Maine Medical Association

Charles F. Pattavina, MD, President | Jabbar Fazeli, MD, President-Elect | Robert J. Schlager, MD, Chair, Board of Directors
Gordon H. Smith, Esq., Executive Vice President | Andrew B. MacLean, Esq., Deputy Executive Vice President & General Counsel

TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

IN OPPOSITION TO

L.D. 125, AN ACT TO ALLOW AN ORDER NOT TO RESUSCITATE TO BE PRESENTED IN THE FORM OF AN INDELIBLE MARK

Joint Standing Committee on Judiciary
Room 438, State House
Thursday, February 9, 2017, 1:00 p.m.

Good afternoon Senator Keim, Representative Moonen, and Members of the Joint Standing Committee on Judiciary. My name is Andrew MacLean and I am Deputy Executive Vice President & General Counsel of the Maine Medical Association and I am speaking in opposition to L.D. 125, *An Act to Allow an Order Not to Resuscitate to be Presented in the Form of an Indelible Mark*.

The Maine Medical Association is a professional organization representing more than 4000 physicians, residents, and medical students in Maine whose mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens.

The MMA and the Maine Chapter of the American College of Emergency Physicians have substantial concern about this proposal to change the Maine Emergency Medical Services protocol in reaction to what I assume is one constituent's specific situation. EMS personnel must react very quickly in the field and, in order to recognize, interpret, and properly respond to a do-not-resuscitate or DNR order, it must be in a format that is commonly recognized among EMS personnel, such as a MedicAlert bracelet or the standard form included as Part 7 (pages 13 and 14) of the model Maine Health Care Advance Directive Form (attached). A MedicAlert bracelet is found and easily recognized on an individual's wrist. When we speak to patient groups about the model DNR form in Part 7, we suggest that it should be displayed in a prominent place in the home, such as the front of the refrigerator and it is even better if it is printed on bright orange paper. EMS personnel can recognize and act in accordance with the DNR order in formats such as these two. In contrast, a tattoo could be anywhere on the body and could be obscured by clothing. Moreover, it could be very difficult for EMS personnel to determine the validity of a tattoo representation of a DNR order because it may not include dates of signature or expiration, and may not have any indication that the patient has been counseled by his or her physician about the implications of a DNR order. How would EMS personnel know if the patient had revoked a tattoo representation of a DNR order?

Frank O. Stred Building | 30 Association Drive | PO Box 190 | Manchester, Maine 04351
TEL: 207-622-3374 | FAX: 207-622-3332 | www.mainemed.com

As additional background, I have attached Opinion 5.4, *Orders Not to Attempt Resuscitation (DNAR)* from the **Code of Medical Ethics** of the American Medical Association.

For the reasons mentioned above, we believe it would be unwise to proceed with L.D. 125.

Thank you for considering the views of the Maine Medical Association and the Maine Chapter of the American College of Emergency Physicians on L.D. 125. I would be happy to respond to any questions you may have.

Maine Health Care
Advance Directive Form

You may use this form now to tell your physician and others what medical care you want to receive if you become too sick in the future to tell them what you want. **You may choose to fill out the whole form or any part of the form and then sign and date the form in Part 6.** These are the parts:

Part 1	Fill this out if you want to choose someone to make all your health care decisions for you, either right away or if you become too sick to tell others what you want. This person is called your agent.
Part 2	Fill this out if: (1) you did not name an agent in Part 1 and now want to choose whether you want certain treatments **or,** (2) you did name an agent in Part 1 and want to tell your agent your wishes about certain treatments, knowing that your agent must follow your directions.
Part 3	Fill this out if you want to give the name of your primary physician, physician assistant or nurse practitioner.
Part 4	Fill this out if you want to make decisions about donating your organs, body or tissues after your death.
Part 5	Fill this out if you want: (1) to choose someone to make all funeral and burial decisions after your death, **or** (2) to tell your family any wishes you have about funeral and burial decisions.
Part 6	You must sign and date your Advance Directive form on this page. Have two witnesses sign the form at the same time you sign it. Tell others about your decisions and give copies to your physician, other health care providers, family and hospital.
Part 7	If you do not wish to be revived by ambulance crews should your heart or breathing stop, then you **and** your physician (**or** nurse practitioner **or** physician assistant) need to sign this Do Not Resuscitate (DNR) form.

Note

You may change any part of this form except for Part 6 and Part 7. You may cross out any words, sentences, or paragraphs you do not want. You can also add your own words. If you make any changes to the form, it is best if you put your initials and the date next to each change so that everyone knows it was your decision to make the change. The form lets you choose different ways to handle your care by checking boxes or filling in blanks. You may initial each box and each blank you fill in to show that it was your decision to check the box or fill in the blank.

Before filling out this form, we suggest that you talk with your lawyer, family members, physicians, and others close to you about your wishes. If you make changes or complete a new form, be sure to let everyone know.

My Name *(please print)*_____

My Address _____

My Birth date_____

This is a list of all the people who have copies of my signed health care advance directive:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Part 1 – Power of Attorney for Health Care

Instructions:
This part lets you choose another person to make health care decisions for you, either right away or when you are too sick to choose your own care. The person you choose is called your agent. You may also name a second and third choice to be your agent, if your first choice is not willing, reasonably available or able to make decisions for you. If you choose an agent on this form, but do not fill out any other parts of the form, your agent will be able to:

- Make all health care decisions for you, including decisions regarding tests, surgery and medication;
- Decide whether or not to have food or fluids given to you through tubes or fed into your veins through an IV;
- Decide whether or not to use treatments or machines to keep you alive or to restart your heart or breathing;
- Choose who will give you health care and where you will get it, such as hospitals, nursing homes, assisted living settings, home health, or hospice care; and
- Make any health decision he or she believes would be consistent with your values or in your best interest, even if it is not listed in the form.

Who can be your agent:
You can name any adult you trust to be your agent, except your agent may not be the owner, operator or employee of a nursing home or residential long-term care facility where you are receiving care, unless that person is your relative.

How your agent must make decisions:
If your agent does not know what you want, the agent must make decisions consistent with your personal values, if known, or based on your best interests. In Part 2, you can decide what you want in advance. If you make choices in Part 2, your agent must make decisions based on those choices.

Who can see your health care information:
Once your agent has the right to make health care decisions for you, your agent can look at your medical records and consent to giving your medical information to others. The state and federal privacy laws let your agent see all of your health information so that he or she can make the right decision for you.

The first part of your advance directive begins on the next page.

YOUR ADVANCE DIRECTIVE BEGINS HERE

Choosing an agent: Fill in your name and the name of the person you choose to be your agent to make health care decisions for you here:

My name_____

My agent's name_____

Title or relationship to me_____

My agent's address_____

My agent's home phone (___)_____ My agent's work phone (___)_____

If the agent I have named above is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice # 2 to be my agent

Name_____

Title or Relationship to me_____

Address_____

_____

Home Phone (___)_____

Work Phone (___)_____

If the person I have named as Choice # 2 is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice # 3 to be my agent

Name_____

Title or Relationship to me_____

Address_____

_____

Home Phone (___)_____

Work Phone (___)_____

You may change your mind later about who you want to be your agent. If you want to stop the agent you have named from making decisions for you, you must tell your primary physician or fill in these blanks:

I do **not** want _____ to be my agent. _____

My signature

Date you filled out and signed this section _____

Any time you cancel, replace or change this form you should give copies of the changed or new form to everyone who has a copy of your original form.

Your agent's power:

When your agent can start making decisions for you: (Check only one box: A **or** B)

A. ☐ My agent can make decisions only when my primary physician or a judge decides that I am too sick to make my own health care decisions.

OR

B. ☐ My agent can start making health care decisions for me right away, but this does not mean I have given up the right to make my own decisions if I am still able and willing to make my own decisions. When my agent makes a health care decision for me, I will be told, if possible, about that decision before it is carried out unless I say I do not want to know. If I disagree with that decision and am still able to decide, I can make a different decision. As long as I am able, I can end my agent's right to make decisions for me, change my agent or make my own decisions. If I want to end my agent's right to make decisions for me, I must tell my primary physician or put my decision in writing and sign it with the date of my signature.

Nominating a guardian:

A guardian is a person chosen by a court to make decisions about your personal care. These decisions can include not only health care, but other decisions such as where you will live and how your personal needs will be met. If you wish, you may ask that a court assign your agent as your guardian, if appointment of a guardian should become necessary. Check the box below to nominate your agent to be your guardian, if a judge needs to appoint a guardian for you.

☐ I nominate my agent to be my guardian if a judge needs to appoint a guardian for me.

If you want to nominate someone other than your agent to be your guardian, you may fill in the section below.

If a judge needs to appoint a guardian for me, I nominate the person named below as my guardian:

Name_____ Title or Relationship to me_____

Address_____

_____

Home Phone (___)_____ Work Phone (___)_____

Part 2 – Special Instructions

Instructions if you did <u>not</u> name an agent in Part 1:

If you did not name an agent in Part 1, you should fill out this Part to state what you want for care if you become too sick to make your choices known.

<u>OR</u>

Instructions if you did name an agent in Part 1:

If you named an agent in Part 1, you do not have to fill out this part of the form. If you want your agent to make all of your health care decisions, DO NOT fill out this part of the form. Your agent will make decisions in your best interests, including decisions to refuse treatment. However, you may fill out this part if you want to give special directions to your agent about your wishes, such as when you are near death, in a permanent coma or no longer able to make your own decisions. You may also cross out or add words. It is best if you put your initials and date next to any changes you make so everyone knows the changes were your decision. If you complete this part, your physician and others will follow these instructions and your agent cannot make a different decision. You may also write your wishes on another piece of paper, sign it, date it, and keep it with this form.

Life-Sustaining Treatment Choices:

You may check <u>one</u> of the two boxes below to show your choice about getting treatments that would keep you alive:

☐ <u>Choice not to be kept alive</u>	☐ <u>Choice to be kept alive</u>
I do not want treatment to keep me alive if my physician decides that either of the following is true; **(i)** I have an illness that will not get better, cannot be cured, and will result in my death quite soon (sometimes referred to as a terminal condition), **OR** **(ii)** I am no longer aware (unconscious) and it is very likely that I will never be conscious again (sometimes referred to as a persistent vegetative state).	I want to be kept alive as long as possible within the limits of generally accepted health care standards, even if my condition is terminal or I am in a persistent vegetative state.

Life-Sustaining Treatment Choices:

You may also check one of the two boxes below to show your choice about treatment that would keep you alive if, in the future, you have late stage Alzheimer's disease or other severe dementia. These choices will not limit the authority under state law for your agent, surrogate, guardian or physician to make treatment choices if you are unable to make your own decisions and are **not** in late stage Alzheimer's disease or other severe dementia.

☐ Choice not to be kept alive	☐ Choice to be kept alive
If my physician and a second physician decide that I am in the late stage of Alzheimer's disease* or other severe dementia, I do not want treatment to keep me alive.	I want treatment to keep me alive as long as possible within the limits of generally accepted health care standards, even if my physician and a second physician decide that I am in the late stage of Alzheimer's disease or other severe dementia.

* Only a physician can determine that someone is in the late stage of Alzheimer's disease. People in the late stages of Alzheimer's disease generally have a number of the following characteristics: loss of the ability to respond to their environment; loss of the ability to speak; loss of the ability to control movement; loss of the capacity for recognizable speech, although words or phrases may occasionally be uttered; needing help with eating and toileting; general incontinence of urine; loss of the ability to walk without assistance, then the ability to sit without support, then the ability to smile, and the ability to hold their head up; reflexes become abnormal; muscles grow rigid; and swallowing is impaired.

Tube Feeding: You may check one of the two boxes below to show your choice about tube feeding or having water and nutrition fed into your body through an IV or tube (artificial nutrition and hydration):

☐ Artificial nutrition and hydration should not be given, or should be stopped, based on the other life-sustaining treatment choices I made about keeping me alive on Pages 6 and 7.	☐ Artificial nutrition and hydration should be given regardless of my condition.

Relief from Pain: You may check the box or fill in the blanks below to show your choice about relief of pain or discomfort.

☐ I want treatment for relief of pain or discomfort to be given at all times, even if it shortens the time until my death or makes me drowsy, unconscious or unable to do other things.	These are my wishes about relief of pain or discomfort:

Other Directions:

You may give more directions or add any other treatment choices in the space below:

Part 3 — Primary Physician

This section is optional. Fill out this part only if you wish to name your primary physician today.

Name of my primary physician:_____

Address: _____ Phone: _____

I want any agent I named in Part 1 to talk with this physician about my health care. If the physician I have named above is not willing, reasonably available or able to carry out my wishes, I want the agent I named in Part 1 to talk with the physician listed below:

Name of physician: _____

Address:_____ Phone:_____

If you want your agent or those making decisions for you to speak with a nurse practitioner or physician assistant before making a decision, you may complete the following section:

Name of nurse practitioner or physician assistant: _____

Address: _____ Phone:_____

Part 4 – Donation of Body, Organs or Tissues at Death

This section is optional. Fill out this part only if you want to give directions about donating your body, organs or tissues after your death.

☐ I do **NOT** wish to donate any organs, tissues or parts.

I have checked below my choices about donating my body, organs or tissues after death. I have spoken with my family so that they will not object to my wishes after I die.

☐ I give my body. **OR**

☐ I give any needed organs, tissues or parts. **OR**

☐ I give only the following organs, tissues, or parts:

_____

_____

My gift is for the following purposes (you may check any number of boxes):

☐ My gift is for transplant or therapy for another person, to be chosen based on generally accepted health care standards.

☐ My gift is for research and education. My preference, if any, is to give my body, organs, or tissues to the following hospital, medical school, or physician:

Name _____

Address _____

_____

I understand that I may need to contact the hospital, medical school, or physician before I die in order for them to accept my body, organs or tissues after my death.

Part 5 – Instructions About Funeral and Burial Arrangements

This section is optional. Fill out this part only if you wish to give special instructions about your funeral or burial arrangements here.

I hope that my family will follow my wishes after I die as noted below.

☐ I choose _____ to have custody and control of my body after my death with the right to decide everything about my funeral and burial.

OR

☐ I want my family to know these are my wishes about: burial, cremation, funeral, or memorial service. (Fill in)

_____

_____

_____

_____

_____

_____

_____

_____

If you plan to die at home, talk with your physician and funeral director about your plans. When you die, your family or agent should call your physician and the funeral home you have chosen. The funeral home staff will pick up your body from your home.

Part 6—Signing the Form

If you have filled out any part of this form, you must sign and date the form on this page. You must also have two other adults sign as witnesses at the same time you sign the form. Your agent cannot sign as a witness. You do not need to have a Notary Public sign your Advance Directive form to make it legal in Maine. However, if you travel or live part of the year out-of-state, it would be wise to have it signed by a Notary. Some states require this. You can find this service under Notary Public in the phone book. Most banks also have Notaries Public and will usually notarize papers for bank customers when asked. The Notary Acknowledgment may be done at any time after you sign this form.

Sign and date the form here:

Sign your name: _____ Your Address: _____

Print your name: _____ _____

Date: _____ _____

First witness:

Signature: _____ Address: _____

Print your name: _____ _____

Date: _____ _____

Second witness:

Signature: _____ Address: _____

Print your name: _____ _____

Date: _____ _____

Notary Acknowledgment.
Then personally appeared the above named _____, known to me or who presented satisfactory evidence of his/her identity, and acknowledged this Advance Directive as his/her free act and deed before me.

Notary signature: _____ Date: _____

Printed name: _____ Notary Public State of: _____ Commission Exp.: _____

Make sure to tell people. Tell your family members, physicians and others close to you what you have decided. You should talk to the agent(s) you have chosen to make sure that they understand your wishes and are willing to carry them out. Give a copy of this form to your physician, to any place where you get health care, and to any agent(s) you have chosen in Part 1. Please be sure to list the people who have copies of this form on the front page.

Canceling or changing the form.
Part 1: You may end your agent's right to make decisions while you are still able to make those decisions by telling your primary physician or putting your decision in writing and attaching it to this form. If you want to name a new agent, you must put that instruction in writing and sign it in front of two witnesses who must also sign their names.

Parts 2-7: You may cancel any other part of this form, or change your instructions in the other parts of this form while you are still able to make those decisions. It is best to do so by (1) writing on this form, (2) writing on another piece of paper and attaching it to this form, or (3) completing a new form. Any of those written changes should be signed and dated by you.

Part 7—Instructions to Emergency Medical Services (ambulance crews) about what to do if your heart or breathing stops.

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your physician (**or** nurse practitioner **or** physician assistant) must both complete and sign this part.

Instructions for Part 7:

- If I stop breathing or my heart stops, I do not want the Emergency Medical Services (ambulance crews) to try to revive me. My physician (**or** nurse practitioner **or** physician assistant) and I have discussed this and signed the special form on the next page. I understand that this decision will not prevent me from receiving other emergency care, or comfort care from health care workers before I die.

- I understand that the form goes into effect when I have signed it **AND** it is signed by my physician (**or** nurse practitioner **or** physician assistant).

- I understand that this directive will not be followed unless my family, caretaker or I give the signed form on the next page to Emergency Medical Services (ambulance crews), and that it is solely my responsibility to make sure they see it.

- I understand that I should carry the signed form with me unless I wear health alert jewelry, such as MedicAlert, that also tells people that I do not want to be revived if my heart or breathing stops (Please call Maine Emergency Medical Services at 207-626-3860 to see if there are other Maine EMS approved health alert jewelry companies).

- I understand that if any health care provider has any doubts about what I want, they will try to restart my heart or breathing.

- I understand that I may revoke this directive at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry. I can also tell the ambulance crews that I have changed my mind.

- I understand that should I change my mind, it is my responsibility to tell my physician (**or** nurse practitioner **or** physician assistant) and other people who have copies of the signed form.

- If I want my agent to make this decision later, my agent should take the form available at: http://www.maine.gov/dps/ems to my physician (**or** nurse practitioner **or** physician assistant) when it is time to make the decision.

If you complete and sign this section, put the original in a safe place and be sure to give copies to ambulance crews, your family, your caregivers, and your physician.

DO-NOT-RESUSCITATE (DNR) DIRECTIVE

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you **and** your physician (**or** nurse practitioner **or** physician assistant) must complete and sign this form.

FOR PATIENT TO COMPLETE after consultation with his or her health care provider:

In the event that my heart or breathing stops and I am unable to speak for myself, I, _____ (printed name)direct that no efforts be taken to restart my heart or breathing and that Emergency Medical Services (ambulance crews) if notified, honor my directive. I have come to this decision after considering my condition and prognosis and the potential risks, burdens and benefits of refusing efforts to restart my heart or breathing.

I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my physician (**or** nurse practitioner **or** physician assistant) and other caregivers if I change my mind.

I understand that this form is not valid until my physician (**or** nurse practitioner **or** physician assistant) **and** I have signed it.

I understand that in a hospital, nursing home, hospice or home health setting, federal law requires that my physician must include a specific DNR order in my medical record or plan of care, even if we have both signed this form.

☐ No expiration date **OR** ☐ Expires on _____

_____ _____

Patient Signature Date Signed

FOR PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER TO COMPLETE:

By my signature I affirm that:

(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made a voluntary informed decision about resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.

_____ _____

Signature and license level (MD, DO, PA or NP) Date Signed

_____ _____

Printed Name Telephone Number

THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES

(h) Ensure that relevant standards for good clinical practice and palliative care are followed when implementing any decision to withdraw a life-sustaining intervention.

5.4 Orders Not to Attempt Resuscitation (DNAR)

AMA Principles of Medical Ethics: I, IV, VIII

Issued: 1992

Updated: 1994, 2005, 2016

Opinions on Related Matters:

1.1.1 Patient-Physician Relationships
2.1.2 Decisions for Adult Patients Who Lack Capacity
5.2 Advance Directives
5.3 Withholding or Withdrawing Life-Sustaining Treatment
5.5 Medically Ineffective Interventions
10.7 Ethics Committees in Health Care Institutions
10.7.1 Ethics Consultations

The ethical obligation to respect patient autonomy and self-determination requires that the physician respect decisions to refuse care, even when such decisions will result in the patient's death. Whether a patient declines or accepts medically appropriate resuscitative interventions, physicians should not permit their personal value judgments to obstruct implementation of the patient's decision.

Orders not to attempt resuscitation (DNAR orders) direct the health care team to withhold resuscitative measures in accord with a patient's wishes. DNAR orders can be appropriate for any patient medically at risk of cardiopulmonary arrest, regardless of the patient's age or whether the patient is terminally ill. DNAR orders apply in any care setting, in or out of hospital, within the constraints of applicable law.

In the event a patient suffers a cardiopulmonary arrest when there is no DNAR order in the medical record, resuscitation should be attempted if it is medically appropriate. If it is found after the "code" is initiated that the patient would not have wanted resuscitation, the physician should order that resuscitative efforts be stopped.

Physicians should address the potential need for resuscitation early in the patient's course of care, while the patient has decision-making capacity, and should encourage the patient to include his or her chosen surrogate in the conversation. Before entering a DNAR order in the medical record, the physician should:

(a) Candidly describe the procedures involved in resuscitation, the likelihood of medical benefit in the patient's clinical circumstances, and the likelihood of achieving the patient's desired goals for care or quality of life to address any misconceptions the patient may have about probable outcomes of resuscitation.

(b) Ascertain the patient's wishes with respect to resuscitation—directly from the patient when the individual has decision-making capacity, or from the surrogate when the patient lacks capacity. If the patient has an advance directive, the physician should review the directive with the patient and confirm that the preferences set out in the directive about resuscitation are current and valid. The DNAR order should

be tailored to reflect the particular patient's preferences and clinical circumstances.

(c) Reinforce with the patient, loved ones, and the health care team that DNAR orders apply only to resuscitative interventions as they relate to the patient's goals for care. Other medically appropriate interventions, such as antibiotics, dialysis, or appropriate symptom management, will be provided or withheld in accordance with the patient's wishes.

(d) Revisit and revise decisions about resuscitation—with appropriate documentation in the medical record—as the patient's clinical circumstances change. Confirm whether the patient wants the DNAR order to remain in effect when obtaining consent for surgical or other interventions that carry a known risk for cardiopulmonary arrest and adhere to those wishes.

(e) Document in the medical record the patient's clinical status, prognosis, current decision-making capacity, and preferences with respect to resuscitation, as well as the physician's medical judgment about the appropriateness of resuscitation.

When the patient cannot express preferences regarding resuscitation or does not have decision-making capacity and has not previously indicated his or her preferences, the physician has an ethical responsibility to:

(f) Candidly and compassionately discuss these issues with the patient's authorized surrogate and document the surrogate's decision in the medical record.

(g) Revisit with the surrogate decisions about resuscitation as the patient's clinical circumstances change, revising the decision as needed and updating the medical record accordingly.

(h) Seek consultation with an ethics committee or other appropriate institutional resource if disagreement about a DNAR order that cannot be resolved at the bedside.

When the patient's preferences cannot be determined and the individual has no surrogate, the physician should consult with an ethics committee or other appropriate institutional resource before entering an order not to attempt resuscitation.