

GUIDELINES FOR TERMINATING LIFE SUSTAINING TREATMENT

These guidelines are based on case law and other legal principles and practices, professional (clinical) practice, and principles of ethical decision-making and are designed for the University of Michigan Health System's adult and pediatric population.

I. INTRODUCTION

A. Purpose of this document. This document provides general guidelines for health care professionals in making decisions concerning treatment for the terminally ill, for patients who have lost cognitive function, or for patients who decline life-sustaining care. These guidelines apply to both adult and pediatric patients.

B. Definitions

1. An **Advance Directive** is a legal document drafted by a competent adult stating the adult's wishes in the event of incompetency. 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 **Appendix A**. Michigan case law also recognizes the usefulness of a living will as valuable evidence of a patient's wishes.
2. **Adults** are individuals age 18 and above. Adults can include inpatients admitted at Mott and outpatients treated in pediatric outpatient clinics.
3. **Cognitive loss of function** is defined here as the irreversible and untreatable loss of capacity to communicate or respond to external stimuli. Irreversible coma and permanent vegetative state are the 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 discuss or make decisions to terminate life-sustaining care.
4. **Competency** is defined as understanding the nature and consequences of one's actions. Thus, if a non-clinically depressed patient has ALS 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 for Health Care Law says that an advance directive goes into effect when the patient's attending physician and another

physician or licensed psychologist determine and document, 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 or common ethical principles..

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 for Health Care Law allows competent adults to name advocates to act on their behalf in the event of incompetency.

5. **Death** .These guidelines also provide advice regarding the cessation of life-sustaining medical services for patients who have died while some organ functions remain artificially supported.
6. **Incompetent** patients (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**, parent or guardian, an advocate appointed by the patient using a durable power of attorney for health care or court-appointed guardians, or, in emergency cases, health care professionals acting in the best interest of the patient. 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. Additional state and federal laws may pertain if child or elder abuse or neglect is known or suspected. For more information, please contact the Health System Legal Office (734.764.2178).
7. **Life sustaining medical treatment – Any treatment that may prolong a patient's life that is not required for the relief of pain and/or suffering. This may include blood transfusions, antibiotics, mechanical ventilation, as well as artificial nutrition and hydration**
8. **Minors** – refer to incompetent patients.
9. **Terminal Illness** is defined here as a condition of the patient which is irreversible, untreatable, and likely to result in death within a period of one year. 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. [For information, or assistance on cases, please contact: the Health System Legal Office (764-2178) for legal consultation; or the Adult Ethics Committee (888-296-2481) for consultation on ethical issues concerning adults; or the Pediatric Ethics Committee (888-296-2481) for consultation on ethical issues concerning minors.]

II. DETERMINATION OF DEATH

- 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.
- B. **Documentation of death through brain function studies.** Documentation of death based on tests of brain function may be required when:
 - 1. 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
 - 2. The information provided by documentation supplementary to clinical evaluation is necessary to resolve disagreements between the attending physician and family members, or
 - 3. The physician wishes to confirm a clinical judgment by brain function testing.
- C. University Hospitals guidelines regarding how to determine and document brain death have been established by the Brain Death Committee. The current guidelines, Policy 03-01-020, Brain Death, were revised February 2007 and can be found at <http://www.med.umich.edu/i/policies/umh/03-01-020.html>.
- D. Cessation of life-sustaining treatment of a patient declared dead does not require specific orders or procedures, nor does it require family consent.

III. PHYSICIAN PRACTICE WHEN WITHDRAWING OR WITHHOLDING LIFE SUSTAINING TREATMENT

- A. The termination of life-sustaining treatment, including life support systems, does not require documentation of death. In appropriate cases, the attending physician may terminate life-sustaining treatment or preclude some or all future life-sustaining treatment with an appropriate written order when the patient is not dead.
- B. **For competent patients:** In making decisions about withholding or withdrawing life-sustaining treatment, the competent patient's wishes must be identified and documented by the medical staff. 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 the patient requests this information. The Health System will not condition the provision of care or discriminate against a patient based on whether or not the patient has executed an advance directive.

For incompetent patients: If the patient is not competent 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 yet have a statute regarding living wills, this type of document should be looked to for guidance about the patient's wishes.

Discussion should occur with the responsible family members, advocate, parent 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 ensure that they are informed.

Minors cannot create a legally valid Advance Directive. However, if a minor has a life limiting illness, parents and minor, if minor understands the nature and consequences of the illness, should both be asked their wishes about a care plan.

If there is a **valid durable power of attorney**:

- The designated advocate makes decisions for the patient. (this may or may not be the spouse)

If there is **no valid durable power of attorney**:

- A spouse can make decisions for their spouse.
- A parent can make decisions for their minor child

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 or parent (if patient is a minor) and no guardian**:

- Other reliable expressions of the patient's intent such as living wills, 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 there is consensus among the members. **Consensus shall be documented, including listing the names of the family members. It is**

desirable to have a note written and signed by the responsible family member(s), guardian, or advocate indicating the patient's reliably expressed wishes, an understanding of the patient's condition, a request to terminate treatment, and an understanding that treatment termination will result in the patient's death. All documentation must occur prior to any definitive action concerning future treatment. In cases of uncertainty or dispute, consult with the Health System Legal Office (764-2178) for possible referral to Probate Court.

- C. The decision to withhold or withdraw life sustaining treatment must be made by the patient's attending physician in consultation with others as appropriate. Such decisions should be supported by the other physicians caring for the patient. Their consultation and agreement with the plan to withhold or withdraw life sustaining treatment should be included in the record. In the event of differences of opinion among the staff, consultation with the Ethics Committee is encouraged.
- D. The circumstances leading to the decision to discontinue or withhold life sustaining treatment should be carefully recorded in the progress notes. 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 decision to decline future life-sustaining treatment. For incompetent patients, the documentation should show informed refusal by advocate, spouse, parent or guardian, or reliably expressed patient wishes conveyed by the family. Decisions of family members, advocate, spouse, parent or guardian shall be guided by the past expressed intention of the patient while competent or the best interests of the minor child as understood by the parent or guardian. 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. Clear and convincing evidence should allow a third person to execute the patient's treatment decisions, even if the decision will result in death, provided the patient is in the condition delineated in the patient's advocate designation or to a family member, spouse, parent or guardian. If there are questions about the nature and strength of the evidence please consult the Health System Legal Office at 764-2178.
- E. Requests by patient, family member, or guardian to withhold or withdraw life-sustaining 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 life-sustaining treatment.
- F. **Withdrawal of life-sustaining treatment when objective physical findings may be misleading.** It is recognized that in certain patients diagnosed with an unrecoverable illness which will likely result in death with the withdrawal of life sustaining treatment, the physical examination may be unreliable due to coexisting independent factors potentially interfering with neurological function (e.g. severe hypernatremia, high levels of a sedating agent in the serum). In such circumstances where the

physical examination might be misleading or difficult to interpret, care should be taken to ensure that the decision to withdraw life-sustaining support has been made on the basis of medical factors independent of the physical examination, and the basis of this decision should be documented in the medical record.

G. Futile Medical Intervention . The autonomy of the patient, or patient's representative(s), 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, or patient's representative(s), does not entail the right of the patient or the patient's representative(s) to command treatment that will cause injury or will not achieve medically accepted goals.. When disagreements in this sphere arise, the following considerations apply:

1. **Futility. The term "Futility" has been used to mean a wide variety of things in the medical-legal literature. For our purposes** a medical intervention can be considered to be medically inappropriate for the patient in the following circumstances:

1. The treatment or intervention is not reasonably likely to achieve the desired results, and/or
2. The treatment or intervention is unlikely to result in any medically recognized improvement in the patient's condition, and/or
3. The treatment or intervention will cause unnecessary pain, suffering, or discomfort to the patient.

Under the circumstances listed above, 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 may be considered futile when it satisfies all of the following conditions:*

- a) *The attending physician has determined that the patient's condition is terminal and incurable; and*
 - b) *The attending physician has determined that the intervention in question is not required for relieving the patient's discomfort; and*
 - c) *The attending physician has determined that the intervention in question offers no reasonable medical benefit to the patient, and that such intervention could serve only to postpone the moment of death.*
2. **Confirmation** . When the attending physician has documented these determinations in the patient's medical record, and another attending physician, after examining the patient, has 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 such

intervention. However, if the patient or the patient's representative(s) disagree with the discontinuation of life-sustaining care, care necessary to extend life should continue to be provided for a reasonable amount of time, while the patient and patient representatives seek an ethics consult or a transfer to another facility.

3. **Notification and Support.** When a decision has been made that the requested treatment or intervention is futile based on the above criteria and that determination has been confirmed by another physician with appropriate expertise who has no prior or present relationship with the patient, the patient or the patient's representative(s) shall be so informed. If the patient or the patient's representative(s) disagree with the decision to withdraw or not to initiate futile intervention, the patient/family/representative should be referred to the Ethics Committee and given the opportunity to secure the services of another physician. The family should be supported in their efforts to secure services of another physician, if that is their wish. Reviews by non UMHS physicians regarding a possible transfer should be initiated immediately and completed within three days. The UMHS physician(s) should be available for telephone consult with the consulting physician.¹
4. **Review .** In the event the patient or the patient's representative(s) disagree with the decision to refrain from or to discontinue the specific medical intervention or treatment that has been determined to be futile, and the services of another physician cannot be secured, the hospitals' ethics committees shall be available for consultation, upon the request of any of the immediately concerned parties.
5. **Futility Example:** A patient with decompensated cirrhosis, hepatorenal syndrome, and multi-system organ failure who is requesting a transplant and is not currently a transplant candidate nor is reasonably medically likely to be a candidate in the near future.

Note: This section considers the ethical issue of the limits of autonomy. This question has not been considered under Michigan law so this section of the Guidelines sets forth the Hospital's ethical position.

IV. 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, or by a house officer responsible for the patient's care after consultation with the attending physician.
- B. "Do Not Attempt Resuscitation (DNAR, no code)" Order.

¹ If a non-UMHS physician plans to evaluate the patient on site, the UMHS physician must assure that the consulting physician follows UMHS Policy 04-06-061 Visiting Observer: For the Individual Who Will Participate In But Not Provide Patient Care. www.med.umich.edu/i/policies/umh/04-06-061.htm.

1. ***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 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 relevant Ethics Committee.
2. A DNAR order does not imply that any other treatment will be discontinued. All appropriate care such as comfort care shall be continued. DNAR orders must be reevaluated as the patient's condition changes.
3. If a written DNAR order is not in the chart, full resuscitation will be instituted in the event of cardiac arrest. Therefore, the Hospitals do 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.
4. On the 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, or is admitted from an outside facility, this step voids all standing orders, including the DNAR order. 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 should be discussed with patient/decision-maker prior to the decision to do a procedure. Following such a procedure, or service transfer, or admission from an outside facility, or operation, the patient's status should be reevaluated to determine whether reinstatement of the DNAR order is appropriate.

C. Orders (DNAR and Comfort Care)

A "do not attempt resuscitation" order accompanied by orders from the CareLink "End of Life" order set will help in defining the individualized specifics of end of life care including limits to life-sustaining interventions and measures to be taken for promotion of comfort and relief of suffering. Based on the needs of the individual patient and family, interventions to consider eliminating include but are not limited to: measurement of vital signs, diagnostic tests, monitoring, and artificial nutrition and hydration. Drugs, fluids, nutrition, and ventilator support should be provided only with specific written orders for the purpose of relieving symptoms.

The health care team has an ethical duty to: (a) discuss options for end of life care with the patient or, if the patient is not competent, with the patient's representatives (family, guardian, advocate); (b) relieve a patient's pain and suffering at the end of life; and (c) 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. There should be serious consideration for a Palliative Care Team consultation.

When death is both inevitable and imminent, and where the patient (or representative) concurs, sufficient dosages 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 must be 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 outlined in these guidelines, or have strong moral objections to implementing them, should find other members of the healthcare team or another physician who will do so.

D. Specified Treatment Withdrawal

Medical treatment not ordered or not renewed is not to be given. For example, it is not necessary to provide transfusion, or antibiotics, or intravenous fluids for terminally ill patients, or for those without cognitive function, unless specifically ordered to relieve unnecessary pain and suffering.

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.**

V. ORGAN DONATION

A. **The decision to withdraw life support is independent of organ donation.**

B. UMHHC Policy

1. In accordance with the Center for Medicare and Medicaid Services (CMS) Conditions of Participation (COP), all patient deaths, imminent or having been pronounced dead, shall be referred to the Gift of Life Michigan (GOLM) for evaluation as a potential cadaveric organ or tissue donor. The doctor, nurse or

designee caring for the patient is responsible to refer, by phone, all such potential donors to the Gift of Life at 800-482-4881 or 973-1577.

Refer to UMHHC Policy 02-05-004 ORGAN and Tissue Donation Following Cardiopulmonary Death and UMHHC Policy 02-05-003 Organ and Tissue Donation Following Brain Death.

- C. Withdrawal or withholding of life sustaining treatment may not occur until Gift of Life Michigan has been notified of the potential donor and completed the necessary steps of the donation process. Federal regulations require hospitals to maintain “potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.”

VI. CONCLUSION

These guidelines are intended to assist the health care team in making legally and ethically appropriate treatment decisions. If further advice is needed, you may call the Health System Legal Office (764-2178) for advice on legal issues and the Adult Ethics Committee or Pediatric Ethics Committee at (888-296-2481) for consultation on ethical issues.

REFERENCES:

Advance Directives UMHHC # 03-07-010

Blood/TX/DX/Refusal UMHHC # 62-10-002

Brain Death, UMHHC Policy 03-01-020

Organ and Tissue Donation Following Brain Death (formerly "Heartbeating Cadveric Organ and Tissue Donation") **UMHHC Policy 02-05-003**

Organ and Tissue Donation Following Cardiopulmonary Death (Formerly known as, "Non-heartbeating Cadaveric Organ Donation") **UMHHC Policy 02-05-004**

Pain Management UMHHC # 62-11-002

Staff Requests Not to Participate UMHHC # 04-06-035

These guidelines were revised by the University of Michigan Hospital and Health Centers Adult and Pediatric Ethics Committees. 3/20/09