

MOLST: Practicalities and Pitfalls



JOHN S. SULLIVAN, MD

**GOLISANO CHILDREN'S HOSPITAL AT STRONG
UNIVERSITY OF ROCHESTER MEDICAL CENTER**

What are the ERDs?



- Promulgated by the USCCB
- First published 1981
- *5th* Edition, November 2009
- Institutionally focused, but also applies to Catholic physicians and patients

Ethical and Religious Directives



- #24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. **The institution, however, will not honor an advance directive that is contrary to Catholic teaching.** If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

ERDs



- #25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. **Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests.** In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.

ERDs



- #56. A person has a **moral obligation to use *ordinary* or *proportionate*** means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community

ERDs



- 57. A person may **forgo** *extraordinary* or *disproportionate* means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

Implications for MOLST

- NY State Form
- Monroe County a leader in implementation
- A tool
- A substitute for medical proxy?

NEW YORK STATE DEPARTMENT OF HEALTH **Medical Orders for Life-Sustaining Treatment (MOLST)**

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT _____
ADDRESS _____
CITY/STATE/ZIP _____
DATE OF BIRTH (MM/DD/YYYY) _____ Male Female #MOLST NUMBER (THIS IS NOT AN #MOLST FORM) _____

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)
This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them. MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check ONE:

CPR Order: Attempt Cardio-Pulmonary Resuscitation
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law.

SIGNATURE _____ Check if verbal consent (Leave signature line blank) DATE/TIME _____
PRINT NAME OF DECISION-MAKER _____
PRINT FIRST WITNESS NAME _____ PRINT SECOND WITNESS NAME _____
Who made the decision? Patient Health Care Agent Public Health Law Surrogate Minor's Parent/Guardian §1750-b Surrogate

SECTION C Physician Signature for Sections A and B

PHYSICIAN SIGNATURE _____ PRINT PHYSICIAN NAME _____ DATE/TIME _____
PHYSICIAN LICENSE NUMBER _____ PHYSICIAN PHONE/PAGER NUMBER _____

SECTION D Advance Directives

Check all advance directives known to have been completed:
 Health Care Proxy Living Will Organ Donation Documentation of Oral Advance Directive

MOLST Section A



- CPR

- Or

- DNR

MOLST Section B



- **Treatment Guidelines**
 - Comfort measures only
 - Limited medical interventions
 - No limitations on medical interventions

MOLST Section B



- **Instructions for Intubation and Mechanical Ventilation**
 - Do not intubate
 - Trial period
 - ✦ **BiPAP**
 - Intubation & long-term mechanical ventilation if needed

MOLST Section B



- **Future Hospitalization/Transfer**
 - Do not send to the hospital unless pain or severe symptoms cannot otherwise be controlled.
 - Send to the hospital, if necessary, based on MOLST orders.

MOLST Section B



- **Antibiotics**

- Do not use antibiotics.
- Determine use or limitation of antibiotics when infection occurs.
- Use antibiotics to treat infections, if medically indicated.

MOLST Section B



- **Artificially Administered Fluids & Nutrition**
 - No feeding tube
 - A trial period of feeding tube
 - Long-term feeding tube, if needed

MOLST Section B



- **Artificially Administered Fluids & Nutrition**
 - No IV fluids
 - A trial period of IV fluids
 - ✦ *May impact other decisions—antibiotics and IV pain medications.*

What Has Changed?



- Preamble to Part 5, Current Text:
 - While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of **basic care** should in principle be provided to all patients who need them, including patients diagnosed as being in a "persistent vegetative state" (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive *ordinary and proportionate care*.

Directive #58



- Current Text I:
 - In *principle*, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.

Directive # 58



- Current Text II:
 - Medically assisted nutrition and hydration become *morally optional* when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed." [41] For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

Directive # 58 Sources



- Pope John Paul II, 2004
- Address to international congress on
 - Life-Sustaining Treatments and the Vegetative State: Scientific Progress and Ethic Dilemmas
- Referred to CDF *Declaration on Euthanasia* (1980) >>
fault line
- “Allocution”
 - in law , "to speak out formally“
 - in apologetics, allocution is generally done in defense of a belief.
 - solemn form of address or speech from the throne employed by the Pope on certain occasions

Pope John Paul II, 2004



- I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering.

Directive # 58 Sources



- Congregation for the Doctrine of the Faith
 - Response to Certain Questions of the USCCB Concerning Artificial Nutrition and Hydration
 - August 2007

“Response to Certain Questions of the USCCB Concerning Artificial Nutrition and Hydration”



- *First question: Is the administration of food and water (whether by natural or artificial means) to a patient in a "vegetative state" morally obligatory except when they cannot be assimilated by the patient's body or cannot be administered to the patient without causing significant physical discomfort?*
- **Response: Yes.** The administration of food and water even by artificial means is, in principle, **an ordinary and proportionate means of preserving life.** It is therefore obligatory to the extent to which, and for as long as, it is shown to accomplish *its proper finality*, which is the hydration and nourishment of the patient. In this way suffering and death by starvation and dehydration are prevented.

“Response to Certain Questions of the USCCB Concerning Artificial Nutrition and Hydration”



- *Second question: When nutrition and hydration are being supplied by artificial means to a patient in a "permanent vegetative state", may they be discontinued when competent physicians judge with moral certainty that the patient will never recover consciousness?*
- **Response: No. A patient in a "permanent vegetative state" is a person with fundamental human dignity and must, therefore, receive ordinary and proportionate care which includes, in principle, the administration of water and food even by artificial means.**

What it Does Not Mean



- **Everyone should die with a feeding tube in place?**
 - Ceasing to eat/feed remains part of the dying process
 - Only people who routinely die with full stomachs are those subject to capital punishment
 - ✦ E.g. *Dead Man Walking*
 - Pope John Paul II End-of-Life History
 - ✦ Pneumonia > UTI > urosepsis
 - ✦ NG tube placed 3 days prior to death

What it Does Mean



- In some institutions, there may be a default position *not* to feed.
- Nutrition and hydration—even when initiated via a medical procedure—are minimal and routine care, akin to keeping the patient clean and turning the person to prevent bedsores

Clarifying Question



- **Would the withholding of food and water be the proximate cause of death, rather than the progression of the underlying illness?**
 - **If yes, such withholding morally illicit.**
 - **If no, artificial nutrition and hydration generally not required.**

“Terminal Sedation”



- **When other modalities of pain control have failed.**
- **Should be used extremely rarely, if at all.**
- **Principle of Double Effect**

Suffering, Means and Ends



- **Death cannot be the desired end of human suffering; cannot shorten life in order to spare the patient or family from suffering.**
 - = euthanasia
- **C.S. Lewis**
 - The Problem of Pain, A Grief Observed
- **CMA 2009 Annual Conference Theme:**
 - The Theology of Suffering

Pope John Paul II,
Evangelium Vitae (The Gospel of Life), #65



- "Even when not motivated by a selfish refusal to be burdened with the life of someone who is suffering, euthanasia must be called a *false mercy*, and indeed a disturbing "perversion" of mercy. True "compassion" leads to sharing another's pain; it does not kill the person whose suffering we cannot bear. Moreover, the act of euthanasia appears all the more perverse if it is carried out by those, like relatives, who are supposed to treat a family member with patience and love, or by those, such as doctors, who by virtue of their specific profession are supposed to care for the sick person even in the most painful terminal stages."