# EP15 – ETHICS, PRIVACY, SECURITY AND CONFIDENTIALITY

## APPLYING RESOURCES TO ADDRESS AN ETHICAL ISSUE

*Provide one example, with supporting evidence of nurse(s) as participant(s) of an interprofessional team, applying available resources to address ethical issues related to clinical practice.*

### Ethics Resources

At NewYork-Presbyterian/Columbia University Irving Medical Center (NYP/Columbia), healthcare team members, inclusive of nurses, have access to ethics resources via the hospital's internal website, the Infonet, which offers information about medical ethics, the Ethics Committee, Patient Services Administration, ethics consultation services, and access to ethics-related hospital policies. Nurses and other healthcare team members can also readily access communication to ethicists through the electronic health record on Epic while providing care to their patients. Nurses are an integral part of the interprofessional healthcare team. At NYP/Columbia, the patient's interprofessional healthcare team works together and applies organizational resources to address ethical issues related to their patient's care. EP15.1—Ethics Resources

### Ethical Issue in Clinical Practice

On June 11, 2023, Christine Yany, BSN, RN, CHPN, CCRN, clinical nurse, CCU (5MB/HH-605495) [CCU], cared for a 75-year-old male patient with progressively worsening heart failure who expressed to Ms. Yany his wishes to die. The patient had recently received intra-aortic balloon pump therapy followed by escalation to an Impella® heart pump for hemodynamic stabilization; however, the patient did not wish to continue relying on these devices and repeatedly stated to Ms. Yany, "Take it all out. I want to go," every time Ms. Yany entered his room. That same day, Ms. Yany sought support to address the ethical issue from interprofessional team member Fatimah Alkhunaizi, MD, cardiology fellow, who verified the patient's wishes including his desire

to withdraw life-sustaining treatment to facilitate his passing. Dr. Alkhunaizi explained the ethical decision-making process to the patient and Ms. Yany that needed to be followed for withdrawal of life-sustaining treatment to the patient. They discussed that his worsening condition was complicated by treatment failure with advancing cardiogenic shock. EP15.2—Ethical Issue in Practice_Nursing Note

**Interprofessional Healthcare Team Applies Ethics Resources in Practice**

Later that day, Ms. Yany and Justin Fried, MD, attending physician, Cardiology, applied ethics resources by accessing the NYP Infonet to review the *Organizational Ethics Policy*, which guided them to affirm the patient's right to high quality end-of-life palliative care. Dr. Alkhunaizi, in consultation with Dr. Fried and the interprofessional team, ordered a palliative care consultation by Mary Callahan, MD, MS, attending physician, Palliative Medicine, to advise on symptom management and end-of-life palliative care that is respectful of patient preferences. Dr. Callahan recommended administering IV hydromorphone as needed (PRN) for any discomfort, continuing dexmedetomidine infusion, and starting lorazepam PRN for anxiety with psychiatry team involvement. The interprofessional team, including Ms. Yany, exchanged communication with Dr. Callahan, the patient, and the patient's family since the patient's wife was the legal surrogate decision-maker. EP15.3—Palliative Care Consult and Organizational Ethics Policy

The interprofessional team implemented the recommendations for palliative care as the patient's condition progressed to an unresponsive state. That afternoon Jhoanne Hilario, MSN, RN, Adult Gerontology Acute Care Nurse Practitioner, Advanced Care Planning (at the time), and Patient Services Representative, acted to allay concerns expressed by the team related to family congruence of wishes. Ms. Hilario held a family meeting with patient's wife, son, brother, daughter in law, and sister, to establish end-of-life decisions and Withdrawal of Treatment orders. While offering support and providing essential information to the family about the patient's condition and treatment options, Ms. Hilario, Dr. Fried, and other interprofessional team providers gathered feedback from the surrogate and family members about their mutual decision to keep the patient comfortable and not pursue aggressive interventions. EP15.4—Family Meeting with APRN and team

Thereafter, Dr. Fried attested to the order to Withdraw the Impella, drips, and continue with transition to comfort measures completed by Dr. Alkhunaizi. The interprofessional team further applied ethic resources, when they notified the Administrator on Call/ Patient Services Representative, for the case review per organizational policy. Lynsey Lipowicz, MBA, BSN, RN, Administrator on Call, Advanced Care Planning completed

the necessary documentation review as mandated by organizational policy. Thereafter the interprofessional team, inclusive of nurses, huddled to share decisions and provide support to the team and family. The clinical nurses, with the interprofessional team, demonstrated compassion and use of ethic resources through the patient's final days.
EP15.5—Patient Services and Withdraw Treatment Policy with APC Note

# Ethics

Posted 1/8/2021 11:32 AM

- NYPH Bereavement Book

Medical ethics is increasingly recognized as an essential element of clinical practice, medical education, and clinical research. NewYork-Presbyterian Hospital is committed to providing the highest ethical standards of patient care, as we strive to fulfill our promise of "We Put Patients First".
Ethics Committees, working in conjunction with Patient Services Administration, are available to assist patients, families and staff. The Ethics Committees, which report to the Hospital's Medical Board, are responsible for providing:

1) A medical ethics consultation service to address ethical issues arising in patient care, in association with Patient Services Administration.
2) Medical ethics education for physicians, nurses and all members of the clinical team.
3) Assistance to the Hospital in the formulation of policies and procedures relating to medical ethics.

**Ethics Consultation Service**

Dealing with ethical dilemmas in patient care can be challenging. The Hospital provides support for patients, families, and clinical staff to address difficult questions and issues. The offices of Patient Services Administration work with the Ethics Committees at each campus to respond to inquiries questions and assist with ethical questions or concerns related to patient care. Any member of the hospital staff, patient, or patient's representative may request an "ethics consultation." The consultant may see the patient, interview family members as needed, discuss the case with the clinical team and, when appropriate, write a consult note in the chart. Selected cases are presented to the entire Ethics Committee for educational purposes. Straightforward questions may be handled by phone.

**How to call an Ethics Consultation:**

NYP/Weill Cornell: Patient Services Administration, 212-746-4293 (ext 64293)
NYP/Westchester: Patient Services Administration 914 997-5920
NYP/Columbia: Patient Services Administration, 212-305-5904 (ext 55904)
MSCHONY:: Patient Services Administration, 212-305-5904 (ext 55904) MSCHONY Ethics Consult Schedule
NYP/Allen: Patient Services Administration, 212-932-4321 (ext 44321)
NYP/Lower Manhattan: Patient Services Administration, 212 312-5034

**When to call an Ethics Consultation:**

There should be a low threshold for calling an Ethics Consultation. Common reasons for elective ethics consultation include questions, concerns, or disputes about:

**When to call an Ethics Consultation:**
There should be a low threshold for calling an Ethics Consultation. Common reasons for elective ethics consultation include questions, concerns, or disputes about:

End-of-life care (DNR, comfort care, etc.)
Conflicts (family-physician, intra-family, among physicians, etc.)
Patient (or family) refusing treatment
Futility of care
Patient decision making capacity
Surrogate decision-making
Brain death determination

Ethics consultation is required by hospital policy before:

1) Withdrawing life-support (ventilator, dialysis, pressors, etc)
2) Withholding or Withdrawing nutrition and/or hydration
3) Extubating a brain dead patient in the case of objection of family
4) Discontinuation of implanted cardiac devices (AICD/PPM/VAD)

The Ethics Consultant may refer questions regarding Hospital policy and the legal standard of care to the Office of Legal Affairs and Risk Management or to any other appropriate resource.

**Link to Hospital Policies**

- Advance Directives
- Consent for Autopsy
- Brain Death (adult)
- Brain Death (pediatrics)
- Death – Autopsy
- Death - Organ Donation
- Protocol for Donation after Cardiac Death
- Disclosure
- DNR Orders
- DNR Dispute Mediation
- Health Care Proxy Law
- Informed Consent - Refusal
- Living Wills
- Organizational Ethics
- Pain Management
- Patients Rights and Responsibilities
- Patient Services Administration
- Use and Control of Investigational Drugs

**Important Documents**

- Healthcare Proxy Form
- Healthcare Proxy Form - Spanish
- Healthcare Proxy Form - Chinese
- Patient Bill of Rights
- Patient Bill of Rights - Spanish
- Ethics Brochure CUMC

Christine Yany, RN
Registered Nurse
Med - Cardiology - Critical Care

Nursing Note
Signed

Date of Service: 6/11/2023 9:08 AM

**Summary:** Patient wishes to die

Patient motioning for nurse to come over to bedside. Pt states "I tried to go," showing nurse bloody finger he had been chewing on. Pt tearful, states "why did I not die?" Pt states "I won't do it again, sorry to bother you, but please take it all out." Pt perseverating on the phrase, "take it all out. I want to go," says this every time RN enters room. RN Yoomi at bedside to speak with patient in Korean and confirm what he is saying. As per RN, in Korean pt states "I want to die. Kill me now." MD Fatima Alkunaizi made aware. MD Fatima at bedside, pt places hands over face in a cupping motion, covering his hands and mouth. Pt states "put me to sleep. Put me to sleep. Please, please." Pt asked clarifying question "do you want to sleep for a little bit, or are you asking us to help you die?" Pt motions again over his face and says "kill me. Help me die." MD informed pt that it is not legal to provide physician-assisted suicide in New York, but we are working to help make him more comfortable and begin to withdrawal devices in the appropriate manner. Pt states "When? When? When?" MD explained the process that needs to be followed for withdrawal of care. Pt tearful, states "Why no one listens to me. Everyone lie. I want to go. I go now. I die now." Pt continues "If you get me better and go home, I suicide." RN sitting outside of room to ensure pt safety.

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**TITLE:** **ORGANIZATIONAL ETHICS**

## POLICY AND PURPOSE:

New York-Presbyterian Hospital recognizes its institutional responsibility to treat its patients, physicians, employees and the community served with courtesy, respect and dignity at all times. The Hospital is committed to act with integrity in all of its activities consistent with its Mission Statement and Statement of Values.

## APPLICABILITY:

It is the responsibility of every member of the Hospital community, including the Governing Body, the Administration, the Medical Staff and all other employees to act in a manner consistent with this policy and its supporting policies.

## PROCEDURE:

Consistent with the Hospital's Vision Statement, Our Credo and Strategic Goals, the organization is committed to the following principles:

### 1. Respect for the patient

Patients, or their significant others when appropriately authorized to receive such information will be fully informed about their illnesses, risks and benefits associated with treatment and therapeutic alternatives; and will be involved in decisions regarding treatment. At all times, the Hospital will treat patients in a manner considerate of their cultural and religious beliefs and practices; and provide language assistance services when necessary.

The Hospital emphasized the importance of our shared commitment to diversity, inclusion and belonging through our Credo, the launch of the Dalio Center for Health Justice and other targeted educational efforts.

### 2. The Ethics Committee

The Hospital is committed to patients and organizational ethics through the Hospital Ethics Committee, a committee of the Medical Board. This committee assists the Medical Board in the development, review and refinement of policies relating to ethical responsibilities and hospital legal responsibilities concerning bio-ethical issues, so as to maintain high ethical standards of patient care and clinical practice, and to enhance and oversee ethics care consultations and education among the medical and health care staff concerning bio-ethical issues.

### 3. Human Rights and Research

The Hospital is committed to the protection of human subjects of research through the Institutional Review Boards (IRB) for each campus, whose function is to review, approve and conduct continuing review of all biomedical research pertaining to human subjects and verify that it is performed in accordance with applicable law.

In addition, such review endeavors to create an environment that: risks to subjects are minimized, risks to subjects are reasonable in relation to anticipated benefits, selection of subjects is equitable, informed consent is obtained from each subject or legally authorized representative; and privacy of subjects is protected, and confidentiality of data is maintained in accordance with HIPAA and state laws.

The Institutional Review Boards for each campus report on a regular basis to the Medical Board. A cooperative agreement through the Office for Protection of Research Risk (OPRR) exists to coordinate the review process between the campus-based Institutional Review Boards.

### 4. Integrity of Clinical Decisions

The Hospital affirms that the sole criterion for treatment decisions is the patient's best interest, and that the clinicians' primary fiduciary responsibilities are professional obligations to the patient irrespective of financial considerations.

### 5. Palliative Care

The Hospital affirms the patient's right to high quality end-of-life palliative care that is respectful of patient preferences and cognizant of the patient's religious beliefs and cultural values. The Hospital is committed to the provision of comprehensive pain and symptom management and psychosocial and spiritual support to patients and their families throughout the dying process.

### 6. Resolution of Conflicts

If conflicts arise among members of the Governing Body, Medical Staff, Nursing Staff, other employees or between caregivers and patients, the Hospital will seek to resolve them promptly and fairly.

In specific cases where conflict occurs between the patient and the Hospital and where resolution cannot be achieved, it is the policy of the Hospital to involve the Patient Services Administration staff, and when appropriate the Ethics Committee, to coordinate the effort to resolve the conflict consistent with patient well being and safety.

**7. Conscientious Objection**

Any request by an employee not to participate in certain aspects of patient care, because of moral or religious objection, including treatment or withholding treatment, shall be reviewed by, and may be accommodated by, the department head or designee. If the request cannot be accommodated, the matter should be referred to Patient Services Administration, and to the Ethics Committee, which will consider alternative arrangements.

Such requests may be granted provided that no negative outcome for the care and treatment of the patient is incurred, and that the mission of the hospital is not compromised. In the event of an emergency, patient care must be provided without any delay.

**8. Recognition of potential conflicts of interest**

The Hospital recognizes that the potential for a conflict of interest exists for decision makers at all levels within the Hospital. The Governing Body has adopted a policy that requires the disclosure of potential conflicts of interest so that appropriate action can be taken to ensure that such conflict does not inappropriately influence important decisions. The Corporate Compliance Office for the Hospital should be contacted for such matters.

**9. Marketing and Public Relations**

Fair representation of the Hospital, and its' patient care capabilities, and range of services in its' marketing and public relations activities.

**10. Community Service**

Services are provided to meet the identified needs of the patient population served in our community (Refer: Community Service Plan)

**11. Adherence to a uniform standard of care throughout the organization**

In all settings in which this organization provides services to patients, consistent standards of care, based on the identified needs of the patient, will be followed.

**12. Competency**

The Hospital ensures that practitioners have credentials and competencies consistent with their positions and clinical privileges. This information is reviewed and verified by the Medical Board.

**13. Confidentiality**

The Hospital is committed to maintaining confidentiality of patient information. Information will be released only in compliance with HIPAA and state laws or regulations. Note: we can release or access without the patient's authorization if it is for treatment, payment or healthcare operations.

**14. Fair billing practice**

The Hospital and the Medical Staff will charge patients or third party payers only for services actually provided to patients, and will provide care consistent with contractual obligations. Bills will be accurate and understandable reflecting services provided to patients.

The Hospital will provide assistance to patients seeking to understand the costs relative to their care and will attempt to resolve questions and objections to the satisfaction of the patient and third party payers.

**15. Compliance with the law**

The Hospital is committed to compliance with the law and requires its staff to obey all pertinent federal and state laws and regulations.

To this end, the Hospital has developed a Compliance Program to continue and enhance the Hospital's programs and procedures intended to assure that all activities and transactions on its behalf are conducted in accordance with the highest ethical and legal standards.

**16. Patients' Rights and Organizational Ethics**

Patient Services Administration and the Department of Ethics are responsible for ensuring that policies and procedures relating to patients rights and organizational ethics are consistent with ethical and professional norms, relevant laws and the mission of New York-Presbyterian Hospital.

**SUPPORTING POLICIES:**

Vision and Strategic Goals

Principals of Behavior

Code of Conduct
Compliance Plan
Advance Directives Policy
Conflict of Interest Policy

Continuum of Care Policy
DNR and DNR/DNI Policy
Employee Grievance Policy
Employee Rules of Conduct Policy
Health Care Proxy Policy
HIPAA Policies
Informed Consent/Refusal Policy

Patient Admission Policy
Patient Complaint /Grievance Process
Patients' Rights and Responsibilities

Personnel Sexual Harassment Policy
Plan for the Provision of Patient Care
Withdraw/Withhold Life Sustaining Treatment Policy

**Questions**
**Any questions regarding interpretation of the Policy should be referred to Patient Services Administration, Monday through Friday, 9:00 AM to 5:00 P.M., or the Administrator-On-Call/Onsite Administrator at all other times.**

| | |
|---|---|
| **NYP-WC** | |
| Patient Services Administration | 212-746-4293 |
| Administrator-on-Call | 212-746-5100 |
| **NYP-WBHC** | |
| Patient Services Administration | 914-997-5920 |
| Onsite Administrator | 914-682-9100 |
| **NYP-LMH** | |
| Patient Services Administration | 212-312-5034 |
| Onsite Administrator | 212-312-5000 |
| **NYP-BMH** | |
| Patient Services Administration | 718-780-3375 |
| Onsite Administrator | 929-354-8641 |
| **NYP-CU & MSCH** | |
| Patient Services Administration | 212-305-5904 |
| Administrator-on-Call | 212-305-2323 |
| **NYP-AH** | |
| Patient Services Administration | 212-932-4321 |
| Onsite Administrator | 212-932-4322 |
| **NYP-W** | |
| Patient Services Administration | 914-787-3074 |
| Onsite Administrator | 914-787-5036 |

**RESPONSIBILITY:**

Patient Services Administration

**POLICY DATES:**

Revised: October: 1999
Reviewed: May: 2002 (Previously Policy #E125)
Revised: July: 2005, July 2017
Reviewed: July: 2007; July 2009; July 2011; August 2013; August 2015
July 2017

**Revised:** March 2019, February 2021, **October 2022**

**Medical Board Approval:** October 2017; May 2019, February 2021,
October 2022

[redacted] Mary Elizabeth Callahan, MD
Attending
Med - Palliative Care

Consults
Signed

Date of Service: 6/11/2023 11:40 AM

Consult Orders
Inpatient Consult to Palliative Care [583982897] ordered by Fatimah Alkhunaizi, MD at 06/11/23 1025

**PALLIATIVE CARE INITIAL CONSULTATION**

**Referring provider:** Dr. Fried

**Referring Service:** Referring Service: CCU

**Reason for Consult:** Symptom Management and Withholding/Withdrawing Life-sustaining Treatments

Palliative Care Flag On: Yes

**Chief Complaint:** "take it out"

**History**

**HPI:**

[redacted] is a 75 y/o man with history of NICM s/p ICD, AFib and recent admissions for decompensated heart failure who was transferred from Engelwood hospital for high risk LVAD evaluation in setting of cardiogenic shock with evidence of worsening renal function and shock liver. An Impella was placed on 6/8 and he has required escalating support given due to worsening cardiogenic shock. Patient and family have expressed desire note to move forward with LVAD evaluation and instead focus on comfort. Palliative care is consulted for symptom management and guidance regarding withdrawal of life-sustaining treatments.

Case discussed with CCU fellow Dr. Alkhunaizi and bedside RN Chrisitine Yany. They shared that the patient has been consistently expressing his desire for the Impella to be removed and to be allowed to die naturally over the past several days. In discussion with patient's family, they are in agreement that his current condition is not an acceptable quality of life for him based on his values and prior stated wishes. Per family, his mood had been down prior to this admission due to his decreased functional status that was greatly impacting his quality of life. The patient and family have made the decision to focus on his comfort and withdrawal Impella support.

Patient seen this morning. No family at bedside. He was resting comfortably and when awoken became agitated and stated repeatedly "take it out, take it out now".

**Past Medical History:**

Electronically Signed By: Thillai Sekar on June 10, 2023 10:44 AM

**Palliative Care Assessment**

[redacted] is a 75 y/o man with history of NICM s/p ICD, AFib and recent admissions for decompensated heart failure who was transferred from Englewood hospital for high risk LVAD evaluation in setting of cardiogenic shock with evidence of worsening renal function and shock liver. An Impella was placed on 6/8 and he has required escalating support given due to worsening cardiogenic shock. Patient and family have expressed desire note to move forward with LVAD evaluation and instead focus on comfort. Palliative care is consulted for symptom management and guidance regarding withdrawal of life-sustaining treatments.

**Recommendations:**

#dyspnea/pain: in the setting of decompensated heart failure requiring Impella support
- continue hydromorphone 0.2mg IV and increase available frequency to q30mins prn moderate pain/dyspnea
- add hydromorphone 0.4mg IV q30min prn severe pain/dyspnea

#anxiety/agitation: significant distress regarding his current condition
- continue dexmedetomidine infusion per primary team
- start lorazepam 1mg IV q30 mins prn
- appreciate Psychiatry involvement and input

#debility/goals of care:
- Goals of care: comfort-focused with plan for withdrawal of life-sustaining treatments
- Prognosis: likely hours to short days after withdarwal of life-sustaining treatments
- Code status: DNR/DNI per prior discussions held by primary team
- HCP/surrogate: no formal HCP documentation found in EMR, wife is legal surrogate decision maker, children are also very involved in decision making
- Palliative care team available to facilitate further discussion regarding goals of care early next week as needed
- Palliative care interdisciplinary team will continue to follow for support

Recommendations discussed with primary team and bedside RN.

For questions or concerns, please Epic message me directly; after 5pm, please contact the Palliative Care clinician on call through Epic/Haiku secure chat (CUIMC Palliative Care Consult) or page 84680.

Mary Callahan, MD, MS
Attending Physician, Palliative Medicine

[redacted] [redacted] [redacted]

**Hilario, Jhoanne Faith, NP**
Nurse Practitioner
Med - Cardiology

ACP (Advance Care Planning)
Signed

Date of Service: 6/9/2023 1:13 PM

**This note has been co-signed/attested; do not edit unless there is an error that will affect patient care. If edited, the attending will need to re-attest. Consider creating an Event note for additional documentation.**

Today, 6/9/23 at 1:27 PM, a meeting took place with the family of [redacted] This meeting was necessary for determining the appropriate course of critical
care treatment.

**Location**:
The meeting was held in the following location:
Family meeting room at [redacted] room

**Patient participation**:
The patient did not participate in the meeting due to other reason why patient was unable or incompetent to participate in providing history and/or to make treatment decisions, specify : agitation, pain

**Family participation**:
The patient's surrogate medical decision make participated and Other surrogate
Name of this person: [redacted] (son)
Family or other relationship to patient: [redacted] (wife), children [redacted]
Other family members/other individuals were present
(identify): brother, daughter in law, sister

**Interpreter Present:** Yes
Interpreter made available

**Clinical team participation**: The following clinical team
members attended this meeting:
MD Dr. Justin Fried, Dr. David Oh and Dr. Jennifer McLeode and NP Jhoanne Faith Hilario

**Topics of discussion**: The following were discussed:
Patient's diagnosis/current condition: [redacted] is in cardiogenic shock from end-stage heart failure requiring inotropic support, and right now also requiring mechanical support through Impella , Patient's prognosis: guarded , Patient/family needs and preferences: Family wishes to not proceed with LVAD and ensure no intubation/resuscitation unless for removal of device , Treatment goals/options/decisions: fpcus on comfort, ensure no pain, ensure he is sleeping and resting , and Review of family's understanding of patient's condition, prognosis, and treatment goals/options/decisions (family was asked to summarize)

Answered all questions regarding treatment plan and prognosis.

**Other content of meeting**:
Opportunity given for family to speak and ask questions, Family was assured of attention to patient comfort, Family was assured that clinical team will not abandon patient or them, even if critical care treatments are withheld or withdrawn, Support was provided for informed, good-faith, family decisions, and Emotions expressed by family were acknowledged and addressed.

We will observe [redacted] continue to stablize him in the next few days on Impella. We will focus on comfort and add pain medications to control his pain, as well as melatonin to aid his sleep. A DNR/DNI order was placed in the chart according to patient wishes which was previously expressed by the patient to his children.
We will continue to discuss options as well as evaluate his response to treatments.

We will HOLD off on LVAD work-up as of right now and they do not wish to proceed at this time.

**Time involved in meeting**:
Time for discussion to determine the appropriate course of critical care treatment: 30 minutes
Total duration of meeting: 60 minutes

Signed:
Jhoanne Faith Hilario, AGACNP-BC
Cardiology NP, Heart Failure & Heart Transplant Service

Cosigned by: Fried, Justin, MD at 6/9/2023 4:07 PM

**Revision History**

| Date/Time | User | Provider Type | Action |
|---|---|---|---|
| 6/9/2023 4:07 PM | Fried, Justin, MD | Attending | Cosign |
| 6/9/2023 1:38 PM | Hilario, Jhoanne Faith, NP | Nurse Practitioner | Sign |
| 6/9/2023 1:31 PM | Hilario, Jhoanne Faith, NP | Nurse Practitioner | Sign |
| 6/9/2023 1:27 PM | Hilario, Jhoanne Faith, NP | Nurse Practitioner | Sign |

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**TITLE:** **PATIENT SERVICES ADMINISTRATION**

## POLICY AND PURPOSE:

To provide a central grievance mechanism for patients, administrative support for staff, a central location for reporting patient occurrences, and access to the Ethics (process) Committee.

## APPLICABILITY:

All Hospital Staff

## PROCEDURE:

1. Patient Services Administration staff are available to respond to patient, family, or visitor concerns about patient care, patient's rights, and services provided by any department. Patients or families may be referred to the Office of Patient Services, Monday through Friday, 9:00 AM to 5:00 PM. Evenings, nights, holidays and weekend the Administrator-on-Call/Onsite Administrator should be contacted via the Page Operator. It is the responsibility of the Administrator-on-Call/Onsite Administrator to notify Patient Services of any problems on the next business day. The Senior Vice President of Patient Services Administration, the Vice President of Patient Services Administration, the Directors of Patient Services Administration or their designees are available at all times to the Administrator-on-Call/Onsite Administrator.

2. Patient Services Administration is available to assist the professional staff with questions about consent, refusal of treatment, living wills, "right to die" issues, DNR, and administrative matters.

3. In the event that an invasive procedure, medication error, or other incident causes harm or death to a patient, the incident should be reported to Patient Services Administration, Monday through Friday, 9:00 AM-5:00 PM, and to the Administrator-on-Call/Onsite Administrator at all other times.

4. Patient Services Administration readily partners with the providers and Hospital staff to promote the best patient experience. The staff proactively anticipates patient needs and strives to address them in a timely fashion.

Please address questions to Patient Services Administration (PSA) as follows:

| | | | |
|---|---|---|---|
| **NYP-WC** | | **NYP-CU & MSCH** | |
| Patient Services Administration | 212-746-4293 | Patient Services Administration | 212-305-5904 |
| Administrator-on-Call | 212-746-5100 | Administrator-on-Call | 212-305-2323 |
| **NYP-WBHC** | | **NYP-AH** | |
| Patient Services Administration | 914-997-5920 | Patient Services Administration | 212-932-4321 |
| Onsite Administrator | 914-682-9100 | Onsite Administrator | 212-932-4322 |
| **NYP-LMH** | | **NYP-W** | |
| Patient Services Administration | 212-312-5034 | Patient Services Administration | 914-787-3074 |
| Onsite Administrator | 212-312-5000 | Onsite Administrator | 914-787-5036 |
| **NYP-BMH** | | | |
| Patient Services Administration | 718-780-3375 | | |
| Onsite Administrator | 929-354-8641 | | |

**RESPONSIBILITY:**

Patient Services Administration

**POLICY DATES:**

Revised: October: 1999
Reviewed: May: 2002
Revised: July: 2005
Reviewed: July: 2007; July 2009; July 2011; July 2013,

**Revised:** February 2014**;** February 2016; February 2018; January 2019, January 2021, **October 2022**

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**TITLE: WITHDRAW / WITHHOLD LIFE SUSTAINING TREATMENT**

## POLICY:

Withdrawal of life sustaining treatment (LST) is the discontinuation of ventilator support (with or without extubation) and/or pacemaker, dialysis, vasopressors, nutrition, hydration or other intervention for the purpose of allowing death to occur from the patient's underlying illness. Withholding of LST other than CPR refers to not initiating an otherwise medically indicated life-sustaining intervention (i.e., artificial nutrition) also for the purpose of allowing death to occur from the patient's underlying illness.

## PURPOSE:

This policy helps guide Hospital staff when there is a request to withdraw or withhold life sustaining treatments (LST) other than CPR. The policy is consistent with the Health Care Proxy Law, see policy # A164, and the Family Health Care Decisions Act (FHCDA). Addendum A provides a glossary of terms, including surrogate priority list. Addendum B is a table noting what level of physician or other clinician is required to participate in decision-making documentation.

*For the purpose of this policy, withhold life sustaining treatment will refer to withhold life sustaining treatment other than CPR.*

## APPLICABILITY:

Attending Physicians, Graduate Medical Staff, Patient Services Administration, Physicians Assistants, Nurse Practitioners, Social Workers, Nurses and other practitioners who care for patients.

## PROCEDURE:

### A. Withdraw / Withhold LST

**Requests to withdraw / withhold LST**

Requests to withdraw/withhold LST must be initiated by the patient, when capacitated, or when the patient lacks capacity, by the health care proxy or surrogate. For patients who lack capacity and have no surrogate, the attending physicians may act on the patient's behalf. All requests to withdraw/withhold LST from patients must be reviewed by Patient Services Administration. Notify LiveOnNY at 1-800-443-8469 when withdrawal/withhold of life sustaining treatment is being considered.

**B. DNR Order**

A DNR order must be in place prior to initiating an order to withdraw/withhold LST.
If the patient has an implantable cardioverter defibrillator (ICD), please refer to policy #H122, DNR and DNR/DNI.

**C. Procedures for withdraw / withhold LST differ depending on the category of patient.**

**1) Adult Patient with Capacity**

An **adult** patient with **capacity** must express his/her wishes to withdraw/withhold LST to their attending physician.

**2) Adult Patient without Capacity with a Health Care Agent**

**a. Health Care Proxy Document**

A copy of the patients duly executed **Health Care Proxy** (HCP) must be in the patient's medical record enabling the Health Care Agent to request withdraw/withhold LST. Questions concerning the validity of the HCP document should be directed to Patient Services Administration.

**b. Capacity Assessment**

Two providers, an attending physician and a concurring practitioner, PGY2 or above, NP or PA, must independently determine that the patient lacks decision-making capacity.

If the patient is believed to lack decision-making capacity due to a mental illness, the capacity assessment is completed by two attending physicians. One of the two physicians must be a board-certified or board eligible psychiatrist.

**3) Adult Patient without Capacity WITH Prior Wishes (With or Without a Surrogate)**

Patient Services Administration must be contacted and may involve Ethics and/or Legal, as needed, to review all requests to withdraw/withhold LST in a patient who lacks capacity when the request is based on evidence of the patient's prior wishes.

**a. Capacity Assessment**
Two providers, an attending physician and a concurring practitioner, PGY2 or above, NP or PA, must independently determine that the patient lacks decision-making capacity.

If the patient is believed to lack decision-making capacity due to a mental illness, the capacity assessment is completed by two attending physicians. One of the two physicians must be a board-certified or board eligible psychiatrist.

**b. Medical Criteria**
Two providers, an attending physician and a concurring practitioner, PGY2 or above, NP or PA, must independently determine that at least one of the following clinical conditions/criteria must be met.

1. The patient has an illness or injury which can be expected to cause death within six months whether or not treatment is provided, AND it has been determined that treatment would pose an extraordinary burden to the patient.

2. The patient is permanently unconscious.

3. The patient has an irreversible or incurable condition, AND it has been determined that the provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances.

**c. Documentation of Prior Wishes**
Evidence of the patient's wishes may be in the form of an advance directive executed by the patient when capacitated (Living Will, MOLST Form, written wishes), or documentation in the medical record of patient expressing his/her wishes in the presence of a healthcare worker. Knowledge of a patient's prior wishes may also be brought forward by family members and friends. This information needs to be reviewed by PSA and may require an ethics consultation.

**d. Notification of the Patient**
1. The patient must be notified of the determination that he/she lacks capacity, and of the request to withdraw/withhold LST if there is any indication that the patient can comprehend such information.
2. If the patient objects, Patient Services Administration must be contacted.

**e. Notification of the Surrogate**

If there is a surrogate, the attending physician shall make diligent efforts to notify the surrogate, and if unable, notify Patient Services Administration.

**4) Adult Patient without Capacity WITHOUT prior wishes with a Surrogate**

Patient Services Administration must be contacted and may involve Ethics and/or Legal, as needed, to review all requests to withdraw/withhold LST in a patient who lacks capacity with a surrogate.

**a. Capacity Assessment**

Two providers, an attending physician and concurring practitioner, PGY2 or above, NP or PA, must independently determine that the patient lacks decision-making capacity.

If the patient is believed to lack decision-making capacity due to a mental illness, the capacity assessment is completed by two attending physicians. One of the two physicians must be a board-certified or board eligible psychiatrist.

**b. Medical Criteria**

Two providers, an attending physician and a concurring practitioner, PGY2 or above, NP or PA, must independently determine that at least one of the following clinical conditions/criteria must be met.

1. The patient has an illness or injury which can be expected to cause death within six months whether or not treatment is provided, AND it has been determined that treatment would pose an extraordinary burden to the patient.

2. The patient is permanently unconscious.

3. The patient has an irreversible or incurable condition, AND it has been determined that the provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances.

**c. Surrogate decision-maker**

1. In the absence of a duly executed HCP in the medical record, the surrogate of the highest priority can request that life-sustaining treatment (LST) be withdrawn or withheld (see Addendum A).

2. The surrogate must make decisions consistent with the patient's wishes, if known. Efforts should be made to elicit whether the patient, when capacitated, communicated preferences regarding end-of-life care.

**d. Notification of the Patient**

1. The patient must be notified of the determination that he/she lacks capacity, of the identity of the surrogate, and of the request to withdraw or withhold LST if there is any indication that the patient can comprehend such information.

2. If the patient objects, the order to withdraw or withhold LST must **not** be written and Patient Services Administration must be contacted.

**5) Adult Patient without Capacity WITHOUT prior wishes without a Surrogate**

Diligent efforts must be made to identify and locate any family member or friend who might serve as a surrogate.

Patient Services Administration must be contacted and Ethics consulted to review all requests to withdraw /withhold LST in a patient who lacks capacity and has no surrogate.

**a. Capacity Assessment**

Two providers, an attending physician and concurring practitioner, PGY2 or above, NP or PA, must independently determine that the patient lacks decision-making capacity.

If the patient is believed to lack decision-making capacity due to a mental illness, the capacity assessment is completed by two attending physicians. One of the two physicians must be a board-certified or board eligible psychiatrist.

**Medical Criteria**
Two providers, an attending physician and a concurring practitioner, PGY2 or above, NP or PA, must independently determine that the following clinical conditions/criteria has been met.

Life-sustaining treatment offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided; and the provision of life-sustaining treatment would violate accepted medical standards.

**c. Notification of the Patient**

1. The patient must be notified of the determination that he/she lacks capacity, lacks a surrogate and of the request to withdraw or withhold LST if there is any indication that the patient can comprehend such information.

2. If the patient objects, the order to withdraw or withhold LST must **not** be written and Patient Services Administration must be contacted.

**6) Adult Patient with a Developmental Disability**

Contact Patient Services/Patient Care Services or the Administrator on Call for guidance.

To withdraw/withhold LST for patients with a developmental disability who lack pertinent decisional capacity and do not have a valid health care proxy, the MOLST Legal Requirements Checklist for People with Developmental Disabilities must be completed **prior** to proceeding to withdraw/withhold LST.

Capacity assessments for individuals who are or appear to be a developmentally disabled have particular requirements.

See https://opwdd.ny.gov/system/files/documents/2020/04/molst-checklist-opwdd-fillable.pdf

**7) Minor Patients**

Parents can request to withdraw/withhold LST. Two physicians, an attending pediatrician and a PGY4 or above must agree with the request. Patient Services Administration must be contacted to review all requests to withdraw/withhold LST in a minor. When a Board Certified Intensivist or Neonatologist serves as the attending physician on the case, Patient Services Administration may involve Ethics and/or Legal as needed. For all other requests to withdraw/withhold LST in a minor, Patient Services Administration will consult Ethics.

**a. Medical Criteria**

Two physicians, an attending pediatrician and a PGY4 or above must determine that the patient meets the following criteria:

1. The patient has an illness or injury which can be expected to cause death within six months whether or not treatment is provided, AND it has been determined that treatment would pose an extraordinary burden to the patient.

2. The patient is permanently unconscious.

3. The patient has an irreversible or incurable condition, AND it has been determined that the provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances.

**b. Surrogate decision-maker**

1. The minor's parent has authority to request withdraw/withhold LST.

2. If the minor patient has a parent or guardian who has not been informed of the decision, reasonable efforts must be made to determine if the uninformed parent or guardian has maintained substantial and continuous contact with the minor, and if so, diligent efforts must be made to notify that person of the decision.

3. If one parent or guardian objects to the other parent's request to withdraw/withhold LST, Patient Services Administration must be contacted.

**8) Emancipated Minors**

1. Emancipated minors with decision-making capacity have the authority to make decisions about life-sustaining treatment.

2. Patient Services Administration must be contacted to initiate a formal review by the Ethics Review Committee.

3. The hospital shall make reasonable efforts to identify and contact the parents of the emancipated minor to notify them of the decision prior to implementation

**2. Contact Patient Services Administration / Administrator on Call**

- All requests to withdraw/withhold LST
- Any questions regarding withdraw/withhold LST

**The Role of Patient Services Administration / Administrator on Call**
Patient Services Administration (PSA)/Administrator on Call (AOC) must be notified of all requests to withhold/withdraw life-sustaining treatment. PSA/AOC staff will review the case and the medical documentation for compliance with Hospital policy. If indicated, PSA/AOC will discuss the request with the Ethics team and the Hospital Legal team. PSA/AOC must document in the appropriate structured note as noted below.

Please contact PSA Monday through Friday, 9:00AM to 5:00PM, at the numbers shown below, or the AOC/Onsite Administrator at all other times.

| | | | |
|---|---|---|---|
| **NYP-WC** | | **NYP-CU & MSCH** | |
| Patient Services Administration | 212-746-4293 | Patient Services Administration | 212-305-5904 |
| Administrator-on-Call | 212-746-5100 | Administrator-on-Call | 212-305-2323 |
| **NYP-WBHC** | | **NYP-AH** | |
| Patient Services Administration | 914-997-5920 | Patient Services Administration | 212-932-4321 |
| Onsite Administrator | 914-682-9100 | Onsite Administrator | 212-932-4322 |
| **NYP-LMH** | | **NYP-W** | |
| Patient Services Administration | 212-312-5034 | Patient Services Administration | 914-787-3074 |
| Onsite Administrator | 212-312-5000 | Onsite Administrator | 914-787-5036 |
| **NYP-BMH** | | | |
| Patient Services Administration | 718-780-3375 | | |
| Onsite Administrator | 929-354-8641 | | |

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### 3. Withdraw / Withhold Life Sustaining Treatment Documentation

Structured Withdraw/withhold life sustaining treatment notes have been developed for the electronic medical record and downtime forms. These structured notes are consistent with the Health Care Proxy Law and the Family Health Care Decisions Act respectively.

#### a. Withdraw / Withhold Life Sustaining Treatment- Structured Notes

**i)** Withdraw/Withhold Life Sustaining Treatment **(Adult WITH Capacity)**

**ii)** Withdraw/Withhold Life Sustaining Treatment **(Adult WITHOUT Capacity)**

This document includes documentation in the case of the:

- Adult without capacity, with a HCP,
- Adult without capacity with a surrogate and with/without evidence of prior wishes
- Adult without capacity without a surrogate and with/without evidence of prior wishes.

iii) Withdraw/Withhold Life Sustaining Treatment **(Minors)**

#### c. Documentation Requirements

Staff required to complete withdraw/withhold documentation are identified by patient category in Addendum B.

**1) Progress Note**

In addition to completion of the appropriate structured EMR note (outlined above), the discussion with the patient, HCP or surrogate regarding Withdraw/Withhold Life Sustaining Treatment, including deactivation of a pacemaker, should also be documented in the progress note section of the EMR.

**2) Withdraw / Withhold Life Sustaining Treatment Orders / Procedure**

Upon completion of all the withdraw/withhold LST documentation, the PSA/ AOC staff will notify the team the documentation is appropriate and completed and it is appropriate to proceed to withdraw/withhold life sustaining treatment.

If the patient has a pacemaker, an order will then be required to deactivate the device. In addition, the Electrophysiology Service (EPS) Physician/NP/PA must be notified to deactivate the device.

**3) Down-Time Form Documentation**
In the event of downtime, forms on demand are available as per policy.

**APPLICABILITY:**

ATTENDING PHYSICIANS, GRADUATE MEDICAL STAFF, PATIENT SERVICES ADMINISTRATION, PHYSICIANS ASSISTANTS, NURSE PRACTITIONERS, SOCIAL WORKERS AND NURSES AND OTHER PRACTITIONERS WHO CARE FOR THE PATIENT.

**RESPONSIBILITY:**

Patient Services Administration
Medical Ethics
Office of Legal Affairs

**REFERENCES:**
NY Public Health Law article 29-CC (The Family Health Care Decisions Act)

**Related Hospital Policies:**
H122, DNR and DNR/DNI
A164, Health Care Proxy Law

**POLICY DATES:**

| | |
|---|---|
| **ISSUED:** | October 1999 |
| Reviewed: | May 2002; July 2007; July 2009: July 2011 |
| Revised: | July 2005 |
| Reviewed | August 2013; August 2015 |
| **Revised:** | September 2017, March 2018, January 2019, February 2021, January 2022, October 2022, **November 2022** |
| **Nursing Board Approval:** | February 2022, October 2022, November 2022 |
| **Medical Board Approval:** | November 2015, October 2017; May 2018, May 2019, February 2021, February 2022**,** October 2022, December 2022 |

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## ADDENDUM A

### Medical Orders for Life Sustaining Treatment (MOLST) Form

The NYS/DOH approved MOLST form can be used to document a patient's treatment preferences concerning life sustaining treatment, including DNR.

### Family Health Care Decisions Act (FHCDA)

New York Public Health Law Article 29-CC, the Family Health Care Decisions Act (FHCDA), effective June 1, 2010, protect patients, including children and emancipated minors, who are unable to make their own decisions by granting medical decision-making authority to the patient's family members or designated surrogate.

### 1. Glossary of Terms

*The following definitions apply for purposes of this policy and documentation in the medical record.*

**Adult:** Any person who is eighteen years of age or older or has married.

**Attending Physician:** The physician selected by or assigned to a patient who has primary responsibility for the treatment and care of the patient. The ATTENDING PHYSICIAN must be a member of the medical staff in the Attending category.

**Practitioner:** The physician, nurse practitioner, or physician assistant selected by or assigned to a patient who has shared responsibility for the treatment and care of the patient**.** The Practitioner must be privileged by NYPH to perform capacity assessments and complete the requisite training.

**Cardiopulmonary Resuscitation (CPR):** Measures taken to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. Cardiopulmonary resuscitation shall not include measures to improve ventilation and cardiac function in the absence of an arrest.

**Clinical criteria for DNR and Withdraw / Withhold Life Sustaining Treatment in the adult patient who lacks decision-making capacity with a surrogate and the minor patient with a surrogate:**

1. The patient has an illness or injury which can be expected to cause death within six months whether or not treatment is provided, AND it has been determined that treatment would pose an extraordinary burden to the patient.

2. The patient is permanently unconscious
.

3. The patient has an irreversible or incurable condition, AND it has been determined that the provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances.

**Clinical criteria for DNR and Withdraw/Withhold Life Sustaining Treatment in the adult patient who lacks decision-making capacity and without a surrogate:**

Life-sustaining treatment offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided; and the provision of life-sustaining treatment would violate accepted medical standards.

**Concurring Practitioner:** The physician or practitioner, selected to provide a concurring opinion.

A **physician**, **PGY-4** or greater, may serve as a **concurring physician** for all requests to withdraw/withhold life-sustaining treatment including DNR and DNR/DNR in the minor patient and emancipated minor.

A **practitioner, PGY-2 or greater**, NP or PA may serve as the **concurring practitioner** for all requests to withdraw/withhold life-sustaining treatment including DNR or DNR/DNI in the adult patient who lacks decision-making capacity with or without a surrogate, and all requests for major medical treatment without a surrogate.

**Decision-making capacity:** Decision-making capacity is the ability to understand and appreciate the nature and consequences of proposed health care. This includes the nature and purpose of the procedure; and the reasonably foreseeable risks and benefits of the procedure/treatment; and the alternatives, including not doing the procedure/treatment; and the reasonably foreseeable risks and benefits associated with the alternative(s). It also includes the ability to reach an informed decision.

**Decision-making standards:** Health Care decisions shall be made:

a. In accordance with the **patient's wishes**, including religious and moral beliefs; or

b. If the patient's wishes are not reasonably known, and cannot with reasonable diligence be ascertained, in accordance with the patient's **best interests.**

**Best Interests Standard:** An assessment of the patient's '**best interests'** shall include:

- Consideration of the dignity and uniqueness of the patient;
- The possibility and extent of preserving the patient's life;

- The preservation, improvement or restoration of the patient's health or functioning;
- The relief of the patient's suffering;
- And any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

An assessment of the patient's wishes and best interests shall be patient-centered. Health care decisions shall be made on an individualized basis for each patient, and shall be consistent with the values of the patient, including the patient's religious and moral beliefs, to the extent reasonably possible.

**Developmental disability:** A developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law as amended,
i.e., a disability of a person which:

- originates before such person attains age twenty-two;
- has continued or can be expected to continue indefinitely;
- is attributable to:
  - intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism;
  - any other condition of a person found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such person; or
  - dyslexia resulting from a disability described in subparagraph one or two of this paragraph;

  and
- constitutes a substantial handicap to such person's ability to function normally in society.

**Do Not Resuscitate (DNR) Order:** An order to withhold cardiopulmonary resuscitation (CPR) in the event a patient suffers cardiac or respiratory arrest.

**Do Not Resuscitate/Do Not Intubate Order:** An order to withhold both cardiopulmonary resuscitative **and** intubation if in respiratory distress. DNI exists only in combination with DNR.

**Emancipated Minor Patient:** A minor patient who is married, the parent of a child, or who is sixteen years of age or older and living independently from his or her parents or guardian

**Ethics Review Committee (ERC):** The ERC is an interdisciplinary committee established in accord with the hospital/FHCDA requirements to review special cases. This is an additional level of review over and above review by the ethics consultant. ERC review is required in the following situations:

1) Requests by an emancipated minor for withdrawal or withholding of LST
2) Cases where an attending physician objects to the surrogate's decision to withdraw or withhold LST including artificial nutrition and hydration (ANH)
3) A stakeholder specifically requests the ERC review.
4) Request to elect hospice care for an incapacitated patient without a Surrogate

**Guardian of a Minor:** An individual appointed by a court with legal authority to decide about life-sustaining treatment.

**Healthcare Guardian:** An individual appointed by a court for the purpose of deciding about life sustaining treatment.

**Health Care Agent:** An adult to whom authority to make health care decisions is delegated under a duly executed health care proxy. When a patient who has a HEALTH CARE AGENT lacks capacity, the agent has the same rights and authority that a patient with capacity would have, subject to the terms of the health care proxy document and NYP Hospital policy #A164, "Health Care Proxy Law."

**Institutional Transfer Orders:** In cases of Institutional transfers of patients with orders or plans of care to withhold or withdraw life-sustaining treatment. The orders remain effective at the receiving hospital until an attending physician first examines the patient. The physician must then either continue or cancel the prior orders.

**Life-Sustaining Treatment:** Any medical treatment or procedure without which the patient will die within a relatively short time, as determined by an attending physician to a reasonable degree of medical certainty.

**Mental Hygiene Facility:** A facility operated or licensed by the New York State Office of Mental Health or the New York State Office for People with Developmental Disabilities.

**Mental Illness:** A mental illness as defined in subdivision twenty of section 1.03 of the mental hygiene law, and does not include dementia, such as Alzheimer's disease, or other disorders related to dementia.

**Minor:** Any person who is not an adult.

**Parent:** for the purpose of a health care decision about a minor patient, means a parent who has custody of, or who has maintained substantial and continuous contact with, the minor patient.

**Patient's prior decisions**: If an adult patient has already made a decision about the proposed health care, expressed orally or in writing or, with respect to major medical treatment and/or withhold or withdraw life-sustaining treatment expressed either orally during hospitalization in the presence of two witnesses (the attending and concurring physician) or in writing and submitted to the attending physician who shall place the statement in the patient's medical record.

**Reasonably available:** The designated person to be contacted can be contacted with diligent efforts by an attending physician, another person acting on behalf of an attending physician, or the hospital.

**Surrogate:** The person selected to make any and all health care decisions on the adult patient's behalf that the patient could make.

**Identifying the Surrogate:** One person shall be identified from the following list from the class **highest in priority**. If this person(s) is not reasonably available, willing and competent to act, a surrogate from the next highest priority shall be identified. This person may identify any other person on the list to act as surrogate as long as no person higher in priority objects.

a. Court-appointed guardian (Legal Guardian)
b. Spouse, if not legally separated from the patient, or **domestic partner**
c. Adult son or daughter - 18 years or older
d. Parent
e. Adult brother or sister, 18 years of older
f. **Close friend**

**Domestic Partner:** The person is in a domestic partnership or other relationship with the patient that is legally recognized in any state or local jurisdiction in the United States, or is listed as the patient's domestic partner in a registry maintained by the patient's employer, or by any state, municipal or foreign jurisdiction; **OR**

The person is formally recognized as a beneficiary or covered person under the patient's employment benefits or health insurance, or the patient is a beneficiary under such benefits of the person; **OR**

The patient and the person are mutually interdependent for support as shown by all the circumstances demonstrating an intention to be domestic partners, including but not limited to factors such as common ownership or leasing of a home, common residence, shared income or expenses, children in common, intention to marry, or the length of the personal relationship.

**Close Friend:** Close friend means any person, eighteen years of age or older, who is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister) who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs, **and who presents a signed statement to that effect to the Attending physician**.

- **Surrogate's right and duty to be informed**: The surrogate shall have the right **to receive medical information and medical records** necessary to make informed decisions about the patient's health care. The Surrogate shall seek information necessary to make an informed decision, including information about the patient's diagnosis, prognosis, the nature and purpose of the procedure; and the reasonably foreseeable risks and benefits of the procedure /treatment; and the alternatives, including not doing the procedure/treatment; and the reasonably foreseeable risks and benefits associated with the alternative(s); including the ability to reach an informed decision.

**Surrogate Expression of Decision:** The surrogate shall express a decision to withdraw or withhold life-sustaining treatment either orally in the presence of two witnesses, the attending physician and a second physician; or in writing and submitted to the attending physician who shall place the statement in the patient's medical record.

| Patient Category | Attending Physician | Concurring Attending Physician | Concurring Physician ≥PGY4 | Concurring Practitioner PGY-2 or greater, NP or PA | Specific Clinical Criteria | Patient Services Administration |
|---|---|---|---|---|---|---|
| Adult Patient with Capacity | √ | | | √ | | √ |
| Adult Patient without Capacity with Health Care Proxy | √ | | | √ | | √ |
| Adult Patient without Capacity with Surrogate with/without written prior wishes | √ | | | √ | √ | √ |
| Adult Patient without Capacity without Surrogate, with/without prior wishes | √ | | | √ | √ | √ |
| Adult Patient with Intellectual or Developmental Disability (special capacity assessment required) | See https://opwdd.ny.gov/system/files/documents/2020/04/molst-checklist-opwdd-fillable.pdf | | | | √ | √ |
| Adult Patient is believed to lack decision-making capacity due to a mental illness | √ | √ | one of the two physicians must be a board-certified or board eligible psychiatrist | | √ | √ |
| Minor Patient | √ | | √ | | √ | √ |

*** Surrogate** - if the surrogate is a **'close friend',** they must be 18 years of age of older, who has maintained regular contact with the patient as to be familiar with the patients activities, health, and religious or moral beliefs, and who **presents a signed document to that effect.** This document must be placed in the medical record.

[redacted] [redacted]

Lipowicz, Lynsey, RN
Registered Nurse
Med - Cardiology

ACP (Advance Care Planning)
Addendum

Date of Service: 6/11/2023 2:10 PM

## DNR / Withhold / Withdraw Treatment (Adult without Capacity)

**Notify PSA in the following cases as special rules apply to these patients:**

**With a Health Care Agent**
- Who lack decision-making capacity due to mental retardation, mental illness, or developmental disability.

**With a Surrogate**
- Who lack decision-making capacity due to mental retardation, mental illness, or developmental disability
- With a Legal guardian
- Whose surrogate disagrees with the patient's previous wishes
- Disagreement among surrogates of the same priority (i.e. two adult children)
- Who are emancipated minors

**Without a Surrogate**
- Who lack decision-making capacity due to mental retardation, mental illness, or developmental disability
- Who are emancipated minors

**Deactivation of ICD**

Please review whether the patient has an implantable cardioverter defibrillator (ICD) and, if so, whether or not deactivation would be desired.
If deactivation is desired/intended, please place an order for ICD deactivation and call cardiology as per Policy.

**All requests to withdraw/withhold life-sustaining treatment other than requests for DNR or DNR/DNI must be referred to Patient Services Administration (PSA) or Administrator on Call (AOC).**

Prior to withdrawal of care, notify LiveOnNY by submitting an electronic referral (LiveOnNY iReferral) through the electronic medical record. If an iReferral was previously submitted, please call LiveOnNY at 1-800-GIFT-4-NY (1-800-443-8469).

**To Withdraw/Withhold OTHER THAN DNR, DNR/DNI, call PSA/AOC NOW**

**Note Completion:**
Please complete all fields within this note, and **DO NOT** delete any text or drop down lists. All elements are **required** and deleting them may cause alerts to fire.

**Order Placement:**
For DNR or DNR/DNI an order must be placed.

**Determination of Decision-Making Capacity:**
Patient lacks decision-making capacity because: End-stage heart failure, on sedating medications
Duration of lack of decision-making capacity is: Unknown

**Health Care Agent/Surrogate Decision Maker:**
Does the patient have a duly executed Health Care Proxy document in the medical record?: No

Does the patient have a Surrogate who is available and willing to serve: Yes
The Surrogate of the Highest Priority Name: [redacted] (wife)

Contact Number: [redacted]
Surrogate Relationship: Spouse or Domestic Partner

Has the Surrogate been notified of his/her designation? Yes/No: Yes
Patient Notification: The patient has been informed that a surrogate has been identified to make health care decisions

**Clinical Criteria**
I have determined to a reasonable degree of certainty: Clinical condition expected to result in death in < 6 months with or without treatment and treatment would pose an extraordinary burden to the patient

Explanation of current clinical condition, diagnosis and prognosis for requested action: Patient has had progressively worsening heart failure and decline in his functional status as an outpatient. He had previously expressed wishes to be DNR/DNI. He is now in cardiogenic shock an being supported by Impella. Patient has expressed clearly, prior to losing capacity, that he does not wish to continue further life-sustaining therapies and would like the Impella removed. Family concurs and is in agreement that the current aggressive measures are not within his goals and not consistent with what he would have wanted. As such, plan will be remove Impella, drips (dobutamine and heparin), and transition to comfort measures.

**Known Prior Wishes MUST be documented here or referred to a specific note**
Are patient's prior wishes known?: Yes
Known Prior Wishes: Prior discussions about end-of-life care
Explanation: Patient has previously been DNR/DNI and has expressed wishes not to undergo heroic measures. Current life-sustaining therapies are not consistent with patient's goals and previously stated wishes.

Surrogate Decision: Withdraw life-sustaining treatment - Explain: Current life-sustaining therapies are not consistent with patient's goals.
Does the Surrogate concur?: Surrogate concurs with patient's known wishes
Surrogate's decision is based on patient's best interests: Yes

**Attending Physician Attestation:** I, Fatimah Alkhunaizi, MD, Attending Physician, by my Electronic Signature on the document, attest that I have reviewed the above and determined the foregoing plan of care based on my personal assessment and examination.

**Concurring Practitioner (PGY-2 or greater, PA or NP) Documentation:**

If the patient lacks capacity due to mental illness, then the concurring practitioner must be an attending physician.

**Concurring Practitioner Attestation Statement:**
I attest that I have independently assessed the patient and reviewed the medical record.
I concur that the patient lacks decision making capacity, the conditions as set forth above to withhold or withdraw life-sustaining treatment, including DNR or DNR/DNI are satisfied, and such decision is in accordance with accepted medical standards.

Concurring Practitioner Attestation: I attest to the statement above

**Electronic Signature:**
Fatimah Alkhunaizi, MD
6/11/2023 2:11 PM

**PATIENT SERVICES ADMINISTRATION**

**Patient Services Administration/Administrator On Call Documentation**

If the patient lacks capacity due to mental illness, then the concurring practitioner must be an attending physician.

Based on the documentation by Justin Fried, Attending Physician and Fatimah Alkhunaizi, Concurring Practitioner (PGY-2 or greater, PA or NP), it has been determined that the decision has been made in

accordance with NYP Policy to

Decision: Withdraw Life-sustaining Treatment and remove Impella, drips (dobutamine and heparin), and transition to comfort measures

**If applicable:**

**Comments:**

I, Lynsey Lipowicz, RN, a member of the Patient Services Administration or Administrator on Call, staff have reviewed and signed off on this note.

## Revision History

| Date/Time | User | Provider Type | Action |
|---|---|---|---|
| 6/11/2023 3:05 PM | Lipowicz, Lynsey, RN | Registered Nurse | Addend |
| 6/11/2023 2:56 PM | Fried, Justin, MD | Attending | Cosign |
| 6/11/2023 2:32 PM | Alkhunaizi, Fatimah, MD | Fellow | Addend |
| 6/11/2023 2:32 PM | Alkhunaizi, Fatimah, MD | Fellow | Sign |