Issues with Substitute Senate Bill 165 (Lehner) Medical Orders for Life Sustaining Treatment: MOLST

Prepared by the *Coalition Opposing Ohio S.B. 165, MOLST (in alphabetical order):*

Advocates for the Family
Citizens for Community Values
Clermont County Right to Life
Cleveland Lawyers for Life
Cleveland Lutherans for Life
Cleveland Prays for Life
Cleveland Right to Life
Euthanasia Prevention Coalition, U.S.A.
Fostoria/Bascom Area Pro-Life
Fostoria Teens for Life
Geauga County Right to Life
Geauga County Tea Party
Greater Toledo Right to Life
H.E.L.P. Pro-Life Apostolate
Hancock County Right to Life
Henry County Right to Life
Hospice Patients Alliance
Institute for Principled Policy
International Right to Life Federation
Lake County Right to Life
LifeLink
Lima & Allen County Right to Life
National Black ProLife Coalition
National Lawyers Association
Northeast Ohio Values Voters
Ohio Pro-Life Action, Inc.
Personhood Alliance
Putnam County Right to Life
Right to Life of Greater Cincinnati
Right to Life of Northeast Ohio
Terri Schiavo Life & Hope Foundation
Tiffin Right to Life
Warren County Right to Life
What's Right/What's Left Ministries

Overview

MOLST not needed if Living Will and/or Durable Power of Attorney are in place; presents duplication of effort/potential conflict with current Ohio law and/or other advance directives.
Much MOLST-like protocol is already addressed in Ohio law but not so open-ended or simplistic:

- Power of Attorney for Health Care (O.R.C. 1337.11-1337.17)
- Living Will (O.R.C. 2133.02)

If patient has MOLST plus other advance directive(s), which has priority?

Specific concerns

1. Page 7: In Section 2133.21(D)(3) and Page 20 (2133.30 (N))--"Issuing practitioner" not necessarily patient's "attending physician" who knows history and needs (2133.30). This opens the door for more than the attending physician to issue a MOLST for a patient; the non-attending practitioner may not have a relationship with the patient.
2. Page 8: Section 2133.22---This statement does not negate the possibility of either euthanasia, physician assisted suicide or mercy killing taking place, as current law is only injunctive relief without criminal penalty. Not condoning, authorizing or approving is not the same as prohibiting and penalizing.
3. Page 16: Section 2133.27 (A)(5)(b)---It is ambiguous what order from a physician would "supercede" an existing DNR order.
4. Page 18: Section 2133.30 (A) and (B)---The "artificially administered" means "technologically administered" standard regarding nutrition and hydration is a tautological and meaningless definition, especially since the phrase "technologically administered" is not defined anywhere in the legislation.

5. Page 18-19: Section 2133.30 (E)(1) and (2)---"Comfort Care" definition is problematic-- Nutrition and hydration used only to "disminish pain or discomfort, but not to postpone death" means no food or water to a person if it might keep them alive--could lead to the type of situation faced by Terri Schindler Schiavo, a reason why the Terri Schiavo Life and Hope Network opposes SB 165.
6. Page 19: Section 2133.30 (E) (3)---Not allowing medicine (i.e., including routine prescriptions, dialysis) that might keep a person alive, e.g., diabetes, blood pressure, kidney function, etc. could lead to euthanasia.
7. Page 19: Section 2133.30 (K)---The definition of "form preparer" is not limited to the attending physician, and thus could possibly reflect a misunderstanding of the patient's needs, or not be an accurate reflection of a patient's informed medical consent, especially if the preparer is not the attending physician for the patient, or not a medical professional.
8. Page 20: Section 2133.30 (O)---Definition of "life sustaining treatment" reduced to "prolong the process of dying" This is a philosophical and legal shift from preserving life to hastening death. Establishes legal bias against helping patient live, recover, survive.
9. Page 20: Section 2133.30 (P)---Definition of MOLST includes "withdrawal of life-sustaining treatment and comfort care" as viable option. Problematic, in that comfort care: 1) is always to be administered to patient until death (would change under this provision), and: 2) also here by definition can include withdrawal of food and water (hydration and nutrition), which is basic not extraordinary care, plus withdrawal of basic medications and treatment (see previous reference in Section 2133.30 (E) 1 & 2 & 3). This change could lead to euthanasia.
10. Page 21: MOLST form itself: There is nowhere on the form requiring a duty of healthcare provider to obtain documented informed consent before MOLST signed or implemented. Obtaining informed consent to treatment (including refusing treatment) or a care plan requires documented disclosure of diagnosis, prognosis, treatment alternatives and their benefits or burdens so that the patient's (or surrogate's) decision is informed. This cannot just be assumed will take place if this form will become a statutory provision in Ohio law.
11. Page 22: MOLST form indicates: "Comfort measures will be provided regardless….", which is actually in conflict with the provisions in Section 2133.30 (P) (see above) which allows for the withdrawal of even comfort care measures. Considering the withdrawal provision in 2133.30 (P) is statutory, this statement on the form is misleading.
12. Page 22-23: MOLST form--Problems with checkbox options on form:
    a. Oversimplify medical treatment decisions; patient cannot predict ahead of time what may be medically necessary or not.
    b. Present all options as morally neutral, including basic nutrition (food) and hydration (water), i.e., non-extraordinary care.
    c. Bear risk of indicating on a brief form withholding treatment that in certain cases could be euthanasia (stating this is not the case in the bill does not negate the possibility.) Does not instruct patient to specify routine medications and treatment, the removal of which could hasten or cause death.
13. Page 23, MOLST form---"Do not use intubation, advanced airway intervention or mechanical ventilation." Most will not know this means do not give breathing help (i.e, suffocation). Choosing this could mean death for a person who might require such intensive care for a limited

time to survive and live (e.g., an accident or heart attack victim, a severely dehydrated or malnourished patient). Could cause patient to unknowingly choosing euthanasia.

14. Page 24: MOLST form Section C: The artificially administered (still undefined) nutrition and hydration can be removed if the patient is declared “terminal” or “in a permanent vegetative state”. These standards are both highly problematic:
    a. TERMINAL: Doctors really don't know when a person will die, yet bill assumes that a person diagnosed as terminal indicates a clear time of death. A terminal diagnosis can assume life expectancy with normal medical care, or without care. Though "terminal," nutrition (food) and hydration (water) remain basic comfort care, to avoid starving a patient to death, until the patient's body is actively shutting down and no longer accepts sustenance. Bill does not take into account person-specific needs regarding terminal diagnosis, e.g., if a patient is insulin-dependent, is life expectancy based on receiving insulin or not?
    b. PERMANENTLY UNCONSCIOUS: Permanently unconscious does not equal dying. Studies are proving brain, awareness, even communication in such locked-in patients, some regaining consciousness.
15. Concerns regarding form Authorization procedures:
    a. There is no information on actual form requiring patient's written acknowledgement that signing MOLST is completely voluntary with no negative treatment consequences if not signed.
    b. No patient signature is required to implement MOLST or to acknowledge that the form truly represents a patient's choices; can be signed by a surrogate.
    c. Not specified that surrogate may sign for patient only after attending physician documents on form that the patient is certified as unable to make healthcare decisions on their own.
16. Page 26, MOLST Form, Section E: Certification/signature by “issuing practitioner” highlights problem of not limiting to the attending physician: certifying "to the best of my knowledge" language is because the medical authorization signer for the medical order is not necessarily the attending physician. This creates situations in which these orders would be given, even though the issuing practitioner's knowledge of the patient will be limited.
17. Page 27-28, MOLST form, Section G, page 30, MOLST Supplement: Form to be reviewed annually---this leads to serious questions: If MOLST intended for those deemed with less than six months to live, why annual review? Who will perform the review? How is review initiated and scheduled? If it is not reviewed, and expires, what happens to the form? These questions are left unanswered by the legislation.
18. Page 30-31, MOLST supplement---”A MOLST form that was revoked will be retained in your medical record". This raises significant questions left unanswered by the legislation: How are revoked forms and current version clearly delineated from each other? If revoked at one facility, how or will it be revoked at all facilities where a copy may exist, since the supplement also states “"Use of the original form is strongly encouraged, although photocopies and facsimiles are legal and valid"? This leaves the picture incredibly unclear how current version would be readily identifiable if copies which may or may not be current exist in multiple locations.

19. Page 31-32, Section 2133.33---The statutory language used in this section is vague, ambiguous, and without definition: "serious illness"-Serious illness could still mean years of life; "frailty" and "would not be surprised if individual died within a year"-both are highly subjective standards– no documented medical reasons for this "diagnosis" required of attending physician under the bill; "always voluntary"- If always voluntary, why ensconce the MOLST form in statute where it can be presented as legally required?
20. Throughout the legislation, there are references that are supposed to protect the rights of conscience of religiously-guided medical practitioners and institutions. However, this language is NOT a conscience clause. "Shall not prevent or attempt to prevent"--How would this actually work in practice – what would a facility or an attending physician unwilling or unable to comply with the MOLST do? Wouldn't they have to refer to another facility or physician? If so, this would still keep the facility or practitioner complicit in a morally objectionable act. Example problems when indicating on MOLST treatment for unanticipated/unpredictable circumstances: What if a patient has indicated on a MOLST against "artificial or technologically administered" food and water, then is admitted severely undernourished and physician knows immediate food and water could restore their life? Same if deny mechanical ventilation, then in an automobile accident and a physician knows a ventilator might restore life?

For these reasons, conscientious pro-life Ohioans, represented by the above-mentioned coalition, cannot and will not support the passage of Substitute Senate Bill 165.