

Medical Orders for Life-Sustaining Treatment in Correctional Settings

Position Statement

The National Commission on Correctional Health Care encourages correctional facilities to adopt the following measures to ensure that patients' desires regarding end-of-life care are followed:

1. Correctional facilities should establish clear policies and procedures for discussing, documenting, and completing advance directives and medical orders for life-sustaining treatment (MOLST), as well as educate providers about these policies and procedures.
2. Individuals should be asked whether they have an advance directive no later than during the initial health assessment and responses are documented.
3. If the patient has an advance directive, it should be honored.
4. When patients are transferred between facilities, the receiving facility is to honor the advance directive.
5. A qualified health care provider should discuss with all patients advance directives, living wills, and health care power of attorney/proxy, especially in circumstances such as admittance to a hospital or having a terminal illness.
6. All patients who are considered geriatric, as defined by the local jurisdiction, and those with a chronic medical disorder should review their advance directive at least annually with a health care provider.
7. A clear surrogacy ladder should be developed for those who lack capacity, have been declared incompetent, or are legal minors.
8. Patients should be informed that, while capable of doing so, they may change their mind about these decisions, and that these discussions should occur as often as necessary.
 - a. The discussion should address end-of-life choices such as resuscitation, intubation, medications, nutritional support, and end-of-life comfort measures.
9. The facility should confirm and communicate with the health care decision maker/proxy whom the patient has identified, especially when there is a change in the patients' health status.
10. The contact information for the health care decision maker/proxy should be periodically reviewed and updated.
11. End-of-life desires should be documented in writing in a MOLST form (if the state has one).
12. All discussions and decisions about end-of-life care should be clearly documented in the health record, regardless of whether the patient agrees to or declines advance directives.
13. This documentation should accompany the patient if transferred to another correctional facility or outside health care facility.

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14. If the facility provides end-of-life services such as palliative care, hospice care, and comfort care:
 - a. Appropriate health staff and support staff should be available
 - b. Appropriate medications should be available on-site
15. If the facility does not provide end-of-life services, the patient should be transferred to a facility where an advance directive will be honored. The lack of ability to provide end-of-life services should among the criteria for compassionate release.

Discussion

The goal of end-of-life care in corrections, as in other contexts, is to prevent or relieve suffering as much as possible while preserving and respecting the patient's expressed desires. At the end of life, it is important to protect the autonomy, rights, dignity, and desires that the patient has considered and expressed^{1,2}.

Decisions regarding end-of-life care may include cardiopulmonary resuscitation, defibrillation, certain antiarrhythmic medications, mechanical ventilation with intubation, artificial nutrition and hydration, terminal sedation, and withholding and withdrawing treatments. These decisions are important because medical interventions can prolong life expectancies despite the chronic or terminal nature of an illness, yet at the cost of pain and suffering and with no promise for recovery.

However, people who are incarcerated are less likely to be offered or participate in advance care planning, less likely to document their treatment preferences, and might not have a surrogate if one is needed³. One study found that correctional health staff have low baseline knowledge about advance care planning: 85% reported familiarity with it, but only 42% provided accurate definitions⁴.

Advance directives are oral and/or written instructions about future medical care in the event a patient becomes unable to communicate and loses the ability to make decisions. The advanced directive is included in the patient's living will, which is a written document in which the competent person provides instructions regarding health care preferences for end-of-life care^{1,2}.

The patient's request to limit end-of-life interventions is expressed in advance directives to a health care proxy or health care power of attorney. (For information about surrogate decision making for incarcerated patients, see Scarlet et al.⁵.) This has historically been referred to as a "do not resuscitate" medical order written by a provider on behalf of the patient and is now commonly known as medical orders for life-sustaining treatment (MOLST). MOLST forms vary from state to state, and some states do not have a form.

The federal Patient Self-Determination Act addresses the right of health care users to stipulate in advance how they would like to be treated by health care providers when they are incapacitated. The

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law does not require individuals to complete any forms of advanced directive, nor do state laws, and it forbids requiring an advance directive as a requisite for treatment. Federal law requires hospitals to give adult patients information and advance directive forms but excludes institutions for the incarcerated from this requirement, despite their involvement in the delivery of health care⁶.

Under each state law, individuals have the right to accept or refuse medical or surgical treatment, to have an advanced directive, and/or to appoint a health care agent or proxy⁶.

Advance directives must be reviewed if the patient's condition has improved or the patient has considered changing their mind regarding desires at end of life. Patients should be given all the information necessary regarding prognosis and treatments to make informed decisions.

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Resources

NCCHC Standards for Health Services (2018) for jails and prisons: F-07 Care for the Terminally Ill

References

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- ² Karnik, S., & Kanekar, A. (2016). Ethical issues surrounding end-of-life care: A narrative review. *Healthcare*, 4(2), 24. doi: 10.3390/healthcare4020024.
- ³ Tobey, M., & Simon, L. (2019). Who should make decisions for unrepresented patients who are incarcerated? *AMA Journal of Ethics*, 21(7), E617-624. doi: 10.1001/amajethics.2019.617
- ⁴ Ekairab, R., Ahalt, C., Sudore, R., Metzger, L., & Williams, B. (2018). "We take care of patients, but we don't advocate for them": Advance care planning in prison or jail. *Journal of the American Geriatrics Society*, 66, 2382-2388. <https://doi.org/10.1111/jgs.15624>
- ⁵ Scarlet, S., DeMartino, E. S., & Siegler, M. (2019). Surrogate decision making for incarcerated patients. *JAMA Internal Medicine*, 179(7), 861–862. doi:10.1001/jamainternmed.2019.1386
- ⁶ National Resource Center on Psychiatric Advance Directives. (n.d.). Federal Law on Advanced Directives. <https://www.nrc-pad.org/images/stories/PDFs/fedaddirectives2a.pdf>