LOMA LINDA UNIVERSITY
MEDICAL CENTER

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OPERATING POLICY

CATEGORY:	PATIENTS' RIGHTS	**CODE:**	P-15
		EFFECTIVE:	09/2019
SUBJECT:	CODE STATUS/ LIMITATION OF TREATMENT FOR PATIENTS BETWEEN BIRTH AND THE EIGHTEENTH BIRTHDAY	**REPLACES:**	08/2016
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PHILOSOPHY:

LLUMC recognizes the interests of parents and appropriate surrogates in decisions regarding withholding or withdrawing life-sustaining treatment for their children, while also recognizing the concurrent duty of health care providers to act in the best interest of patients. In addition, the varying degrees of emerging autonomy exhibited by older children who are chronically or terminally ill, and these children's interest in such decisions, are also recognized. Consequently LLUMC is committed to the principle of shared decision-making based on the best interest of pediatric patients.

Sometimes patients and/or families and the healthcare team disagree regarding what is in the best interest of a patient. While autonomy holds that patients or their decision makers who have decision making capacity are allowed to refuse any and all treatments, autonomy does not mean that patients and/or surrogates can demand treatments that are potentially inappropriate. For example, clinicians do not have to prescribe antibiotics for a viral infection even when a patient or family demands it. Similarly, CPR is a medical procedure that has indications and contraindications. No patient has an autonomous right to demand CPR. There may be situations in which the healthcare team believes CPR is more harmful than helpful and does not have to perform it. In these rare cases, a unilateral DNAR order may be entered into the chart and the patient and/or family informed of the reasons for this. According to the multisociety policy statement on Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units:

> "The committee recommends: (1) Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultants. (2) The term "potentially inappropriate" should be used, rather than futile, to describe treatments that have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing them. Clinicians should explain and advocate for the treatment plan they believe is appropriate. Conflicts regarding potentially inappropriate treatments that remain intractable despite intensive communication and negotiation should be managed by a fair process of conflict resolution; this process should include hospital review, attempts to find a willing provider at another institution, and opportunity for external review of decisions. When time pressures make it infeasible to complete all steps of the conflict-resolution process and clinicians have a high degree of certainty that the requested treatment is outside accepted practice, they should seek procedural oversight to the extent allowed by the clinical situation and need not provide the requested treatment. (3) Use of the term "futile"

should be restricted to the rare situations in which surrogates request interventions that simply cannot accomplish their intended physiologic goal. Clinicians should not provide futile interventions."

Am J Respir Crit Care Med. 2015 Jun 1;191(11):1318-30. doi: 10.1164/rccm.201505-0924ST.
An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units.

Related Policies:
Patients' Rights and Responsibilities (P-1)
Patient Consent (P-2)
Patients' Rights Regarding Advance Directives and Acceptance/ Refusal of Medical Care (P-10)
Conflict Resolution Regarding Patient Care (P-12)

DEFINITIONS: For purposes of this policy,

Patient:
A pediatric patient between birth and 18 years of age (Patients shall be considered adults on and after their eighteenth birthday). For patients with the legal status of emancipated minor, General Counsel should be consulted.

Parent(s):
Either biologic or adoptive parents; or legally designated surrogate decision-makers, such as court-appointed guardians and conservators; or other personally involved advocates with moral standing in decision-making of the affected child, to be determined on a case-by-case basis in accordance with hospital policy and relevant law.

Limitation of Treatment (LOT) order:
One which directs that one or more specifically named treatment modalities are not to be initiated or continued.

"Do Not Attempt Resuscitation" (DNAR) order:
One example of a limitation of treatment order, one which directs that resuscitative efforts are not to be initiated in the event of cardiac and/or respiratory arrest. No chest compressions and no ventilatory support shall be used. However, in the event the conditions surrounding the arrest are considered unique and not part of the natural cause of the underlying disease or illness for which DNAR was originally ordered, the physician or health care worker shall use his/her reasoned medical judgment in determining whether to use CPR, such as if an arrest occurs during complication of therapeutic treatment. If it is the patient's wish that no resuscitative efforts be made, even in such situations, the DNAR order shall stand.

Physician Orders for Life-Sustaining Treatment (POLST):
A document created from a California law (2009) that serves as a communication of patient wishes regarding life-sustaining treatment. It applies across various treatment settings and is supplemental to an advance directive, if there is one. It translates patient wishes into orders for treatment and/or the withholding of treatment.

A. GENERAL PROVISIONS

1. The patient's attending physician shall assume the responsibility for

1.1 Determining the medical diagnosis as well as the short and long term prognosis,

1.2 Providing the patient and the parent or surrogate decision-maker with any and all necessary information in an understandable manner so that an informed decision concerning the withholding and/or withdrawing of medical treatment can be made.

1.3 Providing patients/families with information on end-of-life options as requested, including but not limited to:
- a. Verbal information
- b. Pamphlets and other written materials
- c. Requesting Social Work to provide information on counseling resources

Note: Reference Policy Information and Counseling for Terminal Illness (M-139)

2. The attending physician or his/her licensed designee shall:

2.1 Discuss with the patient and parent
- a. The patient's condition and prognosis, including benefits vs. burdens of life-sustaining treatments
- b. All elements of informed consent (reference Policy Patient Consent (P-2))

2.2 Document in the medical record (to include but not be limited to) the following:
- a. Diagnosis and condition; prognosis
- b. Patient's capacity for decision-making
- c. Summary of discussions with patient or agent for making decisions and family, including all elements of the informed consent process (if there is a decision to limit treatment, the conversation should be documented in the Limitation of Treatment Progress Note),
- d. Basis of decision for limitation of treatment
- e. Goals for further therapy
- f. The benefits vs. burdens of life-sustaining treatments.

2.3 The attending physician or a licensed resident physician, in consultation with the attending physician, writes any needed orders when it has been decided that resuscitation measures are to be withheld or other treatment is to be limited.

Note: Nurse Practitioners and Physician Assistants under the direction of a physician and within their scope of practice may enter orders consistent with a POLST or Advance Directive.

3. The assent or dissent of a patient to treatment decisions shall be given an appropriate degree of consideration, warranted by and proportional to, the emerging autonomy of that patient (e.g., mature minor), or warranted by that patient's legal status (e.g., emancipated minor), in accordance with LLUMC Policies Patient Consent (P-2) and Patients' Rights and Responsibilities (P-1).

4. Limitation of treatment (including withholding of CPR) and discontinuation of life-sustaining procedures orders shall be reviewed by the licensed physician when there is a change in the patient's condition, or at the request of the patient, parent or surrogate decision-maker, as appropriate, when the patient is transferred to another service, and when the patient changes to another level of care (e.g., from ICU to acute care).

4.1 A change in code status must first be personally clarified with the patient/parents by the ordering licensed physician

4.2 A code status order written by a resident should be discussed first with the attending physician.

5. The physician performing a procedure/operation shall review a DNAR/LOT order with a patient who is scheduled for surgery or other invasive procedure and/or the parent or surrogate decision-maker whether the DNAR/LOT order shall be suspended during the surgery/procedure and during the recovery period. The discussion and decision shall be documented.

5.1 The wishes of the patient, where appropriate, or parent shall be honored if the patient or parent does not wish to suspend the DNAR/LOT order.

a. If the patient/parent does not want the Limitation of Treatment/DNAR order to be suspended for the procedure/surgery, the physician may indicate that the procedure/surgery cannot be done under those conditions.

5.2 If a DNAR/LOT order has been temporarily suspended, it shall be reentered in the medical record once the patient has completed the recovery phase.

6. Physicians/NP's/PA's who have had conversations with hospitalized patients/parents regarding goals of care, and who are subsequently discharging those patients, should complete a POLST form to ensure that other providers are aware of those patients' wishes

B. DISCONTINUING LIFE SUSTAINING PROCEDURES

1. The following conditions shall be met when considering the discontinuance of life sustaining procedures:

1.1 The attending physician shall determine and document that:

a. The parent or surrogate decision maker, or patient when appropriate, chooses to discontinue the life sustaining procedures when it has been determined and documented that the conditions in items1) through 5) below have been met.

1) The patient has a condition that, without the administration of life sustaining treatment will, within reasonable medical judgment, result in death.

2) Discontinuation of life sustaining procedures is consistent with the parents'/surrogate decision maker's and, when appropriate, patient's desires.

3) The likely burdens of continued treatment would be disproportionate in terms of the anticipated benefits.

4) There is a full understanding by the parent/surrogate decision maker, and when appropriate, the patient, of the consequences of the discontinuation of life sustaining treatment.

5) The patient's attending physician agrees that the decision under consideration has been made in the best interest of the patient.

1.2 It is recommended that the Organ Procurement Organization (OPO – currently One Legacy) be notified within 60 minutes of awareness that the patient/family are considering withdrawal of support so they can evaluate prior to withdrawal whether organ donation after circulatory death may be an option.

2. There shall be documentation in a Limitation of Treatment progress note, and full documentation in the patient's medical record which demonstrates the

parents'/surrogate decision maker's and, when appropriate, the patient's understanding of

2.1 All treatment options

2.2 The likely results, including the benefits vs. burdens of treatment options.

2.3 The discussion concerning the discontinuation of life sustaining treatment, and

2.4 Responses of the parent(s)/surrogate decision maker and the patient.

3. An attending physician's order shall be required for the discontinuation of life sustaining procedures.

4. All efforts will be made to ensure the comfort of a patient once life-sustaining therapies have been withheld or withdrawn, including Palliative Care consultation as needed.

C. RESOLVING CONFLICTS

1. While physicians or other health care providers shall not be obligated to do that which violates their consciences or professional judgment regarding withholding or withdrawing life-sustaining treatment, the physician or other health care provider shall take all reasonable steps, as promptly as practicable, to transfer care of the patient to another physician or health care provider who is willing to care for the patient as the patient or the agent for making decisions has requested.

2. Any unresolved disagreements among the attending physician(s), members of the health care team, the patient/parent, and/or family members concerning life sustaining procedures for the patient shall be referred to the Clinical Ethics Service for consultation (reference Policies Clinical Ethics Consultations (M-138) and Conflict Resolution Regarding Patient Care (P-12)).

APPROVERS: Hospital Executive Leadership, LLUMC Chief Executive Officer, LLUMC Ethics Committee, LLUMC Medical Staff President and Chair of MSEC, Senior VP, Patient Care Services