

Public Health Committee, public hearing, March 15, 2013  
**Raised Bill No. 6521, An Act Concerning Medical Orders for Life-Sustaining Treatment**

Testimony from

Carin M. Van Gelder, MD FACEP FAAEM  
38 Jonathan Lane  
Storrs-Mansfield CT 06268  
cell 206.627.7414  
vangelder.ems@gmail.com

Madame Chair Johnson, Madame Chair Gerratana, and members of the Committee,

My name is Carin Van Gelder.

I am board certified in Emergency Medicine and one of a handful of physicians in Connecticut who has completed fellowship training in EMS (out-of-hospital medicine, or emergency medical services).

I am providing testimony in SUPPORT of bill #6521, An Act Concerning Medical Orders for Life-Sustaining Treatment.

I am speaking on behalf of five entities; each of which specifically supports this bill:

Connecticut College of Emergency Physicians,  
Connecticut State Medical Society,  
Connecticut EMS Advisory Board,  
Connecticut EMS Medical Advisory Committee, and  
the MOLST Coalition, a *group of advocates dedicated to improving quality end-of-life issues.*

Via establishment of a pilot program, this act supports patients' rights to privacy and autonomy. Even within the acute-care setting of a hospital, communicating these wishes is especially difficult for those in their last year or two of life. These patients do not live in the hospital, however.

Improved access to this information, in the form of actionable orders, is crucial.

Having worked as an EMS Medical Director in the South Central, North Eastern, and North Central regions of the state, I have worked with hundreds of paramedics and many more EMTs and first responders. Their job is to do the right thing for the patient, following specific protocols written at the local (Sponsor Hospital), or Regional level. Whether their organizations are career or volunteer fire departments, commercial or municipal ambulance services, police

departments, or rescue squads... EMS providers follow increasingly *evidence-based medical protocols*. I am proud to have been part of that process.

Many times however, first responders at all levels are unable to provide care following a patient's wishes, because current DNR regulations fail to recognize these options. Medical care in the field, and in the Emergency Department, needs to have actionable orders based on current understanding of the patient's medical condition.

When advance directives have been accomplished, they are often out of date or do not reflect the patient's current wishes. Further, communication among family or within an institution often fails. In my experience as an emergency medicine physician, frustration among health care providers and family is common. Just yesterday, a director at a disabilities facility wanted to know how to document a resident's preference to be resuscitated if he began choking (assuming the Department of Developmental Services' Commissioner agreed) ... since the patient was DNR.

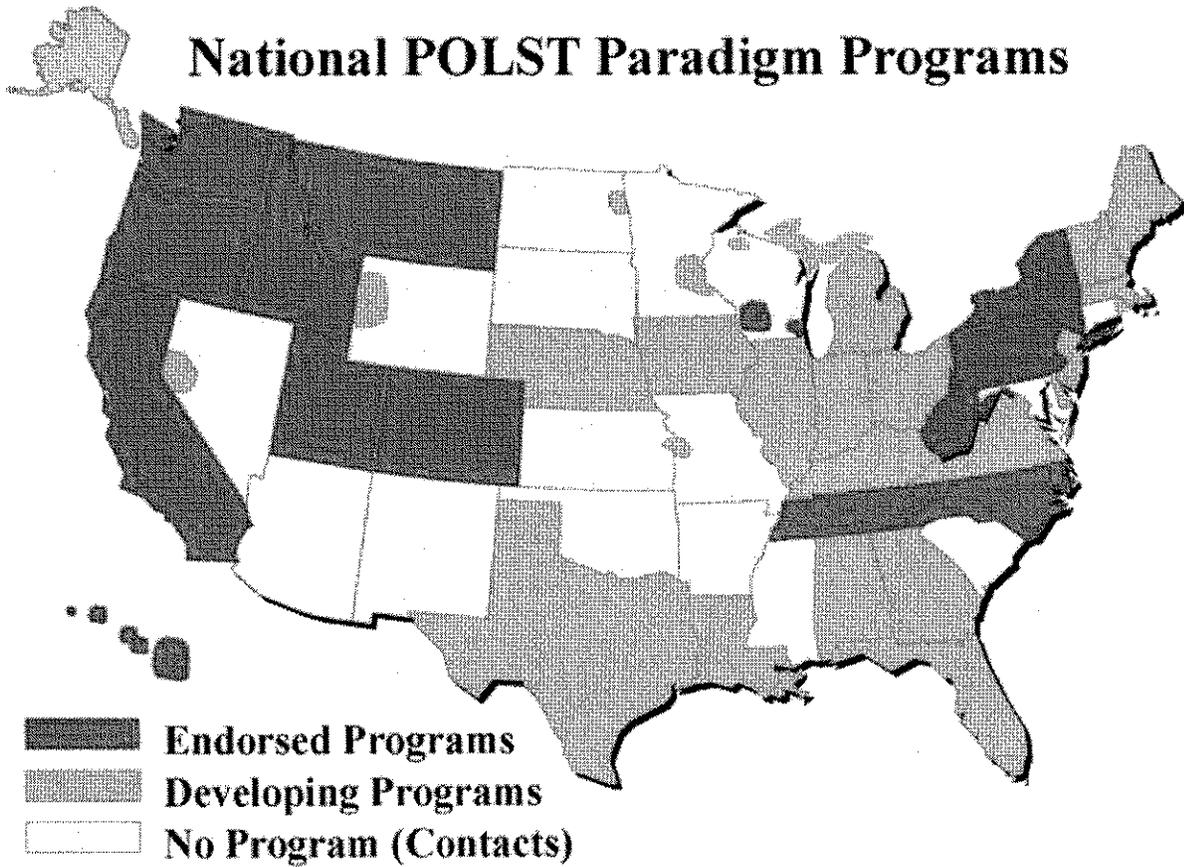
While historic and a monumental beginning, Connecticut's "DNR Orders" will lead to better recognition of patient-centered care.

Last year, when I testified in favor of HB 5435, *16 states* did not even have developing programs. Today, *three states* are not developing programs based on this national model by which patients can provide specific instructions for their end-of-life care.

I'm proud to say that Connecticut has come a long way in recognizing this need.

March, 2012

## National POLST Paradigm Programs



I have submitted this written testimony as well as an article I wrote for CCEP's newsletter, Feb 2013.

I thank you for focusing attention to those who often cannot speak for themselves.

Carin Van Gelder

## **A MOLST program in Connecticut HB 6521 - Van Gelder**

Focus on a patient-centered process that gives the person the most control possible over his or her individual care. This is what Congress intended when it passed the original Patient Self-Determination Act in 1990.

Acute hospital care focuses on curative care; this has been shown to occur *regardless of likelihood of benefit or patient preferences*.

Each patient's goals of care evolve through discussions with treating physicians. Patient autonomy is crucial.

Treatment options must include quality of life and comfort, as well as cure; options must be individualized to the patient and current medical condition.

Patients' preferences may include palliative and hospice care, after an understanding of prognoses and all options occurs.

MOLST forms are more thorough than a simple DNR order. The form allows for decision making *by the patient* regarding (for example) resuscitation, hospital transfer, comfort measures, antibiotic use, hydration and nutrition. Ideally, if the form is not immediately available, a phone call to an electronic state registry will confirm a patient's wishes.

## Moving on, from DNR to MOLST

Carin M. Van Gelder, MD

*Case: A 40 year old male with unknown medical history arrives at your ED.*

*EMS states "He's lethargic and hypotensive. I gave him 400 cc NS. Family is enroute, and they say he shouldn't be resuscitated. He's on hospice."*

*The patient received iv fluids, oxygen, and a 12-lead is unremarkable. He appears to be in some discomfort, is jaundiced, and clinically has dry mucous membranes. His vital signs have improved to: HR 110, BP 90/60, 90% O2sat on a non-rebreather. RR 28. Struggling. There is no DNR bracelet. Medical history is unknown.*

*It's Saturday afternoon in a moderately busy ED. You are working as the sole physician with two physician assistants. A few thoughts immediately cross your mind:*

What would he want? Which hospice program to call? What's his "dispo"?  
and - I wish I had more information.

**What would this patient want?** Family, PMD, specialist, and/or electronic medical records could help. Few are fast enough. A DNR bracelet, if present, would only mean do not perform CPR (compressions and breathing or ventilation – by any means – in CT). There is no term "Do Not Intubate" (DNI) recognized in Connecticut. DNR orders are intended to transfer the order outside the hospital, and are written for EMS and receiving institutions to follow (until the receiving institution's own admitting orders are written).

19a-580d1(5): "DNR order" means an order written by a Connecticut licensed physician to withhold cardiopulmonary resuscitation, including chest compressions, defibrillation, or breathing or ventilation by any assistive or mechanical means including, but not limited to, mouth-to-mouth, mouth-to-mask, bag-valve mask, endotracheal tube, or ventilator for a particular patient."
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Advance directives, outlined in Connecticut statute (Chap 368w, Removal of Life Support Systems), communicate specifically what procedures/resuscitation if any, the patient would want. Health care representatives are designated to speak for the patient in the event he/she cannot make informed decisions.

Physicians are responsible to determine patients' wishes by using advance directives, living will, and/or any communications from the patient, his/her health care representative, or anyone to whom the patient communicated such wishes.

Therefore, per state law:

- DNR orders only apply when the patient has no vital signs. However, hospital staff and institutions across Connecticut have tended to adopt DNR bracelets as the only communication regarding patients' wishes. This is not the intent of state law, and is not currently practical.
- Physicians need to determine the patient's wishes, and then follow them. Health care representatives speaking on behalf of the patient, must do so in accordance with that patient's wishes.

**Disposition.** Not to sound crude, but this patient is not about to go home or die. He needs to be admitted, and it's not a simple decision: ICU, floor, transfer for specialist care? Where is the family? How would that change things?

**More information.** An improved process is coming.

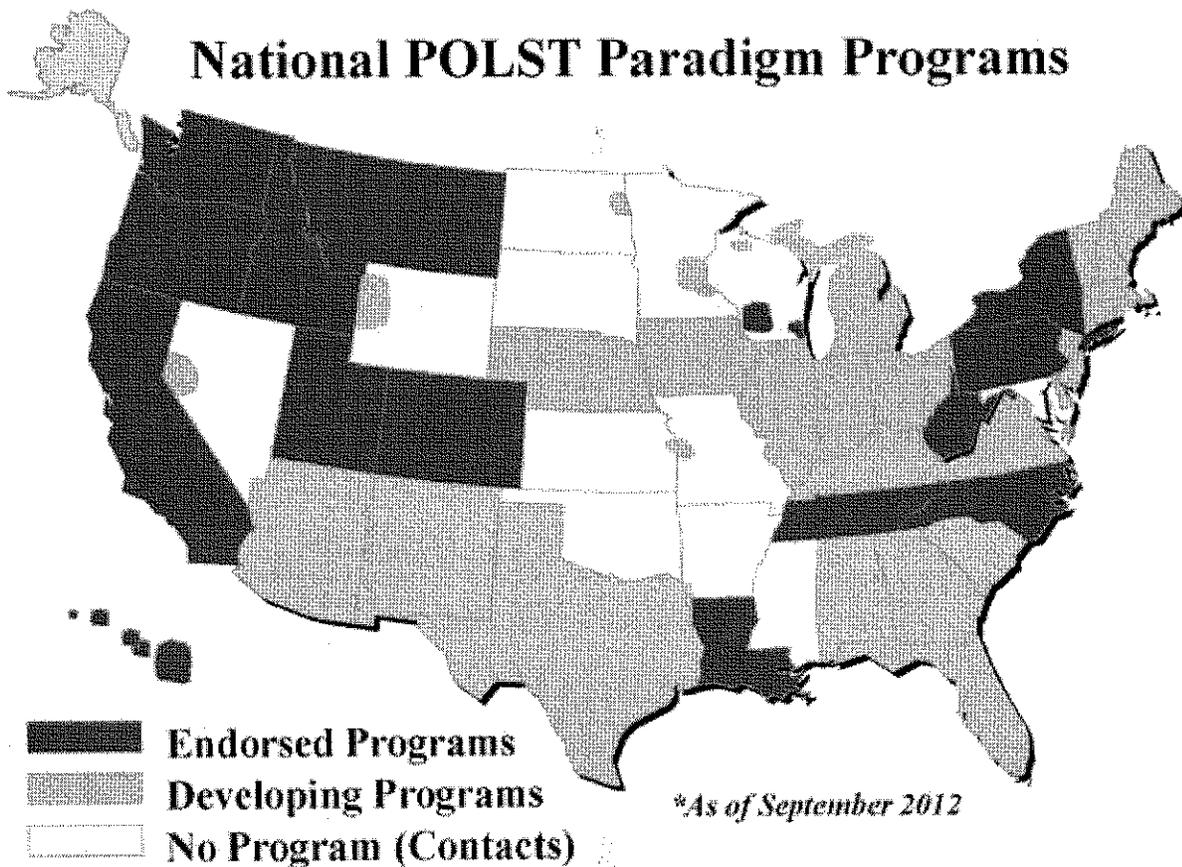
Connecticut has begun the process of transitioning to MOLST, Medical Orders for Life-Sustaining Treatment, which follows the POLST Paradigm. While specifics are developing in Connecticut, understanding the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program is important. The POLST Paradigm provides comprehensive, portable end-of-life physician orders that convey a patient's wishes regarding life-sustaining treatment and resuscitation.

\* Generally, patients with progressive illnesses and a prognosis of less than one year of life expectancy fill out the form with their physician and/or in some states, nurse practitioner/physician assistant.

\* Orders on POLST Paradigm forms are enabled by state statutes or regulations.

\* These orders are to be followed by health care providers across all health care settings, and are not hospital specific.

## National POLST Paradigm Programs



Starting with Oregon in 1991, more than 40 states have adopted these orders in various forms using various acronyms: POLST in Oregon and California, POST (Physician Orders for Scope of Treatment) in West Virginia, MOST (Medical Orders for Scope of Treatment) in North Carolina, and MOLST (Medical Orders for Life-Sustaining Treatment) in New York, Massachusetts, and others.

MOLST forms are more thorough than a simple DNR order. The form allows for decision making *by the patient* regarding (for example; this varies by state) resuscitation, hospital transfer, comfort measures, antibiotic use, hydration and nutrition. Ideally, if the form is not immediately available, a phone call to the state registry will confirm a patient's wishes.

As described on the Oregon Health and Science University's POLST Paradigm Program website ([www.polst.org](http://www.polst.org)), a POLST form permits effective communication of patient wishes and documentation of medical orders, and carries an expectation that health care professionals will carefully follow these wishes. Many states recognize POLST Paradigm forms from other states (reciprocity).

While historic and a monumental beginning, Connecticut's DNR program will lead to better recognition of patient-centered care. For questions, [vangelder.ems@gmail.com](mailto:vangelder.ems@gmail.com).

Physician Orders for Life-Sustaining Treatment (POLST)

Form for use by healthcare providers to document patient's wishes regarding life-sustaining treatment.

Section A: General Information (Name, Address, City, State, Zip, Date of Birth, Gender, etc.)

Section B: Medical History (Current Diagnosis, Past Medical History, Allergies, etc.)

Section C: Advance Directives (DNR, POLST, etc.)

Section D: Patient's Signature and Date

Section E: Healthcare Provider's Signature and Date

Physician Orders for Life-Sustaining Treatment (POLST)

Form for use by healthcare providers to document patient's wishes regarding life-sustaining treatment.

Section A: Patient's Signature and Date

Section B: Healthcare Provider's Signature and Date

Section C: Patient's Wishes (DNR, POLST, etc.)

Section D: Healthcare Provider's Orders (Resuscitation, etc.)

Case resolution:

**Advance Directives:** IF present and available, advance directives need to be interpreted. Looking through a legal document requires clinicians to apply that interpretation to the current situation... which is very difficult when a patient is in extremis.

**DNR bracelet present:** Follow ANY known wishes<sup>1</sup> until there is no pulse/breathing, and then do not perform cardiopulmonary resuscitation.<sup>2</sup> [Note – EMS personnel must to follow their sponsor hospital protocols, and must call for direct medical oversight if patients' wishes differ]. Difficult to do because often, wishes are not known.

**No DNR bracelet present:** Per statute, if no health care instructions exist, one cannot assume a patient would (or would not) want resuscitation<sup>3</sup> (physicians). Per regulations, EMS personnel must resuscitate... or follow sponsor hospital protocols and call for direct medical oversight if patients' wishes differ.<sup>4</sup>

**POLST form:** Patient has detailed what he/she would want in the event they are not able to speak for themselves. This includes care and procedures prior to actual death (unlike Connecticut's current DNR bracelet program).

## References:

- 1 Chap 368W, Sec. 19a-571(a) 3 Liability re removal of life support system of incapacitated patient. Consideration of wishes of patient. “..... In the determination of the wishes of the patient, the attending physician shall consider the wishes as expressed by a document executed in accordance with sections 19a-575 and 19a-575a, if any such document is presented to, or in the possession of, the attending physician at the time the decision to withhold or terminate a life support system is made. If the wishes of the patient have not been expressed in a living will the attending physician shall determine the wishes of the patient by consulting any statement made by the patient directly to the attending physician and, if available, the patient's health care representative, the patient's next of kin, the patient's legal guardian or conservator, if any, any person designated by the patient in accordance with section 1-56r and any other person to whom the patient has communicated his wishes, if the attending physician has knowledge of such person. All persons acting on behalf of the patient shall act in good faith.”
- 2 DNR Orders, 19a-580d-1. Definitions (5) “...withhold cardiopulmonary resuscitation, including chest compressions, defibrillation, or breathing or ventilation by any assistive or mechanical means including, but not limited to, mouth-to-mouth, mouth-to-mask, bag-valve mask, endotracheal tube, or ventilator for a particular patient.”
- 3 Chap 368W Sec. 19a-572. Failure to execute document creates no presumption re wishes of patient. Sections 19a-571 and 19a-573 to 19a-575a, inclusive, create no presumption concerning the wishes of a patient who has not executed a document as described in sections 19a-575 and 19a-575a.
- 4 Office of Emergency Medical Services, Emergency medical services regulations. 19a-179-12 Mobile intensive care services (MICS): MICS authorization for patient treatment and establishment of mobile intensive care services.

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