MOLST in Acute Care Hospitals

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Fast Background

- Two Hospitals
- Committees, champions, understanding, education
- 25% at the start
- Different implementations
  - A: at admission, always re-discuss
  - B: at discharge if required, left to individual
- 100% aware, but different interpretations
Inherent Problems

Burdens and Benefits

- Acute care hospital is for the very sick
- Clinicians juggling a lot: not on the radar
  - Assumption treatment desired
- Generally a new relationship

- Advancing discussions of Goals of Care, bringing information from previous discussions
Have you ever/do you have?
What does it say?
This is an order form about possible treatments: it doesn’t mean that many will come up during this hospitalization, or that your doctors will recommend them or think they will be helpful. But I go over this order sheet with everyone hospitalized.
Mrs. S

- 68, COPD, pneumonia, ICU admission for hypoxia and sepsis, but not needing vent support in the ER but at risk for needing intubation. No other significant medical problems. Husband and children present.
People look Sick

- Clinicians opinions
- Opposite of the PCP’s overly optimistic prognostication.
- Ms. B: 84 yo with trach and PEG in ICU after second hypercapnic near arrest on floor.
Lack of Discussion on Admission

- Mr. T. 92 yo telling nurses he wants to die post op successful nephrectomy for cancer. Has agreed to PEG for failed swallow.

- Full code in chart – no MOLST or AD present
- Mr. T and daughter in law “they have the Advanced Directive here.”
Why no discussion?

- Most people don’t do Advance Directives.
- In a hurry – generally needs explanation.
- Death is scary
- Physicians don’t like to give bad news.
  - Fearful of emotion, failure, being wrong now or earlier.
- Surgery statistics
- Skipped if seems inappropriate
Chinese menu
Inappropriate Choices

- Tom
  - End-stage cardiomyopathy, hospitals, NH and SAR for a year from CHF, trial out patient dobutamine, failed with renal failure once and then sepsis.
  - Can’t accept DNR, or have AICD turned off. “But I want to keep living”

- Capacity
“We live in a very particular death-denying society. We isolate the dying and the old, and it serves a purpose. They are reminders of our own mortality.”

Committee on the Aging 1972
MOLST/Code Discussions
Goals of Care

- Cure

- Living with a chronic disease, stabilize an acute complication, return to a level of function

- A peaceful death
Goals of Care Conversations

- Understanding of current condition and prognosis: physician and patient
- Capacity
- Appropriate and informed surrogate when needed
- 76% of seniors chose independence as primary goal, before pain and symptom control, and third place is extending life.
- >50% cancer or end stage condition patients want to die at home.
- < 25% do
- 53–65% of Americans die in hospitals.
Summary of problems

- Often the wrong time and place
- Can misguide patients and families about their responsibilities and level of control (No mention that doctors may not offer)
- Specific choices are isolated from goals of care/patient’s living preferences
- Physicians lack of comfort, lack of training, lack of practice
Positives

- Patients arrive with MOLSTs
- MOLST is mandatory
- Advancing discussion of EOL preferences
- Advancing education
  - Patients
  - Physicians
Questions?