P.O.L.S.T.

The new Paradigm for Patient Care

How many have considered end of life care? How many have given thought to what will happen as a result of disease or aging? Have you even discussed this with your wife, husband, children, or given consideration to your parent's concerns as we get older and just deal with the infirmities of aging or the steady decline of chronic debilitating disease? What resources will be needed and what technologies will be afforded at the end of days? Will you even be aware of what is transpiring and will you want prolongation of inevitable events that may incur pain or discomfort.

Acute care with a foreseeable resolution will always be available. It will be handled with empathy and concern. Care to protract an inevitable event with the miseries that ensue requires a different paradigm, one that treats anyone at the end of days with compassion, empathy, and comfort, and above all, adherence to ones wishes regarding the type of care one is willing to endure at the end of days.

As medical professionals we deal poorly with all aspects of death, i.e., the acute phase due to trauma or the sudden onset of a medical condition that we fail to reverse; the chronic phase of the continued deterioration of chronic illness either of our own volition by life's choices, congenital conditions recognized early or late but which medicine has no clear cut remedies to reverse, or the general aspects of a failing system due to the adverse affects of aging. We are taught to prolong life at any cost, to fight off the ravages of illness and aging, and we dare not openly discuss the frailties of life in our quest for longevity.

Medical professionals no longer have the time to prepare patients for the eventualities of death. Private practitioners, in the primary care field, no longer practice in hospital, but have come to rely on Hospitalists to manage their patients when the need to be hospitalized occurs. Hospitalist who often are unaware of patients end of life decisions, are now forced to discuss these concerns. So little time to discuss something that should have come before. Private practitioners, in the primary care field, no longer are aware of emergency management in the prehospital setting or in the emergency department. They often rely on others to facilitate care in the nursing home or long term care facilities. And when there are conditional changes do not hesitate to send the patient to a higher level of care where directives may not be available.

A steady decline of conditions is often not recognized until the points of extremis are met in extended care facilities, and then realize something needs to be done. Where is the directive to determine which course of therapy should ensue? When a family member who hasn't seen the patient in six months finds their relative in the normal state of progression of disease and suddenly demands they be rushed to the emergency room, where is the directive to determine the course of treatment? Often multiple studies ensue on repeated occurrences, which will have no bearing on the

quality of life or chance of reversal of fortune. We are all afraid of facing the natural progression and the inevitability of death. And then there are the terminal cases which EMS is summoned to thwart the inevitable. No advanced directive, no available out of hospital DNR, at times only minutes from arrest or already in arrest and do we start CPR on a patient who will not survive or survive only to suffer for a few hours or days.

As medical practitioners we have come to the point where we must provide direction to patients and families. They must be made fully aware of their options and choices. It must be frankly discussed with an open mind, putting all emotions aside and with the best available evidence of what outcomes may come from each direction presented. It must be flexible and scalable to the individual's decision and it must represent what they perceive as to a final solution to the end of their long journey.

To this end the POLST represents the best practices for end of life decisions.

The Out-of-Hospital Do-Not-Resuscitate Order (OOH-DNR) is a request that nothing should be done. It requests that CPR, transcutaneous pacing, defibrillation, advanced airway management, and artificial ventilation be withheld. It is not a request for care. It offers no consideration when pacing, advanced airway management or artificial ventilation may be considered. It does not discuss natural death.

The **POLST** is infinitely flexible and scalable. It works in concordance with the **Advanced Directive**. It allows advanced treatment if the patient chooses and only elucidates a DNR if the patient is both pulseless and not breathing. It **does** allow for advanced airway management at the discretion of the patient and does not withhold artificial ventilation as a prerogative. Depending on the discussion with the attending physician the patient may elect comfort measures only at the end of life as defined by the POLST or more advanced treatments and directs where the treatment is to be performed depending on the particular auspice the patient finds themselves, either nursing or long term care facility or home. It gives direction to EMS as to the type of end of life care the patient desires and does not delay treatment to be sure everything is in order with the form and it is valid.

Being scalable, Medical Interventions, Antibiotics, and Artificially Administered Nutrition are decided upon in concert with the patient's physician. The decision process, choice of surrogate, and revocation can at the discretion of the legislature follow the same guideline as in the present statute.

The POLST would of necessity replace the OOH-DNR, but would be a more robust document.

Today we face other medical concerns. In this age of human directed catastrophic events and the potential for natural occurrences causing untold destruction and/or death or serious illness, we may find ourselves working under altered standards of

care. The State of Texas is preparing plans for transport of populations out of harms way and sheltering of general and special needs populations, as well as, the development of mobile medical resources to supplement already burgeoning resources locally, needing supplemental sources of aide. It would facilitate the determination of equipment and resources made available if we better understood the needs of a particular population. This is not to withhold treatment, but to make the best use of resources available.

Medicine is a dynamic process. In order to make the best decision to the population served, it behooves us to understand the population base. This requires a reeducation of physicians and patients. Reality based decisions must be forthcoming. Empathy and compassion must guide our decisions.

Respectfully submitted, 09 November 2010,

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