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Momentum to better respect patients' end-of-life wishes "growing every day"

POLST is option, but education needed

A growing number of states are promoting Physician Orders for Life Sustaining Treatment (POLST) Paradigm Programs, with the goal of helping physicians to better respect their patients' wishes for end-of-life care. The tool turns an advance directive into actionable medical orders, allowing seriously ill patients to specify choices about certain interventions, giving patients more control of what end-of-life care they receive.

"The big challenge now is the number of states who want to implement POLST, and need support, because the document has been found to be so much more effective than other instruments that have been developed, like out-of-hospital DNR orders," says **Susan W. Tolle**, MD, FACP, director of Oregon Health & Science University's Center for Ethics in Health Care in Portland.

A 2010 study of 90 nursing homes in three states showed a lower rate of unwanted hospitalizations in people who had marked "comfort measures only" on a POLST form.[1] "The momentum is growing every day," says Tolle. "We are struggling to meet the demand for states which want to be evaluated for endorsement. The demand for assistance is five-fold compared to three or four years ago."

EXECUTIVE SUMMARY

A growing number of states are promoting Physician Orders for Life Sustaining Treatment programs, with the goal of helping physicians to better respect their patients' wishes for end-of-life care.

- The tool turns an advance directive into actionable medical orders.
- Unwanted hospitalizations were reduced for people who marked "comfort measures only."
- Health care providers need education on which patients should be offered the form.

This is partly due to the public's growing expectations that their wishes will be honored, and pressure from emergency medical services (EMS) providers who don't want to perform interventions that patients never wanted. There is also increasing pressure on hospitals to decrease re-admissions for the same diagnosis within 30 days to avoid being financially penalized.

"If the patient doesn't want to be readmitted, and you are going to be reviewed negatively by Medicare, your institution may be more motivated to build a program to respect those wishes," says Tolle. "If you want to stay exactly where you are, whether that's in a long-term care facility, private home, or hospice, and you don't want to go back to the hospital, and your comfort is managed where you are, and your wishes are respected, that changes the death rate in the hospital."

States vary regarding how much education is needed, or whether there are any policy issues that create an impediment to moving forward. *(See related story, p. 39, on current laws.)*

"The details of implementation look very different depending on how long you've been working on this," Tolle explains. "For example, in a state like Oregon, where hospitals often offer POLST to every patient going to a nursing home at discharge, the needs are different than in a state that is just getting started building a POLST program. The overall goal in every state is to better respect patients' wishes to have or limit treatment, whatever those wishes may be."

While EMS would like to know the patient's wishes about resuscitation, the information that has a greater impact is whether the patient wants to go back to the hospital or not, she says. "And if you do want to return to the hospital, whether you want to go to the [intensive care unit] or not, that decision has a profound impact on care at the end of life," says Tolle.

Education is needed

Every state continues to struggle in educating physicians and patients on the difference between POLST and advance directives, reports Tolle. "Both the lay public and health care professionals need boosters on how these work together and who needs which one," she says. *(To view a POLST in Action video, go to http://www.oregonpolst.org.)*

If a state is just beginning a POLST program, providers might not have heard of it or have no idea how to implement it. "One area that physicians get into trouble with is in knowing what patient population they should actually be offering POLST to — who is too healthy for POLST, and who is ideal," says Tolle.

Another challenge is what to do if a patient is asking for a POLST form but is too healthy. While all adults should have advance directives, POLST forms should be used for patients with advanced illness or frailty. "The advance directive is a futuristic document, saying that 'If bad things happen to me, I would or would not want life-sustaining treatment.' POLST is when the future becomes the present — tonight, if I'm found down, I do or do not want CPR [cardiopulmonary resuscitation]," Tolle explains. "With POLST you can't say 'if' anything

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EDITORIAL QUESTIONS

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— you have to say 'yes' or 'no' about your current state of health, in the here and now, as a medical order."

Health care professionals need to be educated about which patients to offer the form to and how to use the document appropriately to achieve the patient's goals, she underscores. "Until providers have watched educational materials themselves, some of the nuances about how they work together are confusing," says Tolle. "If they don't understand that perfectly, they will have trouble educating their patients."

Comfort measures are always provided to patients with POLST orders, which is something that a clear-cut "do not transfer" order would not accomplish, adds Tolle. If a patient has orders for comfort measures only, and breaks a hip and cannot be turned because it's too painful, he or she needs to be transported to the hospital to get the hip pinned, for instance.

"When transfer to the hospital was needed for comfort, their POLST orders keep the system focused on the patient's goals. It prevents CPR and transfer to intensive care if the hospital course is complicated by pneumonia or a myocardial infarction," says Tolle. "The goal remains to assure their comfort and return them to the prior setting of care as quickly as possible."

Role of bioethics

Bioethicists can be very helpful to advancing POLST because they know the value of good advance care planning and are aware of the time, resources, and emotional distress that go into medically complex situations in which the patient's wishes are unknown, says **Judy Citko**, JD, executive director of the Coalition for Compassionate Care of California in Sacramento. Bioethicists can help with establishing policies and procedures for POLST form completion that are clear and grounded in good communication, she adds.

"Unfortunately, many tasks in health care are seen as just that — tasks to be checked off a list. Approaching POLST as a 'task' is likely to result in forms that don't accurately capture the patient's true wishes," says Citko. "POLST needs to be grounded in a rich discussion in the context of the patient's diagnosis and prognosis. Bioethicists can help with this."

Bioethicists sometimes unintentionally serve as a hindrance to POLST by making the "perfect" the enemy of the "good," however, says Citko. "Expecting POLST to solve all the advance care planning problems that currently exist is unrealistic," she says. "Problems existed before POLST, and many continue to exist after POLST. POLST creates a system that allows us to more easily identify problems, and thus, develop solutions and measure progress." ■

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1. Hickman, S, Nelson C, Perrin N, et al. A comparison of methods to communicate treatment preferences in nursing facilities: Traditional practices versus the physician orders for life-sustaining treatment program. *Journal of the American Geriatrics Society* 2010;58(7):1241-1248.

SOURCES

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Some existing laws are barriers to POLST

Some existing state laws are hindering implementation of POLST programs, such as Delaware's, which only covers out-of-hospital do-not-resuscitate (DNR) orders that require that people be terminally ill, according to **Amy Vandenbroucke**, JD, executive director of the National POLST Paradigm Program at Oregon Health & Sciences University's Center for Ethics in Health Care in Portland.

"If you try to adapt that law and use POLST under it, like some states have done, you pick up any 'baggage' related to that law," explains Susan W. Tolle, MD, FACP, director of Oregon Health & Science University's Center for Ethics in Health Care in Portland. That means that many frail elders, who very much want to return to the hospital for some interventions but do not want cardiopulmonary resuscitation (CPR) or intensive care unit care, cannot have a POLST form because they are not terminally ill.

"They are very frail, but no one is signing paperwork saying they have six months left to live. They are likely to have a sudden event which determines that, but we don't know what that event is and when it will be," says Tolle. "Frail elders often very much want POLST, and health care professionals were filling it out for that population. It makes sense that they

would want it, but it didn't match an old law in place about out-of-hospital DNR orders."

Delaware has a POLST program in place, but is having problems with implementation due to existing state law on out-of-hospital DNR orders that are only limited to CPR. "Most people who are POLST-appropriate have advanced illness or frailty, and we wouldn't be surprised if they died in the coming year," says Tolle. "If they are in full arrest, are not breathing, and have no pulse, they are not likely to survive an out-of-hospital resuscitation. Depending on just what their medical problems are, the rates can be lower than 1%."

In some states, existing laws have made it difficult for a surrogate to complete a POLST form. "When somebody has taken the time to designate an appropriate person through an advance directive or health care power of attorney document, it is another way for the patient to decide what care they want at the end of their life," says Vandenbroucke. "In some cases, there are barriers to surrogates being able to sign a POLST form for that patient and make that decision."

Many states have started a POLST program, but it's not in every hospice program or long-term care facility, due in part to the need for broader educational outreach. "That would not be true in Oregon or West Virginia, which have overcome all the regulatory impediments and conducted broad statewide education. There is nothing that keeps those states from implementing it everywhere," says Tolle. "But most other states are not completely penetrated yet."

A few state laws say that an advance directive always takes precedence over a POLST form, while most states say the most recent document takes precedence. "A 10-year-old advance directive may not be what you want now because your health status or life situation have changed a great deal," says Tolle.

A change in diagnosis or medical condition may mean the patient no longer has the same desires for level of treatment he or she specified in an advance directive, such as the patient making a much better recovery from a massive stroke than anyone ever guessed, or becoming a lot sicker and wanting to stay with their family during their final weeks of life. Since the POLST form is a medical order, it is easily updated or revoked to accommodate changes in patient status and preferences.

If state law requires that the advance directive takes precedence and the patient becomes unable to make decisions for him- or herself, a surrogate can't make changes that the patient would have wanted because only the patient can revoke or revise the instructions in the advance directive, explains Tolle. "When people complete an advance directive, they often don't look at it again for a decade or more. They can get a bit trapped in a pathway they had not intended," she says. "The intent of the POLST program is that it's entirely voluntary. You can fill it out any way you want to, and you can always change your mind." ■

Ethics of prescribing choices in forefront

Addiction, untreated pain are both concerns

The relief of suffering, including suffering from untreated pain, is fundamental to the idea of ethical practice in medicine, according to **Nancy Berlinger**, PhD, a research scholar at The Hastings Center in Garrison, NY. "The development of palliative medicine as a subspecialty, with parallels in nursing and other clinical professions, and evidence of improved outcomes through the integration of palliative modalities into standard medical treatment, support the idea of access to pain relief as a basic right of patients," she says.

However, it is well established that some medications that are effective in pain are potentially addictive and that some pain medications are misused — for example, diverted from their intended beneficiary to another party; or abused, as when they are consumed at higher dosages or in different ways than prescribed, adds Berlinger.

Recently, a number of states have implemented electronic prescription monitoring programs, allowing physicians to determine if a patient has been prescribed opioid analgesics from other physicians in the recent past. "This information should be factored into the clinical assessment of the patient in determining the appropriateness for

EXECUTIVE SUMMARY

While some pain medications are potentially addictive and in some cases are misused or abused, undertreatment of pain also remains a significant concern. To address ethical concerns, physicians can:

- Factor data from electronic prescription monitoring programs into their clinical assessment.
- Carefully monitor patients to assure that medications are being taken as directed.
- Obtain an ethical consultation if drug-seeking is suspected.