Hospital Guidelines for Reviewing Healthcare Treatment Recommendations for Patients Who Lack Decision-making Capacity and Have No Surrogates and No Advance Directives

Purpose: Many acute care facilities have faced the problem of health-care decisions for patients who lack capacity and have no surrogates or advance directives. These guidelines provide a model for these patients, which can be individualized for specific institutions.

These guidelines apply when a physician wishes to provide or to forgo treatment for a patient who lacks decision making capacity and has no surrogate or advance directive. These guidelines are not intended to address situations where explicit informed consent is not required, e.g.: routine clinical care; emergency care (where consent is implied).

I. Preliminary Determinations:

The physician and other members of the healthcare team should make a thorough and good faith effort to establish that:

a. The patient lacks decisional capacity;
b. No advance directive exists; and
c. No family or friends are available to act as the patient’s surrogate.

This effort should be clearly documented in the patient’s medical record.

II. Institutional Process for Decision-making

Once the above determinations have been made, the physician or any other member of the healthcare team contacts the chair of the institution’s ethics committee. The chair will convene a subcommittee of at least three persons to review the physician’s proposed treatment decision. This subcommittee should be multi-disciplinary and include at least one non-healthcare professional and one person not affiliated with the institution (these can be the same person).

A. Disclosure to the Subcommittee Review

The physician should present the same relevant information that would be told to a patient or his/her surrogate in the usual process of obtaining informed consent. This should include:

1. Diagnosis and prognosis and their certainty.
2. Recommended plan of treatment and its purpose.
4. Alternatives including that of no treatment
5. Any information about the patient’s values, wishes, lifestyle, cultural, ethnic or religious background.

1 Each institution should create the entity that works best for it, whether its existing ethics committee or some other group.
6. Conflicts of interest.
7. Views of all involved healthcare professionals (nurses, social workers, other physicians).

B. The Review Process
The process is intended to determine whether the physician’s proposed goals of care and treatment recommendation falls within the ethically acceptable range of alternatives. In this context, the subcommittee acts in an advisory and facilitative capacity, as in other ethics committee consultations.

1. The sub-committee should begin its deliberations by confirming that the medical information presented is accurate. If necessary, the sub-committee can suggest additional medical opinions.

Once all relevant information is gathered, the subcommittee and the healthcare team should first attempt to evaluate the goals of care and treatment recommendation using the “the substituted judgement standard”. This standard looks to what the patient would choose if he/she were able to do so. For a person with no advance directive or surrogate, this approach is not likely to be possible unless someone who knows the patient well can provide adequate information but is unable or unwilling to be the surrogate decisionmaker. Otherwise the evaluation should use “the best interest standard.” The “best interest standard” is guided by what a “reasonable person” might choose (weighing the benefits and burdens of a proposed action).

Questions about quality of life and goals of therapy are appropriate, provided they are looked at from the patient’s perspective. Appropriate goals include relief of suffering and pain, improvement of function, and recovery of cognition. The best interest standard does not require that all medical treatments be used at all times. Terminal illness or prolonged suffering are examples of clinical situations where burdens may outweigh benefits of treatment. There is no ethical requirement to provide non-beneficial treatment.

If the subcommittee determines that the physician’s recommendation is within the ethically acceptable range of alternatives, the physician can implement the treatment decision.

The chair of the subcommittee should document its findings in the patient’s medical record.

2. If the subcommittee cannot reach consensus or if the subcommittee finds that the physician’s recommendation is not within the clinically acceptable standard of care or the ethically acceptable range of
alternatives, then the process shifts to the full ethics committee. It may be appropriate to involve other individuals from the institution such as leaders of the medical staff and/or administration.

If consensus can then be reached, the healthcare decision can be implemented and documented as above. If consensus cannot be reached, then the case may need to be referred for judicial resolution. Judicial review should be regarded as a last resort.

C. Subcommittee Oversight:
   1. All cases where healthcare decisions are referred to an ethics subcommittee should be reviewed by the full ethics committee on a regular basis.