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3 Title: Advance Directive Planning Education for Medical Students  
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5 Introduced by: John Winterholler for the Medical Student Section  
6  
7 Original Author: Kevin Cates, Michael Chavarria, Rohan Kedar, David Lee, and William  
8 Rasmussen  
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10 Referred to: Reference Committee E  
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12 House Action: **APPROVE**  
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15 Whereas, across adult populations, advance directive planning interventions improve  
16 congruence between patient wishes and patient care, increase the rate of completion of advance  
17 directives, increase frequency of discussions about end-of-life care, and reduce hospitalizations  
18 without increasing mortality<sup>1,2,3,4</sup>, and  
19

20 Whereas, advanced directives are not consistently completed by patients, documented by  
21 hospitals, or followed by providers<sup>2,5,6</sup>, and  
22

23 Whereas, despite advance directive planning discussions occurring with greater frequency,  
24 such discussions can be cursory in nature, wherein physicians do not routinely provide patients with  
25 prognostic insight, detailed options and/or recommendations<sup>7</sup>, and  
26

27 Whereas, neither documentation processes or facility support have reliably improved clinician  
28 confidence, or timeliness, in end-of-life communication with patients and families<sup>8</sup>, and  
29

30 Whereas, established frameworks for teaching advance directives are designed to fulfill a  
31 clinician’s ethical obligation to carefully elicit patients’ detailed viewpoints and desires concerning  
32 their end-of-life care beyond code status<sup>9</sup>, and  
33

34 Whereas, observation and/or participation in end-of-life communication can improve the  
35 confidence and skill of student clinicians in directing end-of-life discussions, when classroom teaching  
36 has not<sup>5,10,11,12</sup>, and  
37

38 Whereas, even among medical students who report some education in advance directives  
39 under updated (2011) curricula, only a minority could reliably distinguish between advance directives,  
40 do-not-necessitate orders and living wills, and subsequently assign code status or interventions  
41 appropriately, as assessed by the TRIAD IV survey<sup>13</sup>, and  
42

43 Whereas, sufficient education in advance directives is recommended as a patient safety  
44 measure by the Joint Commission<sup>9</sup>, and  
45

46 Whereas, solutions to the shortcomings of advance directive planning in America are often  
47 proposed and implemented at the medical education level<sup>5,9,10,11,12,15,18</sup>, and  
48

49 Whereas, teaching, practicing, and reflecting upon end-of-life care conversations in medical  
50 school is linked to persisting knowledge, skill, and confidence in carrying out such discussions with  
51 patients<sup>5,10,11,12,14,15,16,17,18,19,20</sup>, and  
52

53 Whereas, modalities of teaching advance directives that include simulation and skills practice  
54 are favorably rated by students in terms of practicality, clinical decision-making, and applied active

55 learning; and personal advance directives completion has been shown to improve student  
56 confidence, knowledge, and empathy when discussing advance directives with patients<sup>14,15,17,19,20</sup>, and  
57

58 Whereas, advance directive education that includes students' completion of advance  
59 directives for themselves has been shown to produce positive outcomes in knowledge of, confidence  
60 in, and initiation of advance care planning conversations<sup>5,14</sup>, and  
61

62 Whereas, American Medical Association policy, H-85.956, treats completion of advanced  
63 directives by physicians and students as a part of comprehensive education in advance care planning,  
64 and resolves to support "The creation of personal advanced directives for all medical students and  
65 physicians;" therefore be it  
66

67 RESOLVED: That MSMS adopt American Medical Association policy, H-85.956, on educating  
68 physicians about advance care planning:

69 "Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to  
70 increase the prevalence and quality of meaningful advance care planning, including the use of  
71 advance directives, and to improve recognition of and adherence to a patient's advance care  
72 decisions; (2) supports development of materials to educate physicians about the requirements and  
73 implications of the Patient Self-Determination Act, and supports the development of materials  
74 (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to  
75 educate their patients about advance directives and requirements of the Patient Self-Determination  
76 Act; (3) encourages residency training programs, regardless of or in addition to current specialty  
77 specific ACGME requirements, to promote and develop a high level of knowledge of and ethical  
78 standards for the use of such documents as living wills, durable powers of attorney for health care, and  
79 ordering DNR status, which should include medical, legal, and ethical principles guiding such  
80 physician decisions. This knowledge should include aspects of medical case management in which  
81 decisions are made to limit the duration and intensity of treatment; (4) will work with medical schools,  
82 graduate medical education programs and other interested groups to increase the awareness and the  
83 creation of personal advance directives for all medical students and physicians; and (5) encourages  
84 development of a model educational module for the teaching of advance directives and advance care  
85 planning"; and be it further  
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87 RESOLVED: That MSMS supports the teaching of advance directive planning as a clinical skill  
88 through simulation and skills practice in addition to established didactic modalities.  
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91 WAYS AND MEANS COMMITTEE FISCAL NOTE: NONE

### **Relevant MSMS Policy:**

#### **Appropriate End of Life Therapy**

MSMS will continue to work at all levels for improved pain management and symptom control. MSMS will continue education on recognition of depression and its adequate therapy. MSMS will continue to promote advance directives. MSMS will continue support for hospice including education about hospice and the use of hospice care. (Res94-97A)

#### **Creation of Electronic Do-Not-Resuscitate System**

MSMS supports more rigorous efforts to promote advance care planning to ensure patient preference is known when end-of-life care decisions must be made including the need to address better knowledge, availability, and tracking of advance directives or other advisory documents. (Board Action Report 6 per Res53-13)

#### **Declaring a Patient Dead/End-of-Life Care Training**

MSMS supports implementation of curricula in end-of-life care, hospice, and declaration of patient death in residency training programs where appropriate and the development of continuing medical education programs in end-of-life care and sensitivity/communication training for physicians. (Res34-13)

## Living Will

MSMS recognizes the validity of Living Will/Durable Power of Attorney forms in Michigan. (Res92-90A)

No Cardiopulmonary Resuscitation (CPR) Orders in Adult Foster Care and Assisted Living Settings

MSMS supports do-not-resuscitate orders, as well as other advanced directives, for residents of adult foster care facilities, nursing homes and other non-hospital settings. (Res24-97A)

## Pain Management and Hospice Education

MSMS recommends and promotes effective education in pain management and/or hospice care for physicians and medical students. (Res69-93A)

## Pain Management Education and CME Credit

MSMS supports the concept of requiring physicians to be educated in pain management techniques but opposes mandating this type of education through CME credit. (Board-March94)

– Reaffirmed (Board-Oct05)

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