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219 South Washington Street
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Dear Brian:

On behalf of the Patient Care Advisory Committee of the Shore Health System, you have requested my advice on two questions related to oral advance directives. The fact pattern is that an individual who lived in a nursing home is being treated temporarily in a hospital, with a return to the nursing home anticipated. During the hospital stay, the individual, who has capacity at the time, executes an oral advance directive. By the time of the individual's return to the nursing home, however, he or she has lost capacity. Hence, the oral advance directive would then become pertinent if, for example, it identified a health care agent or addressed a treatment issue such as code status.

I

Documentation

Your first question concerns documentation of an oral advance directive, to ensure that it remains in effect after the individual returns to the nursing home. The premise of your question is that, in accordance with the Health Care Decisions Act, the oral advance directive is properly documented in the patient's chart. However, your letter observes that "it is not always practicable for the chart entry to actually be sent along with the patient back to the nursing home upon discharge. In order for the oral directive to be honored by the nursing what documentation is required ...? Is there a difference in documentation if the oral directive alters a previously written directive as opposed to an entirely original directive given orally?"

The Act specifies the following four procedural steps for the proper execution of an oral advance directive: (1) It must be made in the presence of the patient's attending physician, for whom no other health care professional may substitute. (2) The patient's oral statement must be witnessed by someone in addition to the physician. (3) The substance of the statement must be documented in the patient's medical record. (4) The chart entry must be dated and signed by both the attending physician and the witness. § 5-602(d)(2) of the Health-General ("HG") Article, Maryland Code. An oral advance directive may be used "to authorize the providing, withholding, or withdrawing of any life-sustaining procedure or to

appoint an agent to make health care decisions for the individual." HG § 5-602(d)(1). A properly executed oral advance directive "shall have the same effect as a written advance directive." HG §5-602(d)(2).

The requirement that the oral advance directive be documented in the chart has two purposes. First, to the extent that the oral advance directive is to affect decision making during the same stay in which it was created, the chart is a logical place for health care professionals within the facility to become aware of its existence and apply it appropriately. Second, the chart entry can be copied, brought to the attention of other health care providers, and so affect care in other facilities.

Whether an advance directive is written or oral, a health care provider cannot be expected to rely on it based solely on a second-hand account of its contents. Especially if a life-sustaining procedure is to be withheld or withdrawn, the Act presupposes that the advance directive document itself will be reviewed, to reduce the risk of error about the patient's wishes. HG §§ 5-601(b) and 5-606(b). In the case of a written advance directive, the document is the form signed by the patient. In the case of an oral advance directive, it is a copy of the chart entry.

Thus, for an oral advance directive made at the hospital to be honored as such upon the patient's return to the nursing home, a copy of the pertinent chart entry needs to be made available to the nursing home, so that it can be incorporated into the patient's medical record there, just as a copy of a written advance directive would be. The hospital can facilitate this process by sending a facsimile of the chart entry. *See* HG §5-602(f)(2)(ii).

Your question appears to contemplate a situation in which information about the oral advance directive – for example, a reference to it in the discharge summary – reaches the nursing home before a copy of the chart entry. Such a summary may be useful in immediate decision making by the health care agent or surrogate, because it is reasonably reliable evidence of the patient's wishes, but "no one should rely on the summary once the actual advance directive is in hand. Any discrepancy between the summary and the advance directive is to be resolved by adhering to the latter." Letter to Jean Seifarth (June 22, 2000, available at http://www.oag.state.md.us/Healthpol/summaries.pdf.

If the patient had already made a written advance directive, it is all the more important that a copy of the chart entry be transmitted to the nursing home as soon as possible. While a written advance directive may be revoked or modified by an oral advance directive, HG §5-604(a), it has this effect only to the extent of an inconsistency between the former written directive and the later oral one. Consequently, access to the documented "substance of the oral advance directive" in the chart entry is crucial to understanding its impact.

II

Oral Advance Directive and PPOC Form

Your second question concerns the relationship between an oral advance directive and a Patient's Plan of Care (PPOC) form.[1] Your letter posits the situation in which a nursing

[1] Under an amendment effective October 1, 2007, the PPOC form will be renamed as the Instructions on Current Life-Sustaining Treatment Options form. Chapter 70 (House Bill 214), Laws of Maryland 2007. This change in nomenclature will have no effect on the analysis in this letter.

home resident with capacity completed a PPOC form. Later, while being treated in the hospital, the patient (still retaining capacity) makes an oral advance directive that contradicts aspects of the PPOC form. For example, the PPOC form might have indicated the patient's desire to be a "full code" – that is, to have resuscitation attempted in the event of a cardiopulmonary arrest. The oral advance directive, however, might decline life-sustaining treatment, including attempted CPR. According to your letter, when such a patient returns to the nursing home, having lost capacity since making the oral advance directive, some nursing homes "have challenged the validity of the physician in the acute setting altering a previously understood plan of care. Code status and even the EMS/DNR order executed in the acute care setting have been challenged ...." You ask about the documentation that is most likely to ensure compliance with the patient's wishes, as reflected in the oral advance directive.

When the patient completed the PPOC form at the nursing home, he or she was not executing an advance directive. The PPOC form is a summary of preferences about the use of life-sustaining treatments *under current circumstances*. That is quite different from an advance directive, which addresses, in an open-ended fashion, *future* decision making after loss of capacity. If the nursing home construes the PPOC form as itself an advance directive, it errs.[2]

Moreover, the patient's loss of capacity represents a significant change in condition from the circumstances that prevailed when the PPOC form was completed. Even if there were no intervening oral advance directive, the PPOC form would need to be reviewed. HG §5-608.1(c)(8). Under the circumstances, a new PPOC form should be completed by the patient's health care agent or surrogate, given the patient's loss of capacity, and preferences at that point must be consistent with the patient's oral advance directive. HG §5-602(f)(4)(i); COMAR 02.06.03.06B. For the reasons discussed in Part I above, consistency between the PPOC form and the oral advance directive requires that the nursing home obtain a copy of the chart entry containing the substance of the oral advance directive.

I hope that this letter of advice, although not to be cited as a formal opinion of the Attorney General, is fully responsive to your inquiry. Please let me know if I may be of further assistance.

Very truly yours,

Jack Schwartz
Assistant Attorney General
Director, Health Policy Development

[2] Even if the PPOC form were an advance directive, to the extent of an inconsistency between it and a subsequently made oral advance directive, the decisions in the latter control. HG § 5-604(a).