ACTION ITEMS FOR ADVANCE DIRECTIVE SUBCOMMITTEE

I. Explore Better Documentation

Physician Orders for Life Sustaining Treatment (POLST) Form

The POLST form is typically a one-page two-sided document that is designed to help health care providers respect the end of life treatment wishes of patients or their proxies. POLST is a easily recognized physician order that travels with the patient and is honored by key health care providers and facilities. It thus achieves continuity of care across settings. POLST originated in Oregon and has been widely used there, with documented success. Variations are now used in other states, including Georgia, West Virginia, and New Mexico. Currently, in Maryland, each physician treating a patient must interpret that patient's advanced directive (if he/she has one) and issue a set of medical orders.

We believe the Council should explore development of a document similar to the POLST form so that patients' wishes for resuscitation, medical interventions, antibiotics, artificial feedings, and other elements of care at the end of life can be turned into portable orders for improved continuity of care. This Council could draft a sample POLST form and circulate it to key stakeholders such as MedChi, the Maryland Nurses Association, and the National Hospice and Palliative Care Association, among other groups, for comment. The Council should also consider whether authorization for POLST should be codified in statute. If done legislatively, immunity provisions may be granted to health care providers who honor POLST instructions.

Advance Directive Documents

The Council should consider the problem of widely variant language in advance directives, especially those drafted by attorneys who may be unfamiliar with the effect in a clinical setting. The Council should encourage educational efforts aimed at general practice lawyers. The Council should also consider more broadly the question of whether standardized advance directive forms should be a public policy goal.

II. Establish Guidelines for "The Conversation"

Who Should Be Having It and When It Should Be Had

This Council should offer recommendations on the process of identifying groups that should receive priority attention for advance care planning. The subcommittee noted

a failed proposal in the 2003 Session of the Maryland Legislature that would have encouraged the completion of advance directives by Medicaid applicants; the subcommittee questioned whether this was an appropriate population for priority attention. The Council should draft a set of guidelines about the care planning process and the ways in which it can be accomplished and circulate them to key stakeholders for comment.

Public Education Opportunity

In prior years, the Department of Aging and other organizations have distributed pamphlets on patients' wishes. The Council should encourage the dissemination of information on the advance care planning process and the completion of advance directive forms.

An education campaign should also be targeted to minority communities who are less likely to trust the health care system and thus less likely to complete advance directive forms. The Council might look for resources for translating the forms and explanatory material.

III. Guidelines on the Relationship Between Instructions and Proxy Discretion

There is uncertainty among clinicians about how to give effect to advance directives that contain both care instructions, like a living will, and the designation of a health care agent to make care decisions. To what extent should the agent be bound by the living will? Similarly, to what extent should a surrogate be bound? The Council should lead an effort to focus on this issue and, potentially, to recommend changes to the Health Care Decisions Act.

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