Dr. Christian Jacobus, Proponent Testimony SB165 - MOLST
Ohio Senate Civil Justice Committee
December 8, 2015

Good afternoon Chairman Bacon and members of the Civil Justice committee.

My name is Christian Jacobus, I am the medical director for Bridge Hospice and Palliative Care in Findlay. I am somewhat unusual in that I am trained and board certified in both Emergency Medicine as well as Hospice and Palliative Medicine, seemingly opposite ends of the treatment spectrum. I completed my Emergency Medicine training in Cincinnati in 2007 and then spent the next 6 years practicing Emergency Medicine in a variety of settings: academic, community, urban, rural, even some international. In 2014 I completed a Hospice and Palliative Medicine fellowship at Vanderbilt University in Tennessee and then accepted this current position as Medical Director at Bridge. Tennessee has a MOLST form equivalent so I filled out innumerable forms while training in Palliative Care. I also did some weekend moonlighting in an emergency department outside of Nashville so I was on the receiving end of some MOLST forms as well.

As both an emergency physician and a specialist in end-of-life care I can attest that adopting the MOLST form in Ohio would be an invaluable addition to patient care.

Since my return to Ohio to practice I have treated multiple patients who arrived in my emergency department in distress with a Do-Not Resuscitate (DNR) order but little other information about treatment preferences.

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A few months ago I resuscitated an elderly nursing home patient after being told that he was “full code.” After putting him on a ventilator and stabilizing his heart rhythm his family arrived and told me that he had a DNR order. His family decided to remove him from the ventilator a few days later and he died comfortably, but not before experiencing the pain and chaos of a resuscitation.

Even with a DNR-Comfort Care order I may need further guidance on whether to admit to the hospital, start IV fluids, or continue tube feedings. None of these are covered on the existing form, but would be on the MOLST. These pieces of information are vital for providing superlative care for our patients.

Our current system is helpful but confusion still abounds, definitely among the general public but even among physicians who use the DNR form every day. One wouldn’t think that the binary decision of DNR-Comfort Care Arrest versus DNR-Comfort Care would be so confounding, but the confusion comes from what is not explicitly outlined. Most physicians grasp that DNR means not to perform CPR when someone dies, but it is the in-between cases that still confuse. What if someone is dying but not dead yet? Is it ok to admit a patient with a DNR-CC order to the hospital? Are tube feedings a comfort measure? My colleague Elizabeth Kelley and I have educated the staff on an ongoing basis but confusion is still widespread.

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There is more to end-of-life treatment preference than CPR or no CPR. The MOLST form addresses many of the other decisions that are not covered on our current form. Research in other states with similar paradigms has shown that significant numbers of patients who elect not to be resuscitated do choose to have antibiotics, fluids, nutrition, or other aggressive treatments performed up to the point of their deaths, a preference that is not represented on our current form. For example, just yesterday I was discussing resuscitation with a new patient of mine who had a DNR-CCA order but also did not want to be on a ventilator under any circumstances. Lacking any better way of communicating her preferences I wrote a new DNR-CCA for her and wrote across the top in big letters, "NO INTUBATION." This is my clumsy way of getting closer to what the MOLST form offers explicitly.

Emergency physicians are used to operating in an information vacuum; every additional piece of data is gold. In a critically ill patient the importance of guidance about their treatment preferences cannot be understated. The MOLST form will be very helpful for us in the emergency department and for any other provider receiving a new patient, especially in an environment where time is of the essence.

It will be helpful for the primary care providers and others who will be filling out the form as well. It's not only an end product, it's also a guide and prompt to having the kinds of discussions that patients want and need to have about their care.

Finally, this will be most helpful to the patients, not only in its protection from unwanted treatment, but also in its prompting to think about aspects of end-of-life care that patients may not have thought about such as artificial nutrition or hydration. When they carry these discussions back home to their families it brings their loved ones onto the same page, which also prevents more chaos and confusion in difficult situation.

In short, Chairman Bacon and members of the Civil Justice Committee, approving this bill would be a great service for physicians, patients, and their families, and I fully support it. Thank you for your time.