

<b>Name of Policy:</b> <u>Do Not Resuscitate Orders (DNRCC &amp; DNRCC – Arrest) and Refusal of Life Sustaining Treatments</u> <b>Policy Number:</b> 3364-100-45-01 <b>Department:</b> Hospital Administration <b>Approving Officer:</b> Chief Executive Officer <b>Responsible Agent:</b> Chief of Staff <b>Scope:</b> The University of Toledo Medical Center and its Medical Staff	  <b>Effective Date:</b> July 1, 2020  Initial Effective Date: July 1, 1981
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy	<input type="checkbox"/> Minor/technical revision of existing policy <input checked="" type="checkbox"/> Reaffirmation of existing policy

**(A) Policy Statement**

The policy of The University of Toledo Medical Center (“UTMC”) is to provide medically appropriate care and support, including life-sustaining treatment(s) and full resuscitative measures to any patient who develops cardiac and/or respiratory failure and/or arrest, consistent with the patient’s wishes. Life-sustaining treatments and/or resuscitative measures may be withheld or withdrawn only by order of a physician.

**(B) Purpose of Policy**

To assure that the express wishes of the patient or Designated Decision Maker for do not resuscitate decision with regard to life-sustaining treatments and/or the withholding of resuscitative measures in the event of a cardiac or respiratory arrest (i.e., "code situation") are fully considered. To assure that these wishes, the patient's understanding of his/her condition and the consequences of his/her decision are identified and documented in an unambiguous fashion.

To assure uniform action among all health care professionals who might be involved in the care of the patient, including those with no prior knowledge of the patient who are called to provide care during an emergency.

**(C) Categories of Patient Treatment**

All patients of UTMC will be classified by their admitting physician to one of three levels of treatment:

1. Full Support;
2. DNR Comfort Care (DNRCC); or
3. DNR Comfort Care – Arrest (DNRCC – Arrest).

All patients admitted to UTMC are Full Support unless explicitly decided otherwise.

**(D) Procedure Overview**

1. For patients who are admitted to UTMC and who have proper DNR identification (patient possesses a portable DNR order):
  - a. Make a photocopy of the DNR order and place the photocopy in the patient’s medical record.
  - b. A physician shall write an order in the patient’s medical record reflecting the DNR status.
2. For patients who are admitted without a portable DNR order, but where a decision is made to initiate DNR status for the current admission only:
  - a. Follow all procedures outlined below, beginning with Section (E), but excluding Section (H).
  - b. A physician shall write an order in the patient’s medical record reflecting the DNR status.
3. For patients who are admitted without a portable DNR order, but where a decision is made to initiate DNR status for the current admission and per request to have the DNR status be portable:
  - a. Follow all procedures outlined below, beginning with Section E, and including Section (H).
  - b. A physician shall write an order in the patient’s medical record reflecting the DNR status, and the Ohio Department of Health DNR forms will be completed.

Note: The DNR order written into the UPMC medical record must be written by a physician. However, the Ohio Department of Health forms for implementation of a portable DNR order may be completed by a physician, advanced practice nurse (APN), or a certified nurse practitioner (CNP).

**(E) Procedure for making and carrying out decisions to forego life-sustaining treatment for a terminally ill patient who is no longer able to make informed decisions and who does not possess a legally effective advance directive (Living Will, Ohio Department of Health DNR Order or Durable Power of Attorney for Healthcare)**

1. Verification of Medical Status: Prior to withholding or withdrawing life-sustaining treatment(s) the patient's diagnosis, prognosis, severity of illness and treatment options, or lack thereof, must be confirmed by the attending physician on the basis of accepted standards of medical practice. The attending physician and one other physician must determine in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, all of which should be documented in the medical record, that the patient is:
  - a. In a Terminal Condition, which means irreversible, incurable and untreatable condition caused by disease, illness or injury from which both of the following apply:
    - 1) There can be no recovery; and
    - 2) Death is likely to occur within a relatively short time if life-sustaining treatment or resuscitation is not administered.
  - OR
  - b. In a Permanently Unconscious State, which means a state of permanent unconsciousness characterized by both of the following:
    - 1) An irreversible unawareness of one's being and environment; and
    - 2) The total loss of cerebral cortical functioning resulting in the patient's having no capacity to experience pain or suffering, and the patient is in the permanently unconscious state for at least the immediately preceding twelve months.
2. Determination of the patient's decision-making capacity: Prior to obtaining consent to withdraw or withhold life-sustaining treatment and/or implementing or modifying a DNR order, the capacity of the patient to make appropriate decisions regarding the patient's health care, must be established by the attending physician, by standard methods, or if necessary, by psychiatric consultation. If the physician determines that the patient is no longer able to make informed decisions regarding health care, there also must be no reasonable possibility that the patient will regain the capacity to make those informed decisions. If the patient is unable to make informed decisions regarding health care, it should be determined as to whether the patient has any advanced directive(s) and these determinations should be documented in the medical record.
3. Informed Consent and Selecting the Decision Maker for the Patient When Necessary: The patient, and when appropriate the Designated Decision Maker must be informed of the patient's present medical status, expected outcome, treatment options or lack thereof, and must be informed about the nature, benefits and risks of life-sustaining treatment(s) by the attending physician or a consulting physician that is sufficient to satisfy the requirements of informed consent. The attending physician must make sure that the parties involved fully understand the consequences of withdrawing or withholding life-sustaining treatment(s) and/or resuscitation on the patient's life and on the patient's medical condition and care. This must be documented in the medical record. For purposes of providing consent to withhold or withdraw life-sustaining treatment, individuals who are of sound mind and voluntarily grant the consent are determined in descending order of priority to be the Designated Decision Maker as defined in the Definitions Section (O) below.

**(F) DNR Protocol**

The law authorizes a physician, or an advanced practice nurse (APN), or a certified nurse practitioner (CNP) to write an order letting health care personnel know that a patient does not wish to be resuscitated in the event of a cardiac or respiratory arrest. If a DNR order is intended to be portable, the forms approved by the Ohio Department of Health must be completed. (See "(G)" below). DNR orders given at UPMC shall invoke a protocol hereinafter referred to as the DNR Protocol. The DNR Protocol has been adopted by the Ohio Department of Health as appropriate for statewide use and when a DNR order has been written, the DNR Protocol specifies that health care workers are to do the following:

WILL:  
Suction the airway

Administer oxygen  
Position for comfort  
Splint or immobilize  
Control bleeding  
Provide pain medication  
Provide emotional support  
Contact other appropriate health care providers such as hospice or home health

**WILL NOT:**

Administer chest compressions  
Insert artificial air way  
Administer resuscitative drugs  
Debrillate or cardiovert  
Provide respiratory assistance (other than that listed above)  
Initiate resuscitative IV  
Initiate cardiac monitoring

If a health care worker has responded to an emergency situation and initiated any of the WILL NOT actions prior to confirming that the DNR Protocol should be activated, they should be discontinued when the DNR Protocol is activated. Health care workers may continue respiratory assistance, IV medications, etc., that have been part of the patient's ongoing course of treatment for an underlying disease.

**(G) Types of DNR Orders**

Three types of DNR orders may be given for UTMC patients:

1. DNR Comfort Care (DNRCC): A DNRCC order activates the DNR Protocol at the time the order is given. With this order a patient receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life are undertaken from the moment the order is signed by the physician, APN or CNP. A DNRCC order permits comfort care only both before and during a cardiac or respiratory arrest. DNRCC orders can be made portable and be given effect statewide (see Ohio Portability Rules, below).
2. DNR Comfort Care – Arrest (DNRCC – Arrest): A DNRCC – Arrest order activates the DNR Protocol at the time of a cardiac or respiratory arrest. Resuscitative therapies will be administered before an arrest but not during an arrest. A cardiac arrest occurs when there is an absence of a palpable pulse. A respiratory arrest occurs when there are no spontaneous respirations or there is agonal breathing. With a DNRCC – Arrest order, a patient receives standard medical care that may include some components of resuscitation until he/she experiences a cardiac or respiratory arrest. A DNRCC – Arrest order can be made portable and be given effect statewide (see Ohio Portability Rules, below).
3. In the absence of one of the above noted DNRCC or DNRCC – Arrest orders, a DNR order may be written which modifies the DNR Protocol approved by the Ohio Department of Health. This type of DNR order may specify or modify the treatment to be provided. DNR orders which modify the DNR Protocol cannot be made portable and given effect outside UTMC.

A “DNR” order (without additional wording) when recorded in a patient's chart shall be considered a “DNRCC – Arrest” order.

**(H) Ohio Portability Rules**

DNR orders written while a patient is admitted to UTMC are for use within UTMC and generally will not be honored outside UTMC. However, DNRCC and DNRCC – Arrest is a legally sanctioned program/protocol, and some patients wish to have DNR orders travel with them or be “portable.” Portable DNRCC and DNRCC – Arrest orders should be honored statewide by EMS and other emergency/health care workers. An individual is enrolled in the DNRCC program after consultations with his/her physician, APN, or CNP regarding end of life issues. Upon enrollment, the individual will receive a special identification form. Other DNRCC identifications, such as a wallet identification card or bracelet may be used, but must include the Ohio State DNR Logo to be valid. (Ohio Department of Health DNR forms can be found at [www.odh.ohio.gov/pdf/forms/dnrfm.pdf](http://www.odh.ohio.gov/pdf/forms/dnrfm.pdf)).

**(I) Life Sustaining Treatments**

Life sustaining treatments mean any medical procedure, treatment, intervention or other measure that, when administered to a patient, will serve principally to prolong the process of dying and may include, but are not limited to the following:

1. Cardiopulmonary resuscitation (CPR, ACLS);
2. Mechanical ventilation;
3. Artificial nutrition and hydration;
4. Certain surgical procedures;
5. Dialysis;
6. Administration of blood and blood products;
7. Administration of vasopressor agents;
8. Invasive monitoring; or
9. Administration of intravenous antibiotics, steroids, chemotherapeutic and immunotherapeutic agents.

**(J) Patient Consent to Withdraw or Withhold Life-Sustaining Treatment and/or Consent to a DNR Order**

Any decision to withdraw or withhold life-sustaining treatment or any decision regarding a DNR order requires the patient or the Designated Decision Maker to understand the nature of the treatment or resuscitation, the patient's condition and the consequences of deciding to provide or withhold treatment or resuscitation in the case of cardiac or pulmonary arrest.

The procedure for determination of the patient's wishes depends upon the decision making capacity of the patient and his/her prior requests regarding life-sustaining treatment(s) and/or resuscitation as outlined in the following categories:

1. **Patients who have decision-making capacity regarding their care and who express a wish to withdraw or withhold life-sustaining treatment(s) or express a desire to have a DNR order.**
  - a. A patient with decision-making capacity has the right to make the decision to accept or refuse life-sustaining treatment or resuscitation for him/herself. Minors with decision-making capacity may be included in this category in accord with Policy No. 3364-100-10-01 regarding Informed Consent to Medical or Surgical Procedures for Minors.
  - b. Once the patient has clearly expressed his/her wish and there is no question as to the patient's capacity to make this decision, the total support status of the patient may be modified. The entire process must be fully documented in the patient's chart as described under "Documentation."
  - c. If the patient has difficulty deciding his/her code status after discussion with their physician, the patient may choose to seek guidance from other supportive services.
  - d. If there is a disagreement between the patient and immediate family or the patient and his/her Attending Physician, the patient and immediate family will be informed of the availability of supportive services, such as Pastoral Care and social services. If the immediate family disagrees with the patient's decision, the basis for the family's disagreement should be determined. If there is concern regarding the appropriateness of the patient's request, further counseling of the patient is recommended. If the family is having difficulty accepting the severity of the patient's condition, further discussion and support for the family is recommended. If the Attending Physician disagrees with a patient's decision regarding DNR status, he/she shall transfer care of the patient to another qualified physician.
2. **Patients who have lost their decision-making capacity but who have previously informed their family and/or advocate and/or physicians not to provide life-sustaining treatment(s) or resuscitation in the event of cardiac or respiratory failure and/or arrest.**
  - a. Loss of the patient's decision-making capacity should be carefully assessed and documented by the Attending Physician in conjunction with psychiatric or neurologic consultation when deemed necessary.
  - b. If a written advance directive, such as a Living Will, is available, this will be clearly documented in the chart and its intentions will be honored in the decision-making process. If the patient's wishes have not been written but have been expressed verbally to family, friends, physicians or others involved in the care of the patient, this information will also be carefully documented in the chart and given serious consideration.

- c. A Designated Decision Maker will be identified (See “(E)3” above). The optimal advocate is one previously identified by the patient (for example, a close family member or friend or by a Health Care Power of Attorney/Durable Power of Attorney for Health Care) or by a court (e.g., legal guardian). However, if there is no specifically identified decision-maker, either by the patient or a court, a close family member or concerned friend may become the advocate (See Policy No. 3364-100-10-01, Situations When Informed Consent Cannot be Obtained from the Patient). It is recommended that this decision-maker not be viewed in isolation, but rather as part of the existing group of concerned persons.
  - d. If the conditions of a patient’s Living Will are met, the declarations in the Living Will shall be honored. If the patient has made prior verbal or written statements (which are not legally effective as an advance directive) which are consistent with the patient's medical condition, these expressions of the patient's intent should be respected. If there is agreement among those involved in the case, i.e., the Designated Decision Maker, family or close friends, and Attending Physician, that withholding of resuscitation or withdrawal of life sustaining treatment would have been the wish of the patient, than the total support status of the patient may be modified. This should be thoroughly documented in the patient's chart as described under "Documentation."
  - e. In situations in which an agreement cannot be reached or uncertainty exists among the parties involved, the total support order will continue pending further efforts to reach agreement. The caregivers and/or family will be informed of the availability of consultations with other professionals in which the physician, the patient's family and his/her significant others can be assisted in the decision making process. These professionals can include psychiatrists or other appropriate medical specialists, ethicists, the Institutional Ethics Committee, counselors, or clergy.
  - f. The Attending Physician who disagrees with the decision of the Designated Decision Maker or family must transfer the patient's care to another qualified physician.
  - g. If agreement cannot be reached, the matter may be referred to the judicial system.
- 3. Patients who have lost decision-making capacity, but who have expressed their wishes for total support in the event of cardiac or respiratory failure and/or arrest.**
- a. Loss of the patient's decision-making capacity should be carefully assessed and documented in conjunction with psychiatric or neurologic consultation when deemed necessary by the Attending Physician.
  - b. Patients who have expressed the desire for total support will have their wishes respected when medically appropriate.
  - c. If the Attending Physician or someone close to the patient believes that resuscitation is futile or not in the patient's best interest, a patient advocate will be identified as described above. The burden of proof that therapy is futile or not in the patient's best interest will be on those who wish to alter the patient's expressed wishes for resuscitation in the event of cardiac or respiratory arrest.
  - d. If agreement between the Designated Decision Maker and physicians is reached that continued use of life-sustaining treatment(s) and/or resuscitation is futile or not in the best interest of the patient, the patient's code status can be altered per that agreement with documentation of the rationale and discussion in the chart. If agreement cannot be reached, the case may be referred to the judicial system. Full support will be given, if necessary, while the case is being resolved.
  - e. The Attending Physician who disagrees with the decision of the Designated Decision Maker or family may transfer the patient's care to another qualified physician.
- 4. Children or patients who lack decision-making capacity and whose wishes are unknown regarding life-sustaining treatment(s) or resuscitation in the event of cardiac or respiratory failure and/or arrest.**
- a. Loss of the patient's decision-making capacity should be carefully assessed and documented in conjunction with psychiatric or neurologic consultation when deemed necessary by the Attending Physician.

- b. When a question arises as to the appropriateness of life-sustaining treatment(s) or resuscitation in the event of cardiac or respiratory arrest, documentation should be placed in the chart regarding the lack of information about the patient's wishes and describing all attempts to gain such information.
- c. A Designated Decision Maker will be identified as described above. If no Designated Decision Maker for the patient can be identified, the case should be referred to the judicial system for appointment of guardian.
- d. If the Designated Decision Maker and the Attending Physician agree that life-sustaining treatment(s) or resuscitation is futile or not in the patient's best interest, the total support status of the patient may be modified. The physician can proceed as described under "Documentation." (See also "D", above).
- e. If agreement cannot be reached between the Designated Decision Maker and the Attending Physician or uncertainty exists, the case should be referred to the Institutional Ethics Committee for discussion and resolution. If resolution cannot be reached, the case may be referred to the judicial system. Full support will be given, in the event of cardiac or respiratory arrest, if necessary, while the issue is being resolved.
- f. The Attending Physician who disagrees with the decision of the Designated Decision Maker may transfer the patient's care to another qualified physician.

**5. Patients who possess DNR-Comfort Care (DNRCC) or DNR Comfort Care-Arrest (DNRCC-Arrest) identification.**

- a. Patients who possess DNRCC or DNRCC-Arrest identification should be asked to present such identification at time of hospital admission. Such a document signed by a physician, APN or CNP should be respected according to the DNRCC protocols and appropriate orders written. If a DNRCC or DNRCC-Arrest order is communicated verbally from an outside facility, the identity of the physician, APN or CNP must be verified before writing the order.
- b. Verification of DNRCC status with a patient who has decision-making capacity is appropriate.

**(K) Documentation**

1. In the absence of a properly executed Ohio Department of Health DNR form, or other Advance Directive, the patient's decision-making capacity must be documented in the chart by the Attending Physician or his/her designate after assessment by standard methods or in appropriate circumstances by psychiatric consultation.
2. In writing an order to modify the total support care plan, the Attending Physician or House Staff Physician acting on the attending's behalf will proceed as follows:
  - a. The order will be entered on the special "category of care order form and placed in the orders section of the chart. The order will be dated, the time of writing will be recorded, and the physician's signature will follow. Conditional or partial orders regarding resuscitation in the event of cardiac or pulmonary arrest should be specified.
  - b. In the event that a patient does not wish to have intubation regardless of their medical condition, the "No Intubation" line is to be checked. The physician shall document the discussion of the intubation option, be it for short term or long term treatment, so the patient understands the benefits to this treatment. Having understood the process the patient can make an informed decision. The patient also needs to be advised that this designation falls outside of the established state protocol and compliance may vary in the community (i.e., it may not be honored outside of UTMC).
  - c. In the Progress Notes, the same physician will write a progress note encompassing a brief summary of the case, the prognosis and status of the patient as of the time of writing, and a statement that the content and consequences of the above order have been conveyed to the patient or the designated decision-maker. Further, the physician will record that the patient or Designated Decision Maker understood the explanation and gave his/her consent to the withholding of cardiopulmonary resuscitation, in view of the above information. The Progress Note will be signed by the physician and by a witness to the conversation. If the Progress Note is written by a house staff physician, a specific statement will be included to specify that the Attending Physician concurs. The Attending Physician will countersign the order within 24 hours.
  - d. The outside cover of the patient's chart should clearly indicate the patient's modified total support status.
  - e. A blue band will be placed on the patient's wrist or ankle which will indicate their reduced code status.

3. Whenever possible and appropriate, a statement of concurrence should be written in the Progress Notes and signed by the patient and/or Designated Decision Maker.
4. Both the physician writing the DNRCC or DNRCC – Arrest order and the nursing staff caring for the patient should be alert to the necessity of regularly reviewing the order in the event that the patient's condition changes. Anytime the patient's wishes change, the previous order should change immediately. The new orders should be documented in the chart.
5. If a patient with a DRNCC or DNRCC – Arrest order is inadvertently coded, the code should be discontinued when the charge physician becomes aware of the code.
6. A patient who receives a DNRCC or DNRCC-Arrest code status during his/her hospitalization should receive an identification form on transfer or discharge to allow portability of the code status.

#### **(L) Reassessment and Revocation of DNR Orders**

A Properly executed Ohio Department of Health DNR Order/form cannot be changed or modified by anyone other than the patient. A DNR order written to be utilized only while the patient is an inpatient at UTMC (i.e., the patient does not have a portable DNR order and does not have a valid Living Will) should be reassessed as part of the ongoing evaluation of an inpatient. A DNR order should be modified or revoked only after discussion between the primary physician and the patient, if possible, or the surrogate(s) if appropriate, and the consent of the patient or Designated Decision Maker. Reassessment of DNR orders should be documented in the medical chart.

A patient may revoke a DRNCC or DNRCC – Arrest status at any time by verbal or written request.

#### **(M) Conflicts Between DNR Orders and Advance Directives**

In the event of a conflict between a DNR order and an advance directive which has become effective, the following shall prevail, as listed in order of priority:

1. Living Will;
2. Health Care Power of Attorney/Durable Power of Attorney for Health Care;
3. DNR order.

A durable power of attorney for health care may revoke a DNRCC order for an incompetent patient unless there is also a Living Will document, which is consistent with the DNRCC order.

#### **(N) Temporary Suspension of a DNRCC and DNRCC – Arrest Order**

When an inpatient or outpatient with a DNRCC or DNRCC – Arrest order requires a procedure which has the potential of a cardiopulmonary arrest, it is permissible to temporarily suspend the category of care order to allow for appropriate medical/surgical intervention (see Policy No. 3364-100-45-08).

#### **(O) Definitions**

Advance Directives: A written document of the wishes of a person with regard to the type of medical care desired when he/she is no longer capable of making health care decisions, by either giving instructions to health care providers about the types of medical care allowed or denied via a Living Will, and/or by designating a decision-maker (Health Care Power of Attorney/Durable Power of Attorney for Health Care, and/or by enrolling in the State of Ohio DNRCC program.

Comfort Care: Medical and nursing measures that control or decrease a patient's discomfort, pain and suffering and preserve his/her dignity, safety, privacy and individuality. These procedures include, but are not limited to: oral hygiene, bathing, turning the patient, controlling noise, skin care, pain control, etc.

Foregoing: As used in this policy, includes both stopping a treatment already begun (withdrawing) and not starting a treatment (withholding).

Full Support: All appropriate treatment will be used, including Advanced Life Support (ALS), in the care of the patient.

Designated Decision Maker: For the DNR decision (when there is no Living Will, Ohio Department of Health DNR Order or Durable Power of Attorney for Healthcare), is determined in descending order of priority as follows:

1. The legal guardian of the patient, if any (appointment is not required).
2. The patient's spouse.
3. An adult child of the patient, or if there is more than one adult, a majority of the patient's adult children who are available within a reasonable period of time for consultation with the patient's attending physician.
4. The patient's parents.
5. An adult sibling of the patient, or if there is more than one adult sibling, a majority of the patient's adult siblings who are available within a reasonable period of time for such consultation.
6. The nearest adult who is not described in this section who is related to the patient by blood or adoption, and who is available within a reasonable period of time for such consultation.

Health Care Power of Attorney/Durable Power of Attorney for Health Care: A person's written statement appointing an individual (attorney-in-fact) with authority to make medical care decisions on the patient's behalf when the patient has lost decision-making capacity.

Life-Sustaining Treatment(s): Any medical procedure, treatment, intervention or other measure that, when administered to a patient, will serve principally to prolong the process of dying.

Living Will: Document by which a person gives instruction regarding his/her medical care, in particular about the use or refusal of life-sustaining treatments when he/she has lost decision-making capacity.

Resuscitation: For purposes of this policy, resuscitation is the application of Advanced Life Support (ALS), which includes, but is not limited to the coordinated application of all measures needed to restore cardiac and ventilatory function in an emergent situation, such as tracheal intubation, mechanical ventilation, external cardiac compression, electrocardioversion, pharmacotherapy, and other action outlined in the American Heart Association ALS protocol.

## **(P) Guidelines For Effective Implementation**

1. **Communication with The Patient:** If possible, physicians should approach the issue of withdrawing or withholding life-sustaining treatments with their patients long before a serious medical problem or loss of decision-making capacity occurs. These discussions should be conducted in a manner that the individual patient can understand and will allow the patient to make sound decisions. Appropriate other individuals may participate in these deliberations at the request or with the approval of the patient. When the patient has no decision-making capacity the Designated Decision Maker should likewise be involved.

There is some urgency to discuss these aspects of medical care in the following circumstances:

- a. When a patient is terminally ill,
  - b. When a patient has a condition that is likely to result in death, severe disability, or loss of decision-making capacity,
  - c. When a patient has suffered an irreversible loss of consciousness,
  - d. When a patient is at high risk to have a cardiac or respiratory arrest,
  - e. When there is reason to question the presumption of the patient's consent to initiate life-sustaining treatment,
  - f. When life-sustaining treatment is likely to have no medical benefit or when the burden of treatment may be excessive.
2. **Decisions and Consent:** Decisions to withhold or withdraw life-sustaining treatments should be made in accordance with the patient's wishes, directives or best interests. Informed consent should be obtained from the patient with decision-making capacity. Consent by relatives or significant others is not required, but they should be informed about the decision, unless explicitly forbidden by the patient.

For the patient without decision-making capacity, decisions should be made in accordance with his/her written advance directives, or with the wishes/directives of his/her Attorney-in-Fact, or when appropriate, with those of the next-of-kin or significant other(s), unless contrary to the best interests of the patient or [applicable](#) law. A designated decision-maker should be identified and asked to give informed consent.

3. **Communication with Caregivers:** Nurses, house officers and other health care professionals closely involved with the care of the patient should participate, whenever appropriate, in the decision making process by taking part in the deliberations, sharing information and opinions, and providing support.

4. **Effects on Patient Care:** Foregoing a life-sustaining treatment does not indicate that other treatments or care including Palliative, Comfort or Supportive care deemed necessary for the patient's well-being, dignity, safety and privacy should be diminished or not provided.
5. **Refusal by Caregivers:** The right of individual physicians, nurses and other health care professionals to decline to participate in the foregoing of life-sustaining treatment in a patient under their care should be recognized when based on acceptable reasons and/or beliefs. In exercising this right, however, the individual or the Institution must take appropriate steps to transfer the care of the patient to another caregiver.
6. **Conflict Resolution:** Most conflicts can be avoided by good communication and sharing of information between caregivers, patients and their families, by answering all questions and concerns in a thorough and timely fashion, and by demonstrating understanding, flexibility and concern.

The decision by patients with decision-making capacity to forego life-sustaining treatment takes priority over the wishes of their family and/or significant others or the intentions of their physicians. Nevertheless, close family members and/or significant others should be informed and given the opportunity to present their views unless expressly forbidden by the patient.

Patients without decision-making capacity having written advance directives, such as a Living Will or Durable Power-of-Attorney for Healthcare, should have their directives or those of their designated decision-maker fully honored in accordance with applicable law. Close family members or significant others should be kept informed.

Patients without decision-making capacity having no written advance directives, but having previously clearly indicated the circumstances whereby they wish to forego life-sustaining treatment should have their wishes honored. Close family members or significant others should be involved.

Patients without decision-making capacity having unknown or unclear wishes regarding the withdrawing or withholding of life-sustaining treatment should be cared for according to the wishes of their closest relatives or significant others in the order of priority delineated in the Procedure section above provided that the best interests of the patient prevail and that the attending physician is in agreement. When no family or significant others are available and if time permits, the attending physician should seek guardianship to resolve the conflict. In an emergency situation, the attending physician should make an informed decision based on the patient's best interests.

When in any of the previously described situations conflicts, disagreements or uncertainties arise that cannot be resolved by patient-physician interaction, it is recommended to first seek the input and assistance from others such as the patient's nurse(s), social worker, ethicist, clergy, etc., or to obtain the opinion of another physician-specialist chosen by the patient (or when appropriate, by the designated decision-maker, a relative, or significant other) or by the attending physician.

Next, when disagreements persist, other supportive services should be consulted.

Finally, when the conflict remains unresolved, legal advice or intervention by the Court may be required or requested by any of the parties. An attending physician who disagrees with and/or refuses to honor a patient's decision or his/her written advance directives may request (or be requested) to transfer the patient to another physician or institution willing to honor the wishes of the patient. The patient (or when appropriate, the designated decision-maker, next-of-kin or significant other) also has the right to request a transfer to another physician or institution.

7. **Life-Sustaining Treatment Without Medical Benefit:** There are circumstances whereby it may not be in the best interest of a patient to initiate or continue life-sustaining treatment when there is no hope of any medical benefit. This usually occurs during the course of a terminal or irreversibly debilitating condition. The patient (or when appropriate, the designated decision-maker, next-of-kin or significant others) should be informed by the attending physician that in his/her opinion life-sustaining treatment does not have or no longer has any medical benefit and should be withheld or withdrawn. Consent and/or consensus should be obtained when possible and an attempt should be made to resolve any disagreement or refusal if time permits.

The attending physician should not be compelled to initiate or continue life-sustaining treatment that is in his/her professional judgment without medical benefit. However, in situations where consensus is not attainable or elusive, it is recommended that the following conditions be met before the attending physician withholds or withdraws life-sustaining treatment deemed without medical benefit:

