SAMPLE – End-of-Life Decision-Making Policy

Subject: End-of-Life Decision-Making
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I. STATEMENT OF PURPOSE:

To provide general guidelines for healthcare professionals in making decisions concerning treatment for the terminally ill, for patients who have lost cognitive function, and for patients who refuse care

II. STATEMENT OF POLICY:

[Insert facility name] shall establish and maintain procedures for withholding or withdrawing life-sustaining treatment that consider the rights and wishes of patients, comply with state and federal statutes and regulations, and are consistent with the mission and vision of the institution.

III. DEFINITIONS:

Advance Directive: A legal document allowing an individual to make certain provisions for healthcare decisions in case that individual becomes unable to make those decisions at a later date; includes a living will and durable power of attorney for healthcare.

Terminal Illness: A disease without a cure or treatment that is likely to result in the death of a person within a short time period.

Cognitive Function Loss: The irreversible and untreatable loss of all capacities to communicate or respond to external stimuli - Irreversible coma and persistent vegetative state (PVS) are two common forms of cognitive function loss.

Competent Patient: Competency is defined as understanding the nature and consequences of one's actions - Competent patients have the right to refuse any treatment, even if deemed medically necessary.

Incompetent Patient: Incompetency is defined as the inability to understand the nature and consequences of one's actions. Minors and unconscious patients are also considered incompetent.

Brain Death: The irreversible cessation of all functions of the entire brain, including the brain stem - Three specific clinical criteria are required for a diagnosis of brain death - coma (with a known cause), absence of brainstem reflexes, and apnea.
IV. PROCEDURES

1. Incompetent Patient

If the patient is incompetent, treatment decisions shall be made on behalf of the patient by the following surrogate individuals in this order of priority and in compliance with state and federal laws:

1.1. A judicially appointed guardian, if any

1.2. Durable power of attorney for healthcare

1.3. The patient's spouse

1.4. An adult child or the majority of the adult children who are available

1.5. The parents of the patient (this item gains number one priority with minors)

1.6. The adult sibling or the majority of the adult siblings who are available

1.7. The nearest living relative to the patient

1.8. Domestic partner or close friend

2. Physician Responsibility and Decision-Making

The attending physician is responsible for providing the patient or the surrogate, if the patient is incompetent, with all the necessary information for an informed decision.

2.1. The patient's values and beliefs should be given prime consideration in this decision-making process. When a surrogate is representing the patient, the physician should remind the surrogate that the decision should be based on the patient's values and beliefs, not the surrogate's.

2.2. The physician's role may include making recommendations regarding treatment. The recommendations should take into consideration the burdens to the patient and the patient's family, including suffering, anguish and likelihood for prolonging the dying process. Diagnoses, prognoses and treatment options should be discussed and given consideration in the decision-making process.

2.3. If an illness is terminal, the patient or surrogate should be provided with this information as part of the informed decision process.
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3. Withholding Life-Sustaining Treatment

3.1. In making decisions about withholding treatment, a competent patient's wishes must be identified and documented by the attending physician. This documentation and identification should take place only after the competent patient has been allowed to make an informed decision. In order to facilitate appropriate care and ensure that proper decision-making procedures are followed, it is important that documentation be thoroughly completed.

3.2. For incompetent patients (as outlined in the definitions above), treatment decisions made by the surrogate after discussion with the attending physician should be clearly documented in the patient's record.

3.3. For both competent and incompetent patients, any written documents created by the patient should be placed in the medical record.

3.4. After appropriate discussion and documentation, one of the following order types (if not specified by state law) should be entered into the patient's record:

- Code 1 – defined as maximal therapeutic effort without reservation
- Code 2 – defined as any combination of fluid resuscitation, nutritional support, antibiotics, anti-arrhythmia therapy, blood products, presser agents, surgical intervention determined by the physician and patient or surrogate to be in the patient's best interest
- Code 3 – defined as measures continued or instituted for patient comfort - CPR, intubation and electroshock are not to be initiated.

3.5. The attending physician may modify any above mentioned code status by writing an order specifically detailing treatment to be given and treatment to be withheld.

4. Perioperative Care of Patients with DNR orders

Prior to any inpatient or outpatient invasive procedure for which [insert facility name] requires the documentation of informed consent, any existing DNR order should be reviewed by the patient's attending physicians with the patient or patient's surrogate. The goal of the discussion is to determine whether the DNR order is to be maintained, modified or suspended during anesthesia and surgery. As a result of this review, the status of the DNR order during the perioperative period should be affirmed, clarified or modified based on patient preferences.

4.1 Discussion of the existing DNR order by the patient's attending physicians should ensure that the risks and benefits of anesthesia and surgery are discussed prior to surgery.

4.1.1. Discussion should include:

- Goals of the surgical treatment
- Possibility of resuscitative measures
- Description of what the resuscitative measure would include
- Possible outcomes with and without resuscitative measures
Following this discussion, the decision and plan of care must be clearly communicated to all members of the health care team involved in the perioperative care of the patient.

The attending physician should document clarifications or modifications in the medical record. The documentation should include when the original DNR order should be reinstated, as applicable.

Concurrence on the decision reached after discussion with the patient or patient’s surrogate by the primary care physician, surgeon, and anesthesiologist is desirable.

If the situation requires further ethical deliberation after discussion with the patient or patient’s surrogate before surgical intervention, a consultation with the [insert proper name of ethics committee] of [insert facility name] may be necessary.

Any DNR identification should only be removed during the perioperative period if directed by the attending physician with the consent of the patient or patient’s surrogate.

5. Withdrawal of Life-Supporting Care

In the course of treating critically ill patients, life support measures may be instituted with every hope of patient recovery. When the expected recovery does not occur, the physician may face a decision to remove life support systems and/or withdraw treatment from a patient:

- Who is brain dead
- Who is in an irreversible coma or persistent vegetative state (PVS)
- Whose quality of life leads the patient or surrogate to request the withdrawal

5.1. Brain death: The physician shall determine if the patient is brain dead by utilizing the following criteria, which meet local standards of practice and are in accordance with state statutes (concurrence of two physicians may be required by state law and is, in any case, preferable):

5.1.1. Prerequisites
(To be determined by the organization’s medical staff. The following are examples that may be considered)

- Coma, irreversible and cause known
- Neuroimaging explains coma
- CNS depressant drug effect absent (if indicated toxicology screen; if barbiturates given, serum level < 10 g/mL)
- No evidence of residual paralytics (electrical stimulation if paralytics used).
- Absence of severe acid-base, electrolyte, endocrine abnormality
- Normothermia or mild hypothermia (core temperature > 36°C)
- Systolic blood pressure ≥ 100 mm Hg
- No spontaneous respirations
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5.1.2 Examination
- Pupils nonreactive to bright light
- Corneal reflex absent
- Oculocephalic reflex absent (tested only if C-spine integrity ensured)
- Oculovestibular reflex absent
- No facial movement to noxious stimuli at supraorbital nerve, temporomandibular joint
- Gag reflex absent
- Cough reflex absent to tracheal suctioning
- Absence of motor response to noxious stimuli in all 4 limbs (spinally mediated reflexes are permissible)

5.1.3 Apnea testing

5.1.4 Ancillary testing
(To be determined by the organization’s medical staff. The following are examples that may be considered)
- Cerebral angiogram
- HMPAO SPECT
- EEG
- TCD

5.1.5 Documentation
- Time of death (DD/MM/YY)
- Name of physician and signature

5.1.6 Communication among physicians, relatives and nursing personnel must be maintained throughout the period.

5.1.7 If organs are to be donated, the physician pronouncing death may not be the organ recipient's physician and may not participate in the procedures for removing or transplanting a donated physical part.

5.1.8 Brain death must be documented before life support is terminated. However, life support measures may be continued until organs intended for donation have been removed.

5.1.9 If any disagreement exists among family, staff and/or physicians, life support will be maintained until there is a decision from the [insert proper name of ethics committee], or, in the absence of an ethics committee, from the [insert proper name of medical executive committee]; or pursuant to a court order.

5.2 Persistent vegetative state (PVS): A patient will be considered in an irreversible coma or PVS upon the announced opinion of a physician, based on accepted standards of medical practice (concurrence of two physicians may be required by state law and is, in any case, preferable). The patient should be free of any pharmacologic drugs that may induce such a state.

5.2.1 Criteria for diagnosing PVS:
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(To be determined by the organization’s medical staff)

5.3. Statement of unacceptable quality of life: If a patient's quality of life leads the patient or surrogate to request withdrawal of life support, the physician must discuss with the patient and family the disease process, prognosis, and all consequences if life support is terminated. A summary of this discussion, including all supporting rationale, must be clearly documented in the record by the primary physician.

5.4. Life support may not be discontinued in the presence of any of the following:

(To be determined by the organization’s medical staff)

5.5. With respect for federal and state laws and ethical and religious considerations (as applicable), and after the acceptable criteria are met and supportive documentation is written, the attending physician will write and carry out an order for the discontinuation of life support.

6. Disagreement among Parties

6.1. Situations may arise where a primary physician and consulting physician disagree on the need to withdraw or withhold treatment. Situations may also arise when the physician and patient and/or surrogate disagree on the need to withdraw or withhold treatment. These circumstances should initiate a request for review by the [insert proper name of ethics committee]. In the absence of an ethics committee, the review should be held by the [insert proper name of medical executive committee].

6.2. The responsibility of the [insert proper name of ethics committee] or the [insert proper name of medical executive committee] is to make recommendations or offer advice.

7. Summary

The guidelines set forth in the above policy should not be construed to be rigid tenets, since the basis for all decisions regarding a patient's illness is the best judgment of the responsible physician who has taken into consideration the rights and wishes of the patient. This policy, in accordance with state and federal statutes, will enable health care providers to provide the most appropriate care to a patient during a critical illness.

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