

**GRANDVIEW MEDICAL CENTER
ADMINISTRATION**

POLICY: MS-06

PROCEDURE:

RESPONSIBILITY: MEDICAL STAFF

ORIGINAL ISSUE: 11/99

DEPARTMENTS AFFECTED: ALL PATIENT CARE AREA's

REVISIONS: 12/99, 3/01

APPROVAL: _____

President

**SUBJECT: WITHHOLDING/WITHDRAWAL OF LIFE SUSTAINING
TREATMENT**

POLICY:

The hospital recognizes the rights of adult patients to informed self-determination. This includes the right to request the withholding or withdrawal of specific treatments or procedures that may or may not be deemed life-sustaining. This also includes the right of each patient or surrogate to have sufficient information in order to make such decisions. Whenever life-sustaining treatment is withdrawn, withheld, or limited, the action should be based on sound medical practice and accompanied by a plan for supportive care. In the absence of written orders to the contrary, resuscitation should always be given in the event of cardiac or respiratory failure if medically appropriate.

DEFINITIONS:

- A. **ADVANCE DIRECTIVE:** Any document recognized under state law and which relates to the provision, withdrawing or withholding of medical treatment in the event the maker loses the capacity to make such decisions. The term "advance directive" encompasses both a living will and/or a durable power of attorney for health care.
- B. **ATTENDING PHYSICIAN:** The physician who has accepted and to whom a patient, or his/her family, has assigned primary responsibility for the treatment or care of the patient, or, if the patient or his/her family has not assigned that responsibility, the physician who has accepted that responsibility.
- C. **COMFORT CARE:** Artificially or technically administered nutrition or hydration when administered to diminish pain or discomfort, not to postpone death, and any

other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish pain or discomfort, not to postpone death. Examples in the Ohio DNR Comfort Care rules include suctioning of the airway, administration of oxygen, positioning for comfort, splinting or immobilization, controlling external bleeding, providing pain medicine, emotional support and contact of appropriate health care providers.

- D. **CONSULTING PHYSICIAN:** Consulting Physician means a physician who in conjunction with the attending physician makes a determination as to the patient's mental capacity, diagnosis or prognosis. In determining whether a patient is in a permanently unconscious state, the consulting physician shall be a specialist in neurology, neurosurgery or psychiatry and who is qualified to make such a determination.
- E. **DECISIONALLY-CAPABLE ADULT PATIENT:** A person eighteen (18) years of age or older, or an emancipated minor, who is conscious, able to understand the nature, severity, risk and alternatives associated with his/her condition and able to make informed health-care decisions for himself/herself.
- F. **DURABLE POWER OF ATTORNEY FOR HEALTH CARE:** A document in which a person designates another individual (called the attorney-in-fact) as a surrogate decision maker to make health care decisions for that patient whenever the patient has lost the capacity to make such decisions for himself/herself.
- G. **LEVEL OF CARE ORDERS :**
 - 1. **FULL SUPPORT (FULL CODE) -** Unless otherwise ordered, all patients will be in this group in the event of a cardiopulmonary arrest. Full support includes CPR (Cardiopulmonary Resuscitation), ACLS (Advanced Cardiac Life Support) protocols, mechanical ventilation, vasopressors, ICU care if necessary, plus all means of support judged appropriate by the physician.
 - 2. **DNR COMFORT CARE-ARREST (NO CODE WILL BE CALLED) -** All treatment may be implemented as determined or judged appropriate by the physician except in the event of a cardiopulmonary arrest, no code will be called, i.e., cardiopulmonary resuscitation will not be initiated and the patient will be treated as DNR Comfort Care.
 - 3. **DNR Comfort Care -** Per the DNR Comfort Care protocol, only comfort care will be provided, this includes suctioning of the airway, administration of oxygen, positioning for comfort, splinting or immobilization, controlling external bleeding, providing pain medicine, emotional support and contact of appropriate health care providers. The following will not be initiated: chest compressions, insertion of artificial airway, administration of resuscitative drugs or IV, defibrillation or cardioversion, respiratory assistance, and cardiac monitoring. Existing treatments should be reviewed for appropriateness, cardiac monitoring should not continue.
- H. **LIFE-SUSTAINING TREATMENT:** Any medical procedure, treatment, intervention or other measure that, when administered to a patient, will serve principally to prolong the dying process.

- I. **LIVING WILL:** A document or declaration governing the use or continuation, or the withholding or withdrawal, of life sustaining treatment. A living will becomes operative when (i) the living will is communicated to the attending physician, (ii) the attending physician and the Consulting Physician determines that the patient is in a terminal condition or permanently unconscious state, and (iii) the Attending Physician determines that the patient is no longer able to make informed decisions regarding the administration of life sustaining treatment and there is no reasonable possibility that this patient will regain such capacity.
- J. **PATIENT WITH LACK OF DECISIONAL CAPABILITY:** A person who lacks decisional capabilities and is incapable of understanding the nature, severity, risks and alternatives associated with his/her illness or is unable to make informed health-care decisions for himself/herself. Patients should be involved, however, in the decision-making about care and treatment to the extent of their capabilities.
- K. **PERMANENTLY UNCONSCIOUS STATE:** A state of permanent unconsciousness that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the Attending Physician and one Consulting Physician examining the patient, is characterized by both of the following: (1) An irreversible lack of awareness of the self and environment; and (2) a total loss of cerebral cortical functioning, resulting in the patient's having no capacity to experience pain or suffering.
- L. **TERMINAL CONDITION:** An irreversible, incurable and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by both the Attending Physician and one Consulting Physician examining the patient, both of the following apply: (1) There can be no recovery; and (2) Death is likely to occur within a relatively short time if Life-Sustaining Treatment is not administered.

GUIDELINES:

A. APPLICATIONS

Any Decisionally-Capable Adult Patient has the right to refuse any medical intervention, including life-saving procedures. After careful consultation between the patient and the attending Physician, a decision on any medical intervention, including Life-Sustaining Treatment, is made by the patient. The physician should note in the medical record the mental condition of the patient, and reference to the discussion which led to an informed decision, along with the appropriate orders.

A Decisionally-Capable Adult Patient who makes a decision to forego any treatment, including Life-Sustaining Treatment, always has the right to change or revoke such a decision. If the Decisionally-Capable Adult Patient later becomes decisionally incapable, his/her previously expressed decision(s) should ordinarily be respected unless a change in the physical condition of the patient has significantly decreased the benefit to the patient of the health care or is no longer effective in achieving the purposes for which the patient consented to its implementation.

For a Decisionally-Capable Adult Patient, the consent of family members is not necessary. Family disagreement with the patient's decision is not sufficient to override the patient's informed choice.

Hospital personnel and health care practitioners are never required to take action that is contrary to reasonable medical standards. In addition, these guidelines do not limit the authority of a physician to provide treatment to a patient in accordance with reasonable medical standards in an emergency situation. If the Attending Physician or the Medical Center is unable to comply as a matter of conscience with the instructions in a living will or of an attorney-in-fact, the Attending Physician and the Medical Center will cooperate in the transfer of the patient to the care of a physician or health care facility that is willing and able to comply.

Ohio Revised Code Section 1337.11, et seq. (Durable Power of Attorney for Health Care) and Section 2133.01, et seq. (Living Will) and ORC 2133.21, et seq. (DNR) provide the statutory mechanisms to determine the validity, scope and procedures for the implementation of advance directives and DNR orders in Ohio. If the statutory requirements are met, immunity is generally provided. This is not to say that there is liability if the statutory requirements are not followed, nor is it to say that other procedures may not be equally appropriate for making decisions concerning the implementation, continuance, withholding or withdrawal of life sustaining treatment in patients in a terminal condition or permanently unconscious state.

The following sections of this policy attempt to synopsize the Ohio statutory procedures. The actual provisions of the Ohio Revised Code, of course, control, and any question concerning the actual statutory requirements and their implementation to a particular situation should be referred to the Patient Relations Department for review by the Medical Center's counsel.

B. PROCEDURE FOR LIVING WILL

The following outline summarizes the Ohio statutory requirements concerning the conditions which should exist and procedures which should be followed in connection with the implementation of a living will (declaration).

1. The Attending Physician determines that:
 - a. The patient no longer can make informed decisions regarding administration of Life-Sustaining Treatment.
 - b. There is no reasonable possibility of the patient's regaining the capacity to make informed decisions regarding the patient's health care or the administration of Life-Sustaining Treatment.
 - c. The treatment or intervention being considered for withholding or withdrawal is not providing the patient Comfort Care.
 - d. The patient is not pregnant. If the patient is pregnant, then Life-Sustaining Treatment may not be withheld or withdrawn if this would terminate the pregnancy, unless the Attending Physician and one Consulting Physician determine that the fetus would not be born alive in any case.

- e. The patient has executed a valid Living Will governing the use or continuation, or the withholding or withdrawal, of Life-Sustaining Treatment.
- 2.
- a. The patient is determined by both the attending and the consulting physicians to be in either a terminal condition or permanently unconscious state or both and the living will is applicable to the patient's condition as so determined.
 - b. The Attending Physician provides notification of the determinations and of any action to be taken under authority of the Living Will, to:
 - (1) The individuals named by the patient in the Living Will, if any; or, if none,
 - (2) The appropriate individual(s), in accordance with the following descending order of priority:
 - (a) Any guardian of the patient
 - (b) The patient's spouse
 - (c) The patient's adult children who are available within a reasonable period of time for consultation.
 - (d) The patient's parents
 - (e) A majority of the patient's adult siblings who are available within a reasonable period of time for consultation.
 - c. Following the giving of the notification, if the Attending Physician (a) receives affirmative notifications from the persons receiving notice and persons in the next two classes of priority individuals as provided above (or the first class of priority individuals if the person receiving notice was named in the living will) that none of them objects to the action proposed to be taken under the authority of the living will, or (b) does not receive any objection within 48 hours, then the attending physician may proceed in conformity with the directions contained in the living will.
 - d. If the Attending Physician receives an objection within the 48 hour period, then the matter should be promptly brought to the attention of the Hospital administration, for legal consultation.
 - e. The Attending Physician promptly records in the patient's medical record:
 - (1) Acknowledgment of the Living Will
 - (2) All determinations
 - (1) The information conveyed, and all responses.
 - (2) If unsuccessful
 - (a) The reason for the failure
 - (b) The efforts and diligence used.

C. PROCEDURE FOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE

The following outline summarizes the requirements of the Ohio Revised Code in connection with allowing an attorney-in-fact under a durable power of health care to make decisions involving the use, continuation, withholding or withdrawing of life sustaining treatment, including requirements for the withdrawal of nutrition or

hydration. It should be noted that an attorney-in-fact can, within the limits of the authority granted in the power of attorney, make all decisions on behalf of the patient whenever the patient has lost the capacity to make informed health care decisions and that the following requirements apply only in situations involving the use, continuation, withholding or withdrawing of life sustaining treatment.

1. The Attending Physician determines that:
 - a. The patient has lost the capacity to make informed health care decisions; and
 - b. There is no reasonable possibility that the patient will regain the capacity to make informed health care decisions; and
 - c. The patient has a valid Durable Power of Attorney for Health Care.
2.
 - a. The Attending Physician and one other Consulting Physician determine that the patient is in a Terminal Condition; or
 - b. The Attending Physician and one Consulting Physician determine that the patient is in a Permanently Unconscious State.
3. The Attending Physician provides notification of the determinations and of any health care decisions, to the appropriate individual(s) in accordance with the following descending order of priority:
 - a. Any guardian of the patient;
 - b. The patient's spouse;
 - c. The patient's adult children who are available within a reasonable-period of time for consultation.
 - d. The patient's parents.
 - e. A majority of the patient's adult siblings who are available within a reasonable period of time for consultation.

If the only individual who would be notified under the above list is the Attorney-in-Fact, then this should be noted in the medical record.

4.
 - a. Following the giving of the notification, if the Attending Physician (a) receives affirmative notifications from the persons receiving notice and persons in the next two classes of priority individuals as provided above (or the first class of priority individuals if the person receiving notice was named in the living will) that none of them objects to the action proposed to be taken under the authority of the living will, or (b) does not receive any objection within 48 hours, then the attending physician may proceed in conformity with the directions contained in the living will.
 - b. If the attending Physician receives an objection within the 48-hour waiting period, then the matter should be promptly brought to the attention of Hospital administration, for legal consultation.
5. The Attending Physician promptly records in the patient's medical record:
 - a. Acknowledgment of the Durable Power of Attorney for Health Care;
 - b. All determinations;
 - c. All health care decisions;
 - d. All notifications

- e. Names of individuals notified
 - (1) The manner of notification
 - (2) The information conveyed, and all responses.
 - (3) If unsuccessful
 - (a) The reason for the failure
 - (b) The efforts and diligence used.

- 6. The Attorney-in-Fact designated by the patient makes health care decisions the same as the patient would if competent, with certain limitations and exceptions as outlined below.
 - a. In making decisions, the Attorney-in-Fact is to act consistently with the desires of the patient, if known.
 - b. If the desires of the patient are unknown, the Attorney-in-Fact is to make decisions in the best interest of the patient.
 - c. The Attorney-in-Fact signs all necessary consent forms, on behalf of the patient.

- 7. The Attorney-in-Fact never has the authority to:
 - a. Withdraw informed consent for any health care to which the patient previously consented, unless:
 - (1) A change in the patient's physical condition has significantly decreased the benefit of that health care to the patient;
 - (2) The health care is not, or is no longer, significantly effective in achieving the purposes for which the patient consented to its use.
 - b. Refuse or withdraw consent to health care necessary to provide the patient with Comfort Care.
 - c. Refuse or withdraw consent to health care for a patient who is pregnant if this would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to the life of the patient, or the Attending Physician and one other physician determine that the fetus would not be born alive in any case.
 - d. Consent to the withdrawal of Life-Sustaining Treatment unless:
 - (1) The Attending Physician and one Consulting Physician determine that the patient is in a Terminal Condition *or in a permanently unconscious state*.
 - (2) The Attending Physician determines that there is no reasonable possibility of the patient's regaining the capacity to make informed health care decisions for himself.
 - (3) The Attending Physician attempts, in good faith, to determine the desires of the patient to the extent the patient is able to convey them, and places a report of the attempt in the patient's medical record.
 - e. Consent to the withdrawal of nutrition or hydration unless:
 - (1) The Attending Physician and one Consulting Physician determine that:
 - (a) The patient is in a Terminal Condition or a Permanently Unconscious State;
 - (b) Nutrition or hydration will not provide comfort or pain relief to the patient.
 - (2) And in the case of a patient in a permanently unconscious state, the Attending Physician determines that the patient has authorized the

Attorney in Fact to consent to the withdrawal of nutrition and hydration by including the necessary notations on the Durable Power of Attorney for Health Care.

- f. To consent to any procedure contrary to the provisions of the Power of Attorney.

D. PROCEDURE WHEN THERE IS NO ADVANCE DIRECTIVE

1. Section 2133.08 of the Ohio Revised Code makes the following general provisions for providing consent to the withholding or withdrawal of life sustaining treatment in the following circumstances when there is no advance directive document and the patient lacks decisional capability. Any questions should be referred to the hospital's legal counsel.
2. When the appropriate decision-maker has been identified, the physician will discuss decisions concerning the withdrawal of life sustaining treatment with him/her and appropriate orders will be written.
3. Patient must:
 - a. Be an adult
 - b. Not have a valid Living Will or a Durable Power of Attorney for Health Care.
 - c. Be unable to make informed decisions regarding administration of Life-Sustaining Treatment, as determined by the Attending Physician.
 - d. Have no reasonable possibility of regaining the capacity to make informed decisions regarding his health care or the administration of Life-Sustaining Treatment; as determined by the Attending Physician.
 - e. Be in a Terminal Condition, as determined by the Attending Physician and one Consulting Physician *or in a permanently unconscious state for at least 12 months.*
 - f. Not be pregnant, if limiting Life-Sustaining Treatment would terminate the pregnancy, unless the Attending Physician and one other physician determine that the fetus would not be born alive in any case.
4. Surrogate decision-maker must be:
 - a. Of sound mind;
 - b. An individual or group, as appropriate, drawn from the following list, in descending order of priority.
 - (1) any guardian of the patient;
 - (2) the patient's spouse;
 - (3) the patient's adult child; or a majority of adult children who are available within a reasonable period of time for consultation;
 - (4) the patient's parents;
 - (5) an adult sibling; or a majority of the patient's adult siblings who are available within a reasonable period of time for consultation;
 - (6) the nearest adult who is related to the patient by blood or adoption, and who is available within a reasonable period of time for consultation.

- c. Consent must be:
 - (1) Written;
 - (2) Witnessed by two adults, not related to the patient by blood, marriage or adoption, who are not the Attending Physician or the patient, and who are not the administrator of any nursing home in which the patient is receiving care;
 - (3) Given to Attending Physician;
 - (4) Given voluntarily and in good faith;
 - (5) Consistent with:
 - (a) The patient's previously expressed intentions, if any; or, if none.
 - (b) The patient's intentions as inferred from his lifestyle and character, and from any other evidence of the desires of the patient.
 - (6) Based on sufficient information received by the surrogate decision-maker from the Attending Physician to give informed consent.
- d. Other
 - (1) Other priority individuals may communicate within 48 hours to the Attending Physician any objection to a decision made by a surrogate. Such individual(s) then has/have two business days thereafter in which to file a complaint.
 - (2) In the event the Attending Physician has reason to doubt that a consent given by a surrogate decision-maker complies with the consent requirements and should there be no other means of resolving the problem within these Guidelines, then the Attending Physician should contact Hospital Administration so that a legal consultation may be obtained.
 - (3) Special procedures apply in cases of conflicts among members of a priority group.
 - (4) Special procedures apply in the case of withdrawing nutrition or hydration from a patient who has been in a Permanently Unconscious State for the immediately preceding twelve months.

E. DNR COMFORT CARE

1. General Statutory Scheme

- a. Substitute House Bill 354 was passed in April, 1998 and became effective July 9, 1998. This law amends the Ohio Living Will Declaration statute so as to address DNR situations. Ohio Department of Health prepared regulations to implement the statute.
- b. DNR order is communicated to health care providers by means of DNR Identification (DNR ID).
- c. DNR ID may be a wallet card, form, necklace, bracelet and the DNR order itself or a living will with appropriate language which has become "operative". The DNR ID will have the approved ODH logo.

- d. If the DNR ID or order is found, then reasonable steps are to be taken to make sure the patient is the person named. Reasonable efforts are:
 - 1. hospital ID bracelet
 - 2. verification of identity by family, friend or caregiver
 - 3. personal knowledge
 - 4. photo ID

- e. There are two types of DNR status:
 - 1. DNR Comfort Care—DNR protocol activated at the time of the DNR order
 - 2. DNR Comfort Care—Arrest—DNR protocol activated at the time of a cardiac or respiratory arrest

- f. If the DNR protocol is activated, then the following will be provided:
 - 1. suction the airway
 - 2. administer oxygen
 - 3. position for comfort
 - 4. splint or immobilize
 - 5. control external bleeding
 - 6. provide pain medication
 - 7. provide emotional support
 - 8. contact other appropriate health care providers
 The following will not be provided:
 - 1. administer chest compressions
 - 2. insert artificial airway
 - 3. administer resuscitative drugs
 - 4. defibrillate or cardiovert
 - 5. provide respiratory assistance (other than listed above)
 - 6. initiate resuscitative IV
 - 7. initiate cardiac monitoring

- g. DNR status can be revoked by the patient requesting resuscitation.

2. Immunity

- a. Immunity is provided to EMS workers or physicians or persons working at the direction or authorization of a physician in withholding CPR from a person possessing DNR ID.
- b. Immunity is provided to health care facilities, physicians and persons who work for health care facilities and who participate under the direction or with the authorization of the physician in the withholding of CPR pursuant to DNR ID or a DNR order.
- c. EMS and health care facility employees who comply with the DNR order are granted immunity.

3. Transfers

- a. Sending facilities are to inform receiving facilities of DNR status.
- b. DNR ID or order is to accompany a transferred patient.
- c. DNR ID or order remains in effect until it ceases to be current pursuant to the policies of a receiving facility.

- d. GVMC policy is to honor the DNR Comfort Care order upon transfer until the patient is examined by the attending physician and the DNR Comfort Care order is verified or changed.
4. Compliance
 - a. If the attending physician or the health care facility is unwilling or unable to comply with the DNR protocol, neither the facility or the physician shall delay the transfer to a different physician or facility which will follow the protocol.
 - b. Nothing in the ORC condones, authorizes or approves mercy killing, assisted suicide, or euthanasia.
 - c. It is a criminal offense to conceal, cancel a DNR ID; to falsify or forge a revocation of a living will that is the basis of a DNR ID, or to falsify or forge an order superseding a DNR order; to falsify or forge a DNR ID; or to conceal knowledge that a living will has been revoked or a DNR order rescinded.

F. IMPLEMENTATION AND DOCUMENTATION

1. The Advanced Directive is received and placed on the chart in accordance with Hospital Policy PR-06.
2. One of three Levels of Care may be ordered by the physician or recognized from an existing order: Full Support, DNR Comfort Care-Arrest, and DNR Comfort Care. This Level of Care order is signed by the Attending Physician and placed in the Level of Care section of the medical record. In an emergency situation nursing may accept a phone order or recognize an existing order, witnessed by a second nurse, and signed by the Attending Physician within 24 hours. The Level of Care order shall remain in effect unless superseded by another Level of Care order.
3. The Attending Physician should ensure that any orders to limit treatment are clearly communicated to nursing staff and other members of the health care team.
4. The facts and considerations relevant to a decision to limit Life-Sustaining Treatment shall be recorded by the Attending Physician in the progress notes. Documentation should include, but need not be limited to:
 - a. A medical assessment of the patient's physical, cognitive and emotional status, including a report of the patient's diagnosis condition, prognosis and treatment options.
 - b. Specific indication of the patient's decisional capability or lack of capability.
 - c. A justification for limiting treatment, including an assessment of the burdens and benefits expected for the patient under the various treatment and non-treatment options and the rationale and justification for a final decision.
 - d. The outcome of consultation with other physicians, if any.

- e. A statement summarizing the discussions with patient, surrogate decision-maker, guardian or family.
 - f. Other pertinent information about the medical condition of the patient or the decision-making process including the presence of an Advance Directive, and any additional specific information required by this policy.
5. When a decision to limit treatment is made, a care plan should be documented. This plan should include the following: patient or surrogate decision-maker preferences and goals; resuscitative measures and other life-sustaining measures that may or may not be implemented; a plan for Comfort Care including pain management; nutrition and hydration; other relevant information.
 6. Patients with DNR Comfort Care-Arrest and DNR Comfort Care may become candidates for procedures that provide patient comfort, without altering the underlying disease. When such patients undergo procedures with conscious sedation or anesthesia they are subjected to new and potentially correctable physiological changes. Many of the actions employed in cardiopulmonary resuscitation are a part of anesthetic management, such as cardiac monitoring, artificial airway, respiratory assistance and drugs to maintain physiologic function under anesthesia, but would be prohibited with DNR Comfort Care. A part of the informed consent for procedures requiring anesthesia or conscious sedation, in patients with DNR levels of care, includes discussing changing a DNR Comfort Care status to a DNR Comfort Care-Arrest or suspension of the DNR status, during such a procedure, as well as the immediate post operative period. The attending physician or physician doing the procedure shall document and if appropriate write a new Level of Care order, prior to any such procedure. If the patient/designated surrogate does not change the DNR Comfort Care status, the involved physician(s), who does not concur with this decision, may refuse to provide the planned care and will inform the patient/surrogate of their rights as outlined in section G of this policy.
 7. In addition to the assistance received from the medical staff, Pastoral Services, Social Services and nursing staff are ready to assist any patient/family/significant other with the emotional, moral, religious, and ethical concerns that accompany such a decision. The Department of Ethics and Ethics Committee are also resources that may be utilized to assist in decision making.

G. CONFLICT RESOLUTION

1. In instances where the decision-makers request withholding or withdrawal of artificial feeding but the attending physician does not concur with the action, the attending physician or the Chief Executive Officer of the hospital or his designee shall inform the patient or other responsible individuals of their rights. These rights include:
 - a. The right to transfer the patient to the care of a physician on the staff of

- GVMC whose views may be more compatible with their own views.
 - b. The right to request additional consultation.
 - c. the right to transfer the patient from GVMC to another institution whose policy may be more compatible with their views.
- 2. If there are inconsistencies between or among (a) a general consent to treat form signed by or on behalf of the patient, (b) a durable health care power of attorney (health care POA) or decisions made by the attorney-in-fact pursuant to the health care POA, (c) a living will (referred to as a declaration in Chapter 2133 of the Ohio Revised Code), or (d) a DNR identification or order, the following rules should be followed:
 - (a) If in doubt, consult with the Patient Relations Department for review by the Medical Center's counsel, if necessary.
 - (b) As between documents of the same type, the most recent, validly executed document controls.
 - (c) Any document may be revoked by a competent patient at any time, and if revoked, the document should no longer be followed.
 - (d) The attorney-in-fact under a health care POA, in making decisions, must act consistently with the health care POA and with the known desires of the patient and, if the desires are not known, then in the best interest of the patient.
 - (e) Decisions made under the health care POA or the directions of a living will (when operative—patient terminal or in a permanently unconscious state, etc.) supersede the general consent to treatment form, to the extent of a conflict.
 - (f) If the patient is in a terminal condition or permanently unconscious state, the living will supersedes the health care power of attorney, to the extent of a conflict.
 - (g) If the patient is in a terminal condition or permanently unconscious state and the living will contains a DNR identification, then the DNR identification supersedes the health care POA to the extent of any conflict.
 - (h) The provisions of the most recent living will supersede a DNR identification based on a prior living will that is not consistent.
 - (i) A living will supersedes a physician's DNR order if that order is inconsistent with the living will.
- 3. If there is a conflict in decision making, the Ethics Committee can be consulted with contact through the Department of Medical Affairs Office. A request for this consult can be made by the patient, family or any members of the health care team. The actions of the Ethics Committee are advisory.