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Surrogate Decision-Making for "Friendless" Patients

by Casey Frank

This column is sponsored by the Health Law Section of the Colorado Bar Association. The column addresses issues of interest to practitioners in the field of health law. The column editors and Section encourage the submission of articles.

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If a person is mentally unable to make medical care decisions, a substitute decision-maker must do so. As society becomes proportionately older, more people in that situation are likely to also outlive their families and social circles. This article addresses alternative means of substitute decision-making that must then be found.

When a patient needs medical care, but is cognitively unable to give informed consent, the consent must be provided indirectly. Medical care provided without consent often constitutes professional misconduct[1] or, a couple decades ago, battery.[2] There are several sources of indirect consent: self-initiating documents, operation of law, or, most important, surrogate decision-makers.

Some authorities distinguish between incompetence, incapacity, impairment, and disability. However, in the author's view, these are not useful variations. Colorado law uses such terms interchangeably to mean the cognitive inability to give informed consent to medical care.[3]

This article reviews ancillary sources of impersonal informed consent. It discusses the different ways surrogates step into the shoes of patients and make medical decisions on their behalf. The article also addresses the dire straits in which incompetent patients and care providers can find themselves when there is no surrogate available who is personally allied with the patient. Concerns about the decisional competency of surrogates, or the potential abuse of patients, are outside the scope of this article.[4]

Consent by Documents

A self-initiating consent document refers to either a living will[5] or cardiopulmonary resuscitation directive ("CPR directive").[6] These documents provide informed consent unilaterally without further ratification by a person. Unfortunately, because these documents must comply with strict legal formalities, such as being witnessed by a limited group of persons (living wills) or being signed by a physician beforehand (CPR directives), they apply to relatively few real-life situations. Only 18 percent of Americans have a living will, according to a 2004 report.[7]

Living Wills

Living wills, which were first developed in 1967, allow persons, while they are still competent, to limit medical treatment in designated future circumstances. However, a living will only goes into effect if a patient has a terminal condition, which means an "incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to postpone the moment of death."[8]

For example, Karen Ann Quinlan's 1975 case, which became a groundbreaking right-to-die controversy, would not have been affected by the existence of a living will, because she had no terminal disease. She was in a "chronic persistent vegetative state," but unexpectedly lived for nine years with a nasogastric tube after being weaned from a ventilator.[9]

A further limitation is that a living will provides only for the withholding of medical care in the final stages of life.

Thus, it provides little guidance as to intervening treatment decisions.

CPR Directives

Somewhat different than a living will, which directs that medical treatment stop at a certain point, is a CPR directive. It mandates that medical treatment not get started in the first place. A CPR directive is limited (similar to a living will), because it provides only for the withholding of care and must follow strict legal formalities. In contrast, unlike a living will, a CPR directive applies even if a patient has no terminal condition. A CPR directive has the same effect as a do-not-resuscitate order in a hospital.[10]

There are widespread (if anecdotal) reports that emergency personnel fail to consistently enforce CPR directives in the field. An example of the limited benefit of these documents is illustrated by the fact that, in several years of participation in two hospital medical ethics committees, the author has never seen recourse to a living will or CPR directive as the primary source of informed consent.

Consent by Law

Informed consent also can be provided directly by law. For example, the same state statute that authorizes CPR directives also provides informed consent in an emergency, noting: "In the absence of a CPR directive, a person's consent to CPR shall be presumed."[11] This is one formulation of the well-established, common-law presumption of consent in an emergency to any life-saving treatment.[12]

Various laws limit the ability of persons receiving evaluation or treatment for mental illness to consent to or refuse treatment.[13] Especially for short-term treatment, consent is initially sought from the patient. However, a physician can still override a patient's wishes under state statutes and accompanying Code of Colorado Regulations.[14] A full discussion of these issues is beyond the scope of this article.[15]

However, consent by law is even more limited than that provided by a living will or CPR directive. It applies only to a few restricted situations, and no comprehensive consent by direct operation of law is available to facilitate patient care.

Surrogates

Few medical decision-making situations are encompassed by documents or by law. As a result, it is imperative to find a person to act as a surrogate on behalf of an incompetent patient. Only a surrogate —such as a health care agent, proxy, or guardian—can fully deal with the unforeseeable nuances that often attend medical care. (*See* accompanying box regarding the term "surrogate.")

Surrogates generally are expected to employ "substituted judgment," which means making the same decisions that patients would have made. Surrogates may they use their own judgment as to what would be in the best interests of patients only if surrogates do not know what the patients would have wanted.

Health Care Agents

The standards applicable to surrogates are embedded in the statute that creates health care agents:

> The agent shall act . . . in conformance with the principal's wishes that are known . . . [or] in accordance with the best interests of the principal.[16]

Analogous direction also applies to proxies[17] and guardians.[18]

If a patient, while still competent, designates a specific health care agent to make medical decisions when the patient no longer is able do so, and that agent is available when needed, all is well. This is the most reliable and trustworthy type of surrogate, because the patient has made an explicit personal choice, thereby reducing the potential disparity between patient preferences and surrogate choices.

Unfortunately, few people have planned ahead. A six-year study published in 2000 by the director of Georgetown University's Center to Improve Care of the Dying, revealed that even among hospital patients, only 14 percent had advance directives.[19] Hence, the medical profession has prompted government to create alternate methods to address the situation of critically ill patients who lack a designated surrogate.

Proxy Surrogates

A proxy[20] is a distinctive kind of surrogate decision-maker. A proxy is chosen as a decision-maker if a patient failed to name a health care agent before becoming incompetent to make decisions (and thus also incompetent to then designate a health care agent). The attending physician makes "reasonable efforts"[21] to convene a patient's interested persons, who then choose a proxy by consensus. The proxy stands in the shoes of the patient, with an exception for the withdrawal of "artificial nourishment and hydration."[22] The proxy provides informed consent and "[a] health care provider or health care facility may rely, in good faith, upon the medical treatment decision of a proxy decision-maker."[23]

The definition of "consensus" in choosing a proxy is significant. For example, if it meant unanimity, it could be difficult to achieve, because all of the interested persons might not want the same candidate for proxy. "Consensus" is not defined in the statute. In common usage, the term consensus is inconsistently defined as: (1) a mere majority; (2) general agreement; (3) group solidarity; (4) an opinion held by most; or (5) unanimity.[24]

The Colorado Supreme Court shed some light on the meaning of "consensus" —but only indirectly—when it referred to the term as meaning somewhere between unanimity and a majority. In another context, when discussing the test set forth in *Frye v. United States*[25] for the admissibility of scientific evidence, the Colorado Supreme Court stated: "First, we should make clear 'general acceptance' does not require unanimity, a consensus of opinion or even majority support by the scientific community."[26]

If care providers and medical ethics committees facilitated unanimity among interested persons in choosing a proxy, that would naturally aid family harmony and avoid guardianship proceedings by

Different Surrogate Roles

The term "surrogate," as used in this article, is a comprehensive term encompassing all substitute decision-makers, including the following:

- **Health Care Agent:** Explicitly appointed by a patient, while still competent
- **Proxy:** Chosen by the patient's interested persons only after a patient has lost competency
- **Guardian:** Appointed and supervised by a court
- **Institutional Guardian:** Also appointed and supervised by a court
- **Special Guardian for Health Care:** Only in Veterans Administration facilities; allowed without court supervision.

any dissenters. However, when time is of the essence, a mere majority would be legally defensible, as well as more likely to make expeditious decisions.

It would be a mistake to view care providers and medical ethics committees as passive bystanders to this process. Although interested persons ultimately choose a proxy, care providers also have a crucial and defined role. Providers (assisted by ethics committees if needed) first must decide when they have made the required reasonable efforts to contact potential interested persons. Providers also must make medical treatment decisions in dialogue with the proxy. That implies an acknowledgment that the proxy was properly designated.

Although more than thirty-five states have proxy-type statutes, most limit the candidates for a proxy to a formulaic hierarchy of legal family members.[27] Colorado has no hierarchy of potential proxies. Further, the term "interested persons" is broadly defined to include close friends (not strangers with their own agendas), without any order of priority. This is often misstated in the popular press; even nationally syndicated journalists have stated that all states have a hierarchy.[28]

The potential pool for proxies is liberally defined in Colorado. As a result, the odds of finding someone to serve as a proxy naturally are improved.[29] If even one interested person is available, the relatively simple proxy procedure can be used.[30] In addition, the Colorado statute uses a functional—not a categorical—qualifying principle:

> The person selected to act as the patient's proxy decision-maker should be the person who has a close relationship with the patient and who is most likely to be currently informed of the patient's wishes regarding medical treatment decisions.[31]

This individual may be a relative, lover, friend, neighbor, or someone else.

The number of Coloradans needing, but lacking, someone personally known to them to serve as a surrogate is unknown. Apparently, no comprehensive national survey has been conducted. However, in 1995, some researchers estimated that nationally, 60,000 nursing home residents were in that situation.[32] Members of the Denver Community Bioethics Committee,[33] including Denver's adult protective services,[34] report this to be common. In our graying society, more patients are likely to be incompetent, in need of medical care, and without a personal surrogate or other means of providing informed consent.

Guardian Surrogates

Guardians often are referred to as medical decision-makers of last resort, because the process by which they are appointed is cumbersome. After a formal hearing, a guardian is appointed by a court to assist with the affairs of an incompetent patient, called a ward.[35] Appointment of a guardian is justified if a patient is

> unable to effectively receive or evaluate information or both or make or communicate decisions to such an extent that the individual lacks the ability to satisfy *essential requirements for physical health, safety, or self-care*.[36] (*Emphasis added.*)

In Colorado, a guardian is not the same as a conservator, who is appointed to manage a ward's financial affairs.

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A guardian's authority should be only as great as necessary to address the ward's needs. Limits on a guardian's authority usually are stated in an order of appointment. Universal prohibitions prevent all guardians from consenting on behalf of wards to involuntary treatment for mental illness, developmental disability, or alcoholism (without separate court approval). Guardians also have responsibility directly to the courts that appointed them. Guardians must report to the court, which retains indirect but ongoing oversight.

Institutional Guardians

A 2004 ruling by the Colorado Court of Appeals, *In the Interest of Leo M. Yeager*,[37] expanded the availability of institutions to serve as guardians. Leo Yeager appealed a trial court order, which ruled that his appointed guardian, the Morgan County Department of Human Services ("MCDHS"), was authorized to execute a do-not-resuscitate order on his behalf. The Court of Appeals agreed with the trial court, and affirmed MCDHS in its role as a guardian for medical decision making.

Yeager had no known relatives or friends and was legally incapacitated. He suffered from advanced dementia, congestive heart failure, chronic obstructive pulmonary disease, and anemia. His personal physician testified at a hearing that the likelihood of resuscitating him would be one in a hundred and, if successful, would cause rib fractures and pneumothorax. The physician "concluded that attempting resuscitation would be futile, cruel, and unethical."[38]

The court granted MCDHS "unlimited authority to approve and consent to medical decisions for Mr. Yeager, including but not limited to authority to enter DNR directives and orders on behalf of Mr. Yeager."[39] Although departments of human services regularly assume comprehensive guardianships on behalf of incapacitated persons, no appellate court had decided whether a department could do so primarily as a guardian for medical decision-making. The *Yeager* court ruled that it could.

In contrast, it is settled that a governmental entity cannot serve as an interested person under the proxy procedure discussed above. The purpose of that restrictive provision is to prevent government from interfering with a proxy's decision.

However, a guardian is not the same as a proxy. A proxy is chosen and serves privately. In contrast, a guardian serves with court approval and oversight, and only if a patient has no personal ally to serve as an interested person or proxy, as was the situation with Leo Yeager. The distinction is a logical one. If there are interested persons available to choose a proxy, the patient has family or other personal allies available who should make medical decisions. In that situation, the *Yeager* court noted that "the narrowed class of interested persons is an effort to encourage family communication and consensus."[40] In other words, a government agency cannot inject itself into a process if there is a familial or personal solution.

In situations where there no one is available to serve as a proxy, a department of human services ("DHS"), for example, is empowered to serve as a guardian. The contrary interpretation would create an anomalous situation where no one could provide informed consent for an incompetent and friendless patient. *Yeager* accordingly held that a DHS could execute a do-not-resuscitate order, or make any other medical care decisions for an incompetent patient as a guardian.

Yeager explained that the proxy statute did not amend the guardianship statutes, and does not "prohibit all decision-making by a governmental entity acting as guardian."[41] The *Yeager* court concluded: "Any other reading of § 15-18.5-103(8) [the proxy statute] would lead to the absurd result of negating the provisions of other statutes regarding guardianship."[42]

The guardian *ad litem*[43] appointed by the court to represent Leo Yeager concurs with this interpretation.[44] He further stressed that both courts emphasized the need for continuing judicial oversight and the great benefit to patients, as protected persons, to have a guardian *ad litem* appointed on their behalf.[45] Especially in cases with institutional guardians, this provides crucial safeguards while making potentially life-and-death decisions.

Yeager addressed the position of the MCDHS, but the implications extend to other institutions. CRS § 15-14-301 provides that any "person" may be a guardian after appointment by the court. CRS § 15-14-102(10) expands the definition of "person" to include a "government, governmental subdivision, agency, or instrumentality" as it applies to guardianships. Adult protective services within a county DHS are clearly competent to petition for guardianship. In addition, hospitals, nursing homes (with special limitations),[46] and other institutions may avail themselves of this option for the benefit of all concerned.

No statute requires that governments must offer their services as guardians for medical decision-making. Before *Yeager,* some institutions had interpreted the proxy statute as legally prohibiting that role.[47] However, *Yeager* makes clear that this would be a policy choice, not a legal prohibition.

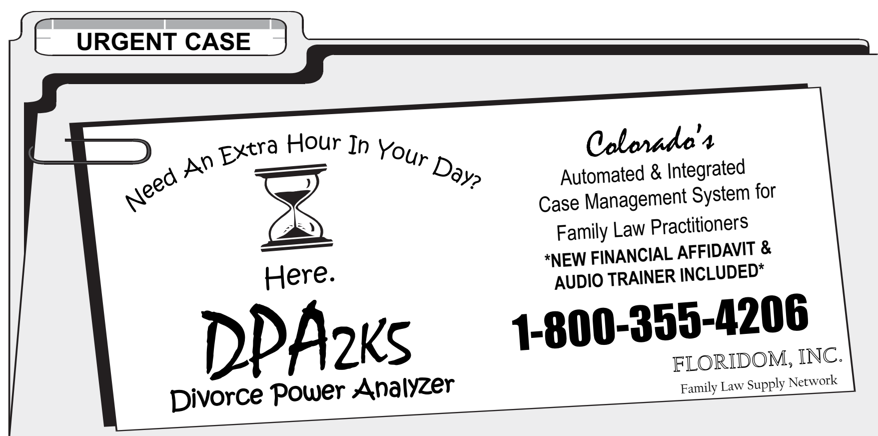
Governmental guardians are entirely consistent with the intent of the 1998 Uniform Guardianship and Protective Proceedings Act ("Act").[48] The Comments to the Act recognize that a governmental agency has a valuable role to play in that context, but should only serve as guardian as a last resort. According to the Act:

> A public agency or nonprofit corporation is eligible to be appointed guardian . . . but is not entitled to statutory priority in appointment as guardian.[49]

Colorado adapted and adopted the Act in 2002, in the last comprehensive revision of the state guardianship statutes.[50]

Special Veterans' Hospital Guardians

Colorado patients are afforded the protection of the state procedures noted earlier, including those in Veterans' Adminis-



tration ("VA") hospitals.[51] However, unlike state guardianship proceedings that are the final option under state law, federal regulations governing the VA provide additional alternatives for obtaining informed consent. If no personal surrogate is available, a health care practitioner "may request Regional Counsel assistance to obtain a *special guardian* for health care."[52] (*Emphasis added.*)

The VA procedure is an internal process that operates without judicial oversight, in contrast to guardianships under state law. There are three levels of decision-making to expedite informed consent with the in-house VA process, depending on the seriousness of the decision to be made:

1. Treatments or Procedures Involving Minimal Risk: A health care practitioner verifies the lack of a surrogate, explains the proposed treatment to the patient, and records this information in the chart.

2. Procedures Requiring Signature Consent: A health care practitioner verifies the lack of a surrogate. The attending physician and Chief of Service also must approve the proposed treatment decision in writing.

3. Any Decision to Withhold Life-Sustaining Treatment: This must be reviewed by a multi-disciplinary committee functioning as the patient's advocate. Committee members may not be members of the treatment team. The Chief of Staff and facility director must approve the committee's decision.[53]

Accordingly, friendless patients at the VA can have medical treatment decisions made in-house, without judicial or other external oversight. These alternatives are conspicuously quicker, cheaper, and more efficient than the state guardianship process. On the one hand, the system's simple efficiency raises concerns about the protection of patients and their rights. On the other hand, the VA procedure provides patients with increasing levels of procedural protections that are in proportion to the seriousness of the decisions to be made.

Conclusion

The absence of a surrogate to represent critically ill patients is a problematic circumstance that can stymie needed medical care. Issues involving surrogates for incapacitated patients are almost certain to expand as baby boomers get older.

Colorado belongs to the majority of states that rely first on proxies (the names vary from state to state), but ultimately fall back on guardians as medical decision-makers of last resort.[54] Colorado's liberal proxy statute should reduce the need for more cumbersome guardianship proceedings before a court.

Some states have empowered others to indirectly authorize medical care when no surrogate personally known to the patient is available, without requiring guardianship proceedings. For example, an attending physician may be authorized to make medical decisions[55] or authorization may be provided through a combination of a physician and an institutional medical ethics committee.[56] Texas allows a member of the clergy to give consent.[57]

Some states, but not Colorado, have established standing decision-making committees to provide consent to patients without surrogates, although these currently deal only with mental illness or developmental disabilities rather than hospital patients. Nonetheless, such approaches combine streamlined decision-making with the checks and balances not found in purely internal procedures and offer an attractive model for future legislation.[58]

The VA process, and other states' in-house procedures or standing surrogacy committees are not applicable outside their defined locations. On the one hand, such procedures are convenient, bypassing the onerous formalities of a guardianship proceeding. On the other hand, they lack safeguards, including the judicial oversight of guardianships and the appointment of guardians *ad litem*. Nevertheless, they suggest creative solutions that are likely to become more compelling as society ages and the number of friendless patients grows.

NOTES

1. CRS § 12-36-117(1)(bb)(I).
2. CJI-Civ.3d 15:12 (1980). *See, e.g., Blades v. Dafoe*, 666 P.2d 1126, 1129 (Colo.App. 1983).
3. "Incapacity" is used in CRS § 15-14-504(1)(b) (health care agent statute); "incompetency" is used in CRS § 15-18-102 (living will statute); "disability" is used in CRS § 15-14-501(1) (health care agent statute). "Impairment" is found in case law. *See, e.g., People in Interest of M.M.*, 726 P.2d 1108, 1117 (Colo. 1986).
4. In addition to having enormous decision-making authority, there is potential for abuse. For a general discussion of preventing abuse of the elderly, *see, e.g.*, Mitchell, "Crisis Intervention to Prevent Elder Abuse: Emergency Guardianships and Other Legal Procedures," 33 *The Colorado Lawyer* 91 (July 2004).
5. CRS §§ 15-18-101 *et seq.*
6. CRS §§ 15-18.6-101 *et seq.*
7. Fagerlin and Schneider, "Enough: The Failure of the Living Will," *Hastings Center Report* 30 (March–April 2004).
8. CRS § 15-18-104.
9. *In re Quinlan*, 348 A.2d 801 (N.J.Super. Ch.Div. 1975), *modified*, 355 A.2d 647 (N.J. 1976).
10. CRS §§ 15-18.6-101 *et seq.*
11. CRS § 15-18.6-104(3).
12. Implied Consent Based on Emergency, CJI-Civ.3d 15:14. *See also* CRS § 18-1-703(1)(e)(II) ("The use of physical force upon another person which would otherwise constitute an offense is justifiable [if the] treatment is administered in an emergency. . . .").
13. CRS § 27-10-116 (right to treatment); *Goebel v. Colorado Dept. of Institutions*, 830 P.2d 1036, 1045 (Colo. 1992).
14. CRS § 27-10-116(2)(a); 2 C.C.R. § 502-1 (care and treatment of the mentally ill).
15. The author is currently co-authoring an article on this topic for future publication.
16. CRS § 15-14-506(2).
17. CRS § 15-18.5-103(1) and (4)(a).
18. CRS § 15-14-312.
19. *Cited in* Grady, "At Life's End, Many Patients Are Denied Peaceful Passing," *The New York Times* (May 29–30, 2000).
20. CRS §§ 15-18.5-101 *et seq.*
21. CRS § 15-18.5-103(3).
22. CRS § 15-18.5-103(6).
23. CRS § 15-18.5-103(1).
24. "Consensus" is variously defined in a number of sources, such as: *Webster's New World Dictionary*, 2d College ed. (New York, NY: Macmillan, 1997) ("[a]n opinion held by all or most; general agreement, esp. in opinion"); *Webster's New Collegiate Dictionary*, 1st ed. (Springfield, MA: Merriam Co., 1979) (a "group solidarity in sentiment and belief"); *Microsoft's Bookshelf Dictionary* (Redmond, WA: Microsoft Corp., 1998) ("an opinion or position reached by a group as a whole or by majority will . . . [g]eneral agreement or accord"). "Consensus *ad idem*" is defined in legal sources, including: *Black's Law Dictionary*, 7th ed. (St. Paul, MN: Thomson/West, 1999) ("[a]n agreement of parties as to the same thing; a meeting of minds"); *Merriam-Webster's Dictionary of Law* (Springfield, MA: Merriam-Webster, 1996) (an "agreement with respect to the same thing: meeting of the minds"). Plain "consensus" is not defined in either legal source.
25. *Frye v. U.S.*, 293 F. 1013, 1014 (D.C.Cir. 1923) (illustrative *dicta*). Colorado relies on C.R.E. 403 and 702 as to the admissibility of scientific evidence; *see People v. Shreck*, 22 P.3d 68 (Colo. 2001).
26. *Lindsey v. People*, 892 P.2d 281, 289 (Colo. 1995).
27. Karp and Wood, "Incapacitated and Alone: Health Care Decision-Making for the Unbefriended Elderly" 9-10 (Washington D.C.: ABA Special Report: Commission on Law and Aging, July 2003).
28. Ellen Goodman's column mistakenly asserted that all states have a hierarchy. *See*

Ellen Goodman, "Schiavo Case Illustrates Why We Each Need a Proxy," *Rocky Mountain News* (Nov. 6, 2003). Corrected in Casey Frank, "Proxy Law in Colorado Has Broad Scope," *Rocky Mountain News* (Nov. 25, 2003) at 34A.

29. In other states, a patient's loved ones might have to petition a court for an appointment as a guardian.

30. CRS §§ 15-18.5-101 *et seq.*

31. CRS § 15-18.5-103(4)(a).

32. Gillick, "Medical Decision-making for the Unbefriended Nursing Home Resident," *Journal of Ethics, Law, and Aging* (1995).

33. Contact the Denver Community Bioethics Committee at (720) 944-2994 or via its website at http://www.denverbioethics.org/pages/1/index.htm.

34. Personal discussion between the author and members of the Denver Community Bioethics Committee, after a presentation by the author: "Lawthics—Law as Crystallized Ethics" (Oct. 6, 2004). For more information, contact David M. Bernhart, Jr., Assistant Denver City Attorney with Denver County Adult Protection Unit, (720) 944-2739.

35. A guardian also may be appointed to resolve non-medical issues for a minor or impaired adult, although that is beyond the scope of this article, which is limited to medical consent. CRS §§ 15-14-101 *et seq.*

36. CRS § 15-14-102(5) ("Persons Under Disability—Definitions").

37. *People ex rel Morgan County Dep't of Human Servs. v. Yeager*, 93 P.3d 589 (Colo.App. 2004).

38. *Id.* at 592.

39. *Id.*

40. *Id.* at 596.

41. *Id.* at 595.

42. *Id.* at 596.

43. The Probate Code allows for appointment of a guardian *ad litem* when a person's interests might be inadequately represented during legal proceedings. CRS § 15-14-115.

44. Personal e-mail communication between the author and attorney Timothy Kerns, guardian of Leo Yeager (Aug. 6, 2004). For more information, contact Timothy Kerns; Furman, Kerns & Bauer, LLC; (970) 867-4460 or (303) 828-9536.

45. *Id.*

46. CRS § 15-14-310(4) prohibits an owner, operator, or employee of a long-term care provider caring for the respondent to serve as guardian unless related by blood, marriage, or adoption. This protection also is found in the Uniform Guardianship and Protective Proceedings Act (1998), § 310 ("[s]trict application . . . is crucial to avoid a conflict of interest and to protect the ward"). However, attorney Glatstein, *infra*, note 47, points out that "*serving* as guardian should not be confused with *petitioning* for another to serve as guardian. For example, the social worker in Nursing Home A can petition for a social worker in Nursing Home B to serve as guardian, if there is no one else with higher priority, assuming the two facilities do not share corporate ownership. A mutually beneficial relationship may be developed between different facilities by doing so."

47. One attorney described this run-around process as follows: "Doctors or social workers would write the Denver Probate Court. The Court would contact the non-profit Guardianship Alliance of Colorado, (303) 423-2898, which would petition for limited guardianship authority for thirty to sixty days. If a proxy was found, the guardian would resign. This evolved into the hospital alerting the Alliance directly, and they would petition." Carl Glatstein (Oct. 10, 2004), personal e-mail communication with the author. For more information, contact Carl Glatstein, Glatstein & O'Brien LLP, (303) 757-4342.

48. Uniform Guardianship and Protective Proceedings Act (1997), in "Uniform Laws Annotated," Vol. 8 (St. Paul, MN: West Publishing, 2004).

49. *Id.* at § 310: "Who May Be Guardian: Priorities." (Comments).

50. CRS §§ 15-14-301 *et seq*. Carl Glatstein, who was co-chair for the CBA Joint Subcommittee on the Uniform Guardianship and Protective Proceedings Act, concurs with the interpretation of *Yeager* as authorizing government entities to serve as substitute medical decision-makers. *See* note 47, *supra*.

51. The Federal Patient Self Determination Act requires providers of health care services to offer written information about "an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives . . . [and] to ensure compliance with requirements of State law." 42 U.S.C. § 1395cc(f)(A-i) and (D) (amended through 2002).

52. 38 C.F.R. § 17.32(f)(1) and (2); *VHA Handbook* 1004.1(8)(c) (Jan. 29, 2003). Special guardians are discussed in Karp and Wood, *supra*, note 27 at 34.

53. *Id.*

54. *Id.*

55. *See, e.g.*, Conn. Gen. Stat. Ann § 19a-571(a).

56. *See, e.g.*, Ariz. Rev. Stat. Ann. § 36-3231.

57. *See, e.g.*, Tex. Health & Safety Code Ann. § 313.004.

58. *See, e.g.*, N.Y. Mental Hyg. Law Art. 80; Tex. Health & Safety Code Ann. Ch. 597; Iowa Code Ann. §§ 135.28 and 135.29. ■

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