1. Policy

1.1. The American University of Beirut Medical Center (AUBMC), shall conform to the community’s religious and cultural norms and shall comply with the prevailing Lebanese Laws on Medical Ethics and Patient’s Rights.

1.2. The AUBMC professionals shall respect the wishes of the patient / guardian / legal representative on withholding resuscitative services when the patient’s condition is medically futile.

1.3. The AUBMC professionals shall abide by the terms of the Lebanese Law on Medical Ethics that does not permit the withdrawal (termination) of life support services.

1.4. Concern for the patient’s comfort and dignity guides all aspects of care. Palliative care is provided to all patients at their end of life care.

1.5. Care and comfort measures during the terminal stage of an illness shall be provided by treating primary and secondary symptoms that respond to treatment, managing pain, responding to the psychosocial, spiritual, emotional and cultural concerns of the patient and the family regarding death, dying and the expression of grief; and involvement in care decisions.

1.6. The ethical commitment of the physician is to sustain life despite disabilities, handicaps, or advanced age, except in circumstances where efforts to prolong life would be inhumane or futile. Efforts should be made to resuscitate patients except, and to the extent permitted by law, when circumstances indicate that this would not be in accord with the patient’s best interest.

1.7. Any patient has the right to revoke his/her refusal of life-sustaining treatment that he/she may have previously made.

2. Purpose

2.1. To provide guidelines to the medical and nursing staff in the ordering and implementation of life-sustaining measures/interventions at the end of life, designed to meet individualized patient/family needs.

2.2. To provide a framework for resolving conflicts in situations of disagreement about appropriate use of life-sustaining treatment.

3. Definitions
3.1. **Adult:** Any person who is 18 years of age or older, or is deemed by Lebanese law as having the legal capacity of an adult, who is competent to understand relevant information, reflect on it in accordance with his/her values, and communicated with the caregivers.

3.2. **Competent:** The ability to understand and appreciate the nature and consequences of refusing life-sustaining measures and to reach an informed decision regarding such refusals. Every adult patient is presumed competent unless there has been a determination of lack of competence. If in doubt this determination is made by an attending physician and a concurring psychiatrist/neurologist to a reasonable degree of medical certainty.

3.3. **Legal Representative:** (by order of priority)
   3.3.1. Spouse of the patient
   3.3.2. Children of the patient if of legal age (18 years). Consent of all is desirable. If there is no such consent, consent by the eldest son or daughter will suffice.
   3.3.3. Parents, consent of both being desirable.
   3.3.4. Grandchildren of legal age – the rule as to children applies.
   3.3.5. Brothers or sisters - the rule as to children applies.
   3.3.6. Nearest relative, usually the one who is assuming responsibility for the patient’s care and consent process, or the relative taking the largest share in the estate.
   3.3.7. Judiciary authorities may supersede all others in medico-legal cases.

3.4. **Medically Futile:** Any treatment that, within a reasonable degree of medical certainty, is believed to be without benefit to the patient, or where the treatment provides neither palliation, nor restoration or cure. Examples of this would be CPR for a permanently unconscious patient or a patient with a medical condition unresponsive to treatment. This shall be determined by the attending physician and a consultant physician.

3.5. **Terminal Condition:** An illness or injury from which there is no recovery and which reasonably can be expected to cause early death (within one year).

3.6. **Irreversible Condition:** A condition, injury, or illness that:
   a. May be treated but is never cured or eliminated;
   b. Is fatal without life-sustaining treatment provided in accordance with the prevailing standards of medical care.

3.6 **Life-sustaining Treatment:** Treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical ventilators, kidney dialysis treatment, and artificial nutrition and hydration. The term does not include the administration of pain management medication or performance of medical procedure considered to be necessary to provide comfort care, or any other medical care provided to alleviate a patient’s pain.

3.7 **Palliative Care:** The active total care of patients whose disease is not responsive to curative treatment. Palliative care neither hastens nor postpones death; it provides
relief from pain and other distressing symptoms; it integrates the psychological and spiritual aspects of patient care; and offers a support system to help the family cope during patient’s illness and their own bereavement.

4. **Procedure**

4.1. **Medically Futile Cardio-Pulmonary Resuscitation (CPR)**

4.1.1. The patient / guardian / legal representative may request to withhold resuscitative services when the patient’s condition is deemed medically futile.

4.1.2. The decision of the patient / guardian / legal representative shall be discussed with the attending physician.

4.1.3. The attending physician shall document the wish of the patient / guardian / legal representative in the patient’s medical record (Multidisciplinary Notes) and shall write a “Do Not Resuscitate” order onto the Physician’s Order Form.

4.1.4. Unless a decision to the contrary has been made by the patient / guardian / legal representative and agreed by the attending physician, the “Do Not Resuscitate” orders shall be suspended during surgical operations and other invasive procedures. The “Do Not Resuscitate” orders shall automatically be resumed upon return to the patient’s care unit.

4.1.5. The patient / guardian / legal representative may decide to revoke the decision to withhold resuscitative services at any time by informing the attending physician who shall document this decision in the patient’s medical record and write the revocation order onto the Physician’s Order Form.

4.1.6. In the case of disagreement between the physician and the patient / guardian / legal representative, then the case is referred to the AUBMC Bioethics Committee.

4.1.7. When CPR is determined as medically futile and the patient/legal representative’s choice is for resuscitation, then the attending physician has an obligation to discuss and clarify to the patient/legal representative the implications of their decision and that treatment may not be of benefit or may be harmful to the patient. The above communication with the patient/legal representative, and the resulting decisions (plan of care), should be documented in the patient’s medical record by the attending physician.

4.1.8. Assessment and reassessment of the dying patient should be documented in the patient’s medical record by the treating team and should include the symptoms related to the disease process or secondary to the treatment; factors that alleviate or exacerbate physical symptoms; current symptom management and the patient’s response.

4.2. **Withholding of Life Sustaining Treatment**

In the case of medically futile patient, life sustaining treatment may be withheld (not started) upon the request of the patient’s guardian / legal representative. The physician shall document the de-escalation plan in the patient’s medical record.
4.3. Conflict Resolution

4.3.1. If refusal of life-sustaining treatment, as requested by the patient/legal representative conflicts with the physician’s beliefs, or his/her medical judgment concerning the patient’s best interest, then the physician should have a candid discussion with the patient/legal representative on these matters to reach an agreement on the course of treatment. If no agreement is reached, then the patient should be given the opportunity to be transferred to the care of another physician willing to comply with the patient’s treatment decisions in refusal of life-sustaining treatment.

4.3.2. In the event of controversies among the patient’s legal representative(s) and/or the medical staff, or among members of the medical staff, the case should be referred to the AUBMC Bioethics Committee for review and resolution of conflicts regarding the ethical aspects of the patient’s care.

4.4. Designation of Terminal or Irreversible Condition

4.4.1. Prior to honoring refusals for life-sustaining treatment the attending physician and a concurring physician must determine to a reasonable degree of medical certainty:
   a. The patient has a terminal condition; or
   b. Is permanently unconscious;
   c. Resuscitation would be medically futile; or

4.4.2. Adults and Minors:
   a. The attending physician must diagnose and record in writing in the patient’s medical record that the patient has a terminal or irreversible condition.
   b. The attending physician shall personally examine the patient and enter a dated and timed statement of the patient’s medical condition in the progress notes of the patient’s medical record including but not limited to:
      i. the patient’s diagnosis and prognosis;
      ii. diagnostic procedures confirming the diagnosis and prognosis;
      iii. a statement that the patient has a terminal or irreversible condition;
      iv. current physical examination;
      v. brief summary of the treatment, date, and results;
      vi. statement of treatment alternatives; and
      vii. description of current life-sustaining treatment being utilized (palliative care measures that emphasize patient comfort and dignity).

c. Documentation in the patient’s medical record should include examinations, discussions, consultations, and any other relevant information which explains the physician’s designation of the patient as incompetent of mental or physical ability to communicate.

4.4.3. Minors
a. The decision of both parents to refuse life sustaining treatment in a minor must be obtained.
b. In case of divergent beliefs of both parents, or controversy between them, the conflict should be resolved as per item 4.3.2.

4.4.4. Pregnant patients
a. Life-sustaining treatment, CPR, nutrition and hydration shall be provided to a pregnant patient unless, to a reasonable degree of medical certainty as determined and documented in the patient’s medical record by the patient’s attending physician and a second physician who is an obstetrician who has examined the patient, it will have one of the following consequences:
   i. they will not maintain the pregnant patient in such a way as to permit the continuing development and live birth of the unborn child.
   ii. they will be physically harmful to the pregnant patient.
   iii. they will cause pain to the pregnant patient which cannot be alleviated by medication.
b. In the event a determination of brain death is being considered in a patient who is known to be pregnant, obstetrical consultation should be arranged.

4.5. Life-sustaining Treatment and Organ Donation (Refer to policy on organ and tissue donation online and 4.6.1 and 4.6.4 of this policy)

4.5.1. Donation and procurement of vital organs after death is reasonable and ethical provided informed consent on organ donation is obtained from the patient/legal representative.
4.5.2. The decision to refuse life-sustaining therapy should preferably be made before, and must be made independent of, any decision to donate body organs/tissues.
4.5.3. Organ preservation, procurement and tissue recovery activities are only instituted after the patient has been pronounced dead.
4.5.4. Confirmation of death must be based on standardized and objective criteria, and must follow the Lebanese law.

4.6. Life-sustaining Treatment and Medication Therapy

4.6.1. Therapy that is harmful to the patient should be avoided even if it might improve organ viability. The patient’s care and treatment must not be altered in any way to the possible detriment of his/her life for the purpose of better preserving organs or tissue for donation after death (refer to 4.5).
4.6.2. When therapy is refused, patients have the right to medications that prevent and alleviate pain and suffering.

4.6.3. Medications whose purpose is to hasten death should not be given to the patient. Medications given to provide comfort are reasonable, even if they might hasten death (Doctrine of double effect).
4.6.4. Medications that do not harm the patient and are required to improve the chances of successful donation are acceptable (refer to 4.5).
4.7. Suspension of Refusals of Life-sustaining Treatment

4.7.1. Unless a decision to the contrary has been made by the patient/legal representative, the attending physician and performing physician shall resume life-sustaining treatment:
   a. Whenever the patient is taken to the operating room for a surgical procedure;
   b. While the patient is in the post anesthesia care unit (PACU) following a surgical procedure with anesthesia or conscious sedation; or
   c. During radiological procedures that are invasive or require injection of contrast media.

4.7.2. The treatment decisions shall automatically be resumed upon the patient’s return to the nursing unit.

4.8. Revocation of Treatment Refusals

4.8.1. Revocation takes effect when the patient/legal representative notifies the attending physician in writing or orally (to be witnessed and confirmed later in writing).

4.8.2. The attending physician or his designee shall immediately record in the patient’s medical record the time and date of the revocation and should enter the word “VOID” on any previous written statement, if available.

4.8.3. Documentation of the revocation can be done by any member of the treating team.

4.8.4. All members of the health care team directly involved in the patient’s care must be immediately informed of the revocation.

4.9. Nurses Role and Responsibilities

4.9.1. In the case where a patient/guardian/legal representative approaches a nurse for a request of withholding resuscitative services or for revoking of a previously made decision, the nurse shall inform the attending physician of this request.

4.9.2. Nurses are encouraged to be present during discussion with the patient/guardian/legal representative relating to end-of-life issues such as: medically futile cardio-pulmonary resuscitation, designation of terminal or irreversible condition, decision of withholding resuscitative services, decision of continuing life sustaining treatment, revoking of previously made decisions etc.

4.9.3. If decision or refusal of life sustaining treatment conflicts with the nurse’s beliefs, then the patients should be given the opportunity to be assigned to the care of another nurse for the dual purpose of honoring patient’s wishes and respecting nurse’s beliefs.

4.9.4. Orders of “Do not resuscitate” should be communicated among nurses during inter-shift hand-offs for the purpose of continuity of care and patient safety.
4.9.5. The nurse who is involved in end-of-life care shall document:
   a. The nature of her involvement during discussions with the patient/guardian/legal representative
   b. Nurse’s interventions (For example, pain management, psychosocial support)
   c. Consultations done (for example to the advanced practice nurse or social worker)
   d. Special arrangements for patient and family (for example involvement of religious person, accommodation)

4.9.6. In the case where an advanced practice nurse is involved in end-of-life care, he she should document the nature of the involvement and nursing interventions provided

5. **Signatures**

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<td>Assistant Hospital Director for Nursing Services</td>
<td>Gladys Mouro, PhD</td>
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<td>VP for Medical Affairs and The Raja N. Khuri, Dean, FM&amp;MC</td>
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6. **Appendices**

6.1. AUBMC Criteria for Diagnosis of Brain Death

7. **Circulation List**

7.1. AUBMC Policy and Procedure Manual Holders
8. **Modifications**

8.1. Basic modifications were introduced to the 1st edition of this policy. The first three policy statements (1.1 - 1.3) and section 4.1 dealing with medically futile cardiopulmonary resuscitation (CPR) were modified as recommended by the AUBMC Risk Management Committee. The section “Nurses Role and Responsibilities was added.

9. **References**

9.1. Lebanese law № 574 on Patients Rights and Informed Consent, Published in the Official Gazette № 9, February 2004 (Translated Version).

9.2. Lebanese law № 228 on Medical Ethics, Chapter Two: Duties of Physicians towards Patients, Article XXVII-10, February 22, 1994 (Translated Version).


9.5. AUBMC Bylaws, Rules, and Regulations of the Medical Staff, Part II, Section I5b: Next of Kin for Purposes of Autopsy Permit, March 2004.


### AUBMC Criteria for Diagnosis of Brain Death

Before the diagnosis of brain death is entertained, the physician should make sure that the patient is:

1. **Not** under hypothermia;
2. **Not** under the effects of central nervous system depressant drugs;
3. **Not** curarized.

For the diagnosis to be established all the following essential criteria should be present as certified by the attending physician and two (2) consultants from any two of the following specialties:

1. Anesthesiology
2. Neurology
3. Neurosurgery

The final decision is the responsibility of the attending physician.

A statement certifying brain death should appear in the patient’s record signed by the three (3) physicians (attending and two consultants).

I. **Essential criteria**

   A. **Clinical criteria**
      
      1. Irreversible loss of cerebral hemisphere function:
         
         a. Unresponsiveness to noxious stimuli by purposeful movements or vocalization
         
         b. Above condition lasting more than 24 hrs.

      2. Irreversible loss of brain stem function:
         
         a. Absence of spontaneous respiration. Patient is on respirator and unable to trigger respirator.
         
         b. Dilated non reactive pupils provided patient is not receiving papillary dilators such as adrenaline, atropine or ganglionic blocking agents.
         
         c. Absence of ocular movements in response to head turning (Doll head maneuver).
         
         d. Absence of ocular movements in response to vestibular stimulation (caloric test).
         
         e. Absence of all motor and cranial reflex movements.

   B. **EEG criteria**
      
      Isoelectric (flat) EEG after 30 minutes recording done twice, twenty four hours apart.

II. **Supporting criteria**

These are not essential for the diagnosis of brain death but may be resorted to as further evidence to support the diagnosis:

1. Absence of visualization of cerebral vessels after carotid arteriography.
2. Absence of radioisotope uptake after cerebral scintography (Brain scan).