



HPNA Position Statement Withholding/Withdrawing Life-Sustaining Therapies

Position Statement

It is the position of HPNA that: It is the position of the Hospice and Palliative Nurses Association (HPNA) that:

- All life-sustaining therapies may be withheld or withdrawn. There is no difference, ethically or legally, between the decision to not initiate a treatment that may not be beneficial or stop or remove a treatment that is not beneficial and/or no longer wanted.
- Every person with decision-making capacity has the right to initiate any medical therapy that offers reasonable probability of benefit and to withhold/withdraw any medical therapy.
- Patients have the right to appoint a surrogate decision-maker, who would make decisions on their behalf if they are unable to do so.

Education

- HPNA will continue to develop evidence-based educational materials that support all levels of hospice and palliative nurses to provide optimum care to patients and their families during the continuum of the illness trajectory including to the end of life. Palliative care nurses shall ensure their professional development in the ethical principles and their relationship to withholding/withdrawing life-sustaining treatments.
- Palliative nurses possess sufficient knowledge about the issues of using, continuing, withholding, and withdrawing life-sustaining therapies to inform patients, families, and other healthcare providers regarding decisions about their use.

Clinical Practice

- The healthcare team must honor any previously communicated advance directive, including those that appoint a surrogate decision-maker if the patient loses decision-making capacity. If, for some reason, it is not possible for a healthcare team to honor advance directives or wishes, they must document the reason they cannot do so.¹
- Palliative care nurses shall ensure continued nursing care when withholding/withdrawing treatments—limitation of life-sustaining treatment does not mean limiting care. Patients and families often need reassurance that a decision to forgo or limit treatment does not result in lack of appropriate personal care or lead to abandonment.

Policy

- Patients who lack decision-making capacity and who do not have a previously designated surrogate decision-maker should have such a person named in accordance with state, local, and institutional regulations.
- A parents/guardian has legal authority to make decisions regarding treatment for a child if the child is younger than 18 years and the parent/guardian is considered to have the child's best interest at heart. However, the child's views and preferences for medical care, including assent and refusal for treatment (when developmentally appropriate), should be documented and given appropriate weight in decision-making. When the child's wishes differ from those of the adult decision-maker, appropriate professional staff members must assist the child as well as the family.¹

Leadership

- Palliative nurses must help the public understand the difference between withholding/withdrawing life-sustaining therapies and euthanasia and assisted suicide.
- Palliative nurses support patients, families, and colleagues in the decision-making process.
- Palliative nurses shall facilitate decision-making and advocate for care that is consistent with the stated wishes of the patient and the patient's surrogates.

Background

When treatment outcomes are insufficient for a terminally ill patient to live a meaningful life, the treatment goal may transition toward care that is comfort-oriented. At that time, patients may consider DNR, which means that cardiopulmonary resuscitation will not be performed on patients in the terminal stage of incurable disease to allow them peaceful death.²

Decisions concerning withholding and/or withdrawing these therapies are often central to advance care planning.² In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research published *Deciding to Forgo Life—Sustaining Treatment*, which still stands as the cornerstone for ethical decisions relating to withholding/withdrawing therapies in current practice. Tenets from the President's Commission report include:³

- The voluntary and informed choice of a competent patient with decision-making capacity should determine whether a life-sustaining therapy would be initiated, withheld, or withdrawn.
- Healthcare professionals serve a patient's best interest by maintaining a presumption in favor of sustaining life, while recognizing that patients with decision-making capacity are entitled to choose to forgo any treatments, including those that sustain life.
- Whether a treatment is warranted depends on the balance of its usefulness or benefits for a particular patient and consideration of the burdens that the treatment would impose.
- It is often acceptable to use an appropriate surrogate, ordinarily a family member, to make decisions for patients who have insufficient capacity to make their own decisions.

Withholding and withdrawing life-sustaining therapies are considered the same in ethics. Both encompass choice of care treatments, unlike euthanasia or assisted suicide.⁴

In the 1990s, the U.S. Supreme Court rejected the argument that limitations to life support constitute physician-assisted suicide or euthanasia.^{5,6} The American Nurses Association states in its position statement *Registered Nurses' Roles and Responsibilities in Providing Expert Care and Counseling at the End of Life*:

“End-of-life choices are a quality-of-life issue. Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care, including the promotion of comfort, relief of pain, and support for patients, families, and their surrogates when a decision has been made to forgo life-sustaining treatments.”⁷

Discontinuation of life-sustaining treatments that results in death may pose emotional challenges for the patient, provider team, and family members.^{8,9,10} Patients have the right to refuse medical treatments even if that decision results in death.⁸ A central issue in decision-making in situations of serious illness is the moral acceptability of actions that can be seen as hastening death.¹¹ If treatments are no longer effective or acceptable to the patient's personal wishes, it is both ethically and legally acceptable that the treatment be discontinued. Treatment discontinuation does not mean a physician is aiding the patient in dying, nor participating in manslaughter or assisted suicide.⁸

In the same manner that a patient's values should be honored, the nurse's values should be honored.¹¹ When nurses are uncomfortable with withholding/withdrawing treatments, they may remove themselves from patient care, after finding another nurse to replace them.¹² Should there be a disagreement among the patient, family, nurse, and healthcare team, ethics committees should be sought out for consultation to ensure that all sides are represented.¹²

Definition of Terms

Allow natural death: death from natural consequences of a disease or injury that emphasizes ongoing supportive care to promote comfort and optimize quality of life¹³

Autonomy (self-determination): the right of an individual to decide a course of action based on his or her personal goals and values^{14,15}

Beneficence: doing good and caring for patients in a way that they would want. Managing refractory symptoms is an example of this principle.^{14,15}

Capacity: the ability of a person to make a decision that is based on developmental and cognitive factors, including age and cognition, which impact the person's ability to receive information about the underlying illness and proposed treatments, understand the relevant information, and apply it to his or her own condition or the condition of an ill child. This also involves having insight into the condition and consequences of treatment options and the ability to communicate the decision and reasoning for choices.¹³

Dignity (respect for persons): the right to be perceived as worthy of honor and respect. It involves the ethical concept of autonomy, as individuals may fear the loss of control (loss of dignity) over their bodies in the dying process.^{14,15}

Do not resuscitate: an order written by an advanced practice provider in the medical record directing that no cardiopulmonary resuscitation is to be performed in the case of an acute event such as a cardiac, respiratory, or neurological decompensation¹³

Fidelity: commitment of healthcare professionals to keep our promises to patients and family members and to not abandon them and their needs, especially during the dying process¹⁴

Informed consent: Persons who possess medical capacity should be given the opportunity to choose what shall or shall not happen to them. The consent process has three elements: information, comprehension, and voluntariness—providing sufficient information about the

treatment; understanding the consequences of a decision, its outcomes, and potential consequences; and deciding without coercion and undue influence. It may be appropriate at times to provide a written or oral test of comprehension.^{14,15}

When a person is considered incompetent (infants, children, mentally disabled patients, those who are terminally ill or comatose), respect requires giving them the opportunity to choose to the extent that they are able and seeking permission of other parties to protect the patient from harm. The third party chosen should understand the patient's condition and be willing to act in that person's best interest.¹⁵ It is important to provide the third party with sufficient information so that the person understands the consequences of a decision, its outcomes, and potential consequences just as the patient would be given.¹⁶

Life-sustaining therapies: interventions that may not control the patient's disease but may prolong the patient's life. These may include not only ventilator support, dialysis, and vasoactive infusions, but also antibiotics, insulin, chemotherapy, and nutrition and hydration provided by tubes and intravenous lines.¹³

Nonmaleficence: not causing harm through omission of care or by not following a patient's request that could result in a loss of dignity, diminish the person's autonomy, result in abandonment, or ignore care wishes¹⁴

Principle of double effect: Both good and bad consequences can come out of a decision, but the decision/action is undertaken with the hope (ethical/moral) or intent that a good consequence will occur¹⁴

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This position statement reflects the bioethics standards or best available clinical evidence at the time of writing or revisions. This position statement is based on evidence that reflects patients with advanced illnesses and may not be applicable in all palliative circumstances.

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