

The Changing Face of Health Decisions Advance Planning:

**From a Transactional Approach
to a
Communications Approach**

**Charles P. Sabatino
and
And Myra Christopher**

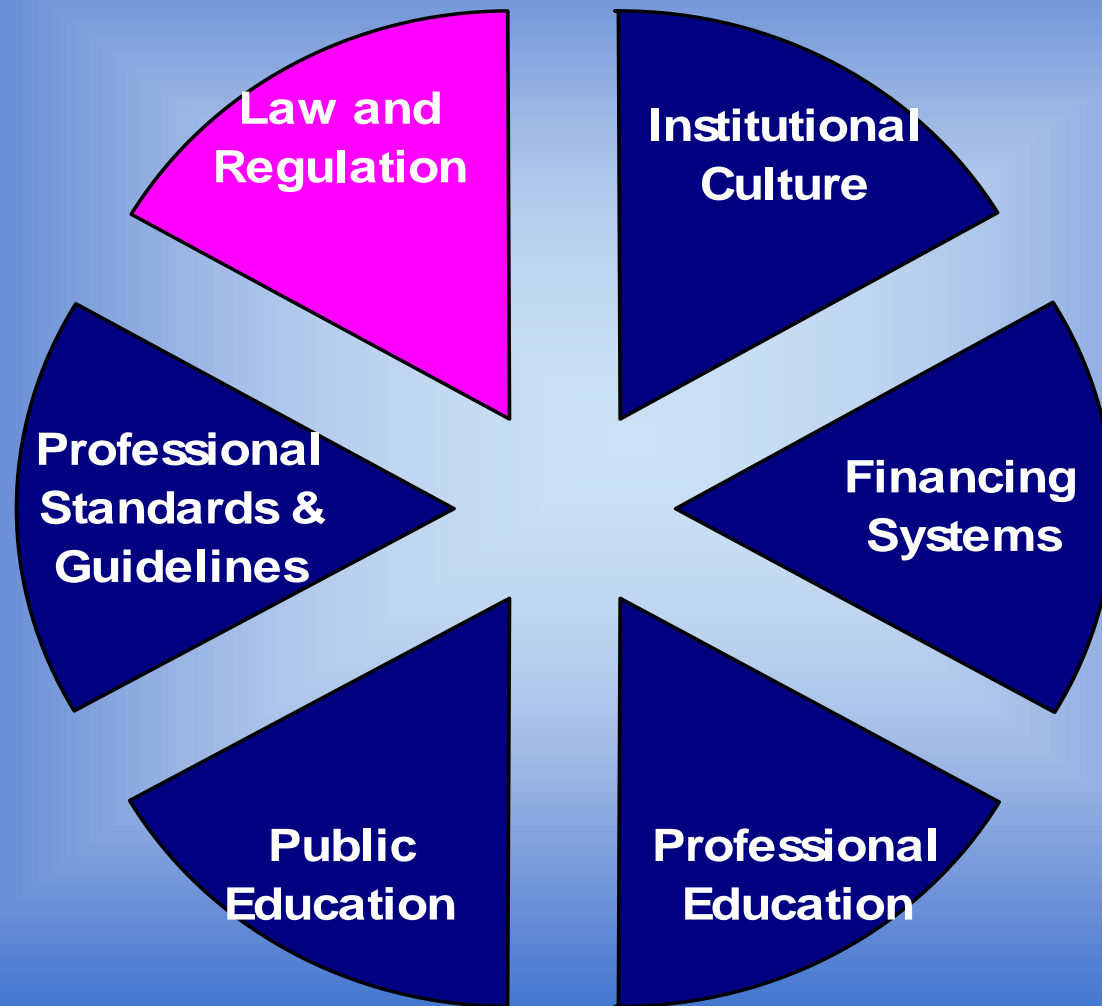
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My Remarks. . .

- 1. The Legal Landscape -- in Context**
- 2. Evolution of Advance Directives**
- 3. Implications for Legal Counsel**
- 4. POLST – a Next Step**

Factors Influencing End-of-Life Care



... Spirituality / Family / Workplace ...

Sources of Law & Interpretation of Law

Federal & State Constitutions

Statute & regulation

Common Law (principles established through case adjudication)

Professional standards/guidelines/statements (by recognized authorities)

“Custom & Practice”

Predominant Feature of the State Legislation

1. Default Surrogate Laws
2. Health Care Advance Directives
HCDPAs / Living Wills / Mental Health ADs
3. Out-of-Hospital DNR Laws
4. Organ Donation Laws
5. Guardianship Laws
6. Physician Aid in Dying (OR)
7. Palliative Care/Controlled Substances
8. POLST

A Quick Legislative History of Advance Planning

- 2000s: More '90s + POLST?
Death of Living Wills?
- '90s: Combined AD Statutes &
EMS-DNR Statutes
- 80'-90's: DPAHC Acts
- '70s-'80s: Living Will Acts
- 1968: Unif. Anatomical Gifts Act

Default Surrogate Laws: '60s -- '00s

2. Evolution of Advance Directives

Conventional AD Laws

Focus: mandatory legal formalities, procedures, and standardization to ensure voluntary, knowing & competent execution & implementation--

- Statutory forms
- Required disclosures
- Prescribed phrases
- Witnessing rules
- Agent/proxy limitations
- Diagnostic and certification requirements
- Limitations on surrogate authority
- Notice requirements

30 years of research on the legal transactional approach...

- Most people don't do.
- Hard to understand the forms.
- Standard form not useful guidance.
- People change.
- Agent/proxy slightly better than clueless.
- Health care providers clueless about the directive.
- Even if providers know directive exists, it's lost in space.
- Even if in the record, it's still lost in space.

Advance Directives

- *the Dark Side* -

See e.g.,

- A .Fagerlin & C. Schneider, “Enough: The Failure of the Living Will,” 34 *The Hastings Center Report* 30-42 (March-April 2004).
- E.J. Larson and T.A. Eaton, “The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act,” *Wake Forest Law Review*, 32 (1997): at 278.
- J. Teno et al, “Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention,” *Journal of the American Geriatrics Society*, 45 (1997): 500-507.
- D. Orentlicher, “The Illusion of Patient Choice in End-of-Life Decisions,” *JAMA*, 267 (1992): 2101-2104.

Communications Approach

“Advance Care Planning”

- **Less focus on legal formalities**
- **Legal focus primarily on naming a proxy**
- **Discussion focused (with proxy, family, health care providers)**
- **More broadly focused on goals of care, and values, spiritual questions, family matters**
- **Less treatment focused**
- **Developmental and iterative in nature**

Signs of Change

**Rise of
Workbook
approaches**

*e.g.,
Five Wishes*
**33 to 40 states
(97-07)**

**Trend toward
simplification of
state laws**

**1993 Uniform
Health-Care
Decisions Act**

POLST

**Oral ADs
14 states**

3. Implications for Legal Counsel

Starting Point: What ADs *Can't* Do

1. Can't provide cookbook directions.
2. Can't change fact that dying is complicated.
3. Can't eliminate personal ambivalence.
4. Can't be a substitute for Discussion.
5. Can't control health care providers.

What ADs *Can* Do

1. **CAN** be an important part of a developmental process of advance planning communication
2. **CAN** help you stop and think and **DISCUSS**.
 - Less about specific medical decisions, more about **GOALS, VALUES & PRIORITIES**: What treatment goals are important to you? What's important to you in living? What conditions of living may outweigh the value of continued life?
3. **CAN** empower and give **DIRECTION** if **reflective of the patient's voice**.
 - Not necessarily the legislature's canned language.

More Effective Advance Care Planning

1. Emphasize process, not transaction. Don't do *McDirectives*
2. Give priority to Proxy appointment
3. Give client tools:
 - i.e., Workbook approach
 - Help educate the agent/proxy
4. Caution drafting instructions
 - Values, goals, quality of life – Yes
 - Specific medical instructions – No, unless connected to known medical probabilities.
5. Periodic review – the 5 D's.

Have you done your own advance care planning?



Workbook example

Tool #1

How to Select Your Health Care Agent or Proxy

Name & Date _____

When you decide to pick someone to speak for you in a medical crisis, in case you are not able to speak for yourself, there are several things to think about. This tool will help you decide who the best person is. Usually it is best to name *one* person or agent to serve at a time, with at least one successor, or back-up person, in case the first person is not available when needed.

Compare up to 3 people with this tool. The persons best suited to be your Health Care Agents or Proxies rate well on these qualifications...

Name #1:		
Name #2:		
Name #3:		
		1. Meets the legal criteria in your state for acting as agent or proxy or representative? (This is a must! See next page.)
		2. Would be willing to speak on your behalf.
		3. Would be able to act on your wishes and separate his/her own feelings from yours.
		4. Lives close by or could travel to be at your side if needed.
		5. Knows you well and understands what's important to you.

Workbook example



Tool #2

Are Some Conditions Worse than Death?

Name & Date _____

This worksheet helps you to think about situations in which you would **not** want medical treatments intended to keep you alive. These days, many treatments can keep people alive even if there is *no* chance that the treatment will reverse or improve their condition. Ask yourself what you would want in the situations described below if the treatment would not reverse or improve your condition.

Directions: Circle the number from 1 to 5 that best indicates the strength and direction of your desire. If you wish, you can add additional thoughts on the *Comment* lines.

- 1 -- **Definitely want** treatments that might keep you alive.
- 2 -- **Probably would want** treatments that might keep you alive.
- 3 -- **Unsure of what you want.**
- 4 -- **Probably would NOT want** treatments that might keep you alive.
- 5 -- **Definitely do NOT want** treatments that might keep you alive.

What If You . . .	Definitely Want Treatment ← ↔ Definitely Do Not Want Treatment				
	1	2	3	4	5
a. No longer can walk but get around in a wheel chair.					
<i>Comment</i> _____					
b. No longer can get outside. – You spend all day at home.					
<i>Comment</i> _____					
c. No longer can contribute to your family's well being.					
<i>Comment</i> _____					

AGING

with *Dignity*

FIVE WISHES™

FOR

Print Your Name

Print Your Birth Date

My Wish For:

1. The Person I Want To Make Care Decisions For Me When I Can't
2. The Kind of Medical Treatment I Want or Don't Want
3. How Comfortable I Want To Be
4. How I Want People To Treat Me
5. What I Want My Loved Ones To Know

Five Wishes makes it easier for you to let your doctor, family, and friends know how you want to be treated if you become seriously ill and cannot tell them. *Five Wishes* is a gift to your fami-

ly members and friends so that they won't have to guess what you want. *Five Wishes* is easy to understand and simple to use.

www.AgingWithDignity.org

Educate the Health Care Proxy

Making Medical Decisions for Someone Else: A Maryland Handbook



By

The American Bar Association
Commission on Law and Aging

In Collaboration with
The Maryland Office of the Attorney General
J. Joseph Curran, Jr., Attorney General

Chapter Project?

Provide a framework for review

Review plan when any of the 5 D's occur::

1. You reach a new **DECADE**
2. You experience a **DEATH** of family or friend
3. You **DIVORCE**
4. You receive a new **DIAGNOSIS**
5. You have a significant **DECLINE** in your condition as measured by Activities of Daily Living (ADLs).

4. POLST – A Next Step

The POLST Paradigm

Last 30 years: Policy goal -- standardizing patient communications, i.e., statutory advance directives

Tipping Point: *POLST* Paradigm – standardizing physicians EOL care orders. Focus on here and now.

***Physicians Orders for Life-Sustaining Treatment* – requires:**

1. Doc to find out patient's wishes re: CPR, care goals (comfort vs. treatment), antibiotics, N&H.
2. Translate into doctors orders on visually distinct (bright pink) med file cover sheet.
3. All providers ensure form travels with patient to enhance continuity of care.

(Bright Pink)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN contact physician, nurse practitioner or PA-C. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name

First/Middle Initial

Date of Birth

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

Check
One

CPR/Attempt Resuscitation DNR/Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B, C and D.

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

Check
One

COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer: EMS contact medical control to determine if transport indicated.**

LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care if possible.**

FULL TREATMENT Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**

Additional Orders: (e.g. dialysis, etc.) _____

C ANTIBIOTICS:

Check
One

No antibiotics. Use other measures to relieve symptoms.

Determine use or limitation of antibiotics when infection occurs, with comfort as goal.

Use antibiotics if life can be prolonged.

Additional Orders: _____

D ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquids by mouth if feasible.

See POLST.org

POLST Paradigm checklist:

1. Form constitutes **set of medical orders**.
2. Process includes **training of HC professionals** across continuum of care about the goals of the program and creation and use of the form.
3. Recommended for persons who have **advanced chronic progressive illness**, those who might die in the next year, or anyone wishing to further define their preferences of care.
4. Requires a valid **Physician signature** (or by NP or PA) & date.
5. May either **limit** medical interventions **or** to clarify a **request** for all medically indicated treatments including CPR.
6. Provides explicit direction about **resuscitation status** if the patient is pulseless and apneic.
7. Also includes directions about **other types of intervention**. For example, decisions about transport, ICU care, antibiotics, artificial nutrition, etc.
8. **Accompanies the patient**, and is transferable and applicable across care settings (i.e. Long term care, EMS, hospital).
9. Form **uniquely identifiable**, standardized, uniform color within a state/region.
10. Plan for **ongoing monitoring** of program and implementation.

Circumstances have changed but the question remains the same as in 1982:

“How to foster a relationship between patients and professionals characterized by mutual participation and respect, and by shared decision-making”

President's Cmsn for the Study of Ethical Problems in
Medicine & Biomedical & Behavioral Research

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