

## OPINION EXCHANGE

# Time for death panels? No. Care directives? Yes.

Advance care planning tools, like the POLST form, can put your loved one's wishes first and take the decisions off of doctors.

By Victor M. Sandler | MARCH 25, 2020 — 5:55PM

What's a death panel? It's misnomer assigned by some to an original element of the Affordable Care Act. This provision of the legislation would have encouraged doctors to have discussions with their patients so they could determine what types of medical treatment they did and did not want if they became unable to communicate their wishes.

Would they want CPR if they suffered a cardiac arrest? Would they want treatment with a ventilator in an ICU if they became critically ill with respiratory failure from pneumonia or heart failure?

We in health care have a more accurate and constructive name for these discussions. We call them advance care planning. To a significant degree patients can do this on their own by writing an advance directive and/or naming someone to make decisions for them if they are no longer able (also known as a health care agent).

And given the hospital chaos COVID-19 promises to deliver within the weeks, if not days, ahead, now is the time to plan for the worst — while hoping for the best, of course.

The emotionally laden phrase “death panels” maligned advance care planning. It implied that these discussions would lead to denial of care to older people and directly lead to their premature deaths. The truth is that people with serious illness who do advance care planning and make informed decisions often choose palliative and hospice care rather than more aggressive interventions. And according to medical studies they live, on average, as long or longer than people that choose ongoing aggressive care. Consequently, I prefer to call advance care planning “life panels.”

So recently my wife and I had a discussion with my 86-year-old mother-in-law who suffers from chronic obstructive pulmonary disease (COPD). She's a widow but still lives independently. We and two of her sons have had discussions with her in the past and we had a good idea of what her desires would be. But we felt more urgency to make her sentiments explicit given the pandemic.

I knew that if she became ill with COVID-19 she would likely develop pneumonia and respiratory failure. Given her age and COPD, she would have a high risk of dying with or without the use of a ventilator.

She did not surprise us. She made it clear to us that she would not want CPR performed and she would not want to be put on a ventilator even if the use of a ventilator would prolong her life. She is willing to be hospitalized for less aggressive care such intravenous fluids, antibiotics and skilled nursing care.

So my wife and I completed with her a POLST form (Provider Orders for Life Sustaining Treatment). This advance care planning tool is used nationally and has been endorsed by the Minnesota Medical Association, the Minnesota Nurses Association, the Minnesota Board of Medical Practice and the Emergency Medical Services Regulatory Board for Minnesota. After we completed the form, I signed it and my mother-in-law signed it. It, unlike an advance directive, will be a doctor's (provider's) order so that it will be followed by first responders and emergency physicians.

On March 22 in the Star Tribune and March 23 in the New York Times important articles addressed the issue of doctors making decisions in the setting of the coronavirus pandemic and the possible (probable, according to many medical experts) likelihood of



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A hospital nurse holds a coronavirus testing kit at a drive-through center.

a shortage of lifesaving ventilators. The doctors may have to ration ventilators to patients who they believe are the most likely to survive. The others would likely die of respiratory failure. These are horrific decisions for doctors to make.

We can all work together to accelerate advance care planning and POLST completion. Individuals and families have the right to decide the types of treatment they do and don't want. There are millions of elderly in the community, in assisted living and in nursing homes, who can right now actively make and communicate their wishes for their end-of-life care. For the many seniors who can no longer decide due to dementia, the question for their family members is: "Would your loved one have wanted aggressive medical treatment used to prolong their life?" Those who decline aggressive care should receive hospice and palliative care to maximize their comfort.

Studies show (and I know from my nearly 40 years of work focused on their care) that many of the elderly decline aggressive medical treatment to prolong their lives.

So let's avoid, if at all possible, placing doctors in the position of rationing ventilators.

Go to the Minnesota Medical Association website: [polstmn.org](http://polstmn.org) to learn about the POLST. We need to enable elderly people to make their own decisions, or in the case of patients with dementia — the decisions their families feel they would have made. The form must be explained by a health care professional.

Let's get this done now. We are in the midst of a national emergency. We need to help the health care system, enable patients to make their own decisions and avoid placing doctors in the position of rationing an inadequate supply of ventilators.

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