Scope:
The provisions in this policy relating to Living Will/Advance Directives (AD) apply to health care providers in inpatient setting and patients under the care of an MHS provider for home health, hospice or personal care services. They do not apply to outpatient services or emergency department patients unless they are admitted to a hospital. However, if a patient gives a copy of his/her AD to a provider in an outpatient clinic or ED, the wishes of the patient will be honored, except as established for surgical and sedated procedures.

The provisions in this policy relating to Mental Health Advance Directives (MHAD) apply to health care providers in both inpatient and outpatient settings at MultiCare Health System (MHS).

Policy Statement:
An Advance Directive allows patients 18 years of age and older to participate in their care and express their desires regarding their health care if they become gravely ill and are unable to speak for themselves. Advance Directives are supported by federal and state laws and are consistent with MultiCare Health System’s support of patient rights.

A Living Will/Health Care Directive/Advance Directive (AD) allows patients to specify how they want decisions to be made about life sustaining treatment if they become gravely ill and are unable to speak for themselves.

Durable Power of Attorney (DPOA) A legal document that enables an individual to designate another person, called the attorney-in-fact, to act on his/her behalf, even in the event the individual becomes disabled or incapacitated. An "advance directive" (sometimes called a "healthcare directive") combines a living will and durable power of attorney, either in one document or two separate ones.

A Mental Health Advance Directive (MHAD) allows patients to specify how they would like their mental health treatment handled in the event they become mentally incapacitated and are unable to make sound decisions about their mental health care due to mental illness. MHADs provide a method of giving instructions and preferences for mental health treatment in advance of a period of incapacity, and may authorize someone else to make mental health decisions on behalf of the patient.

As outlined within the scope of this policy, MultiCare Health System will assess whether the patient has an AD and an MHAD. If the patient does not, staff will provide the patient with written information about his/her right to execute an AD and an MHAD. Execution of an AD and an MHAD is a right, not
a requirement, and staff will not condition the provision of care or otherwise discriminate against a patient based on the presence or absence of an AD or an MHAD. MHS employees and volunteers cannot witness or sign a patient’s AD or MHAD.

It is the policy of MHS to honor Mental Health Advance Directives that meet state law, medical and ethical practice standards, and MHS policies and procedures.

Table of Contents:

I. Procedure for determining if the patient has an AD and obtaining a copy
II. Physician/Health Care Facility Refusal to Participate
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V. Information For Living Will\Advance Directive Only
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VII. Definitions
VIII. Attachment 1 PHYSICIAN’S VERIFICATION OF DIRECTIVE
IX. Attachment 2 Contents of Mental Health Advance Directive
X. Attachment 3 Workflow for Advance Directive (AD) Forms
XI. EPIC screenshots for documentation of the AD

Procedure:

I. **Determining if the Patient has an AD/ and Obtaining a Copy for the Medical Record:**
   
   A. Patient Access Responsibilities:
      
      1. At the time of pre/direct admission personnel will:
         
         a. Review the patient’s electronic record (EMR) for documentation, when appropriate.

      2. If an AD/MHAD is not documented in the EMR, ask the patient/family member if the patient has an AD/MHAD.
         
         a. If a copy of the AD is not available at the time of admission: Request that the patient/family member bring in a copy of the AD/MHAD to be placed in the patient’s chart.

      3. If the patient/family presents with a copy of their AD, place a copy in the patient’s chart.
         
         a. If the patient's status changes, the patient will be given information about AD/MHAD
B. Registered Nurse Responsibilities:

1. Complete the Advance Directives Doc flow sheet located in the Nursing Admission Navigator in the EMR.

   a. If the patient has an executed AD/MHAD, but the document is not immediately available:

      1.) Staff members will follow-up on the progress of obtaining the AD/MHAD copies. A copy of the document will be placed in the paper chart.

C. Physician Responsibilities:

1. Review Content of the Advance Directive and clarify if necessary.

D. If the patient does not have a written AD but wishes to make declarations about his/her wishes:

1. Contact the Social Worker for assistance.

2. The physician should review with the patient and document the patient’s wishes in the record, incorporating the patient's desires into the plan of care (See MHS Policy - Code Status).

II. Physician/Health Care Facility Refusal to Participate:

A. The physician has the responsibility to acknowledge, discuss and incorporate AD/MHAD into the plan of care. If the physician cannot support the patient’s wishes, the physician must discuss this with the patient and make the appropriate provisions for care.

B. The attending physician or health care facility shall inform a patient or patient’s authorized representative of the existence of any policy or practice, or moral or professional objection, that would prevent their compliance with a patient’s treatment preference as stated in an AD/MHAD or otherwise.

C. If the patient, after being informed of such policy or preclusion, chooses to retain the physician or facility, the physician or facility, together with the patient or the patient’s representative, shall prepare a written plan to be filed with the patient’s AD/MHAD that sets forth the physician’s or facility’s intended action should the patient’s medical status change so that the AD/MHAD would become operative.

III. Patient Complaints about Advance Directives or Mental Health Advance Directives:

A. Patient complaints about AD or MHAD requirements may be filed with the State survey and certification agency.

IV. MultiCare Medical Associates (MMA) Sites:

A. If a patient provides an AD or MHAD, staff will place a copy of it in the patient’s medical record. If the patient or hospital personnel
requests, staff will forward/fax a copy of the AD or MHAD to the hospital, hospital-based ambulatory clinic, or the procedural site requested by the patient

B. If patients have questions about AD or MHAD, staff will notify the physician to address their questions.

C. The MMA locations will place brochures containing information on AD, entitled “Your Rights and End of Life Care”, and information on MHAD, entitled “Mental Health Directive” in clinics giving patients the opportunity to consider executing an AD or MHAD before they need inpatient services.

D. MMA procedure for documentation of AD/MHAD:

1. At the time of discharge, Health Information Management (HIM) documents the presence of the current AD/MHAD by choosing and setting the appropriate system flag. The new procedure will consist of POLST, and Advanced Directive forms, (AD, POA, 5 Wishes) will be ordered and scanned into an existing office visit encounter.

2. First review the encounters under the Code tab in Chart Review to see if the physician has ordered a health care directive discussion in Epic.

3. Go into the healthcare directive discussion order and verify that the AD form was submitted during the office visit (there will be a “yes” next to a question, indicating which AD forms (s) were submitted during the office visit.

4. After verification of submission, utilize the “addendum” procedure to go into the office visit in which the health care directive discussion order was placed (the office visit date should correspond with the AD form order date). Click on “progress note” and in the addendum comments section indicate the reason for the addendum: Attach the submitted advanced directive forms (s) to the encounter.” Note: If there is not an existing health care directive discussion order, the following steps shall be completed within an additional order encounter, rather than an office visit, and shall be associated with an annotated abstract diagnosis (document type and date signed).

5. Place an order for the submitted AD forms (s) within the office visit encounter: 3610004- O Health Care Directive (Advanced Directive/Living Will); 3610005 – O DPOA Health Care (Durable Power of Attorney Health Care); 361006 – O DPOA Mental Health (Durable Power of Attorney Mental Health); 3610007 – O Five Wishes;)

6. Associate the order with the existing diagnosis in the office visit.
You can then sign your order(s).

7. Scan the document into the order by clicking on “enter/edit results”, import the document and include the scan description (document type and date signed). Example: POLST form, signed by patient on 10-27-2010.”

8. Select the document type from the drop list, and then add the collection and final result dates. The collection date and final result date must correspond with the office visit date.

9. After final resulting your AD document, sign the Addendum and exit the office visit encounter.

V. Information for Living Will/Advance Directive Only:

A. Complying with Living Will/Advance Directive (AD):
   1. When an AD is presented, the wishes of the patient will be honored and incorporated into the plan of care.
      a. The physician must incorporate the patient’s wishes into the plan of care, unless doing so would be contrary to the accepted standard of care or violate the law.

B. Revocation of Living Will/Advance Directive:
   1. An AD may be revoked verbally or in writing at any time by a patient.
   2. A revocation is effective when communicated to a physician caring for the patient.
   3. Upon revocation, the physician should record in the progress notes the time and date of the revocation, when the physician received notice of the revocation and any other significant information necessary to make sure the patient’s wishes are carried out.
   4. If a patient indicates they wish to revoke his/her AD/MHAD, the nurse will contact the physician and relay this information.

C. Withdrawing or Withholding Life-Sustaining Treatment Based on an Advance Directive:
   1. Before any life sustaining treatment is withheld or withdrawn based on an AD, the attending physician must verify the validity of the AD and compliance with the Washington Natural Death Act, RCW 70.122.030 by signing the attached Physician’s Verification of Directive.

VI. Information for Mental Health Advance Directives Only:

A. Physician, PA, ARNP, Mental Health Professional, Social Worker, RN:
   1. If the patient’s status changes to conscious and competent, the
patient will be given the brochure and information about MHAD.

2. If the patient has an MHAD, review and be familiar with the patient’s MHAD.

3. If the patient has an MHAD, provide care in accordance with the patient’s MHAD, unless:
   a. Complying with the MHAD would violate the accepted standard of care.
   b. Complying with the MHAD would violate the law.
   c. The requested treatment is not available.
   d. There is an emergency situation and compliance would endanger any person’s life or health.

4. In the event one or more of the provisions of the MHAD are not honored for the reasons set forth above, all other parts of the MHAD should be followed.

5. MultiCare employees and volunteers cannot witness or sign a patient’s MHAD.

6. Non-compliance with MHAD instructions:
   a. If unable or unwilling to comply with any part of the MHAD for any reason, promptly notify the patient and his or her agent, and document the part of the MHAD that is objectionable and the reason in the patient’s medical chart.

   b. If a patient is involuntarily committed or detained for involuntary treatment, and provisions of the MHAD are inconsistent with either the purpose of the commitment or any court order relating to the commitment, those provisions of the MHAD may be treated as invalid during the commitment. However, the remaining provisions of the directive are advisory while the patient is committed or detained.

7. The Physician, ARNP or Mental Health Professional will ask the patient if he or she is subject to any court orders that would affect the MHAD. If so, a copy of the court order should be obtained and placed in the patient’s medical record.

B. Complying with a Valid Mental Health Advance Directive (MHAD):

1. When a valid, properly executed MHAD is presented to a health care provider or professional person at MHS, the wishes of the patient will be honored and incorporated into the patient’s plan of care. However, if the MHAD is contrary to state law requirements, medical and ethical practice standards, or the policies and procedures of MHS, the patient and/or the patient’s designated agent will be advised, and appropriate
2. The inability to honor one or more provisions of an MHAD does not affect the validity of the remaining provisions.

3. An MHAD goes into effect only if a person becomes mentally incapacitated. When a patient is not mentally incapacitated, the patient can make decisions about mental health treatment at that time without the help of instructions in an MHAD or the help of an agent.

C. Declaring a Patient Incapacitated:

1. If a patient has an MHAD, the patient, the patient’s agent, a health care provider or professional person as defined above may seek a determination whether the patient is incapacitated or has regained capacity.

2. A capacity determination, for purposes of MHAD, may only be made by:
   a. A court, if the request is made by the patient or the patient’s agent.
   b. One mental health professional and one health care provider, or
   c. Two health care providers

3. For purposes of 2b and 2c above, one of the persons making the determination must be a psychiatrist, psychologist or a psychiatric advance registered nurse practitioner.

4. Capacity Determination:
   a. At least one mental health professional or health care provider must personally examine the patient prior to making a capacity determination.
   b. If a health care provider or professional person requests a capacity determination, he or she shall promptly advise the patient that a capacity determination is being sought and that the patient may request the determination be made by a court.

5. If an incapacitated person is already being treated according to his or her MHAD, a request for redetermination of capacity does not prevent treatment.

6. Capacity Determination Time Frames:  An initial determination of capacity must be completed within 48 hours of a request for a capacity determination. During the period between the request for an initial determination of the patient’s capacity and completion of the determination, the patient may not be treated unless consent is given, or treatment
is otherwise authorized by state or federal law. If the patient qualifies for involuntary treatment under the state involuntary treatment laws, he or she may be treated.

7. When an incapacitated patient is admitted to inpatient treatment pursuant to the provisions of his or her MHAD, the patient’s mental capacity must be reevaluated within 72 hours of admission or when there has been a change in the patient’s condition that indicates he or she appears to have regained capacity, whichever occurs first.

8. When an incapacitated patient who is being treated on an inpatient basis requests, or the patient’s agent requests, a redetermination of his or her capacity, the redetermination must be made within 72 hours of the request.

9. If a patient who does not have an agent asks for a capacity determination or redetermination, complete the capacity determination, or if the patient is seeking a determination from a court, reasonable efforts should be made to notify the person legally authorized to make decisions for the patient about the patient’s request.

10. When an outpatient who has been determined to be incapacitated requests a redetermination of his or her capacity, the redetermination must be made within 5 days of the first request following a determination.

11. If a patient being treated does not have an agent for mental health treatment decisions, the person requesting a capacity determination shall arrange for the determination.

12. If a capacity determination is not made within the time frames set forth above, the patient shall be considered to have capacity.

D. Inpatient Treatment:

1. If the patient is found to have capacity, he or she may only be admitted to or remain in inpatient treatment if he or she consents at the time or is detained under the state involuntary treatment law.

2. If an incapacitated patient continues to refuse inpatient treatment, he or she may seek injunctive relief from a court.

3. Discharge after 14 days of treatment: At the end of the period of time that the patient or his or her agent consented to voluntary inpatient treatment, but not longer than 14 days after admission, if the patient has not regained capacity or has regained capacity but refuses to consent to remain an inpatient for additional treatment, release the patient during reasonable daylight hours unless detained under the state involuntary
4. Discharge for patients with MHAD voluntarily admitted to inpatient treatment: The choices an incapacitated patient expresses in his or her MHAD controls, except if a patient takes action and makes statements demonstrating a desire to be discharged, the patient shall be allowed to be discharged and may not be restrained in any way in order to prevent his or her discharge. (Note, however, that if a patient presents a likelihood of serious harm or is gravely disabled, the patient may be held for sufficient time to notify a community designated mental health professional in order to allow for evaluation and possible detention under state involuntary treatment laws.)

5. Inpatient treatment for patients with an MHAD consenting to admission in the MHAD but currently refusing admission:

   a. The following admission procedures shall be followed for a patient who:

      1.) Chooses not to be able to revoke his or her directive during any period of incapacity
      2.) Consents in his or her MHAD to voluntary admission to inpatient mental health treatment or authorized an agent to consent on the patient’s behalf, and
      3.) At the time of admission to inpatient treatment, refuses to be admitted.

   b. In such cases, a patient may only be admitted for inpatient mental health treatment pursuant to an MHAD, if a physician with privileges at MHS:

      1.) Evaluates the patient’s mental condition and determines, in conjunction with another health care provider or mental health professional, that the patient is incapacitated.
      2.) Obtains the informed consent of the agent, if any, designated in the MHAD
      3.) Documents that the patient needs an inpatient evaluation or is in need of inpatient treatment and that the evaluation or treatment cannot be accomplished in a less restrictive setting, and
      4.) Documents in the medical record a summary of findings and recommendations for treatment or evaluation.
      5.) If the admitting physician is not a psychiatrist, the patient must receive a complete psychological assessment by a mental health professional within 24
hours of admission to determine the continued need for inpatient evaluation or treatment.

E. Agent Authority:

1. Unless the MHAD has been revoked, the decisions of an appointed agent must be consistent with the instructions and preferences expressed in the MHAD or if not expressed, otherwise known to the agent. If the patient’s instructions or preferences are not known, the agent must make a decision he or she determines is in the best interest of the patient.

2. Except as may be limited by state or federal law, the agent has the same right as the patient to receive, review, and authorize the use and disclosure of the patient’s health care information when the agent is acting on behalf of the patient and to the extent required for the agent to carry out his or her duties.

3. A Mental Health Advance Directive may give the agent authority to act while the patient has capacity. Even if the directive gives such authority to the agent, the decisions of the patient supersede those of the agent at any time the patient has capacity.

4. On receipt of an agent’s notice of withdrawal, the notice, and effective date if one is provided, shall be noted in the patient’s chart. If no effective date is specified, the notice is effective immediately.

F. Revocation/Expiration of a Mental Health Advance Directive:

1. A patient with capacity may revoke an MHAD in whole or in part by a written statement. An incapacitated patient may revoke his or her MHAD only if he or she elected at the time of executing the MHAD to be able to revoke when incapacitated.

2. A revocation of an MHAD is effective immediately upon receipt and shall be made part of the medical record.

3. If a patient makes a subsequent MHAD, it revokes in whole or in part (either by its language or to the extent of any inconsistency) the previous MHAD.

4. MHAD remains effective to the extent it does not conflict with a court order and no other proper basis for refusing to honor the directive or portions of it exists.

5. If an MHAD is scheduled to expire, but the patient is incapacitated, the MHAD remains in effect unless the directive specifies that the patient is able to revoke while incapacitated and has revoked the MHAD.

G. Conflicting Directives or Agent Appointments:
1. Discrepancies in the MHAD directives or in agent appointments shall be reported to the supervisor or nurse manager.

2. If an incapacitated patient has more than one valid MHAD and has not revoked any of his or her MHAD then the most recently created MHAD controls any inconsistent provisions unless one of the MHAD states otherwise.

3. If an incapacitated patient has appointed more than one agent through a durable power of attorney with the authority to make mental health treatment decisions, the most recently appointed agent shall be treated as the patient’s agent for mental health treatment decisions unless otherwise provided in the appointment.

4. Any time a patient with capacity consents to or refuses treatment that differs from the provisions of his or her MHAD, the consent or refusal constitutes a waiver of any provision of the MHAD that conflicts with the consent or refusal. However, it does not constitute a revocation of that provision unless the patient also revokes that provision or the MHAD in its entirety.

VII. Definitions:

Advance Directive (AD), is referred to as a “Living Will/Health Care Directive/Advance Directive”: A legal document signed by an adult patient in the presence of two witnesses, that specifies, in advance, how the patient wants decisions to be made about life sustaining treatment if the patient becomes terminally ill or permanently unconscious and cannot express his or her desires regarding health care decisions. The AD can be amended or revoked at any time by the patient.

Durable Power of Attorney for Health Care: A legal document in which a patient names a person as his/her health care agent to make medical decisions on his/her behalf, if the patient becomes incompetent and is not able to make health care decisions. The completed document does not require a witness or notary. The Durable Power of Attorney for Health Care may be revoked at any time by the patient and the revocation does not require a witness.

Terminal Condition: An incurable and irreversible condition caused by injury, disease or illness that within reasonable medical judgment, will cause death within a reasonable period of time and where life sustaining treatment would serve only to prolong the process of dying.

Permanent Unconscious Condition: An incurable and irreversible condition in which the patient is assessed, within reasonable medical judgment, as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

Life Sustaining Treatment: Any medical or surgical intervention that uses a mechanical or other artificial means including artificially provided
nutrition and hydration to sustain, restore, or replace a vital function, which, when applied to a patient, would serve only to prolong the process of dying. Life sustaining treatment does not include the administration of medication, or the performance of any medical or surgical intervention, deemed necessary solely to alleviate pain.

**Personal Care Services:** Encompasses skilled nursing facilities, hospice, home health and other providers of “personal care”, not physicians practicing in a traditional office or outpatient clinic setting.

**Agent:** An agent has legal authority to make decisions for a patient as authorized by the patient’s MHAD.

**Capacity:** An adult who has not been found to be incapacitated under the Mental Health Advance Directives procedures set out in this policy, or under the Washington State guardianship statute RCW 11.88.010(1)(e), has capacity.

**Health care provider:** An osteopathic physician or osteopathic physician’s assistant, a physician or physician’s assistant, or an advanced registered nurse practitioner.

**Incapacitated:** An adult who (1) is unable to understand the nature, character, and anticipated results of proposed treatment or alternatives; understand the recognized serious possible risks, complications, and anticipated benefits in treatments and alternatives, including nontreatment; or communicate his or her understanding or treatment decisions; or (2) has been found to be incompetent under the Washington state guardianship statute, RCW 11.88.010(1)(e).

**Professional person:** A mental health professional, a physician, or a registered nurse.

**Mental health professional:** A psychiatrist, psychologist, psychiatric nurse, or social worker.

**Mental Health Advance Directive:** A written document signed by an adult patient in which the patient provides instructions or preferences about his/her mental health treatment, and/or appoints an agent to make decisions on behalf of the patient about the patient’s mental health treatment, in the event the patient becomes mentally incapacitated and is unable to make sound decisions. (The contents of a valid MHAD are set forth in Attachment B.) An MHAD may include any provision relating to mental health treatment, or the care of the patient or the patient’s personal affairs. It may include, but is not limited to, the following:

1. The patient’s preferences and instructions for mental health treatment
2. Consent to specific types of mental health treatment
3. Refusal to consent to specific types of mental health treatment
4. Consent to admission to and retention in a facility for mental health treatment for up to 14 days
5. Appointment of an agent to make mental health treatment decisions on behalf of the patient

**Related Policies:**
MHS Policy: "Decision Making in Non-Beneficial (Futile) Treatment"
MHS Policy: "Patient's Rights"
MHS Policy: "Code Status, Do Not Resuscitate"
MHS Policy: "Withholding/Withdrawing Life Support"
MHS Policy: "Patient Grievances"

**Related Forms:**
Physician’s Verification of Directive (Attachment A)
Contents of Mental Health Advance Directive (Attachment B)
Your Rights and End of Life Care (87-9905-7)
Health Care Directive form #87-6030-2
Mental Health Advance Directives (#87-9906-9)

**References:**
Washington’s Natural Death Act, RCW 70.122
WAC 388-501-0125
42 CFR §489.102
Durable Power of Attorney for Health Care, RCW 11.94.010(3)
RCW 71.32 (Mental Health Advance Directives)
RCW 11.94 (Power of Attorney)
RCW 7.70 (Informed Consent)

**Attachments:**
Attachment A: PHYSICIAN’S VERIFICATION OF DIRECTIVE
Attachment B: Contents of Mental Health Advance Directive
Attachment C: Workflow for Advance Directive (AD) Forms

**Point of Contact:**
Assistant General Counsel – 403-7861
Director Social Work Services – 403-7795
QM Consultant, Clinical Standards 403-2786

**Approval By:**
Medical Staff Surgical Services
Medical Staff Operations

**Date of Approval:**
11/12
11/12
<table>
<thead>
<tr>
<th>MGSH Medical Executive Committee Quality Steering Council</th>
<th>11/12</th>
</tr>
</thead>
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<tr>
<td>Original Date:</td>
<td>12/91</td>
</tr>
<tr>
<td>Revision Dates:</td>
<td>10/92; 5/94; 3/96; 2/99; 10/00; 5/02; 7/04; 8/07; 11/12</td>
</tr>
<tr>
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<td>none</td>
</tr>
<tr>
<td>Distribution: MHS Intranet</td>
<td></td>
</tr>
</tbody>
</table>
PHYSICIAN’S VERIFICATION OF DIRECTIVE

Date: _________________________
Time: _________________________

PATIENT’S NAME
______________________________________________________________

I am attending physician for
______________________________________________________________
(Patient’s Name)

I have read the attached Directive, executed by the patient. To my best knowledge the directive conforms to the requirements of the Washington State Natural Death Act law (RCW 70.122.030), having been signed by the patient and two witnesses who are not my employees and who, to my best knowledge, are not related by blood or marriage to the patient, have no claim against the patient’s estate, and are not employees of the health facility in which the patient is being treated. To my best knowledge, there has been no revocation of this directive.

_____ The patient, in my opinion, is at this time incapable of communicating with me.

_____ The patient, in my opinion, is mentally competent and has confirmed to me that the directive and the steps proposed by me as to withholding or withdrawing life-sustaining procedures are in accordance with his/her current wishes.

(Physician, please check whichever is the appropriate statement.)

Attending Physician Signature
ATTACHMENT B

Contents of Mental Health Advance Directive

An MHAD must meet the following criteria:

1. Be in writing.

2. Contain language that shows an intent to create a mental health advance directive.

3. Be dated and signed by the patient, or at the patient’s direction and in the patient’s presence if the patient is unable to sign.

4. State whether the directive may or may not be revoked during a period of incapacity, and

5. Be witnessed in writing by at least two adults, each of whom shall declare that he or she personally know the patient, was present when the patient dated and signed the directive, and that the patient did not appear to be incapacitated or acting under fraud, undue influence, or duress. MHS staff and employees, medical staff members or any other person involved in the patient’s health care are not permitted to witness a mental health advance directive.

6. If the directive includes the appointment of an agent, the directive must contain the words “This power of attorney shall not be affected by the incapacity of the patient,” or “This power of attorney shall become effective upon the incapacity of the patient,” or similar words showing the patient’s intent that the authority conferred shall be exercisable notwithstanding the patient’s incapacity.

Effective date: A directive may be effective immediately after it is executed or it may become effective at a later time.
Workflow for Advance Directive (AD) Forms

Advance Directive (AD) forms will be ordered and scanned into an existing office visit encounter. All AD Forms (Advance Directive, POLST, POA etc.) will NO LONGER be scanned into a Consent Form encounter, and will no longer be notated in Patient Demographics.

1. First review the encounters under the Code tab in Chart Review to see if the physician has ordered a Health Care Directive Discussion in Epic.

2. Go into the Health Care Directive Discussion order and verify that the AD Form was submitted during the office visit (There will be a “yes” next to a question, indicating which AD Form(s) were submitted during the office visit).

3. After verification of submission, utilize the “Addendum” procedure to go into the office visit in which the Health Care Directive Discussion order was placed (the office visit date should correspond with the AD Form order date). Click on “Progress Note” and in the Addendum Comments section indicate the reason for the addendum: “Attached the submitted advanced directive form(s) to the encounter”.

   a. NOTE: If there is no existing Health Care Directive Discussion order, the following steps shall be completed within an Additional Order encounter, rather than an office visit, and shall be associated with an annotated Abstract diagnosis (document type and date signed).

4. Place an order for the submitted AD Form(s) types within the Office Visit encounter:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>3610004 _ O</td>
<td>Health Care Directive</td>
<td>(Advance Directive/Living Will)</td>
</tr>
<tr>
<td>3610005 _ O</td>
<td>DPOA Health Care</td>
<td>(Durable Power of Attorney Health Care)</td>
</tr>
<tr>
<td>3610006 _ O</td>
<td>DPOA Mental Health</td>
<td>(Durable Power of Attorney Mental Health)</td>
</tr>
<tr>
<td>3610007 _ O</td>
<td>O Five Wishes</td>
<td>(Five to six pages, non MHS form)</td>
</tr>
<tr>
<td>3610008 _ O</td>
<td>CPR</td>
<td>(Cardiopulmonary Resuscitation)</td>
</tr>
<tr>
<td>3610009 _ O</td>
<td>Revocation Order</td>
<td>(If patient would changes items on the Advance Directive)</td>
</tr>
<tr>
<td>4610011 _ O</td>
<td>POLST Form</td>
<td>(Physician Order Life Sustaining Treatment)</td>
</tr>
</tbody>
</table>

5. You will associate the order with the existing diagnosis in the office visit. You can then sign your order(s).
6. Scan the document into the order by clicking on ‘Enter/Edit Results’, import the document, and include the scan description (Document type and date signed).

Example: “POLST Form, signed by patient on 10/27/2010”

7. Select the document type from the drop list, and then add the collection and final result dates. **The collection date and final result date must correspond with the office visit date.**

8. After final resulting the AD document, sign the Addendum and exit the office visit encounter.
Please see attached screenshots

The Advance Directive Discussion Order will indicate which AD Form was submitted
Associate the AD Form order with the physician’s diagnosis in the office visit

Note: Before placing the AD Form order, ensure that you have included a comment in the Addendum that indicates your reason for altering the office visit.
Advance Directive Discussion and AD Form orders as shown under the Code tab:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Status</th>
<th>Provider</th>
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A scanned health care directive as shown in the office visit:

(Note the description includes the date of the patient’s signature)
Title: CODE STATUS, DO NOT ATTEMPT RESUSCITATION (DNAR)

Scope:
This policy applies to all MultiCare patients.

Policy Statement:
MultiCare Health System supports the patient’s right to make decisions about his/her care including end of life considerations. Code Status will be determined as soon as reasonably possible in accordance with the guidelines established in this policy.

Special Instructions:
1. Resuscitation is typically thought to encompass external heart compressions, electrical shock to the heart, and intubation. The roles of vasopressive agents and intravascular volume resuscitation should also be considered when decisions are made regarding resuscitation.

2. The term “Advance Directive” refers to the patient’s oral and written instructions about future medical care in the event the patient is unable to express his/her medical wishes. There are two types of End of Life Advance Directives: A Health Care Directive (commonly called a “Living Will”) and a Durable Power of Attorney for Health Care. In Washington State, a Mental Health Advance Directive allows patients to specify how they would like their mental health treatment handled in the event they become mentally incapacitated and are unable to make sound decisions about their mental health care due to mental illness. Advanced Directives do not dictate a patient’s Code Status. The patient’s condition, as specified in the directive, must be determined by the attending physician. (The terms “terminal” or “persistent vegetative state” are commonly used in Advanced Directives).

3. A “Living Will,” is a legal document specifying the patient’s wishes regarding end of life care if the patient is unable to communicate for him/herself. In Washington state, the directive is used only if the patient has a terminal condition (diagnosed in writing by the attending physician); or if the patient is in an irreversible coma (as determined by two physicians), and where the application of life-sustaining treatment would serve only to artificially prolong the process of dying. Some directives give more specific stipulations regarding the patient’s values and his/her interpretation of quality of life.

4. A “Durable Power Of Attorney for Health Care,” is a legal document allowing the patient to name a person as his/her health care agent. The named individual is authorized to consent to, stop or refuse most medical treatment for the patient if a physician determines the patient is unable to make decisions him/herself. Once appointed, the health care agent can speak on the patient’s behalf anytime he/she is unable to make
his/her own medical decisions, not only at the end of life.

5. The Department of Health (DOH) Office of Emergency Medical Services & Trauma System (OEMSTS), in conjunction with the Washington State Medical Association (WSMA), has implemented a new form entitled, “Physician Orders for Life Sustaining Treatment,” (POLST). The POLST form is intended for EMS use, and the content should be evaluated and considered upon patient’s admission to the Emergency Department.

   a. POLST is a “portable” physician order form that describes the patient’s code directions and allows individuals to summarize their wishes regarding end of life treatment.
   b. It is intended for use for patients 18 years of age and older with serious health conditions.

Procedure:

I. Establishing the Patient’s Code Status:

   A. When an adult patient, 18 years of age or older, is admitted to the hospital, staff will ascertain whether or not the patient has an Advance Directive, as per MHS Policy, “Advance Directives: Living Will and Mental Health.”

   B. Full resuscitative measures will automatically be instituted if a patient arrests and there is not a written DNAR order in the patient’s medical record.

   C. If a patient has an Automatic Internal Cardiac Defibrillator (AICD) and wishes to have DNAR status, a conversation will ensue regarding disabling the AICD.

II. Guidelines for Designating Patients as “Do Not Attempt Resuscitation,” (DNAR):

   A. Evaluation and Discussion:

      1. Patient’s Code Status, as documented in Epic during any previous hospitalizations at MHS, will be assessed and considered.

      2. The patient's attending physician has the primary responsibility to evaluate the patient and to facilitate discussion with patient and/or family as appropriate.

      3. If the patient has an outpatient primary care physician, her/his input should be sought regarding code-status discussion.

      4. A DNAR order may be considered in clinical situations in which resuscitation would likely be futile or in which the utilization of such treatment would be inappropriate in view of the patient's diagnosis and/or prognosis.

   B. Identification of Decision-maker:

      1. If the patient is a competent adult, the patient is the primary decision-maker.

      2. Refer to MHS Policy, “Informed Consent,” for complete information
on the patient’s legal representative authorized to make health care
decisions on his/her behalf. In general, for adult patients, the following
individuals are authorized in order of priority:

a. The appointed guardian of the patient, if any;
b. The individual, if any, to whom the patient has given a durable
   power of attorney for health care decisions;
c. The patient's spouse or registered domestic partner;
d. Children of the patient who are at least eighteen years of age;
e. Parents of the patient; and
f. Adult siblings of the patient

C. Making the DNAR Decision:

1. The decision about the DNAR order should be made in accordance
   with the expressed wishes or explicit directives of the patient, i.e.
   "advance directives"; or
2. In accordance with the known preferences and values of the
   patient.
3. Lacking any of the above, the decision should be based on a careful
   and reasoned consideration of the patient's interests such as:
   a. When the patient has a terminal condition: Terminal being
      defined as incurable condition caused by injury, disease, or
      illness, which regardless of the application of life-sustaining
      procedures, would, within reasonable medical judgment, cause
      death, and where the application of life-sustaining procedures
      would serve only to postpone the moment of death
   b. When the patient is in an advanced stage of terminal and
      incurable illness and is suffering severe and permanent mental
      and physical deterioration.
   c. When the patient is in a comatose or persistent vegetative state
      from which there is no reasonable probability of recovery.

D. DNAR Decisions When No Surrogate is Available:

1. The patient’s attending physician together with two other physicians
   qualified to assess the patient’s condition, must determine with
   reasonable medical judgment that the patient is in an advanced
   stage of a terminal and incurable illness and is suffering severe and
   permanent mental and physical deterioration, or the patient is in an
   irreversible comatose or persistent vegetative state from which there
   is no reasonable probability of recovery, and further medical
   intervention is considered futile; i.e. prolonging death rather than
   prolonging life, before life-sustaining treatment is withheld or
   withdrawn.

E. Obtaining Informed Consent:
1. The patient’s primary physician should obtain informed consent from the identified decision-maker(s) and should document the informed consent in the progress notes. The discussion should include:

   a. A discussion of the seriousness of the patient’s illness and prognosis, discussing the role of CPR, alternatives to CPR, including DNAR, and the potential risks and benefits of each option
   
   b. The patient and/or primary decision-maker should be informed that he/she may change the resuscitation status at any time.
   
   c. During this discussion it is important to include that during procedures should complications occur, these complications will be treated.

F. Conflict/Disagreement:

1. In the event in which there is disagreement among health care providers or between providers and surrogate decision-makers regarding the appropriateness of a DNAR order, such disagreements should be discussed and examined thoroughly and efforts made to achieve agreement. If they cannot be resolved, arrange for a care conference between family, hospital, and physician on code status of an incompetent patient with the following participants as deemed appropriate:

   a. Patient, if able
   
   b. Immediate family, including legally recognized surrogate
   
   c. Attending and consulting physicians
   
   d. Nurse caring for patient
   
   e. Chaplain and/or social worker
   
   f. Ethics committee representative(s)

2. The conference should address the following issues:

   a. The attending physician and physician consultants should:
      
      1.) *Discuss with the participants the patient’s condition and the patient’s capacity to make decisions.*
      
      2.) *Clarify treatment options and discuss the potential benefits of each option. Treatment that focuses on comfort should be given high priority. Avoid terms such as: “Withdrawal of care”, “withdrawal of support”, and “there is nothing more we can do”. Identify that we are changing the focus of care.*
      
   b. The group should discuss the known preferences and values of the patient.
      
   c. An attempt should be made to facilitate discussion and get agreement of participants to a specific course of action.
d. A physician will place the DNAR order if the surrogate and physician agree. MHS Legal Services and the Ethics Committee are available for consultation if there is disagreement between the physician and the surrogate regarding the indications for attempted resuscitation.

e. Document conference, names of participants, and outcome in patient’s medical record

3. If the care conference fails to resolve the conflict, a full ethics consultation should be considered

G. Writing the DNAR Order:

1. All orders not to attempt resuscitation must be written by the physician providing care for the patient.

2. Telephone orders are acceptable only if the attending physician is not readily available to write the order, and it must be documented in EPIC by two RNs who both sign the order.

3. The POLST is a form used by EMTs in the field. It does not take the place of a DNAR order when a patient is in the ED, or after hospital admission. However, the treatment options as designated on the POLST should be strongly considered at the time of hospitalization as an expression of the patient’s intent, along with any other expressed wishes or known preferences of the patient.

H. Review, Renewal and Revocation:

1. Since the condition of a hospitalized patient may change, code status should be reviewed and renewed at regular intervals at the discretion of the patient’s attending physician.

2. Caregivers and patients/surrogates should also be informed that a decision to forego resuscitative treatment can be revoked at any time by the patient/surrogate.

3. A DNAR in a patient’s medical record shall remain in effect until the patient is discharged from the hospital unless circumstances or the wishes of patient/surrogate warrant a change.

4. When a patient with DNAR status is discharged, a POLST form will be completed to provide continuation of DNAR status outside of the hospital in accordance with the patient’s wishes.

III. “DNAR” Patients and Surgery, Anesthesia, and/or Invasive Procedures:

A. When a patient who has a DNAR order is to undergo surgery, receive an anesthetic agent and/or be subject to an invasive procedure that may be associated with risk to cardio-pulmonary function:

1. The surgeon or physician performing the invasive procedure must engage in discussion with the patient or surrogate regarding the handling of the DNAR order and goals of care. Discussion needs to
include the following elements:

a. The content of the patient’s advanced directive
b. The expectation that if complications from the procedure arise, these complications will be treated
c. The patient’s understanding and agreement to continue with the procedure/surgery

**IV. Communication and Notification of DNAR or Limited Code Status:**

A. Place purple “DNAR” charm on those patients who are strictly a DNAR. Do not use this charm for patients who have requested certain or limited interventions for resuscitation. (These patients will not have an information charm.) Instead, refer to the specific order noted in the Epic “Code” tab.

B. Educate the patient and family on the purpose of the charm and the implications of not wearing it. (i.e. patient may be misinterpreted as a full code and treated accordingly.)

C. If the patient refuses to wear the wristband with DNR charm, document the patient's refusal in the medical record.

**V. Level of Care:**

A. Although a DNAR order may be part of an overall treatment plan which involves reduction of the level or intensity of care the patient is receiving, caregivers, patients and families must understand that the order not to attempt resuscitation has no implications for any other treatment decisions. Patients with DNAR orders on their medical record may remain candidates for all vigorous care, including intensive levels of care.

**Related Policies:**

MHS Policy, "Advance Directives: Living Will and Mental Health"
MHS Policy, "Brain Death"
MHS Policy, "Care of the Dying Patient"
MHS Policy, "Medical Ethics Consultation"
MHS Policy, "Patient Transfer and Transport"
MHS Policy, "Withdrawing and Withholding Life Support"
MHS Policy, "Decision Making In Non-Beneficial (Futile) Treatment"

**References:**

Revised Code of Washington: Chapter 70.122 RCW NATURAL DEATH ACT
Washington Supreme Court cases, In re Grant, 109 Wn. 2d 545 (1987) and In re Hamlin, 102 Wn. 2d 810 (1984).

**Point of Contact:**

MHS Ethics Committee Chair
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| Original Date:                  | 8/91              |
| Revision Dates:                 | 12/98; 1/02; 8/07; 10/09*; 3/11 |
| Reviewed with no Changes Dates: | none              |

Distribution: MHS Intranet

*10/09 policy code standardization changes only
**Policy formerly known as Code Status, Do Not Resuscitate
**Title: DEATH WITH DIGNITY (AID IN DYING) (I-1000)**

**Scope:**
This is a system policy applicable to all MHS acute care hospitals. (Mary Bridge being exempt by definition, as the act applies to adults only.)

**Policy Statement:**
Qualified Patients, as defined in Washington’s Death With Dignity Act (“Act”) (also known as “Initiative 1000” “I-1000” and “Aid in Dying”) may not ingest Life Ending Medications at Tacoma General – Allenmore Hospital or Good Samaritan Hospital or any other MHS acute care hospital.

MHS pharmacies will not fill prescriptions for Life Ending Medications prescribed under the Act.

Members of the Medical Staffs of Tacoma General – Allenmore Hospital and/or Good Samaritan Hospital may counsel their patients with regard to the Act and may serve in the role of Attending Physician and/or Consulting Physician in accordance with the Act, provided that they will not facilitate delivery or ingestion of Life Ending Medications within any MHS acute care hospital.

No employee of MultiCare Health System will be required to participate in any activities directly related to the Act. The provision of general information pertaining to options available to patients under Washington law is to be distinguished from activities directly related to the delivery, ingestion or direct facilitation of life ending activities under the Act.

Any physician employed by MultiCare Health System who chooses to participate in activities under the Act will document all activities performed under the Act in the manner prescribed by the Act and its related regulations. Members of the MHS Medical Staff performing activities associated with the Act within any MHS facility will document such activities as required by the Act. A summary of those documentation requirements is attached.

**Home Health & Hospice Provisions:**
MultiCare • Good Samaritan Home Health & Hospice cannot support the facilitation or administering of life-ending medications at patient’s homes, primarily because Home Health and Hospice nurses and other personnel are not assigned any statutory role under I-1000, and also because any health care provider in the state has the option to “opt out” of participation in I-1000 activities at any time.

Home Health & Hospice personnel will continue to provide all ordinary care routinely delivered to our patients at home, without regard to whether or not a patient has requested qualification for life-ending medications under I-1000.

Home Health & Hospice personnel are precluded from facilitating the delivery
of life-ending medications to a Home Health or Hospice Patient’s residence, and they are precluded from assisting patients in managing their I-1000 prescriptions and/or assisting patients in ingesting life-ending medications.

Home Health & Hospice personnel may, at their option, elect to serve as witnesses, and they may play a role for the family in managing the patient’s remains after death, in the same manner that they would have served in the event of a patient’s ordinary demise at home.

**Effective Date:**
The Act becomes effective March 4, 2009. This policy explains MultiCare Health System’s policies as they relate to activities arising under the Death With Dignity Act.

This policy derives from activities of the Ethics Committees of MultiCare Health System and Good Samaritan Hospital, corresponding directives of the Governing Boards of MHS and GSH, as well as from input from a wide range of physicians with active Medical Staff privileges at each of our hospitals together with various leaders within MHS and GSH.

**Rationale:**
The Act allows any health care provider to “opt out” of participation in activities directly associated with both “qualifying” patients as well as any act directly related to the provision of life-ending medications. This “opt out” provision makes it entirely impractical to support the ingestion of life-ending medications in any acute care setting. Likewise, because of the numerous staff involved in pharmacy operations, it is impractical to manage fulfillment of prescriptions for life-ending medications in our pharmacies.

This policy is not intended to hinder meaningful and appropriate communications and dialogue between physicians and patients concerning a patient’s rights under I-1000, at any point along the care continuum. And for physicians who elect to participate in facilitating patient’s requests under I-1000, they should have the latitude to do so within the guidelines of this policy.

**Special Instructions:**
1. Patients who are otherwise “Qualified Patients” as defined by the Act may not ingest medications intended to end their life while admitted as patients at any MHS acute care hospital.

2. If a Qualified Patient asks for assistance in obtaining or taking Life Ending Medications while admitted at any MHS acute care hospital, staff will not aid or assist any such patient in undertaking acts to end their life in the acute care setting.

3. Any Qualified Patient seeking to end their life in accordance with the Act will be transferred to an appropriate location suitable to the needs of such patient, provided such transfer or transport meets the criteria applicable to such patient transfer, and the patient has consented to such transfer or transport after being fully informed of the risks inherent in such transfer.
Procedure:

I. Rights and Responsibilities:

A. Patients who have questions about the Act or their rights under the Act should be directed to Social Services or their attending physician or primary care provider.

B. Social Services, in coordination with Care Management and other members of the care team, will provide patients who request information about the Act with resource materials appropriate to their inquiry.

C. Patients who desire to ingest Life Ending Medications at any MHS acute care hospital will be informed that they cannot do so while admitted to the hospital.

1. If they wish to proceed prior to their planned discharge from the hospital, they will be advised of the need for discharge and transfer or transport to another suitable location.

2. Reasonable steps will be taken to accommodate the patient’s desire for early discharge and transfer or transport, subject to approval by the patient’s attending physician (unless the patient insists upon leaving against medical advice (AMA).)

D. MHS pharmacies will not fill prescriptions for Life Ending Medications prescribed under the Act.

E. The appropriate House Supervisor will be notified in the event of any attempt on the part of a physician, patient or family member to allow or enable a Qualified Patient, admitted to any MHS acute care hospital, to take Life Ending Medications prescribed under the Act while admitted to such hospital.

1. This shall not preclude, in any manner, the right of a physician to perform any other acts associated with the Act, other than the delivery of Life Ending Medications at the hospital and/or the support of activities directly related to a Qualified Patient’s ingestion of Life Ending Medications while in the hospital.

II. Definitions

Act means Washington’s Death With Dignity Act, codified at RCW 70.245.010, et. seq.

Qualified Patient means a patient who meets all of the criteria under the Act and who has performed all of the requisite steps required under the Act in order to obtain a prescription for Life Ending Medications pursuant to the Act.

Life Ending Medications means medications prescribed to a Qualified Patient under the Act for self-administration by the Qualified Patient for the purpose of ending his or her life in accordance with the Act.
**Attachments:**
Attachment 1: Summary of Documentation Requirements under the Act

**References:**
RCW 70.245 WA Death With Dignity Act
WAC 246.978, DOH Rules Related to Death With Dignity Act
See also: Compassion & Choices of Washington [www.candcofwa.org](http://www.candcofwa.org) and [The Oregon Death With Dignity Act: A Guidebook for Health Care Professionals](http://www.candcofwa.org)
(There is currently no companion volume for Washington’s Act.)

**Point of Contact:** Laird A. Pisto, MHS Legal Services 403-1186

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| Original Date: | 03/09 (Effective Date) |
| Revision Dates: | NONE |
| Reviewed with no Changes Dates: | 9/12 |

Distribution: MHS Intranet
1. **Documentation Related to the Patient’s Request:**
   Document through the statutory form set forth in Section 22 of the Act, that the Patient is requesting medications under the Act.

2. **Documentation Related to the Attending Physician:**
   Document fulfillment of the duties of the Attending Physician who shall:
   a. Make the initial determination of whether a patient:
      i. Has a terminal disease?
      ii. Is competent?
      iii. Has made a request voluntarily?
   b. Confirm the patient’s residency under the Act.
   c. Inform the patient, for informed consent purposes, of:
      i. The patient’s medical diagnosis
      ii. The patient’s prognosis
      iii. The potential risks associated with taking the prescribed medication(s) under the Act
      iv. The probable result of taking the prescribed medication; and
      v. The feasible alternatives, including but not limited to:
         1. Comfort care
         2. Hospice care
         3. Pain control
   d. Refer the patient to a consulting physician for:
      i. Medical confirmation of the diagnosis
      ii. A determination that the patient is competent and
      iii. Determination that the patient is acting voluntarily
   e. Refer the patient for counseling if appropriate under Section 6 of the Act
   f. Recommend that the patient notify next of kin
   g. Counsel the patient about the importance of:
      i. Having another person present when taking the medication; and
      ii. Not taking the medication in a public place
   h. Inform the patient
      i. of his or her opportunity to rescind the request at any time and in any manner; and
      ii. Offer the patient an opportunity to rescind at the end of the fifteen-day waiting period under Section 9 of the Act
   i. Verify, immediately before writing the prescription for medication under the Act, that the patient is making an informed decision
   j. Fulfill the medical record documentation requirements of Section 12 of the Act
k. Ensure that all appropriate steps are carried out in accordance with the Act before writing a prescription for medication intended to enable the patient to end his or her life in a humane and dignified manner

l. Dispense the medications:
   i. Directly, if authorized under statute and rule to dispense and holding DEA certificate; or
   ii. With patient’s permission:
      1. Contact pharmacist and inform of prescription
      2. Deliver written prescription to dispensing pharmacist and make arrangements for the pharmacist to dispense directly to the patient or patient’s agent, or to the Attending Physician

m. Document (by the Attending Physician) that all requirements under the Act have been met and specify the steps taken to carry out the request including a notation of the medication(s) prescribed.

n. Sign the death certificate which shall list the underlying terminal disease as the cause of death (unless another physician has signed the death certificate.)

o. Note: If the Attending Physician elects to attend to the patient at the time the prescribed medications are ingested, the Attending Physician would be prudent to document:
   i. The fact of the Physician’s presence during the patient’s ingestion of prescribed medications;
   ii. The identity of others present;
   iii. The fact that the Physician did not assist the patient in taking the prescribed medications;
   iv. The acts or statements of the patient, as observed by the Attending Physician, at the time of ingestion, and the patient’s noted reaction to the medications subsequent to ingestion; and

3. **Documentation Related to the Consulting Physician:**
   Document fulfillment of duties of the Consulting Physician, who shall:
   a. Examine the patient;
   b. Examine the patient’s relevant medical records;
   c. Confirm, in writing, the Attending Physician’s diagnosis that the patient is suffering from a terminal disease; and
   d. Verify that the patient is competent, acting voluntarily, and has made an informed decision.

4. **Depression or Psychiatric / Psychological Disorder:**
   Document the presence or absence of psychiatric or psychological disorders, or depression causing impaired judgment. If either the Attending Physician or the Consulting Physician determines that the patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either of them shall refer the patient for counseling. Medication shall not be prescribed until the person performing the counseling determines that the patient is not
Patient Care

suffering from a psychiatric or psychological disorder or depression causing impaired judgment. (A report of the outcome and determinations made during counseling should be documented in the patient’s medical record.)

5. **Informed Decision:** Document that the patient is making an informed decision.

6. **Family Notification:** Document that the Attending Physician recommended that the patient notify his or her family, and if family is not informed, document that the Patient declined or was unable to notify family.

7. **Written & Oral Requests:** Document:
   a. That the patient initially made both written and oral requests for medications under the Act;
   b. That fifteen (15) days have passed;
   c. That the patient has reiterated the request at least orally 15 or more days after the original request; and
   d. That at the time of the patient’s second oral request, the patient was given the opportunity to rescind the request.
   e. That at least 48 hours have elapsed between the date that the patient signed the written request and the writing of a prescription under the Act.

   [Author’s note: This seems to be a drafting error, as 15 days must pass between the first oral request and the second oral request, so it would seem that few physicians would write the prescription sooner than expiration of the second oral request. Presumptively it was intended to allow a short waiting period after the second oral request prior to dispensing pharmaceuticals?]

8. **Disposal of Unused Medications.** Document that any medications dispensed under the Act that are not self-administered are disposed by lawful means.

9. **Filing of Dispensing Record.** Document that:
   a. A copy of the dispensing record and other administratively required documentation specified by the Department of Health is mailed to DOH within 30 days of the prescription; and
   b. Within 30 days after the death of the patient, submit any reports required by DOH.

10. **DOH Record-Keeping.** Document collection and/or transmission of all data required by DOH under the Act. See WAC 246.978.
Title: DECISION MAKING IN NON-BENEFICIAL (FUTILE) TREATMENT

Scope:
This policy applies to patients receiving care at MultiCare Health System (MHS) and is meant to guide health care providers in decision-making related to non-beneficial (futile) treatment. It is not designed for use in the urgent/emergent situation in which health care providers must make vital decisions within a distinct and critical time frame.

Policy Statement:
Physicians since the time of Hippocrates have recognized some medical conditions as incurable and have accordingly recommended no further attempts to prolong life for the patients suffering them. There have been recent debates surrounding patients’ rights and the accompanying perception that the right of self-determination (autonomy) extends not only to the refusal of medical treatment but demands for over-treatment as well (or...“insistence on treatment with no expected benefit”). According to the American Medical Association Council of Ethical and Judicial Affairs “Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patient.”

This policy establishes the MultiCare Health System (MHS) Process for decision-making regarding non-beneficial treatment of patients is conducted in a mutually respectful partnership of patient, family, and healthcare team.

Important to this policy is the belief that cure-oriented or stabilizing treatment should have a reasonable probability of achieving the patient’s medical goals. In the absence of such probability, active palliative/comfort care for dying or irreversibly ill patients that alleviates suffering becomes the primary goal of treatment.

The decision to transition from cure-oriented, life-prolonging care, to palliative/comfort care is often a difficult process for patients/surrogate decision-makers, their families/loved ones and members of the healthcare team. Therefore, central to this policy of offering active, palliative/comfort care is the understanding medical treatment decisions should involve a mutually respectful partnership of patient, family, their identified support system, and the healthcare team including the community physician.

The goals of this policy are:
1. To provide the optimal medical care addressing several possible goals which may include maintenance of well being, the cure of a disease, restoration of function, alleviation of pain and suffering, Withholding or withdrawing non-
beneficial treatment is an ethically and legally proper course of action in certain circumstances.

2. To provide avenues of beneficial care which protect the patient’s right of self-determination, the healthcare providers’ right of professional integrity and duty, and society’s concern for the just allocation of medical resources.

3. To provide a process for resolution of issues arising if or when a health care provider is asked to support a plan of care or treatment options that the provider believes will not provide benefit to the long term outcome of the patient and serve only to postpone the decision to address non-beneficial treatment needs.

**Procedure:**

**I. After Determining That An Intervention Is Not Beneficial To A Patient, Physicians May Offer A Family Care Conference:**

A. A family care conference is to be offered to the patient and/or surrogate anytime during difficult decisions. The understanding is that family conferences are occurring in an ongoing manner with critically ill patients and families.

B. If after a family care conference, the patient and/or surrogate are conflicted over the direction of medical care, further conversation is indicated.

**II. When The Attending Physician Determines That A Treatment Is Medically Non-Beneficial But The Patient And/Or Surrogate Decision-Maker Requests That It Be Provided:**

A. The attending physician should:

1. Discuss carefully with the patient or surrogate decision-maker the nature of the ailment, the options including palliative and/or and hospice care, the prognosis and the reasons why the interventions are medically inappropriate.

2. Explain that forgoing a requested intervention in question does not mean abandoning appropriate medical care and humane care designed to promote comfort, dignity, and emotional and spiritual support.

3. Offer to the patient and/or surrogate decision-maker the option of seeking an independent medical opinion to address the medical appropriateness of the intervention in question and of securing transfer of care to another physician or institution.

B. The assistance of the below institutional resources shall be made available to the patient and to the attending physician:

1. Nursing
2. Patient care representation
3. Chaplaincy
4. Social work
5. Medical Specialty consultation
6. Ethics committee


A. The second opinion must be fully documented in the patient’s chart and discussed with the patient or surrogate decision-maker.

B. If agreement is still not reached within 48 hours of obtaining the second opinion, the attending physician may prepare the case for review and contact the chairperson (or a representative) of the MHS Ethics Committee and request committee review. Risk and Legal Services (403-1107) may also be consulted.

IV. Case Review by the MHS Ethics Committee:

A. Possible recommendations from the ethics case consultation:

- If the recommendation is made to continue the current plan of care, a case review follow up will be scheduled in a reasonable and timely manner.
- AND/OR
- If medically non-beneficial treatment will be discontinued a plan of care will be established which addresses comfort care and the preservation of patient dignity. (see MHS Care of the Dying Patient)
- AND/OR
- Disagreements among patients, surrogate decision-makers, and/or health care providers may continue.
- AND/OR
- The MHS ethics consultation group may request a consultation from the ethics Committee of another hospital.
- AND/OR
- The patient can also be offered transfer to another facility.

B. In all cases the primary obligation of the care team is to provide care

V. Definitions:

Family Care Conference: At a minimum, includes the Primary Inpatient or Attending Physician, beside nurse, and the patient, and/or the Surrogate
Decision-maker. Other members of the multidisciplinary team may participate as needed. The discussion addresses the patient’s condition and prognosis, the treatment options, and goals of treatment. The family conference and plan of care is to be documented in the patient’s medical record.

**MHS ethics consultation**: A care conference led by a subgroup of the MHS Ethics Committee to include the following members: a minimum of 2 persons who have advanced ethics training, representatives of the patient care team, and an invitation to the patient or representatives of the patient’s family. Recommendations are communicated to the patient and/or family, the health care team and documented in the chart. (See MHS Policy “Medical Ethics Consultation”)

**Non-Beneficial (Futile) Treatment**: A proposed treatment is considered non-beneficial when at least two attending physicians concur that the treatment would have a very low probability of producing the desired outcome. In making such a judgment the physicians rely on medical experience, medical consultants, medical literature, and observations made in the context of caring for the individual patient. The term “futility” evades an exact medical description. In common usage the word futility is applied to an action which is incapable of producing a given result.

**Palliative Care**: Care that is administered with the primary goals of providing comfort, relieving suffering and emphasizing quality of life. Shared decision making and goal setting by the patient and family are part of the palliative care process.

**Primary Attending or Inpatient Physician**: The physician or physician team who assumed care of the patient at the time of admission and is the coordinator of all medical care including the care of specialists. This physician takes the lead in communicating with the family and patient, and informs/updates them both of diagnosis and prognosis.

**Primary Care Physician**: The physician who is identified by the patient and family as providing the long-term outpatient care of the patient. This physician can be a useful adjunct in communicating difficult information to the patient and family.

**Prognosis**: The expected outcome for the patient based upon the medical judgment of the physician(s).

**Surrogate Decision-maker**: A person other than the patient responsible for making medical decisions. This person is named in a Durable Power of Attorney for Healthcare appointed by the patient or as determined by Washington state law - (See the MHS Policy “Withdrawing and Withholding Life Support from an Incompetent Patient.”)

**Withdrawal** means stopping a treatment already initiated.

**Withholding** means not initiating a treatment. This is ethically the same as withdrawing treatment - (See the MHS Policy on “Withholding and
**Related Policies:**
- MHS Policy, "Advance Directives"
- MHS Policy, "Brain Death"
- MHS Policy, "Care of the Dying Patient"
- MHS Policy, "Code Status"
- MHS Policy, "Medical Ethics Consultation"
- MHS Policy, "Patient Transfer and Transport"
- MHS Policy, "Withdrawing and Withholding Life Support"

**References:**
- CLINICAL ETHICS: A Practical Approach to Ethical Decisions in Clinical Medicine, Sixth Edition by Albert R. Jonsen, Mark Siegler, William J. Winslade

**Point of Contact:** Ethics Committee 403-1125

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| Revision Dates:                     | 6/11              |
| Reviewed with no Changes Dates:     | none              |

Distribution: MHS Intranet
# WITHHOLDING/WITHDRAWAL OF LIFE SUSTAINING TREATMENT

## Scope:
This policy applies to incompetent patients at MultiCare Health System (MHS) who have a terminal condition or who are permanently unconscious and have not executed an Advance Directive (AD).

This policy does not apply:
1. If the patient is competent he/she can make decisions to withdraw or withhold life support. See Informed Consent and Patient Competency Policy, and Refusal to Consent to Medical Treatment Policy.
2. If the patient is brain dead refer to the Brain Death Determination Policy.
3. If the patient has an Advanced Directive/Living Will refer to the Advance Directive: Living Will and Mental Health Policy.
4. If the patient is pregnant with a viable fetus, contact Legal Services (403-1107).

## Policy Statement:
A. This policy establishes the MultiCare Health System (MHS) procedure for withholding/withdrawing life support from an incompetent patient who has not executed an AD.

B. In the interest of protecting individual autonomy the legislature finds that prolonging the dying process for a person with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically beneficial to the patient.

C. The patient has the fundamental right to control decisions relating to his/her health care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.

## Special Instructions:
1. Withholding and withdrawing life-sustaining treatment are considered to be equal acts.
   a. A physician may consider withholding or withdrawing life sustaining treatment from a patient in instances of a terminal condition or permanent unconscious condition.

2. Decisions regarding health care may be exercised by an authorized representative for a patient who is acting in the patient’s best interest.
a. Discussion of the option to donate organs is a separate decision from withdrawal of life sustaining treatment, but must be addressed prior to the withdrawal.

b. Tissue donation (including corneas) may be discussed after the patient has died. An informative discussion should be offered to the family.

c. If the decision has been reached to withdraw life-sustaining treatment and the patient is likely to experience cessation of cardiac activity within 60 minutes, contact should be made with the organ procurement counselor to discuss options with the family concerning donation after cardiac death. See Donation After Cardiac Death (DCD) Organ Donation Policy.

Procedure:

I. Responsibilities:

A. If the patient is unable to make their own decisions, and has no advance directive, the patient’s attending physician should determine with reasonable medical judgment that the patient is in an advanced stage of a terminal and incurable illness and is suffering severe and permanent mental and physical deterioration, or that the patient is in an irreversible comatose or persistent vegetative state from which there is no reasonable probability of recovery, and further medical intervention is considered futile (i.e. prolonging death rather than prolonging life). The attending physician is responsible for meeting with the family and recommending withdrawal of life sustaining treatment as outlined in this policy.

B. If the family does not agree with the attending physician’s recommendation regarding withholding or withdrawing treatment, or no family is present, the attending physician will request that another physician assess the patient’s condition and the value of life-sustaining treatment.

C. The attending physician will meet with the patient’s immediate family and/or guardian to fully explain the patient’s condition, prognosis, and expected future function

1. The risks, limits and benefits of the patient’s current treatment should be thoroughly discussed

2. Other health professionals involved with the patient are encouraged to participate in the discussions and should be advised of the meeting

D. Persons authorized to consent on behalf of an incompetent adult patient (at least 18 years of age) in order of priority, are:

1. Legal guardian

2. Durable power of attorney for health care
3. Spouse or state registered domestic partner
4. Adult children >18 years of age
5. Parents
6. Adult siblings

E. Persons authorized to consent on behalf of a **minor** patient (under the age of 18 years) in order of priority, are:
   1. Legal guardian
   2. Person authorized by the court to consent to medical care for a child
   3. Parents
   4. Individual to whom the minor’s parent has given a signed authorization to make health care decisions
   5. A competent adult who has signed a declaration stating that he/she is a relative responsible for the health care of the minor. (Such declarations are effective for up to 6 months from the date of execution.)

F. Minors over the age of 12, who are conscious and suffering from chronic terminal conditions, should be given the opportunity to actively participate in the discussions and decisions regarding their health care including the withholding/withdrawing life-supportive treatment
   1. The Ethics Committee is available to participate in this discussion at the request of the family or the health care team

G. Once these matters have been fully discussed and no questions remain, the attending physician should encourage the patient’s immediate family and any guardian to consider the facts and discuss the implications

**II. Consent and Decision to Withhold/Withdrawal Process:**

A. The patient’s attending physician should advise the patient’s immediate family and any guardian that consent may be given only after determining in good faith that the patient, if competent, would choose to refuse life-sustaining treatment; or, if such a determination cannot be made, the immediate family and guardian determines that the withholding/withdrawing of life-sustaining treatment would be in the best interest of the patient
   1. If the patient has a primary care provider, she/he should be asked to weigh in regarding the patient’s potential preference

B. If the immediate family, any guardian, and the patient’s attending physician agree that treatment should be withheld/withdrawn, their decision should be implemented
   1. In the absence of agreement between the person(s) authorization
to consent on behalf of the patient and the attending physician, no
life-sustaining treatment should be withheld/withdrawn (see
Decision Making in Non-Beneficial (Futile) Treatment)

C. The attending physician should document in the patient’s record a
summary of the conversation, diagnosis, prognosis, and the specific
treatment that is to be withheld/withdrawn

1. This note should indicate that consent was obtained and who gave the
consent, and that the decision to withhold or withdraw treatment is
consistent with the patient’s intentions or the best interest of the
patient as determined by the person(s) authorized to consent on
behalf of the patient.

D. The attending physician and health care team should take measures to
assure dignity and comfort after life support is withheld/withdrawn,
including hygienic care and medication or medical procedures deemed
necessary to alleviate pain. Refer to: Comfort Care Order set

E. Each decision to withhold/withdraw treatment is specific to the
treatment discussed with the person(s) legally authorized to consent,
and it does not apply to any other treatment not discussed

F. If conflict arises among family, health care providers, and physician
regarding withholding/withdrawing of life support, follow the guideline
below

1. Initiate family conference with the following participants:
   a. Immediate family
   b. Patient’s legal guardian
   c. Attending Physician
   d. Nursing representative
   e. Chaplain/Social Worker
   f. Ethics committee representative(s)

2. Family conference to address these issues:
   a. Attending physician and consultant(s) should discuss the
      patient’s condition and prognosis with participants
   b. Clarify the treatment options and goals of treatment
   c. Determine if patient is able to participate
   d. Document family conference and outcome in patient’s medical
      record

3. If the attending physician, the consulting physician(s), the guardian
   (if one has been appointed), or person(s) authorized to consent
   object to the withholding/withdrawing of life-sustaining treatment,
   no treatment should be withheld/withdrawn. Consult Legal Services
   and initiate a consultation with MHS Ethics Committee
a. If the attending and consulting physicians reach an impasse with the patient’s surrogates and the pursuit of ongoing treatment is determined to be non-beneficial to the patient, refer to the MHS Policy: “Decision Making in Non-Beneficial (Futile) Treatment”


5. No health care provider is required to participate in the withholding/withdrawing of life-sustaining treatment if such action would be contrary to the dictates of his/her conscience or belief

   a. If a physician refuses or does not wish to withhold/withdraw the life-sustaining treatment, the physician shall make a good faith effort to transfer the patient to another qualified physician who will carry out the decision to withhold/withdraw life-sustaining treatment

III. Definitions:

**Life-sustaining treatment:** Any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which when applied to a qualified patient, would serve only to prolong the process of dying. “Life-sustaining treatment” shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

**Terminal condition:** an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

**Permanent Unconscious Condition:** an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state.

**Persistent Vegetative State:** describes the chronic condition that sometimes emerges after severe brain injury and comprises a return of “wakefulness” accompanied by an apparent lack of cognitive function. An operational definition is that the eyes open spontaneously in response to verbal stimuli. Sleep-wake cycles exist. The patients spontaneously maintain normal levels of blood pressures and respiratory control. They show no discreet localizing motor responses and neither offer comprehensible words or obey any verbal commands. This condition usually follows a 2-4 week sleep-like coma and begins upon return of “wakefulness.” Examples of, but not inclusive of, patient conditions that would meet this condition include terminal chronic conditions, chronic unconscious states, and acute terminal conditions.
### Related Policies:
- MHS P & P: "Refusal to Consent to Medical Treatment"
- MHS P & P: "Donation After Cardiac Death"
- MHS P & P: "Brain Death Determination"
- MHS P & P: “Advanced Directives: Living Will and Mental Health”
- MHS P & P: “Decision Making in Non-Beneficial (Futile) Treatment”

### Attachments:
- Appendix 1: "End of Life Modification Suggestion Sheet"
- Appendix 2: “Algorithm for Withholding/Withdrawing Life-sustaining Treatment”

### Point of Contact:
- Adult Palliative Care RN Coordinator: 403-4972,
- Pediatric Palliative Care RN Coordinator: 403-XXXX

### Approval By:
- MHS Ethics Committee
- MGSH Ethics Committee
- MHS Medical Staff Operations Committee
- MGSH MEC
- Quality Steering Council

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### Revision Dates:
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### Reviewed with no Changes Dates:
- None

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Appendix 1
End-of-Life Care Modification Suggestions

- Encourage open visitation of family and friends
- Lower side rails and place patient’s arms (unrestrained) on top of sheets to encourage loved ones closeness – dim lights to reduce harshness
- Sometimes when families are having difficulty with idea of withdrawing treatment, they are able to accept not replacing IV bags with vasoactive drugs as they run empty
- Ask family members to assist you in interpreting the patient’s need for additional pain medication or sedation
- When families ask when the death will occur, it is sometimes helpful to gently liken death to birth – we have an idea of due date, but the timing is quite unpredictable – This also may be a good time to ask if the patient might be “waiting” for someone who has not visited. If someone is unable to travel, consider holding the phone up to patient’s ear so remote loved ones have a chance to speak with (or to) the patient
- Avoid use of the word “agonal” when describing the dying patient’s respiration – loved ones tend to hear this word as “agony”
- Ask questions which encourage loved ones to share stories and reminisce. Get comfortable with standing by in silence – avoid closed posture such as crossing your arms
- Consider ordering a Bereavement Tray from dietary if you feel that the family may be at the bedside for an extended period of time
- Consider asking the family if they would like a lock of hair or handprint – this is especially helpful when a sudden or traumatic death is occurring (Bereavement Box with supplies is located in first cupboard in the equipment room in ICU, the RT room in CVICU, and the equipment room in CCU, and in cupboard of ICU nursing station at Allenmore)
- Offer children’s books on grief and teddy bear if there are young family members present (books and bears are located in the Bereavement Box)
- Ask which family member would like Bereavement Follow-up and fill out Bereavement form (if this person does not live with the patient, get the address – Epic currently has only the phone number listed in demographics)
Appendix 2

Algorithm for withholding/withdrawing life sustaining treatment

Is the patient competent to make decisions?

Yes

Patient makes own decision on whether to withhold or withdraw treatment

No

Does the patient have an advance directive?

Yes

Does the patient have a terminal condition or is the patient in a permanently unconscious state diagnosed in writing by the attending physician who has personally examined the patient

No

Have the following criteria been met?
1. Patient’s attending physician together with one other physician determine that the patient is in an advanced stage of illness and is suffering severe and permanent mental and physical deterioration or permanently unconscious
2. The patient’s guardian or surrogate decision maker determine the patient, if competent, would choose to refuse life sustaining treatment, or, if the patient’s wishes cannot be determined, withholding/withdrawing life sustaining treatment is in the best interest of the patient

No

Treatment may be withheld or withdrawn consistent with the AD

Yes

Treatment may be withheld or withdrawn

No

Treatment continues

Is there a surrogate decision maker?

Yes

Patient’s attending physician together with one other physician determine that the patient is in an advanced stage of illness and is suffering severe and permanent mental and physical deterioration or permanently unconscious

No

Treatment continues

Yes

Treatment may be withheld or withdrawn

No

Treatment continues

Does the patient have an advance directive?

No

Is there a surrogate decision maker?

Yes

Patient’s attending physician together with one other physician determine that the patient is in an advanced stage of illness and is suffering severe and permanent mental and physical deterioration or permanently unconscious

No

Treatment continues

Yes

Treatment may be withheld or withdrawn

No

Treatment continues