SURROGATE DECISION MAKERS

New Health Care Proxy as of January 2020

JANUARY 29, 2020

TAMMY EVANS RN, MSN, CPHRM

Ethics Consultation Request

Dr. Pierce, one of the physicians in the medical intensive care unit, requests an ethics consultation to address discordance between the healthcare professionals and a lack of status for an "end of life care patient". The patient is Charles Emerson Winchester III.

The Case

Dr. Pierce tells the ethics consultant the Mr. Winchester is a 63-year-old man with multiple comorbidities, including acutely decompensated congestive heart failure, type 2 diabetes, and end stage renal disease requiring hemodialysis. He was brought to the hospital via ambulance after sustaining a ground level fall while exiting a Greyhound bus traveling from Sacramento. His past medical history and identification were taken off his persons on arrival to the Emergency Department. Upon examination, Mr. Winchester was noted to have a subdural hematoma; Neuro Surgery was consulted.

Dr. Hunnicutt, the Neuro Surgeon, recommends surgical intervention to remove the tension caused by the hematoma. Mr. Winchester undergoes surgery.

Mr. Winchester came out of surgery in critical condition that was further complicated by a GI bleed requiring 4 units of PRBC and acute MI. The Cardiologist, Dr. Blake, performed an echocardiogram that revealed a 10% ejection fraction. Despite the healthcare team's best efforts Mr. Winchester continues to decline and Dr. Pierce, along with the care team, feel the care provided is futile and would like to make the patient "Comfort Care". Currently Mr. Winchester has a feeding tube and mechanically ventilated via ET tube.

Regarding social considerations, Dr. Pierce tells the ethics consultant that social work and case management have been unsuccessful finding next of kin for Mr. Winchester. Margaret Houlihan, Case Manager, contacted Sacramento agencies and discovered Mr. Winchester lived alone in a weekly rental motel and was recently evicted. Max Klinger, the motel manager, is unaware of any family or friends. Mr. Winchester's personal belongings were destroyed after eviction.

Medical Indications

The principles of Beneficence and Non-Maleficence

1. What is the patient's medical problem? History/Diagnosis? Prognosis?
2. Is the problem acute? Chronic? Critical? Reversible? Emergent? Terminal?
3. What are the goals of treatment?
4. What are the probabilities of success of various treatment options?
5. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided

Patient Preferences

The principle of Respect for Autonomy

1. If incapacitated, has the patient expressed prior preferences?

2. Who is the appropriate surrogate to make decisions for the incapacitated patient? What standards should govern the surrogate's decisions
3. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?

Quality of Life

The principles of Beneficence and Non-Maleficence and Respect for Autonomy

1. What are the prospects, with or without treatment, for a return to normal life, and what physical, mental, and social deficits might the patient experience even if the treatment succeeds?
2. On what grounds can anyone judge that some quality of life would be undesirable for a patient who cannot make or express such a judgment?
3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
4. What ethical issues arise concerning improving or enhancing a patient's quality of life?
5. Do quality of life assessments raise any questions that might contribute to a change of treatment plans, such as forgoing life-sustaining interventions?

Contextual Features

The Principles of Justice and Fairness

1. Are there professional, inter-professional, or business interests that might create conflicts of interest in the clinical treatment of patients?
2. Are there financial/economic factors that create conflicts of interest in clinical decisions?
3. What are the legal issues that might affect clinical decisions?

Ethics Review

After careful consideration of the principles of ethics, the Committee lead by Dr. Sherman T Potter, agreed the with the care team in that Mr. Winchester should be made comfort care.

Historical Process

Artificial Hydration and Nutrition, No Advance Directive & Relative Decision-Maker

> "Where a terminal patient has no advance directive and a "relative-decision maker" is authorized to make life support decisions for the patient under the Act, the relatives may disagree with the attending physician's determination that further care would be futile. In this case, the Act provides that when a patient has no effective advance directive, artificial nutrition and hydration must not be withheld unless a different desire is expressed in writing by his authorized representative or family member". NRS 449.680

In short, regarding the above case, our practice in 2019 was to petition for guardianship with the court as the patient is without representative or family authorized to make withdrawal determination. To date, I am unaware of a guardian who has given consent for withdrawal.

New Process as of Jan 2020 NRS 449A.454

What has changed??? New Health Care Proxy as of January 1, 2020
SB116- "When there are no interested persons available or willing, a physician, physician's assistant or advance practice registered nurse may be designated as proxy decision-maker".

Basic Requirements:

1. The patient lacks decisional capacity
2. There is no guardian, power of attorney for health care, and no one with legal authority to provide consent to or refusal of medical treatment on behalf of the patient; and
3. The is no valid declaration, direction or order concerning the medical treatment in an advanced directive which conflicts with the direction.

Process for Appointment:

If there is no interested person located, or no willing interested person, a willing physician, physician's assistant or advance practice registered nurse may be designated. **The attending provider of health care cannot be designated**.

1. Lack of decision making must be properly documented.
2. Document all efforts to locate any interested person, or that no interested person is willing and able to serve as a proxy decision-maker. This can be done by the attending provider of health care of his or her designee.
3. The attending provider of health care obtains an independent determination of the patient's lack of decisional capacity by another physician or another physician assistant or advanced practice registered nurse who has collaborated about the patient, either in person by telephone or electronically. A court order can also be obtained (though not required).
4. The attending provider or his or her designee has **consulted with and obtained consensus on the proxy decision-maker from the medical ethics committee where the patient is receiving care.** If that facility does not have a medical ethics committee, the medical ethics committee and of another medical facility can be used.
5. The identity of the proxy decision-maker must be documented in the medical record.