POLST
Minnesota Elder Law Institute
October 20, 2015

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Hamline University School of Law

Roadmap

Unwanted treatment
Problems w/ ADs
What is POLST
Benefits of POLST
Unwanted treatment

Unwanted by patients who get it

75% would trade length of life for quality of life
“More important to enhance the quality of life . . . even if it means a shorter life.”
National Journal (Mar. 2011)

Views on End-of-Life Medical Treatments
Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

If I knew I was dying, I would want medical intervention to keep me alive as long as possible.

<table>
<thead>
<tr>
<th>Somewhat or strongly disagree</th>
<th>70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly or somewhat agree</td>
<td>30%</td>
</tr>
</tbody>
</table>
Means to a Better End:

A Report on Dying in America Today

Deaths at home, 1997
Range 14.7% - 35.8%  Mean 24.9%

People over 65 who used hospice in the last year of life, 2000
Range 4.9 - 42.0%  Mean 21.5%
spending, last 2 years

% deaths in hospitals
Who gets unwanted treatment

Patients with capacity

Tool to fix: informed consent
Patients without capacity

Tool to fix: advance directive

Limits of Advance Directives
65-76% of physicians whose patients *have* advance directives do not know they *exist*.

**Individuals fail to make & distribute copies**
- Primary agent
- Alternate agents
- Family members
- PCP
- Specialists
- Attorney
- Clergy
- Online registry
- Not informed
Enough

THE FAILURE OF THE LIVING WILL

by Angela Fagerlin and Carl E. Schneider

In pursuit of the dream that patients' exercise of autonomy could extend beyond their span of competence, living wills have passed from controversy to conventional wisdom, to widely promoted policy. But the policy has not produced results, and should be abandoned.

Annals of Internal Medicine

Controlling Death: The False Promise of Advance Directives

Nancy S. Pollock, MD

Advance directives promise patients a say in their future care but actually have had little effect. Many experts have problems with comprehension and implementation, but the advance directive concept itself may be fundamentally flawed. Advance directives simply do not provide more control over future care than a reliable, trusted, familiar person cannot. Making decisions is not a straightforward process of right and wrong, difficult to adopt, minimal in a healthcare setting. Furthermore, many patients and their families do not have the necessary communication, or do not know their wishes effectively. Thus, unexpected problems are often to derail advance directives as the case in the paper Nicholas Boulus. Advance directives offer only limited benefit, advance care planning should emphasize not the composition of directives but the ongoing support of patients and families in future care. The article has implications for palliation should patients and their families have more control, and in making decisions regarding the inevitable, and thus, should share responsibility for those decisions, and above all, should share, support the patient and the family through the healthcare experience of dying.

13
if ____,
then ____

Trigger terms vague
“Reasonable expectation of recovery”
  75%  51%
  25%  10%
Plus: prognosis uncertain

Preferences vague
“No ventilator”
  Ever
  Even if temporary
SITUATION A

If I am in a coma or a persistent vegetative state and, in the opinion of my physician and two consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my goals and specific wishes — if medically reasonable — for this and any additional illness would be:

Please check appropriate boxes:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>I would want to have life-sustaining treatments.</th>
<th>It would depend on the circumstances.</th>
<th>No</th>
<th>I would not want to have life-sustaining treatments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Cardiovascular resuscitation (chest compres- sions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
<tr>
<td>2.</td>
<td>Major surgery (for example, removing the gall bladder or part of the colon).</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
<tr>
<td>3.</td>
<td>Mechanical breathing (respiration by machine, through a tube in the throat).</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
<tr>
<td>4.</td>
<td>Dialysis (cleaning the blood by machine or by fluid passed through the belly).</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
<tr>
<td>5.</td>
<td>Blood transfusions or blood products.</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
<tr>
<td>6.</td>
<td>Artificial nutrition and hydration (given through a tube in a vein or in the stomach).</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
<tr>
<td>7.</td>
<td>Simple diagnostic tests (for example, blood tests or x-rays).</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
<tr>
<td>8.</td>
<td>Antibiotics (drugs used to fight infection)</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
<tr>
<td>9.</td>
<td>Pain medications, even if they dull conscious- ness and indirectly shorten my life.</td>
<td>I want</td>
<td>I may want</td>
<td>I am unbounded</td>
<td>I do not want</td>
</tr>
</tbody>
</table>
More technology is the default
Patient must opt out

ADs often fail to rebut LST presumption
**Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment**

**Thaddeus Mason Pope and Matilda Hexum**

**ABSTRACT**

This issue's ‘Legal Briefing’ column returns to the development of the POLST (Physician Order for Life-Sustaining Treatment) project. POLST has been the subject of significant legislative, regulatory, and policy attention over the past several decades. These POLST-related initiatives have resulted in a series of POLST forms that are uniformly provided in Guiding Principles.

**1. TERMINOLOGY**

While the POLST paradigm is established and developing, a number of key terms are often used by at least one different audience. For the sake of clarity, this section will define the following POLST terms, as it is the terms used by the POLST community. Even among those terms, POLST forms and data elements may differ based upon state-specific guidelines. Thus, it is important to define them for physician orders for life-sustaining treatment. In Michigan, and Michigan, it results in Michigan. In Pennsylvania, POLST forms for Pennsylvania may vary, but the underlying principles remain the same.
Many acronyms

Same concept

What is POLST

National POLST Paradigm Programs
www.polst.org
*As of January 2015
Order for LST

Life-Sustaining Treatments Received (n = 1,606)††

- POLST Comfort Measures Only (n = 335)
- POLST Laxative Interventions (n = 335)
- POLST Full Treatment (n = 826)
- Traditional DNR (n = 262)
- Traditional Full Code (n = 262)

*Any patient with an order for comfort measures who had any palliative care specialty contact was included in the Comfort Measures Only category.

††Life-sustaining treatments are defined as advanced/lifepreservation AL therapy, VI therapy, dialysis, mechanical ventilation, and other life-sustaining therapies.

JAGS 58: 1241-1248, 2010. A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices versus the Physicians Orders for Life-Sustaining Treatments (POLST) Program. Susan E. Hickman, PhD, Christine A. Nelson, PhD, RN, Nancy A Perrin, PhD, Alvin H Moss, MD, Bernard J Hammes, PhD, and Susan W. Tolle, MD.
For whom

Terminal illness
Advanced chronic progressive illness
Frailty

In last year of life
Others who want to define care
Would you be **surprised** if your patient died in next year?

**POLST supplements AD**

Does not replace

**Both**
1. Bright color
Original POLST printed on lilac card stock

But a copy has the same force as original

2. Single page
3. Same form
4. More informed

The present

Here & now
5. Immediately actionable

Provider
Order
Life
Sustaining
Treatment
No need to "interpret" advance directive

No need to "translate" into orders

6. Easy to follow
7. Better honored

Can follow

Will follow
8. Portable

Home
LTC
Hospital
EMS

Linda Sandhei (71)
Maplewood (Aug. 2015)

Vomited in sleep

**NH staff** finds unconscious, not breathing; begin CPR

Maplewood **paramedics** arrive, resume resuscitation

**Husband** asks paramedics to halt efforts

Medics honored his request

Linda dies 20 minutes later
“Until properly completed orders are presented, pre-hospital personnel will . . . proceed with standing orders for resuscitation . . . .”

9. **Updatable**

POLST does **not** expire
MOLST can be revised or revoked at any time

Review with change in condition or location

Can be completed by surrogate, if patient lacks capacity
70% patient
30% surrogate

10. Proven Effective

POLST is Evidence Based

• Major academic research in 3 POLST states: strong evidence base of efficacy of POLST in ensuring preferences are elicited, documented, honored, w/ pain and symptom management equivalent to those without POLST order

Closes gap between what people **want** and what they **get**

**POLST concerns**

**CHAPTER 14C**

**HEALTH CARE DIRECTIVES**

- 14C.01 Definitions
- 14C.02 Healthcare directive
- 14C.03 Requirements
- 14C.04 Executed in another state
- 14C.05 Suggested verbal provisions that may be included
- 14C.06 When effective
- 14C.07 Authority and duties of healthcare agent
- 14C.08 Authority to review medical records

**REVOCATION OF HEALTH CARE DIRECTIVE**

- 14C.09
- 14C.10
- 14C.11
- 14C.12
- 14C.13
- 14C.14
- 14C.15
- 14C.16
Adopted by Minnesota Medical Association, Emergency Medical Services Board, growing number of health systems, physicians . . .

Oak Hills NH (New Ulm) cited - not following POLST
Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Ilta Living Center
5507 North
Im, MN 56073
County

Visit: September 9, 2013
Visit: 9:00 a.m. - 11:00 a.m.

Report #: H5490012
Date: November 1, 2013
By: Carrie Euerle, R.N., Special Investigator

STATE OF MINNESOTA
COUNTY OF BROWN

Eric J. Whitman, trustee for the
next-of-kin of Karen A. Whitman,

Plaintiff,

v.

Highland Manor, Inc., d/b/a Oak Hills
Living Center, a Minnesota corporation,

Defendant.

DISTRICT COURT
FIFTH JUDICIAL DISTRICT
CASE TYPE: WRONGFUL DEATH

Court File No. __________

COMPLAINT

QuickSafety

End-of-life care: A patient safety issue

DNR is mistaken as Do Not Treat

Issue 15 July 2015