Making Sense of Advance Directives and MOLST

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What if I don’t have the ability to make health care decisions for myself in the future?

Capacity to Make Decisions

- Capacity may change over time
- Loss of capacity may be temporary
  - Medications or acute illnesses
- Capacity may not be “all” or “none”
- Does the individual have the ability to understand the issue and treatment options, including potential benefits, risks, and side effects as well as likely consequences of the decision?

Individuals Who Lack Capacity

- If an individual lacks the capacity to make health care decisions, then a health care agent, guardian of the person, or surrogate makes decisions for the individual

Approaches

1. Silence + assumptions
   - "I'll just leave it to my family to decide"
   - "They'll know what to do"
2. Talk, but no documents
3. Talk + advance directives = highest likelihood that your wishes will be honored

"I'll Just Leave it to my Family and Friends to Decide"

When no health care agent is named, the law sets priority among surrogates:

1. Guardian of the person (by court)
2. Spouse or domestic partner
3. Adult children
4. Parents
5. Adult siblings
6. Friend or other relative

Risks of Leaving Decision to Family and Friends

- Deciding in the dark is very hard
- Risk of disagreement
  - Surrogates of equal rank have equal authority
- Added burden to surrogate decision makers
- Potential for a legacy of guilt, anger, bitterness, or anxiety

Mr. Green

- 82-year-old widower with 3 children
- Former smoker with end-stage lung disease and worsening Alzheimer's disease who lives in a nursing home
- Can't make his own health care decisions
- 3 recent breathing crises
  - 911 called, hospitalized, on/off ventilator

Mr. Green's Prognosis

- Probable recurrent crises, requiring more trips to the hospital
- Death is likely within "several" months

Discussion at Nursing Home

- Would your father want resuscitation to be attempted?
- Would he want to go on the ventilator again?
- Would he want to be transferred to the hospital the next time he is in respiratory distress?
- Would he want to be in hospice?

Family Disagreement

- Elder daughter: "Dad was a fighter. Do everything to keep him alive."
- Son and younger daughter: "Dad wouldn't have wanted this. He's suffering and it's time to stop."
- What would Mr. Green want done?
- Who would Mr. Green want to decide?

Talk by Itself

- Good, but is it enough?
- Perceptions may vary between family and friends
- Memories can fade, but a document serves as a reminder to family and friends
- Document informs doctors and the health care team about your wishes

Best: Talk + Advance Directives

- Don’t wait until too late
- Talk with family and friends about preferences
- Document decisions in a legally valid way

Types of Advance Directives

- Who will speak for me?
  - Name a health care agent(s)
  - AKA durable medical power of attorney
    - *Not* financial power of attorney
- What will be done or not done?
  - Create a living will
  - Covers life-sustaining and perhaps other treatments

Health Care Agents

- Selection, scope of authority up to individual
- Agent to decide based on
  - "Wishes of the patient," unless "unknown or unclear"
  - Then, "patient's best interest"
- Ask your agent to read the *Proxy Handbook* *https://www.marylandattorneygeneral.gov/Health%20Policy%20Documents/ProxyHandbook.pdf*

Living Will or Advance Directive

- Follows "If, then" model
  - "If I lose capacity and I'm in [specified condition/s],
  - Then no CPR, ventilator, feeding tube, etc.
  - Aggressive interventions may be requested

Qualifying Conditions

- Decision to forgo life-sustaining interventions is carried out if two physicians or one physician and a nurse practitioner certify you are in a:
  - Terminal condition
  - End-stage condition
  - Persistent vegetative state (certified by two physicians, including a specialist)

Terminal Condition

- Incurable
- No recovery even with life-sustaining treatment
- Death "imminent"
  - The doctors determine if you meet this definition

End-Stage Condition

- Progressive
- Irreversible
  - No effective treatment for underlying condition
- Complete physical dependency
- Death is not necessarily "imminent"
  - Advanced dementia or perhaps a similar condition

Persistent Vegetative State

- No evidence of awareness
- Only reflex activity and conditioned responses
- Wait a “medically appropriate period of time” for diagnosis

Effect of Instructions on Agent

- Living will usually controls the decision
  - Why? A living will is clear evidence of what you would want done or not done
- Do you really want to bind your agent?
  - Living will can be made non-binding guidance

Maryland Formalities

- Two witnesses
  - Notary not required
- Statutory form *optional* -- other forms okay
  - Out-of-state advance directives valid here
  - Is Maryland's directive honored in other states – it depends on that state's law

Changing or Revoking an Advance Directive

- Presumed valid, no expiration
- New one on same topic revokes old
- Only patient may change/revoke
  - Family, friends, and health care providers cannot change or revoke your directive

Review Your Advance Directive

- Periodically review your advance directive to ensure:
  - Agent/s still available
  - Contact information is correct
  - Care preferences are the same

Some Pitfalls

- No discussion with the health care agent
  - "What? I'm his health care agent?"
  - "I know that's what it says, but she didn't understand."
- Using ambiguous language
  - "No heroic measures."
- Are you sure about a treatment decision?
  - Mexican proverb: "The appearance of the bull changes, once you enter the ring."

Making It Work in the Real World

- Copies to family/friends, doctor and hospital
- Wallet card
- Enter it into a registry or upload or prepare it on MyDirectives.com (your provider can find it on CRISP, the State-designated heath record database)

Making It Work in the Real World

- If you have a current health issue for which you want a medical order to carry out your wishes for care, ask your physician, nurse practitioner, or physician assistant to complete a Maryland MOLST form
- For example, you would need a MOLST form if you do not want CPR

Understanding the Maryland MOLST Form

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What is Maryland MOLST?
Medical Orders for Life-Sustaining Treatment

- It is a standardized medical order form covering options for CPR and other life-sustaining treatments
- It is portable and enduring
- It is valid in all health care settings and in the community
- It helps to increase the likelihood that a patient's wishes regarding life-sustaining treatments are honored

Where Can I get a MOLST Form?

- You can get a form on the Maryland MOLST website at www.marylandmolst.org
- You may call the Maryland Institute for Emergency Medical Services Systems (MIEMSS) at 410-706-4367

Why Have both a MOLST Form and Advance Directive?

- A MOLST form's medical order(s) are needed when a treatment is relevant to your current medical condition
- Unlike a MOLST form, an advance directive contains treatment preferences regarding future hypothetical situations
- If you do not want CPR, you will need to have a MOLST form

What is the certification for the basis of these orders?

- The practitioner is certifying that the order is entered as a result of a discussion with, and the informed consent of, the:
  - Patient, or
  - Patient's health care agent as named in the patient's advance directive, or
  - Patient's guardian of the person, or
  - Patient's surrogate, or
  - Minor's legal guardian or another legally authorized adult

What is the certification for the basis of these orders?

- "I hereby certify that these orders are based on":
  - Instructions in the patient's advance directive
  - Other legal authority in accordance with the Health Care Decisions Act

What if the patient declines or is unable to make a selection?

- An individual or ADM has the right to decline to discuss life-sustaining treatments and the right to not make a decision
- "Mark this line if the patient or ADM declines to discuss or is unable to make a decision about these treatments. If the patient or ADM has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given."

What orders do EMS providers follow?

- Follow *Maryland Medical Protocols for EMS Providers*
- Follow orders in Section 1
- Do not follow orders in Section 2 through Section 9
- Do not follow advance directives and thus you need the MOLST form's DNR order completed if you do not want CPR
- If you have an existing EMS/DNR order form, it never expires

Section 1: CPR Status

- Attempt CPR: If cardiac or pulmonary arrest occurs, CPR will be attempted
- No CPR, Option A-1, Intubate: Comprehensive efforts to prevent arrest, including intubation
- No CPR, Option A-2, Do Not Intubate: Comprehensive efforts to prevent arrest; do not intubate, but use CPAP or BiPAP
- No CPR, Option B: Palliative and supportive care

Section 2: Artificial Ventilation

- Accept artificial ventilation indefinitely, including intubation, CPAP, and BiPAP
- Time limited trial of intubation
- Time limited trial of CPAP and BiPAP, but no intubation
- No artificial ventilation: No intubation, CPAP, or BiPAP

Section 3: Blood Transfusion

- Accept transfusion of blood products, including whole blood, packed red blood cells, plasma, or platelets
- No blood transfusions

Section 4: Hospital Transfers

- Accept hospital transfer
- Hospital transfer only for limited situations, including severe pain or severe symptoms that cannot be controlled otherwise
- No hospital transfer, but treat with options available outside of the hospital

Section 5: Medical Workup

- Accept any medical tests
- Limited medical tests are acceptable when necessary for symptomatic treatment or comfort
- No medical testing for diagnosis or treatment

Section 6: Antibiotics

- Accept antibiotics
- Oral antibiotics only (not IV or IM)
- Oral antibiotics for relief of symptoms only
- No antibiotics

Section 7: Artificially Administered Fluids and Nutrition

- Accept artificial fluids and nutrition, even indefinitely
- Accept time-limited trial of artificial fluids and nutrition
- Accept a time-limited trial of artificial hydration only
- No artificial fluids or nutrition

Section 8: Dialysis

- Accept dialysis, including hemodialysis and peritoneal dialysis
- Accept time-limited trial of dialysis
- No dialysis

Section 9: Other Orders

- This section may be used to indicate preferences for other life-sustaining treatments, such as chemotherapy and radiation
- It should not be used for ambiguous phrases such as “comfort care”

Does a choice have to be made in each section?

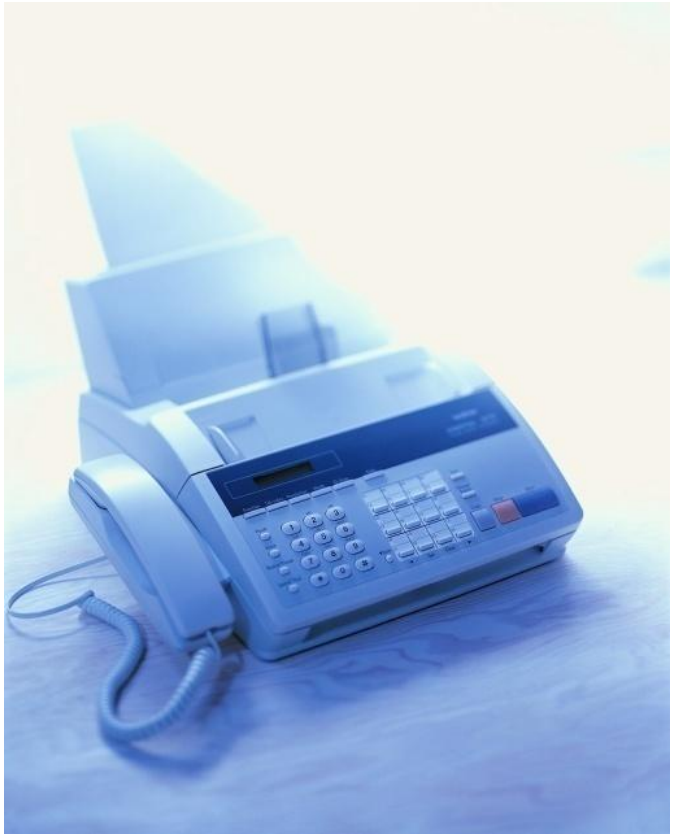
- Section 1, CPR status, must be completed for everyone
- Sections 2 - 9 are only completed if the patient or authorized decision maker makes a selection regarding that specific life-sustaining treatment and/or if specific treatments are determined to be medically ineffective

What if a patient changes his or her mind?

- Patients who have the capacity to make health care decisions may change their advance directive and ask their physician, nurse practitioner, or physician assistant to revise their Maryland MOLST order form at any time

Is a copy of MOLST a valid order?

- The original, a copy, and a faxed MOLST form are all valid orders
- You should make a copy of the MOLST form in case you lose the form you are given by the health care provider



What are the legal requirements for completing Maryland MOLST?

- The Maryland MOLST form must be completed or an existing form reviewed when a patient is admitted to:
  1. Nursing home
  2. Assisted living facility
  3. Home health agency
  4. Hospice
  5. Kidney dialysis center
  6. Hospitals (for certain patients)

Does the patient get a copy of a completed MOLST order form?

- Yes, within 48 hours of its completion, the patient or authorized decision maker shall receive a copy or the original of a completed Maryland MOLST form
- If the patient leaves a facility or program in less than 48 hours, the patient shall have a copy or the original of MOLST when they are discharged or transferred

Where is the MOLST form kept at home?

- By the bedside,
- Behind the bedroom door, or
- On the refrigerator door

Is there a MOLST DNR Bracelet?

- Yes, you may wear an EMS DNR bracelet or necklace or pin it to your clothes
- Contact Medic Alert at 1-800-432-5378
- They will need a copy of your MOLST form and a completed application
- Plastic bracelets may be ordered through MIEMSS at 410-706-4367.

For More Information

MOLST:
marylandmolst.org

MOLST Email: maryland.molst@maryland.gov

Advance Directives:
health.maryland.gov/advance-directives

Advance Directives Email:
advance.directives@maryland.gov