



Hospice of the Carolina Foothills

Hospice Medical Memo

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MOST: A Better Method of Advance Care Planning by Garry Snipes, MD

MOST (Medical Orders for Scope of Treatment) is a new self-determination process and form just passed into law by the North Carolina legislation.

Impetus for such legislation

The last several decades of medical science and practice have brought us major advances in the treatment of human illness and concomitant increases in life expectancy. With the availability of those advances have come difficult ethical dilemmas and more complex decision-making revolving around questions of patient and family autonomy, burden versus benefit of treatment and the need for an individualized process of decision making that allows planning based on personal goals of care.

History of Advance Care Planning

The 1970s - 1990s saw attempts to address these issues through laws implemented to allow for living wills and health care powers of attorney. These

instruments gave everyone the opportunity to state in advance their wishes regarding certain life prolonging measures under a limited set of circumstances, as well as designating another person to make decisions in the event of one's incapacity. While these were valuable measures, they did not realize their potential for several reasons. First of all, only about 15% of people actually executed living wills. Secondly, these documents were not really portable, and were often not available to health care providers when they were needed. Finally, living wills in most states, including the Carolinas, are only operative for a patient who is considered terminal or in a persistent vegetative state. They do not apply to very common situations such as a person who is not necessarily terminal, but is elderly and debilitated with a poor prognosis for successful CPR. "Portable DNR" forms partially alleviated this problem, but were not always honored by

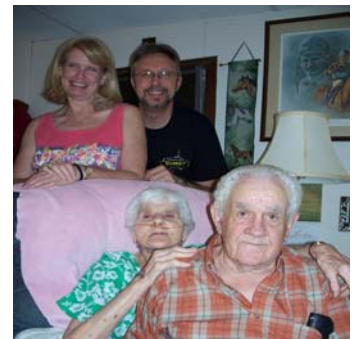
emergency personnel because of liability concerns.

Recent Initiatives

Starting with Oregon in the early 1990s, a series of states have enacted legislation adopting more comprehensive advance directives in the form of a physician order, now known as the "POLST (Physician Orders for Life Sustaining Treatment) paradigm". "MOST" was passed in North Carolina this year as House Bill 634, Session Law 2007-502, after several years of work with the legislature by many interested parties and pilot programs to test the process. The overriding goal of this legislation is to promote patient self-determination at the end of life.

How does MOST differ from an advance directive?

Advance directives—both living wills and health care powers of attorney—are legal instruments implemented by private individuals to reflect their wishes, generally completed without the



Camilla "Cam" Esterling, a patient of Todd Walter, MD, surrounded by her supportive family.

involvement of health care providers. But advance directives can only be implemented through physician (or NP, PA) orders, and this is the major difference represented by MOST.

The MOST document represents an actionable order that instructs other health-care providers what care to provide based on completion and signature of the form by the primary healthcare provider for the patient. MOST may be completed based on decisions by the patient or by proxy decision makers if the patient lacks capacity, and *unlike other physician*

At Hospice of the Carolina Foothills

WHO

- Jean Eckert
Executive Director
- Garry Snipes, MD
Medical Director
- Sharon Maddox, RN, MPH
Director of Patient Care Services
- Wendy McEntire, CMSW, LMSW
Director of Bereavement Services
- Doug Brooks, RN
Admissions Coordinator
- Meg Hoke, LMSW
Palliative Care Program Coordinator
- Maureen Murphy
Program Liaison

WHERE



WHAT

For July–September 2007

Number of Patients served:	131
Average Length of Stay, days:	144
Where served:	
Patient's home:	47%
Nursing home:	53%
North Carolina	67%
South Carolina	33%
Total of Staff & Volunteer Visits:	2438
Deaths in Polk County:	46
We served 57%:	26

MOST: A better method...

orders, is signed by the patient or representative.

The declarations of the MOST must be updated annually in order for them to remain valid.

Another key distinction of MOST is in the scope of its directions. While standard advance directive documents

(and law) only provide for restrictions on CPR and artificial nutrition and hydration, MOST covers these measures, as well as levels of medical intervention (hospital transfer or not); type of hospital care to be delivered (full or limited, comfort oriented interventions); the use of antibiotics; and the administration of IV fluids. It also provides for the possibility of therapeutic trials of certain interventions such as feeding tubes rather than simply indicating a

yes/no preference. This flexibility, while allowing specificity, is one of the major strengths of the MOST process. While you will be hearing a great deal about MOST in the coming months, I hope this series of short articles on this new law and process will provide a useful introduction.

Next quarter: The MOST form and the workings of the process.

You Make A Difference.

by Maureen Murphy

Pilgrims on a journey were looked after by the earliest hospices. People at the end of their lives are also on a journey. The quality of their journey is largely determined by the degree to which they can live at their maximum potential within the limits of their physical and mental capacity and by control of their unpleasant symptoms.

Because of the complexity of their needs, Hospice eligible patients need a wide range of services. They need more than one doctor and/or one nurse. They need a team approach to treat the

many deficits and changes terminal illness creates in a life and in a family.

Why should you, as a physician, refer your eligible patients to Hospice? Because it is a great kindness to recognize the anxiety a terminal illness generates in a patient and to recognize the emotional and spiritual suffering both the patient and family may experience along with the patient's physical suffering. Because Hospice offers help for the patient with the questions of "Why me? Why now? What is the meaning of all this?"

A patient's fear and lack of information can also cause pain.

It can bring up the unfinished business of a lifetime: the frayed relationships, the decisions long delayed which can no longer go untended, the need to make amends and plan for end of life care. How better, as a physician, to see and address these needs than to refer them to Hospice which specializes in the myriad needs of the dying patient? It's a strong message of caring, one that says, "I care about what is troubling you and I want you to get your needs met. I will oversee your care throughout your last journey and I will let Hospice help you get your needs and your family's needs met."