



Withholding and Withdrawing Life-Sustaining Treatments

Department Generating Policy: Risk Management

Purpose

1. To provide guidelines for withholding and withdrawing life-sustaining treatments.
2. To define code status orders and provide guidelines for the use of Code/No Code designations.
3. To promote responsible, ethical, and sensitive communication among those involved in the care and support of patients.

Audience

Organization

Policy

A. Philosophy and General Principles

Astria Toppenish Hospital is dedicated to the provision of healing, restorative, and palliative care to people who are sick and injured and to the care of those who are suffering or are dying.

Both human and technological resources are offered. To restore health and support life are among the hospital's principal goals. This means that every appropriate effort is made to cure the sick and rehabilitate the injured. Helping terminally ill patients to live the end of their lives in a responsible and dignified manner is a valuable goal. We should not treat the terminally ill as if there were curable; they are more in need of comfort and company than of life-sustaining treatments.

Astria Toppenish Hospital respects the rights of patients to make decisions regarding their health care, including decisions regarding withholding or withdrawing life-sustaining treatment. The patient must possess appropriate information to make an informed decision. It is the usual and customary responsibility of the health care team to provide such information in a clear, sensitive, and balanced manner.

B. Definitions

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1. Life-Sustaining Treatment is any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition or hydration to sustain, restore or replace a vital function, which, when applied to a qualified patient 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. Life-sustaining treatments may include but are not limited to the following; Cardiopulmonary Resuscitation (CPR), mechanical ventilation, electrical cardiac shock for arrhythmias, transfer to an Intensive Care Unit, dialysis, and artificially administered nutrition and hydration.
2. Withdrawing Life-Sustaining Treatment is termination of treatment already in progress.
3. Withholding Life-Sustaining Treatment means not initiating life-sustaining treatment. It is consistent with the written NO CODE or DO NOT RESUSCITATE order.
4. Terminal Condition means an incurable and irreversible condition caused by injury, diseases, or illness, that within reasonable medical judgement, 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
5. Permanent Unconscious Condition means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgement as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.
6. Qualified patient means an adult person who is a patient diagnosed in writing to have a terminal condition by the patient's attending physician, who has personally examined the patient, or a patient who is diagnosed in writing to be in a permanent unconscious condition 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.

C. Definition of Code Status Orders (See physician order stamp)

1. Code BLUE: A summons of the Code BLUE CPR team to provide emergency care for a patient following sudden, unexpected cardiac and/or pulmonary arrest. In all instances of a cardiopulmonary arrest, a Code BLUE will be called unless one of the following applies:

- a. The attending or on call physician's order for "No-Code" is present on the patient's chart.
- b. The patient's physician is present during the arrest and makes a clinical judgement that resuscitation is futile.
- c. The attending physician can order a "No-Code" by telephone if the order is witnessed by two professional nurses. The telephone order should be signed by the attending physician within 24 hours.
 - i. No Code: Basic and advanced life support is withheld; automatic initiation of cardiopulmonary resuscitation suspended.
 - ii. Modified Code: One or more of the following measures can be used: CPR, intubation, electrical cardioversion, chemical treatment of arrhythmias, and pressor support.

D. Procedure for withholding or withdrawing life-sustaining treatment

1. General Guidelines

- a. The physician is responsible for communicating the diagnosis and prognosis to the patient and/or surrogate decision maker and coordinating the effort toward making the decision to write the "No- Code" order or the order withdrawing life-sustaining treatment.
- b. A "No-Code" order should be reviewed periodically, particularly if there is a significant change in the patient's status
- c. A "No-Code" status is compatible with maximal medical and nursing care and does not imply that supportive comfort care and/or adequate analgesia will not be continued.
- d. No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in withholding or withdrawal of life-sustaining treatment if such person objects to so doing.
- e. No person may be discriminated against employment or professional privileges because of the person's participation or refusal to participate in the withholding or withdrawal of life-sustaining treatment.
- f. In the even that a hospital employee feels he/she cannot, in good conscience, participate in the withholding or withdrawing of life- sustaining procedures, he/she should communicate this to his/her immediate supervisor.

The supervisor will assign other employees to assist the physician in carrying out the patient's wishes.

2. Competent Patients

- a. A competent patient may give verbal or written request to withhold or withdraw life-sustaining treatments. It is important that this decision be made on an informed basis. Any such request should be documented in the patient's medical record. It is the responsibility of other caregivers to notify the attending physician as soon as possible that such a request has been made.
- b. In those situations where initiating a "Code BLUE" or applying other life-sustaining treatments is not medically indicated, but the patient has not requested the treatments be withheld, it is the attending physician's responsibility to discuss the application of life-sustaining treatments with the competent patient and appropriate staff members.

Documentation of such discussion should be recorded in the patient's medical records. A "Code/No Code" decision may be requested of the physician by nursing staff.

3. Incompetent Patients

- a. An incompetent patient retains his/her right to refuse life-sustaining treatment as expressed through a HEALTH CARE Directive executed when the patient was competent.
- b. An incompetent patient retains his/her right to refuse life-sustaining treatment as expressed through a surrogate decision-maker. Surrogate decision-makers, listed in order of priority according to state law, are (1) a duly-appointed guardian; (2) a person appointed by a durable power of attorney with applicable health care decision provisions; (3) a spouse; (4) a consensus among children age 18 or over; (5) parents; (6) a consensus among adult brothers and sisters.
- c. If the surrogate decision-maker requests withholding or withdrawing life-sustaining treatment and the attending physician agrees, or if the attending physician suggests withholding or withdrawing treatment and the surrogate agrees, the agreed upon treatment plan and appropriate "Code" status should be recorded in the medical chart. (In the event that there is no Health Care Directive and no available surrogate decision maker, a guardian ad litem may be considered.)

- d. The Supreme Court of the State of Washington has required under certain conditions that the attending physician obtain verification in writing of the diagnosis and prognosis of the incompetent patient from two additional physicians who maintain qualifications relevant to the patient's condition in cases such as *In Re Colyer* (1983) 99 Wn. 2d 114, *In Re Hamlin* (1984) 102 Wn. 2d 810, and *In Re Grant* (1987) 109 Wn. Ed 545. However, it is important to note that in all of these cases there were no Advance Directives. "It is the duty of the Staff, through its departmental chairperson and MEC, to insure that a practitioner seeks consultation when indicated.

E. Conflict Situations

1. If the competent patient and the attending physician disagree about the treatment plan or code status after all other avenues of reconciliation have been tried, the physician may either (1) accept the competent patient's request or (2) make reasonable efforts to assist the patient in his/her efforts to find another physician.
2. If the surrogate decision-maker and the attending physician disagree about the treatment plan or code status after all other avenues of reconciliation have been tried, the physician may either (1) accept the surrogate decision-maker's request, (2) make a reasonable effort to assist the surrogate in his/her efforts to find another physician, or (3) seek judicial review in consultation with Administration.
3. In any case of conflict, if the physician is uncertain about the underpinning of the case, he/she may discuss the case with the Consultative Ethics Committee. (Also see Addendum A # IIB)

F. Discharge of Patient to Die at Home

If a patient is capable of making health care decisions and indicates he/she wishes to die at home, the patient must be discharged as soon as reasonably possible. The attending physician or hospital staff (in the absence of the attending physician) has an obligation to explain the medical risks of an immediate discharge to the patient.

ADDENDUM A

Health Care Directive

The patient is the ultimate decision-maker for his/her own health care and must understand and approve the course of medical treatment whenever possible. If a conscious, competent adult patient has not previously executed a Health Care Directive according to the Washington State Natural Death Act of 1979 (amended 1992) thereby

authorizing the withholding or withdrawal of life-sustaining treatment, have the patient execute a Health Care Directive if possible.

I. Prerequisites to Withholding or Withdrawing Under the Act

- A. The patient must be 18 years or older and competent to make health care decisions before executing a Directive.
- B. The form in which a Directive may be worded is set forth in the statute (RCW70.122.020) but may, in addition, include other specific direction.
- C. The patient's signing must be witnessed by two qualified adults. The following persons may not serve as witnesses:
 - 1. Anyone related to the patient by blood or marriage;
 - 2. Anyone mentioned in the patient's then-existing will, or by law entitled to a portion of the patient's estate
 - 3. Anyone who is a creditor or would otherwise have any claim on any portion of the patient's estate at the time the Directive is signed;
 - 4. An attending physician of the patient;
 - 5. An employee of an attending physician of the patient; or
 - 6. An employee of the health care facility in which the declarant is a patient.
- D. The patient must have been diagnosed in writing to have a terminal condition by the patient's attending physician, or to be in a permanent unconscious condition by the patient's attending physician and one other physician. Each of the diagnosing physicians must have personally examined the patient.
- E. Before any life-sustaining treatment is withheld or withdrawn, the attending physician must make a reasonable effort to determine that the Directive complies with the Act, and to ensure, if the patient is capable of making a health care decision, that the Directive and all steps proposed by the physician are in accord with the desires of the patient. If the patient is comatose or otherwise incapable of communicating, the Directive (unless revoked) is conclusively presumed to represent the wishes of the patient.

II. Attending Physician's Obligation.

- A. If the Directive is on file in the physician's office a copy must be forwarded to the hospital and be made part of the patient's medical record prior to the withholding or withdrawing of the life-sustaining treatment.
- B. If the Physician or hospital becomes aware of any circumstances in which a patient Advance Directive cannot be honored due to conflict with hospital policy, a physician, or the Washington State Natural Death Act the patient/surrogate decision maker will be advised.

Discussion and documentation will include:

The difference, if any, between limitations that apply to the hospital versus those raised by the patient's physician.

Any reference to the Washington State Natural Death Act which authorized the limitation.

The medical condition and procedures affected by the limitation.

1. If the patient elects to continue care at Astria Toppenish, the physician or hospital staff, with the patient or patient's representative, shall prepare a written plan to be filed with the patient's directive outlining the physician's or hospital's intended actions to be taken should the patient's medical status change so that the directive would become operative.
2. After complying with the steps outlined, the hospital and/or physician are not otherwise obligated to carry out the patient's directives.
3. If the hospital/physician will not honor an Advance Directive, they will make a good faith effort, if desired by the patient, to transfer the patient to a provider that will.

III. Revocation of a Directive

- A. A directive may be revoked at any time by the declarer regardless of mental competency or state of health, by:
 1. Canceling, defacing, obliterating, burning, tearing, or otherwise destroying the Directive, personally or by someone else in the presence and at the direction of the declarer, or
 2. Signing and dating a written statement (in any form) indicating intent to revoke, or
 3. Verbal expression of intent to revoke.

- B. Written or verbal revocation does not become effective until communicated to the patient's attending physician, whether by the patient or someone on the patient's behalf, or until the physician otherwise has actual or constructive knowledge of the revocation.
- C. Time, date, and place of revocation (and the time, date, and place, if different, when notice thereof was received by the physician), must be entered in the patient's medical record by the attending physician.
- D. A revocation which comes to the attention of the hospital, in the absence of the attending physician, should be promptly communicated to the physician and entered in the patient's medical record.
- E. There is no civil or criminal liability for any person who fails to act on revocation of
- F. Directive unless that person had actual or constructive knowledge of the revocation. If, after consideration of these statutory criteria, there is ever a doubt about whether a patient's Directive has been revoked, a "Do Not Resuscitate" order should not be given. Even if a patient has already signed a Directive, the family should be told of the patient's condition and expected outcome of the present treatment.

Implementation/Education Plan

References

[Advance Care Planning: Health Care Directives | National Institute on Aging \(nih.gov\)](#)
[RCW 70.122.020: Definitions. \(wa.gov\)](#)
[Chapter 70.245 RCW: THE WASHINGTON DEATH WITH DIGNITY ACT](#)