

# UMHHC Policy 03-07-009

## Withdrawal and Withholding of Medical Treatments (Non-beneficial Treatment/Intervention)

**Issued: November 2016**

### I. POLICY STATEMENT, PURPOSE AND SCOPE

#### Policy Statement

Common in medical practice, patients may request treatments that are either physiologically non-beneficial (such as antibiotics for a viral infection) or potentially inappropriate (such as escalating doses of narcotics for chronic non-terminal pain). In these situations, physicians and other health care providers often decline to provide an intervention that is either deemed non-beneficial or potentially inappropriate. In the vast majority of cases, these patient-provider encounters are managed with thoughtful education and communication between involved parties. However, at times these encounters can lead to conflict. Previous UMHHC policies supported the physician's right to not provide interventions that were deemed medically futile but did not cover other requests for non-beneficial or potentially inappropriate care that did not meet the strict criteria of futility. This policy reviews the definitions of non-beneficial, potentially inappropriate, and futile treatment and gives a structured approach when conflict arises between patients, their representatives, and physicians regarding what medical care should and should not be provided. While these conflicts often occur in patients at the end of life, this policy is meant to apply more broadly to any situation in which a patient or family requests interventions that are either non-beneficial or potentially inappropriate.

#### Purpose of this Document

Cases of death and dying raise issues that can be disconcerting to patients, parents, families, faculty, and staff. This policy sets forth approaches to the ethical management of difficult clinical situations. These cases require sensitive open and honest communication and support for all parties. This document provides general policy for health care professionals to aid in making decisions concerning treatment for the terminally ill, for patients who have lost cognitive function, or for patients who refuse treatment. For cases involving the legal system, please contact the legal office (734-764-2178). For specific ethical questions please contact the Ethics Consultation service at 734-615-8377 or page the on-call ethics consultant.

#### Scope of this Document

This policy applies to adult and pediatric cases, both inpatient and outpatient. It reflects relevant Michigan case law, legal principles and practices, professional (clinical) practice, and principles of ethical decision-making.

### II. DEFINITIONS

**Advance Directives** - An advance directive is a document drafted by a competent adult stating the adult's wishes in the event of loss of decision-making capacity. The document can state the individual's preferences for health care (a living will) and can also name an advocate to act on the individual's behalf (a durable power of attorney for health care). Michigan has a durable power of attorney for health care law and its elements are described in [UMHHC Policy 03-07-010, Advance Directives](#). Michigan case law also recognizes the usefulness of a living will as valuable evidence of a patient's wishes. For details please see [UMHHC Policy 03-07-010, Advance Directives](#).

**Terminal Illness and Cognitive Function Loss** - Terminal illness is a condition of the patient that is irreversible, untreatable, and likely to result in death within a period of one year. Loss of cognitive function is the irreversible and untreatable loss of all capacities to communicate or respond to external stimuli. Irreversible coma and permanent vegetative state are two common forms of cognitive function loss. Loss of cognitive function does not by itself constitute terminal illness, but patients without cognitive function may be reviewed under these guidelines. Very sick patients who are neither in a coma, nor in a permanent vegetative state, and for whom life expectancy is greater than one year, are not those to whom this document is directly applicable, but they also may make decisions to terminate medical interventions. Examples of cases to which these guidelines are applicable are: end-stage cancer patients for whom treatment has proved unsuccessful; critically ill patients with multiple organ failures refractory to treatment; end-stage amyotrophic lateral sclerosis (ALS), and patients in irreversible coma or vegetative state for whom there is no reasonable medical likelihood of return to cognitive function. Because every patient is unique, each case must be carefully evaluated on its own facts and in its own context. Terminal illness and loss of cognitive function may be determined only by the attending physician, basing judgment on relevant clinical standards.

### **Competent and Incompetent Patients**

In making a decision about future treatment of patients either terminally ill or without cognitive function, health care professionals must distinguish between decision-making *by* competent patients and decision-making *for* incompetent patients.

Competent patients are allowed by law to refuse treatment even if the treatment is seen to be medically necessary. Michigan courts have clearly recognized this right and the Michigan Durable Power of Attorney Law for health care allows competent adults to name advocates to act on their behalf in the event of incompetency. Competency is defined as understanding the nature and consequences of one's actions. Thus, if a non-clinically depressed patient has Amyotrophic Lateral Sclerosis and understands the need for respirator support and declines that support with the realization that forgoing respirator support entails death, that patient has demonstrated an understanding of the disease and the consequences of refusal of treatment. The Michigan Durable Power of Attorney Law for health care says that an advanced directive goes into effect when the patient's attending physician and another physician or licensed psychologist determine, upon examination of the patient, that the patient is unable to participate in medical treatment decisions. This determination must be in writing and shall be made part of the patient's medical record. Competent patients may request that their treatment be limited (for example, "defibrillate but do not intubate or place on ventilator") or stopped (for example, "stop dialysis and do not do kidney transplant"), and physicians may comply with that request without fear of violating the law.

Patients who lack decision-making capacity (e.g., unconscious patients, patients with cognitive function loss, patients with legal guardians, minors, etc.) do not have the legal ability to make binding decisions about their own treatment, and therefore decisions must be made on their behalf by third parties. These third parties can be a spouse, an advocate appointed by the patient using a durable power of attorney for health care, court-appointed guardians, or health care professionals acting in the best interest of the patient. The guidelines in this document are designed chiefly for the hospitals' adult population. Many of these guidelines apply also to the pediatric population; for pediatric cases, however, additional state and federal laws pertaining to child abuse and neglect must also be considered. In treating incompetent patients, the physician may seek to prevent needless pain and suffering by limiting or ceasing treatment, as set forth in the guidelines below.

**Death** - Death is the irreversible cessation of bodily functions. Death is a physiological process and is determined medically by lack of cardiac or pulmonary function and/or by using brain death criteria (see [UMHHC Policy 03-01-020, Brain Death](#)). These guidelines also provide advice regarding the cessation of medical services for patients who have died while some organ functions remain supported artificially.

**Clinical Ethics Consultation Service** - UMHHC has a clinical ethics consultation service for both adult and pediatric patients. The ethics consultation service can respond to a request for an ethics consult 24/7. For ethics

consultation during business hours call 734-615-1379. Consult requests after hours can be made by calling 734-936-6267 and asking for the ethics consultant on call to be paged.

**Futility** - For the purpose of this section, an intervention is considered futile when it cannot accomplish the intended physiologic goal.

**Non-Beneficial Treatment** - Treatments that the health care team believes have no reasonable medical chance of achieving the outcome sought beyond minor physiologic changes are outweighed by the danger to the patient, and/or would not achieve a medically appropriate goal are considered to be non-beneficial treatments. Under this definition, futile interventions may be considered a type of non-beneficial treatment.

**Potentially Inappropriate Treatment** - Treatments that, while they may achieve a certain goal, are outside the standard of care. Examples may include the use of broad-spectrum antibiotics to treat a simple bacterial infection or use of high-dose narcotics to treat chronic, non-terminal pain.

### III. POLICY STANDARDS, PROCEDURES/ACTIONS

#### A. Clinical Determination of Death

In most cases, death is determined by a physician on clinical grounds following an appropriate examination of the patient. Death can also be determined through brain function studies. Cessation of treatment of a patient declared dead does not require specific orders or procedures, nor does it require family consent.

##### 1. Documentation of Death Through Brain Function Studies

Documentation of death based on tests of brain function is required when:

- Organs are to be removed for transplantation (NOTE: organ donation can also occur using a cardiovascular standard called *donation after cardiac death*. See [UMHHC Policy 02-05-003 Organ, Tissue, and Eye Donation](#)); or
  - The patient's death may become a material matter in a criminal proceeding (for example, the patient is believed to be a murder victim); or
  - The information provided by documentation supplementary to clinical evaluation is necessary to resolve disagreements between the attending physician and family members; or
  - The physician wishes to confirm a clinical judgment by brain function testing
- Guidelines regarding how to determine and document brain death have been established by the Brain Death Committee. The current guidelines are outlined in [UMHHC Policy 03-01-020, Brain Death](#).

#### B. Physician Practice When Withdrawing or Withholding Life Sustaining Treatment

1. The termination of treatment, including life support systems, does not require documentation of death. In appropriate cases, the attending physician may terminate treatment or preclude some or all future treatment with an appropriate written order when the patient is not dead. Note, however, that assisted suicide is illegal under Michigan law. See [MCLA 750-329a](#).
2. In making decisions about withholding or withdrawing treatment, the competent patient's wishes must be identified and documented by the medical staff. If the patient lacks decision-making capacity but has left a durable power of attorney for health care or living will, or has otherwise reliably expressed an opinion about future care, these opinions shall be referred to as an expression of the patient's intent. Any written documents created by the patient should be placed in the patient's medical record. Michigan recognizes the legal validity of a durable power of attorney for health care. Thus, a properly drafted durable power of attorney for health care can state the patient's preferences and designate an advocate to act for the patient. Although Michigan does not have a statute regarding living wills, this type of document is important evidence and should be looked to for guidance about the patient's wishes. Further,

patient conversations with their treatment team about treatment options, patient values, and patient wishes demonstrate intent and should be used in decision making.

Adult patients admitted to the hospital shall be asked whether or not they have executed an advance directive and the information shall be documented in the patient's medical record. Adult patients are provided with information on Advance Directives if they request this information. The Medical Center will not condition the provision of care or discriminate against a patient based on whether or not the patient has executed an advanced directive.

For patients who lack decision-making capacity, discussion should occur with the responsible family members, advocate, or guardian and the results of such discussion should be documented in the progress notes. The treatment team should identify all close members of the patient's family and significant others and ensure that they are informed. If there is a valid durable power of attorney for health care, the designated advocate makes decisions for the patient. In the absence of a document, a spouse can make decisions for their spouse. If there is no durable power of attorney or spouse, but there is a court-appointed guardian, the guardian makes decisions for the patient. If there is no durable power of attorney, no spouse, and no guardian, other reliable expressions of the patient's intent such as living wills and conversations with caregivers and family members should be consulted to determine the patient's wishes. One member of the family may act as representative of the entire group if it is clear that there is consensus among the members. Consensus shall be documented, including listing the names of the family members. In cases of uncertainty or dispute, consult with the Health System Legal Office (734-764-2178) for possible referral to Probate Court.

3. The decision to withhold or withdraw treatment must be made by the patient's attending physician in consultation with others as appropriate. Such decisions should be supported by the other members of the health care team caring for the patient. Their consultation and agreement with the plan to withhold or withdraw treatment should be included in the record. In the event of differences of opinion among the staff, consultation with the Ethics Committee is strongly encouraged.
4. The circumstances leading to the decision to discontinue or withhold treatment should be carefully recorded in the medical record. The patient's condition and reliably expressed wishes should be documented to identify the basis for the decision. Documents written by the patient should be placed in the medical record. For competent patients, the decision should be based on the patient's informed refusal of future treatment. For patients without decision-making capacity, the documentation should show informed refusal by advocate, guardian, or reliably expressed patient wishes. Decisions of family members, advocate, or guardian shall be guided by the past expressed intention of the patient while competent. An advance directive or evidence of a patient's intent must meet the "clear and convincing evidence" criteria set forth by the Michigan Supreme Court in the August 22, 1995 *In re: Martin* decision.

Requests by patient, family member, or guardian to withhold or withdraw treatment should be discussed with the patient's attending physician. A summary of the discussion should be included in the patient's record whether or not a decision is made to withdraw or withhold treatment.

### **C. Potentially Inappropriate or Non-Beneficial Medical Treatment**

The autonomy of the competent patient in rejecting proposed medical treatment, or in selecting among the treatment alternatives offered and practically available, must be respected. But the autonomy of the patient does not entail the right of the patient or the patient's representative(s) to command treatment that is medically inappropriate or non-beneficial. When disagreements in this sphere arise, the following considerations apply:

#### **1. Futility**

When a medical intervention is futile, the attending physician is under no obligation to initiate, or to continue such treatment, even though it may have been requested by the patient, or the patient's family or representative(s). For the purpose of this section, an intervention is considered futile when it cannot accomplish the intended physiologic goal.

## 2. Potentially Inappropriate or Non-Beneficial Medical Treatment

Treatments that the health care team believes have no reasonable medical chance of achieving the outcome sought beyond minor physiologic changes are outside the standard of care, are outweighed by the danger to the patient, and/or would not achieve a medically appropriate goal. Should this determination of the health care team be questioned or not accepted by the patient or patient representative, the following resolution process shall be used:

- a. The team must understand and document the patient's wishes and values.
- b. The team should communicate to the patient their considerations for believing that a specific treatment is inappropriate.
- c. In the event that the patient insists on an approach felt to be inappropriate, there must be an open process for dispute resolution, which shall include:
  - o A second medical opinion.
  - o Expert consultation to keep communications open.
  - o An offer of review by the hospital ethics committee.
  - o An offer to transfer care of the patient to another facility willing to accept the patient.
  - o A period of time adequate to allow for transfer.

## 3. Confirmation

When the attending physician has documented these determinations in the patient's medical record, and another physician with appropriate expertise who has no prior or present relationship with the patient has examined the patient and reached the same medical conclusions and similarly has documented this agreement in the patient's medical record, the patient's attending physician is under no obligation to initiate or to continue any interventions deemed inappropriate.

## 4. Notification and Support

When the appropriateness of available interventions has been determined, and that determination has been confirmed by another physician who has no prior or present relationship with the patient, the patient, family, or the patient's representative(s) shall be informed of the decision. If the patient or the patient's representative(s) disagree with the decision to withdraw or not to initiate an intervention, the patient/family/representative should be given the opportunity to secure the services of another physician, and supported in their efforts to do so, if that is their wish. Reviews by non-UMHHC physicians regarding a possible transfer should be initiated immediately and completed within three days. Patients can directly contact another facility on their own and if U-M is contacted by another facility, the team will provide assistance. The UMHHC physician(s) should be available for telephone consult with the consulting physician. In the event of a transfer, the U-M team will facilitate the transfer.

If a non-UMHHC physician plans to evaluate the patient on site, the UMHHC physician must assure that the consulting physician follows [UMHHC Policy 04-06-061, Visiting Observer: For the Individual Who Will Participate in but Not Provide Patient Care](#).

## 5. Non-Beneficial Medical Intervention Example

A patient with decompensated cirrhosis, hepatorenal syndrome, and multi-system organ failure who is not currently a transplant candidate nor is reasonably medically likely to be a candidate in the near future who desires to be on the transplant list.

## 6. Futility Example

A patient declared brain dead where the family asks that life support be continued for the benefit of the patient and not for organ donation.

## 7. Treatment That Would Not Achieve a Medically Appropriate Goal

A care provider believes that they cannot in good conscience give a patient chemotherapy given his hepatitis, HIV, respiratory failure, and encephalitis.

#### 8. Review

In the event the patient or the patient's representative(s) disagree with the decision to refrain from or to discontinue a medical intervention, and the services of another physician or a transfer cannot be secured, the hospital's ethics committees shall be available for consultation by any party, including the patient and/or the patient's representative. It is strongly suggested that an ethics consultation occur upon the request of any of the immediately concerned parties.

**NOTE:** The issues of futility and inappropriate medical intervention have not been fully decided under Michigan law so this section of the policy sets forth the UMHHC's ethical position.

#### **D. Hospital Procedure When a Decision is Made to Withdraw or Withhold Life-Sustaining Treatment**

When a decision has been made to withhold or withdraw treatment, specific orders must be written by the patient's attending physician, or by a house officer or other authorized provider responsible for the patient's care after consultation with the attending physician.

##### 1. "Do Not Attempt Resuscitation (DNAR)" Order

- a. Do not attempt resuscitation (DNAR) orders (defined as do not call the arrest team and do not start basic cardiac life support (BCLS or CPR)) cannot be verbal orders but must be recorded in the patient's medical record to be valid. The order must be written by the attending physician or by the house officer or other authorized provider with the attending physician's counter-signature within 24 hours. The orders should be written only after discussion with the patient if competent, or with the patient's advocate, legal guardian, family or other appropriate party if the patient is incompetent or a minor. Disagreements among patient/family/treatment team may be referred to the clinical ethicist on call. Michigan law allows for both in-facility and out-of-facility "no code" orders.
- b. A DNAR order does not mean or imply that any other treatment will be discontinued. DNAR orders must be re-evaluated as the patient's condition changes. So-called "partial codes" (defined as when a patient indicates they would like some aspects of BCLS but not others) should always be carefully evaluated for their medical utility and consistency with a patient's stated goals of care.
- c. If a written DNAR order is not in the chart, full resuscitation will be instituted in the event of cardiac arrest. Therefore, the Hospital does not recognize verbal orders to call the physician for advice in the event of an arrest since this could delay resuscitation; so-called "slow code" or "STAT page" orders are therefore not valid. A written order for an incompetent patient could call for less than full code if there is a medically appropriate rationale to do so. Any such order must specifically state what will be done and the medical explanation of why a full code is inappropriate.
- d. On the rare occasion when a DNAR patient is taken to the operating room for a surgical procedure or undergoes a procedure (experimental or otherwise) intended to improve prognosis, or is transferred to another service, any DNAR order must undergo a required re-evaluation to determine if it continues to be appropriate. While undergoing a surgical or medical procedure in the operating room, the patient has full resuscitation status except by agreement of the treating physician and anesthesiologist. This change in code status should be discussed explicitly with the patient or patient representative to ensure that care remains consistent with patient- and family-centered goals and expectations. This discussion may

result in the inpatient remaining DNAR during a surgery or procedure, with agreement of the surgery or proceduralist faculty physician and anesthesiology faculty physician.

- e. The patient's code status must be discussed with patient/decision-maker prior to the decision to do a procedure. Following such a procedure, service transfer, or admission from an outside facility, or operation, the patient's status should be re-evaluated to determine whether reinstatement of the DNAR order is appropriate. See [UMHHC Policy 62-10-003 Patient Care Orders](#).

## 2. "End of Life Palliative Care" Order

- a. A "Do Not Attempt Resuscitation" order accompanied by an "End of Life Palliative Care" order set as defined in MiChart means there should be no resuscitation and all diagnosis and therapeutic measures except those necessary to alleviate symptoms should be stopped. No routine measurement of vital signs, diagnostic tests, or other monitoring should be undertaken. Drugs, fluids, nutrition and ventilator support should be provided only with specific written orders for the purpose of relieving unnecessary suffering. The health care team has an ethical duty (a) to discuss options for palliative therapy with the patient or, if the patient is not competent, with the patient's representatives (family, guardian, advocate); (b) to relieve a patient's pain and suffering at the end of life; and (c) to provide psychosocial and spiritual support for the loved ones of a dying patient. Discussion of end-of-life care with terminally ill patients (or, for incompetent patients, their representatives) should be part of an ongoing conversation and undertaken, whenever possible, long before death is imminent. When death is both inevitable and imminent, and where the patient (or representative) concurs, sufficient dosage of narcotic, sedative, or other therapies should be employed to relieve the patient's pain and suffering, even if doing so might compromise life-sustaining functions. The primary intent of any such therapy is to relieve patient suffering. The attending physician is responsible for coordinating the efforts of the health care team. Health care team members who feel unable to provide care and support as suggested in this policy, or have conscientious objections to implementing them, should find other members of the healthcare team or another physician who will do so.

## 3. Specified Treatment Withdrawal

- a. Medical treatment not ordered or not renewed is not to be given. For example, it is not necessary to provide transfusion, antibiotics, or intravenous fluids for terminally ill patients, or for those without cognitive function, unless specifically ordered to relieve unnecessary pain.
- b. Even though no new treatment (such as IV fluids or ventilation) is ordered by the physician, the means to provide that treatment sometimes remains in place (e.g., intravenous catheters, mechanical ventilators/tubes, circulatory assistance devices, etc.). When ordered by the physician, such treatment devices may be removed or disconnected.

## E. **Organ Donation**

Gift of Life is the UNOS-designated Michigan organ retrieval agency. They should be contacted for any possible organ donation. Some individuals plan for donation in advance directives, notifications on a driver's license, or other documents while others find it difficult to think about donation. The UMHHC Organ and Tissue donation policy sets forth policy and procedures. See [UMHHC Policy 02-05-003 Organ, Tissue, and Eye Donation](#).

Caring for patients at the end of life can be stressful for patient, family, and caregivers. Acknowledging and managing stress is an important part of compassionate and quality care. Counseling is available through the [Employee Assistance Program](#) at (734) 763-5409.

#### **IV. REFERENCES AND RESOURCES**

- Bosset, GT, Pope, TM, Rubenfeld GD et al. An Official ATS/AACN/ACCP/ESICMSCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units. Am J Respir Crit Care Med Vol 191, Iss 11, pp 1318-1330, Jun 1, 2015
  - UMHHC Policy 03-07-010 Advance Directives
  - UMHHC Policy 62-10-002 Refusal of Consent/Treatment
  - UMHHC Policy 62-11-002 Pain Management
  - UMHHC Policy 04-06-035 Staff Requests Not to Participate
  - University of Michigan Adult Ethics Committee
  - University of Michigan Pediatric Ethics Committee
  - UMHHC Policy 02-05-003 Organ Donation
  - UMHHC Policy 03-10-020 Brain Death
  - UMHHC Policy 03-01-025 Cardiopulmonary Resuscitation
  - UMHHC Policy 03-01-025 Do Not Resuscitate
  - UMHHC Policy 62-10-003 Patient Care Orders
  - UMHHC Policy 62-11-013 CIED (Cardiac Implantable Electronic Device)
- NOTE:** This general policy does not replace the Pediatric Medical-Surgical Joint Practice Pediatric end-of-life exception policy and care guidelines

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