

First Supplement to Memorandum 2000-5

Family Consent in Health Care Decisionmaking for Adults (Comments from Dr. Orr)

This supplement sets out comments we have received by email from Dr. Robert Orr, Loma Linda University Medical Center, who also serves as the Chair of the California Medical Association Council on Ethical Affairs. Dr. Orr focuses on several aspects of Eric Carlson's letter attached to Memorandum 2000-5, Exhibit pp. 1-2.

Utility of Rigid Hierarchy

Dr. Orr disputes Mr. Carlson's statement that instances where the priority mechanism does not resolve matters would be "relatively rare":

1. These situations are not "relatively rare" as he asserts near the end of his letter. It is not uncommon in our fractured society to have an elderly individual who has children living out of state, but has a neighbor who comes in every afternoon to have tea and chat, or a niece who lives nearby and is intimately involved in her care and well-being, or a pastor who visits regularly, or a Meals on Wheels delivery person who has taken a special interest in her welfare. In some cases, the distant child may know the patient's wishes or values, but often they don't. The child may voluntarily defer to these closer individuals, but may not.

Just this week I did a consult on a wealthy woman whose only son lives in France, speaks no English, and had not seen her for 3 years. When she recently became incapacitated, the woman who sees her daily, helps with shopping, takes her to appointments, etc. felt she understood the patient's values and wishes; but we felt obligated to contact the son. Using an ATT translator, we talked with him. He said "I am here and have no idea what she wants or what should be done. You are there and should know what to do, so just do what you think." Had he insisted on limitation of treatment, should we be concerned that he might be more interested in his inheritance than in what she would want or what would be in her best interests? With his blessing, we followed the impressions of the friend. When the patient improved and could talk with us, she confirmed that this woman was right in giving us guidance.

A good percentage of my consults involve situations with differences of opinion among family members. I have never felt comfortable with a strict delineation of hierarchy, but try honestly to encourage a decision that those who know the patient best believe would be his or her choice. And this is often not the one who would logically appear on “the list”. In seeking this substituted judgment, (or failing that, best interests) I use criteria much like were in the original CLRC proposal (4712.c). They seem very morally significant.

Application of Standards in Draft Recommendation

Dr. Orr comments on the issue of whether the statutory standards for varying from the presumptive order can be practically applied:

2. Mr. Carlson objects to these proposed guidelines (4712c) saying “how can a physician possibly make an objective determination of the individual ‘best qualified?’” and goes on to question the physician’s motivation in making this choice, and to underscore the difficulty in drawing conclusions regarding the character of a patient’s relatives and friends. While the proposed criteria may not be applicable in a tight algorithm, there is a lot of substance there: “regular contact”, “demonstrated care and concern”, “familiarity with values”, “availability”, etc. I believe these are at least as concrete, and perhaps moreso than the very squishy criteria in the second level of the hierarchy: “long-term relationship of indefinite duration”, “demonstrated an actual commitment”, “consider themselves to be responsible for each other”. I find these descriptors easier to challenge and question than those in 4712.c.

Utility of Rigid Hierarchy

Dr. Orr believes that a rigid hierarchy would result in more frequent court proceedings and finds that this could be troublesome in the clinical setting:

3. The rigid hierarchy will require frequent visits to court for designation of a surrogate. We must occasionally do this now, fortunately rarely, but it only works for decisions which can be postponed for a few days. Most medical decisions must be made more quickly (should we intubate this patient who is slipping into respiratory failure? she will be dead in 6 hours if we don’t. should we insert a chest tube to drain this pussy fluid from her chest? if we don’t in 24-48 hours it will be so thick, it will require a major chest operation in order to remove it, but if we do it now, it can be removed with a needle or small tube). Postponing those decisions

to await a court determination will result in needless patient suffering.

It has been my experience on those rare occasions when we have been forced to go to court (no surrogate or irresolvable conflict between family members) that the judge turns to the physician in charge and asks "What do think should be done and why? And what will happen if it is not done?" and then makes a decision and gives an order. I have never seen an instance where the judge gives an order different from the physician's recommendation. If the judge is going to rely on the physician's recommendation in the vast majority of instances anyway, wouldn't it be better for the physician to share the decision with concerned family and make the decision quickly to avoid patient suffering and compromised outcomes?

Respectfully submitted,

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