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The Ethics of Choosing a Surrogate Decision Maker When Equal-Priority Surrogates Disagree

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Abstract. When decisionally incapable patients need a surrogate to make medical decisions for them, sometimes the patient has not appointed a healthcare agent and there is intractable disagreement among potential surrogates of equal priority, legal rank, or relation to the patient (e.g., child vs. child, sibling vs. sibling). There is no ethical, legal, or professional consensus about how to identify the appropriate surrogate in such circumstances. This article presents a case study involving an elderly female patient whose four children disagree about whether to continue life-sustaining treatment for their mother, along with an ethical analysis of various strategies for selecting the appropriate surrogate in cases of conflicting equal-rank family members. It critically examines three different strategies—chance, majority rules, and quality of relationship with the patient—and defends the third approach.

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Introduction

Family members who assume medical decision making for patients who are decisionally incapable often disagree about medical treatment and goals of care. In some cases, an advance directive, state law, or institutional policy can identify which relative should have decision-making authority. Frequently, however, there is neither a formal appointment of

a healthcare agent nor a clear legal hierarchy of authority among potential surrogates. The most challenging scenario occurs when conflicting family members are of equal priority, legal rank, or relation to the patient (e.g., child vs. child, sibling vs. sibling), and their disagreement is intractable. This is a scenario that many healthcare professionals and ethicists can expect to encounter at some point. Yet

there is no consensus about how to proceed when equal-priority surrogates disagree, and it remains an open question in healthcare ethics, health law, and clinical practice. It is also an issue that has not received much attention in the literature. In this article, I will examine a case that brings the problem into stark relief, involving an elderly female patient whose four children disagree about whether to continue life-sustaining treatment for their mother. I will present an ethical analysis of three different strategies for selecting the appropriate surrogate in cases of conflicting equal-rank family members: chance, majority rules, and quality of relationship with the patient. I will defend the third approach.

Case Summary

Mrs. Lopez was a 70-year-old African American woman with a history of type I diabetes, atrial fibrillation, pulmonary edema, congestive heart failure, and mild Alzheimer's dementia.¹ Prior to hospital admission, she had been living with her son and caregiver Dave for almost ten years. She needed assistance with daily activities but was fairly mobile and enjoyed reading, listening to music, dancing, gardening, walking, and spending time with her children and grandchildren. Mrs. Lopez was on good terms with all four of her adult children, but her son Dave was estranged from his three siblings after a falling out several years ago. As a result, Mrs. Lopez saw her other three children only once or twice a month.

One morning, Dave had trouble arousing his mother and noticed that she was confused and disoriented. After being admitted to the hospital, she was found to have suffered a large acute ischemic stroke resulting in significant cognitive and physical deficits. Mrs. Lopez was able to open her eyes and blink at times, but she was nonverbal, non-interactive, and unable to move purposefully. She was incapable of medical decision making and

her capacity was not expected to return in the near future, if it did at all.

Two weeks out from her stroke, Mrs. Lopez was receiving aggressive treatment with a full code status. Her prognosis was uncertain, but the medical team reported that she was unlikely to recover significant higher brain function and be able to speak or walk; she might, however, eventually be able to recognize the people around her, communicate non-verbally, and regain some upper extremity mobility. Mrs. Lopez was unable to eat safely and needed to begin artificial nutrition and hydration soon. Moving forward, the healthcare team was considering two options: placing a G-tube and continuing full treatment to keep Mrs. Lopez alive; or foregoing the feeding tube, transitioning to comfort care, and allowing her to die. Mrs. Lopez's four children disagreed about the appropriate goal of care for their mother. Her son Dave hoped that her condition would improve and was asking to continue aggressive treatment to prolong his mother's life, claiming that she would want to keep living and spend more time with her family. Mrs. Lopez's other three children disagreed and were requesting a transition to comfort care, claiming that their mother's current quality of life would be unacceptable to her because of her loss of mobility; her inability to perform activities like eating, gardening, walking, and talking; and the months-long recovery period in a skilled nursing facility that would be needed before she potentially could recover physical and cognitive function.

Mrs. Lopez did not have an advance directive and had not left any explicit indication of her treatment preferences or whom she would want to make decisions for her. Despite multiple goals of care discussions and the healthcare team delaying the decision for a week to give the family time to forge a compromise, Mrs. Lopez's children were unable to reach any consensus about how to proceed with their mother's care. During one discussion, the atmosphere became palpably tense when Dave accused his three siblings of not caring about their mother, rarely visiting her, never being involved in her care, and wanting to give up on her and "get rid of her as quickly as possible," while the other three

¹ The names and some details of this case have been changed to protect the identity of the parties involved.

accused Dave of trying to keep their mother alive “as a vegetable” in a state of suffering for the sake of his own financial gain. The result was hostility, hot tempers, and a complete breakdown in communication. Because agreement among Mrs. Lopez’s children seemed impossible and the medical decision could not be delayed any longer, the treating team requested an ethics consult to provide advice on identifying the appropriate decision maker: Dave or the other three children?

The problem was that Mrs. Lopez had not given clear written or verbal direction about her wishes, had no spouse or siblings, and had multiple children, all of whom enjoyed an initial presumption of equal decision-making authority. What made this case especially challenging was that the medical team had to make a decision (it was unavoidable) and the ethicist had to give advice favoring one party or the other, otherwise the ethicist would be failing in the professional duty to advise the team.

For the purposes of my analysis, I am stipulating the following: the patient’s decision-making incapacity was not in doubt; the patient did not give any clear and explicit indication of her wishes regarding her treatment or her surrogate; the health-care team did not think either treatment option was medically inappropriate and futility was not an issue; all four of the patient’s children were adults who were decisionally capable, available, willing to assume decision-making responsibility, and free of problematic motives or conflicts of interest; the two dissenting groups of children were both appealing to what they thought the patient would want; the disagreement was intractable; and there was no applicable law specifying how to resolve disagreement among equal-priority surrogates.

The central question to be answered in this case—which party should have decision-making authority?—should be divided into two distinct questions: (1) The *who* question: who should be the patient’s surrogate? (2) The *what* question: what criteria, standards, or principles should govern the surrogate’s decisions? There is a related distinction among two types of ethical norms: *procedural rules*, like the rules specifying how we should choose among equal-priority surrogates; and *substantive*

principles, namely the ethical considerations that ought to govern surrogates’ decisions. These two sets of questions and norms cannot be completely divorced, and there are important connections between them, as the analysis below will demonstrate. My answer to the procedural question of which party should be the surrogate will depend on a substantive principle about what is ethically relevant when it comes to answering this question. Before offering an ethical analysis of Mrs. Lopez’s case and an answer to the problem of conflicting equal-priority surrogates, I will examine the legal and professional norms that provide the background context for the problem.

Law and Professional Opinion

When it comes to the selection of an appropriate surrogate, most states have a mandatory or suggested legal hierarchy of persons who can act as “default surrogates” in the absence of a formal appointment of a healthcare agent (i.e., a durable power of attorney or court-appointed guardian). The most popular legal hierarchy prioritizes, in descending order, the patient’s spouse, then adult child, then parent, then adult sibling (American Bar Association, 2019; DeMartino et al, 2017). These hierarchies do not solve the problem at hand, however, because our focus is disagreement among individuals within the same class who enjoy equal priority.² Nevertheless, most states (plus Washington, D.C.) do have some legal mechanism for handling such disagreement:

² As Nina Kohn and Jeremy Blumenthal point out, “priority lists often fail to state how a surrogate should be selected within a class of potential surrogates. For example, statutes commonly give priority to adult children, but do not specify which adult child is to be considered the surrogate, even though daughters are typically selected at far higher rates than sons. The result can be that the surrogate within a class is chosen on the basis of factors other than those the incapacitated person would tend to use. In addition, the lack of clarity may lead to intra-group conflict, something prospective patients often wish to avoid” (2008, p. 991).

20 opt for majority rules, 10 have no legal provision on the matter, 8 require consensus, 8 require judicial recourse, and 5 mandate that if there is no majority and the family is deadlocked, the physician or institutional ethics committee should decide (American Bar Association, 2019). On a related note, the Uniform Health-Care Decisions Act endorses the majority rules approach, stating: "If more than one member of a class assumes authority to act as surrogate, and they do not agree on a health-care decision . . . the supervising health-care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider" (National Conference of Commissioners, 1993, §5e). All of these legal mechanisms identify procedural rules for resolving surrogate disagreements, but none of them addresses substantive ethical principles—the actual reasons, criteria, or justification that should be used to identify an appropriate surrogate.

Although there is consensus among bioethicists and healthcare professionals about the ethical appropriateness of relying on family members as default surrogates, there is no professional consensus or received view about how to handle disagreement among equal-priority surrogates.³ This question has received surprisingly little discussion in the literature, but several answers have been offered. In their well-known work on the ethics of surrogate decision making, Allen Buchanan and Dan Brock give the following advice: "In some cases, disagreements among family members are so intractable that the family cannot function as a coherent decision-making unit. If the conflicting

members stand in roughly the same degree of closeness to the incompetent, recourse to probate court for a formal determination of guardianship will generally be appropriate" (1990, p. 138). One problem with this "judicial recourse" solution is that it is usually expensive, impractical, and infeasible due to the amount of time it requires. Waiting for a court's decision often can take weeks or months, and patients, families, and healthcare providers rarely can delay a decision that long. A more serious problem is that this proposal does not answer the substantive ethical question of *why* a particular person is the appropriate surrogate. Buchanan and Brock's strategy does not address the reasons on which the court bases its decision, so it fails to provide a satisfactory answer to our question.

The President's Commission offers a more promising answer. In their opinion, "One possibility is to define a presumptive priority, e.g., that a person living with his or her spouse will speak for that spouse, that adult children will speak for elderly widowed parents, etc. In some cases such presumptions may be helpful. Nevertheless, the Commission believes that it is the responsibility of the practitioner to determine who acts as the patient's "surrogate." No neat formulas or serial orderings will suffice to capture the complexities involved in determining who among the individuals presenting themselves as friends and relatives of the patient knows the patient best and has his or her best interests in view. The responsibility is therefore on the practitioner either to determine who this spokesperson is or to go to court to have a guardian appointed" (1982, p. 182, n. 11). This is wise advice because it recognizes the inherent limitations of any procedural rules designed to resolve internal disagreements among surrogates. As I will argue, there are forceful objections to all the possible solutions to this problem, especially if they are meant to be exceptionless methods that pick out the appropriate surrogate in all cases. As the Commission rightly notes, in this kind of situation there will always be an ineliminable and necessary role for the practically wise judgment of healthcare professionals. Despite this important insight, however, the Commission's proposal, like

³ *The President's Commission clearly and succinctly lays out the reasons in favor of allowing family members to serve as default surrogates in the absence of an advance directive: "(1) The family is generally most concerned about the good of the patient. (2) The family will also usually be most knowledgeable about the patient's goals, preferences, and values. (3) The family deserves recognition as an important social unit that ought to be treated, within limits, as a single decisionmaker in matters that intimately affect its members" (1982, pp. 182–183).*

Buchanan and Brock's, is not a satisfying answer to our question because it does not go far enough in identifying the ethically relevant considerations that should be used to select the proper surrogate. In what follows, I will attempt to provide a better solution to the problem of disagreement among equal-rank individuals.

Ethical Analysis

The two primary ethical considerations governing surrogate decision making are respecting patients' autonomy and promoting patients' well-being. These core values inform the ethical principles governing who the surrogate should be and what criteria should guide the surrogate's decisions. The value of autonomy is tracked by the *known wishes* standard and the *substituted judgment* standard, whereas well-being is tracked by the *best interests* standard (Buchanan & Brock, 1990). When making a substituted judgment, the surrogate attempts to make the decision that the patient himself or herself would have made in the current situation if he or she were capable of doing so. The surrogate interprets what the patient would want and choose in the present circumstances based on his or her knowledge of the patient's history, beliefs, and values (rather than the patient's explicit, previously expressed wishes). When making a best interest judgment, the surrogate attempts to decide what will be most conducive to the patient's overall well-being. The surrogate makes judgments about the benefits and burdens of various treatment options based on objective standards concerning benefits and harms or what a reasonable person would choose (not the patient's own beliefs and values).

In my Case Summary, I said that my answer to the procedural question of who the surrogate should be depends on a substantive principle regarding the ethically relevant facts that determine an appropriate surrogate. In the case of Mrs. Lopez, I will assume that substituted judgment rather than known wishes or best interests is the appropriate standard to use when attempting to answer our central question of how to resolve disagreement among equal-priority surrogates. The reasons for

adopting the substituted judgment standard are that Mrs. Lopez's wishes are unknown, precluding the known wishes standard, and in such cases employing substituted judgment tracks the current ethical, legal, and professional consensus, according to which substituted judgment takes precedent over best interests (Buchanan & Brock, 1990; National Conference of Commissioners, 1993). As the President's Commission states, "decisionmaking for incapacitated patients ought, when possible, to be guided by the principle of substituted judgment, since it promotes the underlying values of self-determination and well-being better than the best interests standard does" (1982, p. 180).⁴ Furthermore, in Mrs. Lopez's case, all four children are appealing to the patient's wishes rather than her best interests, and the treating team and ethicists likewise are operating on the basis of substituted judgment. It should be noted, however, that if we were to adopt the known wishes or best interests standard instead, the ethical analysis and argumentation below might be different. Exploring these differences is beyond the scope of this article.

Given the assumption that the appropriate standard is substituted judgment, the *primary ethical consideration* when it comes to answering our question is: what would the patient want and choose in this situation if she were able to make her own decision? A closely related question is: of the available family members, whom would the patient choose to be her decision maker? These questions are *counterfactual*

⁴ The Commission is not necessarily correct that substituted judgment is superior to best interests in terms of promoting patient autonomy and well-being. There is not a necessary conceptual connection here, and it is both a normative and empirical question which standard will better promote these two central values. In addition, there is some concern about the accuracy of surrogates when making substituted judgments. One meta-analysis of empirical studies on the reliability of surrogate decision makers (Shalowitz, Garrett-Mayer, & Wendler, 2006) found that surrogates accurately predicted patient preferences just 68% of the time, meaning that they failed to do so about a third of the time. I will not explore these issues any further here, though.

in nature—that is, they are concerned with what would happen in a non-actual state of affairs—and thus are to some degree inherently speculative. Answering them comes with significant epistemic challenges.

In most cases, the answers to the “what” question and the “who” question will be the same: the patient would want as her surrogate the person who would make decisions in line with her wishes. They can, however, come apart in rare situations, for example, when a patient chooses a surrogate who is not the person most likely to respect his preferences because he believes that having a good relationship with that person, or with the wider family or community, is more important than having his wishes honored. But since the answers to the two questions usually do go hand in hand, and since the “what” question is more fundamental than the “who” question, because surrogates have an ethical and legal obligation to make decisions in accordance with the patient’s wishes, I will focus on the “what” question as the primary ethical consideration and will not address the “who” question directly in this analysis.

Our question is which party should have surrogate decision-making authority in cases of intractable disagreement among persons of equal rank. We can identify three major opposing answers:

1. *The chance approach (random selection)*: We flip a coin, draw straws, conduct a lottery, etc. to determine the surrogate.
2. *The quantitative approach (majority rules)*: The party that is the numerical majority has decision-making authority.
3. *The qualitative approach (relationship)*: The individual who has the closest personal relationship to the patient is the surrogate.

Applied to the case of Mrs. Lopez and her four children, these three strategies have the following implications. The chance approach favors neither party and makes the choice of surrogate completely dependent on random selection. The majority rules approach entails that Mrs. Lopez’s three children, rather than Dave, should have decision-making authority because there are three of them and one of him. The qualitative approach gives the *prima facie* verdict that Dave should be the surrogate because

he lives with his mother, is her caregiver, and spends much more time with her than his siblings do, which indicates that he is probably the person who has the closest relationship with her.

Which of the three strategies should the health-care team adopt? The first thing to say is that none of the strategies provide an infallible and exceptionless method for identifying the appropriate surrogate in every case. The particular details of the case can have a significant impact on which approach is best. For example, consider a patient who has ten adult children with the parties divided nine vs. one. If the one child is extremely close to the patient and the other nine have all been estranged from the patient, having had no contact with the patient for many years, then the numbers should not matter and we should go with the one child rather than the nine. Since these kinds of extrinsic, contingent factors can have a decisive bearing on which strategy is most fitting, the more fundamental and essential question is which strategy has the most *intrinsic* ethical relevance, i.e., relevance with respect to tracking what the patient would have decided.

I will examine arguments in favor of the three competing solutions and consider various objections to them. I will argue that in the specific case of Mrs. Lopez, we should adopt the qualitative, relational strategy. But when it comes to a general method that can be universally applied to every case of disagreement among equal-priority surrogates, I will defend a pluralistic strategy that combines elements of all three solutions.

Let’s consider the chance approach first. The main argument for this position is that when there is disagreement among equally ranked individuals, random selection is an unbiased, impartial, and fair process that gives everyone an equal chance at being the decision maker. It is also extremely effective and expedient because all it requires is a simple coin toss (or drawing of straws, lottery, etc.), minimizing the time and effort required of the healthcare team.

Notwithstanding these appealing features, there are strong objections to the chance approach. First, it is a *non-rational* process of decision making. The vast majority of people do not make major life decisions on the basis of pure chance; instead, they

make them on the basis of reasoned deliberation. The chance strategy flies in the face of this norm. There is something deficient in basing consequential decisions, such as the selection of a surrogate or the goal of medical care, on mere chance as opposed to reflective and considered judgment. Incapable patients like Mrs. Lopez are owed the same kind of rationally justified decision-making process that we afford other patients, and we should not leave their fate up to chance if there are other available alternatives that are reason-based. Although the chance strategy might be fair to potential surrogates, there are grounds for deeming it unfair to incapable patients because it denies them a rational decision-making process.

The second problem with this approach is that there is no connection whatsoever between chance and the primary ethical consideration of what the patient would choose (nor, for that matter, is there any connection to the patient's best interests). The choice of surrogate is supposed to track the patient's wishes, but there is no link of any kind between the patient's wishes and a coin toss.

For these reasons, the chance approach should be rejected as a stand-alone solution. Indeed, it is the worst of the three options because the other two strategies avoid the serious drawbacks just mentioned. Leaving the choice of surrogate up to chance is acceptable only when the other two strategies cannot be applied because there is an even numerical split and no person stands out relationally in any way. In other words, random selection should be employed only as a last resort in situations where all other things really are equal. But this kind of scenario is rare, so at best the chance solution is applicable to a small percentage of cases.

The majority rules strategy is more promising. Its main attraction is that it is a democratic and egalitarian process based on well-established epistemic principles and rules of evidence. According to this approach, we should presume that all equal-priority surrogates have equal decision-making authority, and therefore we should go with majority rules. The main justification is the intuitive epistemic principle that greater agreement concerning a matter of fact *M* is greater evidence for the truth of *M*.

Formulated another way, multiple attestations to a claim increase the probability of that claim. Or, as Buchanan and Brock put it, "Other things being equal, the greater the number of sources of the evidence, the greater the evidential weight" (1990, p. 121). For example, if four eyewitnesses of a two-car accident are being interviewed about which car hit the other, and one person says it was car A while the other three say it was car B, it is reasonable to side with the majority and conclude that car B most likely was at fault.

In Mrs. Lopez's case, the relevant evidence is the testimony of the children about their mother's wishes. Since her son Dave claims that his mother would want aggressive treatment whereas his three siblings claim that she would not, the same kind of reasoning implies that there is greater evidence in favor of the latter claim. Beginning from the plausible assumption that all four children know their mother well and love and care about her equally, combined with the intuitive evidential principle concerning the relative weight of conflicting testimony, the quantitative strategy implies that Mrs. Lopez's three children should have decision-making power.

Despite its plausibility, there are significant objections to the majority rules approach. First, the epistemic principle it rests upon may not be applicable to the type of case we are considering. It is important to recognize that the validity of the principle depends on the type of fact we are interested in. In our case, the key ethical consideration is a counterfactual fact about what the patient would have wanted if she were capable of making a choice in the present situation. This is a strange kind of fact, so strange that some philosophers have questioned whether counterfactual propositions of this sort are even susceptible of having a truth value at all (Starr, 2019). If we are asking whether car A hit car B or vice versa, then the evidential principle is reliable because for this kind of objective, observable phenomenon, a larger amount of eyewitness testimony constitutes weightier evidence. But if we are asking a hypothetical question about a patient's subjective, unobservable, counterfactual beliefs, desires, and choices, it is far less clear that more

sources translate into stronger evidence. To put the point differently, although there is some reason to think the majority would have better insight into matters of general knowledge, there is no good reason to think the majority necessarily would have any advantage when it comes to particular knowledge of an individual person. The numbers alone may not be a good indicator of the patient's probable wishes.

Another drawback of the majority rules approach is that in many cases there will not be a majority—if the disagreement is 1 vs. 1 or 2 vs. 2, for example—in which case this strategy cannot be used. This means that it has limited applicability and will not resolve all occasions of disagreement, leaving the healthcare team with no guidance in such situations. A similar concern is that it may not be appropriate to select a surrogate on the basis of a simple majority (e.g., a group split 5 vs. 4) rather than a super majority (e.g., a group split 7 vs. 2). Some people might judge that a marginal majority does not provide sufficient justification to discriminate between parties on the basis of numbers alone.

A final problem with the majority rules approach is that it risks the possibility that the majority's decision will be made on the basis of personal animosity or a power struggle rather than patient-focused considerations. Although it does not apply in Mrs. Lopez's case (by stipulation), in a similar case where the patient's children are divided with the majority opposing the sibling who is the closest to the patient, the larger group might be jealous of the sibling's special relationship with the parent and motivated by resentment to unite against that person for the purpose of winning a family feud. A worry with the majority rules approach is that it leaves patients vulnerable to this kind of personal-agenda-driven process that is not aimed at, and may be inimical to, their wishes and well-being. By contrast, the two competing strategies (random selection and relationship) are not as liable to be hijacked by personal politics or toxic family dynamics.

The third and final approach to be considered is the qualitative strategy, which bases the choice of surrogate on considerations regarding the quality of an individual's relationship with the patient. The

appropriate surrogate will be the one who is closest to the patient and knows him or her best, where the relevant knowledge is not just propositional but also personal. This individual presumably will be the most knowledgeable about the patient's character, values, and wishes, and will be in the best position to know what the patient would have wanted by virtue of his or her close personal connection to the patient. This strategy aligns with some general guidelines that are commonly employed within the healthcare profession. A representative example is the California Hospital Association's recommended policy for surrogate selection, which maintains that some important considerations that count in favor of an individual are "Familiarity with the patient's personal values," "Demonstrated care and concern for the patient," and "Degree of regular contact with the patient before and during the patient's illness" (2019, Appendix 2-C). The basic line of thought is that if one person stands out as having spent the most time with the patient, having been the most involved in the patient's medical care, and having the greatest insight into the patient's beliefs, values, preferences, priorities, and plans, then this person should be the decision maker even if he or she is in the minority. In the case of Mrs. Lopez, this approach favors Dave because he is his mother's long-time, live-in caregiver, and the other three children do not spend as much time with Mrs. Lopez and probably are not as familiar with her history, life circumstances, beliefs, and values.

The main argument for this strategy is that it has the strongest intrinsic connection to the primary ethical consideration for the problem at hand. Recall that the central ethical question is what the patient would choose. When deciding between the three possible strategies—random selection, majority rules, and relationship—the third seems to be the most relevant to determining what the patient would choose. The connection between the type of evidence identified (chance, numbers, or relationship) and the morally significant counterfactual truth (what the patient would want) is closer and more direct for the relational strategy than it is for random selection or majority rules, which do not have any intrinsic connection to the

counterfactual truth in question. As I have argued, there are reasons to doubt that chance and majority opinion are truth-tracking with respect to (or *prima facie* evidence for) the patient's wishes. By contrast, the surrogate's relational closeness to the patient is more likely to be truth-tracking.

A second argument in favor of the qualitative approach is that it has universal applicability, like the chance approach and unlike the majority rules approach. Since the healthcare team must choose a surrogate (assuming there are available family members who satisfy the minimal requirements of being a surrogate decision maker), then in the many cases when there is either no majority or an even split, thereby precluding the use of majority rules, the team must resort to one of the other two strategies. In this scenario, the qualitative approach is superior to chance because it is a rational process of decision making and it has an intrinsic connection to the patient's probable wishes, neither of which is true of random selection.

In light of the preceding arguments, I conclude that the qualitative strategy is, all things considered and other things being equal, preferable to the other two by virtue of its intrinsic ethical significance and its scope of application. Nevertheless, we should not conclude that it will always be superior to the other methods and should always be used. It too has drawbacks. The most important one stems from the epistemic limitations of healthcare professionals. Employing the qualitative method requires that healthcare providers have enough insight into the relationships between the patient and the various potential surrogates to judge who is in the best relational position to serve as the decision maker. But healthcare providers may not have the necessary time, resources, or information to determine who satisfies this criterion. Their evidence is limited because they usually do not know the patient or family very well and cannot conduct an extensive study of the patient's history and relationship with each person. They also do not have access to the inner facts about each potential surrogate's truthfulness, character, authentic intentions, or actual reasoning process. Thus, they may not have sufficient evidence to employ the qualitative approach

and judge which potential surrogate is a better candidate than the others. Even if the relational strategy is ideal in principle, it may not be the best in practice because the epistemic bar for this method is much higher than it is for the other two strategies. It is far easier to determine who wins a coin toss or who is in the majority than to determine who has the most intimate knowledge of the patient and her probable wishes. The qualitative approach is thus threatened with being impractical or ineffective in the clinical setting.

Conclusion

Where does all of this leave us with respect to the question of how we should resolve disagreement among equal-priority surrogates? One important conclusion to be drawn from the preceding analysis is that none of the three strategies we have examined—chance, quantitative, and qualitative—succeeds as a stand-alone solution. Instead, the best approach is a pluralistic strategy that combines all three. There is not a fixed hierarchical ordering of the three solutions such that one always takes precedent over the others. Nevertheless, there is a defeasible hierarchy among them, which is to say that certain ones enjoy *prima facie* priority over others.

There should be an initial presumption in favor of the relational approach, and when this is defeated, we should go with majority rules as a fallback option. And if both fail, then we must go with the third option—chance—as a last resort. In other words, the healthcare team should begin by attempting to identify the person(s) who is relationally best positioned to know what the patient would choose. If there is good enough evidence to favor one party over the others, we should select this party as the surrogate even if the majority is opposed. If this method is not decisive because all the parties are equally close to the patient and there is insufficient evidence to favor one of them, then we should default to the majority opinion. If neither of these methods is applicable because the relational evidence is insufficient and there is no majority, so that all other things really are equal, then random selection is the only available option.

In Mrs. Lopez's case, there was disagreement among the ethics consultants about how the clinical team ought to proceed with surrogate selection, with different ethicists endorsing all three of the strategies explored in this article. Initially, the team did not have enough information about the family members to determine who knew Mrs. Lopez best or whether anyone was motivated by self-interest or ill will. After the team engaged in extensive discussions with all four children, and the ethics service participated in a family meeting and heard each person's perspective, the consensus was that all four of them were trying to do what their mother would have wanted, and that Dave had the closest relationship with the patient.

This development did not resolve the dispute among the ethicists, however, which came down to divergent opinions on the relative merits and rankings of the three strategies. In contrast to the approach I laid out above, which incorporates all three strategies and prioritizes relational considerations over numerical considerations, one colleague affirmed a similarly pluralistic approach but took the opposite position that prioritizes quantity over quality. According to this line of reasoning, we should start with the initial presumption that all four children are equally close to the patient and therefore have equal decision-making authority. If we have strong evidence that this is not the case, then we should go with the person who is relationally best positioned to know what the patient would want. Applied to the specific case of Mrs. Lopez, this approach resulted in the judgment that the available evidence concerning the relational difference between Dave and his siblings was not enough to overcome the default presumption of equal authority, hence majority rules was the most appropriate solution.

In general, I think this alternative position is reasonable and justifiable, and there are not decisive reasons to reject it. My main reason for prioritizing relationship over numbers is the former's stronger intrinsic connection to the primary ethical consideration of the patient's wishes. Even the opposing view seems to agree that relational considerations are the most fundamental and important, for it bases

the initial presumption of equal decision-making authority on the logically prior presumption that all of the individuals have an equally close relationship to the patient. In Mrs. Lopez's case, I believe there was sufficient evidence to conclude that Dave had a much closer relationship with his mother than his three siblings did, and thus was significantly more likely to know her probable wishes. In my judgment, the qualitative strategy delivered the correct answer: Dave should be the decision maker because he is in the best position to know what his mother would have wanted. He is also the person she most likely would have chosen as her surrogate. Nevertheless, as so often occurs in clinical ethics, in this case there was room for reasonable disagreement about the bearing of descriptive facts and the relative priority of ethical principles. Grappling with this kind of moral uncertainty is one of the burdens of the ethicist.

Discussion Questions

1. When there is disagreement among potential surrogate decision makers of equal priority, what is the most ethically appropriate strategy for choosing a surrogate? Is it chance, majority rules, quality of relationship with the patient, or some other approach?
2. In cases where neither the known wishes standard nor the substituted judgment standard can be used to guide medical decisions for an incapable patient, and the surrogate must instead make decisions according to the best interests standard, should the strategy for choosing a surrogate remain the same or change?
3. In the case of Mrs. Lopez, who should be the surrogate, and why?

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