

# The Intersection of Palliative Care and Advance Directives: The Benefits of Planning Ahead

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Presenter: Heather Hill, BS, MA

Vice President of Mission Integration & Director of Spiritual Care Services

UM St. Joseph Medical Center

compassion | discovery | excellence | diversity | integrity



## Disclosures

No disclosures to provide.



## Objectives

### Definition of Palliative Care

Be comfortable discussing the difference between Palliative Care and Hospice Care

Improve knowledge and skills for discussing natural and comfortable death

### Understand the importance of Advance Care Planning (ACP)

- Advance Directive vs Maryland **M**edical **O**rders for **L**ife-**S**ustaining **T**reatment (MOLST)

### Understand the things to think about when planning for End of Life (EOL) scenarios

- CPR
- Artificial Ventilation
- Blood Transfusion
- Other interventions

### Resources to help you have the “crucial conversations”



**Nothing could be kinder to people who love you than to give them clear guidance for the hardest decisions they ever have to make. And little could be more empowering than protecting yourself from unwanted medical treatments that, now, far too often dehumanize modern death.**

**~ Katy Butler, *The Art of Dying Well***



## Definition of Palliative Care

Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.



## Elements of Palliative Care



**FOCUS** – RELIEVING SYMPTOMS, PAIN, AND STRESS ASSOCIATED WITH SERIOUS ILLNESSES, REGARDLESS OF PROGNOSIS



**TIMING** – CAN BE PROVIDED AT ANY STAGE OF A SERIOUS ILLNESS, FROM DIAGNOSING THROUGH TREATMENT AND BEYOND



**GOAL** – TO IMPROVE QUALITY OF LIFE AND WELL-BEING FOR PATIENTS AND THEIR FAMILIES



**CURATIVE TREATMENT** – PALLIATIVE CARE CAN BE PROVIDED ALONGSIDE CURATIVE TREATMENTS



**WHO CAN RECEIVE IT -**  
ANYONE WITH A SERIOUS ILLNESS



## What Palliative Care Providers Do

Listen

Provide physical symptom control

Provide emotional, social, and spiritual assessment

Help define goals and choose treatments:

- Burden vs. Benefit

Educate about what to expect

Discuss a peaceful death and transition to hospice, if appropriate

Life review, finding new hope and meaning

Interdisciplinary support



## Death and Natural Aging

Survey of independently living elderly showed that

- 76% want to continue to live independently
- Pain control and length of life were most important concerns

50% of surveyed patients with cancer or end-stage conditions want to die at home

< 25% die at home

53-65% of Americans die in hospitals



## Hospice Care

Hospice care is a specialized type of palliative care for people with terminal illnesses and a **life expectancy of six months or less**, focusing on comfort and dignity during the end of life.





## Elements of Hospice Care

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**Focus** – Comfort, dignity, and quality of life for individuals with terminal illnesses who are no longer seeking curative treatment

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**Timing** – Typically starts when it's clear that a cure is no longer possible, and the focus shifts to comfort and symptom management

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**Goal** – To provide compassionate comfort care and support to patients and their families during the final stage of life

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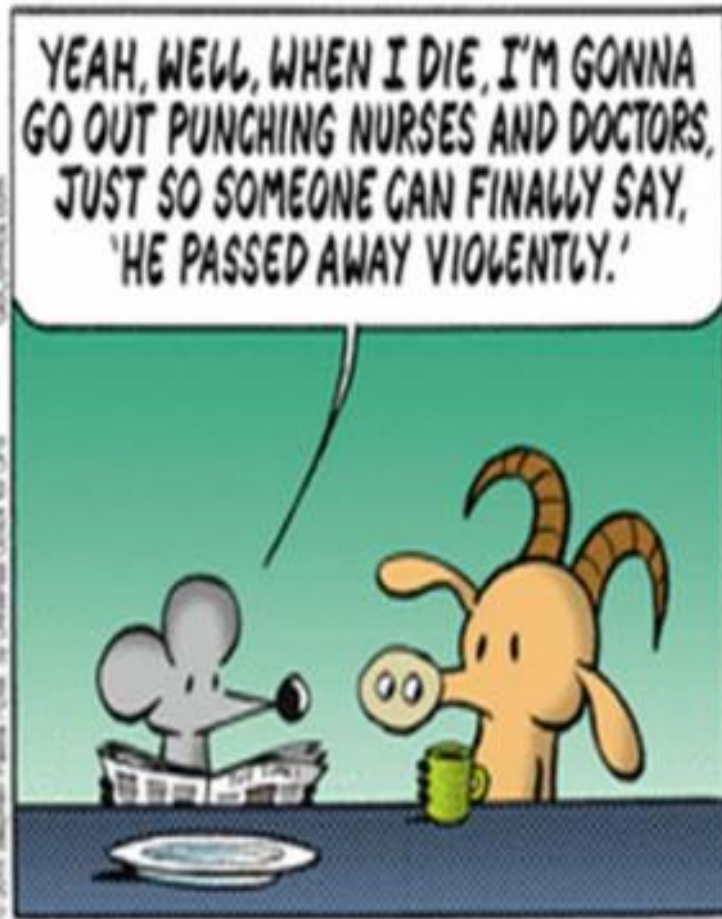
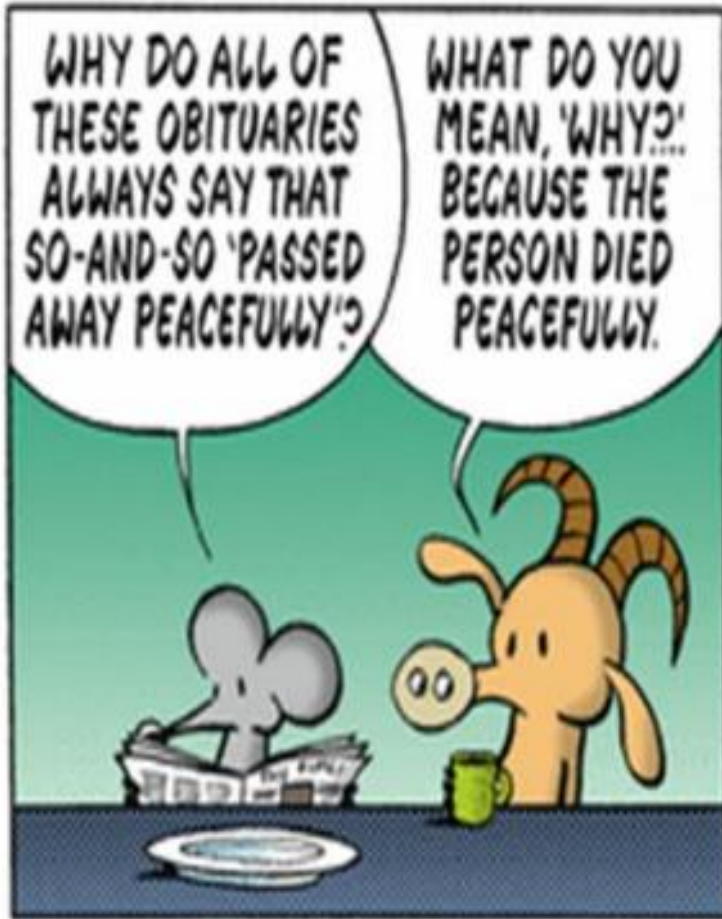
**Life expectancy** – Generally, hospice care is for individuals with a life expectancy of six months or less

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**Curative treatment** – Hospice care does not focus on curative treatment

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**Who can receive it** – People with terminal illness who have a life expectancy of six months or less





**Our reluctance to honestly examine the experience of aging and dying has increased the harm we inflict on people and denied them the basic comforts they most need...People with serious illness have priorities besides simply prolonging their lives. Surveys find that their top concerns included avoiding suffering, strengthening relationships with family and friends, being mentally aware, not being a burden on others, and achieving a sense that their life is complete. Our system of technological medical care has utterly failed to meet these needs, and the cost of this failure is measured in far more than dollars.**

**~ Atul Gawande, *Being Mortal***



## ADVANCE CARE PLANNING



It's a PROCESS



It's about CONVERSATIONS/communication not the document/form



Its about empowering people to have the medical care they want (PERSON-CENTERED CARE)



Its about SHARED DECISION-MAKING



Its about LIVING the final phase of your life as well as you can (and dying well when the time comes)



## Who is Advance Care Planning for?

- Planning ahead is for everyone! (Especially your family!!)
- A serious illness or accident can happen at any age
- Triggers for ACP:
  - Change in life condition (ex: marriage, births/deaths)
  - New diagnosis of a serious illness
  - Change in health condition
  - Preferences elicited
  - Serious illness with unclear goals
  - Medicare wellness visit





## Value of Advance Care Planning

- Enhance patient/family education about their illness including prognosis and likely outcomes of different care plans
- Define key priorities in end-of-life care
- Shape future clinical care to reflect personal preferences/values
- Help patients find hope and meaning in life remaining
- Strengthen relationships with loved ones and **relieve burden of surrogate decision-making**





# Why ACP Now?

- Increasing demographic of persons living longer with heavier burden of illness/complicated treatment options
- Increasing numbers of persons losing decisional capacity as their condition worsens
- Surrogate decision makers put in difficult position of making decisions when they don't know what the patient would choose
- Often results in increased amount of non beneficial or even harmful medical treatment leading to suffering near the end of life



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**~ Katy Butler, *The Art of Dying Well***



# What are the major parts of ACP?

- Naming a healthcare agent who you would trust to make healthcare decisions
- Talking to your loved ones and care team about your preferences for care
- Completing ACP documents such as advance directives/MOLST
- Ongoing conversations over time, as your preferences may change



# Choosing a HealthCare Agent

- Also known as surrogate decision-maker or medical power of attorney (POA) if legally appointed in documents
- Must be  $\geq$  18yo and available when needed
- Legal order in the state of Maryland, if you do not have any ACP documents:
  - A guardian for the patient, if one has been appointed;
  - The patient's spouse or domestic partner;
  - An adult child of the patient;
  - A parent of the patient;
  - An adult brother or sister of the patient; or
  - A friend or other relative of the patient who meets certain requirements



# ACP Documents

- Advance directives:
  - Durable power of attorney for healthcare allows designation of healthcare agent/POA
  - Living will gives written instructions about your healthcare wishes
- Many different advance directive document options
- MOLST
- Most important is quality of conversations that lead to document!
  - Document does NOT preclude ongoing in-the-moment discussions/decisions



# ACP Documents

- PREPARE for your CARE is a step-by-step program with video stories to help:



- Step 1** Choose a Medical Decision Maker
- Step 2** Decide What Matters Most in Life
- Step 3** Choose Flexibility for Your Decision Maker
- Step 4** Tell Others About Your Wishes
- Step 5** Ask Doctors the Right Questions

## Maryland PREPARE Advance Directive




Let PREPARE help you fill out the advance directive.

The pages are easy-to-read and PREPARE will walk you through them.

Fill out the advance directive in PREPARE

## PREPARE has 2 programs with video stories to help you:

1. Have a voice in **YOUR OWN** medical care
2. Help **OTHER PEOPLE** with their medical planning and decisions



### PREPARE™ for YOUR care

**Have a Voice In  
Your Medical Care**

This step-by-step program makes  
it easy with video examples

Click here to do [YOUR OWN](#)  
medical planning



### PREPARE™ for THEIR care

**Help Other People**

Click here to learn how to help  
[OTHER PEOPLE](#) with their  
medical planning and decisions

**New!**



PREPARE Tools for Providers & Organizations

# FIVE WISHES<sup>®</sup>

Rectangular Snip

## MY WISH FOR:

1 The Person I Want to Make Care Decisions for Me When I Can't

2 The Kind of Medical Treatment I Want or Don't Want

3 How Comfortable I Want to Be

4 How I Want People to Treat Me

5 What I Want My Loved Ones to Know

Print Your Name

Birthdate

# FIVE WISHES®

*There are many things in life that are out of our hands. This Five Wishes document gives you a way to control something very important — how you are treated if you get seriously ill. It is an easy-to-complete form that lets you say exactly what you want. Once it is filled out and properly signed, it is valid under the laws of most states.*

## What Is Five Wishes?

Five Wishes is the first living will (also called an advance directive) that talks about your personal, emotional, and spiritual needs as well as your medical wishes. It lets you choose the person you want to make health care decisions for you if you are not able to make them for yourself. Five Wishes lets you say exactly how you wish to be treated if you get seriously ill. It was written with the help of the nation's leading experts in end-of-life care. It's also easy to use. All you have to do is check a box, circle a direction, or write a few sentences.

## How Five Wishes Can Help You And Your Family

- It lets you talk with your family, friends and doctor about how you want to be treated if you become seriously ill.
- Your family members will not have to guess what you want. It protects them if you become seriously ill, because they won't have to make hard choices without knowing your wishes.
- You can know what your mom, dad, spouse, or friend wants. You can be there for them when they need you most. You will understand what they really want.

## How Five Wishes Began

For 12 years, Jim Towey worked closely with Mother Teresa, and, for one year, he lived in a hospice she ran in Washington, DC. Inspired by this first-hand experience, Mr. Towey sought a way for patients and their families to plan ahead and to cope with serious illness. The result is Five Wishes and the response to it has been overwhelming. It has been featured on CNN and NBC's Today Show and in the pages of *Time* and *Money* magazines. Newspapers have called Five Wishes the first "living will with a heart and soul." Today, Five Wishes is available in 29 languages.

## Who Should Use Five Wishes

Five Wishes is for anyone 18 or older — married, single, parents, adult children, and friends. More than 35 million people of all ages have already used it. Because it works so well, lawyers, doctors, hospitals and hospices, faith communities, employers, and retiree groups are handing out this document.

People who use Five Wishes find that it helps them express all that they want and provides a helpful guide to family members, friends, care givers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

## Five Wishes In My State

Five Wishes was created with help from the American Bar Association's Commission on Law and Aging. **If you live in the District of Columbia or most states you can use Five Wishes and have the peace of mind to know that it substantially meets your state's requirements under the law.** If you live in one of six states (**Indiana, Kansas, New Hampshire, Ohio, Oregon, or Texas**) you can still use Five Wishes but may need to take an extra step. Find out more at [FiveWishes.org/states](http://FiveWishes.org/states).

## How Do I Change To Five Wishes?

You may already have a living will or a durable power of attorney for health care. If you want to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will or durable power of attorney for healthcare. Or you can write "revoked" in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you.
- Tell your Health Care Agent, family members, and doctor that you have filled out a new Five Wishes. Make sure they know about your new wishes.

## How Do I Start Using Five Wishes?



Let us help with some tips on how to start using Five Wishes and how to talk about it. Activate your Five Wishes to get these benefits at [FiveWishes.org/activate](http://FiveWishes.org/activate).

## The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

*If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:*

- My attending or treating doctor finds I am no longer able to make health care choices, **AND**
- Another health care professional agrees that this is true.

*If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.*

### The Person I Choose As My Health Care Agent Is:

\_\_\_\_\_  
First Choice Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

If this person is not able or willing to make these choices for me, *OR* is divorced or legally separated from me, *OR* this person has died, then these people are my next choices:

\_\_\_\_\_  
Second Choice Name

\_\_\_\_\_  
Third Choice Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

### Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member **may not** be the best choice because they are too emotionally involved. Sometimes they **are** the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and

follow your wishes. Your Health Care Agent should be **at least 18 years or older** (in Colorado, 21 years or older) and should **not** be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

I understand that my Health Care Agent can make health care decisions for me. I want my Agent to be able to do the following: (Please cross out anything you don't want your Agent to do that is listed below.)

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent's understanding of my wishes and values.
- Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.
- Make the decision to request, take away, or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
- See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.
- Listed below are any changes, additions, or limitations on my Health Care Agent's powers.

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### If I Change My Mind About Having A Health Care Agent, I Will

- Destroy all copies of this part of the Five Wishes form. *OR*
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Agent. *OR*
- Write the word "Revoked" in large letters across the name of each agent whose authority I want to cancel. Sign my name on that page.

### My Wish For The Kind Of Medical Treatment I Want Or Don't Want.

*I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.*

#### What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want to be comfortable. Wish 3 says what can be done to make me comfortable.
- I want to be offered food and fluids by mouth if it is safe for me to eat and drink. I want to be kept clean and warm.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.

#### What "Life-Support Treatment" Means To Me

Life-support treatment means any medical procedure, device, or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

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#### In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a **Do Not Resuscitate** form or bracelet. Many states require a person to have a **Do Not Resuscitate** form filled out and signed by a doctor if you choose not to be

resuscitated. This form lets ambulance personnel know that you don't want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a **Do Not Resuscitate** form filled out.

### Close To Death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (choose *one* of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

### In A Coma And Not Expected To Wake Up Or Recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (choose *one* of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

### Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (choose *one* of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

### In Another Condition Under Which I Do Not Wish To Be Kept Alive:

If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write "end-stage condition." That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)

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**T**he next three wishes deal with my personal, spiritual, and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

## WISH 3

### My Wish For How Comfortable I Want To Be.

(Please cross out anything that you don't agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious or spiritual readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional, and spiritual care for me and my loved ones.

## WISH 4

### My Wish For How I Want People To Treat Me.

(Please cross out anything that you don't agree with.)

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be visited by a chaplain or clergy.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- I wish to have my favorite music played when possible until my time of death.
- I want to die in my home, if that can be done.
- I wish to be called by my name.  
Please call me: \_\_\_\_\_

# WISH 5

## My Wish For What I Want My Loved Ones To Know.

(Please cross out anything that you don't agree with.)

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends, and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried *OR* cremated.
- My body or remains should be put in the following location: \_\_\_\_\_
- The following person knows my funeral wishes: \_\_\_\_\_

If anyone asks how I want to be remembered, please say the following about me:

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If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings, or other specific requests that you have):

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It is important for my health care providers to know what matters most to me. I wish for them to know the following:

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Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Or you may want to give instructions on what should be done with your social media or other electronic records. Please attach a separate sheet of paper if you need more space.

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## Signing My Five Wishes

Please make sure you sign your Five Wishes in the presence of two witnesses.

I, \_\_\_\_\_, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address (cont.)

### Witness Statement • (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age (19 in Alabama) and am NOT:

- The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document or his/her successor,
- The person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person's health care provider,
- Financially responsible for the person's health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption,
- A beneficiary of any legal instrument, account, or benefit plan of the person, and,
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

*(Some states may have fewer rules about who may be a witness. Unless you know your state's rules, please follow the above.)*

\_\_\_\_\_  
Signature of Witness #1

\_\_\_\_\_  
Signature of Witness #2

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

### Notarization • Only required for residents of Missouri, North Carolina, South Carolina, and West Virginia

If you live in Missouri, only your signature should be notarized. If you live in North Carolina, South Carolina or West Virginia, you should have your signature, and the signatures of your witnesses, notarized.

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, the said \_\_\_\_\_

\_\_\_\_\_, and \_\_\_\_\_, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public



# ACP Documents

MARYLAND ADVANCE DIRECTIVE:  
PLANNING FOR FUTURE HEALTH CARE DECISIONS

MARYLAND ADVANCE DIRECTIVE:  
PLANNING FOR FUTURE HEALTH CARE DECISIONS



A Guide to  
Maryland Law on  
Health Care Decisions  
(Forms Included)

STATE OF MARYLAND  
OFFICE OF THE ATTORNEY GENERAL

*Anthony G. Brown*  
*Attorney General*



*May 2024*



## Barriers to ACP/Advance Directives



**Difficult subject  
(serious illness, EOL,  
dying)**



**A lot of work/need for  
ongoing attention**



**Misunderstanding  
(lack of coordination  
between  
legal/medical  
professions)**



**Fear that AD may  
limit options for  
treatment**



**Complicated process  
(lack of evidence for  
impact)**

Lack of uniform, clear  
messaging/response from  
health care system



## Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

MOLST is a process for documenting treatment choices. It is a portable, standardized Medical Order that will be recognized and followed by Maryland health care providers.



The MOLST form is required for patients being discharged from an acute care hospital to any of the following:

Nursing Home

Assisted Living

Home Health

Community Dialysis

Hospice

Other acute care hospitals



The MOLST conversation is an opportunity to understand the likely course of your health and medical condition, so that you may make informed choices that are appropriate and reflect what you want. If you choose, you may invite loved ones to join this conversation.



## Advance Directive vs. MOLST

	Advance Directive	MOLST
Who has one?	Anyone over 18	People with serious illness or frailty
What is it for?	Future care	Current care
Where is it stored?	With other legal documents	Anywhere it can be found easily in an emergency to go with you to the hospital
Form is	Legal Document: Must be translated to medical orders before it can be honored	Medical Orders: Honored in medical institutions, clinics, ambulances, etc
Can it be changed?	Yes – with witnesses	Yes – with doctor
Authorized Representative	Cannot change anything	Can make changes if patient has lost capacity



## Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
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This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy of the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

### CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

- the patient; or
- the patient's health care agent as named in the patient's advance directive; or
- the patient's guardian of the person as per the authority granted by a court order; or
- the patient's surrogate as per the authority granted by the Health Care Decisions Act; or
- if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

- instructions in the patient's advance directive; or
- other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

### CPR (RESUSCITATION) STATUS: EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

**Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR).

This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

**1 No CPR, Option A, Comprehensive Efforts to Prevent Arrest:** Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

**Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation.

**Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

**No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

### SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

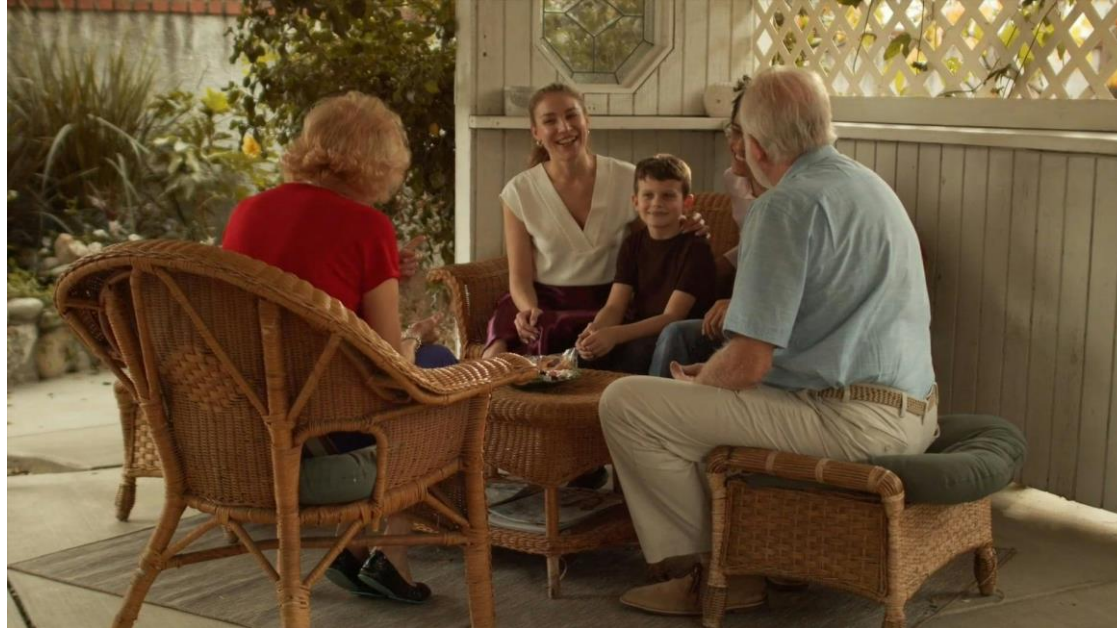
Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

Patient's Last Name, First, Middle Initial	Date of Birth	Page 2 of 2 <input type="checkbox"/> Male <input type="checkbox"/> Female
Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.		
2	<b>ARTIFICIAL VENTILATION</b>	
	2a. <input type="checkbox"/> May use intubation and artificial ventilation indefinitely, if medically indicated.	
	2b. <input type="checkbox"/> May use intubation and artificial ventilation as a limited therapeutic trial. Time limit _____	
	2c. <input type="checkbox"/> May use only CPAP or BiPAP for artificial ventilation, as medically indicated. Time limit _____	
2d. <input type="checkbox"/> Do not use any artificial ventilation (no intubation, CPAP or BiPAP).		
3	<b>BLOOD TRANSFUSION</b>	
	3a. <input type="checkbox"/> May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.	3b. <input type="checkbox"/> Do not give any blood products.
4	<b>HOSPITAL TRANSFER</b>	
	4a. <input type="checkbox"/> Transfer to hospital for any situation requiring hospital-level care.	4b. <input type="checkbox"/> Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise. 4c. <input type="checkbox"/> Do not transfer to hospital, but treat with options available outside the hospital.
5	<b>MEDICAL WORKUP</b>	
	5a. <input type="checkbox"/> May perform any medical tests indicated to diagnose and/or treat a medical condition.	5b. <input type="checkbox"/> Only perform limited medical tests necessary for symptomatic treatment or comfort. 5c. <input type="checkbox"/> Do not perform any medical tests for diagnosis or treatment.
6	<b>ANTIBIOTICS</b>	
	6a. <input type="checkbox"/> May use antibiotics (oral, intravenous or intramuscular) as medically indicated.	6c. <input type="checkbox"/> May use oral antibiotics only when indicated for symptom relief or comfort.
6b. <input type="checkbox"/> May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.	6d. <input type="checkbox"/> Do not treat with antibiotics.	
7	<b>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION</b>	
	7a. <input type="checkbox"/> May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.	7c. <input type="checkbox"/> May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition. Time limit _____
	7b. <input type="checkbox"/> May give artificially administered fluids and nutrition, if medically indicated, as a trial. Time limit _____	7d. <input type="checkbox"/> Do not provide artificially administered fluids or nutrition.
8	<b>DIALYSIS</b>	
	8a. <input type="checkbox"/> May give chronic dialysis for end-stage kidney disease if medically indicated.	8b. <input type="checkbox"/> May give dialysis for a limited period. Time limit _____ 8c. <input type="checkbox"/> Do not provide acute or chronic dialysis.
9	<b>OTHER ORDERS</b> _____ _____ _____	
<b>SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)</b>		
Practitioner's Signature		Print Practitioner's Name
Maryland License #	Phone Number	Date



## Other aspects of MOLST

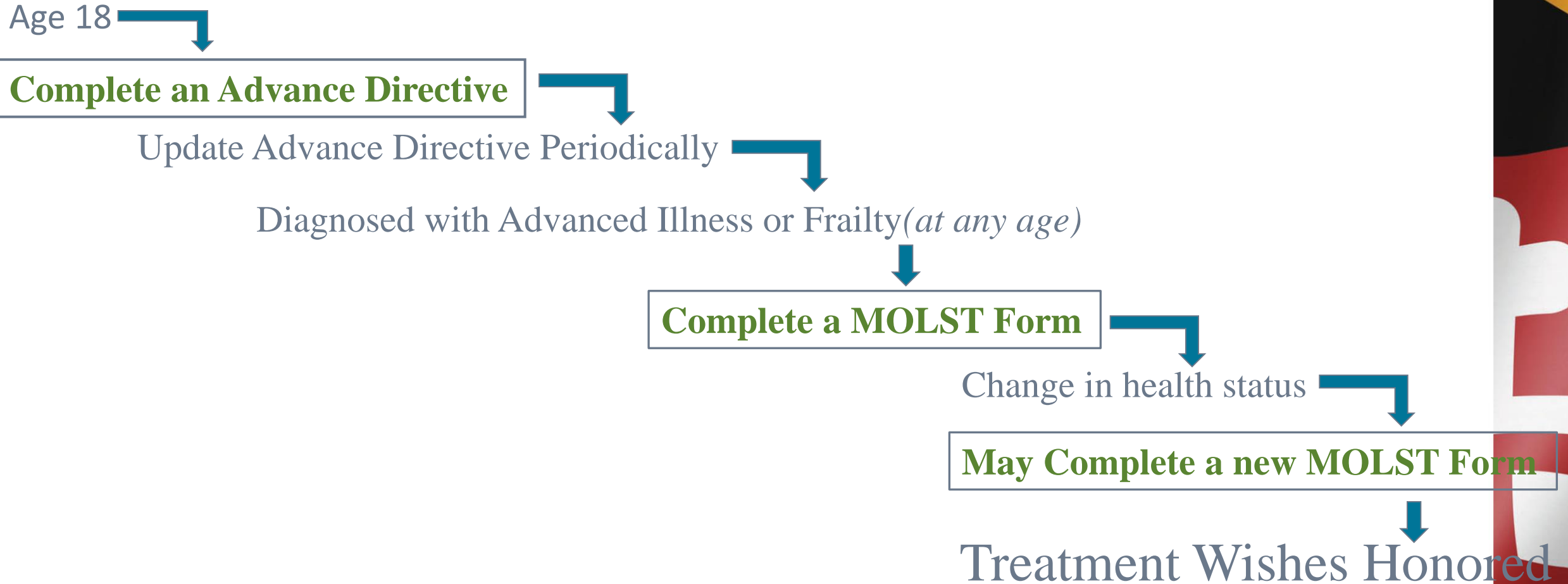
- Designed to work in concert with Advance Directive
- Takes effect immediately (medical order)
- Health care providers are obligated to honor within medical standard of care
- Does not preclude real time-shared decision making and clinical judgement
- Flexible - can be changed, voided with any change in circumstances





## How Advance Directives and MOLST Work Together

Adapted with permission from California POLST Education Program  
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## Can someone else make MOLST decisions for me?



You make health-care decisions for yourself as long as you have decision-making capacity. You have the right to change your authorized representative at any time while you have decision making capacity.



If a physician determines that a person lacks decision-making capacity, an authorized representative can sign a MOLST form on behalf of that person. A MOLST form does not change the decision-maker designated by an Advance Health Care Directive, a Health Care Power of Attorney document, a guardian of person appointed by a Court, or Maryland law on health care surrogates.



If you have capacity and complete a MOLST form, you can sign on the form saying that if you lose capacity, your authorized representative cannot void the form you signed.



## Best Practices for completing Advance Directive

- Ask the right questions to the right people. Quality of the conversation.
- Be fully informed on options
  - Medically consistent
  - Time limited trials
- Communication with POA/loved ones
- Share with health care provider/others
- Simple clear format
- Revisit periodically





## The Four Things

“Please forgive me.”

“I forgive you.”

“Thank you.”

“I love you.”

“When I work with people who are approaching the end of life, I emphasize the value of saying the Four Things and I also encourage them to say ‘good-bye.’ The Four Things offer essential wisdom for completing a lifelong relationship before a final parting. It’s important to say good-bye in a way that affirms our relationship and acknowledges our connection to one another.”

~ Ira Byock, MD, *The Four Things that Matter Most: A Book About Living*



# Questions?



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## Resources

<https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx>

<https://marylandmolst.org/>

<https://agingwithdignity.org/>

<https://prepareforyourcare.org/en/welcome>

<https://www.fivewishes.org/>

<https://www.mydirectives.com/>

<https://respectingchoices.org/>



*Thank you!!*

*Please take a moment and complete the survey using this QR code.*



<https://app.smartsheet.com/b/form/b5d74d1bec9f499a80b78382c3f8adff>