

Speaking Points – Advance Care Planning and the MOLST Program

April 16, 2009

Radio Interview

Advance Care Planning is a process of planning for future medical care in case you are unable to make your own decisions. Advance Care Planning is for everyone 18 and older.

Advance Care Planning assists you in preparing for a sudden unexpected illness, from which you expect to recover, as well as the dying process and ultimately death.

Any one of us can become acutely ill and none of us would want to see the suffering that has gone on in the Schiavo family. There needs to be a shift to earlier completion by encouraging everyone to start the process when individuals are healthy.

See [Community Conversations on Compassionate Care \(CCCC\)](#) video page for 5 Easy Steps.

1. Advance Care Planning is a “gift” to self and family. It allows you to maintain control over how you are treated and to ensure that you experience the type of care and the type of death that you desire. It provides peace of mind for individuals and their families by reducing uncertainty and avoiding conflict over health care provided at the end of life.
2. Advance Care Planning involves exploring and clarifying personal values and beliefs and having open and honest conversations about your values and beliefs regarding end-of-life care with family, health care providers and other trusted individuals.
3. It involves choosing the right spokesperson (known as the health care agent) to make decisions on your behalf if you are unable to speak for yourself.
4. Individuals must understand available life-sustaining treatments in order to make an informed decision.
5. It is critical that individuals document their wishes in traditional advance directives, specifically, a health care proxy and a living will.
6. The Health Care Proxy document is simple. It needs to be signed and dated with 2 witnesses. The witnesses cannot be your agent or primary physician.
7. Aside from signing on the dotted line, it's important to ask your agent tough questions, like will they respect your wants and needs even if they don't agree with them personally.
8. The living will is basically an expression of what we wish if we were in a terminal situation.
9. The Health Care Proxy and the Living Will are completed ahead of time and apply only when the ability to make health care decisions is lost.
10. There are two major practical issues to consider after completing the documents. The documents must be shared and be accessible in time of an emergency. Since life changes with time, it is important to review and update these forms periodically or after major life-altering events.
11. For further information, view www.CompassionAndSupport.org, the community web site dedicated to educating and empowering patients, families and professionals on advance care planning, MOLST, palliative care, pain management and hospice care and related topics.



Medical Orders for Life-Sustaining Treatment (MOLST)

Surveys have shown that people are not dying in the setting of their choice, most do not have advance directives in place, the majority of those being referred to hospice arrive too late to fully benefit, and most fear dying in pain and without dignity or control.

What is the MOLST Program?

The MOLST program is designed to improve the quality of care people receive at the end of life. The MOLST program is based on the belief that individuals have the right to make their own health care decisions, including decisions about life-sustaining treatments, to describe these wishes to health care providers, and to receive comfort care while wishes are being honored.

MOLST is based on effective communication of patient wishes, documentation of medical orders on a bright pink form and a promise by health care professionals to honor these wishes.

What is the MOLST form?

The MOLST form is a bright pink medical order form signed by a New York State licensed physician that communicates patient wishes regarding life-sustaining treatment to health care providers. These valid medical orders must be followed by all health care professionals in all sites of care, including the community.

The MOLST form includes medical orders and patient preferences regarding:

- CPR (cardiopulmonary resuscitation) vs. Do Not Resuscitate
- Intubation and mechanical ventilation
- Artificial hydration and nutrition
- Future hospitalization and transfer
- Antibiotics

Who should have a MOLST form?

Individuals who have advanced progressive chronic illness, are terminally ill or are interested in further defining their care wishes should discuss MOLST with their physician and other health care providers. **An individual should also discuss MOLST if he/she:**

- Wants *all* appropriate treatments including cardiopulmonary resuscitation (CPR)
- Wants to avoid *all* life-sustaining treatments
- Chooses to *limit* life-sustaining treatments
- Wants to avoid cardiopulmonary resuscitation (CPR) by requesting a "Do Not Resuscitate Order" (DNR order)
- Might die within the next year
- Resides in a long-term care facility
- Resides in the community and is eligible for long-term care

MOLST expands on the DNR order and provides additional orders for life-sustaining treatment and future hospitalization. The MOLST can be used in the community instead of the New York State Nonhospital Do Not Resuscitate (DNR) form.

What is the difference between a Health Care Proxy/Living Will and the MOLST?

A Health Care Proxy and a Living Will are traditional advance directives for all adults 18 years of age and older. These documents are completed ahead of time and only apply when decision-making capacity is lost. A properly completed MOLST form contains valid medical orders signed by a licensed New York State physician. It is **not** intended to replace traditional Advance Directives like the Health Care Proxy and Living Will. In contrast to a Health Care Proxy, the MOLST applies right now and is **not** conditional on the patient losing the capacity to make complex medical decisions.