OOD 19: The organization’s policies and procedures that address patient/resident ethical issues/needs. Describe the leadership of nurses at all levels in developing and participating in these programs.

The MGH mission states, “Guided by the needs of our patients and their families, we aim to deliver the very best health care in a safe, compassionate environment; to advance that care through innovative research and education; and to improve the health and well-being of the diverse communities we serve.” Policies and procedures provide guidance to staff to ensure issues of ethical concern are dealt with effectively and that the unique care needs of patients and families are met. These policies and procedures outline our ethical responsibilities related to the protection of patients’ rights as well as our responsibilities for the care of specific patient populations. In addition, they provide guidance in the protection of human subjects and the conduct of research (OOD 27). Adherence to these policies and procedures ensures compliance with both internal and external regulations and practice standards. MGH policies and procedures that address ethical issues related to patient care include:

- Advance Directives (attachment OOD 19.a)
- Death Determination Using Brain Death Criteria in Adult Patient (attachment OOD 19.b)
- Death Determination Using Brain Death Criteria in Pediatric Patient (attachment OOD 19.c)
- Donation After Circulatory Death (attachment OOD 19.d)
- Employee Rights and Patient Care Nondiscrimination Policy (attachment OOD 19.e)
- End of Life Care (attachment OOD 19.f)
- Hospice Inpatient Care (attachment OOD 19.g)
- Life Sustaining Treatment (attachment OOD 19.h)
- Life Sustaining Treatment Resolving Conflict Policy (attachment OOD 19.i)
- Medicating Bereaved and Distraught Visitors (attachment OOD 19.j)
- Organ and Tissue Donation (attachment OOD 19.k)
- Patient Rights Notification (attachment OOD 19.l)
- Restraints and Seclusion (attachment OOD 19.m)
- Transfusion Therapy: Patients Who Decline Blood and Blood Products (attachment OOD 19.n)

Nurses at all levels actively provide leadership and/or participate in the development and revision of such policies through membership and participation on various interdisciplinary committees charged with this work including the Collaborative Governance Ethics in Clinical Practice Committee (EICP), the Clinical Policy and Records Committee, and the Medical Policy Committee (OOD 15). Most often, policies and procedures are vetted, reviewed and approved through a variety of committees to ensure adequate input is obtained from clinicians, administrators, and legal staff as appropriate. Once vetted in one or more of these committees, formal approval is achieved through senior level structures such as the Medical Policy Committee or General Executive Committee. The Senior Vice President for Patient Care and Chief Nurse (CNO) or her designee (e.g. a member of the Patient Care Services Executive Committee such as the Director of Patient Care Services Informatics) is a member of these senior level committees. Often, other nurses including Nurse Directors or Clinical Nurse Specialists are also members of such senior level committees with approval authority of policies and procedures (OOD 15). As an example of the review and approval process, the Patient Rights Notification policy (attachment OOD 19.l) was developed and then revised on an ongoing basis by the Office of Patient Advocacy within Patient Care Services (PCS). The Director of this department is a nurse and other nurses serve as patient advocate nurses. Once
developed and/or revised, the policy is then sent on for final approval through the Clinical Policy and Record Committee and Medical Policy Committee both of which have nursing representation.

Informally, policy language is reviewed at unit-based ethics rounds by nurses, physicians and interdisciplinary professionals. This allows for local input of all professional groups, as well as the opinion of formal committee members. Three examples of committees in which nurses at all levels lead and/or participate in policy/procedure development and review are the MGH Optimum Care Committee (OCC) (co-chaired by the Ethics Clinical Nurse Specialist), the Collaborative Governance Ethics in Clinical Practice Committee (EICP) (co-chaired by a Staff Nurse from the Labor, Delivery and Recovery Unit (Blake 14), and Pediatric Ethics Committee (co-chaired by the Nurse Director of the Pediatrics Units (Ellison 17 and Ellison 18). The strong presence of nursing as both leaders and members on these committees assures a nursing presence and input on policies and procedures as well as the resolution of difficult patient care issues. Moreover, any nurse within the organization has the ability to refer cases to these committees when a patient care issue presents itself, helping to support nurses in their ability to advocate for their patients. A description of the OCC, EICP and Pediatric Ethics Committee and the role of nurses as leaders in the development of ethics policies and procedures follows.

The Edwin H. Cassem Optimum Care Committee

The Massachusetts General Hospital (MGH) Edwin H. Cassem Optimum Care Committee (OCC), the oldest ethics consultation committee in North America, is co-chaired by a member of the Patient Care Services’ Institute for Patient Care (IPC), a doctorally-prepared Ethics Clinical Nurse Specialist and a physician in medicine and palliative care. Nurses from all levels, physicians, and allied health professional practicing across the continuum at MGH may request to join the OCC. Guidelines for membership ensure that prospective members have an interest in clinical ethics and participating in consultation regarding ethical issues (attachment OOD 19.o). Current membership of this committee includes nurses (e.g., Staff Nurses, Nurse Practitioners, Clinical Nurse Specialists, and a Nurse Director from various practice areas), Social Workers, a Chaplain, allied health professionals, community members and physicians (attachment OOD 19.p). The committee’s primary work is ethics consultation in times of conflict within or between families and clinicians. Any clinician can place a consult (attachment OOD 19.q) and nurses who identify conflict are consistently supported by their Nurse Directors, Clinical Nurse Specialists and the Ethics Clinical Nurse Specialist in placing consults. Patients and families are able to access the Ethics Clinical Nurse Specialist or other members of the OCC through referral by the MGH Office of Patient Advocacy, the Maxwell & Eleanor Blum Patient and Family Learning Center, or their care team.

OCC committee meetings serve many purposes. Members are informed of educational opportunities within and outside of MGH; case studies are presented as a way of sharing best practices, illustrating the application of MGH policies and procedures, and educating committee members. The OCC is responsible for the content of three MGH policies:

- End of Life Care (attachment OOD 19.f)
- Life Sustaining Treatment (attachment OOD 19.h)
- Life Sustaining Treatment: Resolving Conflict Policy (attachment OOD 19.i)

A set of minutes which reflects a discussion of educational offerings, two case studies, and the Life Sustaining Treatment: Resolving Conflict policy is included in attachment OOD 19.r.
The Collaborative Governance Ethics in Clinical Practice Committee

The Ethics in Clinical Practice Committee (EICP) was established as part of the Collaborative Governance (CG) structure in 1997. The EICP continues to thrive with over 50 members representing all PCS disciplines as well as a few physicians from across the continuum of care (attachment OOD 19.s). The committee’s co-chairs are a Staff Nurse from the Labor, Delivery and Recovery Unit (Blake 14) and a Social Worker. The coach is a Staff Nurse from the Surgical Intensive Care Unit (Ellison 4) and the advisor is a Clinical Nurse Specialist from a General Medicine Unit (Phillips House 20). As needed, the Ethics Clinical Nurse Specialist is available for support, education and consultation.

The EICP was formed to develop and implement activities and programs to further clinicians’ understanding of ethical aspects of patient care. It provides a structure and a process for clinicians to come together with their peers and colleagues to identify ethical issues and define strategies to integrate ethical standards and judgment into practice.

The work of this committee involves identifying strategies to integrate ethical judgment into professional practice and consultation at both the unit and broader organizational levels related to ethical issues in patient care that can result in practice and policy changes. Strategies to accomplish this work include:

- Design and implement activities and programs to support the development of staff in Patient Care Services in the area of health care ethics.
- Promote culturally competent care and staff education.
- Employ strategies to educate EICP champions the area of health care ethics.
- Student outreach.
- Identify and address ethical issues and conflicts faced by clinicians in Patient Care Services.
- Provide consultation to the organization regarding policies, procedures and programs with ethical implications.
- Expand the impact of EICP through collaboration with other Collaborative Governance Committees, links with organizational initiatives, and professional conference participation.
- Engage in joint projects with other Collaborative Governance committees.
- Align the work of the committee with PCS strategic goals.

As described in EP 23, nurses are specifically supported in their ability to apply the ethical principles in the ANA Code of Ethics to their practice through the work of the EICPC and the relationships developed with other ethics programs within the organization and broader healthcare community. Case discussions at EICPC meetings and unit-based ethics meetings provide additional opportunities for nurses to lead and/or participate in discussions of difficult care issues faced in practice.

Similar to other CG committees, members often form task forces to address specific organizational needs. The Advance Care Planning Task Force, chaired by a Staff Nurse from the Surgical ICU (Ellison 4), is one such interdisciplinary task force of the EICP that seeks to improve patients’, families’ and staffs’ knowledge regarding advance care planning and promote completion of the Health Care Proxy Form (SE 1 EO). In addition, this task force and the EICP participate in the review process of the Advance Directive Policy. A copy of task force minutes that reflects the groups’ discussion and recommended edits in included in attachment OOD 19.t. The policy is once more up for review and will be discussed at the August, 2012, EICP meeting.
Pediatric Ethics Committee

The Pediatric Ethics Committee at the MassGeneral Hospital for Children (MGHfC) is co-chaired by a physician and the Nurse Director of the Pediatrics Units (Ellison 17 and Ellison 18). The committee is comprised of physicians, nurses (e.g., Staff Nurses, Clinical Nurse Specialists, Nurse Directors and an Associate Chief), allied health professionals, and at least one community member (attachment OOD 19.u). The Ethics Clinical Nurse Specialist is also a member of this committee allowing for direct mentorship of nurses and other clinicians.

The major functions of this committee are to educate its members in ethics topics as they relate to pediatrics and to consult in cases of pediatric patients involving ethical issues. It meets on a monthly basis and more frequently if a consult is requested. Although not part of the approval process, this study utilizes MGH policies/procedures in discussions of case studies and literature reviews to promote discussion about difficult ethical issues in caring for children. A set of meeting minutes is included in attachment OOD 19.v to illustrate the content of the meeting.
MASSACHUSETTS GENERAL HOSPITAL
Advance Directives

1. POLICY

1.1. The purpose of the MGH Advance Directives Policy is to inform patients of their rights: a) to participate in and govern their own health care decisions; b) to accept or refuse medical or surgical treatment; c) to prepare an advance directive; and d) to guide practice in assuring that patient’s rights are honored, as in accordance with all State, Federal and regulatory requirements.

1.2. Definition: An advance directive documents an adult’s (18 years of age or older) wishes on how to make health care decisions for the patient in the event that he or she becomes incapacitated. The Health Care Proxy is the Massachusetts accepted advance directive form. The hospital will make every effort to honor documented advance directives in both the inpatient and outpatient setting. Other types of advance directives, such as living wills, may be acceptable forms of documentation. Questions about out-of-state advance directives should be directed to Partners Office of General Counsel.

2. PRINCIPLES APPLICABLE TO ALL ADVANCE DIRECTIVES

2.1. Inquiry of Patient. Inpatients will be asked if they have an advance directive. If unable to respond due to an incapacitating condition, mental disorder or confusion, a surrogate can respond on behalf of the patient and may provide a copy of the patient’s signed advance directive.

2.1.1. Patients may be asked in the Pre-Admission Test Area, Admitting Office, Surgical Day Care Unit or on any inpatient unit or in the Emergency Department or in any area that is clinically appropriate.

2.1.2. If the patient does not have a health care proxy, written information about advance directives and the Massachusetts Health Care Proxy will be provided. Upon request, resources will be provided to any inpatient or outpatient to assist in completing a health care proxy form. Patients may be referred to the Blum Patient Family Learning Center for more information or questions.

2.1.3. If the patient has completed an advance directive, but does not have a copy of it on his/her person, the interviewer or provider may offer assistance in completing a new one.

2.1.4. If the patient is unable to respond and if a surrogate is not available, follow up inquiry must be initiated with the patient when appropriate.

2.1.5. A family member or surrogate cannot complete an advance directive for the patient, if the patient is unresponsive or confused.
2.2. Written information about advance directives is provided to patients and/or family members or surrogates and is available to outpatients upon request or as warranted. Information may be found in the Patient Handbook and/or in admission packets. Additional information may be obtained from the Blum Patient Family Learning Center. The Patient Care Services website has patient information brochures and health care proxy forms available in multiple languages.

2.3. Documentation - Massachusetts General Hospital Advance Directive Questionnaire and/or the medical record is used to document the presence or absence of a patient’s advance directive. The patient’s advance directive and/or the Advance Directive Questionnaire may be found in the red sleeve of the medical record. Scanned copies of advance directives may be found in the “Notes” section of the electronic medical system under Results / Reports.

2.3.1. The existence or lack of an advance directive does not determine the patient’s right to access care, treatment and services.

2.4. Witnessing- In lieu of the patient’s family or friends, hospital personnel may voluntarily witness a patient’s signature of an advance directive, if they wish to do so and are willing to testify regarding the validity of the document, if questioned. The witness is attesting that the patient appears to be at least 18 years old or an emancipated minor, of sound mind and not under any undue influence. Any person who is appointed as an Agent may not serve as a witness. (Refer to the Witnessing of Signature policy / Administrative Policy & Procedure Manual.)

2.5. Hospital Personnel as Agents- Hospital employees may not be named as the Health Care Agent unless the employee is related to the patient by blood, marriage or adoption. A physician not employed by the Hospital is not prohibited by law from serving as an Agent.


2.7. Contact the Partners Office of General Counsel for any legal questions about executing an advance care directive.

3. THE MASSACHUSETTS HEALTH CARE PROXY

Health care providers have certain obligations when the advance directive is a Massachusetts Health Care Proxy, as follows:

3.1. Patient Incapacity- the Agent's authority under a Health Care Proxy does not become effective until the patient becomes unable to make or communicate his or her own decisions regarding medical care.
3.1.1. The patient's responsible physician must document in the patient's medical record when he or she determines the patient is incapable of making or communicating such decisions and state the reason for incapacity and anticipated duration.

3.1.2. If the patient's incapacity is due to mental illness or developmental disability, the responsible physician making the determination must consult with someone who has, specialized training or experience in diagnosing or treating such conditions before determination of incapacity can be made. The responsible physician must notify the patient and the person appointed as the Agent.

3.2. Revocation- A patient may revoke a Health Care Proxy by --any act that indicates an intention to revoke the Health Care Proxy including, stating intent to revoke, ripping the document, or striking out the writing. Signing a new health care proxy also invalidates, and thus replaces any previously signed document. In addition, in the Commonwealth of Massachusetts, a Health Care Proxy is revoked if the patient's spouse was named as the proxy and the couple becomes divorced or legally separated.

A physician who knows of a revocation shall immediately document and orally notify the agent and any health care providers involved in the patient's care. Any agent or member of the nursing staff informed of a revocation shall immediately notify the attending physician.

3.3. Disagreement with Agent- Once the Agent's authority is effective, a health care provider should follow the directions of the patient's Agent unless:

- the treatment requested through the Health Care Proxy is medically inappropriate;
- the provider cannot, consistent with his or her moral or religious beliefs, comply with the Agent's directions;
- the Health Care Proxy specifically restricts the Agent's authority to consent to or refuse the treatment in question;
- the patient objects (even if the patient's responsible physician has determined that the patient is unable to make or communicate health care decisions); or
- the provider believes that the Agent is not following the previously written directions of the patient or, if the patient's wishes are unknown, is not acting in the patient's best wishes interests.
3.4. The Hospital lawyer on-call should be contacted for any legal questions or issues that may arise in honoring the guidelines provided in a patient’s advance directive or health care proxy.

References: Commonwealth of Massachusetts, Division of Medical Assistant Provider Manual, 2005 Transmittal Letter ALL-132; General Laws of Massachusetts – Chapter 201D Health Care Proxies; 008 Joint Commission Standard RI.01.05.01; Code of Federal Regulations, Title 42 Public Health, S489.102, August 29, 2008
MASSACHUSETTS GENERAL HOSPITAL

ADVANCE DIRECTIVE QUESTIONNAIRE

For Admitting Staff: Place this questionnaire and/or a copy of the HCP with the admission paperwork. If a signed HCP form is in an old volume of the record, remove it and place it with the admission paperwork.

For Nursing Staff: Place this questionnaire and/or a copy of the HCP in the red sleeve of the medical record.

Do you have a Health Care Proxy?

Note: If you cannot ask the patient because they are unable to respond due to an incapacitating condition, mental disorder or confusion, ask a family member or a surrogate if the patient has a HCP.

☐ YES
  • Obtain a copy from the patient or from CAS
  • Confirm the HCP accurately reflects the patient's wishes.
  If a copy is not available, ask if they would like to complete a new HCP. Advise them that by signing a new health care proxy, it will invalidate, and thus replace, the one at home.
    ☐ New HCP completed
    ☐ Patient declines - Patient and/or family was asked to bring in a copy

☐ NO
  • Provide patient with written information about advance directives and health care proxies.
  • Inform the patient that they can request assistance with advance care planning at any time.

☐ Unable to respond / no surrogate available
  • Follow up with the patient / or family when appropriate.
  Note: A family member or surrogate cannot complete a HCP for the patient, if the patient is unresponsive or confused.

Hospital Representative ___________________________ Date _________ Time _____________
MASSACHUSETTS HEALTH CARE PROXY
Information, Instructions, and Form

What does the Health Care Proxy Law allow?
The Health Care Proxy is a simple legal document that allows you to
name someone you know and trust to make health care decisions for
you if, for any reason and at any time, you become unable to make or
communicate those decisions. It is an important document, however,
because it concerns not only the choices you make about your health
care, but also the relationships you have with your physician, family,
and others who may be involved with your care. Read this and follow
the instructions to ensure that your wishes are honored.

Under the Health Care Proxy Law (Mass. General Laws, Chapter 201D),
any competent adult 18 years of age or over may use this form to
appoint a Health Care Agent. You (known as the “Principal”) can
appoint anyone EXCEPT the administrator, operator, or employee of a
health care facility such as a hospital or nursing home where you are a
patient or resident UNLESS that person is also related to you by blood,
marriage, or adoption. Whether or not you live in Massachusetts, you
can use this form if you receive your health care in Massachusetts.

What can my Agent do?
Your Agent will make decisions about your health care only when you
are, for some reason, unable to do that yourself. This means that your
Agent can act for you if you are temporarily unconscious, in a coma, or
have some other condition in which you cannot make or communicate
health care decisions. Your Agent cannot act for you until your doctor
determines, in writing, that you lack the ability to make health care
decisions. Your doctor will tell you of this if there is any sign that you
would understand it.
Acting with your authority, your Agent can make any health care decision that you could, if you were able. If you give your Agent full authority to act for you, he or she can consent to or refuse any medical treatment, including treatment that could keep you alive.

Your Agent will make decisions for you only after talking with your doctor or health care provider, and after fully considering all the options regarding diagnosis, prognosis, and treatment of your illness or condition. Your Agent has the legal right to get any information, including confidential medical information, necessary to make informed decisions for you.

Your Agent will make health care decisions for you according to your wishes or according to his/her assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with your doctor, religious advisor, or other people before giving instructions to your Agent. It is very important that you talk with your Agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your Agent will decide based on what he or she thinks would be in your best interests. After your doctor has determined that you lack the ability to make health care decisions, if you still object to any decision made by your Agent, your own decisions will be honored unless a Court determines that you lack capacity to make health care decisions.

Your Agent’s decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except for any limitation you yourself made, or except for a Court Order specifically overriding the Proxy.

**How do I fill out the form?**

1. At the top of the form, print your full name and address. Print the name, address, and phone number of the person you choose as your Health Care Agent. (Optional: If you think your Agent might not be available at any future time, you may name a second person as an
Alternate Agent. Your Alternate Agent will be called if your Agent is unwilling or unable to serve.)

2. Setting limits on your Agent’s authority might make it difficult for your Agent to act for you in an unexpected situation. If you want your Agent to have full authority to act for you, leave the limitations space blank. If, however, you want to limit the kinds of decisions you would want your Agent or Alternate to make for you, include them in the blank.

3. BEFORE you sign your name on the second page, be sure you have two adults present who will be witnesses and watch you sign the document. The only people who cannot serve as witnesses are your Agent and Alternate Agent. Then sign the document yourself. (Or, if you are physically unable, have someone other than either witness sign your name at your direction. The person who signs your name for you should put his/her own name and address in the spaces provided.)

4. Have your witnesses fill in the date, sign their names and print their names and addresses.

5. OPTIONAL: On the second page of the form is a statement to be signed by your Agent and any Alternate Agent. This is not required by law, but is recommended to ensure that you have talked with the person or persons who may have to make important decisions about your care and that each of them realizes the importance of the task they may have to do.

Who should have the original and copies?
After you have filled in the form, remove the information pages and make at least four photocopies of the form. Keep the original yourself where it can be found easily (not in your safe deposit box). Give copies to your doctor and/or health plan to put into your medical record. Give copies to your Agent and any Alternate Agent. You can give additional copies to family members, your clergy and/or lawyer, and other people who may be involved in your health care decisionmaking.
How can I revoke or cancel the document?
Your Health Care Proxy is revoked when any of the following four things happen:

1. You sign another Health Care Proxy later on.
2. You legally separate from or divorce your spouse who is named in the Proxy as your Agent.
3. You notify your Agent, your doctor, or other health care provider, orally or in writing, that you want to revoke your Health Care Proxy.
4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.

* * *

Model Health Care Proxy form developed by a Task Force of the following organizations:

- Boston University Schools of Medicine and Public Health: Law, Medicine, & Ethics Program
- Deaconess ElderCare Program
- Hospice Federation of Massachusetts
- Massachusetts Bar Association
- Massachusetts Department of Public Health
- Massachusetts Executive Office of Elder Affairs
- Massachusetts Federation of Nursing Homes
- Massachusetts Health Decisions
- Massachusetts Hospital Association
- Massachusetts Medical Society
- Massachusetts Nurses Association
- Medical Center of Central Massachusetts
- Suffolk University Law School: Elder Law Clinic
- University of Massachusetts at Boston: The Gerontology Institute
- Visiting Nurse Associations of Massachusetts

For prices and information on quantity orders or for non-English language licensing, contact
Massachusetts Health Decisions, Publications, PO Box 417, Sharon, MA 02067

rev. 4/03
MASSACHUSETTS GENERAL HOSPITAL
Death Determination Using Brain Criteria in the Adult

1. POLICY

1.1. This document establishes a uniform approach to rendering a diagnosis of death based on failure of brain function in line with MGH, state and federal regulations. This has been referred to as brain death, but must be understood to be no different than a diagnosis of death made by other criteria.

1.2. Please read this entire document before starting the process of declaration, as it contains important procedural information and identifies common pitfalls. A required checklist for the proper performance of testing is found at the end of this document.

2. BACKGROUND

2.1. Death by brain criteria is defined under Massachusetts state law as the total and irreversible cessation of spontaneous brain functions, in which further attempts of resuscitation or continued supportive maintenance would not be successful in restoring such function. Stated more simply, brain death is the irreversible loss of all function of the brain, including the brainstem. A patient determined to be brain dead is legally and clinically dead.

2.2. The three essential findings in brain death are coma, absence of brainstem reflexes, and apnea. An evaluation for brain death should be considered in patients who have suffered a massive, irreversible brain injury of identifiable cause. Brain death from primary neurological disease is usually a result of severe head injury or cerebrovascular events. Global ischemic brain insults or fulminant hepatic failure, among other diagnoses, may also result in irreversible loss of brain function.

2.3. The diagnosis of brain death is primarily clinical. No other tests are required if a single full clinical evaluation, including an examination of brain stem reflexes and an apnea test, are conclusively performed. Ancillary testing is required only in situations in which the clinical determination is unavoidably inadequate, e.g. in cases of severe facial trauma, drug intoxication, severe metabolic disturbances or when the apnea test cannot be performed safely. In the absence of either complete clinical findings consistent with brain death, or ancillary tests demonstrating brain death, brain death cannot be diagnosed. These guidelines do not replace the physician's judgment in individual cases, since brain death is a clinical diagnosis.

2.4. For pediatric patients, refer to the policy Death: Determination using Brain Criteria in the Pediatric Population located in the Clinical Policy and Procedure Manual.
3. **REQUIREMENTS**

3.1. One full exam, including apnea testing, must be performed by an attending neurologist or neurosurgeon, or a neurocritical care fellow under the supervision of a neurology attending, and documented as such.

3.2. American Academy of Neurology guidelines stipulate that a single full exam, as detailed below, is required to diagnose brain death. Like any other evaluation, the exam may be repeated after an arbitrary interval if the evaluating physician feels this is necessary.

3.3. Contacting the New England Organ Bank (1-800-446-6362) prior to any discussion with the family is mandatory for any patient who is likely to meet criteria for organ donation.

3.4. A member of the Respiratory Therapy department must be present during apnea testing.

3.5. In cases in which the process of determining death by brain criteria may be in conflict with religious, cultural or personal beliefs of the patient or the patient’s family, consultation of the Medical Ethics Committee (Optimum Care Committee) may be helpful.

4. **PREREQUISITES FOR THE CLINICAL DETERMINATION OF BRAIN DEATH**

4.1. The proximate cause must be known, and must be known to be irreversible. There must be clinical or neuro-imaging evidence of an acute central nervous system catastrophe that is compatible with the clinical diagnosis of death by brain criteria.

4.2. Absence of severe acid-base, electrolyte, or endocrine abnormality that may confound clinical assessment. What constitutes a “severe” abnormality is left to the judgment of the evaluating physician.

4.3. Toxicology screening negative for significant confounding substances. If barbiturates given, serum level < 10 mcg/ml. If significant doses of CNS-depressing medications (e.g. narcotics, sedatives, hypnotics, anticholinergics, etc.) have been administered recently, wait for 5 half-lives of the medication in question or, if serum levels are available, until the level is below therapeutic. Renal or hepatic dysfunction, or preceding hypothermia may prolong clearance. If high suspicion for unknown or unmeasurable CNS-depressants, consider ancillary testing.

4.4. Demonstrated absence of neuromuscular blockade by electrical stimulation (e.g. with train-of-four nerve stimulation) if neuromuscular blocking agents have been administered recently or for a prolonged period.

4.5. Core temperature ≥ 36°C (96.8°F). Temperature may be supported artificially (e.g. with a warming blanket, etc).

4.6. Stable systolic blood pressure ≥ 100 mmHg. BP may be supported with
pressors.

In the presence of confounding variables, brain death may still be determined with the aid of ancillary tests (see Section 8 below).

5. **THE CLINICAL EXAMINATION**

The cardinal findings in brain death are: (1) coma, (2) absence of brainstem reflexes, and (3) apnea.

5.1. **Coma**: defined as the absence of any cerebrally-mediated response to noxious stimuli including pain in all extremities (nail-bed pressure) and in the head (e.g. supraorbital or temporo-mandibular joint pressure). “Spinal” reflexes are consistent with brain death, but decorticate/decerebrate posturing are not.

5.2. **Absence of all brainstem reflexes**:

5.2.1. **Pupils**

- No response to bright light. A magnifying glass may be useful if response is questionable.

- Size: from mid-position (4 mm) to dilated (9 mm). Small or pinpoint pupils should alert the clinician to the possibility of narcotic intoxication (but may also be seen with pontine injury or ocular surgery/disease).

5.2.2. **Ocular movement**

- No oculocephalic reflex (test only when the integrity of the cervical spine is ensured)

- No oculovestibular reflex: deviation of the eyes to irrigation in each ear with 30-50 ml of ice water. Observe for 1 minute after irrigation and wait at least 5 minutes before testing on the opposite side. Testing may be confounded by blood or cerumen in the auditory canal, a disrupted tympanic membrane or injury to the globes or orbits. Perform otoscopy prior to calorics.

5.2.3. **Facial motor response to stimulation**

- No corneal reflex to touch with a cotton swab

- No facial grimacing to any noxious stimulation, including insertion of a Q-tip into the nares

- Facial myokymias (from denervation of the facial nerve) are permissible
5.2.4. Pharyngeal and tracheal reflexes

- No response to stimulation of the posterior pharynx with tongue blade
- No coughing or significant bradyarrhythmia with bronchial suctioning

6. Apnea Testing

6.1. Prerequisites—all prerequisites above plus the following:

6.1.1. Eucapnea (PaCO₂ 35-45 mmHg)

- For patients with chronic CO₂ retention (e.g., COPD, severe obesity), apnea testing may be performed with the baseline PaCO₂—if known—defined as eucapnia. Ancillary testing should be considered in such cases, especially if the baseline PaCO₂ is unknown.

6.1.2. Euvolemia

- If the patient is requiring significant amounts of vasopressor agents for blood pressure support, or is having unstable cardiac dysrhythmias, consider ancillary testing.

6.2. Preparation:

6.2.1. Place the patient on 100% oxygen and reduce positive end-expiratory pressure (PEEP) to 5 cm H₂O for > 10 minutes before beginning test. Oxygen desaturation or PaO₂ < 200 mmHg with these settings may indicate difficulty with apnea testing.

6.2.2. Obtain baseline arterial blood gas

6.3. Procedure:

6.3.1. Remove patient from ventilator

6.3.2. Provide oxygen via catheter at 10 L/min to the level of the carina

6.3.3. Watch closely for respiratory movements (defined as abdominal or chest excursions)

6.3.4. Monitor oxygen saturation and blood pressure

6.3.5. Draw arterial blood gas at 5 minutes and 10 minutes
6.4. Terminate test for:

6.4.1. Spontaneous respirations or respiratory effort (apnea test does not support brain death)

6.4.2. Cardiac ectopy

6.4.3. Pulse oximetry < 90% for > 30 seconds (can retry with T-piece, CPAP 10 cm H₂O, and 100% O₂ at 12 L/min)

6.4.4. Systolic blood pressure < 100 mmHg

If apnea test aborted due to ectopy, oxygen desaturation, or hemodynamic instability, draw an ABG and restart artificial ventilation at original settings. Consider ancillary testing.

6.5. Interpretation:

6.5.1. If respiratory movements are absent and the final arterial blood gas shows:

\[ \text{PaCO}_2 \geq 60 \text{ mmHg} \]

OR

for patients with known CO₂ retention (e.g., COPD, severe obesity) > 20 mmHg increase from the pre-test baseline

then apnea has been demonstrated, supporting the diagnosis of death by brain criteria.

If inconclusive after 10 minutes and the patient was stable for the duration of testing, the test may be repeated with the time extended to 12-15 minutes.

7. CLINICAL OBSERVATIONS COMPATIBLE WITH THE DIAGNOSIS OF BRAIN DEATH

These manifestations are occasionally seen and may be misinterpreted as evidence for brain stem function.

7.1. Spontaneous 'spinal' reflexes in the limbs (not to be confused with pathologic flexion or extension responses, which are NOT consistent with brain death)

7.2. Respiratory-like movements (shoulder elevation and adduction, back arching, intercostal expansion without significant tidal volumes) that may trigger the ventilator to deliver a breath

7.3. Sweating, blushing, tachycardia
7.4. Normal blood pressure in the absence of pharmacologic support
7.5. Absence of diabetes insipidus (i.e., normal osmolar control mechanism)
7.6. Deep tendon reflexes, triple flexion responses or Babinski's reflex
7.7. Facial myokymias
Consider ancillary testing if 7.1 and/or 7.2 are observed.

8. ANCILLARY TESTS SUPPORTING THE DIAGNOSIS OF BRAIN DEATH

8.1. Conventional angiography: Contrast injected under pressure into the aortic arch. No intracerebral filling at the point of entry of either carotid or vertebral artery to the skull. The external carotid circulation is patent, and delayed filling of the superior sagittal sinus may be seen.

8.2. Nuclear flow study: scintigraphy using Technetium 99m hexamethyl propylene amine oxime (99mTc-HMPAO SPECT): No uptake of isotope in the brain parenchyma as interpreted by an attending Nuclear Medicine physician. The extracranial circulation should fill, allowing for uptake within the meninges and skull vessels.

8.3. Electroencephalography: Absence of any electrocerebral activity during at least 30 minutes of recording.
   - Integrity of entire system tested by EEG technician (EKG artifact should be visible)
   - Minimum of 8 scalp electrodes used
   - Distance between electrodes ≥ 10 cm
   - Interelectrode impedance between 100 and 10,000 Ω
   - Sensitivity increased to at least 2 µV
   - High and low frequency filters should not be set below 30 Hz or above 1 Hz, respectively
   - Electroencephalography should demonstrate lack of reactivity to intense auditory, visual, or painful somatosensory stimulation
   - Absence of EEG activity must be confirmed and documented by a neurology attending

8.4. Transcranial Doppler ultrasonography: Reverberating flow or small systolic peaks in early systole without diastolic flow are consistent with brain death. The test must be performed bilaterally, as well as anteriorly and posteriorly. Complete absence of flow may not be reliable owing to
inadequate transtemporal windows for insonation. Diagnosis established by intracranial examination must be confirmed by the extracranial bilateral recording of flow in the common carotid, internal carotid, and vertebral arteries.

8.5. Insufficient data exists to support the use of CT angiography, MRI, MR angiography, or somatosensory evoked potentials for brain death determination, thus these are not currently considered acceptable ancillary tests.

9. **MEDICAL RECORD DOCUMENTATION**

The declaration of death by brain criteria must be documented in the medical record as a death note in a manner similar to any other declaration of death and include the following:

9.1. Etiology and irreversibility of coma

9.2. Absence of motor response to pain

9.3. Absence of brain stem reflexes

9.4. Details of the apnea test, including pre and post test arterial blood gas values

9.5. Justification for ancillary testing, if performed, along with results and name of the attending physician responsible for interpretation

9.6. The date and time of declaration and the name of the attending neurologist, neuro critical care fellow or attending neurosurgeon declaring death by brain criteria

   - Time of death is defined as the time apnea is confirmed (the time the final arterial blood gas is recorded) or the ancillary test is officially interpreted

9.7. Indication that the Medical Examiner was contacted if appropriate (see guidelines in the Report of Death Form)

9.8. Results of repeat neurological examinations, if performed.

The form at the end of this document is provided to assist with the documentation of brain death in the medical record. Its use is **required**, and it must be filed in the patient’s chart after completion of brain death testing. One copy should be used for each examination performed. It is appropriate to write a brief narrative note summarizing the indications for and results of brain death testing as recorded in this document.

**Selected References:**

Evidence-based guideline update: determining brain death in adults: report of the


Commonwealth of Massachusetts 105 CMR 800.003

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Checklist for determination of brain death

Date and time______________________________________

Prerequisites (all must be checked)
☐ Coma, irreversible and cause known
☐ Neuroimaging explains coma
☐ CNS depressant drug effect absent (toxicology screen/serum levels if indicated)
☐ No evidence of residual paralytics (electrical stimulation if paralytics used)
☐ Absence of severe acid-base, electrolyte, or endocrine abnormality
☐ Normothermia or mild hypothermia (core temperature ≥ 36° C/96.8° F)
☐ Systolic blood pressure > 100 mmHg
☐ No spontaneous respirations

Examination (all must be checked)
☐ Pupils nonreactive to bright light
☐ Corneal reflex absent
☐ Oculocephalic reflex absent (tested only if C-spine integrity ensured)
☐ Oculovestibular reflex absent (30-50 mL ice water each ear, observe 1 min, 5 min between ears)
☐ No facial movement to noxious stimuli at supraorbital nerve, temporo-mandibular joint
☐ Gag reflex absent
☐ Cough reflex absent to tracheal suctioning
☐ Absence of motor response to noxious stimuli in all 4 limbs (spinally-mediated reflexes are permissible, posturing is not)

Apnea testing (all must be checked)
☐ Patient is hemodynamically stable and euvoletic
☐ Ventilator adjusted to provide normocarbia (PaCO₂ 35–45 mmHg)
☐ Patient preoxygenated with 100% FiO₂ for > 10 min to PaO₂ > 200 mm Hg
☐ Patient well-oxygenated with a PEEP of 5 cm H₂ O
☐ Provide oxygen via a suction catheter to the level of the carina at 10 L/min or attach T-piece with CPAP at 10 cm H₂ O
☐ Disconnect ventilator
☐ Spontaneous respirations absent
☐ ABG drawn at 5 minutes
☐ ABG drawn at 10 minutes (reconnect ventilator)
☐ PaCO₂ ≥ 60 mmHg or ≥ 20 mm Hg rise from baseline

Pre-test ABG: pH___ pCO₂____ pO₂____ Post-test ABG: pH___ pCO₂____ pO₂____ @____min
OR:
☐ Apnea test aborted (cardiac ectopy, O₂ sat < 90%, SBP < 100 mmHg)

Ancillary testing (only 1 needs to be performed; to be ordered only if clinical examination cannot be fully performed due to patient factors, or if apnea testing inconclusive or aborted)
☐ Cerebral angiogram
☐ SPECT
☐ EEG
☐ TCD

Time of death (MM/DD/YY & 00:00) __________________due to________________________ (etiology of coma)

Name of physician and signature
__________ ____________________________  ☐ attending neurologist/neurosurgeon
_________________________________  ☐ neurocritical care fellow
MASSACHUSETTS GENERAL HOSPITAL

Death Determination Using Brain Criteria in the Pediatric Population

1. **Policy:**

   1.1. This document establishes the Massachusetts General Hospital for Children criteria to be met when making the diagnosis of brain death based on failure of brain function. This has been defined as brain death, but must be understood to be no different than a determination of death made by other criteria.

   1.2. Please read this entire document before starting the process of declaration, as it contains important procedural information and identifies common pitfalls.

   1.3. A checklist for the proper performance of testing is found at the end of this document.

2. **Background**

   2.1. Death by brain criteria is defined under Massachusetts state law as the total and irreversible cessation of spontaneous brain functions after which further attempts of resuscitation or continued supportive maintenance would not be successful in restoring such function. (See 10 C.M.R. 800.004; Commonwealth v. Golston, 373 Mass. 249, 355 N.E. 2nd 744, 1977.)

   2.2. Brain death is defined as the irreversible loss of the clinical function of the whole brain, including the brain stem. Brain death in children is frequently caused by severe head injury or cerebrovascular events; global ischemic brain insults or fulminant hepatic failure also may result in irreversible loss of brain function. The full term newborn (≥ 37 weeks’ gestation) is difficult to evaluate clinically due to many factors, including difficulties of clinical assessment and the determination of proximate causes of coma. These problems are accentuated in a pre-term infant. For these reasons, the determination of death by brain criteria in this population requires two exams 24 hours apart to ensure that a reversible condition does not exist.

   2.3. These guidelines do not replace the physician's judgment in individual cases because brain death is a clinical diagnosis. Ancillary testing should be performed in situations in which the clinical determination is judged by the Attending Physician or Consulting Neurologist / Neurosurgeon to be inadequate, e.g. in cases of severe facial trauma, drug intoxication, severe metabolic disturbances or an inconclusive apnea test. The guidelines are considered to be reasonable, current and generally accepted criteria for use in the determination of death by brain criteria.
3. **IMPORTANT FIRST STEPS AND REQUIREMENTS:**

3.1. If the patient is under the care of a non-neurological physician, an attending neurologist or neurosurgeon must be consulted to make the diagnosis of brain death.

3.2. It is mandatory to consult the New England Organ Bank (NEOB) (1-800-446-6362) prior to any discussion with the family for all patients who are likely to meet criteria for brain death. The NEOB coordinator will review the case with the health care team prior to offering the opportunity for donation to a family.

3.3. The use of psychoactive or sedating medications, especially those with a long half-life, should be avoided. (If psychoactive medications have recently been given, please see Section 6 below).

3.4. In cases in which the process of determining death by brain criteria may be in conflict with religious, cultural or personal beliefs of the patient or the patient’s family, consultation with the Pediatric Bioethics Committee may be considered.

4. **TECHNICAL CRITERIA**

4.1. Diagnostic Criteria for Clinical Diagnosis of Brain Death.

4.1.1. Prerequisites

- The proximate cause must be known, and must be known to be irreversible. There must be clinical or neuroimaging evidence of an acute central nervous system catastrophe that is compatible with the clinical diagnosis of death by brain criteria.

- Potentially confounding medical conditions that might affect the clinical assessment should be excluded (i.e. acid-base or severe electrolyte disturbances, including hyperammonemia, or endocrine disturbances).

- Serum toxicology screening must demonstrate a barbiturate level equal to or less than 10 mcg/ml and no evidence of other drug intoxication or poisoning. If significant doses of CNS depressing medications (e.g. narcotics, sedatives, hypnotics, anticholinergics, etc) have been administered recently, the clinical examination might be unreliable, and ancillary testing should be performed.

- Absence of neuromuscular blockade (i.e. with train of four nerve stimulation) must be demonstrated if the patient has received recent or prolonged use of neuromuscular blocking agents.
Attachment OOD 19.c continued

- Core temperature must be equal to or above 36.5°C (96.8°F).
- In the presence of confounding variables, brain death may be determined with the aid of ancillary tests (see Section 6).

4.2. The three cardinal findings in brain death are: 1. coma, 2. complete absence of brain stem reflexes, and 3. apnea.

- Coma is defined as the absence of any cerebrally-mediated motor response to noxious stimuli, including pain in all extremities (nail-bed pressure) and in the head (e.g. supraorbital or temporo-mandibular joint pressure).
- Absence of brain stem reflexes

  ▪ Pupils
    - No response to bright light (a magnifying glass may be useful if response is questionable).
    - Size: midposition (4 mm) or dilated (9 mm); small or pinpoint pupils should alert the clinician to the possibility of narcotic intoxication and also may be seen with pontine damage.

  ▪ Ocular movement
    - Absent oculo-cephalic reflex (testing only when the integrity of the cervical spine is assured).
    - Absent oculovestibular reflex: deviation of the eyes to irrigation in each ear with ice water. (Observe for 1 minute after irrigation, and wait at least 5 minutes between testing on each side). Testing may be confounded by blood or cerumen in the auditory canal, a disrupted tympanic membrane, prior administration of ototoxic drugs or injury to the globes or orbits.

  ▪ Facial motor response to stimulation
    - Absent corneal reflex to touch with a cotton swab
    - Absent jaw jerk reflex
    - No facial grimacing to deep pressure on the nail bed, supraorbital ridge, or temporomandibular joint
    - Facial myokymias, resulting from denervation of the facial nerve, are involuntary and permissible.

  ▪ Pharyngeal and tracheal reflexes
4.3. Apnea testing is performed as follows:

- Respiratory therapy will assist in performing the apnea test in the presence of the declaring physician. Pediatric Neurology and the Adult Neurointensive Care Unit staff are available for assistance with all aspects of the guidelines.

**Prerequisites:**

- Core temperature equal to or above 36.5°C (96.8°F)
- Systolic blood pressure must be appropriate for age. If the patient requires significant amounts of vasopressor(s) to support the blood pressure to this range, or has unstable cardiac dysrhythmia(s), ancillary testing should be performed in place of apnea testing.
- Correct the electrolyte disturbances of diabetes insipidus, with a positive fluid balance in the past 6 hours if severe hypernatremia is present.
- The patient must not be hypoxic. Preoxygenate with 100% FiO2 for 5 minutes or to arterial PO2 > 200 mm Hg. If adequate pre-oxygenation cannot be obtained, ancillary testing must be performed in place of apnea testing.
- Adjust the ventilator to obtain an arterial pH to 7.35-7.45 and pCO2 to 35-45 mm Hg if possible at least 20 minutes prior to initiating the test. In patients with known CO2 retention, attempt to attain a pCO2 near the patient’s baseline. Apnea testing can be performed if the patient is acidic or hypercapneic.
- Assure the proper functioning of the pulse oximeter. Attach a catheter to an oxygen source and deliver 100% O2 via the endotracheal tube or tracheostomy to the level of the carina immediately after disconnecting the ventilator. We recommend disconnecting the ventilator during the test because most ventilators do not supply a steady flow of oxygen unless the ventilator is cycling, and ventilators can register breaths inappropriately with stimuli.
- Observe closely for respiratory movements (defined as abdominal or chest excursions). Chest wall excursions
secondary to cardiac pulsations are not considered respiratory efforts. pH usually decreases by at least 0.02 units per minute of apnea.

- Measure PO2, PCO2, and pH after approximately 8 minutes and reconnect the ventilator. The apnea test must be terminated if the patient becomes hypoxic, cyanotic or hemodynamically unstable (see below)

- If respiratory movements are absent and the final arterial blood gas shows

\[
pH \leq 7.30 \text{ (from a patient with pre-test pH of } \geq 7.4) \]

or

\[
PCO2 \text{ increases from 40 up to 60 mm Hg (or } \geq 20 \text{ mm Hg increase from the pre-test baseline in patients with known CO2 retention)}
\]

then,

- The apnea test is positive. thus supporting the determination of death by brain criteria.

- If respiratory movements are observed or the blood gas criteria are not met, the apnea test is negative and thus does not support the clinical determination of death by brain criteria.

- If during testing the patient becomes cyanotic or hypotensive during testing or the pulse oximeter indicates significant oxygen desaturation or a cardiac arrhythmia develops, immediately draw an arterial blood sample and reconnect the ventilator. If the patient has remained apneic during the test and blood gas values meet the criteria above (see item e.), the apnea test is positive. If the blood gas values do not meet the criteria, the apnea test is indeterminate.

- If the patient is stable for the duration of testing, and the blood gas values do not meet the criteria above, the test may be repeated for 10-20 minutes, with repeated adequate pre-oxygenation. Alternatively, ancillary testing can be performed.
5. **PITFALLS IN THE DETERMINATION OF BRAIN DEATH**

The following conditions may interfere with the clinical diagnosis of brain death, so that the diagnosis cannot be made with certainty on clinical grounds alone. In such cases ancillary testing is necessary.

5.1. Severe facial trauma
5.2. Pre-existing pupillary abnormalities
5.3. Recent administration of potentially sedative drugs, aminoglycosides, tricyclic antidepressants, anticholinergics, antiepileptic drugs, chemotherapeutic agents, or neuromuscular blocking agents
5.4. Sleep apnea or severe pulmonary disease resulting in severe chronic retention of CO₂.
5.5. Severe acid-base disorders, metabolic derangement, or endocrine disorders.
5.6. Hemodynamic or pulmonary instability.

6. **CLINICAL OBSERVATIONS STILL COMPATIBLE WITH THE DETERMINATION OF BRAIN DEATH**

These manifestations are occasionally seen and should not be misinterpreted as evidence for brain stem function.

6.1. Spontaneous "spinal" movements of limbs (not to be confused with pathologic flexion or extension response)
6.2. Respiratory-like movements (shoulder elevation and adduction, back arching, intracostal expansion without significant tidal volumes)
6.3. Sweating, blushing, tachycardia
6.4. Normal blood pressure in the absence of pharmacologic support
6.5. Absence of diabetes insipidus (i.e., normal osmolar control mechanism)
6.6. Deep tendon reflexes, triple flexion responses or Babinski reflex, all of which may be spinally-mediated reflexes.
6.7. Facial myokymias.

7. **ANCILLARY LABORATORY TESTS SUPPORTING THE DETERMINATION OF BRAIN DEATH**

Determination of death by brain criteria is based on a clinical examination. A confirmatory test is not mandatory but should be used in those patients in whom specific components of clinical testing cannot be reliably performed or evaluated. Write the name of the attending physician interpreting the ancillary test as well as
the time of interpretation, as this is the official time of death, and should be documented as such in the Declaration of Death Note.

7.1. Conventional angiography: A 4-vessel angiogram should be performed. No intracerebral filling of the anterior or posterior circulation should occur. The external carotid circulation is patent, and filling of the superior sagittal sinus may be delayed. There should be no intracerebral arterial filling, with contrast filling of the internal carotid artery abruptly stopping at the cavernous portion, where the artery becomes intracranial.

7.2. SPECT using Technetium 99m hexamethylpropyleneamineoxime (HMPAO) brain scan: There should be no uptake of isotope in brain parenchyma as interpreted by an Attending Nuclear Medicine Physician. The extracranial circulation should still fill, allowing for uptake within the meninges and skull vessels.

7.3. Electroencephalography: Should show an absence of any electrocerebral activity during at least 30 minutes of recording that adheres to the minimal technical criteria for electroencephalographic recording in suspected brain death, as adopted by the American Electroencephalographic Society, using 16-channel electroencephalography. It should include the absence of non-artifactual activity and there should be no change with auditory, visual, or painful stimulation. Electrocardiographic artifact should be visible. Core body temperature should be \( \geq 36.5^\circ C (96.8^\circ F) \). For determination of brain death the absence of EEG activity should be confirmed by a member of the neurology staff.

7.4. Non-validated ancillary Tests:

- Somatosensory evoked potentials (SSEPs) for the determination of brain death have been controversial and are not commonly used.

- MRAngiography and CTAngiography are both under investigation as ancillary tests, but have not been validated to date and are not to be used.

8. **Medical Record Documentation**

The declaration of death by brain death criteria must be documented in the medical record as a death note in a manner similar to any other declaration of death and include the following:

8.1. Date and time of death

8.2. The name of the attending and neurologist or neurosurgeon determining death by brain criteria.
8.3. Etiology and irreversibility of condition.

8.4. Absence of brain stem reflexes

8.5. Coma

8.6. Details of apnea test, including time of apnea, pre and post test arterial blood gas values.

8.7. Justification for ancillary testing if indicated, and results of ancillary test(s) if performed with the name of the staff physician responsible for interpretation

8.8. Indication that the Medical Examiner was contacted if appropriate (see guidelines in the Report of Death Form)

8.9. Indication that the New England Organ Bank (NEOB) was consulted.

9. REFERENCES


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CHECK LIST FOR DETERMINATION OF BRAIN DEATH

This checklist is provided to ensure the proper clinical testing of Brain Death in the pediatric patient. If the clinical examination cannot be performed, ancillary testing should be performed, and the ancillary testing must be documented here and in the patient’s medical record.

PREREQUISITES (ALL MUST BE CHECKED)

- Coma, irreversible and cause known
- CNS depressant drug effect absent (toxicology screen)
  (If barbiturates given, serum level equal to or under 10 mcg/ml)
- Absence of chemical paralysis (electrical stimulation if paralytics used)
- Absence of severe acid-base, electrolyte, endocrine abnormality
- Core temperature ≥36.5°C
- Systolic BP normal for age
- No spontaneous respirations

EXAMINATION (ALL MUST BE CHECKED)

- NEOB consulted
- Pupils non-reactive to bright light
- Corneal reflex absent
- Oculocephalic reflex absent (tested only if C-spine integrity ensured)
- Oculo-vestibular reflex absent (cold caloric testing)
- No facial movement to noxious stimuli at supraorbital nerve, TMJ
- Cog reflex absent
- Cough reflex absent to tracheal suctioning
- Absence of motor response to painful stimuli in all 4 extremities
  (spinally-mediated reflexes are permissible)

APNEA TESTING (ALL MUST BE CHECKED)

- Patient is hemodynamically stable
- Ventilator adjusted to provide normocarbia (PCO2 35-45 mm Hg or to patient’s baseline)
- Patient pre-oxygenated with 100% FiO2 for ≥5 minutes to PaO2 ≥ 200 mm Hg
- Patient well-oxygenated with a PEEP of 5 cm of water
- Oxygen provided via a suction catheter to the level of the carina at ≥6 liters/min
- Ventilator disconnected
- Spontaneous respirations absent
- ABG drawn at 8-10 minutes, patient reconnected to ventilator
- PCO2 ≥ 60 mm Hg, or 20 mm Hg rise from normal baseline value

ANCILLARY TESTING

(To be ordered only if clinical exam cannot be fully performed due to patient factors, or if apnea testing inconclusive or aborted. ONLY ONE NEEDS TO BE CHECKED)

- Cerebral Angiography
- HMPAO SPECT
- EEG

TIME OF DEATH ___________________________ DD/MM/YY
PHYSICIANS NAME (print) ____________________________________________
PHYSICIANS SIGNATURE ____________________________________________

(In cases where two MD’s are required use two forms)
MASSACHUSETTS GENERAL HOSPITAL

Donation After Circulatory Death

1. POLICY

1.1. It is the policy of the Massachusetts General Hospital to support Donation after Circulatory Death for the purpose of procuring organs for transplantation in accordance with the informed consent of the donor's legal next-of-kin. Donation after Circulatory Death (DCD) serves to maximize the number of organs that may be recovered for transplant by expanding the potential donor population beyond those patients who meet brain death criteria.

1.2. The complexity of the DCD process necessitates supporting our intensive care and operating room staff, social work and the chaplaincy with resources from within and outside the MGH including New England Organ bank (NEOB). The NEOB staff are specifically trained in performing Donation after Circulatory Death.

2. CRITERIA

2.1. Patients with irreversible brain injury from an established cause or end stage pulmonary failure for which mechanical ventilation support is no longer medically indicated.

2.2. Brain death criteria not fulfilled.

3. PROCESS

3.1. The physician of record or designated representative\(^1\) determines that it is appropriate to discuss the discontinuation of extraordinary measures of treatment with the patient’s health care proxy, legal next of kin, or designated family spokesperson.

3.2. New England Organ Bank is notified at (800) 446-6362.

3.3. Potential for donation is determined by the NEOB representative

3.4. A plan of approach to introduce the opportunity for donation to the designated spokesperson, health care, agent or legal next-of-kin is determined by the physician of record or designated representative, ICU nurse(s), other support staff and NEOB representative.

3.5. The physician-of-record or designated representative, nurse, and other members such as, social work and chaplain, have discussion with designated spokesperson about patient condition and withdrawal of medical support.
3.6. The donation discussion should not be initiated until the family spokesperson, legal next of kin, or health care agent have determined that discontinuation of medical support is desirable. The family spokesperson, legal next of kin or health care proxy may raise the issue themselves. If that occurs, then the discussion about donation should not be delayed.

3.7. The NEOB representative will be introduced and discuss organ/tissue donation with family spokesperson, health care proxy, or legal next of kin. The NEOB will obtain authorization for donation from the family spokesperson, health care proxy or legal next of kin as per the Uniform Anatomical Gift Act unless the patient has made a legally binding donor designation prior to death.

3.8. Cases reportable to the Medical Examiner's office will be reported prior to extubation and cleared to proceed with donation.

3.9. The following personnel are notified pending recovery:

3.9.1. NEOB Technical Recovery Staff & Medical Director

3.9.2. MGH/BWH Tissue Typing Laboratories

3.9.3. MGH Renal/Liver Transplant Coordinators and Recovering Surgeons

3.9.4. Operating Room Charge Nurse

4. **Preparation**

4.1. The probability of successful organ transplantation is improved when organ recovery takes place in an operating room. The legal next of kin, health care agent or family spokesperson will be informed of the following options:

4.1.1. Extubation in the Operating Room.

4.1.2. Extubation in the ICU.

4.2. OR will be notified of location of extubation.

4.3. End of life care will be discussed with family by nurse and physician, including cultural, religious considerations.

4.3.1. NEOB staff request the ICU staff draw donor blood samples for use by NEOB coordinator

4.3.2. NEOB staff brings appropriate supplies to location where extubation is to occur
4.3.3. Staff from location of extubation (ICU/OR) provide wall suction, 4 pressure bags, and 2 IV poles at the bedside

4.3.4. ICU staff will manage End of Life Care and family support.

4.3.5. MGH physician-of-record or designated representative will remain in attendance for extubation and remain until he/she declares death.

4.3.6. Cannulation for installation of preservate fluid will not occur before declaration of death.

4.3.7. If the transplant surgeon requests Heparin, written informed consent for pre-mortem Heparin just after extubation is obtained by the MGH physician-of-record or designated representative.

4.3.8. Prior to extubation, a timeout will be performed at the location of the event. Elements of the timeout will include; confirmation of patient identity, confirmation of authorization for donation of specific organs to be recovered, and identification of responsibilities of the patient care team, NEOB and the organ recovery personnel.

4.3.9. No member of the organ recovery team or transplant team or NEOB staff may participate in the guidance or administration of palliative care, or declaration of death. No member of the transplant team shall be present during the withdrawal of life-sustaining measures and shall not be present until death has been declared.

5. **Location of Extubation**

5.1. **ICU Extubation:**

5.1.1. NEOB will notify OR of impending travel with donor patient.

5.1.2. Patient is extubated in the ICU and comfort care instituted.

5.1.3. If death occurs within two hours, the MGH physician-of-record or designated representative declares the patient dead. If death does not occur, the patient will remain in the ICU or another unit as appropriate.

5.1.4. Donor patient is moved immediately to the OR with the ICU staff nurse, MGH physician-of-record or designated representative and the NEOB staff.
5.1.5. The NEOB family service coordinator, MGH social worker or chaplain, will support family members in the ICU.

5.1.6. Recovery of organs occurs in the OR.

5.2. OR Extubation:

5.2.1. The ICU nurse will review the process and discusses end of life management plans including cultural, social and religious considerations.

5.2.1.1. The ICU gathers medications and supplies needed to provide comfort care in the OR.

5.2.1.2. It will be the responsibility of the attending physician to assign a physician member to function in the capacity of physician-of-record or designated representative for this process.

5.2.2. The OR nurse meets the ICU team and family in the ICU and provides bunny suits and other attire for staff and family.

5.2.3. The patient is transported to the OR by the ICU staff, including the physician-of-record or designated representative.

5.2.4. The family is escorted to the OR by the OR nurse and the NEOB family service coordinator.

5.2.5. The patient is extubated by the ICU staff and comfort care provided to both patient and family. Heparin is delivered if consented.

5.2.6. If death occurs within 2 hours of the extubation, organs may be recovered.

5.2.7. MGH physician-of-record or designated representative declares the patient’s death.

5.2.8. The family service coordinator from NEOB escorts the family back to the ICU.

5.2.9. Recovery of organs occurs in the OR.

5.2.10. If death does not occur within two hours post extubation, the patient is escorted back to the ICU by the ICU nurse.

5.3. Declaration of Death

5.3.1. Declaration of cardiac death shall be declared on the basis of
irreversible cessation of circulatory and respiratory function in accordance with accepted medical and legal standards. The determination of cessation of circulatory and respiratory function is the responsibility of the MGH physician-of-record or designated representative or designated representative. Intra-arterial blood pressure monitoring may be used to facilitate the determination of cessation of circulatory function. Pulseless Electrical Activity (PEA) will not be considered a contraindication in determining cessation of circulation during the DCD process. Once the physician determines circulation and respiration have ceased, there is a 5 minute observation period to confirm the irreversible cessation of circulation and respiration and to enable a declaration of death. After the 5 minute observation period and once death has been pronounced, the organ recovery procedure may be initiated.

5.4. Post-Recovery

5.4.1. NEOB staff will follow up with the donor family and the hospital staff after the completion of the donation.

5.4.2. Any hospital charges associated with the evaluation or recovery of organs for transplantation are the financial responsibility of NEOB.

6. ENDNOTES

1The MGH physician-of-record or designated representative may be an Attending Physician, assigned Resident, or the physician designated to be present with the patient in the OR from the time of extubation until declaration of death.

| Approved: | Clinical Policy and Record Committee | (10/03/03) (1/09/04) (1/13/06) (7/14/06) (8/28/09) (12/2011) |
| Approved: | Medical Policy Committee | (10/15/03) (1/21/04) (2/1/06) (7/5/06) (9/02/09) (2/2012) |
1. **Policy**

1.1. At Massachusetts General Hospital, one of our objectives is to provide high quality care to all patients. Treatment and care must be provided to all persons in need without regard to race, color, religious creed, gender, gender identity or expression, genetic information, sexual orientation, age, disability, veteran or active military status, marital status or national origin. Upon accepting employment at the Massachusetts General Hospital, all employees of the Hospital’s staff are, as a condition of employment, expected to perform whatever duties are necessary and appropriate to ensure high quality patient care.

It is understood that situations may arise in which the prescribed course of treatment or care for a patient may be in conflict with the personal values or religious beliefs of a staff member. In such situations, it is the responsibility of the employee to notify the supervisor or department head immediately of concerns and to request that the employee be excused from participating in a particular aspect of treatment or care of the patient. Reasonable effort will be made to honor the employee’s request.

However, in no circumstances will a request be granted if it is felt doing so would negatively affect the care of the patient. The requesting employee is responsible for providing appropriate patient care until alternate arrangements can be made.

It must be realized that for reasons of minimal staffing and unavailability of other staff, requests may not be granted. Employees may request a transfer to a department or position where conflict-of-care issues are less likely to occur.

In accordance with state law, employees who provide written statements of conscientious objection to abortion or sterilization are not required to participate in such procedures.

2. **Definitions and Regulations**

2.1. Requests for accommodations in the delivery of patient care as a result of an employee’s personal values and/or beliefs are to be submitted to his/her immediate supervisor. As permitted by the situation, this request must be in writing as soon as reasonably possible and must include the specific aspects of care from which the employee is requesting to be excused and the reasons for making the request. If further review is necessary, the supervisor shall contact his/her assigned Human Resources generalist to make a determination on the justification of the request.
2.2. The Hospital will attempt to make reasonable accommodations for all justified employee requests for exclusion from patient care or treatment resulting from a conflict with the employee’s personal values or beliefs.

2.3. Failure to follow the above procedures may subject an employee to corrective action up to and including termination.

Related Policies:

Corrective Action

Last Revision: 2008

Last Review: 2012
1. **PURPOSE**

1.1. At the end-of-life, patients have unique needs related to the dying process. It is our goal to enhance the quality of each patient's life to the greatest extent possible given his or her illness. Caregivers will seek opportunities to make patients feel comfortable and cared for. When possible and desired by the patient, caregivers will help patients to make sense of their illnesses and to find meaning or spiritual significance for their lives.

1.2. In order to maximize quality of life as defined by the patient, the health care team will make a comprehensive assessment of the patient's needs and of the family's needs and abilities related to the patient's illness. A plan of care based on this assessment will be formulated and implemented. The plan of care will be individualized according to the needs of each patient and family with acknowledgement of and attention to the differing needs of patients and their family members.

(Link to the following policies: Life-Sustaining Treatment Policy: Resolving Intractable Conflict and Life Sustaining Treatment Policy)

2. **GENERAL POLICIES**

2.1. Caregivers are obligated to respect and optimize a patient's quality of life, however a patient, or surrogate defines it to be. (Refer to "Life-Sustaining Treatment" CP&P Manual).

2.2. In order to understand what is important to the patient and family, a discussion of the goals of care should take place. It is not always appropriate or necessary to discuss specific treatments with the patient or surrogate once their goals of care are determined. However, any patient with the capacity to make healthcare decisions, and the surrogates of patients without such capacity, have the right to be provided with adequate information regarding treatment options if they wish. Discussion of any specific treatment option should include its potential benefits and burdens, not merely its possibility.

3. **PROCEDURES**

3.1. The health care team, under the direction of the responsible physician, will involve the patient in the discussion of goals of care unless the patient prefers not to be involved or is unable to be involved. When appropriate, the team also will involve the family, or health care proxy.

3.2. Each discipline involved in the patient's care will continuously assess the patient's needs and revise its plan of care, in accord with the overall plan.
of care established by the responsible physician, to promote the patient's comfort and dignity.

3.3. The health care team should consider the following issues in planning end-of-life care:

- The patient's values, goals, and any preferences for specific treatments,
- Pain control, symptom management and patient comfort,
- Emotional support for patient and family,
- Patient-doctor confidentiality and family privacy.

3.4. When caring for certain patients, it also may be appropriate for the team to consider:

- Meaning of life and suffering for patient and family, cultural values, and spirituality,
- The patient's capacity to understand his/her diagnosis and prognosis,
- Advance directives including Health Care Proxy and Living Will,
- Support services for the patient and/or family, both in the hospital and in the community,
- The patient's preferred site of care and of death,
- Alternative sites of care, including the home of the patient, the homes of family members and hospices,
- Smooth transitions in care, including timely initiation of referrals and sensitivity to patient/family fears of medical abandonment,
- Legal, financial, and family issues,
- Post life issues, organ and/or tissue donation, autopsy (Refer to "Permission for Autopsy and Organ Donation" CPP Manual).

3.5. The patient's and family's goals and preferences for care will be reassessed at regular intervals and as new decision-points arise. Outcomes of decisions and care plans will be documented in the patient record.
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<tr>
<th>Issued and reviewed by:</th>
<th>Palliative Care Service</th>
<th>(3/5/99) (9/03/03) (11/06) (7/09). To be reviewed/approved by 11/2012; newly approved version of policy available on site for review.</th>
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1. **POLICY**

   1.1. The MGH Inpatient Hospice Program is open to patients with life threatening illness that need aggressive pain and symptom management to provide appropriate care at end of life. MGH registered nurses, Hospice of the North Shore and Greater Boston and the Palliative Care Service will formulate an individual Hospice Plan of Care for each patient admitted to the program.

2. **OVERVIEW**

   2.1. Patients have unique needs and challenges at the end of life. In an effort to meet these needs, Massachusetts General Hospital has entered into a contract with Hospice of the North Shore and Greater Boston. Our goal is to address the needs of patients requiring hospice care by: promoting earlier recognition of MGH inpatients who are actively dying; improving end-of-life care for these patients and their families; facilitating earlier hospice and palliative care referrals; and improving the transition of inpatient care to home hospice care.

   2.2. This partnership with Hospice of the North Shore and Greater Boston will allow appropriate inpatients who are transitioning to their hospice benefit while they remain in an acute bed. These patients may not be ready for discharge or transfer, due to severe, refractory symptoms requiring ongoing inpatient care. Coverage of their Hospice Benefit may include Medicare Medicaid and appropriate commercial insurances with Hospice Benefits. Patients without appropriate hospice coverage will not be eligible for general Inpatient Hospice.

   2.3. The creation of the Inpatient Hospice Care Program facilitates the focus of care and treatment to shift toward palliation while the patient remains in an acute care setting. The volume of patients being cared in this program is anticipated to average 3-5 patients per day. The anticipated length of stay for these inpatients admitted to the hospice benefit is 3-5 days. Readiness for discharge to home hospice care or an alternative inpatient hospice setting will continue to be assessed on a daily basis.

3. **PROCEDURE FOR ADMISSION INTO THE PROGRAM:**

   3.1. Patients must meet criteria established by the Medicare Guidelines for General Hospice Inpatient Level of Care (GIP) clinical criteria for an inpatient hospice stay as outlined in the Conditions of Participation for
Medicare certified hospices, including:

- Acute pain and symptom management that cannot be managed in other settings but the acute care setting
- Acute symptom management needs which result in collapse of family care giving support.

3.2. Admission into the Inpatient Hospice Care Program does not prevent discharge to home or an alternative facility at a future date.

3.3. Referrals for admission to the Inpatient Hospice Care Program are reviewed by the Hospice of the North Shore and Greater Boston, who will determine eligibility for Inpatient Hospice level of care.

3.4. The MGH Palliative Care Service will collaborate with the MGH Case Manager to review potential discharge alternatives as well as benefits and eligibility for inpatient hospice care.

3.5. Upon admission into the Inpatient Hospice Care Program, a Palliative Care Service Physician will become the attending of record while the patient remains on the Inpatient Hospice Care Program. MGH staff will continue to provide care to the patient. The Primary Care Physician may continue to be involved as a consultant. House staff will not routinely follow those patients in the Inpatient Hospice Care Program. Other subspecialists may continue involvement as consultants. However, in urgent situations, when the Palliative Care Attending Physician is not on site, the Senior Medical House Officer on call may be requested to perform emergent patient assessment and pronouncements.

3.6. Once accepted and the appropriate paperwork has been completed for the Inpatient Hospice Care Program, the patient is discharged from acute care and admitted to hospice. This is a virtual process; the patient remains on the same unit and in the same bed.

3.7. The Hospice Team and Palliative Care Service work collaboratively with the patient, family, and other health care providers to establish goals and design a hospice plan of care.

3.8. Assessment, plan of care and interventions are documented in a way that facilitates communication, evaluation and follow-up care.

4. ADMINISTRATIVE PROCEDURES

4.1. A patient will initially be identified by his/her provider regarding potential enrollment for the Inpatient Hospice Care Program.

4.2. A referral will be made to Hospice of the North Shore and Greater Boston
for evaluation regarding a potential patient enrollment.

4.3. The Hospice of the North Shore and Greater Boston will evaluate and determine the patient's eligibility for enrollment into the Inpatient Hospice Care Program. In addition, case management will be consulted about insurance coverage and whether there is a covered inpatient hospice benefit available.

4.4. If appropriate for hospice, Hospice of the North Shore and Greater Boston will perform an intake visit for the patient. This will occur most often during the weekday hours between the hours of 8-5pm. With advance notification, this will occur on the weekends between the hours of 8am and 5pm. An intake visit covers description of services and completion of hospice paperwork designating the agreement to utilize one's insurance hospice benefit.

4.5. Necessary paperwork must include signatures designating voluntary assignment of hospice benefits. A patient who has decision-making capacity can sign the papers. A patient without decision making capacity must have papers signed by a proxy. Patients, for whatever reason, without decision-making capacity or without a proxy or relative to sign paperwork, cannot be enrolled into hospice. It would be a conflict of interest for MGH, Hospice of the North Shore and Greater Boston or the Palliative Care Service to sign the patient on without consent.

4.6. Hospice of the North Shore and Greater Boston notifies the MGH Admitting office and the inpatient unit resource nurse when the patient's admission to the Inpatient Hospice Care Program. The Admitting Office shall not convert a patient to hospice without the notification by Hospice of the North Shore and Greater Boston personnel. The Physician responsible for patient's care prior to hospice will complete the appropriate discharge of the patient including a discharge order, the electronic Face Sheet Discharge, a discharge summary and the medication information. The nurse caring for the patient will complete the electronic nursing discharge note and indicate the date and time for last dose administered for each medication. These documents will be printed and placed in the green book located at the patient's bedside.

4.7. The Operations Associate will request a new face sheet and red card from the Admitting Office and a new Inpatient Hospice Care Program medical record will be created. The patient's admission status code changed to "V"; the patient will be listed on the unit census board as "V"; and the medical record will be labeled with Palliative Care on the binder and the front of the chart. The Palliative Care Attending Name will also be listed on the binder. An information sheet confirming the patient is on the Inpatient Hospice Care Program and the Hospice Benefit guidelines will be placed inside the front cover of the record by Hospice of the North
4.8. After the appropriate closing of the prior chart, a member of the unit staff will bring the acute care admission record to Health Information Systems. HIS staff will "fast track" the coding process and return the record to the unit. A copy of the closed medical record from the acute care admission will be kept on the unit and stored with the extra volume charts. Hospice of the North Shore and Greater Boston will also retain a copy of the chart.

4.9. The Palliative Care Service will write admission orders, an admission note, and prepare a death pronouncement form. Using the POE Standard Order Set for Inpatient Hospice Care Program, hospice admission orders will be completed under the "Pre Admit" function. Attention to code status and PAML will be included. Staff can activate these orders under the Pre Admit Function where one Activates Orders. In addition, Palliative Care Service will initiate a death pronouncement form including discussion of autopsy and organ donation because the team has a relationship with patients and family.

4.10. The Hospice of the North Shore and Greater Boston Registered Nurse will complete the Hospice Nurse Assessment Form and set the Hospice Plan of Care. A copy of this documentation will be included in the Inpatient Hospice Care Program medical record of the patient.

4.11. In the new chart, the MGH Registered Nurse will update a nursing data set as an admission note to the Inpatient Hospice Care Program.

4.12. The Palliative Care Service will be responsible for daily assessment and monitoring of the patient including the daily plan of care. This information will be documented in the progress notes of the patient's medical record.

4.13. The MGH nursing staff will work collaboratively with Hospice of the North Shore and Greater Boston and the Palliative Care Service to follow the Hospice Plan of Care. Should there be concerns, questions and/or changes in patient condition, the MGH nursing staff will notify Palliative Care Services for new orders, emergent situations, and the patient's death.

4.14. A member of the Hospice of the North Shore and Greater Boston team will assess the patient on a daily basis, either on-site or by telephone. This assessment will include determination of ongoing eligibility for continuing the hospice benefit as well as consulting as necessary in the patient's plan of care.

4.15. In the event of the patient's death, the MGH registered nurse will notify the Palliative Care Clinician On Call at 34888. It is the Palliative Care Service's responsibility to complete the death process. This must be a physician because admitting needs notification of the death, including
pronouncement time, person pronouncing, name of attending, and admitting diagnosis.

During the hours of 7am-6pm, M-F and on the weekends from 8am-4pm, the Palliative Care Physician On Call will complete the death pronouncement.

During hours that the Palliative Care team is offsite, the Palliative Care Physician will request the Senior Medical House Officer to complete the pronouncement. Unit staff should leave a message with Partners Hospice of the North Shore and Greater Boston Service about the death and can request that a message left in the middle of the night is held until office opens.

If the death occurs during usual hours and the family is not present but chooses to come in, the nurse will call the Palliative Care Service so they can meet with the family and answer questions.

4.16. If a patient no longer meets the hospice criteria, Hospice of the North Shore and Greater Boston is responsible for coordinating, in collaboration with the MGH care team, an appropriate transfer/discharge to another facility. When such a transfer/discharge occurs, the Palliative Care Service will complete the appropriate discharge paperwork including discharge orders, medications, Face Sheet, and discharge summary. Upon the patient’s discharge, the Inpatient Hospice Care Program medical record is disassembled. This record and the closed acute care medical record are sent to Health Information Services as per policy.

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1. STATEMENT OF PURPOSE

1.1. With the development of life-sustaining interventions in modern medicine, there has been the corresponding need to decide when treatments or procedures should be initiated or withheld, continued or withdrawn. The goal of Massachusetts General Hospital is to restore health and relieve suffering whenever possible and by all appropriate available means. At the same time, the Hospital intends never to impose unwanted or unwarranted burdens on those it serves. In this process Caregivers must respect patients' values and beliefs and give due respect and consideration to their wishes regarding continuing, limiting or discontinuing treatment. When families or surrogates are called upon to make decisions about life-sustaining treatment for patients who are unable or unwilling to make decisions for themselves, they may be overwhelmed. Caregivers must recognize that families or surrogates may need support in reaching decisions for the patient. The purpose of this document is to outline principles and procedures to be followed in those circumstances in which the appropriateness of life-sustaining treatment must be considered.

(link to the following policies: Life Sustaining Treatment: Resolving Intractable Conflict and End of Life)

2. STATEMENT OF GENERAL PRINCIPLES

2.1. Principles of Initiating or Limiting Treatments:

2.1.1. Initiation of Treatments--Life-sustaining treatments must have a clinical indication, have a reasonable likelihood of providing more benefit than burden by the patient’s criteria as best we know them, be consistent with the patient’s treatment goals, and be acceptable to the patient or the patient's surrogate. Physicians and other health care providers are not obligated to offer or provide life-sustaining treatments that have no clinical indication or have no reasonable likelihood of providing benefit to the patient in the context of his or her goals, values, and prognosis.

2.1.2. Limitation of Treatments--There are situations when it is ethically and legally permissible, or even necessary, as well as compassionate, to limit life-sustaining treatments: for example, when the patient or surrogate choose not to use them, or when they would be more burdensome than beneficial, in the context of the patient’s goals, values and prognosis.

2.2. Withdrawing Treatments--Although it can be emotionally more difficult to stop treatment, which has been initiated, there is no morally or legally
relevant distinction between withholding and withdrawing life-sustaining treatments when their burdens to the patient outweigh the benefits.

2.3. Decisions to Limit Treatment are Treatment-Specific--Optimal patient care requires a clear agreement between the patient or surrogate, the responsible physician, and the health care team about the primary goal of management. Within the framework of such an agreement, a decision by either the patient or surrogate to limit, discontinue or refuse a particular treatment does not imply the limitation of other treatments. Decisions to limit treatment include the option of withholding or withdrawing medically administered fluids and nutrition.

2.4. Non-abandonment--Withholding or withdrawing life-sustaining treatment must never result in a patient or family being ignored or abandoned. Rather, intensive palliative care, including psychosocial and spiritual support must be offered as an alternative to life-support care. It is essential to emphasize in discussions with patients, surrogates, and families about limitation of life-sustaining treatment that intensive palliative care is available and will be provided.

2.5. Principles of Communication, Decision Making and Responsibility:

2.5.1. Communication--To assure optimal treatment of the patient and respect for the responsibilities of the individuals involved in the patient’s care, communication among the patient, family, and members of the health care team is essential.

2.5.2. Respect for Cultural, Ethnic, and Religious Difference--Persons of different cultures, ethnicities, and spiritual beliefs may have different attitudes toward illness, health care, and death. Respect for cultural and spiritual difference is essential to foster a therapeutic alliance between patients, families, and providers, and to provide optimal care. This respect necessitates that health care providers make efforts to understand the particulars of the cultures and spiritual beliefs that might impact patients’ treatment decisions.

2.5.3. Right to be Informed--Patients with the capacity to make decisions regarding health care, and the surrogates of patients without such capacity, have the ethical and legal right to be provided with adequate information regarding the diagnostic and therapeutic options that are reasonably available. This information should include the potential benefits and burdens of any given intervention. The discussion about life-sustaining treatment often should be considered a process (i.e., a series of discussions over time) rather than a one-time event.

2.5.4. Weight to be Given Advance Directives--An Advance Directive is a document executed by the patient which (1) gives instructions to health care providers as to the patient’s wishes regarding health
care decisions or (2) designates another person(s) (surrogate) to make health care decisions on behalf of the patient if the patient loses decision-making capacity or (3) does both. Examples of Advance Directives are Living Wills, Massachusetts Health Care Proxy Forms, Massachusetts Department of Public Health Comfort Care / DNR Forms, and Medical Orders for Life Sustaining Treatment (MOLST) Forms. When a patient is admitted to the hospital, the Advance Care Planning section of the patient’s longitudinal medical record (LMR), if available, should be checked for the existence of an Advance Directive. Advance Directives are presumed to be valid and binding, although some may require interpretation. (Please see Advance Directives Policy in the Clinical Policy and Procedure Manual).

2.5.5. Presumption of Competency--Patients are presumed competent unless there has been either a medical evaluation indicating a lack of decision-making capacity or a legal adjudication of incompetency. If there is a question about the patient’s ability to understand clinical information or make clinical decisions, a psychiatric consultation is recommended.

2.5.6. Rights of Patients Lacking Decision-Making Capacity--Ethical and legal rights of adult patients who lack decision-making capacity are similar to those of patients who have capacity, except that a surrogate makes health care decisions on behalf of a patient who lacks capacity. The word "surrogate" broadly refers to any person who has a legal, familial, or social relationship to the adult patient and thus a claim or desire to be the decision-maker. If the patient has designated a health care agent through a signed health care proxy or has a legally appointed guardian, then the health care agent or legally appointed guardian has the sole authority to make health care decisions on behalf of the patient in collaboration with the responsible physician. If the patient has not designated a health care agent, and has no legally appointed guardian, then the goal is to find the person most knowledgeable about the patient's values, goals, and preferences. Generally this will be a spouse, domestic partner, adult child, parent or sibling. At times, a close friend or a more distant relative of the patient, or a caregiver who has known and cared for the patient for a significant period of time, may be the only individual available to contribute to such decisions. The surrogate should base health care decisions for a patient lacking decision-making capacity on what the patient would have decided if capacity were intact ("substituted judgment") or, if that is not possible to discern, on what is in the patient's "best interest." Surrogates should be encouraged and assisted to make decisions in light of the patient's diagnosis and prognosis.
2.5.7. Professional Responsibility--Individual health care professionals have the ethical and legal right to decline to participate in the provision, limitation or withdrawal of treatment if they have a strong conscientious objection to this treatment. However, under no circumstances may a patient be abandoned. While joint decision-making by the patient, family, and all members of the health care team is to be respected and facilitated, the ultimate responsibility for the process of defining the boundaries of treatment resides with the patient's responsible physician: the physician with legal responsibility for the patient's care. In a case where the responsible physician feels that he or she cannot accept the decision of the patient or surrogate regarding the primary objective of management or any limitation of life-sustaining therapy, the physician should offer to withdraw. However, the physician may not withdraw until another physician has been found at MGH who will assume responsibility or the patient is transferred to the care of another physician at another hospital willing to assume responsibility. (See MGH Policy: Resolving Conflict over Possibly Inappropriate or Harmful Life-Sustaining Treatment). A house officer or non-physician member of the health care team who finds that the plan of care conflicts with her or his personal values or spiritual beliefs should report this concern to her or his supervisor. (See Human Resources Policy: MGH Employee Rights / Patient Care Non-discrimination Policy).

2.5.8. Doing No Harm--The responsible physician always has an overriding responsibility to protect the patient from harm. The physician is encouraged to consider protecting an imminently dying patient from potential harms of cardiopulmonary resuscitation (CPR) by suggesting this protection to the patient or surrogate or by not offering CPR if it is not deemed to be a responsible treatment option and by entering appropriate code status orders. The responsible physician may obtain a second opinion about not offering CPR from another senior or experienced physician or from the Optimal Care Committee and may also request advice from the Office of General Counsel. If the responsible physician decides not to offer CPR the patient or surrogate should be informed of this decision and its rationale and assured that the patient will continue to receive the highest possible quality of care.

2.5.9. Presumption Against Seeking Judicial Intervention--Patients, surrogates, and health care providers should together do everything possible to achieve consensus regarding treatment plans so as to avoid the need for judicial intervention. Providers should consider seeking judicial intervention only when state laws mandate, or when serious unresolvable conflicts occur regarding patients who lack the capacity to make treatment decisions, or in
whom such capacity is unclear.

2.5.10. Patients lacking Both Decision-Making Capacity and a Surrogate Decision-Maker—On occasion, patients who lack decision-making capacity, whose values and wishes regarding medical care are not known, and for whom no surrogate decision-maker can be found despite a good faith search, have or may develop life-threatening conditions. In these situations, physicians and other healthcare providers are not obligated to initiate or continue life-sustaining treatments if it is certain that death is imminent regardless of what treatment is provided, if the patient has sustained massive neurologic injury from which no meaningful recovery is possible, or if the life-sustaining treatment in question is deemed harmful and without apparent benefit by the patient’s responsible physician and at least one other senior or experienced physician. Advice on these matters may be sought from the Optimum Care Committee (OCC). Although not obligated to do so, the responsible physician may request that the Office of General Counsel petition for appointment of a legal guardian in some situations, such as when the patient is expected to survive for an extended period. In the absence of or until such appointment, however, decisions about life-sustaining treatment should be made based on the patient’s best interests as best this can be determined.

2.5.11. Relief of Pain and Other Distressing Symptoms—The responsible physician of a patient lacking decision-making capacity may provide any medical intervention deemed necessary to relieve pain or other symptoms apparently distressing to the patient, or to comfort such a patient, regardless of the existence and requests of an HealthCare Agent or other surrogate decision-maker. (See General Laws of Massachusetts, Chapter 201D, Section 13.)

3. SPECTRUM OF TREATMENT DECISIONS

3.1. Specification of Treatment Goals--The hospital's patients present a broad range of illness as well as cultures and spiritual beliefs and practices. Whenever possible the individual treatment goals of each patient must be identified in discussion between the responsible physician or delegated physician and the patient or surrogate, and therapy should be planned in light of these goals. It is appropriate to involve the patient's nurse and social worker in this discussion as well as any other health professionals including therapists, interpreters, or chaplain whose involvement may enhance the discussion. For many patients, the primary goal of treatment is to attain a cure of the basic disease process, and all indicated therapies are administered to this end. The primary goal of treatment for other patients is to maintain the patient's current state of health, because the
underlying process cannot be reversed and efforts to cure are no longer desired or appropriate. Finally, for some patients, often considered "terminally ill", the primary treatment goal is to maximize their comfort and quality of life as they approach death.

3.2. Specification of Treatment Limitations--In light of the goals of care decided upon in discussion with the patient or surrogate, specific life-sustaining treatments and other interventions may be provided, withheld, or withdrawn as appropriate. It is not always appropriate or necessary to discuss specific life-sustaining treatments with the patient or surrogate once goals of care are determined. In all cases, the responsible physician or house officer must make clear both the goals of care and any specific treatment limitations to the health care team. Examples of specific treatments or interventions that may be withheld, withdrawn, or discontinued in the appropriate situation include, but are not limited to, chest compressions, defibrillation or electrical cardioversion, implantable cardiac defibrillators, cardiac pacemakers, ventricular assist devices, endotracheal intubation, mechanical ventilation, non-invasive ventilatory support, vasopressors, antiarrhythmics, hemodialysis, blood products, antibiotics, artificial nutrition, artificial hydration, monitoring devices, or diagnostic studies unrelated to comfort care.

3.3. Limitation of Life-sustaining Treatment (LLST) Orders--Life-sustaining treatments may be withheld or withdrawn only by specific order of the responsible physician, a house officer supervised by the responsible physician, or a physician delegated by the responsible physician. In addition, the physician entering the order must describe the goals of treatment and any specific treatment limitations in the progress notes. A nurse practitioner (NP) or physician's assistant (PA) may write an LLST order if the collaborating / supervising physician determines that issuing the LLST order is within the competence of NP or PA given his / her level of training and expertise; if writing such orders is agreed upon by the NP or PA and the collaborating / supervising physician in written practice guidelines; and if the NP or PA consults with the collaborating / supervising physician prior to issuance. The NP or PA must document the consultation with the collaborating / supervising physician in the progress notes. It is the obligation of the NP or PA and his / her collaborating / supervising physician to ensure that the NP or PA is authorized under his / her practice guidelines to write an LLST order.

3.4. Code Call Response--In the event of cardiac or pulmonary arrest, cardiopulmonary resuscitation (CPR) per Advanced Cardiac Life Support (ACLS) protocol will be initiated for all patients for whom no limitation of life-sustaining treatment orders have been written. Unless specifically limited by order, full resuscitative measures will proceed until the patient is stabilized or the code team leader deems it clinically appropriate to discontinue CPR. Any caregiver who cannot in good conscience participate in a resuscitation effort or intubation of a particular patient is obliged to make this known immediately so that a replacement can be
3.5. Disagreement over Treatment Goals or Limitations

3.5.1. **Standard Methods for Resolving Disagreements** -- In the event of questions or disagreements among the patient, surrogate, family or health care team members about the appropriateness of the treatment goals or of any major limitation of treatment, further efforts to reach agreement are required. Sometimes the patient, surrogate, or family may wish to have someone such as the family physician, personal clergy, or family attorney review the information with the treatment team. Consultation from the Optimum Care Committee (OCC) is available to anyone, including patients, surrogates, families, and any members of the hospital staff and health care team. OCC membership consists of physicians, nurses, chaplains, allied health professionals and community members. The tasks of the OCC typically include exploring the views of the key stakeholders in the disagreement; clarifying the patient’s values, goals and preferences related to medical care; clarifying the prognosis for survival, for returning to the pre-morbid state of health, or for neurologic recovery; assessing the relative benefits and burdens of the life sustaining treatments in question in light of the patient’s values, goals, and prognosis; determining the applicable ethical principles and/or case precedents; and recommending a course of action. Consultation also is available to patients, surrogates, and families from the Office of Patient Advocacy. Consultation is available to health care team members from the office of the Chief Medical Officer (CMO), the office of the Chief Nurse, and the Office of the General Counsel. (See Section E4)

3.5.2. Critical Care Committee Consultation--In cases where consultation by the OCC and any other appropriate persons or offices has not resolved a disagreement over life sustaining treatment, the patient, surrogate, family, responsible physician, or the OCC consultants can request further consultation from the Critical Care Committee (CCC). The CCC consultation will be performed by a physician who attends in a critical care setting with or without a critical care nursing leader or nurse designated by the critical care nursing leadership. The tasks of the CCC consultant(s) will be to further clarify the patient’s prognosis for survival, for returning to the pre-morbid state of health, or for neurologic recovery, and to further assess the relative benefits and burdens of the life sustaining treatments in question in light of the patient’s values and goals as clarified by the OCC consultation. (See Section 5.4)
4. **PROCEDURES**

4.1. Physician Responsibility:

4.1.1. Upon admission of the patient, the responsible physician shall determine the goals of treatment. Any goal other than that of sustaining life with all available means must be documented.

4.1.2. During the hospitalization, the responsible physician will be the leader in discussions about the appropriateness of life-sustaining treatments. He or she will see to it that the patient or patient's surrogate, along with members of the health care team -- including, as appropriate, any consultants, house staff, nurses, therapists, social workers, chaplains, students and others -- have an opportunity to contribute to the decision-making process throughout the hospitalization.

4.1.3. Only the responsible physician; a house officer, NP or PA, supervised by the responsible physician; or a physician delegated by the responsible physician, will present recommendations to the patient or surrogate that there should be a change in the goals of management for the patient or any limitation of life-sustaining treatment. It is often appropriate for other members of the health care team who have important relationships with the patient and/or family to participate in these presentations.

4.1.4. The responsible physician, house officer, NP, PA or delegated physician will document in a progress note the decision-making for any change in the goals of management agreed upon with the patient or surrogate and describe any specific limitations of life-sustaining treatments. This note should include the substance of any discussions that have been held with the patient or surrogate. The responsible physician should review within 24 hours all changes in the goals of care and in code status made by another physician or NP / PA and document approval or any additional changes in the progress notes.

4.1.5. All patients must have either an order for: (1) full code (discussed with patient / surrogate), (2) limitation of life-sustaining treatment, or (3) full code (discussion with patient/ surrogate not appropriate or possible at this time). This order must be signed by the responsible physician; a house officer, NP or PA supervised by the responsible physician; or a delegated physician. If limitation of life-sustaining treatment is ordered, the required progress note must accompany the order. When orders to limit life-sustaining treatment are written (entered) by a house officer, NP, PA, or delegated physician, the responsible physician must write a note that reviews the plan within 24 hours. A full code (discussion with patient / surrogate not
appropriate or possible at this time) order should be reviewed by the responsible physician periodically, and changed to full code (discussed with patient/surrogate) or limitation in life sustaining treatment as the patient's preferences and prognosis are known and/or clarified. For patients with a full code (discussion with patient/surrogate not appropriate or possible at this time) order, a reminder will be provided on day 3 in intensive care units and on day 10 on all other units so that a revised order may be entered, if appropriate.

4.1.6. Telephone Orders--In unusual circumstances, the responsible physician may transmit a limitation of life-sustaining treatment order by telephone to a registered nurse. Within 24 hours, the responsible physician must rewrite (re-enter) the order and write the required progress note.

4.1.7. Whenever a decision to limit life-sustaining treatment has been made, all orders should be reviewed by the responsible physician or designated house officer, NP or PA. This is to ensure that all remaining treatments are consistent with the treatment goals and that any appropriate additional orders are written. For example, when a decision to withdraw mechanical ventilation is made, comfort and protection against agonal distress should be addressed.

4.1.8. The responsible physician is not required to rewrite a current limitation of life sustaining treatment order when the patient is transferred from one unit to another, but the house officer shall write in the transfer note: "Specific limitation of treatment order in effect as ordered by Dr. __________________________ on __________________________ (date)". When the patient's care is transferred from one responsible physician to another, the new responsible physician, house officer, NP, PA supervised by the responsible physician or a physician delegated by the responsible physician should review the plan of care with the patient or surrogate and determine and document the goals of treatment. If the plan of care or the goals of treatment have changed significantly, any necessary changes in orders limiting life-sustaining treatments should be entered. The physician, NP, PA entering the orders should document the changes and document either approval or additional change within 24 hours.

4.1.9. A decision to withhold or withdraw the medical administration of nutrition and hydration must be discussed explicitly with the patient (if able), the surrogate, or both. Although artificial nutrition and hydration are properly seen by health professionals as life-sustaining therapies, many others see them as having important
symbolic meanings quite apart from their therapeutic utility. The seriousness of these issues necessitates careful discussions to assure that all concerned understand that the only reasons which can justify this decision by others on behalf of the patient are to avoid unwarranted prolongation of suffering or the imposition of therapy that offers no benefit to the patient.

4.1.10. Massachusetts Comfort Care / Do Not Resuscitate (DNR) Order Verification Form: The responsible physician should complete a Massachusetts Comfort Care / DNR Order Verification form for any patient who elects to continue equivalent limitation of life-sustaining treatment orders upon discharge from the hospital. The form must accompany the patient at discharge. (See Section 6.1.)

4.2. Registered Nurse Responsibility:

4.2.1. The responsible registered nurse will document any discussion with the patient, family, or surrogate that sheds light on the patient’s values or goals or on the patient’s preferences regarding life-sustaining treatment.

4.2.2. The responsible registered nurse will participate in inter-disciplinary patient / family meetings regarding patient care management.

4.2.3. The responsible registered nurse will incorporate into the nursing plan of care any major patient-care decisions and will document any discussions regarding major patient-care decisions.

4.2.4. The responsible registered nurse will utilize appropriate resources as indicated for patients and families at the time of major patient-care decisions. These resources may include chaplains, social services, palliative care services, interpreter services, Office of Patient Advocacy, or the Optimum Care Committee.

4.3. Social Work Responsibility:

4.3.1. The responsible social worker will assist the patient, family, and surrogate with the emotional, psychological, and social impact of the decision-making process and any ensuing major patient-care decisions.

4.3.2. The responsible social worker will document relevant information about the patient and family and participate in interdisciplinary patient / family meetings.

4.3.3. The social worker will work with the patient, family, surrogate, and members of the health care team in the effort to enhance patient /
family resources and offer additional relevant resources in such areas as emotional, social, cultural, and spiritual needs.

4.4. Other Health Care Provider Responsibility:

4.4.1. Consulting medical, allied health or other ancillary services having direct contact with the patient and family are responsible to ensure that treatment plans remain consistent with patient care decisions that have been made. The consulting clinician will communicate directly with the physicians and other members of the health care team in order to establish collaborative goals and care plans reflective of patient care decisions.

5. **SPECIAL SITUATIONS**

5.1. Invasive procedures in patients with limitation of life-sustaining treatment (LLST) orders:

5.1.1. When the responsible physician determines that an invasive procedure such as surgery is appropriate for a patient who has limitation of life-sustaining treatment orders, special care must be taken to ensure that the patient's wishes, goals and values are respected. When a procedure requires use of sedatives or anesthetic agents or brings with it the risk of life-threatening complications, it is necessary to review with the patient or surrogate, whenever possible, all existing orders that limit use of life-sustaining resuscitation techniques. This is particularly important if anesthesia is to be administered, as anesthesia involves some practices and techniques that might be viewed as resuscitation in other settings. Prior to the procedure, the responsible physician must establish guidelines in dialogue with the patient or surrogate for use of life-sustaining treatment during the procedure and during recovery in a Post-anesthesia Care Unit or Intensive Care Unit.

5.1.2. The following three alternatives may be helpful in deliberations about guidelines:

- Suspension of all limitation of life-sustaining treatment orders; full attempt at resuscitation.

- Suspension of only those limitation of life-sustaining treatment orders that would preclude the procedure. For example, if general anesthesia is required, an order limiting endotracheal intubation and mechanical ventilation would be suspended.

- Suspension of limitations on life-sustaining treatment at the
discretion of the physician performing the intervention (interventional physician) or anesthesiologist based on the patient's goals and values. This alternative takes into account that not all life-threatening complications can be anticipated and that some patients may wish for potentially easily reversible complications to be treated. This alternative requires particularly careful discussion of the patient's goals and values and thorough documentation of this discussion in the medical record. If the guidelines established with the patient or surrogate require a change in limitation of life-sustaining treatment orders, new orders must be written by the responsible physician and the discussion that established the guidelines must be documented in the medical record. The medical record also should indicate if or when the original, pre-existent limitation of life-sustaining treatment orders will be reinstated. Orders should generally be reinstated when the patient leaves the Post-anesthesia Care Unit or when the patient has recovered from the acute effects of anesthesia and surgery.

5.1.3. Concurrence with the guidelines by the responsible physician (if not the interventional physician), the interventional physician, and the anesthesiologist (if an anesthesiologist is involved) should be sought. In any case, if the procedure requires involvement of an anesthesiologist, the anesthesiologist must be informed and able to abide by the guidelines. If any physician asked to be directly involved in the invasive procedure cannot abide by the established guidelines, he or she must assist the patient and the responsible physician in obtaining care from physicians willing to abide by the guidelines. Other members of the health care team who will help care for the patient during and immediately after the procedure also should be informed of the guidelines.

5.2. Pediatric Patients:

5.2.1. The principles outlined in this document are generally applicable to the pediatric population. However, the infant or child is unable to speak for him/herself and therefore the child's parents are the primary decision makers for the child. The parents will be better equipped to make decisions if they have (1) as much help as needed to acquire clear and adequate understanding of their child's diagnosis, treatment, treatment choices, and prognosis; (2) a clear medical treatment recommendation made in the best interest of the child.

5.2.2. This decision-making system has its shortcomings at times. Parents may feel guilty, angry, or overwhelmed emotionally. Often a previous episode or crisis in the family may affect the parents'
ability to make a reasoned judgment in the present situation. Hence, decision-making by the parents may be overly hasty or paralyzed. The parents may make emotionally charged judgments rather than well-reasoned ones. Parents therefore need support in reaching decisions, which promote the best interests of the child.

5.2.3. If the judgments by the parents appear not to be in the best interests of the child, the responsible physician, with the support of the health care team, should explore the rationale behind the parents' decision. At times the Pediatrics Bioethics Committee and/or, in selected cases, psychiatric consultation may be a valuable source of help in clarifying the problem. Lastly and rarely, resort to legal intervention may be necessary to protect the child's best interests. (See Child Abuse or Neglect Policy, Clinical Policy and Procedure Manual).

5.2.4. While the parents generally are the ones considered to speak for the child's best interests, there are special situations where the child's own values and judgments must or should be independently sought and respected. Such is the case of the "Emancipated Minor" or "Mature Minor" respectively. (Please see "Informed Consent", in the Clinical Policy and Procedure Manual).

5.2.5. Where the child's decision conflicts with the parents and/or the parents do not agree with each other, the responsible physician should initiate efforts to reach agreement about the treatment plan. Should agreement not be attained, resources available to the physician include consultation from the Office of Patient Advocacy, the Pediatric Bioethics Committee, the President's Office or the Office of the General Counsel.

5.3. Permanent Vegetative State:

5.3.1. For patients with a clinical diagnosis of permanent vegetative state, orders to withhold cardiopulmonary resuscitation (CPR) and to withhold or withdraw other life-sustaining treatments including mechanical ventilation, hemodialysis, artificial nutrition, and artificial hydration are appropriate. When a diagnosis of permanent vegetative state is made, the responsible physician should discuss the diagnosis and prognosis with the patient's surrogate and propose that further life-sustaining treatment be withheld or withdrawn. If the surrogate disagrees with withholding or withdrawing life-sustaining treatment, the case should be referred to the Optimum Care Committee or the Pediatric Bioethics Committee.

5.4. Resolving Intractable Conflicts Over Possibly Inappropriate or Harmful
Life-sustaining Treatments:

5.4.1. On rare occasions, disagreements between the care team and the patient or surrogate over initiation or continuation of life-sustaining treatment may become intractable. When this occurs, the procedure should be followed as described in the MGH Policy "Resolving Conflict Over Possibly Inappropriate or Harmful Life-Sustaining Treatments".

6. **Limitation of Life-Sustaining Treatment in a MGH Ambulatory Setting**

6.1. Inpatients Who Wish to Forego Life-Sustaining Treatment Upon Discharge From the Hospital:

6.1.1. Some patients who have a limitation of life-sustaining treatment order in the hospital may wish to forego cardio-pulmonary resuscitation (CPR) outside the hospital as well. Other patients may request that such limitations begin upon discharge for the hospital. For these patients, the responsible physician, a delegated physician, or a house officer, NP or PA supervised by the responsible physician must document the patient's wishes in the ambulatory medical record (e.g. LMR, On-Call). This documentation should include:

- The goals of care agreed upon with the patient or surrogate.
- The code status screen, if available, must be completed (i.e. LMR template).
- The responsible physician or NP or PA supervised by the responsible physician should complete a Massachusetts Department of Public Health Comfort Care / Do Not Resuscitate Order Verification Form and the form should accompany the patient at discharge.

✓ The form may be obtained from unit-based Case Manager or from the on-call Case Manager after normal business hours
✓ A copy of the completed form should be placed in the patient's medical record. If possible, the form should be scanned and placed in the patient's longitudinal medical record (LMR).

6.2. Limitation of Life-Sustaining Treatment Initiated in the MGH Ambulatory Setting:
6.2.1. A patient or surrogate also may request in an ambulatory setting to forego cardiopulmonary resuscitation outside the hospital. In this case, a responsible physician for the patient's ambulatory care or a NP or PA supervised by the responsible physician must:

- Document the patient's wishes in the longitudinal medical record (LMR).
- Complete the LMR code status screen (if available).
- Complete a Massachusetts Department of Public Health Comfort Care / Do Not Resuscitate Order Verification form.

These (forms) can be obtained from the Department of Public Health Comfort Care Coordinator (617) 753-7300 and will be issued to the physician overseeing a particular setting.

6.2.2. The responsible physician, NP or PA should re-address code status with the patient when warranted by a major change in the patient's condition and if the patient expresses the desire to discuss code status.

6.3. Patients Who Present to the Hospital with a Massachusetts DPH Comfort Care / DNR Order Verification Form:

6.3.1. A patient may present to the hospital for an office visit, admission, procedure, or for emergency treatment with the Massachusetts DPH Comfort Care / DNR Order Verification Form. Although the form was designed to apply only to EMS personnel, the presence of the form or bracelet indicates that a decision was made at some point that the patient should not receive CPR. As always the patient's current wishes, as best they can be known, should be respected. If possible, a physician responsible for the patient's ambulatory care or the NP / PA supervised by the responsible physician should verify with the patient, the patient's treatment goals.

- The treatment goals should be documented along with any life-sustaining treatments to be withheld or withdrawn.
- Appropriate orders should be written.

6.3.2. If a patient presents accompanied by the form and is unable to make or communicate medical decisions, advice should be sought from a surrogate decision-maker. If no credible surrogate can be reached in an emergency, staff should seek documentation of the patient's wishes by accessing the patient's ambulatory medical
record. Guidance may be sought from the physician, NP or PA who signed the Massachusetts DPH Comfort Care / DNR Order Verification Form and / or documented in the LMR a wish for life-sustaining treatment to be limited.

6.3.3. If there is no reason to doubt the applicability of the Massachusetts DPH Comfort Care / DNR Order Verification Form as a reflection of the patient's current wishes, the patient should not receive cardiopulmonary resuscitation and this plan should be documented in the medical record.

6.3.4. If there is a question about the applicability of the Massachusetts DPH Comfort Care / DNR Order Verification Form and there is no clear documentation of a current wish to limit life-sustaining treatment in the patient's LMR, life-sustaining treatment, including cardiopulmonary resuscitation, should be provided.

6.4. Patient's Who Present to the Hospital with Documentation of a Wish to Limit Life-Sustaining Treatment in their MGH Ambulatory Medical Record but Who Do Not Have a Massachusetts DPH Comfort Care / DNR Order Verification Form:

6.4.1. A patient may present to the hospital for an office visit, admission, procedure, or for emergency treatment without a Massachusetts DPH Comfort Care / DNR Order Verification Form, but may have documentation of a wish to limit life-sustaining treatment in the outpatient LMR. - In this situation, a physician responsible for the patient's ambulatory care or a NP or PA supervised by the responsible physician should verify with the patient or surrogate the patient's current wishes as to code status.

6.4.2. If the patient is unable to make or communicate medical decisions and there is no credible surrogate available in an emergency, the responsible physician must determine the patient's treatment in light of the available information about the patient's wishes. Guidance may be sought from the physician, NP or PA who documented in the medical record a wish for life-sustaining treatment to be limited. As always, the patient's current wishes, as best they are known, should be respected.

6.4.3. If the patient does not wish to receive life-sustaining treatment and the patient will be admitted, an appropriate order should be written.

6.4.4. If the patient does not wish to receive life-sustaining treatment and the patient will not be admitted, the responsible physician or a NP / PA supervised by the responsible physician should complete the Massachusetts DPH Comfort Care / DNR Order Verification Form
and the Form should accompany the patient.

6.4.5. In either case, the plan should be documented in the medical record.

7. REFERENCES:

8. RESOURCES:
   Massachusetts Department of Public Health, Office of Emergency Medical Services Emergency Medical Services Do Not Resuscitate (DNR) Order Verification Program, Comfort 1.

   **General Laws of Massachusetts, Chapter 201D, Section 13**

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<th>Reviewed and Revised By:</th>
<th>Dr. Krakauer, Palliative Care</th>
<th>(2/04) (11/05) (3/06) (7/09). To be reviewed/approved by 11/2012; newly approved version of policy available on site for review.</th>
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MASSACHUSETTS GENERAL HOSPITAL

Life Sustaining Treatment: Resolving Intractable Conflict

1. POLICY

1.1. Statement of Purpose

On rare occasions, disagreements between the care team and the patient
or surrogate over initiation or continuation of life-sustaining treatment may
become intractable. When this occurs, an approach is necessary for
ensuring a fair process that can lead to resolution of the conflict. This
process will be invoked only if the usual mechanisms for decision-making
(informal discussions, team meetings, assistance of social workers, clergy,
ethics consultants, critical care consultants) have proven ineffective at
resolving the conflict. Patients and families will be informed about this
process as a part of the educational materials made available through the
hospital. Patients and families as well as clinicians will have access to
consultation about the process as well as the opportunity to initiate the
process through the Optimum Care Committee or the Pediatric Ethics
Committee.

(“Link to the following policies: Life Sustaining Treatment Policy and End of
Life Policy”)

1.2. Criteria for Process Initiation

1.2.1. Patients must be using or considering using therapies
generally regarded as life sustaining. Therapies of this type may
include mechanical ventilation, dialysis, cardiac
inotropes/vasopressors, ventricular assist devices, or artificial
nutrition/hydration. This restriction is intended to limit the
application of this policy to serious questions about life and death
decisions.

1.2.2. In addition, there must be persistent disagreement between the
physicians caring for the patient and either the patient or surrogate
over whether the continued use of life-sustaining treatments is
inappropriate and/or harmful. For these purposes, treatments are
inappropriate when they provide no reasonable possibility of benefit
for the patient, and treatments are harmful when the additional
suffering or other harm inflicted is grossly disproportionate to any
possibility of benefit.

1.2.3. If the physicians are insisting upon the use of a life-sustaining
therapy against the wishes of the patient or surrogate, their
recommendation should be based upon the expected benefits and
burdens of the therapy in the context of the relevant clinical
information, and in consideration of the patient's values,
preferences, and goals. Often consensus can be reached by focusing on a time-limited trial of therapy, with the understanding that the treatment will be discontinued if certain goals are not met within a defined period of time.

1.2.4. If the physicians believe that a life-sustaining therapy desired by the patient or surrogate is either inappropriate or harmful, then they must justify this view on the basis of the expected benefits and burdens of the therapy, again in the context of the preferences, values, and goals of the patient. Under these circumstances, the physicians should emphasize that limiting the use of life-sustaining treatments will not lead to abandonment, nor to neglect of the patient's need for symptom control or emotional support. In particular, the availability of comfort care, consultation from palliative care specialists, and psychosocial and spiritual support should be discussed and offered whenever possible.

1.2.5. If these measures fail to resolve the disagreement, then the responsible physician, i.e. the physician with legal responsibility for the patient's care, has two options: 1) The physician may seek a second opinion from another experienced and respected clinician. The patient or surrogate decision-maker should have an opportunity to meet with this consultant at his or her request. 2) The physician may contact the Optimum Care Committee or Pediatric Ethics Committee for consultation.

1.2.6. If routine consultation by representatives of the Optimum Care Committee or Pediatric Ethics Committee is not successful in resolving the conflict, arrangements will be made for formal evaluation before the Committee.

2. Procedures: Assessing Whether Continued Life-Sustaining Therapy is Inappropriate or Harmful

2.1. Once a case is identified as outlined above, the Optimum Care Committee or Pediatric Ethics Committee will appoint one of its members to act as Coordinator. The Coordinator will arrange for formal evaluation before the Committee, preside over each phase of the evaluation, and assure that recommendations by the Committee are appropriately communicated and documented. The evaluation has three distinct phases. At least five Optimum Care Committee members, including at least one community representative, must be present at each phase. Depending upon the complexity of the case, these phases may be scheduled to occur sequentially in a single meeting, or the phases may be scheduled to occur separately. Parties that should be involved in the process include:
• Members of the Committee.

• Members of the care team as determined by the Committee. These should include the responsible physician, nurse or nurses, members of the house staff, involved social workers, and therapists. Under certain circumstances, consultants may also play an important role.

• The patient and supporting individuals. If the patient is unable to participate, then the patient should be represented by an appropriate surrogate. If the patient does not have an appropriate surrogate, then hospital policies and procedures should be followed for determining who should serve as the patient's representative.

2.2. Meeting Phase One

2.2.1. The first phase of the evaluation should be convened with the Committee and the members of the care team present. The purpose of this first phase is for the Committee to hear the "medical perspective" on the case. This can often be provided by a house officer, with the responsible physician and others present to provide details and clarification. Care should be taken to present the social, psychological, cultural, and spiritual background of the patient as well as the medical issues. At the conclusion of the presentation, the house officer or responsible physician should clearly articulate the basis on which further treatment has been judged to be either mandatory or inappropriate/harmful. The members of the Committee should have ample opportunity to ask questions about the case so that everyone present has an adequate understanding of the relevant issues.

2.3. Meeting Phase Two

2.3.1. Following Phase One, the Committee should offer to meet with the patient or surrogate and supportive individuals. Members of the care team should attend this meeting only if their presence has been requested by the patient or surrogate. The patient or surrogate may ask other individuals to attend the meeting to provide support or to facilitate communication with the Committee. Such individuals might include relatives, close friends, a primary nurse, a community physician, clergy, a social worker, an interpreter, or legal counsel. The Coordinator will act as the moderator and should structure the meeting so that interactions between the patient or surrogate and the Committee are supportive, non-threatening, and productive. The purpose of Phase Two is for the Committee to hear the "patient and family
perspective" on the case. The patient and family should have ample opportunity to explain their understanding of the illness and the prognosis, their hopes and fears about the future, and their preferences for further treatment. Under the guidance of the moderator, members of the Committee should ask questions that seek to understand the differences in values and interpretation of the facts that have led to the conflict. As much as possible, the Committee should strive to attain the perspective of the patient or surrogate in an effort to grasp the essential differences that exist between them and the clinicians.

2.3.2. While the involvement of the larger Committee allows for consideration of a wide variety of perspectives, in some cases the patient or surrogate may feel more comfortable interacting with a smaller group. In these cases a subcommittee should be formed to meet with the patient or surrogate, with responsibility for reporting back to the Committee.

2.3.3. Some patients or surrogates may decline to meet with the Committee. However, their decision not to meet with the Committee should neither be seen as undermining the integrity of the process nor invalidating the Committee's recommendations when good faith efforts have been made to include the patient and family in the process.

2.4. Meeting Phase Three

2.4.1. Following Phase Two, the Committee should meet without either the care team or the patient or surrogate present. The Coordinator should act as moderator. The purpose of Phase Three is for the Committee to come to consensus as to how to resolve the conflict. For the purpose of this policy, consensus is when all Committee members present either agree to or acquiesce in a decision. This may require a determination as to whether further use of life-sustaining treatment is appropriate or harmful. The Committee must understand that this determination requires a synthesis of both the medical facts as well as the unique circumstances of the case itself. In making its recommendations, the Committee should consider the well-being and moral integrity of the patient and family, as well as that of the clinicians and the institution.

2.5. If the Committee Does Not Reach Consensus

2.5.1. If the Committee is unable to reach consensus, then alternative approaches to dispute resolution will be necessary. In any case, lack of consensus does not foreclose any options for the care team or patient. Even in the absence of consensus, the process of
Attachment OOD 19.i continued

deliberation may often lead to new insights and strategies for resolution. An additional resource that may be useful is the hospital administration, specifically the office of the Chief Medical Officer (CMO). Legal advice may be sought from the legal office.

2.6. If the Committee **Does** Reach Consensus

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2.7. If the Committee Supports the Patient's or Surrogate's Refusal of Treatment

2.7.1. An example of this type of conflict is the unwillingness of some physicians to agree to the patient's or surrogate's request to forego artificial nutrition or hydration. (A separate policy addresses the specific situation of patients or surrogates who refuse blood or blood products.⁵) If, in these circumstances, the Committee supports the view of the patient or surrogate that further use of life-sustaining therapy is inappropriate or harmful, then the responsible physician may:

- **Agree to withhold or withdraw the unwanted life-sustaining therapy:** In some cases, the process of deliberation may lead the physicians to see the situation in a different light and be willing to discontinue further use of the life-sustaining treatment.

- **Seek transfer of care to another physician or another institution:** If the responsible physician continues to believe that it is not ethical to withhold or withdraw the unwanted therapy, he or she should seek transfer of care to another physician at MGH who is willing to comply with the patient's or surrogate's wishes. If no physician at MGH can be found who is willing to assume care, then the patient or surrogate should be
informed and their permission sought to pursue transfer to another physician at another institution willing to assume responsibility and to comply with the patient's or surrogate's wishes. This should be arranged by the responsible physician with assistance, if necessary, from the hospital administration (CMO's office). The physician may not withdraw until another physician has been found at MGH who will assume responsibility or the patient is transferred to the care of another physician at another hospital willing to assume responsibility.

2.7.2. A house officer or non-physician member of the health care team who finds that the plan of care conflicts with her or his personal values or spiritual beliefs should report this concern to her or his supervisor for the purpose of being replaced. (See Human Resources Policy: MGH Employee Rights / Patient Care Non-discrimination Policy, p. 34.)

2.8. If the Committee Does Not Support the Patient's or Surrogate's Refusal of Treatment

2.8.1. In this case, the Committee takes the position that foregoing life-sustaining treatment under the circumstances is not acceptable. The Committee thereby affirms that the patient's or surrogate's wishes may be overridden in this case because considerations such as beneficence or nonmaleficence should take precedence. Because a competent adult patient generally may refuse any treatment, this situation may arise when the competency of the patient is in doubt. If there is a question about the patient's ability to understand clinical information or make clinical decisions, a psychiatric consultation should be obtained. If the patient is deemed incapable of making reasonable and informed decisions, the usual procedures for finding a surrogate decision-maker should be followed. This situation also may arise if the surrogate seems not to be making decisions as the patient would have or in the patient's best interests. In this situation, it is important for both the physicians and the Committee to appreciate that provision of life-sustaining treatment against the wishes of a patient or surrogate is not an individual decision, nor even the decision of the care team or Committee, but an institutional decision affecting all of the professionals who work within the institution. For this reason, it is imperative that the hospital administration (CMO) and legal counsel be involved in further decision-making. Available options might include:

2.8.2. Hospital administration (CMO) could request that the responsible physician pursue further attempts at consensus with the patient or surrogate.
• If the consultation process uncovered potential avenues of mediation that might result in consensus between the responsible physician and the patient or surrogate, then the hospital might have legitimate grounds for wanting the physicians to pursue these possibilities. If this option is chosen, the administration needs to indicate explicitly the nature and time-frame of the proposed mediation, and to commit to alternative options if the mediation fails.

2.8.3. **The physician and hospital administration (CMO) could attempt to transfer care.**

• In some cases, the physician and the institution may agree to transfer the patient to another physician, health care team, and facility willing to comply with the patient's or the surrogate's wishes regarding the foregoing of treatment.

2.8.4. **Hospital administration (CMO) and the Office of General Counsel could seek a judicial resolution to the conflict.**

• If the consultation process concluded that the patient lacked decision-making capacity, and/or that the patient's surrogate was not acting in the patient's best interest, then judicial resolution should be sought. This would create the opportunity for re-evaluation of the patient's care plan and re-consideration of the advisability of discontinuing life-sustaining treatments. In this case, the patient or surrogate should be made aware of their right to seek legal counsel.6

2.9. **If the Committee Does Not Support the Physician's Refusal to Provide Treatment**

2.9.1. If the Committee does not support the responsible physician's assessment that further treatment is inappropriate or harmful, the physician may:

• **Continue to provide treatment:** Based upon the deliberations of the Committee, the responsible physician and other clinicians may come to see the situation differently. One of the explicit purposes of the process of deliberation is to elicit values and understandings that may not have been articulated in the initial discussions with the clinicians. If this occurs, the responsible physician may agree that continuation of treatment is an acceptable option; or

• **Seek transfer of care to another physician or another**
institution: If the responsible physician continues to believe that further treatment violates his or her own professional integrity, he or she should seek transfer of care to another physician at MGH who is willing to comply with the patient's or surrogate's wishes. If no physician at MGH can be found who is willing to assume care, then the patient or surrogate should be informed and their permission sought to pursue transfer to another physician at another institution willing to assume responsibility and to comply with the patient's or surrogate's wishes. This should be arranged by the responsible physician with assistance, if necessary, from the hospital administration (CMO's office).

2.9.2. A house officer or non-physician member of the health care team who finds that the plan of care conflicts with her or his personal values or spiritual beliefs should report this concern to her or his supervisor for the purpose of being replaced. (See Human Resources Policy: MGH Employee Rights / Patient Care Non-discrimination Policy)

2.10. If the Committee Supports the Physicians' Refusal to Provide Treatment

- The Committee may support the caregiver's assessment that further treatment is inappropriate or harmful. The Committee thereby affirms that the patient's or surrogate's wishes may be overridden in this case because considerations such as beneficence or nonmaleficence should take precedence. In this case, it is important for both the physicians and the Committee to appreciate that withdrawal of life-sustaining treatment against the wishes of a patient or surrogate is not an individual decision, nor even the decision of the care team or Committee, but an institutional decision affecting all of the professionals who work within the institution. For this reason, it is imperative that the hospital administration (CMO) and legal counsel be involved in further decision-making. Available options might include:

- Hospital administration (CMO) could request that the responsible physician pursue further attempts at consensus with the patient or surrogate. If the consultation process uncovered potential avenues of mediation that might result in consensus between the responsible physician and the patient or surrogate, then the hospital might have legitimate grounds for wanting the physician to pursue these possibilities. If this option is chosen, the administration needs to explicitly indicate the nature and time-frame of the proposed mediation, and to commit to alternative options if the mediation fails.
The physician and hospital administration (CMO) could pursue transfer of care. This option should be used only if the treatment in question is considered inappropriate but not harmful. The process of seeking to transfer the patient to another facility may serve as a "check" on the judgment that continued therapy is inappropriate, since successful transfer might imply a lack of consensus about that judgment within the broader medical community. If the treatment is considered harmful, however, transfer should not be considered as this would abrogate the physicians' and the institution's responsibility to the patient.

Hospital administration (CMO) and the Office of General Counsel could seek a judicial resolution to the conflict. If the consultation process concluded that the patient lacked decision-making capacity, and/or that the patient's surrogate was not acting in the patient's best interest, then judicial resolution should be sought. This would create the opportunity for re-evaluation of the patient's care plan and re-consideration of the advisability of continuing with life-sustaining treatments.

Hospital administration (CMO) could sanction the unilateral foregoing or removal of life-sustaining treatments. Such action should occur only after informing the patient or surrogate of the plan as described below and only after giving the patient or surrogate sufficient opportunity to seek legal advice and possibly judicial involvement, if desired. Unless there is a compelling reason to act more quickly or more slowly, the patient or surrogate should be informed that the life-sustaining treatment(s) in question will be withheld or withdrawn in 5 to 7 working days.

3. **PROCEDURE AFTER THE COMMITTEE MEETS**

3.1. Whatever the outcome, documentation and follow-up on the Committee's recommendations is essential. A designated Representative of the Committee should be assigned to write a note synopsizing the deliberations of the Committee that includes: 1) a Summary of the salient features of the case; 2) an Impression that lists any conclusions reached and the justification for those conclusions; and 3) any specific Recommendations.

3.2. If the Committee supports a patient's or surrogate's refusal to accept or forego life-sustaining treatment (items C5a or C5c above), the Representative should first review the Committee's deliberations and recommendations with the responsible physician, then with the patient or
surrogate, and then place the note in the medical record. If requested, the responsible physician should review the written report with the patient or surrogate.

3.3. If the Committee supports a physicians’ refusal to discontinue or provide life-sustaining treatment against the wishes of a patient or surrogate and thus determines that the wishes of a patient or surrogate may be overridden (items C5b or C5d above), the Representative should first forward the note to the Chief Medical Officer (CMO) and the Office of General Counsel. Next, the Representative should review the Committee's deliberations and recommendations with the responsible physician, then with the patient or surrogate, and then place the note in the medical record. Further action is to be taken by the CMO as per items 2.8.1. – 2.8.4. and 2.10.1. above. If requested, the responsible physician should review the written report with the patient or surrogate.

4. **FOOTNOTES**

* This policy evolved in a length process of debate about legal and ethical issues in decision-making about life-sustaining treatment. The Office of General Counsel assisted with this process. The policy is consistent with current requirements of Massachusetts's law and with current standards of medical ethics.

1The word "surrogate" is used throughout this policy to refer to the person making decisions for a patient who is unable to do so because of incapacity, physical or mental. The surrogate may be any person who has a legal, familial, or social relationship to the adult patient and thus a claim or desire to be the decision-maker. If the patient has designated a health care agent through a signed health care proxy or has a legally appointed guardian, then the health care agent or legally appointed guardian has the sole authority to make health care decisions. If the patient has not designated a health care agent, and has no legally appointed guardian, then the goal is to find the person most involved and knowledgeable about the patient's values, goals, and preferences. Generally this will be a spouse, domestic partner, adult child, parent or sibling. At times, a close friend or a more distant relative of the patient, or a caregiver who has known and cared for the patient for a significant period of time, may be the only individual available to contribute to such decisions. The surrogate should base health care decisions on what the patient would have decided if capacity were intact ("substituted judgment") or, if that is not possible to discern, on what is in the patient's "best interest". The health care proxy is described in another policy in this manual: Advance Directives, III-N-1.

2 Other policies in this manual which may be helpful in thinking through the resolution of conflict in a patient's care are: Life-sustaining Treatment, II-D-1; Informed Consent, III-G-1; and End-of-life Care, V-E-1.
These definitions are adapted from: Tomlinson T, Czlonka D. Futility and hospital policy. Hasting Cent Rep 1995; 25:28-35.

If the patient or surrogate has legal counsel present during the meetings, then the hospital counsel must also be notified and involved.

See policy on "Patients Who Refuse Blood".

If the surrogate is legally designated as the patient's health care agent under a health care proxy, state law requires health care providers to seek court removal of the agent if they choose not to follow the agent's directions. Such removal would be sought based on evidence that the agent is not making treatment decisions the patient would have made, or if that cannot be known, is not making decisions in the patient's best interest.

If the surrogate is legally designated as the patient's health care agent under a health care proxy, state law requires health care providers to seek court removal of the agent if they choose not to follow the agent's directions. Such removal would be sought based on evidence that the agent is not making treatment decisions the patient would have made, or if that cannot be known, is not making decisions in the patient's best interest.

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1. POLICY:

1.1. Nurses may administer a maximum of 2 doses of a sedative or tranquilizer prescribed by a physician for a patient's bereaved or severely distraught visitor.

2. ADMINISTRATIVE PROCEDURE:

2.1. The order must be written in the Provider Order Entry system (POE) with the order clearly signifying to whom the medication should be administered. Note: the order must be documented in the medication order section of Patient's POE record (i.e. may not be written in the general care order section.) The ordering physician must use the Instructions section of the medication order screen to clearly signify to whom the medication should be administered.

2.2. The nurse administering the medication should document in the comment field of the medication order of the patient's medication record the name of the bereaved / distraught visitor to whom the medication was given and should state "given" and the date and time the medication was administered.

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MASSACHUSETTS GENERAL HOSPITAL
ORGAN AND TISSUE DONATION

1. POLICY

1.1. In compliance with Massachusetts General Laws, and Centers for Medicare Services (CMS), it is the policy of MGH to:

- Inform the New England Organ Bank (NEOB) of all deaths.
- Ensure that the NEOB staff (or hospital staff trained by NEOB) informs every family of a potential donor of their right to donate.
- Work with the NEOB to review death records to make sure potential donors are being identified correctly, and to educate staff on donation issues.
- NEOB 24-Hour Number: 1-800-446-6362

2. PROCESS FOR ORGAN DONATION AFTER BRAIN DEATH AND ORGAN DONATION AFTER CARDIAC DEATH (DCD)

2.1. In all appropriate cases, the physician-of-record or designated representative, will contact the NEOB in a timely manner after a collaborative discussion with the members of the health care team.

- “Appropriate cases” include any ventilated patient with a prognosis where he/she is deemed unlikely to survive.
- A “timely” referral is defined as a referral to NEOB prior to brain death testing or discussion of comfort measures for withdrawal of life-sustaining measures.
- According to the Uniform Determination of Death Act, brain death is defined as “an individual who has sustained irreversible cessation of all functions of the entire brain, including the brain stem”; cardiac death is defined as “an individual who has sustained irreversible cessation of circulatory and respiratory functions”.
- Please refer to the Policy on Death Determination Using Brain Criteria in the Adult at (add link)

2.2. No member of the care team should initiate a discussion about donation with the family until the case has been referred to NEOB.

2.3. All members of the care team are responsible to ensure that an effective request process is followed.
For the purpose of this policy, an “effective request process” includes a meeting of the physician-of-record or designated representative, ICU nurse and NEOB representative prior to donation discussions with the family. When possible, other contributing members such as social workers and chaplaincy should be included. This meeting is commonly referred to as a Take 5\(^1\) meeting. Its goal is to develop a collaborative plan for the donation discussion.

3. **Organ Bank Responsibilities for Brain Death and DCD Referrals**

3.1. A coordinator from the NEOB is available 24 hours a day and will as appropriate:

- Evaluate each potential donor for medical suitability for organ and/tissue donation and provide consultation to hospital staff.

- Check applicable first person consent donor registry to learn if patient has made a valid decision to donate.

- Conduct a family discussion about the opportunity to donate.

- Obtain consent from the patient’s legal next-of-k in or if the patient has designated donation through a first person consent donor registry then NEOB Coordinator will complete a disclosure with the patient’s legal next-of-kin.

- Obtain a thorough medical and social history from the family.

- Assist the physician-of-record in documenting the outcome of the referral.

3.2. Regular chart audits of deceased patients will be conducted by the NEOB staff to ensure adherence to organ and tissue donation policy and procedure and improve identification of potential donors. The NEOB will provide compliance data to designated hospital administration on a regular basis.

4. **Consent for Organ and/or Tissue Donation**

4.1. Whether a donor after brain death or a donor after cardiac death, the legal next-of-kin has the right to make the decision regarding organ and tissue donation if the patient has not otherwise specified. The next-of-kin order of priority is as follows: (a) spouse, (b) adult son or daughter, (c) either

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\(^1\) “Take 5” is a 5 minute huddle prior to any discussion of donation will take place. The Take 5 huddle includes the patient’s physician, nurse, and representatives from NEOB, Social Work, and Chaplaincy, who will decide collaboratively how best to approach next of kin regarding organ and tissue donation.
parent, (d) adult brother or sister, (e) healthcare agent (f) guardian (court appointed), (g) any other person authorized or under obligation to dispose of the body.

4.2. Designated Donation (First Person Consent) will be considered if a patient has designated donation through a first person consent donor registry, has a signed donor card, or documentation of wish for donation in a Will. A full discussion with the family regarding donation must still take place. A disclosure form will be reviewed with the legal next-of-kin, by NEOB prior to the donation. Written verification of designated donation will be attached to the disclosure form and placed in the patient's medical record. In cases where a conflict occurs between the family's decision and the designated donation decision of the patient, the hospital administrator on call will be notified by the health care team. The hospital administrator will confer with legal associates and the health care team to determine a course of action.

5. DECLARATION OF DEATH

5.1. The physician-of-record or designated representative is responsible for informing the family of the patient's death. Record of death (date and time) shall be documented in the patient's record. If this is a medico-legal case reportable to the Medical Examiner (ME), it is the responsibility of the physician-of-record or designated representative to notify the ME's office of the patient's death.

6. ASYSTOLIC DEATHS AND TISSUE DONATION

6.1. All inpatient asystolic deaths must be reported to the admitting department for potential tissue donation. This includes deaths in all hospital units including operating room and labor and delivery.

6.2. Once the family has been informed of the death, the admitting department will contact the NEOB's 24-hour number 1-800-446-6362 to refer the patient.

6.3. Timely referral to NEOB of asystolic deaths will occur within 1 hour of a patient death.

6.4. The admitting department representative will provide preliminary information to the NEOB via the 1-800 number to determine donor suitability. This information may include:

- patient's medical record number;
- patient's name;
- patient's age, sex, and race;
- date and time of death;
• cause of death (if known - admitting diagnosis, if not known);

• Past medical history (e.g. history of cancer, prior transplants, etc.);

• name and phone number of legal next-of-kin;

• hospital unit, declaring MD and phone number;

• Person reporting death.

6.5. Based on information obtained in the initial referral, NEOB may contact the declaring MD and other appropriate staff for more detailed medical information, confirming donor suitability. If the deceased is not medically suitable for donation, NEOB will inform the admitting staff and the outcome will be documented on the report of death form or in the patient’s chart.

6.6. In the event that the deceased is medically suitable for donation, NEOB will contact the family to notify them of the opportunity to donate (see section 4.0 for the consent process). NEOB will notify the admitting department of the outcome of the family discussion. In cases where donation is approved NEOB will coordinate with the appropriate hospital staff (OR, Nursing Supervisor, Pathology) to facilitate recovery.

6.7. Tissue recovery, not involving organ donation, may occur at the NEOB Tissue Recovery Facility. NEOB will inform the family if the body is to be transferred for recovery of tissues. The New England Organ Bank will coordinate transfer of the body to the tissue recovery facility. If the family objects to the transfer, the recovery of tissues will take place at MGH. NEOB will provide a copy of the consent to the MGH Admitting and Pathology Departments.

6.8. The Massachusetts General Hospital will not be responsible for personal belongings once the body has been relinquished to the transport company. Next-of-kin, if present on the unit, will be given patient valuables prior to the body being transported. All remaining valuables will be sent with the body to the tissue recovery facility. It will be the responsibility of the NEOB to ensure these valuables are given to the next-of-kin.

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1. **POLICY**

1.1. Every patient at MGH will receive information about patient rights and responsibilities.

1.2. The following statement is given to all adult patients on admission to the hospital and are available to patients in all clinics:

2. **PROCESS**

2.1. Your Rights as a Hospital Patient

2.1.1. It is the goal of Massachusetts General Hospital to give you the care that is right for your illness and to help you to get well as soon as possible. We are committed to maintaining the rights, dignity and well-being of all patients.

2.1.2. The following is a summary of your rights. After that there is a list of steps that you must do (your responsibilities) to help us give you the best care while you are in the hospital. Thank you for taking the time to read this Patient Bill of Rights. If you have any questions about these Rights and Responsibilities, or would like a complete set of the law called the Massachusetts Patient Bill of Rights, please call the Office of Patient Advocacy at (617) 726-3370.

- You have the right to be treated in a caring and polite way.
- You have the right to know all the facts we have about your illness, treatments, and possible outcomes. Your doctor or other health care giver will give these facts to you.
- You have the right to know the name and specialty of the doctor responsible for your care.
- You have the right to say yes to treatment. You also have the right to say no or refuse treatment.
- If you cannot speak for yourself at any time and you want someone else to make decisions for you, you have the right to agree to have an advance directive, such as a health care proxy, which tells the hospital and doctor how you want to be treated and who you want to make decisions for you. If you do not have an advance directive or health care proxy, any member of your health care team can help you fill one out.
• You have the right to be examined in private by your doctor or other health care giver, and you have the right to talk to your doctor in private.

• You have the right to choose who may visit during your hospital stay. MGH has open visiting hours although may limit or restrict visitors if they get in the way of your health or safety or that of other patients or staff.

• You may choose who is present to support you during your hospital stay. MGH does not require that the person be legally related to you.

• You have the right to look at your medical records and get a copy for a reasonable fee.

• You have the right to take part in a research study if you are asked. You also have the right to say no if you do not want to take part. If you choose not to participate your care will not be affected in any way.

• You have the right to expect evaluation and treatment of pain.

• You have the right to expect that we will try to get back to you as quickly as possible when you ask us to do something.

• If you are a female rape victim of childbearing age, you have the right to be promptly offered emergency contraception, receive emergency contraception upon request, and receive written information about emergency contraception.

• You have the right to receive written notice of how your health information will be used and shared in order for you to receive the highest quality of care. This is called our Privacy Notice and it contains patient rights and our legal duties regarding your health information. You may request a copy of this Privacy Notice from any staff member.

• You, your family, your significant other or your guardian have the right to tell us when something is wrong. This is called presenting a complaint. If you present a complaint, your care will not be affected in any way. If you have a problem that you cannot solve with your doctor, nurse, or other caregiver, please call the Office of Patient Advocacy (OPA) at 617-726-3370. If you send a fax, email or written letter, OPA will acknowledge your communication within two business days. A representative from OPA will contact you, review your complaint, and make
every effort to resolve your concerns at that time. If your complaint cannot be resolved in a timely manner it will become a grievance. OPA will review and resolve the grievance within 10 days. If other departments are involved in the review, every effort will be made to resolve it within 30 days. An OPA representative will communicate with you if there is no resolution within the above time frames. A letter will be sent to you that will include: name of the hospital contact; steps taken for the review; results of the review; resolution; and the completion date.

- You have the right to file a complaint with an outside agency. You can file a quality of care complaint to the Massachusetts Division of Healthcare Quality at 617-753-8100 or the Joint Commission on Accreditation of Healthcare Organizations at 800-994-6610. If you think your civil rights have been violated, you can call the Massachusetts Attorney General’s Office at 617-727-2200. Patients on our inpatient psychiatry unit (Blake 11) may file a complaint with the Department of Mental Health at 617-626-8000 or by submitting a complaint form in writing to the Department of Mental Health Central Office of Investigations 25 Staniford Street Boston, MA 02114.

2.2. Your Responsibilities as a Hospital Patient

2.2.1. In order to provide you with the best care, we need your help and cooperation. In that spirit we request that you:

- Be honest with us and tell us all you know about your present illness, including other times you have been in the hospital, your health history, your current symptoms and anything else you know about your health that would help us treat you.

- Tell us the medicines you are taking, including the strength and how often you take them. Include over the counter medications, dietary supplements and herbal products you take and/or alternative medicines or treatments that you receive. Talk about any allergies or reactions you have had to any medications.

- Follow the treatment plan recommended by the practitioner primarily responsible for your care. If you have not been notified of the results of tests or procedures, ask your doctor or nurse when and how you will get the results.

- Tell us if you do not understand what our staff is saying to you or if you do not understand what they are telling you to do; also please tell us if you think you will not be able to do what is asked of you during your care.
• Make sure you understand what will happen if you need surgery. Tell the surgeon, anesthesiologist and nurses if you have allergies or ever had a bad reaction to anesthesia. Make sure that you, the practitioner primarily responsible for your care and your surgeon all agree on exactly what will be done during the operation.

• Accept the responsibility for your actions if you refuse treatment or do not follow your practitioner's instructions.

• Report unexpected changes in your condition to your doctor, nurse or other caregiver.

• Be considerate of the rights of other patients and hospital personnel and assist in the control of noise and the number of visitors.

• Be sure that you and your visitors are not disruptive, threatening, or violent. These behaviors have a negative effect on health, well-being, and safety of patients and our staff and will not be tolerated.

• Follow hospital rules and regulations affecting patient care and conduct, including the No Smoking policy.

• Respect the property of others and of the hospital.

• Give the hospital all the information they will need about the payment of your medical care.

• Ask questions if you do not understand instructions given to you at discharge about the treatment plan that you will use at home, including the medications that you will take and the activities that you can do.

2.3. The following is given to all children and teens on admission:

2.3.1. Respect and personal dignity:

• You are important. We want to get to know you.

• We will tell you who we are, and we will call you by your name. We will take time to listen to you.

• We won't talk in your room or outside your door unless you know what is happening.

• We will honor your privacy.
2.3.2. Care that supports you and your family:

- You and your family are important. We will work together to make you as safe and comfortable as possible.
- You and your family can expect that you will be part of the planning for effective pain relief and control.
- All families are different. We want to learn what's important to you and your family.
- There will be a place for a member of your family to spend the night in the hospital with you or near you.

2.3.3. Information you can understand:

- We will explain things to you. We will speak in ways you can understand. You can ask about what is happening to you and why.
- Someone who speaks your language will help explain things to you.
- Someone from your family can be with you when people in the hospital are explaining things to you.
- We will tell you and your family how information about your health will be used and shared so that you receive the best care. You can receive this in writing by asking for our Privacy Notice.

2.3.4. Quality health care:

- You will be taken care of by doctors, nurses, and people who know about children and teenagers.
- You have the right to know all of the people who take care of you in the hospital. You and your family can meet with them to plan what is best for you.
- We will work together with you and your family to make your stay in the hospital as short and as comfortable as possible.

2.3.5. Emotional support:

- When you are in the hospital, you might feel scared, mad, lonely, and sad. You can let people know how you feel. It is okay to cry or complain.
• You can have your family with you as much as possible. When this is not possible, the other people caring for you will explain why.

• We can help you meet children and families who have had experiences like yours.

• You can wear your own clothing most of the time and keep your special things with you.

• You can talk or play with people who know how to help when you have questions or problems.

• You can ask to be moved to another room if you are uncomfortable or unhappy.

2.3.6. Care that respects your need to grow, play, and learn:

• We will consider all your interests and needs, not just those related to your illness or disability.

• You have the right to rest, to play, and then to learn. We will make sure that you have places and times for the things children your age need to grow and learn.

2.3.7. Make choices and decisions:

• Your ideas and feelings about how you want to be cared for are important.

• You can tell us how we can help you to feel more comfortable.

• You can tell us how you want to take part in your care.

• You can make choices whenever possible. Sometimes you can help decide when and where you get your treatments.

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MASSACHUSETTS GENERAL HOSPITAL

RERAINT AND SECLUSION

1. POLICY:
1.1. Clinical leadership at MGH endeavors to create a physical, social and cultural environment that is focused on preventing and reducing restraint use and limits restraint or seclusion usage to clinically appropriate situations to prevent harm.

2. SCOPE:
2.1. This policy guides practice for patients of any age who are hospitalized in a patient care area. The Massachusetts Department of Mental Health (DMH) regulates the use of restraint and seclusion in the Inpatient Psychiatric Unit.

3. GUIDING PRINCIPLES:
3.1. The decision to use a restraint or seclusion is driven not by diagnosis, but by a comprehensive individual assessment.
3.2. Patient's rights, dignity and well being are protected and preserved, including vulnerable patient populations; emergency, pediatric and cognitively or physically challenged patients.
3.3. Restraints shall not be used when less restrictive interventions would be effective. Restraint or seclusion should be considered only as a temporary means of intervention when the patient is in immediate danger of harming self or others.
3.4. When restraint or seclusion is required, the least restrictive method should be utilized.
3.5. Restraint shall be discontinued when behavior or condition that was the basis for the restraint order is resolved, regardless of the duration of the enabling order.
3.6. The patient will have a plan of care and nursing interventions for the patient in restraint.

4. DEFINITIONS:
4.1. Restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.
4.1.1. Examples of restraint include:

Side rails to prevent the patient from voluntarily getting out of bed
Safety net bed
Roll belt
Vest
Mechanical limb restraint
Elbow splints
Mitts
Chair with locked tray when patient is out of bed
Chair wedge when patient is out of bed
Any type of restraint requested by the patient or family.

4.1.2. Exemptions include:

Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures.

Adaptive support in response to assessed patient need (for example, postural support, orthopedic appliances; Helmets

Forensic and correction restrictions used for security

Use of side rails during patient transport

Use of side rails to prevent a patient from falling out of bed. Examples include when the patient is on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, on seizure precautions, or on certain types of therapeutic beds.

Therapy beds e.g. laterally rotating beds and skin care beds where elevated side rails are required for operation of are recommended by the manufacturer

Age or developmentally appropriate protective safety interventions that a care provider outside of the health care setting would utilize to protect an infant toddler or school age child.
4.2. Behavioral Health Restraint is the restriction of patient movement for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. These are patients who present with behavioral health symptoms for which a medical etiology is ruled out and who are identified as primarily requiring behavioral health services. Examples include: psychotic episodes, manic episodes, attempted suicide, physical assault or violent or aggressive behavior.

4.3. Seclusion is the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving. Seclusion does not include confinement on a locked unit or ward where the patient is with others. Seclusion may only be used for the management of violent or self destructive behavior.

4.4. Non-Behavioral Medical Restraint is restraint that is used for acute medical and surgical care that supports medical healing. These are patients who present with changes that are primarily related to their medical surgical condition. Examples include: delirium due to high fever, sepsis, or dementia.

4.5. A chemical restraint (aka “medication restraint”) is a medication involuntarily administered to a patient for the purpose of restraining the patient (restricting their freedom of movement). Medication administered in an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness is not considered a chemical restraint. In addition, any medications ordered to treat medical conditions (e.g. delirium, acute alcohol withdrawal) are by definition not chemical restraints.

5. **Non-Behavioral Medical Restraint (Also Known As Non-Violent/Non-Self Destructive Restraint)**

5.1. **Indications**

Non-Behavioral Medical Restraint may be used for the following indications when less restrictive means would not be effective in protecting the patient:

The patient is pulling at tubes, lines or dressings.

The patient’s actions are endangering themselves; for example if the patient is thrashing around in bed or attempting to get out of bed in a way or under conditions where it might cause harm (including when such behavior is related to acute withdrawal syndrome).

The patient may unpredictably and suddenly awaken and harm themselves: for example, i) when an intubated patient is being
weaned from Propofol or ii) when an intubated patient has a neurological condition that may cause them to unpredictably and suddenly awaken with a significant risk of self-extubation.

5.2. Physician Order

An MD, NP, or PA order is required for the application of the restraint. All orders for restraint must be accompanied by a documented assessment of the patient stating the specific behavior requiring restraint. This assessment of the patient shall be performed by an MD, NP, or PA as soon as possible, not to exceed 24 hours after the initiation of restraint.

A documented daily assessment performed by the MD, NP or PA must accompany all restraint orders. This assessment should include the specific behaviors requiring restraint, the patient’s response to intervention and rationale for continued use.

In some situations, the need for a restraint intervention may occur so quickly that an order cannot be obtained prior to the application of the restraint. In these emergency application situations, the order must be obtained either during the emergency application of the restraint or immediately (within a few minutes) after the restraint or seclusion has been applied. For example, an emergency application situation would include the risk of self-extubation.

An order is active until it is discontinued by an MD, NP, or PA. A new order is required for each new episode of restraint use. A new episode begins when the type or number of restraints changes or after an order has been discontinued.

An RN may remove the restraint once the behavior requiring the restraint has resolved. The RN must contact an MD, NP, or PA and obtain a discontinue order as soon as it is clinically appropriate for the RN to pause in the process of patient care and no later than the end of his/her shift.

An RN may release (and subsequently reapply) restraints during treatments and other patient interactions without receiving a new order. However, if restraints are removed because the behavior requiring the restraint has resolved and the RN has obtained the discontinue order and the restraints need to be reapplied, it is considered a new episode and a new order is required.

5.3. Patient Monitoring
Attachment OOD 19.m continued

Type and location of the restraining device(s) shall be documented by the RN at least once per shift and when changed.

Rationale for restraint (observed condition or behavior) shall be assessed by the RN on an ongoing basis and documented at least once per shift.

Alternatives to and less restrictive forms of restraint considered by the care giver shall be documented by the RN at least once per shift.

Other monitoring activities shall be performed at least every two (2) hours, or more frequently if indicated by the condition or behavior of the patient. During monitoring, the patient shall be assessed for: signs of any injury associated with the use of restraint, nutrition and hydration needs, circulation, range of motion, hygiene and elimination, physical and psychological status and comfort, readiness for discontinuation or temporary removal from restraint. Such monitoring may be documented through a shift summary of activities.

6. **Behavioral Health Restraint and Seclusion (Also known as Violent or Self Destructive Restraint and Seclusion)**

6.1. Requirements for all settings

6.1.1. Initiation of Restraint or Seclusion: A registered nurse may initiate restraint or seclusion in advance of the physician’s order only if she or he determines that it is necessary to protect the safety of the patient or others. The RN shall obtain the order as soon as possible, but no longer than one hour after the initiation of restraint or seclusion. On inpatient psych unit, orders must be written by MD per DMH.

The initial and all subsequent restraint orders shall expire in:

- 1 hour or less for patients 8 years of age or younger
- 2 hours for patients from 9 to 17 years, and adult patients on inpatient psych unit per DMH guidelines
- 4 hours for patients 18 years of age and older.

New orders may only be written according to the time limits for a maximum of 24 consecutive hours.
6.1.2. One-hour face-to-face assessment

The MD, NP, or PA shall perform a face-to-face assessment of the patient’s physical and psychological status within 1 hour of the initiation of the restraint and within one hour of every subsequent restraint order. On inpatient psych unit, MD only must conduct the face-to-face assessment.

6.1.3. Monitoring

The RN shall assess the patient at the initiation of restraint or seclusion and every 15 minutes thereafter.

The assessment shall include the following, unless it is inappropriate for the type of restraint or seclusion employed.

- Signs of any injury associated with applying restraint or seclusion
- Nutrition and hydration
- Circulation and range of motion in the extremities
- Vital signs (at a minimum respiratory rate every 15 minutes)
- Hygiene and elimination
- Physical and psychological status and comfort
- Readiness for discontinuation of restraint or seclusion

Based on the assessment above, the RN may delegate tasks to a PCA as appropriate.

6.2. Additional Requirements for Patients Restrained or Secluded in the Inpatient Psychiatric Unit

6.2.1. Leadership Notification of Continued or Repeated Restraint or Seclusion

The nurse director/medical director shall be immediately notified of any instance in which a patient:

- Remains in restraint or seclusion for more than 6 hours, or
- Experiences two or more separate episodes of restraint and/or seclusions of any duration within 12 hours.
6.2.2. Thereafter, the nurse director shall be notified every 24 hours if either of the above conditions

Debriefing as soon as possible but no longer than 24 hours after the conclusion of each restraint episode, the patient and, if appropriate, the patient’s family participate with staff members who were involved in the episode in a debriefing. Staff shall use the currently approved debriefing form(s), which shall guide the content of that debriefing.

7. TRAINING OF STAFF

7.1. Restraint and seclusion training of direct care staff occurs during orientation, annually, and with any changes to policy, procedure or equipment. Restraint education includes, but is not limited to:

- Contraindications and risks associated with use
- Restraint alternatives
- Indications for use
- Age-appropriate use
- Safe application and removal of restraint
- Assessment and frequent monitoring of physiological and psychological response
- Documentation

8. EXTERNAL REPORTING

8.1. There are specific requirements to report any death associated with the use of restraint or seclusion.

These requirements can be located in the Patients Rights section of the Medicare Hospital Conditions of Participation

The following must be reported within twenty four hours following knowledge of the patient’s death

Each death that occurs while a patient is in restraint or seclusion

Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion

Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that
the use of restraint or placement in seclusion contributed directly or indirectly to the patient’s death

8.2. The Hospital will screen deaths to determine reportability.  

8.2.1. The Compliance Officer or his/her designee shall review every patient death on the day following the death. If the death occurred while the patient was in restraint or seclusion, if the death occurred within 24 hours after the patient has been removed from restraint or seclusion, or if it the death occurred within one week after restraint or seclusion and is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to the patient's death, then the Compliance Officer or his/her designee shall report the death to CMS pursuant to the CMS Hospital Conditions of Participation.

8.3. The Compliance Officer will file a copy of the report to CMS in the patient record after reporting is complete

9. REFERENCES:

Joint Commission National Patient Safety Goals.
Massachusetts Department of Mental Health Regulations 104 CMR CH 27
CMS Hospital Conditions of Participation in 42CFR 482.13 (Patients Rights). Restraint and Seclusion Standards, 482.13 e, f, g

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1. **POLICY:**

   1.1. It is the hospital policy to respect the legal rights of patients to refuse treatment with blood or blood products, and to provide appropriate care for such patients within this restriction.

2. **INTRODUCTION**

   2.1. The rights of patients who refuse blood may conflict with the personal values of some health care providers who do not wish to treat patients who would forego blood treatment deemed necessary to preserve life or health. This policy will outline a framework that will respect patient autonomy and minimize conflict to the extent possible, and address emergency situations as well as patients who are minors, incompetent, or pregnant.

   2.2. In general, a clinician is not required to treat any patient, including one who refuses blood, and in the outpatient setting (or if the treatment is elective) may simply decline to accept the patient. An inpatient or emergency room patient who refuses blood may present more complexity and it must be remembered that treatment of a patient against his or her wishes may result in legal liability for the clinician and the hospital. Every attempt should be made to transfer the patient to a clinician who will respect the patient's wishes.

   2.3. As in the case of any patient who refuses recommended treatment deemed necessary to prevent death or major impairment, available hospital resources should be used to thoroughly assess the patient's rationale. Other issues may include resolving any concerns about the patient's understanding or ability to understand the implications of the refusal of care, or exploring with the patient the religious implications of accepting blood or whether there are any treatments the patient can accept, or concerns about the care of minor children if a parent dies. Social Workers, Chaplains and Psychiatrists are resources to consider.

   2.4. This policy should be read in concert with:

   - Policy on Informed Consent—who may give consent, how to obtain and document informed consent and definitions for incompetent patient, emancipated minor and guardian.

   - Human Resources Policy: MGH Employee Rights and Patient Care Nondiscrimination Policy (process to follow when strong values conflict with a patient/family request or a colleague's decision).
3. COMPETENT ADULT PATIENTS

3.1. General Rule

3.1.1. A competent adult or emancipated minor patient generally has the right to refuse any medical treatment, including a transfusion of blood or blood products, even if such refusal may result in his or her death. A clinician disagreeing with the patient's decision to forego a transfusion should make every effort to refer the patient to another clinician who is willing to respect the patient's wishes (The referring clinician should communicate to the patient that the decision to forego a transfusion will not lead to abandonment, nor to neglect of the patient's need for symptom control or emotional support).

3.1.2. A physician who agrees to the patient's request for blood-free treatment is responsible for making sure other health team members involved in the patient's care know about and agree with this obligation. When documenting informed consent, the patient should also sign the four-part Release From Liability for Blood-Free Treatment (Attachment A, hereafter called "Release") and, if applicable, the Statement Regarding Arrangements for Care of Minor Child (Attachment B, hereafter called "Statement"). One copy will be placed in the patient's record and one copy each sent to the Blood Transfusion Services. All services are responsible for assigning staff who will honor the patient's request.

3.1.3. Patients scheduled for surgery or invasive procedures should be seen in the Pre-Anesthesia Test Area before their surgery or procedure. When scheduling, the patient's physician should assure that this request is noted on the OR schedule and on orders for the Pre-Anesthesia Test Area, and that sufficient time is allowed to make necessary care arrangements. When documenting informed consent, the patient should also sign the Release and, if applicable, the Statement. One copy will be placed in the patient's record and one copy sent to the Blood Transfusion Services, the appropriate scheduling office (the OR scheduling office for all surgical procedures), and to the Department of Anesthesia and Critical Care. The final OR schedule will indicate the patient's request for blood-free treatment. All services are responsible for assigning staff who will honor the patient's request.

3.2. Emergencies

3.2.1. In an emergency situation, the Hospital encourages clinicians to comply with the patient's request. When possible, the patient should be transferred to the care of another clinician in agreement
with the patient's wishes. If the physician disagrees with a competent patient's refusal of a proposed transfusion but cannot refer to a physician who agrees to treat the patient without a transfusion, the physician should honor the patient's wishes. All clinicians must recognize that treatment against the patient's request may result in legal liability for the Hospital and the clinician.

3.3. Documentation

3.3.1. When a competent patient refuses a potential transfusion, the physician should document on the Procedure Consent Form, if the proposed transfusion is in connection with a procedure for which that form is used, or on the Blood Transfusion(s) Consent Form if the need for transfusion is independent of such a procedure, that the physician has explained the consequences of refusal to the patient. A short note in the patient's chart documenting that the patient was made aware of the potential for an adverse outcome and/or death as a result of withholding appropriate blood transfusion is appropriate.

- All patients refusing blood or blood products for life saving treatment must sign the Release From Liability for Blood Free Treatment form (Attachment A).
- All patients refusing blood or blood products should be advised of their right to designate a health care agent and offered assistance in doing so.

3.4. Exceptions

3.4.1. There are certain exceptions to the general rule, the primary one being the situation in which the patient has minor children who would be abandoned if the patient died. If the physician believes that this exception applies, or if other circumstances exist which call into question a competent adult's right to refuse a transfusion, the physician should contact the Hospital lawyer-on-call. If the circumstances justify doing so, the lawyer-on-call may seek a court order that the transfusion be given despite the patient's objections.

3.4.2. Documentation: All patients should be asked if they have minor children. Any patient having minor children, or who is pregnant, must sign The Statement Regarding Arrangements for Care of Minor Child (Attachment B). This form will be placed in the patient's medical record.

4. INCOMPETENT ADULT PATIENTS

4.1. General Rule
4.1.1. If a patient is incompetent when the need for blood transfusion or a procedure that may involve a transfusion arises, the physician should not accept a refusal of a proposed transfusion by the patient or by the patient's representative, unless the representative is a legally-designated health care agent. If a proposed transfusion is refused by or on behalf of an incompetent patient by anyone other than a legally-designated health care agent, the physician should contact the lawyer-on-call.

4.1.2. This rule may not apply under circumstances in which the physician has clear and convincing evidence that the patient, when competent at an earlier time, had informed the physician of his or her wish not to have a potential transfusion. Alternatively, the patient may have executed a document when competent, such as a living will, or advance directive, expressing his or her wish to refuse a potential transfusion. There may be an obligation to honor such a patient's wishes, depending on the manner in which the patient indicated the refusal, and the length of time between the patient's refusal and the proposed transfusion. In such cases, the physician should contact the lawyer-on-call.

4.2. Emergencies

4.2.1. If an incompetent patient requires an immediate transfusion to prevent death or a serious impairment of his or her physical condition, the physician should proceed with the transfusion without necessarily following the steps set forth in section three above.

5. PREGNANT PATIENTS

5.1. General Rule

5.1.1. Guidelines relating to Competent Adult Patients will apply to competent pregnant patients prior to the viability of the fetus.

5.1.2. If a pregnant patient with a viable fetus refuses potential treatment with blood or blood products when that treatment is clearly medically necessary to save the life of the patient, and by extension, the life of the fetus, and if the physician is unable on grounds of conscience to abide by the patient's wishes and is unable to find a substitute physician to take over the care of the patient, the physician may consult the lawyer-on-call.

5.1.3. If the circumstances justify and if requested by the primary physician and the Chief Medical Officer (or his designee), the lawyer-on-call may seek a court determination balancing the state's interest in protecting the fetus against the mother's interest in determining her own medical treatment, or if requested by the primary physician and the Chief Medical Officer (or his designee),
attempt to obtain a court order for transfusion. Following delivery, the patient generally has the right to refuse treatment with blood, and should be asked to sign the "Statement Regarding Arrangements For Care of Minor Child" (Attachment B).

5.1.4. Several factors would go into determining whether it is appropriate to seek a judicial determination: how close the patient is to delivery of a viable fetus; the degree of certainty that treatment with blood or blood products is medically necessary to preserve the life or health of the fetus and will be effective; the degree of invasiveness of the treatment (e.g., a one-time treatment versus a course of treatment over a period of time with the patient needing to be cooperative).

5.1.5. It should be noted that, although there is no Massachusetts decision on this point, courts in other jurisdictions have upheld the right of the pregnant patient to refuse medical treatment that would benefit the fetus.

5.2. Emergencies

5.2.1. If a competent pregnant patient with a viable fetus requires immediate treatment with blood to prevent death or serious impairment to the fetus and the clinicians cannot in the time available transfer the patient to the care of other clinicians or follow the steps in section three above, if the physician disagrees with a competent patient's refusal of a proposed transfusion but cannot refer to a physician who agrees to treat the patient without a transfusion, the physician should honor the patient's wishes All clinicians must recognize that treatment against the patient's request may result in legal liability for the Hospital and the clinician.

5.3. Exceptions

5.3.1. Exceptions relating to Competent Adult Patients, specifically abandonment of a minor child, will apply to competent pregnant and post-partum patients.

6. MINORS

6.1. General Rule

6.1.1. A physician should not accept the refusal of a transfusion by a patient who is under eighteen years old, nor should he or she accept a refusal on the patient's behalf by the patient's parent, other family member or guardian. When a minor or the minor's representative refuses a transfusion, the physician should contact the lawyer-on-call. The physician and lawyer on-call will discuss the nature of the surgery, and the risks of foregoing the surgery and consider whether it is necessary to seek judicial intervention, such
as a court order, for the transfusion and any other relief needed to render medically necessary treatment to the child. This will be more likely if the treatment is elective and time permits. Because court proceedings in such cases can be time-consuming, the physician should notify the attorney-on-call as far ahead of the planned treatment as possible.

6.1.2. Pursuant to Massachusetts General Laws, chapter 112, section 12F, any emancipated minor may legally give consent to (or refuse) his/her medical care at the time such care is sought if (1) he/she is married, widowed or divorced; or (2) he/she is the parent of a child; or (3) he/she is a member of the armed forces; or (4) she is pregnant or believes herself to be pregnant; or (5) he/she is living apart or separate from his/her parent or legal guardian and is managing his/her own financial affairs. Additionally, "mature minors" may also be determined to be capable of making independent decisions about their medical treatment. Refer to Informed Consent policy and/or consult the hospital lawyer on call for additional information.

6.2. Emergencies

6.2.1. If a minor requires an immediate transfusion to prevent death or a serious impairment of his or her physical condition, the physician should proceed with the transfusion without necessarily following the steps set forth in section 6.1 above.

6.3. Procedure

6.3.1. The parents, family members or guardians who refuse blood on behalf of a minor should be informed that every effort will be made to avoid transfusion of blood or blood products but that, if in the judgment of the treating physicians, transfusion is necessary to save the patient's life, limb or mental function, a court order will be obtained authorizing the needed transfusion. Parents or appointed guardians should not be guaranteed that patients will not be transfused.

6.3.2. Parents or appointed guardians should be allowed to alter the Procedure Consent Form to indicate their refusal to consent to transfusion of blood or blood products. However, the following comment should be added to the Form after the parents' refusal to reflect MGH and state policy in regard to minor patients whose parents or guardians refuse blood:

- "The physicians at the Massachusetts General Hospital will make every effort to avoid administering blood to your child. However, if in the opinion of the child's physician it becomes
necessary to administer a transfusion of blood or blood products in order to save the child's life, limb or mental function, a court order will be sought authorizing such transfusion. In an emergency, transfusion will be administered without obtaining such authorization."

7. **Footnotes**

7.1. Massachusetts' Supreme Judicial Court has ruled that with one exception a competent adult has the right to refuse blood or blood products even when deemed medically necessary to preserve life. (The exception applies if the adults' death would result in abandonment of a dependent minor child).

8. **References**

Massachusetts General Laws, chapter 112.

Joint Commission- Patient Rights

Revised and Approved: Transfusion Committee and Ethics Committee (11/98)(4/03) (11/01/06) (4/10)
Approved: Clinical Policy and Record Committee (4/03) (3/23/07) (9/24/2010)
ATTACHMENT A

RELEASE FROM LIABILITY FOR BLOOD-FREE TREATMENT

In view of my personal beliefs, I refuse to accept any blood transfusion or blood component transfusion in connection with any treatment, procedure or delivery performed on me at the Massachusetts General Hospital, even if such transfusion is deemed necessary in the opinion of the attending physician or surgeon or any of his or her agents to preserve my life, bodily function or to promote recovery. I do allow use of medications, procedures or intravenous products (or components) as indicated below.

I hereby release the Massachusetts General Hospital, its officers, staff and employees and all other agents from any responsibility to me, my dependents and estate for all consequences in connection, directly or indirectly, with my refusal to accept treatment with blood or blood components (or products). This release is signed voluntarily and of my own free will and accord.

COMPLETE AS APPLICABLE:

_____ I further state that I have no minor children, and, if female, that to the best of my knowledge I am not pregnant.

_____ I have _____ minor child(ren), and/or, if female, am pregnant. I have completed and attached a statement regarding arrangements I have made for the care of my minor child(ren), and/or newborn(s) in the event of my death.

COMPLETE AS APPLICABLE:

_____ I agree to allow the following medications, procedures and/or intravenous products (or components) to be used in my care:

_____ Erythropoietin and iron
_____ Withdrawal and storage of my blood through a connection with my blood vessels
_____ Serum albumin
_____ Blood expanders
_____ Non-blood oxygen carrying medications
_____ Other, specify

DATE

SIGNATURE (Patient)

Unit Number

SIGNATURE Physician/Surgeon

(1 copy to Patient Record, 1 copy to Blood Transfusion Services, 1 copy to OR Scheduling Office, and 1 copy to Department of Anesthesia and Critical Care)
ATTACHMENT B

STATEMENT REGARDING ARRANGEMENTS FOR CARE OF MINOR CHILD

I (print name) __________________________ wish to exercise my right to refuse blood and blood components (or products) in connection with any expected treatment, procedure or delivery at the Massachusetts General Hospital.

I have ___ minor child(ren), age(s) _____________________________.

If female: ___ I am pregnant and my due date is ___/___/____.

___ To the best of my knowledge, I am not pregnant.

I have made arrangements with a person or persons ready and able to care for my child(ren), and/or newborn(s). I have consulted with the person or persons named below and he/she/they support my decision to refuse blood and blood products (or components) and agree(s) to take responsibility for my child(ren) in the event of my death:

NAME: ____________________________
ADDRESS: ____________________________
PHONE NUMBER: (____) __________
RELATIONSHIP TO ME: __________
RELATIONSHIP TO CHILD(REN): __________

NAME: ____________________________
ADDRESS: ____________________________
PHONE NUMBER: (____) __________
RELATIONSHIP TO ME: __________
RELATIONSHIP TO CHILD(REN): __________

I understand that if I have any minor child(ren), or if I am a female who is pregnant and I have not made arrangements with a person or persons ready and able to care for my minor child(ren), and/or newborn(s) in the event of my death resulting from my refusal of blood or blood products, then the State interest in preventing the abandonment of my child(ren) will override my right to refuse medical treatment. In such circumstances, the physicians and surgeons at the Massachusetts General Hospital will administer blood in an emergency if it is determined necessary to save my life, limb or mental function.

COMPLETE, SIGN AND ATTACH TO THE RELEASE FROM LIABILITY FOR BLOOD FREE TREATMENT.

DATE ____________________________
SIGNATURE (Patient) ____________________________

Unit Number ____________________________
SIGNATURE (Witness) ____________________________

SIGNATURE (Physician/Surgeon) ____________________________

(1 copy to Patient Record, 1 copy to Blood Transfusion Services, 1 copy to OR Scheduling Office, and 1 copy to Department of Anesthesia and Critical Care)
Massachusetts General Hospital
Edwin H. Cassem Optimum Care Committee (OCC)

Guidelines for Membership and Visitors

Joining the OCC

- Any nurse, physician, social worker, or allied health professional practicing at MGH may request to join the OCC.
- In order to be considered for membership on the OCC, a prospective candidate must be nominated by a current OCC member. For this purpose, the prospective candidate may contact any member of the OCC. If the prospective candidate does not know any current member of the OCC, s/he may contact the OCC administrator who will put him/her in touch with one of the OCC members.
- Before nominating a prospective candidate, the OCC member should, at a minimum, obtain the candidate’s CV and have a discussion with the candidate to explore his/her interest in, and commitment to, clinical ethics consultation.
- When an OCC member wishes to nominate a candidate for membership, s/he should let the OCC Administrator know in advance of the next OCC meeting so that the nomination can be put on the agenda. The candidates CV should be forwarded to the Administrator to be kept on file.
- A candidate for membership must be nominated at an OCC meeting in the following manner:
  1. The OCC member who has agreed to nominate the candidate will present briefly the candidate’s background and motivation for joining the OCC:
  2. The Committee will then consider the following aspects of the candidate:
     - Educational/professional background in ethics or strong interest in acquiring expertise in clinical ethics consultation.
     - Any history of unethical or unprofessional behavior such as, but not limited to, failing to maintain patient confidentiality.
     - Ability to commit to:
       - Participating in the required training program;
       - Participating in 4 – 6 consults per year, recognizing the ethics consultation may sometimes require extended hours in the hospital;
       - Attending 66% of OCC meetings per year;
       - Keeping confidential all information about OCC cases, including those in which the candidate might participate directly and those discussed at OCC meetings or among OCC members;
       - Serving on the OCC for at least two years.
  3. The OCC Chairperson will then ask for a second for the nomination. If the nomination is seconded, the Committee members present will vote on the nomination.
     - Only candidates approved unanimously may join the OCC at the following meeting.
     - If there is one “nay” vote, the nomination will be tabled for further evaluation by the Co-Chairs and possible re-nomination if the dissenter decides, based on additional information, to withdraw his/her opposition.
If there is more than one “nay” vote, the nomination is rejected.

Community Members
- The OCC welcomes members from any of the communities served by MGH who have never been an employee, clinical staff member, or Trustee of MGH. The OCC has a minimum of two community members. Community members are voting members of the Committee.
- Community members must be nominated and approved in the same manner as staff members of MGH (see above).
- The potential community member must meet the following criteria both at the time of application and while serving on the OCC:
  1. Is not currently, and has never been, an employee or staff member of MGH or Partners Healthcare System;
  2. Not currently abusing alcohol or any illicit substances;
  3. No history of a conviction for a felony;
  4. Demonstrates high level of commitment to optimum care for patients with life threatening illnesses and strong motivation to serve as a community member on the OCC;
  5. Able to commit to attend at least 50% of regularly scheduled meetings;
  6. Willing to participate in the OCC’s protocol for resolving intractable conflict over life-sustaining treatment when this protocol is invoked;
  7. Able to understand and sign Partners HealthCare Confidentiality agreement; able to commit to maintain all information about OCC cases and MGH patients strictly confidential;
  8. Able to make at least a two year commitment to the committee.

Office of the General Counsel
- An attorney from Partners HealthCare System’s Office of General Counsel (OGC) may participate in OCC meetings to clarify legal questions and to provide a legal perspective on OCC cases when requested. The attorney from the OGC is a non-voting member.
- Law students who are mentored by Partners HealthCare System’s Office of General Counsel may accompany the legal representative to meetings as observers. It is the responsibility of the OGC to assure that law students who attend OCC meetings will keep confidential all information about MGH patients past or present and about MGH staff members and employees. As observers, law students may not participate in discussion of OCC cases or other OCC business at a meeting unless invited to do so by an OCC Co-Chair.

Visitors / Observers
- An MGH clinician or clinician in training, a student at the college level or higher who can demonstrate a strong interest in clinical ethics, or a clinical or ethics colleague from another institution, may request to sit in on one or more OCC meetings as an observer.
- There should be no more than four observers at a meeting unless special permission is obtained from the Co-Chairs.
- Observers may not participate in discussion of OCC cases or other business at an OCC meeting unless invited to do so by an OCC Co-Chair.
Attachment OOD 19.0 continued

- A current OCC member must propose a prospective observer at an OCC meeting. In general, this should be done at a meeting prior to the meeting(s) the prospective observer wishes to attend.
  1. When proposing an observer, the OCC member must describe her/his background and reason for requesting to observe the OCC.
  2. The OCC will vote on all prospective observers. Only prospective observers approved unanimously may attend an OCC meeting.
- The observer, if not a Partners’ employee, must sign a confidentiality agreement prior to attending an OCC meeting.
- Observers may not retain any of the Committee’s documents and must return them to the OCC Administrator upon leaving the meeting.
<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Department</th>
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<td>Abrams, Joshua, OGC</td>
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<tr>
<td>Allain, Rae M., MD</td>
<td>Anesthesiologist, Department of Anesthesia</td>
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<td>Ananian, Lillian, RN, PhD(c)</td>
<td>Clinical Nurse Specialist, Medical ICU (Blake 7)</td>
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<td>Anesi, George L. MD</td>
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<td>Brendel, Rebecca W., MD</td>
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<td>Brien, Barbara D., RN</td>
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<td>Cist, Alexandra F.M., MD</td>
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<td>Dee, Roberta, RN</td>
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Overall Objective
Provide consultation to patients, surrogates, physicians, nurses and interdisciplinary professionals during times of conflict at end of life. The OCC will also consider clinical consultations that are not end of life. The committee is also responsible for the content of MGH policies, as follows:

- End of Life Care Policy
- Life Sustaining Treatment Policy
- Life Sustaining Treatment Policy: Resolving Intractable Conflict

Leadership
Ellen M. Robinson RN PhD (Co-Chair)
Eric Krakauer MD PhD (Co-Chair)
Cornelia Cremens MD (Interim Co-Chair)
Alexandra Cist MD (Education Coordinator)
Rosemarie Lemole (Acting Administrative Assistant)

Membership
The OCC is comprised of interdisciplinary membership, including physicians, nurses, social workers, chaplains, rehabilitation professionals, respiratory therapists and community members. Patients, families or clinicians can place an OCC consult. Any professionals that wonder about the ‘fit’ of their request to the OCC can page Ellen Robinson RN PhD, Alexandra Cist MD, Marilyn Wise MSW or Mary Zwirner MSW to talk over the case, to determine if the request is appropriate. Occasionally, clinicians want to talk about the case, and consider a consult, but express fear in doing so. In such cases, talking with one of the persons named above can lead to a good strategy to place the consult. The message is this: Do not hold back in a state of ‘moral distress’, rather, reach out to an ethics resource for assistance and support!!

Consult Procedure
- OCC Consults are taken Monday through Friday, 8 AM to 4:30 PM
- Monday or Friday, page Ellen Robinson to place consult
- Tues, Wed, Thurs, call Ms. Rosemarie Lemole @ 617-726-1854
- The following information will be requested, when a consult is called:
### OCC CONSULT REQUEST

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<tr>
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<tr>
<td>DOB</td>
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<tr>
<td>MR #</td>
<td>Social Work Involved (?)</td>
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<tr>
<td>Age</td>
<td>Chaplaincy Involved (?)</td>
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<tr>
<td>Diagnosis</td>
<td>PT / OT / SLP Involved (?)</td>
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#### REASON FOR CONSULT

- OCC consultants will interview stakeholders in the case, including interdisciplinary team members and patient/surrogates
- OCC consultants may recommend a team meeting and/or team-family meeting
- OCC consultants will enter a note into medical record that includes an ethical analysis and recommendations.
- OCC consultants will follow up as needed
- The committee meets once per month to review consults.

Some Examples of OCC consults would include:

- A patient is approaching end of life, and the family does not seem to understand this. Usual measures of trying to assist the family have failed.
- A patient has had a procedure, and does not seem to be recovering. As a clinician, you believe that all signs point to end of life. Others on the team do not agree with you/others. Usual measures of team discussion are not working.
- A patient is very ill, and has an advance directive, but it is unclear if prognosis meets the terms of the patient’s advance directive.
OPTIMUM CARE COMMITTEE
Meeting Minutes
Thursday, April 5, 2012

MEMBERS PRESENT:
Paul Arnstein, RN, PhD, Alex F.M. Cist, MD, Ellen Robinson, PhD, RN, Kitty Craig-Comin, MSW, Jennifer Mello, SLP, Ellen diBonaventura, MS, RD, LDN, Alice Dubois, RN, NP; Sharon Brackett, RN, Marilyn Wise, MSW, Guy Maytal, MD, Ellen Fitzgerald, RN, MS, Cornelia Cremens, MD, Jennifer Repper Delisi, RN, Pamela Grace, RN, PhD, Roberta Dee, RN, Emel Anne Ergul, PhDc, Barbara Brien, RN, Emily Rubin, MD, JD, AnneKathryn Goodman, MD, Mary Zwirner, MSW, Arnold Messing

MEMBERS ABSENT:
George Anesi, MD, Rae Allain, MD, Lillian Ananian, RN, PhDc, Rebecca Brendel, MD, JD, Melissa Brennan, JD, Timothy Ferris, MD, Sara Fisher, RN, David Hwang, MD, Elizabeth Johnson, RN, Ron Hirschberg, MD, Rev. Patti Keeler, Steven Levisohn, MD, Jessica McCannon, Eric Rosenthal, MD, Margot Scheuren, Robert L. Sheridan, MD, Michael Wilson, MD, Yasmin Khalili, RN, Lori Lucas, RN, Eric Krakauer MD, Rev. Angelika Zollfrank; Andrew Courtwright, MD, PhD, Emily Rubin, MD, JD

1. Review and Approval of April 5, 2012 Minutes
2. Welcome: Emel Anne Ergul, PhD
3. New Members recommended & approved: Jason Telles, RN, NP

Ongoing Notices (Consent Agenda)

a. Announcement for Harvard Bioethics Course: June 13-15, 2012. Optimum Care members are encouraged to attend this course as one component of ethics training, especially if you come to committee without significant preparation in clinical ethics. Email DME@hms.harvard.edu for more information, or visit website http://medethics.med.harvard.edu
b. Announcement of Harvard Medical School Division of Medical Ethics Fellowship in Medical Ethics 2012-2013. Applications due April 9. Email inquiries to Helena Martins at Helena_martins@hms.harvard.edu

4. Life Sustaining Treatment: Resolving Intractable Conflict Policy
   a. Dr. Alexandra Cist gave a summary power point presentation about this policy, including purpose, roles, responsibilities, aim for due process and hoped for outcomes in cases with intractable conflict.

5. Case Discussions

OCC Consults:

- MICU Case discussion led by E. Rubin, MD, JD, and E. Robinson, RN, PhD. Clinicians caring for believe that he is chronically critically ill, and approaching the end of his life. His kidneys are failing. He is dependent upon mechanical ventilation, and he is primarily responsive with signs of pain, to nursing & respiratory intervention. The patient’s spouse seems to acknowledge this, when alone with nursing and social work. The patient’s adult children, with
son as Spokesperson, insist on full life sustaining treatment. Debate re: limiting life sustaining treatment via Resolving Conflict Policy, or MGH LST 2.5.8. Many factors considered in discussion. After a team-family-OCC meeting on March 30 in MICU, it was decided that the patient’s status would be monitored over weekend. A full code was still in place. The family was informed about Intractable Conflict Policy, and a copy was provided to them. They were told that if the patient remained semi-stable in his chronically critically-ill state over the weekend, that this due process approach would be invoked in Week of April 1st. They were also informed, however, that if condition deteriorated over weekend that he would not be cardiac resuscitated, and they were given a copy of MGH LST Policy 2.5.8. They continued to request full LST. Renal physicians informed them at this meeting that dialysis was contra-indicated, given that use of dialysis could actually hasten his death given his critical co-morbidities. The OCC was informed of possible invocation of Resolving Intractable conflict Policy. Dr. Alexandra Cist agreed to facilitate the process. The series of meetings was scheduled for April 4, 2012. On 4/3/12, the attending physician informed the family that cardiac resuscitation would not be provided, as it was believed that death was relatively imminent. OCC continued to follow the patient’s case, touch base with family, and support clinicians.

- Bigelow 7. Consult done by J. Repper Delisi, RN, J. McCannon, MD, & E. Robinson, RN, PhD. Discussion led by J. Repper Delisi, RN, with input from AK Goodman, MD, and E. Robinson, RN, PhD. Patient had terminal endometrial cancer, complicated by challenging behavior pattern. Mother of two adult children (one married son in CA, who was present for most of this admission, and a daughter in college). The patient was cachectic, frail, and believed to be approaching her death. She wanted chemotherapy and full code status. GYN Oncology requested OCC involvement to provide opinion re: ethical justification to refuse to provide chemo and resuscitation when patient was requesting both; OCC believed team should ‘first, do no harm’ and thus supported the limitations in life sustaining treatment. Patient did not fully accept this, and spoke of her desire to travel by car to California with her son. This plan was distressing to staff, who managed a delay. The son believed that he should honor his mother’s wishes. Many emotional factors influencing the son’s response. Ultimately, this did not happen. Son agreed to discharge to a facility in Chestnut Hill, and the patient expired 10 hours later.

Meeting adjourned at 6:40 PM.

Respectfully submitted,
Ellen M. Robinson, 4-1765
OCC Co-Chair
## Ethics in Clinical Practice Members

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<tr>
<th>Name</th>
<th>Title</th>
<th>Department/Unit</th>
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<tr>
<td>Alexander, Gail</td>
<td>RN</td>
<td>Norman Knight Nursing Center (POB 4)</td>
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<td>Amihan, Janice Lalitha Serio</td>
<td>RN</td>
<td>Neuroscience (Lunder 7-formerly White 12)</td>
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<td>Andrade, Melanie</td>
<td>RN</td>
<td>General Surgery (Phillips 22)</td>
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<td>Barrett, Adam</td>
<td>RN</td>
<td>Surgical ICU (Ellison 4)</td>
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<td>Black, Lynn</td>
<td>MD</td>
<td>Medical walk in (Wang 1)</td>
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<td>Brackett, Sharon</td>
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<td>Emergency Department (Lunder 1/White 1)</td>
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<td>Cist, Alexandra</td>
<td>MD</td>
<td>Pulmonary and Critical Care Medicine (Cox 2/ Blake 7)</td>
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<td>Cupp, Debbie</td>
<td>RN</td>
<td>Cardiac Medicine (Ellison 10)</td>
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<td>Curran, Marjorie</td>
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<td>Pediatrics (Yawkey 6)</td>
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<td>Donahue, Kathleen</td>
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<td>Radiation Oncology (Cox LL/Lunder LL 2&amp;3)</td>
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<td>Social Services (Wang 037)</td>
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Advance Care Planning Task Force  
Wed. December 17, 2008 1:30pm-3:00pm  
Ellison 4 SICU Conference Room  
Meeting Minutes

Presiding: S. Brackett, RN  
Members Present: P. Bergschneider, RN, T. Evans, RN, K. Hobrecker, C. Lasala, RN, S. Warchal, RN  
Members Excused: A. Cist, MD, E. Robinson, RN, PhD, C. Weaver, RN  
Guests: Mel Heike, RN, Staff Specialist  
Minutes: The minutes of November 19, 2008 were accepted without edits.

Updates/Ongoing Business:
Medical Interpreters ACP training: K. Hobrecker from Interpreter Services looked into logistics. There are 37 staff interpreters and 60 on call interpreters. Goal for 2009: uniform, basic ACP training to 100% staff interpreters and at least 50% on call in common languages. Will need to schedule several sessions as only 10-15 can attend at a time due to patient care needs. 
Action: S. Brackett, RN, will pull together some slides from previous presentations for a powerpoint. K. Hobrecker will confer with interpreters to develop a list of FAQs and common issues/concerns encountered. Aim for March for first session to allow time for planning and development of presentation. Due to time constraints on staff clinicians will need more volunteers trained in ACP to help present the number of sessions. Email to facilitators resulted in C. Lasala, RN, Lorraine Drapek, RN, NP, Donna Slicis, RN, and A. Cist, MD, offering to help facilitate some of the sessions. 

National Health Care Decision Day 2009: Scheduled for April 16. Discussions are ongoing between C. Lasala, RN, T. Pittman, RN, and S. Paiva to coordinate with HOPES and Yawkey Cancer Center. 
Action: C. Lasala, RN, will follow-up after January 1st.

New Business:
Blog rally on Thanksgiving Day for “Talking Turkey”: S. Brackett, RN, passed out copies of a Boston Globe article on November 26 about a blog rally that was taking place to educate and encourage the public about the importance of completing an advance directive. 
Action: Contact S. Brackett, RN if you would like more information or a link to the article.

Guest Mel Heike, RN, re: proposed changes to advance directive policy: M. Heike, RN, described a background to the proposed changes. The policy and questionnaire have been edited to address issues noted during last JCAHO visit and with recent Greeley review. As a Staff Specialist working with Deb Burke, RN, Associate Chief Nurse, M. Heike, RN has been charged with reviewing all of the CMS, JCAHO, and MGL regulations and to revise the policy to assure compliance but at the same time make it more concise. ACPTF members reviewed the changes and rationales with M. Heike, RN, and agreed the new versions of the policy and questionnaire is clearer and more concise. Two small edits/additions were made: section 2.2.2 add The Blum Center as a resource for information rather than Office of Patient Advocacy; section 2.8 change the word “dispute” to question to soften the wording in support of staff acting as witnesses. S. Brackett, RN, raised a concern re section 3.1 and removing the portion about responsible physician documenting patient incapacity. 
Action: S. Brackett, RN, will double check MGL to determine if documentation of incapacity is necessary. M. Heike, RN, will take the edited policy to Clinical Policy and Procedure Committee on Friday and then Medical Policy Committee for final approval.
## Pediatrics Ethics Committee Members 2012

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<thead>
<tr>
<th>Last Name</th>
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<th>Role</th>
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<td>Joshua</td>
<td>JD</td>
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<td>Beauchamp</td>
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<td>John</td>
<td>PhD</td>
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The topic has declared itself, as it has come up repeatedly the last few weeks with a current case.

"Blood Transfusion in a child with a Jehovah's witness parent: Parental beliefs and ethical and legal obligations of caregivers"

Here is some reading:

Wikipedia does a nice readable summary of the Jehovah's beliefs about blood and some of the background on the WatchTower Society that declares what is acceptable for members:
http://en.wikipedia.org/wiki/Jehovah%27s_Witnesses_and_blood_transfusions

Here is the AAP stance on our obligations to minors in these situations.

Here is a nice ethical discussion from one of Bioethics main pillars, using JEW in a child as an illustrative example of how best interests in children must supersede parental autonomy:

And finally, while many legal cases have declared the legal role of states protecting children when these conflicts occur (many in MA itself), I will just provide a well cited quote from a prominent decision:

“the right to practice religion freely does not include liberty to expose … a child … to ill health or death. Parents may be free to become martyrs themselves, but it does not follow that they are free … to make martyrs of their children before the children reach the age of full and legal discretion when they can make that choice for themselves” (Prince vs. Massachusetts, 321 US 158, 166, 1944).
Hope to see you Tuesday!

Pediatric Ethics Committee Meeting

Tuesday, May 15, 2012

1:30 - 2:30 p.m. White 6

"The David Todres" Conference Room

Brian Cummings, MD, Co-Chair
Brenda Miller, RN, Co-Chair