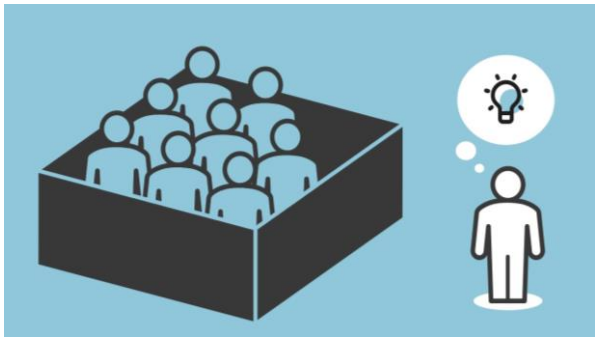
Legal and Ethical Considerations at End of Life

Thaddeus Mason Pope
Weinberg Center for Elder Justice
SPRiNG Alliance Symposium 2021

1

2



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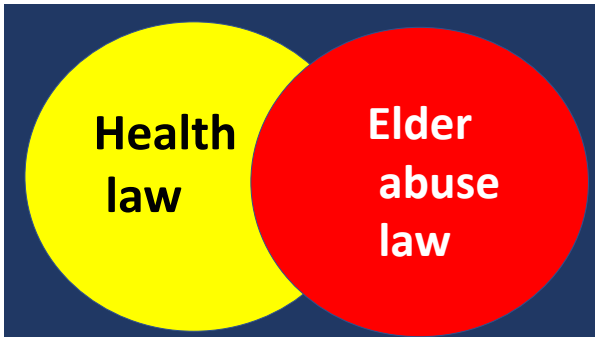


4

Advance care planning

5

6

7

Battery

Tort
Crime

8

9

But **also**

10

11

Unwanted
medical
treatment

12

Too **little** = harm

13

Too **much** = harm

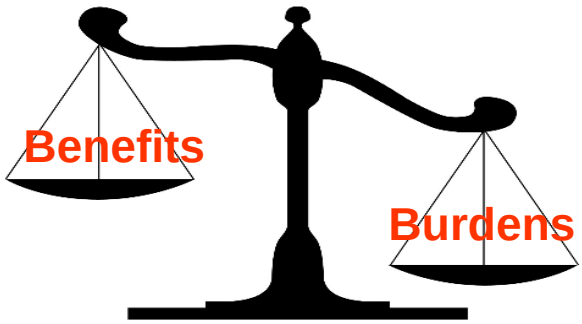
14

How much is too much is **value laden**

15

Preference sensitive decision

16



17

Received: 4 May 2018 | Revised: 24 February 2019 | Accepted: 25 February 2019
DOI: 10.1002/pon.5054

REVIEW

WILEY

Quality of life versus length of life considerations in cancer patients: A systematic literature review

Anne Shrestha[1] | Charlene Martin[1] | Maria Burton[2] | Stephen Walters[3] | Karen Collins[2] | Lynda Wyld[1]

18

More burden than benefit

19

Unwanted

20

Harm

21

The New York Times

The Patients Were Saved. That's Why the Families Are Suing.

Paula Span

THE NEW OLD AGE APRIL 10, 2017

22

SPOTLIGHT TEAM FOLLOW-UP

Hospital staff revived a man's stopped heart – and he sued

A successful 'wrongful prolongation of life' lawsuit in Montana, among other things, reflects the extent to which many Americans will go to gain – and enforce – their rights to control their final days.

By Mark Arsenault Globe Staff, Updated December 26, 2020, 2:48 p.m.

23

FLATHEAD BEACON

NEWS & FEATURES | SPORTS | OUTDOORS | ARTS & ENTERTAINMENT | OPIN

News & Features

Hospital Ordered to Pay $400K in Do-Not-Resuscitate Lawsuit

A jury found St. Peter's Health in Helena and Dr. Virginia Lee Harrison negligent

BY ASSOCIATED PRESS // MAY 24, 2019

24

$1 million

25

Lanzetta v Montefiore Med. Ctr.

2021 NY Slip Op 21026

Decided on February 16, 2021

Supreme Court, Bronx County

Higgitt, J.

26

Don't want to discuss remedies

27

Verdicts & settlements show UMT compensable **injury**

28

Unwanted

29

Medical error

30

Patient / resident
safety

31

So…

32

33

How help
your clients
avoid UMT

34

How help
your clients
avoid UMT

35

The Harry and Jeanette Weinberg
CENTER FOR ELDER ABUSE PREVENTION
AT THE HEBREW HOME AT RIVERDALE

36

Dignity

37

Control

38

39

When **lose** capacity

40

Roadmap

41

3

42

Why
do ACP

43

What
is ACP

44

How
do ACP

45

1:15 – 2:15 ET

46

47

Why ACP

48

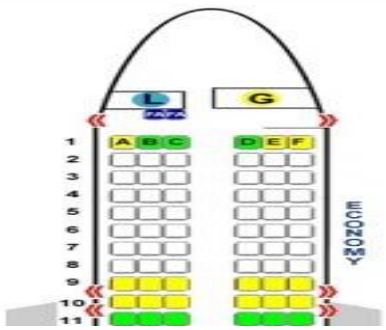
No plan → **default** rule

49

Default rules produce **bad** outcomes

50

51



52

53

54

Default rules for medical treatment probably **bad** for your client

55

Default
- Aggressive curative directed therapy

56

Default
- Aggressive curative directed therapy

57

PewResearchCenter
NUMBERS, FACTS AND TRENDS

NOV. 21, 2013

Views on End-of-Life Medical Treatments

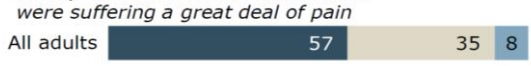
58

Personal Preferences for End-of-Life Treatment

% of U.S. adults who say they would tell their doctors to ... in each circumstance

- Stop treatment so they could die
- Do everything possible to save their lives
- Depends (vol.)/Don't know

If they had an incurable disease and were suffering a great deal of pain



59

The Washington Post

Most people want to die at home, but many land in hospitals getting unwanted care

60

61

Capacity

62

What is "capacity"

63

3

64

Able to **understand** significant benefits, risks and alternatives to proposed health care

65

Able to **make** a decision

66

Able to **communicate** a decision

67

Patient **has capacity** to make decision at hand

Patient decides **herself**

68

All patients **presumed** to have capacity

69

No need to **prove** capacity

70

Must prove **in**capacity

71

Sometimes obvious

72

73

74

Often unclear

75

So,

76

Assess capacity **carefully**

77

78

Not all or nothing

79

Patient might have capacity to make **some** decisions but not **others**

80

Patient may lack capacity for **complex** decisions

81

Still have capacity for **simpler** decisions

82

Still have capacity to **appoint** agent /proxy

83

84

May **fluctuate** over time

85

Capacity in **morning** not afternoon

86

AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults.

87

Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

Except in cases of obvious and complete incapacity, an attempt should always be made to ascertain the patient's ability to participate in the decision-making process.

88

89

Even if really lacks capacity

90

reversible

91

Restore capacity if possible

92

Table 7 Means to enhance capacity

Cause of confusion	Possible intervention
Alcohol or other substances intoxification	Detoxification; supplement diet or other intake needs
Altered blood pressure	Treat underlying cause of blood pressure anomaly wi medication or other treatment
Altered low blood sugar	Management of blood sugar through diet or medicati
Anxiety	Treatment with medications and/or psychotherapy; su groups
Bereavement; Recent death of a spouse or loved one	Support; counseling by therapist or clergy; support gr medications to assist in short term problems (e.g., s depression)
Bipolar disorder	Treatment with medications and/or psychotherapy; su groups

HEC Forum
DOI 10.1007/s10730-016-9317-9

93

We prefer to hear from patient **herself**

94

Do not want 2nd best substitutes unless **necessary**

95

Restore

Preserve

96

Supported decision making

97

Supported DM

≠

Substitute DM

98

Patient still in charge

99

collaborate to help understand situations and choices, so can make their **own** decisions

100

Supported Decision-Making Agreement

This agreement must be read out loud or otherwise communicated to all parties to the agreement in the presence of either a notary or two witnesses. The form of communication shall be appropriate to the needs and preferences of the person with a disability.

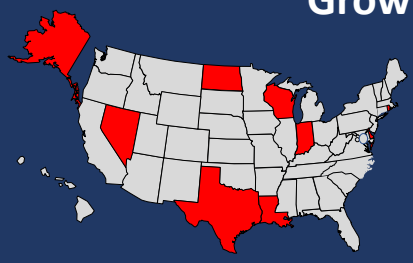
My name is: _____.

I want to have people I trust help me make decisions. The people who will help me are called **supporters.**

My supporters are not allowed to make choices for me. I will make my own choices, with support. I am called the **decider**.

101

Growing



102

If Pt can decide

Patient decides

103

If Pt can decide w/ help

Help them

104

Will lose capacity

105

Can no longer make **own** decisions

106

Need a substitute

107

Someone who can **speak for Pt** when she cannot speak for herself

108

Ideally, people appoint their **own** healthcare agents

109

BUT

110

111

Not completed

112

Before COVID-19

113

114

PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE W

NOV. 21, 2013

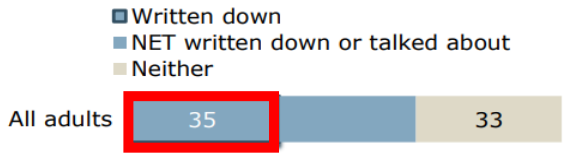
Views on End-of-Life Medical Treatments

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

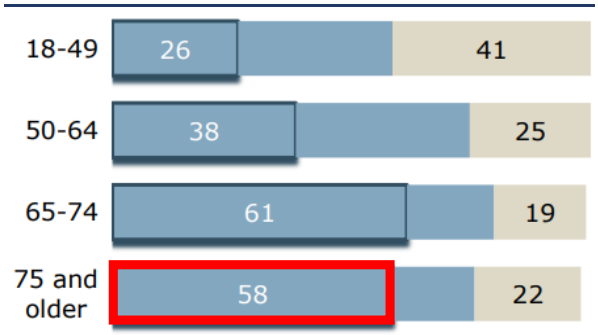
115

Preparation for End-of-Life Treatment, By Age

% who say they have written down or talked with someone about their wishes



116



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RESPECTING PATIENTS' PREFERENCES

By Kuldeep N. Yadav, Nicole B. Gabler, Elizabeth Cooney, Saida Kent, Jennifer Kim, Nicole Herbst, Adjoa Mante, Scott D. Halpern, and Katherine R. Courtright

DOI: 10.1377/hlthaff.2017.0175
HEALTH AFFAIRS 36,
NO. 7 (2017): 1244-1251

Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care

118

Systematic review of 150 studies

800,000 people

119

37%

120

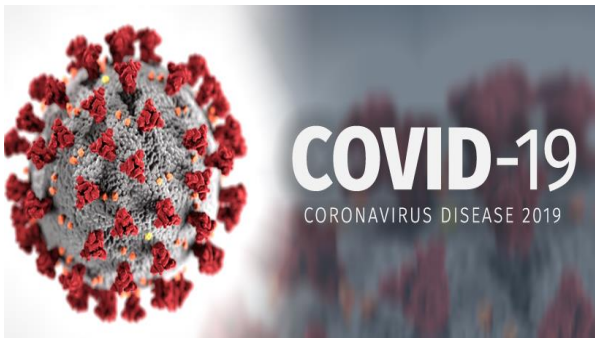
121

Why?

122

123

124



125

126

127

Since

COVID-19

128

Advance directive completion

129

130

JOURNAL OF BUSINESS
Serving Spokane & Kootenai Counties

Advance directive demand

More clients seek end-of-life plan guidance during pandemic, Spokane attorneys say

Virginia Thomas September 24th, 2020

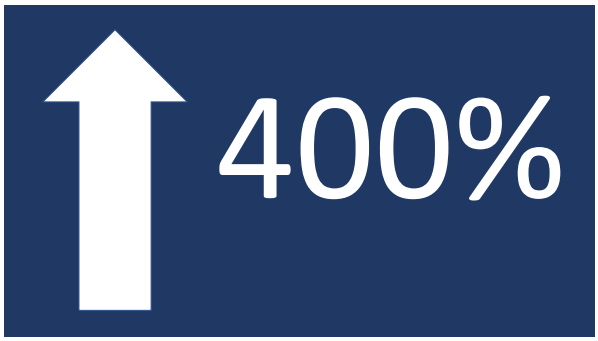
131

THE INDIANA LAWYER

Life and death decisions: Pandemic increases focus on estate planning, health care advance directives

May 26, 2020 | Olivia Covington

132



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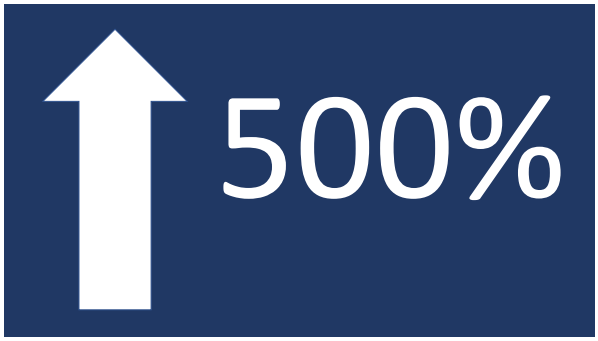
Vol. ▮ No. ▮ ▮ 2020 Journal of Pain and Symptom Management 1

How COVID-19 Changed Advance Care Planning: Insights From the West Virginia Center for End-of-Life Care

Danielle Christina Funk, MS, Alvin H. Moss, MD, and Atticus Speis, MS
West Virginia University, Morgantown, West Virginia

134



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JAMA Network Open

Research Letter | Geriatrics

Completion of Advance Directives and Documented Care Preferences During the Coronavirus Disease 2019 (COVID-19) Pandemic

Catherine L. Auriemma, MD; Scott D. Halpern, MD, PhD; Jeremy M. Asch, BA; Matthew Van Der Tuyn, MA; David A. Asch, MD, MBA

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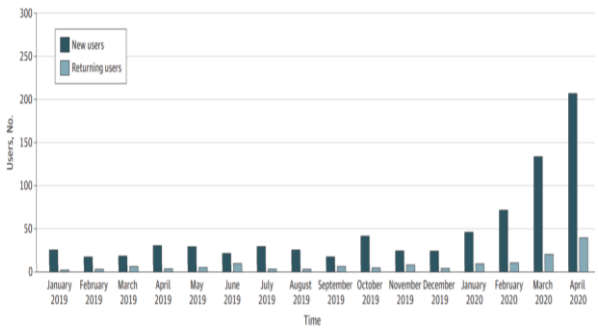


137

JMIR Publications Journal of Medical Internet Research

J Med Internet Res. 2020 Aug; 22(8): e21385. PMCID: PMC7423389
Published online 2020 Aug 11. doi: 10.2196/21385: 10.2196/21385 PMID: 32716900

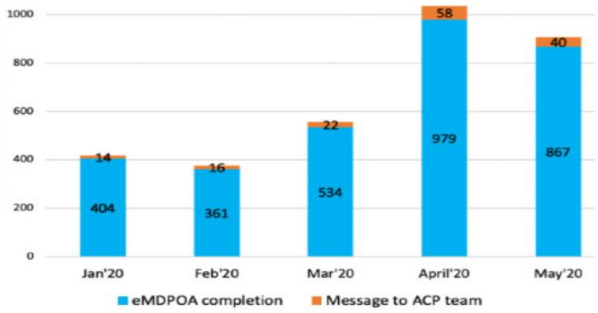
Advance Care Planning Among Users of a Patient Portal During the COVID-19 Pandemic: Retrospective Observational Study

Monitoring Editor: Gunther Eysenbach

Reviewed by Emmanuelle Belanger and Prasad Padala

Jennifer D Portz, PhD,[#1] Adreanne Brungardt, MM, MT-BC,[2] Prajakta Shanbhag, MPH,[2] Elizabeth W Staton, MSTC,[3] Seuli Bose-Brill, MD,[4]

138



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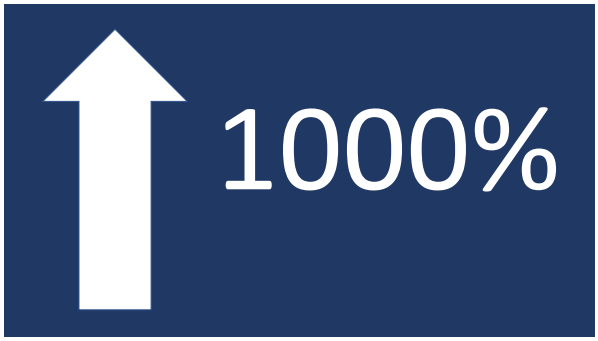

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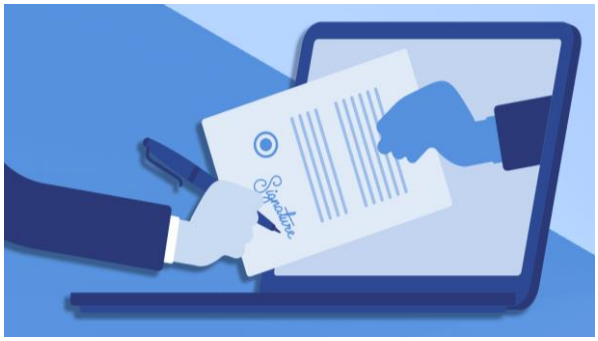


148

149

150

151

Not found

152

76% of physicians whose patients **have** ADs do not know they **exist**

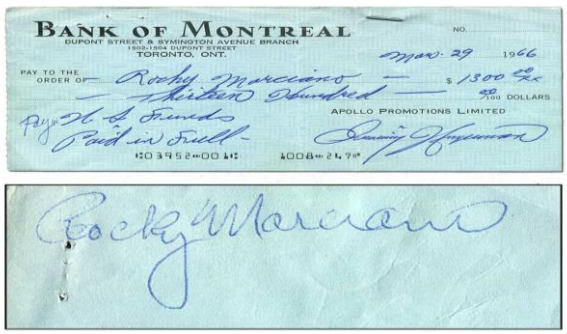
U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

153

Fail to make & distribute copies

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

154



155

Complete ≠ Have

156

Pt have
≠
HCP have

157

158

Completed AD

Have AD

159

Still may not have **agent**

160

Unavailable
Unable
Unwilling

161

Upshot

162

80% incapacitated patients have **no** agent

163

164

Default surrogate

165

3rd choice

166

1. Pt make **own** decision
2. Pt **choose** who she trusts

167

Patient appoints in AD

168

Agent
DPOAHC

169

Surrogate

170

Not chosen
by patient

171

Chosen off
a list

172

Almost all states
specify a
sequence

173

FHCDA

174

Spouse / partner
Adult child
Parent
Adult sibling
Close friend

175

Problems

176

Popular Choices

#1 Default Choice
#2 Choice
#3 Choice

177

Wrong surrogate

178

1

179

Priority sequence in list might **not** match **your** preference

180

Especially true for elder abuse victims

181

Spouse

"if not legally separated"

182

No automatic exclusions for other surrogates

183

2

184

Spouse / partner
Adult child
Parent
Adult sibling
Close friend

185

RESEARCH LETTER

Patients With Next-of-Kin Relationships Outside the Nuclear Family

JAMA April 7, 2015 Volume 313, Number 13 1369

186

Nuclear family member	102 042	92.9
Spouse	53 212	48.5
Adult child	22 495	20.5
Parent	14 031	12.8
Sibling	12 304	11.2

187

BUT

188

Outside the nuclear family	7761	7.1
Nonnuclear relative	3190	2.9
Niece or nephew	1134	1.0
Cousin	523	<1
Aunt or uncle	490	<1
In-law	358	<1
Step-parent or step-sibling	291	<1
Grandparent	170	<1
Grandchild	166	<1
Other blood or legal relative	58	<1

189

3

190

Spouse / partner
Adult child
Parent
Adult sibling
Close friend

191

192

Adult **sibling** might be better surrogate

But **child** trumps

193

Recap

194

Risks from no ACP

195

Risk 1

Wrong surrogate

196

Risk 2

No surrogate

197

198

Increasingly **common** situation

199

Hospitals & LTC **challenged**

200

Patient **needs** treatment

201

BUT

202

No capacity

No surrogate

203

Patient **cannot** consent

204

Nobody else to consent

205

Various terms

206

"unrepresented"

"adult orphan"

207

Patient w/o proxy

Incapacitated & alone

208

Most prevalent

"unbefriended"

209

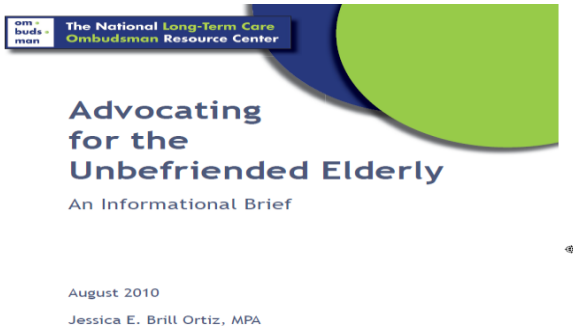
Incapacitated and Alone:
Health Care Decision-Making for the Unbefriended Elderly

Naomi Karp and Erica Wood

American Bar Association
Commission on Law and Aging

July 2003

210



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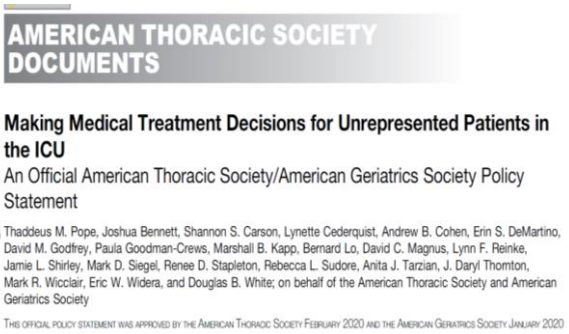


213

Who
are they

214

Definition
Prevalence
Causes

215

Definition
2 conditions

216

1

217

Lack capacity

218

2

219

Lack agent or surrogate

220

Nobody to consent to treatment

221

Big problem

222

Hospital estimates

223

16% ICU admits

Decisions to limit life-sustaining treatment for critically ill patients who lack both decision-making capacity and surrogate decision-makers*

Douglas B. White, MD; J. Randall Curtis, MD, MPH; Bernard Lo, MD; John M. Luce, MD

224

5% ICU deaths

ARTICLE | Annals of Internal Medicine

Life Support for Patients without a Surrogate Decision Maker: Who Decides?

225

> 25,000

US, each year

226

Royal College of Physicians | Marie Curie

Care and support through terminal illness

End of Life Care Audit – Dying in Hospital

National report for England 2016

227

3.4. Is there documented evidence that the cardiopulmonary resuscitation (CPR) decision by a senior discussed with the **nominated person(s) important to the patient** during the last episode of care?

• YES	78%*	7219
• NO	18%	1706
• NO BUT	4%	377

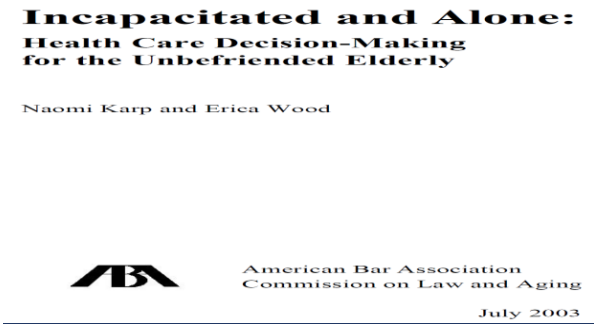
If 'no but' during the last episode of care it was recorded that:

• There was no nominated person important to the patient	47%	177
• Attempts were made to contact the nominated person important to the patient but were unsuccessful	53%	200

228

LTC estimates

229

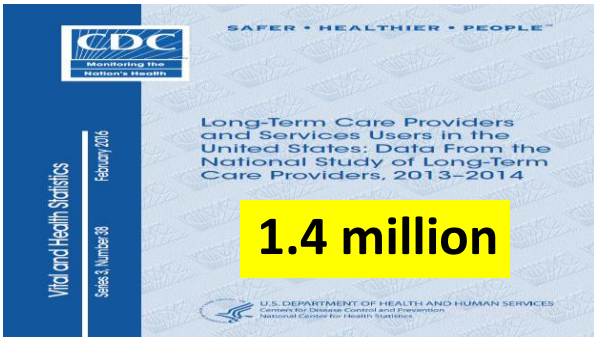


230

3 - 4 %

U.S. nursing home population

231



232

> 56,000

USA

233

Plus

234

Temporarily

unrepresented

235

235

Not just big, but

Growing problem

236

236

4 key factors

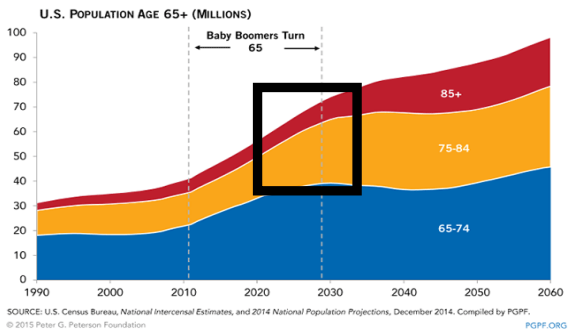
237

237

1

238

238



239

2

240

240

AARP Public Policy Institute

10,000,000 boomers live alone

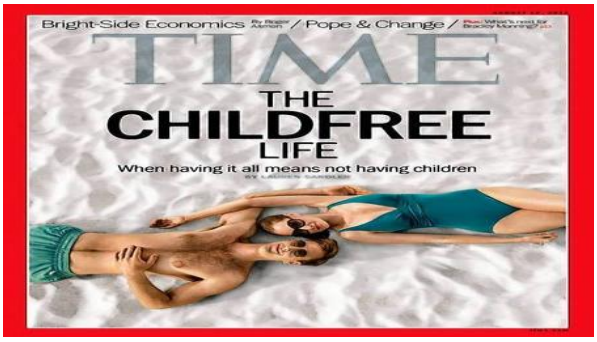
The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers

241

242

3

243



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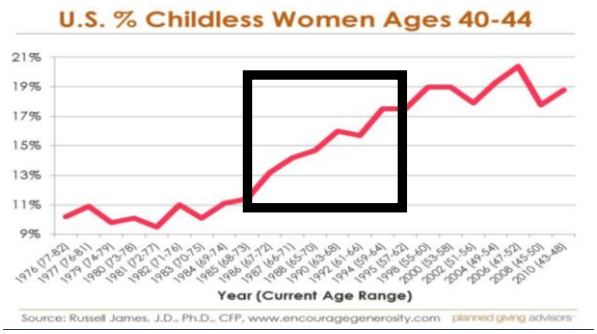


245

4

246

Others "have" family

247

247

Able but **unwilling**

248

248

No **contact** (e.g. LGBT, homeless, criminal)

249

249

Willing but **unable**

250

250

SDM lacks **capacity**

251

251

We have **many** unrepresented

252

252

What's the **problem**

253

Risks & Harms

254

Cannot advocate for self

255

Have **no** substitute advocate

256

POSITION STATEMENT

Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

AGS Ethics Committee

"highly vulnerable"

"most vulnerable"

257

GUARDIANSHIP FOR VULNERABLE ADULTS IN NORTH DAKOTA: RECOMMENDATIONS REGARDING UNMET NEEDS, STATUTORY EFFICACY, AND COST EFFECTIVENESS

WINSOR C. SCHMIDT*

"unimaginably helpless"

258

Problem

259

Nobody to authorize treatment

260

How do clinicians respond?

261

3 common responses

262

1

263

Under-treatment

264

Reluctant to act without consent

265

Wait

266

Until **emergency**

(implied consent)

267

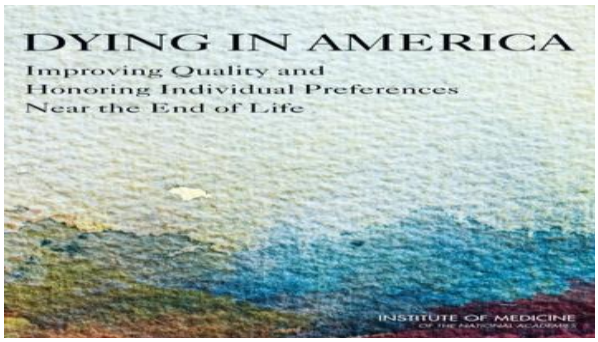
BUT

268

Longer period suffering

Increases risks

269



270

Ethically "**troublesome** . . . wait until . . . condition worsens into an **emergency**"

271

2

272

Over-treatment

273

Fear liability

Fear regulatory sanctions

274

Treat aggressively

275

BUT

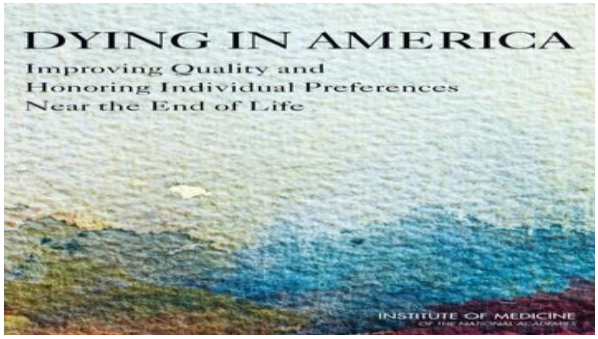
276

Burdensome

Unwanted

277

277



278

"**compromises** . . . consideration of patient preferences or best interests"

279

3

280

280

No discharge to appropriate setting

281

281

282

282

283

No DM → Patient harm

284

Best way to **protect** the unrepresented is to **prevent** them from becoming unrepresented

285

Recap

286

No ACP → default rules

287

Default rules → create risks

288

Wrong surrogate

289

No surrogate

290

UMT

291

Value discordant treatment

292

So…

293

Help your clients plan

294

295

2 parts
to AD

296

Appoint agent

Record wishes

297

Appointing **agent**
more important

298

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

299

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.

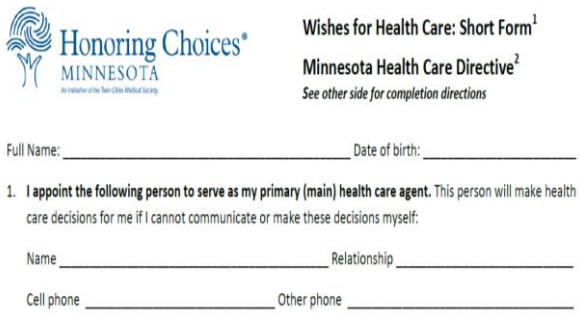
300

Respond **dynamically**

301

Easy

302



Honoring Choices® MINNESOTA

Wishes for Health Care: Short Form[1]

Minnesota Health Care Directive[2]

See other side for completion directions

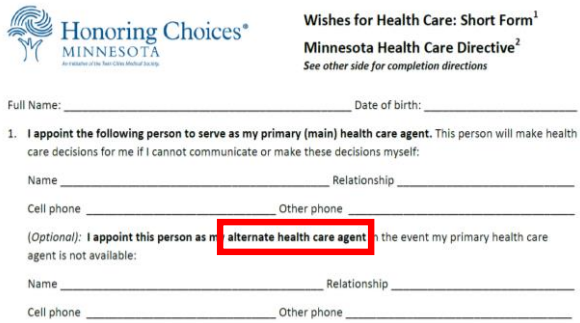
Full Name: _____ Date of birth: _____

1. **I appoint the following person to serve as my primary (main) health care agent.** This person will make health care decisions for me if I cannot communicate or make these decisions myself:

Name _____ Relationship _____

Cell phone _____ Other phone _____

303



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Full Name: _____ Date of birth: _____

1. **I appoint the following person to serve as my primary (main) health care agent.** This person will make health care decisions for me if I cannot communicate or make these decisions myself:

Name _____ Relationship _____

Cell phone _____ Other phone _____

(Optional): **I appoint this person as my alternate health care agent** in the event my primary health care agent is not available:

Name _____ Relationship _____

Cell phone _____ Other phone _____

304

Who?

305

Knows the patient

306

Cares about patient

307

Willing to serve

308

Willing to honor patient wishes

309

Able to serve

health - live nearby

310

Good advocate

311

Other part AD

312

Record wishes

313

FKA

"living will"

314

Record treatment

You want

You do not want

315

Lots of paper forms, e-forms & apps

316

Some are more **treatment** focused

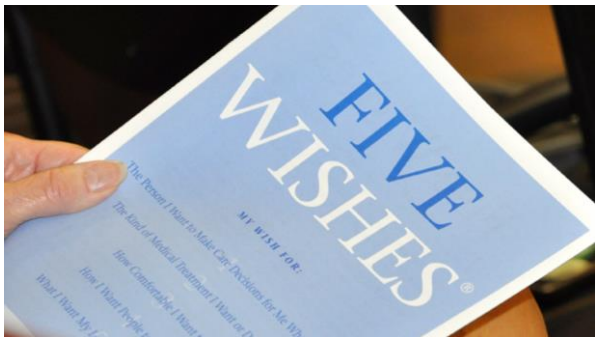
317

For each of the situations at right, check the boxes that indicate your wishes regarding treatment.	**Situation A** If I am in a coma or persistent vegetative state and have no known hope of recovering awareness or higher mental functions:			**Situation B** If I am in a coma and have a small but uncertain chance of regaining awareness and higher mental functioning:			**Situation C** If I am aware but have brain damage that makes me unable to recognize people, to speak meaningfully, or to live independently, and I have a terminal illness:		
	I want	I do not want	I want a trial; if no clear improvement, stop treatment.	I want	I do not want	I want a trial; if no clear improvement, stop treatment.	I want	I do not want	I want a trial; if no clear improvement, stop treatment.
1. Cardiopulmonary resuscitation. The use of pressure on the chest, drugs, electric shocks, and artificial breathing to revive me if my heart stops.			■			■			■
2. Mechanical respiration. Breathing by machine, through a tube in the throat.									
3. Artificial feeding. Giving food and water through a tube inserted either in a vein, down the nose, or through a hole in the stomach.									

318

Others are more **goal** focused

319



320

Part 3: My Hopes and Wishes *(Optional)*

I want my loved ones to know my following thoughts and feelings:

The things that make life most worth living to me are:

My beliefs about when life would be no longer worth living:

321

Advantage

322

Hear from patient **herself**

323

Best DM for you is **you**

324

Purpose

325

Goal concordant care

326

Get Tx you want

Avoid Tx you don't want

327

New growing type of AD

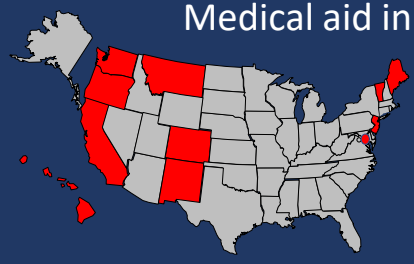
328

Dementia directive

329

330

Medical aid in dying



331

End-of-life option

332

Ask & receive prescription **drug**

333

Self-administer to hasten death

334

Cannot satisfy eligibility conditions

335

Terminally ill

< 6 mo. prognosis

336

Decisional capacity

337

Terminal → no capacity

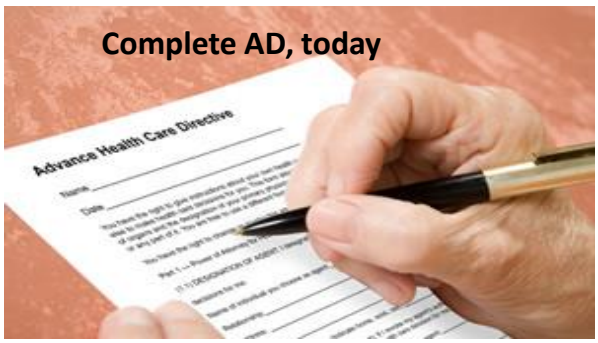
338

Capacity → not terminal

339

So…

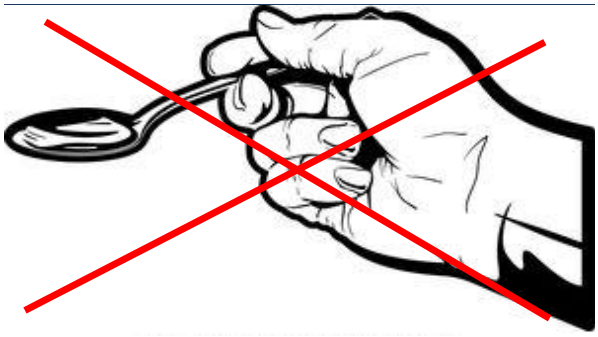
340



341

Direct VSED in **future**

342

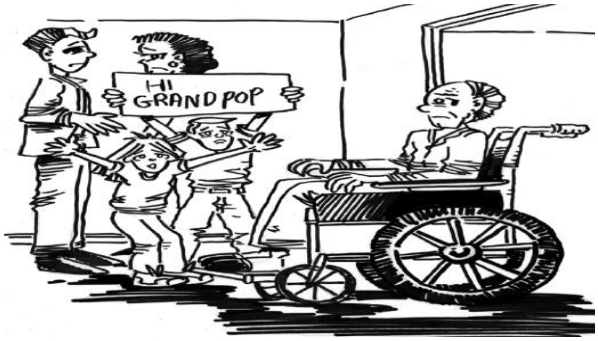


343

At a **point**

you specify

344



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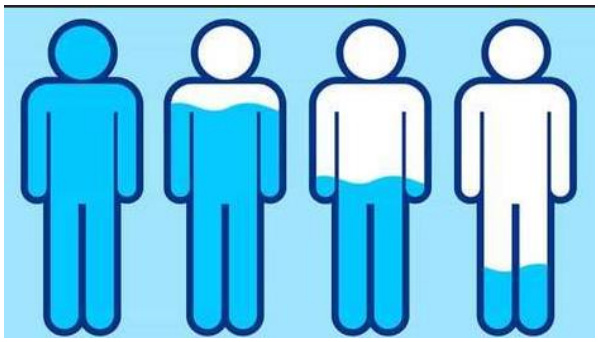
346



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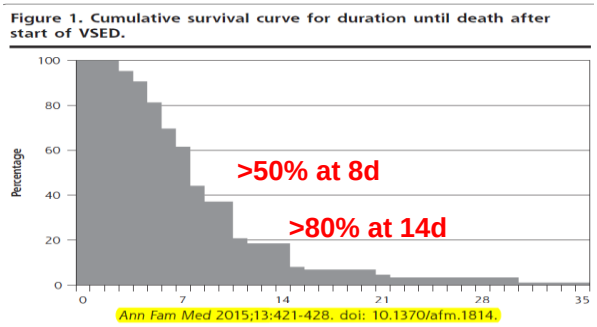


348

Peaceful

comfortable

349

End of Life Choices NEW YORK

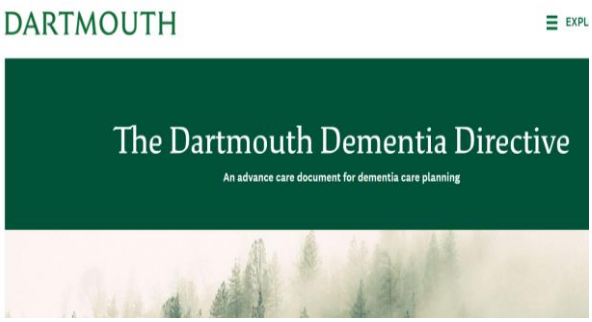
ABOUT THE ADVANCE DIRECTIVE FOR RECEIVING ORAL FOOD AND FLUIDS IN DEMENTIA

350

FinalExit NETWORK

Introduction to our Supplemental Advance Directive For Dementia

351



352

Dehydration

looks like neglect

353

But **no duty**

when refused

354

That's ADs

Appoint agent

Record wishes

355

Help your clients

356

SW **or** JD

(or RN NP PA MD…)

357

Advance directive

358

2

359

Appoint agent & alternate

360

Record values & preferences

361

362

Make it **legal**

363

Witnessed or notarized

364

365

Make it **findable**

366

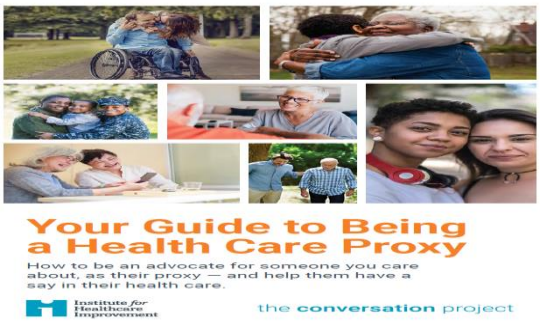
Copies to agents, EHR

367

368

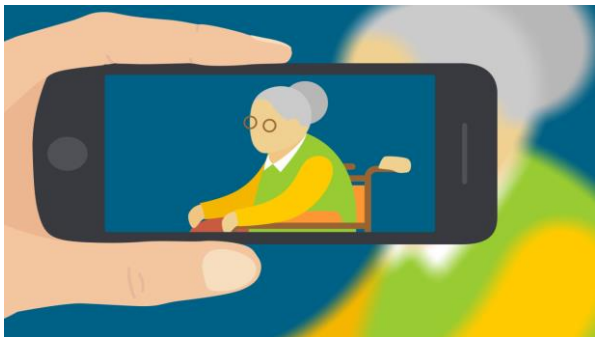
369

370



371

372



373

Videos help resolve disputes over AD validity & meaning

374

375

376

September 3

AD names agent "companion"

377

378

October 16

AD names **new** agent

379

380

381

382

383

Completed
Signed
Witnessed/notarized
Shared
Video

384

385

Review

386

6 Ds

387

Death of family / friend
Divorce
New **Diagnosis**
Significant **Decline** health
New **Decade**
Change of **domicile**

388

389

7th D

390

Desperado

391

Not agent

392

"I want __ to take no part..."

393

394

After complete or update AD

395

POLST

396

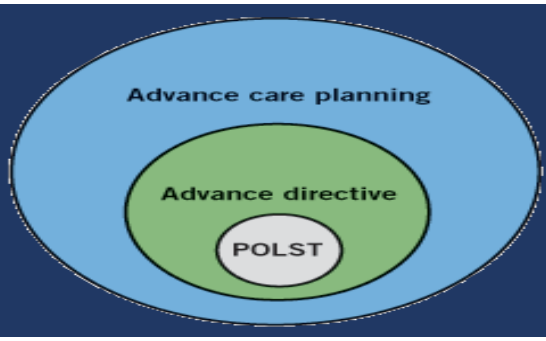
Provider
Orders
Life
Sustaining
Treatment

397

Supplements AD

Does not replace

398



399

For whom

400

Primarily for those expected to die in next year

401

Terminal illness

Advanced chronic progressive illness

Frailty

402

Advantage over AD

403

Transportable order set

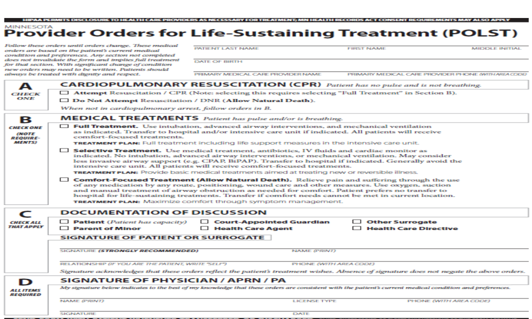
404

Immediately actionable

405

No need to "**translate**" into orders

406



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT; MN HEALTH RECORDS ACT CONSENT REQUIREMENTS MAY ALSO APPLY

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

PATIENT LAST NAME / FIRST NAME / MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME / PRIMARY MEDICAL CARE PROVIDER PHONE *(WITH AREA CODE)*

A *CHECK ONE*

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

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

☐ **Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

B *CHECK ONE (NOTE REQUIREMENTS)*

MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

☐ **Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.
TREATMENT PLAN: Maximize comfort through symptom management.

C *CHECK ALL THAT APPLY*

DOCUMENTATION OF DISCUSSION

☐ **Patient** *(Patient has capacity)* ☐ **Court-Appointed Guardian** ☐ **Other Surrogate**
☐ **Parent of Minor** ☐ **Health Care Agent** ☐ **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE ***(STRONGLY RECOMMENDED)*** / NAME *(PRINT)*

RELATIONSHIP *(IF YOU ARE THE PATIENT, WRITE "SELF")* / PHONE *(WITH AREA CODE)*

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D *ALL ITEMS REQUIRED*

SIGNATURE OF PHYSICIAN / APRN / PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

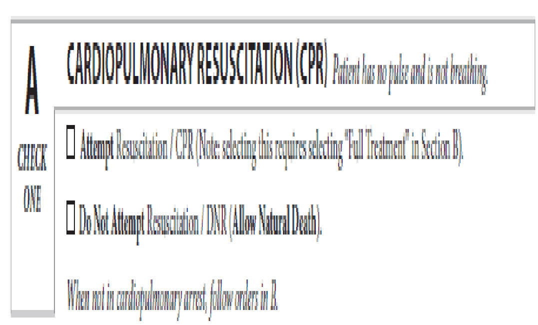
NAME *(PRINT)* / LICENSE TYPE / PHONE *(WITH AREA CODE)*

SIGNATURE / DATE

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). *www.polstmn.org* **PAGE 1 OF 2**

407



A CHECK ONE

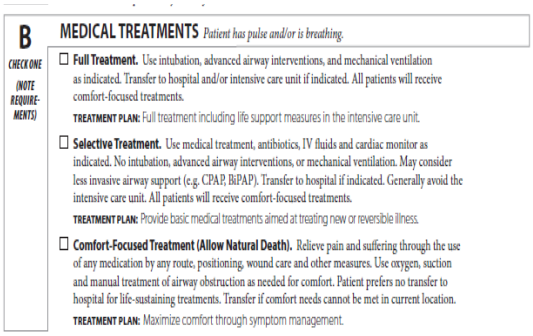
CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

☐ Attempt Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

☐ Do Not Attempt Resuscitation / DNR (Allow Natural Death).

When not in cardiopulmonary arrest, follow orders in B.

408



B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE (NOTE REQUIREMENTS)

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.

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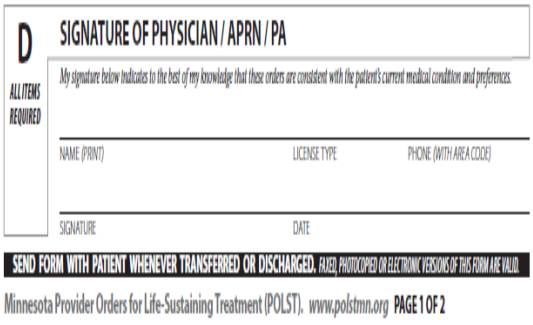
TREATMENT PLAN: Maximize comfort through symptom management.

409



D SIGNATURE OF PHYSICIAN / APRN / PA

ALL ITEMS REQUIRED

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME (PRINT) LICENSE TYPE PHONE (WITH AREA CODE)

SIGNATURE DATE

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). *www.polstmn.org* **PAGE 1 OF 2**

410

You cannot complete POLST but you can **advise** client

411

Getting ready

412

Know your state **statute**

413

Review top 5 **forms**

414

Complete your **own**

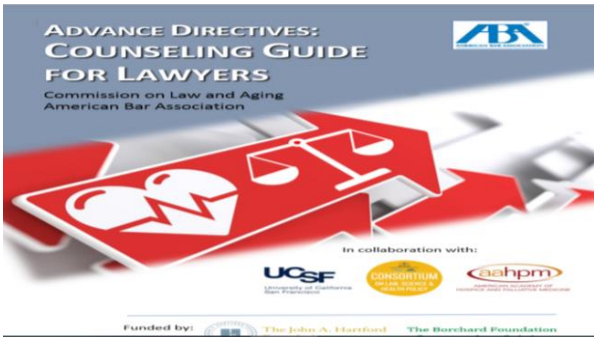
415

Complete with **family**

416

Review facilitator guide

417



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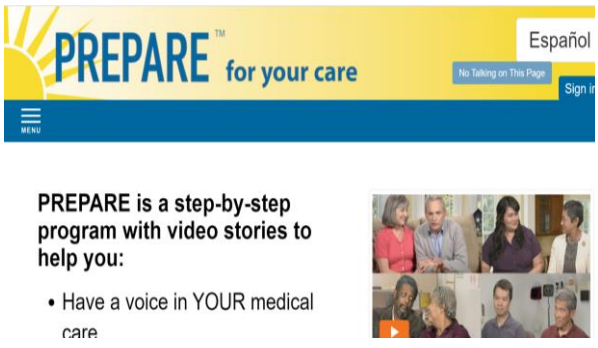

419

Conclusion

420

Elder abuse can happen even at hands of well-meaning licensed health professionals

421

Mitigate that risk with ACP

422

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W www.thaddeuspope.com
B medicalfutility.blogspot.com

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