MultiCare

**Patient Care**

# 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, Auburn Medical Center, Covington Medical Center, Capital 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:
    a. the patient's fundamental right to control decisions regarding their health care, including the decision to refuse life-sustaining treatment, and
    b. health care providers' obligations to provide beneficial treatments, restore health, and/or relieve pain and suffering, and
    c. 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 Ineffective 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 ineffective, 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 ineffective, 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. a treatment is medically ineffective, or
   b. a treatment is contrary to generally accepted medical standards, or
   c. the burden of pain, suffering, and/or intrusiveness 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 about the intractable conflict. It is recommended the CMO informs the Risk and Legal departments about the situation. The 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

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| | Medical Officer or attending physician with support from any relevant clinical staff or MHS representative will inform the patient/surrogate of available options. |
| | **Definitions**<br><br>**Attending Physician:** The physician assigned to the patient who has primary responsibility for the treatment and care of the patient.<br><br>**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.<br><br>**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.<br><br>**Medically Ineffective Treatment: See Associated Policy** Any treatment or course of treatment that:<br>1. holds at least some chance of accomplishing the effect sought by the patient or surrogate, but competing ethical considerations justify not providing it, or<br>2. 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<br>3. 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<br>4. would impose burdens on the patient grossly disproportionate to any expected benefit.<br><br>**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.<br><br>**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.). |
| | **References:**<br><br>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<br><br>American Medical Association. Medically Ineffective Interventions. Code of Medical Ethics Opinion 5.5. *AMA principles of medical ethics.* Accessed 3/2020 from: https://www.ama-assn.org/delivering-care/ethics/medically-ineffective- |

interventions

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**Point of Contact: Clinical Ethicist (253) 403-1136**

| ***Approval By:*** | ***Date of Approval:*** |
|---|---|
| Tacoma Ethics Committees | ***1/20, 3/20*** |
| AMC/CMC Ethics | ***3/20*** |
| GS Ethics | ***3/20*** |
| GS MEC | ***2/20, 4/20*** |
| CMC MEC | ***2/20, 4/20*** |
| AMC MEC | ***4/20*** |
| Tacoma Med Ops | ***2/20, 4/20*** |
| CapMC MEC | ***9/21*** |
| CapMC Executive Board of Directors | ***9/21*** |
| MHS Quality Safety Steering Council | ***3/20, 5/20*** |
| Original Date: | *01/89* |
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4/2017 locations included in scope
7/17, Covington Medical Center added to scope
Approved for Capital Medical Center 9/7/21 by CapMC MEC and Executive Board of Directors
Approved by MHS QSSC e-vote 9/21/2021 to apply to Capital Medical Center