LIFE-SUSTAINING TREATMENT DECISIONS: ELICITING, DOCUMENTING AND HONORING PATIENTS' VALUES, GOALS AND PREFERENCES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook standardizes Department of Veterans Affairs (VA) practices and terminology to promote a more personalized, proactive, patient-centered approach to decisions about life-sustaining treatment (LST). It establishes standardized procedures for eliciting, documenting, and honoring patients' values, goals, and preferences regarding the initiation, limitation or discontinuation of LSTs. ***NOTE:*** *This policy was entered into the concurrence process prior to the release of VHA Directive 6330 and therefore uses the nomenclature of "Handbook" rather than "Directive." This Handbook is otherwise consistent with CNP under VHA Directive 6330 as mandatory policy until its recertification date.*

2. SUMMARY OF MAJOR CHANGES: This is a revised Handbook that:

a. Establishes standardized procedures for eliciting, documenting, and honoring specific decisions regarding the initiation, limitation or discontinuation of LSTs.

b. Replaces paragraph 14.c.(3) of VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, with paragraph 8 of this Handbook in order to update the process for decision making regarding the withdrawal and withholding of LST in patients who lack decision-making capacity and have no surrogate.

c. Mandates that patients' LST orders will not expire or automatically discontinue based upon dates, timeframes, or patient movements (e.g., admission, discharge, transfer) but will remain in effect unless they are modified based on a revised LST plan.

d. Establishes procedures for resolving conflict regarding LSTs.

e. Establishes procedures for situations in which a health care practitioner concludes as a matter of conscience that he or she is unable to participate in carrying out a specific decision regarding LST.

f. Amendment dated March 19, 2020 clarifies language regarding LST requirements for hospice patients and documentation of patient's care goals.

3. RELATED ISSUES: VHA Handbook 1004.01, VHA Handbook 1004.02, and VHA Handbook 1004.04.

4. RESPONSIBLE OFFICE: National Center for Ethics in Health Care (10E1E) is responsible for the content of this Handbook. Questions are to be addressed to 202-632-8457.

5. RESCISSION: VHA Handbook 1004.3, dated October 24, 2002 is rescinded.

6. RECERTIFICATION:
This Handbook is scheduled for recertification on or before the last working day of January 2022.

/s/ David J. Shulkin, M.D.
Under Secretary for Health

DISTRIBUTION: Emailed to the VHA Publications Distribution List on January 12, 2017.

CONTENTS

LIFE-SUSTAINING TREATMENT DECISIONS: ELICITING, DOCUMENTING AND HONORING PATIENTS' VALUES, GOALS AND PREFERENCES

1. PURPOSE: 1

2. BACKGROUND: 1

3. DEFINITIONS: 2

4. SCOPE: 6

5. INITIATING GOALS OF CARE CONVERSATIONS: 6

6. ELEMENTS OF A GOALS OF CARE CONVERSATION: 10

7. LIFE SUSTAINING TREATMENT DECISION MAKING IN THE INTENSIVE CARE UNIT (ICU): 10

8. ESTABLISHING, REVISING AND DOCUMENTING LIFE-SUSTAINING TREATMENT PLANS FOR PATIENTS WHO LACK DECISION-MAKING CAPACITY AND HAVE NO SURROGATE: 12

9. DOCUMENTING PATIENTS' GOALS OF CARE AND LIFE-SUSTAINING TREATMENT PLANS: 14

10. MODIFYING A LIFE-SUSTAINING TREATMENT PLAN: 16

11. LIFE-SUSTAINING TREATMENT ORDERS: 16

12. HONORING PATIENTS' PREFERENCES REGARDING LIFE-SUSTAINING TREATMENTS: 17

13. ASSISTED SUICIDE AND EUTHANASIA: 19

14. NATURALLY ADMINISTERED NUTRITION AND HYDRATION: 20

15. RESOLVING INCONSISTENCIES OR CONFLICT REGARDING LIFE-SUSTAINING TREATMENTS: 20

16. CONSCIENTIOUS OBJECTION: 22

17. RESPONSIBILITIES: 22

18. REFERENCES: 27

LIFE-SUSTAINING TREATMENT DECISIONS: ELICITING, DOCUMENTING AND HONORING PATIENTS' VALUES, GOALS, AND PREFERENCES

1. PURPOSE: This Veterans Health Administration (VHA) Handbook standardizes Department of Veterans Affairs (VA) practices and terminology to promote a more personalized, proactive, patient-centered approach to decisions about life-sustaining treatments (LST). It establishes standardized procedures for eliciting, documenting, and honoring patients' values, goals, and preferences regarding the initiation, limitation or discontinuation of LSTs. **AUTHORITY:** 38 U.S.C. 7331, 7334; 38 CFR 17.32; 42 U.S.C. § 14401 et sec.

2. BACKGROUND:

a. Legal and ethical standards have established that patients with decision-making capacity have the right to accept or decline recommended medical treatments or procedures, including LSTs, and that health care providers have an obligation to respect such decisions by patients. Patients who lack decision-making capacity have the right to have a surrogate make decisions on their behalf based on the surrogate's understanding of the patient's values, goals, and preferences (see paragraph 18.d.).

b. Many patients, however, do not have an opportunity to discuss and make decisions regarding LSTs before they become critically ill or unable to speak for themselves. Practitioners are often reluctant to discuss decisions about cardiopulmonary resuscitation (CPR) and other LSTs with patients, and often postpone such discussions until a crisis occurs or until the patient is within days or even hours of death – at which time patients are often unable to participate in discussions and surrogate decision makers are highly stressed (see paragraphs 18.f.,g.,m.,u.,gg.).

c. Living wills, also called instructional advance directives, can be useful in allowing patients to communicate general preferences in advance. However, instructions provided in living wills are often too simplistic or vague to be readily translated into specific medical decisions. In addition, living wills do not serve as orders. Instead, they need to be carefully read and discussed by health care providers and surrogates before they can be implemented, and they are often interpreted in different ways by different people (see paragraphs 18.i. and 18.k.).

d. Health care powers of attorney,also called durable powers of attorney for health care or proxy advance directives, were developed to address some of the problems with living wills. Patients can use these documents to designate a surrogate to make decisions on their behalf in the event that they lose decision-making capacity. The assumption is that surrogates understand patients' preferences for LSTs. Research has shown, however, that this is not always the case. For example, a meta-analysis of sixteen studies found that surrogates were accurate in stating patient preferences for LST in specific scenarios only 68 percent of the time. In one third of cases, surrogates incorrectly predicted patients' end-of-life treatment preferences (see paragraph 18.x.).

e. For these reasons, advance directives alone are no longer considered sufficient for patients for whom decisions about LST need to be made, such as patients with serious life-limiting medical conditions. For such high risk patients, there is a need for an explicit discussion tailored to each individual patient (i.e., a goals of care conversation) that involves shared decision-making between the patient (or surrogate) and the health care practitioner (see paragraphs 18.a.,c.,e.,l.,o.,p.,q.,r.,w.,ff.). For these discussions to have clinical impact, they need to be translated into a plan and orders in the health record (see paragraph 18.v.). This approach is highlighted in the National Quality Forum's 2010 "Safe Practices for Better Healthcare" which recommends that "written documentation of the patient's preferences for life-sustaining treatments is prominently displayed in his or her chart" and "[o]rganization policies…should be in place and address patient preferences for life-sustaining treatment [such as mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration] and withholding resuscitation." (See paragraph 18.t.).

f. In a 2013 report calling for improved documentation of patients' preferences for LST, The Agency for Health Care Research and Quality observes that "Poor documentation or communication about these preferences can…lead to confusion among staff, miscommunication with families, and errors in code situations" (see paragraph 18.j.).

g. To support VHA's strategic priority of providing personalized, proactive, patient-driven care, and to ensure that the provision of LSTs is aligned with patients' values, goals, and preferences, this Handbook introduces standardized procedures for eliciting, documenting, and honoring patients' specific LST decisions. This approach reflects best practices from the literature, including proactively initiating conversations in high risk patients, discussing goals of care before discussing specific treatments, including the use of CPR (see paragraph 18.n.) and using standardized tools to document LST plans and orders. The specific procedures outlined in this policy were developed over several years with extensive input from numerous VA and non-VA subject matter experts. The tools and procedures were tested in the VHA Office of Informatics and Analytics, Human Factors Engineering Lab and pilot tested prior to the execution of this policy.

3. DEFINITIONS:

a. **Advance Directive.** An advance directive is a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that individual becomes unable to make those decisions. Although verbal statements may also be extremely useful in determining the prior preferences of a patient who subsequently loses decision-making capacity, statements that have been committed to writing in a formal advance directive document are accorded special authority, as described in VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives. Do-not-resuscitate orders, state-authorized portable orders, or other LST orders are not advance directives. See VHA Handbook 1004.02, for more information about types of advance directives and their validity in VA. ***NOTE:*** *An advance directive is not to be used as the basis for decision*

making while the patient has decision-making capacity. The existence of an advance directive never precludes the requirement to discuss treatment options with a patient who has decision-making capacity or the patient's surrogate if the patient lacks capacity.

b. **Artificial Hydration.** Artificial hydration is the delivery of water or electrolyte solution by any route other than swallowing.

c. **Artificial Nutrition.** Artificial nutrition is the delivery of nutrition by any route other than swallowing.

d. **Best Interests.** Best interests is the standard to be used by surrogate decision makers to guide health care decisions when the patient's specific values and wishes are unknown. The surrogate, together with the health care team, uses this standard to determine the optimal outcomes for patients and the interventions most likely to produce them. In making that determination, the surrogate must also take into account the patient's cultural, ethnic, and religious perspectives, if known.

e. **Cardiopulmonary Resuscitation.** Cardiopulmonary resuscitation (CPR) is the use of Basic Life Support and Advanced Cardiac Life Support (see paragraph 18.b.) in an attempt to restore spontaneous circulation following cardiopulmonary arrest (i.e., the loss of airway, breathing, or circulation necessary to maintain life). CPR is an LST.

f. **Decision-Making Capacity.** Decision-making capacity is a clinical judgment about a patient's ability to make a particular type of health care decision at a particular time. In clinical practice (and law), a patient's decision-making capacity is generally presumed; however, when the patient's medical condition or observed behavior raises questions about the patient's decision-making capacity, the responsible practitioner must make an explicit determination based on an assessment of the patient's ability to do all of the following:

(1) Understand the relevant information;

(2) Appreciate the situation and its consequences;

(3) Reason about treatment options; and

(4) Communicate a choice.

NOTE: *In contrast, "competence" is a legal determination made by a court of law. See VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, for information related to determination of decision-making capacity.*

g. **Do Not Attempt Resuscitation Order.** A Do Not Attempt Resuscitation Order (DNAR/DNR) is an order that establishes that CPR shall not be attempted for a patient in cardiopulmonary arrest (i.e., the loss of airway, breathing, or circulation necessary to maintain life). Patients with a DNAR/DNR order should still receive clinically appropriate emergency interventions short of CPR (for example medications, fluids, oxygen, manual

removal of an airway obstruction or the Heimlich maneuver) unless otherwise specified in LST orders. ***NOTE:*** *The terms DNR, DNAR, No-CPR, and No Code are synonymous. DNAR/DNR orders are distinct from advance directives.*

h. **Goals of Care Conversation.** A goals of care conversation (GoCC) is a conversation between a health care practitioner and a patient or surrogate for the purpose of determining the patient's values, goals, and preferences for care, and, based on those factors, making decisions about whether to initiate, limit, or discontinue LSTs. Other health care team members may contribute to the goals of care conversation as specified in this Handbook.

i. **Health Care Agent.** A health care agent (HCA) is a person selected by the patient and named in a Durable Power of Attorney for Health Care to make health care decisions on the patient's behalf if, or when, that individual can no longer do so. In VHA, an HCA is first in the hierarchy of surrogate decision makers and is authorized to make decisions about all types of health care on the patient's behalf.

j. **High Risk Patient.** For the purposes of this policy, a high risk patient is a patient who is considered to be at high risk for a life-threatening clinical event because they have a serious life-limiting medical condition associated with a significantly shortened lifespan. High risk patients are patients about whom the practitioner would not be surprised if the patient experienced a life-threatening clinical event within the next one to two years. In addition to clinical judgment as a basis for identifying these patients, objective criteria also may also be used to make this determination.

k. **Life-Sustaining Treatment.** A life-sustaining treatment (LST) is a medical treatment that is intended to prolong the life of a patient who would be expected to die soon without the treatment (e.g., artificial nutrition and hydration, mechanical ventilation).

l. **Life-Sustaining Treatment Plan.** An LST plan is a treatment plan about LST decisions based on the patients' values and goals of care. An LST plan is distinct from an advance directive.

m. **Life-Sustaining Treatment Progress Note.** An LST progress note is a health record progress note that documents a patient's goals of care and LST plan using a nationally standardized computerized patient record system (CPRS) progress note template.

n. **Life-Sustaining Treatment Progress Note Template.** The LST Progress Note Template is a nationally standardized CPRS progress note template for documenting a patient's goals of care and LST plan.

o. **Life-Sustaining Treatment Orders.** LST orders are DNAR/DNR orders or any other orders to limit or not place limits on one or more LST.

p. **Life-Sustaining Treatment Order Set.** The LST Order Set is a nationally standardized CPRS order set for documenting orders to limit or not place limits on one

or more LST. Orders documented in the LST Order Set will not expire or automatically discontinue based upon dates, timeframes, or patient movements (e.g., admission, discharge, transfer) but will remain in effect unless they are modified based on a revised LST plan.

q. **Mechanical Ventilation.** For the purposes of this policy, the term "mechanical ventilation" refers to an invasive or non-invasive method to mechanically assist or replace spontaneous breathing, e.g., through the use of a ventilator attached to an endotracheal or tracheostomy tube, or the use of ventilatory support, such as continuous positive air pressure (C-PAP) or bilevel positive airway pressure (BiPAP) ventilation.

r. **Practitioner.** For the purposes of this policy, a "practitioner" is an attending physician or other licensed independent practitioner (LIP) in charge of the patient's care or who serves as consultant for GoCCs and LST planning. "Practitioner" also includes the following team members only when an attending physician or other LIP has delegated to them the responsibility for conducting GoCCs and writing LST plans and LST orders, including DNAR/DNR orders:

(1) Physician residents;

(2) Advanced practice registered nurses whose scope of practice agreement, or other formal delineation of job responsibility explicitly authorizes them to write LST progress notes and LST orders, including DNAR/DNR orders; and

(3) Physician assistants when the scope of practice agreement or other formal delineation of job responsibility explicitly authorizes them to write LST progress notes and LST orders, including DNAR/DNR orders.

NOTE: *Even if licensed, residents appointed as trainees are never considered licensed independent practitioners. They do not have privileges, but function under the clinical privileges of the supervising practitioner. See VHA Handbook 1400.01, Resident Supervision.*

s. **Resident.** The term "resident" refers to an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, or podiatrists, and who participates in patient care under the direction of supervising practitioners. ***NOTE:*** *For the purpose of this Handbook, the term "resident" includes individuals in their first year of training, who are sometimes referred to as "interns," and individuals in approved subspecialty graduate medical education programs, who are also referred to as "fellows."*

t. **State-Authorized Portable Orders.** State-authorized portable orders (SAPO) are specialized forms or identifiers (e.g., DNAR/DNR bracelets or necklaces), authorized and governed by state law, that translate a patient's preferences with regard to specific LST decisions into portable medical orders. SAPO are designed to be easily recognizable and understood by first responders and other health care personnel and to physically travel with the patient whenever the patient is transported to or from a health

care facility. Examples of SAPO forms include: Oregon's Physician Orders for Life-Sustaining Treatment [POLST], West Virginia's Physician Orders for Scope of Treatment [POST], New York's Medical Orders for Life Sustaining Treatment [MOLST]), and out-of-hospital DNAR/DNR orders (e.g., New York State's Out-of-Hospital DNR order form). The law of the state that authorizes the SAPO dictates the types of health care providers who may write these orders within the state. See VHA Handbook 1004.04. Portable orders that are endorsed by state medical societies, but not authorized by state law, are not state-authorized portable orders.

u. **Substituted Judgment.** Substituted judgment is the standard to be used by surrogate decision makers who have specific knowledge of the patient's values and wishes pertaining to health care choices. This standard requires that the surrogate decide based on what the patient would have wanted if the patient were capable of expressing those preferences. That decision may not necessarily coincide with what the surrogate and health care team otherwise would consider optimal for the patient.

v. **Surrogate Decision Maker.** Surrogate decision maker (surrogate) refers to an individual or decision-making process authorized under VHA policy to make health care decisions on behalf of a patient who lacks decision-making capacity. See VHA Handbook 1004.01 for information about surrogate selection, priority, and the surrogate's role in health care decision making.

4. SCOPE: This Handbook standardizes VA practices and terminology to promote a more personalized, proactive, patient-centered approach to decisions about LST. It establishes standardized procedures for eliciting, documenting, and honoring patient preferences. The Handbook also explains the prohibition on assisted suicide and euthanasia in VA, and establishes guidance on naturally administered nutrition and hydration, conflict resolution, and conscientious objection.

5. INITIATING GOALS OF CARE CONVERSATIONS:

a. **Responsibility for the Goals of Care Conversation.** GoCCs are the responsibility of attending physicians or other LIPs who are in charge of the individual patient's care or who are serving as consultants for GoCC and LST planning.

(1) Attending physicians or other LIPs may delegate all or part of this responsibility to physician residents, non-LIP advanced practice registered nurses, or physician assistants they deem competent to conduct GoCCs and who meet the definition of "practitioner" in paragraph 3.r.

(2) Health care teams are to determine the team members responsible for identifying patients appropriate for a goals of care conversation. Health care teams are also to determine the team members responsible for identifying the patient's surrogate decision-maker, managing documents reflecting the patient's wishes, preparing patients (or surrogates) for goals of care conversations, and discussing with patients (or surrogates) the patient's goals of care. See paragraph 9.d. for documentation requirements related to these responsibilities. Shared decision-making about LSTs is

the responsibility of the entire team however, confirming the LST plan, obtaining informed consent, and documenting LST orders are the responsibility of practitioners who are authorized to write LST orders whether the goals of care conversation was initiated by the practitioner or others on the team.

b. **Triggering Events.** See paragraph 7 for alternate requirements for patients admitted to the ICU.

(1) In emergency situations when immediate medical care is necessary to preserve the patient's life or avert serious impairment to the patient's health, and the practitioner determines that delaying medical care in order to conduct a GoCC with the patient or patient's surrogate would increase the hazard to the life or health of the patient, the practitioner should defer the GoCC until the earliest opportunity after the patient has been stabilized.

(2) Practitioners who are qualified to write LST orders are required to initiate and document a GoCC with the patient (or surrogate) within a timeframe that meets the patient's clinical needs. This includes initiating and documenting a GoCC under the following circumstances and when otherwise clinically appropriate:

(a) Triggering events for high risk patients without active LST orders and/or LST progress notes.

1. After admission to a VA community living center (e.g., within 7 days);

2. At a primary care visit (including home based primary care) e.g., within 6 months after the patient comes under the care of the primary care practitioner as a high risk patient, or at the earliest opportunity if the patient has an expected survival of 6 months or less;

3. After a new palliative care consultation (e.g., within 72 hours for inpatients and by the second visit for outpatients);

4. Prior to referral or following admission (e.g., within 24 hours) to VA or non-VA hospice; ***NOTE:*** *GoCCs are not required for patients who are receiving non-VA care and are referred for non-VA hospice paid for by VA.*

5. Prior to initiating or discontinuing a treatment intended to prolong the patient's life when the patient would be expected to die soon without the treatment; or

6. After admission to a VA acute care hospital (e.g., within 24 hours, or, if not feasible to do so within that time frame, at the earliest opportunity and not more than 72 hours after admission). See paragraph 7 for alternate requirements for patients admitted to the intensive care unit (ICU). ***NOTE:*** *Goals of care conversations are not required for patients admitted under observation under VHA Directive 1036, Standards for Observation in VA Medical Facilities.*

(b) Triggering events for patients with active LST orders and/or LST progress notes.

1. If there is evidence that the orders no longer represent the patient's preferences; or

2. Prior to a procedure involving general anesthesia, initiation of hemodialysis, cardiac catheterization, electrophysiology studies or any procedure that poses a high risk of serious arrhythmia or cardiopulmonary arrest. ***NOTE:*** *A patient's LST orders must not be automatically suspended (see paragraph 11.a.(3) for more information).*

(c) Triggering events for all patients. See paragraph 7 for alternate requirements for patients admitted to the ICU:

1. Prior to writing DNAR/DNR orders or other orders to limit LST, including SAPO;

2. At any patient encounter when the patient (or surrogate) expresses a desire to make decisions about limiting or not limiting LSTs in the patient's current treatment plan; or

3. At any patient encounter when the patient (or surrogate) presents with SAPO for LST, unless the patient already has LST orders in CPRS that are consistent with the SAPO. See paragraphs 8.b. and 8.e. for more information related to SAPO.

(3) If a GoCC is indicated but the patient or surrogate chooses to defer the conversation or chooses not to make decisions about LSTs, or the practitioner determines that delay is clinically indicated, the practitioner must document this in the progress note for the encounter. Documentation in the encounter note does not discharge the obligation to re-initiate the GoCC when the patient (or surrogate) is ready.

c. **Preparing for a Goals of Care Conversation.** In preparation for a GoCC, the practitioner must:

(1) If the patient's decision-making capacity is in question, perform (or obtain) and document a clinical assessment of decision-making capacity.

(a) If the patient lacks decision-making capacity, identify the surrogate decision maker. Pursuant to 38 CFR 17.32, the order of surrogate priority in VA is:

1. Health Care Agent.

2. Legal Guardian or Special Guardian.

3. Next of kin. The next of kin is a relative, 18 years or older, in the following order of priority: spouse; child; parent; sibling; grandparent; grandchild.

4. Close friend.

(b) If the patient lacks capacity and has no surrogate decision maker, the practitioner may either request the District Chief Counsel's assistance to obtain a special guardian

for health care to serve in this role or follow the process for multidisciplinary committee review outlined in paragraph 8.

(2) Review the health record, including active advance directive(s), state-authorized portable orders, and LST notes and orders available in the record or presented by the patient or surrogate. If an LST progress note documenting an LST plan is located by searching another facility's electronic health record through remote data, the provider must confirm the LST plan with the patient or surrogate prior to writing a corresponding LST progress note and orders in the patient's local electronic health record.

(3) Through review of the health record and relevant discussion with recent health care providers, compile the key diagnosis and prognosis information needed to present to the patient or surrogate to enable accurate discussions and well-informed decision making. Ensure that the patient or surrogate has been informed about the patient's diagnosis and prognosis in advance of the goals of care conversation, whenever possible. When time and circumstances do not permit conveying such information in advance, the diagnosis and prognosis information is to be conveyed during the goals of care conversation.

d. **Participants in the Goals of Care Conversation.**

(1) In addition to the practitioner leading the conversation, required participants include:

(a) The patient, if the patient has decision-making capacity;

(b) The surrogate, if the patient lacks decision-making capacity; and

(c) Core treatment team members as determined by the practitioner, if the patient lacks decision-making capacity and has no surrogate who is willing and available to serve. ***NOTE:*** *Procedures for establishing an LST plan for a patient who lacks decision-making capacity and has no surrogate are specified in paragraph 8.*

(2) Others may attend at the invitation of or with the permission of the patient (or surrogate). It is often helpful for surrogates to participate when the patient has capacity and agrees to have the surrogate present.

(3) If it is impractical for participants to attend in person, the GoCC may be conducted over the telephone or through video conference.

6. ELEMENTS OF A GOALS OF CARE CONVERSATION: GoCCs with patients or surrogates might take place over more than one visit and include more than one member of the health care team. The GoCC must address elements noted in paragraphs 6.a. through 6.e.

a. When talking to the patient, identify the individual(s) who would be legally authorized under VA policy to serve as the surrogate decision maker should the patient lose decision-making capacity. If the patient prefers a different person to serve as their surrogate, refer the patient for assistance in completing a Durable Power of Attorney for Health Care. See VHA Handbook 1004.02 for procedures to assist patients in completing advance directives.

b. Ensure that the patient or surrogate has sufficient understanding of the patient's condition (e.g., diagnosis, prognosis) to make informed decisions about LST.

c. When talking to the patient's surrogate, ensure the surrogate understands their responsibility to make decisions using substituted judgment (see paragraph 3.u.), unless the patient's preferences are unknown, in which case they are to make decisions based on the patient's best interests (see paragraph 3.d.).

d. Elicit the patient's goals of care, to serve as a foundation for treatment decision making.

e. Establish a plan for the use of life-sustaining treatments. This includes a plan for whether CPR will be attempted in the event of cardiopulmonary arrest, and may include a plan for the use of other LSTs in circumstances other than cardiopulmonary arrest.

(1) Practitioners are not required to discuss LSTs that are not relevant to the patient's care.

(2) Obtain oral consent for the LST plan. Practitioners may not write orders to limit LSTs without the oral consent of the patient (or surrogate) (see paragraph 8 for information on obtaining approval for LST plans for patients who lack decision-making capacity and have no surrogate).***NOTE:*** *The practitioner must document the patient's goals of care and LST plan using the standardized progress note template entitled "Life-Sustaining Treatment, per paragraph 9."*

7. LIFE SUSTAINING TREATMENT DECISION MAKING IN THE INTENSIVE CARE UNIT (ICU): The attending physician or LIP is responsible for initiating the conversation regarding life sustaining treatment. This responsibility can be delegated to a physician resident, non-LIP advanced practice registered nurse, or physician's assistant who meets the definition of "practitioner" in paragraph 3.r. and is deemed competent by the LIP to conduct this conversation.

a. If the patient's decision-making capacity is in question, perform (or obtain) and document a clinical assessment of decision-making capacity.

b. If the patient lacks decision-making capacity, identify the authorized surrogate decision maker and ensure that up-to-date contact information is documented. If the patient lacks capacity and has no surrogate decision maker, the practitioner may either request the District Chief Counsel's assistance to obtain a special guardian for health care to serve in this role or follow the process for multidisciplinary committee review outlined in paragraph 8.

c. For critically ill patients without active LST orders, the ICU team will:

(1) With the patient (or surrogate), review documents reflecting the patient's wishes (e.g., advance directive, SAPO), if any.

(2) With the patient (or surrogate), discuss the patient's goals of care and, based on the patient's goals, establish a treatment plan that includes whether CPR will be attempted in the event of cardiopulmonary arrest, and may include a plan for the use of other LSTs in circumstances other than cardiopulmonary arrest.

(3) Obtain oral consent for the LST plan. Practitioners may not write orders to limit LSTs without the oral consent of the patient (or surrogate). See paragraph 8 for information about obtaining approval for LST plans for patients who lack decision-making capacity and have no surrogate. If a patient who lacks decision-making capacity and has no surrogate presents to VA with SAPO and immediate medical care is necessary to preserve the patient's life or avert serious impairment of the patient's health, the practitioner must act in accordance with the Veteran's SAPO, unless there is a reason to doubt the SAPO's validity. The specific procedures related to SAPO are outlined in VHA Handbook 1004.04.

(4) Document the patient's goals of care and LST plan in the LST Progress Note Template and Order Set. ***NOTE:*** *The percentage of patients admitted to ICU who have care preferences documented within 48 hours is endorsed by the National Quality Forum as a measure of quality (NQF #1626) (see paragraph 18.s.).*

d. For critically ill patients with active LST orders, the ICU team will:

(1) Confirm with the patient (or surrogate) that the LST plan and orders are consistent with the patient's goals of care, review surrogate designation, and honor the LST orders.

(2) Document the conversation in an addendum to the LST Progress Note or in a new LST Progress Note, including any changes to the LST plan, discontinue any obsolete LST orders, and write new LST orders, as needed.

e. The ICU team will provide the patient and/or family with chaplain and/or social work support as needed or requested.

f. When there are significant changes in the patient's status, the ICU team will communicate with the patient, family and/or surrogate regarding the patient's medical status, prognosis, goals of care, and treatment plan. A family conference will be offered,

as needed (e.g., within 5 days of ICU admission), for those patients whose anticipated length of stay is prolonged.

8. ESTABLISHING, REVISING AND DOCUMENTING LIFE-SUSTAINING TREATMENT PLANS FOR PATIENTS WHO LACK DECISION-MAKING CAPACITY AND HAVE NO SURROGATE:

a. If the patient lacks decision-making capacity and has no surrogate, the practitioner must either request the District Chief Counsel's assistance to obtain a special guardian for health care to serve as the patient's surrogate or follow the multidisciplinary committee review process below to establish or revise the patient's LST plan and orders.

b. If a patient who lacks decision-making capacity and lacks a surrogate has no active LST orders and presents to VA with SAPO, the practitioner must write an LST progress note and orders in accordance with the SAPO unless there is a reason to doubt the SAPO's validity. For these patients, the practitioner must then initiate a consult to the multidisciplinary committee (as described in 8.e. below) within 24 hours. If, during the multidisciplinary committee review process the patient experiences an emergency, treatment will be based on the documented orders reflecting the SAPO. The specific procedures related to SAPO are outlined in VHA Handbook 1004.04.

c. In an emergency situation, when a patient who lacks decision-making capacity and lacks a surrogate and has no active LST orders presents without SAPO, the practitioner may initiate life saving treatment and initiate a consult to the multidisciplinary committee within 24 hours.

d. To develop a proposed new or revised LST plan and initiate the multidisciplinary committee review process for a patient who lacks decision-making capacity and lacks a surrogate, the practitioner must:

(1) Review, discuss, and clarify the patient's medical condition, including diagnosis and prognosis, with the patient's core treatment team members as determined by the practitioner.

(2) With the health care team, collect and discuss available information about the patient in an effort to understand the patient's values, goals, preferences and life plans (e.g., review the health record, interview patient's providers including the Patient Aligned Care Team or others who knew the patient before the loss of decision-making capacity).

(3) Identify appropriate goals of care based on the team's understanding of the patient's medical condition, prognosis, values, preferences and life plans.

(4) Based on a discussion with the health care team, the practitioner must propose a specific LST plan based on consideration of the patient's known wishes, or, if these are not known, the patient's best interests (see paragraph 3 for definitions) and, to the extent possible, explain the nature and purpose of the proposed plan to the patient.

(5) Submit the proposed LST plan for review by the multidisciplinary committee appointed by the medical facility Director (as described in paragraph 8.e.) by documenting the recommendations in the patient's chart and following local procedures for requesting a review. Except as noted in paragraph 8.b., (in an emergency situation or when the patient who lacks decision-making capacity and has no surrogate presents with a valid SAPO) no LST orders may be written until the review is complete.

e. The multidisciplinary committee, appointed by the medical facility Director, must consider the procedural and ethical validity of the recommended LST plan for the patient who lacks decision-making capacity and has no surrogate. The multidisciplinary committee must:

(1) Be comprised of three or more different disciplines. ***NOTE:*** *The local Ethics Consultation Service, IntegratedEthics Council, subcommittee of the IntegratedEthics Council, or an independent standing or ad hoc group may serve this function*.

(2) Include at least one member of the facility's Ethics Consultation Service.

(3) Not include members of the primary treatment team.

(4) Function as the patient's advocate by determining whether the proposed LST plan is consistent with the patient's wishes or in the patient's best interests.

(5) Review the information provided by the practitioner and collect additional information, if needed, including remote electronic health record data, if available (e.g., VistA web, Remote Data view).

(6) Base its recommendations on substituted judgment or, if the patient's values and preferences are unknown, on the patient's best interests.

f. If the proposed LST plan does not include any limitations on LST, and the multidisciplinary committee determines that the proposed LST plan is consistent with the patient's wishes or best interests, the committee must within 48 hours, or as soon as reasonably possible if over a weekend or holiday and in a timeframe that meets the clinical needs of the patient, document its findings and recommendations in the patient's chart and follow local procedures to notify the practitioner.

g. If the proposed LST plan includes limitations on LST or the multidisciplinary committee determines that the proposed LST plan is not consistent with the patient's wishes or best interests, the committee must, within 48 hours, or as soon as reasonably possible if over a weekend or holiday and in a timeframe that meets the clinical needs of the patient, communicate its findings and recommendation in CPRS and follow local procedures to notify the facility Chief of Staff and practitioner that the committee has completed its review and the associated documentation is available in the patient's record.

h. If the proposed LST plan includes limitations on LST, the Chief of Staff must approve or disapprove the committee's recommendation about the proposed LST orders, in writing, as follows:

(1) If the Chief of Staff does not accept the multidisciplinary committee's recommendation, the Chief of Staff must request review by the District Chief Counsel and consultation from the National Center for Ethics in Health Care. Based on these discussions, the Chief of Staff must concur or non-concur with the proposed LST plan, and document the concurrence or non-concurrence in the patient's electronic health record (e.g., in an addendum to the multidisciplinary committee's note).

(2) After reviewing the record, the medical facility Director may concur with the proposed LST plan, or request further review by the District Chief Counsel and, if appropriate, the National Center for Ethics in Health Care.

(3) The medical facility Director, Chief of Staff, or designee must document the final decision by adding an addendum to the multidisciplinary committee's note.

h. The practitioner must complete the LST progress note and orders to implement the LST plan, per results of the review process.

9. DOCUMENTING PATIENTS' GOALS OF CARE AND LIFE-SUSTAINING TREATMENT PLANS:

a. **Life-Sustaining Treatment Progress Note/Template.** The practitioner must document the patient's goals of care and LST plan using the standardized progress note template entitled "Life-Sustaining Treatment."

b. **Documenting Informed Consent.** The Life-Sustaining Treatment Progress Note is sufficient to document the patient's (or surrogate's) oral informed consent to the LST plan. The practitioner may not require the patient to sign a consent form authorizing the LST plan. However, regardless of whether the patient has an LST plan, the informed consent requirements described in Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, must still be met prior to initiating specific treatments and procedures authorized by the plan (e.g., signature consent must be obtained before initiating dialysis).

c. **Documentation when GoCC are Delegated.** Attending physicians and other LIPs, including consultants for GoCCs and LST planning, may delegate all or part of the responsibility for the GoCC to a physician resident, non-LIP advanced practice registered nurse, or physician's assistant who meets the definition of "practitioner" in paragraph 3.r. and is deemed competent by the delegating practitioner to conduct a GoCC.

(1) The delegated practitioner must, at minimum, document the name of the delegating practitioner in the LST progress note.

(2) The delegating practitioner must document review of the LST plan within 24 hours (or 72 hours in a Community Living Center, outpatient setting, or Home-Based Primary Care setting) and document as follows, based on concurrence or non-concurrence:

(a) If the delegating practitioner concurs with the plan, the delegating practitioner may document concurrence either by writing an addendum to the LST progress note or by co-signing the LST progress note, as determined by the local facility. ***NOTE:*** *LST progress notes awaiting co-signature are viewable on the Progress Notes tab immediately, but will not appear in the Postings section of the Cover Sheet until the co-signature is entered*.

(b) If the delegating practitioner does not concur with the plan, the delegating practitioner must co-sign the note (or sign the note as an additional signer) and place an addendum indicating non-concurrence. Then, the delegating practitioner or designee must, based on discussion with the patient (or surrogate), write a new LST progress note or document changes to the LST plan in an addendum**,** and write new LST orders.

d. **Documentation by Other Team Members of Information Pertinent to the Goals of Care Conversation.** When a team member without the authority to write LST progress notes and orders has a discussion intended to support the GoCC, appropriate documentation of the information depends on whether or not the patient has an existing LST progress note:

(1) When no LST progress note is in the patient's chart and information pertinent to the goals of care conversation (i.e., identification of the patient's surrogate, goals of care, or treatment preferences) is discussed with the patient or surrogate*,* the team member must document this information in a locally-developed progress note designed to capture this discussion. To ensure that the note is easily accessible to the practitioner who will later complete the GoCC and write LST progress notes and orders, the note title may be linked to CWAD and associated with the national standard note title: "Goals & Preferences to Inform Life-Sustaining Treatment Plan."

(2) When an LST progress note is in the patient's chart and the team member has a discussion with either the patient or the surrogate indicating that the patient's goals or preferences have changed, the team member must document the information in an addendum to the LST progress note, if authorized, and add the attending physician or other LIP in charge of the patient's care as an additional signer. If the team member is not authorized to make an addendum to the LST progress note, the team member must document the information in an appropriate, local progress note, and add the attending physician or other LIP in charge of the patient's care as an additional signer. To ensure that the note is easily accessible to the practitioner who will later complete the GoCC and write LST progress notes and orders, the note title may be linked to CWAD and associated with the national standard note title: "Goals & Preferences to Inform Life-Sustaining Treatment Plan." ***NOTE:*** *Per VHA Handbook 1907.01, signing as an "additional signer" indicates receipt of the information, not concurrence with the contents of the note.*

(3) In urgent situations, in addition to documenting information in the electronic health record, the team member should speak directly to the attending physician or other LIP in charge of the patient's care about the information provided.

e. **Patients Who Lack Decision-Making Capacity and Have No Surrogate.** See paragraph 8 for additional documentation requirements related to establishing or revising LST plans through the multidisciplinary committee review process.

f. **Notification of Primary Care Team.** For patients who have an assigned VA primary care team, the patient's primary care team must be made aware of the patient's LST orders. ***NOTE:*** *Notification can be accomplished by listing the primary care team contact as an "additional signer" on the progress note, or according to facility procedures for notification of the primary care team.*

g. **A Copy of the LST Progress Note Must be Offered to the Patient (or Surrogate) Whenever LST Orders are Written.** For inpatients for whom new LST orders have been written during the admission, a copy of the LST progress note must be offered at the time of discharge. The progress note is offered to the patient (or surrogate) for informational purposes about their VA LST plan.

10. MODIFYING A LIFE-SUSTAINING TREATMENT PLAN:

a. The LST plan remains in effect until the patient (or surrogate if the patient does not have decision making capacity) chooses to modify or revoke the plan by communicating the change to their VA practitioner either orally or in writing.

b. The patient's surrogate may modify or revoke the LST plan except if the change would be clearly inconsistent with the patient's values, goals, and preferences (see paragraphs 15.d. through 15.k.).

c. If the patient (or surrogate) decides to modify or revoke the LST plan, including documentation of different LST preferences or a different surrogate in a new advance directive, the practitioner must write an addendum to the LST progress note (or write a new LST progress note) and write new LST orders, as appropriate.

d. For patients who have an assigned VA primary care team, the patient's primary care team must be notified of any change to the patient's LST plan. ***NOTE:*** *Notification can be accomplished by listing the primary care team contact as an "additional signer" on the progress note, or according to facility procedures for notification of the primary care team.*

e. A copy of the new or modified LST progress note must be offered to the patient (or surrogate). The progress note is offered to the patient (or surrogate) for informational purposes about their VA LST plan.

11. LIFE-SUSTAINING TREATMENT ORDERS:

a. **Orders to Implement an LST Plan.**

(1) To enter DNAR/DNR orders and all other LST orders, the practitioner must use the nationally standardized Life-Sustaining Treatment Order Set.

(2) Life-Sustaining Treatment orders do not automatically discontinue or expire based upon dates, timeframes, or patient movements (e.g., admission, discharge, transfer). Modification of the nationally standardized Life-Sustaining Treatment Order Set is not permitted.

(3) DNAR/DNR orders must not be automatically suspended prior to procedures that involve general anesthesia, initiation of hemodialysis, cardiac catheterization, electrophysiology studies or any procedures that pose a high risk of cardiopulmonary arrest. For any proposed exception to a DNAR/DNR order for a specific procedure, the practitioner must obtain oral consent from the patient or surrogate and write orders in CPRS to specify the procedure during which CPR should be attempted in the event of a cardiopulmonary arrest.

(4) As indicated in VHA Handbook 1004.04, the practitioner must offer the patient (or surrogate) state-authorized portable orders to translate a patient's LST plan into orders that will be honored in the community.

b. **Orders to Initiate a New LST.** Orders to initiate an LST are written separately from the Life-Sustaining Treatment Order Set, according to local protocols.

c. **Orders to Discontinue an LST.** Orders to discontinue an LST that the patient is currently receiving are written separately from the Life-Sustaining Treatment Order Set, according to local protocols.

12. HONORING PATIENTS' PREFERENCES REGARDING LIFE-SUSTAINING TREATMENTS:

a. **Decisions about Whether to Initiate an LST in Circumstances Other Than Cardiopulmonary Arrest.** When a patient has a clinical indication for a life sustaining treatment, the practitioner must determine whether the patient has an active LST plan and orders prior to initiating the treatment. ***NOTE:*** *Decisions about CPR are addressed in paragraph 12.c*.

(1) If the patient has active LST orders, the practitioner must determine if the patient's LST plan and orders preclude the use of the LST in question in the patient's current circumstances.

(a) If the patient's LST plan and orders do not preclude the use of the LST in the patient's current circumstances, the practitioner must obtain informed consent as specified in VHA Handbook 1004.01 prior to initiating the LST, unless the conditions required for an emergency exception are met. (See VHA Handbook 1004.01 and VHA Handbook 1004.04).

(b) If the patient's LST plan and orders preclude the use of the LST in the patient's current circumstances, the practitioner must honor the LST plan and orders and not

initiate the LST even in case of a medical emergency, unless there is evidence that the orders no longer represent the patient's preferences. If the orders no longer represent the patient's preferences, the practitioner must modify the patient's current LST plan as described in paragraph 10.

(2) If the patient does not have active LST orders, the practitioner must:

(a) Initiate and document a GoCC as described in paragraphs 5-7 and 9.

(b) Obtain informed consent as specified in VHA Handbook 1004.01 prior to initiating the LST, unless the conditions required for an emergency exception are met.

(3) If the decision is made to initiate an LST (other than CPR), the practitioner must write orders separate from the Life-Sustaining Treatment Order Set, according to local protocols.

(4) If the decision is made not to initiate the LST (other than CPR), the practitioner must:

(a) Offer supportive and palliative services, whether provided by the primary practitioner or palliative specialist, to ensure the patient's comfort and support of the patient's family. Services provided to ensure the patient's comfort do not include assisted suicide or euthanasia (see paragraph 13).

(b) Write orders for supportive and palliative services separate from the Life-Sustaining Treatment Order Set, according to local protocols.

b. **Decisions about Whether to Discontinue an LST in Circumstances Other than Cardiopulmonary Arrest.**

(1) If the patient or surrogate expresses a desire to discontinue an LST that the patient is currently receiving, the practitioner must either conduct a new GoCC and document the resulting LST plan in a new LST progress note, or confirm that the decision to discontinue the LST is consistent with the patient's goals and preferences and document the new plan in an addendum to the existing LST progress note and in new LST orders.

(2) If it is discovered that the patient has an active LST plan and orders that preclude the use of an LST that the patient is currently receiving, the practitioner must discuss the LST plan with the patient or the surrogate, if the patient lacks decision-making capacity, and either honor the LST plan and orders by discontinuing the LST or, if the orders no longer represent the patient's preferences, modify the LST plan and orders as described in paragraph 10.

(3) If the decision is made to discontinue the life-sustaining treatment, the practitioner must:

(a) Write orders to discontinue the LST separately from the Life-Sustaining Treatment Order Set, according to local protocols.

(b) Offer supportive and palliative services, whether provided by the primary practitioner or palliative specialist, to ensure the patient's comfort and support of the patient's family. Services provided to ensure the patient's comfort do not include assisted suicide or euthanasia (see paragraph 13).

(c) Write orders for supportive and palliative services separately from the Life-Sustaining Treatment Order Set, according to local protocols.

c. **Decisions about CPR.**

(1) CPR must be attempted on every patient who sustains a cardiopulmonary arrest, except when:

(a) A DNAR/DNR order is documented in CPRS; or

(b) The patient has valid state-authorized portable orders (SAPO) for DNAR/DNR (see VHA Handbook 1004.04); or

(c) The patient has given unequivocal verbal instructions not to use CPR; or

(d) During the emergency code response, the clinical judgment of the physician or resuscitation team lead determines that initiation or continuation of resuscitative efforts would be ineffective at restoring cardiopulmonary function to a level of viability or that continued efforts would have no chance of producing the patient's goals of care; or

(e) A qualified practitioner has pronounced the patient dead; or

(f) The patient manifests rigor mortis, dependent livedo, or other obvious signs of death.

(2) If a patient is found in cardiopulmonary arrest, and the patient's LST orders include a DNAR/DNR order:

(a) CPR must not be initiated and the resuscitation team must not be summoned.

(b) If CPR is initiated before it is known that the patient has a DNAR/DNR order, such efforts must be terminated as soon as the team becomes aware of the DNAR/DNR order.

13. ASSISTED SUICIDE AND EUTHANASIA: Assisted suicide (intentionally providing a prescription or other lethal agent for the purpose of enabling the patient to perform a life-ending act) and euthanasia, also known as mercy-killing (directly administering a lethal agent to a patient with the intent to mercifully end the patient's life), are prohibited in VA regardless of state law. Federal funds may not be used to pay for items and

services the purpose of which is to cause or assist in causing the suicide, euthanasia, or mercy killing of any individual. (See paragraph 18hh). This includes a prohibition on:

a. Payment (directly, through payment of Federal financial participation or other matching payment, or otherwise) for such an item or service, including payment of expenses relating to such an item or service; or,

b. Payment (in whole or in part) for health benefit coverage that includes any coverage of such an item or service or of any expenses relating to such an item or service.

14. NATURALLY ADMINISTERED NUTRITION AND HYDRATION:

a. Naturally administered nutrition and hydration (i.e., food and fluids taken by mouth, and provided by hand, spoon, cup, or straw) are part of the basic care offered to all patients.

b. Patients may, however, lose the desire to eat and choose to stop eating or drinking. Patients with decision-making capacity have the right to refuse to eat or drink and should not be force-fed.

c. In the case of patients who have lost decision-making capacity, reasonable attempts to provide the patient with food and fluids by mouth must be made unless one of the following conditions apply:

(1) The patient has a serious life limiting condition and made an informed, voluntary decision to stop eating and drinking prior to losing decision-making capacity;

(2) The patient repeatedly resists attempts to provide food and fluid by mouth; or

(3) The patient cannot effectively swallow or has a medical contraindication to food and/or fluid by mouth (e.g., the patient repeatedly chokes or gags or a swallowing assessment indicates that it would be unsafe for the patient to swallow) and the surrogate agrees that, under these circumstances, provision of food and fluids by mouth is disproportionately burdensome or inconsistent with the patient's goals of care.
NOTE: *If the patient lacks decision-making capacity, lacks a surrogate and has no active orders to withhold food and fluids by mouth, decision making regarding the withholding of food and fluids by mouth must be made according to the multidisciplinary process outlined in paragraph 8.*

15. RESOLVING INCONSISTENCIES OR CONFLICT REGARDING LIFE-SUSTAINING TREATMENTS:

a. In some cases, the patient who lacks decision-making capacity may have an active LST progress note and orders and one or more advance directive or SAPO with elements that are inconsistent. For any inconsistent elements, the information in the document with the most recent date generally supersedes the information in the prior document(s). When questions remain about inconsistencies between these documents,

consult the Ethics Consultation Service or the District Chief Counsel, as needed. ***NOTE:*** *See VHA Handbook 1004.02 for specific guidance regarding conflicting advance directives. See VHA Handbook 1004.04 for specific guidance on determining priority when a patient's advance directive and state-authorized portable orders are inconsistent*.

b. Conflicts regarding LSTs can occur between the practitioner and the patient or surrogate(s) when there is disagreement or lack of clarity about the medical condition or prognosis, the patient's values, goals, and preferences, or the appropriate LST(s) to meet the goals of care.

c. As a first step to addressing conflict, the practitioner must engage the patient (or surrogate), and members of the patient's health care team and family, if appropriate, in a GoCC.

d. The practitioner must document this discussion in a new LST progress note or as an addendum to an existing LST progress note. The practitioner must not write LST orders unless the patient or surrogate(s) consent to the LST plan. ***NOTE:*** *If the practitioner considers the surrogate to be clearly acting contrary to the patient's values and preferences or the patient's best interests, the practitioner must notify the Chief of Staff, or designee, and initiate a consult to the local Ethics Consultation Service, or the District Chief Counsel before implementing the surrogate's decision.*

e. If conflicts about LSTs cannot be resolved, the practitioner must consult the facility's Ethics Consultation Service. The facility's Ethics Consultation Service is encouraged to contact the National Center for Ethics in Health Care's Ethics Consultation Service at vhaethics@va.gov for assistance, particularly in cases that might potentially involve limiting or discontinuing an LST over the objection of the patient or surrogate.

f. The Ethics Consultation Service must document the consultation according to standard procedures and in an addendum to the LST progress note.

g. If the conflict is not resolved through the ethics consultation process, the facility Director must make a decision on behalf of the facility and follow the procedures outlined in the Veterans Integrated Services Network (VISN) clinical appeals process in VHA Directive 2006-057, VHA Clinical Appeals, or subsequent policy issue. To assist in this decision, the facility's Ethics Consultation Service must provide a written summary of the consultation to the medical facility Director with information generated by the ethics consultation.

h. Any decision by the medical facility Director to discontinue or limit an LST over the objection of the patient or surrogate must be based on at least one of the following criteria:

(1) The treatment is clearly inconsistent with prevailing medical standards or VA national policy or guidelines; or

(2) The treatment is clearly ineffective and has no chance of producing its intended physiologic effect (e.g., alleged cancer treatments with no substantiation for health care claims); or

(3) The treatment is clearly ineffective and has no chance of accomplishing the patient's goals of care; or

(4) The surrogate is making the decision and the treatment is clearly inconsistent with the patient's known values and preferences.

i. Before limiting or discontinuing an LST over the objection of the patient or surrogate, the facility Director must notify the National Center for Ethics in Health Care.

j. Prior to the writing of any contested order to limit or discontinue LST over the objection of the patient or surrogate, the medical facility Director must provide written notification to the patient or surrogate of the facility's final determination, informing the patient or surrogate of the plan to write the order and describing the VISN clinical appeals process as outlined in VHA Directive 2006-057, VHA Clinical Appeals, or current policy and their option to request a transfer of the patient to another facility. The order should only be written after the processes related to a clinical appeal or request for transfer have been concluded. ***NOTE:*** *Inter-facility transfer must be performed according to applicable criteria in VHA Directive 2007-015, Inter-facility Transfer Policy, or subsequent policy issue*.

k. Entering a DNAR/DNR or other order to limit or discontinue LST over the objection of a patient's surrogate should be reserved for exceptionally rare and extreme circumstances after thorough attempts to settle or successfully appeal disagreements have been tried and failed. In all such cases, contested LST orders may not be written unless the medical facility Director has authorized them on behalf of the facility.

16. CONSCIENTIOUS OBJECTION: A health care provider who concludes as a matter of conscience that he or she is unable to participate in carrying out a particular decision regarding LST may request to be relieved from participation in the patient's care. Before granting such a request, VA should consider the obligation of non-abandonment, which requires that: (a) the responsibility for the patient's care must be transferred to another health care provider of comparable skill and competency who is willing to accept responsibility for the patient's care; (b) the transfer does not cause undue burden on the patient; and (c) the transfer can be practical to accomplish given the existing resources. Consequently, if VA determines that a transfer cannot be accomplished, the request may not be granted. The transfer must be facilitated by the Service Chief, and the original provider must hand off the patient's care to the receiving provider. Care must continue until the receiving provider has accepted responsibility for the patient's care. Any conflict arising over the transfer of care must be referred to the facility's Ethics Consultation Service.

17. RESPONSIBILITIES:

a. **National Center for Ethics in Health Care.** The National Center for Ethics in Health Care is responsible for:

(1) Managing and updating this policy.

(2) Providing field support on the processes described in this document, to include: educational information, policy interpretation and clarification, ethics consultation upon request as described in paragraphs 8 and 15, and support services to local or VISN IntegratedEthics Programs.

(3) Providing support for implementation and maintenance of the LST Progress Note Template patch and building of the LST Progress Note title, Orders, and associated processes in the form of an installation guide and national teleconferences.

(4) Collaborating with the Employee Education System to develop and deliver training to support the implementation of clinical practices outlined in this Handbook.

(5) Collaborating with VHA Office of Information and Analytics to develop appropriate measures, metrics, and monitoring for implementation of requirements in this Handbook.

b. **Office of Information and Analytics.** The Office of Information and Analytics is responsible for collaborating with the National Center for Ethics in Health Care to develop appropriate measures, metrics, and monitoring for requirements in this Handbook.

c. **Medical Facility Director.** The medical facility Director is responsible for:

(1) Ensuring that the medical facility has fully implemented this Handbook within 18 months of publication. This includes ensuring that:

(a) The medical facility policy on LST is in alignment with this Handbook within 18 months of publication.

(b) The medical facility develops and implements a coordinated and well-timed plan with appropriate time dedicated to educate appropriate staff and bring about the significant practice change this policy requires. See the LST implementation guide and other resources at http://vaww.ethics.va.gov/Education/LST.asp. ***NOTE:*** *This is an internal VA Web site not available to the public.*

(2) Implementing procedures to ensure that the appropriate practitioner responsible for the patient's ongoing care initiates and documents a GoCC with patients consistent with the triggering events specified in paragraph 5.b.

(3) Implementing procedures to ensure that the patient's primary care team is notified that an LST plan has been written for the patient and of any changes to the patient's LST plan.

(4) Appointing a multidisciplinary committee for review of proposed LST plans for patients who lack decision-making capacity and have no surrogate, and ensuring that the required multidisciplinary committee review process is followed (see paragraph 8).

(5) Delegating decisions concerning multidisciplinary committee review of LST plans to the facility Chief of Staff or concurring with decisions by the facility Chief of Staff or requesting review by the District Chief Counsel (see paragraph 8).

(6) Addressing conflicts about life-sustaining treatment decisions as outlined in paragraphs 15.f.-j.

(7) Ensuring that local OI&T and Clinical Application Coordinators (CAC) collaborate to build, install and maintain IT resources related to this policy as follows: See LST resources for CACs and nationally standardized specifications at http://vaww.ethics.va.gov/education/LST/cac_his.asp. ***NOTE:*** *This is an internal VA Web site not available to the public.*

(a) Build a local progress note title, "Life-Sustaining Treatment," and link it to the national standard title, "Life-Sustaining Treatment Plan." This note title must be placed in the "Directives" progress note category so it will appear in the "Crises, Warnings, Allergies, Directives" (CWAD) postings on the CPRS cover sheet.

(b) Install and maintain the Life-Sustaining Treatment reminder dialog template managed by the National Center for Ethics in Health Care. This template must be linked to the "Life-Sustaining Treatment" note title.

(c) Build the Life-Sustaining Treatment display group for the Orders tab in CPRS.

(d) Set CPRS orders tab parameters so that the LST orders on the Life-Sustaining Treatment Order Set display group defaults to the top of the Orders tab and these orders are visible to all personnel with access to CPRS.

(e) Build and maintain orders on the Life-Sustaining Treatment Order Set that conform to nationally standardized specifications provided by the National Center for Ethics in Health Care.

(f) Ensure that active LST orders remain active until manually discontinued after an agreed upon change in LST plans between the practitioner and patient or surrogate.

(g) Ensure that active LST orders do not automatically discontinue or expire based upon dates, timeframes, or patient movements (e.g., admission, discharge, transfer).

(h) Ensure VistA business rules and user classes are created/used to restrict the entering of the GUI Template/Progress Note, "Life-Sustaining Treatment" to personnel as defined in paragraph 3.r. Also, ensure business rules and user classes are created/used to restrict the adding of addenda attached to this progress note by additional personnel to only those persons whose responsibilities would require them to enter an addendum to the LST Progress Note (e.g., members of the facility Ethics

Consultation Service) or whose job description or scope of practice would require them to or document changes requested by the patient/surrogate to the information in the LST Progress Note (e.g., Social Worker for documenting changes to a Durable Power of Attorney for Health Care). Access restrictions are only to be placed on entering information into the progress note, not on viewing.

(i) Ensure that active LST orders are not offered to users to be copied and included in event delayed orders (e.g., event delayed transfer orders).

(j) Ensure that national health factors associated with the LST Progress Note Template are not removed or modified.

(k) Ensure that LST orders are presented in appropriate ancillary software products (e.g., CIS/ARK, Shift Handoff Tool).

d. **Facility Chief of Staff and Associate Director for Patient Care Services (ADPCS)/Nurse Executive (NE).** The facility Chief of Staff and ADCPS/NE areresponsible for:

(1) Ensuring that all relevant personnel are appropriately trained and supported to implement and follow the policy, and held accountable for doing so. See the LST implementation guide and resources for clinical staff at http://vaww.ethics.va.gov/education/LST.asp. ***NOTE:*** *This is an internal VA Web site not available to the public.*

(2) Ensuring that the facility has protocols in place to ensure that supportive and palliative services are incorporated into discontinuation of LST when discontinuation is expected to result in the patient's death within a limited period of time (see paragraphs 12.a.(4) and 12.b.(3) and paragraphs 18.h. and 18.ee.

(3) Chief of Staff only per 38 CFR 17.32(f)(2): Reviewing and approving or disapproving in writing, recommendations from the multidisciplinary committee regarding LST plans that are deemed ethically unjustifiable or that limit LSTs for patients who lack decision-making capacity and have no surrogate, and communicating and documenting approval or disapproval in the patient's electronic health record. If the Chief of Staff does not accept the multidisciplinary committee's recommendation, the Chief of Staff must request review by the District Chief Counsel and consultation from the National Center for Ethics in Health Care.

e. **Service Chiefs.** Service Chiefs are responsible for, as established in this policy, facilitating the reassignment of the patient's care when the original provider requests to be removed as a matter of conscience.

f. **Licensed Independent Practitioners.** The licensed independent practitioner is responsible for:

(1) Initiating (or delegating, as in paragraph 5.a.) a GoCC with the patient (or surrogate) when clinically appropriate, including as specified in paragraph 5.b. and documenting the patient's goals of care and LST plan in an LST progress note.

(2) Documenting and implementing specific decisions regarding the initiation, limitation, or discontinuation of LSTs consistent with this policy.

(3) Ensuring that physician residents, non-LIP advanced practice registered nurses, and physician assistants who are delegated responsibility for conducting GoCCs are competent to do so and appropriately apprised of their responsibilities and boundaries regarding GoCCs, documentation, and implementation of orders regarding LSTs. See the LST resources for clinical staff at http://vaww.ethics.va.gov/education/LST/ClinicalStaff.asp. ***NOTE:*** *This is an internal VA Web site not available to the public.*

(4) Ensuring that treatment team members are informed about the patient's LST plan.

(5) Submitting (or delegating submission of) a recommended plan for LSTs to the multidisciplinary committee for review for patients who lack decision-making capacity and have no surrogate.

(6) Requesting (or delegating request of) an ethics consultation in cases of irresolvable conflicts between or among health care providers, patient (or surrogate), family members.

g. **Medical Facility IntegratedEthics Program.** The Facility IntegratedEthics Program is responsible for:

(1) Providing ethics consultation to any health care professional, staff, patient, or family who requests an ethics consultation regarding LST decisions.

(2) Providing members to serve on a multidisciplinary committee for review of cases regarding LST decisions for patients who lack decision-making capacity and have no surrogate (see paragraph 8).

(3) Establishing Ethical Leadership support for a health care culture that encourages practitioners to appropriately elicit, document, and honor specific decisions regarding the initiation, limitation, or discontinuation of LSTs.

h. **Medical Facility Multidisciplinary Committee.** The multidisciplinary committee is responsible for, as described in paragraph 8, considering the procedural and ethical validity of the recommended LST plan for the patient who lacks decision-making capacity and has no surrogate, and documenting and communicating its findings and recommendation.

18. REFERENCES:

a. Almack, K., Cox, K., Moghaddam, N., Pollock, K., & Seymour, J. After you: Conversations between patients and healthcare professionals in planning for end of life care. *BMC Palliative Care*, 2012;11(1), 15.

b. American Heart Association. Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science. *Circulation*. 2010;122 (18) supplement: 639-946.

c. Barnes S, Gardiner C, Gott M, et al. Enhancing patient-professional communication about end-of-life issues in life-limiting conditions: A critical review of the literature. *J Pain Symptom Manage*. 2012; 44(6):866-79.

d. Berlinger N, Jennings B, Wolf S. Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life. New York: Oxford University Press, 2013.

e. Clayton JM, Hancock KM, Butow PN, et al. Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers. *Med J Aust*. 2007;186 (12 Suppl):S77, S79, S83-108.

f. Connors AF, et al. A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) *Journal of the American Medical Association*. 1995;274(20):1591-1598.

g. Cook D, Rocker G. Dying with dignity in the Intensive Care Unit. *N Engl J Med*, 2014;370, 2506-14.

h. Davison SN, Rosielle DA. FAST FACTS AND CONCEPTS # 208: Clinical Care Following Withdrawal of Dialysis, October, 2008. Available at https://www.capc.org/fast-facts/.

i. Dresser R. Precommitment: A Misguided Strategy for Securing Death with Dignity. *Texas Law Review*, 2003; 81:1823.

j. Dy, S. Ensuring Documentation of Patients' Preferences for Life-Sustaining Treatment: Brief Update Review in Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices. March 2013. Agency for Healthcare Research and Quality, Rockville, MD. Available at http://www.ahrq.gov/research/findings/evidence-based-reports/ptsafetyuptp.html.

k. Fagerlin A, Schneider CE. Enough. The failure of the living will. *Hastings Center Report*. 2004;34(2):30-42.

l. Institute for Health Care Improvement. The Conversation Project. Available at: http://www.carenewengland.org/conversationproject/index.cfm and Conversation Ready. Available at http://www.ihi.org/offerings/Initiatives/ConversationProject/Pages/ConversationReady.aspx.

m. Heyland DK, Barwich D, Pichora D, Dodek P, Lamontagne F, You JJ, Tayler C, Porterfield P, Sinuff T, Simon J. Failure to engage hospitalized elderly patients and their families in advance care planning. *Journal of the American Medical Association: Internal Medicine*, 2013; 173(9): 778-787.

n. Jesus JE, Allen MB, Michael GE, Donnino MW, Grossman SA, Hale CP, Breu AC, Bracey A, O-Connor JL, Fisher J. Preferences for resuscitation and intubation among patients with Do-Not-Resuscitate/Do-Not-Intubate orders. *Mayo Clinic Proceedings*, 2013; 88(7): 658-665.

o. Kaldjian, L. C., & Broderick, A. Developing a policy for do not resuscitate orders within a framework of goals of care. *Joint Commission Journal on Quality and Patient Safety/Joint Commission Resources*, 2011;37(1), 11-19.

p. Kaldjian LC, Curtis AE, Shinkunas LA, Cannon KT. Goals of care toward the end of life: a structured literature review. *American Journal of Hospice and Palliative Medicine*. 2008;25(6):501-11.

q. Lynn J. Reliable and sustainable comprehensive care for frail elderly people. *JAMA*, 2013, 310(18), 1935-36.

r. National Quality Forum, National Priorities Partnership. Priorities for the National Quality Strategy. 2011. Available at https://www.qualityforum.org/Setting_Priorities/NPP/Input_into_the_National_Quality_Strategy.aspx.

s. National Quality Forum. NQF-Endorsed Quality Standards, #1626, Patients admitted to ICU who have care preferences documented. Available at http://www.qualityforum.org/measures_reports_tools.aspx.

t. National Quality Forum. Safe Practices for Better Healthcare 2010 Update: A Consensus Report. Available at www.qualityforum.org/Projects/Safe_Practices_2010.aspx.

u. Quill TE. Initiating end-of-life discussions with seriously ill patients: addressing the “elephant in the room.” *Journal of the American Medical Association*. 2000;284:2502-2507.

v. Sabatino CP. The evolution of health care advance planning law and policy. *Milbank Q*. 2010;88(2):211-39.

w. Schenker Y, Barnato, A. Expanding support for “upstream” surrogate decision making in the hospital. *Journal of the American Medical Association: Internal Medicine*, 2014; 174(3): 377-379.

x. Shalowitz DI, Garrett-Mayer E, Wendler D. The accuracy of surrogate decision makers: A systematic review. *Archives of Internal Medicine* 2006; 166(5):493–97.

y. VHA Directive 1036, Standards for Observation In VA Medical Facilities.

z. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

aa. VHA Handbook 1004.02, Advanced Care Planning and Management of Advance Directives.

bb. VHA Handbook 1004.04, State-Authorized Portable Orders (SAPO).

cc. VHA Handbook 1004.06, IntegratedEthics.

dd. VHA Handbook 1400.01, Resident Supervision.

ee. Von Gunten CF, Weissman DE., FAST FACTS AND CONCEPTS #33: Ventilator Withdrawal Protocol, # 34: Symptom Control for Ventilator Withdrawal in the Dying Patient, # 35: Information for Patients and Families About Ventilator Withdrawal, 2nd ed., March 2009. Available at https://www.capc.org/fast-facts/.

ff. Walling AM, Asch SM, Lorenz KA, Roth CP, Barry T, Kahn KL, Wenger NS. The quality of care provided to hospitalized patients at the end of life. *Archives of Internal Medicine*, 2010;170(12): 1057-1063.

gg. Weissman DE. Decision making at a time of crisis near the end of life. *Journal of the American Medical Association.* 2004;292:1738-1743.

hh. 38 USC 1707 and the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14401 et seq.).