WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING TREATMENT AND ADVANCE DIRECTIVES

1. PURPOSE: To define the policy regarding withholding or withdrawal of life-sustaining treatment and advance directives within the Veterans Affairs Greater Los Angeles Healthcare System (GLA).

2. POLICY: This policy defines the policy concerning patients (or surrogate decision makers) requests to withhold or withdraw life-sustaining treatment. It recognizes three circumstances under which GLA will carry out patient expressions with respect to the withholding or withdrawal of life-sustaining treatment:

   A. When the competent patient personally requests that such treatment be withheld or withdrawn; or

   B. When the patient who lacks decision making capacity has executed, while competent, an advance directive specifying that such treatment shall be withheld or withdrawn; and/or

   C. When a "surrogate" acting on behalf of a patient who lacks decision making capacity exercises "substituted judgment"

3. DEFINITIONS:

   A. ADVANCE DIRECTIVE (AD) 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., Durable Power of Attorney for Health Care (DPAHC). A "GLA advance directive" is:

      (1) An oral statement made by a patient to a GLA 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 10-0137, 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 GLA form but whose validity is to be determined pursuant to the applicable State law.

B. ATTENDING PHYSICIAN means the attending or staff physician who has primary responsibility for the treatment of the patient.

C. DECISION MAKING 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 decision-making capacity are competent patients. Adult patients who lack decision making capacity may 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 may 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). Please see Informed Consent policy for further details.

D. LIFE-SUSTAINING TREATMENT means medical care, procedures or interventions, the absence of which will lead proximately to 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 JUDGEMENT means a decision made in accordance with this paragraph by the surrogate decision maker on behalf of a patient who lacks decision making capacity and who has not executed an advance directive. 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 a consensual assessment of the patient's best interests regarding his/her healthcare.

F. SURROGATE DECISION MAKER refers to a person who is authorized by this policy to consent to the withholding or withdrawal of life-sustaining treatment on behalf of a patient who lacks decision making capacity and who has not executed an advance directive. Provision of the informed consent policy, which pertains to the identification of the surrogate decision maker for purposes of informed consent generally, shall govern the identification of the person who properly serves as the surrogate decision maker. 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 decision maker for purposes of paragraph Substituted Judgment.

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. 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 of health and/or a wakeful state (e.g., a persistent vegetative state).

H. APPROPRIATE CLINICIAN refers to a social worker, registered nurse or medical doctor or other independent licensed practitioner who has knowledge of advance directives and is designated by each specific setting for work with patients on advance directives.

4. RESPONSIBILITIES: Individual responsibilities for physicians, nurses, social workers, and ward clerks are delineated below in the Procedure Section.

5. PROCEDURES:

A. Competent Patients’ Rights: Competent persons have the right to direct the course of their own medical care and to determine for themselves, from among the treatment options, the course of treatment which will be administered. This paragraph sets forth GLA policy concerning these self-determination rights as applied in the context of life-sustaining treatment.

(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. 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) GLA 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 in order to decline life-sustaining treatment. Such directives serve as vehicles for the communication of decision making by previously competent patients who lack decision-making capacity at the time such treatment is under consideration.
(4) 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.

(5) GLA procedures applicable to other forms of patient decision-making, including those, which govern physician-patient dialogue and the securing and documentation of informed consent, apply equally to patient decision-making concerning life-sustaining treatment. With respect to the documentation of decision-making concerning life-sustaining treatment, the following information, 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 decision-making capacity;

(c) Treatment options presented to the patient for consideration; and

(d) The patient's decision(s) concerning life-sustaining treatment.

(6) Competent patients will be encouraged, but not compelled, to involve family members in the decision making 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.

B. Advanced Directives: The patient's right to direct the course of medical care is not extinguished by the loss of decision-making capacity. In order that this right may be respected in cases involving such patients, GLA 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.

(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 a GLA 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., clerical staff, volunteers, or Environmental Management Service) may serve as witnesses.
(2) The advance directive shall be set forth in a VA form (10-0137), but may include supplemental instructions.

(3) The desires any GLA 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 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 decision making capacity when the directive was executed and the directive has not been revoked.

(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 receive 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) GLA will ensure that the advanced directive is periodically reviewed with the patient or the healthcare agent. Review will automatically occur at each inpatient admission, change in condition or level of care, annually in long term care facilities, and as is deemed appropriate by the attending physician.

(8) 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.

(9) 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 10-0137 for advance directives.
(b) If there is a question about the completion of the VA form, the physician or designee may contact Regional Counsel (310) 268-3800 to assure that the directive is consistent with this paragraph and with locally established protocols, and/or pursue consultation from the Bioethics Committee (310) 268-3016;

(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 the presence of such on the outside of the chart.

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

(a) The patient lacks decision-making capacity;

(b) The treatment to be withheld or withdrawn is life-sustaining treatment as defined above;

(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.

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

(12) A physician order will be written indicating, at a minimum, "Advance directive to be implemented," and the patient’s expressed treatment preferences in detail (i.e., do not ventilate, do not provide antibiotics, etc.)

(13) 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 (310) 478-3711 ext. 40819, Bioethics Committee (310) 268-3016 and/or Regional Counsel (310) 268-3800. In cases involving a pregnant veteran, Regional Counsel must be consulted prior to implementation.

(14) 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.
(15) Specifics for Inpatients: At admission patients will be screened by the ward clerk, on the patient’s specific inpatient setting (or by the person fulfilling the role of the ward clerk) and provided information concerning advance directives as on the VA acknowledgement form. At this time the patient may check off the box on the form indicating the presence of an advance directive or the desire for more information concerning advance directives. It will be the responsibility of the ward clerk to ensure that the patient is given this information, and signs the said form.

(a) If the patient has brought an AD, the ward clerk will make a copy and place the AD in the medical record and flag the record appropriately.

(b) If the patient doesn’t have an AD in his/her possession or wishes to change an existing AD, and would like more information or assistance related to completing an AD, the clerk will ensure that the box marked “would you like a health care provider to discuss this with you?” is checked. The clerk will then notify the appropriate clinician to speak with the patient.

(c) If the patient is unable to answer the questions due to his/her condition or other reasons, the clerk should indicate such on the form.

(d) The clerk will ensure that patients receive written information about advance directives, and that the copies of the forms are appropriately completed, and delivered to or retrieved by the appropriate clinician on a daily basis.

(e) The nursing staff will also review and be familiar with the content of an AD when one is present. If the patient does express a desire to formulate an AD to any member of the nursing staff, the nurse will assist the patient or notify the appropriate clinician.

(f) In Intensive Care Units (ICUs) or the Emergency Room (ER), the process will be as outlined above, except if the patient desires further information concerning an AD, the patient’s attending physician will be notified to have a complete discussion with the patient concerning their medical condition and appropriate questions. This discussion will be documented and will identify any expressed wishes of the patient.

(g) The clinician will counsel the patient regarding the types of advance directives, and implications of such. While assisting the patients in completing an AD, the clinician will assure that the patient has had all questions resolved by the appropriate disciplines. If not, referrals will be made (the physician will be called.) The AD clinician will also offer the patient the appropriate GLA form(s).

(16) Specifics for outpatients:

(a) The Associate Chief of Staff for ambulatory care will designate staff at each site that will respond to patient inquiries concerning advance directives.

(b) When an outpatient requests information about advance directives, the patient will be referred to the designated staff.
(c) The designated staff member will inform patients of their right to participate in healthcare decision-making, and offer written information about advance directives. This will be entered in a progress note or on the patient education form.

(d) When an outpatient wishes to complete an AD the staff member will:

i. Review the AD form with the patient to make sure the patient understands what he/she is directing. Regardless of whether received in the outpatient clinic or nursing home, a progress note will be completed that will include the patient’s diagnosis and prognosis, an assessment of the patient’s decision making capacity, treatment options presented to the patient for consideration, and the patient’s decisions regarding life-sustaining treatment.

ii. Advise the patient to choose two witnesses to sign the completed document and ensure they:

- are not related to the patient by blood or marriage
- do not have a financial interest in the patient’s estate
- are not financially responsible for the patient
- are not healthcare providers or employees of the healthcare institution who are directly and immediately responsible for the patient’s care.

iii. Counsel the patient to retain the original document.

iv. Send a copy of the AD to be filed in the appropriate section of the medical record and give original to the patient.

(e) Patients seen at home-by-home based primary care will be aided in completing advance directives by HBPC staff

(f) Any time an AD is reviewed with a patient, the discussion will be documented in a progress note including the date of the review and the names of the reviewers.

(g) Any oral statements made by a patient regarding advance directives or wishes regarding life-sustaining treatment, made to any healthcare provider, at any time, must be documented in a progress note.

C. State-Authorized Advance Directives: 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, GLA will, in certain circumstances, honor State authorized "living wills", DPAHC forms or similar documents. This paragraph sets forth GLA policy on when, and to what extent, State-authorized "living wills" or other advance directives will be followed. This paragraph contains policies with respect to the recognition of State-authorized health care agents.
(1) When GLA patients express interest in executing "living wills" or similar documents, they will be encouraged to execute a GLA advance directive. GLA recognizes that patients who lack decision-making capacity and, thus, are incapable of executing an advance directive, may have previously executed a "living will" or similar advance directive recognized by State law. In such circumstances, decision making by the surrogate decision maker, rather than by reference to the patient's written instructions, would be inappropriate. Accordingly, GLA 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 Regional Counsel when necessary;

(c) The patient lacks decision making capacity; and

(d) A medical determination is made that there is little or no likelihood that the patient will regain decision-making 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.

(a) If a State-authorized advance directive contains procedural formalities regarding the implementation of the directive that are inconsistent with GLA procedures, GLA will apply the procedures regarding implementation that are contained in this policy. 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," the patient's wishes will be implemented as set forth in this policy

(b) As the policy of GLA is to affect the patient's wishes regarding treatment, the desires of the patient as expressed in the directive itself will be followed by GLA. 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.

(c) If the non-VA or State-authorized advanced directive is legally deficient, as determined in consultation with Regional Counsel, in that it is not an instrument that is legally binding on GLA, the directive will nonetheless serve as evidence of the patient's desires and should be utilized by the patient's surrogate decision maker.

(3) 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 document presence of an AD in an appropriate manner.

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

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

(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.

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

(6) If there is a concern regarding the validity or implementation of the advance directive, the attending physician may consult with the Bioethics Committee.

(7) A patient may direct that implementation of a State-authorized advance directive be delayed, or that the directive be revoked. The provisions of subparagraphs GLA ADVANCE DIRECTIVE will apply to delays in implementing, and revocations of, State-authorized directives.

D. Substituted Judgments: 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 decision making capacity and who have not executed an advance directive in accordance with either paragraphs GLA ADVANCE DIRECTIVE or STATE AUTHORIZED ADVANCE DIRECTIVE and who are not, due to the lack of decision making 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 decision-making capacity or by the fact that an advance directive under the above noted paragraphs 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.

(1) GLA 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 decision maker. Accordingly, the informed consent policy specifies that "substituted consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations. This paragraph makes explicit what is otherwise GLA informed consent policy: the person making decisions for a terminally ill patient who lacks decision making capacity shall act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment.

(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 decision-making capacity. The same informed consent standards will be applied to the patient's surrogate decision maker as would be applied to the competent patient. In the event that a patient lacks decision making 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 GLA recognized form. If the patient is incapable or lacks the desire to use the VA form, the State-authorized form will be accepted. Regional Counsel may be consulted to determine whether such forms are valid and properly executed.

(4) Consistent with the provisions of informed consent policy, informed consent to the provision of life-sustaining treatment will be obtained from the following individuals in cases involving patients who lack decision making 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 decision making capacity, and there is little or no likelihood that the patient will regain decision making 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 the GLA informed consent policy.

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

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

(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 decision maker is based on reliable indicators of the direction the patient would personally give where the patient is 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 decision making capacity;

(b) Reactions voiced by the patient, when the patient had decision making 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 decision making 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 decision making based on the patient's own subjective wishes, life-sustaining treatment(s) will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. The surrogate decision maker 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 decision maker 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 decision maker 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 the Bioethics Committee
(9) 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 10-0137 for advance directives, DPAHC, and Treatment Preferences.

(b) If there is a question about the completion of the VA form, the physician or clinical designee may contact Regional 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.

(d) The attending physician or clinical designee will file the advance directive in the patient's Consolidated Health Record and make note of such on the outside of the chart and/or in the Advance Directive notification section of the Computerized Patient Record System (CPRS).

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

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

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

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

(c) the patient is afflicted with a terminal illness; the treatment to be withheld or withdrawn is life-sustaining treatment;

(d) the treatment to be withheld or withdrawn is treatment which the surrogate decision maker has directed be withheld or withdrawn; and

(e) all administrative requirements of this paragraph, and locally established protocols, are met.

(12) The attending physician will document, with the written concurrence of another GLA physician (which may include residents), in the patient's Consolidated Health
Record the specific information referred to in the above paragraph and file all existing documents upon which approval is based.

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

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

E. Disputes: Disputes among medical staff, or between health care staff and the patient or surrogate decision maker, may be referred to the Bioethics Committee.

F. Miscellaneous:

(1) 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.

(2) 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.

(3) 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.

(4) The criteria to be applied in determining the time of death will continue to be those applied under the laws of the State of California. Questions on this issue shall be referred to Regional Counsel.

6. REFERENCES:


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

D. GLA Policy “Informed Consent 00-11-47.


8. REVIEW DATE: Review as needed and reissue every three years.

Original signed copy on file in the Office of the COS June 2007