Statement on Withholding and Withdrawing Nonbeneficial Medical Interventions

Approved by the AAHPM Board of Directors in November 2011.

Background

Palliative care seeks to relieve suffering associated with life-limiting illness. As illness progresses, there also may be times when the burdens of medical interventions outweigh their benefits, when the intervention is nonbeneficial, or when its use is inconsistent with the patient's goals. Consideration of withdrawing or withholding such interventions is then appropriate. Examples of specific interventions that may be withdrawn or withheld include, but are not limited to, ventilatory support, hemodialysis, implanted cardiac defibrillators (ICDs), cardiopulmonary resuscitation (CPR), vasopressors, artificial (assisted) nutrition/hydration, and antibiotics.

Statement

AAHPM endorses the ethically and legally accepted view that withholding and withdrawing nonbeneficial medical interventions are morally indistinguishable and are appropriate when

consistent with the patient's goals of care. Withdrawing or withholding nonbeneficial medical interventions is acceptable throughout the course of progressive, life-limiting illness, although patients with whom these discussions are held are often close to death.

When considering withholding or withdrawing a nonbeneficial medical intervention, clinicians should systematically:

- Assess the decision-making capacity of the patient. For patients lacking capacity, review all appropriate advance care planning documents and discuss decisions about withholding and withdrawing interventions with the designated surrogate decision maker, who should use substituted judgment. It is the responsibility of the physician and all members of the care team to keep the focus of decision making on the patient's preferences and best interests, rather than on the surrogate's beliefs.
- Identify the overall goals of treatment and care for the patient, considering the current disease status and the social, familial, psychological, and spiritual dimensions of the patient's situation.
- Identify the intended goals of the intervention under consideration, including the potential burdens and benefits of that therapy.
- Assess the burdens and benefits of starting (or withholding) or continuing (or withdrawing) an intervention. The assessment should include objective medical data, and assessment of the likely outcome for the patient with the proposed intervention, as well as alternative interventions. When the outcome of a proposed intervention is uncertain, clinicians should consider a time-limited trial of the specific intervention.
- Make a recommendation concerning continuing/starting or withdrawing/withholding a nonbeneficial intervention that is based on the patient's values, goals, and expected likelihood of success.
- Explain what treatments will be continued and what additional treatments will be added if a specific medical intervention is to be withheld or

withdrawn, and emphasize the types of support that can be provided to either the patient or family. Engage an ethics committee or other institutional committee in cases of disagreement.

Ethical Principles

Support for withholding or withdrawing of nonbeneficial medical interventions is rooted in Western biomedical ethics and American law. The key ethical features are:

1. A major goal of medicine is to relieve suffering.
2. In the Western biomedical ethical tradition, there is no moral distinction between withdrawing and withholding a medical intervention. Clinicians should recognize, however, that there may be cultural, religious, or psychological reasons for patients and families to be concerned about withdrawing or withholding interventions. Clinicians should strive to understand the basis for the perspective of patients and families and to reconcile their views with standard practice when possible.
3. Clinicians should respect patient autonomy, as directly expressed by the patient, or through his or her surrogate. However, clinicians should not implement therapies that cannot accomplish the patient's goals of care.
4. Imbedded within patient autonomy or self-governance is the notion of patient rights. All should remember that the negative right to be left alone, to refuse an offered intervention, is stronger than a positive right to receive something demanded but not offered.
5. The patient should give informed consent; if the patient lacks decision-making capacity, the surrogate decision maker should give informed consent consistent with the goals of care and the patient's values.
6. Withholding or withdrawing nonbeneficial interventions is ethically and legally distinct from physician-assisted death and from euthanasia. It is ethically appropriate even if the death of the

patient occurs closely following withdrawal of therapy.

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