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# HEALTH CARE DECISION MAKING IN THE VETERANS HEALTH ADMINISTRATION: THE LEGAL SIGNIFICANCE FOR INFORMED CONSENT AND ADVANCE DIRECTIVES

Liliana Kalogjera Barry\*

## I. INTRODUCTION

Voluminous literature exists in both the medical and legal communities on health care decision making, whether it be in regard to advance directives or end of life decisions.<sup>1</sup> There is also a growing body of research and commentary assessing various facets of health care decision making in the Veterans Health Administration (VHA) of the United States Department of Veterans Affairs (VA).<sup>2</sup> There is, however, a relative dearth of

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1. See, e.g., examples cited herein, including Thaddeus Mason Pope, *The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self-Determination Act*, 9 HEALTH MATRIX 139, 156 (1999) (discussing existence of over a hundred publications pertaining to the Patient Self-Determination Act).

2. See, e.g., Kenneth A. Berkowitz, *End-Of-Life Decisionmaking in the Veterans Health Administration*, 9 HEC FORUM 169 (1997); Ruth-Ann Phelps, *VHA Policy-Related Clinical Ethical Issues*, 9 HEC FORUM 159 (1997); and Ladislav Volicer et al.,

literature, particularly legal literature, examining the legal significance of the fact that a patient makes health care decisions within the VA as opposed to alternative care settings that are subject to state law, e.g., private health care facilities. This article provides a background of the VA, an overview of relevant law pertaining to health care decision making, and a discussion of significant ways that health care decision making may differ between VA and non-VA facilities, focusing on Wisconsin law as an example.<sup>3</sup>

## II. BACKGROUND ON THE VHA

The U.S. Department of Veterans Affairs is a federal executive department<sup>4</sup> tasked with the mission described by Abraham Lincoln “[t]o care for him who shall have borne the battle, and for his widow, and his orphan.”<sup>5</sup> Stated statutorily, the VA’s purpose is “to administer the laws providing benefits and other services to veterans and the dependents and the beneficiaries of veterans.”<sup>6</sup> Although Congress formally established the Veterans Administration in 1930, its roots date back to a 1636 Pilgrim law that provided for colony support of disabled soldiers.<sup>7</sup> The VA “became a cabinet-level department in 1989” and provides a variety of benefits, including “pension, education, disability compensation, home loans, life insurance, vocational rehabilitation, survivor support, medical care, and burial benefits.”<sup>8</sup> The VA touches many Americans because of

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*Advance Care Planning by Proxy for Residents of Long-Term Care Facilities Who Lack Decision-Making Capacity*, 50 J. AM. GERIATRICS SOC’Y 761 (2002).

3. For purposes of this article, “non-VHA facilities” refers to non-VHA facilities outside of the federal government (e.g., excluding U.S. Department of Defense facilities).

4. 38 U.S.C. § 301(a) (2012).

5. *About VA*, U.S. DEP’T VETERANS AFF., [http://www.va.gov/landing\\_2\\_about.htm](http://www.va.gov/landing_2_about.htm) (last updated Feb. 17, 2012).

6. 38 U.S.C. § 301(b) (2012).

7. *History – VA History*, U.S. DEP’T VETERANS AFF., [http://www.va.gov/about\\_va/vahistory.asp](http://www.va.gov/about_va/vahistory.asp) (last updated Apr. 5, 2012).

8. *The Executive Branch*, THE WHITE HOUSE, <http://www.whitehouse.gov/our-government/executive-branch> (last visited Oct. 29, 2012).

its size; “About a quarter of the nation’s population — approximately 70 million people — are potentially eligible for V.A. benefits and services because they are veterans, family members, or survivors of veterans.”<sup>9</sup> In addition to other offices and agencies, the VA consists of three administrations: the National Cemetery Administration, the Veterans Benefits Administration, and the Veterans Health Administration.<sup>10</sup>

VHA, which serves over 8.3 million veterans annually, is the nation’s largest integrated health care system, consisting of 152 medical centers, approximately 1,400 community-based outpatient clinics, community living centers, Vet Centers, and Domiciliaries.<sup>11</sup> VHA employs more than 53,000 health care providers,<sup>12</sup> who provide care across the fifty states and in American Samoa, Guam, Puerto Rico, the Philippines, and the Virgin Islands.<sup>13</sup>

### III. OVERVIEW OF LAW PERTAINING TO HEALTH CARE DECISION MAKING

A basic primer on autonomy and informed consent, advance directives and the Patient Self Determination Act, and mental health advance directives helps provide the context for this article’s discussion of differences between VA and non-VA facilities.

#### A. AUTONOMY AND INFORMED CONSENT

The concept of autonomy is the focal point for law and ethics pertaining to health care decision making.<sup>14</sup> Autonomy

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9. *Id.*

10. 38 U.S.C. § 301(c) (2012).

11. *About VHA*, U.S. DEP’T VETERANS AFF., <http://www.va.gov/health/aboutVHA.asp> (last updated Oct. 5, 2011).

12. *Id.*

13. *Browse Veterans Health Administration Facilities by State*, U.S. DEP’T VETERANS AFF., [http://www2.va.gov/directory/guide/Allstate\\_flsh.asp?dnum=1](http://www2.va.gov/directory/guide/Allstate_flsh.asp?dnum=1) (last updated July 23, 2010).

14. See Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed*

means "personal self-governance" in the moral philosophy context and represents "freedom from external constraint and the presence of critical mental capacities such as understanding, intending, and voluntary decision-making capacity."<sup>15</sup>

Autonomy has legal roots in the United States Constitution. These roots include both the federally recognized right of privacy grounded in the Constitution and the Due Process Clause of the Fourteenth Amendment,<sup>16</sup> which prohibits a state from depriving "any person of life, liberty, or property, without due process of law."<sup>17</sup>

The Supreme Court articulated an individual's right "to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law" over a century ago.<sup>18</sup> In the health care arena, this right dictates that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ,"<sup>19</sup> which includes the right to refuse medical treatment.<sup>20</sup> The right to refuse treatment stems from the common law doctrine that touching another without consent or justification constitutes battery.<sup>21</sup> This right to make one's own treatment decisions does not end when an individual becomes incapacitated.<sup>22</sup>

The doctrine of informed consent is an extension of the right to refuse unwanted treatment that is both established in

*Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 434-35 (2006).

15. TOM L. BEAUCHAMP & LEROY WALTERS, CONTEMPORARY ISSUES IN BIOETHICS 22 (6th ed. 2003).

16. Carol J. Wessels, *Treated with Respect: Enforcing Patient Autonomy by Defending Advance Directives*, 6 MARQ. ELDER'S ADVISOR 217, 219-20 (2005).

17. U.S. CONST. amend. XIV, § 1.

18. *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (citing *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

19. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

20. *Cruzan*, 497 U.S. at 270.

21. *Id.* at 269.

22. *Id.* at 262 (holding that, while an incompetent individual may refuse treatment, the state may require clear and convincing evidence of the incompetent's wishes for such refusal).

common law<sup>23</sup> and codified in state statutes and/or regulations.<sup>24</sup> It has evolved from a relatively simple battery-based doctrine (i.e., one focused on unwanted touching) to a more nuanced, negligence-based doctrine (i.e., one focused on the affirmative obligations of a health care provider).<sup>25</sup> Under the doctrine of informed consent, a health care provider has the duty to obtain a patient's informed, voluntary consent for treatment, absent an applicable exception. Courts are split on the standard for informed consent, with about half of all states imposing a physician-based standard (i.e., requiring disclosure based on the perspective of what a "reasonably prudent practitioner" would discuss with a patient),<sup>26</sup> and the other half imposing a "reasonable patient" standard (i.e., requiring disclosure based on the perspective of what a reasonable patient would want to know from a provider).<sup>27</sup> Wisconsin, which imposes a reasonable patient standard, is one example of a state that, in addition to common law requirements,<sup>28</sup> has imposed statutory informed consent requirements to require a treating physician to "inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments."<sup>29</sup>

## B. ADVANCE DIRECTIVES AND THE PSDA

Advance directives are legal tools for extending patient autonomy in the event of decisional incapacity,<sup>30</sup> i.e., in the event the patient lacks decision making capacity. Through an advance directive, an individual expresses his/her preferences

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23. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

24. See, e.g., WIS. STAT. § 448.30 (2012).

25. BARRY R. FURROW ET AL., *HEALTH LAW* 347 (4th ed. 2001).

26. King & Moulton, *supra* note 14, at 430.

27. *Id.*

28. *Trogun v. Fruchtman*, 207 N.W.2d 297, 315 (Wis. 1973).

29. WIS. STAT. § 448.30 (2012).

30. Holly Fernandez Lynch et al., *Compliance with Advance Directives: Wrongful Living and Tort Law Incentives*, 29 J. LEGAL MED. 133, 134 (2008).

regarding health care, and the advance directive is used to guide treatment decisions when the individual is unable to make or express such decisions.<sup>31</sup> Advance directives include the living will and the durable power of attorney for health care. A living will or other "instruction directive" is "an advance directive in which a person establishes a list of guidelines for his or her future care, but does not appoint someone to carry out those instructions."<sup>32</sup> Examples of such guidelines include expressions of the individual's preferences with regard to tube-feeding and mechanical ventilation. A durable power of attorney or "proxy directive" "is an advance directive in which . . . a person is appointed to carry out the desired instructions or make decisions regarding the health care of the person executing the document."<sup>33</sup> The person named as proxy under a health care power of attorney is also known as a "surrogate decision-maker,"<sup>34</sup> "health care proxy or agent."<sup>35</sup> The agent has the duty to make decisions "consistent with the patient's previously expressed choices or best interests."<sup>36</sup>

Today all states have laws in place that recognize some form of advance directive.<sup>37</sup> However, that was not always the case. States began legal recognition of advance directives toward the end of the 1970s, but use of advance directives was relatively rare for their first decade of availability.<sup>38</sup>

The Patient Self-Determination Act<sup>39</sup> (PSDA) represented

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31. Wessels, *supra* note 16, at 218.

32. Werner Gruber, *Life and Death on Your Terms: The Advance Directives Dilemma and What Should be Done in the Wake of the Schiavo Case*, 15 ELDER L. J. 503, 504-05 (2007).

33. *Id.* at 505.

34. Pope, *supra* note 1, at 152.

35. BERNARD LO, *RESOLVING ETHICAL DILEMMAS* 90 (4th ed. 2009).

36. *Id.*

37. *Id.*

38. Pope, *supra* note 1, at 147.

39. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990) (codified in scattered sections of 42 U.S.C., including 42 U.S.C. § 1395cc (1990)).

Congress's attempt to increase the use of advance directives.<sup>40</sup> The PSDA imposes various obligations pertaining to advance directives on health care entities that receive Medicare or Medicaid funds,<sup>41</sup> and VA policy states that it "provides the model and context for VA policy on advance care planning."<sup>42</sup> These requirements include maintenance of written policies and procedures regarding adult individuals receiving treatment from the entity as follows:

(A) to provide written information to each such individual concerning –

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives . . . and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.<sup>43</sup>

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40. Maria J. Silveira et al., *Advance Directives and Outcomes of Surrogate Decision Making Before Death*, 362 NEW ENG. J. MED. 1211, 1212 (Apr. 2010).

41. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990) (codified in scattered sections of 42 U.S.C., including 42 U.S.C. § 1395cc (1990)).

42. *Advance Care Planning and Management of Advance Directives*, VHA HANDBOOK 1004.02 (Dep't Veterans Aff., Washington, D.C.), July 2, 2009, at 1 [hereinafter VHA HANDBOOK 1004.02].

43. 42 U.S.C. § 1395cc(f) (2012).

The PSDA defines “advance directive” as “a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.”<sup>44</sup> Although the PSDA does not create substantive rights with regard to advance directives, it sets forth procedures that “bolster” relevant state laws.<sup>45</sup>

In addition to the PSDA, the Uniform Health-Care Decisions Act of 1993 represents an attempt to promote advance directives through the law.<sup>46</sup> However, only seven states have incorporated this model into law, and they have done so with added restrictions (e.g., witness requirements).<sup>47</sup>

Despite attempts to increase the creation and use of advance directives, weaknesses or limitations of advance directives remain. Overall completion rates remain low, in the range of 18 to 36 percent for adults.<sup>48</sup> In addition, there are practical problems inherent in the creation of advance directives, and these problems can affect the overall quality of the resulting document. For example, due to the information asymmetry between health care providers and patients, patients may have erroneous understandings of the nature of various life-sustaining treatments, which could adversely affect their ability to express their preferences with regard to such treatments.<sup>49</sup> Once an advance directive exists, legal barriers may impede the implementation of an advance directive (e.g., state laws restricting a health care agent’s ability to act according to the

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44. *Id.*

45. Robert S. Olick, *Defining Features of Advance Directives in Law and Clinical Practice*, 141 CHEST 232, 233 (2012).

46. Charles P. Sabatino, *National Advance Directives: One Attempt to Scale the Barriers*, 1 NAELA J. 131, 132 (2005).

47. *Id.*

48. OFF. DISABILITY, AGING & LONG-TERM CARE POL’Y, U.S. DEP’T HEALTH & HUMAN SERV., *ADVANCE DIRECTIVES AND ADVANCE CARE PLANNING: A REPORT TO CONGRESS* 13 (2008).

49. LO, *supra* note 35, at 91.

principal's wishes), such as some of the examples discussed herein.<sup>50</sup> There also may be uncertainty associated with interpreting vague language, as in the case of the patient who requests no "heroic" or "extraordinary" treatment.<sup>51</sup> In addition, the disappointing fact remains that even when a patient has an advance directive, the patient often receives care inconsistent with his/her expressed preferences.<sup>52</sup>

### C. MENTAL HEALTH ADVANCE DIRECTIVES

Mental health or psychiatric advance directives (MHADs) represent a subset of advance directives geared specifically toward mental health or psychiatric care. Whereas advance directives originally focused on end-of-life treatment decisions, MHADs serve "as a mechanism for enabling patients with severe mental illness to retain control over their psychiatric treatment in the event of a mental health crisis."<sup>53</sup> Examples of mental health treatment preferences include preferences with regard to medications, inpatient mental health treatment, and electroconvulsive therapy.<sup>54</sup> Like other advance directives, MHADs may be in the form of a living will (i.e., to state particular treatment preferences), or in the form of a durable power of attorney for health care (i.e., to designate a proxy decision maker). MHADs may represent a section of a general advance directive for health care or a unique document specifically designated for mental health treatment preferences. MHADs may also take the form of a "Ulysses directive," which allows individuals "prospectively to bind themselves to treatment and override, in advance, their refusals during acute

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50. Wessels, *supra* note 16, at 225.

51. LO, *supra* note 35, at 91.

52. Lynch, *supra* note 30, at 137.

53. NAT'L ETHICS COMM. VETERANS HEALTH ADMIN., ADVANCE DIRECTIVES FOR MENTAL HEALTH: AN ETHICAL ANALYSIS OF STATE LAWS AND IMPLICATIONS FOR VHA POLICY 3 (2008).

54. VHA HANDBOOK 1004.02, *supra* note 42, at 3.

episodes of their illnesses."<sup>55</sup> In theory, a properly executed Ulysses directive or "contract" would represent the patient's informed consent for treatment that the patient may not revoke during a later period of incompetency.<sup>56</sup>

Proponents of MHADs highlight their advantages. In general, MHADs promote patient autonomy by providing individuals with a vehicle to control and take responsibility for their treatment.<sup>57</sup> MHADs may yield clinical benefits to patients such as the following: facilitating a patient's timely access to treatment that works for him/her;<sup>58</sup> "enhanc[ing] relationships between patients and mental health professionals and increas[ing] patients' adherence to therapy, . . . decreas[ing] the need for involuntary treatment, and reduc[ing] hospitalization rates for psychiatric patients."<sup>59</sup> Empirical data suggests that MHADs also serve an important communicative function by serving as a record of "medically relevant information that would assist doctors" during an individual's acute crisis, such as "medical conditions (e.g., diabetes) that could be masked by overt mental health symptoms (e.g., depression)."<sup>60</sup>

However, like all advance directives, mental health advance directives also have potential weaknesses. These include patient comprehension of applicable laws, the ability to predict one's feelings about future scenarios, and lack of access to MHADs.<sup>61</sup>

As of 2006, 27 states have legalized MHADs in some form.<sup>62</sup>

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55. Breanne M. Sheetz, *The Choice to Limit Choice: Using Psychiatric Advance Directives to Manage the Effects of Mental Illness and Support Self-Responsibility*, 40 U. MICH. J.L. REFORM 401, 403 (2007).

56. Roberto Cuca, *Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Directive Statute*, 78 Cornell L. Rev. 1152, 1153 (1993).

57. Eric B. Elbogen et al., *Effectively Implementing Psychiatric Advance Directives to Promote Self-Determination of Treatment Among People with Mental Illness*, 13 PSYCHOL. PUB. POL'Y & L. 273, 275 (2007).

58. *Id.* at 274; Sheetz, *supra* note 55, at 404.

59. NAT'L ETHICS COMM. VETERANS HEALTH ADMIN., *supra* note 53, at 3.

60. Elbogen, *supra* note 57, at 282.

61. *Id.* at 275.

62. Sheetz, *supra* note 55, at 408 (citing statutes from Alaska, Arizona, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Jersey, New Mexico, North

Of the remaining states, some have acted in the other direction, i.e., to “specifically limit the degree to which advance directives can be used to make decisions about mental health care.”<sup>63</sup>

A February 2008 Report by the National Ethics Committee of VHA highlights some of the significant features of state law treatment of MHADs.<sup>64</sup> First, some states require automatic expiration of MHADs, a requirement not seen for other advance directives, which typically expire upon revocation or upon a patient’s instructions.<sup>65</sup> An individual wishing to maintain a MHAD in one of these states would have to complete another MHAD each time after passage of the defined time period.<sup>66</sup> Second, to reduce possible coercion, many states restrict who may serve as a witness to MHADs, excluding individuals such as family members and treating providers.<sup>67</sup> Third, some state laws set forth “override provisions” that “give clinicians greater leeway *not* to follow a MHAD than they do with a general advance directive.”<sup>68</sup> For example, some states permit a provider not to follow a patient’s MHAD based on inpatient commitment, emergency, or if a provider determines a treatment is “essential.”<sup>69</sup> Fourth, a couple of states require a positive capacity assessment by a mental health provider as a prerequisite for executing a MHAD, a requirement that no states impose for execution of other advance directives.<sup>70</sup> Fifth, some states permit activation of a MHAD while a patient still has the capacity to make decisions.<sup>71</sup> Finally, some states permit revocation of a MHAD after the patient has lost decision-making

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Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Washington, and Wyoming).

63. NAT’L ETHICS COMM. VETERANS HEALTH ADMIN., *supra* note 53, at 3 (citing North Dakota and Wisconsin).

64. *Id.* at 3–4.

65. *Id.* at 4.

66. *Id.*

67. *Id.* at 5.

68. *Id.* at 6.

69. *See id.* at 7.

70. *Id.*

71. *Id.* at 8.

capacity, which is also true in many states for other advance directives.<sup>72</sup>

Since some states have rejected their use and others have not addressed their legality, MHADs appear to be more controversial and relatively new legal tools, whose impact is still evolving.

#### IV. HEALTH CARE DECISION MAKING WITHIN THE VA

##### A. APPLICABLE LAW

Based on authority rooted in the Supremacy Clause of the United States Constitution, the VA, a federal agency, is subject to federal law.<sup>73</sup> The Secretary of the VA, a presidential appointee, has broad authority and “is responsible for the proper execution and administration of all laws administered by the Department and for the control, direction, and management of the Department.”<sup>74</sup> Within the VA, the “primary function” of the VHA is “to provide a complete medical and hospital service for the medical care and treatment of veterans” as set forth by statute and pursuant regulations.<sup>75</sup>

Pursuant to this authority, the VA has its own specific regulations and policies that pertain to health care decision making. For purposes of this article, the central regulations are at 38 C.F.R. Section 17.32, which sets forth the VA’s general requirements for informed consent and advanced care planning.<sup>76</sup> The VHA’s National Center for Ethics in Health Care has primary responsibility for “the development and interpretation of VHA national policies on ethics in health care,” including “policies on informed consent for treatments and

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72. *Id.* at 9.

73. U.S. CONST. art. VI, cl. 2. *See also* *Ridgway v. Ridgway*, 454 U.S. 46, 54–60 (1981); *Johnson v. Maryland*, 254 U.S. 51, 57 (1920); *Ohio v. Thomas*, 173 U.S. 276, 283 (1899).

74. 38 U.S.C. § 303 (2012).

75. 38 U.S.C. § 7301(b) (2012).

76. 38 C.F.R. § 17.32 (2012).

procedures, ethical aspects of end-of-life care, advance care planning, state-authorized portable orders, disclosure of adverse events to patients, and financial relationships between VHA health care providers and industry.”<sup>77</sup> National policies that pertain to this article include VHA Handbooks on Informed Consent for Clinical Treatments and Procedures<sup>78</sup> and Advance Care Planning and Management of Advance Directives.<sup>79</sup> Local policies reiterate the national policies and often provide more specific guidance on implementation, sometimes incorporating relevant state law provisions. In addition, ethics consultation is available at both the local and national levels to provide guidance in situations involving VA requirements for informed consent and advance directives. Moreover, the VA’s Office of General Counsel (including its local Offices of Regional Counsel) provides legal services to the VA, including advice on legal issues pertaining to health care decision making.<sup>80</sup>

## B. INFORMED CONSENT

As discussed above, the legal doctrine of informed consent provides the foundation for one’s individual right to make health care decisions. The general mandate for VA regulations, under the applicable federal statute, is “to ensure that all medical and prosthetic research carried out and, to the maximum extent practicable, all patient care furnished under this title shall be carried out only with the full and informed consent of the patient or subject or, in appropriate cases, a representative thereof.”<sup>81</sup> The VA regulation governing informed consent and advance care planning provides the

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77. *Nat’l Ctr. for Ethics in Health Care*, VHA DIRECTIVE 1004 (Dep’t Veterans Aff., Washington, D.C.), July 29, 2008, at 2.

78. *Informed Consent for Clinical Treatments & Procs.*, VHA DIRECTIVE 1004.01 (Dep’t Veterans Aff., Washington, D.C.), Aug. 14, 2008 [hereinafter VHA HANDBOOK 1004.01].

79. VHA HANDBOOK 1004.02, *supra* note 42, at T-1.

80. *Id.* at 7, 14.

81. 38 U.S.C. § 7331 (2012).

definitions, policy, general requirements for informed consent and advance care planning, requirements for documentation of informed consent, requirements for surrogate consent, and requirements for special consent situations.<sup>82</sup> The national policies, VHA Handbooks 1004.01 and 1004.02, Informed Consent for Clinical Treatment and Procedures and Advance Care Planning and Advance Directives, respectively, mirror and specify the requirements set forth in 38 CFR Section 17.32.<sup>83</sup>

### 1. INFORMED CONSENT REQUIREMENTS IN THE VA

The VA provides expansive protections for patient rights in relation to informed consent, which the regulations define as “the freely given consent that follows a careful explanation by the practitioner to the patient or the patient’s surrogate of the proposed diagnostic or therapeutic procedure or course of treatment.”<sup>84</sup> VA patients have “the right to accept or refuse any medical treatment or procedure recommended to them.”<sup>85</sup> Although there are some exceptions (e.g., medical emergencies) within the VA, “all treatments and procedures require the prior, voluntary informed consent of the patient, or if the patient lacks decision-making capacity, the patient’s authorized surrogate.”<sup>86</sup> Oral consent suffices for some treatments, while others, e.g., those requiring sedation or anesthesia, require written or “signature” consent.<sup>87</sup> VA policy rejects the concept of “‘general’ or ‘blanket’ consent for medical treatment” and mandates that

82. 38 C.F.R. § 17.32 (2012).

83. NAT’L ETHICS COMM. VETERANS HEALTH ADMIN., *supra* note 53, at 2; VHA HANDBOOK 1004.02, *supra* note 42, at T-1, 6, 11, 12. There are distinct informed consent requirements for research that are beyond the scope of this article and not discussed herein. See, e.g., 38 C.F.R. pt. 16; *Requirements for Protection Hum. Subjects Research*, VHA HANDBOOK 1200.05 (Dep’t Veterans Aff., Washington, D.C.), May 2, 2012, at 56–65; *Assurance Protection for Human Subjects Research*, VHA HANDBOOK 1058.03 (Dep’t Veterans Aff., Washington, D.C.), May 10, 2007.

84. 32 C.F.R. § 17.32(c) (2012).

85. VHA HANDBOOK 1004.01, *supra* note 78, at 3.

86. *Id.* (emphasis in original).

87. 38 C.F.R. § 17.32(d) (2012). See also VHA HANDBOOK 1004.01, *supra* note 78, at 3.

the patient provide “separate consent for each treatment, procedure, therapeutic course of treatment for a particular problem or condition . . . or series of treatments (e.g., cycles of chemotherapy).”<sup>88</sup> The VA also requires a new informed consent process “(1) [i]f there is a significant deviation from the treatment plan to which the patient originally consented; or (2) [i]f there is a change in the patient’s condition or diagnosis that would reasonably be expected to alter the original informed consent.”<sup>89</sup> Heightened consent requirements apply in certain situations, including “unusual or extremely hazardous treatment or procedure,” and forced administration of psychotropic medication.<sup>90</sup>

VA regulations and policy provide specific requirements for the process of obtaining informed consent.<sup>91</sup> The standard for informed consent disclosure is a reasonable patient standard and requires that the practitioner “[p]rovide information that a patient, in similar circumstances, would reasonably want to know.”<sup>92</sup> The discussion must also include an explanation of the patient’s condition and the recommended treatment, expected risks and benefits, and reasonable alternatives.<sup>93</sup>

The informed consent process may only take place with a patient who has decision making capacity, which is presumed in the case of adults not adjudicated incompetent by a court of law.<sup>94</sup> In contrast to “competency” (a “legal determination made by a court of law that a patient has the requisite capacities to make a medical decision”) clinical evaluation determines decisional capacity.<sup>95</sup> VA policy defines decision-making capacity to include four faculties: understanding, appreciating,

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88. VHA HANDBOOK 1004.01, *supra* note 78, at 4.

89. *Id.*

90. 38 C.F.R. § 17.32(g) (2012).

91. 38 C.F.R. § 17.32(c) (2012). VHA HANDBOOK 1004.01, *supra* note 78, at 6–7.

92. VHA HANDBOOK 1004.01, *supra* note 78, at 6.

93. 38 C.F.R. § 17.32(c) (2012). VHA HANDBOOK 1004.01, *supra* note 78, at 7.

94. VHA HANDBOOK 1004.01, *supra* note 78, at 5–6.

95. *Id.* at 1.

formulating, and communicating.<sup>96</sup> Under VA requirements, the “practitioner who has primary responsibility for the patient” determines whether the patient has decision making capacity.<sup>97</sup>

## 2. IMPLICATIONS OF DIFFERING STANDARDS OF CARE

The existence of the VA’s informed consent requirements creates the possibility that the standard of care for informed consent under state law will differ from – and even conflict with – VA requirements. Although the VA and its providers have the legal authority to follow VA requirements pursuant to the Supremacy Clause, as discussed in Section IV.A, the differences between state law and VA requirements for informed consent may have implications for the VA’s liability under the Federal Tort Claims Act and for licensure of VA providers.

Wisconsin law provides an example of state law informed consent requirements that differ from VA requirements. The Wisconsin statute requires a treating physician to “inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments.”<sup>98</sup> However, this duty specifically excludes the following:

- (1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
- (2) Detailed technical information that in all probability a patient would not understand.
- (3) Risks apparent or known to the patient.
- (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
- (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
- (6) Information in cases where the patient is incapable

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96. *Id.* at 1–2.

97. 38 C.F.R. § 17.32(e) (2012). *See also* VHA HANDBOOK 1004.01, *supra* note 78, at 8.

98. WIS. STAT. § 448.30 (2012).

of consenting.<sup>99</sup>

Thus, many of the exceptions to the Wisconsin informed consent regulation differ from the VA informed consent requirements. For example, the VA requires description of “extremely unlikely” risks that “may result in death or permanent disability,”<sup>100</sup> while the Wisconsin provision permits omitting the information if it “might falsely or detrimentally alarm the patient.”<sup>101</sup> The Wisconsin provision’s language of “detrimentally alarm” may even hint at a physician’s potential liability under Wisconsin law for disclosing such information. Another example arises when a patient lacks decisional capacity and has a surrogate who has provided consent for a treatment or procedure. The VA requires the practitioner to “explain to the patient the treatment or procedure to which the surrogate has consented, if feasible,”<sup>102</sup> while the Wisconsin provision appears to reject such a duty.<sup>103</sup>

To the extent a patient wished to pursue legal action for a VA employee’s negligence with regard to informed consent (or any other aspect of medical malpractice), under the Westfall Act, the Federal Tort Claims Act (FTCA) would be the exclusive remedy for such an action, and the proper defendant would be the United States (i.e., not the individual employee).<sup>104</sup> The FTCA represents a limited waiver of sovereign immunity that allows suit against the United States for its negligent actions. Under the FTCA, other than pre-judgment interest and punitive damages, the United States is liable in the same manner and to the same extent as a private individual under like circumstances for negligent acts or omissions of any employee of the government while acting in the scope of employment.<sup>105</sup> The

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99. *Id.*

100. VHA HANDBOOK 1004.01, *supra* note 78, at 7.

101. WIS. STAT. § 448.30 (2012).

102. VHA HANDBOOK 1004.01, *supra* note 78, at 14.

103. WIS. STAT. § 448.30 (2012).

104. 28 U.S.C. §§ 2679(b)(1), 2679(d) (2012).

105. 28 U.S.C. §§ 2672, 2674 (2012).

law of the state where the tort occurred applies to determine negligence in a case brought under the FTCA.<sup>106</sup> In the case of a medical malpractice action based on the failure to meet the standard of care with regard to informed consent, state law would likely consist of common law and possibly codified provisions.

However, if a conflict of laws issue arose between federal and state law in a medical malpractice action based on compliance with VA requirements in the informed consent process, it is likely that the VA's waiver of sovereign immunity under the FTCA would not apply, and, therefore, the VA would not face potential liability under the FTCA. This is due to the fact that the FTCA provides the following "discretionary function" exception to the waiver of sovereign immunity:

Any claim based upon an act or omission of an employee of the Government, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation be valid, or based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of a federal agency or an employee of the Government . . .

. . .<sup>107</sup>

As discussed above, the VA's informed consent requirements are set forth in applicable statute, regulations, and corresponding policies, and, as such, it appears that the discretionary function exception would likely apply to an employee who acts pursuant to those requirements. The net result would be that a potential tort claimant would not be able to sue the United States or its employees based on compliance with the VA informed consent requirements. The author could locate no cases dismissing an individual's claim under the FTCA based on compliance with VA informed consent requirements in the face of a conflict between federal and state informed consent requirements. However, one court has indicated that the United

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106. 28 U.S.C. 1346(b) (2012).

107. 28 U.S.C. § 2680(a) (2012).

States would only face liability under the FTCA for negligence with regard to informed consent if state law imposed liability; i.e., failure to meet the VA informed consent standard set forth in 38 C.F.R. Section 17.32(a) would not suffice to waive sovereign immunity.<sup>108</sup>

Regardless of the VA's potential liability under the FTCA, however, there is also the corollary issue that VA providers must hold a valid state license in at least one state,<sup>109</sup> and some informed consent requirements may represent an exercise of a state's authority with regard to licensure of its professionals. For example, the Wisconsin informed consent statute is set forth under the Medical Examining Board subchapter of the Medical Practices Act.<sup>110</sup> The issue of how a state licensing body would resolve a potential conflict in this area is beyond the scope of this article and would likely depend on the specific state licensure requirement at issue and the clinical facts of a particular situation. However, in the event a state licensing body would pursue action against a VA provider's license based on compliance with VA informed consent requirements, the VA could argue that such compliance is protected by the Supremacy Clause and the VA requirements discussed in Section IV.A.

### C. ADVANCE DIRECTIVES

VA policy with regard to advance care planning is based on the following premises:

- (1) All adult patients who have decision-making capacity have the right to accept or refuse proposed medical treatments or procedures, regardless of the expected consequences; and
- (2) For patients who have lost decision-making capacity, the health care preferences they stated in

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108. *Welch v. U.S.*, 737 F. Supp. 2d 18, 30 n.14 (D. Me. 2010) (citing *Sea Air Shuttle Corp. v. U.S.*, 112 F.3d 532, 536 (1st Cir. 1997); *Dimmick v. Regents of the Univ. of Cal.*, 2006 WL 279350 (N.D. Cal. 2006).

109. 38 U.S.C. § 7402(b)(1)(C) (2012).

110. WIS. STAT. § 448.30 (2012).

advance need to be honored to the extent permitted by clinical and professional standards, and the law.<sup>111</sup>

The VA is committed to honoring patient preferences via “patient-centered care” and “shared decision making, an ongoing collaborative process between practitioners and patients or their surrogates.”<sup>112</sup>

In addition to recognizing its own advance directive forms, the VA recognizes “an advance directive that is valid in one or more States under applicable State law,”<sup>113</sup> which VA policy refers to as “State-Authorized Advance Directive[s],”<sup>114</sup> and the VA also recognizes U.S. Department of Defense (DOD) advance directives.<sup>115</sup> However, VA policy provides that such recognition of non-VA advance directives does not apply to “portions of an Advance Directive . . . that are not consistent with VA policy.”<sup>116</sup> The VA provides patients wide discretion in determining which state’s law to utilize when executing a State-Authorized Advance Directive; “applicable State law” can mean the law of the state where the advance directive was signed, the State where the patient now resides, or the State where the patient is receiving treatment.<sup>117</sup> VA policy explicitly prohibits the use of advance directives for decision making in the case of a patient who has decision making capacity.<sup>118</sup>

Acknowledging that VA advance directives may not bear legal weight outside of the VA, the VA permits patients to have a State-authorized advance directive, a VA advance directive, or both types of advance directives.<sup>119</sup> In doing so, the VA offers its patients greater freedom of choice with regard to advance directives than patients at non-VA facilities, who only have the

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111. VHA HANDBOOK 1004.02, *supra* note 42, at 1.

112. *Id.*

113. 38 C.F.R. § 17.32(h) (2012).

114. VHA HANDBOOK 1004.02, *supra* note 42, at 3, 10.

115. *Id.* at 3.

116. 38 C.F.R. § 17.32(h)(4) (2012).

117. 38 C.F.R. § 17.32(a)(iii) (2012).

118. VHA HANDBOOK 1004.02, *supra* note 42, at 2.

119. *Id.* at 10.

option to use advance directives recognized by state law. (Although most states have reciprocity provisions recognizing advance directives that are valid under the law of another state, such provisions typically limit the recognition to portions that do not conflict with that state's own law).<sup>120</sup> There are various ways that this freedom impacts patient choice, as discussed herein.

### 1. OVERVIEW OF VA ADVANCE DIRECTIVES

The VA advance directive form is VA Form 10-0137, VA Advance Directive: Durable Power of Attorney for Health Care and Living Will.<sup>121</sup> The VA advance directive includes a durable power of attorney for health care, which, like state forms, allows an individual to designate a person to make decisions for that individual in the event he/she is no longer able to do so.<sup>122</sup> The VA advance directive also contains a living will section that allows the individual to express specific treatment preferences, including those pertaining to life-sustaining treatments (e.g., cardiopulmonary respiration, mechanical ventilation, kidney dialysis, and artificial nutrition and hydration) and mental health preferences.<sup>123</sup>

The VA advance directive is perhaps most notable for what it lacks, namely some of the restrictions on patient choice that exist in State-authorized advance directives. The VA advance directive is relatively open-ended in both the power of attorney for health care and living will sections and, as such, allows patients to make certain decisions that may not be permitted under a State-authorized advance directive.

As indicated by the following, the VA advance directive's durable power of attorney for health care provides extremely

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120. Olick, *supra* note 45, at 234. See, e.g., WIS. STAT. §§ 154.11(9), 155.70(10) (2010).

121. VHA HANDBOOK 1004.02, *supra* note 42, at app. A.

122. *Id.*

123. *Id.*

broad discretion to the designated Health Care Agent:

If you get too sick to make decisions for yourself, your Health Care Agent will have the authority to make *all health care decisions* for you. This includes decisions to admit and discharge you from any hospital or other health care institution. Your Health Care Agent can also decide to *start or stop any type of health care treatment . . .*.<sup>124</sup>

In contrast to the VA form, some State-authorized advance directives limit the authority of the health care agent to make certain types of health care decisions. For example, the State of Wisconsin Power of Attorney for Health Care form contains numerous limitations including the following: 1) prohibiting a health care agent from consenting to various types of mental health treatment, including inpatient admission to an institution for mental diseases and electroconvulsive treatment; 2) prohibiting a health care agent from admitting the individual to a nursing home or community-based residential facility for a long-term stay unless the individual executing the form specifically grants the health care agent that authority; 3) prohibiting a health care agent from consenting to withholding or withdrawal of orally ingested nutrition or hydration unless provision of the nutrition or hydration is medically contraindicated *and* the individual specifically grants the health care agent that authority;<sup>125</sup> and 4) prohibiting a health care agent from making health care decisions for an individual who is pregnant unless she specifically grants the health care agent that authority.<sup>125</sup> Wisconsin law also imposes the same limitations on a health care agent designated under a power of attorney for health care form other than the state form,<sup>126</sup> i.e., one drafted by an attorney, as permitted under Wis. Stat. Section 155.30(2).<sup>127</sup>

The VA advance directive's living will is also broad in

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124. *Id.* (emphasis added).

125. WIS. STAT. § 155.30(3) (2012); STATE OF WIS., F-00085, POWER OF ATTORNEY FOR HEALTH CARE (Rev. June 2011).

126. WIS. STAT. § 155.20 (2012).

127. WIS. STAT. § 155.30(2) (2012).

comparison to some state forms. In addition to containing sections addressing preferences about life-sustaining treatments and mental health preferences, the VA advance directive's living will contains an open-ended section for additional preferences.<sup>128</sup> Examples include, "social, cultural, or faith-based preferences for care, or preferences about treatments such as feeding tubes, blood transfusions, or pain medications."<sup>129</sup>

The State of Wisconsin Declaration to Physicians (Living Will), in contrast, only addresses the use of life-sustaining procedures and feeding tubes in the event of a terminal condition or persistent vegetative state, and the applicable statute limits the scope of the State of Wisconsin Living Will to those treatment preferences.<sup>130</sup> Although the State of Wisconsin Power of Attorney for Health Care form provides a section for the individual to address other "desires, special provisions or limitations" not otherwise addressed in the document,<sup>131</sup> the State of Wisconsin Living Will does not provide such a section. Accordingly, individuals who wish to express treatment preferences not listed in the State of Wisconsin Living Will form may only do so through a health care agent. This limitation could restrict choice for isolated individuals who do not have a suitable, willing person to serve as a health care agent.

## 2. MENTAL HEALTH ADVANCE DIRECTIVES IN THE VA

With regard to MHADs, the VA's approach is notable for two reasons: 1) it provides patients the ability to execute a MHAD, a freedom that some states do not provide; and 2) it attempts to provide equal treatment for both MHADs and general advance directives, i.e., by rejecting some of the heightened restrictions and other special requirements imposed

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128. VHA HANDBOOK 1004.02, *supra* note 42, at app. A.

129. *Id.*

130. WIS. STAT. § 154.03 (2012); STATE OF WIS., F-00060, DECLARATION TO PHYSICIANS (Rev. Aug. 2008) (Wisconsin Living Will).

131. WIS. STAT. § 155.30(3) (2012); STATE OF WIS., F-00085, POWER OF ATTORNEY FOR HEALTH CARE (Rev. June 2011).

by some state laws.

The contrast between VA requirements and Wisconsin law with regard to MHADs illustrates the great potential significance of an individual's decision to engage in advance care planning within the VA as opposed to under state law. Under Wisconsin law, individuals are very restricted in their ability to engage in advance care planning for mental health treatment preferences. Wisconsin is one of the states that does not offer a mental health advance directive form. Furthermore, Wisconsin law imposes restrictions on the use of general advance directives that, essentially, prevent their use for mental health treatment preferences.

As discussed above, the VA gives a health care agent under a durable power of attorney for health care wide latitude to make treatment decisions. In particular, VA patients have the ability to designate an agent to make mental health treatment decisions that Wisconsin law would not permit, such as consent to inpatient mental health treatment and electroconvulsive therapy.<sup>132</sup>

The VA also provides patients the opportunity to express specific mental health treatment preferences in directive form in an open-ended section of the VA advance directive living will.<sup>133</sup> This section contains no limitations and offers the option to document any mental health treatment preferences, including but not limited to "medications that have worked for you in the past and that you would want again, or . . . mental health facilities or hospitals that you like and those that you don't like."<sup>134</sup> In contrast, Wisconsin law does not provide the opportunity to express mental health treatment preferences in its living will, which is limited in scope to preferences pertaining to life-sustaining procedures and feeding tubes.<sup>135</sup> Thus, VA

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132. WIS. STAT. § 155.20 (2012).

133. VHA HANDBOOK 1004.02, *supra* note 42, at app. A.

134. *Id.*

135. WIS. STAT. § 154.03 (2012).

patients who are Wisconsin residents have far greater latitude to control their mental health treatment decisions in the event they are no longer able to make those decisions for themselves.

In addition to offering patients broad discretion to engage in advance care planning with regard to mental health treatment preferences, the VA's policy on MHADs is generally one that avoids treating MHADs differently than general advance directives. For example, the VA has declined the following, which, as discussed above, represent some state approaches to MHADs: 1) requiring automatic expiration of MHADs; 2) imposing special restrictions on who may serve as a witness to a MHAD as compared with a general advance directive; 3) permitting providers to override MHADs in special circumstances that would not enable a provider to override a general advance directive; 4) imposing a capacity assessment requirement for execution of an MHAD; 5) permitting activation of a MHAD while a patient has decision-making capacity; and 6) imposing special restrictions on the revocation of MHADs that do not apply to general advance directives.<sup>136</sup> By rejecting such state law approaches, the VA affirms its policy as one that offers parity for mental health treatment as compared with general medical treatment and attempts to minimize the stigma that can accompany mental illness.<sup>137</sup>

### 3. REVOCATION OF ADVANCE DIRECTIVES

In addition to substantive differences in the content of advance directives, the VA may differ from state law on the issue of when a patient may revoke an advance directive. The applicable VA regulation states that, "[a] patient who has decision-making capacity may revoke an advance directive . . . at any time by using any means expressing the intent to revoke."<sup>138</sup> Since there is no provision addressing the right of a non-

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136. NAT'L ETHICS COMM. VETERANS HEALTH ADMIN., *supra* note 53, at 3–4.

137. *Id.* at 2.

138. 38 C.F.R. § 17.32(h)(3) (2012).

decisional patient to revoke an advance directive, it appears that the VA requires a patient have decision-making capacity in order to revoke an advance directive; the National Ethics Committee of the Veterans Health Administration has affirmed this interpretation.<sup>139</sup>

In contrast, Wisconsin law, like a majority of states,<sup>140</sup> permits an individual to revoke his/her power of attorney for health care and/or instructional advance directive (i.e., State of Wisconsin Living Will) "at any time."<sup>141</sup> A principal may revoke a power of attorney for health care via the following methods:

- (a) Canceling, defacing, obliterating, burning, tearing or otherwise destroying the power of attorney for health care instrument or directing another in the presence of the principal to so destroy the power of attorney for health care instrument.
- (b) Executing a statement, in writing, that is signed and dated by the principal, expressing the principal's intent to revoke the power of attorney for health care.
- (c) Verbally expressing the principal's intent to revoke the power of attorney for health care, in the presence of 2 witnesses.
- (d) Executing a subsequent power of attorney for health care instrument.<sup>142</sup>

The methods for revoking a Wisconsin living will are nearly identical to those for revocation of a power of attorney for health care, with the exception that Wisconsin law does not require two witnesses for verbal revocation of a Wisconsin living will but does impose a requirement of notification of the attending physician of the subsequent declaration.<sup>143</sup>

The Wisconsin statutes do not define "principal" (one who executes a power of attorney for health care) to require that the individual has decision-making capacity, and the corresponding statute setting forth the requirements for executing a power of

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139. NAT'L ETHICS COMM. VETERANS HEALTH ADMIN., *supra* note 53, at 9.

140. *Id.*

141. WIS. STAT. §§ 155.40(1), 154.05(1) (2012).

142. WIS. STAT. § 155.40(1) (2012).

143. WIS. STAT. § 154.05 (2012).

attorney for health care explicitly states that such individual must be “of sound mind,”<sup>144</sup> which one could reasonably interpret to include some capacity to make health care decisions. Given that the legislature chose to include the “sound mind” requirement for execution of a power of attorney for health care and *not* for revocation of a power of attorney for health care, it appears that there is no “sound mind” requirement for revocation. Rather, under a “plain meaning” interpretation of the statutory language addressing revocation, an individual may revoke a power of attorney for health care under Wisconsin law regardless of his/her decisional capacity (and regardless of whether his/her power of attorney is activated), provided that the individual is able to perform one of the acts of revocation listed in the statute;<sup>145</sup> this interpretation is consistent with the position of the Wisconsin Guardianship Support Center of the Coalition of Wisconsin Aging Groups.<sup>146</sup> Some of the methods listed in Sections (a) and (c) of Wisconsin Statute Section 155.40(1) are acts that could be relatively easy for an individual with no, or questionable, decision-making capacity to perform. For example, one could readily foresee a situation in which an individual lacks the mental capacity to weigh the risks, benefits, and other complexities of a health care decision but is able to deface a power of attorney for health care or verbally express the intent to revoke the power of attorney for health care in the presence of two witnesses. Due to the “sound mind” requirement for execution of a power of attorney for health care,<sup>147</sup> however, an individual lacking decisional capacity would likely not have the legal authority to revoke an existing power of attorney for health care by executing a new one.<sup>148</sup>

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144. WIS. STAT. § 155.05(1) (2012).

145. WIS. STAT. § 155.40(1) (2012).

146. COAL. OF WIS. AGING GRPS., REVOKING A POWER OF ATTORNEY FOR HEALTH CARE (2011), available at <http://cwagwisconsin.org/wp-content/uploads/2011/03/Revoking-a-Power-of-Attorney-for-Health-Care.pdf>.

147. WIS. STAT. § 155.05(1) (2012).

148. WIS. STAT. § 155.40(1) (2012).

The Wisconsin statutes do not define “declarant” as one who executes a Wisconsin living will. However, similar analysis applies, in that the statute for execution of a Wisconsin living will includes a “sound mind requirement,”<sup>149</sup> while the revocation statute does not.<sup>150</sup> Accordingly, it does not appear that a declarant must have decisional capacity to revoke a Wisconsin living will.

The fact that a nondecisional individual may revoke a power of attorney for health care under Wisconsin law and not under VA requirements can raise complex legal issues. In the case of a VA inpatient who lacks decisional capacity, it appears that such patient would not have the legal authority under VA requirements to revoke either a VA advance directive or a state authorized advance directive. As discussed above, in the event of a conflict between state law and VA requirements, VA requirements (which require decisionality for revocation) would control in terms of VA operations.

However, the issue becomes murkier in some cases. Consider the hypothetical case of an individual who receives care at the VA on an outpatient basis, whose advance directive has been activated (i.e., the patient has been deemed nondecisional), who subsequently commits an act of revocation under state law while in the community (i.e., outside of the VA), and then returns to the VA for care in a nondecisional state. While the revocation may be legally sufficient outside of the VA, it may be difficult to discern whether VA requirements permit or require the VA to honor the revocation.

As stated above, the VA imposes the condition that patients have decision-making capacity in order to revoke an advance directive. According to the proposed facts of the hypothetical scenario, it is unclear whether the patient had the capacity to revoke the advance directive. VA policy states that a patient is “presumed to have decision-making capacity unless an

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149. WIS. STAT. § 154.03(1) (2012).

150. WIS. STAT. § 154.05(1) (2012).

appropriate clinical evaluation determines that the patient lacks decision-making capacity, the patient is a minor, or the patient has been ruled incompetent by a court of law.”<sup>151</sup> Under VA requirements, the “practitioner who has primary responsibility for the patient” determines whether the patient has decision-making capacity.<sup>152</sup> Accordingly, in our example, it appears that the “practitioner who has primary responsibility for the patient” would determine whether he/she had the capacity to revoke the advance directive. Perhaps the patient has a condition (e.g., permanent brain damage) that the VA practitioner knows would have prevented the patient from having capacity at all times since the VA’s activation of the advance directive. Or, perhaps, the VA practitioner saw the patient in close proximity to the time of the revocation and determined that the patient lacked decision making capacity at that time. In such cases, the VA’s capacity requirement for revocation would appear to dictate that the VA not honor the revocation. This would create the result of the revocation having legal weight outside of the VA (i.e., at private facilities), but not in the VA system. Alternatively, the provider may be unable to determine whether the patient had the capacity to revoke the advance directive because the provider did not see the patient around the time of the revocation and/or the patient’s condition is one that results in fluctuating capacity, alternating between periods of nondecisionality and periods of lucidity. Under such facts, the VA requirements may call for the VA to honor the revocation based on the default presumption of capacity. The legal analysis for these types of situations is highly fact-specific, warranting a case-by-case legal analysis. Additionally, ethics consultation may also help to resolve these issues.

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151. VHA HANDBOOK 1004.02, *supra* note 42, at 12.

152. 38 C.F.R. § 17.32(e) (2012). *See also* VHA HANDBOOK 1004.02, *supra* note 42, at 3.

#### 4. DUAL ADVANCE DIRECTIVE SITUATIONS

The fact that the VA permits a patient to have both a VA advance directive and a State-authorized advance directive also can create interesting legal scenarios. VA policy provides that both valid advance directives apply.<sup>153</sup> However, in the event of a conflict, “the most recent one (as determined by examination of the date applied by the patient at the time the document was signed) prevails.”<sup>154</sup> While this approach for resolving conflicting advance directives may sound simple, complexities can (and do) arise. When comparing the VA advance directive with certain State-authorized advance directives, such as the Wisconsin forms, potential conflict is readily apparent and due in large part to the required, restrictive language embedded in the state form. For example, in the “Provision of Feeding Tube” Section, the Wisconsin Power of Attorney for Health Care form expressly states, “[m]y health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated,”<sup>155</sup> while the VA advance directive contains no such restriction.<sup>156</sup> Accordingly, a VA patient could execute a VA advance directive designating a health care agent under the durable power of attorney for health care section and indicate in the living will section that the patient refuses, under any circumstances, to receive nutrition and/or hydration via feeding tube. In the event the VA patient also executed a Wisconsin Durable Power of Attorney for Health Care form, the two forms would conflict and raise the challenge of discerning what the patient truly would have wanted.

It is important to note that the VA provision to honor the “most recent” valid advance directive does not always resolve conflicts between advance directives. Consider a VA social

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153. VHA HANDBOOK 1004.02, *supra* note 42, at 13.

154. *Id.*

155. WIS. STAT. § 155.30(3) (2012).

156. VHA HANDBOOK 1004.02, *supra* note 42, at app. A.

worker who, as part of the discharge planning process, assists a VA patient in completing both a VA advance directive and a State-authorized advance directive. The State-authorized advance directive offers the patient the advantage of its applicability outside of the VA, while the VA advance directive offers the patient broad latitude to express treatment preferences. The VA advance directive form, like some state forms, such as Wisconsin's, does not require or provide a field for the time when the individual executed the document. Unless the individual executing the document happened to note the time of signature or the social worker is available and recalls the execution of the advance directives, it may not be possible to tell which document is "most recent" and, therefore, controls.

#### D. SURROGATES

In addition to having a distinct advance directive form, the VA has its own framework for surrogate decision making. The VA defines Surrogate Decision Maker ("Surrogate") as an "individual, organization or other body authorized under this section to give informed consent on behalf of a patient who lacks decision-making capacity."<sup>157</sup> A surrogate "generally assumes the same rights and responsibilities as the patient in the informed consent process."<sup>158</sup> This delegation of authority is particularly broad in light of the VA's acknowledgment of all patients' "right to accept or refuse any medical treatment or procedure recommended to them."<sup>159</sup> Accordingly, a VA patient's surrogate assumes the position of the patient with substantial freedom to make health care decisions.<sup>160</sup>

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157. 38 C.F.R. § 17.32(a)(1) (2012). See also VHA HANDBOOK 1004.01, *supra* note 78, at 3.

158. 38 C.F.R. § 17.32(e) (2012).

159. VHA HANDBOOK 1004.01, *supra* note 78, at 3.

160. VA policy does provide, however, for certain checks on a surrogate's power, such as when a "practitioner considers the surrogate to be clearly acting contrary to the patient's values and wishes or the patient's best interests. *Id.* at 14. In those cases, "the practitioner must notify the Chief of Staff, or designee, and consult with the local Integrated Ethics program officer or Regional Counsel before

VA regulations and policy set forth the following Priority of Surrogates, who may provide informed consent on a patient's behalf:

- (1) Health care agent;
- (2) Legal guardian or special guardian;
- (3) Next-of-kin: a close relative of the patient eighteen years of age or older, in the following priority: spouse, child, parent, sibling, grandparent, or grandchild; or
- (4) Close friend.<sup>161</sup>

This hierarchy has multi-faceted legal significance. First, VA hierarchy contrasts with states that do not provide a list of surrogates, such as spouse and next of kin, who may make decisions for a patient in the event he/she did not designate a health care agent under a durable power of attorney for health care. Wisconsin is one such state. Under Wisconsin law, if a patient did not execute a durable power of attorney for health care, the patient's spouse would not have legal authority to make health care decisions for the patient absent judicial intervention (i.e., appointment as guardian of the patient's person).<sup>162</sup> In contrast, if the patient received care at a VA facility, the spouse would be the default decision-maker, with full legal authority to make treatment decisions for the patient, absent a health care agent or legal guardian.

Second, when compared with state law, the VA hierarchy may grant authority to individuals in a different order of priority than a particular state does. For example, Illinois law does not include "grandparent" in its hierarchy for surrogate decision making.<sup>163</sup> Thus, assuming no higher-level surrogates were available, a grandparent would have legal authority to make health care decisions for a VA patient but not for the same

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implementing the surrogate's decision." *Id.*

161. 38 C.F.R. § 17.32(e) (2012). *See also* VHA HANDBOOK 1004.01, *supra* note 78, at 13.

162. *See, e.g.*, COAL. OF WIS. AGING GRPS., AN OVERVIEW OF ADVANCE DIRECTIVES (2011), available at <http://cwagwisconsin.org/wp-content/uploads/2011/06/An-Overview-of-Advance-Directives.pdf>.

163. 755 ILL. COMP. STAT. 40/25 (2012).

individual in the event he/she received treatment at a non-VA facility in Illinois.

In addition, by including “close friend” in the list or surrogates, the VA provides individuals who are not related to the patient by blood or marriage the potential opportunity to make health care decisions for the patient. VA defines “close friend” as “[a]ny person eighteen years or older who has shown care and concern for the patient’s welfare; who is familiar with the patient’s activities, health, religious beliefs and values . . . .”<sup>164</sup> This provision may be of particular importance to significant others in the case of unmarried couples, who may not have any legal rights to make health care decisions in the absence of a durable power of attorney for health care under state law.

In the event no surrogate is available, the VA has its own unique process for making health care decisions for an incapacitated individual.<sup>165</sup> In such cases a VA facility may either obtain a guardian or adhere to the following process:

For treatments or procedures that involve minimal risk, the practitioner must verify that no authorized surrogate can be located. The practitioner must attempt to explain the nature and purpose of the proposed treatment to the patient and enter this information in the health record. For procedures that require signature consent, the practitioner must certify that the patient has no surrogate. The attending physician and the Chief of Service (or his or her designee) must indicate their approval of the treatment decision in writing. Any decision to withhold or withdraw life-sustaining treatment for such patients must be reviewed by a multi-disciplinary committee appointed by the facility Director. The committee functions as the patient’s advocate and may not include members of the treatment team. The committee must submit its findings and recommendations in a written

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164. 38 C.F.R. § 17.32(a) (2012). See also VHA HANDBOOK 1004.01, *supra* note 78, at 1.

165. 38 C.F.R. § 17.32(f) (2012). See also VHA HANDBOOK 1004.01, *supra* note 78, at 14.

report to the Chief of Staff who must note his or her approval of the report in writing. After reviewing the record, the facility Director may concur with the decision to withhold or withdraw life support or request further review by Regional Counsel.<sup>166</sup>

This process is significant because it provides a mechanism for decision making in non-emergency situations for patients who lack a surrogate without requiring judicial intervention. One legal commentator has described the benefits of this process as “conspicuously quicker, cheaper, and more efficient than the state guardianship process.”<sup>167</sup> Given the VA’s high population of homeless veterans and other veterans who may lack appropriate or available surrogates, this process provides a useful means to making decisions for incapacitated veterans in a manner that maintains respect and protections for such veterans.

## V. CONCLUSION

There are significant differences between VA and state law requirements pertaining to health care decision making. The examples highlighting Wisconsin law discussed herein represent just a small subsection of these differences, which will depend on the state law at issue. An individual’s decision to make health care decisions and engage in advance care planning within the VA or under state law can have significant impact on the choices available to that individual, the processes for decision making, and, thus, the clinical outcomes. Individuals eligible to receive care from the VA and health care providers who advise them should be aware of this impact and consider the differences between VA and state law when making health care decisions and participating in advance care planning.

In addition, while the use of VA forms may provide patients with increased freedom with regard to the expression of

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166. 38 C.F.R. § 17.32(f) (2012).

167. Casey Frank, *Surrogate Decision-Making for “Friendless” Patients*, 34 COLO. LAW. 71, 75 (2005).

certain health care preferences (e.g., mental health treatment preferences), the VA forms may not have legal recognition outside of the VA system, thus creating the potential need for a patient to also have a state-authorized advance directive. Dual directives, in turn, can raise potential conflicts both legally and in terms of patient preferences.

Individuals who provide care at the VA should be aware of the unique requirements governing practice within the Agency. The VA's authority pursuant to the Supremacy Clause gives the Agency wide latitude to follow these requirements. In the event of a potential conflict between VA requirements and state law, the VA has various resources to navigate such conflicts, including ethics consultation, the National Center for Ethics in Health Care, and the Office of General Counsel. However, additional legal discourse may be warranted to examine the potential conflicts associated with VA requirements and state law requirements (e.g., those pertaining to licensure), and future case law may illustrate the significance of these conflicts.