ADVANCE PLANNING FOR END-OF-LIFE CARE: A PRACTICAL INTRODUCTION

WFUBMC Clinical Ethics Committee

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OVERVIEW

I. Introduction
II. Advance Care Planning—Process and Advantages
III. Advance Directives—Types and Procedures
IV. Organ Donor Designation
V. Portable Physician Orders

I. Introduction

A. The 2005 case of Terri Schiavo shows how difficult decisions about life-prolonging medical treatment can become.

B. Advance care planning offers a preventive approach to moral conflicts about health care near the end of life.

C. Without careful planning, advance directives are often ineffective.

II. Advance Care Planning (ACP)—Process and Advantages

A. Concepts
B. Steps in the Planning Process
C. Advantages of ACP

A. What is advance care planning (ACP)?

1. "an organized approach to initiating discussion, reflection and understanding regarding an individual's current state of health, goals, values and preferences for future treatment decisions"
2. ACP emphasizes a process (of education, reflection, and communication) as much as a product (e.g., an advance directive).

B. Steps in Advance Care Planning

1. **Recognition** (that one has choices and can plan ahead)
2. **Information** (about end-of-life choices, organ donation, and advance directives)
3. **Discussion and Reflection** (about values and preferences)

ACP Steps (continued)

3. **Decision-Making** (formulating and documenting one's plan)
4. **Communication** (of the plan to others)
5. **Review** (should the plan be updated?)

C. Advantages of Advance Care Planning

1. **overcomes barriers of ignorance, fear and avoidance**
2. **enables persons to formulate clear wishes for end-of-life care**
3. **communicates patient's wishes to family and caregivers**
4. **gives physicians clearer guidance about end-of-life treatment**
5. **makes satisfaction of patient's desires more likely**

III. Advance Directives

A. A Basic Definition
B. Types of Advance Directives
C. North Carolina's Natural Death Act
D. North Carolina's Health Care Power of Attorney statute

A. A Basic Definition

An advance directive is a plan indicating preferences for future health care decisions if a person is unable to make decisions.

B. Types of Advance Directives

1. Oral
2. Written
   a. Formal (signed, dated, witnessed)
      --living wills
      --health care powers of attorney
   b. Informal
      --physician's note
      --person's letter

3. **Which type of directive is best?**

   a. **Written plans are usually clearer, more authoritative, but oral discussion is also essential!**

   b. **Health care powers of attorney have several advantages over living wills:**

      --allow a person to choose a surrogate

      --the surrogate can make treatment decisions with the patient's physician when they are needed

      --apply to a wider range of situations

C. North Carolina's Natural Death Act

1. General Purpose

   a. Recognizes patient rights to "a peaceful and natural death" and to control medical decisions

   b. Establishes an "optional and nonexclusive procedure" to exercise these rights

2. Patients may prepare an Advance Directive for Natural Death ("Living Will")

3. **Requirements for the Living Will**
   a. **Expresses the patient's desire that life-prolonging measures not be used if the patient lacks decision-making capacity and:**

      --has an incurable or irreversible condition that will result in death within a relatively short period of time

      --is irreversibly unconsciousness

      --suffers from advanced dementia or other substantial loss of cognitive ability that is irreversible.

b. States that the patient is aware that the document authorizes a physician to withhold life-prolonging measures.

c. Signed by the patient

d. Witnessed by two persons who:

--Are not related to the patient

--Will not inherit from the patient

--Are not the attending physician, his or her employee, or an employee of the patient's health care facility

--Have no claim against the patient's estate

e. Signatures are witnessed by a notary public.

4. **Handout describes additional information about living wills, including:**

   a. other choices prompted by the living will form,

   b. procedure for honoring living wills,

   c. legal safe harbor for professionals who honor living wills,

   d. statutory procedure for forgoing life-prolonging measures without a living will.

D. North Carolina's Health Care Powers of Attorney statute

1. General Purpose

   a. Recognizes an individual's right to control medical decisions; this right may be exercised by an agent chosen by the individual

   b. Establishes an additional, nonexclusive method for an individual to exercise this right when he or she is unable to make or communicate health care decisions

2. **Key Terms**

   a. **"health care agent" - the person appointed as a surrogate decision-maker under a HCPOA**

   b. **"life-prolonging measures" - care or treatment which only serves to postpone artificially the moment of death, including mechanical ventilation, dialysis, antibiotics, and artificial nutrition and hydration**

   c. **"principal" - the person preparing the health care power of attorney**

3. Who may prepare a HCPOA; who may serve as a health care agent

a. Any competent adult may prepare a HCPOA

b. Any competent adult who is not providing health care to the principal for pay may serve as a health care agent

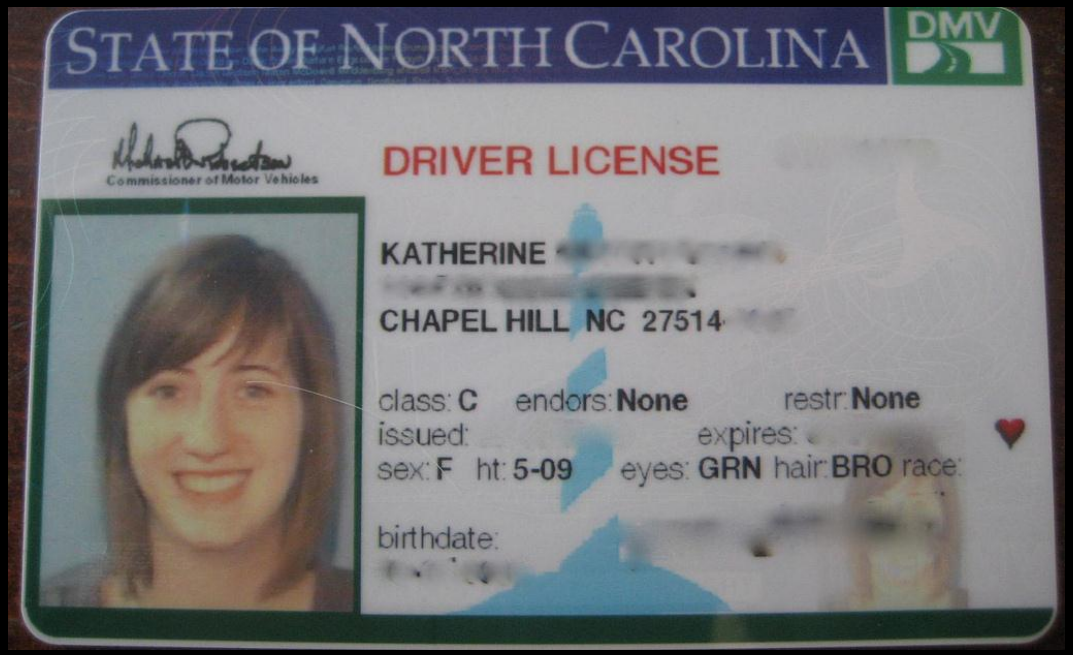
4. **Handout describes additional information about health care powers of attorney, including:**
   a. **extent and limitations of authority granted**
   b. **effectiveness and revocation**
   c. **legal safe harbor for professionals**
   d. **form options for guiding health care agent decisions**
   e. **signature and notarization requirements**

IV. Organ Donor Designation

Text from the Donate Life North Carolina website:

HOW DO I BECOME A DONOR?

Request that a heart be placed on your license at the DMV.



OR…..

Register online with the Donate Life North Carolina donor registry.

(See handout for details)

IV. Portable Physician Orders for End-of-Life Care

A. Portable ('Out-of-Facility') DNR orders
B. Medical Orders for Scope of Treatment (MOST)
C. These order sets translate a patient's wishes into physician orders and travel with the patient!

A. Portable DNR Orders

1. **Physician order directs that cardiopulmonary resuscitation not be initiated *in any setting*.**
2. **NC statute shields health care providers from liability for honoring portable DNR order in any setting.**

Effective Date: _____

Expiration Date, if any _____

☐ Check box if no expiration

DO NOT RESUSCITATE ORDER

Patient's full name _____

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

_____

Signature of Attending Physician/Physician Assistant/Nurse Practitioner

_____

Printed Name of Attending Physician

_____

Address

_____

City, State, Zip

Telephone Number (office) _____

Telephone Number (emergency) _____

Do Not Copy **Do Not Alter**

B. Medical Orders for Scope of Treatment

1. an expansion of portable DNR orders
2. MOST form must be signed by:
   a. a physician, physician assistant, or nurse practitioner, *and*
   b. the patient or his/her representative

4. **MOST form may include instructions re:**
    a. **CPR**
    b. **Other medical interventions (including hospitalization)**
    c. **Antibiotics**
    d. **Artificial nutrition and hydration**
5. **Statutory immunity from liability ("legal safe harbor") for health care providers who honor MOST**

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:	Effective Date of Form: *Form must be reviewed at least annually.*
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if life can be prolonged.**

☐ **Determine use or limitation of antibiotics when infection occurs.**

☐ **No Antibiotics** (use other measures to relieve symptoms).

Other Instructions _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids long-term if indicated**	☐ **Feeding tube long-term if indicated**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **No IV fluids** (provide other measures to ensure comfort)	☐ **No feeding tube**

Other Instructions _____

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY:

Basis for order must be documented in medical record.

☐ Patient	☐ Majority of patient's reasonably available parents and adult children
☐ Parent or guardian if patient is a minor	☐ Majority of patient's reasonably available adult siblings
☐ Health care agent	☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient
☐ Legal guardian of the person	
☐ Attorney in-fact with power to make health care decisions	
☐ Spouse	

MD/DO, PA, or NP Name (Print):	MD/DO, PA, or NP Signature (Required):	Phone #:

Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be reviewed and signed by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or their representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N.C. Gen. Stat. 90-21.17.

Reviewing MOST

This MOST must be reviewed at least annually or earlier if:

- The patient is admitted and/or discharged from a health care facility;
- There is a substantial change in the patient's health status; or
- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

This MOST may be revoked by the patient or the patient's representative.

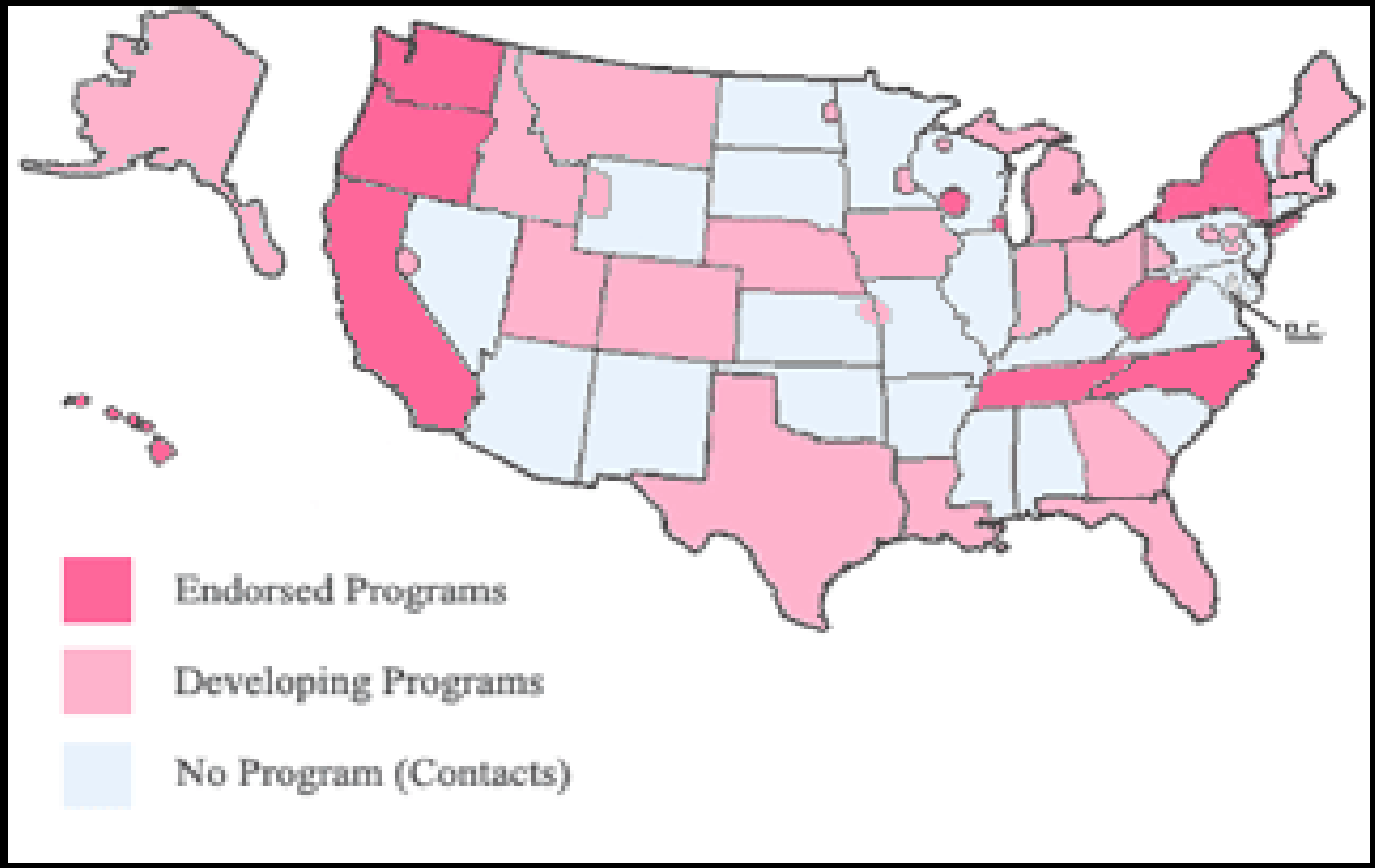
Review of MOST

Review Date	Reviewer and Location of Review	MD/DO, PA, or NP Signature (Required)	Signature of Patient or Representative (Required)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

POLST Paradigm Map

Endorsed States as of January 2011



Idaho & Colorado were endorsed on 1-27-2011
(PA, MT, MA, MD, LA, SC, VA coming soon)