

Tangled Terminology: Avoiding the Ethical Pitfalls of Misnomers in Decision-Making Language

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Let's Play a Game



< Activities



Visual settings



Edit



When poll is active, respond at Pollev.com/cynthiabruzzoese147

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Round 1: Two Truths & A Lie

Patients who have been declared incompetent lack decisional capacity.

In Vermont, a surrogate who is not a health care agent can consent to a DNR/COLST order

In Vermont, a DPOA for health care cannot serve as a witness to an advance directive

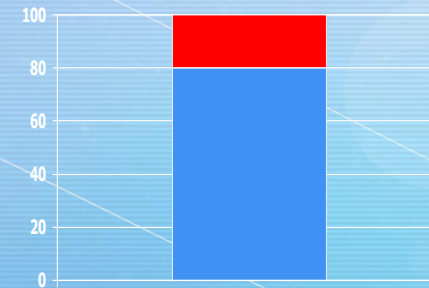
Total Results: 0

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Common Misnomers

- Ability to engage in decision-making
- Surrogates

Competence vs. Capacity



Informed Consent

- Understand and communicate
- Appreciation of/for the decision
- Reason through risks, benefits and alternatives
- Freedom from coercion or undue influence, voluntary



THESE ARE THE 4 BASIC ELEMENTS OF INFORMED CONSENT

Levels of Capacity

The ability to...

... reach a reasonable decision
(reasonable person standard)

...give risk/benefit-related reason

...give a rational reason

... give a reason

...understand relevant information

...understand one's situation and its consequences

...express or communicate a preference or choice

Ethical Significance & Potential Pitfalls

Autonomy & Respect for Persons

- Promote patients (even those declared incompetent by a court) to make as many decisions as their capacity allows and to do so in the least restrictive manner possible.
- Patients with **and without** capacity retain the right to refuse.

- Identify the wrong surrogate
- Convey power to a surrogate inappropriately
- May fail to obtain assent/dissent
- Assume permissibility or authority to consent treatment over objection

Back to our game....

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Surrogate Decision-Makers

FORMAL

- **Health Care Agent**
 - Proxy
 - DPOA-HC
- **Guardian**
 - Private
 - Public

INFORMAL

- Family, friends or other persons with a known close relationship to the patient

Standard: Substituted Judgement then Best Interest

Surrogate Consent for DNR/COLST

Title 18 : Health

Chapter 231 : Advance Directives For Health Care, Disposition Of Remains, And Surrogate Decision Making

Subchapter 002 : Surrogate Consent

(Cite as: 18 V.S.A. § 9731)

§ 9731. Informed consent by surrogate for DNR/COLST order

Ethical Significance & Potential Pitfalls

- Power and scope of authority differs depending on type of surrogate decision-maker and the decision.
- Guardianship is not always the answer and may not solve the problem we are seeking to solve.
- We may end up complicating EOL decision-making

Let's Play Another Round of Our Game

The screenshot shows a mobile application interface for a poll. At the top, there is a navigation bar with a bar chart icon, a back arrow, the text 'Activities', and buttons for 'Visual settings', 'Edit', and navigation arrows. Below the navigation bar, a grey banner contains the text: 'Respond at Pollev.com/cynthiabruzzo147' and 'Text **CYNTHIABRUZZESE147** to **22333** once to join, then **A, B, or C**'. The main content area features a title 'Round 2: Two Truths & A Lie' in bold blue text. Below the title are three poll options, each in a light blue box with a corresponding letter (A, B, or C) on the right. Option A: 'A guardian can engage in advance care planning for a person who is under guardianship.' Option B: 'A patient who indicates NO CPR on their advance directive is considered DNR when hospitalized.' Option C: 'In Vermont the explainer on an advance directive can also sign as a witness'. At the bottom right of the poll area, it says 'Total Results: 1'. At the very bottom, there is a footer that reads 'Powered by Poll Everywhere'.

Activities

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Round 2: Two Truths & A Lie

A guardian can engage in advance care planning for a person who is under guardianship. **A**

A patient who indicates NO CPR on their advance directive is considered DNR when hospitalized. **B**

In Vermont the explainer on an advance directive can also sign as a witness **C**

Total Results: 1

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Common Misnomers

- Tools
- Process

Advance Directive vs. DNR/COLST

ADVANCE DIRECTIVE

Preference-based document *completed by a capacitated patient* to guide **future** medical decisions.

- Typically nuanced document requiring discussion, context and interpretation.
- Only a person with decisional capacity can complete/update one.

DNR/COLST

Outcome of shared a decision-making process; medical order *completed by a clinician*, requires informed consent, and is intended to guide **current** treatment decisions.

- Based on patient's *current medical condition* **and** their *goals and values*.
- Consent can be provided by someone other than the patient

Back to Round 2:

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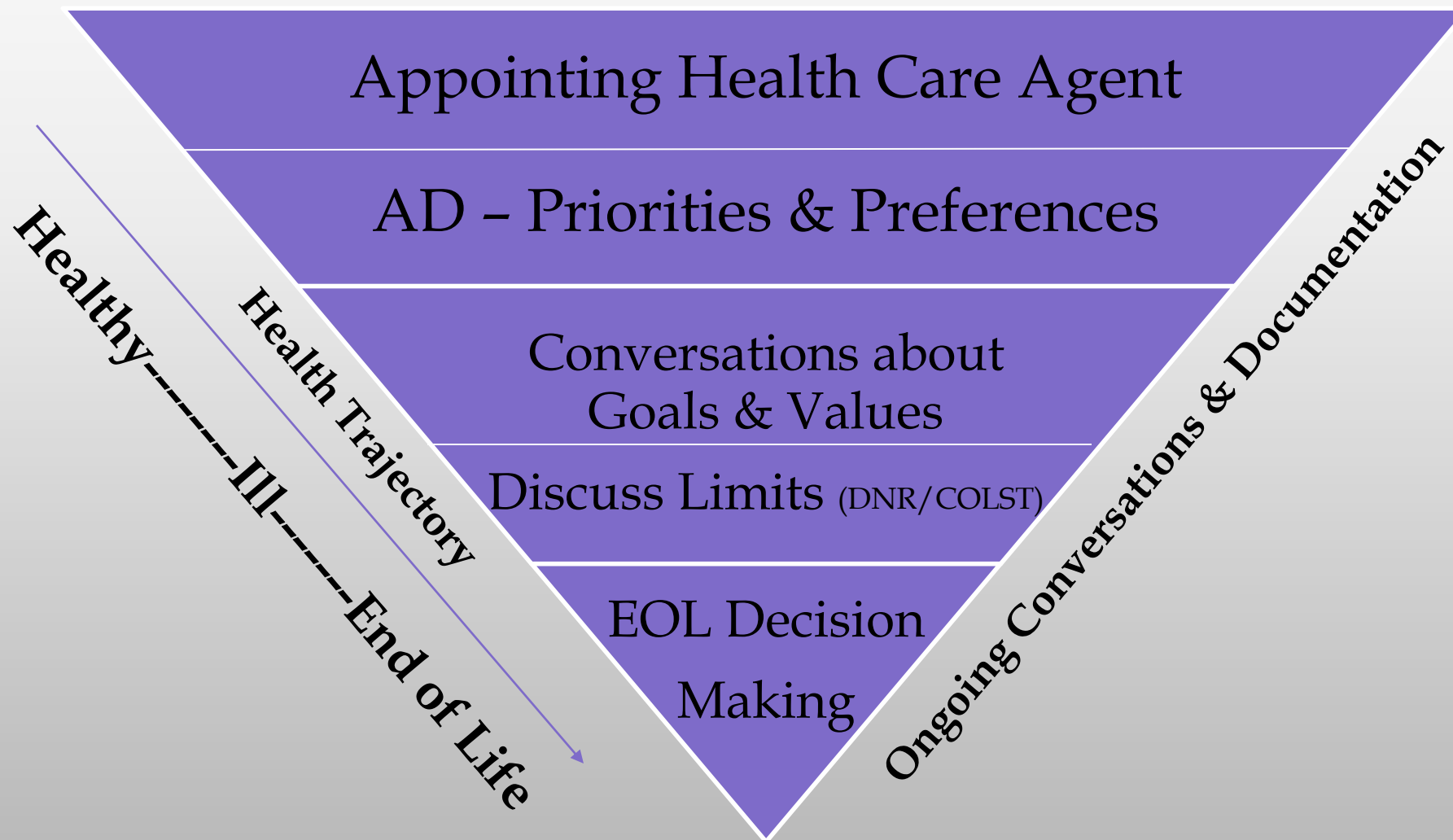
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Advance Care Planning (ACP)

An ongoing process of
discussing, understanding,
planning and potentially
documenting an individual's
goals, values and wishes for
future
health care

ACP Continuum



Execution of Advance Directives

Misinformation

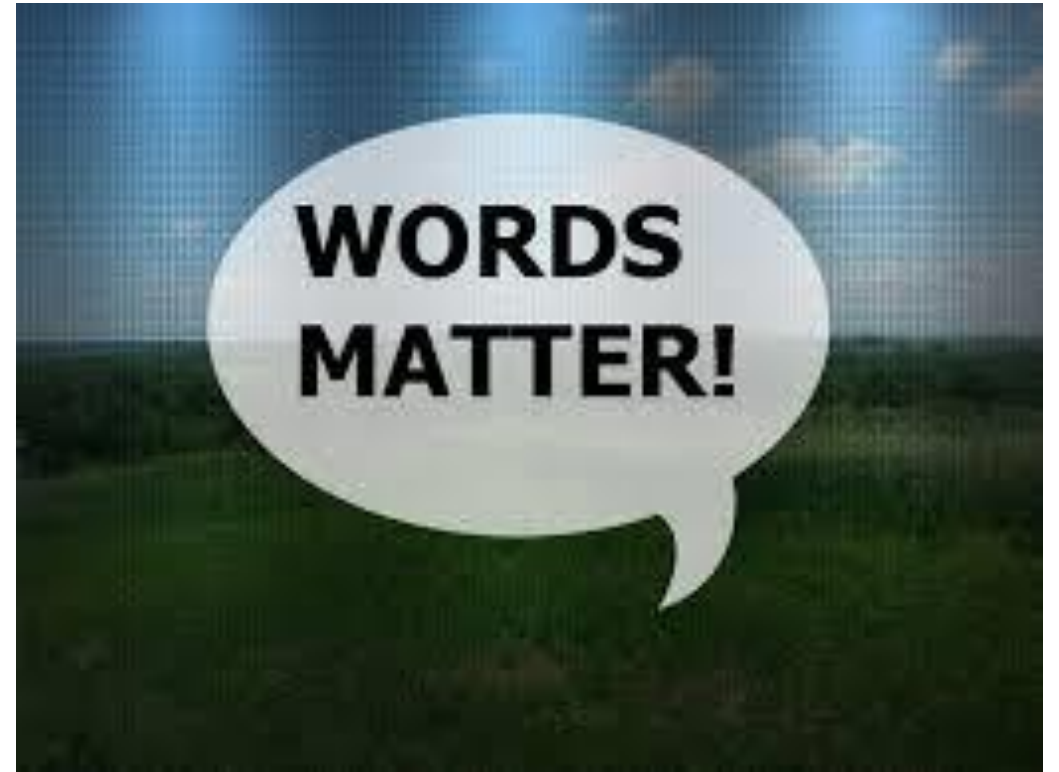
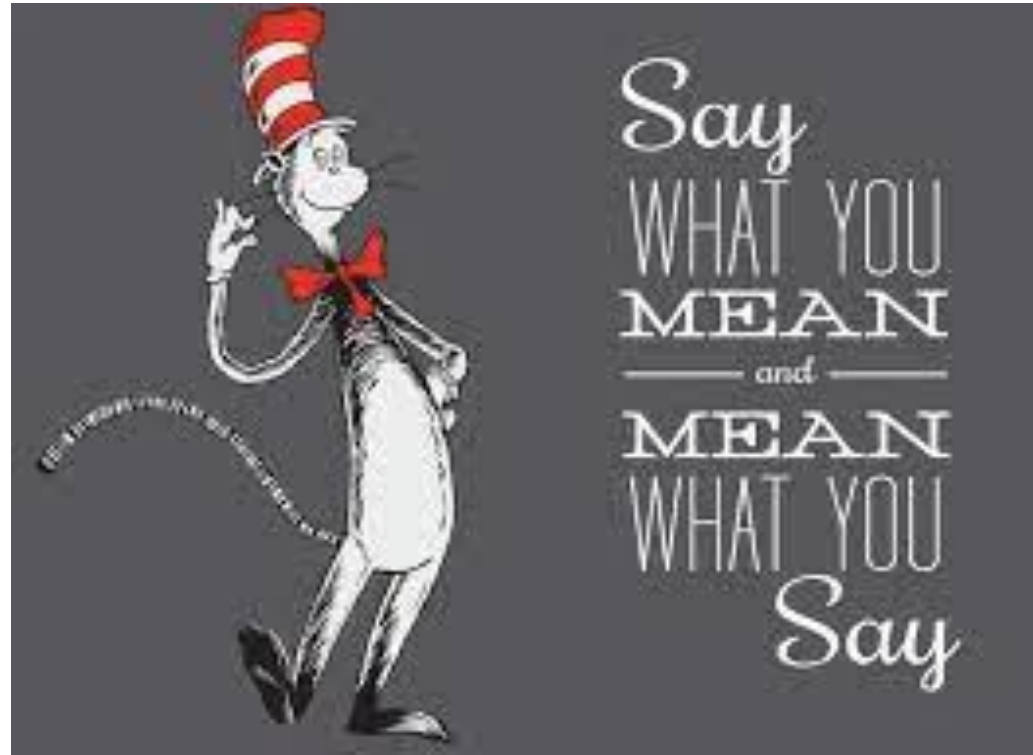
- Witnesses CANNOT be the patient's agent, spouse, parent, adult sibling, adult children or grandchildren
- Health care providers may serve as a witness
- No notary requirement and notary can't take the place of having 2 witnesses

Misnomers

- ACP and ADs are not the same
- Witnesses and Explainers have different responsibilities
 - Explainers can serve as one of the two required witnesses

Ethical Significance & Potential Pitfalls

- Patient autonomy & self determination
- Artificial barriers to completion of AD documents
- Delays to timely decisions, particularly at EOL
- Missed opportunity to ensure alignment of care and treatment with patient goals and values





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