

Maryland MOLST

Guide for Authorized Decision Makers



Maryland MOLST Training Task Force

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Health Care Decision Making: Goals and Treatment Options

Guide for Authorized Decision Makers

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Introduction

This guide is meant to help authorized decision makers make health care decisions for another person. It discusses a process for making such decisions, a worksheet that you can use to consider and document choices on behalf of someone else, and a new order form (the Maryland Medical Orders For Life-Sustaining Treatment form, referred to herein as the MOLST form) that a doctor, nurse practitioner, or physician assistant will use to write orders related to these choices.

The information in this Guide is based primarily on Maryland laws and regulations that have addressed making, documenting, and implementing decisions about life-sustaining treatments. 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 if they were to subsequently lose their capacity to make their own medical decisions. Additional information about the Health Care Decisions Act is at:

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

For authorized decision makers, the basic approach is as follows:

1. Familiarize yourself with the patient's situation and review their known wishes, including any advance directives or other existing documents.
2. Discuss the patient's current medical condition, outlook (prognosis), and potential treatment options with his / her attending physician, nurse practitioner, or physician assistant.
3. Review the Health Care Decision Making Worksheet as a guide to consider and/or document specific life-sustaining treatment options for the person for whom you are the authorized decision maker.
4. Discuss the implementation of these choices with a practitioner who will complete a MOLST form.

Section I: Participating in the Health Care Decision Making Process

When someone has a serious illness or the potential for life-threatening complications, questions arise about how health care providers should respond if the person's vital functions fail. It is common in many health care settings to address issues about the use of life-sustaining medical technology, and documenting care preferences and decisions.

The health care decision making process (see diagram in Appendix A) leads to choosing and ordering treatments options, by considering facts about a patient's current medical situation and their health care goals and wishes. The process applies in all settings and is consistent with Maryland's Health Care Decisions Act (HCDA). For more details about the process, see:

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

By working closely with the patient's physician, nurse practitioner, or physician assistant and getting guidance from others (for example, family and facility staff), you can authorize treatment on behalf of another person that will be consistent with his or her values and wishes, while considering the impact on function and quality of life. As an authorized decision maker, you can do the following to help you make health care decisions more effectively on behalf of another person:

- Familiarize yourself with the patient's situation and review their known wishes, including any advance directives or other existing documents.
- Inform the physician, nurse practitioner, or physician assistant and facility staff (where applicable) about any existing documents (such as a living will or durable power of attorney) related to the patient's wishes about life-sustaining treatments and, where applicable, end-of-life care.
- Inform the physician, nurse practitioner, or physician assistant and staff if you want to initiate or update advance care planning on behalf of the patient.
- Discuss with the practitioner the patient's current medical condition and its impact on his or her function, quality of life, and prognosis (overall outlook).

- Ask the practitioner about possibly treatable underlying causes (such as medication side effects and medical conditions) of impaired mental and physical function that may affect the patient’s prognosis and decision making capacity.
- Ask the patient’s primary practitioner to identify specific issues that need discussion and decisions, and about the pertinence, benefits, and risks of various treatment options.
- Consider, choose, and review with the patient’s practitioner relevant items on behalf of the patient on the “Health Care Decision Making Worksheet.”
- Periodically review the patient’s condition and prognosis, and the effectiveness and continued pertinence of treatments.

Section II: Preparing to Select Life-Sustaining Treatments

Under the law, patients have the right to discuss and document their wishes regarding life-sustaining treatments. If they lack decision-making capacity to do these things, they have the right to have someone else speak on their behalf (that is, function as an authorized decision maker). Sometimes, patients make advance directives that appoint someone as their authorized decision maker. Often, however, there is nothing in writing to guide substitute decision making. Therefore, many people become an authorized decision maker by default.

You act as an authorized decision maker by giving instructions about the patient’s care directly to a health care practitioner for the purpose of generating current medical orders. These instructions should be based on considering the patient’s condition and prognosis and their known wishes (for example, as written in an advance directive). If their wishes are unknown, then you should consider their best interests based on identifying, to the extent possible, the potential benefits and risks to the individual of treatment options.

Before making decisions about specific treatment options, you may wish to ask the patient’s doctor or others some key questions about the patient’s condition and prognosis, and the potential relevance of various life-sustaining treatment options. Table 1 identifies those key questions.

Table 1: Key Questions Related to Considering Life-Sustaining Treatments

Item	Key Questions
<ul style="list-style-type: none"> - Current condition, short-term prognosis, and level of medical stability 	<ul style="list-style-type: none"> - What is the patient’s current medical condition? - What is the likely course of the patient’s condition over the next several days to weeks? - is the patient having significant complications? - How likely is the patient’s condition to stabilize (i.e., not fluctuate or get worse than it is now)?
<ul style="list-style-type: none"> - Longer-term prognosis and likelihood of medical complications 	<ul style="list-style-type: none"> - What is the likely course of the patient’s condition over the coming months to several years? - How likely is the patient to have significant complications over the coming months?
<ul style="list-style-type: none"> - Appropriate level of medical intervention 	<ul style="list-style-type: none"> - How likely are aggressive and repeated medical interventions to help keep the patient stable and/or improve his or her quality of life, function, overall condition, and prognosis?
<ul style="list-style-type: none"> - Pertinence of medical testing 	<ul style="list-style-type: none"> - How likely is medical testing to provide meaningful information to help manage the patient’s situation?
<ul style="list-style-type: none"> - Potential risks and benefits of hospitalization 	<ul style="list-style-type: none"> - What are the possible benefits and likely risks if the patient were to be hospitalized? - Can the patient’s medical illnesses or complications be treated and monitored outside of the hospital?
<ul style="list-style-type: none"> - Risk factors for cardiopulmonary arrest 	<ul style="list-style-type: none"> - is the patient at high risk for possible cardiopulmonary arrest?
<ul style="list-style-type: none"> - Clarify potential to survive and benefit from cardiopulmonary resuscitation (CPR) 	<ul style="list-style-type: none"> - Based on the patient’s overall condition and prognosis, how likely is it that he or she would benefit from attempted CPR if his or her heartbeat and breathing were to stop?
<ul style="list-style-type: none"> - Identify risk factors for losing weight or stopping eating - Clarify potential benefits and risks of artificial nutrition and hydration support 	<ul style="list-style-type: none"> - Does the patient have an underlying condition (for example, at the end of life expectancy, irreversible medical complications, medication side effects) that is causing (or likely to cause) a nutrition or hydration problem? - In the short and long term, how likely is medically administered nutrition and/or hydration to help improve the patient’s condition and quality of life, based on his or her condition, causes of impairments, and prognosis?
<ul style="list-style-type: none"> - Clarify potential risks and benefits of dialysis 	<ul style="list-style-type: none"> - Does the patient have (or is he/she at risk for) kidney failure serious enough to require dialysis? - What are the likely benefits and risks of dialysis, if his or her kidneys are failing? - How likely is dialysis to improve his or her function and overall quality of life?

Section III: Choosing Life-Sustaining Treatment Options

Use of the "Health Care Decision Making Worksheet"

A new "Health Care Decision Making Worksheet" (see separate item) is provided as an optional tool to help you review and authorize orders that reflect the patient's wishes about life-sustaining treatments. You can use it both to address a current situation and to make choices about future situations where life-sustaining treatments may be an option.

Regardless of whether you wish to complete the Worksheet on behalf of the patient, reading it can help you identify issues and treatment options to review with the patient's doctor, nurse practitioner, or physician assistant. For situations that do not apply to the patient's present condition, the Worksheet can be kept for future use. Subsequently, the attending practitioner will use the MOLST form to write orders related to treatment choices on behalf of the patient.

Address any applicable issues. There is no minimum requirement or maximum number.

The worksheet covers the following life-sustaining treatment options:

- cardiopulmonary resuscitation (no limitations, partial limitations, no CPR)
- artificial ventilation (no limitations, partial limitations, no artificial ventilation)
- blood transfusions (no limitations, no transfusions)
- hospitalization (no limitations, hospitalization only in certain circumstances, no hospitalization)
- medical workup (no limitations, workup only in limited situations, no workup)
- antibiotic use (no limitations, use only in limited situations, no antibiotics)
- artificially administered fluids and nutrition (no limitations, artificial nutrition and/or hydration only in certain circumstances, no artificial nutrition or hydration)
- dialysis (no limitations, dialysis for a limited trial, no dialysis)
- other treatments (specific limitations to be written in).

See Appendix B for details of these treatment options, based on the Health Care Decision Making Worksheet items.

Section IV: The Maryland MOLST Order Form Basic Information for Authorized Decision Makers

The health care decision making process outlined in this Guide leads to identifying and implementing treatment options based on matching facts about the patient's current medical condition and prognosis with identifying his or her health care goals and wishes.

If you have 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 common occurrences in many health care settings.

What is "MOLST?"

The Maryland Medical Orders For Life-Sustaining Treatment (MOLST) form is a standardized medical form with orders about cardiopulmonary resuscitation and other life-sustaining treatments.

The MOLST form provides a consistent way to order life-sustaining treatments (for example, whether or not CPR is to be attempted) based on exploring and clarifying a patient's key preferences. It is also intended to help both patients and authorized decision makers understand life-sustaining treatments and discuss them with health care practitioners.

The MOLST form will be used for any medical orders that are needed to implement choices related to life-sustaining treatments (for example, "Do Not Resuscitate" or "Do Not Hospitalize"), whether they are documented in an advance directive, arise from completing the "Health Care Decision Making Worksheet," or come from your input as an authorized decision maker.

Ultimately, orders on the MOLST form will be based on several factors, including (but not limited to) the patient's goals and wishes as expressed in an advance directive, his or her current medical condition and prognosis, the availability and relevance of potential treatment options, and physician determinations about possible medical ineffectiveness of specific treatment options. An authorized practitioner (physician, nurse practitioner, or physician assistant) will complete the MOLST form based on these considerations as well as consultation with you as the authorized decision maker.

The MOLST form will be included in the order section of the patient's clinical or medical record, and it (or a copy) will be transferred across settings when the patient is discharged or transferred. The orders it contains are valid across settings, and are to be applied or updated appropriately as the patient moves across those settings.

How does Maryland MOLST relate to advance directives?

An advance directive is used to name someone else to make health care decisions on behalf of someone who has lost the capacity to decide about medical treatment options. Typically, it describes 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 is not an advance directive. Instead, it orders or limits specific treatment options from the time the orders are signed and until they are subsequently revised. The MOLST form can be used regardless of whether a patient has an advance directive.

Under the law, an authorized decision maker must follow a patient's wishes as documented in any advance directive or, if one does not exist, make decisions that reflect the patient's known values and goals. If a patient's wishes, values, and goals are unknown or unclear, an authorized decision maker should consider the patient's best interests, based on the relative benefits and risks of a proposed treatment.

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 must offer a 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. The facility or practitioner must tell you or your 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. Additionally, the facility or practitioner must give you or your authorized decision maker a copy or the original of the form within 48 hours of its completion, or sooner if discharged or transferred.

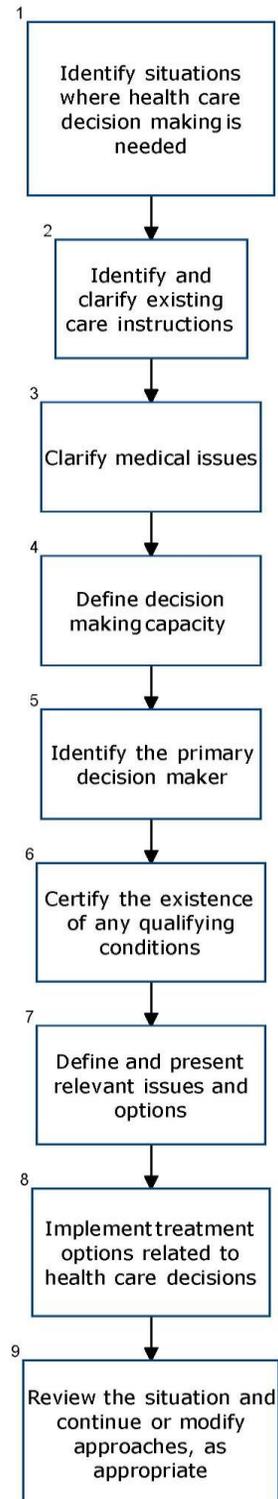
If—for whatever reason—an authorized decision maker does not or cannot discuss or make choices about life-sustaining treatments on behalf of a patient, then subsequent orders will be based on several factors, including 1) whether any treatments have been determined to be medically ineffective or ethically inadvisable; 2) whether the patient has advance directives that include wishes about CPR and other life-sustaining treatments; and 3) whether a treatment is medically indicated. For example, if the patient has an advance directive that declines artificial ventilation and you as the authorized decision maker do not discuss artificial ventilation with the practitioner, the MOLST order will reflect the patient's known wishes not to receive artificial ventilation. Or, if the patient has not made a decision about CPR and you do not make one on behalf of the patient, then the patient will receive CPR.

If the patient is transferred to another facility, the MOLST form (or a copy) must be sent with the patient at the time of transfer. An electronic copy may also be transmitted to the receiving facility or program in addition to, but not instead of, the form or a copy of it.

Upon, or soon after, arrival of a transfer or admission from another facility, a practitioner at the receiving facility must review an existing MOLST form. The purpose of such a review is to assess and, as needed, revise or supplement current orders, and to identify the possible need to discuss and decide about life-sustaining treatments.

For more details and frequently asked questions about the MOLST form, see Appendix C.

Appendix A: Health Care Decision Making Process



Appendix B: Life-Sustaining Treatment Options (in conjunction with the Health Care Decision Making Worksheet)

The following details relate to life-sustaining treatment options as presented on the Health Care Decision Making Worksheet. They are relevant to selecting choices on the Maryland MOLST form, to having a discussion about treatment choices, and to incorporating treatment instructions into 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 (that is, heartbeat and breathing stop). Should the patient receive attempted CPR if his or her heartbeat and breathing stop? Should attempts be made to try to prevent impending cardiopulmonary arrest, and if so, then to what extent? A decision about how to respond to an arrest must be made for every patient, either by accepting or declining attempted CPR. If no decision is made, CPR may be administered by default.

Attempt CPR

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

- If heartbeat and breathing stop, cardiopulmonary resuscitation (CPR) will be initiated and continued within the scope of available interventions, and additional support (e.g., EMS personnel) will be summoned if needed.
- If EMS personnel are involved in the care will, they will initiate and 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 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 the heartbeat and breathing from stopping. This means that:

- If the patient's heartbeat and breathing stop while under the provider's care (including while care is being rendered by EMS personnel), resuscitation will not be attempted (No CPR). Death will be allowed to occur naturally.
- If it appears that the patient's heartbeat and breathing are in danger of stopping, medications and treatments will be given to try to stabilize his or her condition, including insertion of a breathing tube if indicated. If necessary, additional support may be summoned to try to prevent the heart and lungs from stopping.
- To try to prevent the patient's heartbeat and breathing from stopping, EMS personnel involved in his or her care will administer any medications and treatments that are needed, including insertion of a breathing tube, 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 the patient's heartbeat and breathing stop, either within a facility or while care is being rendered by EMS personnel, resuscitation will not be attempted (No CPR). Death will be allowed to occur naturally.
- If it appears that the patient's heartbeat and breathing are in danger of stopping, medications and treatments will be given to try to stabilize his or her condition. A breathing tube will not be inserted; 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. If necessary, additional support may be summoned to try to prevent cardiopulmonary arrest.
- EMS personnel 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 they will not insert a breathing tube but 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 the patient's heartbeat and breathing from stopping. This means that:

- Death will be allowed to occur naturally.
- Health care providers (including EMS personnel that are 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 EMS personnel that are involved in the care) will give supportive measures, including 1) passive oxygen for comfort, 2) efforts to control any external bleeding (i.e., bleeding that is visible to an observer), 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?

Should artificial ventilation be used in case the patient has respiratory failure (i.e., he/she cannot breathe adequately unaided)? In addition to the polar opposites of accepting ventilation indefinitely and refusing it outright, there is an intermediate option, under which mechanical ventilation would be accepted for a limited time as a therapeutic trial. Space in this item permits specification of the time period, as appropriate.

Since intubation (insertion of a breathing tube) and mechanical ventilation (use of a respirator) are more invasive and may be more enduring, there is also the option to try to assist ventilation with external devices (CPAP or Bi-Pap) 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 in light of the 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. As appropriate, a time frame for the trial period may be specified; for example, 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 (time limit should be specified, if desired; for example, up to 30 days) to see if these interventions are effective and if their continued use is pertinent in light of the patient's overall condition, including underlying causes of respiratory failure.
- A breathing tube will not be inserted and the patient will not be placed on a respirator.

2d- No Artificial Ventilation

Choosing this option authorizes withholding of artificial ventilation under all 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 blood transfusions in case of bleeding or life-threatening anemia. This means that:

- Blood and blood products (e.g., plasma, whole blood, platelets) may be administered if indicated to replace blood loss or treat life-threatening anemia.
- 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.

4- HOSPITAL TRANSFERS

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

Is hospital transfer desired if the patient develops a medical 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. This means that:

- Transfer to the hospital is acceptable for any illness or condition requiring medical care (i.e., to diagnose, treat, or monitor the patient's condition) 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 patient's condition 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. This means that:

- Hospitalization may be used if needed to relieve medical symptoms that are causing severe distress and cannot be managed or monitored adequately in a non-hospital setting. Otherwise, efforts to diagnose, treat, and monitor these conditions will be made outside of the hospital, typically in the community or setting where the patient currently resides or is receiving care.

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 condition, prognosis, and wishes.

5 - MEDICAL TESTS

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

Medical workups often can help identify causes of symptoms and monitor the effectiveness of treatments. The exact nature of the tests varies, depending on the symptoms and the suspected diagnosis.

This Section asks whether, and to what extent, the use of diagnostic tests is acceptable. It asks you to consider whether the potential benefits of a medical workup outweigh any associated discomfort or other burdens. For example, the burden of medical testing may not be justified if the suspected diagnosis would not 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.

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 the patient's condition may be obtained, regardless of their complexity or potential risk or discomfort.
- 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.
- Otherwise, assessment, diagnosis, treatment, and monitoring of the patient's condition will be based primarily on clinical findings (signs and symptoms) 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?

Are antibiotics acceptable in case of infection? For some patients, but not for others, attempted cure of infection is feasible and consistent with the main goal of care. There is also an intermediate option, which allows for more limited and less burdensome oral antibiotics.

6a- Antibiotics Broadly Acceptable

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

- Any antibiotics that are medically indicated may be used, by any route of administration (e.g., oral, intravenous or intramuscular injection), and for any duration, 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 try to cure an infection. This means that:

- Oral antibiotics may be used, if medically indicated, to treat an infection. Intravenous or intramuscular antibiotics will not be used, even if infection persists despite oral antibiotics.

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 treatment of symptoms 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?

Are artificially administered fluids and nutrition desired in the event of insufficient oral intake? In addition to either accepting these interventions indefinitely or refusing them outright, there are 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, if that is desired. Another option is to accept the intravenous or subcutaneous administration of fluids but not artificially administered nutrition.

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, unless contraindicated because of pain or other distress caused by trying to eat and drink. 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.

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 or limited use of fluids to deliver treatments (for example, to mix medications for intravenous administration), which would be covered under other sections.

7a- Artificial Nutrition and Hydration Acceptable

Choosing this option will authorize both artificial nutrition and hydration by any route and for any duration. This means that:

- Artificially administered fluids and nutrition may be given, even indefinitely, by any available route.
- This does not mandate giving artificial nutrition and hydration regardless of lack of a medical indication. For example, appropriate assessment and management of treatable causes of anorexia (loss of appetite), weight loss, or fluid imbalance may make artificial nutrition or hydration unnecessary.

7b- Time-Limited Trial of Artificial Nutrition and/or Hydration Acceptable

Choosing this option will authorize a time-limited trial of artificial nutrition and/or hydration. This means that:

- In case of life-threatening impaired nutrition or hydration, artificial nutrition and/or hydration may be administered, as indicated, as a therapeutic trial for a limited time, to see if such interventions are effective and if they should be continued in light of the patient's overall condition and underlying causes of impaired nutrition, weight loss, or fluid imbalance. Whenever possible, a time frame should be specified; for example, for up to 30 days.
- During that trial period, the situation will be reassessed to determine if artificial nutrition and/or hydration should continue or if it should be discontinued (for example, because underlying causes of weight loss cannot be corrected or because medical status and function continue to decline despite nutrition or hydration interventions).

7c- Artificial Hydration Only is Acceptable

Choosing this option means that:

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

7d- No Artificial Nutrition Or Hydration

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, trying to eat 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 irreversible or partially or totally reversible. This section asks whether dialysis is desired regardless of, or depending on, whether impaired kidney function is reversible, 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) may be given, even indefinitely, for any medical indication related to 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 appropriate.

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) to see if dialysis is effective and pertinent in light of the patient'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 used.

9 - OTHER ORDERS

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

This part of the MOLST form provides space to indicate whether you accept or decline 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 protocols that EMS personnel use to provide CPR and treatment prior to arrest, as those are covered by existing Emergency Medical Systems policies.

Appendix C

Frequently asked questions (FAQs) related to the Maryland MOLST order form

1. Requirements to offer the Maryland MOLST form options

1-1. What if the patient has a form documenting life-sustaining treatment options that was done in another state?

Both facilities and EMS personnel can refer to such forms to guide the use, withholding, or withdrawal of life-sustaining treatments. However, as the authorized decision maker, you should review the treatment wishes on an out-of-state form with someone who can help get applicable orders 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 allows a practitioner to write orders about cardiopulmonary resuscitation and other life-sustaining treatments. It is the end point of the underlying health care decision making process. Use the information in this Guide, the Health Care Decision Making Worksheet, and other resources and references to help you discuss, make, and document treatment decisions on behalf of another individual.

2-2. Why are there numerous treatment choices on the Maryland MOLST form? Do they all have to be completed?

The MOLST form includes the most common widely recognized life-sustaining treatment options. It is used to standardize definitions, make the process available and convenient, and remind you and the practitioners of the potential treatment options.

You do not have to make a specific number of choices or to cover all of the items. The MOLST form will only indicate treatment options that you select on behalf of the patient or that are otherwise determined to be relevant (for example, if identified by the physician as medically ineffective).

Some treatment choices and orders will be immediately relevant, while others may not apply until a subsequent time or situation arises. The MOLST form will implement treatment choices that are currently relevant. This may also include treatment options that the patient already decided on for the future. For example, if the patient has an advance directive that declines artificial nutrition (e.g., a “feeding tube”) under all circumstances, then an order for “No Artificial Nutrition” may be appropriate even though food intake is not a current concern because the patient is still eating without difficulty.

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 the patient’s situation. Practitioners are expected to use their clinical judgment to decide whether an intervention is medically indicated. They may also choose not to offer treatments that they believe will be medically ineffective or ethically inappropriate (that is, not in the patient’s best interest), although they must follow the procedure specified in the Health Care Decisions Act.

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 you as the authorized decision maker?

Yes. The patient’s attending practitioner plays a critical role in each step of the health care decision making process (see Section I of this Guide). The practitioner should discuss the meaning and relevance of various treatment options with you. Although he or she may have someone else discuss aspects of the MOLST process with you as the authorized decision maker, the practitioner is ultimately responsible for the orders that are written.

4. Completing and signing the Maryland MOLST form

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

Only an authorized health care practitioner (physician, nurse practitioner, or physician assistant) can sign the Maryland MOLST form. If the patient lacks the capacity to make health care decisions, the orders will be based on consultation with the authorized decision maker representing the patient's wishes and goals as well as other considerations about the medical effectiveness or appropriateness of treatment.

Neither the patient nor any authorized decision maker should complete the MOLST form directly or sign or co-sign orders on the form. However, you may use and sign the optional "Health Care Decision Making Worksheet" (or, refer to such a worksheet that the patient completed previously) to make choices to guide the orders on the MOLST form. Use of this worksheet is encouraged in order to provide relevant and clear guidance related to these choices.

Orders in Section 1 related to withholding, withdrawing, or limiting the provision of cardiopulmonary resuscitation (CPR) by EMS personnel are not valid until they are signed by a practitioner on the MOLST order form. EMS personnel cannot follow orders on any form other than the MOLST form or a previous version of the EMS/DNR Order form.

5. Authorized decision maker declining to make choices

5-1. What happens if you decline to discuss Maryland MOLST life-sustaining treatment options on behalf of the patient?

If—for whatever reason—you are unwilling or unable to discuss or decide about treatments on behalf of the patient, subsequent treatment orders will be based on several factors, including 1) whether any treatments have been determined to be medically ineffective or ethically inappropriate; 2) whether the patient has expressed wishes about CPR and other life-sustaining treatments in any advance directives; and 3) whether a treatment is available and medically indicated. For example, if an authorized decision maker declines to discuss or make a choice on behalf of a patient regarding CPR, then CPR will be administered (i.e., "Attempt CPR" Option on the MOLST form) unless the patient had limited or declined CPR in a valid advance directive or CPR has been certified as being medically ineffective or ethically inappropriate, in accordance with provisions of the HCDA.

A facility should inform you of any of its policies that amount to a default decision for any of the treatment options. For example, if the 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 prior decision by the patient regarding hospitalization or a current decision by you as the alternate decision maker is effectively a decision in favor of hospital transfer.

6. Process related to patient transfer or discharge

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

The MOLST form (or a complete and legible copy of it) in the patient's current setting must accompany any transfers to another setting. The intent of the law is that the MOLST form be available to the receiving facility when the patient arrives, so that existing choices will guide subsequent treatment decisions.

6-2. Suppose a Maryland MOLST order form was completed for the patient in one setting (for example, the hospital) and then the patient is discharged elsewhere (for example, to a nursing home or assisted living facility). Is the receiving facility required to offer a new MOLST form, or may it accept the MOLST order form that was completed elsewhere?

The receiving facility should use the current MOLST form from the sending facility, pending any review and revision based on changes in the patient's condition 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 until it is replaced by an updated MOLST form. If a MOLST form has been filled out and the patient's condition later changes materially, the orders are to be reviewed for continued pertinence and for items that may need discussion and revision or addition.

An authorized decision maker (for example, an agent that the patient appointed in an advance directive) cannot simply rescind or contradict orders that were based on a patient's prior decisions, unless the patient specifically authorized them to do so in an advance directive.

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

You and the patient's physician, nurse practitioner, or physician assistant should review the continuing need and desire 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 the patient's health status, and (4) annually. A review of a previously completed Maryland MOLST form does not necessarily require any changes. However, if the review leads to new decisions about any of the items currently covered by MOLST orders, the practitioner should void the old order form and prepare a new one.

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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