Title: Levels of Intervention for Resuscitation and Other Critical Interventions
Approved by JGH Board: June 21, 2007
(Replaces R4.1)

A. Policy Statement
1. The Sir Mortimer B. Davis Jewish General Hospital (SMBD-JGH) is dedicated to providing the highest quality care in a humane and caring manner. Efforts to achieve this goal will be made according to the plan of care developed with the patient*, and within the limits of the Hospital’s resources.
2. All decisions with respect to the use of potentially life-sustaining interventions (resuscitation and other critical interventions) shall be made in accordance with the policy, procedures and guiding principles outlined in this document.
3. The plan of care must indicate a Level of Intervention for each in-patient. In cases where the Level of Intervention has not yet been determined, Level 1 (i.e., provision of maximal interventions offered by the treating team) is to be assumed. In the event of a cardiopulmonary arrest where the Level of Intervention has not yet been determined, the Code Blue team is called to assess the patient and the patient’s situation, and implement interventions based on that assessment.
4. Because there can be medical reasons not to use a critical intervention, there is no legal or professional obligation to offer or provide an intervention that is clearly ineffective and outside standard medical practice.
5. In some situations (e.g., choking, tension pneumothorax), the healthcare professional’s judgment can override the Level of Intervention that is documented, but should never go against a patient’s explicit and specific wishes.

* Throughout this document the use of the term “patient” will be taken to mean the competent patient, or in the event of an incompetent patient, the patient’s surrogate.
6. The patient will continue to receive appropriate medical and nursing care, even if there is a decision to withhold or withdraw one or more critical interventions.

B. Guiding Principles

Quality Care: SMBD-JGH is committed to providing the highest quality patient care. This includes promoting evidence-based medicine and implementing best clinical practice guidelines.

Compassion, Dignity and Respect: SMBD-JGH is committed to treating its patients and their families with the utmost compassion, dignity and respect. This includes listening and responding to the needs of patients and encouraging participation in decision-making. Patients’ cultural background and values are to be taken into consideration.

Teamwork: SMBD-JGH and its multidisciplinary healthcare team is committed to collaborating and sharing knowledge to achieve a common vision and goals, and providing comprehensive care to patients.

Professional Integrity: Healthcare professionals have duties to the patient, their profession and the public. Professional integrity includes an ethical duty to exercise professional judgment on behalf of patients consistent with evolving standards of clinical practice and professional ethics.

Respect for Autonomy: Healthcare professionals are to respect the personal values and beliefs of their patients, the process by which those values and beliefs are produced, and the choices and actions made based on them.

Promotion of Patient Well-being (Beneficence): The basic goal of healthcare is patient well-being. This involves preventing illness, promoting health and safety, reversing disease states, optimizing function, providing comfort, and when this is no longer possible or appropriate, ensuring a comfortable and peaceful death.

Minimize Harm to Patient (Nonmaleficence): Harm or suffering related to patient care and treatment is to be minimized, and justified by a reasonable expectation of beneficial outcome.

Access to Care: All patients should have equitable access to healthcare. Appropriate Levels of Intervention will be determined through a partnership between the patient and the treating team. Rationing must not be used as the primary mode of determining levels of intervention and outcome.

C. Definitions

Advance Directive: A document in which a person with capacity sets out what and/or how healthcare decisions are to be made in the event that she or he loses capacity in the future. Examples include Living Will, Mandate, and “Enduring” or “Durable” Power of Attorney for Healthcare.

Attending Physician: The physician with the ultimate responsibility for the patient’s care.
Capacity (Competence): The ability to appreciate the nature and purpose of a proposed treatment and other treatment options available, and the consequences of one's choice about whether to undergo such treatment(s). Adults are presumed capable of making informed choices as to treatment, including the refusal of treatment, unless determined to be incapable.

Critical Intervention: Any potentially life-sustaining intervention.

Healthcare Team: The team of healthcare professionals responsible for the patient. This includes:

1. Physicians, including the attending physician, the patient's primary care provider, relevant specialists and consultants
2. Resident physicians and medical students
3. Nurses, including the Head Nurse of the nursing unit, primary nurse where one exists, and any nurses involved in the care of the patient
4. Other healthcare professionals, including social workers, physiotherapists, occupational therapists, dieticians, and others.
5. Ultimate responsibility for the patient's care rests with the attending physician.

Mandate: A type of advance directive (see definition above) whereby someone designates another person to be her/his surrogate for healthcare decision-making in the event of future incapacity.

Mandatary: A person designated by someone in her/his Mandate to be her/his surrogate for healthcare decision-making in the event of future incapacity.

Patient (Client): The person receiving healthcare under the responsibility of an attending physician. Note that a patient can delegate some decision-making responsibilities, or choose to include others (e.g., family members, healthcare professionals) in the process.

Standard of Care: The care provided by a healthcare professional who possesses and exercises the skill, knowledge and judgment of the normal prudent practitioner of her or his specific group in similar circumstances.

Surrogate (Legal Representative or Proxy): A person who has the legal authority to make healthcare decisions on behalf of an individual lacking the capacity to make those decisions for her or his self. For adults in Quebec, the surrogate is identified in the following descending order: Mandatary, tutor, curator, spouse (includes civil union and de facto spouse), close relative or person showing special interest in the person.

D. Levels of Intervention:

Level 1: Provision of maximal interventions offered by the treating team (including chest compressions and transfer to a critical care unit). All patients are assumed to be Level 1, unless medical reasons or patient preference suggest otherwise.

Level 2A: Provision of maximal interventions with some restrictions. Chest compressions are to be initiated in the event of cardiopulmonary arrest. Other restrictions must
be specified (for example, intubation, mechanical ventilation). Restrictions can relate to specific situations or procedures.

Level 2B: Provision of maximal interventions with some restrictions, as described in Level 2A. In the event of cardiopulmonary arrest, however, chest compressions are NOT to be initiated.

Level 3: Provision of maximal interventions on the ward aimed at treating reversible conditions, maintenance of function and comfort care, but no chest compressions and no transfer to a critical care unit. Any additional restrictions must be identified (for example, dialysis, surgery).

Level 4: Provision of interventions adapted to palliation and patient comfort. The primary goal of care is comfort and dignity. This includes relieving or lessening symptoms without achieving cure, and can include treating some reversible conditions. No chest compressions. No transfer to a critical care unit. Instructions regarding treatment of reversible conditions must be specified.

E. When to Call a Code Blue:

1. The Code Blue team is available for resuscitation of acute life-threatening illness and cardio-pulmonary arrest. The expertise of the team and its technical apparatus are sometimes required to diagnose an acute event and determine whether/which interventions may be beneficial. Thus, there may be occasion to call the Code Blue team even if chest compressions are not to be initiated.
2. Typically, a Code Blue is called in the event of a cardiac arrest or life-threatening situation for patients when a Level of Intervention is not yet determined and for patients with Levels of Intervention 1, 2A, and 2B.
3. Typically, a Code Blue is NOT called in the event of a cardiac arrest for patients with Levels of Intervention 3 and 4.
4. In some situations (e.g., choking, tension pneumothorax), the healthcare professional’s judgment can override the Level of Intervention that is documented, but should never go against a patient/surrogate’s explicit and specific wishes.

F. Patients must have a Level of Intervention:

1. A Level of Intervention must be determined for each in-patient (including in-patients in the Emergency Department), but is especially important for in-patients who:
   a. Have one or more chronic illness(es) affecting their quality of life or functional level, or diminishing their life survival, or
   b. Have previously discussed these issues with their families or physicians, or have advance directives, or
   c. Are acutely ill with potentially serious outcomes.
2. There may be situations in which a Level of Intervention should be determined for outpatients; for example patients regularly treated in the out-patient hemodialysis unit or oncology department.
G. Nature and Content of Discussion:

Discussions related to determining the Level of Intervention should include:

1. Obtaining details about advance directives, if any
2. Evaluating and determining goals of care
3. Determining the patient’s expectations
4. Discussing the effectiveness and desirability of chest compressions and other critical interventions for the particular patient and the impact of anticipated benefits and burdens for the patient
5. Evaluating what would happen if the goals of care become unattainable.

The patient must be given the opportunity to ask questions and reflect on information shared. Sufficient information and support must be given to make appropriate decisions. The patient primarily determines the goals of care and evaluation quality of life, but collaboration with the healthcare team is essential. Everyone on the healthcare team should respond in a compassionate and sensitive manner to the goals of care that the patient seeks, especially if there are differences of opinion between patient and others. Discussions and decisions should strive toward mutual agreement between the patient and the healthcare team regarding direction of care.

The benefits and burdens associated with a proposed treatment are assessed in consultation between the patient and the healthcare team and should include social, cultural, and religious interests. Striving for a favorable balance of benefits over burdens should remain the goal. An intervention that is clearly effective should be offered, unless extenuating circumstances apply. If the benefits/burdens of an intervention are difficult to assess, a well-designed trial of the intervention to evaluate the benefits/burdens should be considered with the patient. There is no legal or professional obligation to offer or provide an intervention that is clearly ineffective and outside standard medical practice.

On-going educational support for medical personnel should be available to help ensure that these discussions are appropriate and respectful, especially when addressing the patient’s preferences, values, and spiritual beliefs.

H. Collaborative Decisions:

1. On a routine basis, at the time of admission, the attending physician/resident, in consultation with the patient, determines the Level of Intervention.
2. During hospital stay, patient meetings are held to determine/review/revise the Level of Intervention. Typically, these meetings should include the patient, attending physician, nurse, and anyone else the patient wants to be there. Reasonable efforts should be made to enable the above to be present. Others should be included as the situation warrants (for example, social worker, patient representative, head nurse, spiritual leader, clinical ethicist, family physician, other physicians).

I. Assignment of a Level of Intervention:

The patient should NOT be given a list of levels of intervention to choose from, as this would be contrary to respectful, collaborative patient-healthcare team relationships. Rather, the interpretation and transcription of the discussion and goals of care, and the assignment of a
Level of Intervention, is the responsibility of the attending physician/resident, and should be consistent with the discussion(s) held and consensus achieved.

J. Role of Residents:
In a teaching hospital, residents act under the authority of their attending physician. Accordingly, residents may be involved in discussions and aspects of the decision-making process, and may write Level of Intervention orders. The resident must discuss a Level of Intervention order with the patient’s attending physician and document in the medical record the name of the physician with whom the order was discussed. A Level of Intervention order written by a resident is valid when written. However, the patient’s attending physician is responsible to counter-sign the order as soon as possible, to further indicate communication and agreement of the patient’s attending physician with the order. If counter-signature is delayed more than 24 hours, the attending physician should give a verbal order by telephone that is witnessed by a nurse.

K. Role of Medical Students:
Medical students may participate in Level of Intervention discussions, and writing of Level of Intervention orders, only under direct supervision of the patient’s resident or attending physician. A Level of Intervention order written by a medical student must be counter-signed immediately by the patient’s resident or attending physician; this order is not valid until counter-signed.

L. Role of Nurses:
Nurses typically participate in meetings to determine/review/revise a Level of Intervention that take place during a patient’s hospital stay. They help initiate discussion about the care plan and critical interventions with the patient, validate patient understanding and feeling around the care plan, act as facilitator, and follow up with the patient on discussion held with physicians. If a code situation occurs, nurses have an important role in communicating what Level of Intervention and what restrictions (if any) are in place for the patient.

M. Documentation by Attending Physician/Resident:
1. Levels of Intervention Order Sheet
   a. Record order for Level of Intervention assigned, any specific restrictions or instructions, the date and time of progress note (see below), and rationale for decision, on the Level of Intervention Order Sheet.
   b. An order written by a resident or medical student must clearly indicate who wrote the order, on behalf of which physician and which physician the order was discussed with (e.g., Resident’s name, R1-5, for Dr. X. Discussed with Dr X).
   c. A Level of Intervention order written by a resident must be countersigned by the patient’s attending physician as soon as possible so that communication with and agreement of the patient’s attending physician is documented. A Level of Intervention order written by a medical student must be supervised and immediately countersigned by the patient’s resident or attending physician.
   d. Place and flag Level of Intervention Order Sheet in the orders section of the medical record.
2. Progress Note
   a. The order must be linked to a particular dated and timed progress note in the medical record.
   b. The progress note includes a list of individuals present for discussion, interpretation and transcription of discussion and goals of care, Level of Intervention assigned and any specific restrictions or instructions, and rationale for decisions made.
   c. Any disagreement about a Level of Intervention order must be documented along with the action to be taken. For example “Level of Intervention #1 as per family request. Plan to have additional meetings with family to address disagreement between…”

N. Documentation by Nurse:
   1. A flagged Level of Intervention Order Sheet must be reviewed and carried by the patient’s nurse, who signs the “carried by nurse” section on the order sheet then moves the order sheet to its specific section in the medical record.
   2. The Level of Intervention and specific instructions/restrictions must be recorded on the appropriate nursing documents, i.e., Caremap, Promotion of Autonomy Framework [POFA], or Kardex.
   3. When a resident writes the Level of Intervention order that is not yet countersigned by the patient’s attending physician, the nursing documents should indicate that the order is pending countersignature.
   4. As the situation warrants, the nurse may write a progress note (e.g., describing the patient’s reaction to the change in care plan).

O. Transfer of Patients:
   1. When a patient is transferred within JGH or between healthcare facilities, the healthcare team members involved should ensure that documented decisions and relevant discussions about Level of Intervention and any specific restrictions/instructions accompany the transfer papers.
   2. For patients transferred within the institution, the current Level of Intervention remains in effect until such time as a new order is written.
   3. When a patient is transferred to another healthcare team, it is desirable for the new team to reassess the Level of Intervention.

P. Readmission of Patients:
   Upon readmission to hospital, the admitting physician should inquire whether there are any significant changes regarding goals of care or previously made decisions about potentially life-sustaining interventions. However, a patient readmitted frequently whose circumstances have not significantly changed (e.g., some palliative care patients) should not be subjected to repeat discussions.

Q. Review of Decision:
   Once a Level of Intervention has been determined, that decision prevails until the appropriate decision-makers decide to change it. The decision should be reviewed if:
   1. The patient requests a review of the decision; or,
2. The attending physician/healthcare team member notes: (a) a significant change in the patient’s clinical status or prognosis, or (b) new information that would affect the decision made. The attending physician is responsible for communicating any changes in Level of Intervention to the healthcare team and the patient.

R. Conflict Management and Resolution Process

In most situations, consensus is easily achieved between the patient and healthcare team about the goals of care and care plan, including decisions about resuscitation and other critical interventions. Due to the complexity of issues relating to resuscitation, different understandings, different values, interpersonal dynamics, or some other factors, it is possible for conflict to arise. If this occurs, a process of conflict management and resolution must be initiated that is suited to the particular circumstances of the situation. The following strategies and procedures should be considered.

Step 1. Consensus Building

a. Therapeutic Alliance and Consensus Building (for conflict between patient and healthcare team)
   - The goal is to re-establish trust and a therapeutic alliance through listening, observing and responding, compassionate communication, sensitivity to and respect for different opinions and personal, cultural and spiritual issues.
   - Identify source(s) of conflict.
   - Offer spiritual, psychological and social support; this may include referrals to social services or pastoral care services.
   - Establish what is “understood” by the patient and healthcare team and what each believes will happen. Acknowledge what is said. Integrate what is said throughout the discussion(s).
   - Review diagnosis, prognosis and potential interventions.
   - Review the goals and values that should guide decisions.
   - Attempt to establish goals of care and how resuscitation and other critical interventions may affect the achievement of those goals.
   - Establish a plan of care with respect to resuscitation and other critical interventions.

b. Healthcare Team Alliance and Consensus Building (for conflict within healthcare team)

   Conflicts within the healthcare team should be dealt with in a format that hears serious objections, encourages communication, and emphasizes respect for different professionals regardless of their place in the decision-making hierarchy.

c. Family Disputes Competent Patient’s Choice
   - Healthcare professionals can act as facilitators to help patient and family member(s) to share their points of view.
   - Refer to appropriate resources.
Step 2. Obtaining Additional Information and Advice

a. Second Medical Opinion
   - Obtain a second medical opinion at the patient’s request or if there is particular insolence on an intervention that the attending physician believes is not in the patient’s interests, contrary to an acceptable standard of care, or ineffective in producing the effect the patient wants.
   - If a second medical option differs from that of the healthcare team, the team should assess the difference, reassess intervention options, and discuss with the patient.
   - A second medical opinion that concurs with that of the healthcare team adds medical credibility to the assessment of the healthcare team.

b. Additional Professional Advice
   - Obtain additional professional advice as the situation warrants (e.g., from specialists, family physician, Social Services, Pastoral Care Services, Patient Representative, Director of Professional Services, hospital legal counsel, insurer, medical defense organizations).

c. Clinical Ethics Consultation
   - Consider a Clinical Ethics Consultation if there is an emerging ethical question or conflict over ethical dimensions of the optimal Level of Intervention or restrictions to be applied.
   - If the patient strongly and persistently disagrees with a recommendation of the clinical ethicist consider reassessment by the Clinical Ethicist, consultation to the Clinical Ethics Committee, or consultation to another Clinical Ethicist, i.e., from the Biomedical Ethics Unit of McGill University which jointly provides clinical ethicists to McGill-affiliated hospitals.

d. Trial of Therapy
   - A trial of therapy is appropriate in some situations when the effectiveness of a particular intervention or care plan is in doubt. A trial may help to determine the degree to which the intervention is effective, ineffective, beneficial, and burdensome.
   - The planned trial of therapy and the goals of the trial must be clearly established, agreed upon and documented, before it is initiated.
   - The attending physician should establish with the patient what will happen if the patient’s health status deteriorates during the trial of therapy.
   - The limits of the attending physician’s authority, and the potential need to involve other teams, should be taken into account when establishing a trial of therapy. For example, an attending physician on a ward does not have the authority to admit a patient to a critical care unit, provide dialysis, or provide some other specialized therapies.
   - Reassess at the end of the trial period.
Step 3. Reconciling Conflicts

a. Conflicts Over Who Should be Surrogate
   - Ideally, the person who knows the patient’s wishes, preferences, goals, and values the best is the best person to serve as the patient’s surrogate.
   - A surrogate decision-maker must be willing, available, and capable of making the needed healthcare decisions on behalf of the patient.
   - According to Quebec law, the surrogate of an incapable adult is identified in the following descending order: Mandatary, tutor, curator, spouse (includes civil union and de facto spouse), close relative or person showing special interest in the person.
   - It can be useful to distinguish those who should participate in decision-making – because they have important knowledge or share the burden of care – from the person with the authority to be surrogate. The former can be encouraged to participate in the process, while the latter has the responsibility and authority to make the decision on behalf of the patient.
   - In some situations, the attending physician may petition the court to establish a curatorship, which provides for a court-appointed surrogate. Contact Social Services to facilitate this process.
   - Contact the hospital legal council if conflicts persist.

b. Conflicts Involving Advance Directives
   - The patient’s most recent competent wishes should guide the plan of care, even if those competently-made wishes are inconsistent with a prior-made advance directive.
   - A patient’s surrogate may be acting inappropriately if she/he does not follow the most recent previously expressed wishes of the patient, or, in the absence of expressed wishes, does not make decisions in the patient’s best interests.
   - The healthcare team must first address any concerns about a conflict involving advance directives with the surrogate, since actions may be resulting from misinformation or miscommunication.
   - If the surrogate does not satisfactorily address these concerns, it may be useful to seek advice from other healthcare professionals, the Clinical Ethicist, and/or the Hospital legal counsel.
   - A Quebec court must homologate a Mandate in order for it to come into effect. The person named in the Mandate to be the Mandatary initiates the homologation process. This can take place only after the patient no longer has the capacity for making her/his own healthcare decisions. Social Services can facilitate homologation.
   - The homologation process provides an opportunity for someone to contest the choice of Mandatary. If a Mandate is being contested, a physician may be asked to prepare an affidavit either contesting or affirming the named Mandatary. Such an affidavit typically includes statements about medical best interests, why either the contesting/Mandatary has made a persuasive case that he/she is acting in the patient’s interests, and why the other party is not in a good position to act as patient surrogate.
c. Conflicts Involving Cultural or Religious Requests

- Within the limits of professional integrity and hospital commitments, policies, and resources, ways to honour all relevant, important values should be sought whenever possible.
- Seek an explanation for the nature and rationale of the cultural/religious request. Remember that there are diverse opinions and beliefs within cultural and religious communities, and nothing should be assumed about a particular patient’s wishes, preference, values, and goals simply from membership within a cultural/religious community.
- With the patient’s permission, consider consultation with the spiritual/cultural leader or liaison that the patient relies on. This may involve inviting this person to attend a meeting with the patient and attending physician/healthcare team. If a Jewish patient does not have access to such a resource, they can be referred to the Rabbinical Medical Ethics Committee (RMEC) of Montreal to seek their guidance.
- A distinction may be made in Jewish Religious law between “not starting” (or “withholding”) and “removing” (or “withdrawal”) of an intervention. When the patient indicates a preference to follow Jewish Religious law, this distinction should also be honoured, when possible, by the healthcare team.

d. Providing Doubtfully Effective, Questionable Benefit Intervention(s)

- If the attending physician believes that the intervention requested by the patient may work but it is not clear whether the intervention is in the patient’s interests, the decision of the patient should prevail, unless provision of the intervention contravenes hospital policy.

e. Offer of Patient Transfer

- If conflict remains after the above strategies and procedures have been attempted, an offer to help transfer the patient to another physician or institution willing to provide care must be made to the patient.
- Patient transfers can occur between physicians within JGH, or between health care institutions.
- The reasons for such a transfer and the specific arrangements for the transfer must be clearly documented in the patient’s medical record.
- The health care team should assist the patient in finding another physician or institution.
- If after reasonable effort no other physician or institution will accept the patient it is evident that no physician or institution is willing or available to provide the disputed intervention.

f. Facilitation, Mediation and Conflict Resolution Resources

- Offer the services of a facilitator or mediator if, having tried the above processes, the patient remains dissatisfied with the communication and/or decision-making process.
• The facilitator or mediator chosen should be acceptable to both the patient and the healthcare team.
• Individuals providing this service should have appropriate training, skills, and be seen as someone who has an objective view of the situation.
• Individuals performing this service might include the Hospital’s Patient Representative or any person mutually acceptable to both parties.
• In rare instances, when institutional resources are exhausted, it may be appropriate to seek external professional facilitation, mediation or conflict resolution services through the Office of the Director of Professional Services.

Step 4. Addressing Irreconcilable Conflicts

a. Patient’s Surrogate Not Acting in Patient’s Best Interest
• The healthcare team shall have exhausted all reasonable professional and institutional processes to reconcile those in conflict, once good faith and diligent efforts have been made to utilize the above strategies and processes.
• If after having done so, the healthcare team still reasonably judges that the surrogate is not acting in the patient’s best interest, consult hospital legal counsel about petitioning the court to challenge the surrogate’s decision or establish a curatorship.

b. Withholding or Withdrawing Ineffective and Non-standard of Care Intervention(s)
• The healthcare team shall have exhausted all reasonable professional and institutional processes to reconcile those in conflict, once good faith and diligent efforts have been made to utilize the above strategies and processes.
• If after having done so, the healthcare team still reasonably judges that a requested intervention is clearly ineffective and falls outside the professional standard of care, then the healthcare team may conclude that there is no duty to provide that intervention.
• This conclusion should only be reached on the basis of consistent professional opinions, and open, detailed and continuing communications between the healthcare team and the patient.
• When the patient indicates a preference to follow Jewish Religious law, the distinction between “withholding” and “withdrawal” of an intervention should be respected whenever possible. Whenever possible, abide by similar cultural/religious preferences and distinctions that a patient may indicate relevant to withholding and withdrawal of an intervention.
• The physician may wish to contact CMPA, prior to taking the step of withdrawing a life-sustaining intervention, in order to get independent advice.
• The patient should be informed of a decision to withhold or withdraw an intervention, and the rationale for that decision.
• If acrimony persists, or if a request is made, JGH legal counsel should participate in the process.

APPENDIX:
Levels of Intervention for Resuscitation and Other Critical Interventions Order Sheet