

Surrogate Health Care Decisions

SAMPLE Organizational Model Policy and List of Procedural Issues:

(This policy may be added to you organization's policy guidance related to advance directives, informed consent, etc. The principal is used in this Model Policy to refer to the patient, resident, client, etc. who lacks health care decision making capacity. This Model Policy is not intended to include the entire statute regarding surrogate health care decision-making. Please refer to RSA 137-J to read the law. Procedures to implement this policy and staff training about it should be included in developing a policy for your organization. This document reflects the collective input of members of the NH Healthcare Decisions Coalition.

Model Policy

Surrogate Health Care Decisions

I. Purpose

Organization Name respects the right of all adults to make their own medical decisions and shall honor the decisions of a principal who has the capacity to make health decisions or the decisions of an activated DPOAH or guardian of the person when the principal lacks health decision-making capacity. It is the obligation of our organization to ascertain whether the principal has identified a DPOAH or has a guardian of the person and, if the principal has one, that the DPOAH or guardian of the person is contacted on behalf of the principal who lacks health care decision making capacity.

The New Hampshire Revised Statutes Annotated 137-J defines the circumstances under which a surrogate decision maker, acting on behalf of a patient lacking health care decision making capacity who does not have a DPOAH or a guardian of the person. This law allows the surrogate to make decisions to initiate any type of medical treatment and decisions to withhold or withdraw life-sustaining treatment. Our organization is committed to making a good faith effort to implement a surrogate decision-making process when necessary. The RSA 137-J allows this to be done without judicial involvement.

The surrogate may make health care decisions for a principal to the same extent as a DPOAH for up to 90 days unless the principal regains health care decision-making capacity, a guardian of the person is appointed, or patient is determined to be near death as determined by two physicians or a physician and APRN who have examined the patient.

The surrogate shall also make a good faith effort to explore all avenues reasonably available to discern the desires of the principal including, but not limited to, the principal's Living Will, the principal's written or spoken expression of wishes and the principal's known religious or moral beliefs.

II. Identifying a Surrogate

This policy establishes a process to identify a surrogate health care decision-maker when a principal lacks health care decision making capacity and does not have a DPOAH or guardian of the person. The principal's physician or APRN may identify a surrogate following the order of priority established by RSA 137-J:35.

A surrogate decision-maker may be identified to make medical decisions on behalf of a patient in the following order of priority:

- (a) The patient's spouse, or civil union partner or common law spouse unless there is a divorce proceeding, separation agreement, or restraining order limiting that person's relationship with the patient.
- (b) Any adult son or daughter of the patient.
- (c) Either parent of the patient.
- (d) Any adult brother or sister of the patient.
- (e) Any adult grandchild of the patient.
- (f) Any grandparent of the patient.
- (g) Any adult aunt, uncle, niece, or nephew of the patient.
- (h) A close friend of the patient.*
- (i) The agent with financial power of attorney or a conservator appointed in accordance with RSA 464-A.
- (j) The guardian of the patient's estate.

*"Close friend" means any person 21 years of age or older, pursuant to 137-J:35 who presents an affidavit to the physician or APRN stating that he or she is a close friend of the patient, is willing and able to become involved in the patient's health care, and has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious and moral beliefs. The affidavit shall also state facts and circumstances that demonstrate such familiarity with the patient.

In the event an individual of a higher priority as an identified surrogate becomes available and is willing and able to be the surrogate, the individual with higher priority may be identified as the surrogate. In the event an individual in a higher, a lower, or the same priority level, or a health care provider seeks to challenge the priority or ability of the surrogate or the life sustaining treatment decisions of the recognized surrogate decision-maker, the challenging party may initiate guardianship proceedings in accordance with RSA 464-A.

Current organizational policy regarding health care decision-making, in the absence of a DPOAH or guardian of the person, will take effect if a guardianship proceeding is initiated to establish guardian of the person, as the initiation of that process voids the identified surrogacy.

III. Limitations

A surrogate shall not be identified over the express objection of the principal, and a surrogacy shall terminate if at any time a patient for whom a surrogate has been appointed expresses objection to the continuation of the surrogacy. The surrogate may only make health care decisions for a principal, to the same extent as a DPOAH, for up to 90 days unless the principal regains health care decision-making capacity, a guardian of the person is appointed, or the principal is determined to be near death as determined by two physicians or a physician and APRN who have examined the patient.

A surrogate does not have authority to:

- (a) Consent to voluntary admission to any state institution;
- (b) Consent to a voluntary sterilization; [or]
- (c) Consent to withholding life-sustaining treatment from a pregnant principal, unless, to a reasonable degree of medical certainty, as certified on the principal's medical record by the attending physician or APRN and an obstetrician who has examined the principal, such treatment or procedures will not maintain the principal in

such a way as to permit the continuing development and live birth of the fetus or will be physically harmful to the principal or prolong severe pain which cannot be alleviated by medication[.]; or

(d) Consent to psychosurgery, electro-convulsive shock therapy, sterilization, or an experimental treatment of any kind.

IV. Responsibilities

A. Organization

It is the obligation of our organization to ascertain whether the principal has identified a DPOAH or has a guardian of the person and, if the principal has one, that the person is contacted on behalf of the principal who has been determined to lack health care decision making capacity.

There shall not be a recognized surrogate when a guardianship proceeding has been initiated and a decision is pending. The person initiating the petition for guardianship shall immediately provide written notice of the initiation of the guardianship proceeding to the health care facility where the principal is being treated. This process shall not preempt the care of the principal. Current policy regarding health care decision-making, in the absence of a DPOAH or guardian of the person, will take effect if a guardianship proceeding is initiated to establishment of guardian of the person.

B. Physician or APRN

The physician or APRN has the authority to identify appropriate surrogate or surrogates from the list in section II in order of priority, considering whether the selected surrogate is able and willing to act. If there is more than one person in a category (e.g., several children or several siblings) all of them shall be identified as surrogates with equal standing. The surrogacy provisions of this chapter shall take effect when the surrogate decision-maker name(s) are recorded in the medical record. The physician or APRN shall assure that initiation of a guardianship proceeding will not cause discontinuity in patient care.

C. Multiple Surrogates

Where there are multiple surrogate decision-makers at the same priority level in the hierarchy, it shall be the responsibility of those surrogates to make reasonable efforts to reach a consensus as to their decision on behalf of the patient regarding any health care decision. If 2 or more surrogates who are in the same category and have equal priority indicate to the attending physician or APRN that they disagree about the health care decision at issue, a majority of the available persons in that category shall control, unless the minority or any other interested party initiates proceedings to initiate guardianship.

V. Distribution

The organization is responsible for orientation of all staff to this policy. This policy shall be distributed organization-wide to all departments.

VI. Filing Instructions

This policy shall be filed in the Patient's Rights section of the *Organization Name* Policy Manual and online. It supersedes any and all previous policies issued relative to this subject.

Below is a List of Questions on Procedural Issues to Consider in Implementation of this Model Policy

Surrogate Health Care Decisions

(WHO you may want to consult to discuss this list: medical staff, nursing staff, social workers, bioethics committee members, medical records and risk management staff. All the above staff will likely need to understand how these issues are addressed for the people who receive care at your facility.)

1. Who is responsible for determining that a principal does not have an advance directive or guardian of the person and procedures to initiate this new surrogacy process will be started?

The person responsible for initiating the surrogacy process will vary by organization and facility.

2. How will your organization address step-parents, step-siblings and half-siblings within the priority listing and if 2 or more surrogates who are in the same category and have equal priority indicate to the attending physician or APRN that they disagree about the health care decision at issue, a majority of the available persons in that category shall control, unless the minority or any other interested party initiates guardianship proceedings?

The law does not include any reference to step-parents, step-siblings or half-siblings. Consider how your organization currently handles these relationships in legal matters.

3. How will decision making authority between divorced parents who disagree on care choices be handled?

The law does not include specific reference to divorced parents. Read the divorce decree (Parenting Plan) for parents of a minor child if this situation arises. Divorced parents of an adult are in the same category and have equal standing.

4. What is the procedure for accepting a close friend to be the surrogate? What is an affidavit that is acceptable?

Each organization will have to have a procedure for accepting a close friend as a surrogate. An affidavit is a sworn statement made before a notary or justice of the peace and that is signed by the friend and the witnessing authority.

5. How do we define the end point of the 90 day period?

It will clearly end if the person regains health decision making capacity or if the person dies. If the person regains health decision making capacity it is strongly recommended that the person select a DPOAH to avoid the need for surrogacy in the future. Also, the legislative intent is for surrogacy to be a time period and not 90 days for a surrogate and then 90 more days for a different surrogate, etc.

Less clear...if a hospital establishes a surrogate decision maker for providing care during a hospital admission and the person is discharged then the surrogacy will end from the hospital's perspective but what happens if the person requires on-going out-patient medical care, primary care, home care, etc. How does the surrogate communicate their designation? What if the hospital medical record is not available to the other provider? Does another provider automatically accept the hospital's designation and/or what is another provider's process to determine surrogacy is still needed? Does the 90- days start again if the person goes back to the hospital for an admission in a couple weeks? What if the person is re-admitted the day after discharge?

6. Who is responsible for initiating guardianship if it appears that the person in the hospital will need continued hospital care beyond the 90 day period and what is the procedure to be followed?

Each organization will need to determine who is the person to initiate the guardianship of the person process, if it is needed, and the procedure to be followed.

7. What is the procedure for extending the surrogate's role beyond the 90 day period when the person is near death?

The clinical judgment of 2 physicians or a physician and an ARNP should be employed in determining near death and any extension of the surrogate's role if death is imminent. This should be documented in the medical record.

8. What is the procedure when health care staff has a person whose surrogacy expires, a non-emergent medical decision needs to be made and the Probate Court has not appointed a guardian?

A clear understanding among health care staff of emergency care needs and non-emergent medical care decisions is important. Always check any older medical records to identify a contact person who could be an appropriate consenting party in the absence of DPOAH, surrogate or guardian of the person.

Also, changes effective 1/1/2015 to RSA 137-J (Advance Directive law):

(1.)
RSA 137-J:2 (V.) "Capacity to make health care decisions"- The following sentence (bold) was added to the statutory definition.
The fact that a person has been diagnosed with mental illness, brain injury, or intellectual disability shall not mean that the person necessarily lacks the capacity to make health care decisions.

(2.)
RSA 137-J:5 (V.) The following sentence (bold) was added to the list of limitations on an agents or surrogate's authority.

(d) Consent to psychosurgery, electro-convulsive shock therapy, sterilization, or an experimental treatment of any kind.

(3.)
RSA 137-J:19 The following sentence (bold) was deleted from the statutory Disclosure Statement.

If you want to give your health care agent power to withhold or withdraw medically administered nutrition and hydration, you must say so in your directive. Otherwise, your health care agent will not be able to direct that.