

**Maryland
Attorney General's Office**

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**Instructions on Current Life-Sustaining
Treatment Options**

**Explanatory Guide
for Health Care Professionals**

April 2008

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I. Introduction

A law passed in 2004 authorized the use of the "Patient's Plan of Care" form (PPOC form) in health care facilities. Then in 2007, the law was amended to rename the form. It is now to be called "Instructions on Current Life-Sustaining Treatment Options" (LST Options form). The Attorney General's Office is responsible for issuing the form and has adopted regulations to govern its use. **The LST Options form is to be used starting April 1, 2008.** This Guide explains the purpose and use of the form. Note that, aside from the name change, the law is unchanged. The LST Options form is to be used just the same as the PPOC form.

The LST Options form is meant to help improve existing practice. A process for end-of-life care planning *already occurs* in one way or another, for how could it be otherwise? When a patient has a serious illness, issues inevitably arise about how health care providers are to respond if any of the patient's vital functions fail. Resolving issues about the use of life-sustaining medical technology and documenting care preferences and decisions are daily occurrences in acute and long-term care facilities. The LST Options form simply introduces a standardized way of summarizing and communicating key preferences.

Using the LST Options form is only one part of a broader process aimed at achieving excellence in end-of-life care. To assist health care facilities with this important work, the State Advisory Council on Quality Care at the End of Life has issued an Ethical Framework for decision making entitled "Key Steps in Making and Implementing Health Care Decisions." The Ethical Framework identifies the steps for not only complying with the Health Care Decisions Act but also giving practical meaning to the ethical principles that underlie the Act. Part XI of this Guide provides information on obtaining a copy of the Ethical Framework.

Please note that the Maryland Legislature added provisions about the LST Options form to the Health Care Decisions Act. It did *not* repeal or amend other provisions of the Act. All of the prior provisions remain in force, including those about advance directives, the authority of a health care agent (that is, someone named in a durable power of attorney type of advance directive), the authority of a surrogate decision maker (that is, someone who assumes the role of decision maker based on the Act's priority ranking, including a guardian, a family member, or a friend), the authority of physicians to decline to provide treatments that are properly certified to be medically ineffective or ethically inappropriate, and the provisions on patient transfer after a health care provider declines to carry out treatment instructions.

In particular, there is no change in the authority of surrogate decision makers. If a surrogate is using the LST Options form to withhold or withdraw a life-sustaining medical treatment, the patient must have been certified to be in a terminal or end-stage condition or a persistent vegetative state.

As explained in Section IV below, the LST Options form is *not* a physician's order. Therefore, it cannot serve as an EMS/DNR Order. There is *no change* in the requirements, protocols, or documentation regarding emergency medical services.

II. Objectives of the LST Options Form

The LST Options form has several related purposes:

- to help a patient or, if the patient lacks capacity, the patient's health care agent or surrogate (for short, the "health care proxy") understand and discuss issues about life-sustaining treatments with a physician or other health care professional;
- to document the patient's or the health care proxy's preferences about current or foreseeable life-sustaining treatment issues relevant to the patient's current illness and health status;

- if an advance directive exists and contains instructions related to the use of life-sustaining treatments, to carry out the advance directive in the specific clinical context;
- to serve as a basis for medical orders (for example, whether CPR is to be attempted or not) in the health care facility where the LST Options form is filled out or filed; and
- if the patient is transferred to a different facility (for example, from a nursing home to a hospital), to communicate potentially useful information about prior care planning to the receiving facility and any new attending physician.

Patients and health care proxies are never required to use the LST Options form. Its use is voluntary, and a decision documented on an LST Options form may be revisited at any time.

III. Relationship to “living will” type of advance directives

An instructional advance directive, often called a living will, is used to describe preferences about life-sustaining treatments that are to be honored after the individual who made the advance directive loses capacity. A living will typically describes the individual’s preferences about life-sustaining procedures in a contingent, general way. For example, the optional living will form in the Health Care Decisions Act allows someone to declare that, “If my doctors certify that death from a terminal condition is imminent, ... I do not want any medical interventions used to try to extend my life.” Usually, instructions in a living will are not linked to a current, specific clinical context.

By contrast, treatment preferences documented on a LST Options form are more specific and should be directly related to the patient’s current health status, in light of the patient’s acute and chronic illnesses. A patient who has capacity and does not currently need to decide about life-sustaining treatments, but who wishes to declare an overall preference about this category of treatments for the indefinite future, should make an advance directive instead of using the LST Options form.

What if a patient already has given treatment-related instructions in an existing advance directive? If a patient with capacity uses the LST Options form to document preferences about specific life-sustaining procedures, the patient may select any desired options, regardless of an existing advance directive (because the advance directive only speaks for the patient after loss of capacity). A patient might decide, for example, on treatments aimed at prolongation of life until loss of capacity, and then allow the existing advance directive to instruct that an entirely palliative approach be followed from then on. It is also possible that the discussion about the LST Options form might prompt the patient to revisit the decisions previously made in the advance directive.

A health care proxy's use of the LST Options form on behalf of an incapacitated patient must be within the proxy's legal authority and consistent with the patient's known wishes, including any relevant instructions in an advance directive. For example, suppose an individual made an advance directive that limits interventions in the event of an end-stage or terminal condition or persistent vegetative state. If that individual has lost capacity and has been certified to be in one of these conditions, a health care proxy may use the LST Options form to apply the instructions in the advance directive to the specific procedures covered by the form.

The following table summarizes various potential applications of the LST Options form:

<i>Patient's clinical condition</i>	<i>Instructional advance directive (AD) exists</i>	<i>No instructional advance directive</i>
End-of-life.	- Use LST Options form to state preferences about current or foreseeable life-sustaining treatment issues; if by health care proxy, must be consistent with AD.	- Use LST Options form to state preferences about current or foreseeable life-sustaining treatment issues; if by health care proxy, based on patient's known wishes or best interests.

<p>Not end-of-life, but is so unstable or acutely ill as to require consideration of life-sustaining treatment issues.</p>	<p>- Use LST Options form to state preferences about current or foreseeable life-sustaining treatment issues; if by health care proxy, must be consistent with AD.</p>	<p>- Use LST Options form to state preferences about current or foreseeable life-sustaining treatment issues; if by health care proxy, based on patient's known wishes or best interests.</p>
<p>Not end-of-life; not acutely ill or unstable.</p>	<p>- Use LST Options form for contact and AD information and documentation of CPR ("code" status) preference.</p>	<p>- Use LST Options form for contact information and documentation of code status preference. - Patient with capacity may make AD if desired.</p>

IV. Relationship to medical orders; immunity.

The LST Options form is not a physician's order, but it is to be considered when a physician (or, as authorized, a nurse practitioner) writes orders. Any medical orders that would be needed to implement the decisions documented on the LST Options form (for example, "Do Not Resuscitate" or "Do Not Hospitalize") should be issued in accordance with generally accepted standards of patient care and customary procedures. The physician's signature on the LST Options form only signifies that the physician assisted the completion of the form or, if another health provider did so, that the physician can reasonably rely on the adequacy of the process.

Physicians and other health care providers gain legal immunity if they rely on the LST Options form to develop a care plan and related medical orders, as long as they follow proper procedures and act in good faith.

V. Legal requirements related to the use of the LST Options form

1. A new resident of a nursing home (or the resident's health care proxy) must be offered the opportunity to use the LST Options form.¹ Thus, for every new resident, a nursing home should have in its records one of two things: an LST Options form that the resident or the resident's health care proxy used to document preferences; or documentation that the LST Options form was offered but the resident or health care proxy declined the opportunity. Use of the LST Options form will satisfy any current Maryland regulatory obligation related to documenting care planning for life-sustaining treatments. Of course, a nursing home must continue to comply with other legal obligations related to care planning and residents' rights and to document appropriately matters not covered on the LST Options form.
2. A nursing home or other health care facility may not reformat the LST Options form or change how any of its parts are worded. The regulations provide that the form may be modified to include additional identifying information about a patient, but providers "may not otherwise alter the contents or format of the form." A facility may add its name or logo to the top of the form, because this does not alter the contents or format. But if, for example, a facility uses its own terminology to describe code status, it may not alter the wording of Part C to reflect that unique terminology.
3. The other legal requirements arise only if an LST Options form has been filled out, in whole or part:
 - (a) As discussed in Section III above, if the patient lacks capacity and has an applicable advance directive, the health care proxy's preferences on the LST Options form must be consistent with the advance directive. Therefore, the health care professional who is

¹ The law uses the term "facility," which means a comprehensive care or extended care facility under the regulations of the Department of Health and Mental Hygiene. In this Guide, we generally use the more colloquial term "nursing home."

assisting with an LST Options form should discuss the contents of any advance directive as an integral part of the process.

- (b) In a nursing home, the LST Options form must be kept visibly at the front of the resident's active chart. This practice would be prudent in other health care facilities. If a facility uses an electronic medical records system, the existence of the LST Options form should be prominently flagged.
- (c) If the patient is transferred to another facility, the LST Options form must be sent (physically if feasible, otherwise electronically) at the same time as the patient.
- (d) If the patient is transferred to another facility, the LST Options form must be reviewed by any attending physician at the new facility. This review does not involve signing or otherwise approving the LST Options form, but rather assessing how the identification of the main goal of care and any specific treatment preferences documented on the form should affect treatment in the receiving facility.
- (e) If an LST Options form has been filled out and the patient's condition later changes materially, including loss of capacity, the form must be reviewed. If appropriate – for example, because the patient's current condition is significantly different from the patient's condition when the LST Options form was done previously – the old one should be rescinded and a new one prepared.

VI. Discussing and completing the LST Options form

1. *May the discussion of the LST Options form with a patient or the patient's health care proxy be done by someone other than the patient's attending physician?*

Yes. The attending physician may delegate to another health care professional the task of assisting the patient or health care proxy in considering and, should the patient or health care proxy choose to do

so, completing the LST Options form. The attending physician should review the form before signing it and remains ultimately responsible for the process of presenting and discussing treatment options with a patient or health care proxy.

2. *How soon after a resident arrives at a nursing home must the LST Options form be offered?*

The law does not specify a time period. The LST Options form should be offered, as part of the process of review and discussion of the resident's condition and preferences, as promptly as possible after the resident's arrival. An unreasonable delay would violate the legal requirement.

3. *Must the LST Options form be offered to every newly admitted resident at a nursing home?*

The law simply refers to "residents," who could be in a nursing home for a variety of reasons and time periods, from an indefinite stay to a brief period of rehabilitation. The law does not exempt any subgroup of residents from the requirement. But the "offer" of the LST Options form need not be identical for everyone. Someone who is admitted for what is expected to be a short rehabilitation stay, for example, with no current need for end-of-life care planning, can be offered the form simply as a means of documenting the rehabilitative goal of care, advance directive and proxy contact information, and a preference about CPR. The offering of the LST Options form can be coupled with the provision of information about advance directives. If use of the LST Options form is declined, given the reason for the admission, the nursing home should simply document the offer.

4. *How should a nursing home document that the LST Options form was offered but its use was declined by the patient or health care proxy?*

Neither the law nor the regulations specify a manner of documenting this fact. Some facilities document the offer on the LST Options form itself; others use a separate refusal form; still others document the offer in chart notes. Any method that incorporates the basic facts (who

offered the LST Options form, the date of the offer, and who declined its use) is sufficient evidence of compliance.

5. *Are hospitals, assisted living facilities, home health agencies, and hospice programs required to offer the LST Options form to their patients?*

No. The law's requirement that the LST Options form be offered is limited to nursing homes. All of these other facilities and programs are free to offer the LST Options form, however, and may find that the form is a useful way of complying with accreditation standards or otherwise carrying out end-of-life care planning for patients whose medical condition presents current issues about life-sustaining treatments. Regardless of the setting, use of the LST Options form carries the same legal requirements and protections.

6. *Suppose an LST Options form was completed for a hospitalized patient, and then the patient is discharged to a nursing home. Is the nursing home required to offer a new LST Options form, or may it accept the LST Options form that was completed in the hospital?*

Assuming that there has been no material change in the patient's condition since the form was completed in the hospital, the nursing home may simply ask the patient or the patient's health care proxy whether the existing LST Options form is satisfactory. If so, the "offer" requirement of the law is satisfied, and the existing LST Options form may be used.

7. *May a nursing home offer the LST Options form to residents who were admitted prior to October 1, 2005?*

Yes, but this is not legally required.

8. *If a patient has a PPOC form, must this be replaced by an LST Options form?*

No. If, however a PPOC form is reviewed and then modified on or after April 1, 2008, the LST Options form should be used.

9. *Who is to initial the various parts of the form?*

The patient or the patient's health care proxy. Spaces for initials were chosen, instead of check boxes, to reduce the risk of after-the-fact substitutions.

10. *Who is to sign the LST Options form?*

The patient or the patient's health care proxy, the attending physician, and the person who discussed the form with the patient or the patient's health care proxy (if other than the attending physician).

11. *Under what circumstances, if any, may a health care provider initial or sign an LST Options form on behalf of a patient or proxy?*

Only if the patient or proxy is unable to do so personally and expressly directs the health care provider to initial or sign. The circumstances should be documented in the patient's chart.

12. *What happens if the LST Options form is signed by the patient or health care proxy and a health care professional, but not by the attending physician?*

If a health care professional other than the attending physician assisted in the completion of the LST Options form, the facility should have an established process for submitting the form promptly for the physician's review. The law says that, if the attending physician "has a reasonable basis to believe" that the LST Options form was completed voluntarily and reflects the decisions of the patient or health care proxy, the attending physician "shall sign" the form. If the physician does not sign, this omission could simply be an oversight, or it could reflect the physician's concern that some aspect of the process was unsatisfactory. The facility's procedure should include a follow-up inquiry if the physician does not sign the form promptly. In any event, until the

document is signed by the attending physician, it does not fully meet the criteria for an effective LST Options form.

13. Must the form be witnessed?

No. It is not an advance directive and does not have the same procedural formalities.

14. In Parts D through I, there is an item for "Other"; what does that mean?

This space permits modification or elaboration of a preprinted item, to better reflect the patient's or health care proxy's decision, or to evidence the patient's or health care proxy's right not to decide at this time. "Other" is omitted in Part C, because code status presents a binary choice only.

15. May a part be marked "No decision at this time"?

Yes, in the space in each item for "Other." If the patient or health care proxy is uncomfortable completing any part or desires the opportunity to consult with a trusted advisor, such as family members or religious advisors, he or she can enter "No decision at this time." A patient or health care proxy who is inclined to make no decision should be informed of what will happen in the interim should the clinical situation arise.

16. May a part be omitted or struck through?

Yes. In fact, since for many patients one or more parts will not be relevant to the patient's current medical condition, those parts *should* be struck through. In addition, if the patient's attending and a consulting physician have certified any of the interventions on the form to be "medically ineffective," that part should be struck through.

VII. The parts of the form

Part A. Main goal(s) of care.

All specific treatment preferences should reflect the main goal or goals of care. Part A invites the patient or the patient's health care proxy to identify goals. If a health care proxy is the decision maker, nevertheless the main goal(s) of care should be identified from *the patient's* perspective, based on the health care proxy's understanding of the patient's wishes, if known, or the patient's best interests. The proxy's personal beliefs and values should not override those of the patient, even if the proxy is an appointed health care agent.

Part A allows for the identification of more than one main goal of care. Often, two goals can be pursued at the same time – for example, prolonging life while controlling pain and other distressing symptoms. But if the use of a life-sustaining treatment would be inconsistent with maximum comfort, as sometimes happens, health care providers ought to know which goal is more important.

If more than one health care proxy is involved in the LST Options process (typically, surrogates having equal priority), discord among them may surface. Or, even if health care proxies agree, the attending physician may consider that the identified main goal of care is unrealistic or, if pursued, would result in undue burdens for the patient. A health care provider should follow its customary procedures for addressing such conflicts, including, as appropriate, referral to the facility's patient care advisory (ethics) committee.

Part B. Advance directive and health care proxy contact information.

As explained earlier (see Section III above), the LST Options form is not an advance directive. If a patient has already completed an advance directive, it should be appended to the form. If the advance directive names a health care agent (sometimes called a durable power of attorney for health care), contact information for the health care agent should be inserted. If there is no health care agent, contact information

for the surrogate should be inserted. Even if the patient still has capacity, the contact information for whoever is to serve as proxy after loss of capacity should be included.

Part C. Attempted CPR.

Does the patient or the patient's health care proxy accept attempted CPR in the event of cardiopulmonary arrest? The decision about how to respond to an arrest must be made for every patient, either by accepting or declining attempted CPR. Therefore, this part of the LST Options form may be completed by patients (or by health care proxies on their behalf) for whom other life-sustaining treatment issues are not yet pertinent.

Like the rest of the form, Part C is not itself a physician's order. If Part C reflects a preference that CPR not be attempted, a DNR order should be written, preferably an EMS/DNR Order that could be honored by emergency medical personnel.

Part D. Artificial ventilation.

Does the patient or the patient's health care proxy accept the use of a ventilator in the event of respiratory failure? In addition to the polar opposites of accepting ventilation indefinitely and refusing it outright, this part of the form also invites consideration of an intermediate option, under which ventilator use would be accepted for a limited time as a therapeutic trial. Space in this item permits specification of the time period, if that is feasible and desired by the patient or health care proxy.

Part D refers to a respirator, related intubation, and other technology that sustains lung function. If a patient or health care proxy wants to differentiate among technologies – for example, by accepting Bi-Pap or CPAP, as a comparatively non-invasive form of artificial ventilation – that preference can be stated on the "Other" line.

Part E. Hospital transfer.

Does the patient or the patient's health care proxy accept transfer to a hospital if the patient develops a condition that ordinarily is treated there? Sometimes patients who are at home or in a long-term care facility prefer not to be transferred but instead to be treated with whatever options are available where they are. If this preference is stated by the patient or health care proxy, a "Do Not Transfer" order should be written. A preprinted item also allows a choice of hospitalization if needed to evaluate an acute injury but not for complications related to the patient's underlying disease process.

Part F. Medical workup.

Does the patient or the patient's health care proxy accept diagnostic tests? Outside of the context of end-of-life care, a patient who develops significant symptoms of a potentially treatable condition usually undergoes a medical workup to diagnose the problem. Obviously, the exact nature of the tests varies, depending on the symptoms and the suspected diagnosis. Underlying any medical workup is the premise that treatment will be enhanced by knowing the cause or causes of the symptoms. This may remain true for a patient nearing the end of life. However, this part asks the patient or the patient's health care proxy to consider whether the discomfort or other burden associated with a medical workup makes sense in light of the main goal of care. Particularly if the suspected diagnosis would not be treated, or if the workup is unlikely to add materially to what is already known about the causes and consequences of the patient's current condition, the burden of a workup is probably not justified.

Part G. Antibiotics.

Does the patient or the patient's health care proxy accept antibiotics in case of infection? For some patients, this treatment is consistent with the main goal of care. For others, it is not. This part of the form also invites consideration of an intermediate option, under which a

comparatively burdensome method of antibiotic administration, intravenous infusion, is declined, but other methods are permitted.

Part H. Artificially administered fluids and nutrition.

Does the patient or the patient's health care proxy accept the use of artificially administered fluids and nutrition in the event of insufficient oral intake? In addition to the polar opposites of accepting these interventions indefinitely and refusing them outright, this part of the form also invites consideration of two intermediate options. In one, the use of artificially administered fluids and nutrition would be accepted for a limited time as a therapeutic trial. Space in this item permits specification of the time period, if that is feasible and desired by the patient or health care proxy. Another option is to accept the intravenous administration of fluids but not artificially administered nutrition (whether by feeding tube, intravenously, or any other route). Note that, under another provision of the Health Care Decisions Act, reasonable efforts to offer food and water by mouth must always be made.

Part I. Other treatments.

This part provides space to indicate whether the patient or the patient's health care proxy accepts the use of other life-sustaining treatment issues that might be particularly relevant to a patient (for example, blood transfusions for anemia or internal bleeding, or dialysis for kidney failure). When appropriate to the issue, preferences can be stated in terms of the use of a treatment indefinitely or repeatedly, temporarily to try to resolve an acute episode, or not at all.

VIII. Transferring and reviewing the LST Options form

1. *When a patient is transferred to a different facility, how should the LST Options form be sent?*

The intent of the law is that the LST Options form be available to the receiving facility when the patient arrives, so that the information on it can aid in decisions about treatment. Ordinarily, a complete and

unaltered copy of the form should be the top sheet of whatever documentation physically accompanies the patient. If this is impracticable, the form should be faxed or electronically transmitted to the receiving facility to precede or coincide with the patient's arrival.

2. *Does a completed LST Options form expire after a set period of time?*

No. However, since preferences are to be expressed based on the patient's condition at the time, a material change in that condition might make some elements of a completed form obsolete.

3. *What should trigger a review of an LST Options form?*

Any of the following: a material change in the patient's condition; the patient's loss of capacity; a transfer to a different health care facility, which often signifies a material change in condition; or discharge from a facility. Any of these should lead to a review of a previously completed LST Options form, although not necessarily to a change in it. If the review leads to new decisions about any part of the LST Options form, the old form should be rescinded and voided and a new one prepared.

4. *What counts as a material change in the patient's condition?*

The law does not define this. Consequently, it is left to the clinical judgment of the attending physician, in collaboration with the facility's staff.

5. *Suppose an LST Options form was completed for a hospitalized patient, the patient was discharged, but later is readmitted to the hospital. Is the first LST Options form still valid, or is a new one necessary?*

It depends on whether there has been a material change in the patient's condition since the first hospital stay.

6. *How should an LST Options form be marked to indicate that it has been rescinded?*

A health care facility representative should draw a line through, and write the word "VOID" conspicuously on both pages, sign and date this action, and obtain the signature of the patient or health care proxy.

IX. Additional information

The law about the form is §5-608.1 of the Health Care Decisions Act. You can read this section, or any other provision in the Health Care Decisions Act, via our website. Our home page is: www.oag.state.md.us. From there, select "Health Policy" from the menu on the left of the screen, then select "Health Care Decisions Act," then follow the link to the legislation. Or, if you are viewing this guide in electronic form, you can use this hyperlink: <http://www.oag.state.md.us/HealthPol/HCDAtext.pdf>.

The Attorney General's Office has also issued regulations about the LST Options form. You can find these from the Health Policy page by selecting "LST Options Form." from the left-side menu. Or, if you are viewing this guide in electronic form, you can use this hyperlink: <http://www.oag.state.md.us/Healthpol/lst%20options.pdf>.

Other materials about the LST Options form available on-line include an explanatory guide for patients and health care proxies and a PowerPoint slide presentation. These are on the Patient's Plan of Care page. Advice letters about the PPOC form, and any new letters about the LST Options form, will be posted on the Health Policy page that houses various opinions and letters, which you can visit by using this hyperlink: <http://www.oag.state.md.us/Healthpol/eolcare.htm>.

Various other resources about the Health Care Decisions Act are also available via the Health Policy page. In particular, the Ethical Framework document discussed in Section I, which details the decision making process that is the basis for completing the LST Options form, may be found by selecting "Ethical Framework" from the left-side menu on the Health Policy page. Or, if you are viewing this guide in electronic form, you can use this hyperlink: <http://www.oag.state.md.us/Healthpol/EOL%20Ethics%20Procedures%20RTF.pdf>

You may also contact the Health Policy Division via e-mail or telephone:
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