COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES
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Los Angeles County Department of Health Services

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PURPOSE:

The purpose of this policy is to provide guidelines in the decision-making process regarding non-beneficial or futile treatments for patients of the Los Angeles County Department of Health Services.

DEFINITION(S):

"ADVANCED HEALTH CARE DIRECTIVE (AHCD)": 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 advanced directive may contain information about a patient's desires concerning healthcare decisions, particularly decisions concerning end of life care. An AHCD allows a patient to make their health care wishes known if they are unable to speak for themself or prefer someone else to speak for them. An AHCD can serve one or both of these functions: Power of Attorney for Health Care (to appoint an agent), Instructions for Health Care (to indicate their wishes).

"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 (Probate Code 4609). A person has Capacity when he or she understands 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 with Capacity 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 a broad range of maneuvers and techniques used to restore spontaneous circulation and respiration.” (1) **“DO NOT RESUSCITATE” (DNR):** means a patient will not receive the following Life Sustaining Treatments in the event of a cardiac and/or respiratory arrest: cardiopulmonary resuscitation (CPR), assisted breathing with mechanical devices, electric shocks to the heart, placement on life support machines such as a breathing machine or ventilator, or treatment with medications that would artificially restart a stopped heart. It means "allow natural death." A “Do Not Resuscitate” order refers only to resuscitation efforts in the event of a cardiorespiratory arrest and should not influence other therapy that is appropriate for a particular patient.

“ETHICS COMMITTEE OR ETHICS SUBCOMMITTEE”: multidisciplinary committees 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. Ethics Subcommittees may be established to address the needs of unique patient populations, such as pediatric patients.

“HEALTH CARE DECISION LAW”: the statute that governs health care decisions and advanced 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 un-coerced acceptance (or refusal) of a medical treatment by a patient or patient’s LRHC Decision Maker after full 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.

“LEGALLY RECOGNIZED HEALTH CARE DECISION MAKER” or “LRHC Decision Maker”: a person who is recognized under the law as having the power to make health care decisions for a patient when that patient lacks decision-making Capacity; a LRHC Decision Maker can be referred to as a surrogate. Depending on the circumstances, the LRHC Decision Maker can be a family member, a friend, a patient’s designated decision-maker, an agent

under a Power of Attorney for health care, a court-appointed conservator, or a guardian. 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 LRHC Decision Maker to consent to or to refuse medical care for an incapacitated adult patient. A person designated as a health care agent by an Advanced Health Care Directive or a court appointed conservator, guardian or other appropriate LRHC Decision Maker can also provide such consent or refusal. The appropriate order for recognizing a LRHC Decision Maker is: a) an Advanced Health Care Directive appointed agent; b) a court appointed conservator or guardian with the power to make health care decisions; c) close family and/or friend. Decisions by a LRHC Decision Maker take precedence over opinions of any other person. The LRHC Decision Maker should act in accordance with treatment preferences stated by the patient, if known. It is the LRHC Decision Maker's responsibility to help health care providers understand what the patient would want under the current circumstances. What the LRHC Decision Maker 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 LRHC Decision Maker 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.

"POLST (Physician Orders for Life-Sustaining Treatment)": POLST stands for Physician Orders for Life-Sustaining Treatment and was adopted in California in 2009. This is a voluntary form, which must be signed by the patient (or their LRHC Decision Maker) and their physician, and indicates the types of treatment the patient does or does not want if they become seriously ill. A POLST asks for information about the patient's preferences for resuscitation, use of antibiotics, feeding tubes, etc. A POLST does not replace an AHCD, but helps translate it into medical orders that must be followed in all settings where medical care decisions are made. A POLST is a non-facility specific set of physician's orders regarding patient treatment. The form is completed by the physician (or other health care professional under the direction of a physician) after discussion with the patient or patients LRHC Decision Maker. The form is signed by the physician and also the patient or their LRHC Decision Maker. By California law, the orders must be followed by health care providers until a review has been completed, even if the form was signed by a physician not on staff at the facility.

"PROPORTIONATE BENEFIT": The potential benefit of a treatment weighed relative to the potential burden to the patient.

POLICY:

It is the right of an adult person with Capacity to consent to their own medical care after receiving information regarding the benefits, risks, and consequences of treatment

alternatives, even when such a decision might result in shortening the individual's life. This includes the right to refuse any treatment including life-sustaining treatment. A health care provider may decline to comply with treatment requests for reasons of conscience or when the treatment requires medically ineffective care or care that is contrary to generally accepted standards (Probate Code 4734). The following guidelines are designed to support patients and providers in this decision making process.

PRINCIPLES:

Dignity, hygiene and comfort of patients should be preserved in all circumstances.

Patients' Rights. California Code of Regulations, Title 22, Section 70707 provides that patients have the right to "Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment." (Section 70707(b)(6)). In addition, patients have the right to "Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient." (Section 70707(b)(16)).

1. Patients with Capacity

a. An adult person and/or minor who under California law may give legal consent to medical treatment has the right to make their own decisions regarding medical care after having been fully informed about the benefits, risks and consequences of treatment alternatives. They have the right to make such decisions that might result in shortening the individual's life.
b. Both terminal and non-terminal patients may refuse life-sustaining treatments.
c. 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 LRHC Decision Maker preferences.
d. Patients at times arrive at a health care facility with a pre-hospital "Do Not Resuscitate" form (such as the California Medical Association Emergency Medical Services Pre-hospital Do Not Resuscitate (DNR) Form or Physician Orders for Life-sustaining Treatment (POLST) indicating that the patient desires not to have cardiopulmonary resuscitation or other life-sustaining treatment. Providers should accept such a form as accurately indicating a person's desire not to undergo life-sustaining treatment and should not perform the treatment in such a situation. The instructions on the POLST or "Do Not Resuscitate" form should be followed until the situation can be assessed as specified in a facility's POLST policy. Exceptions to this guideline may be made, when new or additional information is made available, based on the physician's judgment.

   To insure it accurately reflects the patients' goals of care, a review of the POLST with the patient or LRHC Decision Maker is recommended whenever:

- The person is transferred from one care setting level to another, or
- There is substantial change in the person's health status, or
- The person's treatment preferences change.

A person with Capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences through verbal or written instructions including an AHCD or a new POLST form.

2. Patients without Capacity

a. For adult persons who lack Capacity, the legal authority to make decisions regarding life-sustaining treatment rests with a Legally Recognized Health Care Decision Maker (LRHC Decision Maker). See Definition of LRHC Decision Maker.
b. If a patient without Capacity, and whose wishes are not known, lacks family or close associates who are knowledgeable of the patient's values, beliefs and wishes or who, being present, choose not to be involved, then health care providers as a team (e.g. medical staff, nursing staff, and/or social worker) should determine what a reasonable and rational human being would want in the patient's circumstances. Generally, in such circumstances, there is a presumption in favor of sustaining life. When the health care team judges that a reasonable and rational person in the patient's circumstances would judge a treatment to be without benefit, or that the burdens of the treatment would be "markedly and clearly" disproportionate to the potential benefits, that treatment may be withheld or withdrawn. When there are significant disagreements among members of the health care team, consultation should be made with the Ethics Committee or Ethics Subcommittee (Refer to 2c in Procedures section).
c. Some patients who express a desire for aggressive treatment subsequently deteriorate medically to the extent that such treatment is no longer believed by the patient's physician or provider team to be in the patient's best interest. If this occurs when the patient no longer has Capacity, the physician and LRHC Decision Maker should then reevaluate what they believe the patient would want in light of the current medical situation. If the patient's probable wishes cannot be discerned, decisions regarding future care should be guided by what is believed to be in the patient's best interest. (Refer to 3 f. Physician obligations section).

3. Physician's obligations

a. Discussion about withholding or withdrawing therapy is clearly appropriate when any or a combination of the following apply:
   i. whenever such discussion is initiated by the patient, the patient's family, LRHC Decision Maker

   ii. when the patient has a disease that is terminal or in some other sense carries a grave prognosis (e.g., the patient is not expected to survive his or her current illness or hospitalization);
   iii. when the burdens of therapy may be disproportionate to the benefits including when the quality of the patient's life could be unacceptable to the patient, in spite of appropriate therapy.

b. It is the responsibility of the physician to provide sufficient information to the patient or LRHC Decision Maker to enable him or her to understand the medical condition, treatment options and possible consequences of the various treatment options. This process of communicating concerning treatment goals should begin at the earliest possible time.
c. Physicians should identify the patient's values and wishes and utilize that information in the consideration of available therapeutic options. The treatment plan then recommended to the patient or LRHC Decision Maker should be based on both medical appropriateness and the patient's and/or LRHC Decision Makers wishes. In the optimal circumstance, a mutually agreed upon goal of care is established.
d. 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 LRHC Decision Maker initiates the discussion.
e. Under ordinary circumstances, physicians (and health care providers and institutions) are required by California law (Probate Code 4650) to comply with a patient’s (or guardian’s or LRHC Decision Makers) health care instruction. However, physicians are sometimes asked by patients, guardians or LRHC Decision Maker to deliver life support measures which the physician believes to be inappropriate. Conflicts of this nature are usually resolved by extensive discussions among members of the health care team and the patient or LRHC Decision Maker. The Ethics Committee or Ethics Subcommittee may be called upon at any time to assist in the conflict resolution effort. In extreme cases, transfer of the patient's care to another physician may be necessary. The courts should be used as a last resort.
f. California law (Probate Code 4734) does provide that a health care provider or institution may decline to comply with an individual’s health care instruction under certain circumstances. “A health care provider may decline to comply with an individual health care instruction…”
   i. “…for reasons of conscience” (4734); or
   ii. “…that requires medically ineffective health care” (4735); or
   iii. that requires “…health care contrary to generally accepted health care standards.” (4735)

Specific steps must be taken by the health care provider/institution in this circumstance (see "Implementing and documenting decisions to forgo life-sustaining treatment" in Procedure Section 3g).

g. Document discussions and actions in the medical record per Procedure section 3 below.

4. Specific therapeutic issues

a. Medication should be given as indicated for pain or discomfort even if it may hasten death, but shall not be used with the primary intent to cause or hasten death.
b. Neuromuscular blocking agents should not be introduced when the ventilator is being withdrawn, and as a general rule, in patients who are already receiving neuromuscular blocking agents, neuromuscular function should be restored before the life support is withdrawn.
c. The burdens versus benefits of medically administered nutrition and hydration (including nasogastric or gastrostomy feedings, intravenously administered fluids, and hyper-alimentation) should be weighed in the same way as any other medical treatment. However, nutrition and hydration have a powerful symbolic significance to many persons, including caregivers and members of the public. It is therefore particularly important that persons caring for the patient fully understand the rationale for any decision to forgo medically administered nutrition and hydration.
d. Life-sustaining treatment need not be continued solely because it was initiated. In particular, mechanical ventilation need not be continued solely because it was initiated.
e. Refer to Procedure 4 for considerations during surgery.

PROCEDURE:

1. Determining Capacity

a. The patient's physician determines whether or not the patient has Capacity (as previously defined) by assessing the patient's ability to make and communicate treatment decisions as manifested by the following: i) an ability to understand the significant characteristics of one's disease, including prognosis and potential limitations to full recovery; ii) an ability to understand the inherent risks and benefits of the various treatment options; iii) an ability to understand the inherent risks and benefits of refusing treatment; and iv) an ability to consider these options relative to one's values and beliefs.
b. Determining that a patient lacks the Capacity to make decisions does not, in most circumstances, require a psychiatrist or neurologist. 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 or neurologic disease, an appropriate consultation should be obtained.

2. Making the decision to forgo or withdraw life-sustaining treatment

a. **Patients with Capacity** - The decision to forgo or withdraw Life Sustaining Treatment is made following a discussion/s between the physician and patient and/or LRHC Decision Maker. It is the Physician's responsibility to provide sufficient information to the patient or LRHC Decision Maker to enable him or her to understand the medical condition, treatment options and possible consequences of the various treatment options. Physicians should identify the patient's values and wishes and utilize that information in the consideration of available therapeutic options; the burden and benefit from the patients view should be examined. Consideration of economic impact on healthcare providers and hospital should be excluded. The treatment plan then recommended to the patient or LRHC Decision Maker should be based on both medical appropriateness and the patient's or LRHC Decision Maker's wishes. The process should include a mutually agreed upon goal of care if possible.

b. **Patients without Capacity and with a LRHC Decision Maker** - The decision to forgo or withdraw Life Sustaining Treatment is made following a discussion/s between the physician and LRHC Decision Maker. It is the Physician's responsibility to provide sufficient information to the LRHC Decision Maker to enable him or her to understand the medical condition, treatment options and possible consequences of the various treatment options. Physicians should identify the patient's values and wishes and utilize that information in the consideration of available therapeutic options; the burden and benefit from the patients view should be examined. Consideration of economic impact on healthcare providers and hospital should be excluded. The treatment plan then recommended to the LRHC Decision Maker should be based on both medical appropriateness and the patient's wishes. The process should include in the optimal circumstance, that a mutually agreed upon goal of care is established.

c. **Patients without Capacity and without a LRHC Decision Maker** - Patients who are unable to express their wishes and who have no other person or document to reflect their wishes presents a particularly complex issue. Prior to making the decision to forgo or withdraw Life Sustaining Treatment the following conditions should be met:

    i. a diligent search should be made and determined that no LRHC Decision Maker is available;

    ii. all persons involved in the patient's treatment have disclosed any real or apparent conflicts of interest;

    iii. one or more physicians in addition to the attending physician have examined the patient and concur in the prognosis.

The patient's healthcare team will consider the patient's medical condition, treatment options and possible consequences of the various treatment options. Treatment options should be based on what is best for the patient. Physicians should consider any known patient values and wishes and utilize that information in the consideration of available therapeutic options; the burden and benefit from the patients view should be examined. Consideration of economic impact on healthcare providers and hospital should be excluded. The recommended treatment plan should be based on these considerations. The process should include a mutually agreed upon goal of care if possible. Two mechanisms to resolve conflicts among members of the health care team are 1) solicitation of opinions from professionals who are not primarily involved in the care of the patient and 2) consultation with the Ethics Committee or Ethics Subcommittee. 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. The discussions to forgo or withdraw life-sustaining care for those with or without Capacity or without Capacity and without a LRHC Decision Maker should be documented in the medical record. (Refer to Section 3).

3. Implementing and documenting decisions to forgo life-sustaining treatment

a. If the patient has a POLST form, the medical team must review the form and write orders and document (as above) if the patient is admitted.
b. Documenting discussion - A decision to forgo Life-Sustaining Treatment 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. 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 LRHC Decision Maker for the patient, and summary of consultations with the LRHC Decision Maker, should also be placed in the progress notes. If the patient lacks Capacity and no LRHC Decision Maker can be found documentation should indicate that the conditions in the paragraph regarding "patients without Capacity and without a LRHC Decision Maker" (section "Making the decision to forgo life-sustaining treatments"—Procedures 2.b) have been satisfied. A physician may document in the progress note or use standard templates such as "Decision Regarding Life-Sustaining Treatment Documentation" form.
c. Informed Consent - Before implementation, the plans to forgo or limit care must have the patient's or LRHC Decision Maker's informed consent. When a person capable of giving informed consent decides to forgo or withdraw potentially life-sustaining procedures, a notation to that effect should be written in the progress notes of the medical record. When informed consent cannot be obtained and when patients lack Capacity without a LRHC Decision Maker the documentation should indicate that the

conditions in the paragraph regarding "patients without Capacity and without a LRHC Decision Maker" (in the section "Making the decision to forgo life-sustaining treatments"— Procedures 2.b) have been satisfied.

d. A "Do Not Resuscitate" order must be signed by a licensed physician. The physician should communicate to appropriate members of the health care team that such an order has been written. **Other terms—including "No CPR" "No ACLS" and "No BCLS"—will not be accepted as a valid order.**

e. The withdrawal of current treatments must have an order to that effect and documented in the medical record.

f. An attending physician must approve all decisions to forgo life-sustaining treatment. This approval may be given telephonically to a licensed physician who must then document this approval in the medical record, including the attending physician's name, in the progress notes or on the form entitled "Decisions Regarding Life-Sustaining Treatment Documentation".

A health care provider who declines to comply with an individual health care instruction shall do all of the following (Probate Code 4736):

i) "…promptly so inform the patient, if possible" [and/or the LRHC Decision Maker];

ii) "…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";

iii) "…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".

iv) inform his or her supervisor of the decision not to comply.

Consultation with an Ethics Committee or Ethics Subcommittee may be helpful (these steps are not a part of California law).

g. All decisions to forgo life-sustaining treatment (resuscitation) should be re-evaluated periodically as medically indicated. All reviews should be documented in the patient's medical record. A new order "Do Not Resuscitate" does not have to be rewritten whenever the patient is transferred to another service or ward. Once written, a "Do Not Resuscitate" order remains in effect unless specifically reversed by a new order ("discontinue Do Not Resuscitate order"). It is not necessary to rewrite such an order regularly, e.g., every 7 days.

h. When a “Do Not Resuscitate” order is suspended during a surgical procedure, the post-operative orders should reinstate the DNR order once the patient leaves the recovery room (Refer to Number 4 “Orders regarding resuscitation during surgery”).

4. Orders regarding resuscitation during surgery

a. There should be a reconsideration of the decision to withhold Life-Sustaining Treatment (resuscitation) for all patients undergoing surgery. Reconsideration may result in continuation of the order to “Do Not Resuscitate” 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 LRHC Decision Maker. 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. If after reconsideration, there is a decision to suspend the “Do Not Resuscitate” order during surgery, a physician’s order is written on the medical record as “Suspend Do Not Resuscitate order during operative procedure.”
b. No anesthesiologist or physician, can be required to participate in an operation when a “Do Not Resuscitate” order with which he or she disagrees exists. Should a physician refuse to participate they must follow procedures outlined above (3f).
c. When a “Do Not Resuscitate” order is suspended during a surgical procedure, the post-operative orders should reinstate the DNR once the patient leaves the recovery room.

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Resources

Check the California Coalition for Compassionate Care website at www.finalchoices.org for updates on advanced health care directive materials and community education programs.

Advanced Health Care Directive Forms:

~ Download forms in English, Spanish and Chinese from the Coalition website at www.finalchoices.org. ~ Forms are often available at no charge from your local hospital- call the Social Services or Patient Education department, or ask your doctor.

~ The California Medical Association has an Advanced Health Care Directive Kit available in English or Spanish for $5 that includes a form, wallet card and answers to commonly asked questions about advanced directives. To order single copies, call 1-800-882-1262 or visit www.cmanet.org.

~ Five Wishes is a user-friendly advanced directive that addresses the medical, personal, emotional and spiritual wishes of seriously ill persons. To order single copies in English or Spanish at $5 each, send a check or money order to Aging With Dignity, PO Box 1661, Tallahassee, FL 32302-1661. A companion 30-minute video is available for $19.95. For more information call1-888-5-WISHES.

~ Caring Connections has state-specific forms that can be downloaded at www.caringinfo.org

Fact Sheets in Spanish and Chinese:

~ Available on the Coalition website at www.finalchoices.org.

Booklets for consumers:

~ Finding Your Way: A Guide for End-of-Life Medical Decisions. This 13-page, easy-to-read booklet helps those who are starting the advance care planning process or considering whether to initiate or withdraw Life Sustaining Treatment when the end of life is near. Also available in Spanish.

~ Mrs. Lee's Story: Medical Decisions Near the End of Life. This 16-page booklet written in Chinese and English relates the story of 91-year old Mrs. Ming Lee to introduce health issues that concern Chinese elders and their families. It includes basic information on advanced health care planning and advanced directives, pain management and hospice care.

For a single copy of either of the above booklets, send $1.50 check payable to "Center for Healthcare Decisions" to CHCD, 3400 Data Drive, Rancho Cordova, CA 95670 or visit www.chcd.org. Also available at volume rates.

DHS Policy 326, An Adult Patient's Right to Participate in and Direct Decisions Affecting his/her Healthcare