

Sound Ethics in Health Care

Life-Sustaining Treatment Orders and Advance Directives – How Are They Different?

Narrator: Welcome to Sound Ethics in Health Care, from the Department of Veterans Affairs National Center for Ethics in Health Care. Today's topic: differences between life-sustaining treatment orders and advance directives. This podcast is created for clinicians at facilities that are piloting new processes for understanding and respecting life-sustaining treatment decisions of patients with serious illness. Demonstration sites include VA facilities in Black Hills, Madison, Salt Lake City, and North Chicago. With the release of VHA Handbook 1004.03, "Life-Sustaining Treatment Decisions: Eliciting, Documenting, and Honoring Patients' Values, Goals, and Preferences," VA will implement new processes to ensure that goals of care conversations occur proactively with high risk patients, and that those patients' life-sustaining treatment decisions are understood, documented, and honored. Lucy Potter, a social worker and Ethics Policy Specialist with the National Center for Ethics in Health Care, explains which patients are considered high risk, why it is important to initiate a goals of care conversation with those patients, and how the conversation is documented.

Potter: High risk patients are patients with serious life-limiting medical conditions. For these patients, the practitioner would not be surprised if they experienced a life-threatening clinical event within the next two years or so. It's really important to have a conversation with these patients *before* a medical crisis occurs so that we can understand their goals of care and establish a life sustaining treatment plan with them. We now have a life-sustaining treatment progress note to document the goals of care conversation, and the patient's life-sustaining treatment plan. The life-sustaining treatment progress note also launches life-sustaining treatment orders.

Narrator: Advance directives are different from life-sustaining treatment orders in some important ways.

Potter: Patients with decision-making capacity can complete an advance directive to ensure that their wishes and preferences for future health care are documented in their record. Advance directives can be completed by the patient without the assistance of a health care provider, and, unlike life sustaining treatment plans, they can be completed years before he patient becomes sick or loses decision making capacity.

Narrator: Lindsay Secard is a registered nurse in an advance care planning clinic at the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin.

Secard: Everyone should consider completing an advance directive. It's an appropriate tool to complete for advance care planning at any time, regardless of age or health status — the sooner the better.

Narrator: In contrast, life-sustaining treatment orders are intended for patients who are seriously ill, or who have already decided to limit life-sustaining treatment.

Potter: Life-sustaining treatment orders are medical orders written by an appropriate health care practitioner. They're written when the practitioner and patient, or the patient's surrogate, have decided that the patient's condition is serious enough that decisions about life-sustaining treatments may need to be made soon.

Secard: Patients who have a disease process that could escalate to a life-threatening clinical situation would be appropriate for life-sustaining treatment orders. Also, if they are expressing a preference in limiting life-sustaining treatments, or expressing a preference for something specific, such as not wanting CPR, they could also benefit from life-sustaining treatment orders.

Narrator: Kayla Lalande is a social worker specializing in advance care planning at the William S. Middleton Memorial VA. She explains the role of the surrogate in advance care planning.

Lalande: The completion of an advance directive is something that's done by the Veteran before they lose decision-making capacity, and it is not something the surrogate is able to complete on behalf of the Veteran. It is really important, though, for the surrogate to be involved in the completion of the advance directive, so that they really get a good understanding of what is really important to the Veteran, so they can be really well equipped for making decisions for the Veteran when they do lose decision-making capacity.

Narrator: Lindsay Secard notes that while the surrogate cannot complete an advance directive, they can provide information about the patient's values, goals, and preferences, and make decisions about the life-sustaining treatment plan on behalf of the patient after the patient has lost decision-making capacity.

Secard: The surrogate cannot complete an advance directive. The surrogate can have a conversation with the practitioner, and orders can be written based on the conversation for life-sustaining treatments.

Lalande: It is something that needs to be done in a way that honors how the Veteran would have made those decisions if they could be here and telling us how to make those decisions.

Narrator: Advance directives allow the patient to designate an individual to serve as their health care agent. This formal designation cannot be achieved through the life-sustaining treatment progress note or orders.

Lalande: Sometimes it becomes evident that the person that would be identified under the VA policy for informed consent is not the person that the Veteran would actually want to make decisions for them. And it's not enough to just document this preference in the progress note. Let the Veteran know that this could be done through an advance directive, and then either assist the Veteran in completing an advance directive or put in a consult to a social worker so that the Veteran can get that document completed.

Narrator: Stacey Shaffer is a board-certified gerontologic nurse practitioner at the Salt Lake City VA Health Care System who assists patients with both advance directives and life-sustaining treatment plans.

Shaffer: In an advance care planning conversation, I really try to help the patient complete the advance directive to identify the person they would want to serve as their surrogate. That's really a very important piece of this document. We also want to document their preferences for care that they would want to receive in the future, that's after they have lost decision-making capacity.

Narrator: **Some patients need life-sustaining treatment orders in addition to advance directives.**

Shaffer: If a patient is at risk for a life-threatening event, and if the patient is really prepared and ready to make life-sustaining treatment decisions that they want to go into effect now, I make sure the patient has capacity, reinforcing what we discussed in the advance directive, and that I understand the goals of care, and then I help them make treatment decisions about life-sustaining treatments to support these goals. Then we document these decisions in a life-sustaining treatment progress note and order set. Life-sustaining treatment template and order sets can't be completed by anybody except licensed medical providers, including nurse practitioners, physicians, and physician assistants. In contrast, the advance directive can be completed by patients and families on their own, led by social work teams.

Narrator: **Social workers, registered nurses, and others who help patients with their advance care planning may recognize when a patient is a good candidate for life-sustaining treatment orders, and bring that to the attention of the primary care provider or specialist caring for the patient. Kayla Lalande.**

Lalande: When I'm talking with somebody about advance care planning, and it becomes evident that the Veteran would benefit from life-sustaining treatment orders, I really like to explore any past experiences with that Veteran, and then preferences for life-sustaining treatments that they have. I think these are really important pieces for practitioners to understand if the Veteran would ever lose decision-making capacity, because it really shows where they are coming from in their decision-making. And then I go ahead and alert their PCP so that those orders can be completed after a goals of care conversation with the Veteran.

Narrator: **Stacey Shaffer.**

Shaffer: In the past, we really didn't have this option of writing a durable life-sustaining treatment order at the VA, but now we do, which is so important for those patients who are at high risk for a life-threatening clinical event.

Narrator: **For more information and resources related to advance directives, VA life-sustaining treatment orders, and goals of care conversations, visit vaww.ethics.va.gov/education/LST/ClinicalStaff.asp. If you have a topic that you would like to see presented in a podcast, send an email to vhaethics@va.gov. Sound Ethics in Health Care is brought to you by the Department of Veterans Affairs National Center for Ethics in Health Care.**