05-11-16

Medical Jurisprudence

Behavioral Sciences Term
St. Georges University
School of Medicine

Visiting Professor
Thaddeus Pope, JD, PhD

Segment 8 of 8

Wednesday August 3

Death & Dying

Objectives

At the conclusion of this unit, the medical student should be able to answer the following 7 questions

1. What is the legal standard for determining death
2. What are clinician treatment duties after death
3. What is an advance directive
4. Understand a patient's right to refuse life-saving treatment
5. What is the difference between active and passive means of hastening death
6. Identify "passive" mechanisms for hastening
7. Identify "active" mechanisms for hastening

See substitute consent objectives

- What is decision making capacity
- What are the 3 types of substitute decision makers
- Understand the difference between the 2 SDM decision making standards

Death

Disjunctive

An individual is dead who has sustained **either**

irreversible cessation of circulatory and respiratory functions

or

irreversible cessation of all functions of the entire brain

NJ

Religious objection to brain death → use circ./resp. prong only

Treatment duties after death

Consent **not** required to stop LSMT

Dead → Not a patient

Not a patient → No duty to treat

Annals of Internal Medicine

American College of Physicians Ethics Manual

Sixth Edition

Lois Snyder, JD, for the American College of Physicians Ethics, Professionalism, and Human Rights Committee*

"After a patient . . . brain dead . . . medical support should be discontinued."

Guidelines for Physicians: Forgoing Life-Sustaining Treatment for Adult Patients

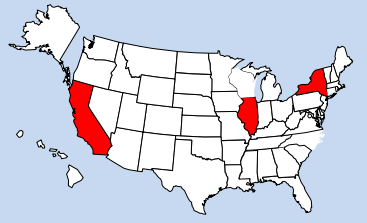
Joint Committee on Biomedical Ethics of the Los Angeles County Medical Association and Los Angeles County Bar Association

Approved by the Los Angeles County Medical Association February 15, 2006
Approved by the Los Angeles County Bar Association March 22, 2006

"Once death has been pronounced, all medical interventions should be withdrawn."

The rule almost everywhere

Some duty to accommodate religious objections to brain death



Usually only 24-48 hours

BUT...

Surrogate resistance is **growing**

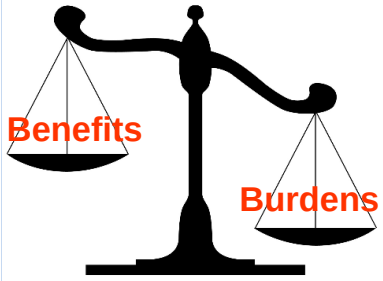
Why hasten death

Physical suffering

Pain
Nausea
Dyspnea
Paralysis
Foul-smelling wounds

Existential suffering

Psychic pain
Loss of control
Anxiety
Delirium
Hopelessness



Self-defined quality of life

Pt **own** assessment

Pt **own** values

Pt **own** preferences

Exit options

Decreasing order of acceptability

Stop LSMT
Accelerate opioids
VSED / VRFF
Palliative sedation (PSU)
PAD / MAID
Euthanasia

Right to refuse

"The logical corollary of the doctrine of informed consent is that the patient generally possesses the **right not to consent,** that is, to refuse treatment."

- *Cruzan v. Missouri DOH* (1990)

Patient may refuse treatment **even** if life-saving

Ventilator
CANH (= med Tx)
Dialysis
CPR
Antibiotics

This is "passive"

Saying no

Who is to say if amount life left to a patient is worth living

Person herself

State interests

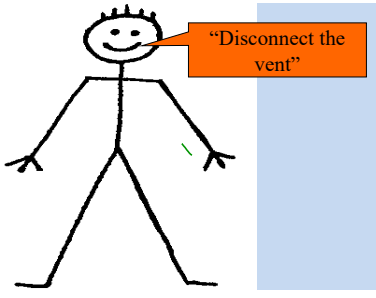
Preservation life
Prevent suicide
Protect 3rd parties
Integrity med profession

Almost always **outweighed** by patient's right to self-determination

Right to refuse by patient with capacity

Easier situation

Contemporaneous patient refusal



Right to refuse: prospective Autonomy

Patient is competent + patient has capacity to make the decision at hand

Patient decides

Tougher situation

When patient now lacks capacity

Many patients lack capacity at the end of life

Patient not lose right of self-determination when lose capacity

Who decides

What standards

Advance directive

Substitute decision maker

We talked about appointing a SDM

SDM can decide for you when you lose capacity

Advance Directive

Patient lacks capacity but left instructions while did

Instructions available

Instructions apply to present circumstances

Follow instructions (self-executing)

SDM **bound** by instructions in advance directive

SDM **lack authority** to contravene patient's instructions (or known preferences or best interests)

Limits of Advance Directives

Not completed

Not found

Not informed

Not clear

Not completed

PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

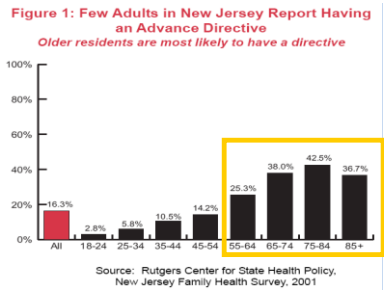
Views on End-of-Life Medical Treatments

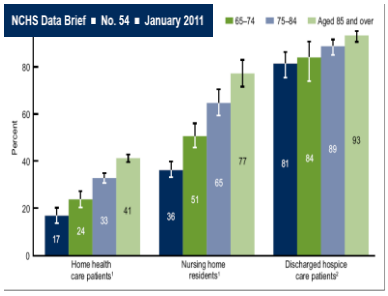
Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

18-29	15%
30-49	33%
50-64	38%
65-74	61%
75+	58%

AMERICAN BAR ASSOCIATION 30%

AARP 28%





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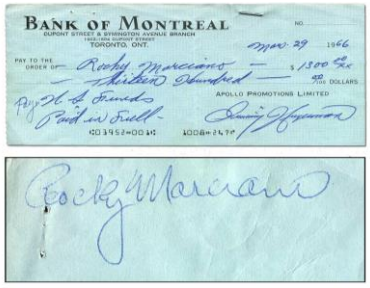


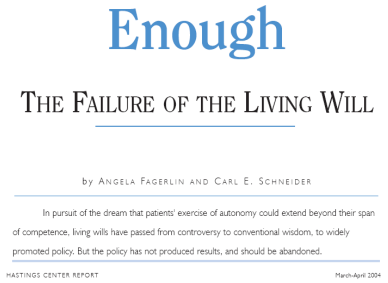
65-76% of physicians whose patients have advance directives do not know they exist

U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Individuals fail to make & distribute copies

- Primary agent
- Alternate agents
- Family members
- PCP
- Specialists
- Attorney
- Clergy
- Online registry

Not informed



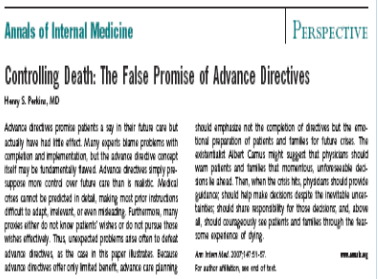
Enough

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.

HASTINGS CENTER REPORT March–April 2004



Annals of Internal Medicine | PERSPECTIVE

Controlling Death: The False Promise of Advance Directives

Henry S. Perkins, MD

Advance directives promise patients a say in their future care but actually have had little effect. Many experts blame problems with completion and implementation, but the advance directive concept itself may be fundamentally flawed. Advance directives simply presuppose more control over future care than is realistic. Medical crises cannot be predicted in detail, making most prior instructions difficult to adapt, irrelevant, or even misleading. Furthermore, many proxies either do not know patients' wishes or do not pursue those wishes effectively. Thus, unexpected problems arise often to defeat advance directives, as the case in this paper illustrates. Because advance directives offer only limited benefit, advance care planning should emphasize not the completion of directives but the emotional preparation of patients and families for future crises. The existentialist Albert Camus might suggest that physicians should warn patients and families that momentous, unforeseeable decisions lie ahead. Then, when the crisis hits, physicians should provide guidance; should help make decisions despite the inevitable uncertainties; should share responsibility for those decisions; and, above all, should courageously see patients and families through the fearsome experience of dying.

Ann Intern Med. 2007;147:51-57. www.annals.org

For author affiliation, see end of text.

Not clear

if ___,

then ___

Trigger terms vague

"Reasonable expectation of recovery"

75% 51%

25% 10%

Plus: prognosis uncertain

Preferences vague

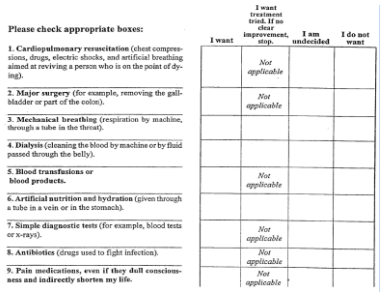
"No ventilator"

Ever

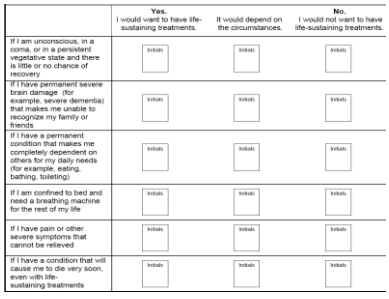
Even if temporary

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:



Please check appropriate boxes:	I want	I want treatment tried. If no clear improvement, stop.	I am undecided	I do not want
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).		Not applicable		
2. Major surgery (for example, removing the gallbladder or part of the colon).		Not applicable		
3. Mechanical breathing (respiration by machine, through a tube in the throat).				
4. Dialysis (cleaning the blood by machine or by fluid passed through the belly).				
5. Blood transfusions or blood products.		Not applicable		
6. Artificial nutrition and hydration (given through a tube in a vein or in the stomach).				
7. Simple diagnostic tests (for example, blood tests or x-rays).		Not applicable		
8. Antibiotics (drugs used to fight infection).		Not applicable		
9. Pain medications, even if they dull consciousness and indirectly shorten my life.		Not applicable		



	Yes. I would want to have life-sustaining treatments.	It would depend on the circumstances.	No. I would not want to have life-sustaining treatments.
If I am unconscious, in a coma, or in a persistent vegetative state and there is little or no chance of recovery	Initials	Initials	Initials
If I have permanent severe brain damage (for example, severe dementia) that makes me unable to recognize my family or friends	Initials	Initials	Initials
If I have a permanent condition that makes me completely dependent on others for my daily needs (for example, eating, bathing, toileting)	Initials	Initials	Initials
If I am confined to bed and need a breathing machine for the rest of my life	Initials	Initials	Initials
If I have pain or other severe symptoms that cannot be relieved	Initials	Initials	Initials
If I have a condition that will cause me to die very soon, even with life-sustaining treatments	Initials	Initials	Initials

More technology is the **default**

Patient must **opt out**

POLST

POLST

Provider
Order
Life
Sustaining
Treatment

POLST

Physician
Order
Life
Sustaining
Treatment

POST Physician Order for Scope of Treatment

MOST Medical . . .

MOLST Medical . . .

COLST Clinician . . .

Volume 23, Number 4 *The Journal of Clinical Ethics* 353

Thaddeus Mason Pope and Melinda Hexum, "Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment," *The Journal of Clinical Ethics* 23, no. 4 (Winter 2012): 353-76.

Law

Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment

Thaddeus Mason Pope and Melinda Hexum

ABSTRACT

This issue's "Legal Briefing" column covers recent legal developments involving POLST (physician orders for life-sustaining treatment.)[1] POLST has been the subject of recent articles in *JCE*.[2] It has been the subject of major policy reports[3] and a recent *New York Times* editorial.[4] And POLST has been the subject of significant legislative, regulatory, and policy attention over the past several months. These developments and a survey of the current landscape are usefully grouped into the following 14 categories:

1. Terminology
2. Purpose, function, and success
3. Status in the states
4. Four legal routes of implementation
5. Which professionals can authorize POLST?
6. Is the patient's signature required?
7. Can surrogates consent to for incapacitated patients?
8. If a POLST conflicts with an advance directive, which prevails?
9. Is offering POLST mandatory?
10. What are the duties of healthcare providers?
11. What is the role of electronic registries?
12. What is the role of the federal government?
13. International adoption
14. Court cases

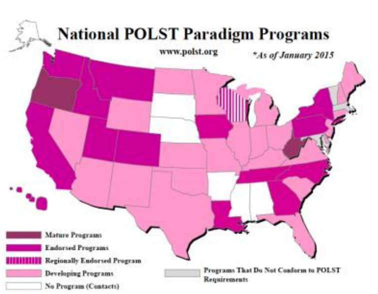
1. TERMINOLOGY

While the POLST paradigm is established or developing in almost every U.S. state, it goes by at least 14 different names.[5] For the sake of clarity, this article will use the acronym POLST, as it is the acronym used by most states. Even among these states, POLST stands for three different terms. In most of the states, POLST stands for physician orders for life-sustaining treatment.[6] In Minnesota and Montana, it stands for provider orders for life-sustaining treatment.[7] In Pennsylvania, POLST stands for Pennsylvania orders for life-sustaining treatment.[8]

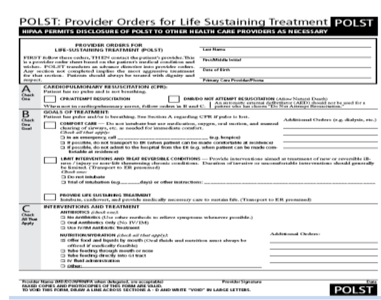
The remaining states use 11 additional ac-

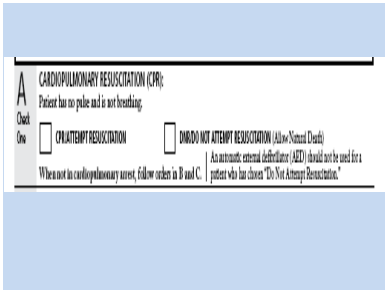
Many acronyms

Same concept



What is POLST





A Check One

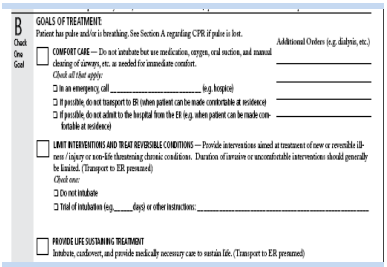
CARDIOPULMONARY RESUSCITATION (CPR):
Patient has no pulse and is not breathing.

☐ CPR/ATTEMPT RESUSCITATION ☐ DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C. | An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

DNR only means “no CPR”

It does not mean “do not treat”



B Check One Goal

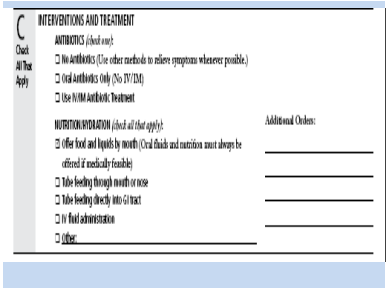
GOALS OF TREATMENT:
Patient has pulse and/or is breathing. See Section A regarding CPR if pulse is lost.

Additional Orders (e.g. dialysis, etc.)

☐ COMFORT CARE — Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.
Check all that apply:
☐ In an emergency, call _____ (e.g. hospice)
☐ If possible, do not transport to ER (when patient can be made comfortable at residence)
☐ If possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

☐ LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS — Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Transport to ER presumed)
Check one:
☐ Do not intubate
☐ Trial of intubation (e.g._____days) or other instructions: _____

☐ PROVIDE LIFE SUSTAINING TREATMENT
Intubate, cardiovert, and provide medically necessary care to sustain life. (Transport to ER presumed)



C Check All That Apply

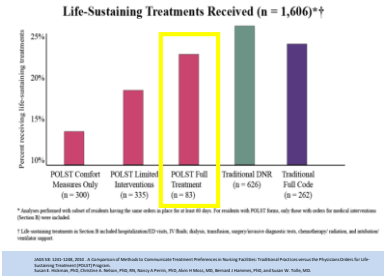
INTERVENTIONS AND TREATMENT

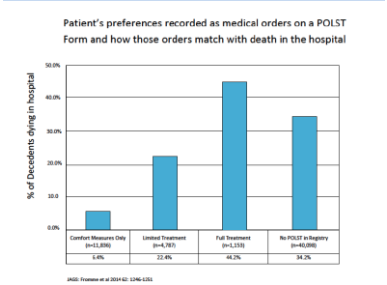
ANTIBIOTICS *(check one)*:
☐ No Antibiotics (Use other methods to relieve symptoms whenever possible.)
☐ Oral Antibiotics Only (No IV/IM)
☐ Use IV/IM Antibiotic Treatment

NUTRITION/HYDRATION *(check all that apply)*:
Additional Orders:
☐ Offer food and liquids by mouth (Oral fluids and nutrition must always be offered if medically feasible)
☐ Tube feeding through mouth or nose
☐ Tube feeding directly into GI tract
☐ IV fluid administration
☐ Other: _____

Order

for LST





For whom

Terminal illness

Advanced chronic progressive illness

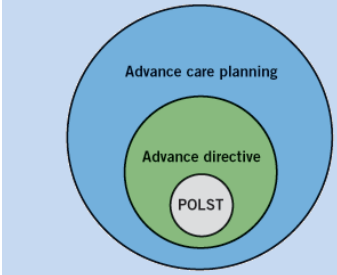
Frailty

In last year of life

Others who want to define care

MOLST **supplements** AD

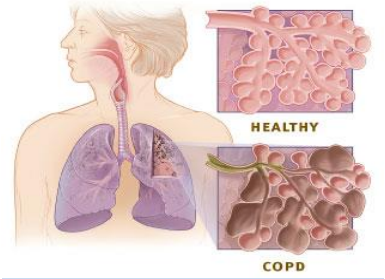
Does not replace



Both

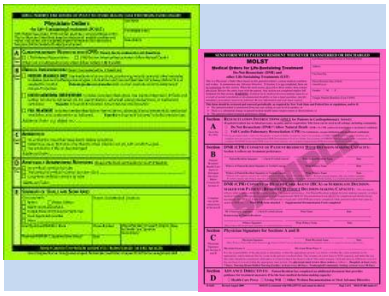
The present

Here & now



MOLST benefits

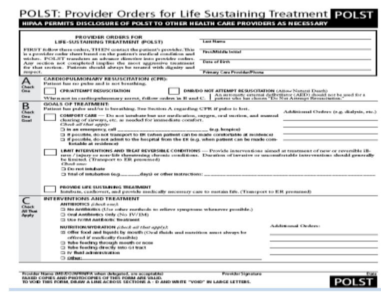
1. Bright color



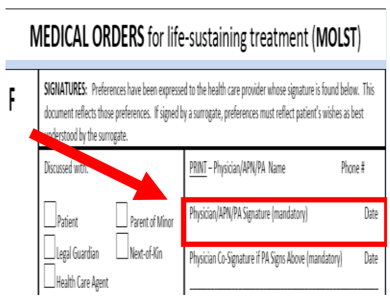
Original MOLST printed on lilac card stock

But a copy has the same force as original

2. Single page



3. More informed



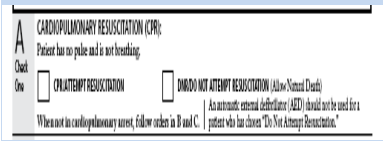
4. Immediately actionable

Provider
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

Home

LTC

Hospital

EMS

8. Updatable

MOLST does **not** expire

MOLST can be revised or revoked at any time

Review with change in condition or location

Can be completed by **surrogate**, if patient lacks capacity

70% patient

30% surrogate

9. Proven Effective

POLST is Evidence Based

- Major academic research in 3 POLST states: strong evidence base of efficacy of POLST in ensuring preferences are elicited, documented, honored, w/ pain and symptom management equivalent to those without POLST order

Hickman et al. "A Comparison of Methods to Communicate Treatment Preferences: Traditional Practices versus the Physician Orders for Life-Sustaining Treatment Program" J Am Geriatr Soc 58:1241-1248, 2010.

Closes gap between what people **want** and what they **get**

Recap

Mostly well settled patient with capacity may refuse life-saving treatment **contemporaneously**

Mostly well settled patient without capacity may refuse life-saving treatment through **advance instructions**

Mostly well settled patient without capacity may refuse life-saving treatment through decision of **authorized SDM**

This is all "**passive**"

Refusing something (chemo, CPR, ventilator, CANH, antibiotics)

Contrast **active** means to hasten death

High dose Opioids

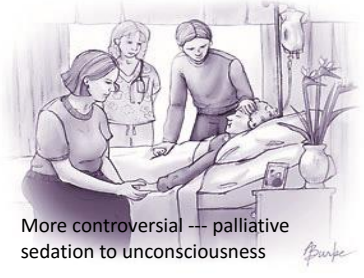
Mostly accepted

Risks respiratory depression and death

Double Effect

1. Action good in itself (not immoral)
2. Intend the good effect (foresee but not intend bad effect)
3. Bad effect not necessary for good effect
4. Proportionality (sufficiently grave reason to risk bad effect)

PSU

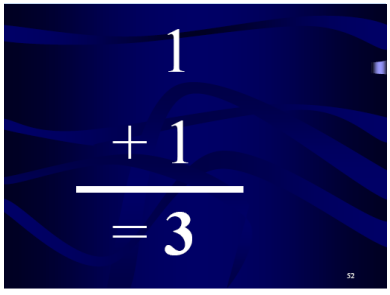


More controversial --- palliative sedation to unconsciousness

	Palliative Sedation	Euthanasia
Intent	Sedate	Kill
Process	Administer drug doses, titrated to effect	Administer lethal drug dose
Outcome	Decreased consciousness	Death

PSU makes Pt **dependent** on CANH

Typically Pt **refuses** CANH



VSED

Voluntarily stopping eating & drinking

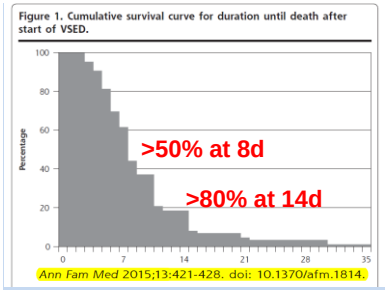
- Find existence intolerable
- Nothing to turn off
- Dehydrate = death 10-14 days
- Generally accepted, if patient decides herself

Definition

Physiologically **able** to take food & fluid by mouth

Voluntary, **deliberate** decision to stop

Intent: death from dehydration



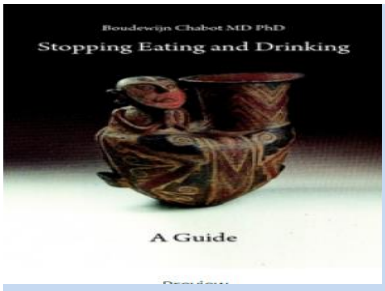
Stop LSMT
Accelerate opioids
VSED / VRFF
Palliative sedation

Passive

PAD / MAID
Euthanasia

Active

Anecdotal reports



NIB Narrative Inquiry in Bioethics
A JOURNAL OF QUALITATIVE RESEARCH

Peer reviewed literature


The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Nurses' Experiences with Hospice Patients Who Refuse Food and Fluids to Hasten Death

Linda Ganzini, M.D., M.P.H., Elizabeth R. Goy, Ph.D., Lois L. Miller, Ph.D., R.N., Theresa A. Harvath, R.N., Ph.D., Ann Jackson, M.B.A., and Molly A. Delorit, B.A.

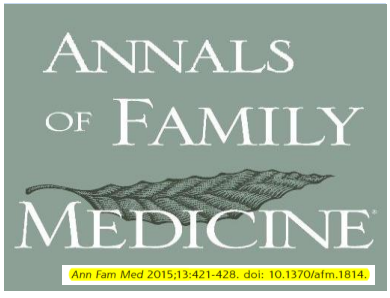
One third of 300 responding OR nurses cared for VSED patient

Even though MAID available, **"almost twice"** chose VSED

"opportunity for reflection, family interaction, and mourning"

Most deaths:

"peaceful, with little suffering"



"the literature mostly comprises commentaries and case reports"

"This study . . . is the **most comprehensive** yet undertaken"

708 responding physicians

46% cared for a patient who VSED

Physicians' impression that dying process went according to the patient's wish	
Yes	80 (71-87)
Partly	18 (11-27)
No	2 (0-8)

If partly or no, reason why[c]	
Duration too long	11 (6-20)
Patient preferred PAS	3 (1-9)
Communication problems	1 (0-6)
Inability to say goodbye	1 (0-6)
Agitation	1 (0-6)

Legal concerns

Capacity

No capacity

Patient with capacity requests VSED now

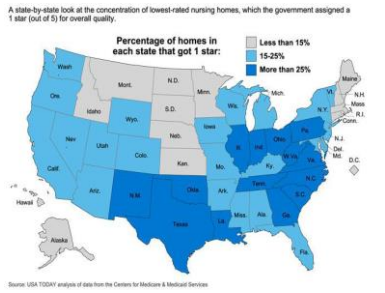
Force feeding is a battery

Does not matter whether food & fluid are "medical treatment"

VSED is not assisted suicide

Active | Passive

VSED is **not** abuse or neglect



Uncertainty & reluctance among providers

Legal & ethical expert support nearly universal

Patient makes "advance" VSED instruction

Trickier & more controversial

The New York Times | http://nyti.ms/1ujCDEh

HEALTH | THE NEW OLD AGE

Complexities of Choosing an End Game for Dementia

By PAULA SPAN JAN. 19, 2015

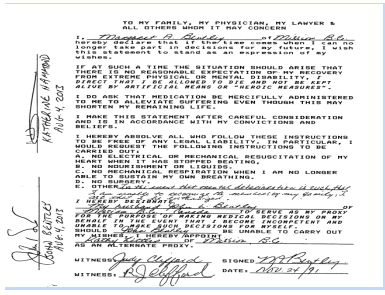
Why "advance" VSED

Not eligible for MAID

Cannot BOTH
- Terminally ill
- Capacity

Be very **specific** on the triggers

Margot Bentley



TO MY FAMILY, MY PHYSICIAN, MY LAWYER & ALL OTHERS WHOM IT MAY CONCERN

I, Margaret A. Bentley of Kitchener, Ont. hereby declare that if the time comes when I can no longer take part in decisions for my future, let this statement stand as an expression of my wishes.

IF AT SUCH A TIME THE SITUATION SHOULD ARISE THAT THERE IS NO REASONABLE EXPECTATION OF MY RECOVERY FROM EXTREME PHYSICAL OR MENTAL DISABILITY, I DIRECT THAT I BE ALLOWED TO DIE AND NOT BE KEPT ALIVE BY ARTIFICIAL MEANS OR "HEROIC MEASURES".

I DO ASK THAT MEDICATION BE MERCIFULLY ADMINISTERED TO RELIEVE MY SUFFERING EVEN THOUGH THIS MAY SHORTEN MY REMAINING LIFE.

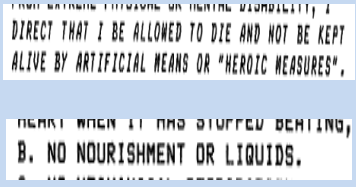
I MAKE THIS STATEMENT AFTER CAREFUL CONSIDERATION AND IS IN ACCORDANCE WITH MY CONVICTIONS AND BELIEFS.

I HEREBY ABSOLVE ALL WHO FOLLOW THESE INSTRUCTIONS TO BE FREE OF ANY LEGAL LIABILITY. IN PARTICULAR, I HEREBY REQUEST THE FOLLOWING INSTRUCTIONS TO BE HONORED QUOTE

A. NO ELECTRICAL OR MECHANICAL RESUSCITATION OF MY HEART WHEN IT HAS STOPPED BEATING.
B. NO NOURISHMENT OR LIQUIDS.
C. NO MECHANICAL RESPIRATION WHEN I AM NO LONGER ABLE TO SUSTAIN MY OWN BREATHING.
D. NO SURGERY.
E. OTHER

I HEREBY APPOINT Margaret A. Bentley OF Kitchener, Ont. TO SERVE AS MY PROXY FOR THE PURPOSE OF MAKING MEDICAL DECISIONS ON MY BEHALF IN THE EVENT THAT I BECOME TERMINALLY ILL AND UNABLE TO MAKE SUCH DECISIONS FOR MYSELF. SHOULD MY PROXY BECOME UNABLE TO CARRY OUT MY WISHES, I APPOINT OF AS AN ALTERNATE PROXY.

WITNESS Judy Clifford SIGNED Margaret A. Bentley
WITNESS B. Clifford DATE Nov. 24/91



DIRECT THAT I BE ALLOWED TO DIE AND NOT BE KEPT ALIVE BY ARTIFICIAL MEANS OR "HEROIC MEASURES".

HEART WHEN IT HAS STOPPED BEATING;
B. NO NOURISHMENT OR LIQUIDS.

Do later requests for water **revoke** the AD?

Maybe

Medical aid in dying

Physician prescribing medication to a mentally capacitated, terminally ill patient, which the patient may ingest to bring about a peaceful death"

aka "death with dignity"

fka "assisted suicide"

"aid in dying" so distinct, so do **not** refer as "PAS"

APHA
AMERICAN PUBLIC HEALTH ASSOCIATION
For science. For action. For health.

AMWA
American Medical Women's Association
The Vision and Voice of Women in Medicine since 1915

1997

Patients in WA and NY sought **constitutional** right to AID

Denied

No right to AID under US Const.

"[T]he . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the **laboratory of the States** . . ."

1994

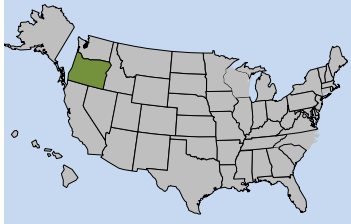
Oregon

Ballot initiative

51%

In operation

1997 - ongoing



Who

Terminal illness
(6 months)
18+
Capacity

How

Doc educates patient about all options –
- palliative care
- pain management
- hospice

Oral request
15 days
2nd oral request
Written request
48 hours

Both treating physician **and** consulting physician must approve

Doc writes prescription

Patient gets at pharmacy

Must self ingest

Self ingest

Patient takes final overt act leading to death

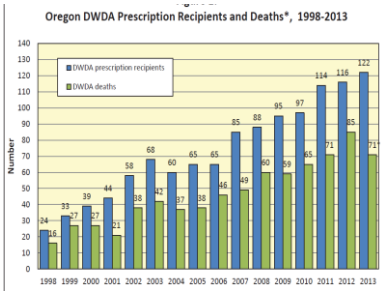
If physician did it, that would be euthanasia & crime everywhere USA

1/3 who get drugs **never** ingest

1200	Get prescription
800	Ingest the drugs

Experience

(18 years)



97% white

98% health insurance

90% enrolled in hospice

72% gone to college

Following Oregon's model

2008	Washington
2013	Vermont
2015	California

Courts, not legislatures

2009	Montana
2016	New Mexico

VAE

IVAE

Voluntary active **euthanasia**: doctor administers lethal agent

Illegal everywhere in North America

What is a medical futility dispute

Very common

Opposite / reverse from right to die situation

Surrogate wants LST, clinician judges inappropriate

Clinician	Surrogate
CMO	LSMT

Futile

Proscribed

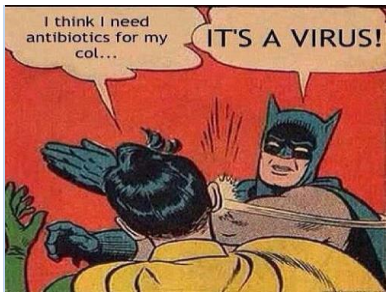
Potentially inappropriate

Futile

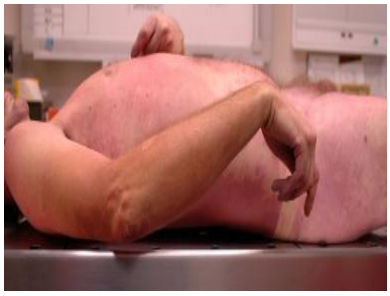
Interventions **cannot** accomplish physiological goals

Scientific impossibility

Example 1



Example 2



Example 3

“Futile”

Value free objective

May & should refuse

Proscribed

Treatments that **may accomplish** effect desired by the patient

Laws or public policies

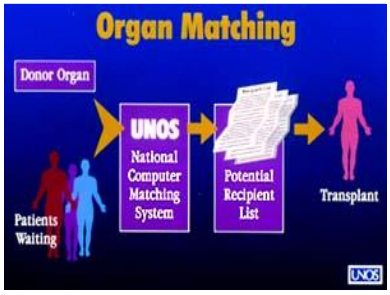
Prohibit

or

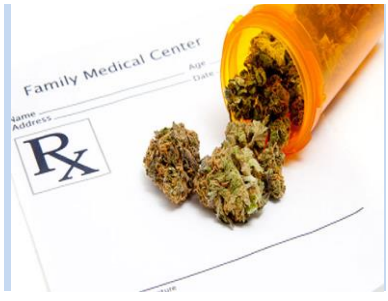
Permit limiting

Prohibited provision

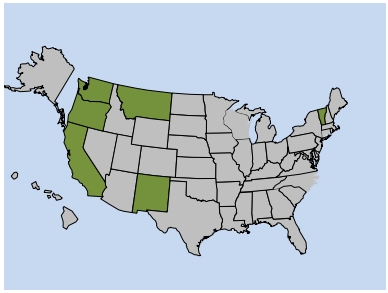
Example 1



Example 2



Example 3



Permitted limiting

Surrogate demand

Appropriate medicine

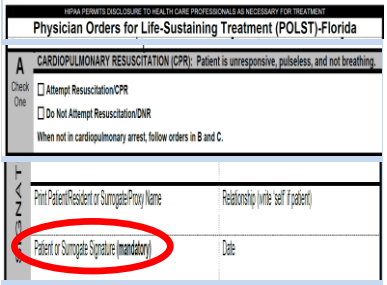
Example 1

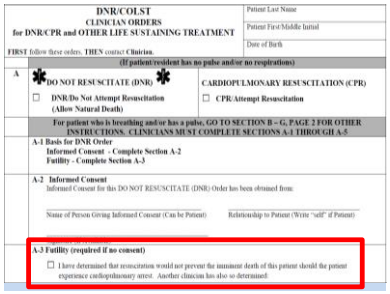
Trisomy 18

22-week gestation

ECMO

Example 2





DNR/COLST
CLINICIAN ORDERS
for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

Patient Last Name
Patient First/Middle Initial
Date of Birth

FIRST follow these orders, THEN contact Clinician.

(If patient/resident has no pulse and/or no respirations)

A
DO NOT RESUSCITATE (DNR)
CARDIOPULMONARY RESUSCITATION (CPR)
DNR/Do Not Attempt Resuscitation (Allow Natural Death)
CPR/Attempt Resuscitation

For patient who is breathing and/or has a pulse, GO TO SECTION B – G, PAGE 2 FOR OTHER INSTRUCTIONS. CLINICIANS MUST COMPLETE SECTIONS A-1 THROUGH A-5

A-1 Basis for DNR Order
Informed Consent - Complete Section A-2
Futility - Complete Section A-3

A-2 Informed Consent
Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

Name of Person Giving Informed Consent (Can be Patient)
Relationship to Patient (Write "self" if Patient)

A-3 Futility (required if no consent)
I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined.

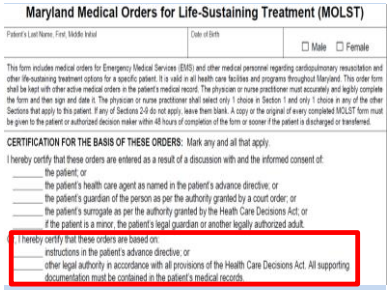
Not ATS "futility"

Might restore CP function

"imminent death"

3 days

http://healthvermont.gov/regs/ad/dnr_colst_instructions.pdf



Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name; First; Middle Initial
Date of Birth
Male Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:
_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

I hereby certify that these orders are based on:
_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

"medically ineffective"

"[not] prevent the **impending death**"

imminent **=** impending

May & should refuse

Potentially Inappropriate

Some chance of accomplishing the effect sought by the patient or surrogate

Not "futile" because might "work"

E.g. dialysis for permanently unconscious patient

E.g. vent for patient w/ widely metastatic cancer

We call them "futility disputes"

. . . BUT . . .

Disputed treatment **might** keep patient alive.

But . . . is that chance or that outcome **worthwhile**

Not a medical judgment

Value judgment

Consent **always**