PALLIATIVE CARE CASE OF THE MONTH

"Medical Surrogacy in the Absence of an Identifiable Surrogate"

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Case:

74-year-old male with a past medical history of schizophrenia was admitted to the hospital with melena and severe anemia. He was found to have a large colonic mass on imaging and radiographic evidence of metastatic disease in his liver, lung, and bone presumed to be from the colonic mass. He was transfused packed red blood cells and transferred to a higher level of care for surgical evaluation.

The patient had resided in a state operated psychiatric facility since the 1980s. Throughout his hospital stay, the patient was informed multiple times that a mass was found in his colon and was presumed to be cancer. The patient was unable to recall being informed of his likely cancer diagnosis, despite being told on numerous separate occasions, raising concern for cognitive impairment in addition to active delusions. He was deemed to not have medical decision-making capacity by multiple medical teams including psychiatry. He had no next of kin and no contactable family members. He had never been assigned a court appointed guardian. Palliative care was consulted to assist with goals of care and medical surrogacy identification.

Discussion:

Considerations in Medical Surrogacy in Pennsylvania:
In the event that a patient lacks decision-making capacity, this responsibility falls to a healthcare agent or representative. In the commonwealth of Pennsylvania, first priority is given to a person whom a patient has previously identified through a valid advanced directive. Secondly, if a court-appointed guardian is in place, they assume the role of healthcare surrogate. Thirdly, if none of the above conditions are met, a healthcare representative is elected from a hierarchal list:

1) a person chosen by the patient (either in writing or verbally to a physician, while of sound mind)
2) spouse
3) adult child
4) parent
5) adult sibling
6) adult grandchild
7) adult who has knowledge of patient's preferences and values

Fourthly, in the absence of any next-of-kind or court-appointed guardian, for persons living in community homes for individuals with intellectual disability or in residential facilities for individuals with mental health disorders, the facility director may act as the healthcare decision maker.

Given the vulnerability of these populations, legal and ethical parameters exists around this law. In the event of the need for emergency medical care, consent is assumed. For non-emergent care the facility director may authorize medical treatment or surgery only with the advice of two physicians that are not employed by the facility. If the patient is not in an "end -stage" condition, the facility director may not authorize a do not resuscitate (DNR) order. The facility director may authorize DNR or other matters of end-of-life care if the patient is deemed to have an "end-stage" condition, with the advice of two physicians. The designation of an "end-stage" condition is at the discretion of the treating attending physician.

Follow up of the case:

After consultation with the ethics and legal departments and discussion with the state psychiatric institution, it was established that, in accordance with Pennsylvania law, the facility director of the psychiatric facility was the surrogate decision maker for the patient. The facility director consulted with his legal team, and as the law defines, he requested that a consensus among physicians (at least 2) involved in the patient's care be made, and that this recommendation should be brought to the facility director based on expert consensus.

Efforts were made by the palliative care team to speak with the staff at the facility who knew the patient in an effort to understand more about his values and preferences. It was shared that the patient consistently demonstrated a preference to have minimal intervention from the medical team, like dressing changes for wounds, blood work, or other similar actions. He preferred to keep to himself most days. The patient had been residing at the facility since the 1980s, and many unsuccessful attempts had been made over the years to reach family members.

The palliative care, surgical, psychiatry, and oncology teams concluded that an invasive surgery that would likely require a permanent ostomy, and not be curative, was not recommended.

Follow up of the case (Continued)

Given the widely metastatic nature of his disease, palliative chemotherapy was determined to be more likely to add significant burden while providing minimal benefit. The recommendation for hospice was made, and the medical decision maker agreed with the plan. The patient was discharged to a nursing facility nearby to the psychiatric hospital with hospice services, so that the staff that he had known for years would be able to visit on a regular basis.

References:

AMA J Ethics. 2017;19(7):675-677. doi: 10.1001/journalofethics.2017.19.7.coet1-1707.

Pennsylvania Code. (2026). *55 Pa. Code § 6000.1013: Individuals who are not competent and who do not have end-stage medical conditions or are not permanently unconscious*.

AMA J Ethics. 2017;19(7):675-677. doi: 10.1001/journalofethics.2017.19.7.coet1-1707.

Pennsylvania Code. (2026). *55 Pa. Code Chapter 6000, Subchapter R: Procedures for surrogate health care decision making*.