

Don't fall for the myths.

Passage of S1046 will protect a patient's choice to die. It may even protect a surrogate's decision to hasten the death of a patient.

However, North Carolina law provides no assurance to the patient whose wish is to continue lifesaving treatment, nutrition, and hydration.

Glossary

Advance Directives

Two types: 1) Living will (written in advance, thus requires speculation on future medical conditions); 2) Health Care Power of Attorney (HCPA — appoints surrogate).

DNR

"Do Not Resuscitate" order.

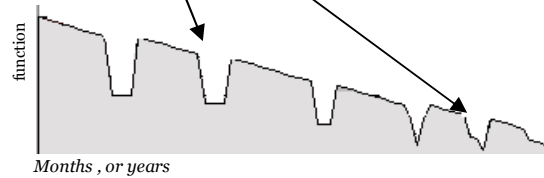
MOST

A new hybrid advance directive. Converts statements regarding limited treatment (e.g., nutrition/hydration) that are usually on living wills, into "immediately actionable" **physician's orders**. Modeled after the "POLST" form in Oregon. Devised by the ethics center that produced Oregon's Death With Dignity Handbook. Also known as an "out-of-hospital DNR."

Terminal illness.

Suppose your condition has just worsened. Time to re-evaluate your MOST.

Are you certain you are here?
Or might you be here?



S1046: Worse than no bill at all.



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STOP S1046

Advance Directives/Health Care Power of Attorney



S1046: Worse than no bill at all.



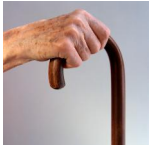
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Get the facts.

Myth #1: S1046 simplifies and clarifies the current NC advance directives and surrogacy laws.

S1046 complicates current law, and adds documents that are difficult to navigate, particularly for the elderly and infirm.



Terminally ill patients have a right to protection too.

Myth#2: The bill addresses dementia patients (i.e., not terminally ill), but only those with “advanced dementia.”

Advanced dementia is not defined, but supposedly “understood.” In fact, neither North Carolina law nor this bill have defined “advance dementia.”

Myth#3: The bill protects the provision of treatment or the withholding of treatment, according to the patient’s wishes.

Section 11 requires physicians to comply with the patient’s request to withhold lifesaving measures, but the bill provides little protection for a patient whose stated wishes are to include lifesaving treatment. Moreover, the HCPA and living will are confusing and complicated.

Myth#4: The “MOST” document gives patients more control, and merely amplifies any advance directives signed previously by the patient.

Patient’s signature may or may not be required

on the MOST form, depending upon the circumstance. In some cases, a signature on a copy, rather than on the original, is deemed sufficient.

It is not clear whether MOST will supersede a previously executed document, and the bill’s supporters refuse to address this issue within the context of North Carolina law.

Myth #5: Patients will complete MOST without pressure, and only after careful review and full information is provided.

Supposedly the benefit of MOST is that it reflects the patient’s condition “at present.” As such, the form must be re-evaluated as the patient’s condition changes. Pennsylvania recommends that the form should be reviewed if “1) the patient is transferred from one care setting or care level to another, 2) there is a substantial change in patient health status, or 3) the patient’s treatment preferences change.”¹ Presumably this means that at a crisis point, when the patient’s condition worsens—or appears to worsen—the patient will be asked to review treatment preferences. An Oregon study confirmed that the forms reduce hospital admissions (patients were allowed to die at the nursing facility).² Patients were not interviewed posthumously to confirm satisfaction with treatment.



New York’s MOLST (like North Carolina’s “MOST”) “generally designates limitations on treatment,” and “it is unclear what the limitations are without reading the form” with care. 3

The Oregon team that devised MOST/POLST tout the forms’ high rate of usage: rates over three times that of the usual living will. This has sparked a debate on the document’s credibility. Noting the “remarkably high proportion (85%)” of decedents with POLST forms, critics suggest the “danger is that rates this high can be achieved consistently only when patients are given too little information and time to make a decision as well-informed and well-considered as [this sort of decision] should be.”⁴



2002 marks the 10th anniversary of Oregon’s Physician Orders for Life-Sustaining Treatment form (POLST). The POLST form was developed over a four-year period and updated in 1997. The bright pink, easily distinguishable form is designed to help health care providers quickly identify and honor the treatment wishes of their patients.

(above) MOST is modeled after POLST—an “out-of-hospital DNR” form. Oregon Death With Dignity celebrated the form’s tenth anniversary.

¹ *Physician Orders for Life-Sustaining Treatment (POLST): Frequently Asked Questions* (University of Pittsburgh Institute on Aging, file created 2007 [cited May 10 2007]); available from <http://www.aging.pitt.edu/professionals/resources-polst/POLST-FAQs.pdf>.

² S.W. Tolle et al., “Oregon’s Low in-Hospital Death Rates: What Determines Where People Die and Satisfaction with Decisions on Place of Death?,” *Annals of Internal Medicine* 130, no. 8 (1999). See also, S. W. Tolle, “Care of the Dying: Clinical and Financial Lessons from the Oregon Experience,” *Annals of Internal Medicine* 128, no. 7 (1998).

³ (Emphasis added). Strong Memorial Hospital, *Facts and Misconceptions About The “New” Molst Form* [PDF online] (2006 [cited May 10, 2007 2007]); available from <http://www.stronghealth.com/services/palliative/documents/MOLSTFactsMis.pdf>

⁴ Angela Fagerlin and Carl E. Schneider, “Letters,” *Hastings Center Report* (2004).

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