NEW YORK CITY HEALTH & HOSPITALS CORPORATION

NAME OF ACUTE CARE FACILITY: _____

WITHHOLD/WITHDRAW LIFE SUSTAINING TREATMENT (WW) AND NON-RESUSCITATION (NR) DOCUMENTATION FORM FOR ADULT PATIENTS

**Do Not Use This Form For Mentally Retarded or Developmentally Disabled Patients. Special Rules Apply For Mentally Ill Patients [SEE BACK].**

**Patient Name:**

**Medical Record Number:**

**1. Determination of Patient's Decisional Capacity to Make Healthcare Decisions.**

To a reasonable degree of medical certainty, the patient lacks capacity to make this health care decision. The cause* and extent of the patient's incapacity are:

_____.

Incapacity is likely to be: [Check one] (1) Temporary _____ (2) Permanent _____ (3) Unknown _____

| | | | | |
|---|---|---|---|---|
| _____ | _____ | _____and _____ | | am |
| Attending Physician | Signature | Date | Time | pm |
| _____ | _____ | _____and _____ | | am |
| Concurring Attending Physician | Signature | Date | Time | pm |

*If the cause of incapacity is mental illness, Special Rules Apply [SEE BACK].

**2. Identification of Decision-Maker.**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Decision-Maker Name | Address | Telephone Number |

Relationship: [Check one]

(1) _____ Health Care Agent/Proxy [SKIP TO STEP 4].

(2) _____ FHCDA Surrogate [GO TO STEP 3, THEN COMPLETE STEP 4].

(3) _____ No Health Care Agent or Surrogate ("Decision-Maker")[SKIP TO STEP 5].

**3. Decision-making Standard for Patient Who Lacks Capacity and Has a Surrogate. [Check one Set of Criteria]**

____ **CRITERIA A**

1. To a reasonable degree of medical certainty:
   ____ (A) the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided;
   **OR**
   ____ (B) the patient is permanently unconscious;
   **AND**
2. Treatment would be an extraordinary burden to the patient.

____ **CRITERIA B**

1. To a reasonable degree of medical certainty the patient has an irreversible or incurable condition;
   **AND**
2. The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances.

| | | | | |
|---|---|---|---|---|
| _____ | _____ | _____and _____ | | am |
| Attending Physician | Signature | Date | Time | pm |
| _____ | _____ | _____and _____ | | am |
| Concurring Attending Physician | Signature | Date | Time | pm |

**4. Consent of Decision-Maker.**

The decision-maker has participated in a discussion of the patient's medical condition as indicated [SEE BACK, 4], understands the alternatives and chooses and consents to: [Check all that apply]

1. _____ Non-resuscitation Order (NRO);
   **AND/OR**
2. _____ Withhold/Withdraw Order (WWO) for the following interventions: _____

_____.

| | | | | |
|---|---|---|---|---|
| _____ | _____ | _____and _____ | | am |
| Attending Physician | Signature | Date | Time | pm |

**5. Threshold for Patient Without Capacity and Without a Decision-Maker. [Check all that apply]**

_____To enter a Non-resuscitation Order: I have determined, to a reasonable degree of medical certainty, that (i) in the event of cardiac arrest or the need for intubation, CPR or intubation would offer the patient no medical benefit because the patient will die imminently, even if the treatment is provided; AND (ii) the provision of CPR or intubation under the circumstances would violate accepted medical standards and would be an extraordinary burden to patient.

_____ To order the withdrawal or withholding of the following life-sustaining treatment: _____

_____, I have determined, to a reasonable degree of medical certainty, that (i) the treatment would offer the patient no medical benefit because the patient will die imminently, even if the treatment is provided; and (ii) the provision of the treatment under the circumstances would violate accepted medical standards and would be an extraordinary burden to the patient.

| | | | | |
|---|---|---|---|---|
| _____ | _____ | _____and _____ | | am |
| Attending Physician | Signature | Date | Time | pm |
| _____ | _____ | _____and _____ | | am |
| Concurring Attending Physician | Signature | Date | Time | pm |

## PRACTITIONER GUIDE: FOR ADULTS WITHOUT DECISIONAL CAPACITY IN ACUTE CARE HOSPITAL

### Appropriate use of the form for Withholding and Withdrawing Orders and Non-Resuscitation Orders

Practitioners should use this guide to address questions in implementing the WW/NR Form. The discussions are numbered to match the form.

Note #1: This Form and Guide are designed for acute care hospitals treating adult patients. **This form should not be used for a patient**: 1. who has a history of receiving services for mental retardation or a developmental disability; 2. where it reasonably appears that the patient has mental retardation or a developmental disability. Special rules apply where the attending physician has reason to believe that the patient has been transferred from a mental hygiene facility operated or licensed by the office of mental health (see below). Long term care facilities should use a form appropriate for these institutions.

Note #2: The Family Health Care Decisions Act [FHCDA] recognizes a valid Health Care Agent/Proxy as the first empowered substitute decision maker. In the case where the patient's wishes regarding the administration of artificial nutrition and hydration are not reasonably known and cannot with reasonable diligence be ascertained, such agent is not authorized to make such decisions. However, such person may be able to make such decisions as a surrogate under the FHCDA.

Note #3: Please refer to Risk Management and, where applicable, to Bioethics for consultation if: a) the patient disagrees or objects to the determination or decision; b) if there is a conflict involving members of the care team, patient or family; or c) there is a prior treatment decision by the patient.

**1. Is the patient capable of making health care decisions?**

Decisional capacity is not an on/off switch. It varies with the complexity and consequence of the decision. The more complicated and important the decision, the more capacity the patient needs to address the elements of the decision, the risks and the alternatives. In order to be capacitated the patient must be able to: (A) Engage with staff and evaluate information; (B) Apply personal values; and (C) Communicate a decision. Some patients may exhibit fluctuating capacity and may be capacitated at some times and not at others. This should be noted in the chart and staff should engage the patient at those times of greatest lucidity.

**For Patients Who Lack Decision-Making Capacity Due to Mental Illness.** If the attending physician makes a determination that the patient lacks capacity due to mental illness, the physician must have the following qualifications, or another physician with such qualifications must make an independent determination, to a reasonable degree of medical certainty, whether the patient lacks decision-making capacity: the physician must be licensed in New York State and be a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology, or certified by the American Osteopathic Board of Neurology and Psychiatry, or eligible to be certified by that Board.

**2. Identification of decision-maker:**

**A. The priority list for decision maker is:** 1. appointed Health Care Agent/Proxy; 2. legal guardian (review paperwork w/risk management); 3. spouse, if not legally separated from the patient, or domestic partner; 4. adult children; 5. parent; 6. adult siblings; 7. close friends which may include extended family members such as in-laws, cousins, etc., where the person has documented sufficiently their relationship to patient. (Note: Generally, NYS law does not recognize Common Law marriage but such person may qualify as a FHCDA surrogate by being a domestic partner or close friend.)

**B. Notice of a determination** that a Health Care Agent/Proxy will make health care decisions because the adult patient has been determined to lack decision-making capacity shall promptly be given: (a) to the patient, orally and in writing, where there is any indication of the patient's ability to comprehend such notice; (b) to the Health Care Agent/Proxy; (c) if the patient is in or is "transferred" from a mental hygiene facility, to the facility director; and (d) to the conservator for, or committee of, the patient. Priority of the patient's decision: Notwithstanding a determination pursuant to this section that the patient lacks capacity to make health care decisions, where a patient objects to the determination of incapacity or to a health care decision made by a Health Care Agent, the patient's objection or decision shall prevail unless the patient is determined by a court of competent jurisdiction to lack capacity to make health care decisions.

**C. Notice of a determination** that a surrogate under the FHCDA will make health care decisions because the adult patient has been determined to lack decision-making capacity shall promptly be given: (a) to the patient, where there is any indication of the patient's ability to comprehend the information; (b) to at least one person on the surrogate list highest in order of priority listed when persons in prior classes are not reasonably available; (c) if the patient was "transferred" from a mental hygiene facility (usually a State operated facility), to the director of that mental hygiene facility and to its office of mental hygiene legal service.

**3. Standards when patients are without capacity and the decision maker is an FHCDA surrogate:**

Medical care providers often ask patients to undergo pain and suffering for the benefit of greater health and well-being. However, there are times when medical intervention is not supportable. **Criteria A:** Treatment is likely to be an extraordinary burden when the benefits of the intervention are greatly outweighed by the burden of pain, suffering and distress and the intervention is unlikely to benefit the patient. **Criteria B:** When the patient has an irreversible or incurable condition and the contemplated intervention would cause harm by increasing suffering, go against standard medical practice, such care would be deemed inhumane. These factors together constitute inhumane treatment and make its foregoing morally supportable. It should be noted that palliative care is always an available option in the aforementioned instances.

**4. Counseling the decision-maker:**

I, as the attending physician have had a discussion with the decision-maker explaining the diagnosis and the prognosis, the alternative treatments and the risks and benefits of those treatments. I have encouraged questions and discussions and have asked questions about the patient's wishes, including the patient's religious and moral beliefs. I have helped the decision-maker to think about the best interests of the patient if it is not clear what the patient would have wanted including considering: the dignity and uniqueness of every person; the possibility and extent of preserving the patient's life; the preservation, improvement or restoration of the patient's health or functioning; the relief of the patient's suffering; and any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider. I have been alert to supporting the decision-maker and shouldering the burden of this decision without disempowering the decision-maker. I emphasized that all measures of comfort for the patient will be provided. I understand that this is a difficult decision for the decision-maker and I am committed to helping this person to bear this burden without guilt.

**5. Patients without a decision-maker:**

**Occasions for considering ad-hoc bioethics consultations:** Patients who are alone in the world have no non-medical advocates. Decisions about their care must be based upon a consideration of all the options that would be examined for patients with a decision-maker. As the culture of medicine exists in support of health and life, and as permitting death may yet be in the best interest of the patient, it is often helpful to convene the members of the care team in order to permit all medical voices to be heard and to reach a consensus that WWO or the NRO is appropriate