

Paul Drager, J.D.

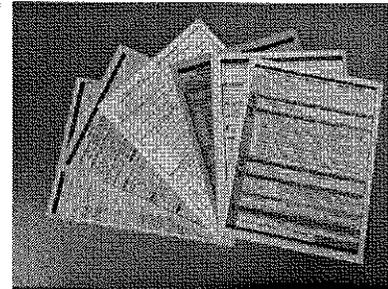
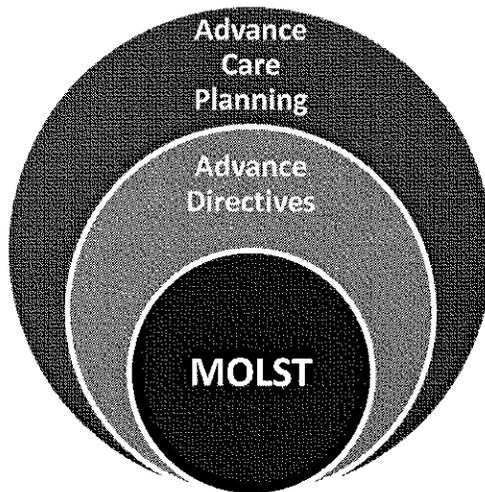
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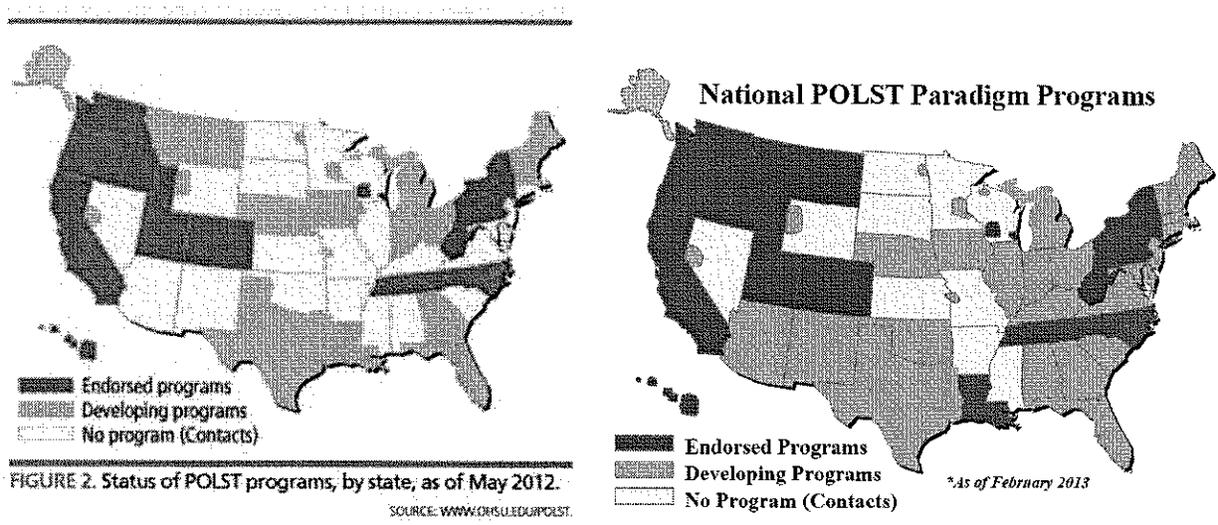
*When one prevents one's emotions from overtaking one's rationality, it is called reason.
When one prevents one's rationality from overtaking one's emotions, it is called compassion.
When one can do both, it is called wisdom. --- Ancient Chinese Proverb*



Good morning Senator Gerrata, Representative Johnson, and members of the Public Health Committee. My name is Paul Drager, and I am the Connecticut contact for the National POLST Paradigm Program and one of the organizers of the Connecticut MOLST Coalition. I am here to testify in **support of *Raised Bill No. 6521, An Act Concerning Medical Orders for Life-Sustaining Treatment.***

My purpose here today is to offer some background on MOLST, which is modeled on the National POLST Paradigm Program (www.polst.org). **Physician Orders** for Life-Sustaining Treatment has its roots dating back to 1990. Over time, many states have adopted and implemented the POLST paradigm. In our immediate area, Maine, New Hampshire, and New Jersey refer to their program as POLST; New

York, Massachusetts, and Rhode Island use MOLST (*Medical Orders* for Life-Sustaining Treatment); and Vermont uses COLST (*Clinician Orders* for Life-Sustaining Treatment). Regardless of the name, the purpose and intent of the POLST paradigm is the same. Each of these states has, through their legislative and regulatory bodies, embraced the POLST paradigm. Connecticut alone in the mid-Atlantic region lacks such authority. Our group has been working for the past year to make MOLST a reality in Connecticut. This work is the basis for Raised Bill No. 6521.



MOLST is designed to improve the quality of care people receive at the end-of-life. It is a process that translates a patient's goals of care at the end-of-life into **actionable medical orders** that follow the patient across care settings.

MOLST is patient centered rather than physician centered. It encourages that difficult **“conversation”** about end-of-life care takes place between the health care professional and the patient. MOLST seeks to achieve patient preferences and goals in end-of-life care by normalizing this conversation. The MOLST discussion provides context by discussing and identifying core patient values and beliefs; determining goals of care; and, documenting the conversation.

MOLST is designed to help health care professionals honor patient treatment wishes so as to promote a patient's autonomy by creating actionable medical orders that reflect the patient's current treatment preferences and to facilitate appropriate treatment by emergency medicine and EMS.

The MOLST form transforms a patient's treatment plan into an actionable medical order.

Advance care planning is appropriate for all adults 18 years of age and older, not only the subset of those with life-limiting illness. People who are healthy and independent can face sudden, unexpected life-limiting illness or injury. Traditional advance care planning, including living wills and appointment of a health care representative, can be a starting a point for end-of-life discussions.

TABLE 1
Differences between POLST and advance directives

CHARACTERISTICS	POLST	ADVANCE DIRECTIVES
Population	For the seriously ill	All adults
Time frame	Current care	Future care
Who completes the form	Health care professionals	Patients
Resulting form	Medical orders (POLST)	Advance directive
Health care agent or surrogate role	Can engage in discussion if patient lacks capacity	Cannot complete
Portability	Provider responsibility	Patient/family responsibility
Periodic review	Provider responsibility	Patient/family responsibility

POLST = Physician Orders for Life-Sustaining Treatment

MOLST **complements** advance directives. Traditional advance directives look to the **future**, but they **are not actionable medical orders**. They are appropriate for anyone of legal age regardless of their medical condition. **MOLST**, on the other hand, **is aimed primarily for persons, regardless of age, at the end-of-life (seriously ill patients with life-limiting advanced illness; patients with advanced frailty; patients who may lose the capacity to make their own health care decisions in the**

next year; persons with strong preferences about current end-of-life care). MOLST is intended to encourage and *facilitate discussions* between physician and patient at this point in a patient's healthcare continuum. The **“conversation”** between patient and the health care professional is important.

MOLST provides a segue from traditional advance care planning as a **“legal transactional approach”** to a **“communications approach”** that helps translate a patients' goals of care into visible and portable medical orders which, in turn, translates patients' wishes into the care that they receive which is consistent with their personal values, spiritual beliefs, cultural background, and preserves their dignity.

MOLST will allow the patients' voice to be heard in end-of-life care. As was stated by Dr. Miles Edwards, “It is one thing to be able to undertake a medical action, and another thing to know whether you should.”

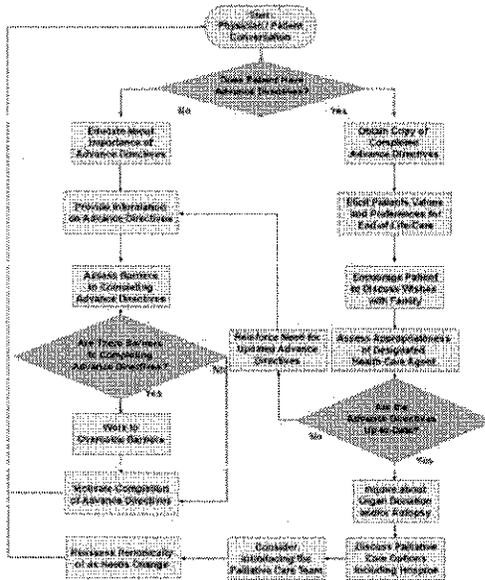
Thank you for your attention. We look forward to your support for Raised Bill No. 6521.

Advance Care Planning: Life Expectancy of More than One Year

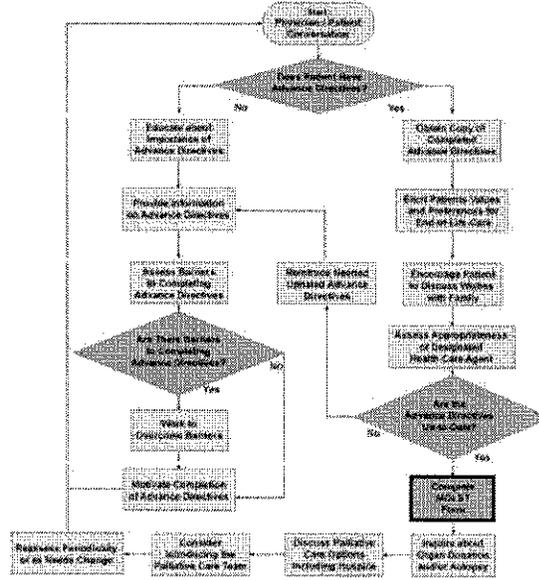
Advance Care Planning: Life Expectancy of Less than One Year

Learn more by clicking on the steps in the algorithm below:

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Bomba, JGCCN 4(8), 2006



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TABLE 3

POLST eight-step protocol

Prepare for discussion

- Review what is known about patient and family goals and values
- Understand the facts about the patient's medical condition and prognosis
- Review what is known about the patient's capacity to consent
- Retrieve and review completed advance directives and prior do-not-resuscitate documents
- Determine who key family members are, and (if the patient does not have the capacity), see if there is an identified health care agent, guardian or health care representative
- Find uninterrupted time for the discussion

Begin with what the patient and family know

- Determine what the patient and family know about the patient's condition and prognosis
- Determine what is known about the patient's views and values in light of the medical condition

Provide any new information about the patient's medical condition and values from the medical team's perspective

- Provide information in small amounts, giving time for response
- Seek a common understanding; understand areas of agreement and disagreement
- Make recommendations based on clinical experience in light of the patient's condition

Try to reconcile differences in terms of prognosis, goals, hopes, and expectations

- Negotiate and try to reconcile differences; seek common ground; be creative
- Use conflict resolution when necessary

Respond empathetically

- Acknowledge
- Legitimize
- Explore (rather than prematurely reassure)
- Empathize
- Reinforce commitment and nonabandonment

Use POLST to guide choices and finalize patient and family wishes

- Review the key elements with the patient and family
- Apply shared medical decision-making
- Manage conflict resolution

Complete and sign POLST

- Get verbal or written consent from the patient or health care agent, guardian, health care representative
- Get written order from the treating physician and witnesses
- Document conversation

Review and revise periodically

*POLST (Physician Orders for Life-Sustaining Treatment) is a medical order form designed to provide a single, community-wide document that would be easily recognizable and would enable the patient's wishes for life-sustaining treatment to be honored. This eight-step protocol was originally developed by Dr. Patricia Bomba for the MDST Program of New York State. Program information is found at www1.compassionandSupport.org.