

POLST ILLINOIS

Physician Orders for Life-Sustaining Treatment

VIGNETTE #1

60 y/o with metastatic prostate cancer who has been able to live at home and manage his own ADL's. A facilitated goals-of-care conversation is conducted. He recognizes that his illness is terminal, and for that reason does not wish to undergo CPR in case of cardiac arrest. He also does not want to be intubated should he suffer a primary respiratory arrest. However, as his quality of life is good, he is willing to attempt low-burden, less-invasive measures to prolong his life.

a. How should his POLST form be completed?

Section A: Do Not Attempt Resuscitation

Section B: Limited Additional Interventions

b. He is admitted to the hospital with urosepsis and hypotension. What life-sustaining treatments can be used? Should/could he be transferred to the ICU?

Because he said he is willing to attempt low-burden, less invasive measures to prolong his life, it would be reasonable to treat him with antibiotics and IV fluids. Whether vasopressors and transfer to the ICU could happen is less clear. With regards to vasopressors, some would regard this as a burdensome and invasive treatment (ie., requires placement of a large-bore IV line and treatment in the ICU) and therefore not consistent with the implied level-of-care of the "Limited Additional Interventions" option. Others would not regard vasopressors as invasive/burdensome, and some hospitals do not require ICU admission for their use. This points to the importance of 1) having appointed a health care agent who can make real-time decisions when the patient is not decisional and additional questions arise and 2) engaging in further discussion about patient wishes when a patient is admitted into an acute care hospital, both to address whether previously documented wishes are still accurate, and to address specific treatments that are not relevant outside of the hospital and are therefore not covered in this out-of-hospital form.

He recovers and returns home. A month later, he visits his physician. He has lost a lot of weight and has become much more frail. Although his quality of life is still

acceptable to him, he no longer wants to spend time in the hospital, and he enrolls in hospice, which will provide services at his home.

c. Should his POLST form be changed? If so, how?

Based on this information, it appears that the patient should complete a new POLST form, with a change in Section B from Limited Additional Interventions to Comfort Measures Only.

One day during lunch at home, he chokes on a hot dog while the hospice nurse is present, and cannot cough, talk or breathe.

d. Should the nurse perform a Heimlich maneuver?

Absolutely. Resolving a choking episode definitely qualifies as an intervention to keep the patient comfortable. However, if during this episode the patient should have a cardiac arrest, he has expressed that he does not want attempt at resuscitation. No matter what its cause, now that he is in cardiac arrest, he has made it clear that CPR should NOT be initiated. This level-of-care plan was selected by the patient based on his underlying condition and the grim odds of resuscitation success, which have not changed, even though the specific cause of the arrest had not been anticipated.

VIGNETTE #2

67 y/o with late-stage COPD who has been intubated and successfully extubated in the past. A facilitated goals-of-care conversation is conducted with the patient, and with his permission, a brother, who is also his POAHC, participates. The patient understands that, should he suffer a cardiac arrest (defined as unresponsive, pulseless, no respirations) the odds of his surviving an attempt at resuscitation all the way to discharge are slim, and he does not wish to have CPR attempted. However, he is willing to be intubated should he suffer a potentially reversible condition, such as a pneumonia, that renders him unable, temporarily, to breathe on his own.

a. How should his POLST form be completed?

Section A: Do Not Attempt Resuscitation

Section B: "Intubation and Mechanical Ventilation"= full treatment plan that also includes treatments described in other two medical intervention categories.

b. He is admitted to the hospital with a pneumonia and mild respiratory distress.

What life-sustaining treatments can be used? Should/could he be transferred to the ICU? Could he be intubated?

All medically indicated treatments may be used in this scenario of a non-cardiac arrest emergency, including intubation/mechanical ventilation/transfer to the ICU if indicated.

c. Following intubation, he develops ventricular tachycardia with chest pain. Could electrical cardioversion be attempted?

Again, this is a treatment that represents a gray area given the contents of the POLST form. Hospitals have different mechanisms for specifying how emergency treatment instructions may be specified. Any time a patient's condition changes, such as, when admitted to the hospital, a revisiting of wishes for emergency treatment should take place.

The patient has been intubated for five days and he is sedated because he is fighting the ventilator. The brother intervenes and says that he can't bear to see the patient suffer like this, and asks that he be extubated and allowed to die. As his POAHC, he also asks to change the POLST form to reflect this.

d. Can the brother change the POLST form Section B selection to "comfort measures only", and authorize extubation?

No, not at this time. Even an assigned agent under POAHC has the responsibility of representing the patient's wishes, not make decisions based on his own discomfort. It appears to be too early for the medical team to come to a conclusion that the patient's inability to breathe independently is not temporary.

The patient has been intubated for two weeks and the primary team is recommending tracheostomy. Upon further discussion, the brother says that subsequent to the patient completing his original POLST form, but prior to this admission, the patient told him that if he could not be weaned from a ventilator, he would not want a tracheostomy and at that point, he would want to receive comfort measures only and not have his dying process prolonged.

e. Can the brother change the POLST form Section B selection to "comfort measures only", and authorize extubation?

Now that the medical team is recommending an invasive surgery likely followed by a chronic if not permanent stay in a long-term ventilator facility, and given that the brother has specific knowledge that the patient would not opt for these himself, this is now a decision that likely represents the patient's own wishes. While a new POLST form would not generally be required for treatment of a patient in the hospital, the brother/agent may authorize palliative extubation and continued comfort measures.

It turns out that although the patient had identified his brother as his agent with POAHC, he never actually completed the document. Fortunately, the brother is also the appropriate surrogate under the Illinois Health Care Surrogate Act.

f. Can the brother change the POLST form and authorize extubation?

If the brother had not been formally assigned in writing as the patient's health care agent, the brother may still represent the patient's wishes as a surrogate decision-maker, provided that he is uppermost individual on the Health Care Surrogate Act's hierarchy who is willing, able and available to make decisions on behalf of the patient.

g. If so, would there be additional steps/documentation required?

Under the Illinois Health Care Surrogate Act, if a surrogate wishes to withhold or withdraw life-sustaining treatment, additional steps must be taken, including: Two physicians assess the patient and document that he 1) lacks decisional capacity, its cause, nature and duration, and 2) that the patient has one of the three qualifying conditions, its cause and nature. Once these and the other legal requirements are met, the brother may authorize the extubation on behalf of the patient.

While the above conversation is transpiring, the patient develops ventricular fibrillation and goes into full cardiac arrest. Could he be shocked? Could he receive intravenous epinephrine and antiarrhythmics?

No. Based on his original the patient had originally selected Do Not Attempt Resuscitation in Section A and this instruction has not changed. In addition, in case of cardiac arrest, it would not make sense to inject medications but not perform chest compressions in order to circulate them.

VIGNETTE #3

Patient is a 67 year-old man with a long history of CAD, MI's and CABG's. Repeatedly, against the odds, he has survived cardiac events and near-death conditions. He now has inoperable CAD and mild CHF. A facilitated goals-of-care conversation is conducted with the patient, and with his permission, a brother, who is also his POAHC, participates. He understands that, should he have a cardiac arrest, his odds of survival of a resuscitation attempt and return to an independent lifestyle are slim, but given his survival with slim odds before, he wants CPR attempted should he suffer cardiac arrest. What is most important to him is that he be able to live independently and interact with his family and friends.

h. How should part A of his POLST form be completed? Part B?

Section A: Attempt Resuscitation

Section B: "Intubation and Mechanical Ventilation"= full treatment plan that also includes treatments described in other two medical intervention categories.

He suffers a cardiac arrest, 911 is called, and despite being without circulation for ten minutes, he is "successfully" resuscitated. He is transported to the hospital, intubated and unresponsive. A week passes in the ICU, and although he is not dead by neurological criteria ("brain-dead"), he is certainly neurologically devastated with little hope of meaningful recovery. His brother/POAHC is informed of his prognosis.

i. Can the brother/POAHC change the patient's instructions as documented on his POLST form and authorize a DNR order?

Yes. The patient had said that he is most interested in living independently and interacting with his family and friends. Given this clinical scenario, it is clear that he will not be able to achieve his goals. This points to the importance of 1) having appointed a health care agent who can make real-time decisions when the patient is not decisional and additional questions arise and 2) exploring one's values and goals in discussing one's advance care planning wishes with one's agent/loved ones.

j. If the brother is NOT the POAHC, but IS the appropriate surrogate by the Illinois Health Care Surrogate Act, could he change the POLST form?

If the brother had not been formally assigned in writing as the patient's health care agent, the brother may still represent the patient's wishes as a surrogate decision-maker, provided that he is uppermost individual on the Health Care Surrogate Act's hierarchy who is willing, able and available to make decisions on behalf of the patient. While a new POLST form would not generally be required for treatment of a patient in

the hospital, the brother/agent may authorize palliative extubation and continued comfort measures.

k. If so, would there be additional steps/documentation required?

Under the Illinois Health Care Surrogate Act, if a surrogate wishes to withhold or withdraw life-sustaining treatment, additional steps must be taken, including: Two physicians assess the patient and document that he 1) lacks decisional capacity, its cause, nature and duration, and 2) that the patient has one of the three qualifying conditions, its cause and nature. Once these and the other legal requirements are met, the brother may authorize the extubation on behalf of the patient.

VIGNETTE #4

Patient is a 70 year-old woman who has just been diagnosed with early stage dementia. A facilitated goals-of-care conversation is conducted with the patient, and with her permission, her husband, who is his POAHC. She is anxious to document her strong wish that under no circumstances does she want to have artificial nutrition through a tube, even temporarily. She is otherwise in good health, and she expresses to her physician and her husband that should she have a cardiac arrest, she would want an attempt made to resuscitate her.

a. How would her POLST form be completed?

Section A: Attempt Resuscitation

Section B: "Intubation and Mechanical Ventilation"= full treatment plan that also includes treatments described in other two medical intervention categories

Section C: No artificial nutrition by tube.

Five years pass, and the patient's dementia has progressed to the extent that she is unable to communicate her wishes. Her husband would like to change her POLST form to reflect what he believes would now be her wish to not have CPR, and in case of other emergencies, to have comfort measures only.

b. Can he change the patient's POLST form to reflect these wishes?

Yes, as her identified agent with POAHC, her husband may now represent what he believes would be patient's real-time emergency treatment wishes. Along with her physician, he may complete a new POLST form, signed by a witness, specifying Do Not Attempt Resuscitation in Section A, and Comfort Measures Only in Section B. In keeping with patient's own previously expressed wishes, the Section C selection would continue to be No artificial nutrition by tube.

It is discovered that the patient did not actually complete a POAHC form. Fortunately, the husband is the appropriate surrogate according to the Illinois Health Care Surrogate Act.

c. Can he still change the patient's POLST form to reflect the patient's wishes?

Again, because the patient does have a qualifying condition, once the assessment, documentation and other requirements of the Health Care Surrogate Act are met, the appropriate surrogate decision-maker by the Act, in this case, the husband, may represent the patient's wishes. If she will continue to live at home or in a long-term

care facility, it will be important for him to create a new POLST form to assure that her end-of-life care wishes are honored.

VIGNETTE #5

Patient is a 23 y/o previously healthy woman who is admitted for new-onset seizures, pneumonia with hypoxia. For the moment she is unable to make her own decisions, but the medical team have no reason to believe she could not return to her prior state of health. Her brother brings in a valid living will that the patient signed while taking a college course on medical ethics. She has not completed a Power of Attorney form, but the brother is the appropriate surrogate according to the Illinois Health Care Surrogate Act. Her brother states that the patient has told him that she would not want to “live as a vegetable”, and did not want to be on any machines.

a. Should she be intubated?

Yes, she should be treated with all medically indicated measures. A statutory living will is applicable only when a patient is “terminally ill and imminently dying” and she is neither of these.

b. Would it be appropriate to assist the brother in completing a POLST form on behalf of the patient?

No, it would not, for several reasons. First, the patient has neither advanced illness nor is a frail elder, so the POLST form is not really designed for someone in her stage of life. In fact, unless she had a wish to limit some emergency medical treatments (rare for a healthy person, and challenging to consider such treatments with no context of a chronic progressive condition), completing a POLST form would in most cases be superfluous, given that the default response for someone who has not specified otherwise is to offer all medically indicated treatments in case of emergency. Second, even if she did wish to complete a POLST form, since an imminent return to full decisional capacity is expected, she should be the person to complete her own form based on her wishes. However, when she regains her decisional capacity, and especially given her current medical history, she should be educated about and encouraged to complete a Power of Attorney for Health Care form. In fact, her brother and her friends should also be encouraged to do the same.