

Admin.

December 20, 2007

Second Supplement to Memorandum 2007-48

**New Topics and Priorities
(Material Received at Meeting)**

The following material was received by the Commission at the meeting on December 13, 2007, in connection with the discussion of new topics and priorities, and is attached as an Exhibit:

- Ronald B. Miller, M.D., University of California, Irvine (12/12/07) 1 *Exhibit p.*

Respectfully submitted,

Barbara Gaal
Staff Counsel

- I. I wish to briefly describe a procedure that could be accomplished by legislation, by regulation, or by becoming community-wide or state-wide practice by physicians, hospitals, nursing home, hospices, and home-health agencies.
- II. The purpose of the procedure is to assure that patients' preferences for medical treatment are honored. You may say: "We have that: Advance directives."
I would reply: "Yes, but..."
- III. As you know, advance directives are documents or statements:
1) to appoint someone to speak for you if you become unable to speak for yourself, that is if you are incapacitated (or in common language "incompetent"),
2) to indicate treatments you would want or not want depending upon your condition and prognosis: that is, a living will or treatment directive,
3) or both, since an advance directive may consist of both a proxy directive and a treatment directive.
- IV. Despite enabling legislation for advance directives in every state (and an outstanding Health Care Decisions Law that your Commission was instrumental in drafting for California), and despite the Federal Patient Self Determination Act, advance directives have not lived up to their promise for many reasons:
1) only 20% of Americans have advance directives,
2) the advance directive may not be available when it is needed: for example, it may not be transferred with the patient from one care setting to another,
3) the advance directive may not be understandable (it may be too general, too specific) or may not be applicable to the patient's current condition, prognosis, and preferences,
4) the advance directive may not be seen or understood by the attending healthcare professionals,
5) the advance directive that is available may be one that was changed or rescinded,
6) the advance directive may not have been translated into a physician's order,
7) the advance directive may be misunderstood or overridden by the treating physician.
- V. POLST is the acronym for physician orders about life-sustaining treatment in Oregon and Washington. There are similar acronyms: MOLST (medical orders for life-sustaining treatment) in New York, POST (physician orders for scope of treatment) in West Virginia, and others. All refer to orders written by a physician to comport with a patient's preferences, perhaps more often for withholding or withdrawing treatment than for requesting it. These standardized order forms are printed on heavy paper that is brightly colored and thus readily identified and easily found in the patient's hospital or nursing home record or on the refrigerator if the patient is at home. There are alternative orders in each of several categories: Cardiopulmonary resuscitation, medical intensity of treatment and preference for location of treatment, antibiotics, nutrition and hydration. I could read you these alternative orders, but I think for present purposes I need to tell you why these orders are such a powerful and important supplement to an advance directive and also tell you the present status of POLST in California.
- VI. There are several great advantages of POLST:
1) they encourage or require the physician to discuss the orders and the patient's preferences with the patient and/or surrogate,
2) the orders convert patients' expressed preferences into medically appropriate, medically worded, understandable, action items likely to conform to the standard of care,
3) the orders are intended to be portable, that is to apply to the care of the patient wherever the patient is located: Hospital, nursing home, hospice, home, or elsewhere in the community. You might ask, what if the signing physician is not on the staff of the hospital or nursing home. This problem has generally been solved if not by legislation or regulation, by community-wide hospital policies that honor POLST even when the physician is not on staff of the institution. The Veterans Administration and probably many other hospitals and nursing homes plan for the staff physician who is the attending or treating physician, to rewrite the orders.
- VII. POLST originated in Oregon in 1991, is statewide also in Washington, West Virginia, New York, Utah, and is utilized in communities in Wisconsin and 5 other states. In California it has been initiated in Riverside, Ventura, and Humboldt Counties, and with recent California Health Care Foundation grants of \$20,000 to each of 7 applicants in California, one would hope that POLST would soon be statewide here as well. On November 28 there was a meeting in New Orleans attended by individuals from 23 states, including 26 individuals from California, and one hopes the POLST Paradigm will soon be national. The California contact for the National POLST Paradigm Initiative Task Force is Judy Citko, JD, Executive Director of the California Coalition for Compassionate Care (jcitko@calhospital.org).
- VIII. Because POLST should supplement, not supplant, a patient's advance directive, POLST policy should supplement our California Health Care Decisions Law. Because your Commission did such an outstanding job with the Health Care Decisions Law, I believe it would be very important for you to study POLST and make recommendations whether that be for legislation, regulation, or simply community-wide or state-wide practice.

Respectfully, Ronald B. Miller M.D. 12-12-07.

Ronald B. Miller, M.D., Clinical Professor of Medicine Emeritus, founding Chief of the Renal Division, founding Director of the Program in Medical Ethics, Department of Medicine, President of the UCI Emeriti Association, University of California, Irvine.