Facilitating End-of-Life Decisions: Advance Directives & MOLST

Thaddeus Mason Pope, J.D., Ph.D.
Wilmington VA Hospital
September 30, 2011

1. DE end-of-life care
2. Advance directives
3. Problems with ADs
4. MOLST
Treatment is unwanted.
71%: “More important to enhance the quality of life . . . even if it means a shorter life.”

National Journal (Mar. 2011)

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n=1006)</th>
<th>Professionals, % (n=774)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If doctors believe there is no hope of recovery, which would you prefer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life-sustaining treatments should be stopped and should focus on comfort</td>
<td>72.8</td>
<td>92.6</td>
</tr>
<tr>
<td>All efforts should continue indefinitely</td>
<td>20.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>
84% would trade length of life for quality of life

Harms from unwanted treatment
1. Harm to Patient
2. Harm to Family
3. Harm to Others
4. Harm to Society
Patients without capacity

Prospective Autonomy
Spouse
Adult child
Parent
Adult sibling

Advance Directives
PART II: POWER OF ATTORNEY FOR HEALTH CARE

A. DESIGNATION OF AGENT: I designate __________________________ as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonably available, to make health care decisions for me, then I designate __________________________ as my agent to make health care decisions for me.

(name of individual you choose as agent)

PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

I do not want my life to be prolonged if (please check all that apply)

_____ (i) I have a terminal condition (a incurable condition from which there is no reasonable medical expectation of recovery and which will cause my death, regardless of the use of life-sustaining treatment). In this case, I give the specific directions indicated:

| Artificial nutrition through a conduit | I want used | I do not want used |
| Hydration through a conduit |   |   |
| Cardiopulmonary resuscitation |   |   |
| Mechanical respiration |   |   |
| Other (explain) |   |   |

Department of Veterans Affairs

VA ADVANCE DIRECTIVE:
DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

PART II: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

PART III: LIVING WILL

VA FORM
DEC 2006 (RS) 10-0137
Limits of Instructional Advance Directives

- Not completed
- Not found
- Not informed
- Not clear
Not completed

30%

28%

Figure 1: Few Adults in New Jersey Report Having an Advance Directive

Older residents are most likely to have a directive

Source: Rutgers Center for State Health Policy, New Jersey Family Health Survey, 2001
Not found
65-76% of physicians whose patients **have** advance directives do not know they **exist**

**Individuals fail to make & distribute copies**
- Primary agent
- Alternate agents
- Family members
- PCP
- Specialists
- Attorney
- Clergy
- Online registry

**Not informed**
Enough

THE FAILURE OF THE LIVING WILL

By Angela Fagerlin and Carl E. Schneider

In pursuit of the dream that patients’ exercise of autonomy could extend beyond their span of competence, living wills have passed from controversy to conventional wisdom, to widely promoted policy. But the policy has not produced results, and should be abandoned.

Annals of Internal Medicine

Controlling Death: The False Promise of Advance Directives

Henry S. Plummer, MD

Advance directives promise patients a say in their future care but actually have not fulfilled that promise. Many experts blame problems with completion and implementation, but the advance directive concept itself may be fundamentally flawed. Advance directives simply perpetuate more control over death than is wanted. Medical ethics must be practiced in detail, making most prior instructions difficult to adopt, irrelevant, or even irrelevant. Furthermore, many patients offer to review patients’ wishes or do not review them at all. Thus, advance directives are often to control advance directives at the risk of the patient. Because advance directives offer only limited benefit, advance care planning should emphasize not the completion of directives but the emotional support of patients and families for their care. This assumption about care might suggest that patients receive more care than desired, and families less care than desired. Thus, in the end, many physicians are left with a sense of futility.

Perspective

For author information see end of text.
Not clear

if ____,
then ____

Trigger terms vague

“Reasonable expectation of recovery”
75%  51%
25%  10%
Plus: prognosis uncertain
Preferences vague

“No ventilator”
Ever
Even if temporary

SITUATION A
If I am in a coma or a persistent vegetative state and, in the opinion of my physician and two consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my goals and specific wishes — if medically reasonable — for this and any additional illness would be:

<table>
<thead>
<tr>
<th>Please check appropriate boxes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cardiopulmonary resuscitation (short compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is at the point of dying).</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>2. Major surgery (for example, removing the gall-bladder or part of the colon).</td>
</tr>
<tr>
<td>3. Mechanical breathing (respiration by machine, through a tube in the throat).</td>
</tr>
<tr>
<td>4. Dialysis (filtering the blood by means of a fluid passed through the kidney).</td>
</tr>
<tr>
<td>5. Blood transfusions or blood products.</td>
</tr>
<tr>
<td>6. Artificial nutrition and hydration (given through a tube in a vein or in the stomach).</td>
</tr>
<tr>
<td>7. Simple diagnostic tests (for example, blood tests or X-rays).</td>
</tr>
<tr>
<td>8. Antidepressants (drugs used to fight depression).</td>
</tr>
<tr>
<td>9. Pain medications, even if they dull consciousness and indirectly shorten my life.</td>
</tr>
</tbody>
</table>
More technology is the **default**

Patient must **opt out**
MOLST
Medical Order Life Sustaining Treatment
**POLST**
Practitioner / Physician Order Life Sustaining Treatment

**POST**
Physician Order for Scope of Treatment

**MOST**
Medical . . .

**COLST**
Clinician . . .
Life with Dignity Order

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**STATE OF DELAWARE MOLST FORM**

**MEDICAL ORDERS for life-sustaining treatment (MOLST)**

<table>
<thead>
<tr>
<th>A</th>
<th>Cardiopulmonary Resuscitation (CPR):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Attempt Resuscitation (CPR)</td>
</tr>
</tbody>
</table>

When person is well in cardiopulmonary arrest, follow orders in B, C, and D.

<table>
<thead>
<tr>
<th>B</th>
<th>Medical Interventions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Person has a pulse and/or is breathing</td>
</tr>
<tr>
<td></td>
<td>Limited Additional Interventions:</td>
</tr>
<tr>
<td></td>
<td>Includes care described above. Use medical treatment, IV fluids, and comfort measures as indicated. Do not intubation or mechanical ventilation. May use less intense sedation.</td>
</tr>
<tr>
<td></td>
<td>Full Treatment:</td>
</tr>
</tbody>
</table>
| | Includes care described above. Use ventilation, advanced airway interventions, mechanical ventilation, and care as described above. Transfer to hospital if needed. Includes invasive care, 

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What is MOLST

MOLST supplements AD

Does not replace
Both

Terminal illness
Advanced chronic progressive illness
Frailty
In last year of life

Others who want
to define care

The present

Here & now
Order for LST

Life-Sustaining Treatments Received (n = 1,606)†

- POLST Conflict: Medicines Only (n = 353)
- POLST Limited Intervention (n = 335)
- POLST Full Treatment (n = 83)
- Traditional DNR (n = 420)
- Traditional Do Not Code (n = 282)

* Limited to patients who had a POLST order in place for at least 6 months. The treatment withPOLST forms, only those with orders for medical intervention (section B) were included.
† Life-sustaining treatments in section B included hospitalization/ICU care, IV fluids, electrolyte, nutrition, oxygen, sedation, diagnostic tests, resuscitation/defibrillation, and admission to hospice or home care.

A Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing:

- Attempt Resuscitation (CPR)
- Do Not Attempt Resuscitation (DNR/No CPR)

* When person is not in cardiac arrest, follow orders in B, C, and D.
B

Medical Interventions: Person has a pulse and/or is breathing.

☐ COMFORT MEASURES ONLY. Use medications by any route, positioning, around care, and other measures to relieve pain and suffering. Use oxygen, oral suctioning, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.

☐ LIMITED ADDITIONAL INTERVENTIONS. Includes care described above. Use medical treatment, IV fluids, and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g., CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care.

☐ FULL TREATMENT. Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

Additional Orders (e.g., dopants, etc.) ______ blood transfusions

C

ANTIBIOTICS:

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics if infection occurs, with comfort as goal.

☐ Use antibiotics if life can be prolonged.

Additional Orders:
ARTIFICIALLY ADMINISTERED NUTRITION:
Always offer food and liquids by mouth, if feasible.
☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
(Goal):
☐ Long-term artificial nutrition by tube.
Additional Orders:

SUMMARY OF MEDICAL CONDITION/GOALS:

SIGNATURES: Preferences have been expressed to the health care provider whose signature is found below. This document reflects those preferences. If signed by a surrogate, preferences must reflect patient's wishes as best understood by the surrogate.

[Check boxes for discussion with: Patient, Parent of Minor, Legal Guardian, Next of Kin, Health Care Agent]

PRINT - Physician/PA/PA Name

Phone #

Physician/PA/PA Signature (mandatory)

Date

Physician Co-Signature if PA Signs Above (mandatory)

Date

Patient or Legal Surrogate Signature (Relationship/Institution)

Date

SEND FORM WITH PERSON WHOEVER TRANSFERS OR DISCHARGED.
Use of original form is strongly encouraged. Photocopies of signed NORES forms are legal and valid.
Can be completed by **surrogate**, if patient lacks capacity

70% patient
30% surrogate

MOLST does **not** expire
Review with change in condition or location

MOLST can be revised or revoked at any time

History of MOLST
1991

PA - implementing 2011
NJ - implementing 2011
MD - implementing 2011
2000  16 Del. Code 9706(h) added by H.B. 332

Nov. 1, 2002  Proposed PACD regulations
Request for written materials and suggestions

Nov. 26, 2002  Public hearing
Comment period extended

Dec. 31, 2002  End comment period
June 13, 2003 Final regulations approved

July 10, 2003 Regulations effective

July 2005 S.B. 195 amends 9706(h) re driver designation

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ALMOST ALWAYS</th>
<th>USUALLY</th>
<th>SOMETIMES</th>
<th>RARELY</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Have seen examples of where DNR orders have not transitioned to a new care setting in an effective way?</td>
<td>32</td>
<td>9</td>
<td>44</td>
<td>29</td>
<td>1 responded N/A, See attached</td>
</tr>
<tr>
<td>6. Have you ever seen the Pre-Hospital Advanced Care Directive (orange form) used effectively?</td>
<td>9</td>
<td>1</td>
<td>19</td>
<td>59</td>
<td>See attached</td>
</tr>
</tbody>
</table>

Mar. 15, 2011 Proposed regulations

Apr. 1, 2011 Published
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2011</td>
<td>End comment period</td>
</tr>
<tr>
<td>Aug. 2011</td>
<td>Final regulations</td>
</tr>
<tr>
<td></td>
<td>MOLST status</td>
</tr>
<tr>
<td></td>
<td>Provider education</td>
</tr>
<tr>
<td></td>
<td>Public education</td>
</tr>
<tr>
<td></td>
<td>Policy writing</td>
</tr>
</tbody>
</table>
Limited

terminally ill
permanently unconscious

Not binding on VHA

Compliance not specifically mandated, except by EMS

But all HCP must honor “decisions” of the patient per DE HCDA & PSDA

Stop completing orange PACD forms

But honor them when presented
MOLST benefits

1. Bright color
Original MOLST printed on lilac card stock

But a copy has the same force as original

2. Single page
3. More informed

MEDICAL ORDERS for life-sustaining treatment (MOLST)

SIGNATURES: Preferences have been expressed to the health care provider whose signature is found below. This document reflects those preferences. If signed by a surrogate, preferences must reflect patient’s wishes as best understood by the surrogate.

- Patient
- Parent of Minor
- Legal Guardian
- Next of Kin
- Health Care Agent

<table>
<thead>
<tr>
<th>Patient/Parent of Minor</th>
<th>Physician/PA/PA's Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician/PA/PA's Signature (mandatory)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

4. Immediately actionable
Medical Order
Life Sustaining Treatment

No need to “interpret” advance directive
No need to “translate” into orders

5. Easy to follow
6. Better honored

Can follow

Will follow
7. Portable

8. Broader than PACD
9. Proven Effective
Closes gap between what people want and what they get.
<table>
<thead>
<tr>
<th>2 roles</th>
<th>Honor</th>
<th>Complete</th>
</tr>
</thead>
</table>

- Act in accordance with MOLST
- Write corresponding VHA orders
- Scan into EHR
Encourage

Educate

Write or review on discharge

Thank you