

CAREGIVERS SUMMIT

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Helping Patients Achieve End of Life Wishes Question & Answer

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Some Common Terms/Concepts

- What is an Advance Directive (AD)?
- What is a Living Will (LW)?
- What is a Health Care Power of Attorney (HCPOA)?
- What is a Medical Order?
- What's the difference in an AD and a Medical Order?
- What is a Do Not Resuscitate (DNR) Order?
- What is a Medical Order for Scope of Treatment (MOST) form?

Advance Directive

- Advance directives are an expression of an individual's wishes regarding the provision of healthcare in the event the individual becomes incapacitated, either by the person directly (living will) or their third party agent (HCPOA)

Living Will

- Confusion with health care POA
- Key differences: Living Will is maker speaking directly to health care provider
- HCPOA is maker appointing agent to speak for him when he can no longer express wishes
- Living will usually limited to “life prolonging measures”

Living Will

- But covers ANY life-prolonging measure the maker selects, defined as:
 - Medical procedures/interventions which, in view of attending MD, serve only to artificially postpone the “moment of death by sustaining, restoring or supplanting a vital life function”

Living Wills

- Authorize withholding of artificial nutrition & hydration
- But can authorize withholding of other life prolonging measures:
 - CPR -- source of confusion with DNR orders
 - Penicillin, artificial respiration
 - Never permits withholding of comfort measures
- If physician certifies patient is incompetent & meets one of several “trigger” medical conditions

Living Will

- Narrower because of limits to “life prolonging measures”
- HCPOA can be much broader generally
 - And include routine healthcare decisions
- Despite state-approved forms, can use any form to document wishes
 - Clear expression of patient wishes
 - Meeting the signature/witness/M.D. certification requirements

Living Will

- Individual must be competent at time living will is made (of sound mind)
- Minimum requirements include:
 - Signature
 - Two witnesses/notary
 - Physician certification. 2nd MD must concur that patient meets “trigger” conditions to get statutory protections
- Durable by its nature: effective only where maker is incompetent & meets trigger conditions
- Maker can select all or some of N.C. statutory 3 “trigger conditions”

They Are:

- Incurable/irreversible condition that will result in death in relatively short time period;
- Am unconscious and HC providers determine, to high degree of medical certainty, that I won't regain consciousness; or
- Have advance dementia or similar cognitive loss that to a high degree of medical certainty, per my providers, is not reversible
 - Maker can select any or all of these as his/her “trigger” conditions

Living Will Options:

- Health care providers *may* or *shall* withhold life prolonging measures
 - That is, maker can DIRECT or PERMIT these options
- Agent under a health care power of attorney shall follow the living will or may override it
- Creates very broad LW form
- But creates exceptions for artificial nutrition and hydration

Form Assumes Withholding Entire Array of Life Prolonging Care

- Maker can say:
 - I DON'T Want my life prolonged by artificial means, BUT
 - I do want both artificial nutrition/hydration
 - I want only artificial nutrition
 - I want only artificial hydration
- Comfort measures never withheld
- Creates more choice but risk of inconsistent selections by patients

Living Will Summary

- So, life prolonging care is withheld:
 - If I have a living will
 - Properly completed
 - Am in one or more of those conditions
 - Unless I limit that list to a partial list of the three
 - As determined by my attending MD
 - And confirmed by a second MD (non-attending)
 - And the care withheld may be ALL life-prolonging care or all such care except where I've directed otherwise

Health Care Power of Attorney

- Names agent to make health care decisions
- Also expresses maker's wishes re health care
 - Including specific instructions/limitations of power
- Durable by its nature
- Most states & (NC): not effective until incompetence of maker
- So it's durable because ONLY effective upon maker's incompetence

Health Care Power of Attorney

- NC and most states have statutory form – optional
- As lawyers, we highly recommend use
 - As advocates, we support other forms
- Minimum requirements include:
 - Clear expressions of agent(s) and powers/limits
 - Signature
 - Witness/notary
- Maker can limit power or give total control

Health Care Power of Attorney

- Some states, including N.C. Have Statutory Form
 - N.C. statutory form grants broad powers over health care decision-making
 - But permits maker to limit agent's authority in areas of artificial nutrition/hydration; mental health; organ donation and remains at death
 - And to write other general limitations on agent's authority
 - Absent those limitations being inserted (or checked where shown), agent has all authority to make all health care decisions

Health Care Power of Attorney

- Provides protections for providers relying upon HCPOA agent
 - No criminal liability (homicide/manslaughter)
 - Civil liability (wrongful death)
 - No risk of losing your professional license
 - Unless we have good faith reason to suspect the document is invalid (forged; created under duress, etc.)

Health Care Power of Attorney

- The rise of “alternative” forms:
 - From hospital systems; hospices; advocacy groups
 - Who feel statutory form is too complex
- Examples:
 - Five Wishes
 - Form created by coalition (Novant, others) in Triad Area
- As long as they clearly express wishes; and are properly signed, notarized and witnessed
- They are legal

How Do I Know if a LW or HCPOA is Valid?

- Is it witnessed by two qualified witnesses?
 - Signed in their presence
 - Believing maker to be of sound mind
 - Who is not:
 - Not related to maker w/in 3rd degree-maker or spouse
 - Not expected to take property under will or intestate succession laws
 - Not a paid employee of facility where maker resides; &
 - Has no claim against maker's estate

How Do I Know if a LW or HCPOA is Valid?

- Is the document properly notarized?
 - Paid employees can be notary
 - Volunteers can be notary
 - Notary simply attests that maker appeared and represented this is their signature and document
- Does it clearly state the maker's wishes?
- If out of state, does it meet our requirements or those of state where executed?

Revocation

- HCPOA can only be revoked by patient while still competent
 - Able to make and communicate health care decisions
- Living Will can be revoked by patient at any time, regardless of their mental or physical condition
 - By saying maker wants it revoked
 - Tearing it up or marking through it or writing “VOID”
 - Or making a later LW or HCPOA
 - If there are 2 LWs, the most recent one governs; the other is revoked
 - Same with HCPOAs

Guardians vs. Health Care Agents

- Guardian may not revoke LW or HCPOA
- If guardian appointed, HCPOA retains powers given unless Court suspends it
- Court must tell guardian whether he must follow a HCPOA or may deviate from it
- Provider can rely upon HCPOA until actual notice from Court of revocation/suspension
- You can name your HCPOA as guardian
 - But require or permit her to honor a LW

Do Not Resuscitate (DNR) Order

- Withhold CPR/other resuscitation
- Trigger event: M.D. order or form completed
- Compare to Living Will – 3 medical triggers.
 - LW requires M.D. certification of trigger condition & 2nd M.D. confirmation of medical condition
 - DNR does not
- DNR can apply to any level of medical status, not just end of life or permanent cognitive impairment

DNR Order

- Who can execute DNR order?
- Only a doctor – not a patient
- Who can “consent” to a DNR order?
 - Competent individual--yes
 - If incompetent, no
 - A court appointed guardian generally can
 - Agent under a HCPOA
 - Next of kin based on N.C. statute governing consent

NC's "Consent" Decision Tree Statute

NCGS 90-21.13

1. Health care agent (from a valid health care power of attorney) to the extent authorized by the power of attorney, unless the court has appointed a guardian of the patient's person and suspended the authority of the health care agent to make decisions; if there is no health care agent, then
2. Court-appointed guardian of the patient's person or general guardian of a person; if there is no court-appointed guardian, then
3. Attorney-in-fact who is granted power over healthcare decisions by a valid power of attorney; if there is no attorney-in-fact authorized to make health care decisions, then

NC's "Consent" Decision Tree Statute

NCGS 90-21.13 (continued)

4. Spouse of the patient; if there is no spouse, then
5. A majority of the patient's reasonably available parents and adult children (those 18+ years of age); if there are no reasonably available parents and adult children, then
6. A majority of the patient's reasonably available adult siblings (those 18+ years of age); and if there are no reasonably available adult siblings, then
7. An individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes.

What is a Medical Order for Scope of Treatment (MOST) form?

- It is a physician's order that outlines a plan of care
- Allows seriously ill patients to outline more comprehensive choices about end of life care
- These choices include: CPR, antibiotics, artificial nutrition and hydration

Medical Order for Scope of Treatment - MOST

- Even though a physician order, must be signed by the patient or appropriate representative to be issued
- Prepared and reviewed by the health care professional in consultation with the patient or patient representative
- If patient is incapable of making an informed decision regarding the order, the patient representative can provide consent
- How can it be revoked:
 - Destroy it
 - Put a line through the first page and write “VOID”
 - Indicate in the “Review of MOST” section on the second page of the form that it has been revoked

What's the difference in an AD and a Medical Order?

- Note – neither a living will nor a health care power of attorney is a medical order
 - care provided that is medical in nature requires an MD order
 - So, if patient has a living will or HCPOA that says “I want this” or “I don’t want that,” you still have to have the MD enter an order to carry out that wish
 - Point: advance directives are just an expression of an individual’s wishes, either by the patient directly (living will) or their third party agent (HCPOA), that still requires an MD order to carry out
 - Advance directives inform while a medical order instructs



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Part II

Questions and Answers

Questions We Always Receive

- The questions below assume that we will involve an attending physician in each scenario because even with an advance directive, we MUST have an implementing physician's order
- Note difference in an Advance Directive (an expression of wishes) and a Medical Order, which implements an Advance Directive (AD)
- In the absence of such an order implementing an AD (DNR, MOST, or other MD order), we always default to full code status

Question

- Patient has a living will saying “no artificial support to keep me alive”
 - She has no HCPOA
 - Husband brings you the N.C. Consent Decision Tree chart (NCGS 90-21.13) and says, “I’m in charge here based on this law and I say she is full code”
 - What do you do?
 - Make her full code?
 - Tell the husband he’s stupid?
 - Call the attending physician?
 - Try to arrange a meeting of social work, MD, husband?

Answer

- Husband has no authority to override her living will, BUT we need an MD order to implement her no code wishes. Talk with MD, husband and others as needed
- Think about this: if health care agent could simply override a LW, would those documents ever be “safe” from well-intentioned loved ones?

Question

- Patient has a living will saying no artificial life support
- She also has HCPOA and agent agrees
- Patient arrests and now needs CPR
- What do we do?
 - Don't give her CPR because of the LW and HCPOA
 - Her wishes are clear
 - Start CPR?

Answer

- Do we have a DNR or MOST order saying no CPR?
- Remember, we MUST have an MD order to implement the LW and HCPOA's wishes
 - We should have already resolved this before a crisis
 - Without an MD order, we implement full-care measures
 - But we could use the LW or HCPOA's consent as authority to enter a DNR order (and already should have done so)

Question

- Husband of patient presents patient's living will and says "I'm making all the health care choices and I say I want you to change her meds." Are we required to follow his commands?

Answer

- What's the problem here?
 - Living will doesn't cover this; only the withholding of life sustaining care
 - This document is not a HCPOA that covers other types of care
 - He MAY be in charge if he's the top dog of our Consent Decision Tree Statute
 - But he may not be
 - So, we have to go through that litany of decision makers to see who has authority

Question

- Sally is an incompetent patient
- Her brother and son don't get along
- Brother presents a durable POA and says do X
- Son disagrees and says do Y, what do we do?

Answer

- We ask these questions:
 - Is there a HCPOA and if so, who has it?
 - If no, does a durable POA contain health powers?
 - If not, look to our Consent Decision Tree Statute (NCGS 90-21.13).

Question

- Patient has a living will that says one thing
- And an HCPOA, dated later than the LW, under which the health care agent is giving directions that conflict with the LW.
- What do we do?

Answer

- N.C. State Law: in the event of a conflict between a LW and the agent under a HCPOA, the LW governs
 - Why? This is the patient speaking to you directly, not a 3rd party surrogate
- Exceptions: if the patient granted the health care agent the power to override her LW, then the agent's decisions govern, not the LW
 - The “may” or “must” language in the HCPOA forms

Question

- Patient admits to your agency with a living will, and HCPOA (has an agent) and a MOST form
 - The LW and MOST form have inconsistent instructions about CPR
 - What do we do?
 - Ignore the MOST form because the LW expresses the patient's wishes?
 - Ignore the LW because the MOST is dated later?

Answer

- The MOST will override a LW while the MOST is in effect
- Contact family (if patient incompetent) for conference and MD to point out conflict in expressed wishes and order
- Our role: help resolve the conflict

Question

- Patient has LW saying no artificial life support
- Son has HCPOA and says full life support
- What do we do?

Answer

- Read both documents
- Does the LW or the HCPOA document give the son, as health care agent, power to override the LW
 - It may or may not
 - If not, he has no authority to override the LW

Question

- Patient has no LW or HCPOA
- Health is failing and he lacks capacity
- His only child says Dad needs a living will
- What do we do:
 - Help him make one for Dad?
 - Tell him we don't need one, just tell us what you want done?
 - Tell him it's too late and he should have thought of this sooner?

Answer

- It is too late after the patient loses competence
- But explore whether son is the decision maker under Consent Decision Tree Statute and, if so, he can still make choices about care and end of life (and then we obtain corresponding MD orders)

Question

- Patient's living will says no life sustaining measures. Now patient is asking for life sustaining measures. What do we do?

Answer

- First, ask, is the patient competent?
 - If so, the LW isn't yet effective and patient wishes govern.
- If not, we follow the LW UNLESS patient is expressing revocation intentions.
 - Distinguish this from a HCPOA.
- Also, do we have a HCPOA or other surrogate to give us some risk management comfort?

Question

- What are the proven, best ways to educate patients and their caregivers about ADs?
- Can that include brief, informative videos?

What are the proven, best ways to educate patients and their caregivers about ADs?
Can that include brief, informative videos?

- Presentations with great attorneys
- Variety of tools
 - GotPlans123.com
 - NC Medical Society Website
 - Every audience is different
 - FAQs
 - Live presentation

Question

- After a stroke left a husband unable to make rational decisions and with a huge change in his personality, his wife wanted him to be taken in for a psych eval.
- However,
 - He had no HCPOA
 - Was aware and articulate enough not to appear to be in need of evaluation to EMS personnel called in to take him, and
 - Did not want to go
 - EMS said she needed some legal document declaring him incompetent and her his legal guardian.
- Is that correct?
- Can a doctor take away a patient's right to make his/her own decisions?

Answer

- Patients are presumed competent, but
- A physician or licensed psychologist can make a determination that patient “lacks capacity” to make or understand health care choices/decisions.
- That can also be conducted at home.
- Once that determination is made, then whoever has legal authority takes over decision making under HCPOA or NCGS 90-21.13.

Answer (continued)

- If husband absolutely unwilling to participate, a court can order him to submit to a mental/physical exam to determine capacity
- So, a guardianship proceeding is one way
- Or an order by a judge requiring husband to undergo mental/physical examination

Question

- What is the responsibility of a provider when a patient's AD permits the HCPOA to make changes and the POA goes against the AD?

Answer

- If a HCPOA grants the health care agent this authority, that is permitted
 - Unless the provider is convinced that the health care agent is truly not acting in the best interests of the patient
- So, provider can only try to persuade the POA to follow the AD
- Or go to court seeking a guardianship based on “not acting in patient’s best interests”

Change Facts:

- What if a patient has a living will, and a HCPOA, and the health care agent is attempting to not follow the LW
 - And either of those documents says HC agent “must” follow the wishes stated in the living will?

Answer:

- In this situation, the health care agent is bound to follow the wishes of the patient as expressed in the living will
- If he/she refuses, the provider should not honor those instructions
- And likely encourage family to seek removal of health care agent via a guardianship proceeding
- CMS guidance: serious deficiency for following instructions of one lacking proper authority

Doctor Determining Incompetence is Absent

- If a patient has assigned the responsibility of determining when the HCPOA is effective to a particular physician who no longer serves the patient and cannot be found, can the HCPOA still come into effect?
 - This relates to the fact that our statutory forms, and many of the option “simplified” forms have a place for the patient to select the MD who will determine decision-making capacity

Answer

- Yes, if the designated physician is not “reasonably available”
- In such a case, the attending physician can make that determination
- NCGS 32A-20

Question

- DNR vs. Distraught Next-of-Kin
- Patient is found without a pulse
- A medical aide is present
 - Knows CPR
 - Knows of the patient's DNR Order
 - Knows there is no HCPOA
- Can the distraught wife demand CPR, as his next-of-kin and surrogate decision maker?

Answer

- DNRs can only be entered by a competent patient or duly employed HCPOA
- Normally, a health care agent does not have authority to authorize, or revoke, a DNR order
- Here, was no health care agent
- However, if spouse is designated person under NCGS 90-21.13, she probably could revoke it
 - Most MDs will not honor it with objecting family
 - This is why patients need LWs along with HCPOAs

Question

- Can a Physician who is also a sibling or loved one pronounce death at home?

Answer

- NCGS 90-323
 - Determination that a person is dead shall be made by a physician licensed to practice medicine applying ordinary and accepted standards of medical practice
 - Not “location-specific” so home, SNF, hospital is fine
 - IF we have a licensed MD
 - That said, most hospice agencies do NOT want family members prescribing meds or pronouncing death, ethically and for risk management purposes

Answer (continued)

- A non-licensed sibling may not “pronounce” death ever
- See NC Board of Nursing website/whitepaper re who may declare death
 - Determination of death is within the scope of practice for an LPN or RN, based upon an assessment, consistent with agency policy and procedure
 - “In order for the nurse to determine that death has occurred, at least one conclusive sign of death must be present”
 - They are: lividity or pooling of blood in dependent parts of body (livor mortis), cooling of the body following death, rigor mortis, or extended downtime with asystole on EKR or injuries incompatible with life

If the Statutory Forms Change, Do We Need to Change Ours?

- No, in fact the laws did change in 2007 and any pre-2007 forms are still valid
- N.C. laws say our statutory forms are “optional, nonexclusive” ways to express wishes
- In N.C. any form of HCPOA or living will that is properly notarized and witnessed is okay
- Also, remember NCGS 90-21.13, which dictates a hierarchy of people who can give consent for any medical decision, including end-of-life decisions

Question

- What are Military (VA) HCPOAs and ADs and what do we do with them?

Answer

- Authorized by federal statute (10 USC 1044b)
- Valid in all states, regardless of the state's statutes
- Must be notarized
- However, statute specifies many military personnel can notarize, even though they may not have a seal

When you receive one

- Check that it is notarized properly
- If not, it is invalid

Question

- What about all of these alternative forms I keep seeing?
- Again, if properly witnessed and notarized, and clearly convey patient's wishes, they are fine.
 - Five Wishes
 - New “Simplified” combination LW/HCPOA form being accepted by most hospital systems