

Special Audio Report Transcript

Headline: End-of-Life Expert Susan Tolle on Rolling Out Physician Orders for Life-Sustaining Treatment

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Text:

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"Advance directives are for adults of any age to say what they would want in the future if something happens. It's not for the here and now. It's not for tonight. It does let you say who would you want to make decisions for you if you can't make decisions for yourself. But it's not of much use to emergency medical personnel. It's not orders. Did you mean tonight? Did you mean if you were a lot sicker? Did you want to be on a breathing machine for a while and then, as your prognosis became more clear, have your loved ones set limits? You can't tell from an advance directive. In a time of crisis, it can't be actionable fast enough. It's very helpful for a family meeting in the intensive care unit to have an advance directive and to have a conversation. But that means treatments were started and a decision is being made to stop. There are those who would like not to go to intensive care at the end of their lives. And what we found in the JAGS study published last month was that it's a vast majority of those in long-term care. Only 12% said, 'I want to go to the ICU.'"

"There are two ways that states approach POLST. One is through regulation, and you simply write regs that don't go through the Legislature. We, for example, worked with the Oregon medical board to write a rule that says, 'Physicians, nurse practitioners, PAs must respect written orders regarding life-sustaining treatment until or unless they have information to the contrary.' So it does the same thing as AB 3000, but it didn't do it through legislation. And we encourage people, if they can, to do it through regs, because you sometimes pick up things you don't want on a legislative pathway. And at the time we did this, we would have picked up some unwanted limitations that would not have served us well. We also encourage people to be careful when they do legislation that they don't write so much detail that they have to go back in two years. If they write, for example, exactly what is on a POLST form in legislation, then you're going to have to go back and change it when you need to write a new type of treatment."

"POLST first of all needs a coalition that brings everybody to the table as you design the form so that everybody has a stake in: Will it work in my EMS? Will it work in my hospice? Will it work in my long-term care? Will it work in my hospital? And everybody is all on the same page in the design so that you

don't end up with something that doesn't work in one part of the system because of some unique features. For example, California does not have a statewide EMS system the way we do, so some modifications might be needed to accommodate that difference and bring those stakeholders in to be sure the system was well designed. That's step one. You get the form; you get the regs changed or the law changed. And then you begin rollout. You have a huge educational job to do. You need to educate EMS. You need to educate all possible health care professionals who would be doing counseling about advance care planning and completing POLST, whether it's in hospice, nursing homes, acute-care hospitals, private offices. You have a lot of places to go and tens of thousands of people to reach. And then you need to reach the public in such a way that they understand that there is a difference between advance directives and POLST and that they complement one another and that an advance directive takes POLST and turns those wishes on the advance directive into action when it's time for people with advanced illness and frailty. Then you need an ongoing arm that checks quality. How can you improve? We, for example, will do a heat map in another month of every county in Oregon, studying the percent of people over 65 who have a POLST form as submitted to the registry, and then we'll design educational conferences for the counties that are low. Not that we don't have educational programs now, but those will need some sort of special intervention if they're lagging the farthest behind in the registry. So data, education, policy. Those are the three legs of the stool."