Guidance on Cardiopulmonary Resuscitation during Pandemics

The purpose of this document is to provide guidance for providers regarding cardiopulmonary resuscitation (CPR) during pandemics including the current COVID-19 crisis.

MultiCare providers should refer to the current *DNaR*, *Medically Inappropriate Treatment*, and *Withholding-Withdrawal of Treatment* policies to guide decision-making related to appropriate treatments and Code Status discussions during the current pandemic. Those policies, copies of which are attached, and this guidance apply to all patients including COVID-19 positive patients as well as those whose COVID-19 status is unknown. They also apply to patients with similar high-risk communicable diseases. Depending on the overall course of the current pandemic*, should crisis standards of care be implemented by the State*, MultiCare may need to develop specific DNaR and/or CPR policies for COVID-19 infected patients.

Primary considerations for CPR during the pandemic include the following:

1) CPR may not offer benefit for some COVID-19 patients (as with other patients), particularly those with advanced age and comorbid cardiovascular disease, diabetes, hypertension, and respiratory disease.
2) Performing CPR on patients with COVID-19 may increase transmission to healthcare workers, threatening their well-being and reducing their availability to treat future patients.
3) Attempting to prevent death in all circumstances in not a proper goal of medicine.
4) Early discussions with patients and representatives authorized to make health care decisions on their behalf is necessary as are ongoing discussions as when there are changes in prognosis.

Recommendations:

1) **PPE must be used by the healthcare team** when **assisting a patient on enhanced isolation for highly communicable diseases.** Medical personnel should not perform CPR without adequate PPE. If PPE is not immediately available, it should be obtained prior to assisting.

2) Consistent with current MultiCare policy (DNaR; Medically Inappropriate Treatment), a physician is **not obligated to offer or to provide CPR** if resuscitative treatment is medically inappropriate, **even at the request/demand of a patient** or legally authorized representative. This applies to patients with or without COVID-19 disease. "Medically inappropriate treatment" is treatment: which offers no reasonable expectation of achieving the goals of care or securing a proper goal in medicine; in which the burdens or risks of the treatment grossly exceed the benefits to the patient; or, which causes or is reasonably likely to cause preventable suffering, unnecessary pain, or loss of dignity.

   <u>Providers are encouraged to review the attached policies in detail when deciding whether it is appropriate to enter a DNaR order or withhold specific treatments.</u>

If an attending physician, in conjunction with other clinicians involved in a patient's care, determines that **CPR is medically inappropriate** for any of the above reasons, s/he should follow established MultiCare policies, discuss the rationale with the patient/representative, obtain assent, and enter a DNAR order.

If assent is not obtained, patient care conferences, Palliative Care and /or Ethics consultation as well as escalation to hospital leadership should be considered when needed to facilitate decision making regarding the DNaR status and resolve intractable conflict (see attached policies for specific guidance).

3) **If the WA Department of Health were to declare the need for Crisis Standards of Care** for the region, it may also be appropriate to not offer CPR for certain patients with or without COVID, on the grounds that if the patient had a cardiac arrest and achieved return of spontaneous circulation, the patient **would not receive a high enough priority for the subsequent critical care required for continued survival**. See WA DOH Scarce Resource Management & Crisis Standards of Care for more information.

Ethical Constructs:

1) **Duty to healthcare workers**: We may not cause unreasonable harm to health care workers. This includes having them perform tasks (including but not limited to CPR) without proper equipment – in this case PPE. A healthcare worker without PPE should not attend to a COVID-19 patient, just as they would not attend to a patient with active TB without proper PPE.

2) **Duty to patients**: We owe a duty to treat COVID patients as we would treat similarly situated patients. This means we should provide CPR if medically appropriate and decline to offer CPR when not medically appropriated.

3) **Futility**: CPR is a medical treatment, not a patient right. It should be offered to patients if it is medically appropriate but withheld if it is not, just as with other treatments (such as surgery).

4) **Autonomy**: Patients with capacity have the right to refuse medical interventions. They do not, however, have the right to interventions that are medically inappropriate. Therefore, patients may refuse CPR if it is offered. All patients (COVID or not) should be counseled regarding the medical appropriateness of CPR as early as possible in their clinical course. This becomes even more critical in the COVID-19 population given the high mortality rate in older patients, particularly those with chronic health conditions.

5) **Justice**: When demand for health care resources exceeds supply, as when crisis standards of care are implemented, it may not be possible to offer CPR to patients who could ordinarily benefit from it.

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Title: CODE STATUS, DO NOT ATTEMPT RESUSCITATION (DNAR)

Scope:

This policy applies to all MultiCare patients. It includes Tacoma General Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center and all ambulatory areas.

Policy Statement:

MultiCare Health System supports the patient's right to make decisions about his/her care including end of life considerations. Code Status will be determined as soon as soon as reasonably possible in accordance with the guidelines established in this policy.

Special Instructions:

1. **Resuscitation** is typically thought to encompass external heart compressions, electrical shock to the heart, and intubation. The roles of vasopressive agents and intravascular volume resuscitation should also be considered when decisions are made regarding resuscitation.
2. The term ***"Advance Directive"*** refers to the patient's oral and written instructions about future medical care in the event the patient is unable to express his/her medical wishes. There are two types of End of Life Advance Directives: A Health Care Directive (commonly called a "Living Will") and a Durable Power of Attorney for Health Care. In Washington State, a Mental Health Advance Directive allows patients to specify how they would like their mental health treatment handled in the event they become mentally incapacitated and are unable to make sound decisions about their mental health care due to mental illness. Advanced Directives do not dictate a patient's Code Status. The patient's condition, as specified in the directive, must be determined by the attending physician. (The terms "terminal" or "persistent vegetative state" are commonly used in Advanced Directives).
3. A ***"Living Will,"*** is a legal document specifying the patient's wishes regarding end of life care if the patient is unable to communicate for him/herself. In Washington state, the directive is used **only if** the patient has a **terminal condition** (diagnosed in writing by the attending physician); **or** if the patient is in an **irreversible coma** (as determined by two physicians), **and** where the application of life-sustaining treatment would serve only to artificially prolong the process of dying. Some directives give more specific stipulations regarding the patient's values and his/her interpretation of quality of life.
4. A ***"Durable Power Of Attorney for Health Care,"*** is a legal document allowing the patient to name a person as his/her health care agent. The named individual is authorized to consent to, stop or refuse most medical

treatment for the patient if a physician determines the patient is unable to make decisions him/herself. Once appointed, the health care agent can speak on the patient's behalf **anytime he/she is unable to make his/her own medical decisions, *not only at the end of life.***

5. The Department of Health (DOH) Office of Emergency Medical Services & Trauma System (OEMSTS), in conjunction with the Washington State Medical Association (WSMA), has implemented a new form entitled, "**P**hysician **O**rders for **L**ife **S**ustaining **T**reatment," (**POLST**). The POLST form is intended for EMS use, and the content should be evaluated and considered upon patient's admission to the Emergency Department.
   a. POLST is a "portable" physician order form that describes the patient's code directions and allows individuals to summarize their wishes regarding end of life treatment.
   b. It is intended for use for patients 18 years of age and older with serious health conditions.

Procedure:

I. Establishing the Patient's Code Status:

A. When an adult patient, 18 years of age or older, is admitted to the hospital, staff will ascertain whether or not the patient has an Advance Directive, as per MHS Policy, "Advance Directives: Living Will and Mental Health."

B. Full *resuscitative* measures will automatically be instituted if a patient arrests and there is not a written DNAR order in the patient's medical record.

C. If a *patient* has an Automatic Internal Cardiac Defibrillator (AICD) and wishes to have DNAR status, a conversation will ensue regarding disabling the AICD.

II. Guidelines for Designating Patients as "Do Not Attempt Resuscitation," (DNAR):

A. Evaluation and Discussion:

1. Patient's Code Status, as documented in Epic during any previous hospitalizations at MHS, will be assessed and considered.
2. The patient's attending physician has the primary responsibility to evaluate the patient and to facilitate discussion with patient and/or family as appropriate.
3. If the patient has an outpatient primary care physician, her/his input should be sought regarding code-status discussion.
4. A DNAR order may be considered in clinical situations in which resuscitation would likely be futile or in which the utilization of such treatment would be inappropriate in view of the patient's diagnosis and/or prognosis.

B. Identification of Decision-maker:

1. If the patient is a competent adult, the patient is the primary decision-maker.
2. Refer to MHS Policy, "Informed Consent," for complete information on the patient's legal representative authorized to make health care decisions on his/her behalf. In general, for adult patients, the following individuals are authorized in order of priority:
    a. The appointed guardian of the patient, if any;
    b. The individual, if any, to whom the patient has given a durable power of attorney for health care decisions;
    c. The patient's spouse or registered domestic partner;
    d. Children of the patient who are at least eighteen years of age;
    e. Parents of the patient; and
    f. Adult siblings of the patient

C. Making the DNAR Decision:

1. The decision about the DNAR order should be made in accordance with the expressed wishes or explicit directives of the patient, i.e. "advance directives"; or
2. In accordance with the known preferences and values of the patient.
3. Lacking any of the above, the decision should be based on a careful and reasoned consideration of the patient's interests such as:
    a. When the patient has a terminal condition: Terminal being defined as incurable condition caused by injury, disease, or illness, which regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, cause death, and where the application of life-sustaining procedures would serve only to postpone the moment of death
    b. When the patient is in an advanced stage of terminal and incurable illness and is suffering severe and permanent mental and physical deterioration.
    c. When the patient is in a comatose or persistent vegetative state from which there is no reasonable probability of recovery.

D. DNAR Decisions When No Surrogate is Available:

1. The patient's attending physician together with two other physicians qualified to assess the patient's condition, must 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 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, before life-sustaining treatment is withheld or

withdrawn.

E. Obtaining Informed Consent:

1. The patient's primary physician should obtain informed consent from the identified decision-maker(s) and should document the informed consent in the progress notes. The discussion should include:

   a. A discussion of the seriousness of the patient's illness and prognosis, discussing the role of CPR, alternatives to CPR, including DNAR, and the potential risks and benefits of each option

   b. The patient and/or primary decision-maker should be informed that he/she may change the resuscitation status at any time.

   c. During this discussion it is important to include that during procedures should complications occur, these complications will be treated.

F. Conflict/Disagreement**:**

1. In the event in which there is disagreement among health care providers or between providers and surrogate decision-makers regarding the appropriateness of a DNAR order, such disagreements should be discussed and examined thoroughly and efforts made to achieve agreement. If they cannot be resolved, arrange for a care conference between family, hospital, and physician on code status of an incompetent patient with the following participants as deemed appropriate:

   a. Patient, if able

   b. Immediate family, including legally recognized surrogate

   c. Attending and consulting physicians

   d. Nurse caring for patient

   e. Chaplain and/or social worker

   f. Ethics committee representative(s)

2. The conference should address the following issues:

   a. The attending physician and physician consultants should:

      1.) *Discuss with the participants the patient's condition and the patient's capacity to make decisions.*

      2.) *Clarify treatment options and discuss the potential benefits of each option. Treatment that focuses on comfort should be given high priority. Avoid terms such as: "Withdrawal of care", "withdrawal of support", and "there is nothing more we can do". Identify that we are changing the focus of care.*

   b. The group should discuss the known preferences and values of

the patient.

c. An attempt should be made to facilitate discussion and get agreement of participants to a specific course of action.

d. A physician will place the DNAR order if the surrogate and physician agree. MHS Legal Services and the Ethics Committee are available for consultation if there is disagreement between the physician and the surrogate regarding the indications for attempted resuscitation.

e. Document conference, names of participants, and outcome in patient's medical record

3. If the care conference fails to resolve the conflict, a full ethics consultation should be considered

G. Writing the DNAR Order:

1. All orders not to attempt resuscitation must be written by the physician providing care for the patient.
2. Telephone orders are acceptable only if the attending physician is not readily available to write the order, and it must be documented in EPIC by two RNs who both sign the order.
3. The POLST is a form used by EMTs in the field. It does not take the place of a DNAR order when a patient is in the ED, or after hospital admission. However, the treatment options as designated on the POLST should be strongly considered at the time of hospitalization as an expression of the patient's intent, along with any other expressed wishes or known preferences of the patient.

H. Review, Renewal and Revocation:

1. Since the condition of a hospitalized patient may change, code status should be reviewed and renewed at regular intervals at the discretion of the patient's attending physician.
2. Caregivers and patients/surrogates should also be informed that a decision to forego resuscitative treatment can be revoked at any time by the patient/surrogate.
3. A DNAR in a patient's medical record shall remain in effect until the patient is discharged from the hospital unless circumstances or the wishes of patient/surrogate warrant a change.
4. When a patient with DNAR status is discharged, a POLST form will be completed to provide continuation of DNAR status outside of the hospital in accordance with the patient's wishes.

III. "DNAR" Patients and Surgery, Anesthesia, and/or Invasive Procedures:

A. When a patient who has a DNAR order is to undergo surgery, receive an anesthetic *agent* and/or be subject to an invasive procedure that may be associated with risk to cardio-pulmonary function:

1. The surgeon or physician performing the invasive procedure must engage in discussion with the patient or surrogate regarding the handling of the DNAR order and goals of care. Discussion needs to include the following elements:
    a. The content of the patient's advanced directive
    b. The expectation that if complications from the procedure arise, these complications will be treated
    c. The patient's understanding and agreement to continue with the procedure/surgery

IV. Communication and Notification of DNAR or Limited Code Status:

A. Place purple "DNAR" charm on those patients who are strictly a DNAR. Do not use this charm for patients who have requested certain or limited interventions for resuscitation. (These patients will not have an information charm.) Instead, refer to the specific order noted in the Epic "Code" tab.

B. Educate the patient and family on the purpose of the charm and the implications of not wearing it. (i.e. patient may be misinterpreted as a full code and treated accordingly.)

C. If the patient refuses to wear the wristband with DNR charm, document the patient's refusal in the medical record.

V. Level of Care:

A. Although a DNAR order may be part of an overall treatment plan which involves reduction of the level or intensity of care the patient is receiving, caregivers, patients and families must understand that the order not to attempt resuscitation has no implications for any other treatment decisions. Patients with DNAR orders on their medical record may remain candidates for all vigorous care, including intensive levels of care.

Related Policies:

MHS Policy, *"Advance Directives: Living Will and Mental Health"*

MHS Policy, *"Brain Death"*

MHS Policy, *"Care of the Dying Patient"*

MHS Policy, *"Medical Ethics Consultation"*

MHS Policy, *"Patient Transfer and Transport"*

MHS Policy, *"Withdrawing and Withholding Life Support"*

MHS Policy, "*Decision Making In Non-Beneficial (Futile) Treatment*"

References:

Revised Code of Washington: Chapter 70.122 RCW NATURAL DEATH ACT

Washington Supreme Court cases, In re Grant, 109 Wn. 2d 545 (1987) and In re Hamlin, 102 Wn. 2d 810 (1984).

	Point of Contact: **Clinical Ethicist 403-1136**

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MMC Campus:	
MHS Ethics Committee	***3/11***
Medical Staff Operations	***4/11***
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**10/09 policy code standardization changes only*
***Policy formerly known as Code Status, Do Not Resuscitate*
3/2017 locations included in scope
7/17 Covington Medical Center added to scope

Title: MEDICALLY INAPPROPRIATE TREATMENT: Decision-Making Guidelines

Scope:

This policy applies to patients receiving care at MultiCare Health System (MHS) in the Puget Sound region including Tacoma General/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Covington Medical Center and all ambulatory care areas.

Policy Statement:

1. MHS supports the right of patients, or their legally authorized surrogate, to participate in decisions about their treatment and to decline any and all medical treatment, including those necessary to sustain life. MHS also supports the principle that health care providers are not required to offer or continue to provide any medical treatment that is medically ineffective or contrary to generally accepted health care standards – referred to in this Policy as "medically inappropriate."
2. The term "medically inappropriate" should be used, rather than futile or non-beneficial, as the latter two definitions can be misleading. The term futility should be used in the rare circumstance that an intervention cannot accomplish the intended physiological goal. Clinicians should not provide futile interventions and should carefully explain the rationale for the refusal. Non-beneficial refers to a quality of life judgement that may differ between patients and providers. Henceforth, "medically inappropriate" describes a treatment or intervention that meets *at least one* of the following criteria *in reference to* the patient's clinical condition, goals of care, medical literature, and the expertise of the treating physicians:
    - The treatment offers no reasonable expectation of achieving the goals of care or securing a proper goal in medicine.
    - The burdens or risks of the treatment grossly exceed the expected benefits to the patient.
    - Treatment is causing or is reasonably likely to cause preventable suffering, unnecessary pain, or loss of dignity.
3. The **goals** of this policy are to provide a process to (a) determine whether an intervention is medically inappropriate, and (b) to manage patient/surrogate requests for medically inappropriate treatment.

Procedure:

I. Determining Medically Inappropriate Treatment

A. General Considerations

1. Decisions regarding potentially inappropriate medical treatment are complex and case-specific, and should be conducted in a mutually respectful partnership

between the patient/surrogate, family and the healthcare team. Decisions should be guided by respect for:

a. The patient's fundamental right to control decisions regarding their health care, including the decision to refuse life-sustaining treatment, and

b. The patient's right to personal dignity, and

c. The health care providers' obligations to provide beneficial treatments, restore health, and/or relieve suffering.

2. Central to this policy is the belief that treatments should have a reasonable probability of achieving the patient's stated goals. Physicians should provide patients with a considered recommendation as to which medically appropriate treatment option(s) will best serve the patient's goals.

3. In the absence of such available treatments, treatments that minimize suffering become the primary goal for patients with a life-limiting illness.

4. Physicians have a professional and ethical responsibility to offer patients only such treatment choices that are medically appropriate for the patient. A medically appropriate treatment:

   a. is reasonably expected to secure a proper goal of medicine, and

   b. has benefits that exceed the burdens or risks to the patient, and

   c. offers the patient the ability to experience the benefit of the treatment.

5. In the context of treating a *life-threatening condition*, the following are among proper goals of medicine:

   a. preventing unexpected, premature death, or

   b. curing disease, or

   c. maintaining or improving quality of life, or

   d. providing for a peaceful death.

Attempting to prevent death in all circumstances is not a proper goal of medicine.

6. A medically ***inappropriate*** treatment is one that:

   a. holds at least some chance of accomplishing the effect sought by the patient or surrogate, but competing ethical considerations justify not providing it, or

   b. would serve only to prolong the patient's irreversible dying process that is actively underway, excluding circumstances in which medical interventions are continued for a brief period of time **(refer to C4 section of Withholding-Withdrawing Policy)**, or

   c. would serve only to maintain the patient's life in a permanent unconscious state or other neurologically devastated state in which the patient is unable to experience the benefits of treatment or survive outside of the hospital's acute care setting, or

   d. would impose burdens on the patient grossly disproportionate to any expected benefit. The relevant considerations include, but are not limited to:

i. How long the treatment is likely to extend life and whether it will improve the patient's prognosis for recovery.

ii. The possibilities of return to a cognitive, sapient life and remission of symptoms enabling return towards a reasonably normal, functioning, integrated existence.

iii. The degree of intrusiveness, risk and discomfort associated with the treatment, including intractable pain, loss of dignity or other forms of suffering.

B. **Establishing Goals of Care**

The treatment team should establish the patient's goals of care promptly after admission. Goals of care discussions are a priority for any patient with medical conditions that threaten his or her life imminently or in the near future (approximately 6 months) where treatment options are particularly burdensome or risky. The following guidelines apply when establishing goals of care.

1. Each patient/surrogate should be given the opportunity to define his or her individual goals of care. The process requires active engagement by the treatment team in eliciting patient or surrogate participation and listening to concerns, goals, and preferences.
2. The attending physician provides guidance regarding whether the patient or surrogate's stated goals of care are attainable based on the best available medical evidence. The guidance should clearly state the nature of the illness, the prognosis, and the therapeutic options (including palliative and hospice care if appropriate).
3. Early involvement of the palliative care team is recommended for patients who have a life-limiting or complex illness, especially when options for treatment include interventions that may prolong the dying process.
4. Communication among physicians and the treating team is essential to reach consensus regarding which treatment to offer the patient/surrogate. The patient's preferences and any advance directives must be considered as treatment options are discussed.

II. Managing Requests for Medically Inappropriate Treatment

A. When requested interventions are deemed medically inappropriate under circumstances presented by the patient's medical condition, the attending should:

1. seek to understand the patient/surrogate's perspective, correct any misperceptions and explain the rationale for why an intervention is not appropriate, and
2. provide recommendations as to which appropriate treatment choices are available to the patient, and
3. document the discussion and rationale in the patient's chart.

B. If the patient or surrogates continue to request interventions that the attending physician and treating team believe are medically inappropriate, the attending physician should consider: Respectfully advocating for an alternative treatment course, including comfort measures if appropriate, and

1. Requesting a multidisciplinary patient care conference that requires the attending physician's attendance, and
2. Enlisting any consultants to help mediate a negotiated agreement, such as, but not limited to: palliative care, medical/nursing specialty consultants, ethics, social work, or chaplaincy.

C. If the request for medically inappropriate treatment remains in conflict despite intensive communication and negotiation, the following process of conflict resolution should be engaged.
   1. As a point of information, contact the Risk and Legal departments, and the Chief Medical Officer.
   2. The attending physician may request a second opinion from an independent physician with expertise in the patient's condition, addressing both the patient's prognosis and the judgment regarding the requested medically inappropriate treatment. The second opinion must be fully documented in the patient's chart and discussed with the patient or surrogate.
   3. Request an ethics consult (if not yet initiated). The ethics consult team will meet with all appropriate parties to ensure inclusion of relevant perspectives. The ethics committee shall promptly notify the patient/surrogate and attending physician/treatment team of their recommendations. The recommendations will be documented in the patient's chart.

D. If the conflict has become intractable, the attending physician and ethics consultant shall inform the patient/surrogate of the options available.

E. If medically inappropriate treatment was initiated, the attending physician should explain to the patient or surrogate that the intervention will be subject to ongoing review of its efficacy, as the norm for all medical interventions and may not be continued in the future. At this juncture, refer to the **Withholding/Withdrawing of Life-Sustaining Treatment** policy.

Definitions:

Attending Physician: The physician assigned to the patient who has primary responsibility for the treatment and care of the patient.

Comfort Care: Care whose intent is to relieve suffering and provide for the patient's comfort and dignity. This includes treatment for physical symptoms, as well as psychological, social, and spiritual support for the patient or family.

Medical Futility: the rare circumstance that an intervention cannot accomplish the intended physiological goal.

Surrogate Decision-maker: Person legally authorized to provide medical consent for a patient who is not competent or lacks decision-making capacity. Refer to the **MHS Policy Informed Consent Section C: Adult patient's Decisional Capacity** for the updated (2019) priority list.

Treatment or Treating Team: All clinicians assigned to care for the patient, including but not limited to: physicians, nurses, social workers, chaplains, and allied health staff (respiratory, dieticians, physician therapy, etc.).

	References: American Medical Association. Caring for patients at the end of life. Code of Medical Ethics Opinion E5.1 – E5.5. *AMA principles of medical ethics*. Accessed 12/2019 from: https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-caring-patients-end-life Bosslet GT, Pope TM, Rubenfeld GD, Lo B, Truog RD, et al. An official ATS/AACN/ACCP/ESICM/SCCM policy statement: responding to requests for potentially inappropriate treatments in intensive care units. *Am J Respir Crit Care Med*. 2015;191(11):1318–1330. doi:10.1164/rccm.201504-0750ST Hanson MJ & Callahan D. The goals of medicine: The forgotten issues in health care reform. Washington: Georgetown University Press; 2000. Jonsen AR, Siegler M, Winslade WJ. Clinical Ethics: A practical approach to ethical decisions in clinical medicine. 8th ed. New York, NY: McGraw-Hill companies; 2015. Schneiderman LJ. Defining medical futility and improving medical care. *J Bioeth Inq*. 2011;8(2):123-131. doi: 10.1007/s11673-011-9293-3 Washington State Legislature. Informed consent—persons authorized to provide for patients who are not competent-priority (amended 2019). Retrieved 12/2019 from https://app.leg.wa.gov/RCW/default.aspx?cite=7.70.065
	Point of Contact: Clinical Ethicist 403-1136

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Ethics Committees	***6/11; 1/20***
CMC MEC	***2/20***
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Title: WITHHOLDING/WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

Scope

This policy applies to patients receiving care at MultiCare Health System (MHS) in the Puget Sound region including Tacoma General/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Covington medical Center and all ambulatory care areas.

The following patients require additional procedures before enacting this policy:

- If the patient has been declared dead by whole brain criteria, refer to the **Brain Death Determination Policy**.
- If the patient is pregnant with a viable fetus, contact the local hospital's Risk Manager and ethics committee.

Policy Statement:

1. MHS recognizes that the decision to withhold or withdraw life-sustaining treatment is ethically and legally appropriate in certain circumstances. It is expected that all involved health care providers will approach the decision-making process with the highest degree of professionalism, engaging in respectful and transparent discussion with the treatment team, the patient or surrogate, and the patient's involved family members.
2. The decision to withhold or withdraw treatment is complex and case-specific, and should be ***guided by respect for***:
    - the patient's fundamental right to control decisions regarding their health care, including the decision to refuse life-sustaining treatment, and
    - the patient's right to personal dignity, and
    - health care providers' obligations to provide medically appropriate treatments, restore health, and relieve suffering, and
    - personal values that bear on the decision-making process and the right of a health care provider to elect not to participate in withholding or withdrawing life-sustaining treatment.
3. The goals of this policy are to provide guidelines for withholding or withdrawing life-sustaining medical treatment and may be referred together with the **Medically Inappropriate Treatment Policy**.

Procedure:

A. General Considerations

1. A discussion concerning the withholding or withdrawal of life-sustaining treatment may be initiated by the patient, the patient's surrogate or family members, the attending physician, or a consulting physician. The attending physician is responsible for coordinating communication between the patient or surrogate, the patient's involved family members, and members of the treatment team.

2. Under Washington law, the right to refuse, withhold or withdraw life-sustaining treatment includes the right to refuse, withhold, or withdraw artificial nutrition and hydration.

3. A surrogate's decision to withhold or withdraw treatment should be guided by the ***substituted judgment*** standard, which means he or she is relying on known or inferred preferences of the patient when deciding about medical treatment. If the patient's preferences are unknown and cannot be reasonably inferred from the surrogate's knowledge of the patient, an advance directive, or knowledge of others who discussed end of life preferences with the patient, the surrogate must consider the ***best interest*** of the patient. The treatment team should support the surrogate decision-maker in reaching decisions that are guided by the ***appropriate standard*** under the circumstances.

B. Establishing Goals of Care and Treatment Plans

1. The treatment team should establish the patient's goals of care, including goals related to life-sustaining treatments as soon after admission as possible.

2. When the patient lacks decision-making capacity, the treatment team should review the patient's advance directives, if any, and engage the patient's legally qualified surrogate decision-maker in a discussion about goals of care. It is appropriate to involve immediate family members who have knowledge regarding patient preferences to assist the surrogate in exercising substituted judgment.

3. When the patient lacks decision-making capacity and has no surrogate, family, or other legal representative to speak for him or her, notify the local hospital's care continuum director to consider a guardianship process. An ethics consult may also be requested.

4. The role of the treatment team includes providing guidance whether the patient/surrogate's goals of care are attainable based on the best available medical evidence. When requested treatments are deemed medically inappropriate, providers must respectfully discuss the rationale for any decision to withhold/withdraw the requested treatment and document the discussion and rationale in the patient's chart.

5. If the goals of care shift to comfort care and/or a decision is made not to escalate treatment, that goal should persist even as attending physicians change. This ensures continuity of care, minimizes the disruption to patients, family and staff, and helps families focus on supporting their dying loved one. The current attending physician should have a conversation with the incoming attending physician to help ensure continuity.

6. If there is clinically significant change in the patient's medical condition, the goals of care should be re-evaluated.

7. Early involvement of the palliative care team is recommended when a patient has a life-limiting or terminal illness, especially when withholding or withdrawing treatment is being considered.

C. Guidelines to Withhold or Withdraw Life-Sustaining Treatment

1. A patient who has decision-making capacity has the right to refuse life- sustaining treatment, including artificial nutrition and hydration. The request can be made directly by the patient or through his or her advance directive. In such cases, life-

sustaining treatment may be withheld or withdrawn, provided conditions of the advance directive are met. Involved family members should be informed of the decision.

2. When the attending physician, with consensus of the treating team, makes a judgment that a life-sustaining intervention is medically inappropriate, the attending should commence a patient care conference (as appropriate) to explain the treating team's recommendations, the medical rationale supporting it, the alternatives and their likely outcomes. It is recommended to include members from palliative care, social work and/or spiritual care for added support.
3. The attending physician seeks the patient/surrogate's agreement to withhold or withdraw the interventions. The discussion should be summarized in the patient's chart. Once a decision is made to withdraw or withhold treatment, the preferences of the patient and his or her involved family members should be taken into consideration when they do not harm the patient or complicate the withdrawal process. In certain circumstances the medical interventions may continue to be provided for a brief period of time, such as to allow travel time to reach the patient or to perform cultural or religious ceremonies.
4. Discussion of the option to donate organs is a separate decision from withdrawal of life-sustaining treatment, and should be addressed prior to the withdrawal. Tissue donation (including corneas) may be discussed after the patient has died. **Refer to the Organ, Tissue and Eye donation** policy for guidance.

D. Conflict Resolution Procedure

1. Conflicts may arise when parties disagree about the best course of action in the care of a patient when the treating team believes that:
    - a treatment is medically inappropriate, or
    - a treatment is contrary to generally accepted medical standards, or
    - the burden of suffering, intrusiveness, and/or loss of dignity resulting from treatment significantly outweighs any benefit.
2. Three types of conflict often arise: (a) intra-professional between members of the treating team, (b) between family members or surrogates, and (c) between the treating team and the patient or surrogate. Depending on the source of conflict the following steps should be taken.
3. Conflict between members of the treating team (intra-professional):
    a) Regular team meetings should be held to discuss the patient's prognosis, goals of care, and proposed treatments to achieve consensus among physicians and/or treating team members.
    b) Care should be taken not to engage the family with intra-professional disagreements. This places an unfair burden on them and can provide confusing information regarding treatment options.
    c) If the intra-professional conflict remains unresolved, support from the ethics committee is recommended.. The ethics committee members help to facilitate a fair resolution of the conflict, identify areas of agreement or consensus, and provide recommendations and ethical rationale for various courses of action.

d) If the conflict is not resolved after an ethics consult, the Chief Medical Officer should be enlisted. Final resolution for intra-professional conflicts is an institutional responsibility that includes of the hospital's Chief Medical Officer, MHS service lines and specialties appropriate to the situation, and MHS leadership.

4. Conflict between family members and/or surrogate:

    a) If disagreement arises between family members or surrogate, a family conference should be held with the members of the treating team to discuss the patient's prognosis, goals of care, and proposed treatments to try and achieve consensus. If disagreement persists, an ethics consult should be requested.

    b) Ultimately, with conflicts between family members and/or surrogate, the final decision resides with the legally authorized surrogate. However, every effort should be made by the treating team to help the family reach consensus regarding the withholding or withdrawing of life-sustaining treatment.

5. Conflict between the attending physician/treating team and pt/surrogate:

    a) If the family does not agree with the attending and treating team's recommendation to withhold or withdraw treatment, an ethics consult should be requested. The ethics consultant will meet with all parties to ensure inclusion of all relevant perspectives and provide recommendations and ethical rationale for various courses of action. The process and outcome of the consult will be documented in the patient's chart and communicated to the providers and patient/surrogate/family. The patient/surrogate will be allowed an appropriate amount of time to consider the recommendations.

    b) If disagreement persists after obtaining the ethics consultation, the attending physician may request second opinion from a physician with appropriate expertise. The consulting physician will inform the treatment team and the patient/surrogate regarding their assessment.

    c) Pursuant to Washington code RCW 70.122.030, prior to withholding or withdrawing life-sustaining treatment for patients who lack capacity, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two physicians shall be documented into the patient's medical record.

    d) As a point of information, the attending physicians should notify the CMO aobut the intractable conflict. It is recommended the CMO informs the Risk and Legal departments about the situationThe patient/surrogate should be offered the opportunity to arrange for transfer to another facility.

    e) Final resolution to withhold or withdraw life-sustaining treatment in situations where there is intractable disagreement is considered an institutional decision that includes the hospital's Chief Medical Officer, MHS service lines and specialties appropriate to the situation, and MHS leadership. The Chief Medical Officer or attending physician with support from any relevant clinical staff or MHS representative will inform the patient/surrogate of available options.

E. Definitions

1. **Life-Sustaining Treatment**: Any medical or surgical intervention that uses mechanical or other artificial means, including artificial nutrition and hydration, to 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.
2. **Attending Physician:** The physician assigned to the patient who has primary responsibility for the treatment and care of the patient.
3. **Medically Inappropriate Treatment:** **See Associated Policy** Any treatment or course of treatment that:
    a) holds at least some chance of accomplishing the effect sought by the patient or surrogate, but competing ethical considerations justify not providing it, or
    b) would serve only to prolong the patient's irreversible dying process that is actively underway, excluding certain circumstances in which medical interventions are continued for a brief period of time, or
    c) would serve only to maintain the patient's life in a permanent, unconscious state or other neurologically devastated state in which the patient is unable to experience the benefits of treatment or survive outside of the hospital's acute care setting, or
    d) would impose burdens on the patient grossly disproportionate to any expected benefit.
4. **Medical Futility:** the rare circumstance that an intervention cannot accomplish the intended physiological goal. Medical futility may be invoked as the basis for a physician's decision to withhold or withdraw a medical intervention.
5. **Surrogate Decision-Maker:** Person legally authorized to provide medical consent for a patient who is not competent or lacks decision-making capacity. Refer to the **MHS Policy Informed Consent Section C: Adult patient's Decisional Capacity** for the updated (2019) priority list.
6. **Treatment or Treating Team:** All of the clinicians assigned to care for the patient, including but not limited to: physicians, nurses, social workers, chaplains, and allied heath staff (respiratory, dieticians, physician therapy, etc.).

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