

**June 21, 1994**

1. Transmitted is a revision to Department of Veterans Affairs, Veterans Health Administration Manual M-2, "Clinical Affairs," Part I, "General," Chapter 30, "Do Not Resuscitate (DNR) Protocols Within the Department of Veterans Affairs (VA)." Brackets have not been used to indicate changes.

2. Principal change is:

Paragraph 3.03: The addition of subparagraph (10) regarding DNR orders in the operating room and peri-operative period.

3. **Filing Instructions**

**Remove pages**

iii through iv  
30-1 through 30-4

**Insert pages**

iii through iv  
30-i through 30-ii  
30-1 through 30-6

4. **RESCISSION:** M-2, Part I, Chapter 30, change 81, dated August 18, 1987.

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**RESCISSIONS**

The following material is rescinded:

Manuals

M-2, Part I, Chapter 30, change 81

**June 21, 1994**

**M-2, Part I  
Chapter 30**



**CHAPTER 30. DO NOT RESUSCITATE (DNR) PROTOCOLS WITHIN  
THE DEPARTMENT OF VETERANS AFFAIRS (VA)**

**30.01 BACKGROUND**

The VA remains committed to the principle of supporting and sustaining life, using the latest life-saving or life-supporting techniques and therapeutic measures. In some instances, however, implementation of therapeutic decisions and application of medical technology may not cure a patient's disease or disability or reverse a patient's course. Some patients who suffer from terminal illness may reach a point where application of additional measures would become not only unwanted, but medically unsound. Then, the physician is seen as not preventing death but merely deferring the moment of its occurrence. Intervention is no longer therapeutic, in the strict sense of curing or treating, but rather becomes an issue of choice among degrees of treatment, involving decisions relating to control over the moment and mode of dying. In this connection, the responsible physician faces the problem of determining either that continued maximal efforts constitute a reasonable attempt at prolonging life or that the patient's illness has reached such a point that further intensive, or extensive, care is in fact merely postponing the moment of death.

**30.02 POLICY**

a. The basic policy of VA is to provide the highest quality medical care to its patients and beneficiaries, with the objective of sustaining life, and practicing in conformity with the highest ethical and medical standards. While it is imperative that VA medical centers and their professional staffs and personnel remain committed to this purpose, this commitment may not supercede the patient's right of self-determination, nor should it operate to undermine a patient's well-being by mandating efforts at resuscitation even where such efforts would be futile or useless.

b. VA medical centers, assisted by District Counsel, shall develop protocols for dealing with issues involved when terminally ill patients request that Do Not Resuscitate (DNR) orders be placed in their medical records and/or that they not be resuscitated in the event of a cardiopulmonary arrest. Even after such a protocol has been adopted, it will continue to be VA policy that, except where the medical record contains a DNR order or resuscitation would be futile or useless, cardiopulmonary resuscitation (CPR) will be administered to every patient who sustains a cardiopulmonary arrest. It will continue to be VA policy that indicated, appropriate medical treatment and care will never be withheld or withdrawn from a patient simply because a DNR order has been entered.

c. It is acknowledge that there will be cases where, in the exercise of the sound medical judgment of the licensed physician, instruction may appropriately be given not to institute resuscitation of a patient who has been experienced an arrest. Such cases would involve patients who suffer a terminal illness, and for whom resuscitative efforts would be futile or useless. Protocols which are adopted under this chapter may permit the withholding of resuscitation in such cases.

d. It is emphasized that the provisions of this chapter are applicable only to situations involving resuscitation, and only to questions concerned with the withholding of resuscitation in the event of cardiopulmonary arrest. VA policies concerning other life-sustaining procedures, and concerning the withholding or withdrawal of life-sustaining procedures (including resuscitation) in situations other than cardiopulmonary arrest, are set forth in M-2, Part I, Chapter 31, "Withholding and Withdrawal of Life-Sustaining Treatment."

### **30.03 PROTOCOLS**

a. DNR protocols established by medical centers shall contain an introductory policy statement which sets the tone and delineates specific ethical, legal and medical considerations which are raised. The following items will be included in DNR protocols which are established:

- (1) Specific definitions of terms or phrases used in the protocol, such as:
  - (a) Attending physician,
  - (b) CPR,
  - (c) DNR,
  - (d) Patient's representative,
  - (e) Qualified patient,
  - (f) Resuscitation, and
  - (g) Terminal illness.
- (2) A patient classification scheme to delineate the class of patients for whom a DNR order might be entered.
- (3) A description of the role of the competent patient, and the role of the patient's representative in cases involving incompetent patients.
- (4) Requirements for consultation, consensus, or committee involvement.
- (5) Requirements for the DNR order itself, including who may write it, how long it will be valid and provisions for its review.
- (6) Requirements for the accompanying note in the Progress Notes and who may write it.
- (7) Requirements for flagging or otherwise highlighting the medical record in such a way as to indicate the entry of a DNR order therein.

(8) Requirements for other or additional indicated, appropriate medical care.

(9) A requirement that when resuscitation is withheld in situations other than those which are acknowledged in subparagraph 30.02(c), the Chief of Staff, or designee, shall certify that either a DNR order, or an order to implement a declaration entered pursuant to Chapter 31, was properly in effect at the time of death.

b. DNR protocols will incorporate the following principles:

(1) Definition of "Terminal Illness." "Terminal illness" shall be defined as a debilitating condition which is considered to be medically incurable or untreatable in terms of currently available technology, and which can be expected to cause death. In situations involving "terminal illness," as so defined, it can be concluded that resuscitation would be of no benefit to the patient since the institution of resuscitative measures, if successful, would only postpone the moment of death. "Terminal illness" definitions need not require that death be "imminent," and may include in their scope chronic conditions from which there is no hope for recovery.

(2) Patient's Role

(a) Competent Patients. In cases where the patient is alert and understands the implications of the diagnosis and prognosis, and the patient has expressed an interest in requesting that a DNR order be entered, the patient shall be instructed that entry of a DNR order must be preceded by discussions with the senior attending or staff physician in charge of the patient's care, and, if indicated, with mental health, social work, and/or nursing service staffs. The patient will be advised that discussions with family members, if any, may be desirable prior to deciding whether a DNR order will be considered; however, a patient's election not to seek the concurrence of family members, or to inform that of the decision, will be respected and honored. If a competent patient requests that a DNR order not be written or instructs that resuscitative measures should be instituted, no DNR order shall be written.

(b) Incompetent Patients. In cases where the patient is comatose or otherwise incompetent, and the patient has not executed either a declaration under Chapter 31, or a similar document under authority of State Law, a decision on entry of a DNR order shall be reached after consultation between the patient's representative and the physician. Since the entry of a DNR order is essentially a question regarding treatment, the provisions of M-2, Part I, Chapter 23, will govern the identification of the appropriate person to act as the "patient's representative" for purposes of this chapter. In cases where the patient's representative consents to entry of a DNR order and the requirements specified herein are met, a DNR order may be written. Should the patient's representative object to entry of a DNR order, no such order will be written. In the event that no person is available, or willing, to act as the incompetent patient's representative, and the treating staff (including the attending physician) conclude that entry of a DNR order is appropriate, consultation shall be undertaken with the medical center Director and/or Chief of Staff and District Counsel to determine whether the entry of a DNR order may be further considered.

(3) "Natural Death" Directives

(a) Declarations Under M-2, Part I, Chapter 31. If an incompetent patient with a terminal illness has executed a declaration under Chapter 31 during a period of competency, and that declaration specifies that resuscitation shall be withheld in circumstances which include cases involving cardiopulmonary arrest, a DNR order may be entered, notwithstanding the absence of consent by the patient's representative, if the conditions specified in this chapter are met.

(b) State "Natural Death Acts." If a patient is unable, due to incompetency, to execute a declaration under Chapter 31, but resides in a State where "living wills" or similar written directives are legally permitted, the exercise of such rights by a patient, prior to the occurrence of a coma or incompetence, shall be considered as evidence of that patient's wishes regarding DNR orders. If the State Law authorized directive specifies that resuscitation shall be withheld in circumstances which include cases involving cardiopulmonary arrest, a DNR order may be entered notwithstanding the absence of consent by the patient's representative, if the conditions specified in this chapter are met and conditions specified by State Law which are not inconsistent with the provisions of this chapter, are met. Prior to entry of a DNR order in such circumstances, District Counsel shall be consulted.

(c) The fact that a VA patient may not have exercised rights recognized by Chapter 31, or by a similar provision of State Law, shall not be considered as an indication that the patient would not have wanted a DNR order written unless there is evidence of the patient's specific wishes in that regard.

(4) Consultation and Other Physician Involvement. The physician who is responsible for determining the propriety of a DNR order in a particular case is the senior attending or staff physician, not a house officer. Medical decisions regarding the patient's diagnosis or prognosis shall be reached by a consensus of the medical treatment team.

(a) In large medical centers, the medical treatment team will include the attending or staff physician, involved house staff, and consultants who may be assisting in the care of patient (oncologist, cardiologist, etc.).

(b) In smaller medical centers, where house staff is not involved with the patient's care and consultants are not readily available, the medical treatment team will include the patient's attending physician, the chief of the bed service (where the patient is located), or chief of the service to which the attending physician belongs, or the Chief of Staff.

NOTE: If there is doubt concerning the propriety of a DNR order or the accuracy of the patient's diagnosis or prognosis, a medical ethics or prognosis committee, or similar body, may be convened on an ad hoc basis to help resolve the problem.

(5) Entry of the DNR Order. After it has been determined that a DNR order is appropriate in a particular case and the foregoing requirements have been met, the order must be written or, at minimum, countersigned by the attending physician, rather than merely by a house office

or resident, into the patient's medical record. NOTE: A verbal or telephone order for DNR is not justifiable as good medical or legal practice. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the medical center staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.

(6) Progress Notes. At the time any DNR order is written, an accompanying note shall be made in the progress notes which includes, at minimum, the following information:

(a) The diagnosis and prognosis which supports the determination that the patient's condition is terminal;

(b) The consensual decisions and recommendations of the treatment team and consultants, with documentation of their names;

(c) An assessment of the patient's competency; and

(d) The competent patient's wishes or, in cases involving incompetent patients, the wishes of the patient's representative and documentation of the relationship of the patient's representative to the incompetent patient.

*NOTE: If a competent patient has requested that family not be involved in or informed of the decision, the patient's decision and request for confidentiality shall be documented in the medical record by a disinterested third party, not a member of the treatment team, e.g., a patient ombudsman or representative, a representative of Medical Administration Service, etc.*

(7) Review of the Order. The protocol shall specify the process for review of DNR orders, and how often reviews should be carried out. The protocol shall specify that the attending physician must rescind the DNR order if the patient's prognosis significantly improves or if the competent patient, or if the patient is incompetent, the patient's representative, requests same.

(8) Related Medical Care. DNR orders are compatible with maximal therapeutic efforts short of resuscitation. The VA patient for whom a DNR order has been entered is entitled to receive vigorous support in all other therapeutic modalities. It may be appropriate to write onto the order sheet those medical efforts which will be maintained to relieve suffering and assure comfort, including:

(a) Basic nursing care (body cleanliness, mouth care, positioning, etc.);

(b) Adequate analgesia;

(c) Suction;

(d) Intake (including hydration); and

(e) Palliative oxygen.

*NOTE: The entry of a DNR order does not justify ignoring the patient or providing less than humane care and concern for the patient's welfare and comfort.*

(9) Physicians. Physicians who conclude, in good conscience and sound medical judgment, that they are unable to comply with the wishes of the patient (or patient's representative) concerning resuscitation, shall arrange to transfer care of the patient to another equally competent physician who is capable of appropriate and skilled care and who is able to comply with the wishes of the patient or patients' representative.

(10) DNR Orders in the Operating Room and Peri-Operative Period. To preserve the right of the patient to choose among treatment options offered, the patient, or the patient's representative, and the health care team must review existing DNR orders, or other treatment limiting documents, prior to any procedures requiring anesthetic care. Local policies which automatically suspend DNR orders or other treatment limiting documents (advance directive, see Ch. 31, par. 304, and Apps. 31A, 31B, and 31C for definition, policy and procedures regarding an advance directive) without discussion with the patient, are not consistent with the patient's right to self-determination, or with current informed consent procedures; they should be reviewed and revised.

(a) The attending physician or surgeon must discuss with the patient any proposed suspension of the DNR order or advance directive during the operative and peri-operative period. This discussion should focus on those aspects of resuscitation or other treatment intervention that are specifically proscribed in the advance directive. The attending physician must document the discussion and any agreed upon suspension of specific instructions contained in the original DNR, or advance directive in the patient's medical record.

(b) Where possible, the attending physician, surgeon, and anesthesiologist should be in concurrence on these issues. If the patient's request for limitations of care conflict with generally accepted medical or ethical standards of care, the attending physician should consult with the Chief of Staff, or the ethics advisory committee. If any one of the physicians feels the patient's wishes are incompatible with their own moral views, they may decline to participate in the care of the patient; in this case the physician should delegate their responsibilities to another appropriate physician.

### **3.04 ADDITIONAL CONSIDERATIONS**

a. DNR protocols can be developed to deal effectively with the trauma and suffering which frequently accompany the circumstances in which such orders are written. These protocols must give fair consideration to the:

- (1) Patient's medical needs,
- (2) Social and psychological needs of the patient's family,

(3) Legal rights and responsibilities of physician and patient, and

(4) Professional needs of the medical center administration and staff.

b. With assistance from District Counsel sound protocols shall be developed and implemented. Obviously, no patient shall be considered for a DNR order in anticipation of possible problems which might occur as the result of unforeseen difficulties during hospitalization or as a result of surgery, or in any case where the patient does not have a terminal illness.

c. Under no circumstances shall DNR orders be written to facilitate request for "assisted suicide" or voluntary euthanasia.

d. "Do Not Resuscitate" does not mean that the medical staff will take any affirmative steps to hasten the patient's death. All parties, including all levels of care providers, shall provide all forms of appropriate therapeutic care, and shall strive to improve the range of acceptable therapeutic options made available to the dying patient.