

CLINICAL VIGNETTE

ADVANCE DIRECTIVES AND POLST: A CLINICIAN'S GUIDE

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Case Report

A 79-year-old male presents as a new patient with no major medical problems. As part of the visit, he is asked if he has ever completed an advance directive form, to which he replies that he did so the year before. After the visit, he mails in an Advance Health Care Directive form. On perusing it, his wife is named as the proxy decision-maker and a friend as the first alternative. The box relating to not wanting efforts to prolong life and not wanting life-sustaining treatments in untenable circumstances, is signed. A separately typewritten "Exhibit A" is attached, which, among other statements, includes: "If I am in a terminal condition and...I will never regain the ability to make decisions and express my wishes, then a) I do not want tube feedings b) I do not want antibiotics c) I want maximum pain relief d) I do not want CPR e) I do not want mechanical respiration."

Advance directives are legal documents that allow an individual to express preferences about end-of-life care in advance. One of the prime times to initiate discussions of advance directives is in the outpatient setting. Most physicians have experience with patients who have no directives in place at the most vulnerable time, such as when the Code Blue team is called in the middle of the night. In the outpatient setting, I like to bring up the discussion in the context of the social history. I start off by asking if the patient has ever completed an advance directive (or "living will" if they are unfamiliar with the former term). If yes, I inquire as to what the essence of their wishes are. I ask them if they have discussed their wishes with the individuals designated in the forms. I then request that they forward me a copy of the forms. If they have never filled one out, I inform them that it's never too early to do so and, along with giving them the form, I encourage them to think over such matters, choose one or more persons to serve as a surrogate decision-maker and to discuss their values and wishes with them. I advise them to avail themselves of various resources to help prepare themselves better such as an internet search of "CMA advance directives". This surprisingly takes very little time to accomplish. I also ask them to send me a copy once the forms are completed and I have it incorporated into the patient's records. If I am pressed for time, I will make notes to initiate or continue the conversation at a future visit. An opportune time to initiate such discussions is on the initial visit or on physical examination visits.

UCLA has recently instituted a Goals of Care Discussion Note that can be incorporated into the Electronic Medical Record. This note can be accessed in the electronic record in the section with Advance Directives and POLST, named "AD/POLST/Goals", above the Document Folders. This greatly enhances accessibility and durability of patients' wishes within the medical records.

One of the most challenging aspects of end-of-life discussions is to try to determine the specifics of the patient's preferences. Indeed, one study found that patient preferences were often not clear in advance directives, and life-sustaining treatment was discontinued only when it was medically futile¹. For example, in the current California Medical Association (CMA) version of the Advance Health Care Directive form, patients have the ability to sign 1 of 2 statements in the case of an irreversible condition rendering a patient unable to make medical decisions and needing life-

support treatments to be kept alive. One statement allows one to die as "gently as possible" with all treatments other than comfort measures to be discontinued or withheld. The other allows the prolongation of one's life as long as possible within limits of generally accepted medical care. There is a third option which is open-ended and allows one to write in one's desires and limitations of medical treatment. I generally emphasize that it is perfectly acceptable to sign 1 of the 2 statements, but it is more helpful if patients think through different scenarios and document their wishes in the open section. For example, I ask them to think about if they were very ill in an intensive care unit and they needed things like dialysis or a feeding tube to keep them alive. While it is not possible to review or even envision every possible scenario of end-of-life care, one can obtain a more accurate reflection of a patient's values and wishes to extrapolate to unanticipated situations.

The CMA (<http://www.cmanet.org/publicdoc.cfm/7>) has a list of questions and answers that address the various aspects of Advance Health Care Directives and has a useful section, "Optional Miscellaneous Requests or Directives" (see Appendix section of this article, reproduced with permission of CMA). While outdated in terms of valid website links, this document provides a useful framework to help patients approach end-of-life discussions and directives. It is worthwhile for physicians to use the website to see examples of common conditions that apply to advance directives, including what is needed to make it a legal document, how it can be changed once completed and what kinds of authority the proxy decision-maker has as it applies to different medical situations.

Although the standard CMA Advance Health Care Directive is a valuable document, it lacks many attributes possessed by those of other organizations. For example, a non-profit organization, Aging With Dignity, has a form "Five Wishes" which is not specific to California (<http://www.agingwithdignity.org/about.php>). In the form, it has sections such as "In a coma and not expected to wake up and recover", "Close to death", "My wish for how comfortable I want to be" and "My wish for what I want my loved ones to know". The Veterans Administration Advance Directive (<http://www4.va.gov/vaforms/medical/pdf/vha-10-0137-fill.pdf>) also has sections portraying different scenarios, such as "If I have a permanent condition that makes me completely dependent on others for my daily needs (e.g. eating, bathing, toileting)" to which one can check "yes", "no" or "it depends", as it relates to choosing life-saving treatment. Both these forms illustrate the power of specificity. Many times, friends or even family, who have been designated as proxy decision-makers, are not privy to patients' wishes and values in advance, due to lack of meaningful discussions about end-of-life issues. The more scenarios one can address on paper, the less challenging decision-making may be in unanticipated situations.

Despite all the above, one of the limitations of forms that ask patients to choose from one end of aggressiveness of care to the opposite is that patients often do not have the medical knowledge and judgment to weigh the benefits and burdens of each situation. Many states, including California, have adopted Physician Orders for Life-Sustaining Treatment (POLST). The premise of POLST is that the physician and patient have a goal-directed discussion which leads to various medical orders based on those goals, such as might relate to nutritional issues, CPR, additional interventions or comfort care². The POLST form is complementary to an advance directives form. It is signed by both physician and patient (or appointed decision-maker if the patient is unable), and intended to be useful to emergency personnel in the home setting as well as hospital or nursing/residential care facilities. It is recommended that the patient post the form prominently in the home, for example on a refrigerator. While advance directives are of value for any person, regardless of health status, in part due to its ability to have a proxy decision-maker appointed, POLST forms are more likely to be of value in those who are seriously ill or in poor health. Nevertheless, if one has the time to discuss POLST in addition to advance directives with any patient, I would encourage that to be done. POLST also expands upon the California Emergency Medical Services Authority's "Prehospital DNR" form, which is really limited to DNR orders at home as it pertains to resuscitation by emergency personnel.

(http://www.codaalliance.org/images/ems_dnr2pageform.pdf)

More information about the POLST form and the form itself can be found via UCLA's Center for Research and

Training in Humane and Ethical Medical Care (<http://chec.ucla.edu/body.cfm?id=53>)

Another innovative and relatively new program allows paramedic personnel in Los Angeles County to accept verbal DNR instruction from family at home or in non-hospital facilities³. Implemented in 2007, the policy allows an immediate family member to verbally request DNR, provided no other family member objects, based on a patient's wishes in the absence of written documentation. It also allows paramedics not to resuscitate if a patient is found in asystole and at least 10 minutes have passed between patient collapse and the start of CPR. Assessment of the policy demonstrated that paramedics were more likely to forego resuscitation efforts after the new policy was begun⁴. Furthermore, no negative outcomes were reported by family members as a result of the policy and paramedics reported satisfaction, in many cases avoiding needless resuscitation attempts in futile cases³. This new policy is of much value given the substantial portion of the population not having completed advance directives and in those who have, the difficulty in family locating paperwork in an emergency situation.

Two years after I first met the patient described in the beginning, he developed failure to thrive and was diagnosed with pancreatic cancer. After his hospitalization, he was enrolled in home hospice and his wish to have maximum pain relief was honored. He died peacefully at home with his wife and loved ones beside him. A pre-hospital DNR form also had been completed and while it, as well as the advance directives, never had to be invoked, it was comforting for me and no doubt him and his family to know that these important documents were readily available.

REFERENCES

1. **Teno JM, Stevens M, Spornak S, Lynn J.** Role of written advance directives in decision making: insights from qualitative and quantitative data. *J Gen Intern Med.* 1998 Jul;13(7):439-46. PubMed PMID: 9686709; PubMed Central PMCID:PMC1496979.
2. **Hickman SE, Hammes BJ, Moss AH, Tolle SW.** Hope for the future: achieving the original intent of advance directives. *Hastings Cent Rep.* 2005 Nov-Dec;Spec No:S26-30. PubMed PMID: 16468252.
3. **Grudzen C and Asch S.** In a Heartbeat: New Resuscitation Protocol Expands EMS Options. California Health Care (electronic publication): www.Chcf.org/publication. April 2010.
4. **Grudzen CR, Hoffman JR, Koenig WJ, Boscardin J, Lorenz KA, Asch SM.** The LA story: what happened after a new policy allowing paramedics to forego resuscitation attempts in prehospital cardiac arrest. *Resuscitation.* 2010 Jun;81(6):685-90. Epub 2010 Mar 16. PubMed PMID: 20236748.

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OPTIONAL MISCELLANEOUS REQUESTS OR DIRECTIVES

There are innumerable matters that you might wish to include in your Advance Health Care Directive. Some of these include:

1. The candor with which you want information about your condition and prognosis disclosed to your agent and/or your loved ones.
2. Your preference for an emphasis on the goals of treatment rather than specifics about treatment. To do this, list goals and statements of what constitutes a desirable quality of life for you as well as your concerns about quality of life.
3. Persons (family members, friends, colleagues, clergy) with whom you would like your health care agent to consult before making any decisions, if circumstances permit.
4. Persons you do not want involved in making health care decisions for you.
5. A statement of your preference of health care provider-- physicians, consultants, hospital, nursing home, home health or hospice program--or those you don't want.
6. Your willingness to undergo experimental or innovative therapy.
7. Expression of religious, spiritual or philosophic beliefs relevant to your health care.
8. Your preference for cardiopulmonary resuscitation. If you do not wish your health care providers to attempt cardiopulmonary resuscitation for you, you should append the "Pre-Hospital Do Not Resuscitate (DNR)" form and obtain a "Do Not Resuscitate-EMS" medallion approved by California's Emergency Medical Services Authority. You may order copies of the DNR form (which includes instructions on ordering the medallion) from the CMA website: www.calmed.org.
9. Your preference to receive or forgo a variety of life-sustaining treatments in certain settings. (For examples, see *New England Journal of Medicine*, March 28, 1991; 324(13): 889-895.)
10. Your preferences for palliative care, referral to hospice, or the use of artificial nutrition and hydration (tube feeding) if you are permanently unconscious, severely demented, or terminally ill.
11. Your preferences for terminal sedation and the omission of artificial nutrition and hydration if you are terminally ill and suffering or have some other condition from which your suffering is unrelieved.
12. Your preference for where you would like to die.
13. Your preference for autopsy and/or preservation of tissue for future genetic or other analysis.
14. A list of things you hope to accomplish before dying.
15. Your preference for disposition of your remains (burial, cremation), funeral or memorial service, eulogy and eulogists, minister, etc. *Do not include this information in your Advance Health Care Directive if you have listed it in your will or other legal document.*
16. A statement of limitations for challenges or petitions against your health care directive.

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