

POLICY

Shared Decisions for Life-Sustaining Treatment

Category: Clinical

Sub-Category: Rights & Responsibilities

Other: Medical Staff, Nursing, and Leadership

Type: POLICY

Status: Active

Last Reviewed: 02/27/2019

Regulatory Source(s): The Joint Commission

Other: CMS and Washington State

Regulatory Citation Number(s): RI.01.02.01, 42 CFR Section 456.80, RCW 70.122, RCW 70.122.030, RCW 70.122.060, RCW 7.70.065, RCW 71.32.020, RCW 11.88.010(1)(e)

Citation title:

RI.01.02.01 The hospital respects the patient's right to participate in decisions about his or her care, treatment, and services

42 CFR Section 456.80 Individual Written Plan of Care

RCW 70.122 Washington State Natural Death Act

RCW 70.122.030 Directive to withhold or withdraw life-sustaining treatment

RCW 70.122.060 Procedures by physician – Health care facility or personnel may refuse to participate

RCW 7.70.065 Informed consent – Persons authorized to provide for patients who are not competent – Priority

RCW 71.32.020 Definitions

RCW 11.88.010(1)(e) Authority to appoint guardians – Definitions – Venue – Nomination by principal

Foundational Mirrored Policy: No

PURPOSE:

This policy describes a standard approach for Shared Decisions to continue, to Limit, or to Withdraw Life-Sustaining Treatment.

SCOPE: Licensed Staff

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Shared Decisions about Life-Sustaining Treatments are complex and patient specific. These decisions involve eliciting the patient's perspective and the clinical expertise of the attending of record along with any other clinicians involved in the patient's care.

GUIDELINE PRINCIPLES:

- A. Virginia Mason's mission prioritizes healing illness and aims to improve a patient's well-being. Clinicians promote a patient's well-being through providing Medically Appropriate Treatment that heals, promotes the patient's Best-Interest, works to prevent illness or injury, minimizes pain and anxiety, and respects a patient's right to personal dignity.
- B. Virginia Mason supports patients' (and/or their Surrogates') rights to actively participate in decisions involving their health. Clinicians must include patients and/or their Surrogates in the Goals of Care and inform them of any changes in their treatment plan. Patients or their Surrogates have the right to accept or refuse Medically Appropriate treatments and services, including the decision to refuse Life-Sustaining Treatment.
- C. Virginia Mason supports health care providers' obligations to provide Medically Appropriate treatment aimed to restore a patient's health, maintain personal dignity, and alleviate suffering. Health care providers' are not obligated to offer or recommend a treatment classified as Medically Futile or not Medically Appropriate.

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- D. Continuing, Limiting or Withdrawing a specific Life-Sustaining Treatment does not indicate that other appropriate treatment is to be diminished or not provided. Ongoing supportive interventions (including surgery, medication or other procedures) aimed at providing comfort will be provided.
- E. Virginia Mason respects a healthcare provider's personal values to endorse a conscientious objection as a reason to not participate in the Limiting or Withdrawing of Life-Sustaining Treatment.

GUIDELINE PROCEDURES:

I. Default Plan of Care:

- A. All patients default to a Full Code resuscitation status and receive all Medically Appropriate treatment(s).
- B. All deviations from Full Code resuscitation must be based on one of the following:
 - i. Agreement from the patient and/or Surrogate along with the rest of the Treatment Team, or
 - ii. As Outlined in Appendix A
 - iii. Upon the completion of a conflict resolution process.

II. Evaluation of Shared Decisions for Life-Sustaining Treatment(s)

- A. Clinicians evaluate all decisions for Life-Sustaining Treatments with their patients and/or Surrogate(s) to create a Plan of Care.
- B. The Plan of Care should be re-evaluated whenever a patient's medical condition changes.
- C. Whenever a patient has an established primary care provider (PCP), clinicians should attempt to contact PCP.

III. All are in agreement with the Plan of Care:

When the patient and/or Surrogate(s) and the rest of the Treatment Team agree to continue, Limit, or Withdraw Life-Sustaining Treatment based on one of the following:

- A. **Patient-directed:** One of the following is present:
 - i. The patient has Capacity to accept or refuse Life-Sustaining Treatment.
 - ii. The patient completed a Physician's Orders for Life-Sustaining Treatment (POLST). If able, the patient does not reject prior wishes stated on POLST.
 - iii. The patient completed an Advance Directive and the patient confirms wishes to accept or decline Life-Sustaining Treatment
- B. **Surrogate-directed:** When a patient lacks Capacity and has a Permanent Unconscious Condition, a Terminal Condition or a Lethal Illness and one of the following is present:
 - i. The patient completed a Physician's Order for Life-Sustaining Treatment (POLST). If able, the Surrogate does not reject the patient's prior wishes stated on POLST.
 - ii. The patient completed an Advance Directive and the Surrogate confirms the patient's wishes for Life-Sustaining Treatment
 - iii. The patient's Surrogate accepts or declines Life-Sustaining Treatment based on the patient's prior expressed wishes or values.
- C. **Clinician-directed:** When a patient has a Permanent Unconscious Condition, a Terminal Condition or a Lethal Illness, the patient's clinician may invite a patient or Surrogate to defer to the clinician's recommendations to continue, Limit or Withdraw Life-Sustaining Treatment

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when either: (i) the clinician elicited the patient's values or treatment preferences or (ii) the treatment(s) is not Medically Appropriate.

- i. The patient and/or Surrogate must provide Informed Assent/Non-Dissent before changing the Plan of Care. If the patient or Surrogate decline or disagree with recommendations – go to Conflict Resolution in Section IV(B)

D. Patients with no decision maker

When a patient lacks Capacity and does not have a Surrogate to help inform a patient's Plan of Care. The attending physician should seek guidance from the clinical ethics consult service, the executive medical director, chief medical officer, or risk management.

- i. A Physician's Order for Life-Sustaining Treatment (POLST) is Present.
 - I. A POLST is an actionable order. Refer to Patient-Directed, Section III(A)
- ii. Withdraw Life-Sustaining Treatment:
 - I. Withdrawing mechanical ventilation or artificial nutrition may require enlisting a court-appointed guardian to participate in the decision-making process unless the treatment is Medically Futile.
- iii. Limiting Life-Sustaining Treatment:
 - I. To align the Plan of Care to Limit Life-Sustaining Treatments, including CPR and intubation the following two things must be present:
 - a. All treating clinicians and at least one physician not involved in the patient's care must agree the treatment is not Medically Appropriate and,
 - b. A Healthcare Ethics Consultant recommends that it is ethically permissible to limit treatment and shares rationale with the Treatment Team.

IV. Conflict is Present about a treatment(s) or the Plan of Care:

When disagreements exist over changes to the Plan of Care to continue, to Limit or to Withdraw Life-Sustaining Treatments, clinicians must continue treatment(s) already started or offered until

- (1) A consensus is reached,
- (2) The treatment proves to be medically futile, or
- (3) A conflict resolution process is complete.

The conflict resolution process at Virginia Mason follows national recommendations and requires involvement of a Healthcare Ethics Consultant. Based on what parties disagree, follow one of the conflict resolution resources available through the Bioethics VNET site.

- (A) Two or more treating clinicians disagree;
- (B) A patient and/or Surrogate disagree with the clinicians; or
- (C) A patient and a Surrogate(s) or Surrogate(s) disagree.

DEFINITIONS:

Refer to Medical Center Policy Development & Approval - Appendix A for standard workforce, roles and work product definitions.

Adult Person: A person who has attained the age of majority as defined in RC 26.28.010 and 26.28.025 (generally 18 years of age) and who had the *Capacity* to make health care decisions.

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Advanced Directive or Living Will: Used interchangeably, these documents reflect a person’s written wishes about treatment preferences in the event the person is not capable and has a terminal or permanently unconscious condition. – see Policy: Advance Directives

Best-Interest: The best-interest standard protects another’s well-being by assessing risks and benefits of various treatments and alternatives to treatment, by considering pain and suffering, and by evaluating restoration or loss of functioning. (Beauchamp, T. & Childress, J., 2001)

Capacity: An assessment by a clinician or a court of a patient or Surrogate’s medical decision making. Virginia Mason uses the clinician’s assessment to determine patients’ and Surrogates’ Capacity for all medical decisions and only petitions the court when directed by a County Mental Health Provider, advised by Administration or when clinicians assess a patient without a Surrogate to lack Capacity.

- i A clinician’s Capacity assessment is defined as the evaluation of the patient’s and Surrogate’s ability to consent or to refuse treatments. A patient or Surrogate with Capacity must 1) understand the medical condition, 2) appreciate the options available and the associated risks of treatment, 3) engage in a process of reason (pros and cons), and 4) be able to communicate a choice. See Policy – Informed Consent
- ii A court assumes all Adult Persons have Capacity unless found to be Incapacitated according to RCW 71.32.020(7) or Incompetent according to RCW 11.88.010 (1)(e).

Consensus: General agreement among the treatment team or the treatment team, the patient and the Surrogate. The judgment arrived at by most of those concerned and endorsed by the patient’s attending physician.

Durable Power of Attorney for Health Care (DPOA-HC): a document that allows an adult patient to give an authorized representative the right to make health care decisions in the event that the patient lacks decision-making capacity – see Policy: Advanced Directives

Full Code: The following medical interventions are provide when Medically Appropriate:

1. Advanced Cardiac Life Support (ACLS) guidelines with high quality Basic Life Support (BLS)
2. Adjunctive equipment and techniques to establish and to maintain effective ventilation and circulation;
3. Cardiac monitoring, dysrhythmia recognition, and treatment with medications and defibrillation

Goals of Care: The primary focus of medical treatments. Goals of care are specific to the individual patient, deriving from the patient’s preferences, desires and values, and the clinical likelihood of achieving those goals. Examples of goals of care include: cure, restoration of health/function, and comfort measures.

Incapacitated: Under Washington State law a court finds a person “Incapacitated” when an Adult Person is unable: (a) to understand the nature, character, and anticipated results of a proposed treatment or alternatives; to understand the recognized serious possible risks, complications, and anticipated benefits in treatments and alternatives, including non-treatment; or communicate understanding of treatment decisions, or (b) has found to be Incompetent pursuant to RCW 11.88.010(1)(e).

Incompetent: Under Washington law a person is “incompetent” to give informed consent to withhold or withdraw life-sustaining treatment (including informed refusal) if s/he is under the age of 18 or if s/he is determined by the court to be incompetent by reason of mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental incapacity to manage one’s property or to care for oneself or both. RCW 11.88.010 (1)(e)

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Informed Assent/Non-Dissent: When a clinician(s) provides a medical recommendation(s) to Limit or Withdraw treatment and the patient or Surrogate does not disagree with the recommendations. It does not require verbal agreement. Clinicians use Informed Assent/Non-Dissent when: (a) a patient or Surrogate agrees to defer to a clinician's judgment, (b) at the end of a Time-Trial, or (c) a Healthcare Ethics Consultant recommends it in a clinical ethics consultation.

Healthcare Ethics Consultant: A professional with advanced training in clinical ethics who provides clinical ethics consultations for patients, Surrogates, and staff.

Lethal Illness: The patient's underlying ailment that will result in imminent death.

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. [RCW 70.122.020(5).]

Limit: Limit means to not initiate a treatment.

Medical Futility: A treatment "may be futile if despite that intervention the patient will die in the very near future or if the patient has an underlying lethal condition which the intervention does not effect and which will result in death . . . even if the intervention is employed." (Brody H, 1995; Schneiderman et. al, 2017)

Medically Appropriate or Necessary: Used interchangeably, a medically necessary treatment or intervention aligns with a patient's Goals of Care and "that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider." (AMA, 2011)

Plan of Care: An individual written document created through Shared Decision making with the patient and/or Surrogate(s) and the physician and other personnel involved in the patient care. The plan of care outlines: the patient's diagnoses, symptoms, complaints, and complications indicating the need for hospital admission; a description of the functional level of the patient; physician orders for medications, treatments, restorative and rehabilitative services, activities, social services, and diet according to physicians' instructions; plans for continuing care, as appropriate; and plans for discharge, as appropriate. 42 CFR §456.80

Permanent Unconscious Condition: An incurable and irreversible condition in which the patient is medically assessed with reasonable medical judgment as having no reasonable probability [to cure] for an irreversible coma or a persistent vegetative state. [RCW 70.122.020(6).]

POLST (Physician Order for Life-Sustaining Treatment) – an actionable physician order that describes the patient's wishes regarding issues of life support and end of life care on a portable document.

Potentially Inappropriate Treatment: A treatment or intervention that has at least some chance of accomplishing the effect sought by the patient/Surrogate, but clinicians believe that competing ethical considerations justify not providing the treatment.

Shared Decisions: Shared decision-making is a process in which clinicians and patients and/or Surrogates work together to make decisions and select tests, treatments and care plans based on clinical

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evidence that balances risks and expected outcomes and the patient preference's, goals, and values. (National Learning Consortium, 2013)

Surrogate(s): The legally designated substitute decision maker(s) who makes medical decisions for living patient in accordance with ethical standards. A patient's Surrogate must be both the:

1. **Legally authorized substitute decision-maker:** The individual who can serve as a patient's substitute decision maker according to the WA State Hierarchy. [RCW 7.70.065]

– AND –

2. **Ethically appropriate representatives :** An individual who may or may not have legal status, who represents the patient's wishes through 1) the patient's previous expressed wishes, 2) a substituted judgment or 3) the Best-Interest standard according to western culture*. **Cultural variances might establish a different ethical framework.*

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. [RCW 70.122.020(9).]

Time-Trial: When clinicians provide a Potentially Inappropriate Treatment for a specific period of time with set goals to achieve.

Treatment Team: While the composition of the treatment team may vary on a case-by-case basis, it includes: the patient and/or Surrogate(s); the attending physician at the time the decision is being made; residents; nurses, social workers or therapists who have a contemporaneous or ongoing treatment relationships with the patient; key consulting physicians and/or treating specialists who are familiar with the patient's medical condition, prognosis and preferences regarding life-sustaining treatment options; the patient's primary care provider; and it may also include representatives from palliative care or other consulting services.

Withdraw: Withdrawal means to stop a treatment already begun.

REFERENCES: (Note: Regulatory references should only be listed above)

Policy:

Physician Orders for Life-Sustaining Treatment (POLST).

Advance Directives

Tools/Resources:

Bioethics VNET site

Legal References:

- Centers for Medicare & Medicaid Services, Department of Health and Human Services, 42 CFR Section 456.80
- Chapter 70.122 RCW, Washington State Natural Death Act.
- Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395i-3, 1395l, 1395cc, 1395mm, 1395bbb, 1396a, 1396b and 1396r
- RCW 71.32.020, Mental Health Advance Directives, Definitions

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- *In Re Hamlin*, 102 Wn.2d 810, 689 P.2d 1372 (1984).
- *In Re Grant*, 109 Wn.2d 454, 747 P.2d 445 (1997).
- *In Re Welfare of Bowman*, 94 Wn.2d 407, 617 P.2d731 (1980).

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4. Bosslet, G. T., Pope, T. M., Rubenfeld, G. D., Lo, B., Truog, R. D., Rushton, C. H., &White, D. B (2015). An official ATS/AACN/ACCP/ESICM/SCCM policy statement: Responding to requests for potentially inappropriate treatments in intensive care units. *American Journal of Respiratory and Critical Care Medicine*, 191(11), 1318-1330.
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10. Statement of the American Medical Association Institute of Medicine’s Committee on Determination of Essential Health Benefits, 2011.
11. National Learning Consortium Advancing America’s Healthcare (2012). *Fact Sheet: Shared Decision Making*. The Office of the National Coordinator for Health Information Technology Accessed on August 30, 2018.
https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf

KEYWORD Indexes: Patient Rights, Limit, Withhold, Withdraw, Life-Sustaining Treatment, Surrogate decisions, Resuscitation

Effective Date:	March 13, 2019	Term Date:	
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Reviewed By:	Patient and Family Partners	Date:	October 2018

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Reviewed By:	Code Blue Committee	Date:	March 2019
Approved By:	Bioethics Committee	Date:	January 2019
Approved By:	Sr VP, Quality & Safety/CNO – Charleen Tachibana, DNP, RN, FAAN	Date:	February 2019
Approved By:	Medical Executive Committee	Date:	March 2019
Next Review Date:	March 2022		

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The current version is on the organization intranet.*

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Appendix A



Shared Decisions for Life-Sustaining Treatment

