NAVIGATING THE ADVANCE CARE PLANNING LANDSCAPE: THE GOOD, THE BAD & THE UGLY

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TAKING STEPS VERMONT

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Advancing Health Care Ethics

Learning Objectives

At the conclusion of the session participants will be able to:

- Describe current terminology and best practice for advance care planning
- Distinguish between advance care planning, advance directives and DNR/COLST orders
- Appreciate the complexity that surrounds medical decision-making at end of life and the interplay between advance directives, DNR/COLST orders & decision-makers

ADVANCE CARE PLANNING (ACP)

An ongoing process of discussing, understanding, planning and documenting an individual's goals, values and wishes for future health care

ADVANCE CARE PLANNING IMPROVES THE QUALITY OF PATIENT CARE

More likely to receive care that is consistent with preferences and priorities

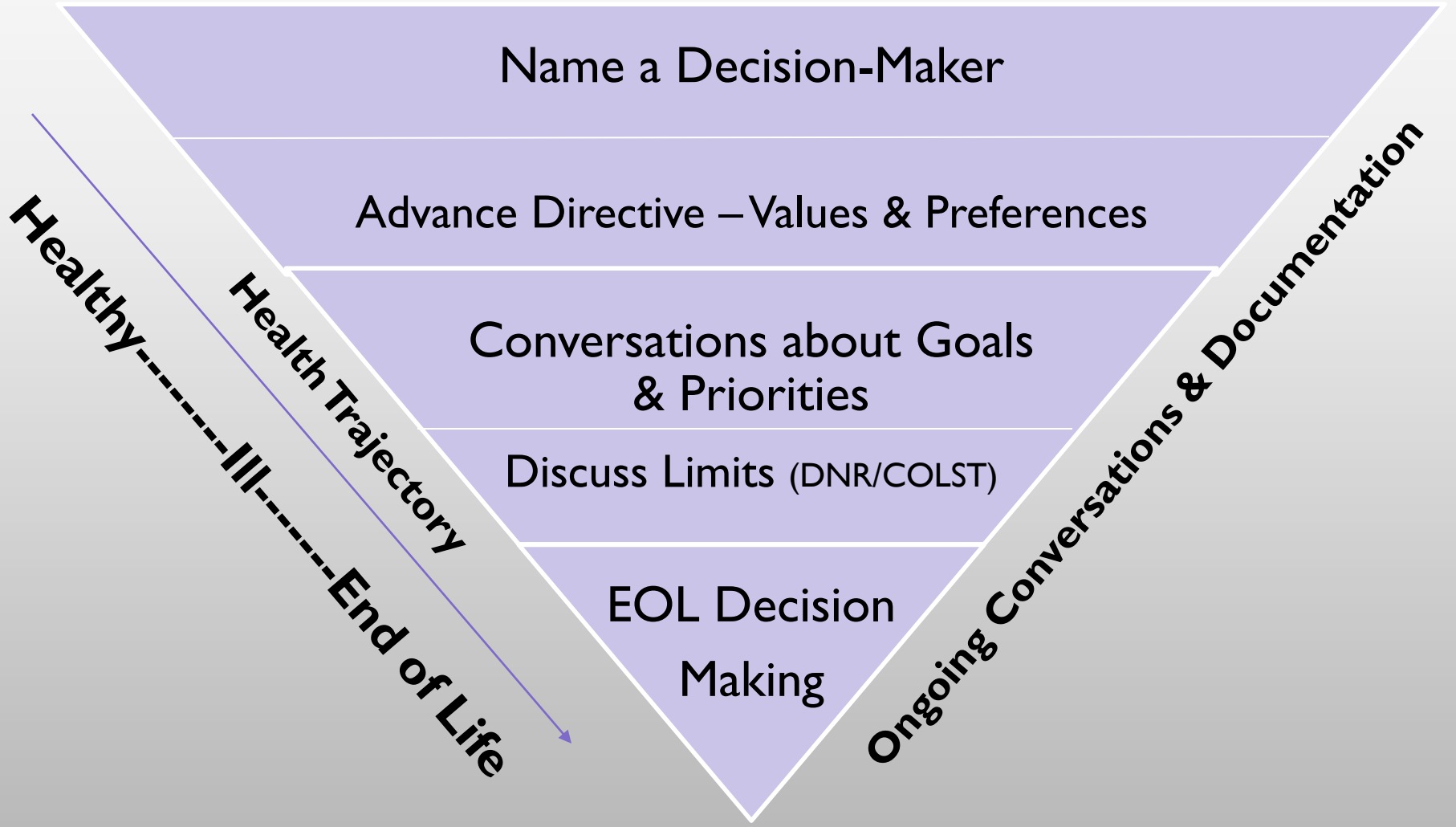
Less likely to die in hospital; more likely to receive hospice care

Receive fewer non-beneficial medical interventions; choose palliation over aggressive measures.

Greater patient and family satisfaction with overall care

Better surrogate communication with provider at end-of-life

Advance Care Planning Continuum



Shigeko Izumi, PhD, RN, FPCN1 and Erik K. Fromme, MD, MCR, FPCN. Jour*nal of Palliative Medicine*. Vol 20; No.7, 2017

TOOLS FOR DOCUMENTING HEALTH DECISIONS

- Appointment of a Health Care Agent Form
- Advance Directive Short Form
- Advance Directive Long Form
- DNR/COLST Order
- Vermont Advance Directive Registry

ADVANCE DIRECTIVE VS DNR/COLST

ADVANCE DIRECTIVE

Preference-based document *completed by a capacitated patient* to guide **future** medical decisions.

- Typically nuanced document requiring discussion, context and interpretation.
- Only the patient/principle with decisional capacity can complete/update one.

DNR/COLST

Outcome of shared a decision-making process; medical order *completed by a clinician,* requires informed consent, and is intended to guide **current** treatment decisions.

- Based on patient's *current medical condition* **and** their *goals and values*.
- Consent can be provided by someone other than the patient

Types of Decision-Makers & Authority

- **Autonomous Decision-Makers:** Patients with decisional capacity
- **Surrogate Decision-Makers:** "Others" making decisions for patients who lack capacity
  - *Health Care Agent* (aka – Durable Power of Attorney for Health Care/Health Care Proxy)
  - *Guardian* (with powers to make medical/health decisions)
  - *Surrogate* (family member(s) or person(s) with a known close relationship to the patient)

Types of Guardians

Public Guardians: appointed by either Family or Probate Court and are available to persons:

- Determined to be developmentally delayed prior to the age of 18 (Title 18)
- At least 60 years of age (Title 14)

Private Guardians: can be either paid or voluntary, confirmed via the Probate Court (Title 14)

Case 1

- 74 year old female
- Moved to LTC a year ago after stroke and increased caregiving needs; admitted to hospital 10 days ago for cardiac reasons
- Assessed as having advanced frontal lobe dementia; is nonverbal, cannot perform any ADLs, is combative and severely agitated at baseline.
- AD completed in 2014 naming a close friend as her HC Agent.
- AD indicates a she wants CPR. AD also states a desire for comfort care and to receive hospice if dying.
- Husband appointed guardian last year when his wife was admitted to nursing home; consented to a DNR/COLST order 6 months ago.
- Hospitalist recommends DNR and comfort care at this time but team is questioning whether DNR/COLST is valid.

Advance Directives & Guardians

- Completed AD prior to guardianship
  - If an Agent was named - Agent maintains authority for health decisions (unless modified by the court).
  - If no Agent - guardian uses preferences & priorities expressed in an AD and knowledge of patient goals and values to guide decisions.
- No AD, the guardian has the authority to consent for most treatments

When Prior Court Approval is Needed

- Guardian has to seek prior approval from the Court:
  - When the person under guardianship objects to the decision;
  - When the court had previously ordered that the decision would not be made without a hearing;
  - **Before withholding/withdrawing life sustaining treatment, other than antibiotics, (unless under an advance directive), except in an emergency*; or**
  - **Before consenting to a DNR order (unless under an advance directive), except in an emergency**.**

** when a decision needs to be made before a court decision could be made*

*** when the clinician certifies in writing that the patient is likely to experience cardiopulmonary arrest before a court order can be obtained.*

14 V.S.A. § 3075

Case 2

- 59 year old male, multiple medical problems including diabetes and end-stage renal disease
- Presents to the ED with confusion, delirium and weakness due to uremia
- Admitted for emergency dialysis
- More clear after one round of dialysis but still very weak, labs better but he is not completely out of the woods. Pt is refusing further dialysis and wants to go home
- Situation is no longer emergent but team feels discharge is unsafe and several more rounds of dialysis are needed before he can safely be discharged.
- Lives alone, has an advance directive stating that he wants to live as long as possible, but did not name an agent in her AD.

Refusals

CANNOT treat a patient over their objection (even if they lack capacity) unless:

They have an AD with a properly executed Ulysses Clause, and

- The agent authorizes the treatment;

OR

- They lack capacity, will suffer serious and irreversible bodily injury or death if the health care cannot be provided within 24 hours, and:

(i) they do not have an agent or an applicable provision in an advance directive, or the agent is not reasonably available; or

(ii) the agent or advance directive authorizes providing or withholding the health care.

18 V.S.A § 9707 (g)

Thank You

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