LOMA LINDA UNIVERSITY
MEDICAL CENTER

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OPERATING POLICY

CATEGORY:	PATIENTS' RIGHTS	**CODE:**	P-23
		EFFECTIVE:	08/2017
SUBJECT:	HEALTHCARE DECISIONS FOR UNREPRESENTED PATIENTS	**REPLACES:**	06/2016
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Related Polices:
Patients' Rights and Responsibilities (P-1)
Patient Consent (P-2)
Emergency Treatment When Consent is Unobtainable (P-8)
Patients' Rights Regarding Advance Directives and Acceptance/ Refusal of Medical Care (P-10)
Family/Representative/Personal Physician Notification of Admission (P-22)

Purpose:

To provide a process for making ethically and medically appropriate treatment decisions on behalf of persons who lack health care decision-making capacity and for whom there is no surrogate decision-maker designated by an Advance Directive or POLST form, or via declaration while hospitalized when still determined to have decision-making capacity.

This policy does not address the criteria for determining and appointing an appropriate surrogate decision-maker. This policy is not meant to be applied in emergency medical situations. This policy shall not apply to decisions pertaining to disposition of remains, autopsies, or anatomical gifts. This policy shall not apply to decisions pertaining to termination of pregnancy.

A. This policy may be used when the following conditions are met.

1. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) to lack capacity to make health care decisions. Capacity means 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. Capacity can be situation specific and may change throughout the duration of the patient's hospitalization due to the patient's underlying medical condition(s). Conditions for which psychiatric or psychological treatment may be required do not, in and of themselves, constitute a lack of capacity to make health care decisions.

2. No agent, conservator, or guardian has been designated to act on behalf of the patient.

3. No surrogate decision-maker or family member can be located who is reasonably available and who is willing and able to serve. Efforts to locate a surrogate should be

diligent and may include contacting the facility from which the patient was referred, and contacting public health or social service agencies known to have provided treatment for the patient.

B. MEDICAL DECISIONS

1. When use of this policy is appropriate (as outlined above) medical decisions shall be made with guidance from a multi-disciplinary team whose members shall include, but not be limited to, individuals directly involved with the care of the patient. The multi-disciplinary team may include:

   1.1 If possible one or more persons familiar with the patient who may have moral authority but not legal authority to make medical decisions such as a friend

   1.2 An attending physician and any physician(s) who is under the supervision of the attending physician

   1.3 Palliative Care team

   1.4 Nurse(s) familiar with the patient

   1.5 Social worker familiar with the patient

   1.6 Case Management representative

   1.7 Ethics consultant on-call and any person under the supervision of the ethics consultant

   1.8 Non-medical (community) member

   1.9 If available and appropriate, any consulting clinicians, pastoral care staff, academic ethicist, and/or other allied health professionals.

2. In order to determine the appropriate medical treatment for the patient, the multi-disciplinary team should:

   2.1 Review the diagnosis and prognosis of the patient and assure itself of the accuracy thereof.

   2.2 Determine appropriate goals of care by weighing the following considerations:

   a. Patient's previously-expressed wishes, if any and to the extent known
   b. Relief of suffering and pain
   c. Preservation or improvement of function
   d. Recovery of cognitive functions
   e. Quality and extent of life sustained

f. Degree of intrusiveness, risk or discomfort of treatment
g. Cultural or religious beliefs, to the extent known

2.3 Establish a care plan based upon the patient's diagnosis and prognosis and the determination of appropriate goals of care. The care plan should determine the appropriate level of care, including categories or types of procedures and treatments.

a. Except to the extent that such a factor is medically relevant, any medical treatment decision made pursuant to this policy shall not be biased based on the patient's age, sex, race, color, religion, ancestry, national origin, disability, marital status, sexual orientation, or any other category prohibited by law, the ability to pay for health care services, or avoidance of burden to family/others or to society.

b. Under the terms of this policy, the multi-disciplinary team may make the same treatment decisions, and will have the same limitations, as does an agent appointed pursuant to a power of attorney for health care specified under current law.

c. The multi-disciplinary team shall assure itself that the medical decision is made based on sound medical advice, is in the patient's best interest and takes into account the patient's values, to the extent known. In determining the best interest of the patient, it is not required that life support be continued in all circumstances, where treatment is otherwise judged non-beneficial or is medically ineffective or contrary to generally-accepted health care standards, when the patient is terminally ill and suffering, or where there is no reasonable expectation of the recovery of cognitive functions.

2.4 Notify the patient that:

a. The patient has been determined to lack decision-making capacity;

b. It has been determined that he or she lacks a surrogate decision maker;

c. Medical intervention has been prescribed; and

d. The patient has the opportunity to seek judicial review of the above determinations.

3. AGREEMENT ON TREATMENT

3.1 If all members of the multi-disciplinary team agree to the appropriateness of providing treatment, it shall be provided.

3.2 If all members of the multi-disciplinary team agree to the appropriateness of withholding or withdrawing treatment, it shall be withdrawn or withheld. Any implementation of a decision to withhold or withdraw life-sustaining medical treatment shall be the responsibility of the primary treating physician.

4. DISAGREEMENT ON TREATMENT

4.1 If the members of the multi-disciplinary team disagree about the care plan, the ethics committee members as recommended by the chair shall meet with the team to explore their disagreement and facilitate resolution.

a. If agreement is reached either to provide or to forgo treatment, the decision of the multi- disciplinary team then becomes final.

b. If agreement still is not reached, current treatments shall be continued and any other medically necessary treatments provided, until such time that the issue is resolved through court intervention or the disagreement is otherwise resolved after presentation at an ethics case conference followed by an ethics committee meeting. Court-imposed legal remedies should only be sought in extreme circumstances and as a last resort.

c. In all cases, appropriate pain relief and other palliative care shall be continued.

5. EXCEPTIONAL CIRCUMSTANCES

5.1 LLUMC's legal counsel may be consulted even barring exceptional circumstances, but should be consulted if a decision to withdraw or withhold treatment is likely to result in the death of the patient and the situation arises in any of the following circumstances:

a. The patient's condition is the result of an injury that appears to have been inflicted by a criminal act.

b. The patient's condition was created or aggravated by a medical accident.

c. The patient is pregnant.

d. The patient is a parent with sole custody or responsibility for support of a minor child.

6. DOCUMENTATION

6.1 Signed, dated and timed medical record progress notes shall be written for the following:

a. The findings used to conclude that the patient lacks medical decision-making capacity,

b. The finding that there is no advance health care directive, no conservator, guardian or other available decision-maker, in the patient's medical record or other available sources,

c. The attempts made to locate surrogate decision-makers and/or family members and the results of those attempts,

d. The bases for the decision to treat the patient and/or the decision to withhold or withdraw treatment, and

e. Any information from the ethics committee or other consult, should it be convened.

References:
Cal. Health & Safety Code § 1418.8
Cal. Prob. Code §§ 4617, 4650, 4652, 4683, 4717, 4734, 4735, and 4736

APPROVED: Hospital Executive Leadership, LLUMC Board, LLUMC Chief Executive Officer, LLUMC Chief Nursing Officer, LLUMC Ethics Committee, LLUMC Medical Staff President and Chair of MSEC