Advance Care Planning: Reviewing Advance Directives, DNR and POLST

Dr. Cynthia McCarthy, DHCE, MA, NREMT
University of Pittsburgh
Teaching Assistant Professor, Dietrich School of Arts and Sciences
Affiliated Faculty, Consortium Ethics Program
Director, Bioethics Certificate, School of Public Health
Assistant Professor, School of Health and Rehabilitation Sciences
Faculty Fellow, David C. Frederick Honors College

Objectives:

1. Recognize the various resources available to patients, surrogates, and health care providers in Advance Care Planning

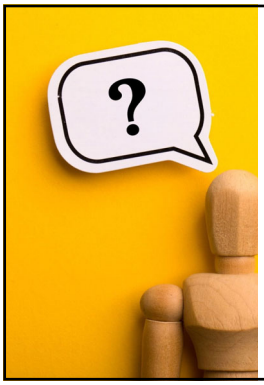
2. Explain the important components of each of the types of documents and when each is used

Documents completed by an individual

Documents completed by a physician in conjunction with an individual (or legally authorized representative)

WHY are these documents important for us to talk about???

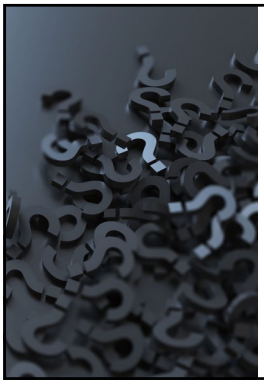
- Relationships with health care providers are often transient
- Recognition of diversity in society and in our practices
- Prominence of autonomy in Western Culture



Does Language Matter?

It does!!

- Evokes emotion
(examples are starve, kill, resuscitate)
- Implies necessity or moral correctness of certain actions
(should/ought, may/can, should not/may not)
- Establishes expectations
(example resuscitate vs attempt resuscitation)



Language Matters - continued

Titles:

Proxy/surrogate/decision maker

Agent/Representative/Guardian

Definitions:

Advance vs Advanced

End-stage condition vs terminal condition

Sample Case

Mr. Jones, a 94-year-old patient, is admitted to the hospital for the fourth time this year from the local senior living facility as a result of a fall and possible concussion. Mr. Jones was admitted to the ICU in 2020 with complications related to an underlying disease process. At the time, his prognosis was very poor. A POLST form was created which included DNAR. Being the fighter that he is, three months later, Mr. Jones was released from the ICU, successfully rehabilitated and returned to his home in the senior living facility. During intake of this week's admission, Mr. Jones' daughter presented his advance directive which consisted of a living will. Medical staff completing the intake were unclear as to which documents are valid and how to make sure that Mr. Jones' autonomous wishes are respected.

Advance Directive Legislation

The Cruzan case established at a federal level that governance, including the amount of evidence needed, regarding advance directives is up to individual states.

*People/patients are subject to the state that they are in. (1990) – Supreme Court Decision

Patient Self-Determination Act (1990) – Federal Law

Advance Directive for Health Care Act (1992) was the first attempt at legislation. PA was the last state in the US to have legislation.

PA Act 169 (2006) is the current law in PA regarding advance directives and decision makers in the absence of advance directives. Although some language is still ambiguous and inconsistently used, many of the gaps in implementation were corrected.

PA uses two types of Advance Directives – these are documents that an individual can create on their own

*Living Will

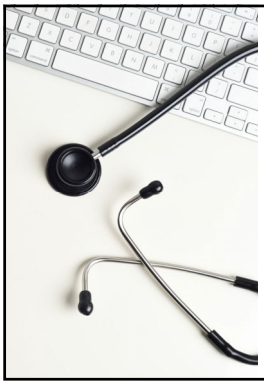
*Durable Power of Attorney for Health Care (also sometimes referred to as Medical Power of Attorney)

*There are mental health versions of these documents as well.

- It is important to note that these documents are NOT the same as a WILL or a Power of Attorney

NOTES:

- A WILL and POWER OF ATTORNEY speak to a person's personal possessions, money, real estate, etc.
- A Will is created before one dies to speak on behalf of a person AFTER he/she dies
- A Power of Attorney is used before death when a patient needs someone to speak on their behalf regarding financial/legal issues, but health care issues are not generally automatically included.



What is a Living Will?

- Living Will – It is a written document, and the purpose is to designate a person's wishes regarding life-sustaining treatment.
- It goes into effect when the patient is incompetent AND has an end-stage medical condition; OR is permanently unconscious.
- NOTE: Notice the placement of the AND and OR. The correct placement is crucial to understanding when these laws go into effect.

End-Stage Medical Condition

- NOTE: End-stage medical condition was an addition in 2006 **replacing** "terminal condition" which does not have a time requirement; the condition needs to be advanced, irreversible, and incurable. Although terminal is no longer a part of the definition of when a living will go into effect, in legislation, PA still occasionally uses it lending to confusion.

Review of definitions related to living will

- WRITTEN – A living will must be written. In PA, the patient's wishes do not need to be on a specific form. There are many forms out there that can be used.
- INCOMPETENT –the term incompetent is a legal term that can only be determined by a judge; however, when we use the term loosely as PA legislation did in Act 169 (and frequently by health care professionals), **it means that the patient is unable to speak to us**.
- PERMANENTLY UNCONSCIOUS – Traditionally this was synonymous with Persistent Vegetative State (PVS). The new term is UNRESPONSIVE WAKEFULNESS SYNDROME. Patients diagnosed with UWS do NOT meet the criteria for brain death. Definitions of brain death require evidence of no brain activity on two EEG's at least 48 hours apart.

What is a Durable Power of Attorney for Health Care (DPAHC)?

- Sometimes this document is also referred to as a Medical Power of Attorney, although the official title is DPAHC.
- In a Durable Power of Attorney for Health Care you assign an "agent"
- It general, the DPAHC document goes into effect when the patient cannot speak for themselves and is incompetent (note the incorrect/loose use of this terminology). Incompetent here means cannot speak to us.
- In general, an agent has the same authority to continue, withhold, withdraw all forms of medical care. An agent can make any decision that a patient with decision making capacity would be able to make.
- The rights of an agent can be limited by the patient when the patient has DMC and is able to speak to us.
- NOTE: A patient may give authority to an agent to speak for themselves even when they can speak.
- An agent will supersede a living will unless limited in a living will by the patient.

**Patients before people and papers.*

Advance Directives in PA

- must be 18 and of sound mind (competent and have decision making capacity); if not 18, one must be graduated from high school, married*, or emancipated
- must be signed by name (or mark) and dated
- must have two witnesses who are at least 18
- individuals may have an agent sign for them
- health care providers may not act as witnesses for those that they are treating (unless it is a relative)
- does NOT need to be notarized in PA or MD

What if you Do Not have an Advance Directive?

- PA Act 169 allows for the designation of a "representative" if there is no active living will, agent, or guardian
- A representative is similar to an agent in that it is someone to make decisions for a patient. However,

- A representative is not selected by the patient. A representative is named based on a predetermined list outlined in Act 169.
- Decisions that a representative can make are **limited** in comparison to those of an agent. Although they may make any positive live saving decisions, representatives are limited in that may only withhold or withdraw life-sustaining care when the patient is permanently unconscious or in an end-stage medical condition.
- This limitation is a protection built in by the state to make sure that representatives, who were assigned through the state hierarchy (remember not assigned by the patient), do not make hasty decisions regarding a patient's treatment that may be life ending.

Representative List

Act 169 includes a list of hierarchical list of pre-determined individuals. The list is as follows:

- Spouse and adult child from another marriage
- Adult child
- Parent
- Adult sibling
- Adult grandchild
- Close friend or neighbor – someone who could speak to the wishes of the patient

How Does the List Work?

A representative is identified through a pre-determined list;

The list is a hierarchy. State law dictates that you begin at the top of the list until at least one person is located in a category.

If there is more than one person in a particular category, such as adult children, actions are taken based on the majority vote of those that fall into that category.

If there is an impasse, we ERR ON THE SIDE OF LIFE, until a majority decision is made. In Maryland, if there is not agreement, an ethics is called.

Other Important Points

- Pregnancy
- Divorce
- Revocation

Other Important Points - Continued

A patient may designate multiple or successor agents

Ex. Mom and Dad

Ex. If something should happen to my husband, then ____ should be designated as my agent

A health care provider must notify an agent or representative if they cannot honor medical directives and provide for a transfer to another physician that can honor the directive

Documents completed by a physician in conjunction with an individual (or legally authorized representative)

DNAR/DNR

POLST

"normal" – inside a hospital or other health care setting

Out-of-hospital (OOH) DNAR

Signed by a physician; not completed independently

Reviewed any time a patient is transferred

When significant changes occur

Recommended at least yearly

Signed by a physician; not completed independently

DNR vs DNAR

- The American Heart Association in 2005 moved from the traditional do not resuscitate (DNR) terminology to do not attempt resuscitation (DNAR). **DNAR reduces the implication that resuscitation is likely and creates a better emotional environment to explain what the order means.**
- Allow natural death (AND) is the name recommended in some settings to make the meaning even clearer.

Ochsner J. 2011 Winter; 11(4): 302–306.
DNR, DNAR, or AND? Is Language Important?; Joseph L Breault, MD, ScD, MPH, CIP

Documents completed by a physician in conjunction with an individual (or legally authorized representative)

DNAR/DNR

"normal" – inside a hospital or other health care setting

Out-of-hospital (OOH) DNAR

Signed by a physician; not completed independently

POLST

Reviewed any time a patient is transferred

When significant changes occur

Recommended at least yearly

Signed by a physician; not completed independently

DNAR is the language used on the POLST form

Out of Hospital DNR Orders

Emergency Medical Personnel may forgo CPR upon arrival if there is evidence of a DNR bracelet, necklace, or Out-of-Hospital DNR order with original signatures.

EMS Personnel without clear evidence of the state approved necklace, bracelet or form with original signatures should proceed with CPR and call command center.

The command center will assess the situation after hearing the concerns of the EMS team and provide direction with regard to how to proceed.

POLST FORMS

Physicians Order for Life Sustaining Treatment (POLST) forms are physician's orders that are comprehensive in nature and covers all aspects of life-sustaining treatment including DNR orders.

P – of POLST – sometimes is written to mean Pennsylvania but was originally intended to be Physician when created in the state of Oregon. In Maryland, the equivalent is a MOLST form.

Its acceptable to have advance directives and a POLST form. Its even encouraged on the PA POLST website. A advance directive can help guide a surrogate decision maker if they need to work with the medical team.

Most effective when clear procedures are in place within a geographic community of acute and non-acute institutions.

Sample Case

Mr. Jones, a 94-year-old patient, is admitted to the hospital for the fourth time this year from the local senior living facility as a result of a fall and possible concussion. Mr. Jones was admitted to the ICU in 2020 with complications related to an underlying disease process. At the time, his prognosis was very poor. A POLST form was created which included DNAR. Being the fighter that he is, three months later, Mr. Jones was released from the ICU, successfully rehabilitated and returned to his home in the senior living facility. During intake of this week's admission, Mr. Jones' daughter presented his advance directive which consisted of a living will. Medical staff completing the intake were unclear as to which documents are valid and how to make sure that Mr. Jones' autonomous wishes are respected.

Thoughts on the Case????

What questions do you need to ask about this situation???

Conclusion

Patients have a variety of ways to communicate their autonomous wishes. Mechanisms allow for the involvement of surrogate decisions makers

The language we use has a significant impact on whether or not interactions are perceived as positive or negative

Education on topics such as this can reduce the moral distress experienced by health care providers, patients and families

Evaluation and Continuing Education Credits:

Note: The evaluation must be completed before December 22nd to receive CE credit.

CONTINUING EDUCATION CREDIT

Upon completion of the evaluation, you will receive instruction via email to request CE credit.

CE Credits available:

- Physician (AMA PRA Category I)
- Physician Assistant (AAPA)
- Nursing (CNE)
- Social Work (ASWB)
- All others will receive a Certificate of Attendance for CEU credit

General Notes:

Advance Directives

Living Wills

Durable Power of Attorney for Health Care (also sometimes referred to as Medical Power of Attorney

DNR/DNAR

POLST