

MOST: A NEW PORTABLE MEDICAL ORDER FOR NORTH CAROLINA*

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Background

In an ideal world, we would all die painlessly in our sleep at a ripe old age. Unfortunately, precious few of us will be fortunate enough to expire peacefully in that manner. The reality is that we generally do not know when or in what manner we will die. What we do have going for us, however, is some ability to say what we do and do not want with respect to medical interventions at the end of life through advance care planning.

Since the 1970s, after the world witnessed the spectacle of Karen Ann Quinlan, we have had statutes that give us the right to express our desire for a natural death through the use of living wills. In the 1990s, in the wake of the Nancy Cruzan case, the durable health care power of attorney (HCPOA) provided us with the ability to name surrogates to speak on our behalf with respect to medical treatment when we are no longer able to do so.

While these legal instruments have helped many people convey their wishes so that they get the level of care they desire at the end of life, a number of others who have taken the time to execute these documents have not been as fortunate. Advance directives often cannot be located when critical decisions need to be made. Even when these documents are available, whenever the patient is transferred from one care setting to another, they must be reviewed by a physician in the new facility who then must issue new medical orders. In cases where a patient with no advance directive is transferred, the receiving facility has even less information to go on and will have more difficulty determining the patient's wishes or the person who can speak on behalf of the patient. If the patient is at home and emergency medical services (EMS) are called, EMS may provide life saving interventions even though the patient has expressed contrary wishes through advance directives.

In the late 1980s and early 1990s, under the auspices of the North Carolina Medical Society Bioethics Committee (now renamed the NCMS Ethical and Judicial Affairs Committee), a portable Do Not Resuscitate (DNR) order was developed. An Attorney General Opinion was sought asking if medical providers who relied on a portable DNR order would have immunity from liability. A favorable opinion was issued,¹ and for many years, the portable DNR order has been used across North Carolina.

As concerns about lawsuits increased, health care providers became increasingly reluctant to rely on portable DNR orders. In 2001, at the urging of the NC Hospital

¹ N.C. Dept. of Justice, Advisory Opinion; Do Not Resuscitate ("DNR") Orders; Liability of Emergency medical Services ("EMS") Personnel Who Withhold Cardiopulmonary Resuscitation ("CPR") Pursuant to Model DNR Orders; N.C. Gen. Stat. §§ 32A-15 and -24; and N.C. 90-320 Through -322, December 22, 1997.

Association, the General Assembly enacted legislation providing immunity from liability to health care providers who relied on portable DNR orders.²

While portable DNR orders were a significant step forward, their scope is limited to preventing the administration of cardiopulmonary resuscitation when a patient is experiencing cardiac arrest. Therefore, many patients who do not wish to have their life prolonged by artificial means continue to receive these interventions. In an attempt to address this situation, Mission Hospitals in Asheville, NC, in 2004, following the lead of other states, embarked on a pilot program utilizing a more comprehensive portable DNR order from West Virginia called POST—Physician Order for Scope of Treatment.³ The West Virginia POST form is part of what has become known as the POLST paradigm.⁴ In 1991, Oregon was the first state to create a more comprehensive portable end of life physician order—Physician Orders for Life Sustaining Treatment or POLST.

In the Fall of 2004, physicians from Buncombe and Henderson Counties asked the North Carolina Medical Society to study better ways to ensure the implementation of seriously ill patients' wishes regarding their medical care, including a POLST paradigm-type form for North Carolina. In early 2005, the idea of a POLST paradigm form was examined by the NCMS Ethical and Judicial Affairs Committee, and an overwhelming consensus developed among committee members that such a form was desirable. A subcommittee⁵ was appointed to look at other POLST paradigm forms and to craft one for North Carolina.⁶

After over a year of meetings and numerous revisions, the subcommittee agreed on a draft form to share with other interested parties. A large multi-disciplinary task force convened in early 2006, and the form received another thorough vetting.⁷ Although a number of changes were made, including a name change from POST to MOST (Medical Orders for Scope of Treatment), the overwhelming sentiment was to continue to pursue the development of the form and legislation recognizing the form and providing immunity to health care providers who rely on it.

In the Fall of 2006, the NCMS Ethical and Judicial Affairs Committee and the NCMS Board of Directors presented the draft MOST form to the NCMS House of Delegates at the NCMS annual meeting requesting approval to seek legislation and develop educational programs for MOST. No dissenting opinions were expressed, and the

² N.C. Gen. Stat. § 90-21.17 (2005).

³ POST is recognized under the West Virginia Health Care Decisions Act, WV Gen Stat § 16-30.1 et seq.

⁴ See www.polst.org.

⁵ The POST Subcommittee of the NCMS Ethical and Judicial Affairs included representatives from two pilot programs—one from Buncombe County and another from Pitt County.

⁶ The three forms studied were: POST from West Virginia, POLST from Oregon, and MOLST from New York.

⁷ The NCMS POST Task Force included the following groups: NC Bar Association (the Elder Law, Health Law, and Estate Law Sections), NC Hospital Association, NC Health Care Facilities Association, Carolinas Center for Hospice and End of Life Care, North Carolina Nurses Association, Office of Emergency Medical Services and the Division of Aging under DHHS, NC Department of Justice, Old North State Medical Society, NC Medical Directors Association, NC Institute of Medicine, Family Policy Council, Life Tree, Catholic Physicians of Raleigh, and others.

measure passed unanimously, providing the MOST form a resounding stamp of approval from North Carolina's physician and physician assistant community.

Legislation was drafted and, around the start of the 2007 Legislative Session, incorporated into the advance directives legislation that had been drafted by the NC Bar Association with input on the medical aspects from members of NCMS Ethical and Judicial Affairs Committee. The overriding principle of this legislation is to promote patient self-determination at the end of life.⁸

Differences and similarities between MOST and advance directives

Advance directives such as living wills and health care powers of attorney are legal instruments executed by individuals and requiring witnesses and notarization. MOST does not require witnesses or notarization because MOST is a physician order (also called a medical order) issued by a physician, physician assistant, or nurse practitioner.⁹ Like all physician orders, MOST should be issued only with the informed consent of the patient or the appropriate patient representative. MOST, however, is the first physician order in North Carolina that requires the signature of the patient or the appropriate patient representative.¹⁰

Patients are not required to execute advance directives, nor are they required to have a MOST. Advance directives and MOSTs are entirely voluntary; and both approaches provide optional, nonexclusive procedures for communicating patients' wishes.

Advance directives *inform* physicians about the level of care desired by or for the patient; physician orders *instruct* other health care providers what level of care to provide. It is critical to understand this fundamental distinction. In order to carry out the patient's wishes regarding medical treatment at the end of life, whether expressed through an advance directive or in another manner, a physician's order is needed.

A MOST is a physician order that must be filled out by a health care professional in direct consultation with the patient or the patient's representative. Advance directives generally do not involve health care professional input or guidance.

⁸ Senate Bill 1046, Advance Directives/Health Care Pwr. Atty., 2007.

⁹ Under North Carolina law, physician assistants and nurse practitioners are authorized to issue physician orders, provided the authority to do so is covered in their supervisory or collaborative practice agreement with their supervising physician. N.C. Gen. Stat. §§ 90-18.1 and 18.2 (2005).

¹⁰ Early drafts of MOST in NC did not require a patient or patient representative signature primarily because physicians were concerned about the precedent it could set. However, this signature was required because (1) the POLST Paradigm Task Force strongly recommended mandatory patient or patient representative signatures, (2) the NC pilot programs indicated that obtaining the patient or patient representative signature had not been problematic, and (3) due to the comprehensive nature of MOST (compared, for instance to the portable DNR form, which only addresses withholding CPR), its portability, and the sensitivity of its subject matter.

Scope of MOST

MOST includes four sections that address different types of medical treatments. Section A addresses cardiopulmonary resuscitation (CPR) and includes two options: “Attempt Resuscitation (CPR)” and “Do Not Attempt Resuscitation (DNR/no CPR).” Only one option should be selected. CPR is only appropriate when the patient has no pulse *and* is not breathing.

Section B spells out different levels of medical interventions that would be appropriate in situations where a patient has a pulse and/or is breathing and indicates whether transfer to a hospital is desired. The available choices are to receive:

- *Full scope of treatment*, which includes: intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc, and comfort care. Patients selecting this option would be transferred to a hospital if indicated.
- *Limited additional interventions*, such as medical treatment, IV fluids, and cardiac monitoring as indicated. Under this option, patients would be transferred to a hospital if indicated. Intensive care should be avoided.
- *Comfort measures*, such as treatments and medication to relieve pain and suffering. Transfer to a hospital would only occur if comfort needs could not be met in the patient’s current location.

Section B also provides space for other or further instructions.

Section C is specific to antibiotics. A patient may elect one of three options: (1) to receive antibiotics if life can be prolonged; (2) to determine use or limitation of antibiotics when infection occurs; or (3) to receive no antibiotics, in which case other measures would be used to relieve symptoms. This section also provides space for other instructions.

Section D addresses medically administered fluids and nutrition. This section states that oral fluids and nutrition must be offered if physically feasible so it will only apply once a patient can no longer take oral hydration or nutrition. Patients may elect the following IV fluids options: (1) to receive IV fluids if indicated; (2) to receive IV fluids for a defined trial period; or (3) to forgo IV fluids (and have other measures provided to ensure comfort). The patient also may elect the following feeding tube options: (1) to receive feeding tubes if indicated; (2) to receive feeding tubes for a defined trial period; or (3) to forgo a feeding tube. As with Sections B and C, space is provided for other or further instructions.

If any of the four sections (A, B, C, or D) are not completed, full treatment will be the default for the treatments addressed by that section, as noted in the box at the top left hand corner on the front page of the MOST form.

Filling out MOST

Since MOST is a physician order, it must be filled out by a qualified health care professional who can explain the various options to the patient or the patient representative. It is not appropriate for patients or their representative to fill out a MOST. The only part of the form that the patient or patient representative should fill out is the patient/patient representative signature block.

Having a MOST prepared by a qualified health care professional in consultation with the patient or patient representative ensures that the patient or patient representative will understand the levels and types of medical treatment. Since a MOST is a medical order, if the health care professional who initially reviews and prepares a MOST with the patient or patient representative is not the physician, physician assistant or nurse practitioner issuing the order, the completed MOST form must be reviewed again with the patient or patient representative by the physician, physician assistant, or nurse practitioner who signs the MOST.

MOST is not designed to be prepared in emergency situations. Since MOST is intended to be part of advance care planning, the completion and issuance of MOST would be appropriate when the patient is in a stable condition.

MOST is intended for patients who have advanced chronic progressive illness, or, in other words, for patients who are seriously ill. It also is appropriate for patients whose life expectancy is less than one year. Unless it is the patient's preference, use of the MOST form is not appropriate for individuals with stable medical or functionally disabling problems who have many years of life expectancy.¹¹

In order for MOST to be effective it must bear the signature of the authorizing physician, physician assistant or nurse practitioner, as well as the patient or the patient representative. The only exception to the signature requirement is when a patient representative cannot be present and the form must be reviewed with and consented to by the patient representative over the telephone or by other electronic or similar means. In such cases, a copy of the completed form should be sent to the patient representative electronically, and upon receipt, the patient representative should sign the copy of the form, and send it back to the health care professional who filled out the form with the input and consent of the patient representative. The health care professional must then include the notation "on file" in the signature field on the original form. The copy of the MOST form with the patient representative signature must be maintained in the patient's medical record.¹²

Other fields that must be filled out include: the patient's last name, the patient's first name and middle initial, the effective date of the form (the date the form was fully completed—meaning all required signatures have been provided); and the patient's date

¹¹ <http://www.ohsu.edu/ethics/polst/professionals.shtml#1>.

¹² N.C. Gen. Stat. § 90-21.17 (b) (as amended by Section 14 of Session Law 2007-502, effective October 1, 2007).

of birth. These four fields appear in the top right hand corner on the front page of the MOST form.

If the patient is capable of making and communicating decisions, only the patient may authorize the MOST form. If the patient is an unemancipated minor, the parent or legal guardian may authorize the form. In all other situations, the MOST form must be completed by a patient representative, selected using the statutory priority list of persons authorized to make these decisions.¹³ The basis for the order must be documented in the medical record.¹⁴

Directly below Section E on the front page are fields for the name, signature, and phone number of the physician, physician assistant or nurse practitioner issuing the MOST. At the bottom of the front page is information for the patient or patient representative signing the form as well as fields for the name, signature, and relationship of the patient or the patient representative.

At the top of the back page are fields for contact information of the patient representative (if applicable), and for the health care professional who prepared the form, and the date the form was prepared. This field is followed by directions for completing, reviewing, and revoking MOST.

The last section of MOST contains fields for updated review of the MOST. For MOST to be in effect, it has to have been either issued or reviewed within the past year (see next section for a more detailed explanation).

If any changes are made to sections A, B, C, D, or E, that MOST should be voided and a new MOST should be issued. MOST can be voided by checking “form voided” under “outcome of review” on the back of the form, or by writing VOID in large letters across Sections A through E. A MOST that is destroyed or lost is not effective.

Using MOST

Only the original form should be used by health care providers treating the patient. Since MOST is a portable physician order, the original order must be sent with the patient when he or she is transferred from one setting to another. Copies of the form are only appropriate to document what orders were given; these copies should be retained in the patient’s medical record.

¹³ N.C. Gen. Stat. § 90-322 (b) (as amended by Section 12 of Session Law 2007-502, effective October 1, 2007).

¹⁴ N.C. Gen. Stat. § 90-21.17 (b) (as amended by Section 14 of Session Law 2007-502, effective October 1, 2007).

To be valid, MOST must bear the signature of the patient or patient representative, subject to the exception discussed above, and the signature of the physician, physician assistant, or nurse practitioner issuing the order.¹⁵

At a minimum, MOST must be reviewed at least annually or earlier if: (1) the patient is admitted and/or discharged from a health care facility; (2) there is a substantial non-emergency change in the patient's health status; or (3) the patient's treatment preferences change. In emergency situations, which generally involve a change of health status, the orders should be followed and any necessary review should occur afterwards.

The longest period a MOST form should be in effect without review is one year from its date of issuance, which should be noted in the top right hand corner of the front page, or one year from its last review, which should be noted in the review section on the back of the form. For example, a form issued on October 1, 2007 (as indicated in the top right hand corner on the front page) may still be valid on October 2, 2008, if it had been reviewed with no change (as indicated in the review section on the back of the form) prior to October 1, 2008. If a MOST issued on October 1, 2007, was updated on July 3, 2008, then the form could be in effect through July 3, 2009. As long as the form has been reviewed within a year of the last effective review date, and this review is appropriately documented on the form and there is no change to Sections A-E (as indicated in the "Outcome of Review" field), the MOST will remain valid. Once all the fields for review are exhausted, a new MOST should be issued within a year of the last noted review date or upon one of the three review triggering occurrences, whichever occurs first.

Note that the person consenting to a MOST may change when it is reviewed. The appropriate authorizing person, whether it is the patient or a patient representative, will be determined at the time of the review.

Other information

Because MOST is a physician order, it is not available for general distribution. Like the portable DNR order, MOST will be adopted and distributed by DHHS¹⁶ through the Office of Emergency Medical Services. Providers will have to pay a nominal fee when ordering MOST forms to offset the cost to the state of printing the form.

MOST will be printed on bright pink ("pulsar pink" paper) to increase visibility of the form. The original MOST should either be at the front of the patient chart, or near the patient's bed. If the patient is at home, the original MOST should be posted at the patient's bedside, on the door to the patient's bedroom, or on the refrigerator in the home where the patient resides.

¹⁵ N.C. Gen. Stat. §§ 90-21.17 (b) and (c) (as amended by Section 14 of Session Law 2007-502, effective October 1, 2007).

¹⁶ N.C. Gen. Stat. s 90-21.17 (b) (as amended by Section 14 of Session Law 2007-502, effective October 1, 2007).

A MOST is designed to implement a patient's wishes, including those set forth in an advance directive. If a MOST is issued to implement an advance directive, that instrument should be attached to MOST if available.¹⁷ If a MOST is completed and conflicts with an advance directive, it may suspend these conflicting directions while the MOST is in effect. However, a MOST, which is a temporary form that changes with reviews, does not have the effect of revoking an advance directive. If a patient signs a MOST, but the patient's condition changes so that his or her health care agent is authorized to act, then that change of circumstances will prompt a review of the MOST and the health care agent ordinarily will be able to change the MOST upon review. Finally, federal and state law permit disclosure of MOST to other health care providers as necessary.¹⁸

Conclusion

The introduction of the MOST form to advance care planning in North Carolina increases the likelihood that patient's wishes regarding treatment at the end of life will be honored. To maximize its utility, the public needs to be educated about this new procedure so that more patients choose the level of care they desire at the end of life. This goal justifies the significant effort that has been and will continue to be put forth in promoting MOST.

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¹⁷ N.C. Gen. Stat. s 90-21.17 (c) (as amended by Section 14 of Session Law 2007-502, effective October 1, 2007).

¹⁸ 45 C.F.R. §§ 164.502, 164.506 (2002); N.C. Gen. Stat. § 90-21.20B (e) (2007).