Background and Rationale: ICU clinicians regularly care for patients who lack capacity, an applicable advance directive, and an available surrogate decision-maker. Although there is no consensus on terminology, we refer to these patients as “unrepresented.” There is considerable controversy about how to make treatment decisions for these patients, and there is significant variability in both law and clinical practice.

Purpose and Objectives: This multisociety statement provides clinicians and hospital administrators with recommendations for decision-making on behalf of unrepresented patients in the critical care setting.

Methods: An interprofessional, multidisciplinary expert committee developed this policy statement by using an iterative consensus process with a diverse working group representing critical care medicine, palliative care, pediatric medicine, nursing, social work, gerontology, geriatrics, patient advocacy, bioethics, philosophy, elder law, and health law.

Main Results: The committee designed its policy recommendations to promote five ethical goals: 1) to protect highly vulnerable patients, 2) to demonstrate respect for persons, 3) to provide appropriate medical care, 4) to safeguard against unacceptable discrimination, and 5) to avoid undue influence of competing obligations and conflicting interests. These recommendations also are intended to strike an appropriate balance between excessive and insufficient procedural safeguards. The committee makes the following recommendations: 1) institutions should offer advance care planning to prevent patients at high risk for becoming unrepresented from meeting this definition; 2) institutions should implement strategies to determine whether seemingly unrepresented patients are actually unrepresented, including careful capacity assessments and diligent searches for potential surrogates; 3) institutions should manage decision-making for unrepresented patients using input from a diverse interprofessional, multidisciplinary committee rather than ad hoc by treating clinicians; 4) institutions should use all available information on the patient’s preferences and values to guide treatment decisions; 5) institutions should manage decision-making for unrepresented patients using a fair process that comports with procedural due process; and 6) institutions should employ this fair process even when state law authorizes procedures with less oversight.

Conclusions: This multisociety statement provides guidance for clinicians and hospital administrators on medical decision-making for unrepresented patients in the critical care setting.

Keywords: substituted judgment; surrogate; unrepresented; adult orphan; patient without advocate
Overview
ICU clinicians regularly face situations in which an adult patient lacks decision-making capacity, an applicable advance directive, and any available surrogate decision-maker (1–6). For these patients, there is no one with whom the clinician can engage in shared decision-making, which is recommended for important, value-laden decisions in ICUs (7). Available evidence shows that the absence of a decision-maker causes patients to face significant risks of being overtreated, undertreated, or otherwise treated inconsistently with their preferences and values (8–10).

This policy statement refers to these patients as “unrepresented patients.” Yet, there is no consensus on which term to use, and others use “unbefriended” or “incapacitated patient without advocate” (11). In addition to terminology, there is considerable controversy over how to make medical treatment decisions for these patients (12). Moreover, in the ICU setting, there is significant variability in how decisions are made and little guidance about how to do so (2).

The committee developed this policy statement to help clinicians and hospital administrators design fair and feasible procedures for making treatment decisions for unrepresented patients in the ICU setting. This policy statement provides 1) an ethical analysis of medical decision-making for unrepresented patients, 2) recommended decision-making procedures for unrepresented patients in the critical care setting, and 3) proposed components of a model institutional policy on decision-making for unrepresented patients in ICUs.

The six recommendations described below have two primary justifications. First, they promote the following five ethical goals: 1) to protect highly vulnerable patients, 2) to demonstrate respect for persons, 3) to provide appropriate medical care, 4) to safeguard against unacceptable discrimination, and 5) to avoid the undue influence of competing obligations and conflicting interests. Second, the six recommendations help strike an appropriate balance between excessive and insufficient procedural safeguards. Excessive safeguards may delay providing patients with appropriate medical care and may be too cumbersome for clinicians and institutions. Insufficient safeguards may fail to adequately promote the five ethical goals.

Recommendation 1
Institutions should promote advance care planning to prevent patients at high risk from becoming unrepresented in the first place, both 1) by helping adult patients with decision-making capacity to identify a preferred surrogate decision-maker and to record their preferences and values in an advance directive and 2) by ensuring that such documents are available to clinicians at the point of care.

Recommendation 2
Institutions should implement strategies to determine whether seemingly unrepresented patients are, in fact, unrepresented by 1) carefully assessing medical decision-making capacity, 2) diligently searching for suitable surrogates among the patient’s family and friends, and 3) involving any nonhospital individuals who have shown care and concern for the patient’s welfare and are familiar with the patient’s values and preferences.

Recommendation 3
Institutions should manage decision-making for unrepresented patients using collaboration between the clinical team and a diverse interprofessional, multidisciplinary committee rather than ad hoc by treating clinicians.

Recommendation 4
Institutions should use all available information on the patient’s preferences and values to guide decisions. If such information is not available, the committee should collaborate with the treatment team to make decisions in the patient’s best interest.

Recommendation 5
Institutions should manage decision-making for unrepresented patients using a fair process that comports with principles of procedural due process, such as transparency, legitimacy, and consistency.

Recommendation 6
Institutions should employ this fair process even when state law authorizes procedures with less oversight.

Introduction
ICU clinicians regularly face situations in which an adult patient lacks both decision-making capacity and any available surrogate decision-maker (1–6). For these patients, there is no one with whom the clinician can engage in shared decision-making, which is recommended for important, value-laden decisions in ICUs (7). Available evidence shows that the absence of a decision-maker causes patients to face significant risks of being overtreated, undertreated, or otherwise treated inconsistently with their preferences and values (8–10).

This policy statement refers to these patients as “unrepresented patients.” Yet, there is no consensus on which term to use,
and others use “unbefriended” or “incapacitated patient without advocate” (11). There is considerable controversy over how to make medical treatment decisions for these patients (11, 12). Moreover, in the ICU setting, there is significant variability in how decisions are made and little guidance about how to do so (2).

Unrepresented patients in the critical care setting are common (5). In 2006, White and colleagues found that 16% of patients admitted to an ICU were unrepresented (1). In 2007, White and colleagues found that 5% of patients who died in the ICU were unrepresented (2). In a more recent survey of critical care clinicians and hospitalists, nearly 50% of respondents reported seeing at least one unrepresented patient per month (3). Other studies measuring the number of unrepresented patients in other healthcare settings corroborate these figures (4, 6, 13).

Incapacitated critically ill patients without an applicable advance directive or a surrogate decision-maker leave clinicians in a quandary. Providers in the United States generally take three different approaches: 1) providing treatment, 2) withholding or withdrawing treatment, or 3) delaying treatment. First, some clinicians might treat the patient without consent. Erring on the side of prolonging life, they may administer improperly prolonged life-sustaining treatment despite limited prospects of benefit, despite burdens on the patient, and even despite evidence of the patient’s wishes to avoid such treatment (5, 14). Second, some clinicians might withhold or withdraw treatment because they unilaterally deem it to be potentially inappropriate. Third, other clinicians may delay treatment until the patient regains capacity or a court-appointed surrogate decision-maker is identified.

These inconsistencies are ethically problematic. Furthermore, this variability in care exposes unrepresented patients to three types of risks: overtreatment, undertreatment, and delayed treatment. In addition, because there is no one to authorize discharge, the unrepresented often have prolonged hospital stays. ICU stays for unrepresented patients are often twice the duration of stays for other patients (9, 10).

Although several professional societies have published policy statements regarding decision-making for unrepresented patients (11, 15, 16), none specifically addresses decision-making for unrepresented patients in the critical care setting. Moreover, these guidelines differ substantially on who may act as a surrogate and authorize treatment decisions on behalf of unrepresented patients (Table 1). State healthcare surrogate laws vary as well (Table 2) (3, 17–19). These conflicting laws and conflicting guidelines from professional societies are problematic. This variability may exacerbate confusion on this topic among clinicians, hospital administrators, and policy makers (15, 20–22).

Both because of these complexities and because clinicians need clear guidance, the American Thoracic Society (ATS) convened a multisociety working group to make recommendations regarding how to make treatment decisions for unrepresented patients in the context of acute critical illness. This ATS/American Geriatrics Society (AGS) policy statement provides clinicians and hospital administrators with guidelines for medical treatment decision-making on behalf of unrepresented patients.

The committee developed this policy statement to help clinicians and hospital administrators design fair and feasible procedures for making treatment decisions for unrepresented patients in the ICU setting. This policy statement provides 1) an ethical analysis of medical decision-making for unrepresented patients, 2) recommended decision-making procedures for unrepresented patients in the critical care setting, and 3) proposed components of a model institutional policy on decision-making for unrepresented patients in ICUs.

This policy statement focuses on decisions regarding life-sustaining treatment for adult patients. It does not address 1) decision-making for unrepresented patients outside the ICU setting, 2) decision-making for biomedical research purposes, 3) decision-making in emergencies, or 4) decisions regarding organ donation and other postmortem decisions. This policy statement also does not address decisions for minor interventions that are less consequential and may require less process and oversight (e.g., administration of most drugs and vaccines or the performance of minor procedures, such as routine X-rays) (7, 23).

Methods

An interprofessional, multidisciplinary expert committee developed this policy statement using an iterative process. The ATS Ethics and Conflict of Interest Committee first convened an ad hoc working group composed of a subset of members of the ATS Ethics and Conflict of Interest Committee. The committee evaluated the need for additional expertise and invited 20 national experts to join the working group. The full working group was diverse and represented a breadth of disciplines, including critical care medicine, palliative care, pediatric medicine, nursing, social work, gerontology, geriatrics, patient advocacy, bioethics, philosophy, elder law, and health law.

The working group first reviewed known relevant literature, including journals with a focus in medicine, critical care, bioethics, and law. The group deemed this broad approach appropriate because this document is a policy statement that relies heavily on theoretical analysis informed by available research data and is not intended to be considered a practice guideline. The group also reviewed existing policies of other medical organizations. The group then developed the content of this policy through a 3-year iterative discussion–based consensus process consisting of face-to-face meetings, teleconferences, web conferences, and electronic correspondence. A writing committee drafted the policy statement, which the working group members then reviewed on multiple occasions and revised. The policy statement was further modified and ultimately approved by members of the ATS and AGS ethics committees. This statement then underwent a peer review process and ultimately review by both the ATS Board of Directors and the AGS Board of Directors.

Ethical Goals for Decision-Making for Unrepresented Patients

A review of the literature on unrepresented patients reveals five key reasons why guarded diligence and careful evaluation are required when making treatment decisions for unrepresented patients: 1) to protect highly vulnerable patients, 2) to demonstrate respect for persons, 3) to provide appropriate medical care, 4) to safeguard against unacceptable discrimination, and 5) to avoid undue influence of competing obligations and interests (Table 3).
Protect Highly Vulnerable Patients

Unrepresented patients in the ICU are extremely vulnerable in several ethically relevant ways (24). First, patients in ICUs cannot advocate for themselves, because they frequently lack decision-making capacity owing to the severity of their illness and/or sedative and pain-relieving medications (7, 25, 26). Second, unrepresented patients lack trusted and reliable friends or family to advocate on their behalf. Third, when admitted to an ICU, patients (including unrepresented patients) usually lack a choice of healthcare proxy. They are completely dependent on the institution and its clinicians. For all these reasons, commentators have described unrepresented ICU patients as “unimaginably helpless” (27), as “highly vulnerable” (11), and as the “most vulnerable” (11).

Demonstrate Respect for Persons

Although manifesting respect for patient autonomy is a core principle of medical ethics, it is generally not applicable in the context of making decisions regarding life-sustaining treatment for unrepresented patients. This is because respecting a patient’s autonomy requires the patient to have expressed an autonomous treatment preference applicable to the clinical situation at hand. By definition, unrepresented patients cannot currently articulate treatment preferences specific to the clinical decision at hand. Most have not done so previously, and even if they have, evidence of those preferences is usually not available (28).

This committee proposes that the broader ethical goal of manifesting respect for persons should be viewed as central to care processes for unrepresented patients. Respect in this context involves both the attitudes one adopts toward the unrepresented patient and the behaviors one manifests. Respect for persons requires an acknowledgment of each person’s worth and dignity. The display of respect can take on numerous forms, such as making extensive efforts to learn about and treat the patient as a unique individual, incorporating all that is known about the patient’s values into treatment decisions, ensuring serious moral deliberation about decisions, and encouraging others to adopt a demeanor of sincere regard and caring for the person in all interactions.

Learning and incorporating the patient’s individuality, values, goals, culture, and previously expressed treatment preferences manifests respect for persons, a core ethical obligation of the medical profession (7, 24). Physical harm is not the only type of risk posed to the unrepresented. Whether overtreated or undertreated, the unrepresented are susceptible to treatment decisions that do not conform to their personal values, morals, or beliefs. This is a serious affront to respect for persons.

The Institute of Medicine observes that patients “who have neither decision-making capacity nor a surrogate decision-maker are at particular risk of not having their wishes known or followed” (8). For instance, several studies report that clinicians often make decisions based on their own idiosyncratic personal preferences. They may not know the patient, or they may not be willing and/or able to take the time to learn the patient’s preferences (29, 30). A treatment decision that is not based on a patient’s own preferences and values, when ascertainable, is particularly offensive in a society that places a premium on individual self-determination (7).

Provide Appropriate Medical Care

In addition to the risk of disrespect for persons, unrepresented patients face three types of treatment risk: overtreatment, undertreatment, or delayed treatment. In overtreated patients, the absence of an authorized surrogate often results in “maximum medical intervention, whether or not a medical ‘full court press’ is clinically and ethically warranted” (31). There are several reasons why the unrepresented receive unnecessary or unwanted treatment, including 1) clinicians’ fear of not providing appropriate treatment, 2) fear of civil liability for failure to treat, 3) institutional fear of regulatory sanctions, 4) clinicians’ economic incentives to treat, and 5) clinicians’ general interventionist philosophy of medicine.

Most unrepresented patients are overtreated, but some are undertreated. With no surrogate to object, some clinicians may decide that treatment is inappropriate and unilaterally withhold or withdraw it.

Table 1. Existing Policy Statements Pertaining to Unrepresented Patients

| Year | Author/Society | Decision-Maker |
|------|----------------|----------------|
| 1992 | New York State Task Force on Life and the Law | Interprofessional, multidisciplinary committee |
| 2003 | American Bar Association | Interprofessional, multidisciplinary committee |
| 2006 | Los Angeles County Medical Association | Interprofessional, multidisciplinary committee |
| 2015 | California Hospital Association | Interprofessional, multidisciplinary committee |
| 2016 | American Medical Association | Hospital ethics committee |
| 2016 | American Geriatrics Society | Institutional committee (e.g., ethics) or healthcare team according to a standardized process |
| 2017 | Veterans Health Administration | Interprofessional, multidisciplinary committee + chief of staff + facility director |
| 2019 | American College of Physicians | Court-appointed guardian |

Table 2. State Healthcare Surrogate Decision Laws Pertaining to Unrepresented Patients

| State                      | Decision-Maker                  |
|----------------------------|---------------------------------|
| Connecticut, Nebraska, North Dakota, Oregon, Arizona, Arkansas, Louisiana, Tennessee, Texas, Alabama, California, Colorado, Montana, Florida, Texas, New York | Attending alone |
|                            | Attending + second physician    |
|                            | Attending + ethics committee    |
|                            | Interdisciplinary team          |
|                            | Medical proxy + ethics committee |
|                            | Independent clinical social worker |
|                            | Member of clergy                |
|                            | Court                           |
Other clinicians may refuse to provide any type of treatment without informed consent. Consequently, important decisions may be “postponed dangerously [or] forgone altogether” (32, 33).

Some clinicians will wait until an emergency, when consent is implied and therefore there is no need for a surrogate to authorize treatment (3). However, waiting for an emergency may result in longer periods of suffering and indignity, increasing the chance of morbidity or even mortality. The absence of a surrogate can “stymie decision-making and possibly leave . . . patients to linger in pain and discomfort” (34). The Institute of Medicine found it ethically “troublesome” to wait “until the patient’s medical condition worsens into an emergency so consent to treat is implied.” Such an approach “compromises patient care and prevents any thorough and thoughtful consideration of patient preferences or best interest” (8).

### Table 3. Five Ethical Goals for Safeguards in Decision-Making for Unrepresented Patients

| 1. Protect highly vulnerable patients |
| 2. Demonstrate respect for persons |
| 3. Provide appropriate medical care |
| 4. Safeguard against unacceptable discrimination |
| 5. Avoid undue influence of competing obligations and conflicting interests |

Avoid Undue Influence of Competing Obligations and Conflicting Interests

Competing obligations occur when clinicians have two or more valid professional responsibilities that conflict. Increasingly, clinicians are perceived to have ethical commitments both to individual patients and to society at large to manage resources in a cost-conscious manner. When clinicians act as decision-makers for their patients, there may be greater likelihood that the patient’s interests are not adequately represented, considered, and balanced against the obligation to populations of patients (12, 46).

A related but distinct concern is that clinicians’ real or perceived conflicts of interest may compromise their ability to act as decision-maker for an unrepresented patient. At least two types of secondary interests could unduly influence the clinician’s professional judgment about the well-being of the unrepresented patient. First, financial interests of the clinician and/or institution could be affected by treatment decisions. For example, potential conflict could lead to overtreatment of patients in fee-for-service reimbursement models and to undertreatment in capitated models. Pressure to make scarce ICU beds available could also lead to undertreatment.

Second, clinicians face nonfinancial conflicts of interest. ICU clinicians generally work as part of an interprofessional, multidisciplinary team. To some degree, their professional satisfaction and advancement depend on good relationships with colleagues. End-of-life care often causes disagreement and moral conflict or distress among staff. Clinicians have an interest in maintaining cordial peer relationships and therefore in making decisions that will keep peace in the ICU. This will push toward overtreatment in some institutions and undertreatment in others.

### Recommendations

Institutions should heed six recommendations outlined below (Table 4). They are designed to promote the five ethical goals. They are also intended to strike an appropriate balance between excessive and insufficient procedural safeguards. Excessive safeguards may unnecessarily delay providing patients appropriate medical care and may be too cumbersome for clinicians and institutions. Insufficient safeguards fail to adequately promote the five ethical goals.

**Recommendation 1**

**Institutions should promote advance care planning to prevent patients at high risk for becoming unrepresented from meeting this definition, both 1) by helping adult patients with decision-making capacity to identify a preferred surrogate decision-maker and to record their preferences and values in an advance directive and 2) by ensuring that such documents are widely available to clinicians at the point of care.**

Ideally, potentially unrepresented patients would engage in advance care planning in the community in places of worship, homeless shelters, social support agencies, legal aid offices, and primary care offices. Unfortunately, limited time and training constrain these discussions in the clinical environment. However, advance care planning can be effectively implemented in the hospital or ICU. Indeed, this is specifically mandated by the Patient Self Determination Act (47). Several studies found that although most ICU patients lack capacity, at least one-fourth remain involved with their treatment (37, 48). Many patients can name a surrogate after admission but before losing capacity (49).

Moreover, even if patients’ capacity is impaired, they might still have capacity to share what they think about death, life, their current living situation, and their hopes for the future. In short, unrepresented patients should participate in making decisions to the extent that they can (50). Given that naming a preferred surrogate may not require as much decisional capacity as creating a living will expressing end-of-life treatment preferences, this “first step” in advance care planning should be encouraged upon admission or during periods of lucidity and documented when possible (23).
Table 4. Policy Recommendations for Medical Decision-Making for Unrepresented Patients in Intensive Care Medicine

| Recommendation | Description |
|----------------|-------------|
| Recommendation 1 | Institutions should promote advance care planning to prevent patients at high risk for becoming unrepresented from meeting this definition, both 1) by helping adult patients with decision-making capacity to identify a preferred surrogate decision-maker and to record their preferences and values in an advance directive and 2) by ensuring that such documents are widely available to clinicians at the point of care. |
| Recommendation 2 | Institutions should implement strategies to determine whether seemingly unrepresented patients are, in fact, unrepresented, including 1) carefully assessing capacity, 2) diligently searching for potential surrogates among the patient’s family and friends, and 3) involving any nonhospital individuals who have shown care and concern for the patient’s welfare and are familiar with the patient’s preferences and values. |
| Recommendation 3 | Institutions should manage decision-making for unrepresented patients using collaboration between the clinical team and a diverse interprofessional, multidisciplinary committee rather than ad hoc by treating clinicians. |
| Recommendation 4 | Institutions should use all available information on the patient’s preferences and values to guide treatment decisions. If such information is not available, the committee should collaborate with the treatment team to make decisions in the patient’s best interest. |
| Recommendation 5 | Institutions should manage decision-making for unrepresented patients using a fair process that comports with procedural due process, such as transparency, legitimacy, and consistency. |
| Recommendation 6 | Institutions should employ this fair process even when state law authorizes procedures with less oversight. |

Second, capacity is not all or nothing; it is decision specific. Several studies found that although most ICU patients lack capacity to make decisions about life-sustaining treatment, approximately one-fourth to one-third still have at least partial capacity (37, 48). For example, although patients may lack the capacity to make complex treatment decisions, they may have sufficient capacity to appoint a surrogate. Moreover, the ability of critically ill patients to participate in decision-making often fluctuates over the course of their illness trajectory (7).

Third, loss of decisional capacity may be transient. Delirium caused by infection, poorly controlled pain, sedating medications, or other substances may temporarily cloud the patient’s decisional capacity. These conditions may be superimposed on psychological conditions such as grief, anxiety, or depression or sensory deficits such as hearing or vision loss. When feasible, it is preferable to delay important treatment decisions until reversible causes of impaired capacity are addressed (51).

Search diligently for potential surrogates. For many individuals who are initially thought to be unrepresented, a diligent search often finds an available surrogate. Therefore, before enacting institutional or judicial mechanisms for the unrepresented, many state laws and medical society policy statements first require careful documentation of diligent efforts to locate family or close friend surrogates (52, 53). Processes include examining personal effects, health records, and other social services records (51). Other processes include searching social media, contacting neighbors, and even hiring a private investigator (33).

Family or close friends are preferred over institutional or judicial decision-making. First, they are more likely to know the patient’s values and preferences (54). Second, involving family or a trusted friend in medical decisions is a highly valued aspect of community in most societies. Third, most patients want a trusted family member or friend to be involved in their treatment decisions (7). Fourth, most states include these individuals on a statutory hierarchical order of surrogate decision-making. For these reasons, the search for potential surrogates should be aggressive and rigorous (51). Even if a surrogate is not identified, this search process may reveal information about the patient’s values and preferences that can guide treatment decisions (and is itself a manifestation of respect for persons).

Involve individuals who know and care for the patient. Clinicians can learn important information about a patient’s preferences and values from people who are not willing or permitted to function as a surrogate. These individuals may know and care about the patient and can play a valuable role as “adviser” even if not as “decider.” Consulting with these individuals is a way to ensure that all pertinent information about the patient is considered. Unfortunately, many state laws are narrow and do not formally recognize some potential surrogates who may know and care about the patient (17). Some states recognize only a few types of family members. Some states do not recognize domestic partners or “close friends” to make decisions when no family member is available (55). Nevertheless, nearly 10% of patients select nonrelatives as their healthcare agents (56). Clinicians are often unfamiliar with these laws, which vary considerably from state to state (3, 57–59).
In fact, clinicians may seek the involvement of such nonhospital individuals, even when state law is too narrowly constructed to officially authorize them as surrogates (7). Although this is not specifically authorized, it is not prohibited. Furthermore, clinicians may seek relevant information from individuals who are uncomfortable with formally assuming the role of surrogate decision-maker.

**Recommendation 3**

**Institutions should manage decision-making for unrepresented patients using collaboration between the clinical team and a diverse interprofessional, multidisciplinary committee rather than ad hoc by treating clinicians.**

**Risks of ad hoc decisions by treating clinicians.** Commonly, treating clinicians assume sole decisional authority when caring for unrepresented ICU patients (6, 12). However, this is problematic for four key reasons. First, there is well-documented variability between clinicians in their judgments about what is appropriate care in such cases, raising the concern of undue variability in treatment decisions (60–65). Second, the perspectives of ICU clinicians about preferences for end-of-life care often differ significantly from the perspectives of patients and their family members (66–70). Third, removing the need for clinicians to justify or explain a treatment plan may eliminate an incentive to carefully consider the plan of care (12). Fourth, giving clinicians unilateral authority risks introducing bias and conflicts of interest. Indeed, most state laws prohibit hospital employees from serving as patient-designated healthcare agents or court-appointed guardians for this very reason (71).

**Advantages of an interprofessional, multidisciplinary process.** Although entrusting decision-making to a single individual may be efficient, this advantage must be weighed against the plurality of views represented in a larger committee. In nonemergencies, institutional mechanisms are preferred to ad hoc strategies by clinicians because they can safeguard key elements of procedural fairness, including transparency, legitimacy, consistency, and the opportunity for appeal and review (72–74).

An interprofessional, multidisciplinary process will improve framing of decisions, putting specific clinical decisions at hand into the broader context of what is known of the patient’s values and goals and the likely prognosis relative to the burdens of interventions (e.g., what probability of recovery, to what level of health, in what time period, and with what burdens?). There are communication techniques that are employed with surrogates (e.g., best case, worst case, or most likely case) that can be extrapolated to diverse interprofessional, multidisciplinary committees to ensure that all relevant factors have been considered to explain to other people the clinical situation, the decisions at hand, and the reasoning behind the plan of care (75).

Procedural fairness is especially important, because the cases in question are often ethically controversial, have important interests at stake, and do not have explicit rules that can be mechanically applied (76, 77). Moreover, these cases inherently involve patients who are vulnerable by virtue of critical illness and incapacity and who have little choice regarding their treating clinicians. It is ethically important to incorporate multiple perspectives to minimize the risk that the values of any one individual carry undue weight. Within institutions, a process-based approach may lessen arbitrariness by ensuring broader input, consistency, transparency, and the possibility for continuous institutional learning about how to manage future cases (72, 78, 79).

There are several potential criticisms of institutional interprofessional, multidisciplinary management. Compared with ad hoc management by clinicians, institutional management strategies 1) potentially have a higher administrative burden; 2) might constrain clinician autonomy; and 3) may require more time; and 4) could lead to groupthink, such that pressure to agree results in failure to think critically and premature closure (20, 80).

However, these possible disadvantages are mitigated because interprofessional, multidisciplinary management strategies can use existing resources (e.g., the institutional ethics committee) and can be tailored to the capabilities of the individual institution (81, 82). There are techniques to elicit all options and arguments, such as assigning one member to make the case for limiting life-sustaining interventions and another to make the case for continuing them. Furthermore, the possible disadvantages are outweighed by the importance of maintaining procedural fairness and the need to protect particularly vulnerable patients.

**Composition of the interprofessional, multidisciplinary committee.** To ensure logistical feasibility, institutions should have flexibility in how to form the diverse interprofessional, multidisciplinary committee. For example, it may be desirable to form a subcommittee from a larger standing committee that already has the requisite interprofessional, multidisciplinary representation, such as an ethics committee. Similarly, institutional policies might assign certain processes to one or more members to accommodate local resources and to enhance efficiency. For example, the individual responding to a request for ethics consultation may also initiate convening the interprofessional, multidisciplinary committee and may delegate tasks to committee members.

Whenever possible, the interprofessional, multidisciplinary committee should include three to five members, including a physician, a nurse, and one person who is neither (e.g., a chaplain or social worker). Whenever possible, this committee should include representation from social work, the ethics committee, and the community (83, 84). The committee should not include members of the primary treatment team or its medical consultants (23). Ideally, the committee is diverse in terms of role, gender, and socioeconomic status.

**Recommendation 4**

**Institutions should use all available information on the patient’s preferences and values to guide treatment decisions.** If such information is not available, the committee should collaborate with the treatment team to make decisions in the patient’s best interest.

The diverse interprofessional, multidisciplinary committee and treating clinicians should use all available information on the patient’s preferences and values to make the medical decision that is maximally consistent with them under the circumstances. Upon admission, most unrepresented patients do not have a clearly applicable advance directive or Provider Orders for Life-Sustaining Treatment (POLST). Regardless, the interprofessional, multidisciplinary committee should attempt to infer patients’ goals, values, or wishes from evidence of the patient’s
Table 5. Summary of Components of Institutional Policy

| Component | Description |
|-----------|-------------|
| Component 1 | Early identification of incapacitated and potentially unrepresented patients |
| Component 2 | Interprofessional, multidisciplinary committee confirms that a diligent search was completed and that the patient is unrepresented |
| Component 3 | Interprofessional, multidisciplinary committee diligently gathers information about patient’s condition, goals of care, and values |
| Component 4 | Interprofessional, multidisciplinary committee engages with clinical team to deliberate and make treatment decisions |
| Component 5 | Expedited processes for time-pressured nonemergency decisions |
| Component 6 | Periodic retrospective review of cases |
| Component 7 | If applicable, follow recommended processes for potentially inappropriate treatment |
| Component 8 | Guardianship for ongoing cases |

3. The interprofessional, multidisciplinary committee diligently gathers information about the patient’s condition, goals of care, and values. The interprofessional, multidisciplinary committee should meet with the attending clinician and team and ascertain the patient’s condition, medical history, social history, and prognosis. The committee should obtain a second opinion from another independent clinician with expertise in the patient’s condition, addressing both the patient’s prognosis and the recommended treatment plan. Consistent with Recommendations 3 and 4 above, the committee should also gather and review evidence (if any) on the patient’s values and preferences, including religious and moral beliefs, and record these in the medical record. Generally, the committee should follow the instructions in an advance directive, POLST, or similar document, if available. However, such information is almost never dispositive of what care should be administered. The specific medical circumstances confronting a patient in the ICU and the decisions that need to be made in these circumstances are extremely difficult to anticipate.

4. The interprofessional, multidisciplinary committee engages with the clinical team to deliberate and make treatment decisions. The interprofessional, multidisciplinary committee should engage with the clinical team to deliberate and make treatment decisions. The institutional policy should establish whether the committee is serving as a surrogate in a shared decision-making model with the treatment team (making the treatment decision) or acting in an advisory and oversight role (providing recommendations and ensuring soundness of deliberations). Either way, the committee should explain the basis for its decisions or recommendations, especially how they are consistent with the patient’s values and priorities, if they are known. If such information is not available, the committee should explain how the decision promotes the patient’s best interest by maximizing benefit and minimizing burden.

The committee should not approve any treatment decision on the basis of the patient’s age, race, color, religion, ancestry, national origin, disability, gender, gender identity, gender expression, sexual orientation, or ability to pay, unless such a factor is clearly clinically relevant or is pertinent to the patient’s known values.
such as Jehovah’s Witnesses patient’s wish not to receive blood products. The committee should always advocate for the provision of appropriate pain relief and palliative care.

5. Expedited processes for time-pressured nonemergency decisions. When time pressures (such as a rapidly deteriorating clinical condition) make it infeasible to convene a diverse interprofessional, multidisciplinary committee, clinicians should endeavor to achieve as much procedural oversight as the clinical situation allows. Whenever possible, clinicians should obtain confirmation from a clinical ethics consultant or from an independent clinician that an expedited process is necessary. In situations in which decisions must be made so quickly that no procedural oversight is possible, there should be retrospective review. Clinicians should, to the extent possible, not allow situations to become time pressured. It is ethically “troublesome” to wait “until the patient’s medical condition worsens into an emergency so consent to treat is implied” (8).

6. Periodic retrospective review of cases. A mechanism for periodic retrospective review of decisions for unrepresented patients should be a component of an institutional mechanism for periodic retrospective review. Even when state law authorizes procedures with less oversight, in situations in which decisions must be made so quickly that no procedural oversight is possible, there should be retrospective review. Retrospective review is useful, especially when local law permits a process to make treatment decisions on behalf of the unrepresented patient.

7. If applicable, follow recommended processes for potentially inappropriate treatment. If the care team believes that the interprofessional, multidisciplinary committee is requesting interventions that are futile or potentially inappropriate, they should refer to the 2015 multiorganization consensus statement on responding to requests for futile or potentially inappropriate interventions in the ICU (86). In these cases, a formal ethics consultation and review by the hospital’s ethics committee should be initiated. Both to ensure due diligence and to avoid role confusion, the interprofessional, multidisciplinary committee in this process should not be the same committee promoting procedural fairness on behalf of the unrepresented patient. In cases of persistent disagreement, if feasible on the basis of local laws and resources, the institution should consider initiating the appropriate processes in its jurisdiction to obtain a legal guardian or conservator.

8. Guardianship for ongoing cases. A goal of this document is to identify a process by which clinicians can provide nonemergent medical care for an unrepresented patient without a surrogate’s consent. The number and complexity of decisions for unrepresented patients may increase as these patients become sicker. However, sometimes the care team expects an unrepresented patient to remain incapacitated with ongoing healthcare needs for a considerable length of time. In these cases, if feasible on the basis of local laws and resources, the institution should consider initiating the appropriate processes in its jurisdiction to obtain a legal guardian or conservator (11).

Recommendation 6
Institutions should employ this fair process even when state law authorizes procedures with less oversight.

Some state laws authorize clinicians to make treatment decisions on behalf of unrepresented patients with little or no oversight (Table 2) (87–91). Yet, because of the vulnerability of unrepresented patients, hospitals within these jurisdictions should still use a diverse interprofessional, multidisciplinary committee. In these states, attending clinicians may be the officially recognized decision-makers, but they should still consult with an interprofessional, multidisciplinary committee and follow the above due process and institutional policy. To reconcile this policy statement with the law in these states, the committee may function in an advisory and consultative capacity rather than in a decision-making capacity.

Conclusions
Unrepresented patients in the ICU are particularly vulnerable. Consequently, treatment decisions on their behalf should be evaluated carefully. This policy statement is designed to help clinicians and hospital administrators design fair and practical procedures for making treatment decisions on behalf of unrepresented patients in the ICU setting.

This official policy statement was prepared by an ad hoc subcommittee of the American Thoracic Society and the American Geriatrics Society.

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1. White DB, Curtis JR, Lo B, Luce JM. Decisions to limit life-sustaining treatment for critically ill patients who lack both decision-making capacity and surrogate decision-makers. Crit Care Med 2006;34:2053–2059.

2. White DB, Curtis JR, Wolf LE, Prendergast TJ, Taichman DB, Kuniyoshi G, et al. Life support for patients without a surrogate decision maker: who decides? Ann Intern Med 2007;147:34–40.

3. Godfrey DM. Health care decision-making during a crisis when nothing is in writing. NAEJA J 2018;15:e1–e16.

4. Sadovnikoff N, Jurchak M. Substituted judgments in the absence of surrogates. Crit Care Med 2007;35:2467–2468.

5. Siegel MD. Alone at life’s end: trying to protect the autonomy of patients without surrogates or decision-making capacity. Crit Care Med 2006; 34:2238–2239.

6. Karp N, Wood E. Incapacitated and alone: health care decision-making for the unbefriended elderly. Washington, DC: American Bar Association Commission on Law and Aging; July 2003.

7. Kon AA, Davidson JE, Morrison W, Danis M, White DB. Shared decision-making in intensive care units: executive summary of the American College of Critical Care Medicine and American Thoracic Society policy statement. Am J Respir Crit Care Med 2016;193:1334–1336.

8. Institute of Medicine, Committee on Approaching Death: Addressing Key End-of-Life Issues. Dying in America: improving quality and honoring individual preferences near the end of life. Washington, DC: National Academies Press; 2015.

9. Pearlman RA. Challenges facing physicians and healthcare institutions caring for patients with mental incapacity. J Am Geriatr Soc 1996;44:994–996.

10. Ricotta DN, Parris JJ, Parris RS, Sontag DN, Mukamal KJ. The burden of decision-making for the unbefriended elderly. Washington, DC: American Bar Association Commission on Law and Aging; July 2003.

11. Redding CM, Schwenk TL, Altekruse SM, Gaskin DJ, Karoly LA. Life support for patients without a surrogate decision maker: who decides? Ann Intern Med 2007;147:34–40.

12. White DB, Jonsen A, L. Ethical challenge: when clinicians act as surrogates for unrepresented patients. Am J Crit Care 2012;21:202–207.

13. Royal College of Physicians. End of life care audit – dying in hospital: national report for England, 2016. London: Author; 2016.

14. Sacco J. Incapacitated, alone and treated to death. New York Times 2008 October 6: Sect D 5.

15. Sulmasy LS, Bledsoe TA. American College of Physicians Ethics Manual: Seventh Edition. Ann Intern Med 2019;170(2 Suppl):S1–S32.

16. American Medical Association (AMA). AMA Code of Medical Ethics Opinion 2.1.2(f) [accessed 2020 Apr 14]. Available from: https://www.ama-assn.org/covering-care/ethics-decisions-adult-patients-who-lack-capacity.

17. DeMartino ES, Dudziniski DM, Doyle CK, Spyrry BP, Gregory SE, Siegel M, et al. Who decides when a patient can’t? Statutes on alternate decision makers. N Engl J Med 2017;376:1478–1482.

18. Hulkerow A, Garijo-Garde S, Flicker LS. Should dialysis be stopped for an unrepresented patient with metastatic cancer? JAMA J Ethics 2019;21:5E57–E581.

19. Schweikart SJ. Who makes decisions for incapacitated patients who have no surrogate or advance directive? JAMA J Ethics 2019;21:5E57–E581.

20. Isacs ED, Brody RV. The unbefriended adult patient: the San Francisco General Hospital approach to ethical dilemmas. San Franc Med J 2010;83:25–26.

21. Volpe RL, Steinman D. Peeking inside the black box: one institution’s experience developing policy for unrepresented patients. Hamline Law Rev 2013;36:265–274.

22. Verma A, Smith AK, Harrison KL, Chodos AH. Ethical challenges in caring for unrepresented adults: a qualitative study of key stakeholders. J Am Geriatr Soc 2019;67:1724–1728.

23. Veterans Health Administration, Department of Veterans Affairs, Life-sustaining treatment decisions: eliciting, documenting and honoring patients’ values, goals and preferences. VHA Handbook 1004.03. Washington, DC: Department of Veterans Affairs; 2017 Jan 11 [accessed 2020 Apr 14]. Available from: https://www.va.gov/vhapublications/publications.cfm?pub=2.

24. Brown SM, Azoulay E, Benoit D, Butler TP, Folcarelli P, Geller G, et al. The practice of respect in the ICU. Am J Respir Crit Care Med 2018;197:1389–1395.

25. Appelbaum PS. Clinical practice: assessment of patients’ competence to consent to treatment. N Engl J Med 2007;357:1834–1840.

26. Raymond V, Bingley W, Buchanan A, David AS, Hayward P, Wessely S, et al. Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. Lancet 2004;364:1421–1427.

27. Schmidt WC. Guardianship for vulnerable adults in North Dakota: recommendations regarding unmet needs, statutory efficacy, and cost effectiveness. N D Law Rev 2012;89:77–142.

28. Brudney D. Choosing for another: beyond autonomy and best interests. Hastings Cent Rep 2009;39:31–37.

29. Anthony DL, Herndon MB, Gallagher PM, Barnato AE, Bynum JP, Gotthelf DJ, et al. How much do patients’ preferences contribute to resource use? Health Aff (Millwood) 2009;28:864–873.

30. Hersh ED, Goldenberg MN. Democratic and Republican physicians provide different care on politicized health issues. Proc Natl Acad Sci USA 2016;113:11811–11816.

31. Kapp MB. Editorial—surrogate decision-making for the unbefriended: social and ethical problem, legal solution? J Ethics Law Aging 1995;1:83–85.

32. Kapp MB. The “voluntary” status of nursing facility admissions: legal, practical, and public policy implications. N Engl J Crim Civ Conf 1998;24:1–35.

33. Pope TM. Unbefriended and unrepresented: better medical decision-making for incapacitated patients without healthcare surrogates. Ga State Univ Law Rev 2017;33:923–1019.

34. Meisel A, Cerminara KL, Pope TM. The right to die: the law of end-of-life decisionmaking, 3rd ed. New York: Aspen; 2020.

35. Fitzgerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMJ Med Ethics 2017;18:19.

36. Zestcott CA, Blair IV, Stone J. Examining the presence, consequences, and reduction of implicit bias in health care: a narrative review. Group Process Intergroup Relat 2016;19:528–542.

37. Cook D, Rocker G, Marshall J, Sjokvist J, Dodek P, Griffith L, et al. Withdrawal of mechanical ventilation in anticipation of death in the intensive care unit. New Eng J Med 2003;349:1123–1132.

38. Danis M. The promise of proactive ethics consultation. Crit Care Med 1998;26:203–204.

39. Yeatch RM. Assault or homicide: treating and letting die without consent. Crit Care Med 2002;30:937–938.

40. Meier DE. Voiceless and vulnerable: dementia patients without surrogates: rethinking policies for a vulnerable population. J Am Geriatr Soc 1997;45:375–377.

41. Miller TE, Coleman CH, Cugilari AM. Treatment decisions for patients without surrogates: rethinking policies for a vulnerable population. J Am Geriatr Soc 1997;45:369–374.

42. Schneiderman LJ, Kaplan RM, Pearlman RA, Teetzel H. Do physicians’ own preferences for life-sustaining treatment influence their perceptions of patients’ preferences? J Clin Ethics 1993;4:28–33.

43. Chamberlain SA, Duggleby W, Teaster P, Estabrooks C. Characteristics and unmet care needs of unbefriended residents in long-term care: a qualitative interview study. Aging Ment Health 2020;24:659–667.
44. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. J Gen Intern Med 2013;28:1504–1510.

45. Christakis NA, Asch DA. Biases in how physicians choose to withdraw life support. JAMA 1993;342:642–646.

46. Krutsinger DC, Halpern SD, DeMartino ES. Conflicts of interest in intensive care medicine. Intensive Care Med 2018;44:1765–1766.

47. Patient Self Determination Act of 1990, 42 U.S.C. § 1395ccc(f).

48. Torke AM, Sachs GA, Helft PR, Montz K, Hui SL, Slaven JE, et al. Scope and outcomes of surrogate decision making among hospitalized older adults. JAMA Intern Med 2014;174:370–377.

49. Liley EJ, Morris MA, Sadownikoff N, Luxford JM, Changoor NR, Bystricky A, et al. *Taking over somebody’s life*: experiences of surrogate decision-makers in the surgical intensive care unit. Surgery 2017;162:453–460.

50. Mack JW, Cronin A, Taback N, Huskamp HA, Keating NL, Malin JL, et al. End-of-life care discussions among patients with advanced cancer: a cohort study. Ann Intern Med 2012;156:204–210.

51. Moye J, Cattin C, Kwak J, Wood E, Teaster PB. Ethical concerns and procedural pathways for patients who are incapacitated and alone: implications from a qualitative study for advancing ethical practice. HEC Forum 2017;29:171–189.

52. Proxy decision-makers for medical treatment. definitions. JAMA 2016;315:18–19.

53. Proxy decision-makers. Mont. Code Ann. §§ 50-5-1304–1305.

54. Buchanan A, Brock DW. Deciding for others. JAMA 1986;64:17–94.

55. American Bar Association. Health care decision-making [accessed 2020 Apr 14]. Available from: https://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/.

56. Cohen AB, Trenthalange M, Fried T. Patients with next-of-kin relationships outside the nuclear family. JAMA 2015;313:1369–1370.

57. Comer AR, Gaffney M, Stone CL, Torke A. Physician understanding and application of surrogate decision-making laws in clinical practice. AJOB Empir Bioeth 2017;8:198–204.

58. Comer AR, Gaffney M, Stone CL, Torke A. “What do you mean I cannot consent for my grandmother’s medical procedure?” Key issues with state default surrogate decision making laws. Indiana Health Law Rev 2017;14:1–29.

59. Comer AR, Slaven JE, Montz A, Burke E, Inger L, Torke A. Nontraditional surrogate decision makers for hospitalized older adults. Med Care 2018;56:337–340.

60. Piers RD, Azoulay E, Ricou B, Dekeyser N, Ducrœnaere J, Max A, et al.; APPROPRICUS Study Group of the Ethics Section of the EICICM. Perceptions of appropriateness of care among European and Israeli intensive care unit nurses and physicians. JAMA Intern Med 2011;306:2694–2703.

61. Sprung CL, Cohen SL, Sjovist P, Baras M, Bulow HH, Hovilehto S, et al.; Ethics Study Group. End-of-life practices in European intensive care units: the Ethics Study. JAMA 2003;289:790–797.

62. Wunsch H, Harrison DA, Harvey S, Rowan K. End-of-life decisions: a cohort study of the withdrawal of all active treatment in intensive care units in the United Kingdom. Intensive Care Med 2005;31:823–831.

63. Garland A, Connors AF. Physicians’ influence over decisions to forego life support. J Palliat Med 2007;10:1298–1305.

64. Curtis JR, Park DR, Krone MR, Pearman RA. Use of the medical futility rationale in do-not-attempt-resuscitation orders. JAMA 1995;273:124–128.

65. Wilkinson DJ, Truog RD. The lack of the draw: physician-related variability in end-of-life decision-making in intensive care. Intensive Care Med 2013;39:1128–1132.

66. Gramelspacher GP, Zhou XH, Hanna MP, Tierney WM. Preferences of physicians and their patients for end-of-life care. J Gen Intern Med 1997;12:346–351.

67. O’Donnell H, Phillips RS, Wenger N, Teno J, Davis RB, Hamel MB. Preferences for cardiopulmonary resuscitation among patients 80 years or older: the views of patients and their physicians. J Am Med Dir Assoc 2003;4:139–144.

68. Steinhauser KE, Christakis NA, Clipp EC, McNeily M, McIntyre L, Tufts YA. Factors considered important at the end of life by patients, family, physicians, and other care providers. JAMA 2000;284:2476–2482.

69. Norris WM, Nielsen EL, Engelberg RA, Curtis JR. Treatment preferences for resuscitation and critical care among homeless persons. Chest 2005;127:2180–2187.

70. Harrison M, Milbers K, Hudson M, Bansback N. Do patients and health care providers have discordant preferences about which aspects of treatments matter most? Evidence from a systematic review of discrete choice experiments. BMJ Open 2017;7: e014719.

71. American Bar Association Commission on Law and Aging. Default surrogate consent statutes. 2019 [accessed 2020 Apr 14]. Available from: http://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/.

72. Daniels N, Sabin J. Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers. Philos Public Aff 1997;28:303–350.

73. Weiss BD, Berman EA, Howe CL, Fleming RB. Medical decision-making for older adults without family. J Am Geriatr Soc 2012;60: 2144–2150.

74. Verma A, Smith AK, Harrison KL, Chodos AH. Ethical challenges in caring for unrepresented adults: a qualitative study of key stakeholders. J Am Geriatr Soc 2019;67:1724–1729.

75. Taylor LJ, Nabozy MJ, Steffens NM, Tucholka JL, Brasel KJ, Johnson SK, et al. A framework to improve surgeon communication in high-stakes surgical decisions: best case/worst case. JAMA Surg 2017;152:531–538.

76. Emanuel EJ. A communal vision of care for incompetent patients. Hastings Cent Rep 1987;17:15–20.

77. Misak CJ, White DB, Truog RD. Medical futility: a new look at an old problem. Chest 2014;146:1667–1672.

78. Daniels N. Accountability for reasonableness. BMJ 2000;321: 1300–1301.

79. Daniels N. Just health: meeting health needs fairly. Cambridge, UK: Cambridge University Press; 2008.

80. Pope TM. Multi-institutional healthcare ethics committees: the procedurally fair internal dispute resolution mechanism. Campbell Law Rev 2009;31:257–331.

81. American Academy of Pediatrics, Committee on Bioethics. Institutional ethics committees. Pediatrics 2001;107:205–209.

82. American Society for Bioethics and Humanities (ABSH). Core competencies for healthcare ethics consultation, 2nd ed. Glenview, IL: Author; 2011.

83. Griggins C, Blackstone E, McAlliley L, Daly B. Making medical decisions for incapacitated patients without proxies: part I. HEC Forum 2020; 32:33–45.

84. Blackstone E, Daly BJ, Griggins C. Making medical decisions for incapacitated patients without proxies: part II. HEC Forum 2020;32:47–62.

85. Chiarchiaro J, Emeneccu NC, Scheunemann LP, Hough CL, Carson SS, Peterson MW, et al. Physicians rarely elicit critically ill patients’ previously expressed treatment preferences in intensive care units. Am J Respir Crit Care Med 2017;196:242–245.

86. Bosslet GT, Pope TM, Rubenfeld GD, Lo B, Truog RD, Rushston CH, et al.; American Thoracic Society ad hoc Committee on Futile and Potentially Inappropriate Treatment; American Thoracic Society; American Association for Critical Care Nurses; American College of Chest Physicians; European Society for Intensive Care Medicine, Society of Critical Care. An official ATS/ACCP/ESICM/SCCM policy statement: responding to requests for potentially inappropriate treatments in intensive care units. Am J Respir Crit Care Med 2015;191:1319–1330.

87. Procedures for natural death in the absence of a declaration. N.C. Gen. Stat. § 130-5-1304.

88. Surrogate; powers; designation of surrogate; priorities; consensus; meeting; continuation of authority; disqualification of surrogate. Neb. Rev. Stat. § 30-604(5)(b)(v).

89. Persons authorized to provide informed consent to health care for incapacitated persons. N.D. Cent. Code § 23-12-13.

90. Liability re removal of life support system of incapacitated patient. Conn. Gen. Stat. § 19a-571(a).

91. Withdrawal of life-sustaining procedures. Or. Rev. Stat. § 127.635(3).