Whose Life Is It Anyway?

Advanced Directives 2024 Update:
A Humorous Look at a Serious Subject

David A. LeVine, MD, CMD
Eric S. Kane, Esq.

1

Objectives . . .

- Restate the steps to proper advance care planning
- Paraphrase the ever-changing paradigm of the physician-patient relationship
- Describe the roles Appointed Guardian, Guardian Advocate, Supportive decision-making agreement supporter, Health Care Surrogate, Proxy by Statute, DPOA,

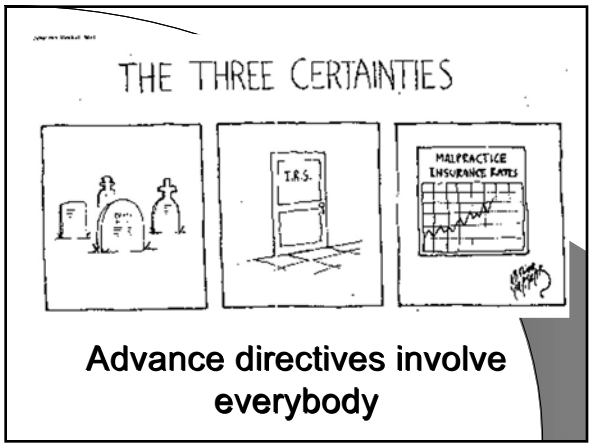
2

. . . Objectives

- Distinguish terminology: "(in)competency" vs. "(in)capacity"
- Define new terms e.g. Ethical will, Affidavit of Health Care Proxy, POLST, PDDO, MAID, DNAR, AND, SAFE
- Apply knowledge of Advance care planning to various clinical case scenarios

3

4


THE THREE CERTAINTIES
I.R.S.
MALPRACTICE INSURANCE RATES
Advance directives involve everybody

5


BIZARROCOMICS.COM
Facebook.com/BizarroComics
I suppose this was inevitable.

6

Patient Self Determination Act

- The patient with decision-making capacity may refuse unwanted medical treatment, even if this may result in their death (even in cases where the individual does not have life-threatening illness).
- Patients who lack capacity to make the decisions at hand have the same rights as those who have capacity (through authorized surrogate decision makers).

7

Health care Surrogate vs. Proxy

- "Proxy" - A competent adult who has not been expressly designated to make health care decisions for a particular incapacitated individual, but who is authorized pursuant to FS765.401 to make healthcare decisions for an individual.
- "Surrogate" - Any competent adult expressly designated by a principal to make decisions on behalf of the principal upon the principal's incapacity.

8

"Seinfeld" The Comeback (1997)

9

Role of the proxy/surrogate

- Entrusted to speak for the patient
- Involved in the discussions
- Must be willing, able to take the proxy role
- "Substituted Judgment Standard" –what the patient would want under the circumstances
- If there is no indication what the principal would have chosen, the surrogate may consider the patient's best interest in deciding what proposed treatments are to be withheld or withdrawn.

10

"Seinfeld" The Comeback (1997)

11

New Provision in the Florida Health Care Surrogate Law

- A principal may stipulate that the authority of the surrogate to receive health information or make health decisions (or both) is exercisable immediately without the necessity for a determination of capacity as provided in 765.204
- If disagreement between principal and surrogate, the principal overrides surrogate

12

13

Proxy Statute (FS765.401)

1. Judicial Appointed Guardian/Guardian advocate
2. Spouse
3. Adult Children (majority)
4. Parent(s)
5. Adult Sibling(s) (majority who are reasonably available)
6. Adult Relative (who exhibited special care and concern and who has regular contact)
7. Close adult friend
8. Clinical social worker who is licensed to FS491 or a graduate of a court-approved guardianship program chosen by the bioethics committee (proxy can not be an employee of the medical provider/facility)

14

What is a guardian advocate?

- Florida statutes allows a Guardian Advocate to be appointed as a less intrusive and costly alternative to full guardianship. However, it is only available for persons with a developmental disability (as explained in Chapter 393,FS) or a person with mental illness (as explained in Chapter 394,FS).

15

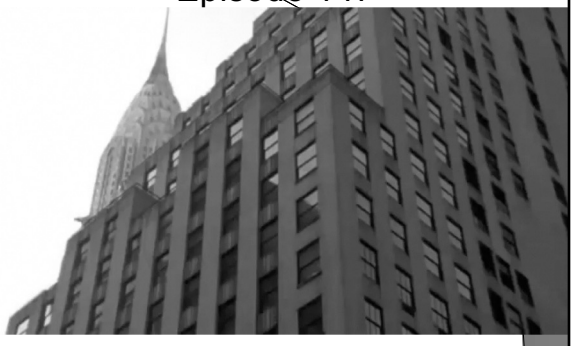
16

Patient and proxy education

- Define key medical terms
- Describe possible situations and outcomes– common and severe
- Instead of citing statistics on risks (pneumonia, infection, stroke, etc.), explain what may happen if things go well or go badly
- Explain benefits, burdens of treatments
  - Life support may only be short-term
  - Any intervention can be refused
  - Recovery cannot always be predicted

17

"Seinfeld" The Comeback (1997) Episode 147

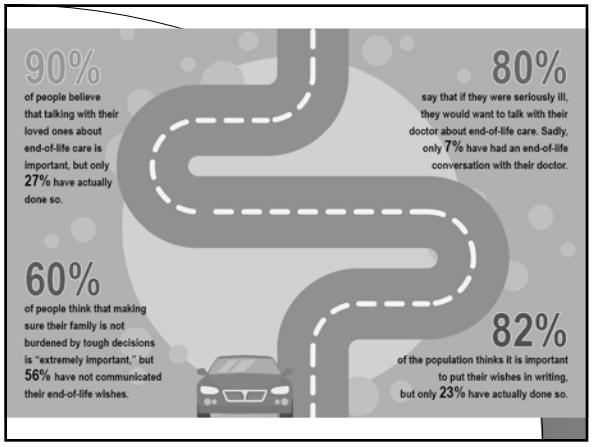


18

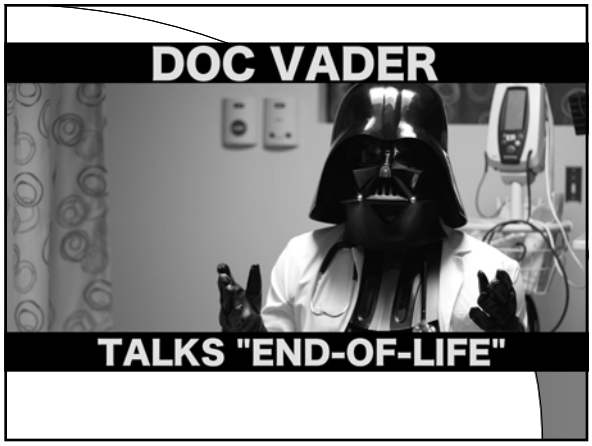
REMEMBER: IMPLIED CONSENT!

The patient and physician need to realize that not wishing to complete an advance directive is the same as consenting to all possible treatment in an emergency situation including electrocardioversion, intubation, and ventilation

19



20



21

96% of people who die in La Crosse have advanced directives

22

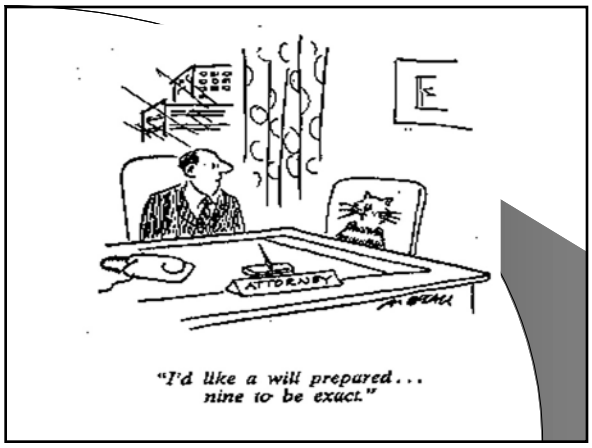
Common pitfalls

- Failure to plan
- Proxy absent for discussions
- Unclear patient preferences
- Focus too narrow
- Communicative patients are ignored
- Making assumptions

23

The Living Will

24



25

DECLARATION OF LIVING WILL

THIS DECLARATION is made under Florida Law and I, [redacted] willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain. I do not want nutrition and hydration (food and water) to be provided by gastric tube, intravenously or otherwise artificially administered.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this Declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences for such refusal.

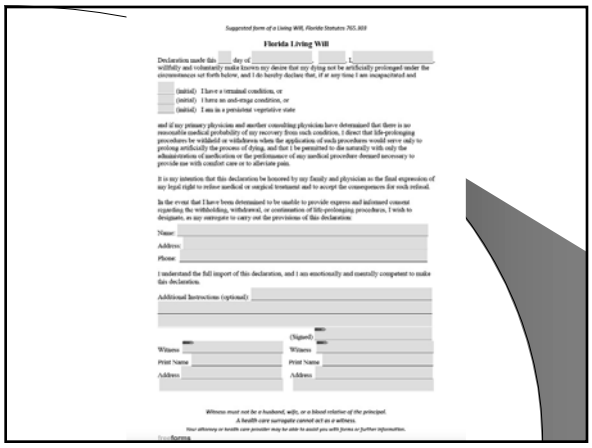
If I have been diagnosed as pregnant and that diagnosis is known to my physician, this Declaration shall have no force and effect during the course of my pregnancy.

I understand the full import of this Declaration and I am emotionally and mentally competent to make this Declaration.

26

performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. I DO (X) I DO NOT ( ) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

27



Florida Living Will

28

(initial) I have a terminal condition, or
(initial) I have an end-stage condition, or
(initial) I am in a persistent vegetative state

and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

Witness _____ Witness _____
Print Name _____ Print Name _____
Address _____ Address _____

Witness must not be a husband, wife, or a blood relative of the principal.
A health care surrogate cannot act as a witness.

29

New Living Will Form

I_____, being of sound mind and body, do not wish to be kept alive indefinitely by artificial means.

Under no circumstances should my fate be put in the hands of peckerwood politicians who couldn't pass ninth-grade biology if their lives depended on it. If a reasonable amount of time passes and I fail to sit up and ask for (Please initial all that apply)

_____a martini, _____a margarita, _____a beer, _____a steak _____ the remote control,_____ A bowl of ice cream, _____ A Kailua on the rocks,_____ Sex,

It should be presumed that I won't ever get better. When such a determination is reached, I hereby instruct my appointed person and attending physicians to pull the plug, reel in the tubes, and call it a day.

Under no circumstances shall the members of the Legislature enact a special law to keep me on life-support machinery. It is my wish that these boneheads mind their own damn business, and pay attention instead to the future of the millions of Americans who aren't in a permanent coma.

Signature: _____
Date:_____
Witness:_____

30

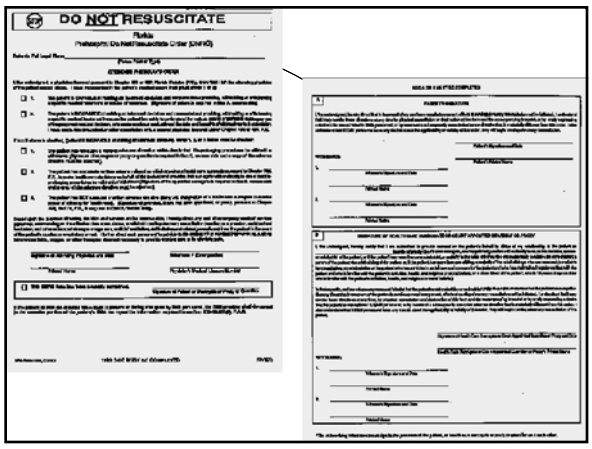
31

Five Wishes

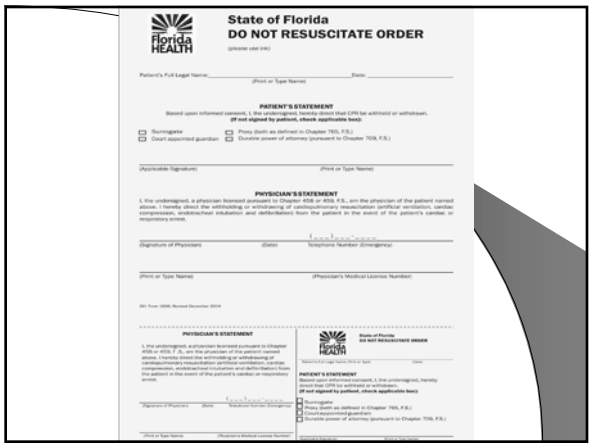
My wish for:

- The person I want to make care decisions for me when I can't
- The kind of medical treatment I want or don't want
- How comfortable I want to be
- How I want people to treat me
- What I want my loved ones to know

32



33



State of Florida
DO NOT RESUSCITATE ORDER

34

Allow a Natural Death (do not attempt resuscitation) Order

AND DNAR

Address

Final Documentation Box

Reason for making decision (e.g. patient's wishes, futility of resuscitation):

Who has been involved in the decision? (give name and relationship/role)

If it has not been appropriate to discuss this decision with the patient then the family/ carers should be aware of it, as part of the general treatment and care plan.

Medical Practitioner (print name)

Signature

Date

Next Review Date	Signature; review completed	Date Signed

35

POLST (Physician Orders for Life- Sustaining Treatment)

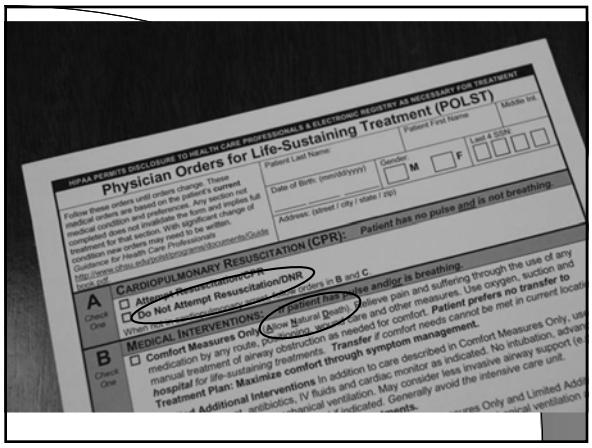
Oregon's registry for people who have made decisions about what kind of medical treatment they want in a life-threatening situation.

The POLST program has been around for two decades and was created to go further than standard "Do Not Resuscitate" orders in making hospitals aware of people's end-of-life wishes.

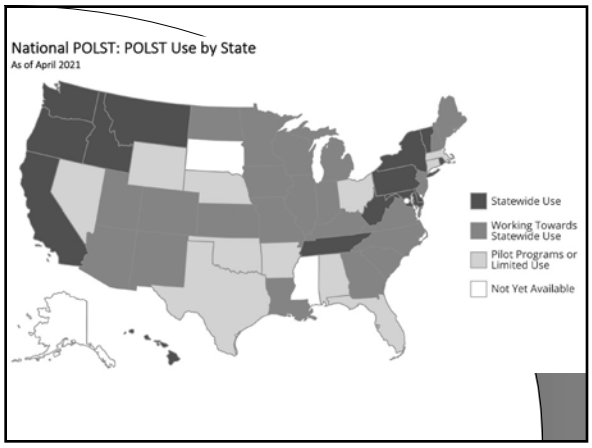
The registry was just instituted in 2009 to help streamline communication among medical professionals about POLST, especially in crisis situations. Since then, several other states have created similar programs.

POLST
physician orders for life-sustaining treatment

36



37

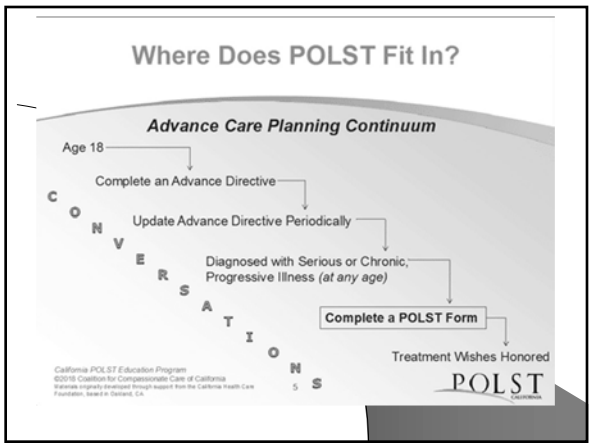


38

Differences Between POLST and Advance Directive

Characteristics	POLST	Advance Directive
Population	Seriously Ill	All Adults
Timeframe	Current and Future Care	Future Care
Form Can Completed By:	Physician / Healthcare Professionals	Patients
Healthcare Agent / Surrogate	Authorized to discuss options if patient lacks capacity.	Cannot complete form.
Transfer/Portability	Provider responsibility	Patient/Family Responsibility
Periodic Review	Provider responsibility	Patient/Family Responsibility

39

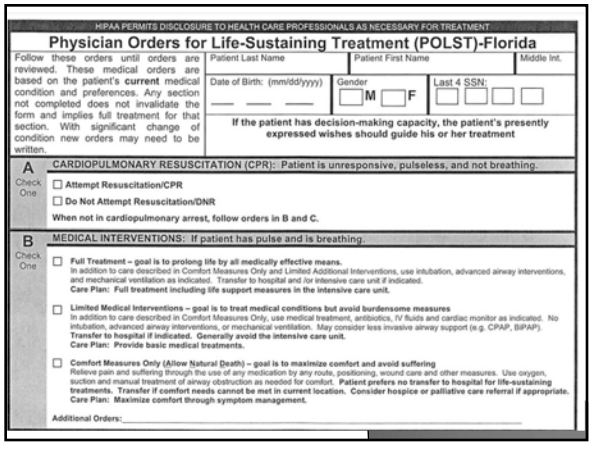


40

How often do POLST forms need to be updated?

- This form does not expire but should be reviewed whenever the patient:
- (1) is transferred from one care setting or level to another;
- (2) has a substantial change in health status; (3) changes primary provider; or
- (4) changes his/her treatment preferences or goals of care.

41



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)-Florida

Follow these orders until orders are reviewed. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name | Patient First Name | Middle Int.

Date of Birth: (mm/dd/yyyy) ___ ___ ___ | Gender ☐ M ☐ F | Last 4 SSN: ☐☐☐☐

If the patient has decision-making capacity, the patient's presently expressed wishes should guide his or her treatment

A Check One — CARDIOPULMONARY RESUSCITATION (CPR): Patient is unresponsive, pulseless, and not breathing.

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders in B and C.

B Check One — MEDICAL INTERVENTIONS: If patient has pulse and is breathing.

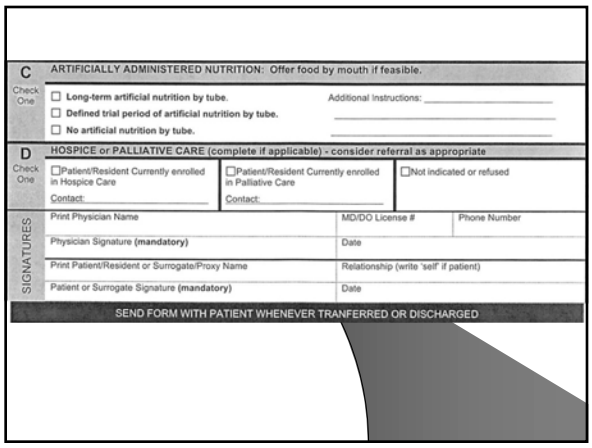
☐ **Full Treatment – goal is to prolong life by all medically effective means.**
In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and /or intensive care unit if indicated.
Care Plan: Full treatment including life support measures in the intensive care unit.

☐ **Limited Medical Interventions – goal is to treat medical conditions but avoid burdensome measures**
In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP).
Transfer to hospital if indicated. Generally avoid the intensive care unit.
Care Plan: Provide basic medical treatments.

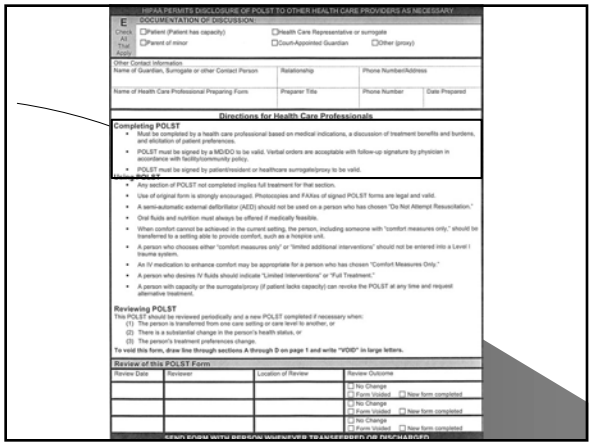
☐ **Comfort Measures Only (Allow Natural Death) – goal is to maximize comfort and avoid suffering**
Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Consider hospice or palliative care referral if appropriate.**
Care Plan: Maximize comfort through symptom management.

Additional Orders:_____

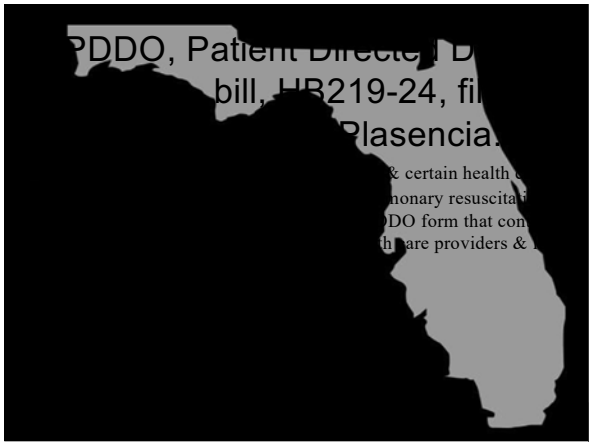
42


C ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible.
Check One
☐ Long-term artificial nutrition by tube. Additional Instructions: _____
☐ Defined trial period of artificial nutrition by tube.
☐ No artificial nutrition by tube.
D HOSPICE or PALLIATIVE CARE (complete if applicable) - consider referral as appropriate
Check One
☐Patient/Resident Currently enrolled in Hospice Care Contact: _____
☐Patient/Resident Currently enrolled in Palliative Care Contact: _____
☐Not indicated or refused
SIGNATURES
Print Physician Name | MD/DO License # | Phone Number
Physician Signature (mandatory) | Date
Print Patient/Resident or Surrogate/Proxy Name | Relationship (write 'self' if patient)
Patient or Surrogate Signature (mandatory) | Date
SEND FORM WITH PATIENT WHENEVER TRANFERRED OR DISCHARGED

43


HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY
E DOCUMENTATION OF DISCUSSION:
Check All That Apply: ☐Patient (Patient has capacity) ☐Health Care Representative or surrogate ☐Parent of minor ☐Court-Appointed Guardian ☐Other (proxy)
Other Contact Information
Name of Guardian, Surrogate or other Contact Person | Relationship | Phone Number/Address
Name of Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Prepared
Directions for Health Care Professionals
Completing POLST
• Must be completed by a health care professional based on medical indications, a discussion of treatment benefits and burdens, and elicitation of patient preferences.
• POLST must be signed by a MD/DO to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
• POLST must be signed by patient/resident or healthcare surrogate/proxy to be valid.
Using POLST
• Any section of POLST not completed implies full treatment for that section.
• Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
• A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
• Oral fluids and nutrition must always be offered if medically feasible.
• When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only," should be transferred to a setting able to provide comfort, such as a hospice unit.
• A person who chooses either "comfort measures only" or "limited additional interventions" should not be entered into a Level I trauma system.
• An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
• A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
• A person with capacity or the surrogate/proxy (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.
Reviewing POLST
This POLST should be reviewed periodically and a new POLST completed if necessary when:
(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.
To void this form, draw line through sections A through D on page 1 and write "VOID" in large letters.
Review of this POLST Form
Review Date | Reviewer | Location of Review | Review Outcome
☐ No Change ☐ Form Voided ☐ New form completed
☐ No Change ☐ Form Voided ☐ New form completed
☐ No Change ☐ Form Voided ☐ New form completed
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

44



45

Ethical Will (Zava'ah)

The ethical will is a document designed to pass ethical values from one generation to the next.

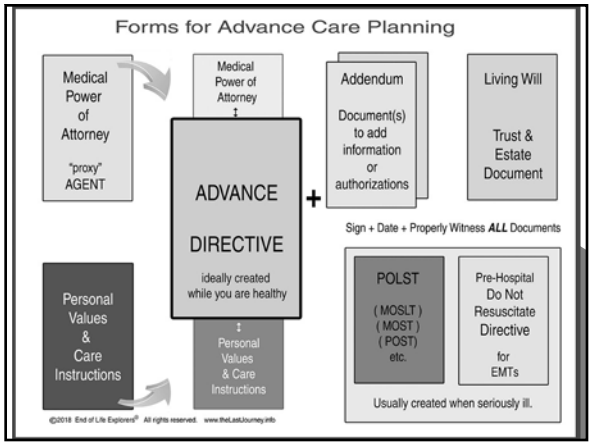
The original template for its use came from Genesis 40:1-33. A dying Jacob gathered his sons to offer them his blessing and to request that they bury him not in Egypt, but instead in Canaan in the cave at Machpelah with his ancestors.

46

The purpose of the ethical will is pass on wisdom and love to future generations

- Cultural and spiritual values
- Blessings and expressions of love for, pride in, hopes and dreams for children and grandchildren
- Life-lessons and wisdom of life experience
- Requests for forgiveness for regretted actions
- Rationale for philanthropic and personal financial decisions
- Stories about the meaningful "stuff" for heirs to receive
- Clarification about and personalization of health directives
- Requests for ways to be remembered after death.

47



48

Advance Directive Documents

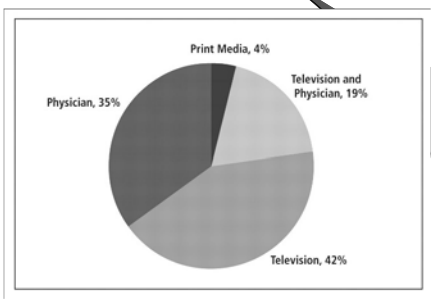
- Last Will and Testament (Trustee designation)
- DPOA (often with medical DPOA)
- Living Will (often with HCS designation)
- Health Care Surrogate designation
- Ethical Will
- Florida DNRO (yellow form)
- CMO
- DNAR
- AND
- Portable medical orders go by 15 different names: POLST/ MOLST/ POST /MOST /TPOPP/ COLST/ DMOST/ IPOST/ TOPP/ LaPOST
- PDDO (Florida)
- Supportive Decision Making Agreement

49

Supported Decision Making Agreement

50

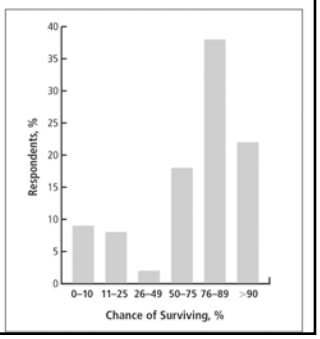
How Misconceptions Among Elderly Patients Regarding Survival Outcomes of Inpatient Cardiopulmonary Resuscitation Affect Do-Not-Resuscitate Orders



51

Misconceptions Among Elderly Patients Regarding Survival Outcomes of Inpatient Cardiopulmonary Resuscitation

- >60% of older pts over 65 believe there is a >75% chance they will be successfully resuscitated



52

Facts regarding code survival and outcomes

Code success in hospital setting overall survival to discharge range from 12-17% for all populations with <8 % surviving 30 days post hospital (UTD Jan 2024)

Patients with stable metastatic cancer have a 6.2% survival to discharge rate. If their condition is deteriorating in hospital, survival drops to 0% (Cancer 2001, 92:1905-1912)

Study of 434,000 Medicare pts found those 85 and older had a 6% chance of surviving hospitalization, and chronically ill elderly have < 5% chance of leaving hospital. Of the survivors, >50% will die within a year post arrest.

Cardiac arrest in community and nursing facilities have similar outcomes to each other and about 1/2 to 1/3 of the success of a hospital setting

53

Decreased likelihood of survival to discharge:

- Age
- Cancer especially metastatic CA
- Cerebrovascular accident
- Congestive heart failure
- Homebound status
- Hypotension
- Pneumonia
- Sepsis
- Serum creatinine level above 1.5 mg/dL

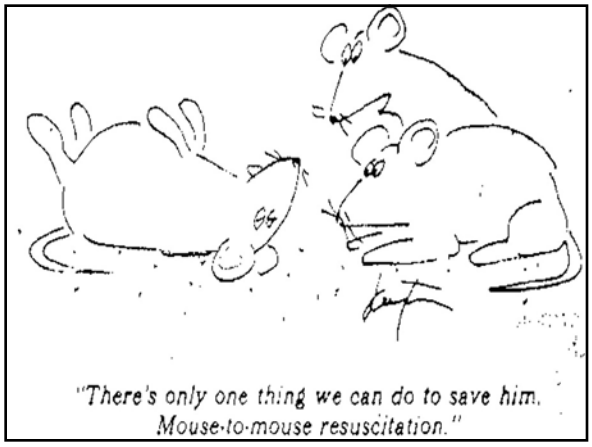
Are cardiac patients more likely or less likely to survive resuscitation?

Acute myocardial infarction on admission and a history of coronary artery disease were both associated with an increased likelihood of survival to discharge.

54

Despite initiatives to require discussion of Advanced Directives with patients on hospital admission, the DNR order is written on approximately 3-4% of the hospitalized patients in U.S.

55



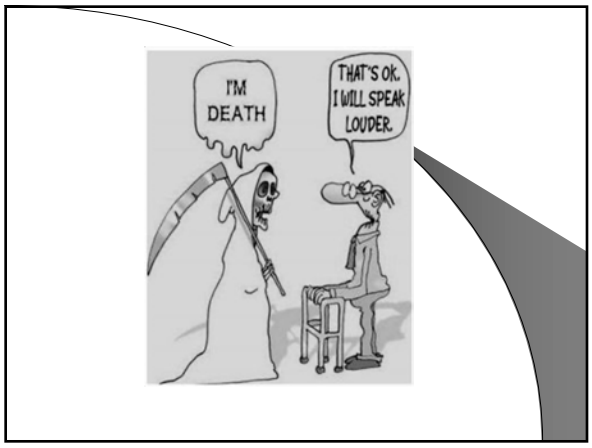
56

Life-sustaining treatments

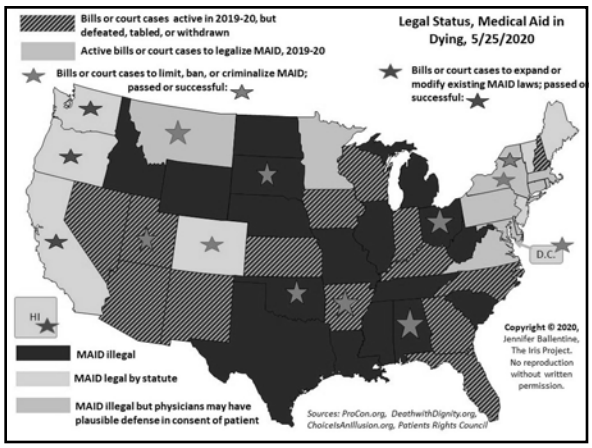
- Resuscitation
- Elective intubation
- Surgery
- Dialysis
- Blood transfusions, blood products
- Diagnostic tests
- Artificial nutrition, hydration
- Antibiotics, O2
- Other treatments
- Future hospital, ICU admissions

57

58


I'M DEATH
THAT'S OK. I WILL SPEAK LOUDER.

59


Legal Status, Medical Aid in Dying, 5/25/2020
Bills or court cases active in 2019-20, but defeated, tabled, or withdrawn
Active bills or court cases to legalize MAID, 2019-20
Bills or court cases to limit, ban, or criminalize MAID; passed or successful:
Bills or court cases to expand or modify existing MAID laws; passed o successful:
D.C.
HI
MAID illegal
MAID legal by statute
MAID illegal but physicians may have plausible defense in consent of patient
Sources: ProCon.org, DeathwithDignity.org, ChoiceIsAnIllusion.org, Patients Rights Council
Copyright © 2020, Jennifer Ballentine, The Iris Project. No reproduction without written permission.

60

61

Determining capacity to give informed consent

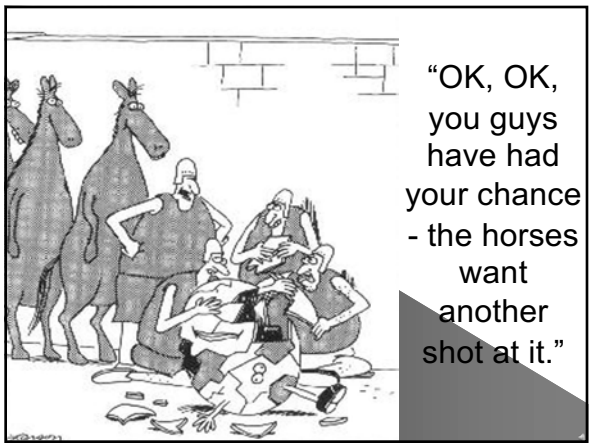
- Problem treatment would address
- What is involved in the treatment / procedure
- What is likely to happen if the patient decides not to have the treatment
- Treatment benefits
- Treatment risks (common and severe)
- Other options/alternatives

62

Special Circumstances: Health Care Surrogate Limitations

- Making End of Life Decisions Without Clear Advanced Directives(Living Will) –degree of certainty varies by state
- Termination of Pregnancy
- Voluntary admission to psychiatric facility
- Electro Convulsive Therapy
- Futile Care

63



64

The changing paradigm

- Paternity
- Autonomy/Self-determination
- Mutuality
  - Shared decision making
  - Patient/Family centered care

65

Models of decision making

TABLE 4.3 Models of treatment decision-making in a doctor–patient dyad

Analytical stages		Paternalistic (intermediate)	Shared (intermediate)	Informed
Information exchange	Flow	One way (largely)	Two way*	One way (largely)
	Direction	Doctor → patient	Doctor ↔ patient	Doctor → patient
	Type	Medical	Medical and personal	Medical
	Amount*	Minimum legally required	All relevant for decision-making	All relevant for decision-making
Deliberation		Doctor alone or with other doctors	Doctor and patient (plus potential others)	Patient (plus potential others)
Deciding on treatment to implement		Doctors	Doctor and patient	Patient

* Minimum required.

66

QUESTIONS WE NEED TO ASK?

Dr. Ronnie Rosenthal, professor of surgery and geriatrics at Yale Schoolof Medicine and co-leader for the Quality in Geriatric Surgery Project
Dr Zara Cooper associate professor of surgery at Harvard Medical School

- What does living well mean to you?
- How does your health affect your day-to-day life?
- What do you hope to do in the next year?
- What should I know about you to give good care?
- Regarding health, what's most important to you?
- What are you expecting to gain from this procedure?
- What conditions or treatments worry you the most?
- What abilities are so critical to you that you can't imagine living without them?

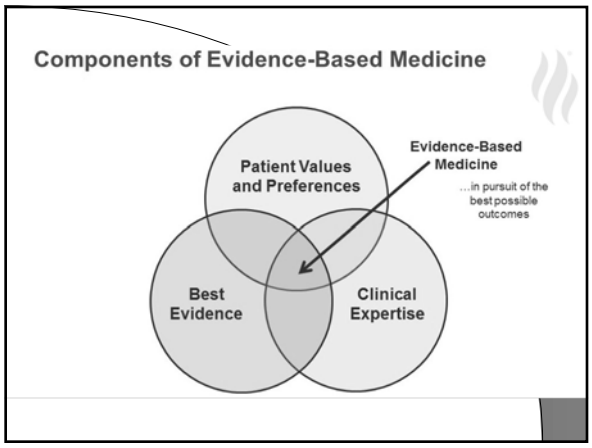
67

"Older patients, it turns out, often have different priorities than younger ones. More than longevity, in many cases, they value their ability to live independently and spend quality time with loved ones"

Dr. Clifford Ko, professor of surgery at UCLA's David Geffen School of Medicine

68

69

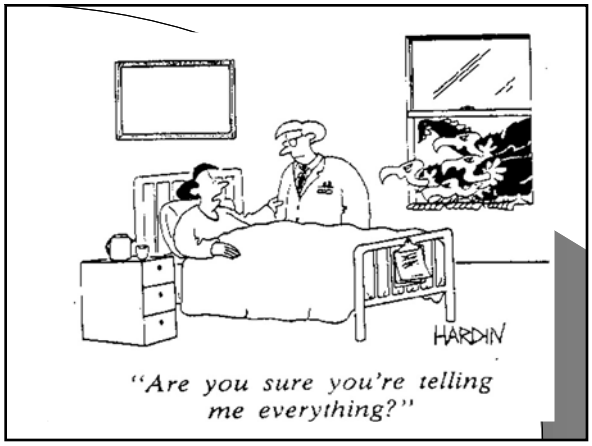


70

Communication is the key

- Many conflicts occur because of lack of communication between medical staff, patient, and family
- Most desirable to communicate before major dilemmas occur (if possible) so that everyone is comfortable with the treatment plan.
- Care plan meetings, frequent telephone and face-to-face communication by physicians, health-care extenders, nursing staff, patients, and families

71



72

"Seinfeld" The Comeback (1997)

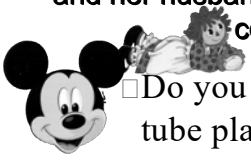
73

Applying Advance directives

Case Scenarios

74

Minnie is readmitted to your SNF following a stroke. She has mild cognitive impairment. She has no Living Will or HCS designation. She is noted to have dysphagia with aspiration. She refuses all food and medicine. Both her husband, Mickey and their daughter, Ann, want a feeding tube, and her husband signs the informed consent.



- Do you order G-tube placement?

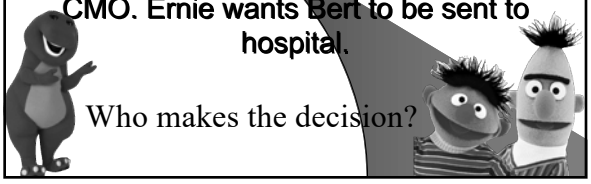
75

Do you order G-tube placement?

- A. YES
- B. NO
- C. NOT ENOUGH INFO
- D. Feeling too groggy from a big meal to think clearly right now

76

Bert has vascular dementia and suspected sepsis. He has no written Living Will or HCS documentation. His brother, Ernie, visits Burt at your LTC facility everyday. Burt's son, Barney, has never called nor seen his father since his LTC admission 3 yrs ago. His son, Barney, is notified and requests CMO. Ernie wants Bert to be sent to hospital.



Who makes the decision?

77

Who makes the decision?

- A. Ernie, the involved brother
- B. Barney, the distant son
- C. Courts need to decide
- D. Have all involved parties watch TV episodes of Barney and Sesame Street together before making their final decision.

78

Raggedy Ann has dementia and needs THR after a fracture. You determine Ann is incapacitated and therefore cannot give informed consent.
Her boyfriend, Donald, has Durable Power of Attorney.

Can he give consent?

79

Can he give consent?

- A. YES
- B. NO
- C. NOT ENOUGH INFO
- D. Only if Donald Duck puts on some pants?

80

Bert is alert, oriented, but depressed. You have discovered that he has cancer. Bert's son, Mickey, the lawyer, and Bert's wife, Barbie, don't want Bert to know this as they feel this info will make him severely depressed, and they believe he will give up.
Do you tell him anyway?

81

Do you tell him anyway?

- A. YES, the patient has the right to know what is going on and needs all pertinent information so that he can make an informed decision
- B. NO, the family knows the patient better than you do and their request should be honored
- C. Consult psychiatry to get an opinion
- D. Consult the patient.

82

Ann is admitted to your LTC facility with diagnosis of dysphagia due to prior stroke and vascular dementia with aspiration. Ann has a Living Will and Health Care Surrogate form naming her frail elderly husband as her HCS and her daughter, Barbie as her alternate HCS. Barbie demands G-tube and threatens to sue if her mother is allowed to aspirate.

Do you insert G-tube?

83

Do you insert G-tube?

- A. YES
- B. NO
- C. NOT ENOUGH INFO
- D. Offer a J-tube instead, as the risk of aspiration is proven to be lower

84

Barney has been your patient for over 25 years and is now well over 100 years old. You have discussed EOL issues, and Barney has made it clear to you that when his time comes , he is ready to die. He has completed a Living Will and a DNRO(including the wallet sized DNRO form). While at a restaurant with friends, he chokes and has a cardiopulmonary arrest. His well-meaning friends start CPR and call 911. He is successfully resuscitated and stabilized on a ventilator in the ICU but still unconscious.

His family arrives at the ICU and demands that Barney's wishes be carried out and that he be taken off the ventilator immediately. Do you comply?

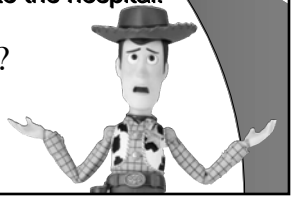
85

Do you remove the ventilator?

- A. YES.
- B. NO.
- C. NOT ENOUGH INFO
- D. Resign from the case and turn the patient over to the critical care doc to figure it out.

86

Woody has terminal widespread metastatic cancer that has failed all therapy. While in the nursing facility, he expressed to his wife, family, and you that he wants to go home with Hospice and comfort measures only. Prior to leaving the building, the patient vomits, has a drop in blood pressure, and lapses into a coma. Wife demands you send him to the hospital.



Do you call "911"?

87

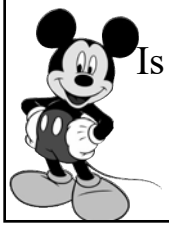
Do you call “911”?

- A. YES
- B. NO
- C. Call Hospice instead
- D. Call Buzz Lightyear

88

Ann has dementia and terminal disease and lacks capacity. She has no Living Will. Her son, Mickey, the attorney, completes a Living Will document through his legal office which he signs and has notarized on her behalf.

Is this document valid?



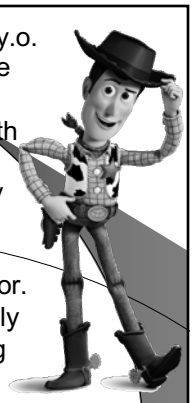
89

Is this document valid?

- A. YES
- B. NO
- C. Only if 2 witnesses sign the document
- D. Use your “Call a Friend” lifeline and get Attorney Kane on the phone

90

Woody is a presumed healthy 59 y.o. man who was hospitalized with the flu. Upon hospital discharge, he suffers a sudden cardiac event with coma. EEG shows minimal brain activity and no chance of recovery documented by 2 separate neurologist. He has multi-system failure and is already on a ventilator. He has no Living Will, but his family believes he would want everything done. His kidneys are failing.



Do you begin dialysis per HCS's request?

91

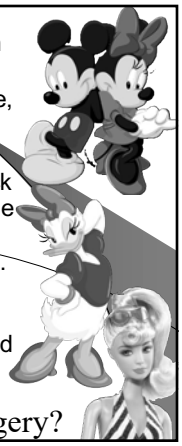
Do you begin dialysis?

- A.YES. The patient has previously expressed his advanced directives orally, and his family acting as his proxy desires dialysis knowing the patient will die without it
- B. NO. Patient is not going to get better.
- C. Time to call the Ethics committee
- D. Defer the decision to the nephrologist.

92

93

Mickey and Minnie Mouse went through an amicable divorce after 40 years of marriage. Two years after their marriage, Minnie Mouse completed a living will naming her husband, Mickey, as her HCS, and her maid of honor, Daisy Duck as her HCS alternate. Mickey and Minnie have one 36 y.o. daughter, Barbie. Minnie Mouse is incapacitated in a SNF. Despite their divorce, Mickey Mouse, visits her every evening to help her eat dinner. Minnie Mouse fell at the SNF and fractured her hip and requires surgery



Who signs the consent for surgery?

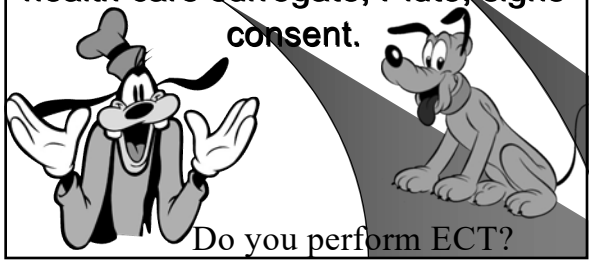
94

Who signs the consent for surgery?

- A. Mickey, Minnie's written and documented designated health care surrogate on Minnie's properly completed and witnessed living will, who understands Minnie's wishes after 40 years of marriage and clearly cares about her well-being
- B. Daisy Duck, her best friend and health care surrogate alternate
- C. Barbie, her adult daughter, and healthcare surrogate per the Florida proxy statute as Minnie is no longer married to Mickey.
- D. Walt Disney

95

Goofy is …well… goofy. He is incapacitated. The psychiatrist recommends ECT. His documented health care surrogate, Pluto, signs consent.



Do you perform ECT?

96

Do you perform ECT?

- A. YES
- B. NO
- C. NOT ENOUGH INFORMATION
- D. Since Goofy and Pluto are both dogs, maybe you are the one that needs some serious psychiatric intervention

97

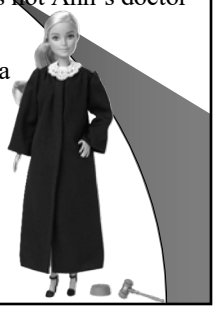
Mickey and Minnie have a 13 y.o. child, Anne. They would like their close friend, Dr. Barbie, to be Anne's HCS and fill out a HCS form naming Barbie as Anne's HCS.

Is this form legal in Florida?

98

Is this form legal in Florida?

- A. YES, but only if Dr. Barbie is not Ann's doctor
- B. YES, this is legal in Florida
- C. NO, this is not legal in Florida
- D. I will defer to Judge Barbie



99

Daisy has been living in Orlando with Donald for the past 43 years (although they were never officially married). Her living relatives are a 17 y.o. son and a 19 y.o. niece. Daisy has never completed a Living Will or HCS document. She becomes ill and is now incapacitated.

Who make medical decisions on Daisy's behalf?

100

Who makes medical decisions on Daisy's behalf?

- A. Donald
- B. Her son
- C. Her niece
- D. Clinical Social Worker appointed by the Ethics Committee

101

Minnie Mouse is declining rapidly in her SNF. She is widowed. She is still full code.
She does not have a Living Will, POLST or DNR.
Mickey Mouse, her only child, has been incarcerated for murder with a life sentence and has not seen his mother for over 10 years.

Can Mickey still make end of life decisions for his mother despite being a convicted felon ?

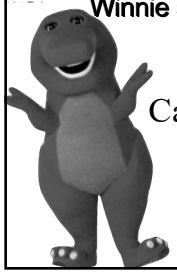
102

Can Mickey still make end of life decisions for his mother despite being a convicted felon ?

- A. NO… as a felon, he loses his legal rights.
- B. YES… he is still the proxy by state law
- C. Not enough information
- D. What jury would ever convict Mickey Mouse?

103

Barney is 102 years old and breaks his hip . Fortunately, his best friend and well-documented healthcare surrogate, Winnie, was present, instructed staff to call "911" and follows Barney to the hospital.
Winnie signs the consent for surgery.



Can surgery proceed?

104

Can surgery proceed?

- A. YES
- B. NO
- C. NOT ENOUGH INFORMATION
- D. Can we go home?

105

Minnie is a 69 year old alert, oriented retired nurse with severe COPD from smoking. She had a psych consult and is not depressed. She has a Living Will. She has been hospitalized and intubated with AECOPD and pneumonia on several occasions. She is now hospitalized with recurrent pneumonia and impending respiratory failure. She will die without BiPAP or intubation but refuses both despite potential reversibility once pneumonia is treated.

Do you let her die?

106

Do you let her die?

A. YES – pt has the right to refuse treatment
B. NO - her Living Will is only valid if patient has a terminal illness with no reasonable chance of recovery.
C. Ask her family to intervene
D. Consult ethics committee

107

Barney is a 65 y.o. convicted convict with end stage pulmonary disease. He has no known relatives or close friends. He has no Living Will or HCS form completed. While in jail he developed pneumonia with sepsis and prolonged hypoxia with severe brain damage. He is now comatose in your ICU for past 6 weeks on a ventilator. Attending hospitalist, pulmonologist and neurologist document no chance of recovery

Can you discontinue the vent?

108

Can you discontinue the vent?

- A.YES
- B. NO
- C. Consult Ethics committee to appoint licensed clinical social worker to make the decision.
- D. Start a guardianship process through the judicial system

109

- Minnie is a 95 y.o. frail WF with end stage dementia who resides in your long-term care facility.
- Her daughter, Daisy, originally was her original DPOA for finances and healthcare and Minnie's brother (who is now deceased) was the alternate.
- 3 years ago, the patient moved away from her daughter and close to her granddaughter, Barbie.
- Barbie was given DPOA for finances only and Barbie's spouse, Tammy, was alternate DPOA.
- The patient has no written Living Will, but Barbie recalls her grandmother telling her 30 years ago that she wanted everything done.

You feel coding this patient would be would be cruel and pointless. What do you do?

110

What do you do?

- A. Keep her a Full Code per the wishes of her granddaughter, Barbie, the DPOA, who recalls that the patient wanted everything done.
- B. Consult her daughter, Daisy.
- C. Ask for guardianship with the court system
- D. NOT SURE

111

Ann is a 65-year-old woman with metastatic, non-small-cell CA of the lung, COPD, and HTN who presents with progressive SOB and back pain. She has acute tachypnea and O2 sat of 84% on 4L NC. CT scan shows marked progression of her disease and new metastases to her spine. You begin a discussion about advance directives and code status. The patient asks for guidance regarding resuscitation.

- What do you tell her regarding her odds of surviving a code in the hospital?

112

What do you tell her regarding her odds of surviving a code in the hospital?

- A. 20%
- B. 5-10%
- C. She will not survive CPR
- D. Don't give her odds as the decision should be left to the patient

113

Goofy has no Living Will. He had an intracranial bleed and in now on a ventilator which is not weanable. His wife, Minnie, wants the ventilator withdrawn as he expressed wishes with her privately that he would not want to be kept alive on a ventilator.

Can you pull the plug?

114

SCENARIO #1:Goofy has brain function on EEG. The neurologist feels, however, that there is no chance of neurological recovery. You agree and both of you document this on the chart.

115

Can You Pull The Plug?

- A. YES
- B. NO
- C. NOT SURE

116

SCENARIO #2: Pulmonologist talks to you, the attending physician, on the phone and both of you agree that the patient is terminal and life support should be withdrawn. The pulmonologist documents this conversation on the chart.

117

Can You Pull The Plug?

- A. YES
- B. NO
- C. NOT SURE

118

SCENARIO #3: The pulmonologist and you, the attending physician, agree that the patient is terminal and document. The neurologist and the cardiologist, however, disagree and document.

119

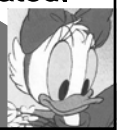
Can You Pull The Plug?

- A. YES
- B. NO
- C. NOT SURE

120

Daisy is 94 y.o. and has end stage COPD. She has no known family, close friend, or Health Care Surrogate. She has spoken to you, her physician, regarding wishes for no heroics, but she has not filled out a written Living Will. She presents with respiratory failure and will die if not intubated.

What do you do?



121

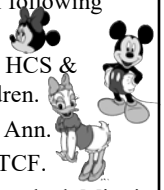
What do you do?

- A. Intubate her
- B. Honor her previously expressed wishes and institute CMO only
- C. Ethics Committee consultation
- D. Not enough information

122

- Minnie is a 85 y.o lady who suffered TBI following MVA 7 years ago. She is incapacitated.
- Her husband, Mickey, is her documented HCS & DPOA. There is no alternate and no children.
- Mickey hired Daisy as a personal CG for Ann.
- 3 years ago, Minnie, was admitted to a LTCF.
- 1 year later, unbeknownst to LTCF, Mickey had Minnie sign divorce papers, and he married Daisy.
- Mickey has continued to make medical decisions for his ex-wife, Minnie, over the past 2 years.
- Minnie's only sibling, Buzz, wants to take over decision making and has hired an attorney for guardianship.

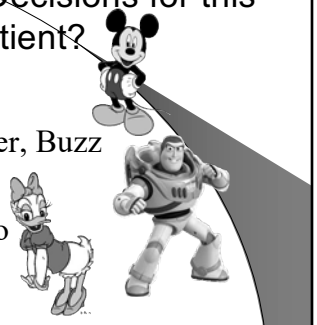
Who makes decisions for this patient?



123

Who Makes Decisions for this Patient?

- A. Mickey
- B. Minnie's Brother, Buzz
- C. Daisy
- D. Not enough info



124

Barney presents to the ER with a ruptured abdominal aortic aneurysm. He is initially alert and oriented and adamantly refuses emergency surgery. After losing consciousness from blood loss, his wife, Minnie, demands that you operate, and she signs consent.

What do you do?

125

What do you do?

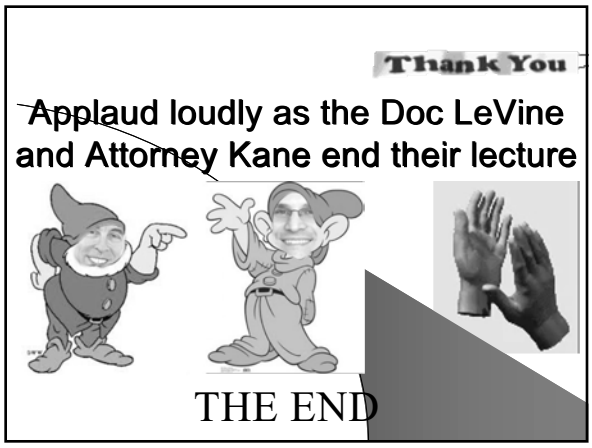
- A. Operate per the wife's wishes
- B. Don't operate per the patient's wishes before he slipped into a coma
- C. Consult Ethics Committee
- D. Call your malpractice attorney ASAP

126

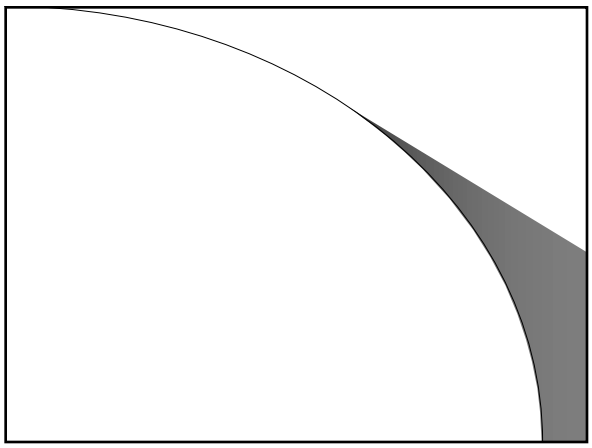
Woody, attending a medical lecture, complains of severe auditory pain after listening to a talk on Advanced Directives. He asks the Doc to end it all.

What do you do?

127



128



129

130

Barbie is 16 y.o. unaccompanied homeless girl in Florida with a 2 y.o. child that requires surgery.

Can she give consent?

131

Can she give consent?

- A. YES - she is the mother of the child and has no known family
- B. NO – she is a minor per Florida laws and a Clinical Social Worker assigned by the hospital Ethics committee would be required to give consent.
- C. Ask the 2 y.o. what she wants with the understanding that 2-year-olds often say “no” to everything.

132

Barbie is now 17y.o., and one of the elderly volunteers who worked with her and befriended her 1 year ago, was so impressed with her maturity, kindness, and knowledge that he listed Barbie as his only HCS in his Living Will. The volunteer is now comatose with a stroke and needs consent for intervention.

Who gives consent?

133

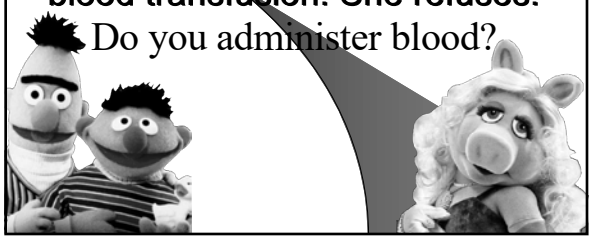
Who can give consent?

- A. Barbie as she is listed as the HCS on a properly completed and witnessed Living Will
- B. The closest adult relative or friend per the proxy statute
- C. Clinical Social Worker assigned by the hospital Ethics committee.
- D. Ken

134

Ms. Piggy is a mother of two small children, Bert and Ernie. She is hemorrhaging from a miscarriage and will die without blood transfusion. She refuses.

Do you administer blood?



135

Do you administer blood?

- A.YES
- B. NO
- C. Request judicial intervention
- D. Not a geriatric question… Next slide please.

136