LOURDES HEALTH

FACILITY: **LMC**
DEPT NO: **01.8720**
POLICY NO: **W-1**
DEPARTMENT: **PATIENT CARE**
TITLE: **Withdrawal of Life Support**

STANDARD: To provide a standard of practice/care for withdrawal of life support.

ETHICAL AND LEGAL PRINCIPLES:

""We believe that life is a gift from God to be cherished and respected in all its stages from conception until death. Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them." * Spiritual support is available to each person and any religious services that may promote a dignified and respectful preparation for death.

"A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community."*

"A person may forego extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail excessive burden, or impose excessive expense on the family or the community.*

"The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching."*

Original Effective Date: 7/90
Original Dept. Nursing Administration
ICU Committee: 7/90
Executive Committee: 7/90

Date of Revisions:
Nursing P&P Cmte:
Administration:
Exec. Cmte:
Ethics Cmte: 3/09;6/09
Rick Mgmt: 3/09
Nurse Dir: 8/05;7/07

Date of Reviews:
Nursing P&P Cmte: 9/95;9/97;11/99;9/01
Administration: 3/96;12/99;1/02
Exec. Cmte: 9/92;7/04;7/06;06/09
Ethics Cmte:3/96;11/97;11/99;1/02;6/04; 8/05; 10/13
Risk Mgmt: 12/97;5/98;12/99;5/02; 7/04;7/07;06/09
Nurse Dir: 5/04;9/06;3/08;3/09

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Part of the gift of life includes choices regarding one's health care. If there is no clear benefit in maintaining life, or if the burden of some medical treatments is too great, there is no moral obligation to undertake those treatments. There are times when it is more in keeping with respect for life to let it go than to cling to it.

Each person has the right to sufficient information to make informed decisions about his/her life and health.

In no case may family members or health care professionals override the decision of a competent patient regarding his/her Code Status.

Refer to the Ethical and Religious Directives for Catholic Health Care Services, the "ERD's" for guidance. Consultation available through the Mission and Pastoral Care Departments.

POLICY:

Lourdes Medical Center responds to the health care needs of the community in a Christian spirit. Respect for life, support of individual dignity, and pursuit of patient well-being are Christian values central to the mission of Lourdes Medical Center.

Physician Assisted Suicide
In November 2008, Initiative 1000, "Washington State Death with Dignity Act," was passed with 59 percent of the vote. This affects terminally ill, competent, adult Washington residents medically predicted to die within six months who request from their physician a lethal dose of medication to end their lives. The Act became effective on March 4, 2009 and includes directives for health care providers, including hospitals, who will participate and those who will not participate. A Task Force, under the leadership of Anita Kongslie, Director of Quality Management, met to evaluate the specifics of the Act and Lourdes response. The following statement is posted on Lourdes Health Network Website:
Lourdes Health Network is committed to the fundamental values of respect for the sacredness of life and compassionate care of dying and vulnerable persons. Lourdes Health Network does not participate nor in any way assist with physician-assisted suicide on any Lourdes Health Network campus.

The patient or his/her representative has the right of patient self-determination. This includes the right to forego specific treatment or procedures that are, or may be, life sustaining. It also includes the right of the patient or the patient's representative to have sufficient information in order to make such decisions. Competent adults may decline both life saving and life prolonging therapy, even if refusal may lead to death.

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It is the responsibility of the attending physician and any consulting physician(s) to record in the medical record, the patient's physical, cognitive, and emotional status including a full report of the patient's diagnosis, condition, prognosis, and identified treatment options.

In the event that the designated person(s), cannot be present, but can be reached by telephone to authorize withdrawal of life support, consent may be obtained in the following manner: the authorization must be verified by two (2) individuals listening to the conversation. Both individuals must document the conversation in the medical record, including the name and relationship of the person authorizing withdrawal for life support.

When a mechanical ventilator or pacemaker is to be discontinued, the attending physician should personally disconnect the device or be present when it is disconnected.

Prior to withdrawal of life support, code status must be evaluated and documented in the medical record as a "No Code".

No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in withholding or withdrawal of life-sustaining treatment.

DEFINITIONS: See pages 6 & 7

1. WITHDRAWAL OF LIFE SUPPORT FROM COMPETENT ADULT/QUALIFIED MINOR:
The competent patient may make his or her own determination as to whether to terminate any or all life support systems. In such an instance, the decision by the patient, as well as an observation concerning the patient's competency, should be reflected in the chart. **In no case may family members or health care professionals override a decision made by a competent patient.**

2. WITHDRAWAL OF LIFE SUPPORT FROM A NOT COMPETENT ADULT:

a. When one or more of the following appropriately witnessed documents are available which indicate the patient's choices regarding medical care and treatment options, these documents shall be honored:
    i. Health Care Directive [Advance Directive(s) to Physician (Living Will) and Supplemental Directive to Physician].

ii. Durable Power of Attorney for Health Care
   a. Copies of these documents must be in the current record.
   b. The physician must document, in the medical record, criteria which support the choices identified by the patient or surrogate decision maker(s) regarding withdrawal of life support measures and equipment.

b. When there is a Durable Power of Attorney, it is the responsibility of the physician to meet with the surrogate decision maker to discuss withdrawal of life support. The discussion should include, but is not limited to: a full explanation of the patient's condition, prognosis, and expected level of function; a thorough discussion of the risks and limits of treatments/equipment that might be withdrawn; and the expected outcome of withdrawal of these measures. Other health care professionals involved with the patient should be advised of the content of this meeting and may be invited to attend such a meeting. Health care professionals commonly invited include, but are not limited to, consulting physician(s), Nursing, Respiratory Therapy, Social Services, Pastoral Care, V.P. Mission, Risk Manager, CEO, and legal counsel.

c. When there is no Directive(s) to Physician (Living Will), Supplemental Directive to Physician, and/or Durable Power of Attorney for Health Care, it is the responsibility of the physician to meet with family and/or significant others to discuss withdrawal of life support. The discussion should include, but is not limited to a full explanation of the patient's condition, prognosis, and expected level of function; a thorough discussion of the risks and limits of treatments/equipment that might be withdrawn; and expected outcome of withdrawal of these measures. Other health care professionals involved with the patient should be advised of the content of this meeting and may be invited to attend such a meeting. Health care professionals commonly invited include, but are not limited to, consulting physicians, Nursing, Respiratory Therapy, Social Services, Pastoral Care, V.P. Mission, Risk Manager, CEO, and legal counsel.

Before withdrawal of life support occurs, the attending physician and at least one other disinterested (impartial) physician must agree that withdrawal of life support is appropriate.

When the family/surrogate decision maker(s) and involved physicians concur, their decision should be implemented. If the agreement is not unanimous, the Ethics Committee should be consulted to render an opinion regarding withdrawal of the life support. The attending physician shall then request a conference which may be attended by the attending physician, consulting physician(s), Nursing Services, Social Services, Pastoral Care, Respiratory Therapy, V.P. Mission, Risk Manager, CEO, at

least one member of the Ethics Committee, legal counsel if indicated, and family members, for the purpose of facilitating an agreement.

3. WITHDRAWAL OF LIFE SUPPORT FROM A PREGNANT PATIENT:

Life support must be maintained until delivery of a viable fetus. After delivery, withdrawal of life support may be implemented per policy.

4. WITHDRAWAL OF LIFE SUPPORT FROM CHILD/INFANT

Withdrawal of life support may be considered in the following situations:

A. The child/infant is in a persistent vegetative state that is very likely to be irreversible.

OR

B. The provision of treatment would merely prolong the moment of death whether or not life sustaining procedures were used.

It is the responsibility of the physician to meet with family and/or significant others to discuss withdrawal of life support. The discussion should include, but is not limited to, a full explanation of the patient's condition, prognosis, and expected level of function; a thorough discussion of the risks and limits of treatment/ equipment that might be withdrawn; and expected outcome of withdrawal of these measures. Other health care professionals involved with the patient should be advised of the content of this meeting and may be invited to attend such a meeting. Health care professionals commonly invited include, but are not limited to, consulting physicians, Nursing, Respiratory Therapy, Social Services, Pastoral Care, V.P. Mission, Risk Manager, CEO, and legal counsel.

Before withdrawal of life support occurs, the attending physician and at least one other disinterested (impartial) physician must agree that withdrawal of life support is appropriate.

When the family/surrogate decision maker(s) and involved physicians concur, their decision should be implemented. If the agreement is not unanimous, the Ethics Committee, should be consulted and the attending physician will request a conference which may be attended by the attending physician, consulting physician(s), Nursing Services, Social Services, Pastoral Care, Respiratory Therapy, V.P. Mission, Risk

Manager, CEO, legal counsel, if indicated, and the family members for the purpose of facilitating an agreement.

5. WITHDRAWAL OF LIFE SUPPORT WHEN PHYSICIAN IS NOT IN AGREEMENT

When the patient, family or significant other(s) request withdrawal of life support, and the physician is not in agreement, the attending physician must document the disagreement and persons involved in the discussion in the medical record. The physician is not required to participate in withdrawal of life support if such action would be contrary to the dictates of his/her conscience or belief. In such case, the physician should make a good faith effort to transfer the patient to another qualified physician and/or facility.

If no agreement can be reached, the attending physician and hospital personnel shall attempt to make a good faith effort to transfer the patient to another facility and receiving physician.

6. WITHDRAWAL OF LIFE SUPPORT WHEN FAMILY IS NOT IN AGREEMENT:

When, in the judgment of the attending physician and two (2) disinterested (impartial) physicians, it is the medical consensus that to continue life supportive measures would be harmful or futile, and would merely prolong the dying process and family and/or significant other(s) are in disagreement with the decision to remove life support, the Ethics Committee should be consulted to render an opinion regarding withdrawal of life support, and the attending physician shall request a conference which may be attended by the attending physician, consulting physician(s), Nursing Services, Social Service, Pastoral Care, Respiratory Therapy, V.P. Mission, Risk Manager, CEO, legal counsel and the family members for the purpose of facilitating an agreement.

DEFINITIONS

WITHDRAWAL OF LIFE SUPPORT:

Removal of any medical treatment or equipment that supports or replaces an organ or body process which has weakened or failed. Life support treatment and equipment may include, but is not limited to: ventilator support, dialysis, temporary pacemaker, medications, nutrition and hydration, and mechanical or other means to sustain, restore, or supplant a spontaneous vital function.

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WASHINGTON STATE ORDER OF PRIORITY:

1. The appointed guardian of the patient, if any.

2. The individual, if any, to whom the patient has given Durable Power of Attorney for health care decisions.

3. The patient's spouse or registered domestic partner.

4. Children of the patient. Children must be at least 18 years of age.

If there are two or more individuals in the same class, the decision must be unanimous.

COMPETENT ADULT:

A patient will be considered competent if the patient is all of the following:

1. An adult (18 years of age or older) or qualified minor
2. Conscious
3. Able to understand the nature and severity of the illness involved
4. Able to make informed choices concerning the course of treatment AND
5. Has not been declared legally incompetent

QUALIFIED MINOR:

Emancipated minor--A minor who obtains a court order declaring emancipation may give consent. Lacking a court order declaring emancipation, a multidisciplinary team including, but not limited to, consulting physician(s), Nursing, Respiratory Therapy, Social services, Pastoral Care, V.P. Mission, Risk Manager, CEO, legal counsel will consider the following: age, maturity, intelligence, training, experience, economic independence, and freedom from parental control. If in doubt, obtain the consent of the parent or parents, if possible, in addition to the patient.

A minor married to a person over the age of 18 may consent.

Minor parent may consent on behalf of his/her child.

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NOT COMPETENT PATIENT:

A patient, who in the judgment of a responsible physician or physicians, lacks the capacity to understand the nature, severity, risks and alternatives associated with his/her illness. (Psychiatric and other consultations may be useful when there is uncertainty in making this determination.)

IMPARTIAL PHYSICIAN:

Is a physician who has no personal, as opposed to professional, relationship with the patient.

FUTILE INTERVENTION:

Futile intervention is that which cannot alter the underlying disease state or significantly improve the patient's condition or prognosis. In addition, it constitutes care which, in the case of CPR, is positively harmful for a patient whose death is expected and whose underlying malady cannot be reversed.

REGISTERED DOMESTIC PARTNER:

State registered domestic partners means two adults who meet the requirements for a valid state registered domestic partnership as established by Washington State of this act and who have been issued a certificate of state registered domestic partnership.

***REFERENCES:**

Ethical and Religious Directives for Catholic Health Care Services, National Conference of Catholic Bishops, 4th edition, July, 2001.

RCW 26.60.030: Registered Domestic Partners, http://apps.leg.wa.gov/RCW/default.aspx?cite=26.60.030 accessed May 30, 2008.