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Taking the MOLST (Medical Orders for Life-Sustaining Treatment) Statewide

Robert S. Olick, Joel Potash & Amy T. Campbell*

On July 7, 2008, New York Governor David A. Paterson signed into law an initiative to make permanent and to extend statewide the use of Medical Orders for Life-Sustaining Treatment (“MOLST”) to document physician orders to carry out decisions near the end of a patient’s life.¹ The MOLST form has been used under a demonstration project in Onondaga and Monroe Counties since 2006.² The MOLST program and corresponding form (known as the “pink form”) were developed by upstate New York insurer Excellus BlueCross BlueShield (“Excellus”) and the Community-Wide End-of-Life/Palliative Care Initiative under the leadership of Dr. Patricia Bomba, Vice President and Medical Director (Geriatrics) for Excellus.³

For the most part, the purpose of the MOLST legislation is to direct health care providers, patients, and families to use the MOLST form to implement existing laws governing decisions

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1. Act of July 7, 2008, ch. 197, 2008 N.Y. Laws 197 (codified as amended at N.Y. PUB. HEALTH LAW § 2977(13) (McKinney Supp. 2009)). See also Robert S. Olick, *Legislative Watch*, BIOETHICS IN BRIEF (SUNY Upstate Med. Univ., Ctr. for Bioethics & Humanities, Syracuse, N.Y.), Sept. 2008, at 4, available at http://www.upstate.edu/bioethics/bnb_8_2008.pdf (discussing the passage of amendment to New York Public Health Law that recognizes the use of MOLST statewide); Press Release, Excellus BlueCross BlueShield, Gov. Paterson Signs End-of-Life Program into Law (July 9, 2008), available at <http://www.nysvara.org/news/2008/jul/080709.pdf>.

2. Prior to the passage of the MOLST, Do Not Intubate (“DNI”) orders could not be honored in pre-hospital settings by emergency medical service (“EMS”) personnel. See Excellus BlueCross BlueShield, *supra* note 1. However, legislation in 2006 amended N.Y. PUB. HEALTH LAW § 2977(13), authorizing EMS personnel in Monroe and Onondaga Counties to honor DNI orders for patients while still en route to the hospital. Act of July 26, 2006, ch. 325, 2006 N.Y. Laws 325 (current version at N.Y. PUB. HEALTH LAW § 2977(13)).

3. Excellus BlueCross BlueShield, *supra* note 1. A copy of the primary MOLST form is attached as Appendix A.

near the end of life.⁴ Although the legislation is new to New York, the program creates no new substantive rights to refuse life-sustaining treatment, except with respect to Do-Not-Intubate (“DNI”) orders.⁵ The MOLST initiative facilitates patients’ rights to execute out-of-hospital Do-Not-Resuscitate (“DNR”) orders, establishes a new patient right to DNI orders, and makes plain a correlative duty of emergency medical personnel to honor DNI orders in the patient’s home and elsewhere.⁶ This article explains the nature and purpose of the MOLST program, placing it in the context of the surrounding New York law. We address the goals of the MOLST initiative and identify some challenges and legal barriers to its full and effective implementation.

More than 147,000 New Yorkers die each year, with more than 110,000 of those deaths occurring in hospitals, nursing homes, and other institutions across the state.⁷ On a national level, approximately seventy percent of hospital deaths occur after a decision to withhold or withdraw life-sustaining treatment.⁸ Considering that patients die every day after a decision to withhold or withdraw life-sustaining treatment has been made, the MOLST form will likely have a wide impact on how people die in the Empire State.

I. The MOLST Legislation and New York Law

The chief aims of the MOLST initiative are to (1) promote communication and planning for decisions near the end of life between seriously ill patients and their physicians; (2) establish a single, uniform approach to documenting all physician orders pertaining to end-of-life care; (3) make those orders transferable

4. EXCELLUS BLUECROSS BLUESHIELD, MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT GUIDEBOOK 3 (2006), available at https://www.compassionandsupport.org/pdfs/professionals/training/MOLST_Booklet%20.pdf [hereinafter EXCELLUS, GUIDEBOOK].

5. *Id.*

6. *Id.* at 1.

7. New York Department of Health, Table 32a: Death Summary Information by Age, New York State – 2006 (June 2008), available at www.health.state.ny.us/nysdoh/vital_statistics/2006/table32a.htm.

8. See, e.g., THE HARPER’S INDEX BOOK 160 (Charis Conn, George Plimpton & Lewis H. Lapham eds., 2000); Thomas J. Prendergast, *Withholding or Withdrawal of Life-Sustaining Therapy*, HOSP. PRACT., June 15, 2000, at 91-92, 95-100, 102.

across care settings; and (4) replace New York's non-hospital DNR form with a universal DNR form regardless of care setting.⁹ Implementing the new law, the New York State Department of Health ("DOH") approved and adopted the MOLST form for use throughout New York for most patients.¹⁰ Though hospitals are not *per se* required to use the form, the imprimatur of the DOH makes it likely that most hospitals will do so.¹¹ In addition, the MOLST form is already in use in many communities, where its shared adoption fosters transferability of orders and continuity across care settings.¹² The MOLST form is modeled after Oregon's Physician Orders for Life-Sustaining Treatment ("POLST").¹³ Some version of the POLST program has been adopted or is presently under consideration in a number of states.¹⁴

A. DNR Orders

The MOLST law adds to and seeks to implement a patchwork of New York laws governing end-of-life decisions. A core feature of the MOLST form is its documentation of DNR decisions governed by the DNR law.¹⁵ Under that law, competent patients have the right to refuse interventions to restore heart function or sustain ventilation in the event of cardio-pulmonary arrest.¹⁶ Family members, in the order of priority set forth by law (e.g., health care proxy, followed by the spouse, then an

9. N.Y. State Dep't of Health, Medical Orders for Life Sustaining Treatment (MOLST), http://www.health.state.ny.us/professionals/patients/patient_rights/molst/ (last visited Apr. 20, 2009) [hereinafter N.Y. State Dep't of Health, MOLST].

10. *Id.* See also *infra* app. A.

11. *Id.*

12. *Id.*

13. Patricia A. Bomba, *Medical Orders for Life-Sustaining Treatment (MOLST): A Paradigm Shift in Advance Care Planning*, N.Y. ST. B.A. HEALTH L.J., Summer/Fall 2006, at 39-51.

14. Susan E. Hickman et al., *The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation*, 36 J.L. MED. & ETHICS 119, 119-25 (2008).

15. See *infra* app. A. A 2006 transmittal letter from the DOH to all hospital CEOs highlights that MOLST "can be used statewide by health care providers and facilities as the legal equivalent of an inpatient Do Not Resuscitate (DNR) form." Letter from Martin J. Conroy, Dir., Bureau of Hosp. & Primary Care Servs., N.Y. State Dep't of Health et al., to Chief Executive Officers (Jan. 17, 2006), available at http://www.health.state.ny.us/professionals/nursing_home_administrator/docs/del_molst.pdf.

16. N.Y. PUB. HEALTH LAW § 2960 (McKinney 2007).

adult child, and so on), may make DNR decisions on behalf of an incompetent patient who is terminally ill (a prognosis of one year or less of life remaining) or permanently unconscious, or when resuscitation would be “medically futile” or impose an “extraordinary burden” on the patient.¹⁷ For example, many would consider it an extraordinary burden (perhaps futile) to perform CPR on an incapacitated, terminally ill patient with severe osteoporosis and advanced dementia or with advanced carcinoma and metastases to the ribs.

Under New York’s DNR law, when the patient lacks decisional capacity, surrogate decision-makers are to base their decision on the patient’s wishes or, if the patient’s wishes are not reasonably known, on the patient’s best interests.¹⁸ Only in the absence of a surrogate decision-maker for the incompetent patient may the attending physician, with the concurrence of a second physician, enter a DNR order on grounds of medical futility, commonly known as a two physician DNR order.¹⁹ Section A of the MOLST form calls upon patients and families to make an initial choice that sets the tone for interpretation of the remainder of the document: whether there is an order not to attempt cardio-pulmonary resuscitation (“CPR”), including endotracheal intubation and electric shock of the heart (a DNR order), or whether the patient would want full CPR (full code status).²⁰

For non-hospital patients who may experience cardiac arrest at home or elsewhere, the MOLST form is an alternative to the standard one-page non-hospital DNR order form that has been used in New York for the past two decades.²¹ Significantly, the MOLST form can be used to enter both hospital and non-hospital DNR and DNI orders.²² Establishment of DNI orders, expressly authorized by the MOLST legislation, clarifies prior confusion about the legal status of such orders, giving emergency medical personnel clear authority to honor non-hos-

17. *Id.* § 2965.

18. *Id.*

19. *Id.* § 2966.

20. *See infra* app. A.

21. N.Y. PUB. HEALTH LAW § 2977(13) (McKinney Supp. 2009); Excellus BlueCross BlueShield, *supra* note 1.

22. EXCELLUS, GUIDEBOOK, *supra* note 4, at 1.

pital DNI orders.²³ To this extent, the MOLST form extends the reach of the right to refuse treatment.

B. *Health Care Proxies*

The right of competent patients to refuse unwanted bodily interventions, including life-sustaining treatments, even when others such as physicians may disagree with the patient's decision, is well-established under both constitutional law and the common law of self-determination.²⁴ This right may be exercised by family members or other surrogate decision makers in the event the patient loses decisional capacity (competence).²⁵ The best way for a person to make his or her wishes count after illness, disease, or injury has taken personal decision-making ability away is to put those wishes in writing by completing an advance directive. Advance directives, that is, a durable power of attorney for health care (more commonly known as a proxy directive), living will, or both, are recognized by statute in all fifty states and the District of Columbia.²⁶

23. Act of July 7, 2008, ch. 197, 2008 N.Y. Laws 197 (codified as amended at N.Y. PUB. HEALTH LAW § 2977(13)); EXCELLUS, GUIDEBOOK, *supra* note 4, at 1.

24. *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580, 584-87 (D.R.I. 1988); Rasmussen v. Fleming, 741 P.2d 674, 681-83 (Ariz. 1987); Conservatorship of Drabick, 245 Cal. Rptr. 840, 844-49 (Ct. App. 1988); *In re* Estate of Longeway, 549 N.E.2d 292, 294-302 (Ill. 1989); *In re* Quinlan, 355 A.2d 647, 662-69 (N.J. 1976). The U.S. Supreme Court affirmed and reinforced this constitutional right and the foundations of the end-of-life consensus that had developed under state law in Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269-87 (1990). For discussion of the law governing end-of-life decisions, see NORMAN L. CANTOR, ADVANCE DIRECTIVES AND THE PURSUIT OF DEATH WITH DIGNITY ch. 1 (1993); ROBERT S. OLICK, TAKING ADVANCE DIRECTIVES SERIOUSLY ch. 1 (2001); Alan Meisel, *The Legal Consensus about Forgoing Life-Sustaining Treatment: Its Status and Its Prospects*, 2 KENNEDY INST. ETHICS J. 309 (1992). These same principles have been recognized in decisions from the New York Court of Appeals in *In re* Westchester County Med. Ctr (O'Connor), 531 N.E.2d 607, 611-12 (N.Y. 1988), and *In re* Storar, 420 N.E.2d 64, 70 (N.Y. 1981). However, as discussed below, by requiring surrogate decision makers not appointed as health care proxy to show the patient's wish to refuse life-sustaining treatment by clear and convincing evidence, the O'Connor decision creates significant obstacles to implementation and recognition of the incompetent patient's right to refuse treatment. *See infra* notes 43-48 and accompanying text.

25. *See* sources cited *supra* note 24.

26. The vast majority of state laws recognize both proxy directives and living wills. *See* Am. Bar Ass'n, Comm'n on Law and Aging, Health Care Power of Attorney and Combined Advance Directive Legislation as of Sept. 1, 2008, <http://www.abanet.org/aging/legislativeupdates/pdfs/HCPA-CHT.pdf>. Three states, New York, Massachusetts, and Michigan recognize by statute only the proxy directive. *See id.*

Under New York's health care proxy law, a competent adult (eighteen or older) may plan ahead for important health care decisions by designating a spouse, trusted family member, or friend as health care agent (more commonly known as the proxy) to make decisions on his or her behalf in the event of future decisional incapacity.²⁷ The patient's proxy is clothed with authority to make any and all health care decisions the patient could make if able to do so.²⁸ First and foremost, the proxy is to decide in accordance with the patient's wishes or, if the patient's wishes are not reasonably known, in the patient's best interests.²⁹

The New York proxy law is among the minority of state advance directive laws that carve out special requirements for the forgoing of artificial fluids and nutrition.³⁰ New York's law creates a presumption that artificial fluids and nutrition are to be provided unless there is some reasonable evidence of the patient's refusal of this medical modality. Specifically, the law states that "if the [patient's] wishes regarding the administration of artificial nutrition and hydration are not reasonably known and cannot with reasonable diligence be ascertained," the proxy has no authority to refuse such measures.³¹ The MOLST form offers a uniform mechanism for documenting patient, proxy, or legally recognized surrogate decisions regarding artificially provided fluids and nutrition, CPR, mechanical ventilation, antibiotics, and other life-sustaining interventions.³² Decisions on behalf of an adult patient who lacks decisional capacity are to be documented on the MOLST supplemental form.³³

27. N.Y. PUB. HEALTH LAW § 2981(1) (McKinney 2007).

28. *Id.* § 2982(1).

29. *Id.* § 2982(2)(a), (b).

30. The other states include Nebraska, Ohio, and Oklahoma. *See* NEB. REV. STAT. § 30-3418 (1997); OHIO REV. CODE ANN. § 2133.09 (WEST 1994); OKLA. STAT. tit. 63, § 3080.4 (2004).

31. N.Y. PUB. HEALTH LAW § 2982(2)(b).

32. *See infra* app. A.

33. *See* Medical Orders for Life-Sustaining Treatment (MOLST), "Supplemental" Documentation Form for Adults, *available at* https://www.excellusbcbs.com/wps/wcm/resources/file/ebd8584ee65b0e9/molst_adult_form.pdf (last visited Apr. 20, 2009) [hereinafter MOLST Supplemental Form]. There is also a separate MOLST form for end-of-life decisions for minors (patients under the age of eighteen) that is beyond the scope of this paper. *See* Medical Orders for Life-Sustaining Treatment (MOLST), "Supplemental" Documentation Form for Minors,

Under the Patient Self-Determination Act (“PSDA”),³⁴ hospitals are required to document whether the patient has an advance directive, such as a health care proxy, living will (also known as an instruction directive) or a combination of the two.³⁵ This is a practice commonly known as documenting the patient’s “advance directive status.” The MOLST form incorporates this requirement by having health care providers indicate whether a patient has executed an advance directive.³⁶ If the patient’s advance directive has been obtained and made a part of the medical record, the MOLST form provides a unified means to effectuate proxy decisions (or the terms of a living will) by entering them as current physician’s orders on the form.³⁷ Section D of the MOLST form expressly recognizes that an advance directive is “an additional document that provides guidance for treatment measures if [the patient] loses decision-making capacity” and provides space to record whether the patient has an advance directive.³⁸ Still, as discussed below, introduction of the MOLST form has created confusion about the differences between a health care proxy and a MOLST form.³⁹

C. *Surrogate Decisions Without a Proxy Appointment*

Most citizens have not executed a proxy directive or a living will. For many years, national studies have found that approximately twenty percent of adults eighteen and older use advance directives.⁴⁰ Although recent studies suggest that the use of ad-

available at http://www.ohsu.edu/polst/programs/documents/MOLST_Minor_Supp_Form_Approved_9.11.08.kr.pdf.

34. 42 U.S.C. § 1395cc (2006).

35. *Id.* § 1395cc(f)(1)(B).

36. *See infra* app. A.

37. *See infra* app. A.

38. *See infra* app. A.

39. *See* N.Y. State Dep’t of Health, Frequently Asked Questions, http://www.health.state.ny.us/professionals/patients/patient_rights/molst/frequently_asked_questions.htm (last visited Apr. 20, 2009) [hereinafter N.Y. State Dep’t of Health, FAQ].

40. *See, e.g.,* Joanne Lynn and Joan Teno, *After the Patient Self-Determination Act: The Need for Empirical Research on Formal Advance Directives*, HASTINGS CENTER REP., Jan.-Feb. 1993, at 20-21. *See also* Bomba, *supra* note 13, at 41 (summarizing several other recent surveys).

vance directives nationally and in New York has increased,⁴¹ most New Yorkers have not executed a health care proxy.⁴²

Family members called upon to make end-of-life decisions for incapacitated loved ones who have not completed a health care proxy form typically find that New York law erects a substantial barrier to their rightful place at the bedside. That barrier, established by the New York Court of Appeals in *In re Westchester County Medical Center (O'Connor)*⁴³ and *In re Storar*,⁴⁴ is the requirement that families (or other surrogate decision makers) provide clear and convincing evidence that their incompetent dying parent, spouse, or sibling would want life-sustaining treatment withheld or withdrawn.⁴⁵ According to the *O'Connor* court, this means that families must show that patients, while competent, “held a firm and settled commitment to the termination of life supports under the circumstances like those presented.”⁴⁶ In practical terms, to truly satisfy this standard, families need to show that their loved one’s values and statements refusing life-sustaining treatment closely fit his or her current medical circumstances and were consistently expressed over time.⁴⁷

Rigidly applied, this is a significant burden for many families to meet and sometimes makes physicians hesitant to comply with family decisions, even when they agree that terminating life support is ethically justified and in the patient’s best interests. In hospital practice, disagreement or uncertainty about whether this standard is met often triggers an ethics consultation. This process typically leads to resolution of the dilemma. However, under the governing law, when a patient has no health care proxy or other written evidence of his or

41. See, e.g., Press Release, Pew Research Ctr., More Americans Discussing—and Planning—End-of-Life Treatment: Strong Public Support for Right to Die (Jan. 5, 2006), available at <http://people-press.org/reports/pdf/266.pdf>.

42. See EXCELLUS BLUECROSS BLUESHIELD, END-OF-LIFE CARE SURVEY OF UPSTATE NEW YORKERS: ADVANCE CARE PLANNING VALUES AND ACTIONS: SUMMARY REPORT 3 (2008), available at <https://www.excellusbcb.com/wps/wcm/resources/file/eb856805385613f/End%20of%20Life%20survey-EX.pdf> (finding that forty-two percent of upstate New Yorkers have executed a health care proxy).

43. 531 N.E.2d 607 (N.Y. 1988).

44. 420 N.E.2d 64 (N.Y. 1981).

45. *In re O'Connor*, 531 N.E.2d at 613-14, *In re Storar*, 420 N.E.2d at 72.

46. *In re O'Connor*, 531 N.E.2d at 613.

47. See *id.* at 614-15.

her wishes, the utility of the MOLST form for New York families may be limited by the clear and convincing evidence standard.⁴⁸ The MOLST form itself acknowledges these limitations but does not change them.⁴⁹

It is important to note that the clear and convincing evidence standard does not apply to decisions made by a health care proxy or to decisions to authorize DNR orders.⁵⁰ Nor can this language be found in recent amendments authorizing family members to make end-of-life decisions on behalf of loved ones with mental retardation or developmental disability.⁵¹ In each case, statutory law has rejected this standard as inappropriate and has crafted a more family-friendly approach to decision-making.⁵² However, absent a change in the law or more extensive use of health care proxies, the clear and convincing evidence standard will remain a major legal obstacle for surrogates and for full and effective implementation of the MOLST form.

D. *Patients With Mental Retardation and Developmental Disability*

The MOLST law acknowledges the “carve out” of more specific rules found elsewhere in New York law that govern decisions near the end of life for patients with mental retardation (“MR”) or developmental disability (“DD”).⁵³ Pursuant to two recent amendments to the Surrogate’s Court Procedure Act,⁵⁴ “qualified” family members may act as guardians (in stated order of priority) without formal court appointment, to make health care decisions, including decisions near the end of life,

48. See *In re O'Connor*, 531 N.E.2d at 613-14; *In re Storar*, 420 N.E.2d at 72.

49. See *infra* app. A.

50. See N.Y. PUB. HEALTH LAW §§ 2960, 2981(1) (McKinney 2007 & Supp. 2009).

51. See Act of July 7, 2008, ch. 262, 2008 N.Y. Laws 262 (codified as amended at N.Y. Surr. Ct. Proc. Act § 1750-b (McKinney Supp. 2009)); Act of July 3, 2007, ch. 105, 2007 N.Y. Laws 105 (codified as amended at N.Y. Surr. Ct. Proc. Act § 1750-b).

52. See N.Y. Surr. Ct. Proc. Act § 1750-b; N.Y. PUB. HEALTH LAW §§ 2960, 2981(1).

53. EXCELLUS, GUIDEBOOK, *supra* note 4, at 2.

54. Act of July 7, 2008, ch. 262, 2008 N.Y. Laws 262 (codified as amended at N.Y. Surr. Ct. Proc. Act § 1750-b); Act of July 3, 2007, ch. 105, 2007 N.Y. Laws 105 (codified as amended at N.Y. Surr. Ct. Proc. Act § 1750-b).

for seriously ill loved ones with MR or DD.⁵⁵ Decisions to forgo life-sustaining treatment may be made when the patient is terminally ill, permanently unconscious, or has an irreversible condition requiring life-sustaining treatment that will continue indefinitely.⁵⁶ Families must base their decision on the patient's best interests, taking into account the patient's wishes and values to the extent known.⁵⁷

The MOLST supplemental form for adults can be used to document decisions for patients with MR or DD who lack decisional capacity.⁵⁸ Importantly, diagnosis of MR or DD does not create a presumption of decisional incapacity. Rather, this is determined on a case-by-case basis, and patients with cognitive impairment due to mental retardation or developmental disability may be able to make their own health care decisions and/or designate a loved one or trusted friend as their health care proxy.⁵⁹ The MOLST form incorporates the legal requirement that a psychiatrist or psychologist, qualified by specialized training or experience with MR or DD patients, must confirm and document that the patient lacks decisional capacity.⁶⁰

II. Challenges and Legal Barriers

As already noted, the major barrier to full and effective use of the MOLST form is New York's failure to fully empower families to make decisions near the end of life.⁶¹ In 1992, the New York State Task Force on Life and the Law recommended enactment of legislation that would empower families confronting

55. N.Y. Surr. Ct. Proc. Act § 1750-b. Qualified family members are those who have "a significant and ongoing involvement in the person's life." *Id.*

56. *Id.*

57. *Id.* See also 14 N.Y. Comp. Codes R. & Regs. tit. 14, § 633.10(a) (2009).

58. See MOLST Supplemental Form, *supra* note 33. MOLST does not apply to patients under the auspices of the Office of Mental Health or who are residents of an Office of Mental Retardation and Developmental Disability facility. See *id.*

59. N.Y. State Dep't of Health, FAQ, *supra* note 39.

60. 14 N.Y. Comp. Codes R. & Regs. tit. 14, § 633.10(a). For further discussion of the amendments to the Surrogate's Court Procedure Act, see Lawrence R. Faulkner, *End of Life Healthcare for Persons with Developmental Disabilities: The New York Policies* (Network on Ethics and Intellectual Disability Edmonton, Can.), Summer 2007, at 1.

61. See *supra* notes 43-49 and accompanying text.

the burdens of these decisions.⁶² Much of the Task Force's original proposal is contained in a bill, known as the Family Health Care Decisions Act, that has been on the legislative agenda for more than fifteen years.⁶³ Absent this critical change in the law, the MOLST form will be of limited value to the many dying patients who lack decisional capacity, who do not have a written health care proxy, and whose families cannot present clear and convincing evidence that their spouse, father, mother, or sibling would refuse life-sustaining treatment.

Further challenges are presented by the interface of the MOLST form with health care proxies. The following case illustrates that the MOLST form can sometimes blur the line between a physician's orders based on contemporaneous patient wishes and proxy decision making and that a MOLST form can even be confused with a living will.⁶⁴

Mr. B is a fifty-nine-year-old man with a history of lung cancer who was admitted to Goodwill Hospital. His physician completed a MOLST form, documenting Mr. B's wish not to be resuscitated in the event of cardiac arrest. At the same time, Mr. B wanted other aggressive interventions, including a feeding tube, if necessary. One month later, he designated his sister as his health care proxy. Shortly thereafter, Mr. B was transferred to WeCare Hospital for an oncology follow up. Two days after admission, he suffered a stroke and lost decisional capacity, although he was still able to communicate and interact with others to an extent.

The attending physician believes that Mr. B is terminally ill but could live another six months with a feeding tube. Mr. B's health care proxy gives his sister authority to "make any and all health care decisions for me, except to the extent I state otherwise," in accordance with Mr. B's wishes and best interests. The standard form document gives no indication of Mr. B's

62. N.Y. STATE TASK FORCE ON LIFE & THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY (1992) (offering a comprehensive analysis of New York law and practice concerning surrogate decision making and the failure to empower families at the bedside).

63. Family Decision Coalition, Family Health Care Decisions Act, <http://www.familydecisions.org/fhcda-bill.html> (last visited Apr. 20, 2009). See also Assemb. 7729, 232nd Sess. (N.Y. 2009), S. 3164, 232nd Sess. (N.Y. 2009).

64. This case is adapted from an ethics consultation provided by one of the authors.

specific wishes regarding a feeding tube. Mr. B's sister refuses the feeding tube, stating, "He told me this is not what he wanted." Two nurses caring for Mr. B object. They insist that the MOLST documents are binding physician orders and constitute Mr. B's informed consent to the feeding tube. Mr. B's sister strenuously insists she is not bound by the MOLST form and that it does not represent her brother's wishes as she understood them when she was made his health care proxy.

Which document controls—the MOLST form or the health care proxy? And to what extent is the proxy bound by the terms of the earlier MOLST form? The nurses' position is understandable. The MOLST form is designed with contemporaneous consent of the patient or surrogate in mind.⁶⁵ Once completed, the MOLST form has no automatic expiration date.⁶⁶ When Mr. B transferred from Goodwill, the MOLST form and his end-of-life wishes went with him. Still, Mr. B's sister has the better argument. We can wonder why the MOLST form was not reviewed or changed when Mr. B signed his proxy, but regardless, his validly executed document gives his sister clear authority under our proxy law.⁶⁷ She may and should look to the prior MOLST form for guidance, but she is not bound by it. Her charge is to ascertain and honor her brother's wishes based on the totality of his statements, beliefs, and values over time. The MOLST form is in this case akin to a living will. It offers written evidence of Mr. B's wishes at the time, but it has only qualified legal standing as a statement of the patient's wishes.⁶⁸ The later proxy document controls.⁶⁹ Further, good medical practice dictates that the Goodwill physician's orders should be reviewed by Mr. B's current attending physician. The orders are presumptively, but not conclusively, binding. They may be

65. See EXCELLUS, GUIDEBOOK, *supra* note 4, at 1; N.Y. State Dep't of Health, MOLST, *supra* note 9.

66. See EXCELLUS, GUIDEBOOK, *supra* note 4, at 11.

67. See N.Y. PUB. HEALTH LAW § 2981(1) (McKinney 2007).

68. The New York proxy law does not recognize living wills. Written statements of the patient's wishes, such as a living will, are important evidence of the patient's wishes and may under the circumstances meet the "clear and convincing evidence" test. See *In re Westchester County Med. Ctr.* (O'Connor), 531 N.E.2d 607, 613-14 (N.Y. 1988).

69. See N.Y. STATE DEP'T OF HEALTH, BUREAU OF EMERGENCY MED. SERVS., POLICY STATEMENT 2 (2008), available at <http://www.health.state.ny.us/nysdoh/ems/pdf/08-07.pdf>.

changed, particularly if the patient's condition has changed as Mr. B's has.

The above viewpoint is expressly supported by the requirement that the MOLST form be periodically reviewed, and, if appropriate, modified with new orders.⁷⁰ Review and modification are specifically required upon transfer from another facility.⁷¹ A WeCare attending physician should either complete a new MOLST form or document any changes on the existing MOLST form.⁷²

It is useful to further compare and contrast the MOLST form and the health care proxy. The MOLST form is intended as a mechanism for documenting physician orders to implement decisions made by the competent patient who is chronically ill or dying.⁷³ The supplemental MOLST form is used to document physician orders to implement decisions of a health care proxy or other appropriate surrogate on behalf of an incompetent patient.⁷⁴ The MOLST form is effective upon proper completion by the physician.⁷⁵ By contrast, the purpose of health care proxies and living wills is to direct medical decisions regarding the end of life in the event of future incapacity.⁷⁶ Proxies and living wills are ideally written when the individual is in good health. An important trigger for planning ahead is diagnosis of a chronic illness or disease. In addition, many physicians and patients perceive the MOLST form as complex to complete. This perception creates further confusion about its proper use and how it differs from advance directives. The confusion is not surprising, especially so when the form was executed some time in the past and at another facility, as in Mr. B's case.

Advance directives and the MOLST form should be understood as complementary tools for documenting patients' decisions near the end of life. Neither is a substitute for the other. Failure to write an advance directive may mean that the physician cannot use the MOLST form to enter orders based on the now-incompetent patient's wishes and values. The DOH,

70. N.Y. State Dep't of Health, FAQ, *supra* note 39.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

health care providers, and policy leaders should make the similarities and differences between a MOLST form and a health care proxy, and their complementary roles in decision making near the end of life, an educational priority.

III. Conclusion

The MOLST initiative offers a standardized DNR form that is effective across care settings, both in the hospital and the home, and holds the promise of improving end-of-life care through the integration of physician orders for all life-sustaining treatments. All of this is achieved through the implementation of one easily recognized document.⁷⁷ The key to the MOLST form's success will be whether physicians use the form effectively and proactively to communicate with patients and families, to manage the difficult task of giving "bad news," and to work with patients and families to ease the burdens of decision making.

The "pink form" serves as a reminder of the importance of the informed consent process, as well as establishing a health care proxy, and of the complementary ways a MOLST form and a health care proxy can be used to make patients' wishes count near the end of life. Physicians, nurses, emergency medical technicians, and others across the state should receive in-service training in the use of the MOLST form, stressing that the MOLST form is a key tool in the larger dialogue about decisions near the end of life. Still, the promise of the MOLST initiative is hampered by the troubling gap in New York law that burdens family members with the clear and convincing evidence standard if they have not been appointed as the patient's health care proxy (agent).⁷⁸ New York case law too often disenfranchises families from their rightful place at the bedside to make decisions on behalf of their loved ones.⁷⁹ Enactment of the Family Health Care Decisions Act would address this critical flaw in New York law.⁸⁰

77. See *infra* app. A.

78. See N.Y. State Dep't of Health, FAQ, *supra* note 39. See also *supra* notes 43-49 and accompanying text.

79. See *supra* notes 43-49 and accompanying text.

80. See *supra* notes 61-63 and accompanying text.

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED																					
<p style="text-align: center;">MOLST</p> <p style="text-align: center;">Medical Orders for Life-Sustaining Treatment Do-Not-Resuscitate (DNR) and other Life-Sustaining Treatments (LST)</p> <p><small>This is a Physician's Order Sheet based on this patient/resident's current medical condition and wishes. It summarizes any Advance Directive. If Section A is not completed, there are no restrictions for this section. When the need occurs, <u>first follow</u> these orders, then contact physician. Review the entire form with the patient. Any section not completed implies full treatment for that section. WARNING: If patient lacks medical decision-making capacity as a result of mental retardation or developmental disability or has a legal guardian, specific, mandatory procedures need to be followed. Review information and seek legal counsel.</small></p> <p>This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:</p> <ul style="list-style-type: none"> ➤ The patient/resident is transferred from one care setting or care level to another, or ➤ There is a substantial change in patient/resident health status (improvement or deterioration), or ➤ The patient/resident treatment preferences change 	<p><small>Last Name/First/Middle Initial of Patient/Resident</small></p> <p><small>Address</small></p> <p><small>City/State/Zip</small></p> <p><small>Patient/Resident Date of Birth (mm/dd/yyyy)</small></p> <p><small>Gender <input type="checkbox"/> M <input type="checkbox"/> F</small></p> <p><small>Unique Patient Identifier (Last 4 SSN)</small></p>																				
<p>Section A</p> <p><small>Check One Box Only</small></p>	<p>RESUSCITATION INSTRUCTIONS (ONLY for Patients in Cardiopulmonary Arrest): (If patient/resident has no blood pressure, no pulse and no respiration) This form can be used in all settings, including community.</p> <p><input type="checkbox"/> Do Not Resuscitate (DNR)*/Allow Natural Death * [DNR = No CPR, endotracheal intubation or mechanical ventilation]</p> <p><input type="checkbox"/> Full Cardio-Pulmonary Resuscitation (CPR) [No Limitations; accepts intubation and mechanical ventilation]</p> <p><small>* For incapacitated adults; and/or for therapeutic or medical futility exceptions; and/or for residents of OMH, OMRDD or correctional facilities, also complete relevant sections of Supplemental DNR Documentation Form for Adults. For residents of OMRDD without capacity in the community, also complete NYSDOH Nonhospital DNR form. For minor patients, also complete Supplemental DNR Documentation Form for Minors.</small></p>																				
<p>Section B</p> <p><small>Patient/Resident/Health Care Agent or Surrogate Decision-Maker Consent for Section A</small></p> <p><small>Complete one of the subsections of Section B</small></p>	<p>DNR (CPR) CONSENT OF PATIENT/RESIDENT WITH DECISION-MAKING CAPACITY: Section A reflects my treatment preferences.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><small>Patient/Resident Signature</small></td> <td style="width: 10%;"><input type="checkbox"/> Check if verbal consent *</td> <td style="width: 30%;"><small>Print Patient/Resident Name</small></td> <td style="width: 30%;"><small>Date</small></td> </tr> <tr> <td><small>Witness of Patient/Resident Signature or Verbal Consent</small></td> <td></td> <td><small>Print Witness Name</small></td> <td><small>Date</small></td> </tr> <tr> <td><small>Witness of Patient/Resident Signature or Verbal Consent</small></td> <td></td> <td><small>Print Witness Name</small></td> <td><small>Date</small></td> </tr> </table> <p><small>*Patient with capacity can provide verbal consent in the presence of two adult witnesses. Written consent requires only one witness signature. If verbal consent, one witness must be a physician. In facility, physician must be affiliated with the facility, e.g. resident physician consent.</small></p> <p>DNR (CPR) CONSENT OF HEALTH CARE AGENT (HCA) OR SURROGATE DECISION-MAKER FOR PATIENT / RESIDENT WITHOUT DECISION-MAKING CAPACITY: This document reflects what is known about the patient/resident's treatment preferences. For Patient/Resident <u>without</u> decision-making capacity, or when medical futility or therapeutic exception is used, Supplemental MOLST Documentation Form MUST be completed and should always accompany this MOLST Form. If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST. <input type="checkbox"/> Prior DNR form attached <input type="checkbox"/> Supplemental Documentation Form completed</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><small>HCA/Surrogate Signature</small></td> <td style="width: 10%;"><input type="checkbox"/> Check if verbal consent</td> <td style="width: 30%;"><small>Print Name</small></td> <td style="width: 30%;"><small>Date</small></td> </tr> </table> <p><small>Relationship to Patient/Resident: _____</small></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><small>Witness Signature (Must witness HCA/surrogate signature or verbal/telephone consent)</small></td> <td style="width: 10%;"></td> <td style="width: 30%;"><small>Print Witness Name</small></td> <td style="width: 30%;"><small>Date</small></td> </tr> </table>	<small>Patient/Resident Signature</small>	<input type="checkbox"/> Check if verbal consent *	<small>Print Patient/Resident Name</small>	<small>Date</small>	<small>Witness of Patient/Resident Signature or Verbal Consent</small>		<small>Print Witness Name</small>	<small>Date</small>	<small>Witness of Patient/Resident Signature or Verbal Consent</small>		<small>Print Witness Name</small>	<small>Date</small>	<small>HCA/Surrogate Signature</small>	<input type="checkbox"/> Check if verbal consent	<small>Print Name</small>	<small>Date</small>	<small>Witness Signature (Must witness HCA/surrogate signature or verbal/telephone consent)</small>		<small>Print Witness Name</small>	<small>Date</small>
<small>Patient/Resident Signature</small>	<input type="checkbox"/> Check if verbal consent *	<small>Print Patient/Resident Name</small>	<small>Date</small>																		
<small>Witness of Patient/Resident Signature or Verbal Consent</small>		<small>Print Witness Name</small>	<small>Date</small>																		
<small>Witness of Patient/Resident Signature or Verbal Consent</small>		<small>Print Witness Name</small>	<small>Date</small>																		
<small>HCA/Surrogate Signature</small>	<input type="checkbox"/> Check if verbal consent	<small>Print Name</small>	<small>Date</small>																		
<small>Witness Signature (Must witness HCA/surrogate signature or verbal/telephone consent)</small>		<small>Print Witness Name</small>	<small>Date</small>																		
<p>Section C</p> <p><small>Physician Signature for Section A and B</small></p>	<p>Physician Signature for Sections A and B:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><small>Physician Signature</small></td> <td style="width: 10%;"></td> <td style="width: 30%;"><small>Print Physician Name</small></td> <td style="width: 30%;"><small>Date</small></td> </tr> </table> <p><small>(Must Witness Patient/Resident Signature <u>or</u> obtain Verbal Consent. Resident physician signature must be co-signed by licensed physician.)</small></p> <p><small>Physician License #: _____ Physician Phone/Pager #: _____</small></p> <p><small>It is the responsibility of the physician to determine, within the appropriate period, (see below) whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the appropriate time period. The physician must review these orders as follows: Hospital: at least every 7 Days; Nursing Home/Skilled Nursing Facility: at least every 60 Days; Nonhospital/Community Setting: at least every 90 Days</small></p>	<small>Physician Signature</small>		<small>Print Physician Name</small>	<small>Date</small>																
<small>Physician Signature</small>		<small>Print Physician Name</small>	<small>Date</small>																		
<p>Section D</p>	<p>ADVANCE DIRECTIVES: Patient/Resident has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity:</p> <p><input type="checkbox"/> Health Care Proxy <input type="checkbox"/> Living Will <input type="checkbox"/> Other Written Documentation or Oral Advance Directive</p>																				

<p>Section E</p> <p><i>Physician may complete form with patient who has capacity or with Health Care Agent. Include Section E consent.</i></p>	<p>HIPAA Permits Disclosure of MOLST to Other Health Care Professionals & Electronic Registry as necessary for treatment.</p> <p style="text-align: center;">ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT AND FUTURE HOSPITALIZATION: (If patient/resident has pulse and/or is breathing)</p> <p>Review patient's goals and patient's choice of interventions and then complete orders for appropriate subsections. Blank subsections can be completed at a later date. If patient has decision-making capacity, patient should be consulted prior to treatment or withholding thereof. <i>After confirming consent of appropriate decision-maker, obtain signature or verbal consent and complete the consent section of Section E, at the bottom of this page. Physician must sign and date each subsection at the time of completion.</i></p>
<p><i>Physician may complete form for incapacitated patients without Health Care Agent only with clear and convincing evidence. Include Section E consent.</i></p>	<p>ADDITIONAL TREATMENT GUIDELINES: (Comfort measures are always provided.)</p> <p><input type="checkbox"/> Comfort Measures Only – The patient is treated with dignity and respect. Reasonable measures are made to offer food and fluids by mouth. Medication, positioning, wound care, and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction are used as needed for comfort. <i>Do Not Transfer to hospital for life-sustaining treatment. Transfer if comfort care needs cannot be met in current location.</i></p> <p><input type="checkbox"/> Limited Medical Interventions - Oral or intravenous medications, cardiac monitoring, and other indicated treatments are provided except as specified in Sections A or E. Guidance about acceptable/unacceptable interventions relevant to this patient/resident may be written under "Other Instructions" below. May consider less invasive airway support (e.g. CPAP, BIPAP). <i>Transfer to the hospital as indicated.</i></p> <p><input type="checkbox"/> No Limitations on Medical Interventions - All indicated treatments are provided except as specified in Sections A. <i>Transfer to the hospital is indicated, including intensive care.</i></p> <p style="text-align: right;">MD Signature: _____ Date: _____</p>
<p><i>Physician should consult legal counsel for MR/DD patients without capacity. See Surrogate's Court Procedure Act §1750-b.</i></p>	<p>ADDITIONAL INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS: If patient/resident chooses DNR, review all options if patient/resident has progressive or impending pulmonary failure without acute cardiopulmonary arrest. If patient chooses full CPR, review options of trial and long-term intubation & mechanical ventilation:</p> <p><input type="checkbox"/> Do Not Intubate (DNI) (Review available symptomatic treatment of dyspnea: oxygen, morphine, etc.)</p> <p><input type="checkbox"/> A trial period of intubation and ventilation <input type="checkbox"/> A trial of BIPAP <input type="checkbox"/> A trial of CPAP (Discuss duration of trial and document in other instructions.)</p> <p><input type="checkbox"/> Intubation and long-term mechanical ventilation, if needed</p> <p style="text-align: right;">MD Signature: _____ Date: _____</p>
<p><i>Physician should consult legal counsel for MR/DD patients without capacity. See Surrogate's Court Procedure Act §1750-b.</i></p>	<p>FUTURE HOSPITALIZATION / TRANSFER: (For long-term care residents and home patients)</p> <p><input type="checkbox"/> No hospitalization unless pain or severe symptoms cannot be otherwise controlled.</p> <p><input type="checkbox"/> Hospitalization with restrictions outlined in Sections A and E.</p> <p style="text-align: right;">MD Signature: _____ Date: _____</p>
<p><i>Physician should consult legal counsel for MR/DD patients without capacity. See Surrogate's Court Procedure Act §1750-b.</i></p>	<p>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (If Health Care Agent makes decision, it must be based on reasonable knowledge of patient/resident's wishes.)</p> <p><input type="checkbox"/> No feeding tube (offer food/fluids as tolerated) <input type="checkbox"/> No IV Fluids (offer food/fluids as tolerated)</p> <p><input type="checkbox"/> A trial period of feeding tube <input type="checkbox"/> A trial of IV fluids</p> <p><input type="checkbox"/> Long-term feeding tube, if needed</p> <p style="text-align: right;">MD Signature: _____ Date: _____</p>
<p><i>Physician should consult legal counsel for MR/DD patients without capacity. See Surrogate's Court Procedure Act §1750-b.</i></p>	<p>ANTIBIOTICS:</p> <p><input type="checkbox"/> No antibiotics (except for comfort) <input type="checkbox"/> Antibiotics</p> <p style="text-align: right;">MD Signature: _____ Date: _____</p>
<p><i>Physician should consult legal counsel for MR/DD patients without capacity. See Surrogate's Court Procedure Act §1750-b.</i></p>	<p>OTHER INSTRUCTIONS: (May include additional guidelines for starting or stopping treatments in sections above or other directions not addressed elsewhere.)</p> <p>_____</p> <p>_____</p> <p style="text-align: right;">MD Signature: _____ Date: _____</p>
<p>Section E Consent</p>	<p>CONSENT FOR SECTION E OF PERSON NAMED IN SECTION B: Significant thought has been given to life-sustaining treatment. Patient/resident preferences have been expressed to the physician and this document reflects those treatment preferences. As the medical decision-maker, I confirm that the orders documented above in Section E reflect patient/resident's treatment preferences.</p> <p>Signature <input type="checkbox"/> Check if verbal consent _____ Print Name _____ Date _____</p>

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED	
RENEW / REVIEW INSTRUCTIONS	
<p>MOLST (DNR and Life-Sustaining Treatment)</p> <p>This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:</p> <ul style="list-style-type: none"> ➤ The patient/resident is transferred from one care setting or care level to another, or ➤ There is a substantial change in patient/resident health status (improvement or deterioration), or ➤ The patient/resident treatment preferences change 	Last Name/First/Middle Initial of Patient/Resident <hr/> Address <hr/> City/State/Zip <hr/> Patient/Resident Date of Birth (mm/dd/yyyy) Gender <input type="checkbox"/> M <input type="checkbox"/> F <hr/> Unique Patient Identifier (Last 4 SSN)

How to Complete the MOLST Form

➤MOLST must be completed by a health care professional, based on patient preference and medical indications.
 ➤Follow the 8-Step MOLST Protocol found at www.CompassionandSupport.org.
 ➤MOLST must be signed by a NYS licensed physician to be valid. Verbal orders are acceptable with follow-up signature by a physician in accordance with facility/community policy.
 ➤If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST.
 ➤Use of original form is strongly encouraged. Photocopies, FAXes and an electronic representation of the original signed MOLST are legal and valid.

How to Review MOLST Form:

Step 1: Review Sections A through E.
Step 2: Complete Section F below:

2a. If **no changes**, sign, date and check the "No Change" box.
2b. For **additions to Section E "optional" directives**, complete the relevant subsection(s) after securing consent from the appropriate decision-maker, sign and date subsection(s) in Section E. Then sign, date and check "Changes-Additions only" in box below.
2c. For **substantive changes**, (i.e. reversal of prior directive), write "VOID" in large letters on pages 1 and 2, and complete a new form. Check box marked "FORM VOIDED, new form completed". (RETAIN voided MOLST form in chart or medical record, or as required by law.)
2d. If this form is voided and no new form is completed, full treatment and resuscitation will be provided. Write "VOID" in large letters on pages 1 and 2 and check box marked "FORM VOIDED, no new form." (RETAIN voided MOLST form in chart or medical record, or as required by law.)

For detailed information about the MOLST Program, view www.CompassionandSupport.org.

Review of this MOLST Form				
Section F (Review of this Form)	Date	Reviewer's Name and Signature	Location of Review	Outcome of Review
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

Section F (Review of this Form)	Review of this MOLST Form (Con't from Page 3)			
	Date	Reviewer's Name & Signature	Location of Review	Outcome of Review
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
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