

New Approaches to End-of-Life Care in Hospitals

BY JOYCE FRIEDEN
Senior Editor

PHILADELPHIA — Two new ways of dealing with end-of-life issues—default surrogates and physician-ordered life-sustaining treatment orders—are becoming more common in hospitals, according to several legal experts.

So far, 37 states have passed default surrogate regulations, aimed at naming a person who can act on behalf of an incapacitated hospital patient who does not have an advance directive, said Nina Kohn of Syracuse (N.Y.) University's College of Law. The vast majority of Americans—especially minorities, those with lower education levels, and younger patients—do not have an advance directive, noted Ms. Kohn, who spoke at a meeting of the American Society of Law, Medicine, and Ethics.

The states that have passed the default surrogate statutes “create a priority list saying if there is not an appointed surrogate, first the spouse does it, then the parent, then an adult sibling, and so on,” she explained. “The common justification is the idea that the statutes help protect wishes of the incapacitated person.”

But does that really work? Ms. Kohn and her associate Jeremy Blumenthal, also of Syracuse University, have been studying whether the laws result in the selection of the surrogates that incapacitated patients would have selected for themselves, and whether those surrogates made the decisions that those patients would have made.

They found that Americans tend to favor close family members as surrogates, which is consistent with most of the state laws. On the other hand, Ms. Kohn said, “The priority lists don’t account for a number of factors predictive of surrogate selection, such as surrogate gender. Women are disproportionately selected as surrogates.” In addition, the statutes “don’t do a good job of accounting for non-traditional family structures such as same-sex couples, or

[situations] where people have more inclusive or more intergenerational notions of families.” This is particularly true of African Americans, who are less likely than are members of other racial groups to select a spouse or adult child as a surrogate, according to studies, she said.

As to whether the surrogates are deciding things the same way the patients would have, “we can’t know for sure ... because the patient is incapacitated,” she said. “But I think we can confidently say that there’s real reason to be skeptical about the congruence levels being obtained.”

The literature on the subject shows that surrogates are very bad at predicting patient wishes; in addition, surrogates are not always willing to do what they know the patients would want them to do. Also, surrogates “tend to be overconfident in thinking they know more about what the patient would want than they actually do,” Ms. Kohn continued.

These problems aren’t necessarily the fault of the people who wrote the statutes, however, Ms. Kohn added. “If we look at the treatment decisions of *appointed* surrogates, they do not appear to be significantly better.” A 2006 meta-analysis of 16 studies found that there was 69% congruence with decisions made by patient-selected surrogates compared with 68% using legally selected surrogates, “a statistical dead heat,” she noted.

Ms. Kohn had two suggestions for improving decision making by surrogates: first, having rules and statutes that move away from selecting surrogates based on familial relations, and more toward surrogates whose values are more consistent with those of the patient. And second, providing surrogates with information to better inform their decisions—for example, what a typical patient would do in a particular situation.

Another emerging tool for hospital-based end-of-life care is the physician orders for life-sustaining treatment (POLST) form, said Robert Schwartz, J.D., professor of

law at the University of New Mexico, Albuquerque. These orders also go by other names: medical orders on life-sustaining treatment, medical orders on scope of treatment, or physician orders on scope of treatment.

“This is the next step from the advance directive,” Mr. Schwartz explained, noting that these forms are usually bright green or bright pink so they will be easily noticed. “These are physician orders that go in the patient’s chart and provide information about the kind of patient care that should be provided.”

Usually, a POLST form addresses resuscitation issues, the extent of appropriate medical intervention, use of antibiotics, provision of nutrition and hydration, desired place of treatment, and the identity of the authorized health care provider, Mr. Schwartz said. The forms all have a place for the physician’s signature, and many have a place for the patient’s signature or surrogate decision maker’s signature.

In a few states, the POLST form is now formally authorized by statute, and other states are looking at passing similar measures. In addition, some POLST forms are authorized by individual hospital policy, and sometimes they’re authorized by networks of hospitals, Mr. Schwartz said.

But he has some reservations about the concept. “My problem with all these documents is that it seems like it’s a step backwards [because] doctors are deciding these things in the hospital [rather than] patients having the authority to make these decisions. On the other hand, if patients make these decisions and they’re never honored, we haven’t achieved a whole lot.”

The proponents of POLST, he added, say that they “lead to the discussions between the health care provider, the families, and the patients that allow for the physician order that actually will be carried out in the hospital, so ultimately they’re more effective than just having the advance directive on the front of the chart.” ■

GUEST EDITORIAL

Facing the Challenge of Pressure Ulcers

Beginning this October, the Centers for Medicare and Medicaid Services will no longer pay hospitals for treatment of skin ulcers acquired during hospitalization. This decision is part of CMS’s new “pay-for-performance” initiative. A wake-up call for hospitals, the new rule has created an opportunity for the nursing home industry to reach out and share its expertise.

Pressure ulcers historically have been associated with chronic care in institutional settings, and only recently have hospitals been fully recognized for their contribution to pressure ulcer etiology as well as related mortality, morbidity, and cost. With a focus on technology and short-term care, hospitals have lagged in their concerns about skin integrity.

Nursing homes have been grappling with increasingly tight regulatory standards regarding wound care for 2 decades, but there have been no similar regulatory incentives for hospitals. With the estimated annual cost for pressure ulcer treatment in hospitals in excess of \$5 billion, facilities that fail to rise to this challenge stand to suffer great financial strain.

Suddenly, hospitals must address aspects

of skin care that nursing home staff have long taken for granted: the team approach to care, pressure relief, the critical importance of nutrition, and the value of prompt and detailed assessments.

Official concern for pressure ulcers in the long-term care arena began in 1987 with the Nursing Home Reform Amendments that Congress inserted in its Omnibus Budget Reconciliation Act. Subsequently, pressure ulcers were clearly addressed in section 483.25 (c) of the Code of Federal Regulations.

It is unclear what will happen when claims for pressure ulcers are denied. Hospitals may have to provide proof that a pressure ulcer was unavoidable if they are to be paid for its treatment.

This will entail documentation of medical conditions that directly contributed to the unavoidability of the ulcer, which may include decreased tissue perfusion due to hypotension and hypoxia, and severe immobility due to life support measures and orthopedic devices.

The American Medical Directors Association recently released a comprehensive clinical practice guideline for pressure ulcers (www.amda.com/tools/cpg/pressureulcer.cfm). The guideline can be

adapted by hospitals to meet their new challenge.

Caregivers in long-term care facilities learn that skin must be inspected not only at the critical times of a resident’s admission and discharge from a facility but also daily. Assessment must be followed by adequate documentation and implementation of a care plan. The proper preventive devices and dressings must be available. Documentation and policy manuals all need to be reviewed and updated.

Nursing homes have long applied the team approach to pressure ulcer prevention and treatment, and this philosophy needs to be adopted by hospitals. The team includes not only the physician and nurse, but also specialists in nutrition and rehabilitation, including those in physical, occupational, and even speech therapy. Nutritionists in nursing homes can offer recommendations for preventing and treating skin breakdown. The rehabilitative subspecialties contribute to nutrition by keeping residents’ upper extremities functioning and optimizing swallowing ability. Other professionals do direct skin and wound care.

The Braden scale for assessing wound risk is widely used for targeting preventive interventions, but it doesn’t fully account for clinical factors that increase pressure ulcer risk, such as malignancy, diabetes mellitus, and factors that affect tissue perfusion

such as hypotension, anemia, and hypoxia. This and other risk-assessment tools must be supplemented with clinical judgment.

In long-term care, certified nursing assistants, nurses, and physicians are all aware of the importance of checking daily for new threats to skin integrity, and of incorporating skin care into an individualized care plan. The new CMS reimbursement guidelines will force hospitals to integrate similar principles into all patient-entry and -exit points, including the emergency department, operating room, and medical unit. Potential areas of skin breakdown must be identified early using the skills that long-term care providers have mastered.

The new pay-for-performance initiatives by CMS going into effect in a few months will financially threaten hospitals. By reaching out and collaborating with their acute-care colleagues in preventing and caring for pressure ulcers, long-term care medical directors and geriatricians can help hospitals reduce costs and improve patient care. ■



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