Foregoing Life-Sustaining Treatment Guidelines 2.0075

Audience: All Staff

References and Citations:

A. **Foregoing life-sustaining treatment in the presence of medically defined death:** Unless provisions have been made, utilizing informed consent, for organ harvesting or medical research, life support measures should be discontinued when a patient is medically dead. Special consideration may be given toward continuing life support in the case of a pregnant patient in the interest of preserving the life of the unborn child.

B. **Deaconess Hospital complies with the Natural Death Act of Washington**

1. The State of Washington recognizes the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person's right to control his or her health care may be exercised by an authorized representative who validly holds the person's durable power of attorney for health care.
2. Any physician, health care provider acting under the direction of a physician, or health facility and its personnel who participate in good faith in the withholding or withdrawal of life-sustaining treatment from a qualified patient in accordance with the requirements of the Washington chapter unless otherwise negligent shall be immune from legal liability, including civil, criminal or professional conduct sanctions.

C. **Definitions surrounding Withholding or Withdrawing Treatment**

1. “Life-sustaining treatment" means any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore or replace a vital function and which would serve only to prolong the process of dying. Life-sustaining treatment shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.
2. "Permanent Unconscious Condition" means an incurable and irreversible condition caused by injury, disease or illness that, within medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards and where the application of life-sustaining treatment serves only to prolong the process of dying.

D. Guidelines for Withholding or Withdrawal of Life Sustaining Treatment

1. In a terminal condition:
   The patient must be diagnosed in writing by the patient's attending physician who has personally examined the patient to have a terminal condition.

2. In a permanent unconscious condition:
   The patient must be diagnosed in writing in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient to be in a permanent unconscious condition.

3. Before life-sustaining treatment can be withdrawn, the patient's immediate family must concur. If the patient has a Durable Power of Attorney for Health Care, the person designated in this document should speak for the patient. In a situation of family conflict, the physician is advised to consult Patient Care Administration, and Palliative Care.

4. A copy of the patient's written Advance Directive should be made a part of the patient's medical record and referenced on the patient's chart. All orders to forego treatment (that are usually automatically initiated), e.g., CPR, etc., or to forego life sustaining treatment should be written and signed by the attending physician(s) or physician designee, and placed in the patient's medical records. Orders may be taken by phone if given to a House Supervisor or Registered Nurse. When possible, a second staff nurse should witness the order. Phone orders should be signed by the attending physician at the earliest possible moment. Progress notes should document the circumstances surrounding the decision to forego life-sustaining or disproportionate care.

   This documentation should include a summary of the medical situation (including mental status, diagnosis and prognosis), outcome of discussion with the patient, family and medical consultations and the basis upon which a person, or persons, has been identified as surrogate decision maker. Additionally, a conference should convene (not necessarily formal) for the purpose of informing those directly involved in the patient's care.

   The existing written Advanced Directive will be honored until such time as the attending physician determines that the Advance Directive is either invalid or otherwise notes in the patient's file that the Directive has been revoked by the competent patient.

5. For all pediatric patients, an attending physician or designated physician will be present at the time disconnection from life support (ventilator) is performed.

E. Competent Patients

Competent adults may decline both lifesaving and life-sustaining treatment, even if refusal may lead to death. If a competent patient and attending or consulting physicians agree that the treatment is disproportionate and the person wishes to discontinue treatment, disproportionate care may be foregone and proportionate measures only may be provided. When the attending or consulting physicians disagree with the competent patient's decision to refuse treatment, the options include: consultation, transfer of care to another physician, allowing the competent patient to remove himself or herself from the Medical Center, if possible, or referral to hospital legal counsel to determine whether judicial resolution should be sought. Where the attending or consulting physicians have questions about the patient's competency, psychiatric or other appropriate consultation should be sought and the procedure followed for competent or incompetent patients depending on the judgment reached.

F. Incompetent Patients

In the case of an incompetent patient, the following principles should be observed to ensure that the patient's best interests are being served.

1. The accurate determination of prognosis is pivotal to the determination of proportionality of care.
2. Disproportionate care may be discontinued when it is apparent that the patient would have refused the treatment if he or she were able to choose. Information bearing on the patient's intent includes oral directives to friends, family members or health care providers; evidence of what the patient said in reaction to medical treatment given to others; deduction from the patient's religious beliefs; and deduction from the patient's consistent pattern of conduct regarding prior decisions about his or her own medical care. In order to ensure that only disproportionate care is being terminated, the patient's surrogate decision-maker must receive the same medical information as one would expect a competent patient to have before consenting to or rejecting treatment.
3. If no sufficient evidence exists that the patient would have wanted to forego disproportionate care, family members may assert the patient's right to termination of same provided the attending physician(s) is in agreement that the termination of that care would serve the patient's best interest that there is no reasonable chance of recovery as a result of therapy. If a disagreement exists between the above parties, a Palliative Care consult should be considered. A court appointed legal decision maker may be requested as a last resort.
4. When no family, friends or guardian have been located, after reasonably diligent search, within a reasonable period of time, in accordance with Washington State law, a court appointed legal decision maker will be requested prior to discontinuing care.

G. Proportionate/Disproportionate Care

The moral distinction between proportionate and disproportionate care is fundamental to decisions regarding the foregoing of life-sustaining treatment for both competent and incompetent persons.

1. A person's moral obligation to preserve his or her life or the obligation of those who represent an incompetent person to preserve that person's life is not unlimited. The distinction between proportionate and disproportionate care is a guideline for determining the moral limits of an individual's obligation to preserve his or her own life. This distinction should also guide those who make decisions on behalf of the incompetent person.
2. Disproportionate care is care (surgery, medication [other than comfort medication] treatment, therapy, etc.) which is so objectionable to the patient in regard to the pain and effort needed to provide that care that the patient or the patient's representative would not morally be obliged to cooperate with the administration of that care.
3. Proportionate care is care by which anticipated benefit is great enough relative to all burdens that it is morally obligatory to provide that care.

H. Care for Dying Persons

The primary goal of care for the dying person should be relief of suffering and the promotion of comfort through the use of patient care measures and appropriate medication. This goal includes support for significant others in the dying and grieving process. The decision to forego artificially provided hydration and nutrition at this point should prompt a careful review of medical prognosis and the patient's comfort.

I. Treatment of the Body after Death

The body, even after death, deserves respect and all procedures affecting it must be conducted with dignity and appropriate consent.

J. Organ Donation

See Protocol for Donation and Procurement T-42c

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