoring choice = **paternalism**, violation of patient autonomy

All patients are **presumed** to have capacity

Until the presumption is rebutted

Patient has capacity to make the decision at hand



Patient decides **herself**

BUT patients often **lack** capacity

1. Had but **lost** (dementia…)
2. Not **yet** acquired (minors)
3. .**Never** had capacity (mental disability)

Let's focus on the most common one

Adults who had but **lost** capacity

3 Mechanisms when patient **cannot** make her own decisions

Advance directive

Agent / DPAHC

Default surrogate

Advance directive

Maybe left prior instructions

Advantage

Patient **herself** decided (earlier)

BUT

Not completed

Not found

Not clear

Obstacle 1

Not completed

AMERICAN BAR ASSOCIATION 30%

AARP 28%

PewResearchCenter

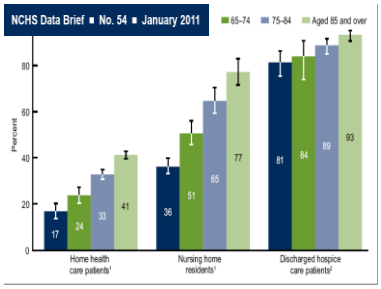
NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

Views on End-of-Life Medical Treatments

Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

18-29	15%
30-49	33%
50-64	38%
65-74	61%
75+	58%



Obstacle 2

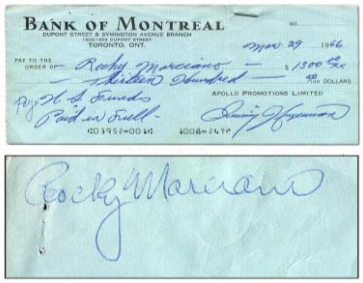
Not found

65-76% of physicians whose patients **have** advance directives do not know they **exist**

U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Individuals fail to make & distribute copies

Primary agent	Attorney
Alternate agents	Clergy
Family members	Online registry
PCP	



Obstacle 3

Not clear

if ___,

then ___

If

Trigger terms vague

"Reasonable expectation of recovery"

75% 51%

25% 10%

Plus: prognosis uncertain

Then

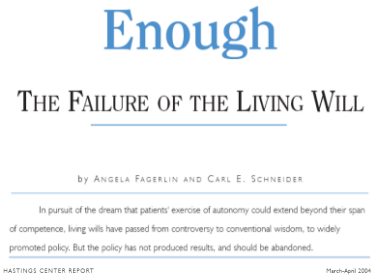
Preferences vague

"No ventilator"

Ever

Even if temporary

Limits



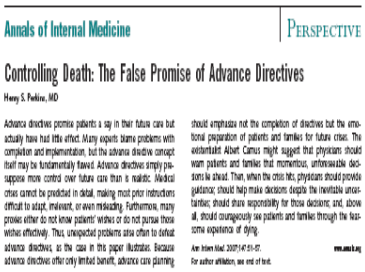
Enough

THE FAILURE OF THE LIVING WILL

by ANGELA FAGERLIN AND CARL E. SCHNEIDER

In pursuit of the dream that patients' exercise of autonomy could extend beyond their span of competence, living wills have passed from controversy to conventional wisdom, to widely promoted policy. But the policy has not produced results, and should be abandoned.

HASTINGS CENTER REPORT March–April 2004



Annals of Internal Medicine | PERSPECTIVE

Controlling Death: The False Promise of Advance Directives

Henry S. Perkins, MD

Advance directives promise patients a say in their future care but actually have had little effect. Many experts blame problems with completion and implementation, but the advance directive concept itself may be fundamentally flawed. Advance directives simply presuppose more control over future care than is realistic. Medical crises cannot be predicted in detail, making most prior instructions difficult to adapt, irrelevant, or even misleading. Furthermore, many proxies either do not know patients' wishes or do not pursue those wishes effectively. Thus, unexpected problems arise often to defeat advance directives, as the case in this paper illustrates. Because advance directives offer only limited benefit, advance care planning should emphasize not the completion of directives but the emotional preparation of patients and families for future crises. The existentialist Albert Camus might suggest that physicians should warn patients and families that momentous, unforeseeable decisions lie ahead. Then, when the crisis hits, physicians should provide guidance; should help make decisions despite the inevitable uncertainties; should share responsibility for those decisions; and, above all, should courageously see patients and families through the fearsome experience of dying.

Ann Intern Med. 2007;147:51-57. www.annals.org

For author affiliation, see end of text.

2 parts

to AD

Instruct

Appoint

~~Instruct~~

Appoint

Need a SDM

1st choice – patient picks **herself**

Patient knows who

(1) They trust

(2) Knows their preferences

(3) Cares about her

"Agent"

"DPAHC"

BUT

Usually in an advance directive

Not completed

Not found

~~Not clear~~

Still need a SDM

Default surrogate

2nd choice – if no agent, turn to **default priority** list

"Surrogate"

"Proxy"

Most states specify a sequence

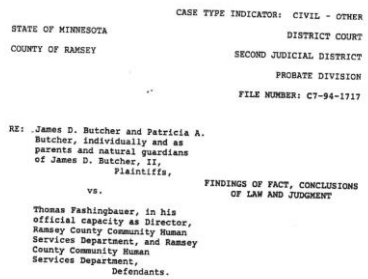
Agent
Spouse
Adult child
Adult sibling
Parent . . . . .

No authoritative list in Minnesota

BUT

Custom & practice

Judicially endorsed



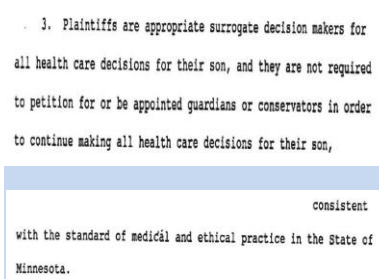
CASE TYPE INDICATOR: CIVIL - OTHER

STATE OF MINNESOTA
COUNTY OF RAMSEY

DISTRICT COURT
SECOND JUDICIAL DISTRICT
PROBATE DIVISION
FILE NUMBER: C7-94-1717

RE: James D. Butcher and Patricia A. Butcher, individually and as parents and natural guardians of James D. Butcher, II,
Plaintiffs,
vs.
Thomas Fashingbauer, in his official capacity as Director, Ramsey County Community Human Services Department, and Ramsey County Community Human Services Department,
Defendants.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT



3. Plaintiffs are appropriate surrogate decision makers for all health care decisions for their son, and they are not required to petition for or be appointed guardians or conservators in order to continue making all health care decisions for their son,

consistent with the standard of medical and ethical practice in the State of Minnesota.

Still need a SDM

Guardian

3rd choice – ask **court** to appoint SDM

Last resort

Not sufficiently responsive

GUARDIANSHIP FOR VULNERABLE ADULTS IN NORTH DAKOTA: RECOMMENDATIONS REGARDING UNMET NEEDS, STATUTORY EFFICACY, AND COST EFFECTIVENESS

300 to 700

WINSOR C. SCHMIDT*

Trust Fund is gratefully acknowledged. This Article is based on a Final Report submitted to the Human Services Committee, North Dakota Legislature: Winsor Schmidt, Study of Guardianship Services for Vulnerable Adults in North Dakota (May 30, 2012).

3 types SDM

Who appoints	Type of surrogate
Patient	Agent DPAHC
Legislature	Surrogate Proxy
Court	Guardian Conservator

How does the SDM decide?

Any type of SDM can usually make **any** decision patient could have made

Hierarchy

1. Subjective
2. Substituted judgment
3. Best interests

Subjective

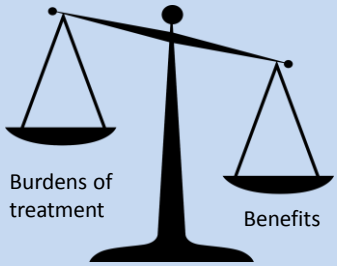
If patient left **instructions**, follow them

Substituted Judgment

Do what patient **would do** (using known values, preferences)

Best interests

If cannot exercise substituted judgment, then **objective** standard



Unit 2 of 5

<u>Who</u> are unbefriended patients?

Definition

Prevalence

Causes

Definition

3 conditions

1

Lack capacity

2

No available, applicable AD or POLST

3

No reasonably available authorized surrogate

Nobody to consent to treatment

Step by step flowchart

1

Does the patient have **capacity**?

If yes, then **patient** makes treatment decision.

If no, can patient decide with **"support"**?

If yes, then **patient** makes treatment decision.

If no, proceed

2

Is there an available AD or POLST

Does the AD or POLST clearly **apply** here

If yes, follow AD or POLST (but involve surrogate)

If no, proceed

3

If patient lacks capacity, a **SDM** must make the treatment decision.

Is there a court-appointed guardian?

If so, is the guardian reasonably available?

If no guardian . . .

Is there a healthcare agent (DPOAHC)?

If so, is the agent reasonably available?

If no agent . . .

Is there anyone on the default surrogate priority list?

If so, is the surrogate reasonably available?

Have social workers diligently searched for surrogates

If yes, then →

Nobody to consent to treatment

157

4

158

Is the situation an emergency

159

If yes →

160

Is there any reason to believe the patient would object

161

If no, proceed on basis of **implied** consent

162

5

Is there an responsive guardianship system?

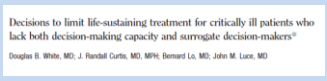
If so, seek a court appointed guardian

Even if a guardian is forthcoming, may need to make decisions in the **interim**

Big problem

Hospital estimates

16% ICU admits


Decisions to limit life-sustaining treatment for critically ill patients who lack both decision-making capacity and surrogate decision-makers*

Douglas B. White, MD; J. Randall Curtis, MD, MPH; Bernard Lo, MD; John M. Luce, MD

5% ICU deaths


ARTICLE | Annals of Internal Medicine

Life Support for Patients without a Surrogate Decision Maker: Who Decides?

> 25,000

Royal College of Physicians | Marie Curie

Care and support through terminal illness

End of Life Care Audit – Dying in Hospital

National report for England 2016

Table 14

	National audit (n=9302)	
3.4. Is there documented evidence that the cardiopulmonary resuscitation (CPR) decision by a senior doctor was discussed with the **nominated person(s) important to the patient** during the last episode of care?		
• YES	78%*	7219
• NO	18%	1706
• NO BUT	4%	377
If 'no but' during the last episode of care it was recorded that:		
• There was no nominated person important to the patient	47%	177
• Attempts were made to contact the nominated person important to the patient but were unsuccessful	53%	200

*81% if the 'NO BUTs' are excluded from the denominator

LTC estimates

Incapacitated and Alone:
Health Care Decision-Making for the Unbefriended Elderly

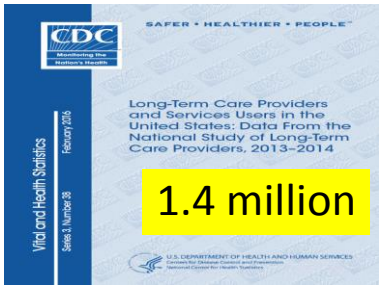
Naomi Karp and Erica Wood

American Bar Association
Commission on Law and Aging

July 2003

3 - 4%

U.S. nursing home population



> 56,000

in USA

Extrapolate

5.5 / 320

1.7%

1400

THE COMMISSION ON END OF LIFE CARE

Final Report

January 2002

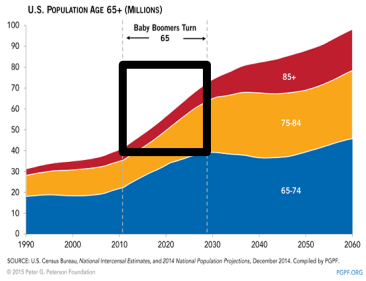
The Commission on End of Life Care was staffed by the Minnesota Partnership to Improve End of Life Care and the Minnesota Department of Health.

Not just big, but

Growing problem

Just **4** causal factors

1



2

INSIGHT

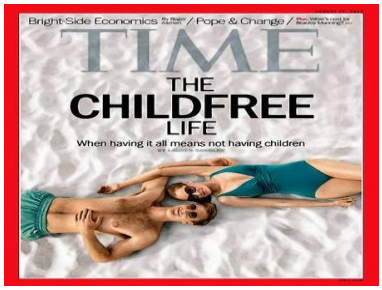
AARP Public Policy Institute

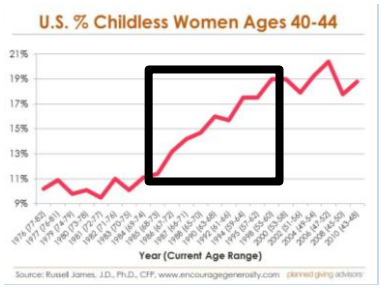
The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers

Donald Redfoot, Lynn Feinberg, and Ari Houser
AARP Public Policy Institute

10,000,000 Boomers live **alone**

3





Key Findings

- The biggest fear (92 respondents) was having no one to speak up for them or act in their best interests when they could no longer do so for themselves

Ageing without Children survey results 2015

4

Others "have" family members

No **contact** (e.g. LGBT, homeless, criminal)

Also lack **capacity**

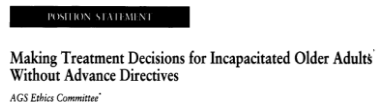
Unwilling

Unit 3 of 5

Risks & Harms

Cannot advocate for self

Have **no** substitute advocate


POSITION STATEMENT

Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

AGS Ethics Committee

"highly vulnerable"

"most vulnerable"


GUARDIANSHIP FOR VULNERABLE ADULTS IN NORTH DAKOTA: RECOMMENDATIONS REGARDING UNMET NEEDS, STATUTORY EFFICACY, AND COST EFFECTIVENESS

WINSOR C. SCHMIDT*

"unimaginably helpless"

Problem

Nobody to authorize treatment

3 common responses

1

Under-treatment

Reluctant to act without consent

Wait

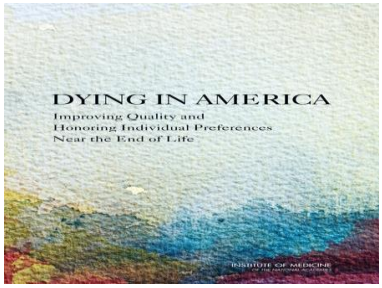
Until emergency

(implied consent)

BUT

Longer period suffering

Increases risks



Ethically "**troublesome** . . . waiting until the patient's medical condition worsens into an **emergency** so that consent to treat is implied . . ."

2

Over-treatment

Fear of liability

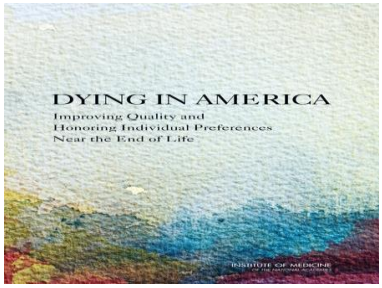
Fear of regulatory sanctions

Treat aggressively

BUT

Burdensome

Unwanted



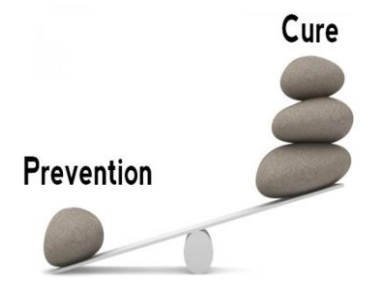
"**compromises** patient care and prevents any thorough and thoughtful consideration of patient preferences or best interests"

3

No discharge to appropriate setting

Unit 4 of 5

Prevention measures



Avoid **being** unbefriended

Avoid **risks** of unbefriended

4

- Better capacity assessment
- Diligent search for surrogates
- More advance care planning
- Better default surrogate lists

1

Assess capacity more carefully

Distinguish 2 related terms

Competence

Legal determination (by a court)

Global (all decisions)

Capacity

Clinical determination

Decision specific (**not** global)

Capacity

relevant in healthcare

Not all or nothing

Patient might have capacity to make **some** decisions but not others

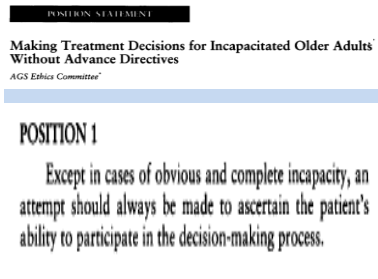
Patient may lack capacity for complex decisions

But **have** capacity to appoint a surrogate

Decision specific

May **fluctuate** over time

Patient might have capacity to make decisions in **morning** but not afternoon



POSITION STATEMENT

Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

AGS Ethics Committee

POSITION 1

Except in cases of obvious and complete incapacity, an attempt should always be made to ascertain the patient's ability to participate in the decision-making process.

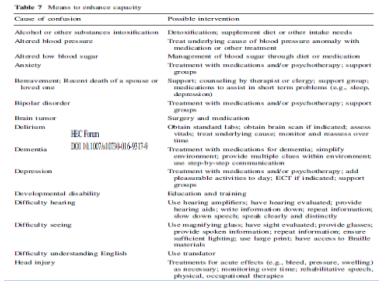


Table 7 Means to enhance capacity

Cause of confusion	Possible intervention
Alcohol or other substances intoxification	Detoxification; supplement diet or other intake needs
Altered blood pressure	Treat underlying cause of blood pressure anomaly with medication or other treatment
Altered low blood sugar	Management of blood sugar through diet or medication
Anxiety	Treatment with medications and/or psychotherapy; support groups
Bereavement; Recent death of a spouse or loved one	Support; counseling by therapist or clergy; support group; medications to assist in short term problems (e.g., sleep, depression)
Bipolar disorder	Treatment with medications and/or psychotherapy; support groups
Brain tumor	Surgery and medication
Delirium	Obtain standard labs; obtain brain scan if indicated; assess vitals; treat underlying cause; monitor and reassess over time
Dementia	Treatment with medications for dementia; simplify environment; provide multiple clues within environment; use step-by-step communication
Depression	Treatment with medications and/or psychotherapy; add pleasurable activities to day; ECT if indicated; support groups
Developmental disability	Education and training
Difficulty hearing	Use hearing amplifiers; have hearing evaluated; provide hearing aids; write information down; repeat information; slow down speech; speak clearly and distinctly
Difficulty seeing	Use magnifying glass; have sight evaluated; provide glasses; provide spoken information; repeat information; ensure sufficient lighting; use large print; have access to Braille materials
Difficulty understanding English	Use translator
Head injury	Treatments for acute effects (e.g., bleed, pressure, swelling) as necessary; monitoring over time; rehabilitative speech, physical, occupational therapies

HEC Forum
DOI 10.1007/s10730-016-9317-0

2 More Advance care planning

Before lose capacity:

Record preferences and/or Name agent

Volunteers of America®
MINNESOTA

CMS

99497

99498

3 Diligent search for surrogates

Surrogates usually found for most **thought** to be unbefriended

NHs, neighbors, service agencies

Access home, apartment

Personal effects

Health records, pension plans

Even if no surrogate found, search may reveal evidence of patient's values, preferences

The standard of decision-making regarding treatment should consider any present indications of benefits and burdens that the patient can convey and should be based on any knowledge of the patient's prior articulations, cultural beliefs if they are known, or an assessment of how a reasonable person within the patient's community would weigh the available options.

4 Better default surrogate laws

Clinical solutions

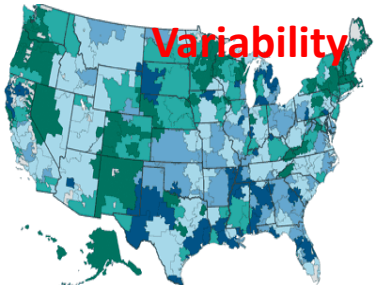
Better capacity assessment

Diligent search for surrogates

More advance care planning

Legal solutions

Law as causal factor



Some states will have **fewer** unrepresented patients

Some states will have **zero** unrepresented patients

Why?

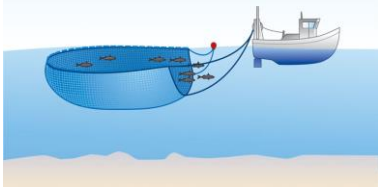
Default surrogate laws

Longer

More flexible

Longer list

Bigger net → catch more fish



More relatives

Spouse
Adult child
Parent
Adult sibling
Grandparent / adult grandchild
Aunt /uncle, niece / nephew
Adult cousin

ND list is **longer** than most

9 categories deep

23-12-13. Persons authorized to provide informed consent to health care for incapacitated persons - Priority.

1. Informed consent for health care for a minor patient or a patient who is determined by a physician to be an incapacitated person, as defined in subsection 2 of section 30.1-26-01, and unable to consent may be obtained from a person authorized to consent on behalf of the patient. Persons in the following classes and in the following order of priority may provide informed consent to health care on behalf of the patient:
   a. The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions, unless a court of competent jurisdiction specifically authorizes a guardian to make medical decisions for the incapacitated person;
   b. The appointed guardian or custodian of the patient, if any;
   c. The patient's spouse who has maintained significant contacts with the incapacitated person;
   d. Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person;
   e. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person;
   f. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person;
   g. Grandparents of the patient who have maintained significant contacts with the incapacitated person;
   h. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person; or
   i. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

Close friend

POSITION STATEMENT

Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

AGS Ethics Committee

POSITION 2

It should not be assumed that the absence of traditional surrogates (next-of-kin) means the patient lacks an appropriate surrogate decision-maker. A nontraditional surrogate, such as a close friend, a live-in companion who is not married to the patient, a neighbor, a close member of the clergy, or others who know the patient well, may, in individual cases, be the appropriate surrogate. Health professionals should make a conscientious effort to identify such individuals.

JAMA April 7, 2015 Volume 313, Number 13 1369

Spouse	102 042	92.9
Adult child	53 212	48.5
Parent	22 495	20.5
Sibling	14 031	12.8
Outside the nuclear family	12 304	11.2
Nonnuclear relative	7761	7.1
Niece or nephew	3190	2.9
Cousin	1134	1.0
Aunt or uncle	523	<1
In-law	490	<1
Step-parent or step-sibling	358	<1
Grandparent	291	<1
Grandchild	170	<1
Other blood or legal relative	166	<1
Other relationship	58	<1
Friend	4571	4.2
Relationship outside marriage	1854	1.7
Ex-spouse	1329	1.2
Other	539	<1
	849	<1

More flexible

Tennessee

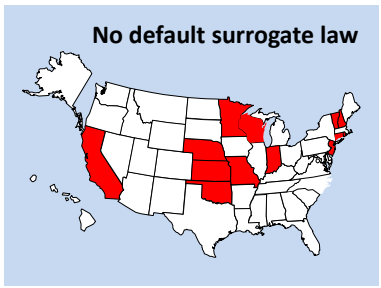
"surrogate **shall be identified** by the supervising health care provider"

"**criteria** . . . in the determination of the person **best qualified** to serve as the surrogate"

- Ability to make decisions
- Regular contact with patient
- Demonstrated care and concern
- Availability to visit the patient
- Availability to engage in face-to-face contact with providers

Limited

No default surrogate statute



Custom & practice

CASE TYPE INDICATOR: CIVIL - OTHER

STATE OF MINNESOTA
COUNTY OF RAMSEY

DISTRICT COURT
SECOND JUDICIAL DISTRICT
PROBATE DIVISION
FILE NUMBER: C7-94-1717

RE: James D. Butcher and Patricia A. Butcher, individually and as parents and natural guardians of James D. Butcher, II,
Plaintiffs,
vs.
Thomas Fashingbauer, in his official capacity as Director, Ramsey County Community Human Services Department, and Ramsey County Community Human Services Department,
Defendants.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Minnesota Medical Association

MMA Policies

2015

(reflects policies adopted through April 30, 2015)

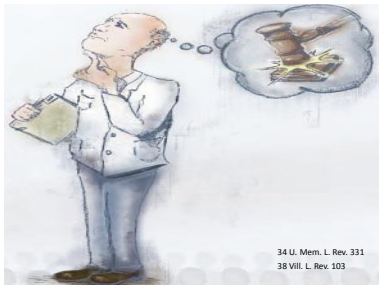
240.22 Decisions to Forego Life-Sustaining Treatment for Patients Lacking Decision-Making Capacity

The MMA endorses the AMA Council on Ethical and Judicial Affairs recommendations adopted at the 1991 AMA Annual Meeting as follows:

2. Without an advance directive that designates a proxy, the patient's family should become the surrogate decision-maker. Family includes persons with whom the patient is closely associated. In the case when there is no one closely associated with the patient, but there are persons who both care about the patient and have some relevant knowledge of the patient, such relations should be involved in the decision-making process, and may be appropriate surrogates.

De facto flexibility

BUT



NJ IN

NY NJ

Unit 5 of 5

Decision making mechanisms

Tried to **prevent** from being unbefriended

Failed

How to make healthcare decisions

Solo physician

Second physician

Ethics committee

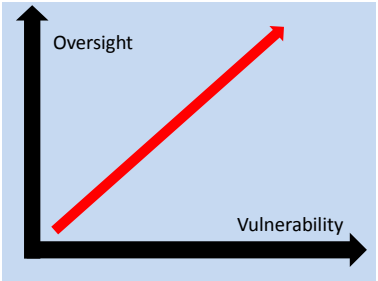
External consent

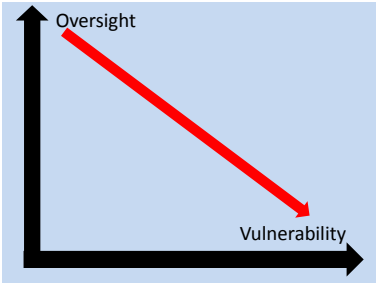
1

Solo physician

Most common approach

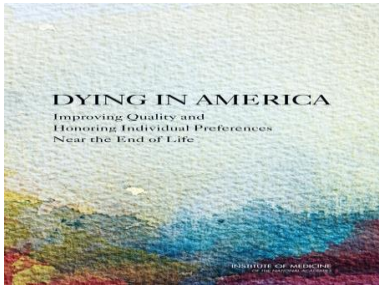
Odd





Scrutiny

Vetting



"Having a single health professional make unilateral decisions . . . is **ethically unsatisfactory** in terms of protecting patient autonomy and establishing transparency."

Bias

COI

Careless

Prohibited in ND and some states

23-06.5-04. Restrictions on who can act as agent.

A person may not exercise the authority of agent while serving in one of the following capacities:

1. The principal's health care provider;
2. A nonrelative of the principal who is an employee of the principal's health care provider;
3. The principal's long-term care services provider; or
4. A nonrelative of the principal who is an employee of the principal's long-term care services provider.

30.1-28-11. (5-311) Who may be guardian - Priorities.

1. Any competent person or a designated person from a suitable institution, agency, or nonprofit group home may be appointed guardian of an incapacitated person. No institution, agency, or nonprofit group home providing care and custody of the incapacitated person may be appointed guardian. However, if no one else can be

2

Second physician consent

3

External consent

"clinical social worker . . . selected by the provider's bioethics committee and must not be employed by the provider"

CANHR
CALIFORNIA ADVOCATES FOR NURSING HOME REFORM

S.B. 503

"independent" medical consultant
+
"independent" patient advocate

CANHR not sat b/c "paid" by NH

4

Multidisciplinary committee

POSITION STATEMENT

Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

AGS Ethics Committee

POSITION 3

After a conscientious effort has failed to identify an appropriate surrogate, a group of individuals who care for the patient may determine appropriate treatment goals and design a humane care plan to meet those goals. This group might consist of a multidisciplinary healthcare team, including physician, nurse, nurse's aide, clergy, and others who have worked most closely with the patient. If an institutional

Physician not attending with consensus ethics committee

BUT

Constitutional due process

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT
DIVISION FOUR

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, et al.
Plaintiffs and Appellants,
vs.
KAREN SMITH, MD., MPH, as Director of the California Department of Public Health,
Defendants and Appellants.

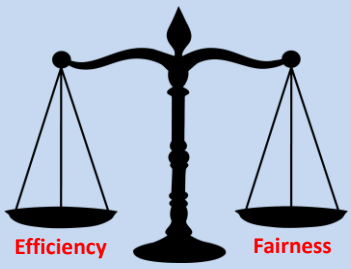
Case No. A147987
Alameda County Superior Court, Case No. RG13700100

ON APPEAL FROM THE JUDGMENT OF THE SUPERIOR COURT
COUNTY OF ALAMEDA
Hon. Evelio M. Grillo, Presiding

California **IDT**

1. Physician
2. Registered professional nurse with responsibility for the resident
3. Other staff in disciplines as determined by resident's needs
4. Where practicable, a patient representative

Conclusion



Fair

Expertise, neutrality, careful deliberation

Too fair → too slow

Accessible, quick, convenient, cost-effective

Sacrifice **some** fairness for efficiency

References

TM Pope, "Unbefriended and Unrepresented: Better Medical Decision Making for Incapacitated Patients without Healthcare Surrogates," *Georgia State University Law Review* 2017 (forthcoming).

TM Pope, "Legal Briefing: Adult Orphans and the Unbefriended: Making Medical Decisions for Unrepresented Patients without Surrogates," *Journal of Clinical Ethics* 2015; 26(2): 180-88.

TM Pope, "Making Medical Decisions for Patients without Surrogates" *New England Journal of Medicine* 2013; 369(21): 1976-78.

TM Pope & T Sellers, "Legal Briefing: the Unbefriended - Making Healthcare Decisions for Patients without Proxies – Part 1" *Journal of Clinical Ethics* 2012; 23(1): 84-96.

TM Pope & T Sellers, "Legal Briefing: the Unbefriended - Making Healthcare Decisions for Patients without Proxies – Part 2" *Journal of Clinical Ethics* 2012; 23(2): 177-92.

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