A Matter of Capacity: Code Status, Professional Guardianship, and the Role of C-L Psychiatry in Determining Goals of Care

Benjamin D. Smart, MD, Department of Psychiatry & Behavioral Medicine, Wake Forest School of Medicine
Margaret A. Cinderella, MD, Department of Psychiatry and Behavioral Medicine, Cone Health
Nona Nichols, MD, Department of Psychiatry and Psychology, Cleveland Clinic
Sahil Munjal, MD, Department of Psychiatry & Behavioral Medicine, Wake Forest School of Medicine

BACKGROUND

- **Professional guardians:** Paid persons selected by a judge to make medical decisions on a patient's behalf.
- Limited data on professional guardians **making end-of-life (EOL) decisions** for patients (Cohen 2019).

CASE

- Mr. K: 38-year-old male w/ R MCA stroke, substance-induced bipolar disorder.
- **Discovered unresponsive,** hospitalized, C2-T1 epidural abscess found. Led to **ventilator dependence and quadriplegia.**
- **Professional guardian assigned** after family not reached.
- Psychiatry consulted, determined **Mr. K had decision making capacity (DMC)** to refuse sacral ulcer dressing changes that previously caused bradycardia and traumatic resuscitation. **Despite this, professional guardian consented** over patient's objection.
- **Patient requested DNR/DNI** after palliative care discussion. Upon guardian request, **DMC assessment provided** by psychiatry and primary team. After several days delay, code status updated.
- One week later, **Mr. K requested reversal to full code status**. Guardian **quickly agreed to care escalation** without DMC assessment.
- Professional guardian consistently escalated Mr. K's care without seeking his input but required multiple professional opinions to consent to care de-escalation.

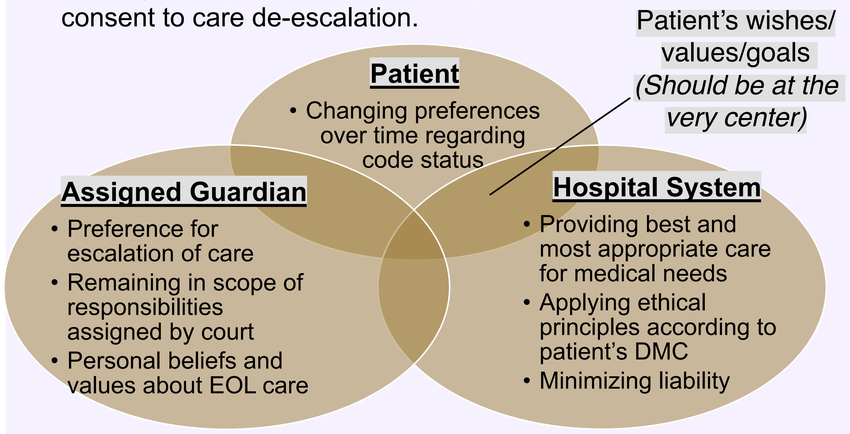

Figure 1. Mr. H: Priorities and factors impacting EOL care

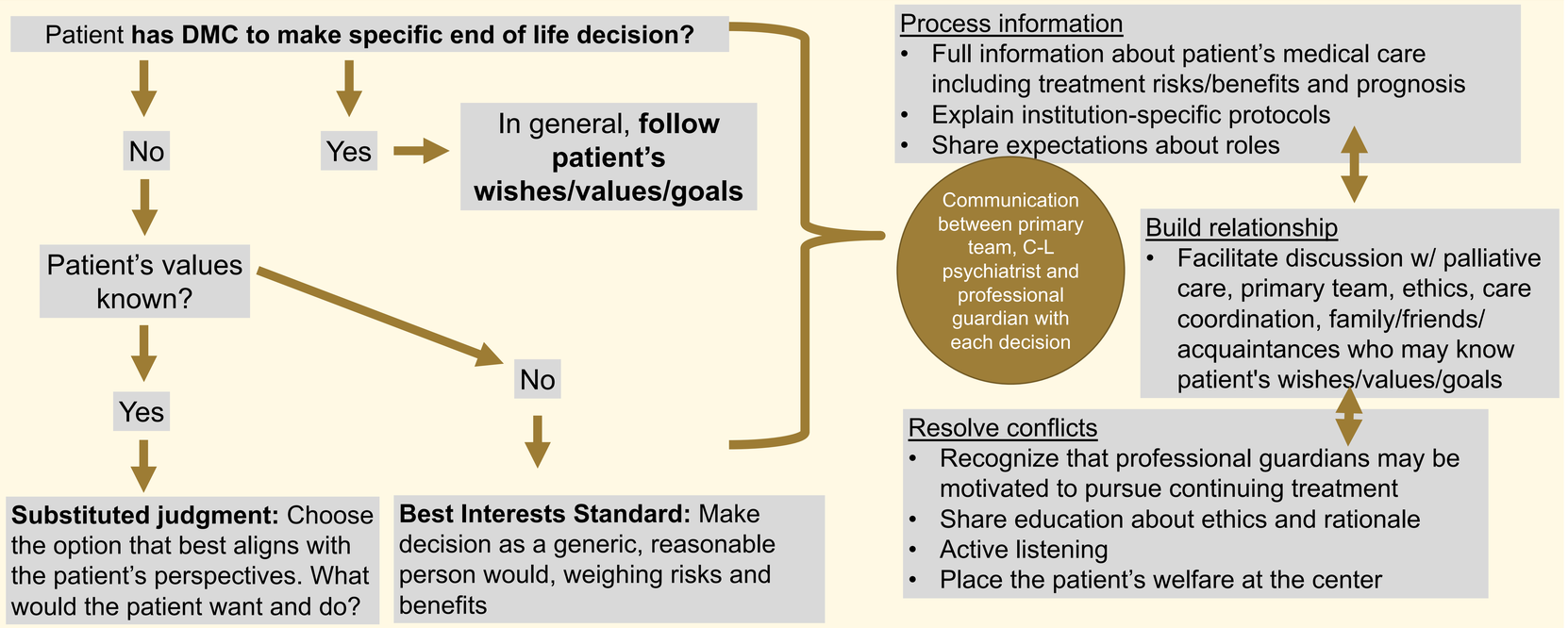

Figure 2. Proposed model for how CL psychiatry can approach communication with EOL care involving professional guardian

DISCUSSION

- **Substituted judgment:** ethical standard for making decisions on patients' behalf without DMC when values are known.
- **Best interests standard:** ethical principle used when patient lacks DMC and when their values are unknown. This is often the case with professional guardians (Jaworka 2017).
- **Quality communication** is essential when working with professional guardians (Torke 2012). Disagreements may lead to prolonged suffering (Hastings 2014).
- Conflict and tension may occur when patients retain DMC for some medical decisions and there is discordance between patient's expressed wishes and guardian's decision.
- Mr. K's deliberation over code status is consistent with research showing **patients often change life-sustaining treatment preferences over time** (Torke 2008).
- **Professional guardian's preference for care escalation** is also consistent with previous research (Cohen 2019).
- Providing care to Mr. H against his wishes creates high potential for **moral injury** among healthcare staff.

REFERENCES