Advance Directives: Legal and Clinical Issues FAQ

Vermont’s advance directive law and rules were intended to make it easier for patients to use advance directives, and make it easier for health care professionals to find advance directives and DNR orders when they are needed to know what patients wishes are. The law includes a number of specific requirements that physicians, nurses, administrators, and other health care professionals need to be aware of.

Table of Contents
1. Advance Directives: Basic Concepts and Definitions
2. Executing Advance Directives
3. Capacity and Conditions: When does an Advance Directive Become Effective?
4. Using Patients’ Advance Directives
5. Incapacitated Patients: Objections to Treatment
6. Ulysses Clauses – Irrevocable Instructions
7. Amendment, Suspension, Revocation of Advance Directives
8. Vermont Advance Directive Registry (VADR)
   a. Requirement to check VADR
   b. Checking VADR - hospitals, physicians, nursing homes
   c. Requirement to report amendments, suspensions and revocations of advance directives to VADR
   d. Accessing VADR, access tracking, customer support
9. Clinician Orders for Life Sustaining Treatment (COLST) and Do Not Resuscitate (DNR) Orders
10. Probate Court Review of Advance Directives
11. Guardian and Agent Responsibilities
12. Penalties and Immunity
13. Advance Directives and Suicide
14. Advance Directives from Other States
15. Vermont Advance Directives – Treatment in Other States
16. Validity of Older Documents
17. Link to Advance Directive Law, Rules and Registry

1. Advance Directives Basic Concepts

What is an advance directive?

An advance directive is a written document, signed by an individual and two witnesses, that outlines the individual’s wishes for medical treatment in the future when he or she no longer can (or no longer wishes to) make decisions about what to do. It is what many people think of as a “living will,” or a “durable power of attorney for health care.”

What are some things an advance directive allows patients to do?

In an advance directive, a person can appoint an agent to make decisions about healthcare. A person can list whom he or she wishes to know about or be involved in
care, including a primary care physician. A person can describe what type of treatment he or she does or does not want when seriously ill or dying. Persons can express desires regarding pain medication and whether they wish to be treated at home if possible, rather than in a hospital or nursing home. In advance directives, people can express their wishes about being an organ donor. They can share wishes about funeral and other arrangements after their death, including designating someone to handle these things.

Who can serve as an agent?

An adult with capacity to make health care decisions.

Who may not serve as an agent?

The patient’s health care practitioner may not serve as agent. Owners, employees, agents and contractors for health care facilities, residential care facilities and correctional facilities where the patient resides or is receiving treatment at the time the advance directive is signed (executed), may not serve as agents unless they are related to the patient by blood, marriage, civil union or adoption. For example, hospital employees can serve as agents as long as unless the individual is not in the hospital receiving care when they sign their advance directive.

When does the agent’s authority begin?

Usually, the agent’s authority only begins when the person who created the advance directive is no longer able to make and communicate decisions about medical care, and a clinician has determined that the patient lacks capacity. However, the law allows people to say in their advance directive what event or condition would trigger the agent’s authority, even though a person still has the capacity to speak for himself or herself. A person can even specify that the agent’s authority is to begin immediately upon signing of the document.

Most people choose to continue to make their own decisions for as long as possible. In cases where the patient has capacity after the agent’s authority is triggered by a condition, the patient retains concurrent decision-making authority with the agent and in cases of disagreement, the patient’s decision controls.

What are the agent’s rights and responsibilities?

The agent will have access to all necessary medical records and the clinicians providing care to the patient, to help in gathering information about the circumstances, diagnosis and prognosis. An agent may also participate in meetings, discussions or conferences concerning the patient’s care, and may consent to disclosure of health care information to others as needed. Agents may also file complaints on behalf of patients.

The law includes a specific hierarchy for agents to follow when they make decisions for patients. If the advance directive includes instructions for care, the agent will be expected to follow the instructions and apply them to the situation at hand. If the advance directive is silent about the circumstances that the patient is in, the agent is
expected to weigh the benefits and burdens and to decide the way the patient would have. If that is uncertain, the agent is expected to do what is in the patient’s best interest.

The agent may not substitute his or her own interests, wishes, values or beliefs for those of the patient, and may not base decisions on the patient’s preexisting long-term disability or economic status. For example, an agent may not base a decision to withhold care solely on the fact that a patient is very poor or has had Down’s Syndrome since birth.

Is there only one copy of an advance directive?

No, there can be multiple copies. People creating advance directives should make sure that any agent named in the document has a copy of the document. Copies may also be provided to a hospital, nursing facility, physician, family member, pastor, neighbors, and close friends. The Department of Health has created an online advance directive registry for Vermont, the Vermont Advance Directive Registry (VADR) where people can store advance directive documents in a secure database that will be available to health care practitioners around the clock. Patients may also store a notice indicating that they have an advance directive and where it can be found in the registry instead of storing the complete document. See, the registry section of this FAQ for more information about the Vermont Advance Directive Registry (VADR).

Definition: What is meant by capacity?

Capacity means an individual’s ability to make and communicate a particular decision.

Capacity to make a health care decision means the patient has a basic understanding of the diagnosed condition, and the benefits, risks and alternatives to the proposed health care.

Capacity to appoint an agent means the patient has a basic understanding of what it means to have another individual make health care decisions and who would be an appropriate individual to make health care decisions and can identify a prospective agent to make health care decisions for him or her.

Definition: Who are considered to be “interested individuals” In online document, link back to this definition from the points in the document that reference the role that interested individuals play?

Interested individuals include the patient’s spouse or reciprocal beneficiary, the patient’s adult children, adult grandchildren, parents and clergy person. Interested individuals may also include other adults who have shown special care or concern for the patient and are personally familiar with the patient’s values.

2. Executing (Signing) Advance Directives

What are the requirements to execute (sign) an advance directive?
Only adults (18 years or older) with capacity may execute advance directives. The advance directive must be dated and signed by the patient in the presence of two or more adult witnesses. It can also be signed at the express direction of the patient by another individual who is in the patient’s presence. The patient’s agent and certain family members may not witness the advance directive. Health care professionals may serve as witnesses, but some facilities do not permit this as a matter of policy. The two witnesses must sign and affirm that the patient appeared to understand the nature of the document and to be free from duress or undue influence at the time the advance directive was signed.

**Can advance directives be executed upon admission to a facility?**

Yes. However, the nature and effect of the advance directives must be explained to the patient by an ombudsman, member of clergy, attorney licensed to practice in Vermont, or a probate court designee, and the person explaining the advance directive to the patient, must sign a statement to that effect. An advance directive signed in a facility will not be valid without this statement, so it should either be incorporated in the advance directive or attached to it. Hospitals (but not nursing homes or residential care facilities) may also designate staff, such as care managers or social workers, to explain advance directives to hospital patients and sign the statement. The law also requires hospitals to have enough individuals available to explain advance directives to patients. If an advance directive is executed while the patient is residing in or receiving care from a facility, employees of the facility may not serve as agents for the patient.

**Can health care professionals witness advance directives?**

Yes, health care professionals can act as witnesses. Close family members (parents, children, siblings or grandchildren), spouses, reciprocal beneficiaries and agents, may not serve as witnesses, however. Witnesses must be adults - over 18 years old.

**3. Capacity and Conditions – When does an Advance Directive become Effective?**

**When does an advance directive become effective?**

An advance directive becomes effective when the patient lacks capacity, as determined by a clinician, when a condition expressed in the advance directive is met (such as reaching a certain age or being diagnosed with a certain illness), or on a date specified in the advance directive.

**When does a Ulysses Clause (irrevocable instruction) become effective?**

A Ulysses Clause becomes effective when two clinicians determine that the patient lacks capacity.

**What are the responsibilities of the clinician who determines that a patient lacks capacity or becomes aware that a triggering condition specified in an advance directive has been met?**
Clinicians must speak with an interested individual, *(reference or link to definition here)* such as a family member, if one is reasonably available, as part of the capacity determination. Clinicians must document the cause, nature and projected duration of the lack of capacity in the patient’s medical record. A clinician must also make reasonable efforts to notify the patient’s agent or guardian that the advance directive has taken effect.

**How is capacity defined?**

Capacity means an individual’s ability to make and communicate a decision regarding an issue that needs to be decided.

Capacity to make a health care decision means the patient has a basic understanding of the diagnosed condition, and the benefits, risks and alternatives to the proposed health care.

Capacity to appoint an agent means the patient has a basic understanding of what it means to have another individual make health care decisions and who would be an appropriate individual to make health care decisions and can identify a prospective agent to make health care decisions for him or her.

**Who can request a re-determination of a patient’s capacity?**

The patient, agent, guardian, ombudsman, health care practitioner, a treating clinician or an interested individual, *(link to definition here)* such as a family member, may request that the patient be reexamined to determine whether the patient has regained capacity.

**What are the responsibilities of the clinician or designee, who reexamines the patient?**

The clinician must document the results of the reexamination in the patient’s medical record and make reasonable efforts to notify the patient, agent and guardian of the results. Consistent with the privacy requirements of HIPAA and state law, the clinician must also notify the person who requested the reexamination.

**What is the effect of a clinical finding that the patient has regained capacity?**

Generally, the advance directive would no longer be effective and the agent’s authority to make health care decisions would cease. If the advance directive was triggered by a condition (such as a certain diagnosis), the agent’s authority and the provisions of the advance directive could remain in effect. In such cases, a patient with capacity retains concurrent decision making authority with his or her agent (similar to how a pilot and co-pilot function), and in cases of disagreement the patient’s decision controls.

4. **Using Advance Directives**

Are health care practitioners and facilities required to inquire whether the patient has an advance directive?
Yes, before treating an incapacitated patient, except in an emergency, health care professionals and facilities must attempt to determine whether a patient has an advance directive. Now that the advance directive registry (VADR) is in place, they should have a protocol for checking the registry to determine whether the patient has an advance directive.

**Are health care practitioners and facilities generally required to follow advance directives?**

Yes, if they know that an advance directive is in effect, they must follow the instructions in the document, or the instructions of an agent or guardian who has authority to make health care decisions for the patient. Health care practitioners must attempt to inform the patient of a proposal to withhold or withdraw care.

**Are there situations in which health care practitioners can refuse to honor an advance directive or the instruction of an agent or guardian?**

Yes. Practitioners have to follow the instructions of an agent or guardian unless their instructions are inconsistent with the advance directive or the statute. Practitioners or family members who have concerns about an advance directive can apply to Probate Court for clarification.

Practitioners do not have to follow instructions of the agent, guardian or advance directive if it would cause the practitioner to violate criminal law or professional standards of conduct. In these cases, practitioners must inform the patient, agent or guardian of the reason for refusing and document the situation fully in the medical record.

Practitioners may also refuse in situations in which they have moral, ethical or other conflicts. In such cases, they must inform the patient and agent or guardian, assist in the transfer of care to another practitioner, provide ongoing care until a new practitioner is found and document the conflict, the steps taken to resolve it, and the final resolution in the medical record. Employees are only responsible to notify the employer of the conflict. The employer must then take the appropriate action to resolve the situation, but in the meantime, the employee may have an ethical or professional obligation to continue to provide care until another employee can be found.

**Do health care and residential care facilities have an obligation to review advance directives and notify patients if they cannot comply with instructions in the advance directives?**

Yes, facilities such as hospitals, residential care homes and nursing homes must review advance directives to determine whether the facility would be able to follow the instructions in the advance directive. Facilities must also make reasonable efforts to notify the patient and agent or guardian in advance if they will not be able to follow any instructions. Efforts to notify the patient and others should be documented in the chart.
If there is more than one agent named in an advance directive, can a practitioner just rely on the decisions of one?

Yes, if one agent informs the health care practitioner that there is agreement among all agents about the pending decision or agreement about which agent will make decisions or if other agents are not reasonably available. Such cases should be documented in the medical record.

What kinds of policies are practitioners required to have in place to address advance directives?

All health care practitioners, health care facilities and residential care facilities must develop protocols to ensure that:

- Advance directives and DNR orders are available when services are provided
- The existence of an advance directive or DNR order is prominently noted on the file jacket of a patient’s medical record or flagged in an electronic record
- Advance directives for individuals, not currently receiving care, but who anticipate future care, are accepted and stored
- The practitioner checks the Vermont Advance Directive Registry (VADR) before admitting or providing services to an incapacitated patient in order to determine whether the individual has an advance directive;
- Agents and guardians have the right to access patient records, participate in discussions about treatment and decisions, and file complaints
- The applicable requirements of the Patient Self-Determination act are followed. (See below.)

In addition, health care and residential facilities must also develop protocols to ensure that:

- Patients are asked if they have advance directives prior to or as soon as possible after admission and periodically while at the facility
- Advance directives are reviewed to determine whether the facility would be able to follow the instructions in the advance directive
- If the facility is unable to follow the instruction, steps are taken to notify the patient and agent, and to assist the patient to transfer to another facility that has the ability to follow the instruction
- Patients are encouraged and helped to submit their advance directives to the registry
- The facility has a consistent process to issue, revoke, and handle DNR orders
- Advance directives and DNR orders are transferred along with the patient when the patient moves from one facility to another

Are there penalties associated with the new requirements in the Vermont advance directive law?
Yes, practitioners and facilities are subject to review and discipline by licensing entities for failure to act in accordance with a known advance directive or instruction of an agent or guardian and for unauthorized accessing of the registry.

**Is there immunity for medical decisions made in reliance on the instructions of an agent or the information in an advance directive, DNR order or identification?**

Yes, there is immunity for health care professionals and facilities if the practitioner or facility has complied with the provisions of the chapter of the law on advance directives. The advance directive law includes a number of specific requirements on following advance directives, determining capacity, preparing DNR orders and establishing advance directive practice protocols.

### 5. Incapacitated Patients: Objections to Treatment

**Can a patient who does not have capacity object to care or to withholding or withdrawing care?**

Yes, patients may object to the provision of care or withholding/withdrawing care, despite the fact that they are incapacitated. As a general rule, health care professionals may not provide or withhold care over a patient’s objection, even if the patient’s objection is inconsistent with the instructions in their own advance directive or with their agent’s instructions. This provision has been part of Vermont law for many years and after much debate, the legislature retained it in 2005 in Act 55, but added two exceptions.

The first exception applies when the patient has created irrevocable instructions (also known as a Ulysses Clause) in his or her advance directive that authorize an agent to provide or withhold care over the patient’s objection. If the patient has an irrevocable instruction, or Ulysses Clause, the agent, after consulting with the patient if possible, may make health care decisions that override the patient’s objection. The agent’s decisions must be consistent with instructions expressed in the advance directive, the patient’s expressed wishes or the patient’s values or religious or moral beliefs.

The second exception applies when the patient would suffer serious and irreversible bodily injury or death within 24 hours if care is not provided. In these cases, if there is no available agent or applicable instruction in an advance directive, the clinician may provide such care over the patient’s objection. If the patient has specified an agent, and the agent is reasonably available, the agent’s authorization is required for the care to be provided.

### 6. Irrevocable Instructions (Ulysses Clause) – (Note: Requires Appointment of Agent)

**Can a patient include irrevocable instructions (a Ulysses Clause) in an advance directive – waive the right to refuse or request treatment?**
Yes, but the patient must prepare a special provision setting out the irrevocable instructions, sometimes referred to as a Ulysses Clause. A Ulysses Clause is a provision that is executed when an individual has capacity in anticipation of a time when he or she will lack capacity. For example, if patients know they are likely to refuse medication or other specific treatments when they are incapacitated, the Ulysses Clause could specify that the patient wants to receive the treatment even if they object at the time. If executed according to the specific provisions described below, when a patient lacks capacity his or her agent can make health care decisions over the patient’s stated objection and the clinician is obligated to follow the agent’s instructions. The provision in the Ulysses clause may refer either to providing care a patient is refusing or withholding care a patient is requesting.

**What are the required elements of a valid Ulysses Clause?**

- The patient must name an agent for the clause to be effective, and the agent must accept in writing the responsibility to enforce the Ulysses Clause over the patient’s objection.
- The patient’s clinician must sign the Ulysses Clause and affirm that the patient understands the risks, benefits and alternatives to the treatment specified in the Ulysses Clause.
- A lawyer, ombudsman, clergy person, probate court designee or hospital designee must explain the clause to the patient and affirm that the patient appeared to understand the provision and be free from duress or undue influence. (If the patient is in a hospital when the Ulysses Clause is executed, the explainer must be independent of the hospital.)
- The Ulysses Clause must specify the treatments that it covers and include a specific statement that the patient desires or does not desire the specified treatments even if he or she objects in the future.
- The clause may authorize the agent to consent to voluntary hospitalization, if expressly stated
- The clause may authorize delay of discharge from a hospital, Vermont State Hospital, for example, if expressly stated in the clause.
- Finally, the clause must include an acknowledgment that the principal is knowingly and voluntarily waiving the right to refuse or receive treatment at a time when he or she is incapacitated.

**When does a Ulysses Clause become effective?**

As an added safeguard, a Ulysses Clause only becomes effective when both the patient’s clinician and a second clinician have determined that the patient lacks capacity.

**What responsibilities do health care practitioners have with respect to Ulysses Clauses?**

Practitioners are required to notify the agent or guardian if a patient makes a decision or objects to care, if agent appears to have authority to override the patient’s decision.
As noted above, practitioners are required to make reasonable efforts to inform the patient of any proposal to withhold or withdraw health care. Practitioners must follow the instructions of the agent, provided the agent is appropriately following the hierarchy for making decisions for the patient by attempting to determine what the patient would have wanted under the circumstances as indicated by instructions in the advance directive, the patient’s expressed wishes, known values or religious or moral beliefs.

7. Amendment, Suspension, Revocation of Advance Directives

How can a patient amend or replace an advance directive?

A patient with capacity can amend or replace an advance directive by preparing a new written advance directive. The new document must be dated and signed in the presence of two adult witnesses, who cannot be relatives of the patient but may be health care professionals. The witnesses must sign and affirm that the patient appeared to understand the nature of the document and to be free from duress or undue influence at the time the amendment or new advance directive is signed.

If a patient amends or replaces an advance directive while in a hospital or nursing home, the new advance directive must be accompanied by a signed statement from an attorney, clergy person, ombudsman, probate court designee or hospital designee attesting that he or she has explained the effect of the amendment to the patient.

The patient should destroy copies of the previous document, or ask people who have copies to destroy them, to avoid confusion. Preparing a complete new advance directive and destroying all copies of older versions is the clearest way for patients to change their wishes. But only patients who have capacity can do this.

Can a patient suspend or revoke an advance directive?

Yes, a patient can revoke or suspend all or part of an advance directive. A suspension makes the advance directive inapplicable for a specific period of time or while a specific condition exists. A revocation cancels or repeals an advance directive indefinitely.

Can a patient revoke or suspend an advance directive if the patient does not have capacity?

Yes, in general, a patient may revoke or suspend their advance directive regardless of capacity. If a patient has executed a Ulysses Clause, he or she may only suspend or revoke that part of their advance directive if they have capacity. See section on Ulysses Clause above.

How can a patient suspend or revoke an advance directive?

A patient can suspend or revoke his or her advance directive including the designation of an agent by:
• Signing a statement that suspends or revokes all or part of the advance directive;
• Personally informing the clinician responsible for his or her care that he or she wishes to revoke or suspend the advance directive; (clinician documents suspension or revocation in chart); or
• Personally burning, tearing, or obliterating the advance directive or by expressly directing another person to do so.

A patient may also suspend or revoke any provision of an advance directive, other than the designation of an agent, orally, in writing or by any other act showing an intention to suspend or revoke.

A Ulysses Clause may only be suspended or revoked if the patient has capacity.

**What are the responsibilities of health care professionals, health care facilities and residential care facilities that become aware of amendments, suspensions and revocations?**

If a practitioner, hospital, nursing home or home health agency becomes aware of an amendment, suspension or revocation while treating an INCAPACITATED PATIENT they must make reasonable efforts to

- Confirm the suspension, amendment or revocation
- Record and flag the amendment, suspension or revocation in the patient’s medical record
- Notify the patient, agent and guardian
- Inform the Vermont Advance Directive Registry (VADR) of the amendment, suspension or revocation

If a practitioner, hospital, nursing home or home health agency becomes aware of an amendment while treating a patient WITH CAPACITY they must make reasonable efforts to confirm, record and flag the amendment. In addition, the health care professional, health care facility or residential care facility must assist the patient to notify the agent, guardian, family members, other interested individuals and the Vermont Advance Directive Registry (VADR) if the patient requests assistance. ([link to definition of interested individual here](#))

The Advance Directive law requires health care facilities and practitioners to develop procedures to maintain advance directives for patients who anticipate receiving care from the practitioner or facility in the future but who are not current patients. If a practitioner, hospital, nursing home or home health agency becomes aware of an amendment, suspension or revocation when they are not providing care to the patient, they must record and flag the amendment, suspension or revocation, and submit a notice of the amendment, suspension or revocation to the Vermont Advance Directive Registry (VADR).

8. **Vermont Advance Directive Registry (VADR)**
8(a) VADR and Requirement to Check VADR

What is the Vermont Advance Directive Registry?

The Vermont Advance Directive Registry (Registry) is a secure, web-based database where patients may submit their advance directive and other documents, such as amendments, or locator forms. Documents are scanned and electronically stored and may be accessed by clinicians either by internet or telephone.

When does the requirement to check the Registry become effective?

As of June 5, 2007, clinicians and facilities must have developed protocols that address the Registry and must check the Registry when treating a patient without capacity.

When must clinicians and hospitals check the Registry?

Health care facilities and clinicians must create protocols to ensure that the clinician or facility checks the Registry when a patient “without capacity is admitted or provided services” to determine whether the patient has an advance directive. 18 V.S.A. § 9709 (a)(3). The terms “admission” and “services” are not defined.

Does the Vermont Advance Directive law require clinicians and hospitals to check the Registry for all patients?

No, the Vermont Advance Directive law only requires them to check the Registry at the time patients without capacity are admitted or provided services. Other laws, rules, best practices or hospital policies may require hospitals or physicians to determine whether all patients have advance directives, and checking the Registry would be a tool that hospitals and clinicians may choose to use to meet those obligations.

8(b) Checking VADR – Hospitals, Physicians, Nursing Homes

How can hospitals implement the legal requirement to check the Registry?

Hospitals should check the Registry upon a patient’s admission to an inpatient unit, upon admission of a patient for observation purposes and in the emergency department prior to admission. Most, if not all, Vermont hospitals already have protocols in place for checking for advance directives for inpatient admissions. These protocols generally call for non-clinical staff who may not be qualified to determine capacity (such as staff at the registration desk) to ask about and obtain advance directives for patients. This basic process can be applied to enable staff to check the Registry for all patients, at the time of inpatient admission, admission for observation or in the emergency department prior to admission. While not required by law, checking the Registry for all patients at the earliest opportunity will ensure the patients’ advance directives are available, should they be needed at a later point in treatment, when the patient is unable to direct his or her care.
Must the Registry be checked for competent patients who will be undergoing general anesthesia or conscious sedation because they will temporarily and foreseeably lose capacity?

No. With respect to surgical procedures, when competent patients who have decisional capacity give their informed consent, there is no reason to check the Registry at that time. We recommend that hospitals and physicians have conversations with patients who will receive anesthesia or conscious sedation, addressing advance care planning, prior to the procedure. Hospitals and physicians are only required to check the Registry if the patient loses capacity subsequent to the procedure.

Are physicians and other clinicians required to check the Registry for inpatients, observation patients and patients in the emergency department, if hospital staff have already checked the Registry?

If hospital staff have checked the Registry, physicians treating a patient who has been admitted to an inpatient unit, admitted for purposes of observation or who is seen the emergency department, are not required to separately and additionally check the Registry, unless they have reason to believe that the patient has changed his or her advance directive since the hospital staff checked the Registry. Physicians providing services in hospitals will rely on the documentation regarding advance directives in the hospital medical record.

When are clinicians such as physicians obligated to check the Registry for patients being treated in hospital clinics and hospital outpatient services units?

Hospital clinics and hospital outpatient services units (such as same-day surgery) will create hospital protocols to ensure that the Registry is checked for all patients without capacity. Physicians practicing in these settings should become familiar with the facility’s protocol, and may rely on documentation in the medical record that the Registry has already been checked for that episode of care unless they have reason to believe that the patient has changed his or her advance directive since it was last checked. Protocols may require staff or clinicians to check the Registry for advance directives for all patients or to alert physicians or other clinicians if a patient appears to lack capacity.

When are clinicians such as physicians obligated to check the Registry for patients they are treating in their offices, in clinics, at home, or in other non-hospital settings?

Physicians and other clinicians must create protocols to ensure that the Registry is checked to determine if a patient has an advance directive before a clinician provides services to a patient, if the patient does not have the capacity to make decisions about his or her care.

What about nursing home patients without capacity coming to a physician’s office for care?
Like hospitals and physicians, nursing homes are required to have protocols that ensure that the Registry is checked for their patients at the time of admission or when services are provided. While in limited cases it may be permissible for a physician to rely on the nursing home’s protocol for checking the Registry, in most cases we recommend that the physician check the Registry to determine if the patient has an advance directive, in case something has changed since the Registry was checked by the nursing home. Physicians who work frequently and closely with nursing homes may wish to develop joint protocols with the nursing home, so that they will know whether the nursing home has checked the Registry recently and will not have to check it themselves every time they see a patient from the nursing home.

The advance directive law requires that a patient’s advance directive accompany the patient when the patient is transferred from one health care facility to another. However, it is not clear that the advance directive would be required to accompany a nursing home patient to a physician’s office or clinic. A physician practice could request that the nursing home send a copy of the Advance Directive with the patient, if it is available.

8(c) Reporting Amendments, Suspensions and Revocations of Advance Directives to VADR – When Required

What are the responsibilities for health care professionals, health care facilities and residential care facilities that become aware of amendments, suspensions and revocations?

1. **Incapacitated patient**: Any health care practitioner, health care facility, or residential care facility who becomes aware of an amendment, suspension, or revocation of a registrant’s advance directive while treating an incapacitated patient, **shall make reasonable efforts to notify the Registry** of the amendment, suspension, or revocation by completing and sending a Practitioner Notification, if the patient’s advance directive has been submitted to the Registry.

2. **Patient with capacity**: Any health care practitioner, health care facility, or residential care facility who becomes aware of an amendment, suspension, or revocation of a registrant’s advance directive while treating a patient with capacity, **on request shall assist the patient in notifying the Registry** of the amendment, suspension, or revocation, if the patient’s advance directive has been submitted to the Registry.

3. **Patient not currently receiving health or residential care**: Any health care practitioner, health care facility, residential care facility, not currently providing health or residential care to a registrant, which becomes aware of an amendment, suspension, or revocation of a registrant’s advance directive shall ensure that the Registry is notified of the amendment, suspension, or revocation by completing and sending a Practitioner Notification, if the patient’s advance directive has been submitted to the Registry.
How does a hospital or clinician notify the Registry that a patient has amended, suspended or revoked his or her advance directive?


Once the form is completed, it can be faxed or mailed to:

Vermont Advance Directive Registry (VADR)
523 Westfield Ave.
P.O. Box 2789
Westfield, NJ 07091-2789

Fax: (908) 654-1919

If during an individual episode of care a patient specifically asks that some component of their advance directive not be followed, does that constitute a “change” to the advance directive about which the Registry must be notified?

No. Hospitals and physicians need not inform the Registry unless a patient indicates that they wish to change their advance directive. Section 9707 (g) permits patients with and without capacity to make treatment decisions that override their advance directives, unless certain limited exceptions are met, (Ulysses clause, likelihood of serious harm within 24 hours).

8.(d) Accessing VADR, Access Tracking, Customer Support

How can I access the Registry?

Clinicians and hospitals may access documents in the Registry in several ways:

(1) Log into the Registry using the registrant’s ID number. (Unlimited 24/7 Internet access)

(2) Call the Registry’s toll-free number (1-800-548-9455) to request a copy of a registrant’s document. After verification, the Registry will fax the advance directive documents to a secure fax at the facility or clinician’s office. Emergency requests, received by phone, should be fulfilled within 30 minutes.

(3) Obtain an access account by becoming an authorized practitioner through the Vermont Department of Health. Authorized practitioners receive access codes which enable them to have unlimited 24/7 Internet access to the Registry to view and print their patients advance directives.

How can I become an authorized practitioner?

Authorized practitioners are required to submit an application form and a practitioner
access agreement to the Vermont Department of Health. More information and the forms are available at: http://healthvermont.gov/vadr/provider.aspx

Completed applications and agreements should be faxed or mailed to:

Vermont Advance Directive Registry
Vermont Department of Health
108 Cherry Street
P.O. Box 70
Burlington, VT 05402-0070
Fax: 802-652-4157

If you have questions about the authorized practitioner application or access agreement, you can contact the Department of Health by phone at 1-800-464-4343 or 802-863-7200.

Is there a “test” advance directive in the Registry I can use to familiarize myself with the system?

Yes. To view the “test” advance directive, use the following identifying information when prompted:
Name: John A. Doe
DOB: 04/24/1955
Registration # US2000005955

Can the Registry help hospitals and other authorized practitioners electronically store advance directives they may already have on file?

No.

Must each person who accesses the Registry have their own user name and password?

It depends. For security purposes and tracking purposes it is important to be able to identify each user individually, but there may be several ways to accomplish that goal. Some hospitals may be able to use the hospital user name and passwords to achieve the security and tracking goals rather than obtaining Registry user names and passwords for each individual.

Is hospital or clinician access to the Registry tracked?

It depends. When an advance directive is accessed on the website, the Registry tracks which registrant’s advance directive was viewed, when, and by which username. When an advance directive is accessed by phone, the Registry will maintain a record of that call.

However when the Registry is searched online, but no advance directive is found for the individual, no record of the search is maintained. When a hospital or clinician uses the patient's registration ID number (from the wallet card) to check the Registry the record
of the search will trace the access back to the registrant and not to the hospital or clinician.

**Should hospitals and clinicians note in the patient record that the Registry was checked?**

Yes. Given that there are some common situations in which the Registry cannot verify that it was checked, VAHHS and VMS recommend documenting that the Registry was checked in the medical record.

**How can I obtain customer support if I have trouble using the Registry?**

**EMERGENCY** support during non-business hours is available by calling 888-548-9455.

Routine help and questions are addressed by sending an e-mail message to the Registry address: support@uslivingwillregistry.com.

Business hours telephone support (Monday - Friday, 9 am - 5 pm EST) is available by calling 908-325-2525.

Non-business hours technical problems with the Registry can be addressed by calling 1-800-548-9455 and following the voice prompts to speak with representatives of the Registry.

More information is also available on the Registry website provider section [http://healthvermont.gov/vadr/provider.aspx](http://healthvermont.gov/vadr/provider.aspx)

**9. Clinician Orders for Life Sustaining Treatment (COLST) and Do Not Resuscitate (DNR) Orders**

**What is a Clinician Order for Life Sustaining Treatment (COLST) form?**

A COLST form is a treatment order form summarizing clinicians’ orders regarding life sustaining treatment.

**What can a COLST form be used for?**

The Vermont COLST form has two parts. The first page is a DNR order for use when the patient has no pulse or respiration. This DNR page includes all necessary legal certifications for a DNR order and can be completed and used without completing the remainder of the COLST form.

The second part of the COLST form may be used to address issues such as intubation, mechanical ventilation, artificially administered nutrition, transfer to hospital and other
Is use of the COLST form mandated?

No, use of the COLST form is not mandatory. Over time, it is expected that increasing numbers of clinicians and health care facilities in Vermont will use the form, and the form will be transferred with patients from one facility to another. Having one consistent form that is used in all parts of the state will make it easier for emergency services workers and health care practitioners and facilities to know quickly what patients’ wishes are with respect to life sustaining treatment.

Must a clinician complete all parts of the COLST form?

No, a clinician is not required to complete all parts of the form. The first page of the form, the DNR portion of the form, may be used on its own. It contains all information, certifications and signatures needed for a DNR order.

Similarly, the second part of the COLST form, which addresses life sustaining treatment such as artificially administered nutrition or intubation, may be used alone or in combination with the first page. In addition, not all sections of the second page need to be completed. So for example, for one patient a physician could complete the part of the second page of the COLST form which addresses intubation and artificial ventilation but not complete the sections of the COLST that address DNR orders or other types of life sustaining treatment. For another patient, a physician might only complete the DNR order portion of the page – the first page.

Any section of a COLST order that is not completed indicates only that the COLST order does not address that subject. It may be addressed in a patient’s advance directive or in other parts of the medical record.

How can I obtain a copy of the Vermont COLST form?
It is available as Attachment B to the Advance Directive Rules on the Vermont Department of Health Website.
http://healthvermont.gov/regs/ad/dnr_colst_instructions.pdf

What are the components of a DNR order?

A DNR order is a treatment order that must be signed by the patient’s clinician. The order must also include the name of the individual giving informed consent to the DNR order and specify that individual’s relationship to the patient. If the patient is in a health care facility or residential care facility, the DNR order should include a certification that the facility’s DNR protocol has been met. Finally the order must include a certification that the clinician has consulted or made effort to consult, with the patient and the patient’s agent or guardian.

May a DNR order be issued, based on medical futility, without consent?
Yes, provided that TWO clinicians certify that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest.

**What must be included in a health care facility’s DNR protocol?**

DNR protocols should include the specific legal requirements for DNR orders and any relevant facility procedures used to implement DNR orders. DNR Protocols must be made available on request.

**Can a clinician authorize DNR identification for a patient?**

Yes, a clinician who issues a DNR order may authorize issuance of a DNR identification, such as a bracelet or wallet card to the patient. A DNR identification is used to identify patients who have DNR orders. Contact information for organizations that provide DNR identification may be obtained from the Department of Health.

**Can patients revoke or suspend their DNR identification?**

Patients may suspend or revoke DNR identification by signing a statement, informing a clinician, destroying the identification or otherwise indicating their intent to suspend or revoke the DNR identification. Patients may not revoke DNR identification issued on the basis of medical futility.

**Must health care professionals and facilities honor DNR orders?**

Yes, unless they believe in good faith that the patient wishes to revoke the DNR order or that the patient is the wrong person, not the individual for whom the order was issued. In making a decision not to honor a DNR order, a clinician must consult with the agent or guardian if possible and document the basis for the decision in the patient’s medical record.

**Does a DNR order preclude all therapeutic interventions for the patient?**

No, a DNR order only precludes efforts to resuscitate the patient in the event of cardiopulmonary arrest and does not affect other therapeutic interventions that may be appropriate. A DNR order is only used when the patient has no pulse or no respiration.

**Do the advance directives rules mandate use of a particular DNR form?**

No, but the Advance Directives law mandates the content of a DNR order. The Department of Health’s Advance Directives rules include a model DNR form - the first page of the COLST form. The COLST form meets all requirements for DNR orders in the Advance Directives law and rules. The COLST form is included as attachment B to the Advance Directive Rules.

http://healthvermont.gov/regs/ad/dnr_colst_instructions.pdf

The intent of the legislators and the Department of Health in designing the model form was that having one form in use statewide would be easier for emergency services
personnel and health care practitioners. If a health care practitioner or facility uses another form, they should check that all requirements of the law and rules are met.

9. Probate Court Review

What issues concerning advance directives can be reviewed in Probate Court?

Probate courts can consider whether to revoke an advance directive on grounds that at the time the patient signed the advance directive, he or she did not have capacity to understand the nature of an advance directive, was under duress, or was the subject of fraud or undue influence.

Probate courts can also consider whether to reinstate an advance directive on grounds that the patient was under duress or the subject of undue influence or fraud at the time of the suspension or revocation.

Probate courts may construe the terms of an advance directive or construe the rights, legal status or legal relationship of the parties with respect to an advance directive.

Patients, agents or family members may challenge determinations that triggering conditions have been met.

Patients, agents or family members may challenge capacity determinations, provided certain procedural steps are taken.

Is an advance directive effective during probate court review?

Yes, if the advance directive is in effect, either because a condition has been triggered or a determination of incapacity has been made, it would remain in effect until the probate court ordered otherwise. Probate judges can issue emergency orders on request when there is a risk of harm occurring before notice and a full hearing can take place.

10. Responsibilities of Guardians and Agents

Do the instructions in an advance directive or the authority of an agent remain in effect after a guardian is appointed for a patient?

Yes, the authority of the agent remains in effect and the instructions in the advance directive remain valid, unless the probate court orders otherwise.

May a patient sign an advance directive after a guardian has been appointed?

No, a ward may not execute an advance directive after a guardian with authority to make health care decisions has been appointed.
11. Penalties and Immunity

Are there penalties associated with the new requirements in the Vermont advance directive law?

Yes, practitioners and facilities are subject to review and discipline by licensing entities for failure to act in accordance with a known advance directive or instruction of an agent or guardian and for unauthorized accessing of the registry. Also, as the protocols for use of advance directives are incorporated into medical practice, they will increasingly become part of the standard of care and subject to challenge as part of a negligence lawsuit.

Is there immunity for medical decisions made in reliance on the instructions of an agent or the information in an advance directive, DNR order or identification?

Yes, the law includes immunity for health care professionals and facilities if the practitioner or facility has complied with the provisions of the advance directives law. The advance directive law includes a number of provisions specifying how and when health care practitioners and facilities should follow advance directives, determine capacity, prepare DNR orders and establish advance directive practice protocols.

Can a clinician, health care practitioner, health care facility or residential care facility be sued or prosecuted for relying on an advance directive?

Health care practitioners and facilities are not subject to criminal or civil liability for relying in good faith on the provisions of an advance directive, a DNR order, or the direction of an agent or guardian. They are also immune from suit when they rely in good faith on a copy of an advance directive, if they are unaware that it has been suspended or revoked.

Can employees be subjected to disciplinary action for following the provisions of an advance directive?

No, employees may not be disciplined for relying in good faith on an advance directive or on an advance directive that has been revoked.

Can employees be disciplined for providing notice of a moral conflict to their employer?

No, as long as the employee informs his or her employer of the conflict and, if required by professional or ethical obligations, provides ongoing health care until another health care practitioner has been found to provide the services.

12. Advance Directives and Suicide

Is withholding or withdrawing life sustaining treatment considered to be suicide?
No, withholding or withdrawing life-sustaining treatment from a patient who has an advance directive that limits the provision of life sustaining treatment is not considered to be suicide.

13. Advance Directives from Other States

What law applies when a patient has an advance directive from another state?

Advance directives that are validly prepared in another state are effective in Vermont and may be relied on by health care professionals.

14. Vermont Advance Directives – Treatment in Other States

What law applies when a patient with a Vermont advance directive is being treated in another state?

Conflicts of law legal doctrine will determine which law applies to patients with Vermont advance directives receiving care in other states. The new Vermont advance directives law (Act 55 of the 2005 session) provides that advance directives will be interpreted under Vermont law to the extent possible.

15. Validity of Older Documents

Are the old standard Vermont documents — terminal care documents (living wills) and durable powers of attorney for health care (DPOAs)— still valid?

Yes, if the document was signed before September 1, 2005 and met the formal requirements (signed, dated, witnessed, etc.) in effect when it was prepared, the document remains valid. Health care practitioners may rely on these older documents to provide guidance and to authorize agents to make health care decisions for patients.

To be sure that advance directives accurately reflect wishes, individuals should review advance directive documents on a regular basis, no less than once every 10 years (decade birthdays). Documents should also be reviewed in other circumstances such as divorce, death or deterioration of a loved one, or when the individual has a new diagnosis. (Also known as the “5 Ds” – decade birthday, divorce, death, deterioration, and diagnosis.)

16. Links to Advance Directives Law, Rules and Registry

- Link to Title 18, Chapter 231 – Vermont Advance Directive Law: http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=231

• Link to Vermont Advance Directive Registry- Practitioner Information
  http://healthvermont.gov/vadr/provider.aspx

10/07