BIOETHICS NEWSLETTER SPRING 2015

INSIDE

Editorial Notes
from Joseph Breault, MD

Included in this issue of the newsletter are the Ochsner Living Will and Healthcare Power of Attorney forms that have recently been revised and updated. The new versions are now available on Ochweb on the Miscellaneous Forms page (http://ochweb/page.cfm?id=965), and the forms have also been updated in the Copy Center system. Please start using the current versions immediately and notify everyone you know who might use these forms. Please discard any old versions you have printed and replace them with the revised forms.

Also in this issue, the article by Hoffman et al on code status discussions and their documentation highlights how important it is to adjust clinical practice so patients receive appropriate care in a crisis—which in some circumstances is to allow a natural death. These discussions about what to do if the patient's heart stops beating should happen early—when a patient is first admitted—but they often do not occur until a crisis. The new Epic Code Status Note described in the article can help everyone involved in hospital medicine document these discussions much better than in the past.

Finally, we invite everyone to attend the Clinical Ethics Symposium; the agenda is printed to the right of my introduction. Please go to www.ochsner.org/cme to register (the symposium is free for employees) for the May 9 Saturday morning program.

5th Annual
CLINICAL ETHICS SYMPOSIUM

Saturday, May 9, 2015

7:30 - 8:00 AM	Breakfast
8:00 - 8:15 AM	Intro and Bioethics Resources ***Dr. Breault***
8:15 - 9:45 AM	Legal and Ethical Issues at End of Life ***Joanne Cain Marier, JD*** *Director, Program in Health Law and Medical Ethics* *Associate Professor, LSU School of Medicine* *Member, Ochsner Bioethics Committee*
9:45 - 10:00 AM	Break/Networking
10:00 - 11:00 AM	Bioethics Mock Panel Case Presentation 1
11:00 - 12:00 PM	Bioethics Mock Panel Case Presentation 2

CME Accreditation Statement
The Ochsner Clinic Foundation is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CME Designation Statement
The Ochsner Clinic Foundation designates this live activity for a maximum of 4 *AMA PRA Category 1 Credits*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Ochsner Health System Nursing Professional Development is an approved provider of continuing nursing education by Louisiana State Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Disclosure
The presenters, their spouses or partners, have no actual or potential conflict of interest in relation to this program or presentation. All presentations have been peer reviewed to eliminate any commercial bias.

Advance Directives: *Answers to Questions when Making Decisions about Your End-of-Life Care in Advance of Need*

The 3-page Ochsner Advanced Directives brochure was revised in January 2015 and is available on the Miscellaneous Forms page of Ochweb. The Bioethics webpage at www.ochsner.org/bioethics also has a link to the new brochure. We present the brochure's introductory text and the revised forms on this page and the next so all are aware of the revision. The brochure is a PDF that can be easily printed. Please destroy any old forms and replace them with this new version.

What are Advance Directives?

Advance Directives allow you to make decisions about your medical care in "advance." They consists of 2 parts:

- Power of Attorney for Healthcare Decisions
- Living Will

Who should receive a copy?

- Your doctor
- Your family and/or friends
- You, to bring when hospitalized

What is the Power of Attorney for Healthcare Decisions?

This form allows you to name the person you want to make healthcare decisions for you when you are not able to make them for yourself.

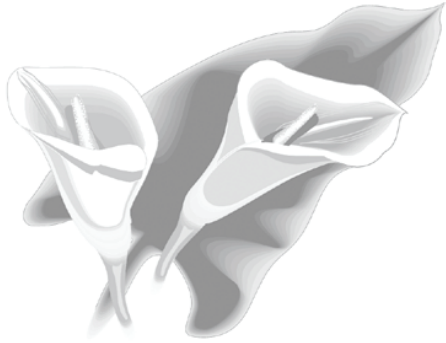
What if I change my mind after completing Advance Directives?

- Notify your doctor
- Notify your family
- Destroy other copies

What is a Living Will?

This form allows you to state what you wish and do not wish to be done in the event you are unable to speak for yourself and have a terminal and irreversible condition, which is defined as "a continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death."

For more information call 504-842-9474 (842-WISH).



OCHSNER HEALTH SYSTEM
ADVANCED DIRECTIVES
LIVING WILL

WITHHOLDING OR WITHDRAWAL OF LIFE SUSTAINING MEDICAL PROCEDURES (LA.REV.STAT.40:1299.58.3)

The Kind of Medical Treatment I Want or Do Not Want

I, _____, believe that my life is precious and I deserve to be treated with dignity. If the time comes that I am very sick and am not able to speak for myself, I would like for my wishes to be respected and followed. The instructions that I am including in this section are to let my family, my doctors and other health care providers, my friends and all others know the kind of medical treatment that I want or do not want.

If at any time I should have an incurable injury, disease, or illness, or be in a continual, profound comatose state with no reasonable chance of recovery, certified to be in a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to prolong artificially the dying process, I would like the following instructions to be followed.
(Choose *one* of the following):

☐ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.
☐ That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.
I understand the full impact of this declaration, and I am emotionally and mentally competent to make this decision.

This declaration is made and signed by me on this _____ day of _____, in the year _____, in the presence of the undersigned witnesses who are not entitled to any portion of my estate.

Signed: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

WITNESS ACKNOWLEDGEMENT: The Declarant is and has personally been known to me, and I believe the Declarant to be of sound mind. I am not related to the Declarant by blood or marriage and would not be entitled to any portion of Declarant's estate upon his/her death. I was physically present and personally witnessed the Declarant execute the foregoing Declaration.

_____ _____
WITNESS SIGNATURE / Print Witness Name / Date / Time WITNESS SIGNATURE / Print Witness Name / Date / Time

Form No. 00128-a (Rev. 1/21/2015) Medical Record Copy

OCHSNER HEALTH SYSTEM
ADVANCED DIRECTIVES

POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

The Person I Want To Make Health Care Decisions For Me When I Cannot Make Them For Myself

If I, _____, being of sound mind, am no longer able to make my own health care decisions, the person I choose as my Health Care Power of Attorney is:

(First Choice Name) _____

(Address) _____(Phone Number) _____

If this person is not able or willing to make these choices for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choices:

(Second Choice Name) _____**(Third Choice Name)** _____

(Address) _____(Address) _____

(City/State/Zip) _____(City/State/Zip) _____

(Phone) _____(Phone) _____

I understand that my Health Care Power of Attorney can make health care decisions for me. I want my Health Care Power of Attorney to be able to do the following:
Please cross out/strike through all items that you do NOT want your agent/attorney in fact to do.

make health care and treatment decisions for me
make decisions concerning surgery
make decisions concerning medical expenses
make decisions concerning hospitalization
make decisions concerning nursing home residency
take any legal action needed to carry out my wishes
make decisions concerning the withholding or withdrawal of life sustaining procedures
make decisions concerning medications
see and approve the release of my medical record
make decisions concerning selection of physicians
apply for Medicare/Medicaid or other programs for insurance

Such Health Care Power of Attorney has full authority to make such decisions as fully, completely and effectually, and to all intents and purposes with the same validity as if such decisions had been personally made by me.

This declaration is made and signed by me on this _____ day of _____, in the year _____, in the presence of the undersigned witnesses who are not entitled to any portion of my estate.

Signed: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

WITNESS ACKNOWLEDGEMENT: The Declarant is and has personally been known to me, and I believe the Declarant to be of sound mind. I am not related to the Declarant by blood or marriage and would not be entitled to any portion of Declarant's estate upon his/her death. I was physically present and personally witnessed the Declarant execute the foregoing Declaration.

_____ _____
WITNESS SIGNATURE / Print Witness Name / Date / Time WITNESS SIGNATURE / Print Witness Name / Date / Time

Form No. 00128-b (Rev. 1/21/2015) Medical Record Copy

Improving Code Status Discussions and Their Documentation

Ross Hoffman, MBBS, Matthew Clark, MBBS, Renee Meadows, MD

Consider two cases:

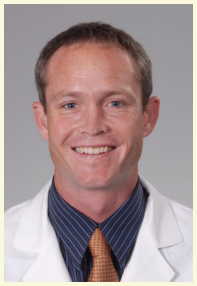
A 75-year-old man with terminal cancer is coded—including chest compressions, vasopressors, and intubation and ventilation—despite the fact that in the days preceding his cardiac arrest, he repeatedly informed hospital staff of his wish to be made DNR (to have a do-not-resuscitate order written). The patient receives these life-sustaining measures, but he dies the next day.

An 87-year-old woman who lives independently and has an advance health directive (AHD) on file is admitted with pneumonia. Because of her age, altered mental status, and presence of an AHD, a DNR order is written. However, her AHD states that she wishes to have all indicated interventions performed unless she is in an irreversible coma from brain death. Intubation is withheld due to her DNR status, and she dies of potentially reversible acute hypoxic respiratory failure.

It is widely accepted that to respect patient autonomy, physicians and healthcare providers should discuss code status with patients to ensure that they understand their prognosis and their likelihood of requiring cardiopulmonary resuscitation (CPR), as well as the risks, benefits, and possible outcomes of CPR. Code status, however, is a difficult subject. It is difficult for patients because it involves confronting the hard reality that at some point the dying process will become irreversible. It can be difficult for healthcare providers because they must accept that medicine does not ultimately save anyone from death. Discussing code status may also require breaking much-delayed bad news to the patient, whose outlook on his prognosis may not be realistic and who may believe CPR to be much more life-saving than it actually is. (Survival-to-discharge rates following resuscitation are estimated to be approximately 15% at highest.) Despite well-described guidelines about CPR from respected medical organizations and despite its poor success rate, CPR continues to be performed on terminally and critically ill patients for whom it is likely to confer minimal benefit.

Many patients do not have clear documentation of their preferences about code status. Barriers to discussing code status include lack of patient-centered advance care planning; patient misunderstanding (for example, believing an AHD and a DNR order are the same thing); and provider reluctance because of discomfort, lack of training, or lack of time. Consequently, modern medicine often fails patients at a most critical time in their lives—when they are dying.

A research team from the Ochsner Internal Medicine residency program, The University of Queensland–Ochsner Clinical School, and the Department of Hospital Medicine at OMC-New Orleans has been investigating how to improve both documentation about code status discussions and the quality of the discussions themselves.



Ross Hoffman, MBBS

Matthew Clark, MBBS

Renee Meadows, MD

Code Status Note
Hospital Medicine

Calculate your patient's *GO-FAR SCORE*
The Good Outcome Following Attempted Resuscitation (GO-FAR) Score* provides validated risk stratification for a patient's chance of neurologically intact survival to discharge should he/she be successfully resuscitated following in-hospital cardiopulmonary arrest. The clinical significance of the GO-FAR score may be discussed with the patient and/or family while coming to a decision about code status.

Variable	Point Range
Age @AGE@	0-11 points (depends on age)
Chronic neurologic deficits Prior to admission, did the patient have chronic cognitive or sensory/motor neurologic deficits that significantly affect his/her ability to function and live independently? (Tremor, mild dysphagia, and cranial nerve deficits are not considered significant.)	-15 to 0
Acute stroke during the current admission Does the patient have a documented diagnosis of acute intracranial or intraventricular thrombosis or hemorrhage present on admission (or transfer) or during the current admission?	0-8
Medical non-cardiac diagnosis Does the patient have a significant medical diagnosis not associated with cardiac disease? (This diagnosis need not be the primary diagnosis.)	0-7
Major trauma Has the patient suffered trauma that has led to shock or altered mental status present on admission or during the current admission?	0-10
Metastatic or hematologic cancer Does the patient have blood-borne malignancy or solid tissue malignancy with evidence of metastasis?	0-7
Septicemia Does the patient have a documented bloodstream infection (positive blood cultures) for which antibiotic therapy is ongoing or will be started?	0-7
Pneumonia Does the patient have a diagnosis of acute pneumonia for which antibiotic therapy is ongoing or will be started?	0-1
Hepatic insufficiency Does the patient have either a diagnosis of cirrhosis **or** total bilirubin > 2 mg/dL ***and*** AST > 80 U/L within the past 24 hours?	0-6
Renal insufficiency or dialysis Does the patient require dialysis **or** have a serum creatinine > 2.0 mg/dL within the past 24 hours?	0-4
Acute hypotension or hypoperfusion Has the patient had hypotension as defined by any of the following within the past 4 hours? - SBP < 90 or MAP < 60 - Requirement of vasopressors or inotropes after volume expansion - Requirement of an intra-aortic balloon pump	0-5
Respiratory insufficiency Does the patient have *acute or chronic* respiratory insufficiency as defined by any of the following within the past 4 hours? - Spontaneous respiratory rate > 40/min or < 5/min - SaO2 < 90% - PaO2 < 60 mmHg - PaO2/FiO2 < 300 - PaCO2, ETCO2, or TcCO2 > 50 mmHg - Non-invasive ventilation (CPAP, BiPAP, bag-valve mask) - Ventilation via intubation or tracheostomy	0-4
Admit from SNF Was the patient admitted directly from a skilled nursing facility?	0-6

GO-FAR SCORE = ***

Interpretation key
Use the *GO-FAR Score* to predict the patient's likelihood of neurologically intact survival to discharge (NISD) should he/she be successfully resuscitated following cardiopulmonary arrest.

GO-FAR SCORE	Likelihood of NISD
- 15 to - 6	Above average > 15 %
- 5 to 13	Average 3 to 15 %
14 to 23	Low 1 to 3 %
> 23	Very low < 1 %

Our initial question was, "What are we already doing?" From the start, it was evident that whatever we are already doing, we are not documenting it well. Guidelines from the American Heart Association maintain that a DNR order should be accompanied by a note in the patient's chart explaining the rationale for the order and other specific limitations of care. DNR orders should be periodically reviewed to ensure relevancy over the evolving course of a patient's health, and if the patient is admitted to hospital, his/her code status preference should be reviewed as part of the admission process to avoid any errors of presumption by hospital staff.

Regarding the details of the discussion about code status:	
Patient's likelihood of neurologically-intact survival to discharge after successful resuscitation:	{AVERAGE:29244}
Has the patient/proxy been made aware of his/her overall prognosis?	{YES/NO:20890}
Has the patient/proxy been made aware of his/her predicted survival to discharge after successful resuscitation?	{YES/NO:20890}
Code status discussion included:	{GOFARPROVIDER: 23121}
Code status was discussed with:	{PALLIATIVE CARE FAMILY MEMBERS OHS:28938}
Code status preference was chosen by:	{PALLIATIVE CARE FAMILY MEMBERS OHS:28938}
Reason, if any, that code status was not discussed with the patient:	{GOFARCODEDISCUSSIONREASON: 23125}
Does the patient have an Advance Health Directive (AHD)?	{advanced directive:12455}
Does the AHD indicate a preference for Full Code?	{YES/NO:20890}
If not Full Code, does the AHD specify which life-sustaining interventions are to be taken, and in what circumstances? If yes, please specify in Further Comments section.	{YES/NO:20890}

CODE STATUS: {GOFARCODESTATUS: 23126}

Further Comments:
Please remember to:
- Enter the appropriate order for code status into EPIC.
- If appropriate, sign a DNR or PDNR form and put it in the patient's chart.

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*Ebell MH, Jang W, Shen Y, Geocadin RG; Get With the Guidelines–Resuscitation Investigators. Development and validation of the Good Outcome Following Attempted Resuscitation (GO-FAR) score to predict neurologically intact survival after in-hospital cardiopulmonary resuscitation. *JAMA Intern Med*. 2013 Nov 11;173(20):1872-8. doi: 10.1001/jamainternmed.2013.10037.

However, in a chart review of more than 100 patients who were made DNR during a hospitalization in 2013, the Ochsner research team found that only 22% of the notes regarding patients' choice of DNR status made any reference to the rationale for their choice. Only a fraction of these DNR orders were entered on admission; many were entered subsequently, often after the patient had been critically ill for days or after the patient had lost the capacity to participate in a discussion about his/her own code status. Furthermore, only a small percentage of the notes made any reference to which members of the hospital staff had been present for the discussion about code status, which family members and other proxies of the patient were present, and who ultimately made the choice about code status—whether it was the patient or a surrogate decision maker. These inadequacies in documentation cast doubt on the quality of the discussions themselves: how and when they were conducted, who participated, what details of care were addressed, and whether the selected code status faithfully reflected the patient's wishes.

In early February 2015, our research team introduced a new tool—Code Status Note—in the Epic electronic medical record to help providers adequately document essential details about code status. Code Status Note (see images) is a template that incorporates both quantitative and qualitative aspects of a patient's care.

The quantitative element is represented by the Good Outcome Following Attempted Resuscitation (GO-FAR) score, the product of a 2013 study published by Ebell et al (Ebell MH, Jang W, Shen Y, Geocadin RG; Get With the Guidelines–Resuscitation Investigators. Development and validation of the Good Outcome Following Attempted Resuscitation (GO-FAR) score to predict neurologically intact survival after in-hospital cardiopulmonary resuscitation. JAMA Intern Med. 2013 Nov 11;173(20):1872-8. doi: 10.1001/jamainternmed.2013.10037.). The GO-FAR score considers 13 health indicators (neurologic deficits, disease burden, trauma, infection, stroke, and liver and renal function, among others) to calculate the patient's chance of neurologically intact survival to discharge if successfully resuscitated following in-hospital cardiopulmonary arrest. The GO-FAR score determines whether a resuscitated patient has an average, above average, or below average chance of surviving to discharge without significant neurologic deficits. Therefore, the score can help guide the discussion about code status.

The qualitative element of Code Status Note incorporates essential details such as which health providers led the discussion about code status, which family and friends of the patient participated in the discussion, who ultimately made the decision about code status, whether the patient has an AHD in place, what the AHD may stipulate about end-of-life care, and specifically what life-sustaining measures are to be taken and in what circumstances.

It is important to note that in keeping with the ethical principle of autonomy, a patient's wishes regarding code status must be respected regardless of whatever guidance the tool provides and whatever outcome the tool predicts.

Code Status Note is currently available for use exclusively by the residents in Ochsner's Internal Medicine residency program. The tool and its impact on code status discussions will be examined in the coming months to determine if the tool is of benefit to residents in their discussions about code status and in their documentation of these discussions. If the tool shows promise, it may be adapted in Epic so it can be distributed systemwide with the goal of enabling all Ochsner providers to deliver better care to patients.

Bioethics Resources *for You*

How to Request a Bioethics Consult at Any Ochsner Facility

- Request a consult online - http://academics.ochsner.org/bioethicsform.aspx
- Call an Ochsner Chaplain 504-842-3286
- Call Risk Management 504-842-4003
- Contact your OMC local bioethics coordinator

Any Clinic	Contact Chaplain's Office
OMC-Eastbank	Contact Chaplain's Office
OMC-Westbank	Contact Chaplain's Office
OMC-Kenner	Aderonke Akingbola, MD
OMC-Baptist	Gretchen Ulfers, MD
OMC-BR	Ralph Dauterive, MD
OMC-St. Anne	Allyson Vedros, CNO
OMC-Elmwood	Contact Chaplain's Office
OMC-Slidell	James Newcomb, MD
Chabert MC	Jana Semere, CNO

"...most hospitals in the USA provide clinical ethics consultation that is mainly due to the requirement of The Joint Commission for Accreditation of Healthcare Organizations—in 2007 renamed the Joint Commission—that accredited hospitals must have a method for addressing ethical issues that arise." From http://www.iep.utm.edu/bioethic/

Bioethic Education Fund

When a bioethics consult is called, the expectation is that those providing services are well trained, not just people of good will. This training is the responsibility of the Bioethics Committee. Please support the committee's educational work by donating to the Bioethics Education Fund - Endowed, managed by the Philanthropy Department as fund #3804126. In Lawson, employees can select the Bioethics Education Fund in the dropdown box during the annual giving campaign, and anyone can click the Donate Now button at www.ochsner.org/lp/bioethics_fund/. Every donation, however small, does great good and is used to build an endowment fund to permanently support bioethics educational programs at Ochsner.

End-of-Life Resources

- **5 Wishes** http://academics.ochsner.org/bioethicsdyn.aspx?id=54656
- **Advance Directives, Living Wills, & Healthcare Power of Attorney** http://ochweb/page.cfm?id=3919 scroll down to Miscellaneous Forms
- **Palliative Care** http://ochweb/page.cfm?id=2429
- **State Living Will Declarations** http://www.sos.la.gov/OurOffice/EndOfLifeRegistries/Pages/default.aspx
- **UpToDate: Ethical Issues in Palliative Care** http://www.uptodate.com/contents/ethical-issues-in-palliative-care
- **Katy Butler: Slow Medicine** http://katybutler.com/site/slow-medicine/
- **Dr. Atul Gawande: Letting Go** http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande?currentPage=all
- **LaPOST: Handbook for Health Care Professionals** http://lhcqf.org/images/stories/LaPOST/LaPOST-Handbook-for-Health-Care-Professionals-2013.pdf
- **LaPOST: State Website** https://lhcqf.org/lapost-home
- **LaPOST video: Using the LaPOST Document to Improve Advance Care Planning (intranet only)** http://mediasite.ochsner.org/mediasite50/Viewer/?peid=b54700807b474e1e8fe96113ca985e4b
- **Respecting Choices Training** http://respectingchoices.org/training_certification

Bioethics Q&A

What is a bioethics consult?

- Medical Ethics Website http://academics.ochsner.org/bioethics.aspx
- Bioethics Consultations and Resources http://www.ochsnerjournal.org/doi/pdf/10.1043/1524-5012-11.4.357

What is sometimes helpful prior to a bioethics consult?

- Asking the chaplain to come visit
- Holding a family conference http://www.atsjournals.org/doi/pdf/10.1164/rccm.2501004
- Requesting a palliative care consult http://ochweb/page.cfm?id=2429
- Having a discussion with Risk Management http://ochweb/page.cfm?id=3325

Bioethics Education Program

- **Annual Clinical Ethics Symposium** - Saturday, May 9, 2015
- **Bioethics Website** (consults) - http://academics.ochsner.org/bioethics.aspx
- **Bioethics Website** (resources) - http://ochsner.org/bioethics
- **Quarterly Bioethics Newsletter** - http://ochsner.org/bioethics
- **The Ochsner Journal Bioethics column** - http://www.ochsnerjournal.org
- **Schwartz Rounds**