ADVANCE DIRECTIVES-MORE THAN JUST DNR

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OBJECTIVES

• Present overview of forms and terminology of advance directives
• Examine who makes decisions – with directives or not
• Describe issues when using advance directives
DISCLAIMER

• STATES HAVE RULES FOR EVERYTHING
• MOST EXAMPLES COME FROM TEXAS
• OVER-ARCHING PRINCIPLES AND PROCEDURES
“DO NOT RESUSCITATE”

- Only 40 years old
- Advent of CPR and issues using it on everyone
- Need to formalize policies and make decision making transparent for those who would not benefit.
  
“DO NOT RESUSCITATE”

• Order written into a chart to convey the status of the individual
• Governs actions that occur at that facility
• Result of discussions and/or decisions made at the time the order is written or prior
• End of a process
TERMS TO KNOW

• ADVANCE DIRECTIVE
• ADVANCE CARE PLANNING
• MEDICAL POWER OF ATTORNEY
• “LIVING WILL”
• POLST/MOLST
• “OUT OF HOSPITAL – DO NOT RESUSCITATE”
• “ALLOW NATURAL DEATH”
• HOSPICE VS. PALLIATIVE CARE
• “PHYSICIAN ASSISTED SUICIDE”
WHAT IS AN ADVANCE DIRECTIVE?

- A legal document (such as a living will) signed by a living competent person in order to provide guidance for medical and health-care decisions (as the termination of life support and organ donation) in the event that the person becomes incompetent to make such decisions.
CARINGINFO

- WWW.CARINGINFO.ORG
- Consumer section of the National Hospice and Palliative Care Organization
- State specific advance directives
ADVANCE CARE PLANNING

• Process to express values and desires about end of life
• Educate on the decisions that can be made
• Future care in event individual is unable to speak for himself
• End of Life counseling as Medicare benefit – “death panels” – January 1, 2016
ETHICS OF MEDICAL DECISION MAKING

• BENEFICENCE
• NON-MALEFICENCE
• AUTONOMY
• JUSTICE
FIVE APPROACHES

• Do Everything
• Be Aggressive Only if I Have Reasonable Chances
• Only Admit Me to the Intensive Care if I Have Excellent Chances
• Don’t Admit Me to the Intensive Care Unit
• Don’t Admit Me to a Hospital; Focus Only on My Comfort

• Samuel Brown, MD; Director of Center for Humanizing Critical Care at Intermountain Medical Center (Blog – McKnight News, 8/4/2016)
WHO MAKES DECISIONS

• Ideally the individual himself
• Medical Power of Attorney
• Family members – usually in order of their relationship (spouse, adult children, parents, adult siblings, other family members)
• Physicians – no family available and no one designated, at least two physicians (often one of which who is not taking care of the individual)
• Hospital ethics committee – conflict between parties
• Legal proceedings
DECISION MAKING CAPACITY

• Individual is presumed to have capacity for making decisions
• Capacity can be defined by state law and can vary for different functions
• Supported decision making – ability to make decisions with help of trusted persons in life
SPECIAL POPULATIONS

• Older adults
• Individuals with Intellectual disability
• Minors
• Pregnant women
WHAT KINDS OF DECISIONS?

• Cardiopulmonary resuscitation
• Ventilator use
• Artificial nutrition (“tube feeding”) and artificial hydration (intravenousous fluids)
• Other – Dialysis, antibiotics, organ donation, etc.
LIFE SUSTAINING TREATMENTS VS. “COMFORT CARE”

- Life sustaining treatments are treatments that, based on reasonable medical judgment, sustain an individual’s life and without it the individual will die.
- “Comfort care” is medication, medical procedures or other interventions used in order to alleviate discomfort or pain.
- Refusing life sustaining treatment does not keep an individual from receiving comfort care.
PATIENT SELF DETERMINATION ACT
(Federal - 1991)

• Requires most health care entities to:
  • At the time of admission, provide a written summary of health care rights and the entity’s policy in respect to honoring advance directives
  • Ask if the individual has an advance directive and document the answer in his chart
  • Educate their staff about advance directives
  • Not discriminate against an individual on the basis of whether or not he has an advance directive or not require one to be completed.
FORMS AND FORMS

• Variety of ways to express wishes
• Future and immediate forms
• Orders vs. forms
“LIVING WILL”

• Directive to Physician
• Often made when individual is not diagnosed with life limiting illness
• Legal requirements vary state to state
• General “future” instructions
• Limits to use – emergency personnel, hard to predict specific decisions that might need to be made
Directive to Physicians and Family or Surrogates

I, [name], recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

- I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
- I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE).

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

- I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
- I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE).

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificially administered nutrition and hydration or intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment).
TEXAS DIRECTIVE TO PHYSICIAN

• If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months:

• If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:
TEXAS DIRECTIVE TO PHYSICIAN

• I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

• I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE).
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

• Medical Power of Attorney/Surrogate/Healthcare Proxy

• Document delegating decision making power to an agent in the event that the person delegating that authority becomes incapacitated

• Legal requirements vary – witnesses, notarized

• Need to keep updated
POLST/MOLST/POST

- Physician Orders for Life Sustaining Treatment (or Medical or Scope of Treatment)
- Legality is approved by state
- Written after discussion with individual or family
- Can be updated at any time
- More specific and actionable than directives to physician
- Follows the individual
- Usually in response to chronic illness or other condition
POLST/MOLST/POST/MOST

- National POLST Paradigm (5/2016)
  - “Mature” states - Oregon, West Virginia, California
  - Endorsed states (19) – worked through legal/regulatory barriers
  - Developing states (25) – in process
  - Other (6) – either not following the guidelines from POLST organization or not working on project
- [www.polst.org](http://www.polst.org)
TENNESSEE POST FORM

• Section A – CPR if no pulse or breathing
• Section B – Medical interventions (comfort care, limited interventions, full interventions)
• Section C – artificial nutrition and hydration
• Section D – who discussed decisions and basis of the orders
• Physician/NP/PA signature
• Patient/surrogate signature
ADVANCE DIRECTIVE VS POLST

**ADVANCE DIRECTIVE**
- For anyone 18 and older
- Provides instructions for **future** treatment
- Appoints a Health Care Representative
- Does not guide Emergency Medical Personnel
- Guides inpatient treatment decisions when made available

**POLST**
- For persons with serious illness — at any age
- Provides medical orders for **current** treatment
- Guides actions by Emergency Medical Personnel when made available
- Guides inpatient treatment decisions when made available
**OUT OF HOSPITAL – “DO NOT RESUSCITATE”**

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**OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER**

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES**

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

<table>
<thead>
<tr>
<th>A. Declaration of the adult person:</th>
<th>I am competent and at least 18 years of age. I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person's signature</td>
<td>Date</td>
</tr>
<tr>
<td>Person's full legal name</td>
<td>Printed name</td>
</tr>
</tbody>
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<tr>
<th>B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:</th>
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<tbody>
<tr>
<td>I am the:</td>
</tr>
<tr>
<td>[ ] legal guardian;</td>
</tr>
<tr>
<td>[ ] agent in a Medical Power of Attorney; OR</td>
</tr>
<tr>
<td>[ ] proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.</td>
</tr>
<tr>
<td>Based upon the known desires of the person, or a determination of the best interest of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.</td>
</tr>
<tr>
<td>Signature</td>
</tr>
<tr>
<td>Date</td>
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<tr>
<td>Printed name</td>
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<th>C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication:</th>
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<td>[ ] spouse,</td>
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<td>[ ] adult child,</td>
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<td>[ ] parent, OR</td>
</tr>
<tr>
<td>[ ] nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.</td>
</tr>
<tr>
<td>To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.</td>
</tr>
<tr>
<td>Signature</td>
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<tr>
<td>Date</td>
</tr>
<tr>
<td>Printed name</td>
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<th>D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person:</th>
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<tr>
<td>I am the above-noted person's attending physician and have:</td>
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<tr>
<td>[ ] seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR</td>
</tr>
<tr>
<td>[ ] observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.</td>
</tr>
<tr>
<td>I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.</td>
</tr>
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OUT OF HOSPITAL – “DO NOT RESUSCITATE”

- States the procedures that should not be done – CPR, ventilator, intubation, etc.
- One of the sections is signed
- Section A is individual if able, otherwise -
- Section B is surrogate
- Section C is qualified family member
- Section D is physician
- Section E is parents of minor
- Signed by Physician
- Section F – two physicians if no other person to sign
- Witnesses
OUT OF HOSPITAL – “DO NOT RESUSCITATE”

• Pros – If EMS is called, they are able not to act. Follows the person out of hospital. Physician order.

• Cons – “one size fits all”
“ALLOW NATURAL DEATH”

- Do Not Resuscitate (DNR) versus Allow Natural Death (AND): A Dichotomy In Perception Between Provider and Patient, Buscaino, Kristina Stacey et al. Journal of the American Medical Directors Association, Volume 14, Issue 3, B21

- Difference between physician/medical student and patient/family member perceptions

- “Abandoning/withholding” vs. “allowing”
HOSPICE VS. PALLIATIVE CARE

• Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice. (NHPCO)
HOSPICE VS. PALLIATIVE CARE

• Hospice Care is considered Palliative Care.
• Hospice reimbursement is based on certification by physician that individual has less than 6 months to live if disease runs its course.
• Adults forgo curative care. Children can continue curative care.
• Difficult to prognosticate
“PHYSICIAN ASSISTED SUICIDE”
PHYSICIAN ASSISTED SUICIDE

• States that allow have protocols (except Montana)
  • Patient eligibility
  • Physician Protocol
  • Timeline for requests
  • Other – vary (physician protections, documentation, etc)

• States that don’t allow have varying criminal penalties for the act
  • No penalty – because no specific statute
  • Misdemeanor
  • Felony
  • Misdemeanor for attempt, felony for completion
RESOURCES

- POLST - http://www.polst.org/ - forms for states
- CaringInfo - http://www.caringinfo.org/ - advance directive forms for each state
- Physician assisted suicide - http://euthanasia.procon.org/
QUESTIONS?

- Contact information:
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