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### **Medical Decisions for the Incapacitated Patient**

An incapacitated patient with dementia fails a swallowing study or refuses to eat. The patient has legally authorized a medical durable power of attorney for medical decisions, including the withholding or withdrawal of life sustaining treatment. In accordance with the patient's wishes, the holder of the medical power of attorney refuses to authorize percutaneous endoscopic gastronomy (PEG) or other artificial feeding ordered by a physician. The health care facility does not induce feeding measures. Around the same time a state surveyor inspects the facility. The surveyor states that if the health care facility will not provide the patient with adequate nutrition to support life, then the patient should be transferred to another facility that will carry out the physician's orders. When the facility refuses to transfer the patient, the surveyor writes the facility a citation relating to nutritional standards.

Although we have not heard of this scenario in Colorado, it has been experienced by long term care facilities in other states. The situation presents both a moral and legal quandary. How can a health care facility respect the wishes of its patients and their legally authorized decision-makers, but also accommodate contrary demands of a state agency? The answer is for providers to follow the procedures set forth in the medical decision-making statutes, and to be prepared to present thorough documentation to a state agency if challenged.

In Colorado (and all of the United States), a competent patient always has a right to consent to or refuse any treatment option. As a basic rule, health care providers should always obtain documented consent from a competent patient or authorized representative before initiating or changing any treatment protocol. Colorado law contains several statutes that outline providers' obligations to obtain a patient's informed consent for medical treatment. Health care facilities must ensure that they strictly follow such procedures while providing care.

Further, currently competent individuals often take steps to provide that their wishes will be carried out if they were to become incompetent. The purpose of this process is to identify a patient representative to act once the patient becomes incompetent. The statutes for appointing such a personal representative in Colorado are described below.

Under the Colorado Medical Treatment Decisions Act, CRS §§ 15-18-101 *et seq.*, competent individuals may dictate their future treatment through a living will. While "living will" is the colloquial term, the statute provides that an individual can express in a documented declaration that he or she desires to forego artificial life support in the case of terminal illness. The declaration in a living will to withhold or withdraw life-sustaining treatment can be carried out when two physicians find the patient terminally ill *and* either the spouse, children, parent, or the



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person with a Medical Durable Power of Attorney (MDPOA) (in that order) are notified. The notified individual has 48 hours to challenge the physician's finding of a terminal condition. If any challenge is rebuffed, then the patient's wishes to terminate life-sustaining treatment should be honored.

A MDPOA is much broader than a living will because it can be drafted to apply to patients who do not have terminal conditions. This can be important for dementia patients or patients with long term conditions that may periodically interrupt competency but not be immediately life-threatening. A then-competent patient (called the "principal") may create an MDPOA to appoint an "agent" to carry out the wishes of the principal once the principal is incompetent. Under CRS § 15-14-506, the agent's power arises once the patient-principal lacks decisional capacity. The agent must then act in accordance with the *patient's subjective wishes*, as expressed when he or she was competent. If the patient's wishes are not known, the agent must act in the *best interest* of the patient *as determined by the agent*. The agent has the same decision making authority that the patient would have.

Both competent adults and incompetent patients' representatives may also execute a CPR directive leading to the familiar Do Not Resuscitate (DNR) order. While most facilities have forms for a CPR directive, the state also offers a form available at [www.cdphe.state.co.us/em/AdvancedDirectives](http://www.cdphe.state.co.us/em/AdvancedDirectives). The information required in a CPR directive includes name, birthdate, sex, eye and hair color, race or ethnicity, program of care, attending physician, signature and date, and the nature of the directive. Providers have a duty to comply with the directive if it is "apparent and immediately available," e.g. by physician order. Therefore, providers should do their best to make the order apparent by marking it in the medical record and using a bracelet that provides notice. If no CPR directive exists, consent to CPR is presumed. Revocation by a competent patient is allowed at any time, but a patient's representative may not revoke a directive originally created by the patient.

Where an incompetent patient did not appoint a patient representative or prepare other advance directives, a decision maker may be appointed through guardianship proceedings. Nearly any person "interested" in the welfare of an incompetent individual may petition for guardianship. In appointing a guardian, a court will identify the nature of the incapacity, state any limitations on the guardianship, and ensure that the patient has been given notice. The court may also appoint a guardian *ad litem* to reflect the incompetent patient's interests as the court determines if a permanent guardianship should be imposed. A guardianship application is often accompanied by an application for a conservatorship, where a conservator will be appointed by a court to manage the patient's finances and living affairs.

Alternatively, where a patient has maintained a social fabric but has not developed a written advance directive, Colorado has a unique law that allows medical personnel to identify a patient's "proxy" representative to exercise informed consent on behalf of the incapacitated patient.



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Under CRS §§ 15-18.5-101 *et seq.*, a medical doctor may determine that there is a need to identify a proxy decisionmaker to act on the incapacitated patient's behalf. The physician may direct a process for nomination of a proxy by a consensus of "interested persons." Interested persons include the patient's spouse, parents, any adult child, sibling or grandchild, or close friends. The interested persons are asked to meet to determine who among them shall be the proxy. There is no hierarchy of interest, and the hope is that the interested parties will choose the person most likely to know and follow the patient's stated values around health care. (If they cannot agree, then a guardianship procedure should be initiated.) Once the proxy is identified, then the proxy can be the patient's representative for health care decisions, except that the proxy may decide to withhold or withdraw artificial nourishment and hydration only if two physicians (one of which is trained in neurology or neurosurgery) certify that such care is only "prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."

It is clear that physicians are integral to a thorough, well documented decision making process for incapacitated patients. Physician orders and diagnoses will start the entire process and should be clearly documented. Moreover, if no living will or MDPOA exists, and a guardianship proceeding is initiated, the physician will report to the court on the decision making capacity of the patient. Finally, if the proxy process is warranted, the physician is required to initiate the gathering of interested people for determination of a proxy. All of the above examples of physician influence in the decision making process should be documented by the physician in the patient's record so that, if challenged by a state authority, the health care facility holds the proper support for its reliance on a patient representative.

With so many steps in the process to appoint an appropriate representative for an incapacitated patient, there are many opportunities for state and federal agencies to find gaps in your facility's actions. Moreover, state regulators may bring their own values to the health care setting, and these may conflict with an incapacitated patient's medical decision making autonomy. Surveyors might challenge your facility to prove that the decision maker is in fact acting in accordance with the patient's wishes or in the patient's best interest, or push for the facility to seek appointment of a guardian to ensure the validity of the decision. Therefore, and this cannot be over-emphasized, uniform procedures and thorough documentation by all stakeholders is imperative when dealing with an impaired patient's life sustaining care.