

Decision Making for Unrepresented Patients Who Lack Capacity: Guidelines for Health Care Facilities in Colorado

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On behalf of the Colorado Collaborative for Unrepresented Patients (CCUP), November 4, 2016

I. Preamble

The purpose of this document is to assist facilities in preparing policies and procedures for decision-making on behalf of unrepresented patients, consistent with the 2016 amendments to CRS 15-18.5-103 “Proxy Decision Makers for Medical Treatment.” A summary of the amendment entitled “Concerning medical decisions for unrepresented patients (HB 16-1101)” is included in Appendix 2.

These guidelines have been created to facilitate health care for this vulnerable population that is timely, appropriate and reasonably consistent across health care settings. The guidelines are recommendations based on the combination of stakeholder input, commonly accepted practice, and specific statutory requirements (as noted).

The statute allows latitude for facilities to adopt policies and practices that are practical and effective in their settings. Likewise, the guidelines encourage development of policies and procedures that are well suited to both the intent of the statute and the nature and context of the health care setting. HB 16-1101 does NOT compel any provider, individual or facility, to adopt the practice of appointing a physician proxy.

II. Summary of HB 16-1101

As of August 10, 2016, Colorado law allows the appointment of a physician acting as proxy decision-maker under the following circumstances:

- A physician may, on a voluntary basis, be appointed to serve as a proxy decision-maker when no other interested person can be located [CRS 15-18.5-103(4)(c)(I)].
- The physician acting as proxy CANNOT also be the patient’s attending physician [CRS 15-18.5-103(1.5)(b)].
- The appointment of the physician as proxy must be made through consultation and consensus with the medical ethics committee of the facility where the patient is receiving care or by consultation with the ethics committee of another facility. Any facility using this statute must have access to a medical ethics committee [CRS 15-18.5-103(4)(c)(I)(C) and CRS 15-18.5-103(4)(c)(II)].
- An independent determination of capacity must be obtained from another physician or an advanced practice nurse who has collaborated about the patient with a licensed physician either in person, by telephone, or electronically, or by a court [CRS 15-18.5-103(4)(c)(I)(B)].
- The appointment and the termination of the physician acting as proxy are documented in the medical record [CRS 15-18.5-103(4)(c)(I)(D) and [CRS 15-18.5-103(4)(c)(IV)].

- Statements prohibiting euthanasia have been added consistent with other Colorado statutes [CRS 15-18.5-103(6)(b)(I) and CRS 15-18.5-103(6)(b)(II)].
- A physician acting in good faith in accordance with this article **is not subject to civil or criminal liability or regulatory sanction** for acting as a proxy decision-maker [CRS 15-18.5-103(9)(b)].

As always, health care teams can use the established emergency waiver of informed consent to make decisions for incapacitated patients in emergencies.

III. Identification of an Unrepresented Patient:

An unrepresented patient is defined as an adult patient who lacks decisional capacity to give informed consent for medical treatment, does not have an applicable advance directive, and for whom there is no legally authorized surrogate decision maker, family, or friend available, competent and willing to assist with medical decision-making (also referred to as “unbefriended patient”, “adult orphan”, or “patient without proxy”).

The identification of an unrepresented patient involves capacity assessment and reasonable effort to locate an appropriate proxy decision-maker. [CRS 15-18.5-103(3)].

Functional Assessment of Decision Making Capacity

- The attending physician should assess and properly document decision making capacity (DMC) in the medical record according to the usual institutional processes. A sample capacity assessment and documentation guide is included at the end of this guideline (Appendix C).
- An independent clinician who will not be serving as health care proxy should also assess and document capacity if it has not been determined by a court. [CRS 15-18.5-103(4)(c)(I)(B)]
- The attending physician should seek consultation from appropriate resources for difficult capacity determinations – such as geriatricians for patients with dementia or psychiatrists/psychologists for patients with a significant mental illness diagnosis.
- Patients who lack capacity to make complex health care decisions may still be able to identify a person who they would trust to make decisions. This can provide a start in locating someone who could serve as health care proxy. Patients can also sometimes describe what is important to them and how they lived their lives.
- DMC may operate on a continuum. A patient may be able to express some wishes, even without full formal DMC. A proxy may also be required for a patient whose DMC fluctuates or who requires assistance in making significant treatment decisions.
- The attending physician should reassess DMC as appropriate when medical and mental conditions change.
- If the patient regains capacity, the patient should resume the role of providing informed consent and sharing in treatment team decisions. This change should be documented in the medical record. Take advantage of such opportunities to have the patient appoint a medical power of attorney agent, and explore values and wishes, as well as complete other written advance directive documents when appropriate.

Reasonable Effort to Find a Health Care Proxy

- In the absence of a guardian or agent, document attempts to locate potential proxy decision makers among: family, friends, neighbors, landlords, personal lawyers, work colleagues.
- Search for proxy decision-makers should start immediately and be ongoing when a patient without DMC is admitted to a facility.
- The scope of a diligent search for a proxy decision maker depends on the time and urgency of decisions needing to be made to care properly for a patient.
- Documentation of a thorough search is important for legal purposes. A reasonable effort should include timely and thorough medical records review and consultation with other health care organizations and providers. It is important to use all resources that may provide information, particularly as a facility moves towards the long-term goal of establishing assignment of guardianship in front of a judicial body. The following list contains some suggested sources which might be appropriate to search and document, but is not all-inclusive:
 - Patient's personal property at the hospital
 - Old medical records
 - Medical information from other nearby facilities who may know patient
 - Hospital ICU/floor visitor list
 - Primary Care Provider (PCP) including clinics
 - Local mental health organizations
 - Local ARCs or other advocacy groups for persons with intellectual disabilities
 - Adult Protective Services (APS)
 - Police department or missing persons
 - www.publicrecordsnow.com
 - VA/Fed government SSI, SSDI applications
 - Skilled nursing facilities or other previous residences
 - Housing Authority (applications)
 - Previous landlords (Google patient and previous addresses)
 - Shelter, motels, food banks
 - www.intelius.com ;
 - www.spokeo.com;
 - www.peoplefinders.com Google search
- The medical record should document which of the above has been searched, and by whom. A sample Checklist can be used to efficiently document this in the medical record (see Appendix D).
- If "interested parties" are located who decline to serve as formal proxies, document their names as contacts and try to engage them in discussion of how patient lived his/her life, what was important to them, and how the patient/person might have judged quality of life.

- If an appropriate proxy is located at any time during this process, use this proxy instead of the attending physician or his/her designee. Properly document the change in proxy.

IV. Ethics Committee Roles and Responsibilities

A facility's ethics committee should be contacted as soon as an unrepresented patient is identified. The ethics committee should provide coordination from the point of initial identification of the patient through discharge, or until the patient regains capacity or a proxy known to the patient is located. Coordination may involve the entire committee or a designated subset. This new role and responsibility should be added to any existing policies and procedures that govern the functioning of a facility's ethics committee.

Roles:

It is NOT the role of the ethics committee to serve as the proxy. The ethics committee serves several roles when a physician proxy is appointed.

1. Consultation:
 - Consult and reach consensus on appointment of the proxy designation of a particular physician [CRS 15-18.5-103(4)(c)(I)(C)].
 - Consult and reach consensus on the decisions made by that proxy as appropriate and consistent with facility policies and procedures about when written informed consent is required. [CRS 15-18.5-103(4)(c)(V)].
 - Provide ongoing consultation when no willing proxy (including a physician proxy) can be found.
2. Policy: Advise on the development and review of policies related to unrepresented patients.
3. Education: Educate consultants and potential physician proxies on the standards for surrogate decision making (see Appendix F).

Responsibilities:

The Ethics Committee should:

1. Respond in a timely fashion as soon as an unrepresented patient is identified.
2. Establish a procedure that maximizes the opportunity for full and thoughtful review and continuity of review over time. Frequency of review and the scope of decisions reviewed are dependent on the nature of the case. Involve ethics consultants or ethics committee members from a variety of backgrounds when possible. Seek out special expertise as needed – such as input from mental health, addiction, aging, or disability experts
3. There are many different ways to constitute an ethics committee response, depending on current practices at the facility. **For example:**

- Identify a single point person / lead consultant who can spearhead the response in a timely fashion, coordinate the response and provide continuity. This lead person can be the contact for all people involved from the clinical team and from the ethics committee. This lead person would not be a solo consultant – but the identified contact person from among the ethics consult team/committee.
 - Constitute a multidisciplinary team led by persons experienced in ethics consultation. The team could be formed with:
 - Three persons – a clinician, a non-clinician, and a community member.
 - Three or more experienced ethics consultants
 - A subgroup of the hospital’s ethics committee membership
4. Document ethics committee/consult processes and decisions in the patient’s medical record.
 5. Review all cases as part of an established internal case review process of the ethics committee. Create appropriate internal documentation to track and report these cases to existing governance structures as established in the facility (i.e. Medical Staff, Board of Directors, Quality Improvement Committees)
 6. Other potential responsibilities for facility ethics committees in regard to unrepresented patients:
 - Serve as a resource in the development and ongoing review of policies and procedures regarding who will serve as physician proxies.
 - Help facility develop a roster of physicians, who are willing to serve as potential proxy decision-makers, from among such groups as active facility physicians, community-based physicians and retired physicians.
 - On a voluntary basis, participate in requests from the Colorado Healthcare Ethics Forum to provide information for tracking and research purposes as intended to update and improve the guidelines on an ongoing basis.

If there is no Ethics Committee within the Healthcare Facility:

1. Make arrangements to use the ethics committee at another health care facility that is willing and able to help. Small rural hospitals that are part of a system may use system resources. Small rural hospitals who are not a part of a system can locate another health care facility in the area or
2. Contact the Center for Bioethics and Humanities at the University of Colorado at coloradobioethics.org or 303/724-3994 to access a list of names of volunteer consultants who are willing to act as an ad hoc ethics committee. This list of names will be compiled by CHEF – the Colorado HealthCare Ethics Forum.

V. Appointment and the Role and Responsibilities of a Physician Proxy

A physician proxy may be appointed by the attending physician for an unrepresented patient. The appointment is voluntary and can be terminated at any time with reasonable notice.

The facility should develop a list of physicians willing to consider appointment as proxy to an unrepresented patient. Willing physicians may include the facility's active medical staff, physicians from a different practice, retired members of the medical staff, or community physicians as determined by facility. Medical directors who are not directing the patient's care can be considered. Physicians in training should not be used as proxies under this statute.

- A physician appointed as physician proxy must not be an attending or consulting physician for the patient [CRS 15-18.5-103(1.5)(b)].
- Potential conflicts of interest should be identified and mitigated; for example, use a physician from a different service or practice, a different specialty or an independent physician.
- Date and time of appointment should be recorded in the patient's medical record.

Process of Appointment

1. The attending physician nominates a willing physician to serve as the physician proxy.
2. The ethics committee reviews the recommendation and, if consensus is achieved, the physician is appointed by the attending physician. The ethics committee can help inform the proxy physician of his/her role as proxy.
3. The attending physician documents the appointment in the medical record, including the proxy physician's name, contact information and the date and time the appointment becomes effective.
4. Reasonable effort is made to inform the patient of the physician proxy and, if possible, gain patient assent.
5. A member of the consult team documents the appointment process and ethics committee concurrence in the patient medical record.

Role and Responsibilities of the Physician Proxy

The role of the physician proxy is to make decisions in the best interest of the patient and consistent with the patient's wishes to the extent they are known. While the physician possesses medical expertise and experience, the physician acting as proxy is NOT acting in the role of a physician. The physician acting as proxy may NOT

- Directly access the patient medical record (other than through the usual proxy request standard).
- Initiate, change or discontinue medical treatment orders.

In order to ensure the best possible representation for the patient, the physician proxy should:

- Stay informed of the patient’s current medical condition and prognosis
- Request medical information, ask questions and discuss treatment options
- Be available to members of the care team by phone or in person to discuss the patient’s condition and treatment options
- Participate in scheduled care team meetings when requested
- Consult with any persons known to the patient that may have some idea of the patient’s interests, goals, values and wishes.
- Be aware of and comply with any known advance directives.

VI. Requirements When Using a Physician Proxy

- For routine treatments and procedures that are low-risk and within broadly accepted standards of medical practice, the attending physician may make health care treatment decisions. [CRS 15-18.5-103(4)(c)(V)(A)]
- For treatments that otherwise require a written informed consent, such as treatments involving anesthesia, treatments involving a significant risk of complication, or invasive procedures, the attending physician is required to obtain the written consent of the proxy decision-maker and a consensus with the medical ethics committee. [CRS 15-18.5-103(4)(c)(V)(B)]
- For end-of-life treatment that is nonbeneficial and involves withholding or withdrawing specific medical treatments, the attending physician is required to obtain an independent concurring opinion from a physician other than the proxy decision-maker, and obtain a consensus with the medical ethics committee. [CRS 15-18.5-103(4)(c)(V)(C)]

VII. Decision Standards and Conflict Resolution

Types of Decisions

- Routine treatment (the **attending physician** can make decisions about these treatments) – medical interventions that are within broadly accepted standards of medical practice, do not pose significant risk to the patient’s health or life and about which major differences in personal, social or religious values are unusual. This generally includes interventions and procedures for which signed informed consent is normally not required. Low risk treatments may include, but are not limited to, administration of parenteral medications, routine laboratory and radiographic diagnostics, and placement of intravenous access.
- Treatments for which signed informed consent is normally required. (a **physician proxy** is necessary and facility policies for written informed consent should be followed)
 - Substantial Risk: – medical interventions for which there is substantial risk to the patient for serious injury, significant suffering, or death, or for which there is a reasonable likelihood of major differences in personal, social or religious values. This includes most, but not all, interventions for which signed informed consent is normally required.

Examples of major invasive treatment may include, but are not limited to: most surgery, most invasive diagnostic and therapeutic procedures, interventions that carry substantial morbidity or mortality risk (such as cancer chemotherapy), or lower risk interventions that imply large decisions about overall treatment goals (dialysis, feeding gastrostomy, tracheostomy, etc.).

- Life-sustaining treatment – medical intervention without which there is reasonable medical expectation the patient will die within a brief time period.
- End-of-life treatment – medical interventions intended to provide comfort during the dying process. This includes withdrawal of life support, or transition to comfort care, or hospice.
- Transfer to the most appropriate care setting, including rehabilitation, hospice, or long-term care facilities.
- Organ donation -- physician proxies should only make organ donation wishes in accordance with a patient's known wishes via a driver's license or other written documentation.

Decision Making Standards in Hierarchical Order

Berger JT, DeRenzo, EG, Schwartz, J; Surrogate Decision making: Reconciling Ethical Theory and Clinical Practice. *Ann Intern Med.* 2008;149:49-93; and Sulmasy DP, Snyder L. Substituted Interests and Best Judgments: An Integrated Model of Surrogate Decision Making. *JAMA.* 2010;304(17):1946-1947.

1. Patient's Known Wishes – If there are known wishes in the form of advance directives – they should be followed. Physician proxies may not be necessary if there is sufficient clarity in advance directives.
2. Substituted Judgment – Decisions made on information about what the patient would likely choose based on information gathered from prior medical records or key informants who are not willing to be proxies, but have important information about the values, life-choices and preferences of the patient.
3. Best Interests – Decisions based on a calculation that potential benefits of treatment options (and the likelihood of achieving these) outweigh the risks or burdens of treatment options (and their likelihood.)

Factors that should be considered by a proxy in determining whether treatment decisions are in the best interests of the incapacitated individual include:

- Patient's present level of physical, sensory, emotional, and cognitive functioning;
- Various treatment options and the risks, side effects, and benefits of each of the options;
- Life expectancy and prognosis for recovery with and without treatment;
- Degree of pain and discomfort resulting from the medical condition, treatment, or termination of treatment;

- Degree of dependency and loss of dignity resulting from the medical condition and treatment (adapted from Washington State Hospital Association, 2010).

Other important considerations include respect and cooperation. These particularly vulnerable patients, who lack decision making capacity and someone who can speak for them, should be treated with the respect that comes with careful attention and due diligence to decisions and reasonable efforts to gain their cooperation with treatment choices. If patients lack capacity, they cannot consent to treatment; neither can they refuse treatments and treatment refusals should not be honored. But careful assessment of what treatments are absolutely necessary and working to gain a patient’s cooperation are important.

Conflict Resolution

If the ethics committee is not able to reach consensus or there is disagreement between the physician proxy and the ethics committee, attempts should be made to mediate the conflict using internal resources as identified by the facility (i.e. risk management, medical director). The facility could also reach out to other identified ethics consultation resources through the Center for Bioethics and Humanities and/or CHEF (The Colorado Healthcare Ethics Form).

VIII. Guardianship

Colorado HB 16-1101 does not alter the responsibility of a health care facility to initiate a guardianship petition when appropriate. Even if a willing physician proxy is appointed in accordance with the law, the appointment of a permanent guardian will help facilitate an appropriate discharge and continuity of services. Guardianship should be considered when the patient is found to have impaired decisional capacity that is permanent or unlikely to recover within a reasonable period of time and:

- Informed consent is required for ongoing non-emergent medically advised procedures or other courses of treatment, or
- The patient no longer requires the level of care being provided but is unsafe to discharge to a former living situation, or
- No agent, proxy or guardian can be located.

Appointment of a guardian can often require 4-6 weeks once a guardian nominee is identified, so it is important to anticipate the eventual need for guardianship early in a patient’s healthcare facility stay.

Types of guardians

When a patient is unrepresented, there are two primary avenues to obtaining a guardian.

1. Volunteer guardian

A volunteer guardian may be an interested individual known to the facility or an individual connected to a non-profit agency such as Guardianship Alliance, ARC, Silver Key, or other social

service agencies. Each facility should initiate and maintain working relationships with these agencies.

2. Professional guardian/fiduciary

A professional guardian may be sought by the health care facility under circumstances in which the facility is willing to pay the necessary costs and fees (typically for 3-12 months). In addition to court costs, the guardian's fees are generally based on an hourly range dependent on the type of service. The typical range is \$65-\$150 an hour. The facility should establish a list of professional guardians in the area. The Colorado Guardianship Association, the Aging Life Care Association, and the National Guardian Association are resources for locating professional guardians.

An order appointing a guardian may be permanent or time-limited (emergency guardians usually serve for up to 60 days). In rare cases a judge may serve as a guardian for the purpose of non-emergency decisions while a nominee is sought.

Process to request a guardian

1. Complete a thorough functional assessment of decisional capacity, ideally with a second opinion. Document both the initial assessment and second opinion in the patient's medical record.
2. Document reasonable efforts in a search for a proxy for the patient.
3. Identify a nominee guardian.
4. Complete the required forms, including the capacity evaluation, and file a request for hearing date.
5. Facilitate arrangements for the service of the guardianship petition and a subsequent visit from the court.
6. Appear at the hearing with the patient if possible. The court may be amendable to patient presence via the internet other audio video capabilities.

Note: If the volunteer nominee is from a non-profit agency, the agency will typically assume the role of petitioner and initiate the petition for guardianship. If the volunteer guardian nominee is an unaffiliated individual, or the guardian nominee is a professional guardian, then the health care facility assumes the role of petitioner and completes and submits the required materials to the court.

At such time as a guardian is appointed by the court, the responsibility of the physician proxy terminates. Both the appointment of the guardian and termination of the physician proxy are documented in the patient's medical record.

IX. No Willing Proxy, Termination of Physician Proxy and Transitions of Care

In all circumstances, the ethics committee of the facility, or a consulting ethics committee, will follow the patient until an appropriate discharge has occurred. Regular consultation with the attending physician and care team is conducted and documented in the patient's medical record.

No Willing Physician Proxy

If the attending physician or ethics committee is unable to locate a willing physician to be appointed as proxy, the guardianship process should be strongly considered. In the interim, efforts should continue to locate a proxy known to the patient, to locate a physician proxy, and to locate a nominee for guardianship if it is anticipated that permanent guardianship will be needed.

The health care facility can also petition for the appointment of a guardian ad litem. The role of the guardian ad litem is to investigate the patient's situation and report back to the court. In most circumstances a guardian ad litem is not authorized to make decisions. Therefore, there are a limited number of circumstances in which a guardian ad litem should be considered. These include situations in which there is conflict among the care team or between the team and the appointed proxy regarding the best interests of the patient, and that conflict cannot be resolved with ethics committee consultation or the facility's conflict resolution processes (sometimes occurs particularly with decisions about non-beneficial treatment and transfer to hospice). The appointment of a guardian ad litem may also facilitate the eventual appointment of a guardian in complex cases.

Physician Proxy Resigns [CRS 15-18.5-103(4)(c)(III)(D)]

A physician appointed as proxy may resign from the patient's care at any time. A minimum of one week's notice is recommended to allow for location of a replacement proxy. The notification of resignation and the effective date and time are documented in the medical record.

Patient Recovers Decisional Capacity or a Suitable Proxy is Located [CRS 15-18.5-103(4)(c)(III)(A-C)]

If at any time a member of the care team believes the patient has regained enough decisional capacity to resume medical decision-making, the ethics committee and the attending physician should be contacted so another functional assessment of capacity can be conducted. The patient may request that the appointed proxy continue to assist or be involved in decision-making and the physician may choose to do so. If not, the physician proxy is relieved of the appointment. Both the assessment of capacity and the date and time the physician proxy is relieved of the appointment are recorded in the patient's medical record.

If an appropriate surrogate is identified and agrees to serve as the health care proxy, the ethics committee should be contacted and the proxy physician notified and relieved of the appointment with relevant entries in the patient's medical record.

Patient Discharge or Transition of Care [CRS 15-18.5-103(4)(c)(III)(E)]

The physician proxy is authorized to consent to a safe discharge, including an appropriate transition of care into another health care setting. The responsibility of the physician proxy generally terminates at the point of transfer.

A physician may choose to remain in the proxy role in another health care setting (e.g., hospital to nursing home in a small community). In this event, the new care setting must document a new appointment of this physician as proxy per policies and operating procedures of the facility accepting transfer or placement.

X. Appendices and Additional Resources

Appendix A: Glossary

Appendix B: Summary of Colorado HB16-1101

Appendix C: Decision Making Capacity (DMC) Assessment Tool

Appendix D: Checklist for Reasonable Efforts to Find a Proxy

Appendix E: Resources for Consultation

Appendix F: FAQs handout for potential physician proxies

APPENDIX A

Glossary of Terms

Attending physician: the physician who is directly responsible for the patient's plan of care.

Consensus: Agreement about how to proceed – either in the choice of a proxy or the decision to be made. Does not require unanimity. A majority opinion could be a consensus.

Decisional Capacity: The capacity by a patient to make an informed decision to consent or refuse a therapy.

Emergency waiver of consent: The rendering of medical care to an incapacitated person without the patient's consent in an emergency situation, using the standard of what a "reasonable person" would want. Emergent surgeries, antibiotic treatments and invasive testing and treatment can be initiated under the "emergency waiver".

Ethics Committee: Refers to the mechanism in a facility to address ethical issues within the organization. For the purposes of dealing with unrepresented patients, the ethics committee may act in its entirety or designate a subset for working with the proxy.

Facility: Any health care institution that could have patients who are unrepresented, including hospitals, nursing homes, hospices, home care and private clinics and practices.

"Interested person" in Colorado Revised Statutes, 15-18.5-103: a patient's spouse, either parent of the patient, any adult child, sibling, or grandchild of the patient, or any close friend of the patient.

"Physician proxy" in Colorado Revised Statutes, 15-18.5-103 is a willing physician appointed by the attending physician to act as proxy when no other proxy is willing and able to serve.

"Proxy decision-maker" in Colorado Revised Statutes. 15-18.5-103: the person selected from among and by the interested persons. They should make reasonable efforts to reach a consensus as to whom among them shall make medical treatment decisions on behalf of the patient. The person selected to act as the patient's proxy decision-maker should be the person who has a close relationship with the patient and who is most likely to be currently informed of the patient's wishes regarding medical treatment decisions.

Surrogate: A person making decisions for a patient, either as a medical power of attorney agent or as a proxy.

APPENDIX B

Summary of House Bill 16-1101 Concerning medical decisions for unrepresented patients

This is an amendment to the current “Proxy Law”. Colorado Revised Statutes 15-18.5-103 – Proxy Decision Makers for Medical Treatment Authorized. All sections of the existing proxy law which were not amended remain in force. This new amendment received bipartisan support in the House and Senate and was signed into law by Governor Hickenlooper on May 18, 2016. **It went into effect August 10, 2016.**

Purpose and Summary

The purpose of the amendment is to enable a proxy decision-maker of last resort when no other interested person can be located and the patient lacks decisional capacity. The proxy of last resort is a willing physician who is appointed by the attending physician. The statute further requires ethics committee involvement and consensus when an unrepresented patient is identified. Finally the statute establishes additional protections for decisions at the end of life and limits the liability of a physician acting as a proxy of last resort.

What has changed?

- A physician may, on a voluntary basis, be appointed to serve as a proxy decision-maker when no other interested person can be located.
- The physician acting as proxy CANNOT also be the patient’s attending physician .
- The appointment of the physician as proxy must be made through consultation and consensus with the medical ethics committee of the facility where the patient is receiving care or by consultation with the ethics committee of another facility. Any facility using this statute must have access to a medical ethics committee.
- An independent determination of capacity must be obtained from another physician or an advanced practice nurse who has collaborated about the patient with a licensed physician either in person, by telephone, or electronically, or by a court.
- The appointment and the termination of the physician acting as proxy are documented in the medical record.
- Statements prohibiting euthanasia have been added consistent with other Colorado statutes.
- A physician acting in good faith as a proxy decision-maker in accordance with this article **is not subject to civil or criminal liability or regulatory sanction** for acting as a proxy decision-maker.

What guidelines must be followed for treatment decisions?

- The attending physician may make decisions regarding **routine treatments** and procedures that are low-risk and within broadly accepted standards of medical practice.
- For treatments that otherwise require a written **informed consent**, such as treatments involving anesthesia, significant risk of complication, or invasive procedures, the attending physician must obtain the written consent of the appointed proxy and consensus of the medical ethics committee, both of which are documented in the medical record.
- **For end-of-life treatment** that is considered nonbeneficial and involves withholding or withdrawing specific medical treatments, the attending physician must obtain an independent concurring second opinion from a physician (other than the proxy-decision-maker) and a consensus with the medical ethics committee.

Under what circumstances does the authority of the physician acting as proxy end?

Authority of the physician acting as proxy terminates when: An interested person is willing to serve as proxy decision –maker

- A guardian is appointed
- The patient regains decisional capacity
- The proxy decision-maker decides to no longer serve
- The patient is transferred or discharged from the facility – unless the proxy decision maker expresses his/her intention to continue to serve

In what health care facilities does the statute apply?

The statute is applicable in all health care facilities as defined by the original medical POA statute C.R.S. 15-14-505. A “health care facility” includes a hospital, hospice, nursing facility, assisted living, and any entity that provides home and community based services.

What hasn’t changed?

- A health care facility must make the same reasonable effort to locate an interested person, per current statute, who is willing to serve as a proxy decision-maker.
- The process for determining a proxy decision-maker when one or more interested parties are available has not changed.
- Patient rights regarding appeals of capacity or proxy appointment have not changed.
- Appropriate steps should still be taken to obtain a permanent guardian when applicable.
- An attending physician or his/her designee remains responsible for his/her negligent acts or omissions in rendering care to an unrepresented patient.

How should the new law be implemented in our facility?

- Because appointment of a proxy of last resort is voluntary, not mandatory, each facility should determine policies and procedures appropriate to its intended use of the statute.
- The Colorado Collaborative for Unrepresented Patients* has begun a stakeholder process that will generate best practice guidelines for implementation of the statute. The guidelines will address practical and logistical use of the statute in a variety of settings.
- The guidelines are targeted for release in the fall of 2016.
- Questions or suggestions for guidelines development can be address to CCUP members noted below.

*The Colorado Collaborative for Unrepresented Patients is a group of interested citizens whose work facilitated the drafting and passage of HB 16-1101 on behalf of Colorado’s unrepresented patients.

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Link to The Colorado Medical Treatment Decision Act (Proxy is 15-18.5-103. Proxy decision-makers for medical treatment authorized.)

http://www.coaccess.com/documents/Colorado_Law_Advance_Directives.pdf

APPENDIX C: Decision Making Capacity (DMC) Assessment Tool

Date/Time Assessed: _____

Indication for assessment of DMC: Patient: Refusing treatment or disposition

Decisional capacity in question Other: _____

Is there an impediment that could affect my assessment of this patient's DMC? Yes No

Language , Cultural issues , Communication , Other : _____

Capacity – Assess the patient's understanding of the following and document findings:

A1. Ability to understand the medical problem: Yes No Unsure

Why are you in the hospital now? What have you learned from the medical team about your illness?

A2. Ability to understand the proposed treatment: Yes No Unsure

What is the recommended treatment for your problem? What can we do to help you?

A3. Ability to understand the alternatives to treatment: Yes No Unsure

Are there any other treatments available? What other options do you have?

A4. Ability to understand the option of refusing treatment: Yes No Unsure

Can you refuse the treatment? Can we stop the treatment?

A5. Ability to appreciate consequences of accepting or refusing treatment: Yes No Unsure

What could happen to you if you have the treatment? How could the treatment help you?

Could the treatment cause problems or side-effects? Could you get sicker or die without the treatment?

A6. Ability to weigh the risks, benefits and burdens of treatment options: Yes No Unsure

A7. Ability to rationally reason how to reach a decision to accept or reject treatment: Yes No Unsure

Can you tell me how you arrived at your decision? What factors helped you come to your decision?

B. Is the patient able to communicate the above in her/his own words: Yes No Unsure

C. Is the patient consistent with her/his communication regarding the above? Yes No Unsure

Conclusion: Decision Making Capacity – Intact Unclear Lacks capacity

(Consider lack of DMC if "No" was checked under sections A 1-7, B, or C above)

Etiology of incapacity: (developmental delay, dementia, psychosis, delirium, other _____)

Plan to keep patient safe and restore capacity:

Is incapacity from a reversible cause? Yes No Unclear

Is a safety plan in place? Yes No

Provider Conducting assessment (Print)

Signature

ID

Date/Time

Attending Name and cosign if appropriate: _____

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Pearls to use as Guideline for Decision Making Capacity Assessment

- DMC is not the same as “competency”, which is a legal term decided by a formal judicial proceeding.
- DMC does not require a psychiatry consult. It is best done by the primary care team, who knows the patient, the treatment options, and can more efficiently ask the questions on the front side of this Assessment Tool. Formally using the Tool, however, may uncover deficits in reasoning that are not obvious in daily conversation. (e.g. Korsakoff syndrome)
- An Ethics Consult can be useful if you are left “unsure” as to whether the patient has DMC.
- Patients with mental illnesses such as dementia or schizophrenia may still have DMC if they meet the other criteria outlined above. The “rightness” of the decision a patient makes is less important than the process by which the patient comes to that decision. If the patient has a concomitant psychiatric diagnosis, a psychiatry consult may be useful to help determine if the patient has DMC.
- Incapacitation is not determined by using the Mini Mental Status Exam, which evaluates cognition only, and not the ability to reason. Cognitive deficits may contribute to incapacitation, and MMSE scores of < 20 are often associated with lack of DMC. However, patients with normal MMSE scores may still be incapacitated, MMSE scores > 24 lower the likelihood of incapacity. Intermediate scores – all bets are off.
- The degree to which patient wishes are honored when a patient has doubtful DMC varies with the risks and benefits inherent in the decision. The greater the risk of death or injury from a patient’s decision, the more obligations the physician has to assure himself or herself that the patient has DMC. Hence, for a life threatening condition, the failure to meet any criterion might be sufficient to deem as patient incapacitated, while for less serious decisions, more evidence might be required.
- While patients may lack DMC for one type of medical decision, this does not imply that he/she lacks capacity for all other medical decisions. Likewise, capacity may vary with time.
- The medical care team has an obligation to restore or attempt to maximize the patient’s DMC through treatments. Thus, patients with delirium, drug toxicities, etc should be supported to help them regain DMC.

Sessums LL, et al. Does this patient have medical decision-making capacity? JAMA 2011; 306: 420-427.

Echtells E, et al. Assessment of patient capacity to consent to treatment. J Gen Intern Med 1999; 14: 27-34.

Appelbaum, PS. Assessment of Patients’ Competence to Consent to Treat. NEJM 2007; 357: 1834-70.

APPENDIX D

Checklist for Reasonable Efforts to Find a Proxy

The purpose of this checklist is to suggest sites to document as potential sources of family and friends and which may need to be researched by a facility prior to considering using a physician proxy. It provides an excellent record for Ethics Committee review and for use when applying for guardianship.

Potential Search Site	Person checking source	Date completed
Patient's personal property at the hospital		
Old medical records		
Medical information from other nearby facilities who may know patient.		
Hospital ICU/floor visitor list		
Primary Care Provider (PCP) including clinics		
Local mental health organizations		
Local ARCs (or other)		
Adult Protective Services (APS)		
Police department or missing persons		
www.publicrecordsnow.com		
VA/Fed gov SSI, SSDI applications		
SNF or other previous residences		
Housing Authority (applications)		
Previous landlords (Google previous addresses)		
Shelter, motels, food banks		
www.intelius.com ;		
www.spokeo.com ;		
www.peoplefinders.com		
Google search		
Others:		

APPENDIX E

Resources for Ethics Consultation

Under development

Additional Resources (including useful websites)

Center for Bioethics and Humanities at the University of Colorado Anschutz Medical Campus:
www.coloradobioethics.org

Colorado Health Ethics Forum (CHEF): www.coloradoethicsforum.org

Appendix F:

Frequently Asked Questions for Physicians Serving as Proxy Decision Makers for Patients without Any Surrogate (Unrepresented Patients)

How do I get appointed to be a patient's proxy? *You need to be nominated by the attending physician and the ethics committee of your facility (or the committee that the facility will use for this purpose if the facility does not have an ethics committee) and willing to serve.*

What is my role? *Your responsibility is to reflect and speak in the voice of the patient as the medical team proposes diagnostic and treatment decisions, and to represent the patient as long as he or she lacks capacity and can't give informed consent.*

How do I represent a patient whom I don't even know?

Even patients without decisional capacity to make big medical decisions may be able to share something of what is important to them and how they lived their lives. There may also be acquaintances who can teach you something about the patient. This allows you to use some measure of "substituted judgment" in making decisions on behalf of the patient. You may be left with considering what is in the "best interest" of the patient – balancing suffering with potential for restoring a life that the patient might find meaningful. The ethics committee can assist you.

What if my patient is near the end of his/her life?

HB16-1101 provides extra safeguards for end-of-life decisions: the attending physician caring for the patient for whom you are proxy needs to obtain a second opinion about prognosis from another physician, as well as the concurrence of you (proxy) and the ethics committee about the actual decision.

Can I look at the medical record?

Proxies can request to review the medical record, and you can too. In this proxy role, you may not routinely either write orders or review the chart. Remember that you are acting as a proxy, not as a medical consultant!

Should I set aside my medical expertise?

Just as you would when speaking on behalf of one of your family members or friends, your medical understanding can be helpful. But your primary role is to represent the patient's values, and make decisions about what they wish or what is in their best interests.

What are the potential conflicts of interest that I need to overcome?

We all have potentially conflicting roles in our professional and personal lives. You are probably a member of the staff of your facility, and the providers taking care of your patient are your colleagues. You must remember that you are not their consultant and not there to "rubber stamp" their decisions,

but rather to hear them articulate what and how they are making medical decisions, and to balance that with what you think the patient would want.

Can I say “no” or stop being a “proxy”?

This is a voluntary appointment, and you can step aside at any time. You must step aside if a suitable proxy is found or if your patient regains decisional capacity. It is natural to step aside when your patient transfers to another facility or is safely discharged. At any time when you are unable or unwilling to continue in the proxy role, you just need to notify the patient’s medical provider and the ethics committee and are free to step away.

How do I work with my facility’s ethics committee?

The ethics committee’s role is to approve your appointment, follow the patient and decision-making to confirm that it is ethically acceptable, and to support you, the patient and the facility in making decisions in the patient’s best interests.

How do I know I will be supported by my health care facility?

Health care facilities should have established a formal policy and procedure that supports you, the care team and the ethics committee in these cases. While there may be disagreements, as there are now when proxy decision makers are involved, the process set out by the statute ensures transparency and opportunities for conflict resolution.

Why has this amendment been adopted by the state of Colorado?

“Unrepresented” patients are extremely vulnerable, and decisions outside of emergency interventions are often delayed. Diagnostic, therapeutic and end-of-life decisions are either decided unilaterally by the patient’s physician, or delayed because there is nobody to give informed consent. The use of physician proxies is meant to help vulnerable patients.