

MERITER HOSPITAL
Madison, WI

**GUIDELINES REGARDING DECISIONS
TO WITHHOLD, USE OR WITHDRAW
LIFE-SUSTAINING TREATMENT**

PREPARED BY A SUBCOMMITTEE OF THE
MERITER HOSPITAL ETHICS ADVISORY GROUP
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GUIDELINES and *CASEBOOK ON THE
TERMINATION OF LIFE-SUSTAINING TREATMENT*

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**GUIDELINES REGARDING
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1. PURPOSE

TO ASSIST HEALTH CARE PROVIDERS

- By establishing ethical guidelines for making decisions on whether to withhold, use or withdraw specific life-sustaining treatments for individual patients;
- By defining patient decision-making capacity, procedures for determining capacity, and for choosing surrogates when patients lack capacity;
- By outlining procedures for the decision-making process with regard to specific treatment modalities; and
- By identifying the role of the Ethics Advisory Group in the process. (Refer to Hospital Policy #507, "Ethics Advisory Group.")

2. ETHICAL GUIDELINES (These apply to all patients or to their surrogate if the patient has lost decision-making capacity. See Section 3)

2.1 CARING FOR PATIENTS

2.11 Well Being

The primary goal of medical treatment is to promote patient well-being by increasing patient benefits and decreasing patient burdens. For patients with terminal or serious, irreversible illness, such well-being includes improved functioning, relief of pain or suffering, the opportunity to live longer, and the satisfaction of engaging in activities.

2.12 Well-Informed

Health care providers bear the responsibility of explaining clearly to patients the benefits and burdens of the available treatment options.

2.2 CARING FOR FAMILY AND SURROGATES

2.21 Well Informed and Support

During times of critical illness or dying, the patient's family and surrogates are often impacted greatly - emotionally, spiritually, economically and in relationship to one another - by the possible decisions they are faced with making and by living with the decisions

2. ETHICAL GUIDELINES (continued)

2.2 CARING FOR FAMILY AND SURROGATES (continued)

2.21 Well Informed and Support (continued)

and outcomes. Health care providers bear the responsibility of communicating clearly in a compassionate and timely manner the benefits and burdens of the various options available.

Family and surrogates will be cared for and given support by the appropriate professionals, for example, the Department of Patient and Family Services and Pastoral Services. Appropriate follow-up will be provided as needed.

2.3 RESPECTING PATIENT SELF-DETERMINATION

2.31 Patient Autonomy

Although it is the responsibility of health care providers to know and explain the benefits and burdens of the various treatment options, it is the patient's right to choose among them. Patients may not always regard the opportunity for a longer life a significant benefit in relation to the burdens of their illness and of treatment.

2.32 The Provider's Role

Although the ultimate decision whether to withhold, use or withdraw specific medical treatments usually lies with the patient, this critical decision should be made in the context of an informative and supportive relationship with the health care provider.

2.4 INTEGRITY IN PROVIDING HEALTH CARE

2.41 As A Professional

A health care provider has the responsibility to care for patients in keeping with the ethical traditions and the standards of practice of the provider's field. S/he should provide compassionate care, affirm the patient's human dignity, and respect the informed and considered choice of the patient.

2.42 As An Individual

Within the bounds of this responsibility to care, individual providers have the right to maintain and not to violate his/her own ethical and/or religious commitments.

2. ETHICAL GUIDELINES (continued)

2.5 EQUITY IN PROVIDING HEALTH CARE TREATMENTS

2.51 In Decisions to Provide a Treatment

The health care provider's first responsibility is to the patient, and s/he should strive to offer the patient treatments comparable to those offered to others with similar prognoses.

2.52 In Decisions Not to Provide a Treatment

If a treatment is considered futile in the physiologic sense, permission is not needed to withhold the treatment. Examples of physiologic futility include attempting cardiopulmonary resuscitation in patients with: irreversible multiple system organ failure; end-stage cancer with rib/sternum metastases; ruptured abdominal aortic aneurysm with inability to stop the bleeding; cardiogenic shock with maximal vasopressor and/or mechanical support. If it is a treatment that may otherwise be expected, e.g. a resuscitation attempt, the patient/surrogate should be informed why it is being withheld. "Futility" for the purposes of these guidelines should be used only to refer to a treatment that will not achieve the physiologic end for which it is designed. The term should not be used for decisions based on personal value judgments or social considerations such as cost.

For treatments which are not physiologically futile, but which in the opinion of the physician are not appropriate for other considerations (e.g. the physician believes the quality of life won't justify the intervention; the physician believes the burdens are excessive in light of the expected benefits), s/he should discuss his/her reasons with the patient/family. If there are disagreements, consultation should be sought with the Ethics Advisory Group.

2.6 RESOLVING CONFLICT

2.61 Sources of Conflict

Patient and provider choices may sometimes conflict. Examples of such conflict may include:

- the patient refuses indicated treatment;
- the patient requests treatment that the provider believes will not aid in achieving well-being;
- the provider finds that the patient's treatment choice would require action contrary to the provider's personal, ethical, legal or religious beliefs.

2.62 Efforts to Resolve Conflict

When conflict arises, the provider should attempt to resolve the conflict by discussing it with the patient and other providers. If the conflict is not resolved, the Ethics Advisory Group should be consulted. If the conflict remains unresolved, the provider should make a reasonable effort to transfer care to another provider and must continue care until transfer of care is made. Guidelines for this process are in the Medical Staff Bylaws, Rules and Regulations.

3. CAPACITY CONSIDERATIONS

3.1 DECISION-MAKING CAPACITY: ITS CONTEXT AND DEFINITION

3.11 Its Definition

An adult patient has decision-making capacity when the patient can do the following:

1. Comprehend information regarding the illness, the proposed treatments and available alternatives;
2. Comprehend the consequences (i.e. benefits vs. burdens) of the proposed treatments and alternatives in the context of the patient's own values;
3. Communicate a choice.

3.12 Its Context: Informed Consent

1. In the process of informed consent, providers must disclose relevant information such that an ordinary person could make an informed decision about the treatment alternatives and provide ENOUGH TIME to ensure discussion of the following essentials:
 - treatment options
 - risks and benefits of each option
 - likely success of each option
 - longterm morbidity anticipated
 - acute and longterm care needs
 - where appropriate, options available at other institutions or options whose success rate is significantly greater at other institutions;
2. Providers also encourage an informed decision by the patient without coercion from providers or family.

3.2 DETERMINING DECISION-MAKING CAPACITY

3.21 Its Nature and Purpose

Determining whether or not a patient has capacity is a medical judgment to be made by providers in the context of each individual case. Its purpose is to protect the patient's right to make informed decisions.

3. CAPACITY CONSIDERATIONS (continued)

3.2 DETERMINING DECISION-MAKING CAPACITY (continued)

3.21 Its Nature and Purpose (continued)

The process of determining incapacity requires that the attending physician and another physician or psychologist have examined the patient and concur. (See Hospital Policy #500, “Advance Medical Directives.”)

3.22 Provider Certainty of Patient Capacity

Providers presume patient capacity in the process of informed consent unless the patient gives cause to question his/her ability. Both the criteria to be used in judging capacity and the degree of certainty to be attained are not absolute but depend upon the medical context. The Hastings Center *Guidelines* propose the following rule: “The more harmful to the patient his or her own choice appears to be, the higher the level of capacity required and the greater the level of certainty the providers should have about their assessment of capacity.”

Thus, if the process of informed consent results in a choice by the patient that most likely will result in grave irreversible damage or severe shortening of life, and if that decision appears to be contrary to what a reasonable person would make in the patient’s situation, then providers must seek appropriate consultation before proceeding.

3.23 Consultation in Cases of Questionable Capacity

This consultation may include the following:

1. The health care providers should review the consequences of the patient’s choice in the context of the patient’s own values and in consultation with others, e.g., family, friends, clergy.
2. In the event of continuing uncertainty, a neurologist or psychiatrist should be consulted.
3. If there is continued conflict concerning determination of capacity, the Ethics Advisory Group may be consulted. As a last resort determination of legal competence may be necessary.

3.3 CHOOSING SURROGATES FOR PATIENTS WHO LACK CAPACITY

- 3.31** If the patient has identified a surrogate through a written advance directive or verbally prior to incapacity, then the health care provider is required to consult with that surrogate with respect to matters of the patient's health. The only exception to this rule is if the health care provider believes that the surrogate is not acting in a way consistent with the known wishes of the patient or is not acting in the best interests of the patient. Under these circumstances there is legal recourse for review of the decision-making abilities of the surrogate. (See Hospital Policy #500, "Advance Medical Directives.")
- 3.32** The surrogate must be a competent adult and should be well acquainted with the patient's values and views regarding life-supporting medical treatments. The surrogate may be the spouse, a son or daughter, a parent, a brother or sister, a grandparent, and so on down the line of kinship. In some cases a surrogate may be a close friend rather than a relative.
- 3.33** If the patient has not identified a surrogate and if there is no court appointed guardian for the patient who has the authority to make medical treatment decisions on behalf of the patient, then a surrogate should be chosen by the appropriate interested parties. Health care providers do not choose the surrogate but may assist the interested parties in choosing a surrogate. Generally, the presumption should be made that the individual most familiar with the patient may act as a surrogate.
- 3.34** If the interested parties are unable to choose a surrogate, or if no person chosen by them is willing to serve, or if a surrogate is chosen and then fails to perform in a way consistent with the known wishes of the patient or in the patient's best interest, then the Ethics Advisory Group and/or hospital attorney should be consulted.
- 3.35** No health care provider directly involved in care of the patient should serve as a surrogate, unless that health care provider is a relative of the incapacitated patient and has been determined to be the most appropriate person to serve as the surrogate.

4. THE DECISION-MAKING PROCESS

4.1 DIAGNOSIS, PROGNOSIS AND UNCERTAINTIES

- 4.11** When a decision whether to initiate, continue or withdraw a specific medical treatment is to be made, diagnosis and prognosis are often subject to uncertainties. Groundwork for good decision-making must include informing the patient about these uncertainties.
- 4.12** This groundwork should begin with any uncertainties in the diagnostic testing to be done. The physician in consultation with the patient/surrogate should establish how much certainty is needed, recommend the tests required, and amend that recommendation in the light of the patient's judgment of their burdens and benefits.

4.2 PATIENT MAKES THE DECISION IN DIALOGUE WITH THE PHYSICIAN

- 4.21** Decisions regarding medical treatments should be made by the patient, incorporating the patient's own wishes. The decision should follow an informative dialogue between doctor and patient.
- 4.22** In preparing for this dialogue, the physician should consult with nurses and others who are working most closely with the patient because they are often the first to recognize increasing debilitation, lack of responsiveness to treatment, and other indications of burden to the patient. They also may be the first to realize that the patient, family, or concerned friends are considering whether the patient should forgo a treatment.
- 4.23** In the dialogue the physician advises and informs the patient of the following:
- the diagnoses, prognoses and their uncertainties.
 - the treatment options along with their benefits/burdens.
 - the physician's recommendations.
 - the probable effect of the treatment on the patient's condition.

This dialogue should incorporate the patient's values, since the ultimate decision rests with the patient.

- 4.24** It is often desirable that other members of the health care team participate, as well as family members or concerned friends. Patients, nonetheless, are entitled to privacy and confidentiality and have a right to limit discussion with family and friends.

4. THE DECISION-MAKING PROCESS (continued)

4.2 PATIENT MAKES THE DECISION IN DIALOGUE WITH THE PHYSICIAN (continued)

4.25 The physician should not unilaterally decide that the patient should forgo life-sustaining treatments based solely on criteria of age or the physician's judgment about the patient's quality of life.

4.3 DISCUSSION OF BENEFITS AND BURDENS

4.31 The patient with capacity is the ultimate judge of the benefits and burdens of a life-sustaining treatment. Possible burdens include pain or suffering, hardships imposed on their loved ones and financial cost. Possible benefits include improved functioning, the relief of pain or suffering, the opportunity to live longer and the chance to engage in satisfying activities.

4.32 Some patients may decide that the burdens of a particular treatment outweigh the benefits and choose to forgo that treatment. The physician should explore the decision with the patient and make certain that the patient is aware of the availability of pain treatments for alleviation from pain or suffering.

4.4 WHEN PATIENT CAPACITY IS UNCERTAIN OR FLUCTUATES

4.41 At times patients may neither clearly possess nor clearly lack decision-making capacity. If the patient, the physician, and surrogate agree on the treatment decision, then there is no need to clarify the patient's capacity.

4.42 When they do not agree or when no surrogate is on hand, it is best to delay the decision until the patient has decision-making capacity. If that is not possible, the guidelines for patient without decision-making capacity should apply instead. (See 3.2, "Determining Decision-Making Capacity." on pages 4-5.)

4.5 WHEN THE PATIENT CLEARLY LACKS CAPACITY

4.51 When a patient clearly lacks the capacity to make treatment decisions so that a surrogate has decision-making authority instead, the surrogate should seek to choose as the patient would if he or she were able. In making this decision, the surrogate should apply the following standards.

4.511 Follow the patient's explicit directives: The surrogate must make the treatment decisions given in an advanced directive or given as an oral directive for the treatment in question.

4.512 Adhere to the patient's preferences and values: If the patient had left no directive about the treatment in question, the surrogate should apply what is known about the patient's preferences and values, trying to choose as the patient would have wanted.

4. THE DECISION-MAKING PROCESS (continued)

4.5 WHEN THE PATIENT CLEARLY LACKS CAPACITY (continued)

(4.51) 4.513 If the patient currently lacks decision-making capacity, decisions regarding limitation of life-sustaining medical treatment, should be made by the patient's surrogate in consultation with the patient's attending physician. The patient's surrogate has authority to make such decisions on behalf of the patient only if it is clear that he/she is acting reasonably and in the patient's best interest.

Wisconsin law restricts the authority of court-appointed guardians to limit life-sustaining treatment, in the absence of a prior written or oral statement from the patient supporting the limits on treatment. In the absence of such statements it is recommended that the Ethics Advisory Group be consulted on these issues.

4.52 In making such decisions, physician and surrogate should recognize that even the patient without decision-making capacity may be able to understand some of what the physician has to say and may be able to express preferences. Respect for persons, including persons without decision-making capacity, means that any patient who can participate to any extent in the decision-making process should be encouraged to do so.

4.53 Terminating, withholding or withdrawing medical treatment is inappropriate or unreasonable in the following situations: (assuming the treatment is not futile as defined in 2.52 on page 3)

- a) The incapacity is temporary and the decision can wait.
- b) Incapacity is permanent (e.g., retardation), but there is a reasonable hope of a meaningful life. (This applies for patients who have never achieved capacity.)
- c) Before losing capacity, the patient requested full treatment under the circumstances at hand.
- d) The surrogate requests withholding or terminating medical treatment that is standard medical practice under the circumstances, and the patient has left no directive pertaining to it.

4.6 DECIDING WHETHER TO WITHHOLD

4.61 When possible, the physician should present to the patient/surrogate the pros and cons of starting or continuing a particular life-sustaining treatment on a trial basis with reevaluation after specific time.

4. THE DECISION-MAKING PROCESS (continued)

4.6 DECIDING WHETHER TO WITHHOLD (continued)

4.62 In cases of uncertainty, it is ethically preferable to try a treatment and to withdraw it if it fails than not to try it at all. Setting a limit may reduce the patient's fears of losing control of treatment and being kept alive indefinitely.

4.63 The Brain Dead Patient

The Wisconsin Statutes define brain death as the irreversible cessation of all functions of the entire brain, including the brain stem.

The decision-making process is unnecessary when the patient meets the accepted medical standards for brain death.

4.7 CARE FOR INFANTS AND MINORS WITH LIFE-THREATENING CONDITIONS

4.71 General Considerations

Generally, parents have the right to make medical decisions on behalf of a minor child. This includes the withholding and withdrawal of life sustaining treatment. The wishes of the minor should be considered whenever possible.

4.72 Who Can Consent

- 1) **Married Parents:** If the parents are married, then one, but preferably both parents should consent.
- 2) **Divorced or Unmarried Parents:** If the patient is a minor with divorced or unmarried parents, the consent of the parent having legal custody of the child should be obtained. If possible, consent from both parents is advisable but not necessary. If both parents have legal custody and both are authorized to make treatment decisions, consent from both should be obtained when possible.

4.73 Disagreement About Treatment

If the minor refuses treatment consented to by parents, then the Ethics Advisory Group should be consulted when the disagreement cannot be resolved. The same is true if there is disagreement between two parents as to appropriate treatment. If the disagreement continues, it may be necessary to seek resolution through the courts or appropriate public agency. Decisions on how to proceed will be made by hospital administration and legal counsel.

4. THE DECISION-MAKING PROCESS (continued)

4.7 CARE FOR INFANTS AND MINORS WITH LIFE-THREATENING CONDITIONS (continued)

4.74 Parent's Refusal for Medically Indicated Treatment

If the physician is of the opinion that treatment is medically indicated, but the parent(s) or other authorized representative of the minor refuse to consent to treatment, then the Ethics Advisory Group should be consulted. If resolution does not take place, appropriate agencies should be contacted so necessary court proceedings can be instituted. (See Hospital Policy #139, "Bloodless Medicine & Surgery Program.")

4.75 Withholding of Treatment

Generally, the decision to withhold treatment from an infant or child remains with the parents or other legally authorized representative. Any decision, however, must be based on informed consent. (See item 3.11 on page 4) When parents and caregivers disagree, or it is believed the parents are not acting in the child's best interest, the Ethics Advisory Group should be consulted. If it is decided to withhold treatment, the caregivers should explain to the parents or representative what can be expected and reassure them that appropriate comfort measures will be employed.

4.8 DOCUMENTING THE DECISION TO WITHHOLD OR WITHDRAW SPECIFIC LIFE-SUSTAINING TREATMENT

When a decision has been made to withhold or withdraw specific life-sustaining treatment, it is necessary to make the appropriate documentation in the patient's medical record. Documentation is likely to protect the interests of all involved by promoting adherence to the decision, providing an explanation, and allowing for orderly review when needed.

The Physician Should Document the Following in the Patient's Record:

- 1) Patient's diagnosis, condition and prognosis.
- 2) Treatment options, recommendations of treating physicians, and consultations.
- 3) Specific treatment limitation and/or termination of treatment with rationale for that decision.
- 4) Patient's consent or prior instructions, with documentation as to the patient's decisional capacity at the time he or she provided the consent or instructions; or consent of the authorized representative of the patient if the patient lacks decisional capacity.
- 5) Identification of those involved in the decision.
- 6) How conflicts were addressed.

5. SPECIFIC TREATMENT MODALITIES

5.1 CARDIOPULMONARY RESUSCITATION

5.11 General Considerations

It is the responsibility of the attending physician to determine and document the patient's code status as soon as feasible after admission. This includes clarification of any preexisting advance medical directive at the time of each admission. If no comment on cardiopulmonary resuscitation is documented, it is presumed that full life support measures will be instituted. A "No Code" order or "Limited Code" order should mean the patient/surrogate has decided that attempting resuscitation without restrictions is not in the patient's best interest. (See Hospital Policy #157, "No Code (Do Not Resuscitate).")

5.12 Limited Code

Limited code is generally inconsistent with the decision not to implement full life support measures. Moreover, limited resuscitation may be harmful in that the patient may survive in a more impaired state due to inadequate perfusion or oxygenation. Nevertheless a fully informed patient/surrogate has the right to choose this treatment modality, and the treatment limitations chosen must be clearly stated in the medical record.

5.13 No Code

No code excludes both CPR and advanced life support (intubation, cardioversion and emergency medications). This does not necessarily exclude nutrition, antibiotics, or other therapies. Patients must always receive appropriate comfort measures. (See Hospital Policy #133, "Administration of Analgesics/Sedatives to the Dying Patient.")

5.14 Reconsideration of No Code Order for The Purpose of Medical/Surgical Interventions

Patients and their physicians should recognize that certain procedures and medications can induce significant cardiopulmonary compromise. Before proceeding, all physician(s) involved in implementing the proposed treatment should discuss significant risks with the patient/surrogate. The patient/surrogate along with these physicians should decide whether the "No Code" orders should be maintained, modified or suspended.

Generally, "No Code" orders are binding for the purposes of interventional surgical, radiological or medical procedures, unless reevaluated and modified. There is an exception to this general rule. The treating

5. SPECIFIC TREATMENT MODALITIES (continued)

5.1 CARDIOPULMONARY RESUSCITATION (continued)

5.14 Reconsideration of No Code Order for The Purpose of Medical/Surgical Interventions (continued)

physician(s) may temporarily suspend the “No Code” status when both of the following conditions are present: 1) the treatment induces cardiopulmonary compromise; 2) the physician cannot obtain informed consent through no fault of his/her own.

If the physician(s) involved cannot comply with the limitations desired by the patient, the physician(s) may decline to perform the procedure while making a reasonable effort to transfer care to another physician.

The physician will document in the hospital chart the treatment plan, including the extent of resuscitative measures to be used and the length of time they will be used. (See 4.8 on page 11.)

Possible examples of documentation in chart regarding code status prior to interventional procedure:

- 1) I discussed the procedure and major risks with the patient/surrogate. The prior “No Code” orders were discussed and will remain in effect for this procedure.
- 2) I discussed the procedure and major risks with the patient/surrogate. The patient/surrogate wishes to rescind the “No Code” orders for the purpose of this procedure. This decision will be reevaluated within 24 hours.
- 3) I discussed the procedure and major risks with the patient/surrogate. The prior “No Code” status is amended to allow all routine intraoperative and postoperative measures, including mechanical ventilation, but excluding chest compression, for up to 48 hours postoperatively.
- 4) The patient arrived in the Emergency Room unconscious, having been transferred from the nursing home for treatment of GI hemorrhage with “No Code” order in place. No known family exists, and there is no health care agent. The patient was taken to surgery, and as a result of the anesthesia, suffered a cardiac arrest. Since I was unable to discuss changes in the “No Code” status with the patient, the “No Code” orders were temporarily suspended. We will reevaluate when the patient regains consciousness.

5. SPECIFIC TREATMENT MODALITIES (continued)

5.1 CARDIOPULMONARY RESUSCITATION (continued)

5.14 Reconsideration of No Code Order for the Purpose Of Medical/Surgical Interventions (continued)

- 5) The patient developed status epilepticus. Dilantin was given to control the seizures. The patient became bradycardic and suffered cardiopulmonary compromise due to the Dilantin. There was no opportunity to discuss a change in code status. I felt this was a readily reversible, treatment-induced emergency and therefore temporarily suspended the “No Code” order and resuscitated the patient.

5.2 VENTILATOR

5.21 General Considerations

The use of a ventilator is subject to the approval of the patient/surrogate. However, in emergency situations, when the wishes of the patient are unclear, it is appropriate to initiate such treatment. Consent should be obtained from the patient or his/her surrogate as soon as possible.

Decisions to withhold or withdraw this treatment should rest on whether the burdens of treatment and the life it offers exceed the benefits from the patient’s perspective. It is not ethical for the health care professional to unilaterally withhold this treatment purely based on her/his assessment of the patient’s quality of life.

5.22 Decision to Start Use

As is often evidenced by advance medical directives, some patients choose not to start the use of a ventilator out of fear about loss of control and inability to ever get off the device. However, in certain circumstances, temporary use of this technology may allow the patient to recover from an acute period of decompensation.

The most important determination to be made before starting a ventilator is the degree of probability that the patient can ever be successfully removed from it. The possibility that the underlying condition will worsen and the patient will never be able to live free of the ventilator must be discussed with the patient/surrogate and appropriate other parties. Plans should be made at the time of the initial consent for such eventuality. In this situation patients may choose to use a ventilator, because they are acutely short of breath and they see no alternative. It is important to offer the option of aggressive treatment, including sedation and/or non-invasive ventilation to maintain comfort and relieve dyspnea.

5. SPECIFIC TREATMENT MODALITIES (continued)

5.2 VENTILATOR (continued)

5.22 Decision to Start Use (continued)

A time-limited therapeutic trial with clearly outlined parameters as to the duration of treatment may be desirable in uncertain cases.

5.23 Withdrawal of Ventilator

There is often substantial emotional stress associated with the withdrawal of the ventilator, even when it is at the patient's request. It is usually most difficult when the patient is alert.

Discussions with the patient/surrogate as well as family and other interested parties should stress that the patient will not be allowed to suffer when coming off the ventilator. Adequate sedation should be utilized to keep the patient comfortable until death.

Under all circumstances, if concerns arise out of the decision to start, withhold or withdraw ventilator use, consultation with the Ethics Advisory Group is recommended. All decisions should be appropriately documented. (See 4.8 on page 11.)

5.3 NUTRITION AND HYDRATION

Tube and intravenous feedings have burdens as well as benefits, just like any other intervention. They benefit patients when they provide time to treat underlying medical problems or clarify prognosis and when patients would want such feedings. Very few patients with conditions such as severe dementia or metastatic cancer, however, are able to discontinue tube feedings because treatable conditions have been found and corrected. In addition, the burdens of tube feedings may be substantial. They often result in the use of restraints to prevent patients from pulling them out. Restraints often increase agitation which may result in increased use of sedation. Both restraints and sedation increase the risk of serious complications, such as pneumonia and pressure sores. The risk of aspiration pneumonia is very high in patients with feeding tubes, including gastrostomy tubes.

When patients stop eating and cannot be fed by hand, physicians and surrogates need to discuss the goals of care as well as the benefits and burdens of tube feedings. Decisions are difficult when patients have not provided advance directives. If there are reversible problems that impair oral intake, temporary intravenous or tube feedings are appropriate. Long-term tube feedings are appropriate if the patient has no irreversible life-threatening problems and would consider his/her quality of life acceptable. But tube feedings are not indicated if the patient has irreversible life-threatening medical problems and a poor quality of life, and a surrogate agrees that the goal should be to provide comfort rather than prolong life.

5. SPECIFIC TREATMENT MODALITIES (continued)

5.3 NUTRITION AND HYDRATION (continued)

A trial of tube feedings may be helpful. If they are well tolerated, the benefits probably outweigh the burdens. If the patient repeatedly pulls out a feeding tube, the goals need to be reconsidered. Tying the patient down or sedating him/her to keep the tube in place is difficult to reconcile with the goal of providing humane care. Instead it might be appropriate to withhold tube feedings. When a patient can no longer eat or be fed, it is not recommended to give intravenous hydration alone. Fluids given in this situation do not decrease suffering and will likely increase fluid in the lungs, leading to breathing problems. Symptoms of dehydration are better dealt with by swabbing the mouth and applying lip moisturizer. Although food and water should still be offered by hand, compassion and comfort are probably better expressed through directly providing attention and affection than by forcing calories or fluids through artificial methods. (paraphrased from “Resolving Ethical Dilemmas” by Bernard Lo)

If unresolved concerns arise in deciding to withhold or withdraw nutrition and hydration, consultation with the Ethics Advisory Group is recommended.

5.4 LIFE-SUSTAINING MEDICATION (ANTIBIOTICS, ANTI-ARRHYTHMICS, VASOPRESSORS, ETC.)

5.41 General Considerations

Medications can constitute a beneficial life-sustaining treatment for many patients. The administration of medications should be based upon an evaluation of benefits and burdens to the patient.

When using medications as a life-sustaining treatment the consent of the patient/surrogate should be obtained. On rare occasions, if it is thought necessary to override the patient’s refusal of medication (e.g., patient with tuberculosis), consult with the hospital administration or the hospital attorney.

5.42 Discussion

The use of medications should be included in discussions about other life-sustaining treatments since the use of medications could affect the feasibility of employing other therapeutic modalities. Discussions should include information bearing on the possibility that the patient might survive in an even more impaired state.

Since a patient who forgoes life-sustaining medication may suffer pain as a result of the underlying condition, discussions should include managing pain and promoting the patient’s comfort. Appropriate documentation of the discussion and decision should be entered in the patient’s record. (See 4.8 on page 11 and Hospital Policy #133, “Administration of Analgesics/Sedatives to the Dying Patient.”)