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# Objectives

- $\bullet$  Ethical & legal framework and components of advance care planning
- Advance Directives
- Anticipatory Physician Orders
- Impact of COVID-19

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## Advance Care Planning

- Three major areas:
  - Financial (estate planning)
  - Final arrangements (funeral, body disposition, etc.)
  - Health care decisions (today's topic)
- The process of establishing and communicating your preferences for your future needs should you be unable to speak for yourself
- Informal conversation and/or legal documents

## Advance Care Planning

- Anticipates scenarios involving serious / terminal illness
- Advance Directives: legal mechanism if you are unable to
- speak for yourself
  - Living Will
  - Health Care Power of Attorney
- · Anticipatory Physician Orders for your care in specific situations
  - Portable Do Not Resuscitate (DNR)
  - Physicians Orders for Life-Sustaining Treatment (POLST)

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# Autonomy (bioethical)

- A competent adult has the right to accept or refuse virtually any medical intervention or treatment
- Informed consent example
- Legal basis
  - Quinlan, 1976
  - Cruzan, 1990
  - Statutory, reciprocity
  - Regulatory opportunity mandate

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## Autonomy is Not Absolute

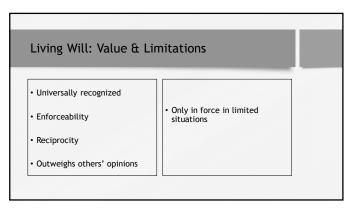
- Specific statutory exclusions (state to state)
- Ability to accept or refuse, but not demand
- To whom or what have you given your life?

 Stewardship • e.g. BCP 491

## Advance Directives: Living Will

- States your directions for care if you are in a persistent comatose state or are terminally ill and unable to speak for yourself
- Usually:
  - Refusal of resuscitation, intensive care, ventilators & other aggressive support devices
  - Request comfort care interventions
  - Separate section on artificial nutrition & hydration (tube feeding)

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## Health Care Power of Attorney

- Gives a person of your choosing authority to make medical decisions on your behalf when you are unable to speak for yourself
  - Usually at least one alternate
- Universally recognized; more wide applicability than Living Will • LW outweighs if contradiction
- Few restrictions on the designated surrogate (vary by state)

## Advance Directives: Caveats

- Duty of surrogate to chose what <u>YOU</u> would want, not their choice • Choose carefully, communicate honestly
- To be effective, need to be known
  - EMR goal of ACA, not in place now
- Ohio forms: <u>https://www.nhpco.org/wp-content/uploads/Ohio.pdf</u>

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# Anticipatory Physician Orders

- Advance directives are your instructions to future caregivers • Rely on someone else to initiate (e.g. doctor's order)
- Anticipatory physician orders come into play when the anticipated situation arises
- EMT example

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## Portable "Do Not Resuscitate (DNR)"

- ${\mbox{ \bullet}}$  Orders that in case of cardiac arrest, CPR / resuscitative attempts not be done
- Orders comfort care
- Portable: follow you wherever you go (OH)
- Ohio DNR information: <u>https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/do-not-resuscitate-comfort-care/DoNotResuscitateDNR</u>

## **CPR Statistics:**

- Public, witnessed arrest, immediate bystander CPR with defibrillation, prompt EMT arrival:
   Make to the hospital: 24%
  - Discharged alive from hospital: 10%
- With frailty, chronic illness, "success" rates approach negligible
- Risks of CPR injury, brain hypoxia

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## POLST (Not Available in OH)

- Physician Orders for Life-Sustaining Treatment • Sometimes called MOLST or other
- · Anticipates scenarios and orders desired interventions
  - Antibiotics
    Tube feeding
  - Hospitalization
- Particularly useful in dementia, facilities

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#### Death and Dying in the ERA of COVID-19: Additional Considerations

- In the hospital or other facilities, visitors are markedly limited
- If you are hospitalized, where can you go after discharge?
  - Rehab unit: hospital, NH
    Home?
- If you require care / assistance at home, who will do it?
  - Hospice tremendous help but not for 24/7 personal care
  - High risk of virus exposure for personal caregivers