

Title: WITHHOLDING/WITHDRAWAL OF LIFE SUSTAINING TREATMENT

Scope:

This policy applies to incompetent patients at MultiCare Health System (MHS) who have a terminal condition or who are permanently unconscious and have not executed an Advance Directive (AD).

This policy does not apply;

1. If the patient is competent he/she can make decisions to withdraw or withhold life support. See Informed Consent and Patient Competency Policy, and Refusal to Consent to Medical Treatment Policy.
2. If the patient is brain dead refer to the Brain Death Determination Policy.
3. If the patient has an Advanced Directive/Living Will refer to the Advance Directive: Living Will and Mental Health Policy.
4. If the patient is pregnant with a viable fetus, contact Legal Services (403-1107).

Policy Statement:

- A. This policy establishes the MultiCare Health System (MHS) procedure for withholding/withdrawing life support from an incompetent patient who has not executed an AD.
- B. In the interest of protecting individual autonomy the legislature finds that prolonging the dying process for a person with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically beneficial to the patient.
- C. The patient has the fundamental right to control decisions relating to his/her health care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.

Special Instructions:

1. Withholding and withdrawing life-sustaining treatment are considered to be equal acts.
 - a. A physician may consider withholding or withdrawing life sustaining treatment from a patient in instances of a terminal condition or permanent unconscious condition.
2. Decisions regarding health care may be exercised by an authorized representative for a patient who is acting in the patient’s best interest.

- a. Discussion of the option to donate organs is a separate decision from withdrawal of life sustaining treatment, but must be addressed prior to the withdrawal.
- b. Tissue donation (including corneas) may be discussed after the patient has died. An informative discussion should be offered to the family.
- c. If the decision has been reached to withdraw life-sustaining treatment and the patient is likely to experience cessation of cardiac activity within 60 minutes, contact should be made with the organ procurement counselor to discuss options with the family concerning donation after cardiac death. See Donation After Cardiac Death (DCD) Organ Donation Policy.

Procedure:

I. Responsibilities:

- A. If the patient is unable to make their own decisions, and has no advance directive, the patient’s attending physician should determine with reasonable medical judgment that the patient is in an advanced stage of a terminal and incurable illness and is suffering severe and permanent mental and physical deterioration, or that the patient is in an irreversible comatose or persistent vegetative state from which there is no reasonable probability of recovery, and further medical intervention is considered futile(i.e. prolonging death rather than prolonging life). The attending physician is responsible for meeting with the family and recommending withdrawal of life sustaining treatment as outlined in this policy.
- B. If the family does not agree with the attending physician’s recommendation regarding withholding or withdrawing treatment, or no family is present, the attending physician will request that another physician assess the patient’s condition and the value of life-sustaining treatment.
- C. The attending physician will meet with the patient’s immediate family and/or guardian to fully explain the patient’s condition, prognosis, and expected future function
 - 1. The risks, limits and benefits of the patient’s current treatment should be thoroughly discussed
 - 2. Other health professionals involved with the patient are encouraged to participate in the discussions and should be advised of the meeting
- D. Persons authorized to consent on behalf of an incompetent adult patient (at least 18 years of age) in order of priority, are:
 - 1. Legal guardian
 - 2. Durable power of attorney for health care

3. Spouse or state registered domestic partner
 4. Adult children ≥ 18 years of age
 5. Parents
 6. Adult siblings
- E. Persons authorized to consent on behalf of a minor patient (under the age of 18 years) in order of priority, are:
1. Legal guardian
 2. Person authorized by the court to consent to medical care for a child
 3. Parents
 4. Individual to whom the minor's parent has given a signed authorization to make health care decisions
 5. A competent adult who has signed a declaration stating that he/she is a relative responsible for the health care of the minor. (Such declarations are effective for up to 6 months from the date of execution.)
- F. Minors over the age of 12, who are conscious and suffering from chronic terminal conditions, should be given the opportunity to actively participate in the discussions and decisions regarding their health care including the withholding/withdrawing life-supportive treatment
1. The Ethics Committee is available to participate in this discussion at the request of the family or the health care team
- G. Once these matters have been fully discussed and no questions remain, the attending physician should encourage the patient's immediate family and any guardian to consider the facts and discuss the implications

II. Consent and Decision to Withhold/Withdrawal Process:

- A. The patient's attending physician should advise the patient's immediate family and any guardian that consent may be given only after determining in good faith that the patient, if competent, would choose to refuse life-sustaining treatment; or, if such a determination cannot be made, the immediate family and guardian determines that the withholding/withdrawing of life-sustaining treatment would be in the best interest of the patient
1. If the patient has a primary care provider, she/he should be asked to weigh in regarding the patient's potential preference
- B. If the immediate family, any guardian, and the patient's attending physician agree that treatment should be withheld/withdrawn, their decision should be implemented
1. In the absence of agreement between the person(s) authorization

to consent on behalf of the patient and the attending physician, no life-sustaining treatment should be withheld/withdrawn (see Decision Making in Non-Beneficial (Futile) Treatment)

- C. The attending physician should document in the patient's record a summary of the conversation, diagnosis, prognosis, and the specific treatment that is to be withheld/withdrawn
 - 1. This note should indicate that consent was obtained and who gave the consent, and that the decision to withhold or withdraw treatment is consistent with the patient's intentions or the best interest of the patient as determined by the person(s) authorized to consent on behalf of the patient.
- D. The attending physician and health care team should take measures to assure dignity and comfort after life support is withheld/withdrawn, including hygienic care and medication or medical procedures deemed necessary to alleviate pain. Refer to: Comfort Care Order set
- E. Each decision to withhold/withdraw treatment is specific to the treatment discussed with the person(s) legally authorized to consent, and it does not apply to any other treatment not discussed
- F. If conflict arises among family, health care providers, and physician regarding withholding/withdrawing of life support, follow the guideline below
 - 1. Initiate family conference with the following participants:
 - a. Immediate family
 - b. Patient's legal guardian
 - c. Attending Physician
 - d. Nursing representative
 - e. Chaplain/Social Worker
 - f. Ethics committee representative(s)
 - 2. Family conference to address these issues:
 - a. Attending physician and consultant(s) should discuss the patient's condition and prognosis with participants
 - b. Clarify the treatment options and goals of treatment
 - c. Determine if patient is able to participate
 - d. Document family conference and outcome in patient's medical record
 - 3. If the attending physician, the consulting physician(s), the guardian (if one has been appointed), or person(s) authorized to consent object to the withholding/withdrawing of life-sustaining treatment, no treatment should be withheld/withdrawn. Consult Legal Services and initiate a consultation with MHS Ethics Committee

- a. If the attending and consulting physicians reach an impasse with the patient's surrogates and the pursuit of ongoing treatment is determined to be non-beneficial to the patient, refer to the MHS Policy: "*Decision Making in Non-Beneficial (Futile) Treatment*"
- 4. Withholding/withdrawing of life sustaining treatment from a patient with an Advance Directive/Living Will should refer to the MHS P & P: "*Advance Directives: Living Will and Mental Health*"
- 5. No health care provider is required to participate in the withholding/withdrawing of life-sustaining treatment if such action would be contrary to the dictates of his/her conscience or belief
 - a. If a physician refuses or does not wish to withhold/withdraw the life-sustaining treatment, the physician shall make a good faith effort to transfer the patient to another qualified physician who will carry out the decision to withhold/withdraw life-sustaining treatment

III. Definitions:

Life-sustaining treatment: Any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which when applied to a qualified patient, would serve only to prolong the process of dying. "Life-sustaining treatment" shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

Terminal condition: an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

Permanent Unconscious Condition: an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state.

Persistent Vegetative State: describes the chronic condition that sometimes emerges after severe brain injury and comprises a return of "wakefulness" accompanied by an apparent lack of cognitive function. An operational definition is that the eyes open spontaneously in response to verbal stimuli. Sleep-wake cycles exist. The patients spontaneously maintain normal levels of blood pressures and respiratory control. They show no discreet localizing motor responses and neither offer comprehensible words or obey any verbal commands. This condition usually follows a 2-4 week sleep-like coma and begins upon return of "wakefulness." Examples of, but not inclusive of, patient conditions that would meet this condition include terminal chronic conditions, chronic unconscious states, and acute terminal conditions

Related Policies:	
MHS P & P: <i>"Refusal to Consent to Medical Treatment"</i>	
MHS P & P: <i>"Donation After Cardiac Death"</i>	
MHS P & P: <i>"Brain Death Determination"</i>	
MHS P & P: <i>"Advanced Directives: Living Will and Mental Health"</i>	
MHS P & P: <i>"Decision Making in Non-Beneficial (Futile) Treatment"</i>	
Attachments:	
Appendix 1: <i>"End of Life Modification Suggestion Sheet"</i>	
Appendix 2: <i>"Algorithm for Withholding/Withdrawing Life-sustaining Treatment"</i>	
Point of Contact: Clinical Ethicist 403-1136	
Approval By:	Date of Approval:
MHS Ethics Committee	2/11
MGSH Ethics Committee	3/11
MHS Medical Staff Operations Committee	12/11
MGSH MEC	12/11
Quality Steering Council	1/12
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Reviewed with no Changes Dates:	<i>None</i>

Distribution: MHS Intranet

Appendix 1

End-of-Life Care Modification Suggestions

- Encourage open visitation of family and friends
- Lower side rails and place patient's arms (unrestrained) on top of sheets to encourage loved ones closeness – dim lights to reduce harshness
- Sometimes when families are having difficulty with idea of withdrawing treatment, they are able to accept not replacing IV bags with vasoactive drugs as they run empty
- Ask family members to assist you in interpreting the patient's need for additional pain medication or sedation
- When families ask when the death will occur, it is sometimes helpful to gently liken death to birth – we have an idea of due date, but the timing is quite unpredictable – This also may be a good time to ask if the patient might be "waiting" for someone who has not visited. If someone is unable to travel, consider holding the phone up to patient's ear so remote loved ones have a chance to speak with (or to) the patient
- Avoid use of the word "agonal" when describing the dying patient's respiration – loved ones tend to hear this word as "agony"
- Ask questions which encourage loved ones to share stories and reminisce. Get comfortable with standing by in silence – avoid closed posture such as crossing your arms
- Consider ordering a Bereavement Tray from dietary if you feel that the family may be at the bedside for an extended period of time
- Consider asking the family if they would like a lock of hair or handprint – this is especially helpful when a sudden or traumatic death is occurring (Bereavement Box with supplies is located in first cupboard in the equipment room in ICU, the RT room in CVICU, and the equipment room in CCU, and in cupboard of ICU nursing station at Allenmore)
- Offer children's books on grief and teddy bear if there are young family members present (books and bears are located in the Bereavement Box)
- Ask which family member would like Bereavement Follow-up and fill out Bereavement form (if this person does not live with the patient, **get the address** – Epic currently has **only** the phone number listed in demographics)

Appendix 2

Algorithm for withholding/withdrawing life sustaining treatment

