

Medical Implications of the Advance Directive

Colorado Bar Association
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Multidisciplinary
Center on Aging
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

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Today's Goal: An Interactive Discussion

- ▶ How clinicians use advance directives
- ▶ What life-sustaining treatment choices look like in medical situations
- ▶ How clinicians approach ethically-sensitive situations involving a medical decision maker

Overview of advance care planning

- ▶ Emphasize values
- ▶ Discuss preferences and values with the agent!
- ▶ Use understandable documents that are available
- ▶ Engage in ongoing discussions over time, as health changes
- ▶ Documents provide general instructions, not specific details
- ▶ Colorado Care Planning - Free guidance and forms

www.ColoradoCarePlanning.org



Care Planning Umbrella

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COMMENTARY

Journal of the
American Geriatrics Society

The care planning umbrella: The evolution of advance care planning

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- ▶ Planning involves ongoing communication and medical decision making over the life span
- ▶ Individuals, trusted surrogate decision makers, legal and medical professionals need to be involved over time

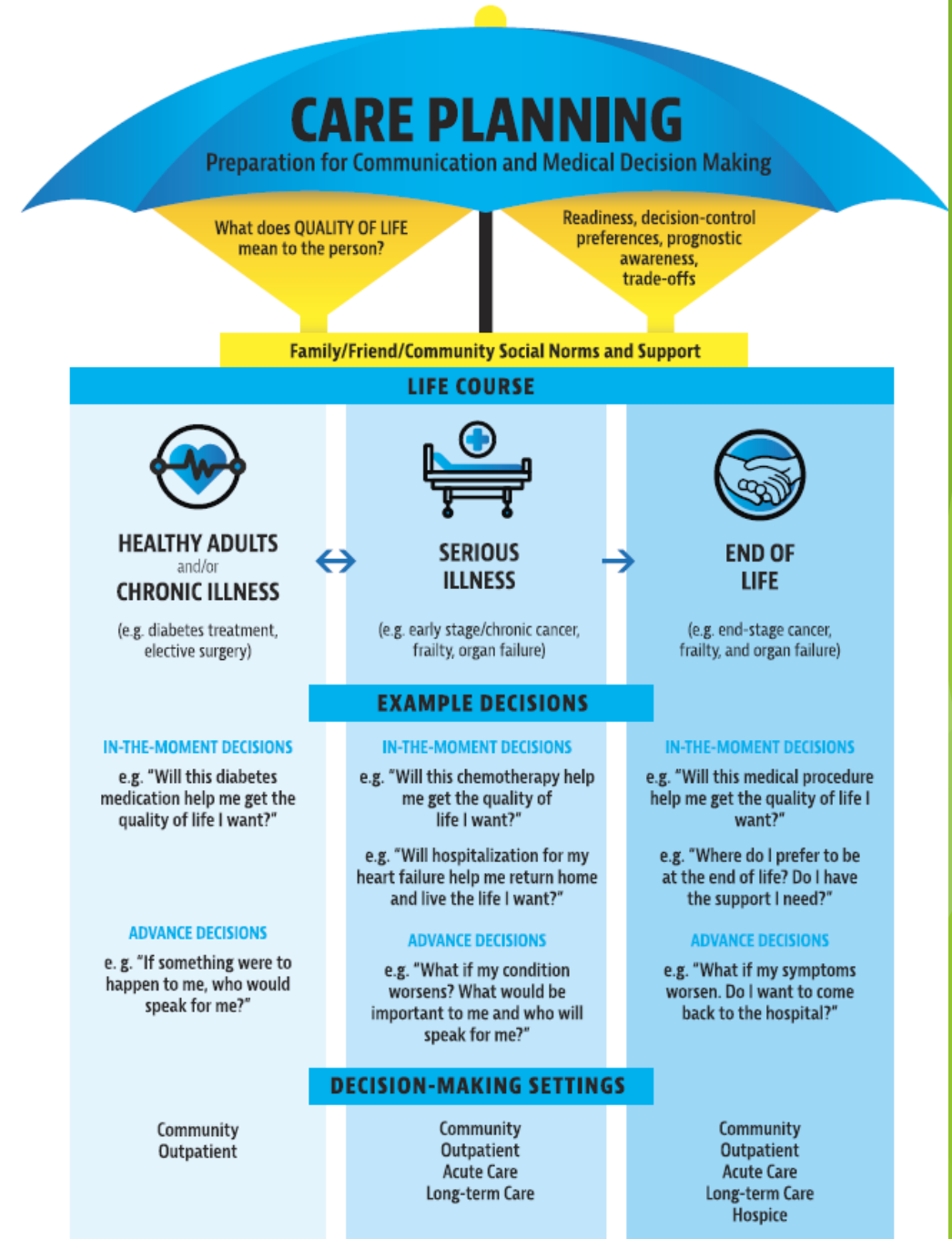


FIGURE 1 The care planning umbrella model.

Examples of Life-Sustaining Treatments

- ▶ Mechanical Ventilation
 - ▶ So many types (Ventilation, BiPAP, High flow oxygen, etc)
- ▶ ICU-level “Circulatory Support”
 - ▶ Blood pressure medications - “Pressors”
 - ▶ ECMO
 - ▶ Left ventricular assist devices - “LVADs)
- ▶ Dialysis
- ▶ Artificial Nutrition and Hydration
- ▶ Also, decisions can be related to surgery, procedures, chemotherapy, radiation, etc.

What does withdrawal of life-sustaining treatment look like?

- ▶ Avoid saying “withdrawal of care” - we continue providing care
- ▶ Multiple conversations, often involving the agent, others, multiple health care teams (specialists, etc.)

Options when transitioning from life-sustaining treatments:

- ▶ Comfort care in the hospital
 - ▶ Prognosis may be hours to a few days
- ▶ Discharge home or to a residential care setting, with support (such as hospice)

Clinical perspective:

- ▶ If a person desires a quality of life and comfort-focused approach, it is appropriate to NOT have ICU level care, such as mechanical ventilation

Feeding Tubes and Hydration (“IVs”)

- ▶ Feeding tubes and artificial nutrition are generally NOT beneficial in serious illness
 - ▶ Can be harmful in dementia
- ▶ Feeding tubes may have specific benefit in restoring health in certain reversible conditions (i.e., esophageal issues, non-terminal illnesses)
- ▶ People do not die from starvation or dehydration when they have a terminal illness
- ▶ Appropriate to shift to a comfort feeding approach

Great Book - Death Interrupted

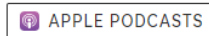


podcasts ▶ science

Radiolab

From NJPR

Radiolab is on a curiosity bender. We ask deep questions and use investigative journalism to get the answers. A given episode might whirl you through science, legal history, and into the home of someone halfway across the world. The show is known for innovative sound design, smashing information into music. It is hosted by Lulu Miller, and Latif Nasser.



MOST RECENT EPISODES

DECEMBER 15, 2023

Death Interrupted

As a lifeguard, a paramedic, and then an ER doctor, Blair Bigham found his calling: saving lives. But when he started to work in the ICU, he slowly realized that sometimes keeping people (and their hopes) alive just prolongs the suffering. He wrote a book arguing that a too-late death is just as bad as a too-early one, and that physicians and the public alike need to get better at accepting the inevitability of death sooner. As the book hit the bestseller list, Blair's own father got diagnosed with a deadly case of pancreatic cancer. Blair's every impulse was in direct contradiction of the book he just wrote. What should he do? And how can any of us know when to stop fighting death and when to start making peace with

- ▶ Dr. Blair Bigham
- ▶ Death Interrupted - A book arguing that a too-late death is just as bad as a too-early one.
- ▶ Radiolab podcast (Dec 15) - Dr. Bigham's experience related to discomfort around his own father's end-of-life experience

Advance Directives and the MOST form

	LEGAL DOCUMENTS	MEDICAL ORDERS
Forms	<ul style="list-style-type: none">• Medical Durable Power of Attorney (MDPOA)• Living Will	<ul style="list-style-type: none">• CPR Directive (DNR Order)• Colorado Medical Order for Scope of Treatment (MOST)
What	<ul style="list-style-type: none">• Identifies decision maker• Provides general guide for treatment	<ul style="list-style-type: none">• Specific orders specific treatment during a medical emergency, especially for emergency personnel
Who	All competent adults	Seriously ill patients
When	When a patient does NOT have decision making capacity	

Colorado MOST FORM

► What is the MOST form?

► Portable medical orders about patient's preferences for life-sustaining treatments

► CPR

► Medical interventions: ICU care, Hospitalization, comfort-focused care

► Artificially administered nutrition

► Who should have a MOST form?

► People at risk for a life-threatening clinical event because they have a **serious life-limiting medical condition**, which may include advanced frailty.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

FIRST follow these orders, **THEN** contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.
 • These Medical Orders are based on the person's medical condition & wishes.
 • If Section A or B is not completed, full treatment for that section is implied.
 • May only be completed by, or on behalf of, a person 18 years of age or older.
 • Everyone shall be treated with dignity and respect.

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. (See additional instructions on page 2.)

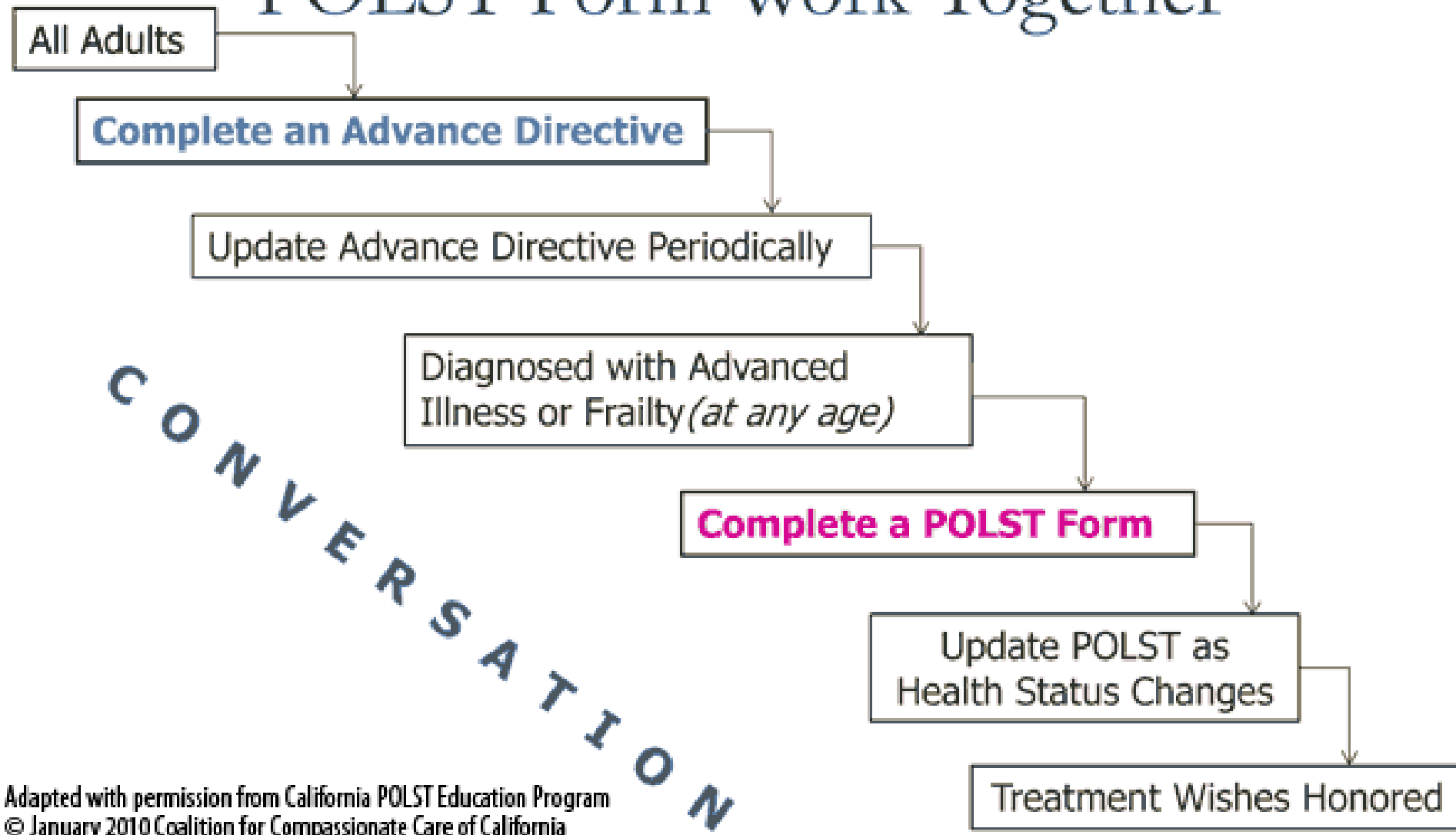
A Check one box only	CARDIOPULMONARY RESUSCITATION (CPR) *** Person has no pulse and is not breathing.***
	<input type="checkbox"/> Yes CPR: Attempt Resuscitation <input type="checkbox"/> No CPR: Do Not Attempt Resuscitation <small>NOTE: Selecting "Yes CPR" requires choosing "Full Treatment" in Section B. When <u>not</u> in cardiopulmonary arrest, follow orders in Section B.</small>
B Check one box only	MEDICAL INTERVENTIONS *** Person has pulse and/or is breathing.***
	<input type="checkbox"/> Full Treatment—primary goal to prolong life by all medically effective means: <small>In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardiopulmonary as indicated. Transfer to hospital if indicated. Includes intensive care.</small> <input type="checkbox"/> Selective Treatment—goal to treat medical conditions while avoiding burdensome measures: <small>In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. <u>Do not intubate</u>. May use noninvasive positive airway pressure. Transfer to hospital if indicated. <u>Avoid intensive care.</u></small> <input type="checkbox"/> Comfort-focused Treatment—primary goal to maximize comfort: <small>Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. <u>Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.</u></small>
C Check one box only	ARTIFICIALLY ADMINISTERED NUTRITION <u>Always offer food & water by mouth if feasible.</u>
	<small>Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section does not imply any one of the choices—further discussion is required. NOTE: Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.</small> <input type="checkbox"/> Artificial nutrition by tube long term/permanent if indicated. <input type="checkbox"/> Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders") <input type="checkbox"/> No artificial nutrition by tube.
D	DISCUSSED WITH (check all that apply):
	<input type="checkbox"/> Patient <input type="checkbox"/> Proxy-by-Statute (per C.R.S. 13-18.5-103(3)) <input type="checkbox"/> Agent under Medical Durable Power of Attorney <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other: _____
SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (MANDATORY)	
<small>Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power of Attorney, DNR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these Medical Orders for Scope of Treatment, they shall remain in full force and effect.</small>	
<small>If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.</small>	
<small>Printed/legible Patient/Agent Signature (Mandatory)</small> _____	<small>Printed/legible Date (Mandatory)</small> _____
<small>Physician / APN / PA Signature (Mandatory)</small> _____	<small>Print Physician / APN / PA Name, Address, and Phone Number</small> _____
<small>Physician License #</small> _____	<small>Date Signed (Mandatory)</small> _____
<small>MDPOA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY</small> <small>Authority for this form and process is granted by C.R.S. 13-18.7: Directive Concerning Medical Orders for Scope of Treatment, enacted 2009.</small>	

Colorado MOST FORM

- ▶ Specific conversations about choices is key
 - ▶ Discuss diagnosis, prognosis, available treatment options (benefits & burdens) within context of patient's goals of care & values.
- ▶ Signed by patient/surrogate and physician, nurse practitioner, or physician's assistant
- ▶ **Medical orders are immediately effective.**
- ▶ **MOST form should align with advance directives (but can also override advance directives)**

- ▶ Colorado MOST form available at: <https://www.civhc.org/wp-content/uploads/2018/10/MOST-Form-2018.pdf>
- ▶ CIVHC hosts a voluntary, open Colorado ACP Stakeholder Workgroup (kdegerness@civhc.org)

How An Advance Directive and POLST Form Work Together



Surrogate decision making: Who decides?

- ▶ Patient with capacity to make decisions
- ▶ Guardian - legally appointed
- ▶ Agent with medical durable power of attorney
 - ▶ Assigned by patient with decision making capacity
- ▶ Proxy - chosen by people who care about patient
 - ▶ No hierarchy in Colorado
- ▶ Physician-proxy of last resort (for an admission)

Physician as proxy decision-maker

CRS 15-18.5-103 (signed 5/18/2016)

- ▶ Medical Decisions for Unrepresented Patients
 - An attending physician may designate another willing physician to make health care treatment decisions as a patient's proxy decision-maker if:
After making reasonable efforts, the physician cannot locate any interested persons, or none of the interested persons are willing and able to serve as proxy decision-maker;
 - The attending physician has obtained an independent assessment of the patient's lack of decisional capacity by another health care provider;
 - The physician has consulted with and obtained a consensus on the proxy designation with the medical ethics committee of the health care facility where the patient is receiving care; and
 - The identity of the physician designated as proxy decision-maker is documented in the medical record

Medical Case for discussion

A patient with dementia is hospitalized due to COVID and unable to make their own decisions

- ▶ Their breathing is worsening and transfer to the ICU and mechanical ventilation may be needed
- ▶ A family member is the MDPOA
- ▶ An advance directive from 8 years ago indicates 7 days of life support...
- ▶ A Colorado MOST form, completed by the MDPOA 6 months ago, indicates “No transfer to the ICU”

Question: What should be done?

What does holistic support for end-of-life planning look like?

The background of the slide is white with abstract, overlapping green geometric shapes on the right side. These shapes include various shades of green, from light to dark, forming a complex, layered pattern that tapers towards the right edge. The overall aesthetic is clean and modern.

the conversation project
in boulder county



CENTER FOR IMPROVING
VALUE IN HEALTH CARE



Resources & Websites

- ▶ www.ColoradoCarePlanning.org
- ▶ **The Conversation Project - Boulder County**
<http://theconversationprojectinboulder.org/>
- ▶ **Easy to Read Advance Directive:**
www.prepareforyourcare.org
- ▶ **Advance Care Planning - Center for Improving Value in Health Care (CIVHC):**
<https://www.civhc.org/programs-and-services/advance-care-planning/>