

HEALTH DECISIONS

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VEN Recruiting for Interim Executive Director

It is with mixed feelings that the VEN Board of Directors accepted John Campbell's resignation after 12 years of service at the helm of the organization. As VEN's executive director since 1996, John has led VEN through several signature projects including "Journey's End", which addressed end-of-life issues and the statewide wide Study Circles forums on the topic of "Access to Health Care for All Vermonters." More recently, John has been intimately involved in changes in the Vermont Advance Directive law, the Vermont Advance Directive Registry and the revised edition of VEN's booklet *Taking Steps* (11th edition). VEN's Board Chair, Patrick McCoy, expressed the feelings of the board of directors when he stated: "We are proud of the work VEN has accomplished under John's leadership and wish him the best in his next big venture." John has accepted the position as the Rutland Regional Manager for Vermont Adult Learning. "I will miss the many friendships, the collaboration, the mind-expanding consideration of ethical health care issues as well as the hands-on community workshops on Advance Directives and the new Registry," John said. "Though I will miss VEN a great deal, my new position will involve me directly in education and community improvement at the local level, both of which are very important to me at this point in my career. What I will not miss is the daily commute to Montpelier from my home in Chittenden."

The VEN Board is moving quickly to fill an Interim Executive Director position. This will be a time-limited contract term, subject to possible extension. To view a copy of the current job description, visit the VEN website at www.vtethicsnetwork.org or call VEN at (802) 828-2909. A letter of interest and a resume with references should be sent to:

Attn: Interim ED Search Committee
Vermont Ethics Network
64 Main Street, Room 25
Montpelier, VT 05602

...to be received no later than 4 pm on Friday, July 25, 2008.

"Having an AD means never having to say, 'I'm done!'"

The above paraphrase of a well-known quotation applies particularly well to Advance Directives. In the early days of the standard forms – the late eighties and early nineties – many people felt reasonably secure that if they had signed these documents: the Terminal Care Document (aka "Living Will") and the Durable Power of Attorney for Health Care - they were, in fact, done with this important piece of "getting their affairs in order." Many people still do. It is not rare to see documents that were signed and witnessed in Vermont in 1989 or earlier in other jurisdictions (a 1976 California Living Will is like a 1909 Lincoln penny!) Where situations have remained the same – the "agent" is still alive and living at the same address, for example – there may be no need to change. The brevity of the early Vermont DPOA/HC had much to recommend it and even dealt with the ubiquitous "feeding tube" choice in a fairly elegant way. But the intervening years have brought many important changes in the way we think about choices in health care and communication with family and caregivers. Here are some:

1. **There is now one document called an Advance Directive.** This is a significant improvement because it combines the important role of appointing an “agent” with the detailed instructions about care to be desired or not desired under different circumstances.
2. **Other people can be named for roles in health care decisions.** In addition to naming an “agent” and alternate agents, Vermont’s new advance directive law allows you to appoint co-agents or specify who should or should not be consulted about aspects of your medical care.
3. **Funeral and burial arrangements can be specifically addressed.** Vermont and a handful of other states have recognized that even after death it is important to have a way to communicate wishes concerning disposition of remains, and that it is logical to include these directions in the Advance Directive document itself.
4. **Specific Choices about some important choices are clarified.** People have more opportunity to consider options about choices, including feeding tubes, breathing machines, CPR and antibiotics – as well as directing that the “agent” be empowered to make particular decisions depending on the circumstances.
5. **The Vermont Advance Directive Registry stores and distributes copies.** One of the most important features of the new 2005 Vermont advance directive law was the establishment, through the VT Dept. of Health, of a voluntary “free” Registry for Advance Directives that stores copies of the Advance Directive and transmits them electronically to medical providers and others in emergencies.

Another good feature of the Vermont law is a clarification that any properly signed and witnessed document can serve as a valid Advance Directive. The older documents can still remain in force or documents from other jurisdictions can be substituted. Any changes can be made at any time – things as simple as address changes, for example – or a whole new document can be crafted based upon changing circumstances. The Elder Law Project came up with a handy list of times when documents might be or should be reviewed and, potentially, revised to give more up-to-date information. This list is called the **5 D’s**: They stand for the following:

Decade Birthday

Death of Someone Close

Diagnosis

Decline

Divorce

Each of these occurrences provides us with a wake-up call to revise our thinking about ourselves and our changing circumstances. Maybe nothing about our approach or beliefs, wishes or desires, will change as a result; on the other hand, we may be given a whole new perspective that changes our thinking dramatically. The last area of the list, “Divorce”, is especially important if we have appointed our former spouse as our health care agent. The law presumes that relationship to be ended with break-up of a marriage.

There is another “D” suggested by our state’s experience with writing a new law as well as with ever-present possibilities of medical knowledge and technology. It might be best encapsulated in the word: **Developments**.

For all these reasons, it is important to periodically find, dust off, re-read, and consider what we wrote, even just a few years ago, to be sure it still accurately reflects what we still want and who we want involved in our care. Our health is, fortunately or unfortunately, a dynamic system with other dynamic systems, changing families, cultural and spiritual beliefs, medical options and opportunities. To think that we are “done” when we finally sign a piece of paper is at best an illusion or, at worst, delusional thinking. Doing nothing is always an option, but staying involved and communicating changes to others who need to know is the “right way” to approach Advance Directives and what more properly has been called “advance care planning.” It’s like an insurance policy that needs updating every so often in order to be most beneficial based upon our changing needs and circumstances.

(This is a draft segment of a little booklet that is being planned and produced to assist volunteers and other workshop leaders or individual coaches who work with people on their Advance Directives. Other segments of the booklet will go into more detail on such topics as “Dealing with the Denial Factor” and the “Vermont Advance Directive Registry”. A limited number of these will be available. If you would like to be on a list to receive copies (at a small fee) please call the VEN Office or mail in the note at the end of this newsletter. Thank you! -JC)

Please send me when ready the planned booklet designed for AD Workshop leaders:

Little Guide to Advance Directives Workshops
(anticipated ready by October 2008)

Name: _____

Address _____

_____ Phone _____

email address: _____

(Optional): In advance I would like to send the enclosed donation to VEN _____

VENnotes and Musings -

Mark your Calendars: **The 27th meeting of the NH/VT Hospital Ethics Committee Network will be at Dartmouth Hitchcock in Auditorium G from Noon – 4 PM on Monday, September 22.** This meeting will be preceded by the Rural Ethics Network meeting from 10 – Noon at the same location.

(NYTimes article: July 8, 2008 Section D1 – **“Nurses Step Up Efforts to Protect Against Attacks”**) As reported in this issue of the Times, a number of studies have shown the increasing and alarming rate of physical abuse against nurses – often in settings where short staffing, stress and lax security combine to put them in jeopardy. “In a 2006 by the Emergency Nurses Association, a national group, 86 percent of respondents said they had experienced violence in the previous three years, and a fifth said they encountered it frequently.” We may feel less threatened in Vermont, but the issues of security and potential for violence against health care workers and personal care attendants is or should be of concern everywhere. There is also the ethical issue of addressing the needs of desperately ill or confused patients who may at times be violent – concerns that they not be abandoned at the same time we seek to protect nurses and other workers.

Unrepresented Patients – How big a problem is it? It is hoped that one issue the members of Vermont’s Rural Ethics Network and VEN might explore in the coming year is the extent to which there are patients and residents (particularly in nursing homes) who have nobody to represent them in critical care decisions. In other states the number ranges from 5 –20% but we have no idea to what extent it is a problem here.