WITHOLDING AND WITHDRAWING OF LIFE-SUSTAINING MEDICAL INTERVENTION

POLICY: The decision to withdraw or withhold life-sustaining medical intervention is always a difficult one and requires medical judgment, a consideration of personal values, and much discussion between and among the medical care team, patient, and family. The following guidelines have been developed by Children’s Ethics Committee to help all of those involved in such decisions understand the process of making the determination to withdraw or withhold life-sustaining medical intervention. The guidelines are intended to be a flexible guide, adaptable to individual situations, and are not intended to be rigid standards or a statement of legal requirements. Oftentimes these determinations will be made with full agreement of the medical care team, patient, and family. In such instances, Ethics Consultation and Ethics Committee review are not necessary. In the event that the medical care team, patient, or family wishes reassurance or review of their decision, Ethics Consultation and/or Ethics Committee review are available. At any time that there is an unresolved conflict among the medical care team or between the medical care team and the family regarding the issues of withdrawing and withholding life-sustaining treatment, Ethics Consultation and/or Ethics Committee review are recommended and are available at the request of any of the parties involved.

PROCEDURE:

1. Determination that a Life-Sustaining Medical Intervention Should be Withdrawn or Withheld

   A. Definition
   A life-sustaining intervention may, in certain circumstances, be withdrawn or withheld when there is no reasonable medical probability that it would be effective. (For example, continued ventilatory support in a patient with progressive respiratory failure, despite maximal respiratory management, might reach this point). Under Washington law, the right to refuse, withhold, or withdraw life-sustaining treatment includes the right to refuse, withhold, or withdraw artificially provided nutrition and hydration. In re Grant, 747 P.2d 445 (Wash. 1987).

   B. Determination to Withdraw or Withhold Medical Intervention—All In Agreement
   In many cases, all those involved with a patient, including the care team, parents, the patient (if old enough to have a viewpoint), and others, agree that the best course of action is to withhold or withdraw a medical intervention because there is no reasonable medical probability that the intervention would be effective. In such cases, the medical intervention under consideration may be withheld or withdrawn, without further process under this policy. The precise legal standards to apply are these (see In re Grant):
   1) The attending physician determines that the patient is in the advance stages of a terminal and incurable illness;
   2) The patient, or if the patient is not legally competent, the legal guardian (usually the parents), determines that withholding or withdrawing the life-sustaining intervention is in the best interests of the patient (or, in the case
of an incapacitated patient over the age of 18, is consistent with the patient’s wishes as expressed on reaching adulthood.

3) No members of the immediate family object to the withholding or withdrawal of the life-sustaining intervention;

4) The members of the care team do not object to withholding or withdrawing the life-sustaining intervention.

The attending physician should document the discussion with and agreement among the members of the care team, the parents, the patient (if applicable), and other involved interested parties.

C. Determination to Withdraw or Withhold Medical Intervention—Lack of Full Agreement

Where not all involved agree about withholding or withdrawing the medical intervention, a determination that an intervention should be withdrawn or withheld in a particular case requires agreement among the attending physician and two other physicians, at least one of whom is not directly involved in the care of the patient. Except in extremely unusual situations, as described below, the agreement of the parent or legal guardian is also required. The process outlined below applies in such cases.

D. Documentation

The required method for documenting that an intervention will be withdrawn or withheld is a note from each physician in the patient’s chart stating that the intervention under consideration has no reasonable medical probability of effectiveness. All three physicians (the attending plus two) must write and sign notes. The agreement of the parent or legal guardian must also be documented.

E. Ethical Considerations

There is no ethical obligation to provide treatments that are ineffective. It is not the general policy of Children’s to provide such intervention to patients. In general Children’s encourages physicians to refrain from using these interventions.

1) There is an obligation of a single physician, usually the attending of record, to discuss the withholding or withdrawing of treatment at issue with the patient, parent, or legal guardian and to ensure that other members of the patient care team are informed of the determination to withdraw or withhold treatment.

2) If the patient, parent or legal guardian, the immediate family, and the care team concur with the recommendations of the physicians, treatment may be withdrawn or withheld.

3) In the event of a dispute among members of the care team or between the care team and the parent or legal guardian, follow the pragmatic conflict resolution process described below. In cases of unresolved disagreement, court intervention may be invoked, as described below.

4) Exceptional reasons may exist for providing continuing treatment for short periods of time in order to provide short term benefit to family members.

5) The commitment to provide comfort care should be affirmed in discussions with the patient and family.

F. Conflict Resolution

The preferred sequence of steps for addressing disagreements among parties is:

1) Communication among parties

Every effort should be made to resolve conflicts about providing, withdrawing or withholding medical intervention through respectful
discussion among the parties involved in the dispute. Strong consideration should be given to involving Social Work, Child Psychiatry, Palliative Care, and Pastoral and Spiritual Care in these discussions.

2) Ethics Consultation
If disagreement about the provision, withdrawing or withholding of medical intervention persists, an ethics consultation should be sought. (See appendix A for further detail.)

3) Ethics Committee
If disagreement about the provision, withholding or withdrawing of medical intervention continues, the case should be referred to the full Ethics Committee for review. (See appendix A for further detail.)

4) Medical Director
Final resolution is the responsibility of the Medical Director. After these consultations, if the Medical Director determines that the medical intervention should be withdrawn or withheld, but a disagreement persists with the parent or legal guardian, the Medical Director may choose to seek court intervention as set forth below.

G. Court Intervention to Withdraw or Withhold Medical Intervention
In extremely rare cases, it may be appropriate to seek a court order to withdraw or withhold medical intervention even when the parent or legal guardian disagrees. This section outlines both relevant considerations in making the decision to seek a court order and the process to follow in doing so.

1) Relevant Considerations
a) Court intervention to override the wishes of a parent or legal guardian is extraordinary. In any such situation, the burden of proof will rest very heavily on the person or entity who wants to override those wishes, especially if the result is to hasten or fail to prevent the death of a minor patient. Any such decision will require a strong consensus that the parent or legal guardian’s wishes are outside acceptable boundaries.

b) Court intervention is possible under Washington law when a patient is abused, neglected, or dependent. There can be a wide gulf between what clinicians may consider sub-optimal clinical decision-making and the relevant legal standards of abuse, neglect, or dependency. There is no legal mechanism for establishing a patient’s “best interests” or promoting them through clinical decision-making.

c) Clinicians, parents, the courts, and the public mean different things when discussing the “best interests” of a patient. In general, clinicians tend to think there is one “best” course of action for a patient, primarily dictated by the patient’s medical condition. Parents, the courts, and the public tend to think in terms of a range of choices, many of which may be acceptable at any given time, and no one of which may be clearly “best” for all the issues facing the patient. In particular, these groups may give more weight to non-clinical considerations than do clinicians.

d) In any case where a clinician believes that the acts of a parent or legal guardian constitute abuse or neglect, a report to Child Protective Services must be made. Prior to making such a report in cases involving a dispute over withdrawing or withholding medical intervention, clinicians should follow the suggestions for conflict resolution outlined above.
e) In considering court intervention, Children’s supports an analysis based on harm: where continuing the treatment at issue creates a substantial risk of serious harm to the patient, which extends beyond the harm contemplated or expected if the clinician’s recommendations are followed, court intervention may be warranted. There must be both a “substantial” risk, and the risk must be of “serious” harm, to warrant an override of the parent or legal guardian. The incremental benefit of the recommended course – not just the total benefit, but the increase in benefit over the course desired by the patient or legal guardian – should be substantial before any consideration of court intervention.

f) Court intervention takes time. This time is likely measured in weeks if not months (though it is essentially impossible to predict total time). Clinicians should take this timing into account when considering the natural progression of the disease process and the feasibility of court intervention.

2) Process to Obtain Court Intervention

a) When the conflict resolution process does not result in agreement between the care team and the parent or legal guardian, and the Medical Director believes that court intervention is in the best interests of the patient, the Medical Director will notify the President and Chief Executive Officer (CEO).

b) When so notified, the President/CEO will appoint an ad hoc committee to advise whether court intervention is appropriate. The ad hoc committee will include the Medical Director, the Nurse Executive, the General Counsel, and the Chair of the Ethics Committee, or their respective designees.

c) The ad hoc committee will meet as soon as possible to consider the matter. The committee may request information or consultation from any employee or member of the Medical Staff. Unless there are compelling reasons not to do so, the ad hoc committee will meet with the legal guardian and solicit the guardian’s views.

d) The ad hoc committee will make its report and recommendations to the President/CEO as soon as possible. The committee will recommend either that i) Children’s should bring a court petition for appointment of an alternative guardian because the patient is abused, neglected, or dependent; or ii) Children’s should not seek court intervention.

e) The final decision whether to seek court intervention rests with the President/CEO.

3) Court Intervention

a) When the President/CEO determines to seek court intervention for appointment of an alternative guardian, the General Counsel will prepare or cause to be prepared the Petition and other legal documents to initiate the court action. The General Counsel may request supporting affidavits or other assistance from any appropriate Children’s employee or member of the Medical Staff.

b) Children’s will assure that the parent or other current legal guardian of the patient has legal counsel in proceedings on any Petition. If the parent or legal guardian is unable to afford counsel, Children’s will pay for such counsel.
c) The General Counsel will follow all procedural steps necessary to obtain a determination on the Petition at the trial court level, and will report the court’s decision to all interested parties including the parent or other legal guardian, the President/CEO, the Medical Director, the Nurse Executive, the Chair of the Ethics Committee, and any involved clinicians.

d) The President/CEO will determine whether to appeal any adverse court decision.

2. Ethical and Practical Considerations When Disputes Arise Regarding Withdrawing and Withholding Medical Intervention

A. Ethical Considerations

All treatment decisions should be based on the patient’s overall best interest. Best interests are determined by weighing relative benefits and burdens to the patient. Ideally, this weighing is done by the patient’s family and the patient in consultation with the medical care team.

B. Necessary Elements of Care

Consistent with the informed consent of the patient, parent, or legal guardian, Children’s respects the integrity of all caregivers and supports provision of clinically appropriate necessary elements of care as determined by responsible clinicians. Patients, parents, and legal guardians do not have the right to tell clinicians how to practice their profession. A clinician may determine that it is only ethical to offer a treatment or intervention on certain conditions. For example, it is reasonable, appropriate, and ethical to require pain control following surgery; it is reasonable, appropriate, and ethical to require anti-nausea medication as part of chemotherapy. Other determinations of necessary elements of care may be made by the care team. See the following policies on informed consent for more information: “Informed Consent to Operation, Postoperative Care, Invasive Medical Procedure, and Anesthesia”, “Consent for Care and Treatment”, and “Emergency Medical and Surgical Treatment Including Transfusion of Blood and Blood Products for Minor Patients Without Parental Consent”.

C. Staff Support

Staff support, at all levels, is crucial to help staff deal with clinical decisions that are contrary to the ones the staff member would make. Given the gap that sometimes arises between clinicians’ perceptions of the ideal course of treatment and the willingness of the courts to intervene, staff may be called on to participate in care that they consider sub-optimal. Beyond upholding the principle that clinicians can define their scope of care, as described in “Necessary Elements of Care”, above, Children’s also gives staff the ability to opt out of care, if possible. It may not be possible to honor all requests to opt out of care in every situation involving withdrawing or withholding life-sustaining care. If sufficient numbers of staff choose to opt out of care, Children’s may seek to transfer care to another institution if a transfer can be arranged. See “Staff Request Not to Participate in An Aspect of Patient Care” policy and procedure.

D. Palliative Care

Palliative care approaches have much to offer in cases involving difficult decisions and the risk of significant pain for the patient. Bringing in the Palliative care team early in the process makes palliation part of normal care, not something only considered when therapeutic interventions are abandoned. Cure and pain control
are important twin goals of care; they should be explicitly considered and balanced throughout the course of care.
APPENDIX A

Ethics Consultation

Ethics consultation is recommended as the next step when conflicts between care providers and patient/family cannot be resolved. Ethics consultation can be requested by any hospital staff or by a patient’s family. Ethics consultation can be obtained by calling the hospital switchboard at (206)-987-2000 to page the ethics consultation team member on duty. The consultant will meet with the patient care team or family within 24 to 48 hours of the consultation request. At the completion of the consultation a consultation note will be placed in the patient’s chart.

Ethics Committee Review

The need for an Ethics Committee review will be determined by the Ethics Committee chair or by the chair’s designee after an Ethics consultation has been obtained. Attempts will be made to schedule the meeting within 48 to 72 hours of the request. A “quorum” is defined as those members of the committee present at the meeting. The committee’s review process will generally have the following structure:

1. The committee will have a brief closed door meeting to hear an overview of the case.

2. The medical care team will then present information. Ideally the medical information will be presented by the attending physician and the primary nurse. Other members of the patient care team are encouraged to attend. When the presentation and ensuing discussion are completed, the medical care team may be excused.

3. The family is welcome to attend the Ethics Committee review and will be invited to participate after the presentation of the medical care team or at a point in the committee’s deliberation that input from the family would be most helpful. At the conclusion of their presentation and ensuing discussion the family will be excused.

4. The discussion of the committee will be focused to determine if there are issues relevant to the care of the patient and to the decision-making process which have not been considered by the medical care team. The determination that the committee will make at the end of the review process is whether all relevant issues have been considered in the care of the patient. The results of the committee deliberations will be relayed by a designated member of the committee to the attending physician. A written summary of the committee’s review will be placed in the patient’s chart.
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Additional Key Words:  CIS; CPOE; Family Participation; Health Care Decisionmaking; Care Decisions; Informed Consent; Refusal; Surrogate Decisionmaker; Legally Authorized Person; Code 188; 6188; Code Blue; End of Life; Care at Death; Anatomical Gift; Organ and Tissue Donation; DCD; Advance Directive; Healthcare Directive; Patient Self-determination; Living Will; Power of Attorney; DNAR; Do Not Resuscitate; No Code; Modified DNR; Ethics