BOARD OPINION RELATING TO USE OF THE
MEDICAL ORDERS FOR SCOPE OF TREATMENT ("MOST") FORM

LEGAL AUTHORITY

Pursuant to KRS 311.602, the following Board opinion is issued to assist Board licensees in determining what actions would constitute unacceptable conduct under the provisions of KRS 311.595. The Board has decided to publish this opinion because it addresses issues of significant public and medical interest.

This opinion is not a statute or administrative regulation and it does not have the force of law.

ACCEPTABLE AND PREVAILING MEDICAL PRACTICES RELATING TO THE USE OF THE MEDICAL ORDERS FOR SCOPE OF TREATMENT ("MOST") FORM

I. INTRODUCTION

This opinion is issued in order to (1) encourage and promote clarification of a patient's treatment preferences into medical orders for care; and (2) encourage and promote transfer of information among healthcare professionals in a reliable and consistent format.

The Board has determined that the following principles constitute the standards of acceptable and prevailing medical practice relating to use of the medical orders for scope of treatment ("MOST") form by the Board's licensees. In making this determination, the Board has considered the relevant statutes (which are cited where appropriate), practice standards relating to physicians' conduct and interactions with other health care professionals and basic practice standards.

II. DEFINITION

In this opinion, the standardized medical order for scope of treatment form, defined and referenced in KRS 311.621 to be an actionable medical order signed by a patient, a patient's legal surrogate, or a responsible party, and the patient's physician directing the scope of treatment for the patient, shall be referred to as the "MOST form."

III. WHERE TO OBTAIN THE MOST FORM

It is acceptable and prevailing medical practice to use the MOST form developed and adopted by the Kentucky Board of Medical Licensure and made available through the Board's website at http://kbml.ky.gov.

It is the acceptable and prevailing medical practice that the MOST form be a single double-sided form, printed on pink paper, and maintained as a paper original in the patient's medical chart. If the patient's medical chart is maintained electronically, it is the acceptable and prevailing medical practice to scan the original of the MOST form (both sides) to the electronic record or to use an electronic template identical to the paper MOST form.

IV. WHEN TO USE A MOST FORM

A MOST form is primarily intended for patients who have an advanced chronic progressive illness. In addition to those who are seriously ill, a MOST form is appropriate for patients whose life expectancy is less than one year. Although a MOST form is generally not intended for patients with stable medical conditions or for those who have many years of life expectancy, some patients may feel strongly that they want to further define their treatment preferences for end-of-life care by using a MOST form. Patients are not required to have a MOST form; it is optional.

A MOST form is designed to express the patient's preferences for levels of treatment and can indicate either full treatment, including resuscitation attempts, or can be used to limit those interventions that are not desired by the individual. Unless it is the patient's preference, use of the MOST form to limit treatment may not be appropriate for persons with stable medical or functionally disabling problems who have many years of life expectancy. In the absence of a MOST form or an Out-of-Hospital Do-Not-Resuscitate Order patients will receive advanced cardiac life support, including CPR, endotracheal intubation, and defibrillation, based on standard protocols. It is the acceptable and prevailing practice to review a MOST form at least annually or as necessary as the patient's condition changes.

V. COMPLETING THE MOST FORM

The MOST form should be completed only after discussing the patient's current medical condition, prognosis, and treatment options including life-prolonging measures with the patient (or if the patient no longer has the capacity to make or communicate healthcare decisions, with the appropriate patient representative). A physician who signs a MOST form is always responsible for ensuring that the patient or patient representative understands the patient's current medical condition, prognosis, and the potential benefits and burdens of the various treatment options.

It is unacceptable to issue a MOST form without the informed consent of the patient or the patient's representative. A process for cases in which the patient or the patient representative cannot sign the form is outlined below. It is the acceptable and prevailing practice to document the basis for the MOST in the progress notes of the patient's medical record.

It is the acceptable and prevailing practice to review a MOST form at least annually or earlier. Instances in which the patient is admitted and/or discharged from a healthcare facility, there is a substantial change in the patient's health status, or the patient's preferences change are times in which it would be acceptable and prevailing practice to review a MOST form earlier.

By law, any section of the form which is not completed shall be interpreted as a preference for full treatment in relation to that section.

A. Section A – Cardiopulmonary Resuscitation

The Resuscitation section refers only to the circumstance in which the patient is not breathing and has no pulse. This section does not apply to any other medical circumstances. For example, this section does not apply to a patient in respiratory distress because he/she is still breathing. Similarly this section does not apply to a

patient/resident who has an irregular pulse and low blood pressure because he/she has a pulse. For these situations, the caregiver should refer to Section B–Medical Interventions described below and follow the appropriate orders.

If the patient/resident wants cardiopulmonary resuscitation (CPR) and CPR is ordered, then the "Resuscitate" box is checked and full resuscitative measures should be carried out and 911 should be called.

If a patient/resident has indicated that he/she does not want CPR in the event of no breathing and no pulse, then the "Do Not Resuscitate (DNR)" box is checked. The patient/resident should understand that comfort measures will always be provided and no resuscitative efforts would be given.

B. Section B – Medical Intervention for Patient with Pulse or Breathing

This section refers to circumstances that are not covered in Section A. If full treatment is indicated and desired, the "Full Treatment" box is checked and 911 is called. However, if the patient and physician determine that some limitation is preferred, then only one of the other boxes is checked. Caregivers will first provide the level of services ordered and then contact a physician or other qualified provider. Comfort care is always provided regardless of indicated level of medical intervention treatment.

Comfort Measures Only indicates a desire for only those interventions that enhance comfort. In general, the patient and physician would not want an EMS response unless necessary for patient comfort. The patient would not expect to be transported to a hospital unless indicated later by the attending physician because acute care skills are needed to enhance comfort (e.g. to treat intractable pain). Oxygen, suction, and manual treatment of airway obstruction may be used as needed for comfort.

Limited Additional Interventions includes comfort measures above and may include cardiac monitor and oral/IV medications. Transfer to a hospital if indicated, but no endotracheal intubation, advanced airway interventions, or mechanical ventilation or long-term life support measures. Avoid intensive care.

Full Scope of Treatment indicates all measures above plus endotracheal intubation, advance airway, and cardiovascular/automatic defibrillation. Transfer to hospital if indicated and includes intensive care.

C. Section C – Use of Antibiotics

This section records the desired use of antibiotics. If there is no limitation, the physician/ checks the first box. If limitation of antibiotics is desired, the physician should check the appropriate box indicating whether the use is limited to instances in which infection occurs; to relieve pain and discomfort; or whether antibiotics are not to be used at all (in which case, other measures may be implemented to relieve symptoms).

There is also space for other instructions on the use of antibiotics. For example, a patient may want antibiotic treatment for a urinary tract infection but not pneumonia. These types of specific limitations should be written in the space provided.

D. Section D – Medically Administered Fluids and Nutrition

The provision of nutrition and fluids, even if medically administered, is a basic human right and authorization to deny or withdraw shall be limited to the patient, the surrogate in accordance with KRS 311.629, or the responsible party in accordance with KRS 311.631. This section allows the physician to record patient instructions regarding both (1) artificially administered fluids and (2) artificially administered nutrition for patients who cannot take fluids or nutrition by mouth.

The *first column* pertains to artificially administered fluids. If the patient wants long-term intravenous IV fluids, the "Long-term IV fluids" box should be checked. If the patient wants a defined period, or a trial period, of intravenous fluids, that box should be checked and a "goal" specifying the period or objective measures by which to withdraw artificially administered fluids should be written. If the patient desires no intravenous fluids, the appropriate box should be checked.

The *second column* pertains to artificially administered nutrition. If the patient wants long-term feeding tube, the "Long-term Feeding Tube" box should be checked. If the patient wants a defined period, or a trial period, of artificially administered nutrition, that box should be checked and a "goal" specifying the period or objective measures by which to withdraw artificially administered nutrition should be written. If the patient desires no artificially administered nutrition, the appropriate box should be checked.

Each column in this section needs to be addressed and marked. Any column left blank may result in long term treatment.

E. Section E – Patient Preferences as a Basis for the MOST Form

It is the acceptable and prevailing medical practice for the patient's physician to review, prepare and sign the MOST form while in personal communication with the patient, the patient's surrogate or responsible party. In fact, the MOST form must contain the original signature of the patient's physician in order to be valid. The physician must sign the form and print his/her name and the date the orders were written and reviewed. If the physician does not sign the form it may not be treated as a valid order and EMS personnel may not be able to limit EMS services.

It is the acceptable and prevailing medical practice for the patient's physician to document the basis of the MOST form in the progress notes of the patient's medical record, including the mode of communication (i.e. in person, by telephone, etc.).

It is the acceptable and prevailing medical practice for the patient's physician to explore whether the patient has an advance medical directive, such as a health care power of attorney or living will. If the patient has an advance health directive, the name, position and signature of the individual certifying that the MOST form is in accordance with the advance directive should be obtained. The patient's physician should then mark the MOST form to indicate whether oral or written directions were given and by whom.

It is acceptable and prevailing medical practice to ensure that the original form accompany the patient when/if transferred or discharged because it allows a receiving

facility to have the same information regarding the medical indication and patient preferences for scope of treatment and increases the likelihood that these orders will be respected in a new care setting.

F. Information for Patient, Surrogate or Responsible Party

It is the acceptable and prevailing medical practice that the physician review the information in the section titled "Information for Patient, Surrogate or Responsible Party on This Form" with the patient, surrogate or responsible party in order to relay that:

- the MOST form is voluntary;
- the provision of fluids and nutrition, even if medically administered, is a basic human right and the authorization to deny or withdraw that right is limited to the patient, the surrogate or the legally responsible party;
- treatment wishes may change;
- the patient can change their directives in the MOST form at any time;
- an advance directive may be more detailed and is recommended; and
- if there are conflicting directions between an enforceable living will and a MOST form, the provisions of the living will shall prevail.

G. Implementing the MOST Form

If a physician cannot comply with the orders on the MOST form, due to policy or personal ethics, it is the acceptable and prevailing medical practice that the physician arrange for transfer of the patient to another physician.

H. Reviewing and/or Revoking the MOST Form

It is acceptable and prevailing medical practice to review the MOST form annually or earlier, if:

- The patient is admitted and/or discharged from a helath care facility;
- There is a substantial change in the patient's health status; or
- The patient's treatment preferences change

If the MOST form is revised or becomes invalid, it is acceptable and prevailing medical practice for the physician to draw a line through Sections A-E and write "void" in large letters.

The MOST form may be revoked by the patient, the surrogate or the responsible party and it is acceptable and prevailing medical practice for the physician to not interfere with the patient's right to do so.

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