EvergreenHealth Monroe

Title: **Withholding/Withdrawing Life Sustaining Treatment and Do Not Resuscitate (DNR)**

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PURPOSE

To provide guidance to the multidisciplinary team when a patient desires limitation of life-sustaining treatment, including resuscitation, or when such limitation is deemed appropriate by the health care professional.

PRINCIPLES:

1. Presumption in favor of Treatment:

Efforts will be made to resuscitate patients who suffer cardiac or respiratory arrest except when circumstances indicate that administration of CPR would be futile or not in accord with the desires or best interests of the patient, or not in accord with a valid health care directive as directed by a physician's order.

2. Right to Refuse Treatment:

As a general rule, all patients may decline any treatment or procedure.

3. Decisions to Forego are Particular to Specific Treatment or Classifications of Treatment.

4. Preservation of Patient Dignity:

The dignity of the individual shall be preserved and measures to promote comfort shall be maintained, including nursing care, hygienic care, comfort and analgesics.

5. Surrogates and Patients:

If a patient is incapable of rendering a decision regarding medical treatment, decision may be made by an appropriate surrogate decision maker, based on the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient's best interests, and in accord with applicable law.

6. Physician/Patient Discussion:

When reasonable and practicable, physicians should discuss with appropriate patients the possibility of cardiopulmonary arrest. Patients who are at risk of cardiac or respiratory failure should be encouraged to express, in advance, their preferences regarding the use of resuscitation. These discussions should include a description of the procedures encompassed by resuscitation. When practical, an outpatient setting is preferable as in such setting the patient is more likely to be mentally alert.

Early discussions that occur on a non-emergent basis help to ensure the patient's active participation in the decision-making process. In addition, subsequent discussions are desirable, on a periodic basis, to allow for changes in patient's circumstances or in available treatment alternatives that may alter the patient's preference.

7. Physician/Health Care Rights:

It is the ethical and legal right of individual healthcare providers to decline to participate in the limitation or withdrawal of therapy. However, the provider shall continue to care for the patient until another provider has been secured. The physician has an ethical obligation to honor the resuscitation preferences expressed by the patient or the patient's surrogate. Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient's or surrogate's preferences regarding the use of resuscitation. The physician also should be prepared to discuss appropriate alternatives, such as obtaining a second opinion or arranging for transfer of care to another physician.

8. Futility:

Resuscitative efforts should be considered futile if they cannot be reasonably expected either to restore cardiac or respiratory function to the patient or to achieve the expressed goals of the informed patient. This determination is made by the physician.

9. Judicial Review:

Families and health care professionals should work together to make decisions for patients who lack decision-making capacity. Recourse to courts should be reserved for the occasions when adjudication is clearly required by state law, when concerned parties have disagreements that they cannot resolve over matters of substantial import, or where the hospital deems such review in its best interest.

POLICY AREAS

1. Patient Conditions to Consider DNR

a. A patient diagnosed in writing to have a terminal condition by the patient's attending physician who has personally examined the patient.

b. A patient diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two
appropriate physicians, one of whom is the patient's attending physician, both of whom have personally examined the patient.

c. Conditions in which resuscitation would only prolong suffering or when treatment would impose an unreasonable burden without offering the hope of a proportionate benefit. Burden versus benefit considerations may include pain, level of intellectual activity, happiness, personal relations, financial concerns and any expressions of the patient's intent.

2. Informed Consent:

The patient's attending physician shall be responsible for determining the patient's diagnosis and prognosis and providing the patient or the patient's proxy decision maker with the information to enable him/her to evaluate a proposed course of treatment and assess its benefits and burdens and make a reasonable decision based on the information given.

Information includes:

- Possible alternative forms of treatment and character of proposed treatment.
- Anticipated results of the proposed treatment.

- Recognized risks of treatment.

Recognized serious risks, possible complications and anticipated benefits involved in the proposed treatment or in non-treatment and in the recognized possible alternative forms of treatment.

The physician will give the patient or patient's proxy decision maker a reasonable period of time to decide on the course of treatment.

The physician will keep them informed and request appropriate support from nursing service and social service.

Understanding of options by the patient or proxy decision maker will often increase over time. Decision making should be treated as a process, rather than an event.

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.

A patient (or surrogate) may not compel a physician to provide any treatment which in the judgment of that physician is unlikely to provide the patient with significant benefit.

If the patient (or surrogate) is willing 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.

Patients should be encouraged to discuss foregoing life-sustaining treatment with family members and close friends. However, a patient's privacy and confidentiality may dictate that his or her wish not to enter into such a decision or not to divulge to the family members the patient's decision to forego treatment should be respected.

3. **Determination of Competency:**

Patients should be considered to possess the capacity to make health care decisions, unless there is clear and substantial evidence of incapacity.

A patient's authority to make his or her decisions should be overridden only after a clear and substantial demonstration of lack of capacity.

Inquiry into a patient's capacity may be initiated by conditions, including but not limited to the following: delirium, dementia, depression, mental impairment or developmental delay~~retardation~~, psychosis, intoxication, stupor or coma.

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.

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.

Competency will be determined by the physician.

Generally:

The decisionally capable patient:

1. An adult (18 years of age or older);
2. Conscious;
3. Able to understand the nature and severity of his/her illness;
4. Able to understand the risks and alternatives;
5. Able to make informed and deliberate choices about the treatment of the illness;
6. Has not been declared legally incompetent.

The decisionally impaired patient:

1. A minor (17 years of age or younger) (see consent policy for minors);
(a) When decisions are made involving minors; their views will be elicited whenever possible;
2. Unconscious;
3. Unable to understand the nature and the consequences of his or her illness;
4. Unable to understand the risks and alternatives;
5. Unable to make informed and deliberate choices about the treatment of the illness;
6. Has been declared legally incompetent.

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, health care decisions may 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" (health care directive) or any other form of advance directive to a health care provider, this document should be treated as the patient's wishes, unless clear and convincing evidence demonstrates that the directive was not properly executed or is no longer the patient's intent.

Formal Assessment of Capacity:

The formal assessment of capacity is a process that ordinarily should 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. Determination of Proxy Decision Maker:

In the case of a patient who, after proper assessment, is determined to lack decision-making capacity, a surrogate may be chosen to make decisions on behalf of the patient. The attending physician in collaboration with the RSC and the Care Transition Team (Social Workers and Utilization Reviewers) will determine the proper proxy decision maker.

a. Consent may be obtained from a person authorized to consent on behalf of such patient. Persons authorized to provide informed consent shall be a member of one of the following order of priority as per RCW 7.70.65:

1) The appointed guardian or guardian ad litem of the patient, if any.
2) The individual, if any, to whom the patient has given a durable medical power of attorney that encompasses the authority to make such health care decisions.
3) The patient's spouse/domestic partner.
4) Adult children of the patient.
5) Parents of the patient.

6) Adult brothers and sisters of the patient.

b. When no proxy decision maker can be identified:

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.

Where the patient, prior to losing decision-making capacity, has designated a surrogate either formally or informally, the patient's choice must be respected.

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 may serve as the patient's surrogate.

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 may be sought.

5. Advance Directives:

Refer to policy, Advance Directives.

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

b. A competent patient's wishes may override a previous advance directive.

c. Weight to be Given Advance Directive: A written advance directive signed by the patient shall be presumed valid. In cases in which an advance directive is not honored, 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 clear and convincing evidence of invalidity. 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.

6. Artificial Fluids and Nutrition:

Intravenous fluids and/or feeding by tube or other artificial means may be considered life-sustaining and therefore may be withheld or withdrawn. If there are no directives regarding artificially provided fluids and nutrition in a properly executed advance directive, these may be provided.

7. Organ Donation:

Refer to policy, Organ and Tissue Donation.

The attending physician will assist nursing service and/or social service in providing information to the patient or patient's proxy and seeking out the patient's wishes with regard to tissue and organ donation.

8. Resolution of Conflict:

In the event it is determined an order to DNR may be appropriate, but a family member or significant other disagrees, the immediate supervisor shall be notified, he/she will advise the Risk Manager. An attempt at a family conference will be made to seek resolution. An order will not be delayed in the case where the patient has a valid advance directive that applies or an oral substitute is documented. An Ethics Committee consultation may be considered.

An ethics consult order can be placed in the electronic health record by clinical staff throughout the EvergreenHealth System. A physician co-sign is not required. Any member of the EvergreenHealth community can access the Healthcare Ethics Consultation service by calling 425-899-2320 where pertinent information can be relayed to the Ethicist or CECT for appropriate management.

9. Special Notice:

Although the following circumstances should not delay implementation of orders with informed patients, immediate notice should be made to the risk manager when a DNR order is written for a patient where circumstances such as but not limited to the following exist:

The patient's condition has resulted from injury which appears to have been inflicted by a criminal act.

The patient's injury or condition has been created or aggravated by a medical accident.

The patient is pregnant.

The patient is a parent with custody or responsibility for the care and support of minor children.

10. Documentation:

a. Orders : The physician will enter a DNR order via CPOE, or on special order form 1760x or a Physician order form during downtime. The order is flagged with a bright code sticker for quick reference. Telephone orders will be honored if two registered nurses witness the order and the physician signs the order within twenty-four hours. **Verbal orders are not accepted.**

- The DNR designation is automatically rescinded upon surgery or anesthesia, unless there is a timely, specific, and documented agreement to the contrary between the patient/proxy and the surgeon. After surgery, a DNR order may again be initiated in accordance with this protocol.

b. Progress notes/history and physical should generally include:

- Diagnosis
- Prognosis
- A description of the patient's decision making ability at the time the decision was made and the efforts to ascertain the patient's capacity.
- Patient's wishes (when known) or proxy decision maker (if patient is decisionally impaired), including a determination that an advance directive if presented, is valid.
- Reference to any consultation with another physician.
- Reference to discussions concerning the DNR order with the patient or other persons.

c. Nursing notes:

The physician order is to be acknowledged by nursing in the patient's chart in the EMR per the chart review policy, and the status of DNR communicated in each nursing shift report.

Changes in the patient's condition will be reported in a timely manner to the attending physician. Changes in the patient's condition and reporting to physician will be documented in nurse's notes.

(Changes in patient status may necessitate a review of DNR orders.)

d. Social Services:

The multi-disciplinary sheet may have documentation by the social service worker including but not limited to:

- A collaborative discussion with the attending physician.
- Identification of the proxy decision maker.
- Family conference participants and results of any family conferences.
- And other appropriate documentation.

e. Changing the Order:

The attending physician should inform the patient/proxy decision maker that the patient/proxy may change the resuscitation status at any time.

A DNR order in a patient's chart will remain in effect until the patient is discharged from the hospital. However, the attending physician will promptly rescind a DNR order in writing if the requesting party withdraws the request for any reason. If there is a clinical improvement that affects the patient's resuscitation status, the physician will rescind the DNR order pending discussion with the patient or patient's representative, as appropriate.