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I. PURPOSE

This policy provides procedural mechanisms whereby health care decisions can be made for Stanford Hospitals and Clinics (SHC) patients who do not have available surrogates, and who lack health care decision-making capacity.

This policy was developed since no clear-cut legal guidelines exist that cover treatment circumstances for this vulnerable group of patients. This policy provides guidance to clinicians on making decisions for this group of patients to avoid inconsistent management and potential delay in the provision of medical treatment. Finally, this policy and its procedural protections were considered especially important for the irreversible decisions to forgo life-sustaining treatment for unrepresented patients.

This policy is procedural in nature and applies to all medical decisions for which informed consent is usually required.

This policy is meant to supplement the institution's underlying Informed Consent and Health Care Decisions When Adult Patients Lack Capacity policies.

II. POLICY

Despite their incapacity, unrepresented patients are entitled to have appropriate medical decisions made on their behalf and to have these decisions made in their best interest, respecting their wishes and values as much as they can be known.

The procedures set forth here are intended to meet these goals.

III. PROCEDURES

A. Goals to be achieved

1. To make and effect health care decisions in accordance with a patient's best interest, taking into consideration the patient's personal values and wishes to the extent that these are known.

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2. To establish uniform procedures to implement appropriate health care decisions for unrepresented patients. Appropriate health care decisions include both the provision of needed and wanted medical treatment, and the avoidance of non-beneficial or excessively burdensome treatment. Appropriate health care decisions are also those that are based on sound medical advice and made without the influence of material conflicts of interest.

B. Circumstances where policy is not applicable or is applied only with additional considerations

1. This policy does not apply in emergency medical situations.
2. This policy does not apply in situations where, using sound medical judgment, a physician makes a bedside decision to cease attempts at cardio-pulmonary resuscitation of a patient.
3. If the Public Guardian is appointed, the Public Guardian must be involved in medical decision-making under this policy. Medical circumstances will dictate when medical providers can delay decision-making in order to include the Public Guardian.
4. Hospital legal counsel should be consulted if a decision to withdraw treatment is likely to result in the death of the patient and if any of the following circumstances apply:
 - a. The patient's condition is the result of an injury that appears to have been inflicted by a criminal act.
 - b. The patient's condition was created or aggravated by a medical accident.
 - c. The patient is pregnant.
 - d. The patient is a parent with sole custody or responsibility for support of a minor child.

C. Application

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The patient's age, sex, religion, ethnic or social status, the ability to pay for healthcare services, or avoidance of burden to family or to society shall not be used to bias considerations about the appropriateness of any health care decision under this policy.

D. In order to qualify for treatment under this policy, the patient must meet the following criteria:

1. Incapacity. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) to lack capacity to make health care decisions. The primary care physician should, if possible, communicate that determination to the patient. Capacity means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision.
2. Unrepresented. No agent, surrogate, conservator, or guardian has been designated or appointed to act on behalf of the patient.
3. No dispositive individual health care instruction is known to exist.
4. No surrogate decision-maker can be selected or a surrogate is not reasonably available. For the purpose of this policy, a surrogate must be an adult, and can be a family member. Also, an individual with a close personal relationship to the patient can serve as a surrogate. Any surrogate needs to have shown care and concern for the patient's welfare and must have some familiarity with the patient's activities, health, religious beliefs and values. There must be medical record documentation (such as by a social service worker) that this surrogate has been interviewed and satisfies the above criteria to serve as a surrogate decision-maker.

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Efforts to establish whether or not a surrogate is reasonably available should be diligent and at a minimum should include examining the personal effects, if any, accompanying the patient, as well as reviewing the patient's medical records and any verbal or written reports made by emergency medical technicians or the police. Efforts can also include contacting the facility from which the patient was referred and contacting public health or social service agencies known to have provided treatment for the patient.

For further guidance on surrogate selection, see Section III (A)(3) of the Health Care Decisions for Adult Patients Who Lack Capacity policy.

E. Referral to Ethics Committee

If no surrogate can be located, medical decisions on behalf of incapacitated patients will be made using the following procedures:

1. Medical decisions for courses of treatment where informed consent is required
 - a. An Ethics Committee consultation is strongly encouraged in those situations where the normal process is to obtain informed consent such as surgery and complex or invasive treatment or procedures.
 - b. If the patient objects to the proposed treatment decision or the patient cannot voice preference where normally informed consent is required, the following procedures will be followed:
 - (1) The medical team will obtain a second opinion about the proposed decision from an independent physician with relevant medical qualifications.

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- (2) The Chair of the Ethics Committee will appoint a member of the Ethics Committee to review the proposed decision to ensure that the decision was made in conformity with this policy and, if so, to provide assent to the decision. If in the opinion of the Chair, the proposed treatment is invasive in nature and involves significant risk or will have a significant adverse impact upon the patient's physical independence or lifestyle, the review will be conducted by two members of the Ethics Committee, one of whom will be a non-medical member.
 - (3) The member(s) of the Ethics Committee conducting the review will follow the procedures described at Sections (III)(E)(2)(d) and (e) below, to the extent appropriate to the circumstances.
 - (4) If at the conclusion of the process, the member(s) of the Ethics Committee support(s) the proposed decision, the decision may be implemented. However, if the patient continues to object to the decision, Risk Management should be consulted prior to implementation of treatment to determine whether judicial intervention is required.
2. Medical decisions about withholding or withdrawing life-sustaining treatment
 - a. The medical team will obtain a second opinion about the proposed decision from an independent physician with relevant medical qualifications.
 - b. The Ethics consultant on call will appoint a sub-committee to review the proposed decision to ensure that the decision was made in conformity with this policy and, if so, to provide assent to the decision.

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- c. **Composition of Sub-Committee:** The sub-committee will consist of a multidisciplinary group, including medical personnel capable of independently appreciating the medical consequences of the proposed healthcare decision. At least one non-medical member of the Ethics Committee will be named to the sub-committee. In addition, every effort will be made to include a community member of the Ethics Committee. All members will be asked whether they have any material conflict of interest, real or apparent, in the matter and, if so, will be excused from the sub-committee.
- d. **Conduct and Standards of Review by Sub-Committee:** The sub-committee will advocate on behalf of the patient. The sub-committee will interview the patient, if practicable, to determine the patient's values and preferences, as well as the relevant medical treatment providers and anyone else closely involved with the patient. The sub-committee will inquire about the process to determine the decision-making capacity of the patient, the attempts made to learn about the patient's medical preferences and to locate a surrogate decision-maker, the medical basis for the conclusion that medical treatment should be withheld or withdrawn, and about the other available medical options and their likely outcomes. The sub-committee will consider the patient's cultural, ethnic or religious perspectives, if known. If possible, someone of the patient's cultural, ethnic or religious background should be consulted to determine if it is likely that these factors would influence what treatment the patient would prefer. The sub-committee will also inquire about the likelihood of restoring the patient to an acceptable quality of life. The patient's quality of life will be considered from the perspective of the patient and not from that imposed by any sub-committee member.

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The sub-committee will weigh and balance all of the above considerations, keeping in mind that the best interest of the patient do not require that life support be continued in all circumstances, such as when the patient is terminally ill and suffering, where there is no hope of recovery of cognitive functions, or where treatment is otherwise non-beneficial.

- e. **Decision-making by Sub-Committee:** The sub-committee will assure itself that there were adequate safeguards to confirm the accuracy of the diagnosis and that the proposed medical decision was made in good faith, was based on sound medical advice, and is in the patient's best interest according to this policy. The sub-committee can ask for further medical opinions to verify the primary conclusions. The sub-committee can also ask that further investigations be made about the availability of surrogates, the patient's treatment preferences, or other relevant matters. After this investigation is completed, the sub-committee will then make an independent finding about the proposed decision.

- f. **Subsequent Action:** If the sub-committee is in general agreement about the proposed decision, the decision should be communicated to the Chief of Staff and, if there is any indication that the patient could understand, to the patient. Prior to implementation of a medical decision to withhold or withdraw life-sustaining treatment, the Chief of Staff must approve the decision. In the event that the patient objects to the decision, the decision cannot be implemented prior to obtaining a judicial determination of the patient's incapacity and an order authorizing implementation of the decision. If the sub-committee cannot reach a general agreement or if it disapproves of the proposed medical decision, the Chief of Staff or his/her designee will be included in the decision-making process to assist in resolving any disagreements.

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Irresolvable conflicts among sub-committee members should be referred to Risk Management for possible legal resolution with the understanding that a legal remedy should only be sought in extreme circumstances.

Any implementation of a decision to withhold or withdraw life-sustaining medical treatment will be the responsibility of the primary treating physician.

3. **Other types of medical decisions**

Decisions about medical treatments which do not ordinarily require informed consent can be made based on best clinical judgment, so long as it is in the patient's best interest and no prior objection has been expressed.

4. **Record Keeping**

Signed, dated, and timed medical record progress notes will be written for the following:

- a. The findings used to conclude that the patient lacks medical decision making capacity.
- b. The finding that there is no durable power of attorney for healthcare, no conservator or guardian, no patient-designated surrogate, and no medical instructions.
- c. The attempts made to locate surrogate decision-makers and the results of those attempts.
- d. Any interviews of individuals with a close personal relationship to the patient willing to serve as surrogate and facts to substantiate their qualifications under this policy.
- e. The medical bases for the decision to withhold or withdraw life-sustaining treatment and the likely outcome if the decision is implemented.

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- f. Any findings and conclusions by the independent physician, the ethics consultant, the appointed ethics sub-committee, or the Chief of Staff.

IV. COMPLIANCE

- A. All workforce members including employees, contracted staff, students, volunteers, credentialed medical staff, and individuals representing or engaging in the practice at SHC/LPCH are responsible for ensuring that individuals comply with this policy;
- B. Violations of this policy will be reported to the Department Manager and any other appropriate Department as determined by the Department Manager or in accordance with hospital policy. Violations will be investigated to determine the nature, extent, and potential risk to the hospital. Workforce members who violate this policy will be subject to the appropriate disciplinary action up to and including termination.

V. RELATED DOCUMENTS

- A. Informed Consent Policy
- B. Health Care Decisions for Adult Patients Who Lacks Capacity Policy

VI. DOCUMENT INFORMATION

- A. Legal Authority/References
 - 1. Veterans Health Administration, Department of Veterans Affairs, Informed Consent, VHA Directive 1004, February 21, 1996, pages 5-7, citing as authority 38 CFR 17.32 and 62 FR 53961.
 - 2. Kirschner, M. and Michel, V., The Guideline Addendum, April 2, 1990. LACMA Physician Guidelines for Foregoing Life-Sustaining Treatment for Adult Patients. Supplement: Patient's Without Decision-Making Capacity Who Lack Surrogates, LACMA Physician, July 12, 1993.
 - 3. 22 CCR 70707
 - 4. Joint Commission, Hospital Accreditation Manual, 2009
 - 5. California Probate Code § 3200 et seq
 - 6. Health Care Decisions Law (California Probate Code § 4600), specifically, Part 2, Uniform Health Care Decisions Act (California Probate Code §§ 4670, 4735)
- B. Author/Original Date

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May 2002, M.L. Eaton, PharmD, JD, Stanford University Center for Biomedical Ethics

- C. Gatekeeper of Original Document
Administrative Manual Coordinators and Editors
- D. Distribution and Training Requirements
 - 1. This policy resides in the Administrative Manual of Stanford Hospital and Clinics.
 - 2. New documents or any revised documents will be distributed to Administrative Manual holders. The department/unit/clinic manager will be responsible for communicating this information to the applicable staff.
- E. Review and Renewal Requirements
This policy will be reviewed and/or revised every three years or as required by change of law or practice.
- F. Review and Revision History
This is a new policy, July 2003.
August 2006, Sheetal Shah, Esq., Director, Risk Management
April 2009, Sheetal Shah, Director Risk Management
- G. Approvals
October 2002, Ethics Committee
July 2003, SHC Medical Board
July 2003, SHC Board of Directors
August 2006, Ethics Committee
September 2006, Quality Improvement & Patient Safety Committee
October 2006, SHC Medical Board
October 2006, SHC Hospital Board
April 2009, SHC Ethics Committee
May 2009 Quality Improvement & Patient Safety Committee
June 2009, SHC Medical Executive Committee
July 2009, Board Credentials, Policies & Procedures Committee