WEST VIRGINIA UNIVERSITY HOSPITALS ***and Ambulatory Services*** ***POLICY AND PROCEDURE MANUAL***	**Policy IV.056** **1st Effective 6–16-93** **Revised 5-1-97; 11-26-99; 11-1-00; 12-12-01; 6-20-02; 7-25-02; 4-4-05; 8-12-13; 8-25-16** **Reviewed: 8-15-08**

WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT

POLICY

A. Statement of Rationale

West Virginia University Hospitals has the capacity to provide patients with high quality, state-of-the-art, life-sustaining treatments. However, these treatments do not benefit all patients, nor do all patients desire such treatments. Therefore, it is necessary to establish a policy at West Virginia University Hospitals for withholding and withdrawing life-sustaining treatments.

B. Statement of Purpose

It is the policy of West Virginia University Hospitals to honor the informed refusal of life sustaining treatment by patients with decision-making capacity or by their medical power of attorney representative or surrogate.

C. General Principles

When decisions are made to withhold or withdraw life-sustaining treatment, the following principles shall apply:

1. Respect for patient autonomy is the primary basis for withholding and withdrawing life-sustaining treatment. Patients with decision-making capacity must be consulted about decisions to withhold or withdraw life-sustaining treatment, and they have a right to accept or refuse such treatment. While patients with decision-making capacity have a right to accept or refuse life-sustaining treatment, they do not have a right to receive treatment that falls outside the accepted standards of medical practice.

2. If a patient lacks decision-making capacity, the instructions written in the patient's advance directive, either a living will or medical power of attorney, are to be followed, provided they are consistent with accepted standards of medical practice.

3. When a patient who lacks decision-making capacity has completed a medical power of attorney, the designated representative should serve as the legal representative for the patient (i.e., the person to make decisions on the patient's behalf). When a patient lacks decision-making capacity and has not completed a living will or medical power of attorney, a health care surrogate decision-maker should be selected as set forth in Policy No. III.010, Informed Healthcare Decision-Making by Patients or Surrogates. If the surrogate knows the patient's values or wishes, these decisions should be based on substituted judgment. If the patient's values or wishes are unknown, surrogate decision-making should be based on the patient's best interest.

4. A consideration of best interest (the balance of benefits and burdens offered by a treatment) is the primary basis for withholding or withdrawing life-sustaining treatment when a patient lacks decision making capacity and his/her wishes for treatment are unknown and when the patient is a non-emancipated or non-mature minor. In the case of an infant or child, it is presumed that the parents or legal guardians are the appropriate legal representative on behalf of their infant or child

and will act according to the infant's or child's best interest. If there is uncertainty or disagreement about what constitutes the child's best interest, it is recommended that the WVUH Ethics Committee be consulted. Parents do not have an unqualified right to refuse clearly beneficial treatment for their minor children or to require treatments that fall outside the accepted standards of medical practice. If the minor is emancipated or is determined to be mature, he or she should be the person making decisions concerning life-sustaining treatment. (See Policies No. III.010, Informed Healthcare Decision-Making; No. IV.055, Do Not Resuscitate (DNR); IV.059 End of Life Care; III.025 Patient Advance Directives.

5. A physician's decision to withhold life-sustaining treatment because the burdens of it outweigh the benefits to the patient must be discussed with the patient, or the patient's Medical Power of Attorney representative or surrogate, or the patient's parent or legal guardian if the patient is a minor (other than an emancipated or mature minor), before it is implemented. If the patient or Medical Power of Attorney representative or surrogate disagrees with withholding or withdrawing treatment, the patient Medical Power of Attorney representative or surrogate must be given an opportunity to request a second opinion or to transfer the patient's care to another physician. At WVUH, respect for the values of each patient or Medical Power of Attorney representative or surrogate in defining benefits is of utmost priority; however, there are limits to what reasonably may be considered to be beneficial. There is no ethical obligation for WVUH to provide life-sustaining treatment if such treatment falls outside the bounds of accepted medical practice even if requested by a patient or Medical Power of Attorney representative or surrogate. The attending physician should refer the patient and his or her family members to clergy or other spiritual advisors for consideration of issues of withholding or withdrawing life-sustaining treatment as appropriate. The hospital's Guidelines for Medically Ineffective Treatment found in Appendix N of the Medical and Dental Staff Rules and Regulations are also a potentially helpful resource if there is disagreement between the treating physician and the patient or if the patient lacks decision-making capacity the patient's Medical Power of Attorney representative or health care surrogate.

6. WVUH subscribes to the consensus in the medical literature that there is no ethically relevant difference between withholding and withdrawing a life-sustaining treatment.

7. When the balance of benefits to burdens of a life-sustaining treatment for a particular patient is not clear, a time-limited trial of life-sustaining therapy is appropriate. Such a trial of therapy will allow the physicians and nurses to observe the patient's response to this treatment and will provide the patient or Medical Power of Attorney representative or surrogate with a better understanding of what the treatment involves. At the completion of time-limited trial, physicians and the patients or Medical Power of Attorney representative or surrogate may be in a better position to assess the efficacy and desirability of the treatment and decide whether to continue or stop it.

8. The ultimate responsibility for implementing this policy rests with the patient's attending physician.

DEFINITIONS

A. For definitions of many of the terms used in this policy see Policy III.010 Informed Healthcare Decision making.

PROCEDURE

A. Patients with Decision-Making Capacity

1. For patients with decision-making capacity, including mature or emancipated minors, decisions to withhold or withdraw life-sustaining treatment should be the result of shared decision-making between the patient and the attending physician. To facilitate shared decision-making and to enable a patient to exercise his or her right to accept or refuse life-sustaining treatments, a physician must disclose relevant information to the patient. Relevant information includes the

potential benefits and burdens (harms, discomforts, and side-effects) of each treatment option, including nontreatment, as well as the probability of each potential outcome, if known. (See Policy No. III.010, Informed Healthcare Decision-Making.)

2. Patients are presumed to possess decision-making capacity unless there is good reason to doubt such capacity. Refusal of treatment that most patients would request does not necessarily imply that a patient lacks decision-making capacity. However, refusal in such circumstances may initiate an inquiry concerning the patient's decision-making capacity.

B. Patient Who Lack Decision-Making Capacity

1. The assessment of decision-making capacity is a clinical judgment to be made by the attending physician. If the attending physician is uncertain about the patient's decision-making capacity, the attending physician should consult the psychiatry liaison service or the WVUH Ethics Committee, or both. The determination of incapacity must be recorded in the patient's medical record by the attending physician. The recording should state the basis for the determination of incapacity, including the cause, nature and expected duration of the patient's incapacity, if known.

2. If the patient has completed a medical power of attorney document, the wishes of the patient as stated in the written document must be followed, provided they are consistent with accepted medical practice. If the patient has not provided instructions in the document the wishes of the patient as stated by the Medical Power of Attorney representative must be followed provided they are consistent with accepted medical practice.

3. If a patient lacks decision-making capacity and has not provided a written advance directive, the attending physician shall appoint a health care surrogate and inquire of the identified surrogate whether the patient has expressed his or her wishes orally with regard to future healthcare. If the surrogate has knowledge of patient's wishes, the surrogate shall make decisions with the attending physician based on a substituted judgment of what the patient would have wanted.

4. If the patient lacks decision-making capacity and has not expressed his or her wishes in advance for healthcare, either verbally or in writing, the surrogate shall make decisions with the attending physician based on the patient's best interest.

5. If the attending physician cannot reach agreement with the surrogate in regard to the use, withdrawal, or withholding of a life-sustaining treatment for a patient who lacks decision-making capacity, consultation with the WVUH Ethics Committee is strongly encouraged.

C. Physician Responsibility

1. The attending physician is responsible for initiating a discussion of the appropriateness of life-sustaining treatments with a patient who has decision-making capacity. When the patient lacks decision-making capacity, the attending physician is responsible for initiating a discussion of appropriateness of life-sustaining treatments with the patient's medical power of attorney representative or surrogate decision-maker (whom the attending physician is responsible for selecting if one has not already been designated).

2. The attending physician is responsible for documenting in the hospital chart the substance of conversations about life-sustaining treatments. He or she shall document who participated in the conversation and the rationale for decisions.

3. If life-sustaining treatments are to be withheld or withdrawn, the attending physician is responsible for entering Treatment Limitation Orders in the electronic medical record. (The attending physician may direct a resident responsible to him or her to enter such orders.) It is the responsibility of the attending physician to ensure that these orders and their meaning are discussed with all the physicians and nurses caring for the patient.

4. If, because of personal moral convictions, the attending physician cannot in good conscience honor a patient's or surrogate's request to withhold or withdraw a life-sustaining treatment, the attending physician shall arrange for the prompt and orderly transfer of the patient to the care of another physician.

D. Nurse's Responsibility

1. The registered nurse is responsible for incorporating the Limited Treatment Plan Orders in the electronic medical record into a plan of care and to communicate these orders at nursing report.

2. If, at any time, Limited Treatment Plan Orders are rescinded, the registered nurse is responsible for updating the patient's plan of care and for reporting to other nurses involved in the patient's care changes in the patient's orders.

3. If a patient Medical Power of Attorney representative, or surrogate expresses the desire to have life-sustaining treatment withheld or withdrawn to other members of the healthcare team (e.g., RN, social worker, chaplain, or students) this information shall be communicated to the attending physician as soon as possible. Members of the healthcare team shall be receptive to patient or surrogate discussion regarding this issue, but the attending physician remains responsible for Treatment Limitation Orders.

4. If, because of personal moral convictions, the nurse objects to particular Treatment Limitation Orders, he or she should conscientiously withdraw from the care of the patient consistent with Policy No. V.208, Staff Rights Mechanism for Exclusion from Patient Care.

E. Treatment Limitation Orders in the electronic medical record

1. To implement decisions to withhold or withdraw life-sustaining treatments, special Treatment Limitation Orders are available in the electronic medical record.

2. The discussion and rationale resulting in the Treatment Limitation Orders in the electronic medical record shall be documented in the progress notes of the Hospital chart.

3. Attending physicians or their designees are responsible for entering Treatment Limitation Orders in the electronic medical record. (The attending physician may direct a resident responsible to him or her to enter such orders). These orders may include but are not limited to the following: No CPR, Do Not Intubate, No transfer to the ICU, and No BiPAP. Medications or treatments, or both, which may be limited include the following: vasopressor drugs, inotropic agents, antiarrhythmics, hyperalimentation, tube feedings, dialysis, blood products, antibiotics, blood tests, oxygen, intravenous fluids, x-rays, and other treatments and medications.

4. The Treatment Limitation Orders may be revoked at any time. The most common reason that might lead to a revocation of a Treatment Limitation Order is a change in the patient's medical condition, such that the patient's prognosis is improved and the likelihood of response to treatment is increased. The attending physician is responsible for notifying the patient or the patient's Medical Power of Attorney representative or surrogate of any significant changes in the patient's medical condition and for making decisions with the patient about revisions in the treatment plan. Changes in treatment orders should be consistent with Paragraph E(3), above.

F. Patient Medical Power of Attorney representative or Surrogate Requests for Life-Sustaining Treatment with No Expected Benefit:

1. If the attending physician judges that a life-sustaining treatment will cause more harm than benefit to the patient, the physician shall recommend withholding or withdrawing it to the patient or surrogate. If the patient or surrogate does not accept the physician's recommendation and consent to withholding or withdrawing life-sustaining treatment, the physician has the following options: 1) the physician may seek a second opinion; 2) the physician may consult the WVUH Ethics

Committee; and 3) the physician may seek a transfer of the patient to another physician or institution, or any thereof.

2. If a transfer is not feasible and if, after consultation with another physician or the WVUH Ethics Committee, or both, the physician believes that provision of a life-sustaining treatment requested by the patient Medical Power of Attorney representative or surrogate is contrary to the accepted standards of medical practice, the physician may complete Treatment Limitation Orders in the electronic medical record after notification of the patient or Medical Power of Attorney representative or surrogate. Since this action, while medically and ethically correct, may place the physician at risk for litigation, the physician contemplating this action is strongly encouraged to consult with the hospital's Guidelines for Medically Ineffective Treatment found in Appendix N of the Medical and Dental Staff Rules and Regulations, the WVUH Ethics Committee (if he or she has not already done so), the Robert C. Byrd Health Sciences Center Office of Risk Management, or hospital legal counsel.

G. Resolution of Disputes About the Use, Withholding or Withdrawal of Life-Sustaining Treatment

1. Consultation with the WVUH Ethics Committee is strongly encouraged if physicians, other members of the healthcare team, patients, family members, Medical Power of Attorney representatives and surrogates, disagree about whether to use, withhold, or withdraw life-sustaining treatment.

   A consultation may be requested by any of these parties. Consultation with the WVUH Ethics Committee shall be performed according to Policy No. III.027, Hospital Ethics Committee

2. Recourse to the courts should be reserved for occasions when adjudication is clearly required by state law or when concerned parties have disagreements over matters of substantial import such that they cannot resolve and that cannot be resolved in consultation with the WVUH Ethics Committee.

H. Use of the POST Form

1. The Physician Orders for Scope of Treatment (POST) form is used throughout West Virginia to communicate physician orders for life-sustaining treatments based on patients' preferences. When a patient is admitted with a completed POST form, the unit clerk is responsible for placing the original in the file folder for the patient on the unit. The attending physician and/or his/her designee shall review the POST form with the patient, or if the patient lacks decision-making capacity his medical power of attorney representative or health care surrogate, and verify the physician orders with them. The physician shall enter orders into the electronic medical record consistent with those in the POST form in accordance with current patient wishes.

2. At discharge, the attending physician or his/her designee is responsible for verifying the current POST orders with the patient or medical power of attorney representative or health care surrogate, and any changes are to be recorded on a new form. When the file folder for the patient on the unit is being disassembled at discharge, the unit clerk is responsible for sending a photocopy of the current POST form to Health Information Management to be scanned into the patient's electronic medical record. The original POST form is to be returned to the patient to accompany the patient on transfer to another facility or to home.

3. Prior to discharge to another facility (i.e., long-term care facility, personal care home, home with home health care, another hospital, or home with hospice treatment), a POST form should be completed by the attending physician and/or his/her designee for patients who desire one and do not already have a completed POST form.

4. If the patient expires during the hospital admission, the original POST form is to be scanned into the electronic medical record by Health Information Management.

5. If a POST form is rewritten during the hospitalization, the attending physician or his/her designee is responsible for voiding the non-current version of the form in Section F of the form and writing the word "VOID" across the first page of the form. The voided POST form shall be scanned into the patient's electronic medical recoryby Health Information Management.

6. Consistent with the hospital No CPR policy IV.055, patients with No CPR orders during the hospitalization should have West Virginia Do Not Resuscitate (DNR) cards issued to them at the time of discharge if they are not being issued a POST form or if they will be outside the home and want a more portable form of DNR identification (section B.4 in IV.055).

I. Relationship to Existing Hospital Policies

1. This policy is cumulative with other Hospital policies regarding life-threatening emergencies. Nothing in this policy is meant to replace consent procedures in emergency situations.

2. See Policies No. III.010, Informed Healthcare Decision-Making; No. III.025, Patient Advance Directives; and No. IV.055, No CPR.

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