Minnesota Surrogate Decision Making

MN Fall Aging Conference (Oct. 26, 2017)

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

Thank you

Legal

Medical ethics
Health policy

Roadmap

Decision making capacity

Making decisions when patient **lacks** capacity

3 **preferred** mechanisms

3 other mechanisms

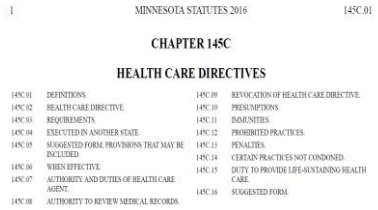
Capacity

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

Patient has capacity to make decision at hand

↓

Patient decides **herself**



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.		

3

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

Able to **make** a decision

Able to **communicate** a decision

That's the **definition**

How to implement

When/How to Assess

All patients **presumed** to have capacity

Clinicians must **rebut** the presumption

No need to **prove** capacity

Must prove **in**capacity

Sometimes obvious

Often unclear

Assess capacity **carefully**

Not all or nothing

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

Patient may lack capacity for **complex** decisions

Still have capacity for **simpler** decisions

Examples

Still have capacity to **appoint** surrogate

May **fluctuate** over time

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

AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults.

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.

Restore capacity if possible

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., blood, pressure, swelling) as necessary; monitoring over time; rehabilitative speech, physical, occupational therapies

HEC Forum
DOI 10.1007/s10730-016-9317-9

Patients often **lack** capacity

3

Not **yet** acquired (minors)

Never had (mental disability)

Had but **lost** (dementia…)

Most common

Adults who **once had** but later **lost** capacity

Can no longer make **own** decisions

Mechanisms

3 preferred

Advance directive
POLST
Agent / DPAHC

3 other

Default surrogate
Guardianship
Ad hoc

Promise
Pitfalls

Advance directive

2 parts
to AD

Instruct
Appoint

Instruct

FKA
"living will"

Record what you want & do not want

Advantage

Hear from patient **herself**

Best DM for you is **you**

Obstacle 1

Not completed

AARP 28%

PewResearchCenter

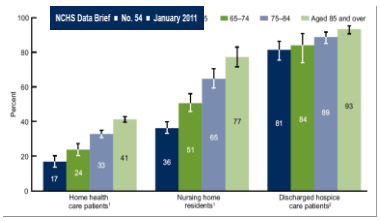
NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

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%



CMS

99497

99498

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

Fail to make & distribute copies

- Primary agent
- Alternate agents
- Family members
- PCP
- Attorney
- Clergy
- Online registry

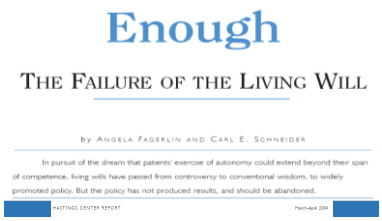
Complete ≠ Have

Obstacle 3

Even if completed & available

Not clear

if ___,
then ___

If	"Reasonable expectation of recovery"	75% 51% 25% 10% ?
Then	"No ventilator"	Ever Even if temporary
Vague Ambiguous	**Limits**	

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

Hear from the patient **herself**

BUT

Advance directives not self-executing

Need a SDM

~~Instruct~~
Appoint

"Agent"
"DPAHC"

1st choice – patient picks **herself**

BUT

Usually in an advance directive

Not completed
Not found

Still need a SDM

Overcome some AD limitations by **supplementing** AD

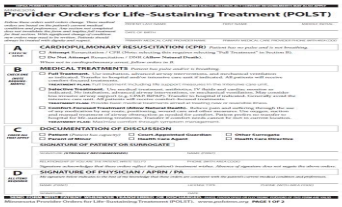
POLST

Provider
Orders
Life
Sustaining
Treatment

What is POLST

1 page form

front & back


Provider Orders for Life-Sustaining Treatment (POLST)

A CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing*

CHECK ONE

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

☐ **Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.


B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE (MUST ASSURE-MENT)

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.

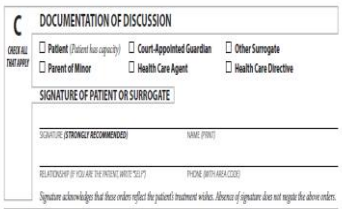
TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

☐ **Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

TREATMENT PLAN: Maximize comfort through symptom management.


C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

☐ **Patient** (*Patient has capacity*) ☐ **Court-Appointed Guardian** ☐ **Other Surrogate**

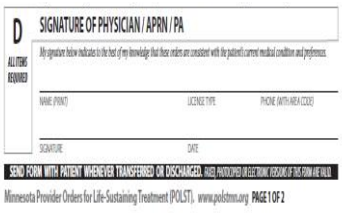
☐ **Parent of Minor** ☐ **Health Care Agent** ☐ **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE (**STRONGLY RECOMMENDED**) NAME (PRINT)

RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF") PHONE (WITH AREA CODE)

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.


D SIGNATURE OF PHYSICIAN / APRN / PA

ALL ITEMS REQUIRED

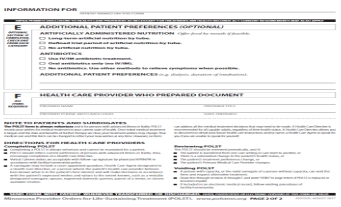
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME (PRINT) LICENSE TYPE PHONE (WITH AREA CODE)

SIGNATURE DATE

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. COPIES PROVIDED IN ELECTRONIC RECORD OF THIS FORM ARE VALID.

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). www.polstmn.org **PAGE 1 OF 2**


INFORMATION FOR

E ADDITIONAL PATIENT PREFERENCES *(OPTIONAL)*

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

☐ Long-term artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ No artificial nutrition by tube.

ANTIBIOTICS

☐ Use IV/IM antibiotic treatment.

☐ Oral antibiotics only (no IV/IM).

☐ No antibiotics. Use other methods to relieve symptoms when possible.

ADDITIONAL PATIENT PREFERENCES *(e.g. dialysis, duration of intubation).*

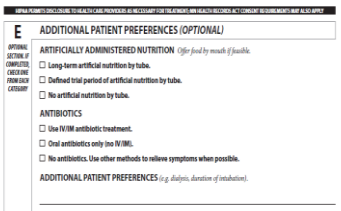
F HEALTH CARE PROVIDER WHO PREPARED DOCUMENT

NOTE TO PATIENTS AND SURROGATES

DIRECTIONS FOR HEALTH CARE PROVIDERS

Revoking POLST

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). www.polstmn.org **PAGE 2 OF 2**


HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT. MN HEALTH RECORDS ACT CONSENT REQUIREMENTS MAY ALSO APPLY

E ADDITIONAL PATIENT PREFERENCES *(OPTIONAL)*

OPTIONAL SECTION. IF COMPLETED, CHECK ONE FROM EACH CATEGORY

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

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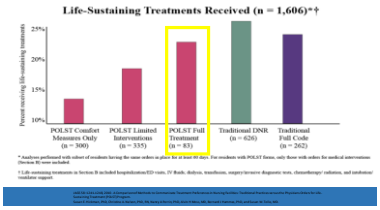
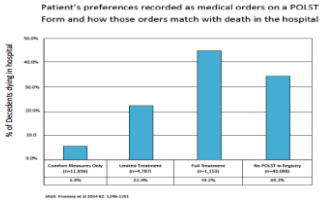
ADDITIONAL PATIENT PREFERENCES *(e.g. dialysis, duration of intubation).*

Order

for LST

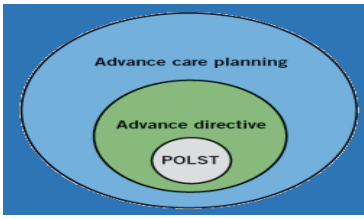




For whom

POLST **supplements** AD

Does **not** replace



POLST **primarily** for those expected to die in next year

Also: others who want to define care

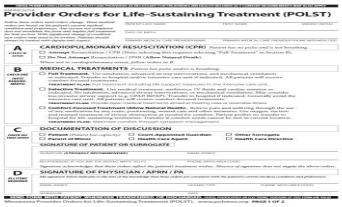
Terminal illness

Advanced chronic progressive illness

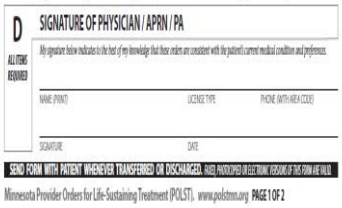
Frailty

POLST benefits

Single page


Provider Orders for Life-Sustaining Treatment (POLST)

More informed


D ALL ITEMS REQUIRED

SIGNATURE OF PHYSICIAN / APRN / PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME (PRINT) LICENSE TYPE PHONE (WITH AREA CODE)

SIGNATURE DATE

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. NEW ORDERS IF NEEDED MUST BE DOCUMENTED ON A NEW POLST FORM

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). www.polstmn.org PAGE 1 OF 2

Immediately actionable


EAST METRO

Maplewood fire chief, 5 others placed on leave after death at nursing home

By DAVID PETERSON , STAR TRIBUNE
August 18, 2015 - 11:51 PM

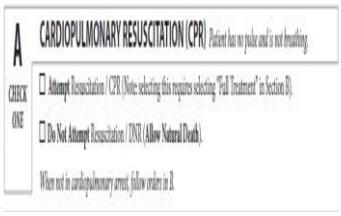
EMS **will** follow POLST but **not** AD

Provider **Orders** Life Sustaining Treatment

No need to "**interpret**" advance directive

No need to "**translate**" into orders

Easy to follow



Better honored

Can follow

Will follow

Portable

Home

LTC

Hospital

EMS

Updatable

POLST does **not** expire

POLST can be revised or revoked anytime

Review with change in condition or location

Can be completed by **surrogate**, if patient lacks capacity

70% patient

30% surrogate

Recap

Patient cannot speak for herself

No AD

No agent

No POLST

Default surrogate

2nd choice – after agent

Not chosen by patient

Chosen off **a list**

"Surrogate"

"Proxy"

Almost all states specify a **sequence**

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

More relatives

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

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

JAMA April 7, 2015 Volume 313, Number 13 1369

No authoritative list in Minnesota

BUT

Custom & practice

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:

"**Without** an advance directive that designates a proxy . . ."

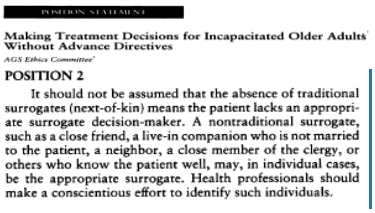
"**patient's family** should become the surrogate . . ."

"**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."



POSITION STATEMENT

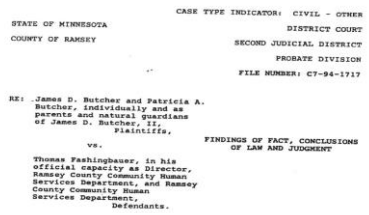
Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

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.

Judicially endorsed



CASE TYPE INDICATOR: CIVIL - OTHER

STATE OF MINNESOTA — DISTRICT COURT

COUNTY OF RAMSEY — 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.

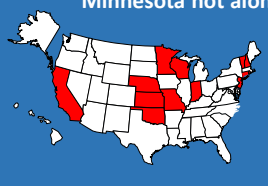
FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

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,

[redacted] is consistent with the standard of medical and ethical practice in the State of Minnesota.

No default surrogate statute

Minnesota not alone



De facto flexibility

BUT

Some providers **refuse** to recognize family

NJ IN

NY NJ

Still need a SDM

Guardian

3rd choice – After agent & surrogate

Ask **court** to appoint SDM

Last resort

Not sufficiently responsive

3 SDM types

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

How does SDM decide?

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

Minn. Stat. 145C.07(3)

Health care agent must "act in the **best interests** . . . considering . . . the principal's **personal values** to the extent known"

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

~ 60% accuracy

More aggressive treatment

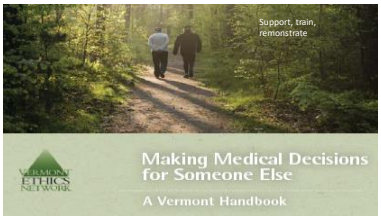
Code of Medical Ethics

of the American Medical Association

"surrogate's decision . . .

almost always accepted"

AMA



State of Minnesota
District Court—Probate Court Division
County of Hennepin
Fourth Judicial District

In Re: The Conservatorship of Helga M. Wanglie

File No. PX-91-283

Findings of Fact: Conclusions of Law And Order

Advanced dementia

End stage kidney disease

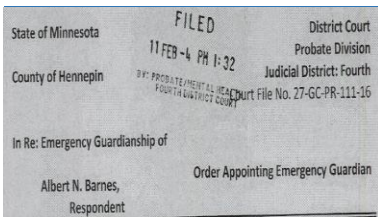
Chronic respiratory failure

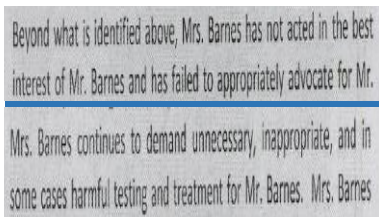
Abel Tello

aggressive treatment is **unethical & painful**

CMO

BUT


State of Minnesota
County of Hennepin
FILED
11 FEB -4 PM 1:32
BY: PROBATE/MENTAL HEALTH
FOURTH DISTRICT COURT
District Court
Probate Division
Judicial District: Fourth
Court File No. 27-GC-PR-111-16
In Re: Emergency Guardianship of
Albert N. Barnes,
Respondent
Order Appointing Emergency Guardian


Beyond what is identified above, Mrs. Barnes has not acted in the best interest of Mr. Barnes and has failed to appropriately advocate for Mr. Mrs. Barnes continues to demand unnecessary, inappropriate, and in some cases harmful testing and treatment for Mr. Barnes. Mrs. Barnes

Clinicians should **not** follow "bad" surrogates

Recap

We looked at **5** SDM mechanisms

Advance directive
POLST
Agent / DPAHC

Default surrogate
Guardianship

Unrepresented

POSITION STATEMENT

Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

AGS Ethics Committee

"highly vulnerable"
"most vulnerable"

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"

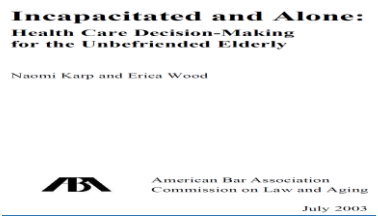
"adult orphan"

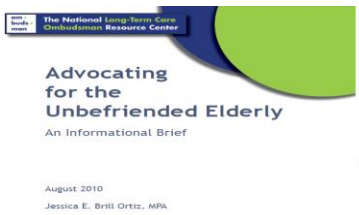
Patient w/o proxy

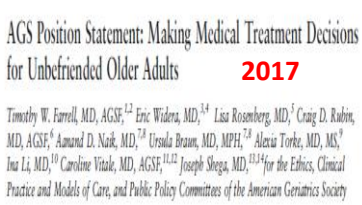
Incapacitated & alone

Most prevalent

"unbefriended"







AGS Position Statement: Making Medical Treatment Decisions for Unbefriended Older Adults **2017**

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

Who 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

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

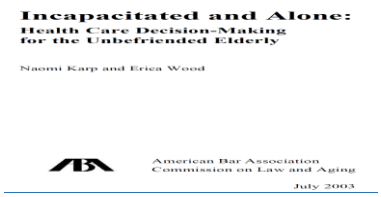
National report for England 2016

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

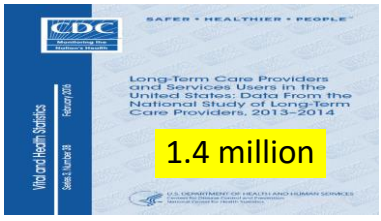

Incapacitated and Alone:
Health Care Decision-Making for the Unbefriended Elderly

Naomi Karp and Erica Wood

American Bar Association
Commission on Law and Aging
July 2003

3 - 4%

U.S. nursing home population



> 56,000

Extrapolate
5.5 / 320
1.7%

1400

Not far off

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).

THE COMMISSION ON END OF LIFE CARE

Final Report

January 2002

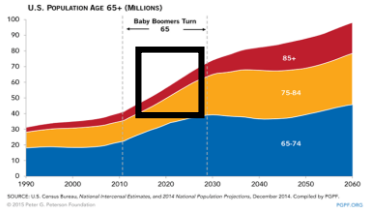
The Commission on End of Life Care was staffed by the Minnesota Partnership to Improve End of Life Care and the Minnesota Department of Health.

Not just big, but

Growing problem

Just **4** causal factors

1



2

AARP Public Policy Institute

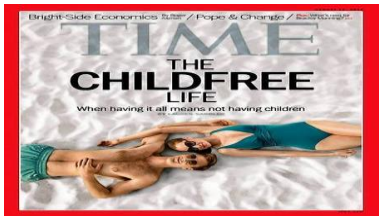
INSIGHT

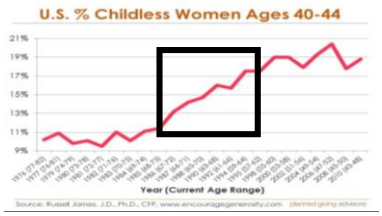
10,000,000 Boomers live **alone**

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

3





4

Others "have" family members

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

Family member also lacks **capacity**

Able but **unwilling**

Risks & Harms

Cannot advocate for self

Have **no** substitute advocate


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 . . . consideration of patient preferences or best interests"

3

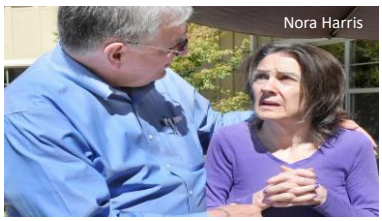
No discharge to appropriate setting

Challenges

Default surrogate law for MN

Mechanism for unbefriended

SDM help avoid advanced dementia



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