Advance Directives Evolve to Ensure Better End-of-Life Planning

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When first developed in the 1970s, advance directives focused on providing specific legal instructions, such as a patient's wishes to withdraw or withhold life-sustaining treatment in cases of terminal illness or incapacity. The documents helped physicians avoid legal problems associated with fulfilling the patient's wishes.

The instructions "did not turn out to be very helpful in real clinical situations and tended to be overly simplified," said Charles Sabatino, a lawyer with the Commission on Law and Aging at the American Bar Association.

He chronicled the history and evolution of advance directives in the June issue of *The Milbank Quarterly*.

The report also highlighted the increasing use of a protocol called Physician Orders for Life-Sustaining Treatment (POLST), currently in use statewide in 11 states. Although POLST is not an advanced directive, it complements related documents such as a living will or durable power of attorney for health care.

The use of POLST begins with a discussion about end-of-life care between the health care provider and the patient or the designated health care decision maker. The physician records the patient's and family's wishes and enters them into the patient's medical record. The POLST forms travel with the patient, even if he or she is moved another facility.

“Instead of standardizing patient’s wishes, this standardizes the medical orders. That sets the process in the right direction,” Sabatino said. “Medical care operates on standardized doctor’s orders — this process translates patient’s wishes into exactly that.”

In a 2004 Journal of the American Geriatrics Society survey, 93 percent of emergency medical technicians indicated that POLST orders were useful in determining treatments. EMTs also reported that when POLST orders were present, 45 percent of the time they changed treatment based on the patient’s wishes.

A 2009 Journal of Palliative Medicine survey of hospice personnel found that POLST preferences for treatment were used 98 percent of the time.

“The POLST model is a very good one, and I think it complements the advance directive care planning discussion very well. It allows [advance directives] to be used in a way that makes them practical and implementable by nurses and even emergency medical personnel,” said Ira Byock, M.D., director of palliative medicine at Dartmouth-Hitchcock Medical Center.

In the next 10 years, Sabatino foresees most states adopting POLST as part of the advance care planning process. For health care consumers, he recommends revisiting advance directives whenever the “5 Ds” occur: “Every decade, at the death of a loved one, divorce, new diagnosis or a significant decline in condition — those are the times when it’s more important to think about whether you want to change anything,” he said.

“The message here is to have conversations. Conversations can only help you and your family get the care that you desire and avoid treatments that may be burdensome,” Byock said.

More information: Sabatino CP. The evolution of health care advance planning law and policy. The Milbank Quarterly, 88(2), 2010.

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