Module: Communication: Advance Care Planning

Learning Objectives

Attitudes	• Understand the importance of ACP in the outpatient setting prior to surgery • Respect the patient's autonomy • Understand the role of the physician in helping patients with designating future medical care knowledge
Knowledge	• Demonstrate the difference between a surrogate decision maker and a medical power of attorney • Demonstrate knowledge of the components of a POLST form
Skills	• Demonstrate how to have a discussion about a medical power of attorney • Demonstrate the ability to incorporate Goals of Care into the appropriate written documentation/form • Demonstrate the ability to respect the patient's wishes when the family requests a different path.

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Teaching Outline

There are many Advance Care Planning documents and patients, families, and health care professionals often don't understand the nuances or which document is appropriate for which situation. This module will first describe the many documents available, then cases will be presented to determine which document is applicable.

Advance Care Planning Documents

1. **Durable Power of Attorney for Health Care**
   a) Legal document that lists medical decision makers for the patient, should they be incapacitated and unable to make decisions for themselves.
   b) Anyone can be listed as medical power of attorney; it does not have to be the spouse, children, or parents. It can be a friend. It should not be the patient's physician.
   c) Should a patient not designate a medical power of attorney, each state has a statute that lists the hierarchy of surrogate decision makers (usually spouse, children, parents, etc).
   d) A financial power of attorney is a separate document.

2. **Advance Directive (AD)**
   a. Legal document that lists medical decision makers for the patient, should they be incapacitated and unable to make decisions for themselves.
   b. Anyone can be listed as medical power of attorney; it does not have to be the spouse, children or parents. It can be a friend. It should not be the patient's physician.
   c. Should a patient not designate a medical power of attorney, each state has a statute that lists the hierarchy of surrogate decision makers (usually spouse, children, parents, etc).
   d. A financial power of attorney is a separate document.

3. **Do Not Resuscitate (DNR)**
   a. DNR can be included as part of the Advance Directive.
   b. DNR can also be an entirely separate form. Several states have "out-of-hospital DNR" forms.
   c. The in-hospital form for DNR is usually not transferable to out-of-hospital settings, and the out-of-hospital form usually must be transferred to the in-patient form.
   d. Do Not Intubate (DNI) can be a separate order.

4. **Physician Orders for Life-Sustaining Treatment (POLST)**
   a. Variations on the name include POST, MOLST (medical orders for life-sustaining treatment).
   b. These are actual orders signed by a physician (and in some states an NP).
   c. POLST is transferable across health care settings (hospital, nursing home, home, etc.)
   d. Must have life-limiting disease with limited life expectancy, usually 6 months.
   e. Includes code status, limited interventions, comfort care, artificial nutrition and hydration (ANH) and antibiotics. Only parts or all of the form can be used.
   f. Can be signed by patient or medical power of attorney. Some states will allow the surrogate decision maker to sign.

g. Can be revoked at any time. If the patient signed it, only the patient can revoke it; the patient's signed POLST form supersedes the medical power of attorney or surrogate decision maker.

5. Tips for application

a. The most important document is the Durable Power of Attorney for Health Care. The patient should designate someone who knows them well and their wishes/goals for life and will speak for them when the patient cannot direct their medical care. An Advance Directive cannot cover every single variation of treatment options and procedures, especially since it directs theoretical treatment options.
b. Goals of Care is critical, instead of choosing treatments/procedures. Focus on the desired outcome of the patient rather than the patient choosing or refusing each individual intervention.
    i. Longevity focused: CPR and life support machines
    ii. Independence focused: no CPR and time-limited trial for life support machines
    iii. Comfort focused: no CPR or life support machines
c. Honor patient's expressed wishes. If patient signs a DNR form in the long-term care setting, consider applying that DNR to the hospital setting. Location doesn't usually change goals of care.

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Pre/Post Test

Questions

1. Is a financial power of attorney sufficient for medical decision making?
2. Is a living will and an advance directive the same?
3. Is only the state templated form for an advance directive permissible?
4. Does every part of the POLST form need to be completed for it to be valid?
5. Can the medical power of attorney override the patient's POLST?

Answers

1. No. Must have separate forms for medical and financial.
2. Basically yes, but the current terminology is advance directive
3. No, the form can be modified, or created from scratch
4. No, only parts of it can by completed, usually the code status and the remainder of the form left blank.
5. No, only the patient can revoke or change a POLST they signed.

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Module: Communication: Advance Care Planning

Case 1

Mrs. Conner, a 74yoF, has been diagnosed with colon cancer and is in your office discussing her elective colectomy. She is concerned she may not do well with surgery and wants to know what she should do before surgery about paperwork. What do you recommend?

Questions

1. Ask her what her goals are for her surgery. If she were to have a complication, what is important to her and her life.
2. Ask her if she cannot make decisions, who does she want to speak for her. Encourage her to designate a medical power of attorney and use the standard form on the internet for her state. Document such discussion in the medical record.

Case 2

She does well with surgery. A year later she falls and has a mild traumatic brain injury. Family wants to know if she can make decisions and if not, who should make decisions for her.

Questions

1. Determine medically if she can make decisions, depending upon her health status. If unclear, you can have Speech Therapy perform a cognitive evaluation.
2. Review her Durable Medical Power of Attorney form and she who she designated as her decision maker. If she did not complete one, then the state has a designation list for surrogate decision maker.
3. If she is unable to make decisions now, it does not mean that she cannot make decisions in the future as she recovers.

Case 3

Several years later, she presents with a metastatic cancer, carcinomatosis and a malignant bowel obstruction. She wants to know what happens now and what paperwork she needs.

Questions

1. Her Advance Directive may be specific enough to cover to this event, but likely not.
2. Better to have a Goals of Care discussion with her regarding longevity focused, independence focused, or comfort focused goals.
3. She meets criteria for a POLST form, given her limited life expectancy. Code status, and artificial nutrition and hydration (ANH) should be considered within her goals and documented.
4. Consideration for hospice is appropriate as her life-expectancy is less than 6 months.

Case 4

She goes home with hospice after she signs a POLST form which says comfort-measures only, DNR and no ANH. She becomes unresponsive and her family panics and calls an ambulance and she is brought to the ED. Family requests intubation and "everything done". What do you do now?

Questions

1. Her POLST orders signed by her overrides any requests of the family.
2. Discussion with the family about respecting her wishes and goals for her life, and the limitations of medical treatment at the end of life, is indicated. She should not be intubated. Family should be reassured she will be made comfortable with end-of-life care, and she will not suffer.

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Giving Bad News Learner Assessment Form

Content Checklist: Make an "X" if the resident did this without prompting, mark with "✓" if the resident did this only after prompting and leave blank if this was not done.

_____ Asks about a medical decision-maker prior to surgery

_____ Recommends patient fills out a Durable Medical Power of Attorney.

_____ Determines if patient is unable to make decisions and her medical power of attorney is now the decision maker

_____ Recognizes the patient may recover to the point that she is able to make her own decisions

_____ Has Goals of Care discussion when patient presents with malignant bowel obstruction

_____ Reviews and completes a POSLT form with the patient

_____ Respects the patient's expressed written wishers on her POSLT form

_____ Reassures the family

Communication Skills—Please check one box per question using the following rankings:

3 = Excellent

2 = Good

1 = Marginally Satisfactory, and

0 = Unsatisfactory (poorly done or not done at all)

	3	2	1	0
Assures comfort and privacy				
Assumes a comfortable interpersonal communication distance				
Maintains an open posture				
Reflects patient's emotions				
Displays empathy through words, expression, or touch that is appropriate to situation				
Reflects patient's thoughts and concerns				

Please provide your overall assessment.

_____ Competent to perform independently

_____ Needs close supervision

_____ Needs basic instruction

Do you believe the physician was able to present bad news with compassion in a manner as to do no harm? ☐ Yes or ☐ No

If you believe additional training is needed, please indicate what problems need to be addressed (check all that apply):

☐ Basic communication skills (eye contact, rate of speech, excessive use of jargon, personal space)

☐ Professional attitude (sullen; not empathetic; angry; giggles; or other, please describe in the space below)

_____

_____

☐ Other

NOTES

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