

Sample Decisionmaking Protocols

Do-Not-Resuscitate Protocol (see pp. 46-50)

“Guidelines for Orders Not to Resuscitate, ”
Beth Israel Hospital, Boston, MA

Care-Category Protocols:

Treatment Levels (see pp. 51-62)

“(Guidelines on Foregoing Life-Sustaining Treatment, ”
Presbyterian-University Hospital, Pittsburgh, PA

Treatment Goals (see pp. 63-67)

“The Supportive Care Plan—Its Meaning and Application:
Recommendations and Guidelines, ” Task Force on Supportive Care, St. Paul, MN

Treatment-Plan Protocol (see pp. 68-72)

“Limiting Life-Sustaining Treatment, ”
University Hospitals of Cleveland, Cleveland, OH

Model Guidelines (see pp. 73-74)

“Medical Management Decisions in Nursing Home Patients,
Principles and Policy Recommendations, ”
King County Medical Society, WA

Beth Israel Hospital
Boston, Massachusetts

SUMMARY
GUIDELINES: ORDERS NOT TO RESUSCITATE

The Medical Executive Committee has adopted guidelines for the entry of orders not to resuscitate. If questions arise which are not answered by the Guidelines, the Administrator on call should be consulted. The Committee's recommendations are described in full in the attached Guidelines.

Medical Record

Orders not to resuscitate (DNR) should be entered in the patient's record with full documentation by the responsible physician as to the patient's prognosis and the patient's concurrence (competent patients) or family's concurrence (incompetent patients).

Chief of Service

The Chief of Service, or his designee (see list of designees at end of policy), must concur in the appropriateness of a DNR order on incompetent patients. This second opinion must be entered in the patient's record.

The Chief of Service (or his designee) must be notified promptly of DNR orders on competent patients. Notification must be documented in the medical record.

Daily Review

All DNR orders should be reviewed daily.

Competent Patients

Competent patients must give their informed consent to a DNR Order.

If, however, it is the responsible physician's opinion that a full discussion of whether CPR should be initiated would be harmful to the patient, this conclusion and its rationale should be documented. If the physician and the Chief of Service deem a DNR order appropriate, and the patient's family concurs, the order may be written.

Incompetent Patients

The assessment of incompetence should be documented, together with the documentation of patient's medical condition, and prognosis and the concurrence of the Chief of Service or his designee.

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If the patient's available family agrees that a DNR order is appropriate, the order may be written.

If there are no available family members, the responsible physician may enter an order with the written concurrence of the Chief of Service.

Judicial Approval Required

Judicial approval should be obtained before entering a DNR order if:

1. Patient's family does not agree to a DNR order.
2. There is uncertainty or disagreement about a patient's prognosis or mental status.

The Administrator on call must be contacted on any case which warrants judicial review.

Departmental Designees:

Medicine:	Firm Chief
Surgery:	Associate Chief
Obstetrics & Gynecology:	Associate Chief
Neurology:	Deputy Chief

FOR FULL DETAILS SEE COMPLETE POLICY AVAILABLE
AT ALL NURSING STATIONS AND DEPARTMENTAL OFFICES

Beth Israel Hospital
Boston, Massachusetts

GUIDELINES: ORDERS NOT TO RESUSCITATE

In certain circumstances it becomes appropriate to issue a "Do Not Resuscitate" (DNR) order and to enter this order in a patient's medical record. In all cases, the procedures and documentation described below should be carried out. Observe that in certain cases the Hospital Administrator on call must be contacted to assess the necessity of prior judicial approval. In all cases the Chief of Service must be kept informed as specifically listed below.

The following procedural guidelines have been adopted by the Medical Executive Committee of the Beth Israel Hospital to promote thorough decision-making, and to ensure accurate and adequate record keeping and the clear communication of all such decisions. When individual patient decisions present questions which are not answered by these guidelines, or when judicial approval may be required, nursing and medical staff should contact the Hospital administration through the Administrator-on-call who is available 24 hours a day.

A. The Competent Patient

A competent patient, for the purpose of these guidelines, is an adult (18 or over, or an emancipated minor) patient who is conscious, able to understand the nature and severity of his or her illness and the relative risks and alternatives, and able to make informed and deliberate choices about the treatment of the illness.

The competent patient may request the entry of a DNR order at any time without prior judicial approval. The attending physician must then consult with the patient to insure that the patient understands his or her illness and the probable consequences of refusing resuscitation treatment, that is, that the decision represents the informed choice of a competent patient. The patient's mental condition should be documented in the medical record. If there is any question about the patient's competence, a consultation should be obtained from the psychiatry service.

The execution of a "living will," if any, should be considered by the staff, but it is neither essential nor sufficient documentation of a decision to order the entry of a DNR order.

In this circumstance, approval of the next-of-kin is not required, and their refusal of such approval is not sufficient to overrule the informed decision of a competent patient. Nevertheless, the patient's family should be informed of the patient's decision and of the Hospital's intention to abide by that decision.

In all instances where a competent patient requests entry of a DNR order, the Chief of Service or his designee (see list of designees at end of policy) must be informed promptly that such orders have been written, even though the Chief of Service cannot deny such a request from a competent patient. Notification of the Chief of Service or his designee must be documented in the medical record.

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If in the opinion of the attending physician the competent patient might be harmed by a full discussion of whether resuscitation would be appropriate in the event of an arrest, the competent patient should be spared the discussion; therefore if the physician and the Chief of Service deem a DNR order appropriate and the family members are in agreement that the discussion might harm the patient and that resuscitation is not appropriate, the DNR order may be entered by the physician. In such cases, the physician shall follow the procedures described below for orders on incompetent patients.

B. The Incompetent Patient

An "incompetent" patient, for the purpose of these guidelines, is a patient who is under 18 (unless an emancipated minor) or who is unable to understand the nature and consequences of his or her illness or is unable to make informed choices about the treatment of the illness.

If an incompetent patient is irreversibly and terminally ill, and death is imminent, DNR orders may be entered without prior judicial approval, if family members concur in this decision. Before entering such an order the attending physician must consult with the patient's family including, at least, the same family members who would be sought out to consent to post-mortem examination. In addition, the attending physician should consult with, and have the concurrence of, the Chief of Service or his designee, before entering such orders. This second opinion as to the irreversible nature of the patient's illness and his or her moribund condition must be entered in the patient's record as well as the opinion of the first physician.

If the patient has no family who can be contacted, the DNR order may be entered by the responsible physician with the written concurrence of the Chief of Service or his designee.

C. Review

DNR orders for all patients should be reviewed at least daily to determine if they remain consonant with the patient's condition and desires. Therefore, it is most appropriate for the physician to discuss his or her opinion and decision with nursing and house staff from the outset and frequently thereafter.

D. Documentation

When a "DNR" order is decided upon, the order should be entered in the patient's chart along with the justification for the order and notes by all consultants involved. Specific reference should be made to:

1. Summary of a staff discussion regarding the patient's condition.
2. A descriptive statement of patient's competence or incompetence. For the incompetent patient, the record should include a notation of signs or conditions which indicate or constitute his or her inability to understand and make medical decisions on his or her own behalf.

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3. A statement of the circumstances of the consent by the patient if the patient is competent, including staff discussions with the patient concerning the consequences of the DNR order, and any discussion with the family. For the incompetent patient, note in detail the discussions with and concurrence of all involved family.

E. Prior Judicial Approval

In any instances where judicial review is sought, the Administrator on call and the Chief of Service or his designee must be consulted in advance. The decision to seek judicial approval of an order not to resuscitate should be made jointly and hospital counsel should be consulted prior to initiating contact with the court.

Prior judicial approval should be sought if:

1. an incompetent patient is not suffering from a terminal illness or death is not imminent;
2. family members do not concur in the entry of a DNR order.

F. Support and Counseling for Patients, Families and Staff

Nothing in these procedures should indicate to the medical and nursing staff or to the patient and family an intention to diminish appropriate medical and nursing attention for the patient, whatever his or her situation.

When the incompetent patient is sufficiently alert to appreciate at least some aspects of the care he or she is receiving (the benefit of doubt must always assign to the patient the likelihood of at least partial alertness or receptivity to verbal stimuli), every effort must be made to provide the emotional comfort and reassurance appropriate to the patient's state of consciousness and condition regardless of the designation of incompetence.

In every case in which DNR orders are issued, the Hospital shall make resources available to the greatest extent practicable to provide counseling and other emotional support as appropriate for the patient's family and for all involved Hospital staff, as well as for the patient.

G. Departmental Designees

Medicine:	Firm Chief
Surgery:	Associate Chief
Obstetrics & Gynecology:	Associate Chief
Neurology:	Deputy Chief

9/8/87

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**PRESBYTERIAN-UNIVERSITY HOSPITAL
GUIDELINES ON FOREGOING LIFE-SUSTAINING TREATMENT**

Prepared by: Ethics and Human Rights Committee

Approved: Executive Committee, May 30, 1985

I. INTRODUCTION

These Guidelines are applicable to all kinds 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 health care interventions that have the potential effect of increasing the life span of the patients. Although the term includes respirators, kidney machines, 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 treatment is to prolong the patient's life. (See Section III.2.b)

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 PRINCIPLES

1. Presumption in Favor of Treatment

It is the policy of PUH 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. However, this commitment must recognize the right that patients have in making their own decisions about their health care and in continuing, limiting, declining or discontinuing treatment, whether life-sustaining or otherwise.

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 futile life-sustaining treatment.

3. Decisions to Forego Are Particular to Specific Treatments
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 and analgesics 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 the Hospital (Policy #4011). 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 PUH 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 health care 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 health care to do so. Furthermore, it is the concomitant ethical and legal right of each patient to be provided with adequate information about the diagnostic and therapeutic options (including risks, benefits, nature and purpose 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 as thorough discussion of therapeutic options as is reasonably possible.
 - (b) When a patient is terminally ill and the treatment to be foregone is, in the professional judgment 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) 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 significant benefit.
 - (d) If the patient (or surrogate) is unwilling to forego such treatment, 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 hospital.
3. Physician's 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 a 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 and financial costs of treatment, the potential benefits of treatment, and the likelihood, if known, that the treatment will realize its intended beneficial effects.
 - (c) The physician 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, should provide truthful and complete answers to such questions, should attempt to ascertain whether or not the patient or surrogate understands the information and advice provided and should 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 health care (including a decision to forego life-sustaining treatment) should be provided to the decision maker (i.e., the patient or surrogate).

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- (b) Information may not be withheld from a patient or surrogate on the ground 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 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 it 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 or her right to have such information.
 - (e) When disclosure is purposely limited, the reasons, therefore, must 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 or not to divulge to family members that patient's decision to forego life-sustaining treatment must be respected.
7. Ethics and Human Rights Committee Consultation.
The attending physician, any member of the health care team, patient, surrogate or any family member may seek a consultation with representatives of the Ethics and Human Rights 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 a 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 effectively to exercise this prerogative, they must be made aware of the existence and purpose of the Ethics and Human Rights Committee.

IV. DECISION MAKING PROCEDURES FOR PATIENTS WHO LACK DECISION MAKING CAPACITY

1. Presumption of Capacity; Decision Making Capacity in general

- (a) Patients should be considered, in the first instance, to possess the capacity to make health care 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.

2. Rights of Patients Lacking Decision Making Capacity
Patients who lack decision making capacity have the same substantial 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, health care 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 advance directive to a health care provider, this document should serve as strong evidence of the patient's wishes. (See Section V).

3. 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 be indicated 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.
4. Selection of a Surrogate Decision Maker.
 - (a) In the case of a patient who, after proper assessment, is determined to lack decision making capacity, a surrogate must be chosen to make decisions on behalf of the patient.
 - (b) Ordinarily the surrogate should be a close family member but a friend may occasionally be the best choice.
 - (c) In the case of a patient who has several concerned and available family members, decisions should be made by consensus of those family members whenever possible.
 - (d) Where the patient, prior to losing decision making capacity, has designated a surrogate either formally or informally, the patient's choice must be respected.
 - (e) 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 health care team in consultation with the Ethics and Human Rights Committee, may serve as the patient's surrogate.
 - (f) 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 advance 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 health care professional or provider as to the patient's desires about health care decisions, or (b) designates another person (i.e., surrogate) to make health care 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 advance 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. It may, but need not, use a preprinted "living will" form or be in the form of durable power of attorney pursuant to title 20 of Purdon's Pennsylvania Consolidated Statutes, Annotated section 5603 (h) or section 5604 or a similar statute (including a "Natural Death Act") of the state of which the patient was a resident at the time of the execution of the document. The document need not be witnessed.

2. **Effect To Be Given Advance Directive.**
An advance directive is merely a written manifestation of a patient's wishes concerning health care 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 Advance Directive.**
An advance 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 health care 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 should 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 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 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. A notation must be made in the Progress Notes of the existence of the advance directive.

VI. DOCUMENTATION OF DECISIONS AND ENTRY OF ORDERS

1. Orders.
When it has been determined that a particular life-sustaining procedure is to be foregone (i.e., limited, terminated or withheld, should it become needed) and the above procedures have been followed, the resulting order must be written into the patient's medical record by the attending physician or a designate as directed by the attending physician. A verbal or telephone order is not acceptable. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the hospital staff (including nursing staff and house staff) so that all involved professionals understand the order and its implications.
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 patient lacks decision making capacity) a family member's wishes (where known);
- d. the recommendations of the treating team and consultant 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. However, if detailed orders are not provided, to facilitate communication when therapy is to be limited, one of the following categories should be indicated.

- (a) All But Cardiac Resuscitation. These patients are treated vigorously, including intubation, mechanical ventilations and measures to prevent cardiac arrest. However, should such a patient develop cardiac arrest in spite of every therapeutic effort, no resuscitation 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 at once, unless specified not to by written order. Further, it is understood that a cardiac arrest of an "All But Cardiac Resuscitation" patient occurring unexpectedly, for example as an iatrogenic complication, may be treated with full cardiopulmonary resuscitation. However, 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. Therapy already initiated will be limited by specific written order only. 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.

SUMMARY OF GUIDELINES ON FOREGOING LIFE-SUSTAINING TREATMENT

PURPOSE: The purpose of this summary is to provide access to information contained in the PUH Guidelines on Foregoing Life-Sustaining Treatment. It is not to be used as a substitute for those guidelines which should be referred to when specific medical-ethical dilemmas occur. Page numbers and appropriate sections of the guidelines are here included to facilitate this access.

INTRODUCTION: No ethically relevant distinction exists between failing to institute new treatment and discontinuing treatment that has already been initiated. Therefore, the term "forego" is used to include stopping treatment already begun as well as not starting a new treatment. These guidelines are applicable to all kinds of life-sustaining treatment and are not limited to decisions to forego cardiopulmonary resuscitation.

STATEMENT OF GENERAL PRINCIPLES (section II, pp 3-4) and GENERAL PRINCIPLES GOVERNING DECISION MAKING (section III, IV pp 4-7): As a general rule, all adult patients who do not lack decision making capacity may decline any treatment or procedure. Patients who lack decision making capacity have the same ethical and legal rights as do patients who possess such capacity but health care decisions must be made on their behalf by a surrogate decision maker. It is the ethical and legal right of an individual physician to decline to participate in the limitation or withdrawal of therapy, if he or she considers this action inappropriate. However, no physician may abandon his or her patient until care by another physician has been secured. Further, a patient or his surrogate may not compel the physician to provide any treatment which in the physician's professional judgment is unlikely to provide the patient with significant benefit, i.e. the treatment is not medically indicated. Procedures for assessing decision making capacity, for selecting a surrogate decision maker and for Ethics Committee consultation are outlined in this section.

ADVANCE DIRECTIVES (section V pp 7-8): The definition of, weight to be given to and procedures for handling advance directives (living wills) are outlined in this section.

DOCUMENTATION OF DECISIONS AND ENTRY OF ORDERS (section VI, pp 9-10): When it has been determined that a particular life-sustaining procedure is to be foregone, the resulting order must be written into the patient's medical record and an appropriate progress note written including information on diagnosis, prognosis, patient's or surrogate's wishes, the recommendations of the treating team and a description of the patient's decision making ability. It is the physician's responsibility to communicate this information to other members of the health care team.

Detailed orders are usually required but one of the following categories may be used:

A. All But Cardiac Resuscitation. These patients are treated vigorously, including intubation, mechanical ventilation and measures to prevent cardiac arrest. However, should such a patient develop cardiac arrest in spite of every therapeutic effort, no resuscitative 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. Further, it is understood that a cardiac arrest of an "All But Cardiac Resuscitation" patient occurring unexpectedly, for example as an iatrogenic complication, may be treated with full cardiopulmonary resuscitation. However, 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. Therapy already initiated will be limited by specific written order only. 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 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.

THE SUPPORTIVE CARE PLAN—ITS MEANING AND APPLICATION: RECOMMENDATIONS AND GUIDELINES

I. What Is Supportive Care?

A decision to provide supportive care to an individual means a decision to provide care and treatment to preserve comfort, hygiene and dignity, but not to prolong life. Supportive care is not considered to be part of the concept of euthanasia or causing death, but rather should be viewed as not extending life in hopeless situations. See Section II, For Whom Supportive Care Might Be Considered.

Once it has been determined that supportive care is appropriate, after utilizing the decision-making procedures outlined below, written orders for the individual plan of care must be established. The primary aims of a supportive care plan should be to promote the dignity of the individual and to minimize pain or discomfort. There should also be active support for the psychological, social, emotional and spiritual needs of the individual and family.

An individual supportive care plan for a resident in a long term care facility should include consideration of the following guidelines:

A. A specific disease or life-threatening condition which could end life but which does not cause pain or discomfort normally would not be treated. For example, pneumonia not causing dyspnea or pleuritic pain would not be treated.

B. Specific medical conditions which compromise comfort, hygiene, and dignity would be treated. For example, oxygen would be provided to alleviate dyspnea; pneumonia causing pleuritic pain would be treated; a clear airway would be maintained as by suctioning; localized infections and fractures would be treated,

C. Specific nursing care for comfort, hygiene, bowel care, skin care, pas-

sive range of motion (PROM) and positioning, and catheter care would be given.

D. Hospitalization or more extensive medical intervention would not ordinarily be indicated. There may be exceptions to this (see above).

E. In most cases, a resident with a supportive care plan would have a do not resuscitate (DNR) order in the medical record.¹

F. Life sustaining nutrition and hydration needs would ordinarily be met. There is no consensus within the task force on the controversial issue of when and under what circumstances food and fluids may be withheld. We do agree, however, that the existence of a supportive care plan does not in itself predetermine whether artificial means of providing fluids and nutrition will be continued or discontinued. Each individual case must be given careful and sensitive consideration.

G. The resident and family shall have as much control as possible over the care and activity level of the resident,

II. For Whom Supportive Care Might be Considered

Residents in long term care facilities who fall within the following major categories of medical conditions may be considered potential candidates for supportive care plans, when there exists clear documentation of the medical condition, and a high degree of certainty of the diagnosis and prognosis. Our intent in setting forth these categories is to limit rather than expand the numbers of long term care residents who may be considered for supportive care plans.

A. Terminally Ill and Imminently Dying, for example, from cancer or cardiac disease.

B. Severe and Irreversible Mental Disability, where the resident demonstrates a significant inability to communicate, or to interact meaningfully with the environment, and an unawareness of self and/or the environment; for example, those with pre-senile and senile dementia (Alzheimer's disease) and cerebral vascular disease (strokes).²

C. Severe and Irreversible Physical Disability, where there may exist normal mental functioning but, because of pain and suffering, or severe motor impairment, the resident demonstrates a significant inability to interact physically in a meaningful way with the environment; for example, spinal cord injury, head trauma, emphysema, and amyotrophic lateral sclerosis.³

111. Procedures for Initiation of a Supportive Care Plan

A. When a Supportive Care Plan Should Be Considered. There is no need for any haste in evaluating a resident for initiation of a supportive care plan. Time should be allowed to carefully and thoroughly consider all aspects of the resident's condition.

1) A supportive care plan is generally inadvisable as part of the initial admission care plan. Before the appropriateness of supportive care can be fully determined, a complete medical record, including a full analysis of rehabilitative potential, should be created within the long term care setting itself. However, in some cases a supportive care plan on admission may be appropriate depending on the resident's condition, previous course of care, completeness of previous record, and so forth. The physician and the facility should be open to full discussion of the issue if it is raised at admission.

2) We recommend that the facility not affirmatively suggest the initiation of a supportive care plan. Such a plan is a very personal medical, religious and ethical matter for the resident, family and attending physician. However, we do recommend that the facility staff be open and receptive to discussions of death and the dying process. The facility staff may serve as a valuable resource to residents and families, but should also act as a champion for any rehabilitative potential that may exist.

3) If a resident is admitted to a facility with physician orders for a supportive care plan, we recommend that the order not be followed without going through the decision-making process outlined below, or, at the very least, without thoroughly assuring, and carefully documenting, that a decision-making process raising all relevant issues had previously been undertaken. In all cases, the facility should clarify the orders received so that no ambiguity exists about the intentions of the physician and the resident.

B. Participants in a Supportive Care Decision.

1) **Resident:** The resident must always be involved to the fullest extent possible, even if the resident is under guardianship. The procedures recommended here are intended to involve all interested persons to the fullest extent possible in the final decision so that all viewpoints are represented and thoroughly aired, and so that legal risks are minimized if the resident is unable to make the final decision.

Since supportive care may be viewed by some as placing a resident in a life-threatening situation, any such plan for an incompetent or questionably competent resident involves considerable exposure to serious legal risks. Such a plan may, however, be in the best interests of the resident if all viewpoints, including medical, religious, ethical and personal, as

well as legal, are weighed against one another.

There is some question under guardianship law as to whether a guardian of a person has the legal authority to consent to a supportive care plan. Therefore, while these guidelines recommend having a guardian appointed if at all possible, a guardian's consent is not an absolute guarantee of proper authority to undertake a supportive care plan.

a) **Competent Resident:** When the resident is clearly competent, the resident has the full authority to make the decision on a supportive care plan, one way or the other.

b) **Questionably Competent Resident:** When there are questions about the resident's competence, but the resident is not under guardianship and is still able to express his or her wishes, the following principles should govern:

(i) If the resident does not want a supportive care plan, no plan should be initiated.

(ii) If the resident seems to want a supportive care plan, the initiation of a guardianship for the resident should be encouraged so that someone is legally designated to speak for the resident.

(iii) If the resident seems to want a supportive care plan and if guardianship is not a viable alternative, a supportive care plan may properly be initiated after thorough family, physician, staff and Bio-medical Ethics Committee involvement, as outlined below.

c) **Incompetent Resident Not Under Guardianship:** If the resident is clearly incompetent but not under guardianship, and the resident is unable to express himself or herself, the following principles should govern:

(i) Without a guardian, no one is legally authorized to speak for the resident. This situation involves serious risks for the physician, the facility and the family. However, we all agree that an incompetent resident should not be deprived of the right to a sup-

portive care plan merely because of incompetence. Therefore, we recommend the initiation of a guardianship for the resident, so that someone is legally authorized to speak for the resident.

(ii) If guardianship is not a viable alternative, but a supportive care plan seems highly appropriate under all the circumstances, a supportive care plan can be initiated after the careful involvement of family, interested parties, staff, physician and Bio-medical Ethics Committee. Be aware, however, that such a situation does pose great risks to all involved.

(iii) If there is no guardian and no family to involve in the decision-making process, but a supportive care plan seems highly appropriate, a physician and a facility should carefully consider whether to initiate a supportive care plan without receiving court approval. In this case, the involvement of the Bio-medical Ethics Committee is particularly important and strongly recommended. Facilities and physicians are cautioned, however, that deciding against a supportive care plan in highly appropriate circumstances because of potential legal risks for themselves may in itself violate the rights of the resident, both legally and ethically'.

d) **Incompetent Resident Under Guardianship:**

(i) The consent of both the guardian and the resident should be obtained, if the resident can in any way express his or her wishes. The family should be involved as outlined below.

(ii) A guardian may wish to seek probate court approval of a supportive care plan; however, at this point, it is not at all clear how the court would view such a request.

2) Family and Interested Persons:

a) Whenever possible, unless the resident is clearly competent and forbids it, the family should be fully involved in the decision-making process. All family members who are in-

involved with the resident's care and activities should be included, and all family members as close or closer in degree of relationship to the resident as the involved persons should be notified of the discussion. Any other family members who may reasonably wish to be included in the decision-making process should also be notified.

b) Other persons or groups involved in the resident's care and/or activities, or in support of the family should also be involved.

c) We recommend that the resident's attending physician take primary responsibility for the notification and involvement of family and others. Each physician and facility **could**, however, develop cooperative procedures in this respect.

3) **Resident's Attending Physician:**

a) A supportive care plan should be initiated by orders of the resident's attending physician only, never by the facility medical director unless the medical director is the attending physician.

b) If the resident and family are strongly in favor of supportive care and the physician is not, they have the right to consult another physician whose philosophy is more akin to their own. However, the resident and family should be strongly encouraged to consider why the physician is opposed and we encourage the involvement of the Biomedical Ethics Committee.

c) If the physician questions a family's motivation for initiation of supportive care plan, or if there is irresolvable conflict among family members, the matter should be referred to the facility Bio-medical Ethics Committee for additional guidance.

4) **Long Term Care Facility Involvement:**

a) Administrative and Professional Staff:

(i) The Director of Nursing

Services, the Resident Services Director and the Social Services Director, or their delegates, should be involved in the discussion. Minimally, the Administrator should be informed of the existence of the discussion.

(ii) General supportive care policies should be developed, along with a basic evaluation sheet, to ensure that all relevant information is gathered and assessed.

b) Direct Care Givers: Input should be solicited from those directly involved in care of the resident as they may notice small details or patterns of significance in the condition of the resident. Careful note should be given to the observations and opinions of the direct care givers, particularly when they conflict with the recommendation of the resident or the physician that a supportive care plan is appropriate.

c) Medical Director: The medical director of a long term care facility should not direct a supportive care plan unless he or she is also the resident's attending physician.

We recommend involvement of the medical director in each supportive care decision-making process, but do not see this as an absolute requirement. He or she should at least be informed of the existence and progress of the consideration, and should be available for counsel or conflict resolution, if necessary.

The medical director should participate in the development of, and ultimately approve, all general supportive care policies developed by the facility.

d) Biomedical Ethics Committee: We encourage consideration of each potential supportive care plan by an inter-disciplinary Bio-medical Ethics Committee. In most facilities, the beginnings of such a committee may already exist (e.g., Utilization Review),

Even when it is quite certain that a competent resident may authorize a supportive care plan for himself or herself, we nevertheless would en-

courage committee review. In cases of questionably competent or incompetent residents, we feel it very important to have the committee's more objective involvement.

While the use of a facility's Utilization Review Committee as a Bio-medical Ethics Committee may be reasonable for the present, we would recommend future development of an expanded committee to include lay, religious, medical, legal and other professional representation.

C. Supportive Care Decision Making Process

1) The decision making process should be designed to encourage full discussion of all relevant facts and options so that the meaning and significance of supportive care is fully understood by all participants, and to ensure that **all** views are expressed and weighed, and so that full documentation of the plan will be possible. The following steps are recommended:

a) The issue is raised by the resident, family or physician.

b) The attending physician and facility should obtain complete medical and psycho-social information from the resident's records, at both the hospital and the long-term care facility. Observations and other comments which may not be completely reflected in the medical records should be solicited from direct care givers.

c) The physician and/or facility staff should privately discuss the potential supportive care plan and the significance with the resident, if at all possible, so that an assessment can be made in the absence of any pressure by family members.

d) The physician should participate in a full discussion with family members and/or other interested and involved persons, with the consent of the resident if competent. Other family members should be notified of the discussions by the physician.

e) **The resident's physician and facility staff should discuss the issue thoroughly among themselves.** The facility should assure itself that full discussion between the physician and the resident and family has taken place.

f) All issues should be raised and discussed with facility staff **in a care conference format.**

g) The proposed plan should be considered by the Bio-medical Ethics Committee, particularly if the plan is for an incompetent or questionably competent resident.

2) **General Admonitions:**

a) Document **all conferences carefully and thoroughly.**

b) **Do not force a final decision too soon after all discussions have taken place.** Let all involved have time to mull matters over.

3) **Conflict Resolution Principles:**

a) If the resident can express himself or herself and does not want a supportive care plan, it should not be initiated, or, if initiated by the physician, it should not be carried out by the facility.

b) If the resident and family want a supportive care plan and the resident's physician will not initiate one, the resident and family have the right to consult another physician. In such cases, however, the facility should ensure that the initial physician's concerns and viewpoints are fully considered.

c) If the resident is unable to express himself or herself and family seems to be pressing for a plan, the physician and facility should carefully weigh all factors before initiating and **carrying out the plan to ensure its appropriateness.** The physician and facility should carefully consider the family's intentions and motivations and should refer the case to the Bio-medical Ethics Committee before initiating the plan.

d) If there is an intra-family dispute over the appropriateness of a

plan, we recommend careful consideration by the physician and facility as this poses a great risk of legal challenge. We also recommend utilization of the Bio-medical Ethics Committee or other facility or community resources to resolve the conflict prior to initiating the plan.

e) If the facility staff, medical director or Bio-medical Ethics Committee do not concur with the resident, family or physician on the appropriateness of a plan (for example, if the facility feels significant rehabilitation potential exists), the facility should forcefully express such opinion to the resident, family and physician to ensure that its objections are heard and understood. The facility may choose to refuse to implement the plan and recommend discharge, or may even consider resort to the courts.

D. **Documentation of a Supportive Care Plan.**

1) Physician authorization for a supportive care plan should be a specific, **individualized** set of orders, stating explicitly what will and will not be done for the resident. It must be part of the medical record. An order saying just "Supportive Care" (unlike "DNR") is not sufficient.

2) Written authorization for the plan should be obtained from the resident whenever possible, even if under guardianship. The guardian should also authorize the plan.

3) Written acknowledgment of the plan should be obtained from those interested persons **who have been involved** in the decision-making process whenever possible.

4) The specific plan and the facility policies on supportive care should be given to the resident and family so that no ambiguity exists.

5) The decision, the nature of the plan, and other relevant matters should be thoroughly **discussed with all staff involved with the resident.**

E. **Re-Evacuation of a Supportive Care Plan.**

1) The plan must be re-evaluated **whenever the facts or conditions which led to the initial plan change,** or whenever the resident, family or other involved person requests it. The same persons should be involved in re-evaluation as were included in the initial decision.

2) The supportive care plan should be reviewed periodically, when the general plan of care is reviewed. We recommend review on a 30-day basis, in any event.

3) We recommend that criteria and an input sheet be developed for re-evaluation, to ensure that direct care givers are given guidance on what changes in conditions to look for.

IV. **Conclusion**

The task force does not view these recommendations and guidelines as the definitive resolution of the dilemmas raised by the supportive care concept, but rather as part of an ongoing dialogue on supportive care issues and practices. Comments are welcome and may be directed to individual members of the task force.

The recommendations and guidelines set forth in this report represent the views of the signatories as individuals. They do not necessarily reflect the policy of any institution, professional organization or governmental agency with which the signatory is affiliated.

References

1. See Minnesota Medical Association, DNR Guidelines (adopted by the Board of Trustees of the Minnesota Medical Association) (January 1981).
2. The life of a physically or mentally disabled person is just as valuable as that of a person described as normal or healthy. It is not appropriate to consider a supportive care plan on the basis of a physical or mental disability alone.
3. *Id.*

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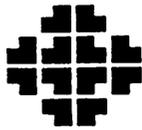
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UNIVERSITY
HOSPITALS
OF CLEVELAND

ADMINISTRATIVE POLICY
and
PROCEDURE MANUAL II

Policy # 16,218

Page # 1

Date Revised 1/88

LIMITING LIFE-SUSTAINING
TREATMENT

Subject:

Policy:

A. Statement of Purpose

It is the policy of University Hospitals of Cleveland to provide high quality medical care to its patients with the objective of saving and sustaining life. However, this commitment involves recognition that initiation or continuation of treatment may not constitute optimum care when the burdens of such treatment outweigh its benefits to the patient. At these times, the objective is to allow as peaceful a death as possible.

B. Guidelines and Principles

When such treatment limitation is considered, the following guidelines and principles should apply:

1. Competent patients must be consulted and have a right to refuse treatment.
2. The wishes of incompetent adults and legal minors should be given consideration.
3. Plans to limit treatment must be discussed with the family unless the patient requests otherwise.
4. Consultation with other health professionals involved with the care of the patient is strongly recommended.
5. Members of the health care team, particularly physicians and nurses, have the responsibility to provide an appropriate level of assistance to patients in reaching decisions about their care. Such efforts should be carefully coordinated.
6. Maintaining the dignity and comfort of the patient will receive the highest priority.
7. Limitation of life-sustaining treatment in no way implies abandonment.
8. There is no morally relevant distinction between withholding and withdrawing a life-sustaining treatment when its burdens outweigh its benefits to the patient.
9. If treatment limitation is not **documented in the patient's**

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record, as set forth in this policy, the presumption will be that life-sustaining interventions, including cardiopulmonary resuscitation, will be provided.

10. The ultimate responsibility for implementation of this policy rests with the patient's primary physician.

C. Goal

The following policy and procedure is intended to implement these guidelines and principles, enhance communication between health professionals, patients, and families, and to maximize treatment consistency.

D. Levels of Treatment

Limitation of life-sustaining treatment must be identified with a Levels of Treatment order as set forth below when:

- 1) withholding resuscitation in the event of an arrest; and
- 2) limiting treatment of other selected life-threatening conditions which might lead to arrest and death.

1. Do Not Resuscitate (DNR) in the Event of an Arrest

In the event of a cardiac, pulmonary, or cardiopulmonary arrest, no resuscitative measures will be initiated including mechanical ventilation, endotracheal intubation, chest compression, or the administration of emergency medications or fluids. Defibrillation is allowed. Short of an arrest, patients in this category are candidates for all active treatment measures.

NOTE: If a decision has been made to attempt resuscitation in the event of an arrest, but to limit the resuscitative measures used, e.g., to utilize all resuscitative measures except intubation, this limitation should be specified on the standard Physician's Order Record, form 5-1835-2, and the rationale detailed in the progress notes.

2. Do Not Resuscitate (DNR) Plus Other Selective Treatment Limitation

In addition to the above DNR order, which only applies in the event of an arrest, treatment of other potentially life-threatening conditions will be limited as outlined below.

- a) Initiation of treatment may be limited in the following ways:
 - no defibrillation
 - no electrocardioversion

- no vasopressors/inotropic agents
 - no intubation
 - no mechanical ventilation
 - no antiarrhythmic drugs
 - no hyperalimentation
 - no transfer to an ICU
 - no dialysis
 - no blood/blood products
 - no electrolyte or acid/base corrective measures
 - other (specify)
- o) Treatment limitation may also include orders to withdraw or discontinue these or any other interventions.
3. For outpatient dialysis patients, do not resuscitate and other treatment limitation orders for patients receiving chronic outpatient dialysis will be rewritten on a monthly basis.
4. Upon admission of an outpatient, any treatment limitation order should be rewritten.

Procedure:

A. Physician Responsibility

1. Document in progress notes, at the time of writing orders, the rationale for the order and the relevant discussions held with the patient and family.
2. Review and complete the Levels of Treatment Order, form 5-1005-0. Any specific orders related to treatment limitation are to be written on this form.
3. If a decision has been made to attempt resuscitation in the event of an arrest, but to limit the resuscitative measures used, e.g., to utilize all resuscitative measures except intubation, this limitation should be specified on the standard Physician's Order Record and the rationale detailed in the progress notes.
4. The Levels of Treatment Order form must be signed by a physician; telephone and verbal orders are not valid. It is preferable that the attending physician sign the order form; if this is not possible, the most senior physician present should sign the order form and the attending physician sign as soon as possible.
5. The Levels of Treatment Order form should be reviewed as appropriate. A new order form must be completed at least

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once a week when all medical orders are reviewed. If the patient's condition is unstable or the patient is in an intensive care unit, the orders should be reviewed more frequently.

6. An order to discontinue a specific treatment, such as "D/C hyperalimentation" that is not a part of a decision to limit life-sustaining treatment or part of a "Do Not Resuscitate" decision can be written in the usual fashion on the standard Physician's Order Record.
7. In order to change or discontinue the orders written on the Levels of Treatment Order form, the physician must sign the bottom of the order form, below the DISCONTINUE order. If the order is being renewed or changed in any way, a new order form must be completed.

B. RN Responsibility

1. The nurse acknowledges the order by co-signing the Levels of Treatment Order form.
2. Insure that Levels of Treatment Order form is placed as the first sheet in the Physician Order Record section of the patient chart. This page should be the first sheet at all times.
3. The carbon copy of the Levels of Treatment Order form should be placed as the first sheet in the patient's MTR. It should always be the first sheet.
4. If the order is rescinded or changed, draw a solid red line diagonally from top to bottom of the original and copy of the order form; sign name next to line. Remove the copy of the order form from the MTR and file with the patient's chart in the section with expired MTR forms. Place the discontinued original order form in the Physician's Order Record section of the chart in chronological order according to the date on which the order was written.

C. Critical Care Advisory Committee

The Limiting Life-Sustaining Treatment policy will be reviewed annually by the Critical Advisory Committee (see 16.218a for a description of the Critical Care Advisory Committee).

Medical Council Approval

Archieles Pankoski

Date

1/88

UNIVERSITY HOSPITALS OF CLEVELAND PHYSICIANS ORDER RECORD

Policy # 16.218

Page # 5

DRUG ALLERGIES _____ NONE

Drug Dispensed by generic composition unless this brand only is specified

DATE TIME ALL ORDERS MUST INCLUDE DATE, TIME AND PHYSICIAN'S SIGNATURE
LEVELS OF TREATMENT ORDERS (Check to indicate order)

<input type="checkbox"/>	1. <input type="checkbox"/> Do Not Resuscitate
--------------------------	--

in the event of a cardiac, pulmonary, or cardiopulmonary arrest, no resuscitative measures will be initiated, including mechanical ventilation, endotracheal intubation, chest compression or the administration of emergency medication or fluids. **Defibrillation is allowed.** Short of an arrest patients in this category are candidates for all active treatment measures. Maintaining the dignity and comfort of the patient will continue to receive the highest priority.

<input type="checkbox"/>	2. <input type="checkbox"/> Do Not Resuscitate
--------------------------	--

In addition to the above Do Not Resuscitate order, which only applies in the event of an arrest, treatment of other potentially life-threatening conditions will be limited in the following ways:

- No defibrillation
- No cardioversion
- No vasopressor/inotropic agents
- No increase in vasopressors
- No intubation
- No mechanical ventilation
- No antiarrhythmics
- No hyperalimentation
- No transfer to ICU
- No dialysis
- No blood/blood products
- No electrolyte or acid/base corrective measures
- Other _____

<input type="checkbox"/>	<input type="checkbox"/> In addition to the Do Not Resuscitate order above, discontinue the following measures:
--------------------------	---

Physician Signature: _____ Printed Name: _____

<input type="checkbox"/>	<input type="checkbox"/> DISCONTINUE ABOVE ORDERS IMMEDIATELY (see next order sheet for specific orders)
--------------------------	---

Physician Signature _____ Printed Name _____

5-1008-0 (5/12/87)

DISTRIBUTION: WHITE-Medical Records

CANARY-Pharmacy

NOTE: YELLOW COPY MUST SHOW THROUGH HOLE BEFORE WRITING ORDER

PHYSICIAN'S ORDER RECORD

PHYSICIAN'S ORDER RECORD

MEDICAL MANAGEMENT DECISIONS IN NURSING HOME PATIENTS PRINCIPLES AND POLICY RECOMMENDATIONS

A Model Developed by the King County Medical Society

Principle	Practice
Patients have "autonomy," the right to choose health care options, including those at the end of life.	Physicians have the responsibility to elicit patient preferences about treatment decisions, including life-sustaining treatment.
Patients should be provided with adequate information to make informed choices regarding health care options.	Comprehensible information pertaining to rationale, benefits, risks, and alternatives should be provided to allow patient to make informed choices.
Unpleasant information should not be withheld from patients simply because it is unpleasant.	The provision of information, even if unpleasant, allows the patient to make informed choices. Information regarding poor prognosis may also allow the patient to attend to personal matters at the end of life. Such information can be communicated in a humane and compassionate manner.
Although the patient's desires are primary, the physician is not required to follow them if they violate professional ethics or judgment, or if they violate the physician's moral or religious beliefs.	As examples, assisting patients with suicide or treating them with unapproved drugs violates the physician's ethic. Some treatments in terminally ill patients maybe medically futile. Limitation of life-sustaining treatment, such as cardiopulmonary resuscitation, may violate the physician's moral or religious beliefs.
When patients and physicians irrevocably disagree on treatment options, patients may obtain another physician and physicians may withdraw from the patient's care.	Either the patient or the physician may terminate the patient-physician relationship. The physician is responsible for the patient's care until another physician has assumed the patient's care,
The preeminence of the patient's choice does not preclude physicians from sharing with the patient a personal judgment about treatment options.	The physician may share his judgment with the patient, but alternatives should also be made apparent. Statements such as "You have no choice" and "You must . . ." are inappropriate.
Advance care directives in the form of "instruction" (living wills) or "proxy" (durable power of attorney) carry moral authority and are helpful guides to caregivers should patients become unable to communicate their treatment preferences.	Physicians and other caregivers should make advance directives available to nursing home patients early in their institutionalization when they are maximally competent to make choices. Advance directives are legal, under specific circumstances, in most states. Although living wills refer only to "terminal" conditions they may be legally enforceable for other conditions.
Patients lacking full decisionmaking capacity should be consulted to the degree feasible.	Although a patient's memory may be impaired, he or she may understand the ramifications of certain decisions. In these situations, patients' preferences deserve preeminence.
When the patient is not capable of choosing a course of action and does not have an advance directive, the physician should seek to discover the patient's preferences.	Often patients have previously declared to family, friends or caregivers how they would choose to care for themselves at the end of their lives. If the patient is no longer competent, his or her previous desires should be respected if they can be discovered.
When a patient's desires cannot be discovered, a substituted judgment or determination of best interest should be made.	Some patients who are incapable of decisionmaking have never been capable (such as the congenitally mentally retarded) or were capable at one time but never made their wishes known. For these persons family (especially spouses) or, if available, existing legal guardians are preferred surrogates. They should provide substi-

Principle	Practice
<p>In the absence of these preferred decision-making surrogates, a surrogate must, nevertheless, be sought to represent the patient.</p>	<p>tuted judgment, that is, seek to choose as the patient would have chosen. If the surrogate is uncertain as to what the patient's preference would have been, they should act according to their interpretation of what would have been in the patient's best interest.</p>
<p>When decisions to limit treatment are based on substituted judgments or determinations of best interest, consensus among involved parties is preferable.</p>	<p>Several options for alternative surrogate decisionmaking exist. These options include but are not limited to legal guardians, ethics committees, and physicians. Although physicians may have a long-standing relationship with the patient, they may also be heavily invested in the patient's medical outcome. From this perspective, guardians and ethics committees may provide a more balanced perspective for the patient and are preferable surrogates. The physician, however, may function as surrogate if designated by the patient.</p>
<p>When in doubt about the appropriate course of action, the physician should presume in favor of life.</p>	<p>Irrevocable differences may be resolved by third parties, such as institutional ethics committees or the courts.</p> <p>If patients' desires are not known or their prognosis is unclear, the physician should act to support life.</p>
<p>The physician's desire to sustain the patient's life can conflict with two venerable values in medicine, the relief of suffering and the avoidance of harm.</p>	<p>When further intervention has only the prospect of prolonging the dying process, it may be preferable to limit life-sustaining treatment if this enhances patient comfort.</p>
<p>For patients who are in a chronic vegetative state, it is morally justifiable to limit life-sustaining treatment, allowing the patient to die.</p>	<p>Nutrition and hydration provided by vein or gastric tube and treatment for life-threatening intercurrent illness may be withheld from such patients.</p>
<p>No-code status never means withdrawing personal attention from the patient or limiting attention to the relief of suffering.</p>	<p>Continuation of care and support must be explicitly expressed to the patient and other caregivers and documented in the medical record. Orders may direct action for the relief of pain, thirst, dyspnea, anxiety, and other discomforts and may take priority over correcting physiologic conditions in the dying patient. In addition, vigorous treatment of potentially reversible superimposed conditions may be appropriate.</p>
<p>Resuscitation status of nursing home patients should be determined prospectively, defined in terms of specific interventions, and communicated to caregivers.</p>	<p>patients' resuscitation preferences can usually be determined on admission and made readily identifiable in the medical record. Decisionmaking at the time of cardiac arrest is a suboptimal standard of care.</p>
<p>As the patient's advocate it is inappropriate for the physician to deny treatment on the basis of cost or social allocation priorities.</p>	<p>Withholding costly or scarce medical resources should be based on explicit normative standards such as laws, regulations, or institutional policies and not on physicians' personal values.</p>