LAC+USC MEDICAL CENTER POLICY

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FORGOING LIFE-SUSTAINING TREATMENT	7/11/75	**222**
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Departments Consulted & Approved by:	Reviewed & Approved by:	Approved by:
Office of Risk Management Medical Administration Ethics Resource Committee Fetus/Infant/Child Ethics Committee	Attending Staff Association Executive Committee Senior Executive Council	(Signature on File) Chief Medical Officer (Signature on File) Chief Executive Officer

PURPOSE

This policy governs forgoing life-sustaining treatments for adult and pediatric patients at LAC+USC Medical Center.

POLICY

It is the policy of LAC+USC Medical Center (the "Medical Center") to comply with state and federal statutes and legal precedents recognizing the right of a competent patient to refuse medical care, even if such refusal results in shortening of the individual's life, and recognizing that providers are not legally obligated to provide care would be medically ineffective, contrary to generally accepted health care standards, or that they object to providing for reasons of conscience. In all cases, the clinician has no obligation to offer or provide therapy that is ineffective. Implausible treatments with no known or possible therapeutic effect need not be discussed unless the patient or surrogate initiates the discussion.

Providers must inform the patient or their surrogate decisionmaker about the benefits, risks, and consequences of treatment alternatives to assist the patient or surrogate decisionmaker in making such decisions. For all patients, every medical action should include considerations regarding the relief of suffering and maintenance of patient comfort, hygiene and dignity. Dignity, hygiene and comfort of patients should be preserved in all circumstances to the extent medically possible.

DEFINITIONS

Advance health care directive (advance directive): a document that may authorize another person to make health care decisions for a patient who is no longer able to make decisions for himself or herself. The advance directive may contain information about a patient's desires concerning healthcare decisions, particularly decisions concerning end of life care.

Capacity: a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks and alternatives, and to make and communicate a health care decision (California Probate Code 4609).

A person has capacity when he or she can understand his/her diagnosis and treatment options and has the ability to choose among the options (see, further, "Determining capacity" in the Procedures section of this document). A person may

be able to make decisions regarding his/her health care but not regarding other matters such as finances.

Cardiopulmonary resuscitation (CPR): a medical treatment for cardiopulmonary arrest that, in a health care setting, includes basic and advanced interventions (BCLS and ACLS) ("CPR refers to attempting any of the broad range of maneuvers and techniques used to restore spontaneous circulation and respiration." Advanced Cardiac Life Support [provider's manual], p 17-5, AHA, 1997). CPR is <u>not</u> just external chest compressions and assisted breathing.

Despite warnings that the technique could be inappropriate in other clinical situations ("CPR is not indicated in certain situations such as in cases of terminal irreversible illness..." ibid.), CPR became a default procedure. It was presumed that a patient wanted CPR unless there was a specific order (DNR) to avoid it. This is a unique presumption in medicine.

Do not resuscitate (**DNR**):

DNR means <u>only</u> "do not do CPR". Its use is not intended to indicate that any other therapeutics are to be withheld or limited. Its use is compatible with other forms of treatment, including intensive care. Unfortunately, the true meaning of DNR—"do not do CPR"—has taken on additional connotations for many health care providers. As a consequence of the imprecision of the term's usage, other statements have arisen, including "No ACLS", "No BCLS" and "continue current care except CPR". See Section 4 (Orders and Documentation) for acceptable and unacceptable terminology within the Medical Center.

Ethics Resource Committee (ERC) and Fetus, Infant, Child Ethics Committee (FIC): multidisciplinary committees of the Medical Center designed to help in discussing and exploring alternative approaches to ethical problems, clarifying legal or ethical and related issues, facilitating communication, and identifying perspectives on issues not previously considered.

Health Care Decisions Law: the statute that governs health care decisions and advance health care directives in California (Probate Code Sections 4600-4805).
In part the law states that an adult having capacity may give an individual health care instruction orally or in writing and may also designate another adult as a surrogate to make health care decisions for him or her. The patient must do so by personally informing the supervising health care provider. An oral designation of a surrogate must be promptly recorded in the medical record and is effective only during the course of treatment or illness or during the stay in the healthcare institution when the designation is made (Probate Code Section 4711).

Informed Consent (or refusal): The willing and uncoerced acceptance (or refusal) of a medical treatment by a patient or patient's surrogate after adequate disclosure of the patient's medical condition, and after disclosure of the nature, risks and benefits associated with available treatment options, to the degree the physician determines is adequate for decision-making by the patient/surrogate.

Life-sustaining Treatment: Any medical intervention that is expected to extend the length of a patient's life, e.g., ventilation, medically administered nutrition or hydration, or medications.

POLST (Physician Orders for Life-Sustaining Treatment): A statewide non-facility specific set of PCP physician's orders patients may present to the hospital with, regarding life-sustaining treatment. After discussion with a patient or surrogate about treatment decisions, the form is completed by the physician (or other health care professional under the direction of a physician) and signed by the physician and also the patient or their surrogate. By California law, the orders once signed by both the physician and patient, POLST becomes part of a patient's medical record. And because it's a dynamic document, POLST can be modified or revoked, based on new information or changes in a patient's condition or preferences.

	Advance Directive	POLST
Who?	Every adult	Seriously ill
What?	Broad outline	Specific wishes, actionable physician orders
Where?	Needs to be retrieved, no universal system	Travels with patients across settings

Proportional Benefit: The potential benefit of a treatment weighed relative to the potential burden to the patient.

Surrogate Decision Maker: The person who makes decisions for a person who cannot or who chooses to not make decisions for himself or herself. This person may be a health care agent appointed by a Durable Power of Attorney for Health Care, a conservator, guardian, or a family member or close friend of the patient. Parents are the legal surrogates of their minor children, unless that responsibility has been specifically revoked by court order. In that case another guardian or surrogate have been appointed by the court. A legally recognized health care decisionmaker include the person's agent as designated by a power of attorney for healthcare, surrogate, conservator or closest available relative described in Probate Code §§ 4671, 4711, 1880, and Cobbs v Grans, 8 Cal3d 229, 244 (1972) respectively.

PROCEDURE

1. **Determining "capacity" (see definition)**

   a. The patient's physician determines whether or not the patient has capacity by assessing the patient's ability to make and communicate treatment decisions as manifested by:

1) an ability to understand the significant characteristics of one's disease, including prognosis and the potential limitations to full recovery;
2) an ability to understand the inherent risks and benefits of the various treatment options;
3) an ability to understand the inherent risks and benefits of refusing treatment; and
4) the ability to clearly communicate a choice.

b. Determining that a patient lacks the capacity to make decisions does not, in most circumstances, require a psychiatrist. Patients should not be considered to lack capacity simply because they have a psychiatric disease or are unable to make other kinds of decisions. If there is suspicion that the patient's ability to reason is impaired by psychiatric disease, a psychiatric consultation should be obtained.

2. **Making the decision to forgo life-sustaining treatment**

a. Patients *with capacity*:
When a patient with capacity decides to forgo a future potentially life-sustaining procedure, all that is required is that a notation to that effect should be written in the progress notes of the medical record. In addition, if the procedure being refused is CPR, a Do Not Resuscitate (DNR) or equivalent order must be entered into the medical record by the provider. The latter order must be signed by an Attending physician to be valid.

A decision to forgo life-sustaining treatment made by a patient, who at the time of the decision demonstrated capacity, continues even if the patient subsequently loses decision making capacity, and regardless of surrogate preferences.

b. Patients *without capacity but with a surrogate*:

For persons unable to give informed consent, the first step is to attempt to identify a surrogate decision maker. Although California does not have a statute that specifically provides for a hierarchy of persons who can give consent, both statute and case law support the use of a surrogate to consent to or to refuse medical care for an incapacitated adult patient. California law indicates that an appropriate surrogate is one who is best able to reflect the wishes that the patient would have had had they been able to communicate and does not establish a hierarchy of relatedness for establishing an appropriate surrogate. The key question in identifying a surrogate is, who is best able to reflect the patient's wishes and values?

At LAC+USC Medical Center, an appropriate order for recognizing a surrogate decisionmaker is:

1) Parents of minor children unless that responsibility has been specifically revoked by court order, in which case the court appointed guardian is paramount
2) an Advanced Health Care Directive appointed agent;
3) a court appointed conservator or guardian with the power to make health care decisions;
4) other relatives (including immediate family) or close friends/companions

The surrogate should act in accordance with treatment preferences stated by the patient, if known. It is the surrogate's responsibility to help health care providers understand what the patient would want under the current circumstances. What the surrogate wants for the patient is not the primary concern. Previous directives, statements, or behavior on the part of the patient may be of value in this determination. If the patient's preferences are unknown, the surrogate should act in the patient's best interest by weighing the comparative benefits and burdens of proposed treatments, as well as the patient's values and beliefs, as far as they are known.

If the surrogate gives informed consent to forgo a life-sustaining procedure, a notation to that effect should be entered in the patient's medical record.

In the event of differing opinions among the health care team or surrogate(s) or guardians, the physician should generally initiate treatments until the disagreement is resolved or a conservator is appointed. In cases where a surrogate's decisions appear to be inconsistent with the patient's preferences or best interests, the physician should thoroughly discuss the issue with the surrogate. If discussion does not lead to resolution of the physician's concerns, the physician should advise the surrogate that he or she may be unable to follow the directions of the surrogate and then consult the Chief Medical Officer, as well as Risk Management, as necessary, to seek a resolution. The clinician has no obligation to offer or provide therapy that is ineffective. Implausible treatments with no known or possible therapeutic effect need not be discussed unless the patient or surrogate initiates the discussion. Consultation with the Medical Center Ethics Committee may be requested. In extreme cases, legal remedies exist to replace the surrogate or mediate disputes among parents.

c. Patients *<u>without</u> capacity and <u>without</u> a surrogate*:

The principles of autonomy, professional duty, and the common law require physicians and healthcare providers to obtain consent before administering a treatment, except in emergency circumstances. Appropriate health care decisions include both the provision of needed medical treatment and the avoidance of nonbeneficial or excessively burdensome treatment, or treatment that is medically ineffective or contrary to generally-accepted health care standards.

The ethical principles underlying decisions to forgo life support are the same whether applied to withholding or withdrawing therapy for a patient without capacity and without a surrogate and are based on application of the best interest standard for the patient. In general, it will fall to the patient’s primary attending to decide on a course of care that is consistent with accepted standards and encompasses the best interest of the patient, balancing the likelihood of success with specific interventions with the burdens or suffering that possible treatments may invoke. Typically, a primary attending must show that a significant burden, either with the disease itself or with proposed therapies, is present to override the default position of sustaining life whenever possible. Critically ill patients without capacity or surrogates are an especially vulnerable population and as such it is prudent to invoke multidisciplinary analysis of these decisions in order to be sure that

unrecognized biases have not been introduced into the decision-making process. This should include referral of the case to the appropriate ethics committee whenever circumstances permit.

For patients who lack capacity and lack a surrogate decisionmaker, the following conditions should be met when contemplating forgoing life-sustaining care:

1) a diligent search has been made and no surrogate is available (e.g., a search of > 1 business day for a patient who is new to the hospital);
2) all persons involved in the patient's treatment have disclosed any real or apparent conflicts of interest;
3) all relevant medical information has been obtained and reviewed;
4) opinions of the entire health care team have been reviewed;
5) the burden and benefit from the patient's view have been examined;
6) consideration of economic impact on health care providers and the hospital has been excluded; and
7) steps have been taken to ensure that the "benefit of continued life to a disabled patient is not devalued or underestimated".

d. In general, decisions to withdraw or withhold care will fall into one of the scenarios described below. All decisions must be compatible with current accepted standards of care and the rationale for each decision clearly documented in the EMR.

1) Imminent cardiopulmonary arrest

A patient with or without capacity or surrogate, imminently dying from a known and irreversible cause, may have CPR withheld on the basis of a single attending physician's judgment when that physician believes that CPR will not be effective in prolonging life to the extent that the above usual steps can be invoked. The attending physician may unilaterally write a "Do Not Resuscitate" order of in this situation. The same expectations for documentation of rationale and departmental peer review apply.

2) Withholding or withdrawing potentially life-sustaining therapies because of excessive burden and lack of sustainable benefit to the patient

In order to avoid potential conflicts of interest a primary attending should not act as a patient's sole surrogate. A second independent attending physician must concur with the patient's prognosis and the primary attending physician's plan to forgo or withdraw specific therapies. Both attending physicians must document the rationale for their decisions in the medical record.

In addition, referral to an ERC or FIC ethics committee should be made whenever possible. This will include all cases of withdrawing supportive care and some cases of withholding care where the time constraints for decision making permit. The ethics committee should be multidisciplinary. Medical, nursing, social

work, and pastoral care services should be represented at a minimum. A representative of the ethics committee should document in the medical record the opinion that all appropriate steps have been taken to ensure the patient's best interests have been considered and potential biases excluded.

At times, decisions to forgo excessively burdensome life-sustaining treatments must be made in a limited time frame that practically eliminates the possibility of convening an ethics committee, see Appendix A. In this case, the 2 independent attending physicians must agree in the course of action and document the rationale for limitation of life sustaining therapy and the need for an expedited decision.

All deaths are reviewed by the department of the primary attending and any questions that arise related to decisions to forego life-sustaining care resulting in death should be referred by the department to the appropriate ethics committee for retrospective review as part of a peer review process.

The Ethics Resource Committee or Fetus, Infant, Child Ethics Committee may bring in individuals who are independent of the Medical Center (e.g. representatives of a patient advocacy group) as needed to advocate for the patient. These actions can help assure and verify that no opportunity to learn of the patient's wishes has been missed and that no reasonable opportunity for further medical intervention exists.

In the event of disagreement among the care team, including nursing, great caution is warranted and care should generally be continued until consensus can be achieved.

3. **Declining to Comply with Individual Health Care Instructions for Ineffective Care**

a. California law states that a health care provider shall "comply with an individual health care instruction of the patient" [or surrogate] (California Probate Code {CPC} Sec. 4733). However, "a health care provider may decline to comply with an individual health care instruction"...

1) "that requires medically ineffective health care" (CPC Sec. 4735); or
2) that requires "health care contrary to generally accepted health care standards" (CPC Sec. 4735); or
3) "for reasons of conscience" (CPC Sec. 4734).

b. A health care provider who declines to comply with an individual health care instruction shall do all of the following (CPC Sec. 4736):

1) "promptly so inform the patient, if possible" [and the surrogate];
2) "immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction";

3) "provide continuing care [including appropriate pain relief and other palliative care] to the patient
[1] until a transfer can be accomplished or
[2] until it appears that a transfer cannot be accomplished".

Furthermore, the health care provider should inform his or her supervisor of the decision not to comply. In all of these cases, consultation with the on-call representative of the Medical Center Ethics Resource Committee or FIC Committee and notification of Risk Management or Medical Officer of the Day is required at LAC+USC Medical Center.

4. **Orders and Documentation**

A resuscitation status order conveys whether a patient should receive CPR, defibrillation or intubation. The resuscitation order may be placed by a housestaff/provider but must be co-signed by a licensed attending physician in the patient's medical record. The ordering physician/provider should communicate to appropriate members of the health care team that such an order has been written. The ordering provider must document the attending's approval in a note or on the order, since the order goes into effect pending the attending co-signature.

The withholding of other emergency treatments—such as cardioversion for arrhythmias (other than defibrillation for cardiac arrest) and vasopressors for circulatory shock—require a physician's physical participation and decision, but do not require a "Do Not Do" order. Documentation of a decision to not provide (in the future) one or more specific therapies needs to be made by a physician in an appropriate progress note (such as in the Appendix B).

The withdrawal of current treatments must have an order written to that effect.

An attending physician must approve all decisions to forgo life-sustaining treatment. This approval may be given telephonically to a physician/provider who must then document this approval, including the attending physician's name, in the progress notes. A nurse need not witness the telephone conversation between the attending and another physician/provider.

A decision to forgo life-sustaining treatment, including resuscitation must be supported by a clear statement in the physician's progress notes of relevant information such as that concerning the treatment decision, the treatment plan, the diagnosis and prognosis, and how these were established. It is recommended to utilize the "Goals of Care" Note Type or the "Advance Care Planning" Ad Hoc form to document conversations with patients or surrogates about forgoing resuscitation and other life-sustaining treatments. This will allow proper routing of the note to the Advance Care Planning tab in the electronic medical record. Further, documentation of any consulting physicians' opinions, findings and recommendations, and documentation of relevant test results should be included in the progress notes. The basis upon which a particular person has been identified as appropriate surrogate for the patient, and summary of consultations with the surrogate, should also be placed in the progress notes. The documentation should indicate that the

conditions in the paragraph regarding "patients without capacity and without a surrogate" (in the section "Making the decision to forgo life-sustaining treatments"—Procedures 2.c) have been satisfied. See Appendix B for documentation and Appendix C for notification.

A new resuscitation status order does not have to be rewritten whenever the patient is transferred to another service or ward; once written, a resuscitation status order remains in effect unless specifically reversed by a new resuscitation status order. It is not necessary to rewrite such a resuscitation status order regularly, e.g. every 7 days.

Orders regarding resuscitation during surgery. There should be a reconsideration of the decision to withhold resuscitation on all patients undergoing surgery. Reconsideration may result in continuation of the resuscitation status order or in its modification in some way. The process of this reconsideration should emphasize the principles of patient's rights and dignity that resulted in the original order. In addition, the patient's surgeon (if different from the primary treating physician) and anesthesiologist should be involved in this discussion with the patient and/or family. The principles of informed consent must be maintained. Concerns regarding the specifics of treatments in the perioperative period (anti-arrhythmic medications, treatment of electrolyte abnormalities, etc.) should be addressed at the time of the reconsideration. No anesthesiologist, and indeed no physician, can be forced to participate in an operation when a DNR order with which he or she disagrees exists. Any refusal to participate should be accompanied by a diligent search for a replacement.

When a DNR order is suspended during a surgical procedure, the post-operative orders should be reordered it once the patient leaves the recovery room.

5. Patients with a POLST

a. POLST orders will be followed by health care providers as a valid physician order. The physician should document his or her review of the POLST in the medical record.

b. If the provider, upon review of the POLST and evaluation of the patient, determines that a new order is indicated, if feasible, he or she shall review the proposed changes with the patient and/or surrogate decisionmaker, and issue a new order consistent with the most current information available about the patient's health status, medical condition, treatment preferences and goals of care. The attending physician should document the reasons for any deviation from the POLST in the medical record.

c. Copy the POLST form for the medical record and/or scan into the electronic medical record.

d. If the patient is admitted to an inpatient unit, send the current original POLST with the patient to the inpatient unit.

e. Because the current original POLST is the patient's personal property, ensure its return to the patient, or legally recognized health care decisionmaker, upon discharge or transfer.

f. At discharge, send the most current original POLST with patient during any transfers to another health care facility or to home. Document in the medical record that the POLST was sent with the patient at the time of discharge.

g. If the patient lacks a POLST but they or their legally recognized healthcare decisionmaker wishes to complete a POLST form, the patient's physician should be contacted. The provider should discuss treatment options with the patient or legally recognized healthcare decisionmaker. The discussion should include information about the patient's advance directive (if any) or other statements the patient has made regarding his/her wishes for end of life care and treatments. These discussions should be documented in the medical record.

h. In order to be valid, the POLST must be signed by a physician, and by the patient or their legally recognized healthcare decisionmaker.

i. Discussions about revising or revoking the POLST should be documented in the medical record. At any time, the attending physician and patient or their legally recognized healthcare decisionmaker may review or revise the POLST consistent with the patient's most recently expressed wishes.

The POLST can be voided if the current POLST is no longer valid due to a patient changing his or her treatment preferences, or if a change in the patient's health status or medical condition warrant a change in the POLST,

If a new POLST is completed, a copy of the original POLST marked "VOID" (that is signed and dated) should be kept in the medical record directly behind the current POLST.

To void POLST, a line must be drawn through Sections A through D and "VOID" written in large letters. This line must be signed and dated. A legally recognized health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interest.

APPENDIX A: Conditions in which potentially life-sustaining treatments are considered medically inappropriate due to excessive burden and lack of sustainable benefits

1. In the following circumstances, medical interventions which are typically considered life-sustaining treatments are generally deemed to be medically inappropriate because they either provide no direct benefit to a patient or cause more harm than actual or reasonably expected potential benefits:

   a. The patient's death is imminent as determined by the Primary Attending (or designee).

   b. The patient has a condition in which medical interventions would, according to the judgment of the Primary Attending (or designed attending), only prolong the dying process that the Primary Attending (or designee) determines is already irreversibly underway.

c. Medical interventions are judged by the Primary Attending (or designed attending) to offer the patient no reasonable expectation of achieving the physiological effects for which they would be used, i.e., they are judged to be medically ineffective.

d. The patient has a medical condition for which the Primary Attending (or designed attending) does not expect medical interventions to achieve the patient's minimal acceptable outcome as expressed by the patient or as determined by the patient's Legal Representative or Surrogate in the patient's best interests (examples of minimal acceptable outcome would be restoring physical function of the organs, returning to a pre-morbid baseline, or achieving a certain activity of daily living or quality of life).

e. The patient has an irreversible, incurable or terminal condition in which the Primary Attending (or designed attending) determines that medical interventions would impose burdens greatly disproportionate to any expected patient benefit.

2. In those circumstances in which there is uncertainty or disagreement regarding whether proposed or current medical interventions are of benefit, consideration should be given to:
   a. The patient's personal or religious values to the extent known;
   b. The medical alternatives, burdens, risks and benefits of continued treatment
   c. The relief of suffering
   d. The possible preservation or restoration of function;
   e. The patient's medical condition, diagnosis, and prognosis;

   f. The impact of the decision on those people closest to the patient.

APPENDIX B: Recommended Documentation for Decisions Regarding Life-Sustaining Treatment Documentation

Medical situation: (Describe the medical situation that warrants limitation of treatment)
Diagnosis:
Prognosis:

Capacity and Decision-making: (check appropriate box)

- ☐ Patient has capacity to make and communicate decisions relating to his or her own healthcare.
- ☐ Patient lacks capacity, but has a surrogate and/or has an advance directive stating medical preferences. Surrogate's name:
  Relationship to patient:
- ☐ Patient lacks capacity, and has neither an appropriate surrogate, nor an advance directive.

- □ a diligent search has been made and no surrogate is available (e.g., a search of > 1 business day for a patient who is new to the hospital); By whom:
- □ all persons involved in the patient's treatment have disclosed any real or apparent conflicts of interest;
- □ all relevant medical information has been obtained and reviewed;
- □ opinions of the entire health care team have been reviewed, including documentation by an independent attending;
- □ the burden and benefit from the patient's view have been examined;
- □ consideration of economic impact on health care providers and the hospital has been excluded; and
- □ steps have been taken to ensure that the "benefit of continued life to a disabled patient is not devalued or underestimated".
- □ MC222 Appendix C Notification Form for Unrepresented Patients has been completed and left at the patient's bedside.

Patient/Family conference: Date:

Note participants and discussion:

Treatment plan: (choose appropriate box(es), and document additional information)

- □ 1. Do not intubate.
- □ 2. Do not attempt cardiopulmonary resuscitation or intubation.
- □ 3. Do not escalate disease directed therapy. Diagnostic tests should be used only if necessary, to monitor current therapy.
- □ 4. Withdraw life-sustaining treatment(s), provide comfort focused care. Indicate treatment(s) to be withdrawn:_
- □ 5. Other:_
- □ 6. No change in treatment.

Consent:

- □ I have informed the patient/surrogate of the patient's medical condition and prognosis, and of the nature, risks and benefits of recommended and alternative treatments including the option of not limiting therapy. I have done this to the degree I have judged to be adequate for decision-making by a reasonable person in the patient's/surrogate's circumstances. The patient/surrogate agrees with the above treatment plan.

- □ The patient is without capacity, without a surrogate, and without an advance directive. I certify that in seeking the patient's best interest I have complied with the MC222 Forgoing Life-Sustaining Treatment in the following manner.

Name of Attending Physician:

APPENDIX C: Notification Form for Unrepresented Patient at LAC+USC Medical Center

Patient Name:_____ Medical Record Number:_____
DOB:_____

Your doctor, Dr_____ has carefully evaluated your physical and medical condition and concluded that you don't have the ability to make decisions about your medical treatment.

The hospital has tried to find a family member or friend of yours to make health care decisions for you. The hospital hasn't been able to find anyone to do that. If you have a family member or friend who you want to make health care decisions for you, please tell us.

Your doctor has recommended the following treatment, believing that this is the best treatment for you under the circumstances:

A team of health care professionals, including your doctor and nurses and others, agrees that this is the best treatment for you.

> Unless your doctor receives direction otherwise, your doctor intends to proceed with this treatment. You can ask a judge to stop this treatment. You can also ask a judge to let you make your own health care decisions. You can contact a judge at:

Los Angeles County Superior Court
Metropolitan Court House
1945 South Hill Street Los Angeles, CA 90007

Your assigned hospital social worker, or the LAC+USC patient advocate office, may be able to help you contact a judge. If you are interested in this, please notify your nurse or doctor that you want to talk to a social worker or the hospital's patient advocate.

HOSPITAL EMPLOYEE TO COMPLETE:
I gave a copy of this form to the above-named patient on _____*[date]* at _____ *[time]* a.m./p.m.
Signature:
Print name:

Original to Patient **Copy in Medical Record**

RESPONSIBILITY

Attending Staff
Housestaff
Allied Health Professionals
Nursing Staff
Social Workers
Spiritual Care

PROCEDURE DOCUMENTATION

Medical Center Policy Manual

REFERENCES

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State of California: Probate Code Section 4701, (Amended by Stats. 2018, CH 287, Sec. 1. (AB 3211) Effective January 1, 2019.) and sections 4600-4805.

REVISION DATES

August 31, 1995; November 13, 1998; April 15, 1999; April 16, 2002; May 10, 2005; September 30, 2008; November 10, 2015, February 22, 2019; October 22, 2019; January 22, 2021