5. Surrogate-Written Advance Directives

Introduction

The Subcommittee on Surrogate-Written Advance Directives was asked to consider whether surrogate decision-makers[1] should be permitted to write advance directives[2] for incompetent patients.[3] The primary charge was to determine whether such a policy would benefit the patient. Accordingly, the inquiry focused on two ethical issues: First, would such a policy increase the ability of the health care team and the surrogate to carry our the patient's wishes? Second, if the patient's wishes are not known, would such a policy better enable the surrogate and the health care team to act in the patient's best interest?

The question of whether surrogates should be permitted to write advance directives for incompetent patients has not been explored or debated in the bioethics literature. Further, very few states have enacted legislation pertaining to this issue.[4] Under VA policy, surrogates may make the decision to withhold or withdraw life-sustaining treatment for incompetent patients who are terminally ill. However, the policy does not address the extent to which surrogate decision-makers are permitted to make such decisions in advance. Surrogate instructions about life support are generally documented in the progress notes, but the patient's medical record is not routinely flagged to indicate the presence of these instructions.[5] The only exception is "Do Not Resuscitate" (DNR) orders.[6] Under VA policy, surrogates may consent to placement of a DNR order in the medical record of an incompetent patient who is terminally ill. The patient's DNR status is typically indicated on the outside of the medical record.

The current VA policy on advance directives[7] does not specifically state whether anyone other than a competent patient may execute a "VA Living Will", "Durable Power of Attorney for Health Care,"[8] or "Treatment Preferences Form." VA has historically interpreted this policy as permitting only the patient to execute an advance directive on his or her own behalf. When the proposal to allow surrogates to write advance directives on behalf of incompetent patients was debated before the VHA Bioethics Committee, members expressed widely divergent views. Some argued the proposed change would promote patient autonomy by allowing incompetent patients to exercise their right of self-determination through a surrogate. Others expressed grave concern that while such a policy might be clinically or economically expedient, it would not necessarily benefit the patient.[9] The substance of the debate is set forth below.

Discussion

Benefits of Allowing Surrogate Decision-Makers to Execute Advance Directives

The argument in favor of allowing a surrogate to execute an advance directive on behalf of an incompetent individual begins with the premise that, to the extent feasible, patients who lack decision-making capacity should be afforded the same rights and privileges as other VA patients. Allowing a surrogate to write an advance directive on behalf of an incompetent patient would further the goal of patient self-determination when the patient has expressed his or her wishes, but has not executed an advance directive form. A family member or guardian who is involved in the patient's care, and who knows what the patient would have wanted, could write an advance directive to that effect. Current VA policy concerning the withholding and withdrawal of life-sustaining treatment provides that the rights of 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. . .has not been previously executed." M-2, Part 1, Chapter 31, paragraph 31.06 (emphasis added). If a patient's right to direct the course of his or her medical treatment includes the right to make

certain decisions concerning future health care by an advance directive, then arguably it would be reasonable of VA to allow a patient to exercise that right through a surrogate.

VA policy expressly authorizes surrogates to make treatment decisions concerning life support for incompetent patients. The surrogate is responsible for making that decision based on his or her knowledge of the patient's wishes. In the absence of any reliable indication of what the patient would have wanted, the surrogate and the physician must decide what is in the patient's best interest. The criteria for making such a determination would not change if the surrogate were authorized to write an advance directive on the patient's behalf.

VA advance directives apply to limited situations, e.g., when the proposed treatment or procedure at issue involves life support. Even the VA Treatment Preferences form, which allows patients to give specific examples, e.g., "Life support may be discontinued if I am permanently unconscious," does not cover every contingency. The physician is required to get the surrogate's consent for any treatment or procedure related to the patient's ongoing medical care, including life support procedures not expressly covered in an advance directive. If there is a significant change in the patient's condition or new technology becomes available, the surrogate's prior treatment decisions may no longer apply.

When discussing treatment options for an incompetent patient who is terminally ill, the physician will often ask the surrogate about the use of life support procedures. If the physician is confident that the surrogate's response is based on reliable information about what the patient would have wanted, then the physician is obligated to comply with that decision. Except for DNR orders, surrogate instructions concerning the use of life support are not indicated on the face of the medical record. This increases the risk in an emergency setting that treatment will be initiated despite the surrogate's instructions to limit the use of extraordinary medical procedures. Although the surrogate may later request the withdrawal of life support, the patient's desire

not to undergo this type of procedure has been thwarted. One benefit of allowing a surrogate to execute an advance directive on behalf of the patient is that it would avoid circumstances where treatment is initiated contrary to the patient's wishes when the surrogate is not immediately available. An advance directive executed by the surrogate would ideally be indicated on the outside of the patient's medical record. Consequently, information provided by the surrogate about the patient's treatment preferences would be more accessible to the health care team.

Allowing surrogates to execute advance directives may encourage the physician and surrogate to discuss the question of life support before there is a need to make a specific treatment decision. Competent patients are encouraged to discuss their feelings about end-of-life decisions with their family members and physician well in advance. Similarly, surrogates should consider the question of life support before there is a need for this type of clinical intervention. Careful consideration of this subject before the surrogate has to decide to withhold or withdraw life support for a loved one is more likely to result in a decision consistent with the patient's wishes. A policy that permits surrogates to write advance directives may promote communication between the health care team and the surrogate about this sensitive subject. As a result, the surrogate is more likely to make a decision consistent with the patient's overall treatment goals and/or in the patient's best interest.

Potential Drawbacks to Allowing Surrogates to Execute Advance Directives

It is possible that the use of an advance directive may actually decrease, rather than increase, communication between the surrogate and the health care team. If the surrogate has prepared a written document detailing treatment preferences, the health care team may be tempted to rely on that document rather than contact the surrogate to discuss specific treatment issues. Such a practice may be convenient for the facility or for the surrogate, but it would not necessarily advance the patient's wishes or best interest. Advances in medical technology

may also alter the treatment scenario. Although the surrogate's decision may have been valid when the advance directive was written, the factual circumstances may have changed by the time the decision is implemented. In addition the patient's adaptation to his or her medical condition may have changed. The risk to the patient is that the health care team will implement a decision, based on outdated information, inconsistent with the patient's wishes or contrary to the patient's best interest. A "best interest" determination must be based on contemporaneous information.

In a typical informed consent discussion with the surrogate, the physician explains the effect of the proposed treatment or procedure given the patient's present condition. New information may cause the surrogate to rethink previous assumptions about what the patient would have wanted, or reconsider whether a proposed treatment is in the patient's best interest. Before implementing a decision to withhold or withdraw life support, the physician must be confident that the surrogate's decision is consistent with the patient's desires as indicated, e.g., by the patient's prior statements or religious philosophy. If there are no reliable indicators of the patient's wishes, the physician and surrogate must agree that the withholding or withdrawal of life support is in the patient's best interest. Their decision must be based on whatever information is available about the patient's subjective wishes. In addition, the physician and surrogate must consider the patient's diagnosis and prognosis and the nature and extent of the proposed treatment. This requires ongoing communication between the surrogate and the health care team. If the health care team relies solely on a written directive, its ability to gauge the accuracy or appropriateness of the surrogate's decision may be diminished. This circumstance lessens the opportunity of the health care team to assess the motivations for the surrogate's decision.

A different problem may result if a surrogate of higher priority comes forward after an advance directive has been executed on the patient's behalf. Problems may also develop if a subsequent surrogate is required to abide by decisions made by a previous surrogate. If that individual has died or relinquished his/her responsibilities as surrogate

some time ago, it may be difficult to determine the previous surrogate's rationale for making a particular treatment decision. This situation may be exacerbated if the subsequent surrogate has additional or conflicting information regarding the patient's wishes or best interest.

When a surrogate makes a decision on behalf of an incompetent patient, the surrogate is arguably acting as the agent of the patient. It is a well-established principle, under both common law and state law, that an agency relationship terminates with the death of the agent. A policy that allows a surrogate to dictate the course of the patient's medical treatment in a written directive that survives the surrogate's death may violate the basic principle of agency law noted above.

Conclusion

The committee strongly supports advance planning and coordination of decision-making between the surrogate and the health care team. The committee's discussion of surrogate-written advance directives focused on whether a policy that allows a surrogate to execute an advance directive on behalf of an incompetent patient would promote the ability of the health care team to either carry out the patient's known wishes or determine what is in the patient's best interest. The committee remains divided, however, on whether such a policy would promote the patient's wishes or best interest. The majority felt that the drawbacks outweighed the potential benefits. Furthermore, the novel nature of this issue, the absence of any discussion in the bioethics literature, and the limited scope of state legislation on the subject count against formalizing a VA policy on the issue at this time. The VHA Bioethics Committee expects to revisit the issue of surrogate-written advance directives in the future when existing policies on VA advance directives are revised.

Notes

1 **Surrogate decision-maker**: a person authorized under VA policy to make decisions on behalf of an incompetent patient.

2 **Advance directive**: specific oral or written statements made by a competent adult which provide direction as to that person's desires concerning the withholding or withdrawal of life-sustaining treatment (e.g., a living will or similar document) and/or specific written instructions as to who should make decisions regarding medical care in the event the individual is unable to do so, e.g., DPAHC (Durable Power of Attorney for Health Care).

3 **Incompetent patient**: an individual who lacks the capacity to formulate and/or communicate decisions concerning health care. This definition includes, but is not limited to, a person determined to be incompetent to make decisions concerning his or her person by a court.

4 As of January 1996, one state, Arkansas, allows surrogates to sign advance directives on behalf of minors or adults who lack the ability to make health care decisions. Three other states, Texas, New Mexico, and Louisiana, allow designated surrogates to complete advance directives on behalf of terminally ill minor children.

5 A survey of 15 VA medical facilities suggests that there is support for formalizing the process by which surrogates make decisions concerning life support for incompetent patients. Four of the facilities surveyed (Miami, Newington, Bedford, and Amarillo) use forms designed by their respective bioethics committees expressly for this purpose.

6 See VHA Manual M-2, Part 1, Chapter 30, "Do Not Resuscitate (DNR) Protocols."

7 See VHA Manual M-2, Part 1, Chapter 31, "Withholding and Withdrawal of Life-Sustaining Treatment."

8 Subcommittee members rejected the idea of allowing surrogates to

designate a health care agent under a DPAHC. If the surrogate or designated health care agent is unable or unwilling to make health care decisions for the patient, then the responsibility would fall to the next authorized surrogate under VA policy. See VHA Handbook 1004.1, "Informed Consent."

9 Three of the 15 VA medical facilities surveyed, Martinsburg, Portland, and Topeka,were strongly opposed to any policy change that would allow surrogates to write advance directives on behalf of incompetent patients.

Writers

Jane F. Joyner, R.N., J.D. - Chairperson

Many E. Bozeman, M.S.W.

Richard J. Dunne, M.A.

Julia S. Hysom, M.A., M.H.A.

William A. Nelson, Ph.D.

Ruth-Ann Phelps, Ph.D.

Angela Prudhomme, J.D.

Dorothy Rasinki-Gregory, M.D., J.D.