

Maryland MOLST

Guide for Health Care Professionals

Maryland MOLST Training Task Force

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Health Care Decision Making Guide for Health Care Professionals

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Introduction

This guide is meant to support health care professionals to help patients (or authorized decision makers on behalf of incapacitated patients) make beneficial health care decisions. It covers the decision-making process that precedes the use of the Maryland Medical Orders for Life-Sustaining Treatment form (herein referred to as the MOLST form) and helps health care professionals understand the appropriate use of that form. The information in this guide is based on Maryland laws and regulations that have addressed making, documenting, and implementing decisions about life-sustaining treatments.

In light of the above, it may be helpful to read the guide through at least once, to understand how all the pieces fit together into a cohesive approach to health care decision making and related medical orders using the MOLST form. Recognizing that the guide may also be referred to segmentally to find specific information, there is a certain amount of repetition among sections.

In 1993, the Maryland legislature passed the Health Care Decisions Act (HCDA), clarifying and broadening the rights of all Maryland citizens to make advance directives and to have others speak for them in the event of subsequent incapacity to make health care decisions. For example, the HCDA covers certification of decision-making incapacity, selection of a surrogate decision maker, determination that treatments may be medically ineffective, and the criteria for qualifying conditions that allow a surrogate to withhold or withdraw life-sustaining treatments. Additional information about the Health Care Decisions Act can be found at the following site:

<http://www.marylandattorneygeneral.gov/Pages/HealthPolicy/hcda.aspx>

For health care providers and practitioners, these basic steps apply:

1. Follow the health care decision making process to identify patient wishes and goals, clarify medical issues, and identify treatment options.
2. Guide the patient or authorized decision maker by summarizing key facts and opinions about the current medical situation and prognosis, and by discussing the relevance of specific treatment options.
3. Use the Maryland MOLST form to write orders related to decisions about life-sustaining treatments.

Section I: The Health Care Decision Making Process

Health care decision making includes definable steps in a desirable sequence. The process is universally relevant (i.e., it applies in all settings), enduring (i.e., it has applied over time and will remain applicable in the future), and legally sound (i.e., it is consistent with the HCDA). Diligent adherence to this process can help meet patient needs and professional standards for clinical care, despite challenges.

Table 1 on the next page outlines the process and related practitioner and provider responsibilities at each step. Appendix A provides additional considerations for each step. Additional references and resources discuss the process in more detail. See the following website for additional guidance on the overall ethics decision making process:

<http://www.marylandattorneygeneral.gov/Health%20Policy%20Documents/EOL%20Ethics%20Procedures%20RTF.pdf>

Appendix B offers a worksheet that practitioners can use to summarize key points about a patient's condition and prognosis and to help guide discussion with, and decision making by the patient or an authorized decision maker. If utilized, this optional worksheet may be included in the patient's medical record.

Table 1: The Health Care Decision Making Process Framework

Process Step	Some Key Issues	Practitioner Roles
1. Identify situations where health care decision making is needed	- Decision making may be routine or may be needed more urgently because of acute medical illness or significant risk of complications	- Help identify situations that warrant discussion of treatment options and documentation of patient-specific treatment choices
2. Identify and clarify existing care documents and instructions	- Existing documents may be general or incomplete - For facility-based patients (e.g., nursing home), staff can help clarify the content of these documents - Patients and families may be unfamiliar with the content, or unclear about the implications of, advance care planning documents	- Inquire about existing documents related to wishes regarding life-sustaining treatment and end-of-life care - Help identify individuals who wish to initiate or update advance care planning
3. Clarify medical issues	- Defining problems, impairments, and risks, and their underlying causes, is key to recognizing situations where current or advance care planning is needed, understanding relevance and risks of treatment options, and identifying factors affecting decision making capacity	- Clarify factors affecting a person's physical condition, function, quality of life, prognosis, and decision-making capacity - Identify prognosis
4. Define decision making capacity	- This step is essential to optimize individual participation in personal and health care decisions - Decision making capacity may change with time, as existing conditions resolve or new illnesses and condition changes arise	- Certify decision-making capacity * - Determine and document the rationale for conclusions about decision making capacity - Address, as indicated, treatable causes of impaired mental and physical function that affect decision making capacity
5. Identify the primary decision maker	- An individual with impaired decision-making capacity may still be able to participate to some extent in advance care planning and treatment selection - The HCDA identifies a sequence for choosing authorized decision makers	- Help define a patient's role in making health care decisions, based on determining decision making capacity and other pertinent factors
6. Certify the existence of any qualifying conditions	- Certification of these conditions must be compatible with definitions in the HCDA	- Identify and certify whether the patient meets criteria for end-stage condition, terminal condition, or persistent vegetative state*
7. Define and present relevant issues and options	- It is important to clearly and correctly identify the issues, to the extent possible, before addressing them - CPR status should be distinguished from wishes about treatment prior to any cardiopulmonary arrest	- Help define specific issues that need discussion or decisions - Present and discuss the pertinence, benefits, and risks of various treatment options
8. Implement treatment options related to health care decisions	- Orders should be consistent with applicable laws and regulations and with valid choices made by a patient or authorized decision maker - Orders should specify relevant aspects of any limited care plan; i.e., what exactly will not be provided	- Give medical orders to implement treatment and care choices
9. Review the situation and continue or modify approaches, as appropriate	- An individual's situation may change with time, or the patient or authorized decision maker may change their wishes about treatment choices	- Periodically reevaluate a patient's condition, prognosis, and wishes - Continue to adjust approaches, as indicated

* Adapted from: Levenson SA. The Health Care Decision Making Process. Maryland Medicine. Winter 2010;11(1):13-16.

Section II: Choosing Treatment Options

Among other things, the HCDA concerns documenting wishes about life-sustaining treatments and authorizing orders to implement selected treatment options. A health care facility should inform patients of the right to discuss and document their wishes regarding life-sustaining treatments; for example, by making or updating an advance directive or by giving instructions about their care directly to a health care practitioner for the purpose of generating current medical orders.

Historically, treatment instruction forms such as living wills and other advance directives have been used to document treatment wishes for the future. The MOLST form is used to authorize current orders related to treatment choices, regardless of whether there is any other written documentation of such wishes.

The “Health Care Decision Making Worksheet”

An optional “Health Care Decision Making Worksheet” (Appendix C) is provided as a tool to help patients and authorized decision makers choose and document treatment wishes, whether for the present or for the future. Generally, the MOLST form is completed for any decisions on the worksheet that apply at present. For treatment choices that are not yet applicable, the worksheet can be held as a record for the care planning process or a patient can apply the decisions to treatment instructions in an advance directive.

Section III: Using the Maryland MOLST Form to Implement Treatment Orders

The health care decision making process outlined above includes steps to identify and implement treatment options by matching facts about a patient's current medical condition with identification of the patient's goals, wishes, and prognosis.

When a patient has a serious illness or the potential for life-threatening complications, issues inevitably arise about how health care providers are to respond if any of the patient's vital functions fail. Resolving issues about the use of life-sustaining medical technology, and documenting care preferences and decisions, are daily occurrences in many health care settings.

In 2011, the Maryland legislature amended the HCDA to introduce the Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form that is required to be used in certain health care facilities and programs and is valid in all health care facilities and programs throughout Maryland. While this legislation added provisions about the MOLST form to replace the existing "Life-Sustaining Treatment Options Form (LSTO)," it retains the HCDA's other provisions, including procedures related to advance directives, the authority of a health care agent or surrogate decision maker, and a physician's right to decline to provide treatments that are certified as being medically ineffective.

What is "MOLST?"

The Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form is a standardized medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments.

The MOLST form provides a consistent way to order life-sustaining treatments (for example, whether CPR is to be attempted or not). It is also intended to stimulate discussions of these issues to help patients and authorized decision makers understand and discuss life-sustaining treatments with a physician, nurse practitioner, physician assistant, or another health care professional, in order to:

- carry out any instructions related to the use of life-sustaining treatments, including those in existing advance directives, and
- if a patient is transferred to another healthcare setting, communicate any orders that stem from prior care planning and discussion to the receiving facility and any new health care practitioners.

The MOLST form is to be completed based on consultation with the patient or an authorized decision maker (health care agent, guardian, or surrogate) on behalf of an incapacitated patient and is to be signed by a physician, nurse practitioner, or physician assistant (i.e., an "authorized practitioner"). A patient who wants or needs to make decisions about life-sustaining treatments for a current situation (or, someone who is making such decisions on behalf of an incapacitated individual) should discuss the current medical situation and the potential treatment options. As desired, they may use

the “Health Care Decision Making Worksheet” to guide their thinking and discussions. An authorized practitioner will sign orders on the MOLST form that are needed to implement these decisions.

The MOLST form is included with other active medical orders in the patient’s medical record, and a copy or the original must be transferred across settings when a patient is discharged or transferred. The orders it contains are valid across settings, even if the physician, nurse practitioner, or physician assistant who signed the order is not on the medical staff at the receiving facility or program. The MOLST orders are to be applied or updated appropriately as patients move across those settings.

Ultimately, MOLST orders are based on several factors, including patient preferences, values, and goals (or the input of an authorized decision maker on behalf of someone who lacks decision-making capacity), the current medical situation and prognosis, the availability and relevance of potential treatment options, and determinations about the likely medical effectiveness of various treatment options. Practitioners will be guided by information from several sources, including the direct input of a patient or authorized decision maker, any advance directives, and contents of any Health Care Decision Making Worksheet or comparable documentation about treatment options.

How does Maryland MOLST relate to advance directives?

An advance directive may be used to name another individual to make health care decisions in case the person who makes the advance directive subsequently loses decision-making capacity. An advance directive may also include a living will, which is used to describe preferences about life-sustaining treatments that are to be honored after the individual loses decision-making capacity. A living will typically describes the individual’s preferences about life-sustaining procedures in a contingent, general way; for example, “If my death from a terminal condition is imminent. . . I direct that my life not be extended by life-sustaining procedures. . .”

The MOLST form documents current orders related to life-sustaining treatment options (for example, “Do Not Resuscitate” or “Do Not Hospitalize”), based on any valid source of such orders (for example, an advance directive or the direct input of a patient or an incapacitated patient’s authorized decision maker. The orders on the MOLST form are to be part of the current medical orders during a person’s stay in their current health care setting, and to apply in a subsequent setting unless and until they are changed.

The MOLST form is not an advance directive, and an advance directive is not a medical order. Use of the MOLST form does not require that a person have an advance directive. Therefore, a patient who has capacity and does not currently need to decide about life-sustaining treatments, but who wishes to declare preferences about such treatments for the indefinite future, should make an advance directive. However, a MOLST order can be written regarding any definitive choice of treatment options for the present or future. (see FAQs).

A patient who still has decision-making capacity may select any desired options for life-sustaining treatments, regardless of an existing advance directive. For example, a capable patient who wishes to be resuscitated and to have treatment to try to prevent cardiopulmonary arrest, would tell an authorized practitioner, who would then write an order for CPR on the MOLST form. In such situations, the patient's current wishes may differ from those documented in an advance directive. It is also possible that the discussion about the MOLST options might prompt the patient to revisit decisions made previously in the advance directive. Both the advance directive and MOLST form should be reviewed and updated if appropriate to reflect the patient's or authorized decision maker's wishes.

In contrast, if a patient who made an advance directive now lacks decision-making capacity, the advance directive should guide any current medical decisions. For example, if a patient's advance directive limits interventions in the event of an end-stage or terminal condition or persistent vegetative state, and that individual has subsequently lost capacity and has been certified to be in a terminal condition, an authorized decision maker must apply the patient's wishes, as documented in the advance directive, to guide the choice of specific treatment options covered on the MOLST form. Maryland law requires an authorized decision maker to carry out the patient's known and clear wishes, whether those wishes are contained in an advance directive, a previous MOLST form, or based on the patient's past statements, beliefs, values, attitudes, behaviors, and decisions relating to the treatment at issue or medical treatments in general. An advance directive is usually, but not always, the best evidence of a patient's wishes.

In both of the instances discussed above, the orders may be affected by a physician determination that a desired treatment would be medically ineffective. The HCDA requires certain steps be taken in case of a determination of medical ineffectiveness, prior to implementing the related orders.

What are the legal requirements for offering and using the Maryland MOLST form?

Assisted living programs, home health agencies, hospices, kidney dialysis centers, and nursing homes are required to accept, update if appropriate, and complete the MOLST form for each patient during the admission process in accordance with the form's instructions. A hospital is required to accept and update, if appropriate, a completed MOLST form in accordance with the form's orders. The hospital must complete a MOLST form during a patient's inpatient stay if he or she is to be discharged to an assisted living program, home health agency, hospice, kidney dialysis center, nursing home, or another hospital.

When initiating a MOLST form or updating an existing MOLST form, a health care facility shall offer the patient or authorized decision maker and any physician, nurse practitioner, or physician assistant selected by the patient or authorized decision maker the opportunity to participate in completing or updating the MOLST form. It shall be noted in the medical record when a patient or authorized decision maker declines to participate in the discussion, indicating the date and time of the conversation, with whom the form was discussed, and a summary of the conversation.

The facility or practitioner shall inform the patient or authorized decision maker that the form will become part of the medical record and can be accessed through the procedures used to access a medical record. The facility or practitioner shall give a copy or the original of the form to the patient or authorized decision maker within 48 hours of its completion, or sooner if the patient is discharged or transferred.

Completing the MOLST form means (1) certifying the bases for the orders contained therein; (2) completing sections of the form that are related to the patient's current medical condition and wishes for care; and (3) signing and dating each page of the MOLST form that contains any documentation or orders.

There is no requirement to make a certain number of choices or to cover all of the items. Only treatment options that are selected by the patient (or a duly authorized decision maker in case of the patient's incapacity), or otherwise determined to apply (for example, if identified by the physician as medically ineffective) need to be indicated.

Discussing life-sustaining treatments on the MOLST form can be coupled with the provision of information about advance directives. If the patient or authorized decision maker declines to consider MOLST form options, for whatever reason, the facility should document this and clarify that the patient or authorized decision maker understands the effects of making no decision about CPR status (for example, that cardiopulmonary resuscitation will be attempted in the event of an arrest and Section 1 of the MOLST form will be marked "Attempt CPR").

A health care provider or practitioner may not reformat the MOLST form, change the preprinted wording of any of its parts, or add its name or logo to the top of the form. However, additional orders related to life-sustaining treatments may be written in under Section 9 "Other Orders." The practitioner signing the order form must ensure that any additional orders in Section 9 are compatible with orders selected in other Sections of the document. Only Section 1 should be used for CPR orders, and other orders cannot override the Maryland Medical Protocols for EMS Providers.

The provider or practitioner must give the patient or authorized decision maker a copy or the original of a completed MOLST form within 48 hours of its completion. If the patient is discharged or transferred to another facility in less than 48 hours, a copy or the original of the MOLST form must be given to the patient upon discharge or transfer. An electronic copy may also be transmitted to the receiving facility or program in addition to, but not instead of, the original form or a copy of it. During the admissions process at the receiving facility, a practitioner must review the MOLST form. The purpose of such a review is to assess and, as needed, revise or update current orders, and to identify the possible need to discuss and decide about life-sustaining treatments.

Thus, for every new patient, a health care facility should include in its clinical records any of the following that apply: an advance directive, a "Health Care Decision Making Worksheet" (or something comparable) used to document preferences, a MOLST form with pertinent sections completed, and related documentation.

Frequently Asked Questions (FAQs) About Maryland MOLST

1. Requirements to offer the Maryland MOLST form options

1-1. *How soon after a patient or resident arrives at a health care facility must discussion of the treatment options on the Maryland MOLST form be offered?*

Assisted living programs, home health agencies, hospices, kidney dialysis centers, and nursing homes are required to accept, update if appropriate, and complete the MOLST form for each patient during the admission process in accordance with the form's instructions. A hospital is required to accept and update, if appropriate, a completed MOLST form in accordance with the form's orders. The hospital must complete a MOLST form during a patient's inpatient stay if he or she is to be discharged to an assisted living program, home health agency, hospice, kidney dialysis center, nursing home, or another hospital.

In settings or situations where the offer of the MOLST form is not required, the provider or practitioner must still review and use an existing MOLST form that accompanies the patient or that is presented on admission. Also, the MOLST form must be made available upon the request of a patient or an authorized decision maker, and must be used for a patient who has any limitations on CPR or other life-sustaining treatment options. In any setting, any competent patient may request completion of a MOLST form for him or her.

1-2. *What if someone presents to an EMS provider, or arrives at a health care facility with a form documenting life-sustaining treatment options that was done in another state?*

Both facilities and EMS providers can use such forms to guide the use, withholding, or withdrawal of life-sustaining treatments. At some point, the treatment wishes on the out-of-state form should be reviewed with the patient or the authorized decision maker and applicable orders should be transferred to a Maryland MOLST form.

2. What Maryland MOLST Covers

2-1. *Does the Maryland MOLST form cover everything that patients and practitioners need to know about the process of making choices and completing the form?*

The MOLST form is the end point of the underlying health care decision making process and the means for documenting specific orders related to cardiopulmonary resuscitation and other life-sustaining treatments. The MOLST order form itself is not the same as the process of making decisions and choosing treatment options that are ultimately ordered on the form. Patients and practitioners should use the information in this guide and other resources and references to help them discuss, make, and document treatment decisions prior to the completion of the MOLST form.

2-2. Why does the Maryland MOLST form contain numerous treatment choices? Do they all have to be completed?

The MOLST form includes the most common widely recognized life-sustaining treatment options. It was desirable to offer a broad range of treatment options in addition to cardiopulmonary resuscitation, in order to standardize definitions, make the process available and convenient; remind patients, providers, and practitioners of the available options; and match as closely as possible the Life Sustaining Treatment Options form.

Some of the treatment choices and orders will be immediately relevant, while others may not apply until later. The MOLST form will implement treatment choices that are currently relevant and can also be used for those treatment options that are already decided for the future. For example, an order for “No Artificial Nutrition” may be appropriate both for someone who declines the option while currently not eating and losing weight and for someone who is eating without difficulty at present but whose advance directive specifies that he or she never wants artificial nutrition under any circumstances.

For example, an order for “No Artificial Nutrition” may be appropriate both for someone who declines the option while currently not eating and losing weight and for someone who is eating without difficulty at present but has decided unambiguously about artificial nutrition/hydration in the future after being able to explore with the clinician, in meaningful detail, the risks and benefits of, and alternatives to, artificial nutrition/hydration in consideration of the individual’s current condition or the well-known future course of their disease.

2-3. Do Maryland MOLST orders mandate the administration or withholding of specific treatments?

Orders on the MOLST form to limit a treatment (that is, to not give a treatment or to only use it to a limited extent) are to be honored as specified. While orders for unlimited or unrestricted treatment authorize their use if medically indicated, they do not mandate giving treatment regardless of its relevance to your situation. Practitioners are expected to use their clinical judgment to decide whether an intervention is medically indicated and may choose not to offer treatments that they believe will be medically ineffective, although they must follow the procedures specified in the Health Care Decisions Act.

For example, a MOLST order for hospitalization does not automatically require hospital transfer for any acute illness or acute change of condition. It permits hospitalization for situations where acute medical care is indicated and cannot be provided adequately in the patient’s current setting. If the acute care (for example, treatment of an acute infection) can be provided appropriately in the current setting, then hospitalization may not be necessary.

3. Discussing, presenting, and choosing treatment options

3-1. *May someone other than the patient’s attending physician, nurse practitioner, or physician assistant discuss the life-sustaining treatment options on the Maryland MOLST form with a patient or the authorized decision maker?*

Yes. The health care practitioner plays a critical role in each step of the health care decision making process (see Section 1 and Appendix A). The practitioner should participate to the extent needed to inform patients and authorized decision makers about the availability and relevance of various treatment options. Although he or she may delegate to another health care professional the task of helping the patient or authorized decision maker consider desired life-sustaining treatments, the authorized practitioner is ultimately responsible for the accuracy and relevance of information that is presented, the treatment options that are discussed, and the orders that are written.

3-2. *In Section 9, what is the purpose of “Other Orders?”*

This part of the MOLST form provides space to indicate whether the patient or the authorized decision maker accepts or declines the use of other life-sustaining treatment options that have not already been covered in Sections 1-8. The space under “Other” is not meant to offer ambiguous choices such as “comfort care. Rather, it could be used appropriately to refer to a treatment option that is not otherwise covered on the form (for example, no radiation therapy or chemotherapy) or to give specific additional direction regarding the use of a life-sustaining treatment. Any orders in Section 9 should be compatible with the orders that have been authorized in those other Sections. Also, this Section cannot be used to modify treatment the protocols that EMS providers will use in providing CPR and treatment prior to arrest, as those are covered by existing Emergency Medical Systems protocols.

3-3. *May sections of the Maryland MOLST form be omitted or struck through?*

Only those parts that are pertinent to the patient’s condition and wishes need to be completed. As with other preprinted orders, Sections that do not currently apply can be left blank or a line may be drawn through a Section with no orders.

4. Completing and signing the Maryland MOLST form

4-1. *Who can sign the MOLST order form?*

Only health care practitioners authorized under the law (including physicians, nurse practitioners, or physician assistants) can sign the Maryland MOLST form. Whoever signs the MOLST order form is responsible for ensuring the accuracy and basis for the orders and that they meet legal and regulatory requirements. While a practitioner’s signature on the MOLST form authorizes medical orders, a practitioner signature on any other form (for example, a worksheet) only indicates review of the form, but does not make it an order.

While not required, it is strongly recommended that the practitioner initial (instead of check off) the specific treatment options as a way to indicate that he or she has reviewed the accuracy and pertinence of selected options. However, checking or otherwise marking the spaces rather than initialing them will not invalidate the MOLST form.

Practitioners shall not pre-sign blank order forms and leave them for others to complete.

The patient or authorized decision maker should not complete the MOLST form directly or sign or co-sign these orders. They may (but do not have to) use and sign the "Health Care Decision Making Worksheet" to make choices that can then be used to guide the orders on the MOLST order form. Use of the Health Care Decision Making Worksheet is encouraged in order to provide relevant and clear guidance related to these choices.

4-2. What should happen if a practitioner is not present to sign the form?

If an authorized practitioner is not present to sign the form, then the facility can transmit it electronically (e.g., by secure fax or secure scanning and emailing) to the practitioner for signature. The practitioner returns the form after completing and signing. If other transmittal methods are not available, the MOLST form may be mailed to the practitioner.

Nurses can accept and implement verbal orders for specific life-sustaining treatment options. However, the MOLST order form itself is not valid until it is actually signed. Therefore, any verbal orders obtained from a physician, nurse practitioner, or physician assistant (for example, updated CPR orders related to an acute change of condition or a change in patient wishes) should be written on a standard (not MOLST) order form if they are to be implemented before the practitioner can sign the MOLST form. The MOLST form should then be completed or revised and signed in order to make the orders valid for use by EMS providers. While other providers can follow verbal orders related to LSTs while awaiting completion or updating of the MOLST form, EMS providers cannot follow orders on any form other than the MOLST form or a previous version of an EMS/DNR Order form.

4-4. Must the order form be witnessed?

No. The Maryland MOLST form is not an advance directive and does not have the same procedural formalities.

5. Patient / authorized decision maker declining to make choices

5-1. How should a facility proceed if the patient or authorized decision maker declines its offer to discuss Maryland MOLST options?

If the patient or authorized decision maker declines to consider the MOLST form options, for whatever reason, the facility should document this and clarify that the patient or authorized decision maker understands the consequences of making no decision. Under those circumstances, several factors influence whether and to what extent treatment will be given, including: 1) whether any treatments have been determined to be medically ineffective or ethically inappropriate, 2) whether the person declining to select an option is the patient or an authorized decision maker, 3) whether an incapacitated patient has an advance directive, and 4) whether treatment is available and medically indicated.

A facility should also inform the patient or the patient's authorized decision maker of any facility policy that amounts to a default decision for any of the treatment options. For example, if a facility's policy is that anyone who has a change in condition will be transferred to the hospital unless a choice is made to limit such transfers, then the absence of a decision regarding hospitalization is effectively a decision in favor of hospital transfer.

If a choice regarding cardiopulmonary resuscitation (CPR) is not made, and in the absence of other exceptions (e.g., authorized decision maker has declined to discuss but the patient has an advance directive that declines CPR) the default order is to administer cardiopulmonary resuscitation using all available treatment options (i.e., "Attempt CPR" Option on the form). For other treatment sections (e.g., hospitalization, medical testing, etc.), failure to make choices authorizes the use of these other life-sustaining treatments if they are medically indicated and are not otherwise precluded (for example, by certification of medical ineffectiveness or based on an incapacitated patient's existing advance directives), but does not mandate their use regardless of their medical indication. If EMS personnel are involved in the care of a patient for whom there is not an order related to CPR either on the MOLST form or on a previous version of the EMS/DNR form, they will follow the "Attempt CPR" option, per the MIEMSS protocol.

Under the Health Care Decisions Act, determination that certain treatments would be medically ineffective or ethically inappropriate must follow a specific process before implementing such decisions.

6. Process related to patient transfer or discharge

6-1. When a patient is transferred or discharged to a different facility, how should the Maryland MOLST form be sent?

A complete and legible copy of the MOLST form (or the original) in the patient's current setting must physically accompany the patient. It can also be securely faxed or electronically transmitted to the receiving facility to precede or coincide with the patient's arrival in addition to—but not instead of—accompanying the patient. The sending facility or program should always maintain the original or a legible and complete copy of the MOLST form in the patient's medical record, before and after transfer or discharge.

The law intends for the MOLST form to be available to the receiving facility when the patient arrives, so that the information on it can be incorporated into treatment decisions. The receiving setting has a responsibility to inquire about the existence of a MOLST order form, either from the patient or authorized decision maker or from the setting that is sending the patient. In addition, any EMS providers who are involved in the patient's care must attempt CPR unless they have a signed copy of either the patient's MOLST form or an EMS DNR Order form.

6-2. Suppose a Maryland MOLST form was completed for a hospitalized patient and the patient was then discharged, but later is readmitted to the hospital. Is the first MOLST form still valid, or is a new one necessary?

Upon readmission, the current MOLST form should be reviewed. Whatever MOLST form is current in the sending facility would be applied in the receiving facility, pending any review and revision based on changes in condition, changes in patient wishes, or other relevant factors. So, if the MOLST orders that had been sent with the patient upon hospital discharge were unchanged upon subsequent hospital readmission, the first MOLST form would still apply. Otherwise, the most recent modified version of the MOLST form would apply upon readmission to the hospital.

6-3. Suppose a Maryland MOLST order form was completed for a hospitalized patient, and then the patient is discharged to a nursing home or assisted living facility. Is the nursing home or assisted living facility required to offer a new MOLST form, or may it accept the MOLST order form that was completed in the hospital?

Upon transfer, the current MOLST form from the sending facility shall be reviewed and used at the receiving facility, pending review and any revision based on changes in condition, changes in patient wishes, or other relevant factors.

7. Duration, review, revocation and updating of Maryland MOLST orders

7-1. Does a completed Maryland MOLST form expire after a period of time?

A MOLST form endures indefinitely or until it is replaced by an updated MOLST form or voided. For example, if the situation changes significantly for a patient who is currently covered by MOLST orders, then it is appropriate to reconsider previous choices. In such cases, the MOLST orders shall be reviewed for continued pertinence and for items needing discussion and revision or addition. If there are any changes, a new MOLST form must be completed and the old one voided.

The orders on the MOLST form can be updated, or otherwise revised or voided at any future time, as long as the decision making behind such changes is consistent with applicable laws and regulations, including the Maryland Health Care Decisions Act. For example, an authorized decision maker cannot rescind or contradict orders based on the prior decisions of a capable patient who subsequently loses his or her decision-making capacity, unless that patient specifically authorized him or her to do so in an advance directive.

7-2. What should trigger a review of a Maryland MOLST order form?

According to the law, patients (or their authorized decision makers) and practitioners shall review the continuing pertinence of, and need for, these orders: (1) when the patient is transferred between healthcare facilities or programs, (2) when the patient is discharged, (3) when there is a substantial change in health status, (4) when the patient loses capacity to make healthcare decisions, (5) when the patient's wishes change and (6) annually.

Review of a previously completed Maryland MOLST form does not necessarily require making any changes. However, if the review leads to new decisions about any of the current MOLST orders, the old order form must be voided and a new one prepared, signed and dated.

7-3. How is the Maryland MOLST order form to be revised and updated?

Once a MOLST order form has been completed and signed, a new form should be completed and signed whenever there are any changes to the order form. Previous orders that still apply should be transferred to the updated form, and the updated form should be signed and dated by the current responsible practitioner, even if that practitioner was not involved in signing the previous version of the MOLST form. To void a current MOLST form, the practitioner or a health care facility representative should draw a diagonal line through the order form, print the word "VOID" in large letters across the page, and sign and date below the line.

Section IV: Life-Sustaining Treatment Options

The following discussion of life-sustaining treatment options reflects the treatment options as presented on the Maryland MOLST form and the Health Care Decision Making Worksheet. These options are relevant both to selecting orders on the MOLST form and to those who have made, or may wish to make or expand, treatment instructions as part of an advance directive.

Part 1. CPR Status.

This item addresses the issue of what should be done to try to prevent or manage an actual or impending cardiopulmonary arrest. Does the patient or the authorized decision maker accept attempted CPR in the event of cardiopulmonary arrest? Should an attempt be made to try to reverse impending cardiopulmonary arrest, and if so, then to what extent? The decision about how to respond to an arrest must be made for every patient, either by accepting or declining attempted CPR.

In addition to guiding CPR decisions in the facility, these orders regarding CPR will also direct the decisions and actions of EMS providers in Maryland regarding cardiopulmonary resuscitation. Therefore, this Section 1 on the MOLST form must be completed to guide EMS providers who may become involved in the individual's care (for example, while transferring the individual to or from the current facility), regarding whether and to what extent to provide cardiopulmonary resuscitation and to try to prevent impending cardiopulmonary arrest. If there is no order related to limiting CPR on the MOLST form or on a previous EMS/DNR form, EMS providers will give cardiopulmonary resuscitation by default.

All EMS providers involved in the care of a patient will follow the Emergency Medical Systems medical protocols for giving these treatments. Facilities and others will use their own protocols unless and until an EMS provider is involved and takes over the care.

Attempt CPR

Choosing this option will authorize cardiopulmonary resuscitation without restrictions. This means that:

- If cardiac and/or pulmonary arrest occurs, cardiopulmonary resuscitation (CPR) will be initiated and continued within the scope of available interventions, and additional support (e.g., an EMS provider) will be summoned if needed.
- If summoned for someone who has experienced cardiopulmonary arrest, or if someone experiences cardiopulmonary arrest while being transported, an EMS provider will initiate and/or continue any and all medical efforts that are indicated during arrest, including artificial ventilation and comprehensive efforts to restore and/or stabilize cardiopulmonary function, consistent with the EMS medical protocols.

No CPR, Option A-1, Intubate. Comprehensive Efforts to Prevent Arrest, Intubate

Choosing this option will authorize withholding cardiopulmonary resuscitation while also authorizing aggressive efforts to try to prevent impending cardiopulmonary arrest. This means that:

- If cardiac and/or pulmonary arrest occurs while under the provider's care (including while care is being rendered by an EMS provider), resuscitation will not be attempted (No CPR). Death will be allowed to occur naturally.
- If cardiopulmonary arrest appears to be imminent, medications and treatments will be given to try to stabilize the patient's condition, including intubation if it is indicated. If necessary, additional support may be summoned to try to prevent cardiopulmonary arrest.
- To try to prevent cardiopulmonary arrest, an EMS provider that is involved in the patient's care will administer any medications and treatments that are needed, including intubation if it is indicated.

No CPR, Option A-2. Do Not Intubate. Comprehensive Efforts to Prevent Arrest, Do Not Intubate (DNI)

Choosing this option will authorize withholding cardiopulmonary resuscitation while also authorizing aggressive efforts to try to prevent cardiopulmonary arrest, except for intubation. This means that:

- If cardiac and/or pulmonary arrest occurs while under the provider's care (including while care is being rendered by an EMS provider), resuscitation will not be attempted (No CPR). Death will be allowed to occur naturally.
- If cardiopulmonary arrest appears to be imminent, medications and treatments will be given to try to stabilize the patient's condition, excluding intubation. However, CPAP or BiPAP (external devices that are used to try to improve lung ventilation) may be used if indicated to try to prevent respiratory failure or pulmonary arrest. If necessary, additional support may be summoned to try to prevent cardiopulmonary arrest.
- An EMS provider that is involved in the patient's care will administer any medications and treatments that are needed to try to stabilize the patient's condition prior to arrest, except for intubation. Instead of intubation, they will use CPAP or BiPAP if indicated.

No CPR, Option B, Palliative and Supportive Care

Choosing this option will authorize withholding cardiopulmonary resuscitation as well as efforts to try to prevent cardiopulmonary arrest. This means that:

- Death will be allowed to occur naturally.
- Health care providers (including an EMS provider if involved in the care) will not initiate cardiopulmonary resuscitation or attempt to prevent cardiopulmonary arrest (e.g., they will not attempt to identify and manage

underlying causes of an unstable condition and will not intubate or use CPAP or BiPAP).

- Health care providers (including an EMS provider if involved in the care) will give supportive measures, including 1) passive oxygen for comfort, 2) efforts to control any external bleeding, and 3) medications that are indicated for symptom relief (e.g., pain management).

2- ARTIFICIAL VENTILATION

What should be done for respiratory failure where cardiopulmonary arrest is not present?

Does the patient or the patient's authorized decision maker accept the use of a ventilator in case of respiratory failure (i.e., the individual cannot breathe adequately unaided)? In addition to the polar opposites of accepting ventilation indefinitely and refusing it outright, this part of the form also invites consideration of an intermediate option, under which ventilator use would be accepted for a limited time as a therapeutic trial. Space in this Section permits specification of the time period, if feasible and desired by the patient or authorized decision maker.

Since intubation and mechanical ventilation are more invasive and may be more enduring, there is also the option to try to assist ventilation with external devices (CPAP or BiPap) that can be more readily discontinued if artificial ventilation is subsequently either not needed, ineffective, or determined to be contrary to the patient's goals and wishes.

2a- Artificial Ventilation

Choosing this option will authorize the use of artificial ventilation in case of respiratory failure. This means that:

- In case of respiratory failure, intubation and artificial ventilation may be initiated and continued for as long as breathing needs mechanical assistance, even indefinitely.

2b- Time-Limited Trial of Artificial Ventilation (Intubation Acceptable)

Choosing this option will authorize a time-limited trial of artificial ventilation, which may include intubation. This means that:

- In case of respiratory failure, intubation and artificial ventilation may be initiated and continued for a limited time to see if artificial ventilation is effective and pertinent in light of a patient's overall condition and underlying causes of respiratory failure. During that trial period, the situation will be reassessed to determine if continued use of artificial ventilation is warranted and desired or if it should be discontinued. Whenever possible, a time frame should be specified; for example, for up to 30 days.

2c- Time-Limited Trial of Artificial Ventilation (No Intubation)

Choosing this option will authorize a time-limited trial of artificial ventilation, but without intubation. This means that:

- In case of respiratory failure, only CPAP or BiPAP will be used for artificial ventilation, as indicated, and continued for a limited time until the prognosis is clarified (time limit should be specified, if identified (for example, up to 30 days) to see if these interventions are effective and their continued use is pertinent in light of the patient's overall condition and underlying causes of respiratory failure.
- The patient will not be intubated or placed on a ventilator.

2d- No Artificial Ventilation

Choosing this option authorizes withholding of artificial ventilation under any circumstances, including intubation, CPAP, BiPAP, or other means of mechanical ventilation.

3-BLOOD TRANSFUSION

Should blood transfusions or infusion of blood products be given in case of life-threatening bleeding or anemia?

3a- Transfusions Acceptable

Choosing this option will authorize the transfusion of blood products. This means that:

- Blood and blood products (e.g., plasma, whole blood, platelets) may be administered if indicated to replace blood components.
- This does not mandate transfusion for anemia or acute bleeding, regardless of medical indication, but authorizes it if it is medically indicated (for example, another approach to treating anemia is not available or not feasible).

3b- No Blood Transfusions

Choosing this option means that no blood or blood products will be given under any circumstances.

4- HOSPITAL TRANSFERS

Should hospital transfers occur to assess or treat medical conditions, and under what circumstances?

Does the patient or the authorized decision maker accept transfer to a hospital if the patient develops a condition that cannot be readily treated in his or her current setting? For example, some individuals who are at home or in a long-term-care facility may prefer not to be transferred, but instead to be treated with whatever options are available where they are. This item also allows a choice of hospitalization if needed for limited circumstances.

4a- Hospital Transfer is Acceptable

Choosing this option will authorize hospitalization as an option for someone who is currently not hospitalized. This means that:

- Transfer to the hospital is acceptable for any situation requiring medical care (i.e., if hospitalization is needed to diagnose, treat, or monitor the individual) that cannot be given outside of a hospital.
- This does not mandate automatic hospital transfer for any acute change of condition or illness, but authorizes it if the situation cannot be addressed adequately outside of a hospital.

4b- Hospital Transfer Only For Limited Situations

Choosing this option will authorize acute hospitalization only under limited circumstances for someone who is currently not hospitalized. This means that:

- Hospitalization will not be used primarily to try to diagnose, treat, or monitor medical illness but may be used if it is necessary for comfort; i.e., to relieve medical or psychiatric symptoms that are causing severe distress and cannot be managed adequately in a non-hospital setting.

4c- No Hospital Transfer

Choosing this option means that:

- Hospital transfer will not occur under any circumstances.
- The patient may still be assessed, treated, and monitored with options available outside the hospital, consistent with his or her medical needs, condition, prognosis, and wishes.

5 - MEDICAL TESTS

To what extent should medical tests be performed for diagnosis, treatment, and monitoring?

Medical workups are typically justified by the assertion that treatment will be enhanced by knowing the causes of symptoms and the effectiveness of interventions. Does the patient or authorized decision maker accept diagnostic tests? Outside of the context of end-of-life care, a patient who develops significant symptoms of a potentially

treatable condition usually undergoes a medical workup to diagnose the problem and may have medical tests to monitor the effectiveness of treatment. The exact nature of the tests varies, depending on the symptoms and the suspected diagnosis.

This Section asks the patient or authorized decision maker to consider whether the discomfort or other burdens associated with a medical workup makes sense in light of the main goal of care. Particularly if the suspected diagnosis would not, or cannot, be treated, or if the workup or monitoring is unlikely to add materially to what is already known about the causes and consequences of the patient's current condition, the burden of medical testing may not be justified.

5a- Any Medical Tests Are Acceptable

Choosing this option will authorize a broad scope of medical testing (i.e., laboratory and other diagnostic testing), as indicated. This means that:

- Any medical tests that are indicated to diagnose, treat, or monitor a patient may be obtained, regardless of their complexity or potential discomfort to the patient.
- This does not mandate performing medical tests, but authorizes that testing may be done if medically indicated.

5b- Limited Medical Tests Are Acceptable

Choosing this option will authorize limited medical testing for specific purposes. This means that:

- Medical tests will be obtained only when necessary to enable symptom relief or facilitate comfort.
- Assessment, diagnosis, treatment, and monitoring of the patient will be based primarily on clinical findings instead of on diagnostic testing.

5c- No Medical Testing

Choosing this option means that:

- No medical tests will be done.
- Any need to assess, diagnose, treat, or monitor a patient for palliative purposes will be based on clinical findings instead of on diagnostic testing.

6 – ANTIBIOTICS

When should antibiotics be given, and how extensively?

Does the patient or authorized decision maker accept antibiotics in case of infection? For some patients, but not for others, attempted cure of infection is consistent with the main goal of care. This part of the form also invites consideration of an

intermediate option, under which a comparatively burdensome method of antibiotic administration, intravenous infusion or intramuscular injection, is declined, but other methods are permitted.

6a- Antibiotics Broadly Acceptable

Choosing this option will authorize antibiotics by any route of administration and for any duration. This means that:

- Any antibiotics (e.g., oral, intravenous or intramuscular injection) that are medically indicated may be used, by any route of administration, to try to treat an infection.
- This does not mandate the use of antibiotics, but authorizes that they may be used if medically indicated.

6b- Limited Antibiotic Use Acceptable

Choosing this option will authorize oral antibiotics to treat an infection. This means that:

- Oral antibiotics may be used, if medically indicated, to try to treat an infection. Intravenous or intramuscular antibiotics will not be used, including situations where oral antibiotics may not cure the infection.

6c- Antibiotics Acceptable For Palliation

Choosing this option means that:

- Antibiotics will only be given when indicated for relief of symptoms or for comfort, and only orally, with the primary objective of symptom relief, not cure.

6d- No Antibiotics

Choosing this option means that:

- No antibiotics will be given. Only other symptomatic treatment for infections (e.g., medication for fever and pain relief) will be offered.

7- ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION

Under what circumstances, and to what extent, should artificial nutrition and hydration be administered?

Does the patient or the authorized decision maker accept the use of artificially administered fluids and nutrition in the event of insufficient oral intake? In addition to either accepting these interventions indefinitely or refusing them outright, this Section of

the form also invites consideration of two intermediate options. In one, the use of artificially administered fluids and nutrition would be accepted for a limited time as a therapeutic trial. Space in this item permits specification of the time period, as appropriate. Another option is to accept the intravenous or subcutaneous administration of fluids but not artificially administered nutrition. Artificial nutrition and hydration may also be administered for palliation, if consistent with the patient's goals and wishes, without necessarily having a specific weight target or medical goal.

Note that the Health Care Decisions Act requires that, if artificially administered fluids and nutrition are not used, reasonable efforts to offer food and water by mouth must always be made.

In this Section, "hydration" refers to fluids given for the purpose of maintaining or restoring the body's fluid and electrolyte balance. It does not refer to intermittent uses of fluids to deliver treatments—for example, to mix medications for intravenous administration-- which would be covered under other sections.

7a- Artificially Administered Fluids and Nutrition Acceptable

Choosing this option will authorize both artificially administered fluids and nutrition by any route and for any duration. This means that:

- Artificially administered fluids and nutrition may be given, even indefinitely, if indicated, by any available route.
- This does not mandate giving artificially administered fluids and nutrition regardless of the lack of a medical indication. For example, appropriate assessment and management of treatable causes of anorexia, weight loss, or fluid imbalances may make artificially administered fluids and nutrition unnecessary.

7b- Time-Limited Trial of Artificially Administered Fluids and Nutrition Acceptable

Choosing this option will authorize a time-limited trial of artificially administered fluids and nutrition. This means that:

- Artificially administered fluids and nutrition may be administered, as indicated, as a therapeutic trial for a limited time, to see if any of these interventions are effective and if their continued use is pertinent in light of the patient's overall condition and underlying causes of impaired nutrition, weight loss, or fluid and electrolyte imbalance. Whenever possible, a time frame should be specified.
- During that trial period, the situation will be reassessed to determine if continued use of artificially administered fluids and nutrition is warranted and desired or if it should be discontinued (e.g., because underlying causes of weight loss cannot be corrected or because the patient's overall condition and function are likely to continue to decline regardless of any nutrition or hydration interventions).

7c- Artificial Hydration Only is Acceptable

Choosing this option means that:

- Artificially administered hydration (e.g., using subcutaneous or intravenous fluids) may be given, but artificial nutrition will not be administered.

7d- No Artificially Administered Fluids and Nutrition

Choosing this option means that:

- No artificial fluids or nutrition will be administered. The patient will be offered food and fluids by mouth as tolerated, unless medically contraindicated (for example, eating causes substantial pain or other distress).

8- DIALYSIS

Should dialysis be used in case the kidneys do not function adequately, and under what circumstances?

Among other things, the kidneys perform critical functions of eliminating wastes from the body and maintaining fluid and electrolyte balance. Dialysis (either peritoneal or hemodialysis) refers to the use of specialized equipment to perform essential functions that a person's kidneys are too impaired to perform unaided.

Kidney (renal) failure may be acute or chronic and may be partially or totally reversible or may be irreversible. This section asks whether a patient would accept dialysis regardless of the reversibility of impaired kidney function and if needed indefinitely or for a limited period.

8a- Dialysis Acceptable

Choosing this option will authorize dialysis by any route and for any duration. This means that:

- Dialysis (either hemodialysis or peritoneal, as indicated) may be given, even indefinitely, for inadequate kidney function including end-stage kidney disease.
- This does not mandate giving dialysis regardless of lack of a medical indication, but authorizes its use if medically indicated.

8b- Time-Limited Trial of Dialysis is Acceptable

Choosing this option will authorize a time-limited trial of dialysis. This means that:

- Dialysis (either hemodialysis or peritoneal) may be administered, but only for a limited period (for example, up to 30 days, or until prognosis is clarified) to

see if dialysis is effective and pertinent in light of a person's overall condition and underlying causes of renal failure. After that time, dialysis may be continued or stopped, depending on the results of the trial period.

8c- No Dialysis

Choosing this option means that no dialysis of any type or duration will be provided.

9 - OTHER ORDERS

Are there any other instructions related to life-sustaining treatments that are not otherwise covered in these orders?

This part of the MOLST form provides space to indicate whether the patient or authorized decision maker accepts or declines the use of other life-sustaining treatment issues that have not already been covered in Sections 1-8.

The space under "Other" is not an invitation to offer ambiguous choices such as "comfort care." Rather, it could be used appropriately to refer to a treatment option that is not otherwise covered on the form (for example, no radiation therapy or chemotherapy) or to give specific additional direction regarding the use of a life-sustaining treatment.

Any orders in Section 9 should be compatible with the orders that have been authorized in those other Sections. In addition, this Section cannot be used to modify treatment the protocols that EMS providers will use in providing CPR and treatment prior to arrest, as those are covered by existing Emergency Medical Systems policies.

Appendix A

Health Care Decision Making Process: Additional Key Considerations

Step 1: Identify situations where health care decision making is needed

- It is important to identify individuals who have done, or who wish to do, advance care planning and situations where advance care planning is urgently needed.
- Some individuals have already participated in advance care planning and have made decisions and/or documented their wishes; for example, a “No CPR” decision in the hospital prior to transfer to a post acute care facility.

Step 2: Identify and clarify existing care instructions

- One goal of this step is to identify individuals who have existing written care instructions or have otherwise previously made decisions related to life-sustaining treatments and end-of-life care.
- Another goal is to clarify the content and implications of existing advance directives and other care decisions. Sometimes, advance directives are too general, too specific, or self-contradictory. Patients and authorized decision makers may not be fully aware of the content, or clear about the implications of advance care planning documents.
- Health care choices are generally either treatment-specific or situation-specific. For example, a treatment-specific directive might say, "I do not want to be placed on a ventilator under any circumstances." A situation-specific directive might specify not to use aggressive medical interventions if they are deemed to no longer be likely to make a difference in the outcome or improve quality of life.
- Health care practitioners commonly face situations that are not discussed explicitly in advance directives, or where it is unclear whether and how a directive applies. It is often necessary to consider whether and how such instructions apply, and to try to extrapolate the general tone or direction of a patient’s wishes or instructions.

Step 3: Clarify medical issues

- “Quality of life” and “quality of care” are related in all healthcare settings. Medical conditions affect function and quality of life, and impact the potential for improving someone’s overall status and prognosis.
- Clarifying underlying causes of impaired function and quality of life is essential to identifying the relevance and risks of treatment options, recognizing situations where advance care planning is urgent, and recognizing factors affecting decision making capacity.
- Prognosis refers to how likely someone is to stabilize, improve, decline, or die.
- It is often fruitful for practitioners to try to distinguish potentially treatable acute symptoms (e.g., delirium or medication side effects) from untreatable complications of acute illness, exacerbations of irreversible chronic problems, or a terminal condition.

- A potentially correctable acute change in cognition and function may temporarily affect decision making capacity and may sometimes erroneously appear to portend an irreversible or end-of-life situation.

Step 4: Define decision-making capacity

- The Maryland Health Care Decisions Act (HCDA) requires that a practitioner confirm decision-making capacity.

- The HCDA protects the rights of competent individuals to make their own health care decisions. However, many patients have partially or totally impaired decision-making capacity.

- Because certifications related to decision-making capacity can have major implications for a patient's subsequent opportunities to influence his or her care, practitioners should try to do the best job possible in assessing and drawing conclusions about a person's decision-making capacity.

- Decision-making capacity is a functional capability that is influenced by medical conditions, cognition, functional abilities, and psychosocial factors.

- A single test or assessment may be useful for screening cognition, but multiple factors must be considered in determining decision-making capacity. The evaluation must be individualized.

- Decision making capacity may be all, none, or partial. For instance, an individual may have the capacity to consent to a blood draw, but may not have the capacity to decide between medical and surgical treatment options for carotid stenosis.

- Decision making capacity may change over time. A patient who is hospitalized for pneumonia with respiratory failure may lack capacity in the hospital but several weeks later may regain the capacity to make decisions about their health care.

- Even if a patient has limited decision-making capacity, it is still important to get their input about health care decisions. For example, a patient who cannot readily discuss the rationale for wanting or declining a feeding tube may try to pull out an indwelling tube or repeatedly state "I don't want it."

- The physician or nurse practitioner should document the process and rationale for his or her determination of a patient's decision making capacity in the medical record.

- Any disagreements about an individual's capacity to make health care decisions should be resolved promptly. It may be necessary to consult a practitioner with more knowledge and experience in determining capacity in order to resolve the issue in a timely manner.

- Addressing medical conditions that influence decision-making capacity (DMC) is essential to optimizing individual participation in personal and health care decisions.

- There is published guidance about determining decision-making capacity. For example, four performance levels relevant to determinations of DMC have been suggested, including 1) evidencing a choice, 2) factual awareness of issues, 3) rational manipulation of information, and 4) appreciation of the nature of the situation.

[Applebaum PS, Grisso T. Assessing patients' capacities to consent to treatment. N Engl J Med. 1988;319:1635-1638.] Practitioners who are involved in determining decision making capacity should familiarize themselves with related criteria and processes.

Step 5: Identify the primary decision maker

- If it is determined that a patient lacks sufficient decision-making capacity for the situation, the HCDA specifies a sequence of involvement, restrictions, and process requirements for authorized decision makers.
- Practitioners should be aware of the law's requirements related to authorized decision making, including the stipulation that authorized decision makers cannot simply override someone's expressed wishes and substitute their own.
- Ultimately, it is a practitioner's ethical responsibility to protect and enhance a patient's rights to direct their own care, to the extent possible.

Step 6: Certify the existence of any qualifying conditions

- The HCDA identifies three situations where the attending physician and a second physician or nurse practitioner must certify the existence of a qualifying condition, in order to permit surrogate decision makers to act on behalf of a patient to withhold or withdraw potential life-sustaining treatments: 1) end-stage condition, 2) terminal condition, and 3) persistent vegetative state. An advance directive's language may similarly limit a health care agent's decision-making authority.
- Although the HCDA defines these situations, it does not provide detailed criteria for identifying their existence. Therefore, it is important for practitioners to be familiar with the definitions and to understand their role in determining that a qualifying condition is present.
- The medical literature provides guidelines for considering the permanence of a vegetative state (PVS).³ The HCDA's definition of PVS focuses on awareness of self and surroundings and does not specify any duration of unconsciousness as a marker of persistence.
- The medical issues should be examined in the context of the patient's overall condition and prognosis. For example, patients with end-stage kidney disease or chronic obstructive pulmonary disease may or may not be end-stage functionally. Conversely, a patient may be terminal or end-stage due to the cumulative effects of age and/or medical illnesses, despite not having a specific identifiable end-stage or terminal illness.

Step 7: Define and present relevant issues and options

- Patients and authorized decision makers often need help to understand how specific treatment options might relate to their general goals and wishes.
- While those of other disciplines can give general guidance on procedural issues (such as how to complete advance directives), practitioners need to discuss the pertinence, benefits, risks, and advisability of specific treatment options.
- The way in which information is presented can influence patient or authorized decision maker understanding of issues and their potential for making appropriate decisions.
- Even with time constraints and the pressures of emergency situations, it is crucial to define the issues as clearly as possible before trying to address them.

- Recommended interventions (e.g., hospitalization, medical testing, resuscitation, or artificial nutrition and hydration) should be relevant to a person's values, goals, wishes, and overall condition and prognosis, not just to treating a specific disease or condition.

- The HCDA does not require or suggest that physicians offer all treatment options, regardless of their pertinence. It gives physicians the option to decline to offer treatments that are deemed to be medically ineffective or ethically inappropriate, provided they follow the required process.

- Resuscitation (CPR) status should be distinguished from wishes about treatment prior to cardiopulmonary arrest. Patients who decline CPR may still want—and be able to benefit from—other medical treatments, or they may only desire select interventions (e.g., dialysis or artificial ventilation), but not others (e.g., artificial nutrition or hydration).

Step 8: Implement treatment options related to health care decisions

- Orders to implement specific choices to withhold or withdraw treatments should be consistent with a patient's valid choices as well as with applicable laws and regulations.

- Orders related to palliative or limited care should specify what will not be provided. "Comfort care" or "palliative care" orders are too vague to guide precise and consistent interpretation.

Step 9: Review the situation and continue or modify approaches, as appropriate

- This step involves revisiting previous steps, based on reevaluating a patient's condition, prognosis, and wishes, and the results of treatments. Interventions may be continued, discontinued, or adjusted, as appropriate.

- A patient's situation may change with time, and new clinical and ethical issues may arise.

- Competent patients have the right to change or revoke their advance directives, and authorized decision makers can change their instructions, within limits. The HCDA has specific procedural requirements for changing advance directives.

- Updating related medical orders on the MOLST form should be done within a time frame that is relevant to changes in a patient's prognosis, condition, and wishes. Sometimes, new or revised documents and orders are needed to implement revised or new treatment choices.

Appendix B

Medical Information and Opinions Related to Potential Life-Sustaining Treatment Options

A practitioner with adequate knowledge of the patient may address, to the extent possible, the following questions. Taken together, and regardless of whether this form is actually completed in writing, the answers to these questions can help a patient or authorized decision maker consider pertinent treatment life-sustaining treatment options on the MOLST form.

As with any oral or written discussion of these issues, these opinions are provided with the understanding that they are based on the best available information at the time and on recognizing the usual and likely course of medical illnesses and functional impairments for a patient's current and anticipated condition. This is only a guide and not a guarantee of results or a definitive predictor of complications.

Current condition and prognosis

- At present, how would you rate this person's current level of medical stability?

- Stable
- Somewhat unstable
- Highly unstable

- Based on the current medical situation, what level of improvement appears likely for this individual in the near term (i.e., the next several weeks to several months)?

- Complete recovery at least to former level of function is likely
- Partial recovery to less than former level of function is anticipated
- Stabilization (neither decline nor improvement) is anticipated
- Continued instability and decline are most likely
- Death in the near term is most likely
- Prognosis not clear at present

- How likely is this individual to have significant medical complications in the near term (next several weeks to several months)?

- Very likely
- More likely than unlikely
- More unlikely than likely
- Cannot say at present

- What is the most likely longer-term (beyond the next 6 months) outlook for this person's level of function?

- Becomes or remains highly functional
- Becomes or remains moderately impaired
- Becomes or remains severely impaired
- Likely to die
- Cannot say at present

Likely Benefits of Medical Testing and Treatment

- Given this person's overall condition, prognosis, and recent clinical course, what level of medical intervention appears most appropriate in the near term?

- Aggressive medical care oriented towards substantial improvement or cure
- Limited medical care oriented towards partial improvement or stabilization
- Symptomatic or palliative care only

Risks of cardiopulmonary arrest and potential to benefit from cardiopulmonary resuscitation

- Do any of the following apply to the patient, which could increase the short-term risk for cardiopulmonary arrest? [mark all that apply]

- Has a terminal condition or appears to be at or near the end of his or her life expectancy
- Has a generally progressive, irreversible, or end-stage condition
- Multiple organs and body systems have failed or are failing
- Vital signs are fluctuating significantly and cannot be stabilized readily

- If this individual's heartbeat and breathing were to suddenly stop, how likely are they to survive cardiopulmonary resuscitation (CPR)?

- More likely than unlikely
- More unlikely than likely
- Highly unlikely

Possible impact of artificial nutrition and hydration on medical stability and quality of life

- Does this individual have any of the following conditions or situations that could affect weight and nutrition/hydration status? [mark all that apply]

- Individual has a terminal condition or is at or near the end of his or her life expectancy
- Individual has a generally progressive, irreversible condition
- Multiple organs and body systems are failing

- Given this person's overall condition and prognosis, and the underlying causes of any weight loss or fluid imbalance, how likely is it that artificial nutrition and/or hydration can help restore or maintain overall stability and prevent progressive decline?

- Very likely
- More likely than unlikely
- More unlikely than likely
- Highly unlikely

Appendix C

Health Care Decision Making Worksheet

This is a template of the Health Care Decision Making Worksheet. The actual current worksheet is available as a separate document.

This worksheet is to be used either to indicate current preferences for treatment (which will be reflected in Maryland MOLST orders) or to clarify wishes for future situations (which will be applied only when the issues become relevant at some future time). Although the choices on this worksheet represent wishes regarding various life-sustaining treatment options, this is not an order sheet.

The patient or authorized decision maker should choose one option for each of the categories, as appropriate and desired, by initialing the appropriate line. They can clarify specific care instructions, as needed. The remaining items can be left blank and may be completed later.

For example, preferences about artificial nutrition/hydration would be incorporated into current orders if the individual currently has impaired nutrition or fluid/electrolyte balance that cannot be corrected by some other means. On the other hand, if the individual is eating or drinking adequately at present, and issues related to nutrition and hydration are not anticipated, then orders related to limiting artificial nutrition/hydration may not be needed on the MOLST form. However, it may still be appropriate to do so if the individual has decided unambiguously about artificial nutrition/hydration for the future after being able to explore with the clinician, in meaningful detail, the risks and benefits of, and alternatives to, artificial nutrition/hydration in consideration of the individual's current condition or the well-known future course of their disease.

Part A. Main goal(s) of care. Specific treatment preferences should reflect the main goal or goals of care. Part A invites the patient or the patient's authorized decision maker to identify goals. It allows for the identification of more than one main goal of care. Often, two goals can be pursued simultaneously; for example, prolonging life while controlling pain and other distressing symptoms. But if the use of a life-sustaining treatment would be inconsistent with maximum comfort, as sometimes happens, then health care providers ought to know which goal is more important.

If the patient lacks capacity, the main goal(s) of care should be identified from *the patient's* perspective, based on the authorized decision maker's understanding of the patient's wishes, if known, or the patient's best interests. The authorized decision maker's personal beliefs and values should not override those of the patient, even if he or she is an appointed health care agent.

If more than one potential authorized decision maker (for example, surrogates having equal priority) is involved in the preparation of the Health Care Decision Making

Worksheet, they may not fully agree. Or, even if they agree, the attending physician may consider that the identified main goal of care is unrealistic or, if pursued, would result in undue burdens with little or no benefit for the patient. A health care provider should follow its customary procedures for addressing such conflicts, including, as appropriate, referral to the facility's patient care advisory (ethics) committee.

Part B. Advance directive and authorized decision maker contact information. As explained earlier (see Section III above), the "Health Care Decision Making Worksheet" is not an advance directive. If a patient has already completed an advance directive, this worksheet could be attached to it. If the advance directive names a health care agent (sometimes called a durable power of attorney for health care), contact information for the health care agent should be inserted. If there is no health care agent, contact information for the surrogate decision maker should be inserted. Even if the patient still has capacity, the contact information for whoever is to serve as an authorized decision maker after loss of capacity should be included.

Health Care Decision Making Worksheet

Instructions

Use this worksheet either to indicate current treatment preferences (which will be reflected in Maryland MOLST orders) or to clarify wishes for future situations (which will be applied only when the issues become relevant in the future). Only initial those items for which a decision has been made or is needed. The remaining items can be left blank and may be completed later.

Although the choices on this worksheet represent wishes regarding various life-sustaining treatment options, this is not an order sheet or an advance directive.

For example, preferences about artificially administered fluids and nutrition would be incorporated into current orders if the individual currently has impaired nutrition or fluid/electrolyte balance that cannot be corrected by some other means. On the other hand, if the individual is eating or drinking adequately and related problems are not anticipated soon, then orders related to limiting those treatment may not need to be entered on the MOLST form. It may still be appropriate to do so if the individual has definitely decided about these treatments for the future after being able to explore with the clinician, in meaningful detail, the risks and benefits of, and alternatives to, artificial nutrition/hydration in consideration of the individual's current condition or the well-known future course of their disease.

Make one choice for cardiopulmonary resuscitation, by initialing the appropriate line. If no choice is made, resuscitation will be attempted by default. Choose one option for each of the other categories, as appropriate and desired, by initialing the appropriate line. Clarify specific care instructions, as needed.

Part A, Main goal(s) of care: Specific treatment preferences should reflect the main goal or goals of care. Part A invites the patient or the patient's authorized decision maker to identify goals. It allows for the identification of more than one main goal of care. Often, two goals can be pursued at the same time – for example, prolonging life while controlling pain and other distressing symptoms. But if the use of a life-sustaining treatment would be inconsistent with maximum comfort, as sometimes happens, then health care providers should know which goal is more important.

If the patient lacks capacity, the main goal(s) of care should be identified from the patient's perspective, based on the authorized decision maker's understanding of the patient's wishes, if known, or the patient's best interests. The authorized decision maker's personal beliefs and values should not override those of the patient, even if he or she is an appointed health care agent.

If there are multiple surrogate decision makers of equal authority involved in the preparation of the Health Care Decision Making Worksheet, they may not all agree on a life-sustaining treatment. Or, even if they agree, the attending physician may consider that the identified main goal of care is unrealistic or, if pursued, would result in burdens with little or no benefit for the patient. A health care provider should follow its customary procedures for addressing such conflicts, including, as appropriate, referral to the facility's patient care advisory (ethics) committee.

Part B, Advance directive and authorized decision maker contact information: The Health Care Decision Making Worksheet is not an advance directive or an order form. If a patient has already completed an advance directive, this worksheet could

be attached to it. If the advance directive names a health care agent, contact information for the health care agent should be inserted. If there is no health care agent, contact information for the guardian or surrogate decision maker should be inserted. Even if the patient still has capacity, the contact information for whoever is to serve as authorized decision maker after loss of capacity should be included.

HEALTH CARE DECISION MAKING WORKSHEET

Patient's name	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Part A Fill in briefly, then initial on the line	Most Important Goal(s) of Care: What does the patient or authorized decision maker hope to achieve? _____	
Part B	<p>If the patient has a written advance directive check this box <input type="checkbox"/> and attach a copy.</p> <p>If the patient does not have the capacity to make health care decisions, check this box <input type="checkbox"/>.</p> <p>In case the patient lacks or loses capacity, the following individual will make decisions:</p> <p>_____</p> <p style="display: flex; justify-content: space-between;"> Name Phone Number </p> <p><input type="checkbox"/> Health Care Agent <input type="checkbox"/> Guardian <input type="checkbox"/> Surrogate Decision Maker</p>	
1	CPR Status: What should be done to try to prevent or manage an actual or impending cardiopulmonary arrest?	
	<p>_____ Attempt CPR, Comprehensive Cardiopulmonary Resuscitation Efforts</p> <ul style="list-style-type: none"> If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). CPR should include comprehensive medical efforts to try to restore and/or stabilize heart and lung function and prevent arrest, including any form of artificial ventilation. 	
	<p>_____ No CPR, Option A-1, Intubate, Comprehensive Efforts to Prevent Arrest, Including Intubation</p> <ul style="list-style-type: none"> If cardiac and/or pulmonary arrest occurs, resuscitation should not be attempted (No CPR). Allow death to occur naturally. In order to try to prevent cardiopulmonary arrest, use comprehensive efforts to try to stabilize and/or restore heart and lung function, including intubation where indicated. 	
	<p>_____ No CPR, Option A-2, Do Not Intubate, Comprehensive Efforts to Prevent Arrest, No Intubation</p> <ul style="list-style-type: none"> In order to try to prevent cardiopulmonary arrest, make a comprehensive effort to try to stabilize and/or restore heart and lung function, except for intubation. It is acceptable to use CPAP or BiPAP to try to prevent respiratory failure. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally. 	
	<p>_____ No CPR, Option B, Palliative and Supportive Care, Palliative and Supportive Care Before and After Cardiopulmonary Arrest</p> <ul style="list-style-type: none"> Do not initiate cardiopulmonary resuscitation (No CPR). Allow death to occur naturally. Give supportive measures only, including 1) passive oxygen for comfort, 2) efforts to control any external bleeding (i.e., bleeding that is visible to an observer), 3) only medications indicated for symptom relief (e.g., pain management). Do not attempt to prevent cardiopulmonary arrest. Do not intubate or use CPAP or BiPAP. 	

2	Artificial Ventilation: What should be done for respiratory failure where cardiopulmonary arrest is not involved?
2a	_____ In case of respiratory failure (the individual cannot breathe adequately unaided), intubation and artificial ventilation may be initiated and continued for as long as breathing needs mechanical assistance, even indefinitely.
2b	_____ In case of respiratory failure, intubation and artificial ventilation may be initiated and continued for a limited time (time limit up to _____ days) to see if artificial ventilation is effective in light of a patient's overall condition and underlying causes of respiratory failure. During that trial period, reassess the situation to determine if continued use of artificial ventilation is warranted or if it should be discontinued.
2c	_____ In case of respiratory failure, only CPAP or BiPAP may be used for artificial ventilation, as indicated, and continued for a limited time (time limit up to _____ days), to see if any of these interventions are effective and their continued use is pertinent in light of the patient's overall condition and underlying causes of respiratory failure. However, do not intubate or place on a ventilator.
2d	_____ Do not use artificial ventilation (i.e., no intubation, CPAP or BiPAP) under any circumstances.
3	Blood Transfusion: Should blood transfusions or infusion of blood products be given in case of bleeding?
3a	_____ Blood and blood products (plasma, whole blood, and platelets) may be administered if indicated to replace or try to stop blood loss or to treat life-threatening anemia. This does not mandate transfusion for anemia or acute blood loss, regardless of medical indication, but authorizes it if it is medically indicated.
3b	_____ Do not give any blood transfusions or blood products.
4	Hospital Transfers: Should hospital transfers occur to assess or treat medical conditions, and under what circumstances?
4a	_____ Transfer to the hospital is OK for any situation requiring medical care (i.e., if hospitalization is needed to diagnose, treat, or monitor the individual) that cannot be given outside of a hospital (This does not mandate automatic hospital transfer for any acute illness or change of condition, but only authorizes it if the situation cannot be addressed adequately outside of a hospital).
4b	_____ Hospital transfer may be used if necessary for comfort; to relieve distressing medical symptoms that cannot be managed elsewhere. Hospitalization should not be used primarily to try to identify, diagnose, and treat or cure underlying causes of symptoms.
4c	_____ Do not transfer to a hospital under any circumstances. Assess, treat, and monitor the patient with options available outside the hospital, as needed and consistent with patient goals.

5	Medical Tests: To what extent should medical tests be performed for diagnosis, treatment, and monitoring?
5a	_____ Any medical tests that are indicated to diagnose, treat, or monitor a patient may be obtained. This does not mandate medical tests, but authorizes testing if medically indicated.
5b	_____ Only perform limited medical tests necessary for symptomatic relief or comfort. Beyond that, it is acceptable to base any needed assessment, diagnosis, treatment, and monitoring on clinical findings instead of on diagnostic testing.
5c	_____ Do not do any medical tests. It is acceptable to base assessment, diagnosis, treatment, and monitoring on clinical findings instead of on diagnostic testing.
6	Antibiotics: When should antibiotics be given, and how extensively?
6a	_____ Any antibiotics (oral, intravenous or intramuscular injection) that are medically indicated may be used, by any route of administration, to try to treat an infection. This does not mandate antibiotics, but authorizes their use if medically indicated.
6b	_____ Oral antibiotics may be used, if medically indicated, on a limited basis and not indefinitely, to treat an infection. Intravenous or intramuscular antibiotics should not be used.
6c	_____ Antibiotics should only be used if needed to try to relieve symptoms for comfort, and should only be given orally, and not with the primary goal of trying to cure an infection.
6d	_____ Do not give antibiotics. In case of an infection, give only symptomatic treatment, such as medicines for fever or pain relief.
7	Artificially administered fluids and nutrition: Under what circumstances, and to what extent, should artificially administered fluids and nutrition be given?
7a	_____ Artificially administered fluids and nutrition may be given, even indefinitely, if indicated, by any available means. This does not mandate giving these interventions regardless of lack of a medical indication. It recognizes that medical treatment may address treatable causes of weight loss and fluid imbalances.
7b	_____ Artificially administered fluids and nutrition may be administered, if indicated, as a therapeutic trial for a limited time (up to ____ days). During that trial period, reassessment will be done to determine if continued use of these interventions is indicated and desired or if it should be discontinued. For example, because underlying causes of weight loss cannot be corrected. Artificially administered fluids and nutrition may also be administered for palliation, if consistent with the patient's goals and wishes.
7c	_____ Artificially administered hydration (intravenous or subcutaneous fluids or PEG tube) may be given, but not artificial nutrition.
7d	_____ No artificially administered fluids and nutrition will be given. Offer food and fluids by mouth as desired and tolerated.

8	Dialysis: Should dialysis be used if the kidneys do not function adequately, and under what circumstances?
8a	_____ Dialysis (either hemodialysis or peritoneal) may be given, even indefinitely, for any medical indication related to inadequate kidney function including end-stage kidney disease.
8b	_____ Dialysis (either hemodialysis or peritoneal) may be administered, but only for a limited period (time limit: up to _____ days), until prognosis is determined, etc.), to see if dialysis is effective and pertinent in light of the overall situation. This does not mandate giving dialysis regardless of lack of a medical indication, but authorizes its use if medically appropriate.
8c	_____ No dialysis of any type or duration should be provided.
9	Other Treatments: Are there any other instructions related to life-sustaining treatments not otherwise covered in Sections 1-8 above? _____

Print patient's name	

Signature of patient	_____
	Date

Print name of authorized decision maker	
<input type="checkbox"/> Health Care Agent <input type="checkbox"/> Guardian <input type="checkbox"/> Surrogate Decision Maker	_____
	Phone

Signature of authorized decision maker	_____
	Date

Print name of health care professional assisting with form	_____
	Phone

Signature of health care professional assisting with form	_____
	Date

Print name of patient's physician, nurse practitioner, or physician assistant	_____
	Phone

Signature of patient's physician, nurse practitioner, or physician assistant	_____
	Date

Appendix D

Glossary of Terms

Advance directive: A witnessed oral statement or a written or electronic document, voluntarily executed in accordance with the Health Care Decisions Act, regarding a person's wishes in case of regarding medical treatment and substitute decision makers.

Agent: An adult who the declarant appoints to make health care decisions under an advance directive, in case of subsequent incapacity.

Antibiotics: The subgroup of anti-infective medications that are used to treat bacterial infections.

Antivirals: The subgroup of anti-infective medications that are used to treat viral infections.

Artificial ventilation: The process of supporting respiration by manual or mechanical means when normal breathing is inadequate or has stopped.

Artificially administered fluids and nutrition: The medically assisted administration of fluids or nutrition via means other than normal eating and drinking; for example, via feeding tubes or injection.

Attending physician: The physician who has primary responsibility for the treatment and care of the patient.

Authorized decision maker: An individual who meets legal criteria for making health care decisions on behalf of another person; for example, a health care agent, guardian, or surrogate decision maker.

Best interest: A recognized basis for making health care decisions on behalf of another person, considering the balance between a treatment's overall benefits to the individual relative to its burdens and risks.

Bi-level positive airway pressure (BiPAP): A type of artificial ventilation, used to assist patients who are breathing spontaneously but who need help to breathe. It combines positive pressure ventilation with inspiratory positive airway pressure and a lower expiratory positive airway pressure setting used to keep the alveoli open at the end of exhalation, to improve oxygenation and reduce the work of breathing.

Blood products: Human blood or any component (packed red blood cells, plasma, or platelets) of blood or serum that is used to treat a medical condition.

Blood transfusion: The intravenous administration of any blood products to a patient.

Cardiopulmonary arrest: The cessation of cardiac and respiratory function, resulting in loss of effective blood circulation and breathing.

Cardiopulmonary resuscitation: An emergency procedure in which the heart and lungs are made to work by manually compressing the chest overlying the heart and forcing air into the lungs.

Competent individual: A person who is defined under state law as being old enough and having the capacity to consent to medical treatment and who has not been determined to be incapable of making an informed decision.

Continuous positive airway pressure (CPAP): A method of positive pressure ventilation used with patients who are breathing spontaneously, but need help to breath. It keeps the alveoli open at the end of exhalation, thus improving oxygenation and reducing the work of breathing.

CPR: Short for *cardiopulmonary resuscitation*. See above.

Declarant: A competent individual who makes an advance directive while capable of making and communicating an informed decision.

Dialysis: A mechanical method for removing waste products from the body, as well as maintaining the body's fluid balance, when kidney function alone is inadequate to do so. There are two kinds of dialysis treatment: hemodialysis and peritoneal dialysis. Hemodialysis gains access through a joined artery and vein and filters the blood directly. Peritoneal dialysis gains access via a catheter placed through the skin into the abdominal cavity.

Do Not Resuscitate (DNR): A medical order to withhold cardiopulmonary resuscitation in the event of a cardiac or respiratory arrest.

Emergency Medical Services (EMS) Do Not Resuscitate (DNR) order: A physician's, nurse practitioner's, or physician assistant's written order in a form established by protocol issued by the Maryland Institute for Emergency Medical Services Systems that authorizes certified or licensed emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation in the event of a cardiac or respiratory arrest.

End-stage condition: As defined by the Maryland Health Care Decisions Act, an advanced progressive, irreversible condition that has caused severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

End-stage kidney disease: A severe, irreversible loss or failure of kidney function.

Health care practitioner: An individual licensed under state law and regulation to diagnose and treat medical and psychiatric illnesses.

Health care provider: A health care practitioner and his/her employees; or a facility or organization that provides health care and its employees.

Intubation: The insertion of a tube through the nose or mouth into the larynx to maintain an open airway or to administer anesthetics or oxygen.

Life-sustaining treatment: Any medical procedure, treatment, or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function, including, but not limited to, artificially administered hydration and nutrition and cardiopulmonary resuscitation.

Maryland MOLST (Medical Orders for Life Sustaining Treatment): A legally defined and authorized, enduring and portable order form that specifies orders for cardiopulmonary resuscitation and other life-sustaining treatments.

Medically ineffective treatment: As defined in Maryland's Health Care Decisions Act, a medical procedure that, to a reasonable degree of medical certainty, will not prevent or reduce the deterioration of the health of an individual or prevent his/her impending death.

Nurse practitioner: A nurse with specialized advanced skills in patient assessment, diagnosis, and management who is licensed to diagnose and treat patients and to sign Maryland MOLST forms, within a framework defined by law and regulation.

Palliative care: Treatment or interventions that focus on trying to reduce or relieve the symptoms of a disease or disorder instead of on trying to cure the underlying causes of those symptoms (see also "supportive care").

Persistent vegetative state: A condition in which a patient has a loss of consciousness, exhibiting no behavioral evidence to observers of self-awareness or awareness of surroundings in a learned manner other than reflex activity of muscles and nerves for low level conditioned response. After a passage of medically defined period of time, it can be determined to a reasonable degree of medical certainty that there can be no recovery.

Physician: A person who is licensed under law and regulation to practice medicine in the State or jurisdiction where the treatment is to be rendered or withheld.

Physician assistant: An individual who is licensed under law and regulation to practice medicine with physician supervision.

Resuscitation status: The level of medical efforts desired by a patient or authorized decision maker to attempt to reverse a cardiopulmonary arrest, including the use of cardiopulmonary resuscitation.

Supportive care: Treatment or interventions that are intended primarily to reduce or relieve the symptoms of a disease or disorder (see also “palliative care”), regardless of whether the underlying causes of those symptoms can be identified and resolved.

Terminal condition: As defined in Maryland’s Health Care Decisions Act, an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery.

For More Information

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