

Policy: End of Life

It is the policy of Regional Hospital that all services rendered in our facilities shall be supportive of life. Regional Hospital's goal is to help patients make informed decisions about end of life care without the Hospital actively participating in the provisions associated with the Death with Dignity Act. It is the policy of Regional Hospital to provide tools and support to a patient and their family that improves their quality of life when facing the problems associated with life threatening illness. At no time may direct actions to terminate life be performed or permitted. Extraordinary means to sustain life need not be utilized when death appears to be imminent and inevitable.

REGIONAL HOSPITAL For Respiratory and Complex Care

<small>o-oucyNin14ll</small> Physicians Orders for Life-Sustaining Treatment (POLST) or Orders for Cardio-pulmonary Resuscitation	Policy Number: AD0108 Page: 1 of 5
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<small>t r"fnctv))<ou>e t anaaito r t trinctwrhou*us uatodt r.t p. c-j</small> Appendix 1: Physician Orders for Life-Sustaining Treatment (POLST) Appendix II: Orders for Cardio-Pulmonary Resuscitation	<small>..pProno (Qu-n</small> Dept Manager: M. Hays 10.21.2013 CNO: C. Sifri 10.21.2013 CMO CEO Medical Executive Committee 10.23.2013

Purpose:

Staff needs clear directions on code status and patient/surrogate decision-maker preferences for treatment for all patients admitted to Regional Hospital. The POLST form (Appendix I) is a "portable" physician order form which provides this information. The form guides the care provider to have clear and direct communication with the patient and/or their legal surrogate decision-maker regarding the wishes of the patient. It does not replace an Advance Directive, but does translate an Advance Directive into a physician order.

Policy:

All patients or legal surrogate decision-makers will be asked to complete a POLST form by the admitting provider; however completion of the form is not mandatory. If a patient/surrogate declines to complete the form, the provider will note this refusal in the record and complete the "Orders for Cardio-Pulmonary Resuscitation" form (Appendix II) instead. The "Orders for Cardio-Pulmonary Resuscitation" form will ONLY be used if the patient/surrogate refuses to complete a POLST form.

Because patient/surrogate treatment options can change during the course of care, a new POLST form will be completed at each change in status for life-sustaining treatment choices, and will supercede the previous form.

Upon transfer to any other setting, the most current POLST form will be copied (the copy stays in the Regional Hospital record) and the current original POLST form will be sent to the subsequent facility or home with the patient.

Definitions:

POLST: Physician Orders for Life-Sustaining Treatment

Procedure :

Patient Admitted to Regional with an existing completed POLST form :

- Upon admission to Regional Hospital, the RN will review and confirm the POLST form content with the patient/legal surrogate decision-maker. This information will be conveyed to the admitting physician or nurse practitioner who will initial the POLST form for this hospital admission. If the existing POLST form is incomplete, the RN will request that the provider complete a new form with the patient/surrogate .
- Staff will honor the directions on the POLST form while the nurse confirms the orders; unless the patient/surrogate indicates they do not want the POLST directions followed. If the patient/surrogate does state that they do not want the POLST directions followed, the RN will inform the admitting provider and request that the provider complete a new form with the patient/surrogate.
- The Unit Secretary (US) will photocopy the POLST form, place a patient sticker on the copy, and place the copy in the Physician Orders section of the Chart. The US will place the original POLST order form in the front of the grey chart in a plastic sleeve marked "legal documents" and maintain it there (do not thin) until the patient is discharged or transferred. The US will indicate on the Personal Inventory Record that the patient has a POLST form and that the original needs to be sent with the patient at the time of discharge/transfer from Regional Hospital.

Completing a POLST form while a Patient at Regional Hospital:

- Upon admission to Regional Hospital, the admitting provider will approach the patient/legal surrogate decision-maker to discuss the contents of the POLST if the patient:
 - Does not have a POLST in place,
 - Has an incomplete or incorrectly completed POLST form, or
 - Does not want an existing POLST followed.
- The provider will review each section of the POLST, discuss the meanings of issues not understood, and record the selections of the patient. Once completed, the provider and the patient or the legal surrogate decision-maker will sign the completed form in the appropriate spaces .
- The Unit Secretary (US) will photocopy the POLST form, place a patient sticker on the copy, and place the copy in the Social Work section of the Chart. The US will place the original POLST form in the front of the grey chart in a plastic sleeve marked "legal documents" and maintain it there (do not thin) until the patient is discharged or transferred. The US will indicate on the Personal Inventory Record that the patient has a POLST form and that the original needs to be sent with the patient at the time of discharge/transfer from Regional Hospital.

Review and Changes to the POLST Form:

- The patient/surrogate may review the POLST form at any time during hospitalization . The provider will review the areas requiring clarification or provide additional information to aide in understanding and ultimate decision making.
- When making changes to an existing POLST form, the provider and patient/surrogate will void the old form and complete a new POLST form, following the directions above .
- All copies of the now voided POLST form will be moved to the Physician Orders section of the grey chart, and the newly completed and signed POLST will be placed in the above described chart locations.
- The provider will make a note in the physician progress notes stating that the POLST has been reviewed and changed accordingly .

Discharging a patient with a POLST form

- If during discharge planning, the patient's condition has changed, the provider may wish to review the POLST to see if it needs revision or if the patient's condition warrants review/revision prior to discharging to home or transferring to another care facility/provider .
- Upon discharge/transfer review the Personal Inventory Record and note that the POLST form was sent with the patient at that time. Also, record that the POLST form was sent with the patient in the Nursing Notes and on the Discharge Checklist .

Attachments/Appendices

Attachment I – POLST form content (2 pages)

Attachment II – Orders for Cardio-Pulmonary Resuscitation

REGIONAL HOSPITAL
For Respiratory and Complex Care

Palliative Care Consultations and Care		Policy Number: AD3012
		Page: 1 of 2
Patient Care Services	Date used 2000.12	1 Lost O... 2013 .10.21
Policy NS0381 Care of Deceased Patient Policy NS0613 Organ Donation	Dept Manager: M. Hays CNS: C. Sifri Medical Executive Committee	

purpose:

The goal of a Palliative Care consultation is to provide consultations to providers, staff, patients and families to:

- Clarify goals of treatment;
- Clarify resuscitation preferences; and
- Discuss and educate regarding treatment options.

The Palliative Care Consultants, along with Regional Hospital providers and staff will provide support addressing the emotional, spiritual and/or relational distress of patients and families when the patient's disease process is not responding to curative treatment .

The goal of Palliative Care is the achievement of the best quality of life for patients and their families.

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It is the policy of Regional Hospital to provide tools and support to a patient and their family that improves their quality of life when facing the problems associated with life threatening illness, through prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems physical, psychosocial and spiritual.

Procedure:

Referral process:

1. When a patient is identified as nearing the end of their disease process and their disease is not responding well to curative treatment, the providers may write an order requesting a Palliative Care Consultation and obtain the authorization to release information to the consultants.
 - a. Any staff member may discuss this topic with providers. The provider will decide whether to write the order and obtain releases, or not, based on their clinical judgment.
 - b. If a patient or a legal surrogate decision-maker for a patient requests a Palliative Care Consultation, the provider will write the order and obtain the release as requested by the patient or legal surrogate.
2. The Unit secretary will fax the order and the release of information, along with the required supportive documentation, to the consultant .

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3. The consultant will register the patient in the UW system and schedule time to come meet with the patient and family.

Consultation process:

1. The consultant will consult with providers, staff, patients and families as needed to make the most effective recommendation for treatment.
2. Completed notes from the consultation will be provided to the Unit Secretary and placed in the chart.

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Providers and staff will provide quality coordinated palliative care as outlined below:

1. Pain/Symptom Management
 - a. Providers will write orders for the appropriate treatment for primary and secondary symptoms as desired by the patient or surrogate decision-maker. Changes in a patient's wishes or changes in a patient's medical status may lead to reevaluation and to an appropriate change in treatment status. These changes will be discussed with the patient and surrogate decision-maker, and documented in the medical record. Orders will communicate the changes.
 - b. Nursing will provide optimal and safe management of pain and symptoms for the patient, through the appropriate use of analgesic and adjuvant medications.
 - c. Nursing will individualize therapy to meet the patient's pain and symptom management needs. Nursing will closely monitor the patient's medications.
2. Physician and staff (nursing/social work/chaplain) will assess the spiritual needs of the patient and family. They will determine if a chaplain is needed or if the family has their own priest or minister or spiritual advisor. Chaplain will help locate appropriate resources.
3. Physician and staff will help the family with understanding the dying process and the physical changes in the patient.
4. Nursing will attempt to involve the family in the care of the patient whenever possible. They will give instructions to the family about the care.
5. Staff will identify psychological, emotional or cultural issues that arise. They will help the patient and family find the appropriate resources, including the written material and internet sites that contain pertinent information. Staff will also contact hospital resources for the family--for example Social Worker, Chaplain, Patient Representative, etc.
6. Staff will be sensitive to the appropriate time to ask the family about funeral arrangements, autopsy and organ donation.

In conjunction with the patient's rights to palliative care, The Washington State Natural Death Act also provides rights to providers and/or hospital employees, namely that any provider or hospital employee may elect to refuse to participate in withdrawing or withholding care. In such cases, the provider or hospital staff member must take appropriate steps to transfer care to another staff member before removing themselves from caring for the patient. Employees are not to be discriminated against in employment or professional privileges if they decline to participate in the withholding or withdrawal of life-sustaining treatment.

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Withholding or Withdrawing Life-Sustaining Treatment in Adults		Policy Number: MS0012
Administration- Medical Staff		Page: 1 of 4
2013.10		2013.10
Manager: C.Sifri;M. Hays		CMO
CEO		Medical Executive Committee

PURPOSE:

There are several possible goals to the provision of health care to patients. These goals may include maintenance of well being, the cure of a disease, restoration of function, alleviation of pain and suffering, and the sustaining of life, but also include withholding or withdrawing life-sustaining medical treatment. The purpose of this policy is to guide health care personnel in situations where withholding or withdrawing such treatment is contemplated or requested.

POLICY:

Life-sustaining medical treatment does not need to be initiated or continued for patients in the following situations:

Competent patients who elect to refuse any recommended medical care.

Incompetent patients who were previously competent, and have expressed their desire to have such treatment withheld or withdrawn in the circumstances of their current condition via a previously completed Advance Directive.

For patients who are now incompetent, a qualified surrogate who now represents the interests of the incompetent patient may request the withdrawal or withholding of such care. In this situation, the surrogate must first determine in good faith that the patient, if competent, would consent to such withdrawal or withholding of care. If such a determination cannot be made, the surrogate must instead determine that such a decision regarding treatment is in the patient's best interest.

Patients who meet the criteria for declaration of death by brain or cardiopulmonary criteria.

A decision to forego life-sustaining care shall not impact the patient's right to receive or the hospital's obligation to provide other types of medical care including care designed to relieve pain or discomfort. These latter types of care remain appropriate and are encouraged for all patients.

Authorization for withholding or withdrawing life-sustaining care will be by patient or legal surrogate decision-maker only. According to the Revised Code of Washington (RCW 7.70.065): Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent, shall be a member of one of the following classes of persons in the following order of priority:

The legally-appointed guardian of the patient, if any;

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The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;

The patient's spouse or state registered domestic partner;

All children of the patient who are at least eighteen years of age;

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Parents of the patient; or
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All adult brothers and sisters of the patient.

No person under this section may provide informed consent to health care if a person of higher priority under this section has refused to give such authorization; or if there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

The WSNDA authorizes any adult to execute a written advance directive directing the withholding or withdrawal of life-sustaining treatment if they were to be in a terminal condition or permanent unconscious condition.

There are no significant ethical differences between decisions to withhold life-sustaining medical care and decisions to withdraw life-sustaining medical care. However it is important to realize that the emotional aspects of a decision to withdraw previously provided life-sustaining treatment may be more difficult for patients, family or staff. In every case in which life-sustaining care is limited, it remains especially important to properly evaluate and treat pain and suffering and to be sensitive to emotional issues on the part of the patient, patient's family and friends, and the hospital care-givers and other staff.

When a health care directive specifically directs that life-sustaining treatment be withheld or withdrawn, the WSNDA also specifically states that health care personnel should still proceed with "the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain." A decision to withhold or withdraw one treatment is specific to that treatment and does not automatically apply to any other treatment.

Disagreements among patients, surrogate decision-makers, and/or health care providers may occur. In these cases it should be remembered that the primary obligation of the hospital is to base decisions on the best interest of the patient. Disagreements may be addressed by a variety of mechanisms such as convening a patient care conference, obtaining additional medical opinions, performing a time-limited trial of intervention, consulting with the hospital ethics consultation service or resources, contacting the hospital's legal office, or by other actions as appropriate.

The WSNDA provides that any physician or hospital employee may elect to refuse to participate in withdrawing or withholding care. In such a case the physician or employee must take appropriate steps to transfer care to another person prior to withdrawing from the patient's care. Employees are not to be discriminated against in employment or professional privileges if they decline to participate in the withholding or withdrawal of life-sustaining treatment.

Situations will arise which are more complicated than those addressed by this policy or by the WSNDA (for example when a patient's competency is in question or when qualified surrogates representing a patient disagree among themselves as to what is in the best interest of the patient they represent). In such complex circumstances the hospital medical director, ethics consultation or advisory systems, Assistant Attorney General's office, or other relevant sources should provide assistance to the health care personnel as requested and appropriate. If the matter remains unresolved, a petition for guardianship may be filed requesting the court to appoint a guardian.

REGIONAL HOSPITAL
DEFINITIONS:
For Respiratory and Complex Care

The Washington State Natural Death Act (WSNDA) refers to substitute house bill 1481 as signed into law on March 31, 1992.

Life-sustaining treatment is defined in the WSNDA as "any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which, when applied to an individual patient, would only serve to prolong the process of dying." Examples include but are not limited to: continuing nutrition and hydration, mechanical ventilation, dialysis, antibiotic therapy, and vasoactive agents or blood products.

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

A permanent unconscious condition is defined by the WSNDA as "an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state."

Adult means a person who has attained the age of majority (usually age 18 years or older).

Withdrawal means stopping a treatment already begun.

Withholding means not initiating a treatment.

Competency refers to the capacity of persons to make medical care decisions for themselves, that is the

ability to understand the nature of the issues and to appreciate the consequences of the choice they are making. Patients have a right to disagree with and to decline the recommendations of medical personnel. Patients' competence is thus not judged by the content of their decisions but instead by the process by which they make decisions. Accordingly the competency of patients to make health care decisions can be judged by a variety of means including whether they can make other types of

decisions, whether they communicate their decisions consistently, whether they can deliberate about decisions, whether they can understand the implications of the medical information presented to them, and whether they can reflect on information according to their individual values and preferences.

Death is defined by the Uniform Determination of Death Act as follows: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain *stem*, is dead."

PROCEDURE:

1. The hospital should document the presence of any advance directives at or before the time of the patient's admission according to hospital procedure.
2. In a situation where withholding or withdrawal of life-sustaining treatment is contemplated, the attending nurse practitioner or physician shall make a reasonable effort to determine that any advance directive complies with the WSNDA. In cases where the patient's Health Care Directive appears to substantially differ from the form provided in the WSNDA, the Assistant Attorney General's office is available to review advance directives.

Note: The WSNDA requires that in following an advance directive, the diagnosis of a "terminal condition" need be made only by the attending nurse practitioner or physician but that a diagnosis of a "permanent unconscious *state*" needs to be documented in writing by two licensed physicians.

3. In a case where a decision to withdraw or withhold life-sustaining treatment is *made*, the attending nurse practitioner or physician shall document in the progress notes of the medical record:

- A. . The medical condition and prognosis of the patient,
 - B. The presence of a terminal condition or of a permanent unconscious condition,
 - C. the expressed desires of a competent patient regarding treatment ,
 - D. The identification of the surrogate and desires of the surrogate (in the circumstances where a patient is incompetent),and
 - E. The process by which the decision was made, including witnesses present at the time the decision was made.
4. All orders to discontinue life-sustaining treatment must be communicated by the attending nurse practitioner or physician to the other caregivers and specifically written in the physician's orders after the

pertinent progress note is inserted in the chart.

5. In accordance with the WSNDA ,if a qualified competent patient wishes to die at home, the patient shall be discharged as soon as reasonably possible after an explanation to the patient of the risks of hospital discharge.

Note: In complex or difficult situations where additional expertise in matters of ethics would be useful, consultation with the hospital's ethics consultation or advisory service is strongly encouraged

Attachments/Appendices

None

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Physician Assisted Death		Policy Number: MS0018
		Page: 1of2
Medical Staff	2013.10	sec
The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals	Manager: C. Sifri; M. Hays	
Initiative 1000/Washington Death with Dignity Act Washington State Department of Health Regulations WAC Chapter 246-978	CMO CEO Medical Executive Committee Board of Directors	

PURPOSE

Washington State law recognizes certain rights and responsibilities of qualified patients and health care providers under the Death with Dignity Act (the Act). Under Washington law, no health care provider, including Regional Hospital is required to assist a qualified patient in ending that patient's life. The purpose of this policy is to clearly define the decisions made by Regional Hospital and its providers regarding the Death with Dignity Act.

POLICY

Regional Hospital providers and staff, in the performance of their duties at Regional Hospital, shall not assist in ending a patient's life under The Washington Death with Dignity Act (70.245 RCW). If a patient requests this end-of-life option, while admitted to Regional Hospital, the hospital will assist in transferring the patient to another facility of the patient's choice while assuring continuity of care.

Regional Hospital has chosen to not participate under the Death with Dignity Act. This means in the performance of their duties, Regional Hospital physicians, employees, independent contractors and volunteers shall not assist a patient in ending the patient's life under the Act. In addition, no provider may participate in ending a patient's life on the premises of the Regional Hospital.

No patient will be denied other medical care or treatment because of the patient's participation under the Act. The patient will be treated in the same manner as all other Regional Hospital patients. The appropriate standard of care will be followed.

Any patient wishing to receive life-ending medication, while a patient at this hospital, will be assisted in transfer to another facility of the patient's choice. The transfer will assure continuity of care. All providers at Regional Hospital are expected to respond to any patient's query about life-ending medication with openness and compassion. Regional Hospital believes our providers have an obligation to openly discuss the patient's concerns, unmet needs, feelings, and desires about the dying process. Providers should seek to learn the meaning behind the patient's questions and help the patient understand the range of available options, including but not limited to comfort care, hospice care, and pain control. Ultimately, Regional Hospital's goal is to help patients make informed decisions about end-of-life care.

PROCEDURE

As needed, patients will be provided with educational materials about end-of-life options. These materials will include a statement that Regional Hospital does not participate in the Act.

If, as a result of learning of Regional Hospital's decision not to participate in the Act, the patient wishes to have care transferred to another hospital of the patient's choice, Regional Hospital staff will assist in making

arrangements for the transfer. If the patient wishes to remain at Regional Hospital, staff will discuss what end-of-life care will be provided consistent with hospital policy.

If a patient requests a referral to a physician who will fully participate under the Act or expresses the desire to take medication that will result in the patient's death, the provider may choose to provide the patient with a referral, or may instruct the patient that he or she must find a participating provider on his or her own.

The relevant medical records will be transferred to the physician taking over the patient's care. The patient's primary clinical caregiver (nurse or social worker) will be responsible for:

- a. Informing the patient's attending physician as soon as possible, but no later than one working day later, that the patient wishes to take life-ending medications.
- b. Ensuring the medical record is complete and all required documentation is included. A copy of the Resuscitation Status (DNR-Do Not Resuscitate) *order*, copies of advance directives, and a POLST (Physician Orders for Life Sustaining Treatment) form are to be included.
- c. Communicating with other clinicians involved with the patient to ensure continuity of care.
- d. Documenting all communication in the patient's medical record.

Nothing in this policy prevents a physician or provider from making an initial determination that the patient has a terminal disease and informing the patient of his/her medical prognosis. Nothing in this policy prevents a physician or provider or other Regional Hospital staff from providing information about the "Washington State Death with Dignity Act" to a patient when the patient requests information. Nothing in this policy prohibits a physician who is employed by or who is a credentialed medical practitioner of Regional Hospital from participating under the Act when not functioning within the scope of his or her duties as an employee or credentialed medical practitioner of Regional Hospital. Nothing in this policy prohibits any Regional Hospital from participating under the Act when not functioning within the scope of his or her duties as an employee.

If a provider participates in the Act beyond what is allowed in this policy, that provider may be subject to corrective action under Regional Hospital's Medical Staff Bylaws. Regional Hospital shall follow due process procedures as provided for in the Medical Staff Bylaws to investigate any incident in possible violation of this policy and pursue corrective action based on the outcome of the investigation. Consequences for violation of this policy may include, but are not limited to, any of the following: loss of medical staff privileges; restriction from Regional's provider panel; restriction of privileges; termination of contracts with Regional Hospital; and report to WSMA Ethics department.

PUBLIC NOTICE

Regional Hospital will provide public notice of this policy in the following ways: posting the hospital's stance on the Death with Dignity Act on the hospital's web page; including information in hospital materials regarding advance directives; including information in patient's rights handbooks and advising physicians at the time of initial appointments and reappointments to the Regional Medical Staff.

RESOURCES

Any patient, employee, independent contractor, volunteer or physician may contact their Social Worker, the Ethics Committee, or the Chaplain for information.

ATTACHMENTS/APPENDIXES

None

Resolution of Conflicts Concerning Care Policy# AD0007 to consider other avenues of resolution. The Ethics Committee Consultation may be engaged as part of that process.

1. METHOD:

- A. . Clarifying the information through the use of CLINICAL ETHICS/JONSEN (1) approach :
(See Appendix I for the four-box tool)

MEDICAL INDICATIONS	PATIENT PREFERENCE
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 QUALITY OF LIFE

 CONTEXTUAL

- B. Identifying the unresolved issues and the ethical principles that would apply.
- C. Identifying the appropriate Medical Staff and/or Hospital policies that would apply.
- D. Making an advisory recommendation from the consultant physician to the attending physician.

2. MEMBERSHIP :

An Ethics Consultation Team will have at least one physician trained in Clinical Ethics who is NOT involved in the ongoing care of the patient; at minimum, input for the attending physician; a nurse, a social worker and the chaplain. The Chaplain will assure that the resource pool of Medical Staff and Regional staff trained in clinical ethics is maintained.

3. ACCESS:

- A. The request for a consultation may be made by:
 - 1. patient, family and/or significant other
 - 2. physician
 - 3. nursing or hospital staff
- B. The request for a consultation will be made to the Social Worker or the Hospital Chaplain. The chaplain or social worker will coordinate Committee Consultation.
- C. A decision regarding whether a consult will be conducted will be given as soon as possible. (Target: within 24-hours). A general note about the decision for consult will be put in the Progress note.
 - 1. If Yes, a consultation will be arranged and appropriate people notified (e.g. physician, family and patient).
 - 2. If No, not indicated and directed to the appropriate Medical Staff Committee or Hospital Administrative Person. (See decision making algorithm in Policy #AD 0007 Resolution of Conflicts Concerning Care).

4. REPORTING:

- A. When an ethics consultation is held, the recommendation and the rationale will be written on the Progress Notes and signed by two members of the team. The CLINICAL ETHICS/JONSEN worksheet will be included in the patient's record.
- B. The CLINICAL ETHICS/JONSEN worksheet will be reviewed by the Ethics Committee. A log of consultations will be maintained with the Ethics Committee's minutes. The chaplain will be responsible for maintaining those records.
- C. Issues identified for future education or policy development will be referred to Pastoral Care or the Ethics Team Chair. The Quality/Risk Manager will be informed of recommended process changes.

Attachments/Appendices

Appendix I-Jonsen's Four Box Model
Issue:

Ethical Principle(s):

Recommendation:

<p>Medical Indications <i>Principles of Beneficence and Non-maleficence</i></p> <ul style="list-style-type: none"> • What is the patient's medical problem? History? Diagnosis? Prognosis? • Is the problem acute? Chronic? Critical? Emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided? 	<p>Patient Preferences <i>Principle of Respect for Autonomy</i></p> <ul style="list-style-type: none"> • Is the patient mentally capable and legally competent? Is there evidence of incapacity? • If competent, what is the patient stating about preferences for treatment? • Has the patient been informed of benefits and risks, understood this information and given consent? • If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making? • Has the patient expressed prior preferences, e.g., Advance Directives? • Is the patient unwilling or unable to cooperate with medical treatment? If so, Why? • In sum, is the patient's right to choose being respected to the extent possible in ethics and law?
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Quality of Life

*Principles of Beneficence and Non-maleficence
And Respect for Autonomy*

- What are the prospects, with or without medical treatment, for a return to normal life?
- What physical, mental and social deficits is the patient likely to experience if treatment succeeds?
- Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
- Is the patient's present or future condition such that his or her continued life might be judged undesirable?
- Is there any plan and rationale to forgo treatment?
- Are there plans for comfort and palliative care?

Contextual features

Principles of Loyalty and Fairness

- Are there family issues that might influence treatment decisions?
- What are the provider (physicians and nurses) issues that might influence treatment decisions?
- Are there financial and economic factors?
- Are there religious, spiritual and/or cultural factors?
- Are there limits to confidentiality?
- Are there problems of allocation of resources?
- How does the law affect treatment decisions?
- Is clinical research or teaching involved?
- Is there any conflict of interest on the part of the providers or the institution?

