

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

**Replaced by VHA Handbook
1004.2 available at**
<http://vaww.va.gov/publ/direc/health/handbook/1004-2hk.doc>

M-2, Part I
Chapter 31

November 18, 1991

1. Transmitted is a new chapter to the Department of Veterans Affairs, Veterans Health Administration Manual M-2, "Clinical Affairs," Part I, "General," Chapter 31, "Withholding and Withdrawal of Life-Sustaining Treatment."

2. Purpose of this chapter is to define VA policy concerning patient (or surrogate decisionmaker) requests to withhold or withdraw life-sustaining treatment in VA health care facilities.

3. Filing Instructions

Remove pages

Insert pages

31-i through 31-12

31A-1 through 31C-3

James W. Holsinger, Jr., M.D.
Chief Medical Director

Distribution: RPC: 1054 is assigned
FD

Printing Date: 11/91

CONTENTS

CHAPTER 31. WITHHOLDING AND WITHDRAWAL OF
LIFE-SUSTAINING TREATMENT

PARAGRAPH	PAGE
31.01 Policy	31-1
31.02 Definitions	31-1
31.03 Competent Patients' Rights	31-2
31.04 VA Advance Directives	31-4
31.05 State-authorized Advance Directives	31-6
31.06 Substituted Judgments	31-8
31.07 Disputes	31-11
31.08 Miscellaneous.....	31-11
31.09 References	31-12

APPENDICES

31A VA Living Will/VA Advance Directive.....	31A-1
31B VA DPAHC (Durable Power of Attorney for Health Care)	31B-1
31C Treatment Preferences	31C-1

CHAPTER 31. THE WITHHOLDING OR WITHDRAWAL OF
LIFE-SUSTAINING TREATMENT

31.01 POLICY

a. This chapter defines VA (Department of Veterans Affairs) policy concerning patient (or surrogate decisionmaker) requests to withhold or withdraw life-sustaining treatment in VA health care facilities. It recognizes three circumstances under which VA will carry out patient expressions with respect to the withholding or withdrawal of life-sustaining treatment:

(1) When the competent patient personally requests that such treatment be withheld or withdrawn (see par. 31.03); or

(2) When the patient who lacks decisionmaking capacity has executed, while competent, an advance directive specifying that such treatment shall be withheld or withdrawn (see pars. 31.04 and 31.05); and/or

(3) When a "surrogate" acting on behalf of a patient who lacks decisionmaking capacity exercises "substituted judgment " (see par. 31.06).

b. VA medical centers will adopt local protocols which conform to the provisions of this chapter.

31.02 DEFINITIONS

a. Advance directive refers to specific oral or written statements made by a competent adult which provide direction as to their desire for the withholding or withdrawal of life-sustaining treatment (e.g., a living will or similar document) and/or specific written instructions as to whom should make decisions regarding medical care in the event the individual is unable to do so, e.g., DPAHC (Durable Power of Attorney for Health Care). A "VA advance directive" is:

(1) An oral statement made by a patient to a VA clinical employee concerning the patient's wishes regarding the withholding or withdrawal of life-sustaining treatment, or

(2) A written statement made by a patient on a VA Form 10-0137A, VA Living Will/VA Advance Directive; VA Form 10-0137B, VA Durable Power of Attorney For Health Care; and/or VA Form 10-0137C, Treatment Preferences, which sets forth the patient's wishes regarding the withholding or withdrawal of life-sustaining treatment.

(3) A "State-authorized advance directive" is a written statement made by a patient concerning the patient's wishes regarding the withholding or withdrawal of life-sustaining treatment, which statement is not made on a VA form but whose validity is to be determined pursuant to the applicable State law.

November 18, 1991

M-2, Part I
Chapter 31

M-2, Part I
Chapter 31

November 18, 1991

NOTE: Attached VA Forms 10-0137A, 10-0137B, and 10-0137C are for local reproduction pending receipt of distribution.

b. Attending physician means the attending or staff physician who has primary responsibility for the treatment of the patient.

31-4

31-4

M-2, Part I
Chapter 31

November 18, 1991

c. Decisionmaking capacity refers to the ability of a patient to reach informed decisions concerning health care by being able to understand and appreciate the nature and consequences of the decisions including the intended benefits and foreseeable risks of, and alternatives to, proposed treatment options. Adult patients who have decisionmaking capacity are competent patients. Adult patients who lack decisionmaking capacity include those who have been judicially determined to be incompetent to make decisions concerning their person (i.e., those who have a court-appointed guardian of the person, or the legal equivalent), and also include those who have not been judicially determined to be incompetent to make decisions concerning their person but who, nonetheless, lack the capacity to formulate and/or communicate decisions concerning health care (e.g., the comatose, severely demented).

d. Life-sustaining treatment means medical care, procedures or interventions which, when applied to a patient with a terminal illness, would have little or no effect on the underlying disease, injury or condition and which would serve only to delay the timing of a death. This may include but is not limited to resuscitation, artificial nutrition and hydration, mechanical ventilation and dialysis. Life-sustaining treatment does not include medical procedures deemed necessary to provide comfort care such as oxygen for dyspnea, morphine for pain, etc.

e. Substituted judgment means a decision made in accordance with paragraph 31.06 by the surrogate decisionmaker on behalf of a patient who lacks decisionmaking capacity and who has not executed an advance directive under paragraphs 31.04 or 31.05. Substituted judgment decisions shall be made on the basis of indicators of the patient's own desires or, when such indicators are absent or insufficient, on the basis of an assessment of the patient's best interests.

f. Surrogate decisionmaker refers to a person who is authorized by this chapter to consent to the withholding or withdrawal of life-sustaining treatment on behalf of a patient who lacks decisionmaking capacity and who has not executed an advance directive under paragraphs 31.04 or 31.05. Provisions of M-2, part I, chapter 23, which pertain to the identification of the surrogate decisionmaker for purposes of informed consent generally shall govern the identification of the person who properly serves as the surrogate decisionmaker for purposes of paragraph 31.06. In circumstances where a health care agent has been designated by the patient through execution of a DPAHC form, or similar document, the person so designated shall be deemed to be the surrogate decisionmaker for purposes of paragraph 31.06.

g. Terminal illness refers to a debilitating condition which is medically incurable or not treatable in terms of available technology, and which can be expected to cause death. In situations involving terminal illness, as defined herein, it can be concluded that the provision of life-sustaining treatment would be of limited or no benefit to the patient since the institution or continuation of such treatment would only postpone the moment of death.

M-2, Part I
Chapter 31

November 18, 1991

Terminal illness, as defined herein, includes but is not limited to, conditions where death is imminent, as well as chronic and debilitating conditions from which there is no reasonable hope for recovery (e.g., a persistent vegetative state).

31.03 COMPETENT PATIENTS' RIGHTS

a. Purpose

Competent persons have the right to direct the course of their own medical care and to determine for themselves, from among treatment options presented, the course of

M-2, Part I
Chapter 31

November 18, 1991

treatment which will be administered. This paragraph sets forth VA policy concerning these self-determination rights as applied in the context of life-sustaining treatment.

b. Policy

(1) Competent patients have the right to consent to and, equally, to decline any treatment including the provision of life-sustaining treatment. Accordingly, life-sustaining treatment will not be provided to competent patients who decline it (38 U.S.C. §7331; 38 CFR §17.34 and see M-2, part I, chapter 23). Similarly, life-sustaining treatment will be provided, as consistent with prevailing medical practice, when the competent patient consents or in emergent situations where informed consent may be implied. When the competent patient withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn.

(2) VA will provide available life-sustaining treatment to competent patients who consent to such treatment. Also, VA will continue to provide such treatment, once initiated, unless informed consent is clearly withdrawn. Accordingly, available life-sustaining treatment modalities will be presented as treatment options for patient consideration. Notwithstanding this general policy, VA acknowledges that situations will arise where the provision of some or all forms of life-sustaining treatment would not accord with prevailing medical practice (e.g., when such treatment would be futile). In such situations, life-sustaining treatment options (like other treatment options which do not accord with prevailing medical practice) need not be presented for patient consideration.

(3) Competent patients need not execute an advance directive under paragraphs 31.04 or 31.05 in order to decline life-sustaining treatment. Such directives serve as vehicles for the communication of decisionmaking by previously competent patients who lack decisionmaking capacity at the time such treatment is under consideration.

c. Procedures

(1) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending physician in consultation with, as appropriate, other members of the treatment team.

(2) VA procedures applicable to other forms of patient decisionmaking, including those which govern physician-patient dialogue and the securing and documentation of informed consent, apply equally to patient decisionmaking concerning life-sustaining treatment. With respect to the documentation of decisionmaking concerning life-sustaining treatment, the following information,

M-2, Part I
Chapter 31

November 18, 1991

at a minimum, will be documented in the progress notes by the attending physician:

- (a) The patient's diagnosis and prognosis;
- (b) An assessment of the patient's decisionmaking capacity;
- (c) Treatment options presented to the patient for consideration; and
- (d) The patient's decision(s) concerning life-sustaining treatment.

M-2, Part I
Chapter 31

November 18, 1991

(3) Competent patients will be encouraged, but not compelled, to involve family members in the decisionmaking process. Patient requests that family members not be involved in or informed of decisions concerning life-sustaining treatment will be honored, and will be documented in the medical record.

31.04 VA ADVANCE DIRECTIVES

a. Purpose

The patient's right to direct the course of medical care is not extinguished by the loss of decisionmaking capacity. In order that this right may be respected in cases involving such patients, VA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. This paragraph sets forth VA policy concerning advance directives which will be honored by VA on a system-wide basis.

b. Policy

(1) Any competent patient may execute a declaration requesting that some or all life-sustaining treatment(s) be withheld or withdrawn. The declaration shall be signed by the declarant in the presence of two subscribing witnesses, neither of whom is:

(a) Related to the declarant by blood or marriage;

(b) Entitled to, or a claimant against, any portion of the declarant's estate;

(c) Financially responsible for the declarant's care; or

(d) Employed by the VA health care facility in which the declarant is being treated, except in cases where other witnesses are not reasonably available, employees of the Chaplain Service, Social Work Services or nonclinical employees (e.g., Medical Administration Service, Voluntary Service, or Building Management Service) may serve as witnesses.

(2) The advance directive shall be set forth in a VA form(s) (see app. 31A, 31B and 31C), but may include supplemental instructions.

(3) The desires any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in the advance directive. In addition, an advance directive may be revoked by a declarant at any time by any of the following methods:

(a) By being cancelled, defaced, obliterated, burnt, torn or otherwise destroyed by the declarant or by some other person acting at the declarant's direction and in the declarant's presence;

(b) By a written statement signed and dated by the declarant expressing an intent to revoke; or

(c) By an oral statement by the declarant expressing an intent to revoke.

(4) VA health care providers may presume that advance directives which conform to this paragraph are valid, and that in the absence of actual notice to the contrary, a declarant had decisionmaking capacity when the directive was executed and the directive has not been revoked.

M-2, Part I
Chapter 31

November 18, 1991

(5) All patients being admitted to the facility will be queried as to the possession of an advance directive and will be provided such information as may be appropriate. Patients may be encouraged to exercise rights recognized by this chapter, but shall not be required to execute an advance directive as a condition to receiving care. The fact that a patient has not executed an advance directive shall create no presumption concerning the patient's wishes concerning the provision, or the withholding or withdrawal, of life-sustaining treatment.

(6) If a competent patient desires to provide a new advance directive, at a time other than when it is to be implemented, the attending physician, or clinical designee, will request that the patient complete a new document.

(7) VA facilities will ensure that the advanced directive is periodically reviewed with the patient or the health care agent.

c. Procedures

(1) Upon notification of the competent patient's desire to execute, or of the existence of, an advance directive, the attending physician, or clinical designee, will document such notification in the progress notes.

(2) The attending physician or clinical designee will:

(a) In the case of a patient who has not previously executed an advance directive, provide the patient with the VA form(s) (see app. 31A, 31B and 31C);

(b) If there is a question about the completion of the VA form, the physician may contact District Counsel to assure that the directive is consistent with this paragraph and with locally established protocols;

(c) Ensure that administrative formalities required by this paragraph and by locally established protocols are met; and

(d) File the advance directive in the patient's Consolidated Health Record, and display on the outside thereof ADVANCE DIRECTIVE INSIDE in bold print on VA Form 10-1079, Emergency Medical Identification, or other appropriate label.

(3) The attending physician shall have authority to approve implementation of advance directives. Approval shall be preceded by determinations that:

(a) The patient lacks decisionmaking capacity;

(b) The treatment to be withheld or withdrawn is life-sustaining treatment (as defined in par. 31.02(5));

(c) The treatment to be withheld or withdrawn is treatment which the advance directive requests be withheld or withdrawn; and

(d) All administrative requirements of this paragraph, and locally established protocols, are met.

(4) The attending physician will document, with the written concurrence of another VA physician (which may include residents), in the patient's Consolidated Health Record the specific information referred to in subparagraph (3) (a) through (c).

(5) A physician order will be written indicating, at a minimum, "Advance directive to be implemented."

M-2, Part I
Chapter 31

November 18, 1991

(6) If there is concern regarding the implementation of the advance directive, the attending physician may consult with the chief of the service, Chief of Staff, Ethics Advisory Committee and/or District Counsel. In cases involving a pregnant veteran, District Counsel must be consulted prior to implementation.

(7) If a patient revokes, in whole or in part, an advance directive, or requests that implementation of an advance directive be delayed, the attending physician, or clinical designee, shall note in the patient's medical record the nature of the direction received, and the time and date when the direction was received. If the patient revokes an advance directive, the directive, or the portion that is revoked, shall be of no further effect. If the patient requests that implementation of the directive be delayed, the patient's wishes shall be honored, as practicable.

31.05 STATE-AUTHORIZED ADVANCE DIRECTIVES

a. Purpose

Many states recognize the validity of "living wills" and otherwise recognize patients' rights to informed consent and self-determination in the context of life-sustaining treatment. While federal institutions are generally not governed by State laws, VA will, in certain circumstances, honor State authorized "living wills", DPAHC forms or similar documents. This paragraph sets forth VA policy on when, and to what extent, State-authorized "living wills" or other advance directives will be followed. Paragraph 31.06 contains policies with respect to the recognition of State-authorized health care agents.

b. Policy

(1) When VA patients express interest in executing "living wills" or similar documents, they will be encouraged to execute a VA advance directive pursuant to paragraph 31.04. VA recognizes that patients who lack decisionmaking capacity and, thus, are incapable of executing an advance directive under paragraph 31.04, may have previously executed a "living will" or similar advance directive recognized by State law. In such circumstances, decisionmaking by the surrogate decisionmaker under paragraph 31.06, rather than by reference to the patient's written instructions, would be inappropriate. Accordingly, VA will follow the State-authorized advance directive previously executed by patients if:

(a) The document is produced;

(b) The document conforms to the requirements of State law, as determined by District Counsel when necessary;

(c) The patient lacks decisionmaking capacity; and

(d) A medical determination is made that there is little or no likelihood that the patient will regain decisionmaking capacity within a reasonable period of time.

(2) If the conditions in subparagraph (1) are met, and requirements of State law are also met, the VA health care facility will follow the patient's wishes as expressed in a State-authorized advance directive, to the extent that the patient's directive does not conflict with VA practices and procedures, as expressed in this chapter.

M-2, Part I
Chapter 31

November 18, 1991

(a) If a non-VA advance directive is not a valid, binding document under the applicable State law, it will nonetheless be followed by VA if it would be sufficient to constitute a valid VA advance directive (app. 31A). This provision applies in, but is not limited to, states which do not recognize the validity of "Living Wills" or advance directives, generally, as well as states whose requirements concerning execution of the instrument are different from, and more stringent than, VA's requirements, as indicated in appendix 31A.

(b) If a State-authorized advance directive contains procedural formalities regarding the implementation of the directive that are inconsistent with VA procedures, VA will apply the procedures regarding implementation that are contained in this chapter. For example, if State law, and/or the State-authorized advance directive, requires that there must be two physicians, each of whom must be licensed in that state, to certify that the patient is "terminal," that aspect of the directive will not be followed since this chapter sets forth the role of the physician(s) and contains no such requirement concerning the licensing of the physician.

(c) As the policy of VA is to effect the patient's wishes regarding treatment, the desires of the patient as expressed in the directive itself will be followed by VA. Thus, if the advance directive incorporates, either directly or by implication, substantive state law, the patient will be presumed to have intended to limit his directive in accordance with state law. For example, if state law permits advance directives but does not permit the withholding or withdrawal of artificial nutrition and hydration, and the patient's State-authorized advance directive does not expressly address the issue of artificial nutrition and hydration, then, in accordance with the state's substantive law, artificial nutrition and hydration will not be withheld.

(d) If the non-VA or State-authorized advanced directive is legally deficient, as determined in consultation with District Counsel, in that it is not an instrument that is legally binding on VA, the directive will nonetheless serve as evidence of the patient's desires and should be utilized by the patient's surrogate decisionmaker, according to the provisions of paragraph 31.06.

c. Procedures

(1) The attending physician, or clinical designee, who is notified of the existence and has been given a State-authorized directive will:

(a) Document possession of such in the patient's progress notes;

(b) File the advance directive in the patient's Consolidated Health Record and display on the outside thereof ADVANCE DIRECTIVE INSIDE in bold print on VA Form 10-1079, Emergency Medical Identification, or other appropriate label.

M-2, Part I
Chapter 31

November 18, 1991

(2) The attending physician shall have authority to approve the implementation of State-authorized advance directive. The attending physician, with the written concurrence of another VA physician (which may include residents), shall document in the patient's medical record:

(a) That the patient lacks decisionmaking capacity and is not likely to regain it in a reasonable period of time;

M-2, Part I
Chapter 31

November 18, 1991

- (b) The patient's prognosis and diagnosis;
 - (c) The treatment to be withheld or withdrawn;
 - (d) That the treatment to be withheld or withdrawn is treatment which the directive clearly directs to be withheld or withdrawn; and
 - (e) That all administrative requirements of this paragraph and locally established protocols are met.
- (3) A physician order ill be written indicating, at a minimum, "Advance directive to be implemented."
- (4) If there is a concern regarding the validity or implementation of the advance directive, the attending physician may consult with the chief of service, Chief of Staff, Ethics Advisory Committee and/or District Counsel.
- (5) A patient may direct that implementation of a State-authorized advance directive be delayed, or that the directive be revoked. The provisions of subparagraphs 31.04 b(3) and c(6) will apply to delays in implementing, and revocations of, State-authorized directives.

31.06 SUBSTITUTED JUDGMENTS

a. Purpose

The purpose of this paragraph is to set forth policies governing the withholding or withdrawal of life-sustaining treatment in situations involving patients who lack decisionmaking capacity and who have not executed an advance directive in accordance with either paragraphs 31.04 or 31.05, and who are not, due to the lack of decisionmaking capacity, capable of expressing consent, at the time the withholding or withdrawal of life-sustaining treatment is under consideration. The rights of such patients to direct the course of medical treatment are not extinguished by the lack of decisionmaking capacity or by the fact that an advance directive under paragraphs 31.04 or 31.05 has not been previously executed. This paragraph also sets forth VA policies on how a competent patient can designate an agent or representative through a DPAHC form; who shall act as the patient's "surrogate" in circumstances when there is no designated agent; and on how an agent's or "surrogate's" decisions concerning the withholding or withdrawal of life-sustaining treatment will be made and documented.

b. Policy

(1) VA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decisionmaker (38 U.S.C. § 7331). Accordingly, M-2, part I, chapter 23, specifies that

M-2, Part I
Chapter 31

November 18, 1991

"substituted consent" shall be secured from an incompetent patient's surrogate decisionmaker prior to the initiation of treatment, except in emergent situations. This paragraph makes explicit what is otherwise VA policy pursuant to chapter 23: the person making decisions for a terminally ill patient who lacks decisionmaking capacity shall act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment.

M-2, Part I
Chapter 31

November 18, 1991

(2) Any competent adult may execute a DPAHC indicating who will serve as their agent or representative to make health care decisions, including the use of life-sustaining treatment, in the event the patient thereafter lacks decisionmaking capacity. The same informed consent standards will be applied to the patient's surrogate decisionmaker as would be applied to the competent patient. In the event that a patient lacks decisionmaking capacity, the party appointed to be the patient's health care agent in a DPAHC, or similar document, shall act on the patient's behalf.

(3) If the patient presents an executed State-authorized DPAHC form, the competent patient should be encouraged to fill out the VA recognized form. If the patient is incapable or lacks the desire to use the VA form, the State-authorized form will be accepted. District Counsel may be consulted to determine whether such forms are valid and properly executed.

(4) Consistent with the provisions of M-2, part I, chapter 23, informed consent to the provision of life-sustaining treatment will be obtained from the following individuals in cases involving patients who lack decisionmaking capacity and who have not previously executed advance directives or a DPAHC:

(a) If the patient has been judicially determined to be incompetent to make decisions concerning their health care, and a guardian of the patient has been appointed who has power to make health care decisions, consent will be obtained from the court-appointed guardian of the person.

(b) If a medical determination is made that a patient, who does not have a court-appointed guardian of the person, lacks decisionmaking capacity, and there is little or no likelihood that the patient will regain decisionmaking capacity within a reasonable period of time, consent will be obtained from the patient's next of kin in the order of priority specified in M-2, part I, chapter 23.

(c) If a medical determination is made that a patient, who does not have a court-appointed guardian of the person, lacks decisionmaking capacity, but the patient is likely to regain decisionmaking capacity within a reasonable period of time, life-sustaining treatment shall be provided pending the regaining of decisionmaking capacity. In the event that the patient does not regain decisionmaking capacity within a reasonable period of time, the provisions of subparagraph (4)(b), shall govern the obtaining of consent.

(5) VA recognizes that cases will arise involving patients lacking decisionmaking capacity for whom a court-appointed guardian of the person, next of kin, or a designated agent is not available, or willing, to serve as the patient "surrogate". In such cases, District Counsel will be consulted and may initiate action to secure the appointment of a surrogate decisionmaker. Until such time that a surrogate decisionmaker is appointed, consent to life-sustaining treatment will be implied.

M-2, Part I
Chapter 31

November 18, 1991

(6) Except for the following, life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending physician is satisfied that the decision of the surrogate decisionmaker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:

(a) Oral or written statements or directives rendered by the patient during periods when the patient had decisionmaking capacity;

M-2, Part I
Chapter 31

November 18, 1991

(b) Reactions voiced by the patient, when the patient had decisionmaking capacity, concerning medical treatment administered to others; and/or

(c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decisionmaking with respect to prior medical care.

(7) In cases where such indicators are lacking, conflicting or are insufficient (due, for example, to remoteness or nonspecificity) to form a reliable basis for decisionmaking based on the patient's own subjective wishes, life-sustaining treatment(s) will be withheld or withdrawn only when the surrogate decisionmaker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. The surrogate decisionmaker and the attending physician shall consider, and give greatest weight to, those indicators of the patient's subjective wishes as are available. In addition, the surrogate decisionmaker and the attending physician shall consider the patient's diagnosis and prognosis, and the nature and proportionality of the treatment(s) under consideration, and may consider other factors.

(8) In cases where the attending physician believes in good faith that the decision of the surrogate decisionmaker is equivocal, does not reflect the patient's own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Advisory Committee or similar body. See paragraph 31.07.

c. Procedures

(1) Upon notification of the competent patient's desire to execute, or of the existence of, a DPAHC form, the attending physician or clinical designee will document that notification in the progress notes.

(a) In the case of a patient who has not previously executed an advance directive, the attending physician or clinical designee will provide the patient with the VA Form 10-0137B, VA Durable Power of Attorney for Health Care and VA Form 10-0137C, Treatment Preferences.

(b) If there is a question about the completion of the VA form, the physician or clinical designee may contact District Counsel to assure that the DPAHC is consistent with this paragraph and with locally established protocols.

(c) The attending physician or clinical designee will ensure that administrative formalities required by this paragraph and by locally established protocols are met.

M-2, Part I
Chapter 31

November 18, 1991

(d) The attending physician or clinical designee will file the advance directive in the patient's Consolidated Health Record, and display in bold print on the outside thereof, DPAHC INSIDE.

(2) The attending physician, or clinical designee, who learns of a surrogate decisionmaker's desire to direct that life-sustaining treatment be withheld or withdrawn shall document that communication in the progress notes.

M-2, Part I
Chapter 31

November 18, 1991

(3) The attending physician shall have authority to approve the withholding or withdraw of life-sustaining treatment pursuant to decisionmaking by the surrogate decisionmaker. Approval shall be preceded by determinations that:

(a) The patient lacks decisionmaking capacity, and is not likely to regain decisionmaking capacity within a reasonable period of time;

(b) The person who is acting as the surrogate decisionmaker has authority to so act;

(c) The patient is afflicted with a terminal illness (as defined in paragraph 31.02(g));

(d) The treatment to be withheld or withdrawn is life-sustaining treatment (as defined in paragraph 31.02(d));

(e) The treatment to be withheld or withdrawn is treatment which the surrogate decisionmaker has directed be withheld or withdrawn; and

(f) All administrative requirements of this paragraph, and locally established protocols, are met.

(4) The attending physician will document, with the written concurrence of another VA physician (which may include residents), in the patient's Consolidated Health Record the specific information referred to in subparagraphs 3(a) through (e) and file all existing documents upon which approval is based.

(5) A physician order will be written indicating, at a minimum, "Advance directive to be implemented."

(6) If the surrogate decisionmaker directs that life-sustaining treatment not be withheld or withdrawn, or requests that the withholding or withdrawal of such treatment be delayed, the surrogate decisionmaker's directions will be followed.

31.07 DISPUTES

Disputes among medical staff, or between health care staff and the patient or surrogate decisionmaker, may be referred to the chief of the service, Chief of Staff, District Counsel and/or Ethics Advisory Committee or similar body.

31.08 MISCELLANEOUS

a. Any health care provider may decline to participate in the withholding or withdrawal of life-sustaining treatment. In such cases, responsibility for the patient's care shall be delegated to another health care provider.

M-2, Part I
Chapter 31

November 18, 1991

b. The withholding or withdrawal of some or all life-sustaining treatments is compatible with maximal therapeutic efforts short of the provision of the life-sustaining treatment in question. VA patients shall receive vigorous support in all treatment modalities which are not withheld or withdrawn pursuant to this chapter. It may be appropriate to write onto the order sheet those medical efforts which will be maintained to relieve suffering and to assure comfort and dignity, such as body cleanliness, mouth care, positioning, analgesia, suction, intake and palliative oxygen, if provided, etc.

M-2, Part I
Chapter 31

November 18, 1991

c. A decision to withhold or withdraw life-sustaining treatment never justifies ignoring the patient, or providing less than humane care and total concern for the patient's welfare, comfort and dignity. Nor does it justify the active hastening of the moment of death, or the withholding or withdrawal of any treatment except as specifically authorized. All members of the health care team shall provide all forms of medically indicated treatment which are not subject to the advance directive, and shall strive to improve the range of acceptable therapeutic options made available to the patient.

d. The criteria to be applied in determining the time of death will continue to be those applied under the laws of the State in which the VA health care facility is located. Questions on this issue shall be referred to District Counsel.

31.09 REFERENCES

a. Joint Commission for Accreditation of Healthcare Organizations, Accreditation Manual for Hospitals, 1992 Edition, "Patient Rights" chapter.

b. M-2, part I, chapter 23.

c. 38 U.S.C. § 7331.

d. 38 CFR § 17.34.

VA LIVING WILL/VA ADVANCE DIRECTIVE

To any medical facility in whose care I happen to be in and to any individual who may become responsible for my health care: If the time comes when I, _____ (print name), can no longer take part in the decisions affecting my health care and treatment and my future, it is my intention, while I am still of sound mind, that this document shall stand as an expression of my wishes.

A terminal illness, for the purposes of this directive, is a debilitating condition which is medically incurable or not treatable in terms of available technology, and which can be expected to cause death. A terminal illness is also one in which death will occur whether or not life-sustaining treatment is utilized, and the application of life-sustaining treatment would serve only to artificially prolong the dying process. In addition, terminal illness shall include conditions where death is imminent as well as debilitating conditions from which there is no reasonable hope for recovery, e.g., a coma or persistent vegetative state.

"Life-sustaining treatment" means medical care, procedures or interventions which, when applied to a patient with a "terminal illness," would have little or no effect on the underlying disease, injury or condition and which would only serve to delay death. Such treatment may include, but is not limited to, resuscitation, artificial nutrition and hydration, mechanical ventilation and dialysis.

If at any time I should have a terminal illness, as defined herein, as determined by my attending (or primary treating) physician, with the concurrence of another physician, I direct that such life-sustaining treatment, as defined herein, be withheld or withdrawn, and that I be permitted to die naturally with only the administration of such medical care and procedures deemed necessary to help make me comfortable.

In the absence of an ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored as the final expression of my moral and legal right to refuse medical or surgical treatment and to accept the full consequences (including death) of such refusal.

I understand that this is a pre-printed form. Therefore, any comments, restrictions or additional instructions that I wish to make are described on the attached document entitled, "Treatment Preferences." The specific matters addressed in the attached document shall take priority over the provisions set forth in this document if there is any conflict. THIS PARAGRAPH SHALL TAKE EFFECT ONLY IF MY INITIALS ARE ENTERED HERE: _____.

November 18, 1991

M-2, Part I
Chapter 31

M-2, Part I
Chapter 31

November 18, 1991

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

VA Form 10-0137A
Nov 1991

31-27

31-27

I understand the full importance of this declaration and I am emotionally and mentally competent to make this declaration.		
Signature		Date
Social Security Number	Date of Birth	Mother's Maiden Name
We declare that _____ (print name) has signed this VA Living Will/VA Advance Directive in our presence and that he/she appears to be of sound mind and free from duress at the time this instrument was signed. In addition, we declare that the signer of this document has affirmed that he/she is aware of the nature and potential consequences of this document and that it has been signed freely and voluntarily.		
Signature of Witness		Address of Witness
Signature of Witness		Address of Witness

VA DPAHC (DURABLE POWER OF ATTORNEY FOR HEALTH CARE)

I, _____ (print name) do hereby appoint

Name: _____

Address: _____

Telephone: (work) _____ (home) _____

as my true and lawful personal care attorney in fact, my health care agent. This appointment shall take effect only if I am unable to make or communicate my own health care decisions. My health care agent shall be authorized to make any and all health care decisions for me except to the extent I provide otherwise in this, or another document. My agent is specifically authorized to grant, refuse or withdraw consent on my behalf for any health care service, treatment or procedure. This authority expressly includes the withholding or withdrawal of life-sustaining treatments.

My health care agent shall have the authority to talk to health care providers, get information and sign any forms necessary to carry out these decisions. I hereby consent to the release by VA, to my health care agent appointed hereunder, of any and all information from my medical records that is, or may be, relevant to enable or assist my health care agent to make decisions about my health care and treatment. This authorization to release information is intended to include any information related to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus and sickle cell anemia.

My health care agent is instructed to follow the treatment preferences, if any, expressed by me in the attached document entitled, "Treatment Preferences," or similar document. If the other document does not assist my health care agent in making the decision at issue, I instruct my agent to follow those preferences that I previously expressed, when I was competent to make such decisions. If this information is not known or available, I trust my agent to make decisions that he/she believes to be in my best interests.

In the event the person I have appointed is unable, unwilling or unavailable to act as my health care agent, I appoint the following as my alternate agent:

Name: _____

Address: _____

November 18, 1991

M-2, Part I
Chapter 31

M-2, Part I
Chapter 31

November 18, 1991

Telephone: (work) _____ (home) _____

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

VA Form 10-0137B
Nov 1991

31-30

31-30

TREATMENT PREFERENCES

I, _____ (print name) intend for this document to guide my health care provider and my health care agent, guardian or representative and may be a used in conjunction with a living will or durable power of attorney for health care document.

Below are listed some situations I may encounter. I recognize these cannot exactly predict what might happen, but I instruct my agent to use this information to the best of his/her ability in making treatment decisions for me and on my behalf.

A. TERMINAL ILLNESS WITHOUT EXPECTATION OF RECOVERY AND PERMANENTLY LACKING DECISIONMAKING CAPABILITY

If the situation should arise in which I am in a terminal condition, am permanently lacking of decisionmaking capability, and there is no reasonable expectation of my recovery, I direct that I be allowed to die a natural death and that my life not be prolonged by extraordinary measures. I do, however, ask that medication be given to me as necessary, to relieve pain and suffering even though this may shorten my remaining life. Yes_____ No_____ Initials _____

B. PERMANENT UNCONSCIOUSNESS

Whether or not I am terminally ill, if I become permanently unconscious, I direct that life support be discontinued
Yes_____ No_____ Initials_____

C. BRAIN DAMAGE - UNABLE TO COMMUNICATE

Whether I am terminally ill or not, if I become unconscious and have very little chance of ever recovering consciousness, and would almost certainly be very brain-damaged if I did recover consciousness, I direct that life support be discontinued. Yes_____ No_____ Initials_____

D. DOES LIFE SUPPORT INCLUDE FOOD AND FLUIDS?

The above situations (A, B, or C) may occur such that life can be prolonged when food and fluids are provided by tubes or other invasive measures. These include TUBES IN THE NOSE OR STOMACH, and INTRAVENOUS FEEDINGS. If one of the above situations develops, I direct that tubes or other invasive measures for providing food and fluids not be started. If they are started, they are to be discontinued in the following situations (see above descriptions):

- A. Terminal illness Yes_____ No_____ Initials_____
- B. Permanent unconsciousness Yes_____ No_____ Initials_____
- C. Brain damage Yes_____ No_____ Initials_____

November 18, 1991

M-2, Part I
Chapter 31

M-2, Part I
Chapter 31

November 18, 1991

I direct that although other forms of life-sustaining therapies may be withheld or withdrawn as directed by my agent, food and fluids are to be given or maintained.

Initials _____

VA Form 10-0137C
Nov 1991

M-2, Part I
Chapter 31

November 18, 1991

Witness	Address:
Witness	Address:

VA Form 10-0137C
Nov 1991