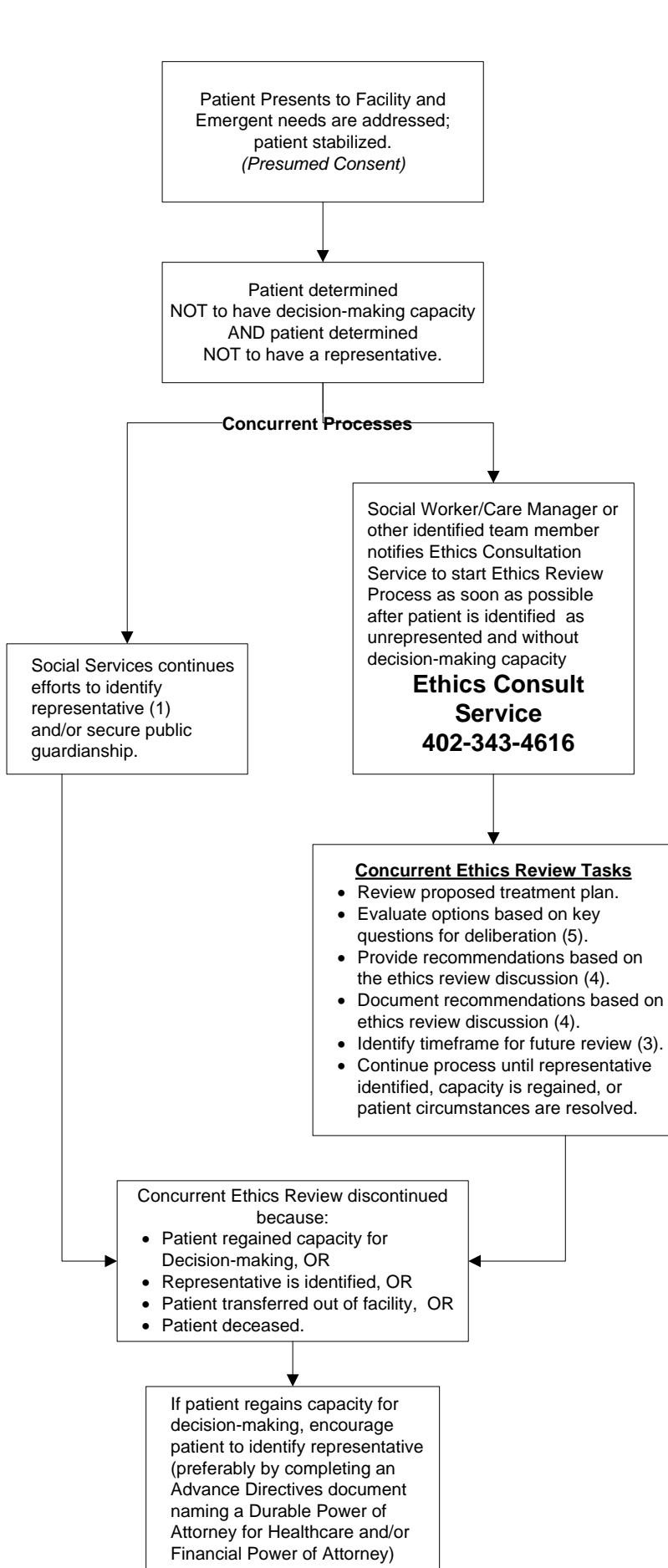


Unrepresented Patient Ethics Review Process



1. Representative Hierarchy

Reasonably available in this order of priority:

- Durable Power of Attorney for Healthcare
- Court-appointed Guardian
- Spouse
- Adult Child(ren)
- Parents
- Siblings
- Next closest Next-of-Kin
- Other adult who exhibits special care and concern

2. Concurrent Ethics Consultation Participants

- Ethics consultant (facilitator/convener)
- Campus Chief Medical Officer (or designee)
- Campus Chief Nursing Executive (or designee)
- Patient's attending provider
- Other providers as indicated by case needs
- Nurse/Nursing Unit representative
- Palliative Care Team representative
- Social services/care management
- Pastoral Care/chaplain
- Therapists and Dieticians
- Legal Council
- Risk Management/Safety representative
- Corporate Responsibility Program representative
- Language Services Interpreter/Translator

When possible, and as appropriate, include the following:

- Patient (to the degree possible)
- Patient acquaintances (individuals who are not a legally-recognized surrogate but may be able to provide relevant information and support, if appropriate)
- Other members of local Healthcare Ethics Committee Community representative (from vulnerable community of which the patient may be a part, if appropriate)
- Other key stakeholders whose perspectives are relevant to the case/question

3. Concurrent Consult Prompts (Post, et al, 2007, 205 - 208)

- The proposed treatment typically requires a signed informed consent form.
- The patient, though incapacitated, is refusing or requesting recommended treatment.
- There is disagreement within the care team about the treatment recommendations and/or treatment necessity.
- There is a significant shift in the goals of treatment.
- Treatment or interventions are irreversible.
- There are other ethical or legal concerns (for example questions about adherence to Catholic Teaching or the **Ethical and Religious Directives for Catholic Health Care Services**).

4. Documentation:

Documentation of unrepresented patient ethics reviews will be included in the patient's medical record.

Documentation will include participants, discussion points, recommendations, and time of next review.

Documentation can serve as consent for a procedure that would otherwise involve a signed informed consent form. However, if preferred by the care team, a consent form can also be used, with the signature of the CMO along with a note referring to notes from the Unrepresented Patient Ethics Review meeting on (date).

Patient's Name: _____ Facility/Room Number: _____
Date of Consultation: _____ Participants: _____

5. Key Questions for Consideration

- What, if any, decisions does this particular patient have the capacity to make at this time?
Note that decision-making capacity can vary based on the type of decision and over time.
- What are the potential sources of conflict of interest and bias within the review team and how can we mitigate?
- What are the goals of treatment and how would this intervention move towards those goals?
- What is the usual treatment plan for patients in this clinical condition (standard treatment/clinical best interest)?
- Is there any way to ascertain what the patient's values/preferences might be? What the patient might say?
For example, cautious consideration of past behaviors/decisions, or perceptions of acquaintances.
- How would this intervention be in the patient's best interest as defined by the following
 - Clinical indications/standards of treatment
 - Promotion of health
 - Protection of the right to bodily integrity (least invasive means)
 - Pain and symptom management
 - Maintenance or enhancement of comfort and function
 - Prevention/alleviation of suffering
 - Obligatory nature of treatments that are "ordinary" vs. "extraordinary"
- How is this decision aligned with/informed by *the Ethical and Religious Directives for Catholic Healthcare (the "ERDs")*?
- From whose voice(s) have we not yet heard? Can we hear from them prior to the decision?
- Given all of the information at hand what is the most reasonable option at this time?
- What if the patient would disagree with this plan even after careful review?
- What opportunities might there be to proactively identify a representative at a later time?
- When should we plan to meet for continued review?

6. Hallmarks of a Well-Designed System (ABA Consensus Statement – 2003)

- **Focus on the patient.** Any system should be patient-centered.
- **Independence and freedom from conflicts of interest.** There should be sufficient objectivity so that decisions are not subject to undue personal and institutional biases.
- **Continuity of care.** Care should not be disrupted or needlessly postponed while the process operates.
- **Applicability to a full range of decisions.** While any one mechanism might be limited in scope (for example, specifically excluding end-of-life treatment decisions), the system as a whole should cover the gamut of medical treatment.
- **Emphasis on least restrictive alternatives.** Options that stress patient involvement where possible and that do not unnecessarily remove fundamental rights are preferred. Thus, guardianship, which strips individuals of basic rights and puts their lives and medical treatment in the hands of the court, is truly a last resort.
- **Promptness.** Decisions should be timely. As with justice, care delayed is often care denied.
- **Cost-effectiveness.** As states and localities face budgetary crises, they must prove that systems are economical. Careful tracking may show that effective decision-making mechanisms for this at-risk population can actually save public dollars over time.
- **Accountability.** Decisions should be tracked and regularly evaluated to ensure a high quality system.
- **Expertise.** Decision-makers should have sufficient background and/or receive training on health care law and ethics and on communicating with elderly patients—and should have timely access to sufficient expertise on clinical issues.
- **Credibility.** The system should be recognized as a qualified arbiter on health care decisions and should have the trust and confidence of professionals and the public.