



## E-2.225 Optimal Use of Orders - Not - To - Intervene and Advance Directives

More rigorous efforts in advance care planning are required in order to tailor end-of-life care to the preferences of patients so that they can experience a satisfactory last chapter in their lives. There is need for better availability and tracking of advance directives, and more uniform adoption of form documents that can be honored in all states of the United States. The discouraging evidence of inadequate end-of-life decision-making indicates the necessity of several improvement strategies:

- (1) Patients and physicians should make use of advisory as well as statutory documents. Advisory documents aim to accurately represent a patient's wishes and are legally binding under law. Statutory documents give physicians immunity from malpractice for following a patient's wishes. If a form is not available that combines the two, an advisory document should be appended to the state statutory form.
- (2) Advisory documents should be based on validated worksheets, thus ensuring reasonable confidence that preferences for end-of-life treatment can be fairly and effectively elicited and recorded, and that they are applicable to medical decisions.
- (3) Physicians should directly discuss the patient's preferences with the patient and the patient's proxy. These discussions should be held ahead of time wherever possible. The key steps of structuring a core discussion and of signing and recording the document in the medical record should not be delegated to a junior member of the health care team.
- (4) Central repositories should be established so that completed advisory documents, state statutory documents, identification of a proxy, and identification of the primary physician can be obtained efficiently in emergency and urgent circumstances as well as routinely.
- (5) Health care facilities should honor, and physicians use, a range of orders on the Doctor's Order Sheet to indicate patient wishes regarding avoidable treatments that might otherwise be given on an emergency basis or by a covering physician with less knowledge of the patient's wishes. Treatment avoidance orders might include, along with a Do Not Resuscitate (DNR) order, some of the following: Full Comfort Care Only (FCCO); Do Not Intubate (DNI); Do Not Defibrillate (DND); Do Not Leave Home (DNLH); Do Not Transfer (DNTransfer); No Intravenous Lines (NIL); No Blood Draws (NBD); No Feeding Tube (NFT); No Vital Signs (NVS); and so forth. One common new order, Do Not Treat (DNT), is specifically not included in this list, since it may unintentionally convey the message that no care should be given and the patient may lose the intense attention due to a dying person; FCCO serves the same purpose without the likely misinterpretation. As with DNR orders, these treatment avoidance orders should be revisited periodically to ensure their continued applicability. Active comfort care orders might include Allow Visitors Extended Hours (AVEH) and Inquire About Comfort (IAC) b.i.d. (twice daily). (I, IV)

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## E-8.081 Surrogate Decision-Making

Competent adults may formulate, in advance, preferences regarding a course of treatment in the event that injury or illness causes severe impairment or loss of decision-making capacity. These preferences generally should be honored by the health care team out of respect for patient autonomy. Patients may establish an advance directive by documenting their treatment preferences and goals in a living will or by designating a health care proxy (durable power of attorney for health care) to make health care decisions on their behalf.

In some instances, a patient with diminished or impaired decision-making capacity can participate in various aspects of health care decision-making. The attending physician should promote the autonomy of such individuals by involving them to a degree commensurate with their capabilities.

If a patient lacks the capacity to make a health care decision, a reasonable effort should be made to identify a prior written expression of values such as a pertinent living will, or a health care proxy. When reasonable efforts have failed to uncover relevant documentation, physicians should consult state law. Physicians should be aware that under special circumstances (for example, reproductive decisions for individuals who are incompetent), state laws may specify court intervention. In the absence of state law specifying either appropriate surrogate decision-makers or a process to identify them, the patient's family, domestic partner, or close friend should become the surrogate decision-maker. When there is no family, domestic partner, or close friend, persons who have some relevant knowledge of the patient should participate in the decision-making process. In all other instances, a physician may wish to consult an ethics committee to aid in identifying a surrogate decision-maker or to facilitate sound decision-making.

When there is evidence of the patient's preferences and values, decisions concerning the patient's care should be made by substituted judgment. This entails considering the patient's advance directive (if any), the patient's views about life and how it should be lived, how the patient has constructed his or her identity or life story, and the patient's attitudes towards sickness, suffering, and certain medical procedures.

If there is no reasonable basis on which to interpret how a patient would have decided, the decision should be based on the best interests of the patient, or the outcome that would best promote the patient's well-being. Factors that should be considered when weighing the harms and benefits of various treatment options include the pain and suffering associated with treatment, the degree of and potential for benefit, and any impairments that may result from treatment. Any quality of life considerations should be measured as the worth to the individual whose course of treatment is in question, and not as a measure of social worth. One way to ensure that a decision using the best interest standard is not inappropriately influenced by the surrogate's own values is to determine the course of treatment that most reasonable persons would choose for themselves in similar circumstances.



Physicians should recognize the proxy or surrogate as an extension of the patient, entitled to the same respect as the competent patient. Physicians should provide advice, guidance, and support; explain that decisions should be based on substituted judgment when possible and otherwise on the best interest principle; and offer relevant medical information as well as medical opinions in a timely manner. In addition to the physician, other hospital staff or ethics committees are often helpful to providing support for the decision-makers.

In general, physicians should respect decisions that are made by the appropriately designated surrogate and based on the standard of substituted judgment or best interest. In cases where there is a dispute among family members, physicians should work to resolve the conflict through mediation. Physicians or an ethics committee should try to uncover the reasons that underlie the disagreement and present information that will facilitate decision-making. When a physician believes that a decision is clearly not what the patient would have decided, could not be reasonably judged to be within the patient's best interests, or primarily serves the interest of a surrogate or a third party, an ethics committee should be consulted before requesting court intervention.

Physicians should encourage their patients to document their treatment preferences or to appoint a health care proxy with whom they can discuss their values regarding health care and treatment in advance. Because documented advance directives are often not available in emergency situations, physicians should emphasize to patients the importance of discussing treatment preferences with individuals who are likely to act as their surrogates. (I, III, VIII)

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