PMH MEMORIAL HEALTH
BOARD OF COMMISSIONERS POLICY AND PROCEDURES

DEPARTMENT:	BOARD OF COMMISSIONERS	PAGE 1 OF 9 PAGE(S)
REGARDING:	FOREGOING LIFE-SUSTAINING TREATMENT	NUMBER: 100.0027
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I. INTRODUCTION

These guidelines are applicable to all types of life-sustaining treatment and are not limited to decisions to forego cardiopulmonary resuscitation. The term "life sustaining treatment," as used in the Guidelines, encompasses all healthcare interventions that have the potential effect of increasing the life-span of the patients. Although the term includes respirators, intravenous fluid, and all the paraphernalia of modern intensive care medicine, it also includes, for instance, physical therapy and special feeding procedures, provided that one of the anticipated effects of the treatments is to prolong the patient's life.

The term "forego" is used to include both stopping a treatment already begun as well as not starting a treatment, because there is no significant ethical distinction between failing to institute new treatment and discontinuing treatment that has already been initiated. A justification that is adequate for not commencing a specific treatment is also sufficient for ceasing that treatment.

II. STATEMENT OF GENERAL POLICY PRINCIPLES:

1. Presumption in Favor of Treatment: It is the policy of Prosser Memorial Health (PMH) to provide high quality medical care to its patients with the objective of sustaining life and practicing in conformity with traditional and current ethical and medical standards. It is imperative that the professional staff remain committed to this objective by maintaining a presumption in favor of providing treatment to all patients unless such treatment would be judged to cause harm. However, this commitment must recognize the right that patients have in making their own

decisions about their health care in continuing, limiting, declining, or discontinuing treatment, whether life-sustaining or not.

2. Right to Refuse Treatment: As a general rule, all adult patients who do not lack decision-making capacity may decline any treatment or procedure. There is sometimes, however, a reluctance to apply this rule to patients who seek to forego life-sustaining treatment. Thus, the Guidelines are adopted and promulgated to deal specifically with decisions to forego life-sustaining treatment.

3. Decisions to Forego Are Particular to Specific Treatment: A decision to limit, decline, discontinue, or otherwise forego a particular treatment or procedure is specific to that treatment or procedure and does not imply that any other procedures or treatments are to be foregone unless a specific decision is also made with respect to them.

4. Preservation of Patient Dignity: The dignity of the individual must be preserved and necessary measures to assure comfort must be maintained at all times by the provision of appropriate nursing care, hygienic care, comfort care, analgesics, psychological, spiritual, and cultural needs to all patients, including those who have elected to forego a specific life-sustaining therapy.

5. Surrogates and Patients: In these Guidelines, the term "surrogate" decision-maker is defined as specified in the informed consent policy of PMH. Unless otherwise indicated, the term "patient" includes the surrogate of a patient who lacks decision-making capacity.

6. Physicians' Rights: It is the ethical and legal right of individual physicians to decline to participate in the limitation or withdrawal of therapy. However, no physician may abandon his or her patient until care by another physician has been secured (see Section III.3).

7. Availability of Guidelines to Patients: These Guidelines must be freely available to all patients (and their families), who upon admission to PMH, will be given a general explanation of the existence and content of these Guidelines (e.g. through an introductory brochure) and be given the opportunity to name a surrogate decision-maker in writing. Patients (and their families) will be able to obtain copies of the guidelines at each patient unit station.

8. Presumption Against Judicial Review: Families and healthcare professionals should work together to make decisions for patients who lack decision-making capacity. Recourse to the courts should be reserved for the occasions when adjudication is clearly required by state law or when concerned parties have

disagreements that they cannot resolve over matters of substantial import (see Section V).

III. GENERAL PRINCIPLES GOVERNING DECISION-MAKING:

1. Right to decide and to be informed: It is the ethical and legal right of each patient who possesses the capacity to make decisions regarding his or her healthcare to do so. Furthermore, it is the concomitant ethical and legal right of each patient to be provided with adequate information about the diagnostic, therapeutic, and alternative options (including risks, benefits, nature, purpose, and prognosis as a result of the options) which are reasonably available.

2. Collaborative Physician/Patient (or Surrogate) Decision-Making:
   (a) Decisions to forego life-sustaining treatment should be made between the patient (or surrogate) and the attending physician after a thorough discussion of all options, as is reasonably possible, has been conducted.
   (b) When a patient is terminally ill and the treatment to be foregone is, in the professional judgement of the attending physician, unlikely to provide the patient with significant benefit, the patient (or surrogate) should be so informed, unless there is evidence that such disclosure would be harmful to the patient.
   (c) If a patient (or surrogate) is unwilling to forego such treatment (as described in 2b), the treatment may nonetheless be foregone (that is, either stopped or not started) after notice to the patient (or surrogate) that is sufficient to permit transfer of the patient's care to another physician or medical center.
   (d) A patient (or surrogate) may not compel a physician to provide any treatment which, in the professional judgment of that physician, is unlikely to provide the patient with sufficient benefit.

3. Physicians' Rights: Any physician may decline to participate in the limitation or withdrawal of therapy. In exercising this right, however, the physician must take appropriate steps to transfer the care of the patient to another qualified physician. Such a decision should be made only for reasons of conscience and after serious efforts have been made to dissuade the patient (or the patient's surrogate) from the decision to forego treatment, and after adequate notice has been given to the patient that the physician will have to withdraw from the case.

4. Informing for Decision-Making:
   (a) It is the physician's responsibility to provide the patient (or, in the case of the patient who lacks decision-making capacity, the patient's surrogate) with adequate information about therapeutic and diagnostic options so that the patient or surrogate may make an informed decision.

(b) This information should include the risks, discomforts, side-effects, the potential benefits of treatment, and the likelihood, if known, that the treatment will realize its intended beneficial effects.
(c) The patient may, in addition to providing such factual information, also wish to provide advice about treatment.
(d) The physician should: seek to elicit questions from the patient or surrogate; provide truthful and complete answers to such questions; attempt to ascertain whether or not the patient or surrogate understands the information and the advice provided; and attempt to enhance understanding when deficient.
(e) Understanding of options by the patient or surrogate will often increase over time. Therefore, decision-making should be treated as a process rather than an event. In order to provide adequate time to deal with patients before they lose their capacity to decide, the process of informing patients or surrogates should begin at the earliest possible time.

5. Withholding of Information from Patients (or Surrogates):
(a) There is a strong presumption that all information needed to make an appropriate decision about healthcare (including a decision to forego life-sustaining treatment) should be provided to the decision maker (i.e. the patient or surrogate).
(b) Information may not be withheld may not be withheld from a patient or surrogate on the grounds that its divulgence might cause the patient or surrogate to decline a recommended treatment or to choose a treatment that the physician does not wish to provide. Nor may any information be withheld because of the belief that its disclosure would upset the patient or surrogate.
(c) Only if, in the exercise of professional judgment, the physician believes that disclosure would lead to an immediate and serious threat to the patient's (or surrogate's) health or life, may information be withheld. In such cases, the least restrictive degree of withholding, consistent with the patient's (or surrogate's) well-being should be practiced (i.e. disclosure of relevant information not presumed to be immediately and seriously harmful should be provided). Since the process of decision-making will often take place over a period of time, such information should gradually be given to the patient or surrogate, when possible, so as to minimize the presumed harmful impact.
(d) Information may also be withheld from a decision-maker who clearly makes known that he or she does not wish to have the information in question, as long as the decision-maker has previously been informed of his right to have such information.
(e) When disclosure is purposely limited, the reasons therefore should be documented in the medical record.
6. Consultation with Family: Patients should be encouraged to discuss foregoing life-sustaining treatment with family members and, where appropriate, close

friends. However, a patient's privacy and confidentiality require that his or her wish not to enter into such a decision not to divulge to family members the patient's decision to forego life-sustaining treatment must be respected.

7. Ethics Committee Consultation: The attending physician, any member of the healthcare team, patient, surrogate, or any family member may seek a consultation with representatives of the Ethics Committee at any time. Motive for consultation might include family/staff conflicts, conflicts between family members, staff/staff conflicts, and unclear moral or legal status of any aspect, including a lack of clarity as to who should act as the patient's surrogate. The goal of such consultation may include: correcting misunderstandings, helping in the acquisition of needed information, allowing ventilation of emotions, and otherwise aiding in the resolution of disputes. In order for patients and surrogates to effectively exercise this prerogative, they must be made aware of the existence and purpose of the Ethics Committee.

IV. DECISION-MAKING FOR PATIENTS WHO LACK DECISION-MAKING CAPACITY:

1. Definitions:
   Competent Patient: A patient shall be considered to be competent if the patient is: (1) an adult 18 years of age or older, or a minor who is married, pregnant, or a parent; (2) conscious; (3) able to understand the nature and severity of the illness involved; (4) able to understand the possible consequences of alternatives to the proposed treatment; and (5) able to make informed choices concerning the course of treatment.

   Incompetent Patient: A patient shall be considered to be incompetent if the patient: (1) is a minor under 18 years of age unless the patient is a minor who is married or emancipated; (2) is unable to understand the nature and severity of the illness involved; (3) is unable to understand the possible consequences of and alternatives to, the proposed treatment; (4) is unable to make informed and deliberate choices concerning the course of treatment; or (5) has been declared legally incompetent by a court.

2. Presumption of Capacity: Decision-Making Capacity in General:
   (a) Patients should be considered, in the first instance, to possess the capacity to make healthcare decisions.
   (b) In the case of conscious and alert patients, the ethical and legal presumption of capacity will govern, unless countervailing evidence arises to call the presumption into question.
   (c) A patient's authority to make his or her own decisions should be overridden only after a clear demonstration of lack of capacity.

(d) Inquiry into a patient's capacity may be initiated by such conditions as delirium, dementia, depression, mental retardation, psychosis, intoxication, stupor, or coma.

(e) Refusal of specific treatment to which most patients would agree does not mean that the patient lacks decision-making capacity, but may initiate inquiry into the matter of such capacity.

(f) Furthermore, decision-making incapacity can be a transient condition and can be specific to a particular decision. Therefore, patients who suffer from any of the above conditions may not lack capacity at all times for all purposes, and decision-making capacity may need to be reassessed from time to time.

3. Rights of Patients Lacking Decision-Making Capacity: Patients who lack decision-making capacity have the same substantive ethical and legal rights as do patients who possess such capacity. The only distinction is that in the case of patients lacking decision-making capacity, healthcare decisions must be made on their behalf by a surrogate decision maker. Decisions made on behalf of patients who lack decision-making capacity should, when their wishes are known, replicate the decision that they would have made for themselves had they had the capacity to do so. If the patient has executed a "living will" or any other form of an Advanced Directive to a healthcare provider, this document should serve as strong evidence of the patient's wishes (see Section V).

4. Formal Assessment of Capacity: The formal assessment of capacity is a process that ordinarily ought to be performed and documented by the attending physician. A psychiatric consultation may indicate if psychological factors are thought to be compromising capacity. However, a consultation is not required if the attending physician is able to assess capacity without it.

5. Selection of a Surrogate Decision-Maker:
   (a) If a patient is incompetent, treatment decisions shall be made on behalf of the patient by the following individuals, if reasonably available, willing, and competent, in this order or priority:
      (1) A judicially appointed guardian, if any;
      (2) A person or persons designated by the patient in writing to make the treatment decisions for him/her, e.g. by a durable power of attorney;
      (3) The patient's spouse;
      (4) An adult child or the majority of the adult children who are available;
      (5) The parents of the patient; or
      (6) The nearest living relative of the patient.

The individual of the highest priority shall act as an incompetent patient's representative. If none of the individuals listed in (1) through (6) are available, willing, or competent, the Risk Manager shall be notified.

(b) If the patient has no family or friends to serve and if the patient so requests while still possessing decision-making capacity, the attending physician or another member of the healthcare team, in consultation with the Ethics Committee, may serve as the patient's surrogate.

(c) In the case of intractable conflict among family members or when there is no appropriate person to serve as a surrogate and the patient has not previously designated a surrogate, the judicial appointment of a surrogate must be sought.

V. ADVANCE DIRECTIVES:

1. Definition: An advanced directive is any written document drafted by an individual, either while a patient or prior to becoming one, that either (a) gives instructions to a healthcare professional or provider as to the patient's desires about healthcare decisions, or (b) designates another person (i.e. surrogate) to make healthcare decisions on behalf of the patient if the patient is unable to make decisions for himself or herself, or (c) both gives instructions and designates a surrogate. To meet this definition for purposes of these Guidelines, an advanced directive need not comply with any particular form or formalities, as long as it is in written form, and it appears to be authentic and unrevoked. It may be handwritten by the patient or at the patient's direction or it may be typewritten.

2. Effect to be Given Advanced Directive: An advanced directive is merely a written manifestation of a patient's wishes concerning healthcare decision-making. It should, therefore, be accorded the same effect as an oral declaration from a competent patient. That is, it should be followed to the extent that it does not request a physician to perform or refrain from performing any act which is criminal, which violates that physician's personal or professional ethical responsibilities, or which violates accepted standards of professional practice.

3. Weight to be given Advanced Directive: An advanced directive should be accorded a presumption of validity. The fact that it is written in the handwriting of a person other than the patient, for example, should not necessarily invalidate the document, but should be taken into account in determining the weight to be accorded to the directive. Similarly, the fact that the patient who executed the advance directive may have lacked the capacity to make a healthcare decision at

the time the directive was executed may be taken into account in determining the weight to be accorded the directive. In all cases in which an advance directive is to be disregarded, such a decision must be based on more than surmise or speculation as to the circumstances surrounding the execution of the document, and instead be based on persuasive and credible evidence. A document that is notarized and witnessed, or complies with similar legal formalities for that particular type of document, ought to be disregarded for only the most compelling reasons. However, the failure to notarize or witness a document by itself should not invalidate the document.

4. Probate of an Advance Directive: Ordinarily there should be no need to seek judicial review of the enforceability of a written advance directive any more than there ought to be routine judicial review of a patient's oral wishes to forego life-sustaining treatment. However, in extraordinary cases, such as where there is conflict between the written advance directive and the wishes of the patient's family, or where there is a substantial doubt as to the authenticity of the advance directive, judicial review should be sought.

5. Procedures for Recording the Advance Directive: A written advance directive must be filed in the appropriate section of the patient's medical record. Further, a notation must be made in the Progress Notes of the existence of the advance directive. If a copy of the advance directive is not available for placement in the patient's record, the provider should record this fact as well as the substance of the advance directive, in the progress notes.

6. Implementation of an Advance Directive: When the patient is deemed to be incompetent (See section IV) implementation of the advance directive will occur by provider order.

VI. DOCUMENTATION OF DECISIONS AND ENTRY OF ORDERS:

1. ORDERS:
   (a) The order must be written, timed, dated, and signed by the attending physician. Under extraordinary circumstances, a telephone order can be taken by two nurse witnesses, providing that a full explanatory documentation has previously been recorded on the chart.
   (b) If the patient's attending physician cannot, in good conscience, write a DNR order in compliance with the wishes of the competent patient representative, the attending physician shall offer to transfer the patient to the care of another physician in this or another healthcare facility.
   (c) The other must be reviewed and reconsidered prior to any surgical procedures being performed.

2. Progress Notes: At the time an order to limit life-sustaining treatment is written, a companion entry should be made in the progress notes, which includes at a minimum, the following information: (a) diagnosis; (b) prognosis; (c) patient's wishes (when known) or surrogate's wishes (if the patient lacks decision-making capacity), and family members' wishes (where known); (d) the recommendations of the treating team and consultants with documentation of their names; (e) a description of the patient's decision-making ability at the time the decision was made and the efforts made to ascertain the patient's capacity.

3. Acceptable Orders: Each situation is unique, necessitating individual consideration. Detailed orders are usually required in each specific case. Orders may address one of the following categories but should be specific:
   (a) All But Cardiac Resuscitation – These patients are treated vigorously, including, intubation, mechanical ventilation, and measures to prevent cardiac arrest. However, should a patient develop cardiac arrest in spite of every therapeutic effort, no resuscitate efforts are made and the patient is permitted to die. In those situations, where patients are being monitored for arrhythmia control, cardioversion or defibrillation for ventricular tachycardia or fibrillation will be attempted once, unless specified not to by written order. This possibility should be discussed with the patient and/or family in advance.
   (b) Limited Therapy – In general, no additional therapy is initiated except for hygienic care and for comfort. Should cardiac arrest occur, no resuscitative efforts are made. Exceptions may occur. For example, it may be appropriate to initiate certain drug therapy in a patient who has decided in advance against intubation, dialysis, etc.
   (c) Comfort Measures Only – These patients will only receive nursing and hygienic care and medications appropriate to maintain comfort as ordered. Therapy (e.g. administration of narcotics) which is necessary for comfort may be utilized even if it contributes to cardiorespiratory depression. Therapies already initiated will be reviewed by the physician and discontinued if not related to comfort or hygiene.