2010

Medical Decision-Making for Incapacitated Elders: A 'Therapeutic Interests' Standard

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ABSTRACT

Some older individuals lack sufficient present cognitive and/or emotional ability to make and express autonomous decisions personally. In those situations, health care providers routinely turn to available formal or informal surrogates who often must apply the best interests standard in making decisions for the incapacitated person. This article contends that defining the best interests standard of surrogate decision making for older adults in terms of optimal or ideal choices (truly the patient’s “best” interests) frequently sets out an unrealizable goal for surrogates to satisfy. Instead, a decision-making standard based on the incapacitated person’s “therapeutic” interests is more realistic and hence more honest to adopt and apply from legal, ethical, and medical perspectives.
INTRODUCTION

In the context of medical decision-making for adults, the modern American legal system gives firm priority to the doctrine of informed consent. In the case of some older individuals, the patient may lack sufficient present cognitive and/or emotional ability to make and express autonomous decisions personally. In those situations, unless (and frequently even if) the patient previously executed an advance instruction


directive such as a living will, health care providers routinely turn to available formal[^4] or informal surrogates. These surrogates are expected to give or withhold informed consent to medical treatment options on behalf of the decisionally-incapacitated patient.[^5] The legal and medical systems expect surrogate decision-makers to be guided in their task, if at all reasonably possible, by the previously expressed or implied preferences of the now-incapacitated patient.

A large problem, however, is that often it is not reasonably possible to be guided in that manner because the wishes of the now-incapacitated patient really are unknown. In those common circumstances, surrogates have been expected, at least in theory, to fall back on the best interests standard and ask what course of action would be most beneficial, or optimal, for that patient.

This article contends that defining the best interests standard of surrogate decision-making for older adults in terms of optimal choices—truly, the patient’s “best” interests—frequently sets out an unrealizable goal for surrogates to satisfy. Instead, a surrogate decision-making standard based on the incapacitated individual’s “therapeutic” interests is much more realistic and therefore more honest to adopt and apply from legal,[^4] formal surrogates are those named in a proxy directive such as a durable power of attorney or health care agent document, appointed by the court in a guardianship or conservatorship proceeding, or named in a state health care surrogate statute.

ethical, and medical perspectives. The best interests standard should not necessarily be replaced by another competing model of surrogate decision-making; however, it should be embraced only if it is explicitly re-conceptualized to define “best” differently than in the optimal terms within which it is most frequently defined at present.

GROPING FOR AUTONOMY

As already noted, modern American medical-legal jurisprudence is characterized by the primacy of informed consent. It is predicated on the fundamental ethical precepts of autonomy (self-rule) and beneficence (helping others, in this case by empowering patients to make choices most consistent with their own values). The informed consent doctrine enforces respect for the right of adults to make their own medical decisions so long as they do so voluntarily and on the basis of sufficient information.

However, legal and medical approaches based on the principle of autonomy only make sense when the patient has sufficient present cognitive and/or emotional capacity to actually exercise autonomy—that is, to arrive at authentic choices through personal participation in a rational deliberative process. Many individuals undergo a substantial diminution in their cognitive and/or emotional abilities as they age or suffer traumatic


[7] Regarding the “informed” element of the informed consent doctrine, see generally Chris White et al., Informed Consent to Medical and Surgical Treatment, LEGAL MEDICINE 338-39 (S. Sandy Sanbar et al. eds, 7th ed. 2007).
injuries. Hence, we have witnessed a major push in the United States (and around the world) encouraging people to preserve their medical autonomy prospectively, while they are still mentally and hence legally able. This preservation may be accomplished by taking advantage of various advance health care planning techniques authorized by statute in every American jurisdiction. Most notable among these advance planning alternatives are the timely execution of instruction directives (commonly referred to as living wills or declarations). Ideally, the written directive provides definitive guidance regarding the autonomous future medical preferences of the individual even after he or she has become decisionally incapacitated.

Unfortunately, timely advance medical planning of this type may not always take place and the patient may need medical decisions made when he or she becomes decisionally incapacitated. The next preference of contemporary medical practice and legal theory is for surrogate decision makers to act on the basis of substituted judgment.


The substituted judgment concept expects surrogates to preserve the incapacitated patient’s autonomy interests in the absence of a documented advance instruction. It is expected to do so by inferring from that person’s past statements and conduct what specific medical decisions that person would choose if capable of making and expressing his or her own autonomous choices.\footnote{See, e.g., BLACK’S LAW DICTIONARY (8th ed. 2004) (defining the substituted judgment doctrine as “a principle that allows a surrogate decision-maker to attempt to establish, with as much accuracy as possible, what decision an incompetent patient would make if he or she were competent to do so”).}

There are a number of empirical problems with the substituted judgment standard of surrogate decision-making.\footnote{See, e.g., Alexia Torke et al., Substituted Judgment: The Limitations of Autonomy in Surrogate Decision Making, 23 J. GEN. INTERN. MED. 1514 (2008).} In many cases, accurate inferences about a previously capable patient’s present wishes cannot reasonably be drawn. Then, the exercise becomes a highly speculative—and frequently erroneous\footnote{Terri R. Fried et al., Valuing the Outcomes of Treatment: Do Patients and Their Caregivers Agree?, 163 ARCH. INTERN. MED. 2073 (2003) (finding that caregivers often guess wrongly about patients’ medical preferences); Brian J. Zikmund-Fisher et al., A Matter of Perspective: Choosing for Others Differs from Choosing for Yourself in Making Treatment Decisions,” 21 J. GEN. INTERN. MED. 618 (2006) (same); Sara M. Moorman & Deborah Carr, Spouses’ Effectiveness as End-of-Life Health Care Surrogates: Accuracy, Uncertainty, and Errors of Overtreatment or Undertreatment, 48}—one built on the false premise that
the previously capable patient’s present wishes are knowable. Often in those situations, the patient’s supposed substituted judgment becomes equated with either the choice the surrogate would have made for himself or herself\[14\] or the choice that it is believed would be made by most other people in similar circumstances.\[15\]

The last choice of American\[16\] jurisprudence and medical practice regarding decision making about the initiation, continuation, withdrawal, or withholding of specific

GERONTOLOGIST 811, 812 (2008) (noting “research on substituted judgment consistently reveals that surrogates are no better than chance at naming the treatments that patients desire”).

\[14\]Vig, supra note 5, at 1691 (listing the surrogate’s own beliefs, values, and preferences as a basis for surrogate decision making).

\[15\]See Sumeeta Varma & David Wendler, Medical Decision Making for Patients Without Surrogates, 167 ARCH. INTERN. MED. 1711 (2007) (proposing the use of a computer program—which the authors label a“population-based treatment indicator”—specifically designed to predict what medical interventions most people would select under a given set of circumstances).

diagnostic and treatment interventions is a surrogate model to be employed only when a
decisionally-incapacitated patient’s autonomy cannot be honored through an advance
instruction directive or inferences drawn as a genuine matter of substituted judgment.
This model is the best interests standard.\[17\] Despite its long, rich history and broad
application,\[18\] the best interests test as it is widely understood in the context of surrogate
medical decision-making on behalf of decisionally-incapacitated older adults has serious
shortcomings. As I argue below, it should be replaced in this context by the more realistic
concept of “a therapeutic interest.”

THE BEST INTERESTS STANDARD

[17]Lois Snyder & Cathy Leffler, for the Ethics and Human Rights Committee of
Med. 560, 567 (2005):

Treatment should conform to what the patient would want on the basis of
written or oral advance care planning. If these preferences are not known,
care decisions should be based on the best evidence of what the patient
would have chosen (substituted judgments) or, failing that, on the best
interests of the patient.

See also Jeffrey T. Berger et al., Surrogate Decision Making: Reconciling Ethical Theory
hierarchy of 3 decision-making standards [that] is endorsed widely by both organized
medicine and the law”).

[18] The best interests standard was developed originally in the context of child
custody disputes. See Joseph Goldstein et al., Beyond the Best Interests of the
The moral basis for the best interests standard is the fundamental principle of beneficence. In legal terms, the societal imperative to do good for others translates into the state’s exercise of its *parens patriae* authority to protect persons who cannot protect themselves. People may need such protection, for example, because they failed while decisionally capable to directly or impliedly indicate their future medical treatment wishes. The focus of the traditional best interests test is satisfaction of the patient’s needs, as those needs are perceived by others.


\[21\] The state’s legal authority to intervene on behalf of vulnerable persons to protect them from danger is extremely important. However, we must keep in mind that, in the vast majority of situations, the best interests analysis is conducted by a combination of family members and health care professionals, and not formally by the courts. Judicial review or prior approval of a surrogate’s best interests decision are exceedingly rare.

\[22\] Michael McCubbin & David N. Weisstub, *Toward a Pure Best Interests Model of Proxy Decision Making for Incompetent Psychiatric Patients*, 21 Int. J. L. &
Despite the best interests standard’s impressive ethical and legal pedigree, the creation and adoption of a comprehensive and integrated operational definition remains frustratingly incomplete and elusive. Such a definition is necessary to apply the best interests standard to older individuals for whom concrete surrogate medical decisions must be made at a particular point in time from among a finite range of options. Gutheil and Appelbaum’s insightful 1983 admonition that the best interests standard in the medical decision making context “is often undefined, unguided, and unspecified”[23] has been echoed repeatedly in subsequent years. According to another set of authors, “this standard is poorly understood and variously interpreted.”[24] Stated even more forcefully:

The ethicists’ and policymakers’ near-obsession with defending the competent person’s right to control her future treatment has left the best interests standard inadequately developed and subject to widely varied interpretation. As a practical matter, this omission leaves proxy

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decision-makers and clinicians with insufficient guidance about how to resolve the vast majority of real cases.[25]

Commentators point to “a judicial history of inadequate analysis and intellectual evasion.”[26] They have claimed that the standard has essentially become a mantra (“application of the formula ‘best interests’ has generally been seen as sufficient to resolve the matter”) and “that the absence of a systematic examination of the test and its application leads to decisions which are subjective and lacking legal or ethical force.”[27]

These critiques notwithstanding, one may certainly find attempted explications of the best interests standard in judicial opinions, state statutes, organizational policy statements, model acts, and professional literature. In these diverse forays into the definitional endeavor, the best interests concept appears to contain both subjective and objective components that complement each other.

In subjective terms, the surrogate decision-maker is supposed to decide whether the likely benefits to the patient resulting from a medical intervention would outweigh the foreseeable burdens to the patient resulting from the intervention. Put differently, would the burdens be disproportionate to the benefits? The surrogate is supposed to perform this balancing task subjectively, by taking into account the ways that the potential


[27] Id. at 406.
benefits and burdens would be experienced and valued by the particular patient. Consequently, one would expect the surrogate’s own unique set of experiences and values to inform her evaluation.

Regarding the individual patient’s perspective, the National Conference of Commissioners on Uniform State Laws’ Uniform Health-Care Decisions Act has served as the model (with some variations) for legislation enacted or considered in a number of states. It provides: “In determining the patient’s best interest, the surrogate shall consider the patient’s personal values to the extent known to the surrogate.”[28] Similarly, case law has “elaborate[d] that in determining the best interest of the patient, ‘quality of life’ is not considered from the subjective point of view of the surrogate, but is an objective inquiry into ‘the value that the continuation of life has for the patient.’”[29] At least one state statute instructs surrogates to take into account “the religious beliefs and basic values of the person receiving treatment, to the extent these may assist the decision-maker in determining the best interest.”[30] In this same vein, there is commentary contending that ordinarily family members should be respected as the most appropriate parties to make choices in the now-incapacitated patient’s best interests. This is because


the family member knew the person most intimately before the onset of whatever medical or psychological problem caused the current decisional incapacity.\[31\]

Regarding the patient’s welfare as envisioned through the eyes of the surrogate’s own values (and, therefore, interests), surrogates have been admonished to consider a wide variety of factors...relevant to this determination [concerning decisions about life-sustaining medical interventions], including, but not limited to: (1) the patient’s levels of functioning; (2) the physicians’ prognosis for the patient and treatment options, if any; (3) whether the life-sustaining treatment is causing, or alternative treatment would cause, pain or discomfort to the patient; (4) the degree of dependency and loss of dignity endured and likely to be endured by the patient if life is prolonged; (5) whether withdrawal of treatment might cause pain or discomfort to the patient and the extent to which that pain can be ameliorated; and (6) the opinions of spouse and family members, factors that are preventing them from agreeing on a treatment decision, and circumstances that might be motivating certain family members to opt for either termination or continuation of treatment.\[32\]

Explications of the best interests standard as entailing use of an objective “legal yardstick” by the surrogate—“a ‘balance sheet’ approach”\[33\]—promote a complementary decision-making strategy. By viewing the patient’s best interests objectively, through the eyes of a dispassionate and rational third-party, the surrogate is


supposed to comparatively evaluate “the risks, side effects, and benefits of each of [the realistically available treatment] options.”[34] This involves asking “what sort of decision a reasonable person would make”[35] under the same or a similar set of circumstances. Thus, ordinarily “[a] best interests formula...draws on the elements that [the majority of] people commonly define as their interests when facing a critical affliction.”[36] These quality of life components are primarily the elements of physical pain, emotional suffering, pleasure, and indignity or humiliation.[38]


[35] *Joseph J. Fins, A Palliative Ethic of Care: Clinical Wisdom at Life’s End* 113 (2006). See also McCubbin & Weisstub, *supra* note 22, at 6 (“The best interests standard, as it is generally understood, requires an ‘objective’ weighing of costs and benefits of alternatives facing the patient or, under a formulation that recently has become more common, the decision that a reasonable person might make under the same circumstances.”).

[36] Norman L. Cantor, *Déjà Vu All Over Again: The False Dichotomy Between Sanctity of Life and Quality of Life*, 35 STET. L. REV. 81, 95 (2005). See also *id.* at 98 (equating reasonableness with the idea of intolerability for a specific medical condition “held by an overwhelming number of people”).

An objective best interests analysis, while centered on the welfare of the specific patient, is not (and cannot be, given the informational limitations with which the surrogate is confronted) determined by the known unique wishes of that particular patient. As explained by the National Guardianship Association (NGA): “This ‘Best Interest’ principle of decision-making is not based upon the ward’s wishes, but on what a reasonable person would do after considering all the options and alternatives and their potential risks, side effects and dangers.” The NGA similarly opines in another document that the incapacitated person’s best interests are “defined by more objective, societally shared criteria,” than by the individual’s own presently unknown preferences.

Each of the approaches to defining and applying the best interests standard to medical decisions on behalf of decisionally incapacitated older individuals discussed above has engendered some significant criticism. To a large degree, the courts, legislatures, commentators, and others trying to apply the best interests standard through practical application of the best interests principle always requires the decision maker to refer to an account of quality of life.”

\[38\] Id.


a subjective, patient autonomy-conscious approach may end up confusing and conflating the two logically distinct concepts of best interests and substituted judgment.\[41\] Such confusion and conflation are neatly illustrated by the following instruction contained in an article purporting to explain the best interests standard: “[T]he nurse has a responsibility to ensure that the actions and decisions that are taken are truly the ones that are in the best interests as expressed by the patient at a time when they (sic) could speak and decide for themselves (sic).”\[42\] When this sort of conceptual confusion and conflation occurs, the best interests standard is rightly subject to the same workability objections that have been leveled against substituted judgment as a model of surrogate decision-making.

When it is considered on its own merits (and not just because people confuse it in practice with substituted judgment), the best interests standard still remains wanting. First, commentators argue that a family member acting in the surrogate role may

\[41\] See, e.g., Karen B. Hirschman et al., Why Doesn’t a Family Member of a Person With Advanced Dementia Use a Substituted Judgment When Making a Decision for that Person?, 14 AM. J. GERIATR. PSYCHIATRY 659 (2006) (finding that many family members were unable to distinguish between the substituted judgment and best interests standards). See also Berger et al., supra note 17, at 49 (claiming that substituted judgment and best interests comprise the endpoints of a decision-making continuum, with the patient’s “immediately discernible interests” in between).

\[42\] Suzanne Fullbrook, Best Interests: A Review of Issues that Affect Nurses’ Decision Making, 16 BRIT. J. NURS. 600, 601 (2007) (emphasis added).
conscientiously endeavor to fulfill his or her fiduciary/trust responsibilities\textsuperscript{[43]} to concentrate on the patient’s current interests (framed in terms of the patient’s history).\textsuperscript{[44]} Nonetheless, the surrogate’s own self-centered emotional, physical, and financial interests, as well as the interests of other family members, are going to intrude into and influence the surrogate’s decisions.\textsuperscript{[45]} There may be an actual or apparent conflict—or at least a tension—between the respective interests of the patient and involved family

\textsuperscript{[43]}\textsc{Black’s Law Dictionary} (8th ed. 2004) (defining fiduciary as “a person who is required to act for the benefit of another person on all matters within the scope of their relationship; one who owes to another the duties of good faith, trust, confidence, and candor”); \textsc{Marshall B. Kapp, Key Words in Ethics, Law, and Aging: A Guide to Contemporary Usage} 31 (1995) (“In a fiduciary relationship, the more powerful party (i.e., the fiduciary) accepts the special obligation to act in a manner consistent with the best interests of the less powerful party, rather than primarily to serve his or her own interests. ...[Fiduciary relationships] are sometimes referred to as trust relationships, since they enable the less powerful figure to place trust and confidence in the fiduciary.”).

\textsuperscript{[44]}Crystal D. Moore et al., \textit{Surrogate Decision-Making: Judgment Standard Preferences of Older Adults}, 37 \textsc{Soc. Work Health Care} 1, 3-4 (2003) (asking “How can one make a decision that promotes a patient’s current interests without considering a patient’s past?”).

\textsuperscript{[45]}See Gutheil & Appelbaum, \textit{supra} note 23, at 9 (commenting on “arbitrary ‘best interests’ considerations, with their attendant conscious and unconscious biases”).
This conflict or tension may lead to anxious speculation that the best interests model “might incorporate a paternalistic conception of what society, family members, or doctors believe is, in general, good for the patient, rather than exploring what actually would serve the interests of a unique patient having particular values in a specific context.” Some courts have affirmatively rejected (or, more realistically, have purported to reject) consideration of the family’s (and also society’s) perceived welfare as part of the best interests standard. Those courts insist on the possibility and desirability of restricting the decisional analysis to the patient’s interests alone.

Most commentators do not consider this potential tension or conflict of interest to be serious, let alone fatal. Rather, it is understood that the realistic and explicit recognition of the inevitability of family interests being included in the decision making calculus is imperative if any surrogate decision making framework for incapacitated persons is going to have usefulness in actual practice. As a general (albeit admittedly


[49]Alexia M. Torke et al., The Physician-Surrogate Relationship, 167 ARCH. INTERN. MED. 1117, 1119 (2007) (“Because the values and needs of family members will inevitably affect decision making, ethical and legal models of the physician-surrogate relationship should explicitly acknowledge these factors and incorporate them into the
not a universal)\(^{[50]}\) rule, when surrogates base decisions in part on their own interests, they do so for praiseworthy reasons.\(^{[51]}\) Furthermore, many older people affirmatively prefer that decisions made for their incapacitated selves by surrogates purposefully

\[\text{decision-making process.}^\); Donnelly, \textit{supra} note 16, at 415 (“[A]lthough the test is undoubtedly flawed, it is not possible to operate any decision-making process on the part of incompetent persons without using a best interests determination at some level.”). \textit{See also} Alexia Torke et al., \textit{Rethinking Surrogate Decision-Making: Evidence from a Qualitative Study of Physicians}, 19 J. CLIN. ETHICS 110 (2008) (advocating the position that decision-making guidelines should explicitly include the presence of surrogate interests).


\(^{[51]}\)Vig et al., \textit{supra} note 5, at 1692 (“Even the surrogates who planned to base decisions on their own needs... explained that they did so because they cared too much for loved ones and anticipated having trouble making life-and-death decisions.”).
consider the interests of the patient’s loved ones as well as the individual patient’s interests.\[^{52}\]

Some commentators additionally object that, because the best interests standard inherently involves subjectivity on the part of the surrogate, consistency and uniformity must be sacrificed. To some unavoidable degree, different incapacitated individuals will have different decisions made for them based on the luck of the draw in terms of the particular surrogate involved. We generally assume a broad consensus on the specific criteria to be considered in judging the patient’s best interests under a particular set of circumstances. Nevertheless, different surrogates may weigh and balance those criteria differently in applying them tangibly. Lack of uniformity in outcome seems an unreasonable objection, though; surrogate decision making cannot follow a rigid formula or algorithm. A variance in decisions depending on the identity of particular surrogates is unavoidable. As discussed below, so long as the varying results of the decision-making process fall within an ethically acceptable range, those results and the process that produced them ought to be legally permissible as well.

Another misgiving among certain critics stems from the measurement of a person’s best interests according to the course that a reasonable person in the same or similar circumstances would have pursued. When surrogate decision makers equate the objective “reasonable” person with the numerical majority of people, the argument is made that the reasonable/majority choice might not be conclusive regarding what any

\[^{52}\]Moore et al., supra note 44 (reporting on a study finding that older individuals prefer a “best judgment” standard of decision making that takes into account the interests of the family).
specific incapacitated adult might have chosen for himself or herself. This concern, however, is circular. The very reason to use the best interests standard in the first place is that we do not—and realistically cannot—know the current competent wishes of the patient whose care is at issue. But for that irresolvable informational deficit, the family and health care providers would have been able to rely on the patient’s stated choices or substituted judgment and avoid the entire best interests conundrum altogether. As explained by legal scholar Lawrence Frolik: “The best-interests standard can ... be justified because we can never be confident as to what the [incapacitated person] might do, so it makes sense to choose another value as the basis for the decision.”[53]

Unquestionably, “[i]dentification of best interests of the patient as the prevailing standard for surrogate decision-making leaves many questions unresolved.”[54] Ultimately, the most vexing of these questions is whether participants who make and implement surrogate decisions for decisionally incapacitated adults need to interpret the “best” terminology of best interests literally. This question is central to tangible application of the standard in factual cases. In other words, must “the best” interests be strictly equated with “optimal” interests of the incapacitated person? Conversely, are there sufficient virtues in a more flexible interpretation of the standard to satisfy the fiduciary obligations of the surrogate?


[54] Cantor, supra note 20, at 156.
FROM BEST INTERESTS TO THERAPEUTIC INTERESTS

In the ethical commentary and medical-legal pronouncements, there appears to be a widespread, but rarely carefully examined, supposition that the best interests principle "is defined as acting in a way that most optimally promotes the good of the individual."\[^{[55]}\] For example, in their seminal essay *Deciding for Others*, philosophers Allen Buchanan and Dan Brock explain one of their "Guidance Principles," best interests, as "acting so as to promote maximally the good of the individual."\[^{[56]}\] They go on to assert that "[t]he course of action to be followed, then, is the one with the greatest net benefit to the patient."\[^{[57]}\]

Equating a decisionally incapacitated older person’s best interests with that person’s optimal interests, and attempting to hold surrogate decision makers to that strict standard, is appealing. In the end, though, it is not very realistic. Instead of clinging to this unrealizable fiction, I propose explicitly moving from a “best interests equals optimal interests” equation to a revised approach. Under the suggested approach, surrogates are expected to act in the incapacitated older person’s “therapeutic” interests as defined below.

A few illustrative cases may help to explain the intended point. First, take the story of Mr. M, a 75-year-old man with severely impaired cognitive and communication

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\[^{[55]}\]Bailey, *supra* note 37, at 285 (emphasis added).

\[^{[56]}\]Allen Buchanan & Dan Brock, *Deciding for Others*, 64 MILBANK Q. 17, 49 (1986) (emphasis added).

\[^{[57]}\]*Id.* at 73 (emphasis added).
abilities stemming from a stroke three years ago. Mr. M has been diagnosed with an advanced and invariably fatal form of leukemia. Standard therapies (such as they are) have been attempted, resulting in substantial adverse side-effects but no alleviation or retardation of the disease. He is offered the opportunity to receive an FDA-approved but still innovative medication at a major medical center a thousand miles away from his home and extended family. Based on limited available data, Mr. M’s legal guardian, his wife, is told that the medication may achieve a 50% chance of extending his life up to six months; few if any adverse side-effects are anticipated. Mr. M has not executed an advance instruction directive, nor previously discussed this type of scenario with his family.

If Mr. M’s best interests are defined in optimal terms, his wife/surrogate decision maker ought to subject him to the innovative medication in the medical center a thousand miles away. There is no other even temporarily curative or death-delaying alternative available; the innovative medication is Mr. M’s only—and hence his optimal—chance at obtaining clinical benefit. It is the last, ergo by default, the “best,” resort. (Some readers may object to my premise about Mr. M’s optimal interests here; objections would just be demonstrating the subjectivity and hence dishonesty of the supposedly objective best interests standard in the first place.)

However, subjecting Mr. M to the regimen of innovative medication in the medical center, although medically optimal, might cause Mr. M to suffer anti-therapeutic effects, in terms of being physically and emotionally upended from his familiar home environment and extended family support system. Being thrust into the unfamiliar environment of a major medical center a thousand miles away might be physically and
psychologically stressful for Mr. M’s wife and the rest of his family. Certainly, this “optimal” pathway would impose significant financial costs on Mr. M and his eventual heirs.

Conversely, maintaining Mr. M in his home environment and local, familiar hospital for his final days or weeks, assuming the provision of decent palliative care for him and his family, probably would not constitute the optimal medical choice. It involves forgoing the only possibility of achieving temporary limitation of the disease and the resulting, physically tolerable, life extension. Yet, even if not the optimal path, by any measure the palliative care alternative would serve Mr. M’s therapeutic interests. While they might be chided for not doing “the best” for Mr. M, his surrogate decision maker(s) should be deemed ethically and legally justified in acting in Mr. M’s therapeutic interests.

In Case 2, Mr. Y is an 85-year-old, moderately demented widower who has been living alone in a house not far from his only family, which consists of a middle-aged son (to whom he has given durable power of attorney), daughter-in-law, and their two teenage sons. Mr. Y has a number of chronic medical problems and has been receiving four hours per week of home health care. He has recently been diagnosed with stomach cancer. His physician recommends surgical insertion of a permanent percutaneous endoscopic gastrostomy (PEG) tube for artificial feeding and placement of Mr. Y in a skilled nursing facility that can provide continuous care for his medical and nursing needs. Mr. Y never executed an advance instruction directive nor previously discussed this type of scenario (or much of anything else, for that matter) with his family.
Mr. Y’s family members all love Mr. Y and want what is “best” for him. They all agree that the PEG should be inserted. However, they are divided about the proper venue for Mr. Y’s subsequent placement. They all, in good faith, would like Mr. Y to reside in their home and are willing to divide up caregiving responsibilities among themselves, supplemented by whatever home health services Medicare and Mr. Y’s private savings will finance. Nonetheless, the son sincerely fears that, because his well-meaning family has very limited education, many other obligations, a poor track record of dependability, and a variety of other psycho-social issues such as occasional heavy drinking and internal arguing, Mr. Y would receive sounder and safer ongoing care in a professional facility. The wife and grandchildren insightfully, and regretfully, agree with the son’s assessment of the situation and that institutional placement likely would objectively be the optimal choice for Mr. Y. Still, they contend that the care Mr. Y would receive from them in their home (even given the family’s demonstrable weaknesses) would be “good enough” to serve his therapeutic interests and that they would feel much better about the whole situation if this approach were at least attempted.

The cases of Mr. M and Mr. Y are not atypical in geriatric practice. With these scenarios in mind, I advocate a shift in legal and medical thinking away from conceptualization of best interests as optimal interests, and toward a much more workable model of best interests as therapeutic interests. Obviously I am relying very heavily on ideas that have been generated and tried over the last several decades surrounding the analytical lens of therapeutic jurisprudence. Therapeutic jurisprudence (TJ) is largely the
brainchild of legal scholars David Wexler and Bruce Winick\textsuperscript{[58]} and originally centered on the impact of mental health law on discrete human beings.\textsuperscript{[59]} It has been defined succinctly as “the study of the role of the law as a therapeutic agent.”\textsuperscript{[60]}

Christopher Slobogin is among those commentators who have pointed out a “definitional dilemma” pertaining to TJ. He contends that delineations of the terms “therapeutic” and “well-being” within the TJ context “are still extremely vague.”\textsuperscript{[61]} Another commentator notes, “A weakness and strength of therapeutic jurisprudence has been its embracing a wide array of definitions of what is ‘therapeutic’.”\textsuperscript{[62]} In response to comments of this sort, TJ co-pioneer Wexler has opined:

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\textsuperscript{[59]}David B. Wexler & Bruce J. Winick, \textit{Introduction to Law in a Therapeutic Key} XVII, xix (David B. Wexler & Bruce J. Winick eds., 1996) (“Therapeutic jurisprudence was originally developed within the ‘core’ content areas of mental health law.”) [hereinafter KEY].
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\textsuperscript{[60]}Id. at xvii.
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Therapeutic jurisprudence has been criticized for not offering a clear-cut definition of the term therapeutic. As a mere lens or heuristic for better seeing and understanding the law, however, I think therapeutic jurisprudence has quite rightly opted not to provide a tight definition of the term, thereby allowing commentators to roam within the intuitive and common sense contours of the concept.\[^{[63]}\]

Within the context of best interests medical decision making by surrogates on behalf of decisionally incapable older persons, I accept Professor Wexler’s invitation “to roam within the intuitive and common sense contours of the concept” of TJ. Accordingly, I argue that, as a pragmatic matter, a surrogate’s decisions should count as being made in the patient’s best interests so long as those decisions serve a therapeutic interest of the patient. A decision serves a patient’s therapeutic interests in the limited but important sense of not being abusive or neglectful of the patient and the patient’s needs.\[^{[64]}\]

Realistically, any standard to be used by surrogates in making medical decisions for decisionally incapacitated older persons will at best establish therapeutically “good enough” (as opposed to optimal) parameters for evaluating available treatment and non-
treatment options.\textsuperscript{[65]} “Good enough” choices are “at least acceptable choices for those unable to choose for themselves.”\textsuperscript{[66]} We are ordained to live out our lives in an imperfect world of limited knowledge and finite economic, emotional, and physical resources. Sometimes a surrogate decision is “good enough” or “at least acceptable” if it is reasonably consistent with the therapeutic interest of the incapacitated person for whom selections within acceptable options must be made. Moreover, a course of conduct should be deemed consistent with the therapeutic interest of the incapacitated person so long as it is not abusive or neglectful of that person.

To some, a negative standard of surrogate decision making predicated on the absence of patient abuse or neglect may seem an impoverished effort on behalf of older individuals who cannot presently speak for themselves in the medical decision making realm. However, a standard that validates and equates the incapacitated person’s therapeutic interest with that person’s interest in avoiding abuse or neglect is fully consistent with the prevailing legal and ethical approach to delineating family caregiving responsibilities to older loved ones generally. It thereby “gives families greater

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\item\textsuperscript{[65]} Loretta M. Kopelman, \textit{The Best Interests Standard for Incompetent or Incapacitated Persons of All Ages}, 35 J. L. MED. & ETHICS 187, 188-89 (2007).
\end{itemize}
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discretion to decide about [medical] treatment”[67] than the excessively idealistic best interests standard.

The challenge is to define which family decisions are “beyond the pale”[68] of ethical and legal permissibility. A useful place to look for guidance concerning the outer limits of acceptable decision making is the collection of state laws regarding abuse and neglect of older persons.[69] Every jurisdiction explicitly imposes criminal liability for caregivers’ willful acts or omissions amounting to elder mistreatment.[70] It is a practical impossibility to impose affirmative obligations on the part of caregivers by attempting to “legislate love.” States realistically must satisfy themselves with legislatively discouraging potentially harmful (non-therapeutic) conduct by individuals in a position of trust and power that jeopardizes the well-being of vulnerable older people. Similarly, in the real world, we cannot affirmatively require surrogate decision makers to absolutely optimize the welfare of every decisionally incapacitated older patient with each discrete medical decision. Accordingly, we must be content to marshal society’s legal and moral


[68]Id.


[70]Marshall B. Kapp, Legal Aspects of Elder Care 277-91 (Jones and Bartlett: Sudbury, MA 2009).
forces to highlight parameters of unacceptability, informed by state elder mistreatment statutes and regulations. Those boundaries distinguish the patient’s therapeutic versus anti-therapeutic interests and compel surrogate decision making that is consistent with the former.

CONCLUSION

The prevailing official interpretation of the best interests standard of surrogate medical decision making on behalf of decisionally incapacitated older persons perpetuates the pretense, but fails to embody the reality, of objective, accurate, optimal choices even when the patient cannot speak for himself or herself. A more honest and workable approach would adapt a somewhat different best interests model. The new model would embrace the idea of serving older persons by protecting them from the sort of abusive and neglectful decisional acts and omissions that, in a very real way, threaten their therapeutic interests. In this way, we may most productively optimize “the role of the law as a therapeutic agent.”[71]

[71] KEY, supra note 59, at xvii.