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Life Prolonging Treatment Adult Patients, 8610-L-0

POLICY:

It is the policy of Samaritan Hospital that decisions about using or forgoing life prolonging treatment for adult patients shall occur in accordance with the hospital's ethical principles, philosophy of health care, and standards of medical practice. Medical criteria of diagnosis and prognosis are necessary components in this decision-making. A choice to use or to refuse to use life prolonging medical treatment is ultimately based upon whether the results of the treatment help or hinder attainment of the *patient's goals* and purposes of living.

PURPOSE:

This policy has two primary purposes: 1) to provide for a process of decision-making that contributes to the quality of care for patient, family, and caregivers deciding the use of life prolonging medical treatment at Samaritan Hospital; and 2) to assist these persons in reaching choices about life prolonging medical treatment that are professionally sound, ethically justifiable, and legally defensible.

PRINCIPLES:

1. Biological existence need not be prolonged at all costs. A person's life should not be technologically extended beyond the point of human dignity. Health caregivers are not obliged to initiate or continue medical treatment that would be clearly futile.
2. A key goal of health care is to provide compassionate care to enhance comfort and dignity of the person whose physical condition is beyond cure.
3. A patient may morally refuse to undergo a treatment that either: a) offers no reasonable expectation of improving health, or b) entails serious burdens disproportionate to anticipated benefits of the treatment.
4. Each patient is the primary decision-maker for choices regarding his or her treatment. Each person has the moral right to information needed to make informed decisions about his or her life and health. In no case may family members or health care professionals override the

ethically appropriate decision of a patient who has decision-making capacity.

5. When a patient lacks decision-making capacity, the surrogate's duty is to choose the ethically appropriate alternative most in accord with the patient's expressed preferences, if known, or in accord with the patient's cherished values.
6. The primary responsibility of health care professionals in the process of reaching decisions about life prolonging treatment is to provide the patient or surrogate with sufficient medical information and adequate psychological-social-spiritual support to enable a free and informed choice.
7. There is no ethical or legal difference between withholding and withdrawing treatment. Considerations that justify not initiating treatment also justify withdrawing treatment. But the emotional intensity of decisions to withdraw life prolonging treatment requires special sensitivity, especially because these decisions are often reached at an uneven pace by patient, family, physicians, and other caregivers.

PROCEDURES

A. **Assisted Informed Consent**.

1. During admission of an adult as an inpatient, the admitting clerk or nurse shall attempt to document pertinent information about any advance directive of the patient (i.e. expressed preferences about treatment, name of agent of durable power of attorney for health care) and to provide the patient with written information about Washington law and hospital policy on using or forgoing treatment.
    a. A copy of any written advance directive, i.e. Directive to Physician ("living will") or durable power of attorney for health care, shall be placed into the medical record. (Administrative Policy and Procedure #8610-A-3.1, Advance Directives)
    b. No employee of the hospital or of a physician providing care may act as a legal witness to a Directive to Physician by a patient of the hospital. These persons may not serve as the agent of the durable power of attorney for health care unless related to the patient by blood, marriage, or adoption.
2. At the earliest appropriate time, the primary physician(*) shall initiate discussion about treating, withholding, continuing, or withdrawing life prolonging medical treatment with each patient. All those participating in the decision-making process shall communicate among themselves and with the primary physician any choices expressed as well as pertinent psychological-social-spiritual information.
(*)Primary physician is the physician with designated responsibilities for the overall management of the patient's medical care as indicated in the Medical Staff Rules and Regulations, General Conduct of Care.
3. In the event that agreement among patient, family, and caregivers about using or forgoing life prolonging treatment cannot be reached, the primary physician or nurse manager, acting with administrative support, must convene a conference for the purpose of reaching a decision. This conference shall include the patient and involved family as well as the primary physician, the nurse manager, involved nursing staff, and a representative from Administration; as appropriate, the primary physician

or nurse manager may also request other caregivers to participate. Prior to convening a conference that would involve family, the primary physician and nurse manager should concur that this is appropriate. If desires of family conflict with expressed preferences of the patient, they should be noted and discussed but should not override the patient's own choices. If caregivers cannot act in accord with the patient's preferences, it is appropriate to arrange transfer of care of the patient to a physician and other clinicians who can accept the patient's desires.

4. As soon as a medically and ethically appropriate decision has been reached, the order will be written in the applicable section of the patient's medical record. Orders to the effect that a patient will not receive advanced life support as routinely performed by the code blue team must be written as a no code order. Orders for anything less than a full code blue response must be detailed in writing on the order form. All orders to forgo life prolonging medical treatment will also be recorded in the progress notes by the primary physician and will include the explanation of the following: justification for the order; a statement of the circumstances of the patient's decision-making capacity or lack thereof; the extent of participation by the patient and/or surrogate(s) in the decision-making and choice. Nursing will identify the patient as "Do Not Resuscitate" by placing a purple armband on the patient when the order is written.
5. Only the patient's primary physician or his/her designee (i.e. attending physician covering or taking call) may give orders to forgo life prolonging medical treatment.
6. The physician may give the orders in writing or, if necessary, by telephone. Telephone orders are to be taken and recorded by a registered nurse or a resident physician, and must be countersigned by the physician within 24 hours.

B. **Determining Decision-Making Capacity**.

1. The primary physician or designee, after consultation with family or friends and other caregivers, shall ordinarily make the determination that a patient has or lacks the capacity to make some or all treatment choices independently. The patient is presumed to have decision-making capacity unless it is clearly shown to be lacking. This requires assessing:
    a. The patient's capacity to understand information relevant to the decision;
    b. The patient's capacity to communicate with health care professionals about it; and
    c. The patient's capacity to consider alternatives and make a choice.
2. When disagreement persists about the determination regarding the patient's decision-making capacity, the primary physician or nurse manager shall convene a conference that includes the primary physician and the person(s) disputing the determination in order to resolve the disagreement. When the disagreement is not resolved, it may be appropriate to seek court determination of the patient's decision-making capacity.
3. There shall be a continuing reassessment of the patient's capacity to participate in decision-making. Efforts should be made to reduce any factors contributing to lack of decision-making capacity.

C. **Acknowledging the Surrogate Decision-Maker**.
When a patient is determined to lack decision-making capacity, the primary physician or designee shall initiate the process of identifying the surrogate decision-maker. In conjunction with family or friends, the physician shall acknowledge a surrogate decision-maker for the patient. This is intended to unify participation of family or friends and to ensure a clear assignment of authority for decision-making.

1. This surrogate decision-maker should be a person concerned for the welfare of the patient with knowledge about the patient's previously expressed preferences regarding treatment. Washington state's informed consent statute stipulates, "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: a) the individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions; c) the patient's spouse; d) children of the patient who are at least eighteen years of age; e) parents of the patient; and f) adult brothers and sisters of the patient." If there are two or more individuals in the same class, all available members must consent for a decision to be effective.
2. When confusion or disagreement persists regarding the acknowledgement of the surrogate decision-maker, the primary physician or nurse manager must convene a conference of the concerned family and staff for the purpose of resolving the confusion or disagreement. When the confusion or disagreement is not resolved, it may be appropriate to seek court appointment of a surrogate decision-maker.

   If no surrogate is available, a care conference should be held with the primary physician, nurse manager, and a representative from Administration to reach a treatment decision to promote the patient's well-being in accord with prognosis and potential outcomes of treatment alternatives.

   a. If all participants agree on a treatment decision, the primary physician shall document the results of the care conference and rationale for the choices in the medical record.
   b. If the participants disagree, the highest agreed upon level of care should be chosen and court appointment of a surrogate decision-maker should be initiated.

D. **Making Surrogate Treatment Choices**.
When the surrogate decision-maker has been acknowledged, the primary responsibility of the caregivers is to assist the surrogate to make a treatment choice in accord with the patient's values, based upon sound medical criteria and in keeping with Samaritan Hospital's ethical principles.

1. Three clinical situations may occur:
   a. When a patient's likely decision is **known**: The surrogate decision-maker shall attempt to reach a treatment choice in accord with the patient's previously expressed desires (i.e. verbal statements, written directives, durable power of attorney for health care).
   b. When a patient's likely decision is **not known**: The surrogate decision-

maker shall attempt to reach a treatment choice that will promote the patient's well-being in accord with the patient's values.

2. Surrogate treatment decisions are emotion laden and may, on occasion, generate differing view points among those involved. In the event that such disagreements cannot be resolved, the primary physician or nurse manager, acting with administrative support, must convene a conference for the purpose of reaching a decision. This conference shall include the surrogate(s) and involved family as well as the primary physician, nurse manager, involved nursing staff and a representative from Administration. The primary physician or nurse manager may also request other caregivers to participate. If the disagreement includes questions about the accuracy of the medical prognosis, prior to the conference, the primary physician shall request consulting opinions from two appropriately qualified physicians. If the disagreement is not resolved, it may be appropriate to seek court involvement.

E. **Withdrawing Life Prolonging Treatment**.
A decision to withdraw life prolonging treatment should be made as part of a supportive care plan providing comfort, emotional, and spiritual support for patient and family. Although needs of family and caregivers are important considerations, they should not override the obligations to abide by a patient's own choices or previous directives about using or forgoing life prolonging treatment.

F. **Reaching Decisions About Code Blue Status**.
(Cardio-Pulmonary-Cerebral Resuscitation)

1. All persons admitted to the hospital have a full code blue status unless otherwise specified as a no code order, EXCEPT: patients being admitted with a properly documented medical order not to attempt resuscitation. In such cases, these previous orders shall be placed in the medical record and will be honored until a Samaritan Hospital order is given, **up to a maximum of twenty-four hours**.
2. In cases where two appropriately qualified physicians concur with the primary physician that a code blue response would be clearly futile, i.e. offers no physiological benefit to the patient, the primary physician or designee may give a no code blue order prior to informing the patient or surrogate of this decision. The primary physician shall inform the patient or surrogate as soon as possible and should document "clear futility" as the justification for the order in the progress notes.
3. The primary physician or designee must review a no code order whenever:
    a. The patient's medical status changes in an unexpected and significant manner; or
    b. An active medical intervention is considered that poses risk of inducing an arrest.
4. Normal induction and maintenance of a patient during anesthesia is not considered a code procedure.

All Revision Dates

6/29/2018, 2/20/2009, 6/18/2007, 1/20/2005

Approval Signatures

Step Description	Approver	Date
Senior Leadership	Anne Foss Durant: Interim CNO	9/13/2022
PCS Committee	Jodi Mauseth: Director of Acute Care Services	9/1/2022