SURGICAL ETHICS CHALLENGES

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Dominions of surrogate opinions: who is in charge?

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A man with one watch knows what time it is; a man with two watches is never quite sure.

- Lee Segall

A week ago you successfully repaired an acute aortoduodenal fistula in Mr. R. O. Under. He was alert on admission but now remains ventilator dependent and comatose. The criteria for neurological death have not been met. He is married and has several grown children. His second wife and he have not been together for 5 years. He has been living with another woman for several months. They intend to marry when his divorce is final. His children have been frequent visitors to the bedside. His wife called this morning and insists that life support be discontinued; his first wife agrees. The patient lives in Texas but not his exes. A close friend insists the patient would not want to live this way and that the patient wanted him to be the surrogate but did not put it in writing. His children and live-in girlfriend adamantly insist that therapy be continued. The patient has a properly executed DNR expressing that if in coma he did not wish resuscitation. Whose instructions should be followed?

A. Follow the wishes of the girlfriend.
B. Follow the wishes of the wife.
C. Follow the wishes of his children.
D. Follow the wishes of the ex-wife.
E. Follow the advice of the friend.

Surrogates are helpful in making serious decisions most of the time but they also can make the situation perplexingly difficult.¹ In the time of effortless medical ethics, before the autonomy epidemic and the introduction of living wills, and the rise of medical technology, decision making was a binary yes/no with little associated handwringing. Most often, in difficult cases, surgeons told patients and relatives what they were going to do next and did what they thought best with little discussion. Nature decided when someone died and death was battled all out until the resuscitation failed. The preamble at the meeting to inform families of a death often started, “We did everything possible but . . .”

Then as life-extending therapies became burdensome both from their extending misery and chewing up resources, patients’ rights advocates trotted in surgical autonomy and problems with surrogates surfaced.

Surrogate decision making has been accepted in law and medical ethics for more than 3 decades and is therefore very well established. Surrogate decision making is required when the patient has a court-appointed guardian after being adjudicated incompetent or, when there is no guardian (which is usually the case) and the patient is judged by his or her attending physician to be unable to participate in the informed consent process about his or her medical care.

In medical ethics and law, 2 standards guide surrogate decision making.² The priority standard is substituted judgment: the surrogate should conscientiously attempt to make the decision that the patient would make, based on the surrogate’s knowledge of the patient’s values, beliefs, and preferences. When the surrogate cannot meet this standard, the best interests standard applies: the surrogate should make a decision that protects and promotes the patient’s health-related and other interests. The best interests standard does not mandate continued life-sustaining treatment when discontinuation is indicated because of a very poor prognosis and iatrogenic morbidity, pain, distress, and suffering are increasing.

Theoretically, these standards are clear but humanity by nature is subjectively vague. Surrogate decision makers frequently do not understand the ICU status of the patients they represent.³ Less than half, regardless of educational level, had adequate knowledge of what was going on and what would happen in the event of a cardiac arrest. Non-English-speakers had even worse knowledge. Nurses’ explanations were better understood than physicians’ explanations. Reasons surrogates gave for the ICU communication problems were the explanation was too hurried, the explanation was too complicated, and the explanation was too emotionally upsetting.

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Competition of interest: none.
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0741-5214/$36.00
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doi:10.1016/j.jvs.2008.10.001

249
Another impediment to surrogate decision making is that an incredible 88% of family members of critically ill patients doubted the physician’s prognosis. Some harbored a belief that God would alter the course of the illness; others believed that predicting the future is inherently uncertain, remembering prior experiences where physicians’ prognostications were inaccurate.

Surrogate decisions that inaccurately represent the patient’s wishes, provided the surgeon has a basis for reasonable certainty that the surrogate is mistaken, do not meet the substituted judgment standard. These decisions are therefore not ethically binding on the surgeon. Surrogate decision-making fails to reflect the patient’s wishes accurately in 70% of important treatment issues. To address this problem, the surgeon should ask the surrogate to relate what he or she knows about the patient’s values, beliefs, and preferences and the basis for this knowledge. Asking the surrogate to report conversations with the patient that are relevant to the decisions at hand can be very helpful in satisfying the substituted judgment standard.

There are several problems in the present case concerning surrogate decision making. First, the patient’s current wife is legally his surrogate decision maker. No one else has legal standing. Second, the surgeon knows only her decision, not its basis and thus whether it meets the substituted judgment standard. Third, there are other reports on what the patient’s decision would be and these might meet the substituted judgment standard even if they come from someone other than the patient’s current wife. In short, there are too many surrogates and those most involved disagree with the one who is higher on the legal preference list.

The first step is to make it clear who has legal authority to act as the surrogate decision maker. Texas, along with 14 other states and the District of Columbia, are common law states where a cohabiting couple can be considered married if the following criteria are met: they must live together for a significant period of time (not defined in any state); hold themselves out as a married couple – typically this means using the same last name, referring to the other as “my husband” or “my wife,” and filing a joint tax return; and intend to be married. The patient, however, is still legally married so his girlfriend cannot be his common-law wife. She may have the best wishes of any participant, but this gives her no legal standing. Option A is out, legally.

The ex-ex wife has even less legal standing than the present near ex-wife, and perhaps time has healed some wounds, but we can’t count on it. Option D is out. Without proof of the patient’s wishes, the friend has the least standing of those involved. His lack of standing emphasizes the need for all adults to execute a living will to avoid the angst that similar emergency situations can cause. Option E is out, legally.

Option B is the correct legal option, insofar as designating the appropriate surrogate decision maker; she should be informed that she has an ethical obligation to make the decision that, on the basis of reliable knowledge of her husband’s values, beliefs, and preferences, he would make. Some states also make this the legally preferred standard, Texas among them. Because she has not lived with her husband for 5 years, she cannot report reliably on his most recent values, beliefs, and preferences. She can, however, report on what she knows of her husband’s values, beliefs, and preferences when they were together and she should be asked to do so. The patient’s girlfriend can, however, report on his more recent values, beliefs, and preferences. If in the surgeon’s judgment, the girlfriend’s report meets the substituted judgment standard, then the surgeon should ask the wife to endorse these and authorize continued treatment.

If the patient’s wife declines to do so, then her request to discontinue treatment loses ethical authority and, in Texas, legal authority. The surgeon should immediately contact institutional counsel to explore legal responses to the wife’s failure to meet her ethical and legal obligation as a surrogate decision maker in this case.

Although the legally correct answer is Option B, it is confined to the issue of who is the legally designated surrogate decision maker. However, the ethically correct answer to this case is Option C; if the wife is unable to faithfully represent her husband’s wishes, she should decline the role of surrogate decision maker, in which case this role passes by law to their children.

In a socially awkward situation such as this, the surgeon would be wise to ask patients beforehand who should be their surrogate decision maker, should the need arise.

This scenario in a less complicated format was suggested by Dr. Julian E. Losanoff of John D. Dingell Veterans Administration Medical Center of Detroit and the Harper University Hospital.

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Conception and design: JJ
Analysis and interpretation: JJ
Data collection: JJ
Writing the article: JJ
Critical revision of the article: JJ
Final approval of the article: JJ
Statistical analysis: JJ
Obtained funding: JJ
Overall responsibility: JJ

REFERENCES