What Is the Moral Authority of Family Members to Act as Surrogates for Incompetent Patients?

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As MEDICINE'S CAPACITY TO TREAT DISEASE, particularly to extend the lives of elderly patients when previously they would have died, has dramatically expanded in recent decades, the frequency with which physicians and others face decisions about the care of incompetent patients has sharply increased as well. Because the requirement to secure the informed consent of competent patients does not apply in these cases, how should decision making proceed? Caregivers of both hospitalized and nonhospitalized patients usually turn to close family members, typically spouses or adult relatives, when they are available to serve as surrogates or proxies for the incompetent patient. When there is no controversy over who should serve as a particular incompetent patient's surrogate, and when the surrogate's decisions appear to all parties to be in accord with what the patient would have wanted and to be in the patient's interests, decision making proceeds smoothly. But when conflict arises about who should serve as surrogate, or about a surrogate's decision, the moral grounds of the family member's decision-making authority come into question and must be clarified. That is the subject of this article,.which has been expanded from an earlier version (Brock 1992).

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A central thesis here is that these grounds are more diverse, complex, and sometimes conflicting than is often supposed, and that failure to attend to that complexity is an important source of confusion and controversy about family members' proper authority. But even with explicit recognition of the multiple sources of family members' moral authority, controversy about the scope and weight of that authority will often remain because reasonable people differ in the moral importance they assign to these different grounds. While there are parallels with some, but not all, of the grounds of the authority of parents to make health care decisions for their children, children raise special issues, and my concern will be limited to family members acting as surrogates for incompetent adult patients.

There are two central and related moral issues concerning surrogates' authority: Who should be selected to be the surrogate? What principles should guide surrogates' decision making and limit their discretion? What follows is an analysis of the different grounds in support of the selection of family members as surrogates and their implications for the standards applied to surrogate decision making. I emphasize that these different grounds are not mutually exclusive and that any combination, or all, might be appropriate in a particular instance of surrogate decision making. I group them by type, and so the order in which I examine them does not represent their relative moral importance.

Three limitations in the scope of my concern in this article must be made explicit at the outset:

First, I am concerned with the moral, not the legal, authority of family members to act as surrogates for incompetent patients; consequently, I try to construct the main moral arguments for that authority. What the legal authority of surrogates in fact is in any particular jurisdiction will depend on relevant statutory and case law, which I do not review or analyze here; I am not qualified to provide an authoritative legal analysis. The relation between the morality of surrogate authority and what the law should be is complex. While there is a presumption that the morality of surrogate authority should form the basis of ideal legal standards and practice, there are reasons not to expect a precise match between the two. First, some particular moral considerations may be difficult or impossible to incorporate into legal practice. Second, the complexity and variability of the full array of moral considerations, most of which can obtain in different degrees in particular cases, will also be difficult to incorporate into clear legal standards that must apply in many different circumstances over time. Third, there may be special features or needs of the legal process that require giving weight to considerations otherwise not morally important. Moreover, because the relative weight that should be given to the different moral grounds I consider here is controversial, the appropriate legal standards and practice will be controversial in turn. In what follows I shall note a few of these complexities in the relation between the morality and law of surrogate authority, as well as places at which morality, law, and public policy converge. But my central concern will be with the morality of surrogate authority, which is at the core of what legal practice should be. In the vast majority of cases of surrogate decision making, the legal system is not directly involved, and so the relevant moral grounds of surrogate authority can more directly guide the practice of health care professionals and family members.

Second, I am concerned with the moral grounds for family members acting as surrogates, not the grounds for others who might do so either instead, or in the absence, of available family members.

Third, I also do not pursue the question of decision making when no family member is available. That does, and should, vary, depending on the nature of the particular decision to be made and the institutional context in which it occurs.

Democratic Ground for Surrogate Authority

First Ground:

Establishment by democratic political processes.

The first ground of the moral authority of surrogates rests neither on the relation of the surrogate to the incompetent person nor on the content of the surrogate's decisions, but rather on the pedigree of the process by which the surrogate was appointed. Whenever someone has received formal appointment as legal guardian of an incompetent person from a court, for example, his or her moral authority is based, at least in part, in the general authority commanded by the democratic political processes that established the appointment procedure. Increasingly, many states have passed some form of family decision-making act, which gives the legal authority to make treatment decisions to the closest family member of an incompetent patient without going to court for the formal establishment of a guardianship (Menikoff, Sachs, and Siegler 1992).

This ground provides no reason for the law or medical practice to favor the selection of any particular kind of person as surrogate, nor any basis for a particular standard for surrogates' decisions. It appeals instead to the commonly accepted moral obligation, even if that obligation is not always morally decisive, to obey the law simply because it is the law and apart from the content of the law. This general moral obligation lends moral support to following any legally established surrogacy procedure. The overall moral importance of this ground will be greatest when there are no, or only limited, moral reasons in support of a particular surrogacy practice; but because there are important independent moral reasons for families to serve as surrogates, those reasons are the principal moral basis for a family's surrogate authority. Consequently, this democratic ground is not the main moral basis for surrogates' decision-making authority.

Patient-Regarding Grounds for Surrogate Authority

Second Ground:

The self-determination of the incompetent person.

An increasingly utilized process for establishing a surrogate's legal authority is the Durable Power of Attorney for Health Care (DPAHC), created either through explicit statutes limited to health care decisions or through general durable power-of-attorney statutes that exist in all states (*Hastings Center Report* 1994). DPAHCs gain some moral authority from the first democratic process ground, but they have an additional, more important, moral basis that can make them preferable to other means of establishing a surrogate, such as guardianship appointments. DPAHCs leave the identification of who is to serve as surrogate for a person should he or she become incompetent to that person him- or herself. The most important moral value supporting this practice is individual self-determination or autonomy, the interest of ordinary people in making significant decisions about their lives for themselves and according to their own conceptions of a good life (Rawls 1980; Haworth 1986; Dworkin, 1988). Even without a DPAHC, however, it is often equally clear who the incompetent person wished, or would have wished, to be his or her surrogate. In such cases, the incompetent person's self-determination likewise supports that person's selection as surrogate, although with less moral weight than when an explicit act of designating the other as surrogate has been performed (Buchanan and Brock 1989).

Creating a DPAHC that explicitly designates someone as one's surrogate utilizes a social and legal practice whose purpose is to establish, at least within limits, the binding authority of a particular person as one's surrogate, that is, to confer decision-making authority on that person. DPAHCs are obligation-creating instruments, both legally and morally; like wills, they presuppose that the person making one has authority on the issues in question—disposition of one's property after death or decisions about one's health care—and they then enable the person to use or exercise that authority by transferring it to another. DPAHCs do not just provide extra evidence about who individuals want to be their surrogates, although they typically accomplish this as well; they also create a moral right of the appointed surrogate to serve in that role and confer obligations on others to respect that right.

The moral authority or discretion of duly appointed surrogates is not, however, unlimited (Brock 1991). DPAHCs typically allow the person creating one to give instructions to the surrogate about his or her wishes regarding health care in a variety of possible circumstances, and they oblige the surrogate to respect those wishes. Even if no instructions have been given to the surrogate in the DPAHC, the surrogate is commonly legally precluded from making decisions that are seriously contrary to the significant or best interests of the incompetent person, at least in the absence of clear evidence that the decision would conform to the patient's wishes; this limitation is only as clear as is the account of "best interests." Finally, the surrogate is morally responsible for acting in good faith, which will often require him or her to attempt to determine how the incompetent person's instructions or more general wishes and values apply to the particulars of unanticipated circumstances and choices. These two aspects of DPAHCs—designating both who is to be the surrogate and what preferences and values are to guide the surrogate's choice—correspond to the two central aspects of individual self-determination in the case of competent patients: (1) making the decision oneself and (2) according to one's own preferences and values.

A long line of legal cases through most of this century strongly supports the paramount moral importance of individual self-determination as the primary moral basis of the legal requirement to obtain a competent patient's informed consent for medical treatment (President's Commission . . . 1982; Faden and Beauchamp 1986). The special moral dignity of persons lies in their capacity for self-determination, that is, to form their own conception of a good life, to revise it over time in the light of new experience, and to pursue it in action (Frankfurt 1971; Dworkin 1988). Respecting self-determination, at least in the sense of not interfering with a person's pursuit of his or her own conception of a good life when the choice in question concerns and affects primarily that person, is the fundamental meaning of the moral requirement of respect for persons (Beauchamp and Childress 1994). The importance of individual self-determination supports a strong moral presumption that the surrogate should be the person whom the now incompetent patient either designated while competent or would have wanted in the absence of such a designation, and that the surrogate's decision should be in accordance with the aims and values of the patient.

Individual self-determination in general and individual liberty in particular are widely agreed not to extend to actions that seriously harm the interests of others (Mill 1859; Feinberg 1984). For example, when patients with a serious and highly contagious disease like tuberculosis are serious public health risks to others, public health authorities can, if necessary, justifiably coerce patients to undergo treatment and monitor their compliance with treatment. Similar limits on a patient's action and choices should restrict the actions and choices of a family member acting as surrogate.

Although the degree of moral weight that should be given to individual self-determination is ethically controversial, both in general and in the selection of a surrogate, there is wide agreement that it protects two kinds of bad choices. Many champions of self-determination defend a moral right to it, or, more specifically, a right to bodily integrity that secures self-determination regarding one's body, entitling competent patients to decide about their own treatment even if their decision is a poor one and contrary to their own best interests. These rights should protect at least some similarly bad choices in the selection of one's surrogate and at least some poor choices made by the surrogate. It is reasonable to accord less discretion to surrogates than to competent patients to make choices apparently contrary to the patient's interests because, in the case of surrogates, it will often be less clear that the surrogate's choice is what the patient would want. Recognizing these rights of patients and surrogates to make some bad choices is consistent both with criticizing those choices as irrational and mistaken and with attempting noncoercively to persuade them to make better choices.

The moral right to self-determination protects some morally, not just prudentially, bad choices. When patients do not present a public health threat that overrides their self-determination, they are entitled to determine how much weight, if any, to give to how their treatment choices affect others. But a person's failure to give morally reasonable consideration to how others would be affected by his or her choices can be consistently criticized morally, for example, as selfish, disloyal, or ungrateful, while nevertheless acknowledging the person's right to make that morally bad choice. Some theorists have defended a moral "right to do wrong," but even those who would reject such a *moral* right can consistently acknowledge a morally justified *legal* right in public policy (Waldron 1981). Based in part on the moral importance of individual self-determination, the law establishes a very strong presumption that competent individuals can select their surrogates and that their choice can only be set aside in cases of gross abuse or disqualification of the surrogate. In morally assessing the selection of the surrogate and the surrogate's choices, however, our judgments can be more fine-grained and discriminating than a simple consideration of whether the selection and choices are within the patient's and surrogate's moral or legal rights.

Rebecca Dresser has argued that a person's self-determination does not extend to treatment choices in cases in which the cognitive impairments causing incompetence are so severe as to call into question whether personal identity is maintained, that is, whether the patient before us is the same person who made the earlier choices (Dresser 1989). The same worry about the authority of earlier treatment choices applies both to an earlier surrogate selection and to whether the surrogate should follow the patient's previous wishes or instructions. A hard case of this sort is exemplified by a moderately demented patient who is unable to recognize others close to him. Perhaps this patient, who said earlier that he would want no life-sustaining treatment in such circumstances, now needs antibiotics for an easily treatable but life-threatening pneumonia. If the patient's life appears to be pleasant for him despite the dementia, should the surrogate withhold the antibiotics? Doing so appears to be against his current interest in continuing his pleasant life.

If, on the correct theory of personal identity, his dementia has undermined personal identity, then the patient before us is as different a person from the one who earlier expressed a wish not to be treated as he is from any other distinct individual. The earlier choice should then carry no more moral authority regarding his care than would the preference of any other distinct individual about it. Self-determination supports choosing one's own treatment, not the treatment of another person.

Allen Buchanan and I have argued elsewhere that even if personal identity is a matter of degree depending on psychological continuity and correctness, as Derek Parfit has argued, there may be good policy reasons for setting a relatively low threshold for such connections as are necessary for earlier choices to constitute the authoritative choices of the same later person (Parfit 1984; Buchanan and Brock 1989). Thus, the demented patient would be the same person who gave the earlier instructions, despite his inability either to recognize others or to remember his earlier wishes. I cannot pursue this issue further here, but instead only note that how we settle whether personal identity is sufficiently maintained for self-determination to apply in such cases determines not only the authority of advance directives, which is Dresser's main concern, but also the authority of surrogates based on this self-determination ground.

Third Ground:

> *Someone must decide for the incompetent person and a family member will usually do so best.*

The self-determination ground of surrogate authority derives that authority from the choice of that surrogate by the patient. This third ground bases the surrogate's authority instead on the likely content of the surrogate's choices. Put most simply, this ground seeks the person who will make the best choice, based on an assumption about the standard for doing so, and argues for a presumption that he or she would be a family member. A close family member will usually know the patient best and so will usually be best able to determine what the patient, if competent, would have wanted or decided in the circumstances (the substituted judgment standard or guidance principle) or, if this cannot be determined, what is in the best interests of the patient (the best interests standard or guidance principle). A family member will also usually be more concerned for the patient's well-being and thus motivated to secure the course of action that is best for the patient. Together, this general advantage in knowledge and concern suggests that family members will usually make the best treatment choices for incompetent patients and supports the general practice of using family members as surrogates.

Considerable skepticism is warranted, however, about how well family members can know or predict patients' treatment preferences, at least in the absence of having had explicit discussions with the patient about his or her wishes. A number of studies have shown that in such circumstances family members do little better than chance in their ability to predict what the patient would have wanted (Uhlmann, Pearlman, and Cain 1988; Zweibel and Cassel 1989; Tomlinson et al. 1990; Seckler et al. 1991; Pearlman, Uhlmann, and Jecker 1992). Even with the benefit of previous discussions, there is a substantial error rate in family members' judgments of what the patient would have wanted. Nevertheless, no other class of persons, such as the patient's physician or a lawyer appointed as a guardian, has been shown to do better in judging what the patient's wishes would have been. Data require caution about family members' claims to know patients' wishes, but they do not support claims that any alternative practice using different surrogates would result in decisions more in accord with patients' wishes. However, in individual cases when others who are not family members know the patient better and care more about him or her, this ground supports those others' selection as surrogates; for example, many homosexual patients with AIDS are closer to lovers with whom they have had long-term relationships than with sometimes estranged family members.

This ground supports no authority of surrogates to decide in ways seriously in conflict with the patient's important wishes or interests—when they do so, the presumption that they should serve as surrogate based on superior knowledge and concern is overcome or rebutted. In such cases, to the extent that the surrogate's authority is based on this ground, others involved in the patient's care, like the attending physician, other treating health care personnel, or other family members, then have a responsibility to protect the patient's welfare by seeking to have that family member removed as surrogate. In some cases, this may require appeal to the courts to seek a formal designation of another as surrogate.

This third ground is compatible with different standards for surrogates' decisions, that is, different standards for what makes such decisions "best." But it is because the self-determination ground gives strong reasons for seeking decisions in accord with the patient's wishes that family members are likely usually to be the best decision makers. By that standard for decisions, there is no basis for the family member giving *direct* consideration or weight to the interests of others besides the incompetent person, for example, the surrogate's own interests or the interests of other family members potentially affected by a decision under consideration, such as whether to pursue expensive medical treatment or to place the patient in a long-term-care facility. This ground does permit the interests of others who will be affected by the decision to receive *indirect* consideration, however, to the extent that there is evidence or other reason to believe that the patient, if competent, would have given them consideration; on this ground, others' interests should receive only the weight that the incompetent person would have given them.

Non-Patient-Regarding Grounds for Surrogate Authority

Fourth Ground:

> *Family members should be surrogates because, except for the incompetent person, they will be most affected by the decisions to be made.*

This might be called the "democratic ground" (although in a different sense than applied in the first ground): those most affected by the decision are entitled to participate in making it. Since incompetent persons are unable to make treatment decisions for themselves, families should serve as surrogates because, second only to the patient, they will usually be most affected by what is decided. This ground too, like the third, can at most support a presumption that a family member should be the surrogate because the family is only usually, but not always, most affected by decisions. The degree of support it provides for a family member's role as surrogate will vary because the difference between many medical treatment alternatives may have little impact on the patient's family, whereas choices such as whether a demented parent remains in his or her adult child's home may have enormous impact on that child's life.

This ground supports a family member serving as surrogate giving direct consideration to his or her own interests, or the interests of other family members or other persons significantly affected by the decision, not just indirect consideration based on the weight the patient, if competent, would have given to the interests of other persons (Hardwig 1990). If being affected by the decisions to be made morally supports the family member's selection as surrogate, it should support as well giving weight to those same effects in the decisions to be made.

It is not clear why the interests of others affected should not receive comparable weight in decisions made by competent patients as well, if this argument for doing so with incompetent patients is sound. Neither the law nor practice, however, requires competent patients either to weigh the effects of their choices on other persons or to give other persons besides the physician any role in decisions about their treatment. This may be because public and legal policy gives sufficient weight to individual self-determination when competent patients are capable of exercising it to justify excluding the effects on others from the decision unless the patient him- or herself chooses to give them weight. In the case of incompetent patients, however, although someone else must decide for them, this alone does not require or support giving weight to interests other than the patient's in doing so. It is problematic whether the importance of self-determination can justify giving direct weight to the effects on others only in decisions for incompetent, but not competent, patients.

There is a different reason why public policy might accept this fourth ground of surrogate authority while not giving direct weight to the interests of others besides the patient in decision making for competent or incompetent patients. Public policy and the law must govern many instances of health care decision making by many different persons in widely varying conditions, and they must be structured to avoid serious potential abuses. As instruments they are too blunt to reflect all of the moral nuances of individual cases. A morally justified legal practice might properly ignore features of individual cases that we also properly take to be morally relevant to them. Thus, there need be no inconsistency in a competent patient or a surrogate for an incompetent patient being legally entitled to ignore the effects of the choice on others besides the patient, while morally criticizing him or her for doing so; if there can be a *moral* right to do wrong, such a patient or surrogate might even be morally entitled to ignore those effects but again be subject to moral criticism for doing so.

On this fourth ground for surrogate selection, the effects on others *besides* the family member who is acting as surrogate should receive moral consideration as well. Decisions can either impose or remove health care burdens on personnel caring for an incompetent person; for example, employing a feeding tube may make maintaining nutritional status in a demented patient easier than difficult and time-consuming hand feeding by caretakers. Decisions about medical treatment and living arrangements can also have a substantial financial impact on other family members besides the surrogate or on society when it bears the costs through public programs. From a general, consequentialist, moral perspective, the significant effects on all others besides the patient should be considered in making treatment choices. From a different, rights-based perspective that assigns a moral right to a competent patient to decide as he or she sees fit—for example, one grounded in a right to self-determination—such effects can justifiably be ignored by a competent patient and should be as well by a surrogate deciding for an incompetent patient if the patient him- or herself would have ignored them. Controversy over the moral relevance of effects on others besides the patient in decision making by either a competent patient, or by a surrogate for an incompetent patient, can reflect this schism in moral theory (Scheffler 1985).

The controversial nature of this fourth ground can also be seen in its sharp conflict with the traditional, patient-centered ethic in medicine (Jonsen, Siegler, and Winslade 1982; President's Commission . . . 1982). According to that ethic, physicians must place the interests of their patients first and foremost and set aside their own interests and those of others that conflict with their patients' best interests. Controversy about the weight to be given this fourth ground of surrogate authority rests in part on more general controversy about the nature and limits of the patient-centered ethic.

This fourth ground of surrogate authority is arguably of relatively less importance with previously competent patients than with never competent patients like newborns, young children, and adults with serious, lifelong cognitive disabilities. In the latter cases, the patient has never had preferences or values, or more generally the capacities for forming a conception of the good life and for exercising self-determination, and so there is no patient self-determination to be respected. Previously competent but now incompetent adult patients, on the other hand, will have a whole life history of values, projects, and aims that defined their own particular conception of a good life. We can respect their self-determination by honoring their past values and/or exercises of self-determination, for example, when they have made advance directives. Their self-determination interest makes it more ethically problematic to defer to the interests of others in surrogate selection or decisions when doing so contravenes the patient's past wishes and thereby infringes a part of his or her interest in self-determination.

Fifth Ground:

> *Distributive justice requires consideration of the effects on others, like the family, of decisions about an incompetent person.*

This fifth ground is clearly related, and in some interpretations essentially identical, to the fourth ground. For example, the reason some proponents of the fourth ground offer for considering effects on other family members of decisions about an incompetent person is that it would be unfair or unjust to give no weight to the sometimes great burdens those others would bear as a result of some choices. Perhaps the most important example is the increasingly common case of the elderly person with Alzheimer's dementia who is cared for at home. One writer characterized the job of caring for such persons as the "36-hour day" to underline the extraordinary demands such patients often place on their caretakers (Mace and Rabins 1981). When the caretaker must virtually sacrifice his or her own life, interests, and pursuits to provide the care, doing so would be supererogatory—praiseworthy to do but not morally required—and those who choose not to do so can justly make that choice. Even if children have moral obligations to provide some care to their parents because of the care their parents earlier gave to them, there are limits to that obligation, which are sometimes far exceeded by the incompetent person's needs.

It could be argued that these extraordinary demands on family members are grounds for disqualifying them from serving as surrogates for incompetent persons. When conflicts of interest between family members are sufficiently great that family members serving as surrogates fail to give due weight to the needs of the incompetent person, disqualification of the surrogate is sound. But it should be the failure to give due weight to the patient's needs, not the mere presence of conflicting interests, that disqualifies the surrogate. What constitutes "due weight," however, will sometimes be controversial, just as the amount of resources and efforts that justice requires families to give to an incompetent member with extraordinarily great needs can be an area of disagreement (Callahan 1987; Daniels 1988). Failure to secure the best possible care should not disqualify a family member from serving as surrogate. Instead, only the failure reasonably to serve the extraordinary needs of an incompetent person, in a manner compatible with the equitable treatment of other family members, should disqualify the person's family member from serving as surrogate.

The more important point to be drawn from the limits that justice or fairness places on the efforts and resources that must be devoted, either by the family or the broader society, to an incompetent person with extraordinary needs concerns not the selection of a surrogate, but rather the limits on the patient-centered ethic. As already noted, in its most extreme form that ethic tells the physician to focus only on the needs and interests of the patient, without regard for the effects on others. The application of this ethic to incompetent patients is spelled out in the ordered set of guidance principles that Allen Buchanan and I have argued elsewhere (Buchanan and Brock 1989) should guide surrogates' decisions:

1. advance directives: when a valid advance directive exists that applies to the choice in question, surrogates' decisions should conform to it
2. substituted judgment: decide as the patient, if competent, would have decided in the circumstances that obtain
3. best interests: decide so as best to promote the overall interests of the patient

These three principles are entirely patient centered. They give no direct weight to the interests of others besides the patient, according them only indirect weight: under advance directives and substituted judgment, the weight that the patient gave, or would have given them; under best interests, the degree to which the patient's interests depend on those others' interests.

Like the fourth ground, this fifth ground for surrogate authority, which appeals to considerations of distributive justice, shows that the patient-centered ethic must be qualified when following it would result in injustice either within small-scale social units like the family or within large-scale social units like the broader community or society; different standards of justice, of course, apply in highly intimate contexts like the family and more impersonal contexts like the larger society. This limit applies equally to just or fair treatment choices of both competent and incompetent patients. Sometimes distributive justice *supports*, and even requires, family members who are serving as surrogates to consider their own and other family members' interests, and not solely the interests of the patient. Of course, in most health and personal care decisions made by surrogates for an incompetent patient, the impact will be substantially greater on the patient than on others; the patient's preferences and interests will then usually determine the choice. Considerations of distributive justice, however, do provide moral justification in some cases of clinical and supportive-care decision making for giving the interests of others substantial, or even decisive, weight in decisions for an incompetent person, just as they do regarding alternatives made available to competent persons.

Sixth Ground:

The family as an independent moral unit with decision-making responsibility for its members.

Both the nature of the moral appeal and the implications of the sixth ground are the hardest to articulate precisely, but it is critical to a full account of family members' authority as surrogates. The family is an extremely important social unit in nearly all societies. Important responsibilities like childrearing are assigned to the family. But for the elderly as well the great bulk of care continues to be given by family members in the home, despite the growth of nursing homes and other long-term-care institutions. To play these roles as care providers, families must have significant, although not unlimited, authority and discretion in making the myriad decisions necessary to carry out their responsibilities.

The family is also the principal social institution in which long-term, intimate personal relations are developed. For the family to fulfill powerful human needs for intimacy and privacy, it requires significant freedom from external observation, oversight, and control. Moral and legal rights to privacy, with the authority and control they give individuals over highly personal matters, thus have a significant place in American society.

People's most important, deepest, and longest-lasting commitments and loyalties to other persons are also typically developed in the family. Many of these commitments are given the force of law in the complex systems of family law governing marriage, child-raising responsibilities, and financial and other responsibilities to spouses and other family members (Houlgate 1988). Here, as in many places, the law not only prohibits behavior and limits our freedom, but also structures social practices that serve important needs and thereby enlarge our freedom.

Hilde and James Nelson have argued for what I interpret as a version of this sixth ground by stressing the family's central role in forming and maintaining the identity of individual members (Nelson and Nelson 1995). We belong to families, and for most of us the central parts of our life stories are lived out in families; moreover, as individuals our identity is strongly determined by our place in our family and its history. It is not just as children that families shape us; as adults too our deeply powerful and intimate relations with other family members form who we are and become. The family's role in times of illness is not only to provide care and to help make decisions, but also to anchor the self and counter the alienation from self and body that serious illness can bring. To turn to a close family member to be the surrogate decision maker for an incompetent patient is typically to turn to the person who has lived out a life intertwined with that of the patient; the Nelsons recount a case in which a wife felt an unintended, but deep, hurt and rejection when her husband selected a cousin who was a lawyer to be his proxy, believing that her legal training made her best qualified for the role despite the 35 years husband and wife had lived together.

In the family setting, individuals become to a significant extent one member of a larger decision-making unit. The interests, needs, and values of all members now affect and constrain joint decisions taken for and by the group. This ceding of some individual decision-making authority to the family unit takes place largely voluntarily among competent adult family members and subsequently provides part of the moral authority of families acting as surrogates for incompetent members. But family relations are to an important extent not consensual and voluntary: we do not choose either our parents or the other members of the families we are born into. This need not, however, undermine the moral significance of the relations, obligations, and responsibilities that develop in families.

Decisions within families should not be guided by a single-minded concern only for the wishes, preferences, or needs of an incompetent member. The legitimate interests and needs of, and obligations to, other family members, including but not limited to those of the surrogate, will properly affect and sometimes be critical in decisions regarding care and treatment of the incompetent member. On this sixth ground, it is the complex special relations between family members that justify both the surrogate's authority and the weight given to the interests of family members of the incompetent person, not simply the more general properties of being affected by the decision (the fourth ground) or being a party to a distribution of benefits or burdens that falls under principles of distributive justice (the fifth ground).

This sixth ground especially, but several of the other grounds as well, for the surrogate authority of family members, appeals to features of at least reasonably well-functioning families. Unfortunately, many real families do not function well, and some of the grounds for family authority as surrogates may fail to apply. I am not idealizing the family in the face of the all too frequent pathological or immoral features found in real families. But understanding the grounds of the moral authority of families to serve as surrogates in more fortunate circumstances can help us to understand more clearly when and for what reasons that authority should be limited or removed. It is as important to develop reliable social and legal practices to limit or remove surrogate authority from families when doing so is morally appropriate as it is to secure the authority when that is morally appropriate.

Conclusion

My account of the several grounds of the moral authority of family members to be surrogates for incompetent persons has been complex. More simplified treatments of that authority that locate its basis in some single ground—the patient's self-determination, or the family's ability to make the best decision, or the role of the family in the formation of identity and the fostering of intimacy and privacy—have the attraction of providing a single, unified account of surrogates' authority. When the relevant condition, such as a particular family member's ability to know what the patient would have wanted, can obtain in different degrees, then that family member can likewise have comparable degrees of authority as surrogate, but this simplicity is bought at too great a cost: ignoring other morally important considerations relevant to the family member's authority as surrogate.

A somewhat less simplistic account of families' authority as surrogate recognizes diverse grounds of that authority, like those I have developed, and concedes that the different grounds can be in conflict in particular cases; for example, the family member designated by the now incompetent patient has made a decision apparently in conflict with the patient's wishes or interests. This account would resolve such conflicts in all cases with a single ranking of the relative importance or weight of the different grounds. But a moment's thought should make clear that no such ranking for all cases is possible. Sometimes the particulars of individual cases will reveal that more or less weight should be given to a particular ground. For example, the long and deep relationship of patient and surrogate shows that their identities are deeply bound together; in another case, the patient and family member have had more limited contact; in still other cases, the family member will not be familiar with all the wishes and values of the patient.

Any single ranking of the relative importance of the different grounds of surrogates' moral authority to be applied to all cases of surrogate decision making would inevitably miss important differences like these between cases. Seductive as the simplicity of such a single ranking may be, it should be resisted. In the scientific aspects of medicine, simplicity can be seductive as well when looking for the causes of a patient's condition and the factors likely to affect treatment, but we have learned to resist it when unwarranted and to respect the complexities presented by disease, medicine, and individual patients. The same should be true in our moral understanding of complex practices like surrogate decision making by family members for incompetent patients that implicate multiple subtle and complex components of our moral lives and moral beliefs.

In any particular case in which either the selection or decision of a surrogate is in question, a full analysis of these different grounds of the surrogate's authority is required. To do less should be no more acceptable than doing only part of a diagnostic workup, or pursuing only part of an indicated treatment, for a particular condition. The complexity of the different factors bearing on family members' moral authority as surrogates should also make obvious why the scope and weight of that authority is often morally controversial. Reasonable people often disagree about the relative weight or importance of the grounds of that authority, just as they do in their overall assessment of the moral authority of particular surrogates, but this too is no different from the reasonable disagreement that is common in the scientific aspects of medicine.

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