

GUIDELINES FOR TERMINATING TREATMENT

These guidelines are based on case law and other legal principles and practices, professional (clinical) practice, and principles of ethical decision-making.

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 refuse care.

B. Advance Directives. An advance directive is a 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.

C. Terminal Illness and Cognitive Function Loss. 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. Loss of cognitive function is defined here as the irreversible and untreatable loss of all capacities 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 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 make decisions to terminate care. 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.]

D. Competent and Incompetent Patients. In making a decision about future treatment of patients either terminally ill or without cognitive function, health care professionals must distinguish between decision-making by competent patients and decision-making for incompetent patients.

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 Law for health care allows competent adults to name advocates to act on their behalf in the event of incompetency. 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 Law for health care says that an advanced directive goes into effect when the patient's attending physician and another physician or licensed psychologist determine, 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.

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**, an advocate appointed by the patient using a durable power of attorney for health care, court-appointed guardians, or health care professionals acting in the best interest of the patient. The guidelines in this document are designed chiefly for the Hospitals' adult population. Many of these guidelines apply also to the pediatric population; for pediatric cases, however, additional state and federal laws pertaining to child abuse and neglect must also be considered. For more information, please contact the Pediatric Ethics Committee (888-296-2481). 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.

E. Death . These guidelines also provide advice regarding the cessation of medical services for patients who have died while some organ functions remain supported artificially.

F. Contents of this document.

Part II. Determination of Death

Part III. Physician practice when withdrawing or withholding life-sustaining treatment.

Part IV. Hospital procedure when a decision may be made to withdraw or withhold life-sustaining treatment.

Part V. Conclusion

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 is required when:

1. Organs are to be removed for transplantation, or
2. 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
3. The information provided by documentation supplementary to clinical evaluation is necessary to resolve disagreements between the attending physician and family members, or
4. 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, 03-01-020, were revised October 24, 2001 and can be found at <http://www.med.umich.edu/i/policies/umh/03-01-020.html>.

D. Cessation of 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 treatment, including life support systems, does not require documentation of death. In appropriate cases, the attending physician may terminate treatment or preclude some or all future treatment with an appropriate written order when the patient is not dead.

B. In making decisions about withholding or withdrawing treatment, the competent patient's wishes must be identified and documented by the medical staff. 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. 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 Medical Center will not condition the provision of care or discriminate against a patient based on whether or not the patient has executed an advanced directive.

For incompetent patients, discussion should occur with the responsible family members, advocate, 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. If there is a valid durable power of attorney, the designated advocate makes decisions for the patient. A spouse can make decisions for their spouse. 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 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, 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 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 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 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 refusal of future treatment. For incompetent patients, the documentation should show informed refusal by advocate, guardian, or reliably expressed patient wishes conveyed by the family. Decisions of family members, advocate, or guardian shall be guided by the past expressed intention of the patient while competent. 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.

E. Requests by patient, family member, or guardian to withhold or withdraw 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 treatment.

F. Futile Medical Intervention. The autonomy of the patient 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 does not entail the right of the patient or the patient's representative(s) to command treatment that is medically inappropriate. When disagreements in this sphere arise, the following considerations apply:

1. Futility. When a medical intervention is futile, 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 physician with appropriate expertise who has no prior or present relationship with the patient has examined the patient and 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.

3. Notification and Support. When the futility of available interventions has been determined, 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 given the opportunity to secure the services of another physician, and supported in their efforts to do so, 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 futile medical intervention, 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 not currently a transplant candidate nor is reasonably medically likely to be a candidate in the near future.

Note: The issue of futility has not been considered under Michigan law so this section of the Guidelines sets forth the Hospital's ethical position.

I would also like to add links to the bottom of this document for Policies 03-01-025 Cardiopulmonary Resuscitation and 03-01-020 Brain Death.

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 Resuscitate (DNR, no code)" Order.

1. Do not resuscitate (DNR) 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 DNR order does not imply that any other treatment will be discontinued. DNR orders must be reevaluated as the patient's condition changes.

3. If a written DNR 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

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.

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. For competent patients see Section ID.

4. On the rare occasion when a DNR 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 DNR 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 DNR order is appropriate.

C. "Palliative Care Only" Order.

A "do not resuscitate" order accompanied by a "palliative care only" order means there should be no resuscitation, and no new treatment, and all diagnosis and therapeutic measures except those necessary to alleviate symptoms should be stopped. No measurement of vital signs, or diagnostic tests, or monitoring should be undertaken. Drugs, fluids, nutrition, and ventilator support should be provided only with specific written orders for the purpose of relieving unnecessary pain.

The health care team has an ethical duty (a) to discuss options for palliative therapy with the patient or, if the patient is not competent, with the patient's representatives (family, guardian, advocate); (b) to relieve a patient's pain and suffering at the end of life; and (c) to 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.

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

D. 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, or antibiotics, or intravenous fluids for terminally ill patients, or for those without cognitive function, unless specifically ordered to relieve unnecessary pain.

2. 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. 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

Pain Management UMHHC # 62-11-002

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

[University of Michigan Adult Ethics Committee](#)

[University of Michigan Pediatric Ethics Committee](#)
