Purpose

A. To provide a mentally capable patient or the authorized representative of an incapacitated or a minor patient with the autonomy to refuse medical treatment which conflicts with the patient's values and life goals (refer to Appendix A Definitions, Informed Decision, right of Self Determination, Appendix B Ethical Principles, Patient Autonomy).

B. To support the attending physician or attending physician's designee to withhold or withdraw medical treatment that will be or has become ineffective and/or harmful (refer to Appendix A Definitions, Futility, Benefits vs. Burdens Appendix B Ethical Principles, Beneficence/Non Maleficence).

C. To provide guidelines for healthcare professionals in formulating, documenting, and communicating decisions to withhold or withdraw medical treatment.

Policy:

I. BASICS TENETS

A. It is understood that the physician and clinical healthcare providers at Foote Hospital are committed to the provision of quality medical care with the objective of sustaining life when appropriate in a setting of compassion and respect for the patient. It must be recognized with this commitment that patients have the right to make their own decisions about health care and in continuing, limiting, declining, or discontinuing treatment, whether life-sustaining or otherwise.

B. There is no significant moral or legal difference between failing to institute (withholding) new treatment and discontinuing (withdrawing) treatment that has already been initiated.

C. Providing medical interventions without benefit is inappropriate and not consistent with the standard of care medicine.

II. VALUE OF POLICY

A. Healthcare commitment to improve the quality and delivery of appropriate healthcare through the evaluation of evidence based medical care that requires a method that avoids the over use of medical care.

B. Provide institutional support for the physician's determination that futile treatment need not be provided simply because the family requests it.

C. The institution of appropriate procedures and documentation ensures a thorough review of the decision-making process prior to the implementation of an order to avoid any misinterpretation of the policy.
III. GENERAL DESCRIPTION OF FUTILE TREATMENT

A. Medical care and treatment that is unable to achieve likely physiological effect.
B. Medical care and treatment that will not be able to reverse nor prevent imminent death.
C. Medical care and treatment that will not benefit the patient because the patient is permanently unconscious or in a vegetative state.
D. Medical care and treatment that cannot release the patient from total dependence on intensive medical care.
E. The general description of futile treatment is not limited to the example delineated above but are examples of conditions and situations that aid the attending physician in determining that a futile medical condition exists.

IV. PROCESS FOR DETERMINING FUTILITY

A. The admitting physician, after examining the patient, reviewing their medical record (present and past medical history), and determining that the patient’s medical condition is futile, will discuss with the patient (family and/or guardian) the patient’s condition, diagnoses, objectives, goals of care and potential benefits of treatment, as soon as possible. The results of these discussions will be documented in the patient’s medical record.
B. When the admitting or treating physician determines that a particular treatment desired or expected by a patient, family member or guardian is futile, the physician must explain to the parties involved that in his/her opinion, the treatment will not help/benefit the patient or may be injurious to the patient.
C. If the patient, family or guardian disagrees with the determination that the requested treatment and care is futile, the treating/admitting physician will request a second opinion and consult from an appropriate specialist.
D. If the consulting physician/specialist supports the determination that the care requested is futile and the family continues to disagree and demand the futile treatment, an emergency ethics consult may be considered. An ethics consult serves as a multi-disciplinary resource that may be able to mediate and help resolve any conflict and discuss the situation by reviewing, helping to educate and clarify the issues, advise and educate all parties involved.
E. If an ethics consult is completed and the review supports the determination that the medical care requested is futile as suggested by the attending and consulting physicians, the ethics consulting team along with the attending and consulting physician will attempt to educate the patient, family, and/or guardian as to the medical condition that exists. Afterwards if the patient family and/or guardian continues to disagree, Foote Hospital’s General Counsel (Attorney) and Administration will be notified of the situation that exists.
F. The patient, family and/or guardian in this situation will be informed that Foote Hospital supports the judgment of the attending and consulting physician(s); that the requested treatment is futile and will not be provided. The patient, family and/or guardian will then be given a period of time
and the assistance to arrange for transfer to another institution and to find another physician(s) to care for the patient.

G. If there is no subsequent transfer nor another physician willing to assume management of the patient's care and the patient remains at Foote Hospital, the treatment that has been determined to be futile, will be withdrawn (terminated) or withheld.

V. LIFE SUSTAINING MEDICAL INTERVENTION

A. A variety of medical interventions can be considered life sustaining in a given situation. Utilizing the benefits/burdens approach, any treatment is subject to a decision making process. This specifically includes artificial hydration and nutrition.

B. Endotracheal intubation, artificial ventilation, electrical therapy for cardiac arrhythmias, inotropic, vasoactive, and anti-arrhythmic medications, chest compression for artificial circulation, volume resuscitation, parenteral or enteral nutritional support, parenteral antibiotics, dialytic procedures, cancer chemotherapy, and artificial hydration are examples of interventions/treatments subject to a decision-making process using principles outlined in Appendix B.

C. Cardiopulmonary resuscitation (CPR) for cardiac or respiratory arrest is an intervention for which a decision to withhold is frequently considered. A "Resuscitation" order or a "Do Not Resuscitate" (DNR) order with DNR Treatment Level orders per Hospital POLST defines the restriction or specific interventional parameters to be utilized in a specific situation (i.e. cardiac or respiratory arrest).

D. Comfort Measures: A "Do Not Resuscitate" (DNR) order accompanied by a "Comfort Measures Only" order specifies that there should be no resuscitation, no new treatment, and all diagnostic and therapeutic measures except those necessary to alleviate symptoms of pain and discomfort should be stopped. No measurement of vital signs, diagnostic tests or monitoring should be undertaken. Medications, fluids, nutrition and ventilator support should be provided only with specific written orders for the purpose of relieving unnecessary pain and discomfort.

When death is both inevitable and imminent, a sufficient dosage of narcotic, sedative or other pharmacological and non-pharmacological therapies should be utilized to relieve the patient's pain and suffering, even if doing so might compromise life sustaining functions. The primary extent of any such therapy is to relieve patient suffering and discomfort, utilizing both non-pharmacological and pharmacological modalities. The attending (admitting) physician is responsible for coordinating all the efforts of the healthcare team.

E. Specified Treatment Withdrawal

1. 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 and discomfort in an attempt to make the patient as comfortable as possible.

2. Even though no new treatment (such as IV fluids or ventilation) is ordered, the means to provide that treatment sometimes remain in place, thus presenting the nursing staff with an unsolved dilemma. Therefore, when a treatment is not ordered or when an order to discontinue treatment is written, but the physical means for providing that treatment remains in place, the means should be discontinued. This applies to the discontinuation of mechanical ventilators, supplemental oxygen and circulatory assistance devices, etc. Where applicable the physician may write a specific order to discontinue the usage of any device (i.e. NG tube, IV cannula, nasal oxygen, oxygen mask, etc.) normally initiated or terminated by a nurse, respiratory therapist or technician upon receiving a written order from the physician per hospital protocol.

VI. WITHDRAWAL/WITHHOLDING OF LIFE SUPPORT SYSTEM

A. Competent Patient: A patient who has the ability to understand the nature and effect of their illness and associated treatment, and maintains the ability to communicate their wishes. Prior to issuing an order to withdraw/withhold life support systems for the patient, the attending physician must discuss the situation and prognosis of the illness with the patient to determine that the patient fully understands the consequences of consenting to the withdrawal/withholding of life support systems.

1. The attending physician must verify the patient's diagnosis, prognosis, and treatment alternatives. The attending physician will document the assessment and the verification in the patient's progress notes as part of the permanent medical record.

2. The attending physician must discuss with the patient and (with the consent of the patient) the patient's family, the patient's diagnosis, prognosis, treatment alternatives, the patient's request to terminate life support systems, and the consequences of terminating life support systems, including death. The results of these discussions must be documented in the patient's medical record.

3. The attending physician may personally withdraw/withhold any treatment modality that may result in an immediate change in the patient's condition. Medical and nursing support will be maintained to relieve any pain or discomfort experienced by the patient.

4. In the event that the physician disagrees with the patient's request to withdraw/withhold life support systems, the attending physician may request that the care be transferred to another qualified physician and/or may request an ethics consult to help resolve any issues, by mediating, advising and educating all parties involved as to the issues of conflict/discussion.

5. If a patient requests withdrawal/withholding of life support systems and the attending physician does not agree with that decision, the attending physician must document in the patient's medical record and inform the patient, family and/or guardian of his/her conflict with
the requested treatment. The attending physician will then assist the patient, family and/or guardian in arranging for the transfer of the patient's care to another qualified physician or institution.

B. An incompetent patient is a patient who is unable to understand the nature and severity of his/her illness, the relevant risk, alternatives to treatment options, and who is cognitively and mentally unable to make any informed and deliberate choices about the treatment of their illness.

1. Prior to withdrawing/withholding life support systems, the attending physician, a consulting specialist (physician), and/or a psychiatrist/licensed psychologist shall assess and document in the patient's medical record the following:
   a. That the patient is incompetent and cannot reasonably be expected to change.
   b. The validity of the medical diagnosis and that the patient is terminally ill.

2. The patient's diagnosis, prognosis, alternative care options, and the consequences of terminating life support systems shall be discussed with the patient advocate or guardian, if either has been appointed. In the absence of a patient advocate or guardian, the attending physician shall consult the patient's family regarding such matters. Consideration should be given to prior statements (written or oral: advanced directives, POLST, etc.), which may have been made by the patient when competent, which disclose the patient's wishes as to future medical treatment options. The results and directives resulting from this discussion with the family (member(s)) shall be documented in the patient's medical record.

3. A patient advocate may consent to the withdrawal/withholding of life support systems only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision.

4. The attending physician, under his/her direction, may withdraw/withhold any treatment modality that may result in a deterioration of the patient's condition. Medical and nursing support shall be maintained to relieve any pain or discomfort experienced by the patient.

5. In the event that the patient has no family member available to consult and has not designated a patient advocate, the life support system may be withdrawn if treatment is determined futile by the primary care physician, and an appropriate consulting specialist agrees with the medical findings. In such cases, an ethics consult as well as notification of the hospital's general counsel may be recommended.

6. In the event that the physician disagrees with the patient advocate, guardian or family member's request to remove life support, the attending physician may request that the care of the patient be transferred to another qualified physician and/or institution.

VIII. CIRCUMSTANCES WHERE WITHDRAWAL/WITHHOLDING OF LIFE SUPPORT SYSTEMS IS INAPPROPRIATE.

A. A competent patient or patient advocate (of an incompetent patient) requests full life support measures unless the patient's condition is deemed futile.
B. The guardian or family of an incompetent patient requests full life support measures in the absence of a patient advocate, unless the patient's condition is deemed futile.

C. All members of the incompetent patient's family do not concur with the withdrawal of life support systems, unless the patient's condition is deemed futile. In such cases, family members should be referred to the Probate Court to seek appointment of a guardian. Consideration may also be given to requesting a consultation with the Foote Hospital Ethics Committee to assist the family members in understanding the nature and potential futility of the illness while addressing the pertinent treatment options.

D. Any circumstances in which the required authorization has not been obtained and documented in the patient's medical record.

E. A guardian has not been appointed when a patient has no available family or patient advocate for consultation unless the patient's condition is deemed futile.

F. Pregnant Patients: A pregnant female or her spokesperson(s) cannot make a decision regarding life-sustaining medical interventions, as defined in this document, for herself, which would be known to cause the death of an unborn child. This is a stipulation of the Michigan law for designation of a patient advocate. It is recognized that this situation is distinct from the issue of therapeutic abortion.

IX. HOSPITAL PROCEDURE WHEN A DECISION IS MADE TO WITHDRAW OR WITHHOLD LIFE SUSTAINING TREATMENT

A. When a decision has been made to withhold or withdraw treatment, specific orders must be written by the patient's attending physician defining the parameters of care.

B. Do Not Resuscitate Order:
   1. Do Not Resuscitate (DNR) orders should preferably be written in the patient’s medical record to be valid, preferably be written on the Hospital POLST form. However, phone orders may be taken if the physician has a pre-existing relationship with the patient. If a written DNR order (or a written order defining the parameters of care) is not in the chart, full resuscitation will be instituted as the patient's condition changes.
   2. A DNR order does not imply that any other treatment will be discontinued unless specified by a written order. DNR orders must be reevaluated as the patient's condition changes and documented in the medical record.
   3. On rare occasion, when a DNR patient is taken to the operating room for a surgical procedure, or undergoes a procedure (experimental or other) intended to improve his/her prognosis, will initiate a review, modifications and revision of all previously written orders including the DNR order (as well as a clarification of the advanced directive). While undergoing a surgical or medical procedure in the operating room, the patient normally has full resuscitation status except by agreement of the treating surgeon or specialist performing the procedure) and anesthesiologist. This determination should be discussed with the patient and/or his/her decision-maker prior to the decision to perform the procedure and the
results of this discussion documented in the patient's medical record, prior to the procedure being performed (or cancelled) by both the surgeon and anesthesiologist. This discussion should address degree, type of resuscitation(s) and reason why "resuscitation" during surgery may be necessary. A clarification of issues surrounding the surgical procedure being performed as well as the performance of intra-operative procedures such as intubation and ventilation that may be necessary to perform anesthesia, but may be considered a degree and type of "resuscitation"; unpredictable but reversible adverse medical reactions, anesthetic and medication complication(s) as well as performing CPR and other resuscitative activities during and immediately after surgery in the post-surgical recovery phase, should be discussed, documented and the appropriate (agreed upon) orders written prior to performing the surgical procedure.

In the event that a patient is determined to be incompetent and unable to make a decision for his/herself, but has an advanced directive, or a surrogate decision maker (guardian or power of attorney), the wishes expressed by the surrogate decision maker and/or the advanced directive should be followed and the surgical procedure if necessary cancelled if it is in conflict with the wishes expressed. Any deviation from the wishes expressed must be clarified, discussed and documented in the patient's medical record.

X. DOCUMENTATION: Any discussion of withdrawing, withholding or foregoing any treatment with the patient/surrogate by any physician (primary care, consulting specialist, surgeon, anesthesia, etc.) must be documented in the physician's progress notes within the patient's permanent medical record. The documentation needs to note that the patient/surrogate was informed of the risks, alternatives, and consequences of foregoing, withdrawing, or withholding treatment and the patient's capacity to understand.

XI. THE ETHICS CONSULT: Situations in which consideration is given to withholding or withdrawing life-sustaining medical interventions are diverse. In some the desired course of action is clear to all concerned while others may be quite complex and result in a genuine uncertainty. This uncertainty may represent a need for further information, and communication, or may comprise an ethical dilemma. It is recommended that the physician(s) involved in such a situation should discuss the issues comprising the ethical dilemma with the patient, patient's family, patient advocate, power of attorney, etc., in an attempt to resolve the dilemma. In the event that the dilemma cannot be resolved by the treating physician(s), a consult with the hospital's multidisciplinary Ethics Committee may be considered. The multidisciplinary Ethics Committee functions as an institutional resource and as an advisory group to provide consultation for clinicians and or patient/families. The use of this resource is recommended when clinicians and or patients/families face difficult and uncertain situations or when there is a conflict between or among clinicians and patient/spokesperson(s). A request for an ethics consult may be made by calling 788-4743 or paging 534-1147.
Allegiance Health Policy and Procedures

Section: Patient Rights and Organizational Ethics
Policy Name: Decisions About the End of Life: Futility Policy
Scope: Hospital
TJC Ref. Number: RI.01.05.01
Date: September 2001 (Rev. 11/03, 9/04, 2/14) Page 8 of 10

Approvals:

1. Signature on File Date: 10-27-04
   John Maino, MD, ACLS Chairman

2. Signature on File Date: 11-10-04
   John A. Axelson, MD, Chairman, MEC

3. Signature on File Date: 11-11-04
   Mark Zande, MD, Chairman, HOC

Author:
John Maino, MD, ACLS Chairman

Reviewed 2-2014 and found to have no immediate substantive changes.
Kenneth Empey, General Counsel
APPENDIX A

Definitions

1. **Informed Decision**: In order to exercise self-determination, the patient is entitled to the information necessary to make an informed decision including diagnosis, prognosis, the range of alternatives and the risks and benefits associated with each.

2. **Right of Self-Determination**: The patient’s right of self-determination survives incapacity. This right may be effectuated by an appropriate surrogate as he/she is guided by:
   a. The patient’s explicit advance directive,
   b. In the absence of (a), the surrogate’s judgment about what the patient would have wanted—substituted judgment,
   c. In absence of (a) and (b), the patient’s best interest. The more ambiguous the patient’s best interest, the more knowledge one should have about what the patient wants, wanted, would have wanted before life sustaining medical treatment is withheld/withdrawn or before particularly burdensome treatment is provided.

3. **Benefits vs. Burden**: To allow the expression of patient autonomy, an approach is practiced whereby the patient is informed (truth-telling) of the anticipated benefits (preservation/prolongation of life, alleviation of suffering) in relation to anticipated burdens (shortening of life span, indication of suffering/pain). This terminology is preferred to a specific situation rather than attempting to label to intervention more generally.

4. **Futility**: While always representing an assessment of probabilities rather than certainties, the attending physician or designee, with consultation if necessary, may reach an opinion that life-sustaining medical interventions are or would be futile for a patient. The Foote Hospital recommended approach would be to advise the patient/spokesperson(s) of the recommendation to withhold/withdraw life-sustaining medical intervention(s) recognizing that a period of time may be necessary for the understanding and acceptance. While physician is not obligated to provide intervention(s) perceived as futile, a responsibility for the exchange of information always exists.
Ethical Principles

1. Beneficence/Non-Maleficence: An imperative toward preservation of life in conjunction with, but at times counterbalanced by, alleviation of suffering are the underlying goals for the provision of medical care to individual patients. A mediating influence in the ancient principle of “primum non nocere” (first, do not harm).

2. Patient Autonomy: Patient autonomy, the right of an individual to accept or refuse medical interventions is accepted. The expression of this right for a patient unable to participate in decision-making is transferred formally to a specific individual by an advance, or by necessity, to family or friends if no formal designation has been made.

3. Veracity: The clinician is responsible for truth telling, providing to the patient information relevant to the prognosis and therapy for that patient’s situation. The information conveyed should be as accurate as possible recognizing the inherent uncertainties of medical practices and the differing levels of training and experiences among different clinicians.

4. Justice: The clinicians should be concerned with the principle of justice in providing medical care, the concept, that medical care should be available to all members of a society. While at the present time, societal standards do not exist which impact on the decisions relating to individual patients in the area of life-sustaining treatment, individual clinicians and the institution should be aware of and considered participating in the expected establishment of such societal-level guidelines.