Physicians caring for the sickest patients with COVID-19 sometimes have to make the difficult decision to withdraw life-sustaining treatment. However, that painful choice does not obviate a physician’s obligation to provide supportive care to dying patients thereafter.

The AMA has created an ethics resource page, “Caring for patients at the end of life,” that offers expert advice on the ethical and emotional challenges involved. Citing numerous opinions from the AMA Code of Medical Ethics, the page provides a comprehensive guide to eliciting and following patients’ wishes for how they want to die.

More broadly, the AMA and the Centers for Disease Control and Prevention are closely monitoring the COVID-19 pandemic. Learn more at the AMA COVID-19 resource center. Also check out pandemic resources available from the AMA Code of Medical Ethics, JAMA Network™ and AMA Journal of Ethics®, and consult the AMA’s physician guide to COVID-19.

A transition, not an end

“A decision to withhold or withdraw life-sustaining treatment is not a decision to withhold or withdraw care entirely,” the page says. It goes on to quote the Code opinion on “Withholding or Withdrawing Life-Sustaining Treatment,” which requires that physicians reassure “the patient and/or surrogate that all other medically appropriate care will be provided, including aggressive palliative care, appropriate symptom management if that is what the patient wishes.”

Citing the same opinion, the page notes the emotional toll this process takes on everyone involved and recommends establishing the patient’s preferences and setting specific goals for care.

Ideally, patients will have already expressed their end-of-life wishes to their physicians or their surrogates. Often, though, patients haven’t given much thought to the care they will want or not want
at the end of their lives. In those situations, per the Code, physicians should “elicit the patient’s values, goals for care, and treatment preferences” and capture those preferences in the patient’s medical record.

If the patient lacks decision-making capacity, the resource page notes, his surrogate may make health care decisions on his behalf.

Read the Code opinion on surrogate decision-making.

Understanding advance directives

If, however, the patient has an advance directive, the preferences set out in the directive should govern care decisions.

“Some physicians think advanced directives are only useful for declining care. They’re not. You can say what you want,” said Elliott Crigger, PhD, director of ethics policy at the AMA. “Now, you may not get it—there may be reasons why it won’t work—but you can say what you wish and how you want to die. And that includes either declining care or asking for care.”

There’s a similar misunderstanding around do-not-resuscitate orders, Crigger noted.

A few physicians may wrongly interpret a DNR order as a sign that the patient also is less interested in other supportive care. “But that’s not what it means,” Crigger said. “It means, ‘Don’t resuscitate me.’ It doesn’t mean, ‘Don’t provide every other kind of supportive care you can.’”

Read the Code opinions on advance care planning and the use of advance directives.

When sedation is appropriate

“When it proves impossible to adequately manage symptoms despite vigorous palliative care efforts, for some terminally ill patients an option of last resort is sedation to unconsciousness,” the page says.

Referring to opinion 5.6, “Sedation to Unconsciousness in End-of-Life Care,” the resource page notes that physicians should reserve this option for patients in the final stages of terminal illness and “ensure that options for appropriate, symptom-specific palliative care have been exhausted, ideally in consultation with a multi-specialty team,” adding that the patient or his surrogate must give informed consent before sedation is administered and the decision should be recorded in the patient’s medical

URL: https://www.ama-assn.org/delivering-care/ethics/when-life-support-withdrawn-commitment-care-must-not-end
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