

Module 5

Case 5.3: Withdrawing or Withholding Treatment—Respecting Patients' End-of-Life Decisions

Case Presentation

Dr. Lee prescribed Mrs. Scott a low-dose opioid patch and anti-nausea medication. He also recommended that Mrs. Scott undergo a psychological evaluation for depression and maintain an ongoing relationship with the medical oncologist. A few weeks later, Dr. Lee received a call that Mrs. Scott was en route to the hospital. She had passed out while her sister was visiting and had knocked her head against a coffee table. Upon arriving at the hospital, Dr. Lee discovered that Mrs. Scott had lost even more weight and was dehydrated. Her heart rate was a little low and her blood pressure was weak but steady. The most significant concern at that point was the possibility of an internal cranial hemorrhage. Mrs. Scott was not conscious, and her sister agreed to have her undergo a head CT to determine if there was internal bleeding.

As they waited for the head CT, Mr. Scott arrived and informed Dr. Lee that his wife had not been eating regularly, though she had been keeping close contact with her family and friends. Everyone, it seems, had been encouraging her to seek hospice services, a course of action she resisted.

The neurosurgeon informed Mr. Scott and Dr. Lee that the CT showed several small acute subdural hematomas, but no edema. She recommended observation with daily re-evaluation. She suggested that, at least for a few days, Mrs. Scott might not be consistently lucid. Over the next several days, as expected, Mrs. Scott cycled through periods of lucidity and confusion. Although she was not worsening, she also was not eating—her albumin was very low and she was losing even more weight. The medical oncologist, Dr. Walker, recommended the placement of a PEG tube—if Mrs. Scott was to reverse her cachectic state and improve her quality of life, she would need better nutrition. Because of Mrs. Scott's compromised condition, Mr. Scott was asked to consent, which he did.

Over the next several days, Mrs. Scott's periods of confusion were diminishing and the subdural hemotoma was resolving with no lasting effects or edema. Her albumin levels had increased and she even gained a little weight. As she became more and more consistently lucid, she requested that the PEG tube be removed. Finally, she asked Dr. Lee to remove the PEG tube. After a short conversation, he recommended that they meet the next day with her family and the medical oncologist.

To begin the meeting, Dr. Lee and Dr. Walker describe Mrs. Scott's diagnosis and prognosis and identify her possible courses of treatment, including aggressive therapy, palliative care, and no treatment. They describe in some detail the risks and benefits of each course and recommend palliative care including the PEG. Mrs. Scott seems to accept their recommendation. She explains that she has suffered long enough and asks Dr. Lee to recommend a hospice facility. Before he has chance to respond, she adds, "But first, as I asked you yesterday, I'd like you to remove the PEG tube."

What should Dr. Lee do? (select an option)

- A. [Order the removal of the PEG tube.](#)
- B. [Ask Mr. Scott to persuade Mrs. Scott to keep the PEG tube in.](#)

- C. [Call for a psychological evaluation of Mrs. Scott.](#)
- D. [Inform Mrs. Scott that he will not remove the feeding tube.](#)

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Option Assessment

- A. Because Mrs. Scott apparently has decision-making capacity, ordering the removal of the PEG tube is **preferable** and supported by the *Code* in Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment": "The principle of patient autonomy requires that physicians respect the decisions to forego life-sustaining treatment of a patient who possesses decision-making capacity."
- B. Asking Mr. Scott to persuade Mrs. Scott to keep the PEG tube should be **avoided**. It is not supported by, and may violate the *Code* in Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment": "The principle of patient autonomy requires that physicians respect the decisions to forego life-sustaining treatment of a patient who possesses decision-making capacity."
- C. Calling for a psychological evaluation of Mrs. Scott should be **avoided** because it is not a sensible alternative unless Mrs. Scott has given some indication that she may lack decision-making capacity. If she has not, then this is merely an attempt to circumvent her autonomy which violates the *Code* in Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment": "The principle of patient autonomy requires that physicians respect the decisions to forego life-sustaining treatment of a patient who possesses decision-making capacity."
- D. Informing Mrs. Scott that he will not remove the PEG tube should be **avoided** because it violates the *Code* in Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment": "The principle of patient autonomy requires that physicians respect the decisions to forego life-sustaining treatment of a patient who possesses decision-making capacity."

[Compare these options](#)

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Option Comparison

Without reason to suspect that her decision-making capacity is compromised, all courses of action that override or circumvent Mrs. Scott's decision (options B, C and D) should be avoided.

Because the autonomous choices of patients to refuse medical treatment should be respected, option A is preferable.

Preferable: Option A

Avoid: Options B, C, and D

[Additional discussion and information](#)

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Additional Information

The principle of patient autonomy requires that physicians respect a competent patient's decision to forgo any medical treatment. This principle is not altered when the likely result of withholding or withdrawing a treatment is hastening the patient's death.

Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment"

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity...There is no ethical distinction between withdrawing and withholding life-sustaining treatment. A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. A patient may also appoint a surrogate decision maker in accordance with state law. If the patient receiving life-sustaining treatment is incompetent, a surrogate decision maker should be identified...Though the surrogate's decision for the incompetent patient should almost always be accepted by the physician, there are...situations that may require either institutional or judicial review and/or intervention in the decision-making process...When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decision making is recommended before resorting to the courts...Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis.

Decisions to forgo life-sustaining treatment, which so profoundly affect a patient's well-being, cannot be made independent of a patient's subjective preferences and values. Many types of life-sustaining treatments are burdensome and invasive, so that the choice for the patient is not simply a choice between life and death. When a patient is dying of cancer, for example, a decision may have to be made whether to use a regimen of chemotherapy that might prolong life for several additional months but also would be painful and debilitating. Patients, however, are no longer required to choose between aggressive life-sustaining or life-prolonging treatment and no treatment; medical professionals are becoming increasingly aware of the value of palliative care.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment. A patient's right to refuse treatment is independent of whether treatment has begun.

In summary, according to the principle of respect for patient autonomy, patients who possess decision-making capacity have the right to forgo any life-sustaining treatment. Physicians must respect these patient decisions, and they must

ensure that patients are well-informed about their prognoses and treatment options and understand that comfort and dignity will be top priorities whether or not they decide to forgo life support.

[Related topic: DNR orders](#)

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Related topic: DNR orders

Cessation of cardiac or respiratory function will be an inevitable part of Mrs. Scott's dying process; accordingly, CPR could be used prior to her death. Two sets of circumstances indicate that CPR should not be used in this and similar cases.

First, as previously discussed, patients have the right to refuse medical treatment, even when such a refusal is likely to result in serious injury or death. Mrs. Scott, therefore, may express in advance her preference that CPR be withheld in the event of cardiac arrest. Such a refusal serves as the basis for a do-not-resuscitate order. DNR orders, at least in theory, permit patients to express their preferences regarding the use of life-prolonging treatment while they still have decision-making capacity.

Second, CPR should not be used when an attempt to resuscitate the patient would be futile in the judgment of the health care team. A physician is not ethically obligated to make a specific diagnostic or therapeutic procedure available to a patient, even upon specific request, if the use of such a procedure would be futile (see also Case I of this module). Specifically, futility in this case and others like it would be the inability to restore pulmonary or respiratory function.

Opinion 2.20, "Do-Not-Resuscitate Orders"

...Patients at risk of cardiac or respiratory failure should be encouraged to express in advance their preferences regarding the use of CPR, and this should be documented in the patient's medical record. These discussions should include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed or as early as possible during hospitalization...Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient's preferences regarding the use of CPR...

DNR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient.

In practice, physicians and patients alike may find it difficult to engage in discussions about the possibility of patient death, particularly in the early stages of hospitalization. However, as the need for such a discussion becomes urgent, the patient no longer may be capable of participating in the decision-making process. An absence of patient involvement may result in mistaken impressions about the medical procedures employed during resuscitation efforts

and the probable outcome of CPR, or may result in the implementation of decisions that are not in accord with the patient's values and preferences. There is a good deal of evidence that Mrs. Scott would not want to be resuscitated, but this conclusion would be presumptuous on the part of the medical staff without direct discussion of a DNR.

In some cases, the successful application of CPR has been gauged by criteria that relate to the length of patient survival. Such criteria include, for example, survival for at least 24 hours following initial resuscitation, survival until discharge from the hospital, and survival for some other timeframe. Using any of these definitions of successful treatment, CPR is judged to be futile if it is unlikely to prolong the life of the patient for the period of time set forth in the criteria. This interpretation of futility is inconsistent with the principle of patient autonomy, which requires that patients be permitted to choose from among available treatment alternatives that are appropriate for their condition, particularly when such choices are likely to be influenced by personal values and priorities.

Judgments of futility that involve value judgments are appropriate only if the patient is the one to determine what is or is not of benefit among reasonable treatment alternatives, in keeping with his or her personal values and priorities. Patients, therefore, should be encouraged to discuss the expected benefits and objectives of medical treatment with their physicians and to engage in an ongoing dialogue regarding the potential for achieving these goals.

[Module 5 Feedback Questionnaire](#)

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Module 5: End-of-Life Care

Feedback Questionnaire

In Module 5 on end-of-life care, how would you rate the relevance of the cases?

- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the explanation of courses of action?

- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the overall coverage of the topic?

- Excellent
- Very good
- Good
- Fair
- Poor

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