Advance directives in the emergency department

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Abstract
Advance directives are documents to convey patients’ preferences in the event they are unable to communicate them. Patients commonly present to the emergency department near the end of life. Advance directives are an important component of patient-centered care and allow the health care team to treat patients in accordance with their wishes. Common types of advance directives include living wills, health care power of attorney, Do Not Resuscitate orders, and Physician (or Medical) Orders for Life-Sustaining Treatment (POLST or MOLST). Pitfalls to use of advance directives include confusion regarding the documents themselves, their availability, their accuracy, and agreement between documentation and stated bedside wishes on the part of the patient and family members. Limitations of the documents, as well as approaches to addressing discrepant goals of care, are discussed.

KEYWORDS
advance directives, emergency medicine, DNR, POLST, living will

1 | INTRODUCTION

Advance directives can be confusing for patients and physicians, alike. Patients may lack a clear understanding of the implications of the documents they sign. Although advance directives are intended to clarify a patient’s end-of-life wishes, physicians frequently find themselves struggling to reconcile bedside requests for care with those outlined in the documents with which they are presented. This paper describes advance directives frequently encountered in the emergency department setting. Limitations of the documents, as well as approaches to addressing discrepant goals of care, are discussed.

2 | TYPES OF ADVANCE DIRECTIVES

The most common advance directives encountered in the ED are living wills, health care proxies, and Do Not Resuscitate orders. As of September 2019, 48 US states are actively participating in Physician (or Medical) Orders for Life-Sustaining Treatment (POLST or MOLST) or Medical Orders for Sustaining Treatment (MOST).1,2 Venkat and Becker provide a detailed assessment and review of state laws pertaining to the authority of substitute decision makers in all 50 US states and the District of Columbia.3,4 Understanding the terms and limitations of these documents can assist physicians in their bedside discussions with patients and families.

2.1 | Living Wills

The living will allows patients to document treatment options they wish to pursue if terminally ill or injured. Specifications regarding life support measures, cardiopulmonary resuscitation (CPR), defibrillation, ventilation, dialysis, and artificial hydration and nutrition are common components of the living will. Do Not Resuscitate (DNR) direction also...
may be included, but generally requires separate DNR documentation.
Living wills provide the opportunity for the patient to define what she
believes constitutes quality of life with regard to standards of personal
health and comfort during a medical emergency or personal illness.

Living wills provide good guidance for the treatment of those in a
persistent vegetative state, for those with debilitating disease, or for
those who clearly wish to have comfort care only. They are more neb-
ulous, however, with regard to acute care situations, especially those
countered in the ED. Although it may be clear that a patient does
not wish for long-term dependence on a ventilator, that same patient
might benefit from short-term ventilation with diuresis to treat an
acute exacerbation of congestive heart failure, for example. Living wills
do not direct physicians adequately in situations where the physician
can foresee benefit to a short-term medical intervention that a patient
would otherwise reject for the long-term. Further, physicians may not
be able to predict how quickly a patient might recover from an acute
medical insult. Patients with end-stage chronic obstructive pulmonary
disease may recover quickly or may be unable to be weaned from the
ventilator.

2.2 | Health care proxies

Establishing exactly who should be making decisions on behalf of the
patient is important. At times, the family member who presents with
the patient may not be the legal medical proxy. Patients may designate
health care proxies using a Durable Power of Attorney for Health Care
Form, granting power to make health care decisions on behalf of the
patient, when the patient is rendered incapacitated by illness or injury.
When facing real-time, critical decisions in the ED, physicians may need
to rely on those who do not legally represent the patient as proxy, but
who are familiar with the patient’s wishes. Health care proxies only
function at times when patients lack capacity, so determining when a
patient lacks capacity for health care decision making is key.

2.3 | Do not resuscitate

Do Not Resuscitate (DNR) orders vary by state, which only adds to the
confusion of how to honor advance directives. Physicians who prac-
tice close to state borders may be unable to honor the DNR orders of
patients from out of state. Further, many states do not recognize living
wills or health care proxies in the out-of-hospital setting. Emergency
medical system (EMS) personnel may be required to initiate resusci-
tative measures. But eschewing long-term maintenance on a ventilator or other life-support
is quite different from directions to initiate or withhold pressors, intu-
bation, pressure support ventilation, or other potentially short-term
interventions. DNR forms may specify those measures that will or will
not be performed, under the DNR order. This may include not adminis-
tering chest compressions, resuscitative drugs, defibrillation, artificial
airways, and cardiac monitoring. Under “comfort care” protocols, su-
tioning of the airway, oxygen administration, bleeding, control, splint-
ing, and emotional support may be provided. Knowledge of state law
is critical to the appropriate enactment of a DNR order. An example of
Ohio DNR law is shown in Figure 1.5

Despite such details, the extent to which patients wish to be resusci-
tated (if not a “full code”) can be difficult to ascertain. Frequently, mis-
derstandings about DNR documents lead patients to fear that “do
not resuscitate” means “do not treat.” They worry that signing a DNR
order condemns them to suffering from painful conditions at the end
of life. Conversely, physicians can be confused by orders such as “com-
fort care-rescue” or “slow code” protocols that ostensibly entail full
resuscitative measures until the patient succumbs to cardiopulmonary
arrest. Knowing how aggressively to treat the critically ill patient can
be daunting. Finally, laymen lack an understanding of the realities of
resuscitation. The majority of patients in full cardiopulmonary arrest
cannot be resuscitated or returned to their previous functional sta-
tus. Television depictions of CPR and other resuscitative measures
paint a very different picture. For example, Grey’s Anatomy and House
show CPR to be life-saving 70% of the time, while in reality CPR suc-
ceds only 37% of the time. Furthermore, only 13% of patients sur-
vive to leave the hospital after CPR.6 Enlightening patients who are
signing DNR orders would be helpful, but may not be done by pri-
mary care physicians. Often, explaining the prognosis of resusci-
tative efforts to family members at the bedside falls to the emergency
physician.

2.4 | POLST/MOLST

One document with the potential to alleviate confusion about resusci-
tative measures is the Physician (or Medical) Orders for Life-Sustaining
Treatment form. POLST are portable medical orders designed to assist
health care providers to implement patient medical wishes, by translat-
ing them into medical orders to be followed in both in patient and out-
patient settings.7 As of September, 2019, three programs are “mature,”
a designation by the National POLST Paradigm reserved solely for pro-
grams where use of POLST is statewide and part of the standard of care
for appropriate persons. Nineteen states and the District of Columbia
are “endorsed,” that is, actively participating in National POLST gov-
ernance and meeting the National POLST standards. There are 24
“active” programs, which are at various stages of development, work-
ing towards implementing POLST statewide. Seven states’ programs
are “unaffiliated,” which does not indicate the level of development of
POLST in that state, but rather that the National POLST Paradigm does
not confer a designation on it.2,7

POLST orders contain five sections, detailing instructions for CPR,
medical interventions, antibiotics, artificially administered nutrition,
and reasoning for orders with signatures. POLST, like DNR, is an action-
able medical order, signed by both a health care provider and the
DNR ORDER FORM

A printed copy of this order form or other authorized DNR identification must accompany the patient during transports and transfers between facilities.

| Patient Name:                                      | Patient Birth Date: |
|---------------------------------------------------|---------------------|

Optional Patient or Authorized Representatives Signature

Printed name of Physician, APRN or PA *                                      Date

REQUIRED Signature of Physician, APRN or PA

Phone

REQUIRED for APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician’s NPI, DEA or Ohio medical license number.

CHECK ONLY ONE BOX BELOW

☐ DNR Comfort Care — Arrest: Providers will treat patient as any other without a DNR order until the point of cardiac respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will be implemented.

☐ DNR Comfort Care: The following DNR protocol is effective immediately.

DNR PROTOCOL

Providers Will:

- Conduct an initial assessment
- Perform Basic Medical Care
- Clear airway of obstruction or suction
- If necessary for comfort or to relieve distress, may administer oxygen, CPAP or BiPAP
- If necessary, may obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death
- If possible, may contact other appropriate health care providers (hospice, home health, physician, APRN or PA)

Providers Will Not:

- Perform CPR
- Administer resuscitation medications with the intent of restarting the heart or breathing
- Insert an airway adjunct
- De-fibrillate, cardiovert or initiate pacing
- Initiate continuous cardiac monitoring

Physicians, emergency medical services personnel, and persons acting under the direction of or with the authorization of a physician, APRN or PA who participate in the withholding or withdrawal of CPR from the person possessing the DNR identification are provided immunities under section 2133.22 of the Revised Code. This DNR order is effective until revoked and may not be altered. Any medical orders, instructions or information other than those required elements of the form itself, that are written on this order form are not transportable and are not protected provisions or immunities.

* A DNR may be issued by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) when authorized by section 2133.211 of the Ohio Revised Code.

FIGURE 1 Ohio Do Not Resuscitate Form.
Credit: Figure reproduced with the permission from the Ohio Dept of Health®
3 | PEARLS AND PITFALLS OF ADVANCE DIRECTIVES IN THE EMERGENCY DEPARTMENT

3.1 | Lack of advance directives

Unfortunately, most ED patients do not have advance directives. It has been estimated that only 7%–42% of Americans have a completed advance directive.\(^\text{10-16}\) Without advance directives, families and providers may erroneously assume inaccurate end-of-life wishes.\(^\text{17-20}\)

3.2 | Availability

Availability of advance directive documents may be limited in the ED environment. Some patients may have documentation in the medical record; however, this documentation may not be current.\(^\text{21}\) Often, families do not have the appropriate documentation when the patient and family arrive in the ED.

3.3 | Accuracy and interpretation of advance directives

With all advance directives, a patient with decision making capacity can change or revoke his/her previously documented orders. Times when a health care proxy can revise or rescind such orders is less clear. It is not unusual, at the bedside, for emergency physicians to find themselves confronted with confusing documents, or with documents that contradict the wishes expressed by the surrogate decision maker. The situation is made even more difficult when the legal health care proxy is absent, or when patients have never discussed their wishes for end-of-life care with their family. When such documents are absent, physicians should ascertain patients’ wishes through bedside discussion with the patient and family members (regardless of proxy status). States typically designate spouses as proxy decision makers, followed by children and siblings, where appropriate. Importantly, some states make a clear distinction between the authority of the health care power of attorney versus the next-of-kin to make decisions regarding withholding and withdrawing care.\(^\text{3}\) Parents or guardians serve as decision makers for minors, although teens or “mature minors” may possess legal standing for medical decision making in some circumstances. Making such difficult decisions at the bedside is never ideal. In general, however, physicians enjoy medical-legal protection when following advance directives in good faith.\(^\text{1}\)

Patients and families may not agree regarding the application of advance directives to clinical scenarios, for example, trauma, surgery, or other clinical settings.\(^\text{22}\) This underscores the importance of a discussion to ascertain the accuracy of advance directives, and the appropriate application to the clinical setting.

4 | ADDRESSING PATIENT AND FAMILY PREFERENCES FOR END-OF-LIFE CARE IN THE EMERGENCY DEPARTMENT

Despite the importance of advance directives, many patients do not have an advance directive, the advance directive may not be available or may not be current. These pitfalls underscore the importance of a valid discussion in the ED of the patient’s preferences for end-of-life care.

If patients are able to communicate, their wishes should be established. Patient wishes should be discussed in an open, honest, and com-
TABLE 2  Bedside emergency department approach to patients in extremis, without an advance directive

| Step | Action |
|------|--------|
| 1.   | Stabilize the patient<br>Oxygen, positioning, suction, BiPAP<br>Consider endotracheal intubation |
| 2.   | Attempt to ascertain the patient’s wishes<br>From the patient (prior to interventions/intubation)<br>From the family; try to find health care power of attorney or nearest relative |
| 3.   | Ask the patient/family:<br>What is your understanding or your/your loved one’s illness?<br>What is your/your love one’s baseline functioning?<br>What do you /does your loved one desire for quality of life?<br>What are you hoping we can do for you/your loved one?<br>What are you/is your loved one most afraid of?<br>What symptoms is your loved one experiencing? |
| 4.   | Assure that DNR does not mean do not treat. Appropriate interventions may include:<br>Infection: antibiotics<br>Secretions: suction, glycopyrrolate atropine, scopolamine<br>Dyspnea: oxygen, morphine, lorazepam<br>Agitation: lorazepam, diazepam, haloperidol<br>Pain: pain control |
| 5.   | Do not argue or engage in a power struggle |
| 6.   | When in doubt, institute life-saving interventions (may be withdrawn later) |

 Adapted from: Episode 70 End of Life Care in Emergency Medicine. Emergency Medicine Cases. https://emergencymedicinecases.com/end-of-life-care-in-emergency-medicine/, accessed October 17, 2019.

American College of Emergency Physicians Policy on Ethical Issues at the End of Life provides important guidance for emergency physicians (Table 1). Table 2 provides advice on the treatment of patients who present in extremis without an advance directive.

5 | CONCLUSIONS

With advance directives, patients communicate end-of-life wishes. Despite such intentions, confusion regarding the documents themselves, their availability, their accuracy, and agreement between documentation and stated bed-side wishes are not uncommon. Physicians should discuss treatment options in an open, honest, and compassionate manner. Patients should be assured that medical treatment will be provided to maintain comfort and dignity. Valid advance directives should be followed, in the absence of advance directives, providers should provide information regarding the disease process, prognosis, and treatment alternatives to the patient and family to guide care. No conflicts to declare.

CONFLICT OF INTEREST

The author declare no conflict of interest.

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