

**THE PHYSICIAN ORDERS
FOR LIFE-SUSTAINING TREATMENT (POLST)
COMING SOON TO A HEALTH CARE COMMUNITY
NEAR YOU**

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Editors' Synopsis: The estate, trust, and elder law community is seasoned in explaining and assisting in the implementation of advance health care directives. While directives are useful because they allow patients who are 18 years old and older to provide instructions for future treatment, they often fall short of conveying patients' current wishes in light of existing conditions. POLST forms aim to fill this gap and provide consistency for patients who have a serious life-threatening illness. Through a decision-making process with their health care professionals, POLST give patients the tools for deciding upon and documenting their medical treatment preferences, thereby keeping the patients in control of their end-of-life treatment.

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in some jurisdictions as POLST.¹ The wide acceptance and spread of POLST has gone largely unnoticed by estate, trust, and elder law practitioners despite its purpose to implement their clients' care wishes when the client is dying or near death—a purpose that was traditionally a focal point of their professional efforts. This Article is intended to remedy that lack of awareness.

A POLST program serves different purposes from those of the living will declaration and the power of attorney for health care. A living will declaration puts into writing a declarant's wishes as to life-sustaining treatment if, at some point in the future, the declarant is terminally ill, in an end-stage medical condition, or in a permanently unconscious state. The living will declaration applies in the future, and goes into effect only if the declarant is no longer able to make health care decisions. A health care power of attorney gives a surrogate the authority to make health care decisions, but again, it typically takes effect only if the principal is unable to make decisions. By contrast, POLST programs are designed to elicit and honor the medical treatment goals of persons with advanced progressive illnesses or frailty by creating an immediately effective medical order.²

POLST also differ from do-not-resuscitate (DNR) orders, which focus only on preventing resuscitation. DNR orders do not communicate affirmative orders to attempt resuscitation for those individuals who desire all possible interventions. A POLST program allows patients to document choices about the level of intervention they currently want while living out the final phase of their lives. POLST always addresses cardiopulmonary resuscitation, and importantly, can also address other end-of-life health care issues such as the level of medical intervention desired in an emergency and the uses of artificially supplied nutrition and hydration, antibiotics, and ventilation.

¹ The authors use two language conventions throughout this Article. *POLST* is a generic identifier for all programs fitting its definition, regardless of the actual name of the program in a particular state. *Surrogate* encompasses an agent under a health care power of attorney, a guardian of the person with health care decision-making powers, a default family surrogate under state law, and any other similarly authorized decision maker, regardless of the terminology used in a particular state.

² See generally Patrick M. Dunn et al., *The POLST Paradigm: Respecting the Wishes of Patients and Families*, ANNALS LONG-TERM CARE, Sept. 2007, at 33, available at www.annalsoflongtermcare.com/article7708 (outlining the elements of a POLST program and describing the challenge to respecting a patient's end-of-life treatment preferences).

A POLST program is valuable because it creates standardization and consistency.³ Ideally, a POLST form should move with the patient wherever the patient goes—from his or her home, then to a hospital, to a skilled nursing facility,⁴ to a long-term care facility—so that health care professionals can provide care in a consistent fashion and so that the patient can re-evaluate his or her end-of-life health care decisions as needed. DNR orders typically vary from one setting to another because each hospital or care facility has preferred to create and use its own form, so traditional DNR orders are only effective within that health care facility. The end-of-life care of patients, and the patients themselves, have suffered from this lack of consistency and differences in multiple DNR forms, duplicate orders, and impaired communication of the patients' wishes.

Perhaps the most important point the authors intend to make in this Article is that a POLST program must be viewed and implemented as a shared decision-making process, not just a form. To be effective, POLST requires a conversation, or a series of conversations, between health care professionals and the patient or the patient's authorized surrogate. The purpose of the conversations is to clarify the patient's goals and treatment decisions in light of the patient's current condition, and the quality of the conversation is the key to the success of POLST. The POLST conversation results in actionable medical orders that are recorded in a standardized form, which is kept in the front of the patient's medical records or with the patient in his or her home. The form helps to bring structure and consistency to the process, but it forms only one part of the process.

Many of the criticisms and concerns discussed in Part VII originate from the fear that end-of-life decisions will become bureaucratized by the adoption of a POLST form. The process, and specifically the conversation by which a patient's wishes are elicited and recorded, is what makes a POLST program an unequivocal improvement on pre-POLST

³ See generally Susan E. Hickman et al., *A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program*, 58 J. AM. GERIATRICS SOC'Y 1241 (2010) (evaluating the relationship between POLST programs and traditional practices as methods to communicate treatment preferences); Susan E. Hickman et al., *The Consistency Between Treatments Provided to Nursing Facility Residents and Orders on the Physician Orders for Life-Sustaining Treatment Form*, 59 J. AM. GERIATRICS SOC'Y 2091 (2011) [hereinafter *Consistency Between Treatments and POLST Orders*] (evaluating the consistency between POLST forms and treatments).

⁴ See generally Marshall B. Kapp, *The Nursing Home as Part of the POLST Paradigm*, 36 HAMLIN L. REV. 151 (2013).

standards and practices, which often resulted in a patient's wishes being unknown or overlooked.

II. HISTORY OF POLST

During the 1990s, much discussion in the United States surrounded end-of-life care reform, which had begun in the 1970s, but remained ineffective in many respects. In *A Hastings Center Special Report*, a group of authors published a compilation of essays summarizing the flaws in the end-of-life reform process that had been underway for at least two decades.⁵ The authors discussed the need for systemic changes and the concept of autonomy, and emphasized the importance of improved communication and understanding.⁶ Studies and reports such as *Hastings* encouraged Oregon to move forward, and other states following suit.

A. Development in the State of Oregon

POLST started in the State of Oregon in 1991 because clinical-ethics leaders observed that patients' preferences regarding life sustaining treatment, as embodied in advance directives, frequently were not found or not transferable and, therefore, not honored.⁷ The decision was made, in Oregon, to implement a system to honor patients' values and wishes regarding their end-of-life medical treatment.

Beginning in 1990, a task force developed, revised, pilot-tested, and ultimately released a POLST form for use throughout Oregon.⁸ In 1999, the administrative rules in Oregon were changed to provide that emergency medical technicians (EMTs) or first responders would respect patients' wishes, including choices regarding life-sustaining treatments reflected in a POLST.⁹ Over time, it became accepted practice to allow nurse practitioners and physicians' assistants to sign POLST medical orders, and to allow minors with terminal illnesses to be included in the

⁵ See HASTINGS CTR., IMPROVING END OF LIFE CARE: WHY HAS IT BEEN SO DIFFICULT? 2-4 (Bruce Jennings et al. eds., 2005).

⁶ See *id.*

⁷ See *Oregon POLST History*, OR. POLST, <http://www.or.polst.org/history> (last visited May 12, 2014). POLST began in Oregon and it quickly spread to the states of New York, Pennsylvania, Washington, West Virginia, and Wisconsin. See *History*, NAT'L POLST, <http://www.polst.org/about-the-national-polst-paradigm/history/> (last visited May 12, 2014).

⁸ The form was created by a task force that implemented POLST through a grassroots approach. See CHARLES P. SABATINO & NAOMI KARP, AARP PUB. POLICY INST., IMPROVING ADVANCED ILLNESS CARE: THE EVOLUTION OF STATE POLST PROGRAMS 47 (2011), available at assets.aarp.org/rgcenter/ppi/cons-prot/POLST-Report-04-11.pdf.

⁹ See OR. ADMIN. R. 847-035-0030(6) (2014).

POLST program.¹⁰ In 2008, the Oregon POLST form was modified to include a section for the special concerns of persons with disabilities.¹¹ In 2009, the legislature enacted a statute creating a statewide registry of POLST forms in Oregon that permitted access to the forms as needed, including access by providers of emergency medical care.¹²

As of 2013, the Oregon POLST registry received over 150,000 POLST forms,¹³ making the use of POLST forms the accepted medical standard of care.¹⁴ The Oregon POLST form is used by almost all hospices and nursing homes in the state.¹⁵ The POLST form currently in use in Oregon is attached to this Article.¹⁶

B. Development in LaCrosse, Wisconsin

While the POLST paradigm was developing in Oregon, the leaders of the two major health organizations in LaCrosse, Wisconsin decided to focus on end-of-life planning and decision-making. Like the state of Oregon, the community of LaCrosse, Wisconsin has taken on a leadership role in effectively using both advance directives and POLST forms.

In 1991, the LaCrosse health organizations launched a unique program, Respecting Choices,[®] to increase the use and effectiveness of advance directives.¹⁷ The program not only used printed materials and videos to educate the community, but also provided assistance through trained staff of LaCrosse health organizations as well. The community of LaCrosse decided to establish the use of advance directives as a routine standard in the process of health care decision-making.¹⁸ The goal of Respecting Choices was to create consistent practices throughout the

¹⁰ See OR. POLST TASK FORCE, GUIDANCE FOR OREGON'S HEALTH CARE PROFESSIONALS 6, 17 (2013), available at <http://www.polst.org/wp-content/uploads/2013/12/2013.12.26-OR-Guidebook-2013.pdf>.

¹¹ See *Oregon POLST History*, *supra* note 7.

¹² See OR. REV. STAT. §§ 127.663-684 (2013).

¹³ See OR. POLST REGISTRY, OREGON POLST REGISTRY ANNUAL REPORT 1 (2013), available at http://www.orpolstregistry.org/wp-content/uploads/2012/09/Oregon-POLST-Registry-Annual-Report_2013_Final_electronic_version.pdf.

¹⁴ See *id.* at 2.

¹⁵ See *id.*

¹⁶ See *infra* Appendix 1.

¹⁷ See *Respecting Choices: History/Overview*, GUNDENSEN HEALTH SYS., <http://www.gundersenhealth.org/respecting-choices/about-us/history-and-overview> (last updated May 12, 2014).

¹⁸ See *id.*

community. Community leaders and health care leaders supported the program.¹⁹ A study completed from 1995 to 1996 found that advance directives were written by 85% of persons who died in LaCrosse.²⁰ The study also found that 96% of those advance directives actually were found in the medical records and typically followed by family members and physicians.²¹

The community of LaCrosse started using POLST forms in 1997;²² this was done by clinical consensus, as no legislation in Wisconsin authorizes the use of the forms.²³ In a follow-up study of the LaCrosse community, researchers reviewed medical record and death certificate data of persons who died from 2007 to 2008. The researchers concluded that “POLST can be a highly effective program to ensure that patient preferences are known and honored in all settings. [Powers of attorney for health care] are valuable because they identify appropriate surrogates when patients are incapacitated.”²⁴

Over the past 20 years, the leaders of the LaCrosse end-of-life health care projects have concluded that a staged approach to choices about end-of-life health care is most effective.²⁵ Respecting Choices advocates for a three step approach to the stages of planning as follows:

(1) First Step: An adult signs a living will declaration and durable power of attorney for health care.

(2) Next Step: As the adult ages, the person’s agent and family members become more involved in the planning process and are prepared to act.

(3) Last Step: POLST paradigm implemented.²⁶

The goal in utilizing POLST is to create discussion and shared health care decision-making among patients, their families and health care

¹⁹ *See id.*

²⁰ *See id.*

²¹ *See id.*

²² *See* Bernard J. Hammes et al., *The POLST Program: A Retrospective Review of the Demographics of Use and Outcomes in One Community Where Advance Directives are Prevalent*, 15 J. PALLIATIVE MED. 77, 78 (2012).

²³ *See id.*

²⁴ *Id.* at 77.

²⁵ *See Respecting Choices: Stages of Planning*, *supra* note 17.

²⁶ *See id.*

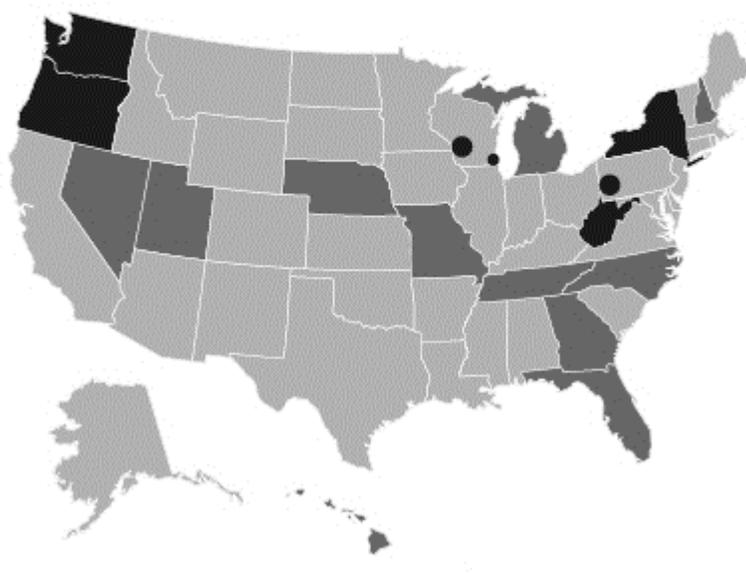
professionals. The LaCrosse community uses trained “facilitators for all stages of advance care planning, including POLST.”²⁷

C. Nationwide Development

A nationwide movement focusing on improving the end-of-life health care process is underway. By 2011, approximately one quarter of the states adopted POLST by statute, regulation, or clinical consensus and most of the other states were considering development.²⁸ The following maps reflect the accelerating adoption of POLST between 2006 and 2013 with a total of fifteen states currently meeting the standards of an endorsed program.²⁹

National POLST Paradigm Programs—2006

■ Endorsed Programs ■ Developing Programs ■ No Program (Contacts)

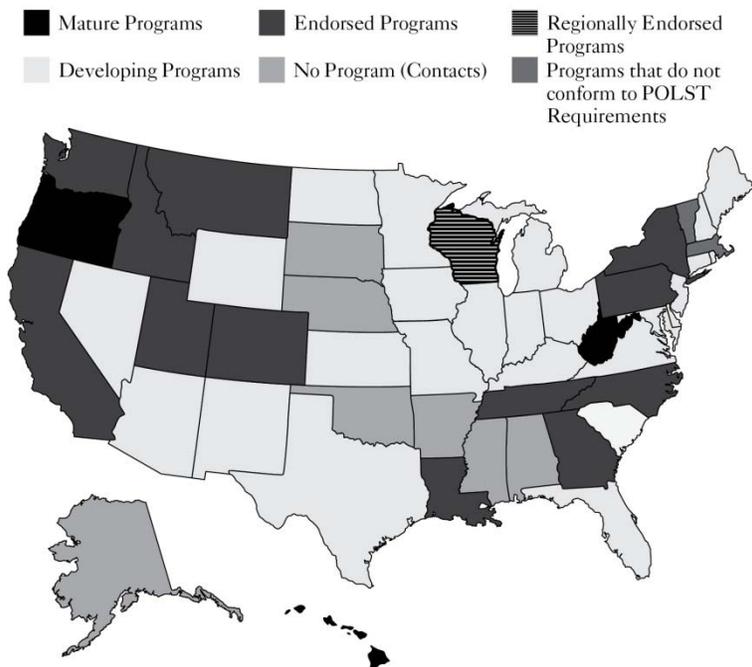


²⁷ SABATINO & KARP, *supra* note 8, at 24 (citation omitted).

²⁸ *See id.* at 26.

²⁹ *See* discussion *infra* Part II.D.

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The forms used in the adopting states are known by various names, including MOST (Medical Orders for Scope of Treatment), MOLST (Medical Orders for Life-Sustaining Treatment), and POST (Physician Orders for Scope of Treatment).³⁰ The actual forms used also vary from state to state. For a comparison of important characteristics for all of the states that currently have an established POLST program, refer to the POLST Program Legislative Comparison chart (Legislative Comparison Chart).³¹

³⁰ See *About the National POLST Paradigm*, NAT'L POLST, *supra* note 7.

³¹ See *infra* Appendix 2. The authors prepared and reproduced the chart with permission from the American Bar Association Commission on Law and Aging and the Task Force.

D. The National POLST Paradigm Task Force

The purpose of the National POLST Paradigm Task Force (Task Force) is to provide information and guidance to organizations that are pursuing the process of implementing POLST in their various states.³² The Center for Ethics in Health Care at Oregon Health & Science University convened the Task Force.³³ The Task Force has developed standards for a successful program drawn from the experiences of successful state programs and based upon requirements thought necessary for a successful program. The Task Force can endorse a program for meeting these standards.³⁴ Each state with an endorsed program provides one member to serve on the Task Force. The Task Force includes committees that consist of members from both endorsed and developing POLST programs.³⁵ According to the Executive Director of the Task Force, Amy Vandenbroucke, the objectives of the Task Force encompass the following:

1. Facilitating the development, implementation, and evaluation of POLST Paradigm Programs in the United States;
2. Educating the public and health care professionals regarding the POLST Paradigm;
3. Supporting, performing, and funding research related to end-of-life care; and
4. Improving the quality of end-of-life care.³⁶

III. HOW POLST WORKS

The most frequently cited clinical standard for determining if a POLST form is appropriate for a patient is the “surprise” question.³⁷ If a

³² See *History*, NAT'L POLST, *supra* note 7.

³³ See *id.*

³⁴ See SABATINO & KARP, *supra* note 8, at 3; see also *About the National POLST Program*, NAT'L POLST, *supra* note 7.

³⁵ See *National POLST Paradigm Task Force (NPPTF)*, NAT'L POLST, *supra* note 7.

³⁶ See *Renewing the Conversation: Respecting Patients' Wishes and Advance Care Planning: Hearing Before the S. Spec. Comm. on Aging*, 113th Cong. (2013) (statement of Amy Vandenbroucke, Executive Director, National POLST Paradigm Task Force), available at www.aging.senate.gov/hearings/renewing-the-conversation-respecting-patients-wishes-and-advance-care-planning.

³⁷ See generally Alvin H. Moss et al., *Prognostic Significance of the “Surprise” Question in Cancer Patients*, 13 J. PALLIATIVE MED. 837 (2010) (“The surprise question

patient's physician and other caregivers would not be surprised if the patient died within the next year, then that person should have a conversation, or a series of conversations, about end-of-life care and should consider completing a POLST form. It is important to note, however, that the surprise question is intended for a broader group than those patients with an end stage medical condition or a terminal condition. Persons of advanced age or considerable frailty, or both, may want to specify the level of care they prefer.

The POLST process allows each person to clarify his or her own goals regarding end-of-life care in light of the person's current condition and to receive guidance in translating those goals into medical orders addressing likely emergencies.³⁸ For example, a very elderly patient who has requested a DNR order may choose to make it clear, through a POLST form, that except with regard to the DNR order, the patient prefers full intervention and treatment or, in another instance, more limited care. The POLST process increases the likelihood that each person will receive the desired care and not receive the undesired care. It avoids the assumption that every person, regardless of frailty, wants aggressive treatment, or at the other extreme, that every person who appears to be in the final stage of life does not want any intervention at all.

The POLST process is initiated by a conversation between a patient and a physician, physician's assistant, nurse practitioner, or other trained facilitator.³⁹ If the patient has lost the capacity to evaluate, make, or communicate health care decisions, then the conversation may take place with the patient's surrogate.⁴⁰ Any of these parties may initiate the conversation. Ideally, the conversation is a team effort with different health care professionals playing complementary roles. The conversation is essential to POLST and, in fact, is the key to its success.

To create a written document that clearly and accurately reflects a patient's wishes, the health care professionals have to start with an open and frank discussion of the patient's current medical condition, the likely progression of the patient's medical condition, the treatment alternatives,

is a simple, feasible, and effective tool to identify patients with cancer who have a greatly increased risk of 1-year mortality."); Alvin H. Moss et al., *Utility of the "Surprise" Question to Identify Dialysis Patients with High Mortality*, 3 CLINICAL J. AM. SOC'Y NEPHROLOGY 1379 (2008) ("The 'surprise' question worked quite well to identify a subset of hemodialysis patients with a high risk for early death in the next year.").

³⁸ See *POLST: What It Is and What It Is Not NAT'L POLST*, *supra* note 7.

³⁹ See *id.*

⁴⁰ See *id.*

the likely outcomes of those treatment alternatives, the level of intervention that is available, and the level of intervention the patient wants. This discussion is primarily the responsibility of the physician, but a trained facilitator may work with the physician to explore the patient's personal values, priorities, and goals of care, given the medical facts.⁴¹

Because the patient's medical needs will evolve over time and the treatment options will also change, the patient and the health care providers must continue to have conversations over time. Effective discussion allows the patient to articulate and record his or her choices. Without adequate communication and ongoing conversations, health care providers cannot be certain they are documenting and implementing the wishes of the patient. Communication and ongoing conversations are needed to make certain the patient understands changes or developments in the patient's medical condition and is making informed decisions about treatment.

Effective discussion results in written medical orders, which are then documented on a POLST form that accurately expresses the patient's choices. The medical orders are reviewed and updated as all medical orders are reviewed and updated. If a patient and a patient's physician complete a POLST form and later the patient or the physician (or both) decide it may be appropriate to change the medical orders, an updated POLST form can be completed. If a patient does not have the mental capacity to participate in the POLST process, an agent acting under a power of attorney for health care may participate in the discussion—the initial discussion and follow-up discussions—and sign the POLST form on behalf of the patient.⁴² The agent may take these steps only to the extent authorized by state law, including authorization under any specific POLST statute and as established by the power of attorney document itself. If a patient does not have the mental capacity to participate in the POLST process and has not signed a power of attorney for health care, then the patient's default surrogate may be authorized to participate in the process on behalf of the patient, depending upon the applicable provisions of state law.⁴³

⁴¹ *See id.*

⁴² *See, e.g.*, TENN. CODE ANN. § 34-6-203 (2007 & Supp. 2013).

⁴³ *See, e.g.*, N.Y. PUBLIC HEALTH LAW § 2994-D (McKinney 2014); WASH. REV. CODE ANN. § 7.70.065 (2014).

A. The Medical Treatments Covered by POLST

The medical treatments covered by POLST vary slightly from state to state, and will presumably change over time as medical treatments change and improve, and as empirical evidence of the usefulness of including or excluding specific treatments becomes available.⁴⁴ The treatments addressed tend to fall into three categories.

The first section of the POLST form (generally Section A) covers the question of cardiopulmonary resuscitation (CPR). The patient decides whether CPR should be attempted. If not, the POLST form may serve as a DNR order.

The next section of the POLST form (generally Section B) addresses the next level of medical interventions. The patient decides the level of medical intervention that he or she desires. The patient may choose the full treatment that is available, including steps such as intubation, ventilation, cardioversion, advanced airway techniques and transfer to the intensive care unit of a hospital. Alternatively, the patient may prefer limited interventions, such as the use of antibiotics and other medical treatments, thereby generally avoiding more invasive forms of treatment and the intensive care unit. The third general category is the choice of comfort care only. Note that a POLST form can always be used to provide additional orders—whatever is desired and appropriate considering the unique needs and desires of each patient.

A third section of the POLST form (generally Section C) may document the patient's choices with regard to medically supplied nutrition. The type of nutrition referred to here is not ingestion by mouth, but nutrition that is delivered through medical, sometimes described as "artificial," means. The most common example of medically or artificially administered nutrition is a feeding tube, which can be a nasogastric tube or a feeding tube directly inserted into the stomach or duodenum (a percutaneous endoscopic gastrostomy or "PEG" tube). Section C allows for documentation of the patient's preference for a feeding tube on a long-term basis. Alternatively, the patient may want a feeding tube for a trial period only or may state that the patient does not want medically administered nutrition at all. Additional orders and specific instructions

⁴⁴ To review the POLST forms currently used by various states, visit the National POLST website. See *Programs in Your State*, NAT'L POLST, *supra* note 7. Many states also have created websites to explain POLST and to make their form available statewide. See, e.g., *Physician Orders for Life Sustaining Treatment (POLST)*, WASH. STATE MED. ASS'N, www.wsma.org/POLST (last visited May 12, 2014); *POLST California*, COAL. COMPASSIONATE CARE CAL., www.capolst.org (last visited May 12, 2014).

may be added to this Section C to make the patient's choices regarding current care as clear as possible.

B. Application of a POLST Program to a Patient Who Has Lost Mental Capacity

Unless state law imposes limitations through statutes or regulations, a surrogate recognized under state law may consent to a POLST form on behalf of a patient when the patient has lost the capacity to make health care decisions.⁴⁵ The surrogate may be an agent or a proxy appointed by the patient through a power of attorney for health care, a court-appointed guardian, or a default surrogate given authority by a statute.⁴⁶

For as long as a patient is able, the patient has the freedom to make health care decisions. The patient may decide to sign a living will and to designate an agent who will make health care decisions when the principal cannot. At some point in time, however, the patient may lose the ability to understand his or her medical condition and to evaluate the options that are available. The ability of another person to step in and make decisions becomes critical. The surrogate carries out the patient's wishes, as expressed in the patient's living will, but frequently must participate in a broader shared decision-making process relating to the patient's care plan. Because POLST involves medical orders regarding a patient's care, the patient must be mentally competent to give informed consent to those orders.⁴⁷ If the patient no longer can give informed consent, then state surrogacy law applies to these decisions.⁴⁸

Ideally, a surrogate is selected by the patient and authorized by a power of attorney for health care, or similar document, to act on the patient's behalf.⁴⁹ If the patient has not designated an agent or proxy, then state law typically includes a default statute.⁵⁰ The statute lists

⁴⁵ See, e.g., TENN. CODE ANN. § 34-6-203; W. VA. CODE ANN. § 16-30-8 (LexisNexis 2011).

⁴⁶ See, e.g., OHIO REV. CODE § 1337.12 (2014) (governing the appointment of an agent under a durable power of attorney for health care); *id.* § 2111.02 (governing the appointment of a guardian); *id.* § 2133.08 (governing the statutory priority of persons who may consent to the withholding or withdrawal of life-sustaining treatment when the patient cannot and there is no agent or guardian in place).

⁴⁷ See NATIONAL POLST PARADIGM TASK FORCE, POLST LEGISLATIVE GUIDE 17 (2014) [hereinafter LEGISLATIVE GUIDE], available at <http://www.polst.org/wp-content/uploads/2014/02/2014-02-20-POLST-Legislative-Guide-FINAL.pdf>.

⁴⁸ See *id.*

⁴⁹ See, e.g., W. VA. CODE ANN. § 16-30-4 (medical power of attorney representative).

⁵⁰ See, e.g., *id.* § 16-30-8 (health care surrogate).

family members of the patient, in priority order, who will assume the role of surrogate.⁵¹ For example, if the patient has a spouse, then the spouse will act as surrogate and engage in the decision-making process. If the patient is not married, then the patient's adult children will serve as surrogate.⁵² Most default statutes continue designating family members in priority order to act as surrogate.

State law varies greatly on the issue of the surrogate's authority.⁵³ In some states, the surrogate, whether designated by the patient personally or serving under a default statute, has the same authority as the patient to make health care decisions.⁵⁴ Some states limit a surrogate's authority to withhold or withdraw life-sustaining treatment for the patient.⁵⁵ Some states place even greater limitations on a default surrogate who serves with statutory authority, than on a surrogate designated by the patient.⁵⁶ These limitations may affect the POLST decision-making process by limiting the nature of the medical orders reflected on the POLST form that the surrogate is able to sign on behalf of the patient.⁵⁷

Note that states with statutory limitations on a surrogate's authority may adopt a POLST program.⁵⁸ The limitations were put in place by state legislatures, often after many hearings and hard-fought compromise, to protect patients' lives and guard against abuse.⁵⁹ The statutory limitations on decision-making authority have been in place in many states for 20 years or more. Physicians and other health care professionals are familiar with the limitations currently in place. The entire process does not have to be changed; rather, a POLST program may be added to the picture, with surrogate decision makers participating to the extent permitted under state law.

In addition to statutory limitations on a surrogate's decision-making authority, the patient's directions may also limit a surrogate's authority. A living will expresses specific choices by the declarant with regard to end-

⁵¹ *See id.*

⁵² *See id.*

⁵³ *See infra* Appendix 2.

⁵⁴ *See* LEGISLATIVE GUIDE, *supra* note 47.

⁵⁵ *See id.* at 18.

⁵⁶ *See id.* at 17.

⁵⁷ *See id.*

⁵⁸ *See id.* at 18; *see also* discussion *infra* Part VII.C.3.

⁵⁹ *See, e.g., End of Life Care Manual—Surrogate Decision-Making*, WASH. STATE HOSP. ASS'N, www.wsha.org/EOL-SURrogateDecisions.cfm (last visited May 12, 2014).

of-life medical care. A surrogate is expected to follow and implement those directives. A durable power of attorney for health care, or the POLST form itself, may also include limitations, put in place by the principal, on the surrogate's authority to make medical decisions. Thus, early communication between the patient and surrogate is important. The surrogate must know and understand the patient's choices.

Because the patient's medical condition is always changing, especially towards the end of life, the surrogate decision maker may have to modify or reverse a decision previously made by the patient after consultation with the physician. Accordingly, a new POLST form must be completed on behalf of the patient to apply the patient's wishes to their current medical condition and treatment alternatives. The Task Force recommends that each state consider establishing reasonable safeguards to make certain that the surrogate is, at all times, acting to carry out the patient's wishes. Examples of safeguards include:

- (1) a requirement that a surrogate engage in further consultation with the treating physician before authorizing a change to the patient's POLST;
- (2) a requirement that the patient's advance directives be consulted, if available;
- (3) a requirement that good faith efforts be made to act consistently, at all times, with the patient's known wishes; and
- (4) a requirement that the reasons for any change in the patient's POLST be documented.⁶⁰

C. How Does POLST Relate to Advance Health Care Directives?

While all adults are encouraged to think about and sign advance directives, POLST forms are appropriate for patients towards the end of life when the doctor would not be surprised if the patient is not alive in a year. POLST forms include medical orders addressing the patient's current situation, not a possible future scenario. Advance directives are signed at home, in law offices, at hospitals, or wherever convenient. POLST forms are signed in medical settings by health care professionals and result in medical orders. Figure 1 shows the differences between these documents.

⁶⁰ LEGISLATIVE GUIDE, *supra* note 47, at 20.

FIGURE 1

Key Comparison of Advance Directives and POLST Paradigm Forms⁶¹

	Advance Directives	POLST Paradigm Forms
Population:	All adults	Serious illness or frailty
Timeframe:	Future care/ future conditions	Current care/ current condition
Where completed:	Any setting, not necessarily medical	Medical setting
Resulting product:	Surrogate appointment [and] statement of preferences	Medical orders based on shared decision-making
Surrogate role:	Cannot complete	Can consent if patient lacks capacity
Portability:	Patient/ family responsibility	Health Care Professional responsibility
Periodic review:	Patient/ family responsibility	Provider responsibility to initiate

When a living will is executed, a direction is given in advance and is conditional on the occurrence of a future medical condition. A living will is, by definition, only applicable if certain conditions occur in the future. A POLST form, on the other hand, consists of current medical orders addressing the patient's current needs. The fact that state law requires conditions be met before a living will becomes operational should not interfere with the implementation of a POLST program.

Both in theory and clinical practice there are no strict medical preconditions applicable to the completion of a POLST form. The POLST program addresses the patient's current goals of care, and results in medical orders to implement those goals.⁶² While POLST is not appropriate and necessary for everyone, it should not harm anyone completing the process and the form properly because it allows for the direction of full medical treatment for anyone desiring full treatment.

⁶¹ *Id.* at 8 (citations omitted).

⁶² However, as noted previously, the POLST program is intended to apply to a person who is experiencing advanced illness, frailty, or both. The most frequently cited standard for evaluating the appropriateness of the POLST form is when the patient's physician would not be surprised if the patient is not alive for more than 1 year. *See* sources cited *supra* note 37.

1. *Origin and Purpose of Advance Health Care Directives*

The need for an advance health care directive is essentially universal. Advance health care directives are prepared most frequently for older adults as older adults, undoubtedly, are more likely to encounter the need for a health care agent and a living will sooner, rather than later. But thinking of these documents, the planning process, and the conversation they reflect as something that can wait until a person is a senior citizen is unwise. In fact, the most notorious and difficult cases concerning the rights of patient self-determination involved young women. Karen Ann Quinlan was 21 years old in 1975 when she fell into a persistent vegetative state.⁶³ Nancy Beth Cruzan was 25 years old at the time of her accident in 1983.⁶⁴ Teresa Marie Schiavo was 26 at the time of her cardiac arrest in 1990.⁶⁵ No doubt their youth made their cases all the more challenging for the courts of law and the court of public opinion.

The legal and ethical debate that swirled around these three young women was made all the more difficult by two critical findings. First, none of them were any longer capable of making a decision about their own medical care. Second, none of them had clearly expressed their wishes as to who should speak for them or what they would have wanted done in the excruciatingly difficult medical situations they unexpectedly encountered. What is not surprising at that time, or now, is that such young women would fail to reflect upon death and express themselves on the subject in a clear and unequivocal manner. Advance care planning and advance health care directives deal with life and health, rather than money and property. The young generally have more of the former and less of the latter to protect than older adults, who are more inclined to address the issues of health care decision-making, death, and dying.

2. *Advance Directives Across the Life Cycle*

Generations of all age groups should discuss advance health care planning as they all are potentially affected. Parents should realize that once their children become adults, they may have no rights to access health care information or to make health care decisions for their child who is in

⁶³ See *In re Quinlan*, 355 A.2d 647, 651 (N.J. 1976), *abrogated by In re Conroy*, 486 A.2d 1209 (N.J. 1985).

⁶⁴ See *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 267 (1990).

⁶⁵ See Kathy Cerminara & Kenneth Goodman, *Schiavo Timeline, Part I*, UNIV. OF MIAMI ETHICS PROGRAMS, http://www.miami.edu/index.php/ethics/projects/schiavo/schiavo_timeline/ (last updated April 8, 2014).

an accident or falls suddenly ill. Adult unmarried children should recognize that the parents who have protected them since birth may be helpless if they land in a hospital somewhere far from home. While most states provide a default medical decision maker some ability to speak for a patient who does not have a health care power of attorney and is incompetent, those default decision makers may not be the ones desired by the patient. This reality is particularly true for single adults, unmarried couples, and nontraditional families. Further, in many states the default decision maker may not have the same authority to make medical decisions for the patient as would a health care agent,⁶⁶ so it behooves all of us to protect ourselves and our families by having proper advance health care directives in place. Properly viewed, an advance health care directive should be as common and immediate a rite of passage for young people as registering to vote or indicating on their drivers' licenses whether they would wish to be an organ donor. We need to normalize discussions about death and dying and achieve a level of "existential maturity" as described by noted medical ethicist Linda Emanuel.⁶⁷

Initially, advance health care directives are best completed when a person is healthy and no time pressure exists. This approach allows for the beginning of thoughtful reflection on the choice of a health care agent and on the level of aggressive treatment preferred by the person if they became ill. Like all planning, starting the conversation early is best. Actually, the conversation itself needs to take place with practitioners, spouses, parents, and children. The conversation can begin with the patient and his or her doctor, or more frequently, the client and his or her lawyer, but communication must also begin with the health care agent. The agent, at the very least, needs to know of his or her appointment and

⁶⁶ For example in Pennsylvania, a health care agent can exercise all of the powers of the principal, but a default surrogate, called a health care representative, may only decline care necessary to preserve life if the patient is in an end-stage medical condition or is permanently unconscious. *See* 20 PA. CONS. STAT. § 5456(a), 5462(c) (2014).

⁶⁷ "Existential maturity (is) a kind of peaceful acceptance of mortality and of the relationship between generations of life that mitigates the pain of our transience by allowing an understanding of how we can die without entirely ceasing to exist." *See* Judith Johnson, *How's Your Existential Maturity?*, HUFFINGTON POST BLOG (Apr. 24, 2012, 4:48 PM) (quoting Linda Emanuel), http://www.huffingtonpost.com/judith-johnson/existential-maturity-_b_1447249.html. Linda Emanuel is a pioneer and leading authority on advance directives, health care decision-making, and medical futility. She coauthored and published the first case specific advance medical directive. *See generally* Linda L. Emanuel & Ezekiel J. Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 J. AM. MED. ASS'N 3288 (1989).

needs to have a copy of the document itself to make sure he or she understands it.

More importantly, the agent needs to understand the patient's wants, goals, and values. Estate planning attorneys tend to think of planning in terms of the legal documents, legal entities, and relationships produced by those documents, while particularly with advance health care directives, what is key is the conversation and communication. Most of the documents produced by estate planners are drafted with a specific intent to protect against a potential risk of harm from an adverse event or adverse party, whether that adverse party might be a taxing authority, a creditor or claimant, or someone seeking to upset an estate plan. Therefore, estate planners work very hard at drafting language that is legally clear⁶⁸ and less likely to be misinterpreted. This diligence is also the reason so many legal documents are much longer than clients would prefer. Estate planners want to make as certain as possible that the client's intent is expressed clearly and precisely. Advance health care directives are fundamentally different in this respect because there really are no parties whose interests should be adverse to the client. The important point is simply that the client's wishes need to be conveyed clearly and effectively to his or her health care agent and doctor so his or her wishes will be carried out.

As time passes, the patient may develop more significant medical conditions that require management, the patient may feel less able to make his or her own medical decisions, and the decisions may become more difficult. An appropriate and helpful approach is for the patient's current care to involve the health care agent even though the patient may still be making his or her own health care decisions. For the agent to be prepared to make those decisions when needed, the agent will need to generally understand the underlying medical conditions of the patient and the medications and treatments the patient is receiving. This preparation means that the agent will need to be a part of a continuing care conversation with the patient and the doctor. This involvement is both helpful and authorized by the patient's consent, or a more formal HIPAA authorization.⁶⁹

⁶⁸ Unfortunately, clarity and certainty to a reviewing court or taxing authority will generally have an inverse relationship with clarity to a client or other person who is tasked with interpreting the estate planner's work product.

⁶⁹ See 45 C.F.R. § 164.508 (2013).

3. *POLST Decision-Making in Context*

In contrast to the universal need for every competent adult to have an advance directive or living will, the POLST form is appropriate for a much more limited group of patients—those patients with serious advanced illness or frailty whose clinicians would not be surprised if the patient died within the next year. Despite the efficacy and usefulness of the POLST form, it is critically important to recognize that POLST in no way diminishes the need for the advance health care directive.⁷⁰ The advance health care directive appoints the health care agent to continue the conversation and be part of the decision-making after the patient is no longer able to take part in that conversation.

The POLST reflects a discussion and set of decisions that results in medical orders that are immediately effective, but that does not mean that the POLST form should remain effective without review or revisions as necessary from time to time. Indeed, one of the great advantages of the POLST form is the fact that it reflects the patient's wishes and decisions in light of the patient's current medical condition and treatment alternatives. The form is intended to reflect "in the moment" medical decision-making to a far greater degree than is likely with an advance health care directive, which is most typically and properly done months or even many years before it should take effect. But for this very reason, the POLST form must be reviewed to see if it remains appropriate when medical conditions, settings, or preferences change. Situations where the POLST form warrants review, include:

1. When a patient is transferred from a hospital to a skilled nursing facility and then to a long-term care facility, the POLST form is intended to travel with the patient and be honored at the new facility. However, this setting will inevitably involve a change in the capabilities of care, and may often imply a change in condition. When this change happens, the POLST form should be reviewed for appropriateness and applicability in the new setting.

2. Whenever a patient's condition changes significantly, whether for the better or for the worse, the POLST form should be reviewed to see if it still appropriately reflects the patient's wishes. Most often this review will occur as a patient's medical condition becomes more serious, and the patient may decide that less aggressive care is appropriate. On the other hand, a POLST form completed within the context of a very

⁷⁰ Stanley A. Terman, *It Isn't Easy Being Pink: Potential Problems with POLST Paradigm Forms*, 36 *HAMLIN L. REV.* 177, 183–84 (2013).

serious medical condition may no longer be appropriate if the patient has made a significant recovery.⁷¹

3. Because the patient intends the POLST form to reflect his or her current wishes, any change in those wishes should be respected. The POLST form is never intended to be irrevocable, and state law typically broadly protects the patient's ability to change or revoke the POLST, an advance directive, or an out-of-hospital DNR order.

4. While there is no broadly recognized time period, the passage of which should trigger a review of the POLST form, the authors suggest that a review at least once a year is appropriate. For a patient in a skilled nursing or long-term care facility, care conferences will typically occur every three months and a brief review of the POLST form can be easily incorporated into the facility's procedures to screen for a change in the patient's condition or preferences that might warrant a more detailed review between the patient, his or her surrogates, and a healthcare professional.⁷² One very recent research article makes a strong case for the involvement of a certified nurse practitioner for at least some of these care conferences at which the POLST is reviewed.⁷³

Because both advance health care planning and the POLST process are most effective when they reflect a continuing conversation, appointment of an empowered and informed decision maker to continue that conversation is critical when the patient is unable to continue that conversation directly because of illness or incapacity. When a review of the POLST form is required for one of the reasons discussed above, a surrogate decision maker, preferably a healthcare agent appointed by the

⁷¹ This situation is not as rare as it might seem. In fact, one of the authors acted as a health care agent for a patient for whom a POLST form was completed during a grave acute illness. The patient recovered and returned to the long-term care facility where 2 years later she enjoyed the celebration of her 100th birthday. Her recovery required a review and revision of her POLST form.

⁷² A frequent question at professional seminars often reflects concern that a POLST form may be applied at a much later date without sufficient thought as to different circumstances that do not justify the POLST treatment choices. This concern is valid and it must be addressed by thoughtful application of the POLST process, which never allows the existence of a POLST form to discourage active and thoughtful medical decision-making.

⁷³ Almost one quarter of the POLST form orders were changed after a care conference in which a certified registered nurse practitioner was present. See Gerald A. Hartle et al., *Physician Orders for Life Sustaining Treatment in U.S Nursing Homes: A Case Study for CRNP Engagement in the Care Planning Process*, NURSING RESEARCH & PRACTICE, Apr. 29, 2014, at 1, 3 available at <http://www.hindawi.com/journals/nrp/2014/761784/>.

patient, needs to be kept informed and should participate with the doctor in the review process.

When a response to an emergency situation is required, the POLST form must be followed first, even before discussion with the patient's physician.⁷⁴ When there is time to do so, both the patient's physician and the patient's health care agent should be kept informed so that patient care continues to reflect the patient's wishes as accurately as possible.

IV. THE ROLE OF THE ESTATE PLANNER

Estate planners need to understand advance health care directives because these important documents are part of the standard forms recommended for all of their estate planning clients. The POLST form, on the other hand, is for clients with serious advanced illness or frailty when it would not be surprising if they might die within the next year. But while estate planners typically prepare advance health care directives, POLST is a set of medical orders that can only be properly prepared, discussed, and completed by the health care professional, and signed by a licensed health care professional—a doctor, certified nurse practitioner, or physician's assistant—consistent with state law and scope of practice rules. An estate planning attorney cannot prepare or legally sign a form that is a set of medical orders, but that limitation does not mean that estate planners should be uninvolved in the POLST process.

The estate planner should inform clients about the POLST form during the estate planning process as part of the discussion about health care decision-making and advance directives. The clients need to know that if their medical condition substantially declines or if they receive a significant medical diagnosis, they should review their advance directives to be sure they continue to reflect their wishes. If the situation is serious, they should know that the POLST form is a tool available to them and their doctor to try to ensure that their wishes are carried out properly in light of their new current medical condition. The estate planner should consider giving clients written resource materials about the POLST process and how it fits in with the advance directives prepared in the estate planning process.⁷⁵

⁷⁴ Cardiopulmonary resuscitation must be applied immediately to be effective, as must intubation, so the patient has no time for even the briefest of delays for consultation and discussion.

⁷⁵ See, e.g., *POLST in Action in Pennsylvania*, YOUTUBE (Feb. 12, 2013), <http://www.youtube.com/watch?v=KNcf8BZXbFk>. Educational information on POLST

The estate planner may know when a POLST form should be completed. Often, the estate planner may know when a patient is facing serious illness because of the close personal relationship they often enjoy with their clients and families, or because the client (or a family member on the client's behalf) may contact the estate planner to review, update, or change estate planning documents. The patient and his or her family may not know about POLST, and in such situations the estate planner may helpfully suggest that the patient discuss the POLST form with his or her physician.

The estate planner should know how a POLST should be completed. Ideally, the POLST is the result of a meaningful conversation about the patient's medical condition, treatment options, and preferences. When the patient has appointed a health care agent, the agent should participate in the conversation even if the patient is still capable of making medical decisions. The agent may help express the patient's current wishes based on the patient's goals, values, and religious faith. A health care agent can make sure that the patient's advance health care directive is available for review and discussion. Just as importantly, the agent's participation in the conversation will help him or her understand as well as possible, through a first-hand discussion with both the doctor and the patient, what the patient may want in terms of care. This discussion is all the more valuable because the time is likely very close to when such care decisions must be made—this is when the health care agent needs to be present to talk with the doctor, ask the right questions, and obtain the answers.

The estate planner can help the health care agent make sure that the conversation takes place with the right people present. Optimally, the patient's physician should be present for this conversation, particularly where the medical condition, treatment options, or outcomes are less certain. Doctors vary a great deal in their skill level at having these conversations, however, and sometimes a well-trained facilitator may be able to help with the conversation and filling out the POLST form just as effectively, or even more effectively, than the physician alone when the medical condition is common and the progression of the illness is well known. A team approach with health care professionals may be ideal where the knowledge, time, and skill levels of health care professionals complement each other. Because the POLST form is a medical order, a licensed medical professional must in all events sign the form within his or her scope of practice rules, though the medical professional is not

is easily accessible online. This thirteen minute video was prepared in partnership with the Task Force and adapted to accurately reflect Pennsylvania law.

necessarily required to do so at the same time as the patient or patient's legal representative signs the POLST form.

The estate planner may know when the POLST form should be reviewed. If the estate planner knows that a POLST form has been completed, he or she may suggest review when one of the triggering circumstances⁷⁶ occurs to make sure that the patient's care documents continue to reflect the patient's wishes given any changes in setting or condition. The estate planner, in this connection, is serving more as a trusted family advisor than as a technical legal advisor, but the importance of that role should never be underestimated. Nothing is more important or strengthens relationships more than being there for the client family in times of crisis. The estate planner may be needed to be sure the patient's wishes are carried out within the context of existing laws and the patient's advance health care directive and POLST order form. In some cases, the estate planner may be required to enforce the patient's rights so that their wishes under the law are respected:

Attorneys who work with their clients' health care professionals can play an important role. They can help ensure that existing laws are followed so patients and their families receive the necessary information to make informed decisions about treatment and care. Attorneys can ensure that health care proxies are completed, and that when patients have decisionmaking capacity, they communicate their wishes to loved ones and health care professionals. This will help make certain that desired treatment is provided, unwanted and harmful treatment is not provided, and the expressed wishes of patients or directions of their health care agents or surrogates are respected. Attorneys should think about possible remedial legislation and work to facilitate such legislation. There are many opportunities for involvement.⁷⁷

⁷⁶ See discussion *supra* Part III.C.3.

⁷⁷ David C. Leven, *Health Justice Denied or Delayed at the End of Life: A Crisis Needing Remedial Action*, 58 N.Y.L. SCH. L. REV. 403, 415 (2013–2014); see also Kathryn Tucker, *Elder Law: Counseling Clients Who are Terminally Ill*, 37 WM. MITCHELL L. REV. 117, 124–25 (2010). Both of these articles discuss the inadequacies of the current approach to severe pain management in certain cases. Leven discusses the last options for patients experiencing intractable pain at the end of life: sedation (eventually leading to unconsciousness) and voluntarily stopping eating and drinking (VSED). These

Leaders of the Bar and lawyers who serve on legislative advisory committees should help incorporate the POLST program within their state's laws and procedures that cradle our most basic human liberty to participate in medical care decisions at the end of life.

State laws concerning living wills, durable health care powers of attorney, and medical health care decision-making in the context of end-of-life care have come about as a result of well-known and well-publicized court cases. Both on a federal and state level, the laws recognizing living wills and health care powers of attorney are largely a response to the issues those cases brought to light. The development of those laws was very visible within the legal community, and particularly, within the estate planning and elder law communities.

The POLST program, on the other hand, has emerged from the scientific, medical, and clinical world. The wide acceptance and spread of POLST is not well known to the majority of estate and trust and elder law practitioners. Very important to the proper functioning of POLST is that it fits within state laws governing living wills, health care powers of attorney, out-of-hospital DNR statutes, guardianships, and health care decision-making laws generally. This fit requires estate and trust and elder law practitioners to become familiar with POLST and its objectives, assess its risks and benefits, and to take a seat at the table during the proposal of the POLST program so that it fits properly within state and federal jurisprudence.

V. THE CONSTITUTIONAL CONTEXT OF POLST, ADVANCE DIRECTIVES, AND INFORMED CONSENT

Any consideration of the federal constitutional protections afforded to a POLST regime must begin (and, for the time being at least, end) with the United States Supreme Court's decision in *Cruzan v. Missouri Department of Health*.⁷⁸ The specific legal issue presented by *Cruzan* was the constitutionality of an en banc decision of the Missouri Supreme Court that held that Missouri state law required "clear and convincing" proof of an incompetent individual's wishes not to receive apparently futile life-prolonging treatment as a prerequisite to the discontinuation of such measures.⁷⁹ The Missouri Supreme Court's divided decision was in stark

options shorten the process of dying when no other alternatives are available to relieve patients' suffering. See Leven, *supra*, at 411.

⁷⁸ 497 U.S. 261 (1990).

⁷⁹ See *Cruzan v. Harmon*, 760 S.W.2d 408, 424 (Mo. 1988) (en banc).

contrast to an, even then, overwhelming majority of state appellate court decisions in their treatment of individuals (such as Nancy Cruzan) whose medical condition had been deemed to be “a . . . vegetative state.”⁸⁰

As discussed at length in the *Cruzan* decision and noted briefly below, state courts have struggled for some years to provide a rationale for sustaining the constitutional right of an individual to refuse medical treatment. The resulting jurisprudence, while inconsistent in its reasoning, has generally favored a patient’s (or surrogate decision maker’s) determination to refuse treatment. Connecticut, for example, began its modern judicial analysis of the issue in *Foody v. Manchester Memorial Hospital*,⁸¹ which focused on the “distinction between ordinary and extraordinary treatment.”⁸² The *Foody* court held that the parents of an adult daughter with multiple sclerosis who was hospitalized in a semi-comatose condition could obtain permanent injunctive relief prohibiting further treatment.⁸³ In *McConnell v. Beverly Enterprises-Connecticut, Inc.*,⁸⁴ the supreme court’s opinion provides a strong rationale, derived from both constitutional and common law sources, for patient self-determination: “The right to refuse medical treatment is a right rooted in this nation’s fundamental legal tradition of self-determination.”⁸⁵ This rationale has defined Connecticut law since that time. Other states have an equally mixed jurisprudence, and as will be seen, that approach, on a national level, is encouraged by Justice O’Connor’s concurrence in *Cruzan*.

The U.S. Supreme Court’s *Cruzan* decision comprises not only Chief Justice Rehnquist’s opinion for the Court, but two separate concurring and two separate dissenting opinions. However, Justice O’Connor’s relatively brief concurrence is generally viewed as establishing the constitutional principle for which *Cruzan* is known: “[T]he liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual’s deeply personal decision to reject medical treatment”⁸⁶

⁸⁰ *E.g.*, *Cruzan*, 497 U.S. at 347 (Stevens, J., dissenting).

⁸¹ 482 A.2d 713 (Conn. Super. Ct. 1984).

⁸² *Id.* at 719.

⁸³ *See id.* at 721–22.

⁸⁴ 553 A.2d 596 (Conn. 1989).

⁸⁵ *Id.* at 601.

⁸⁶ *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 289 (1990) (O’Connor, J., concurring).

Moreover, Justice O'Connor, whose vote was essential to the Court's five to four majority affirmance of the Missouri Supreme Court's determination of the applicable evidentiary standard, was at pains to undercut the suggestion that *Cruzan* decided anything other than a state's constitutional authority to establish its own evidentiary standard for the withdrawal or withholding of life-prolonging medical treatment:

Today's decision, holding only that the Constitution permits a State to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, in the first instance.⁸⁷

Yet, with the exception of Justice Scalia, who would remove all "right to die" cases from the federal courts in favor of a purely state sourced jurisprudence,⁸⁸ all the then members of the U.S. Supreme Court were united in their view that, under either a privacy-liberty rationale, such as that relied upon in the seminal New Jersey decision of *In re Quinlan*,⁸⁹ or the venerable (if sometimes criticized) New York "informed consent" doctrine of *Schloendorff v. Society of New York Hospital*,⁹⁰ a competent individual, absent a showing of a specific compelling contrary public interest has a right to refuse medical treatment.

"On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases

⁸⁷ *Id.* at 292 (O'Connor, J., concurring) (citation omitted).

⁸⁸ *See id.* at 292-93 (Scalia, J., concurring).

⁸⁹ 355 A.2d 647 (N.J. 1976), *abrogated by In re Conroy*, 486 A.2d 1209 (N.J. 1985).

⁹⁰ 105 N.E. 92, 93 (N.Y. 1914), *abrogated on other grounds by Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient's competency to make a rational and considered choice."⁹¹

While much of the majority opinion in *Cruzan* may be *dicta*—Nancy Cruzan was understandably incapable of expressing her own wishes and some (minimal) controversy existed over what her personal wishes really were—that *dicta* is clearly decisive for the constitutional validity and enforceability of a POLST, properly executed in accordance with local law. Indeed, the reasoning of the *Cruzan* majority as stated by Justice O'Connor essentially mandates such validity and enforceability.

By its terms, a POLST form is executed only after a discussion between a (competent) patient and physician or other health care professional, generally within the medical context of a patient for whom it would not be surprising if death were to occur within the next year. Thus, any concerns as to the individual's treatment wishes are largely eliminated and both the informed consent and privacy (and liberty) interests of the individual patient are all satisfied. The refusal of providers to honor the medical treatment orders set out in a POLST form clearly would implicate both common law and constitutional violations, as well as statutory ones in many states.

That implication is not to say that, constitutionally, states may not reasonably regulate the use of a POLST, perhaps prescribing certain colored forms or requiring witnesses or dates (although a POLST lacking such formalities still should be considered evidence of the individual's constitutionally protected medical treatment wishes), but any attempt to prohibit the use of a POLST by a competent individual unquestionably would violate well-established American constitutional and common law protections.

A separate issue is the ability of a surrogate to use a POLST form for an individual who is incapable of making informed medical decisions. This issue remains, for now, within the "laboratory" of the states. Because every state now allows medical treatment decisions to be delegated to a duly appointed agent or surrogate, the constitutional force of the interests at stake argue strongly for compliance with a POLST form. In those states that limit the power of a third party to direct the withholding or withdrawal of life support, the authority of a third party (for example, default surrogate) to execute a POLST form will be limited

⁹¹ *Cruzan*, 497 U.S. at 273 (quoting *In re Conroy*, 486 A.2d at 1225).

consistent with state law in the absence or an explicit judicial broadening of the principles set forth in *Cruzan*.⁹²

VI. CONCERNS, CRITICISMS, AND FEARS SURROUNDING POLST

Commentators have raised criticisms and concerns about POLST, particularly within the Catholic community, about its scope, safeguards, effect, and implementation. Those criticisms and concerns deserve examination. Understanding those concerns is important, and they should be given weight. Those concerns should be taken into account to the extent possible within the context of the design, process, and implementation of a POLST program. While some of the issues raised are more fundamental than others, they should all be understood and reflected upon by those wishing to advance a POLST program or to consider legislation that would address POLST within their home state. An exposition of these concerns is outlined in an issue of *Ethics & Medics*,⁹³ and set forth much more thoroughly and rigorously in an article described by the authors as a “White Paper”), published in the *Linacre Quarterly* by the Catholic Medical Association.⁹⁴ Most recently, a very rigorous point by point analysis of the White Paper was authored by Father Thomas Nairn, Senior Director of Ethics for the Catholic Health Association.⁹⁵ This analysis agrees with some of the concerns expressed in the White Paper, but ultimately concludes that the arguments do not invalidate the arguments for the POLST. They do however, expose valid areas of concern. Ultimately, the importance of these concerns, particularly those which are theological in nature, is properly left to the reader.

⁹² See *id.* at 286–87 (opining for the Court, Chief Justice Rehnquist specifically rejects any constitutional basis for surrogate decision-making in the absence of evidence of a patient’s own wishes).

⁹³ See generally E. Christian Brugger et al., NAT’L CATHOLIC BIOETHICS CTR., *POLST and Catholic Health Care: Are the Two Compatible?*, ETHICS & MEDICS, Jan. 2012, at 1 (“[Recommending] . . . Catholic health care institutions either refuse to accept [POLST Forms] or, if the forms are already in use, revise POLST forms and policies to bring them in line with Catholic moral training.”).

⁹⁴ See generally E. Christian Brugger et al., *The POLST Paradigm and Form: Facts and Analysis*, 80 LINACRE Q. 103 (2013), available at www.maneyonline.com/doi/pdfplus/10.1179/0024363913Z.00000000027 (analyzing the risks that POLST poses to sound clinical and ethical decision-making).

⁹⁵ See generally Thomas Nairn, *The Catholic Medical Association’s White Paper, “The POLST Paradigm and Form: Facts and Analysis,”* 21 HEALTH CARE ETHICS USA 17 (2013), available at <https://www.chausa.org/docs/default-source/hceusa/the-catholic-medical-association-s-white-paper-the-polst-paradigm-and-form---facts-and-analysis.pdf?sfvrsn=2>.

A. POLST May be Implemented When the Patient is Not Terminally Ill

Most state laws authorizing living wills address the typical medical conditions involved in the high profile cases that prompted legislative action—that is, terminal illness, permanent unconsciousness, or permanent vegetative state found in the seminal *Quinlan*, *Cruzan*, and *Schiavo* cases. These medical situations made their way into our laws as medical conditions required for a living will to become operative. They are not typically incorporated into the POLST process nor into statutes authorizing a POLST program. The constitutionality of these medical limitations as they relate to living wills or POLST is questionable in light of the fundamental liberty interest of each person to control his or her own medical care as announced in *Cruzan*.⁹⁶

The fundamental right of the patient under the Constitution and the doctrine of informed consent simply does not square with a bright line boundary covering only terminal illness or permanent unconsciousness. A 95-year-old resident of a long-term care facility may well be medically stable but not wish to have aggressive medical care imposed in light of the resident's age and frailty. Certainly a DNR order for such a resident would raise no eyebrows in the presence or absence of a POLST form. The really well-informed resident might well be aware that even the initial effectiveness rate for resuscitation under such circumstances is “less than 5%” and the probability of real success in such circumstances is essentially nonexistent.⁹⁷ Accordingly, the resident may well consider resuscitation to be both inappropriate and burdensome. Because a DNR order or a POLST form addressing the situation is the decision of the patient—relative to the patient's present condition as agreed between the patient and the doctor—the limitations on triggering a living will should not be imposed on a patient's present medical care choices as a matter of law.

As a matter of Catholic moral teaching, some theologians argue that the POLST is ethically problematic for several reasons:

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life.

⁹⁶ See *Cruzan*, 497 U.S. at 286–87.

⁹⁷ CHARLES F. VON GUNTEN & DAVID E. WEISSMAN, PALLIATIVE CARE CTR.: MED. COLL. OF WIS., *FAST FACT #024: DISCUSSING DNR ORDERS—PART 2* (Drew A. Roslille ed., 2d ed. 2005), <http://www.eperc.mcw.edu/filelibrary/User/jrehm/fastfactpdfs/concept024.pdf>; see also Michael Gordon, *Cardiopulmonary Resuscitation in the Frail Elderly: Clinical, Ethical and Halakhic Issues*, 9 ISR. MED. ASS'N J. 177, 178 (2007) (discussing CPR success rate for frail elderly individuals).

Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.⁹⁸

Specifically, Dr. E. Christian Brugger of the St. John Vianney Theological Seminary and coauthors argue that “making a morally good decision for the refusal of medical care requires a careful and detailed inquiry into particular facts related to the specific treatment options of a specific patient. The POLST model's one-size-fits-all approach to medical orders excludes this necessary process of inquiry.”⁹⁹ However, proportionality in a POLST paradigm does rely upon “the patient's judgment”¹⁰⁰ and the consideration of burdens, including burdens to the family or community—factors that appear far more favorable and liberal to patient freedom than the positions espoused by Dr. Brugger.

The second objection is that nutrition and hydration, even by artificial means, “should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality.”¹⁰¹ Because POLST would allow a patient to direct the withholding or withdrawal of medically supplied nutrition or hydration, it may be objectionable, particularly where the patient may be in a permanently unconscious state—a circumstance in which the Catholic Church has considered medically supplied nutrition and hydration to be morally obligatory.

⁹⁸ U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 31 (5th ed. 2009) (citing VATICAN, DECLARATION ON EUTHANASIA pt. IV (1980)), available at <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

⁹⁹ Brugger et al., *supra* note 93, at 1–2.

¹⁰⁰ U.S. CONFERENCE OF CATHOLIC BISHOPS, *supra* note 98.

¹⁰¹ John Paul II, Pope, Address of John Paul II to the Participants in the International Congress on “Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas” (Mar. 20, 2004), *quoted in* Brugger et al., *supra* note 93, at 2.

Additionally, moral teachings in the Catholic Church condemn both suicide and euthanasia.

[Because the] POLST documents permit any patient, whether terminally ill or not, to refuse all life-sustaining care, including routine antibiotics and even food and water; refusals can be made for any reason, including for the purpose . . . of causing one's own death. Inevitably, the use of POLST documents will involve Catholic health care workers at times in facilitating euthanasia through the wrongful removal of life support.¹⁰²

Father John Tuohey and others differ on this point and other points, noting that POLST does not direct the withdrawal of care. It merely permits it.

Key here is that the POLST is a physician's order *about* life-sustaining interventions, not an order simply to *forgo* them. Especially for patients with complex medical conditions or chronically critical illness, some interventions may offer reasonable hope of benefit, others may not. POLST orders allow for pursuing the interventions that do and avoiding the ones that will pose an excessive burden. POLST is a validated way to help assure clinically appropriate care is delivered at the end of life, consistent with the Catholic moral tradition.¹⁰³

Lastly, the precondition requirement of a terminal illness to justify withholding or withdrawing care is questioned within the Catholic tradition as a matter of law:

A second concern is the notion that one must be terminal in order to forsake life-sustaining treatment. Is this really the Catholic tradition? What seems to be central in the tradition and in the Church's teaching is that one has a moral obligation to use ordinary means to sustain one's life, but there is no obligation to use

¹⁰² Brugger et al., *supra* note 93, at 2.

¹⁰³ John Tuohey & Marian O. Hodges, *End of Life: POLST Reflects Patient Wishes, Clinical Reality*, HEALTH PROGRESS, Mar.-Apr. 2011, at 60, 63-64, available at <http://www.chausa.org/docs/default-source/health-progress/end-of-life---polst-reflects-patient-wishes-clinical-reality-pdf.pdf?Sfvrn=0>; see also Naim, *supra* note 95, at 20.

extraordinary means—means that offer little or no hope of benefit or that are excessively burdensome. Determining what is ordinary and extraordinary consists in an assessment of the means—cost, availability, etc.—and the benefits and burdens upon this patient in this particular situation. It is not clear that one must be terminal, whatever that means in this day and age.

For example, an active and relatively healthy 87 year-old woman with poor circulation in her legs is told by her physician that she needs a double amputation. She refuses because, for a number of reasons, this surgery and the loss of her legs are seen to be excessively burdensome. Or take the patient who has undergone dialysis three times per week for the past six years and declines further dialysis because it has become too burdensome. While the patient will die without dialysis, he is not strictly speaking terminal at the time of the decision. Or the patient who develops a rare cancer for which there is an experimental treatment available at considerable cost in a foreign country for a lengthy period of time. The individual refuses because seeking such treatment would impose excessive burdens on the individual and her family. She is not strictly speaking terminal at the time of her decision. Having said this, however, if we are dealing with “life-sustaining treatments,” then, in the vast majority of cases, we will be dealing with patients who have a life-threatening condition.¹⁰⁴

Regardless of the outcome of this theological debate, the mere fact that a patient could utilize the POLST form to carry out a personal health care decision that conflicts with a particular moral and religious tradition is not a valid reason to reject it as a tool for effectuating patient wishes as a matter of law and clinical practice. The POLST form does not in any event mandate any particular decision. It merely permits it, allowing for the exercise of an individual’s free will. Health care decision-making is left up to the individual to apply his or her own goals of care, values, and religious beliefs. Our society is multicultural with citizens of widely

¹⁰⁴ Ron Hamel, *POLST Under Fire*, 20 HEALTH CARE ETHICS USA 30, 33–34 (2012), available at <http://www.chausa.org/docs/default-source/general-files/2f04a948aa0a4109a63a2ee0b25509ad1-pdf.pdf?sfvrsn=0>; see also Nairn, *supra* note 95, at 22–23.

divergent religious perspective who have the firmly established right to select any one perspective or none at all. POLST, in short, is an empowering tool intended to reflect patient wishes in accordance with proper constitutional and legal principles. The fact that it can be used to effectuate a patient's wishes that may be inconsistent with a particular moral tradition is not a valid criticism if it can also reflect a choice that is consistent with that moral tradition.

Further, there is a significant distinction between the individual's right to refuse medical care and the administration of medical care directed at hastening death to shorten a period of suffering that cannot otherwise be relieved. The affirmative application of medical care to assist a patient in this way, now generally referred to as "aid in dying," is neither endorsed by the POLST paradigm nor facilitated by the POLST form. It is expressly legal only in the states of Oregon and Washington by statute¹⁰⁵ and in Montana by a decision of the Montana Supreme Court.¹⁰⁶ A thorough discussion of the development, history and results in these three states can be found in the writings of Kathryn L. Tucker, a forceful advocate of patient choices at the end of life.¹⁰⁷

B. A Patient's Signature May Not be Required

While all states require the signature of a physician or other health care professional, several states adopting a POLST program do not require a patient's signature.¹⁰⁸ Of course, physicians' orders typically do not require a patient's signature, but good reasons exist for requiring a patient's signature on the POLST. The most important reason is ensuring that health care professionals have had a discussion and conversation with the patient or the patient's legal representative. Some commentators have concerns about requiring a signature, particularly a legal representative's signature for the patient. Surrogates may be afraid or discouraged from making a decision by the formality of their signature on behalf of

¹⁰⁵ OR. REV. STAT. §§ 127.800-897 (2003 & Supp. 2010); WASH. REV. CODE §§ 70.245.010-.940 (Supp. 2010).

¹⁰⁶ *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

¹⁰⁷ See generally Tucker, *supra* note 77; Kathryn L. Tucker, *When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life*, 33 WHITTIER L. REV. 109 (2011). One interesting finding is that the Death with Dignity Act in Oregon has "galvanized improvements in end-of-life care and benefited all terminally ill Oregonians." Tucker, *supra*, at 120. One can understand how the existence and exercise of this option might spur further efforts to provide better options in palliative and end-of-life care.

¹⁰⁸ See *infra* Appendix 2, at rows 5–6.

the patient.¹⁰⁹ But the better approach is to require a patient or legal representative signature as a safeguard.

Without some assurance that the POLST form is a result of a meaningful conversation between the patient or the patient's legal representative and a health care professional (preferably including the attending physician), no reason exists to have confidence that the POLST form represents an informed patient decision. The National POLST Paradigm Task Force recommends requiring the signature of the patient or a legal representative of the patient. States considering POLST would do well to follow that recommendation. While a patient signature does not ensure that a proper informed discussion took place, it does prove that at least some interchange with the patient or the patient's legal representative occurred. As discussed later in this Article, states can create provisions recommending signature equivalents when necessary, such as a witnessed verbal consent or electronic signature.¹¹⁰

C. POLST May be Driven by Fiscal Concerns

Dr. Brugger correctly points out that high-tech, life-sustaining treatment is expensive and suspects that fiscal considerations are behind much of the impetus to adopt the POLST.¹¹¹ He notes that the highly successful implementation of POLST in La Crosse, Wisconsin earned La Crosse the dubious distinction of "Cheapest Place to Die" from Good Morning America.¹¹² Saving money is possible by reducing very expensive care that is ultimately not desired by an informed patient. It hardly makes sense, however, to criticize POLST if its use produces both better end-of-life care and less expensive care—just as long as the decisions reached are the result of a patient choice that is medically well informed. The POLST form is merely the endpoint of the informed consent process—not the process itself.

Health care practice may well ultimately reach a point of limiting expensive end-of-life care where the results are not justified. The harsh reality is that about 33% of the total cost of health care in America is

¹⁰⁹ Signing an order limiting care creates a certain feeling of finality and gravity, which is not inappropriate, but is more off-putting than a conversation with the doctor.

¹¹⁰ See discussion *infra* Part VII.D.2.

¹¹¹ See Brugger et al., *supra* note 93, at 3.

¹¹² See Kate Snow & Elizabeth Tribolet, *End-of-Life Lessons from the Cheapest Place to Die*, GOOD MORNING AM. (Aug. 10, 2009), <http://abcnews.go.com/GMA/story?id=8250195&page=1>.

incurred in the last year of life.¹¹³ To the extent that we can have better care that is cheaper as well, health care legislation and policy should embrace it. But patient freedom is very important and we must be vigilant, as always, for conflict of interest in the informed consent process. This conflict is a real concern and will likely become a greater concern as time goes on and the financial pressures on cost control within our health care system increase. This concern may be most strongly felt within the disability community and within minority populations who, with some cause, may feel most vulnerable and least trusting of the health care system when it must balance cost against the extension of their lives.¹¹⁴

D. POLST May be “Too Effective” and May Discourage “In the Moment” Thoughtful Medical Decision-Making

The POLST form itself says “FIRST follow these orders. THEN contact physician”¹¹⁵ Some may argue this language would discourage a physician from considering a change in the order after taking into account the patient’s current condition and medical treatment alternatives. However, this language is included because the first section of the POLST form deals with emergency situations, for which no time to consult with a physician is available. Reviewers of a POLST form should not read it to discourage thoughtful consideration and reconsideration of the most medically appropriate treatment. A danger is present in any form of order or advance directive that readers will follow it without thought. Also, the fact that a patient has a living will is dangerous because that living will may prompt a medical provider to conclude that the patient does not desire important or life-sustaining care, without considering that the living will is conditional upon the establishment of the conditions that cause the living will to become operational. A living will most typically becomes operational after establishment of a terminal condition, end-state medical condition, or a state of permanent unconsciousness.

A similar “spillover” effect can occur as a result of a patient having a DNR order. A medical provider may assume that because a patient has a DNR order, the patient does not want relatively full medical care short of

¹¹³ *See id.*

¹¹⁴ *See* TASK FORCE FOR QUALITY AT END OF LIFE IN PA., END-OF-LIFE CARE IN PENNSYLVANIA: FINAL REPORT AND RECOMMENDATIONS 48–51 (2007).

¹¹⁵ *See infra* Appendix 1.

CPR. This assumption is unjustified and inaccurate, and in this respect the POLST form can be of significant benefit in avoiding the unwanted limitation of care and encouraging better expression of care decisions, particularly regarding long-term care residents. As a result of a detailed study of Oregon POLST forms, after an electronic registry had been implemented, the analysis noted that while 72.1% of the patients' POLST forms included a DNR order under Section A, "only half of these forms indicated an order for 'Comfort Measures Only' in Section B"¹¹⁶ This data both strengthens the argument that patients with a DNR order do not necessarily wish to limit other significant care and makes a powerful argument for the POLST form itself, which allows an expression for limited interventions and transfer to a hospital even though resuscitation is not desired.¹¹⁷

Within the context of long-term care facilities, the questions raised by Section B of the POLST form are really important in carrying out patient and family wishes because Section B deals directly with whether the patient wishes to be hospitalized and whether he or she would desire the highest level of medical care (with its resultant burdens and intrusions that are customarily applied in an intensive care unit). A patient may have had his or her fill of hospitals and aggressive care and may wish to be cared for where they are, as best they can be treated there, in the absence of the need for hospitalization to treat a fracture or other acute injury. On the other hand, hospitalization might be required even if "Comfort Care Only" is selected when the hospitalization is necessary for a fracture or other acute injury because comfort could not be maintained in the long-term care setting without some acute care treatment.

E. POLST May Dictate Choices Weeks, Months, or Even Years Before the Choices Are to be Carried Out

Dr. Brugger expresses a concern often expressed about advance directives:

The forms are completed prior to the time that many people know the exact nature of their conditions or the range of reasonable treatment options. In other important

¹¹⁶ OR. POLST REGISTRY, OREGON POLST REGISTRY ANNUAL REPORT 18 (2011) (citing Erik K. Fromme et al., *POLST Registry Do-Not-Resuscitate Orders and Other Patient Treatment Preferences*, Research Letter, 307 J. AM. MED. ASS'N 34, 35 (2012)), available at http://www.orpolstregistry.org/wp-content/uploads/2012/09/OregonPOLSTRegistryAnnualReport_2011_FINAL_June29.pdf.

¹¹⁷ See *id.*

areas of life ([for example,] investing), people are ill advised to make consequential decisions without knowing all the facts. But the POLST paradigm invites patients to make the most consequential decision of their lives before many facts are even possibly knowable: What precise ailment will I be suffering from? What treatment alternatives will be available? What probability of medical benefit does each offer? What burdens are associated with each? . . . A POLST form is a blunt and inadequate instrument that is as likely to do damage as good for people at vulnerable moments of life.¹¹⁸

These concerns, however, are general ones that apply to any health care directions given in advance by whatever means expressed. The POLST form is the least susceptible to this argument of any directions given in advance simply because the form is an explicit medical order immediately effective with reference to the patient's *current condition*, rather than a hypothetical future condition, which is usually the case with a living will that addresses a future terminal illness or permanent unconsciousness. In this context, the argument should be directed at how frequently a POLST form should be reviewed and updated, rather than whether there should be one at all because the primary premise behind the POLST paradigm is that the agreed-upon orders reflect the patient's actual current medical condition, the treatment options and probable outcomes of those treatments, and the benefits and burdens of those treatment options.

F. POLST May be Forced on Patients

Concerns have been expressed that the POLST, in effect, may be forced upon patients. This concern is valid if institutional policy requires the execution of a POLST form, even though the form itself gives patients the freedom to decide with their doctor for full treatment, comfort measures only, or anything in between. Documentation of patient wishes for code status is generally required under existing regulations for skilled nursing facilities, and the Centers for Medicare and Medicaid Services' guidance provides that "failure to obtain and implement medical orders related to life-sustaining treatments" is the highest level deficiency: 'Level 4: Immediate Jeopardy to Resident Health or

¹¹⁸ Brugger et al., *supra* note 94, at 114.

Safety.”¹¹⁹ However, the execution of an advance directive or other order governing the limiting of care is not required. In fact, requiring an advance health care directive or a medical order such as POLST is against the law in most states and is not the best policy for any state. Pennsylvania’s statute is an example.

A health care provider, a health care service plan, a health maintenance organization, an insurer issuing disability insurance, a self-insured employee welfare benefit plan, a nonprofit hospital plan and a Federal, State or local government sponsored or operated program may not:

- (1) Require an individual to execute an advance health care directive or order or to designate or disqualify a health care representative as a condition for being insured for or receiving health care services.
- (2) Charge an individual a different rate or fee whether or not the individual executes or has executed an advance health care directive or order or designated or disqualified a health care representative.¹²⁰

Some documentation of patient preferences is necessary, and the best POLST process should properly require a patient signature. While a refusal of a patient to sign a POLST form, even for full medical treatment, should be rare, institutions seeking to utilize POLST because they do not want to have multiple forms relative to life-sustaining treatment orders may encounter this issue. Perhaps the only simple solution is for the physician to sign “POLST refused, full treatment requested.” If the order is for something other than full treatment, physicians ought to use a different form to avoid the confusion caused by an unsigned POLST form.

¹¹⁹ Thaddeus Mason Pope, *Clinicians May Not Administer Life-Sustaining Treatment Without Consent: Civil, Criminal, and Disciplinary Sanctions*, 9 J. HEALTH & BIOMEDICAL L. 213, 294 (2013) (citing Memorandum from Thomas E. Hamilton, Dir. of Survey & Certification Grp., Ctrs. for Medicare & Medicaid Servs. to State Survey Agency Directors, Ctrs. for Medicare & Medicaid Servs. (Sept. 27, 2012), available at <http://www.cms.gov/medicare/provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-47.pdf>).

¹²⁰ 20 PA. CONS. STAT. § 5428 (2014).

G. Physician's Signature May Not be Required and "Facilitators," Rather than an Attending Physician, May be the Ones to Have the Conversation with the Patient

This concern covers two related questions. First, who is the medical professional entitled to sign the POLST form? Second, and likely more important, who is the one who actually has the conversation with the patient? The most important part of the POLST process is the conversation when the patient is informed of the medical treatment choices and the likely course of his or her illness. The concern expressed is that a person who is specially trained as a facilitator of these conversations is not equipped to give the medical guidance needed for that conversation or even capable of making a decision about whether the patient is sufficiently competent to have that conversation. This concern has the greatest weight when the patient's medical condition is an uncertain or unusual one because the facilitator may not be able to properly inform the patient of the likely outcomes for his or her personal situation and the appropriate treatment options.¹²¹ When the medical condition is more common and the course more predictable, such as in the case of chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), or end-stage renal failure, such a facilitator is likely to have substantial experience to guide a patient very well in the conversation. The facilitator may also have a very precious resource that is in shorter supply for the physician—time—the time to have an unhurried conversation about something very important and very personal.¹²² Furthermore, the unfortunate truth is that not all doctors are very good at having this conversation about care at the end of life. However, as Dr. Brugger points out,¹²³ the American Medical Association counsels physicians to be directly involved in the process of informed consent.

In the communications process, you, as the physician providing or performing the treatment and/or procedure (not a delegated representative), should disclose and discuss with your patient:

¹²¹ See Brugger et al., *supra* note 93, at 3.

¹²² However, facilitators will only have that precious time if this critical task is respected by health care employers eager to increase employee productivity. It should not be assumed that a facilitator will have more time for this conversation. The employer must *give* the facilitator that time.

¹²³ See Brugger et al., *supra* note 93, at 117.

- The patient's diagnosis, if known;
- The nature and purpose of a proposed treatment or procedure;
- The risks and benefits of a proposed treatment or procedure;
- Alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance);
- The risks and benefits of the alternative treatment or procedure; and
- The risks and benefits of not receiving or undergoing a treatment or procedure.

In turn, your patient should have an opportunity to ask questions to elicit a better understanding of the treatment or procedure, so that he or she can make an informed decision to proceed or to refuse a particular course of medical intervention.¹²⁴

This point is not without merit, and the authors would always recommend that the critical POLST conversation include the patient, the patient's primary or attending physician, and the patient's surrogate, when possible. But a team approach from health care professionals and more than one conversation can be ideal, particularly when the knowledge and skills of the health care professionals are different and complement each other.

The related question of which medical professionals are authorized to sign the form is also important, and is more likely to be included in a statute or regulation, even though the conversation is the most important. Legislating or regulating a conversation is awkward, at best. The POLST form is just the end product of that conversation. California,¹²⁵ Hawaii,¹²⁶ Louisiana,¹²⁷ New York,¹²⁸ Tennessee,¹²⁹ and West Virginia¹³⁰ require a

¹²⁴ AM. MED. ASS'N, INFORMED CONSENT, available at <http://www.leg.state.nv.us/Session/77th2013/Exhibits/Senate/HHS/SHHS1054M.pdf> (last visited May 12, 2014).

¹²⁵ See CAL. PROB. CODE § 4780(c) (West 2009).

¹²⁶ See HAW. REV. STAT. ANN. § 327K-1 to -2 (LexisNexis 2013).

¹²⁷ See LA. ADMIN. CODE tit. 48, § 207(B) (2011).

¹²⁸ See N.Y. PUB. HEALTH LAW § 2994-dd(6) (McKinney 2014).

physician's signature. Colorado,¹³¹ Idaho,¹³² Maryland,¹³³ New Jersey,¹³⁴ North Carolina,¹³⁵ Rhode Island,¹³⁶ Utah,¹³⁷ Vermont,¹³⁸ and Washington¹³⁹ by statute more broadly allow others, such as a certified nurse practitioner, advanced practice nurse, or physician's assistant, to sign the POLST form. Montana¹⁴⁰ and Oregon¹⁴¹ do so by regulation. Pennsylvania's statutory committee¹⁴² recommended this broader approach, while Minnesota did so by clinical consensus alone.¹⁴³ A qualified health care professional must always sign the POLST form as a medical order, but the conversation is the most important part of the process. The health care professional must empathetically inform the patient about the health care choices that relate to his or her care, and listen to the patient's goals, values, and preferences in this process. In the opinion of the authors, the best setting for the completion of the POLST form is a full discussion with the patient, the patient's primary or attending physician, and the patient's surrogate. This conversation should guide the treatment choices and the orders that reflect those choices.

¹²⁹ See TENN. CODE ANN. § 68-11-224 (2013).

¹³⁰ See W.VA. CODE ANN. § 16-30-25 (LexisNexis 2011).

¹³¹ See COLO. REV. STAT. § 15-18.7-103 (2013).

¹³² See IDAHO CODE ANN. § 39-4512A(1) (2011 & Supp. 2013).

¹³³ See MD. CODE ANN., HEALTH-GEN. § 5-608.1 (LexisNexis 2009 & Supp. 2012).

¹³⁴ See N.J. STAT. ANN. § 26:2H-134(b)(3) (2014).

¹³⁵ See N.C. GEN. STAT. § 90-21.17 (2013).

¹³⁶ See R.I. GEN. LAWS § 23-4.11-2(12) (Supp. 2012).

¹³⁷ See UTAH CODE ANN. § 75-2a-106(2) (2014).

¹³⁸ See VT. STAT. ANN. tit. 18, § 9708(e)(1) (2013).

¹³⁹ See WASH. REV. CODE §§ 70.122.030, 70.122.051 (2014).

¹⁴⁰ See MONT. ADMIN. R. 37.10.101, .104-.105 (2008).

¹⁴¹ See OR. ADMIN. R. 847-035-0030(6) (2014) (requiring EMS personnel to honor POLST); *see also id.* 847-010-0110(1) (requiring facilities to honor POLST even though the signer, who may be a physician, nurse practitioner, or physician assistant is not on the facility medical staff).

¹⁴² See 20 PA. CONS. STAT. § 5488 (2014). The Pennsylvania POLST Form is available on the University of Pittsburgh Schools of Health Sciences' website. *See* PENNSYLVANIA ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST), PA. DEP'T OF HEALTH, *available at* www.upmc.com/Services/AgingInstitute/partnerships-and-collaborations/Documents/POLST-Form.pdf (last visited May 12, 2014).

¹⁴³ *See* SABATINO & KARP, *supra* note 8, at 10.

H. “Steering” Decisions in POLST

Another criticism leveled at the POLST is that the structure, wording, and manner of explanation of the POLST form is intended to influence the patient towards the withdrawal of care.¹⁴⁴ The first medical-intervention choices presented on the POLST form itself are “comfort measures only” and “no artificial nutrition,” which prompts some critics to wonder whether the order of choices is intended to influence the way the form is completed. This concern isn’t silly as evidence shows that presenting a choice first on a form does tend to influence responses.¹⁴⁵ But the criticism ignores the fact that the resuscitation choice is the first listed option at the top of the form.¹⁴⁶ Further, the default choice if no decision is made within a particular section of the POLST form is full treatment. In those respects POLST is slanted towards full medical treatment, which in any event is the general default within our health care system. Whether that default is the best choice to reflect actual patient preferences, full medical treatment is certainly well established and the most protective.¹⁴⁷ More importantly, the POLST form is not filled out by the patient but by a health care professional for whom the order of choice should have no significance.

But the discussion, rather than the form, is really the most important, and the patient and health care provider should give the most attention to the integrity of this discussion. With POLST, just as with an advance health care directive, the process and the form should reflect and effectuate patient wishes, not influence them for or against additional medical care. Sensitivity is extremely important to the way in which information, and particularly the way in which health care providers present questions involving care, as they may significantly influence patient responses.

While the effectuation of properly informed patient choices is very important, the “properly informed” part of the equation should never be

¹⁴⁴ See generally Scott D. Halpern et al., *Default Options in Advance Directives Influence How Patients Set Goals for End-Of-Life Care*, 32 HEALTH AFF. 408 (2013), available at www.cmu.edu/dietrich/sds/docs/loewenstein/DefaultOptions.pdf (“[P]eople were significantly more likely to indicate preferences to forgo life-sustaining interventions when completing advance directives in which forgoing these interventions was the default than when they had to actively choose to forgo the interventions.”).

¹⁴⁵ See *id.*

¹⁴⁶ See *infra* Appendix 1.

¹⁴⁷ See Halpern et al., *supra* note 144, at 413 (arguing for the reversal of this presumption based upon those authors’ experiences with actual well-informed patients). However, such a shift would provoke widespread controversy and concern.

ignored. Although patient autonomy has become a very strong medical value in recent years, the input of the medical professional should not be ignored. Why after all do we go to the doctor in the first place? Obviously, we go to the doctor to get the doctor's professional opinion. If a doctor who is overly concerned with patient autonomy asks "Well, what would you like me to do?" or "What are you looking for?" the rational patient's answer ought to be the following: "I am looking for your professional guidance and judgment." A doctor's primary function is to guide and give direction on medical matters, and if substantial and burdensome medical care will be ineffectual or against the patient's best interests, the doctor ought to advise the patient of this plausible result. If this guidance is undesirable "steering," critics must bear in mind that after all, someone has to steer, and directions are only helpful if the one steering knows how to drive! There must be room for both professional judgment and guidance and patient freedom in these most critical and meaningful conversations.

VII. STATUTORY, REGULATORY, POLICY, AND PROCEDURAL QUESTIONS FOR STATES CONSIDERING A POLST PROGRAM¹⁴⁸

A state can adopt and implement a successful POLST program through clinical consensus, without legislation.¹⁴⁹ Broad clinical consensus will set the medical practice standard for the state and will allow for flexibility going forward. Broad clinical consensus importantly establishes a generally accepted medical practice standard, which is the fundamental basis for assessing proper medical care. Once consensus is established, it both protects the medical provider from liability and encourages

¹⁴⁸ Much of the topic for this concluding section, which is intended to give guidance to attorneys, health care professionals, and legislators who wish to implement a POLST program, coincides with the task of a legislative working group for the Task Force. The Task Force included two of the authors of this Article, Marilyn J. Maag and Robert B. Wolf, together with Charles P. Sabatino, Executive Director of the American Bar Association's Commission on Law and Aging, Thaddeus M. Pope, Director of the Health Law Institute and Professor of Law at Hamline University School of Law, Margaret Murphy Carley, former Executive Director of the National POLST Paradigm, and Amy Vandembroucke, Executive Director of the National POLST Paradigm and Chair of the Oregon POLST Task Force. Therefore, significant overlap exists in the discussion of issues, ideas, and phrasing of responses between this section of the Article and the working group product on the Legislative Guide. The statements and opinions as expressed in this Article are, however, the sole responsibility of the authors of this Article and should not be attributed to the National Task Force. The official Legislative Guide can be found on the National POLST website. *See* LEGISLATIVE GUIDE, *supra* note 47.

¹⁴⁹ *See id.*

consistency in practice. However, state health, human service, health care licensing departments, or medical board recognition by some means is necessary to enable meaningful implementation.

If the state legislative process is involved each time the POLST program is modified or improved, then refinements, even when agreed to by the appropriate constituencies, will be slower and more difficult to implement. Oregon is an example of a state that adopted the use of POLST through clinical consensus and then improved the POLST program in the state over time as the need for modification became apparent.¹⁵⁰ Even in a state without legislation formally adopting POLST, a state-level organization, such as the health department, medical board, health-decisions coalition, or a university-based ethics center must take on responsibility for convening a task force of interested and affected organizations to study, deliberate and make recommendations for the adoption of a POLST program, circulate a POLST form for statewide use, and provide information, such as on a website, about the POLST program and the POLST form.

In those states where clinical consensus initiates the POLST program, legislation relating to POLST still may be prudent for a specific purpose. For example, in Oregon, legislation was adopted specifically to create a statewide registry of POLST forms.¹⁵¹

In some states, there are legislative barriers to POLST and, therefore, the state must adopt legislation to open the door to effective use of POLST. The most common barriers relate to out-of-hospital DNR orders and to surrogate decision-making.¹⁵² For example, a state's statutes may not permit the combination of a DNR order with other medical orders, or may allow the use of an out-of-hospital DNR order only in limited circumstances.¹⁵³ These barriers may interfere with the implementation of POLST in that state. Statutory limitations on a surrogate's ability to make medical decisions relating to a patient's end-of-life medical care may complicate the implementation of POLST in a state. However, adopting the POLST program in a state is possible (and perhaps even

¹⁵⁰ See *supra* Part II (summarizing the history of POLST).

¹⁵¹ See OR. REV. STAT. § 127.663 (2013).

¹⁵² See generally Susan E. Hickman et al., *The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation*, 36 J.L. MED. & ETHICS 119 (2008) (finding that the requirements for out-of-hospital DNR orders are highly detailed and incompatible with requirements for POLST forms).

¹⁵³ See *id.* at 119.

essential and wise) while leaving existing statutory limitations on surrogate medical decisions in place for situations when limitations are deemed necessary to protect against patient abuse.

Where legislation is not required, the proponents of a POLST program in a particular state may nonetheless choose or prefer legislation.¹⁵⁴ Legislation can create a statewide uniform system that a state can follow consistently, as well as study and improve.¹⁵⁵ Additionally, legislation can provide legal immunity to health care professionals who make the POLST program available to their patients.¹⁵⁶

A. Is a Statute Necessary or Desirable to Implement a Successful POLST Program?

While the short answer to the question of whether a statute is necessary to implement a successful POLST program is “No,” that answer falls far short of telling the full story.¹⁵⁷ Arguments in favor and against having a statute addressing POLST exist, but these arguments apply differently in different states. Anyone working to implement a state POLST program should understand that the question demands a highly individualized examination of individual state law, practice, policy, and politics. And just as important, if a state law is deemed necessary, that state must determine after thorough study and appropriate discussion how best to strike a proper balance between patient liberty and patient protection.

The Legislative Comparison Chart, prepared and reproduced with permission by the ABA Commission on Law and Aging and the Task Force, is attached to this Article. That chart contains information on important characteristics and references that pertain to the twenty-four states that either have legislation concerning POLST, or have implemented POLST without specific authorizing legislation. Many of the statutes and POLST programs contained in the chart are discussed in this section of the Article. For insight into how other states have approached common issues, this chart may provide useful comparisons for states considering the implementation of a POLST program.

¹⁵⁴ See discussion *infra* Part VII.A.2.

¹⁵⁵ See, e.g., LA. REV. STAT. ANN. § 40:1299.64.1 (2010) (creating Louisiana Physician Orders for Scope of Treatment forms, which document “the wishes of a qualified patient in a physician order”).

¹⁵⁶ See SABATINO & KARP, *supra* note 8, at 11, 17.

¹⁵⁷ See *id.* at 17.

Oregon, where POLST was initially developed, adopted the POLST paradigm through voluntary health care professional consensus.¹⁵⁸ This consensus was later supported by targeted changes in professional board regulations applicable to physicians, physician assistants, nurse practitioners, and first responders.¹⁵⁹ The regulatory changes acknowledge the obligation of these health care professionals to comply with life-sustaining treatment orders executed by a physician, nurse practitioner, or physician assistant, and additionally provide for immunity from criminal prosecution, civil liability, or professional discipline.¹⁶⁰ This clinical consensus approach, followed by flexible regulatory support, has enabled the Oregon POLST Task Force to modify the POLST form and implementation program periodically as lessons are learned without having to renavigate the complexities and politics of the legislative process.¹⁶¹ As noted earlier, Oregon did enact a statute several years ago to create a POLST registry,¹⁶² but that law merely enhances documentation and access to POLST; it was not necessary for creation and initial implementation of the POLST program. Whether created by consensus, law, or regulation, POLST programs need the flexibility to evolve over time through processes of evidence-based research, quality improvement, and clinical experience.

1. *Arguments Opposing a Statute*

Even for those readers less cynical than Baron Otto von Bismarck,¹⁶³ the legislative process is cumbersome and the legislation itself is often very detailed, making it an inflexible approach. This view of legislation is true, in part, because drafters must take into account not only the situations to which the legislation is primarily addressed, but in addition, every possible situation created by the language of the legislation. This issue arises with all legal documents, lest the reader misconstrue the drafter's intent and harm results because of the document, such as a will or a trust. But a will or trust is actually a much simpler task because the drafter actually knows, for the most part, the situation and the people the

¹⁵⁸ See *id.* at 10.

¹⁵⁹ See *id.* at 17, 22, 32.

¹⁶⁰ See OR. ADMIN. R. 847-010-0110(1), 847-035-0030(6) (2014).

¹⁶¹ See SABATINO & KARP, *supra* note 8, at 3.

¹⁶² See OR. REV. STAT. 127.663 (2013).

¹⁶³ "Laws are like sausages, it is better not to see them being made." Otto von Bismarck, BRAINYQUOTE, <http://www.brainyquote.com/quotes/quotes/o/ottovonbis161318.html> (last visited May 12, 2014).

document is intended to address. But a statute has no such boundaries. Statutes must cover all situations that might come within their purview—resulting in very detailed and specific legislation in an effort to cover all of the situations intended and none of those situations not intended for coverage. Those efforts, however, reduce the flexibility of the statute’s application to specific situations.

Mandatory statutory forms are seldom a good idea, but language and form are often mandated with a statutory approach. If a form is set forth as required by the statute, it will be very difficult to change when needed, each time exposing itself to a legislative process that may take a number of years, and each time taking some risk that the legislature may change the statute or the form in a way that causes more harm than good. Even when an example form is clearly labeled as nonmandatory, often a private party or a state agency may interpret the form as mandatory so as to produce this inflexibility even when the statute does not express or intend that result.¹⁶⁴

A more subtle influence of a statutory form is the reaction of health care professionals and drafters to think that a statutory form is “safe” and any other form may not be safe, or, at the very least, any other form may require someone with knowledge of the subject matter to actually read and interpret it. This need for detailed review of a form would be in direct opposition to the strong trend towards institutional standardization of processes, which may overall improve system care and efficiency, but would interfere with person-centered care. In today’s world, every institution has a process, but few adequately encourage their employees to think outside the process when needed. As a result, statutory forms will often trend towards a mandatory practice that cannot be easily changed. And the forms placed in statutes, always being the work of committees and the end product of political process and compromise, are generally not that good.

Ideally, the forms and procedures used within a POLST program will be continuously reviewed with input from the field, health care professionals, patients, and families to judge the effectiveness of the form and the process that is used to produce and implement the form. This review is best done with a relatively small group of persons with expertise in the

¹⁶⁴ In Pennsylvania, for example, a sample form of an advance directive passed in 1992 was essentially required by state agencies for a number of years, despite the fact that the statutory form was not intended to be mandatory. As a result, the current statute added the following language: “A Commonwealth agency that licenses health care providers or regulates health care may not prescribe a mandatory form of an advance health care directive.” 20 PA. CONS. STAT. § 5433(a)(2) (2014).

field, responding to the clinical evidence of how effective the form is shown to be in helping patients and health care professionals.

Experience demonstrates that a small-expert working group can be highly effective in reaching decisions and providing guidance. The larger the group, the more challenging the entire task of communication, consensus, decision, and implementation. This dynamic is seen everywhere; thus, when approaching a process that must adapt to change from time to time based upon responses and evidence of ways to improve the performance of the form or the process, something more nimble than a legislative process is highly desirable. Regulatory change based upon the recommendations of a standing, broadly representative, and inclusive working group consisting of representatives of constituencies that contribute to end-of-life care is likely the ideal.

2. *Arguments Favoring a Statute*

On a day-to-day basis, physicians and other health care professionals issue countless orders and prescriptions for which no statutory immunity is available. Fulfillment of generally accepted medical practice standards is their only protection, but the history of end-of-life care has been written differently. Technological advances enabled doctors and hospitals to maintain life in a manner that merely prolonged the process of dying or maintained the patient in a permanently unconscious state. Advance health care directives were developed in response, and at that time, the concept of withholding or withdrawing such care was novel, even though constitutionally protected. As a result, advance directive laws and out-of-hospital DNR statutes uniformly protect health care professionals from criminal or civil liability or disciplinary sanctions. Consequently, many health care professionals across the country want this more explicit reassurance for following POLST. While they may not need it, they want statutory immunity. When they follow the orders in a POLST form in good faith, they want protection from criminal prosecution, civil liability, and disciplinary sanctions. Health care providers may contend that if they have this protection for following an advance health care directive, they should also have that same protection for following POLST.

The state of Washington is illustrative. Current Washington law affords immunity only to EMTs,¹⁶⁵ but legislative testimony, in early 2013, demonstrated that emergency room and long-term care providers

¹⁶⁵ See WASH. REV. CODE § 18.71.210 (2014).

are reluctant to comply with POLST orders that decline treatment.¹⁶⁶ These clinicians and facilities want to carry out patient wishes, but they are fearful of legal risk. Whether or not this fear is grounded, it is real, and it can lead providers to disregard patient wishes. Consequently, statutory or regulatory immunity can be a critical factor to assuring that patient wishes embodied in a POLST form are carried out.

For a successful POLST program, institutions and health care providers must uniformly recognize and honor the POLST form. In order for the form to be readily honored, accepted, and consistently applied, it needs to be the same form in all respects, including wording, layout, and color. Anything else will cause delay in implementation and will increase the possibility that providers will misread or misapply the form. A statute that prescribes the form of the POLST would produce that uniformity. Better still, a statute might authorize or direct the state's health department to design, approve, and promulgate a POLST form with the help and guidance of a broadly representative state-wide committee. This committee could review and revise both the form and the process from time to time based upon feedback of what works and what does not work effectively. The work and recommendations of such a state-wide committee could be subject to the approval of the department of health or another suitable agency, such that the result of that collaboration will have checks and balances as well as flexibility. Without a statute to encourage or require providers to honor the form, and a process and hosting entity to design, approve, and revise the form, and to promulgate procedures and educational materials to health care providers and the public, avoiding the circulation of multiple versions of the POLST form will be challenging. A state may need this encouragement and structure to produce the most effective and beneficial POLST program.

A statute which requires health care providers to honor the POLST form would obviously cause a state to utilize POLST much more quickly and uniformly. A statute or department of health regulation that requires medical providers to accept the POLST form and provides immunity for those accepting it would encourage use of the POLST form within a state much more quickly than anything else. In this regard, note that a requirement that a medical provider accept a POLST form is not the same as a requirement that a medical provider use or even offer POLST to a patient. Those requirements raise separate and important policy

¹⁶⁶ See H. 63-1000, Reg. Sess., at 3 (Wa. 2013), available at <http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bill%20Reports/House/1000-S.E%20HBR%20APH%2013.pdf>.

questions. More important, from a policy standpoint, neither the POLST form nor an advance health care directive should be required as a condition of care or for the issuance of insurance to a patient. But a valid advance health care directive is enforceable. The health care provider does not have the option to ignore these documents. They must follow them. Similarly, following a POLST order should also be required.

B. Model Act or Uniform Law?

The National POLST Paradigm's Legislative Guide (Legislative Guide)¹⁶⁷ replaced the Model Act¹⁶⁸ that was previously posted on the website. However, the Model Act is worth review as a helpful starting point for wording in those states considering legislation. While some language from this short Model Act could be very useful in crafting legislation, state health care decision-making law must fit together as a unified, consistent whole. Consequently, individual state law pertaining to living wills, health care powers of attorney, guardians, default health care decision makers, and out-of-hospital DNR orders should be considered to make sure they all fit together.

Recognition of a POLST order executed out-of-state should be provided, at the very least, with respect to execution formalities of the POLST form itself, some of which will undoubtedly vary from state to state. This problem is similar to that encountered with respect to advance health care directives. Out-of-state POLST orders are particularly important in major medical centers geographically close to adjacent states, such as Philadelphia, where patients are frequently drawn from New Jersey or Delaware, or Pittsburgh, where patients are frequently drawn from West Virginia or Ohio. Should this portability apply only to execution formalities? Can the provider presume a POLST form from another state is valid? If the out-of-state POLST form is signed by a surrogate, how does the provider know if the surrogate's signature on a POLST is within the surrogate's powers? This issue may require further study and perhaps may provide the basis for a future Uniform Law project.¹⁶⁹

¹⁶⁷ See LEGISLATIVE GUIDE, *supra* note 47.

¹⁶⁸ See *infra* Appendix 3.

¹⁶⁹ See discussion *infra* Part VII.D.

C. State Specific Considerations and Barriers are Critical

Those interested parties and their advisors wishing to implement a POLST program in their state must examine the framework of that state's health care decision-making law to identify issues, considerations, and barriers to the implementation of a POLST program. A 2008 article, coauthored by Susan Hickman, identifies state law barriers that exist in a number of states.¹⁷⁰ A review of these issues and potential barriers may suggest a helpful re-examination of state laws addressing living wills, out-of-hospital DNR order statutes, and health care decision-making generally. Some of these issues may require resolution by statutory change, while other barriers may limit the usefulness of the POLST form in certain situations and for certain patients, but they do not fundamentally interfere with the implementation of a POLST program. Many other decisions (of a less fundamental nature) are involved in the design of a POLST form and in the implementation of a successful POLST program. This Article will focus upon the issues and barriers the authors believe to be most fundamental to a POLST program and most frequently encountered in state law and policy.

1. *State Law Limitations on Advance Directives*

Simply stated, POLST is designed for persons with serious advanced illness, frailty, or both, whose clinicians would not be surprised if they died within the next year. This design is not intended, however, to be a bright line distinction of terminal illness or permanent unconsciousness.¹⁷¹ POLST is intended to be a flexible approach, reflecting clinical judgment and differences in patient preferences. The preferred approach is to make POLST available to anyone meeting the above clinical description. When state law limits the freedom of an individual and the individual's doctor's use of a living will or an out-of-hospital DNR, further analysis and consideration is necessary to fit POLST comfortably within state law.

State advance directive law may impose medical preconditions on the operation of advance health care directives that may cause confusion relative to POLST, but the law should not fundamentally interfere with the functioning of POLST. For example, for a living will to be triggered

¹⁷⁰ See generally Hickman et al., *supra* note 152.

¹⁷¹ At least two studies have shown that, while not perfect, this test has proved to be a practical one that clinicians can reasonably make and apply. See sources cited *supra* note 37.

in Pennsylvania, the patient must be incompetent and either permanently unconscious or suffering from an end-stage medical condition¹⁷²—a term very similar to “terminal condition,” but without any express or implied reference to a time frame for life expectancy. A physician or other health care professional, unfortunately, is rarely involved in the process of preparing and signing a living will, and thus, he or she lacks an important part of the informed decision-making process and must be more conditional and speculative. A POLST form, however, is not a living will or an advance health care directive. Instead, the POLST form is a medical order signed by the physician or other authorized health care professional. The order is then effective immediately, taking into account the patient’s current condition with the intent to reflect the patient’s contemporaneous shared decision-making.

The POLST form documents “in the moment” shared health care decision-making and reflects the informed consent necessary for medical treatment. When the POLST form is completed with the health care professional while the patient is competent and able to participate fully in the health care decision-making process, the rationale for any limitation of the patient’s rights to an end-stage medical condition does not exist. The execution of a POLST form is thus an effectuation of the patient’s constitutional, common law, and statutory rights reflecting informed consent. States, over time, should reconsider limitations on a patient’s rights to say “yes” or “no” to medical care, particularly where the limitation is intrusive and burdensome. Why for example, should a very elderly but competent patient not be able to say “No” to intubation or resuscitation even if the patient is not suffering from an end-stage medical condition? Should the patient not be able to document that preference by an express written health care instruction such as a living will?

Any limitations in state law applicable to living wills should not be applied to a POLST regime, and these limitations over time should be reconsidered within the context of advance health care directives in light of the fundamental liberty interests of the patient to avoid unwanted, intrusive, and burdensome care. However, even if those limitations on living wills are left in place, the existence of such limitations should not limit the patient’s rights to a POLST form without those conditions because the POLST form reflects contemporaneous decision-making concerning the patient’s current medical condition, treatment options, and treatment decisions.

¹⁷² See 20 PA. CONS. STAT. § 5443(a) (2014).

2. *Out-of-Hospital Do-Not-Resuscitate Order Statutes*

An out-of-hospital DNR order is much more closely related to the POLST form than a living will. A POLST form always includes an order to either attempt resuscitation or to not attempt resuscitation. The POLST form is specifically designed to be portable and effective outside of a hospital. Consequently, the form is intended to literally operate as an out-of-hospital DNR order when that is the choice made on the POLST form. Two critical differences exist between a POLST and an out-of-hospital DNR order: First, the POLST form gives the patient a choice as to resuscitation, whereas the out-of-hospital DNR order is issued only when nonresuscitation is the patient's choice confirmed by the medical order. This choice would illustrate a broader availability of the POLST form since the form does not mandate the limitation of care and allows the patient to express the desire for full treatment. Second, the POLST form covers a much broader range of choices and preferences.¹⁷³ Specific medical preconditions for the issuance of such DNR orders are present under the law in fifteen states,¹⁷⁴ creating a barrier or inconsistency with respect to the POLST form. Further, in six states, state law dictates the wording of out-of-hospital DNR orders, which is inconsistent with the POLST form.¹⁷⁵

This inconsistency is somewhat ironic in that these statutes were intended to expand patients' rights to control their medical care should they suffer an arrest outside of a hospital where they might appropriately have a DNR order. DNR orders in a hospital setting have been available as a matter of clinical practice for virtually as long as cardiopulmonary resuscitation. The use of a DNR order in the hospital setting is based upon proper clinical judgment and the informed consent of the patient or the patient's surrogate health care decision maker. DNR orders do not require (nor should they) express a medical precondition apart from the shared informed decision-making of the physician and the patient or surrogate. The out-of-hospital DNR order statutes grew out of the need for Emergency Medical Service (EMS) responders to have clear direction and protection regarding when their life-saving protocols would

¹⁷³ The expression of these additional preferences is actually what gives POLST its greatest benefit, as many patients who opt for DNR want significant medical care apart from resuscitation. Those preferences should not be ignored, and that is a danger in a form that only covers resuscitation.

¹⁷⁴ See Hickman et al., *supra* note 152, at 122.

¹⁷⁵ See *id.*

be inappropriate. An out-of-hospital DNR order, necklace, or bracelet provides clear communication and safe authority to the EMS providers.

An example of how an out-of-hospital DNR statute can be a challenge, but not an insurmountable barrier, to an effective POLST program may be helpful. Pennsylvania has an out-of-hospital DNR statute making an order, bracelet, or necklace available to a patient through their attending physician when the patient has an end-stage medical condition or is permanently unconscious with a living will directing nonresuscitation.¹⁷⁶ The alternatives of limiting the POLST form to patients with an end-stage medical condition and requiring inconsistent and inflexible language in the order, or leaving the existing out-of-hospital DNR order form as a parallel stand-alone form faced a statewide advisory committee tasked by statute to study the need and advisability of a POLST form.¹⁷⁷ The advisory committee chose the latter approach while recommending that its first preference would be for legislative change if such change would allow the combination of the POLST form and the out-of-hospital DNR order without requiring medical preconditions for the issuance of a POLST form.¹⁷⁸ In the meantime, EMS providers in Pennsylvania must rely upon the medical command physician to order nonresuscitation if that physician considers it appropriate after being informed of the existence and content of a POLST form.

There seems little doubt that patients should have the right to refuse resuscitation regardless of their medical condition as an exercise of the patients' constitutionally protected rights. The right to control medical care over our own bodies is one of our most fundamental and personal rights that should not be infringed, particularly by statutes originally intended to protect those rights.

3. Medical Preconditions or Limitations to Decisions of Health Care Surrogates

Ideally, health care decisions are the product of a shared decision-making process with the full participation of the patient, the patient's physician, and perhaps other health care professionals. This full participation requires that patients have the mental capacity to understand their condition, the benefits and burdens of the proposed course of treatment,

¹⁷⁶ See 20 PA. CONS. STAT. §§ 5483-5484.

¹⁷⁷ See *id.* § 5488.

¹⁷⁸ See Patient Life-Sustaining Wishes Committee, Pennsylvania Department of Health, Report to the Secretary 9 (Nov. 20, 2008) (unpublished) (on file with authors).

and any possible alternative treatments. Inevitably, many or even most patients will reach a point where someone else will need to make one or more health care decisions for them.

State law allows a surrogate in the form of an agent under a health care power of attorney, a guardian, or a default surrogate to make decisions for the patient when the patient is no longer able to do so.¹⁷⁹ Some states, however, limit the right of an individual to delegate termination of life sustaining treatment to a surrogate. For example, in Ohio, the agent acting under a power of attorney for health care may refuse or withdraw informed consent to life-sustaining treatment only if the principal is in a terminal condition or a permanently unconscious state.¹⁸⁰ In addition, there must be no reasonable possibility of the principal's regaining the capacity to make informed health care decisions.¹⁸¹

When there is no health care agent appointed by the patient or a guardian appointed by the court, most states provide for a "default surrogate," generally selected from a priority list similarly to the laws disposing of a person's property when he or she has no will. In some states, the default surrogates have the same authority to make health care decisions as one appointed by the individual, but in others, their authority is more limited, particularly with reference to their authority to withhold or withdraw life sustaining treatment. These limitations may limit the choices for the completion of the POLST form by a surrogate. For example, state law may preclude a default surrogate from consenting to a POLST order indicating DNR for a 95-year-old long-term-care resident even though the resident may well have desired it, because the resident, though very elderly, is not in an end-stage medical condition or permanently unconscious.¹⁸²

These limitations on the power of surrogates to make health care decisions for an incapacitated patient may interfere with the effectiveness of the surrogate's ability to effectuate the patient's intent. However, these state law limitations are not unique to the POLST program. When state law limits the surrogate's authority, such authority is limited with respect to an ordinary in-hospital DNR order or an out-of-hospital DNR order, as well as any other medical orders that would limit life-sustaining treatment. Note that a state with statutory limitations on a surrogate's

¹⁷⁹ See discussion *supra* Part III.B.

¹⁸⁰ See OHIO REV. CODE § 1337.13 (2014).

¹⁸¹ See *id.*

¹⁸² See, e.g., 20 PA. CONS. STAT. § 5461(b) (2014).

authority may adopt and utilize a POLST program. While such limitations on surrogate decision-making may be thought to be unhelpful, they are not a barrier to the implementation of a successful POLST program. This point is important if discussions among the appropriate constituencies, balancing patient freedom and patient protection, do not permit the removal of those limitations as a matter of policy and political reality. A state can still implement a POLST program while showing respect for those limitations on surrogate authority. Limitations on the ability of a surrogate to agree to a POLST order may constitute an impediment to health care decision-making in general and to a POLST program in particular, but they do not preclude the implementation of a beneficial POLST program.

In addition to statutory limitations on a surrogate's decision-making authority, the patient's advance health care directive may also limit a surrogate's authority. A living will expresses specific choices by the patient with regard to his or her end-of-life medical care. A surrogate is expected to follow and implement those directives unless the document gives the agent leeway to vary, or even overrule, the patient's instructions. Pennsylvania, for example, provides a choice in its sample form for the patient to require the agent to follow the instructions or treat them as guidance only, allowing the agent to have the final say.¹⁸³ A durable power of attorney for health care also may include limitations, put in place by the principal, on the surrogate's authority to make medical decisions. The surrogate must be aware of and act within the limitations established by the principal.

The POLST program is a particularly useful tool for individuals with serious advanced illness or frailty, when critical care decisions are highly likely and fairly imminent, and in many or perhaps even most of these cases, when the patient may not be well enough to speak for him or herself. In a La Crosse, Wisconsin health system with widespread use of POLST, a study of deceased patients found that 67% of deceased patients had a POLST form, and, on average, the patient completed the last POLST form only 4.3 months before death.¹⁸⁴ These are patients who need a crisis care plan in the form of medical orders so that no unwanted surprises occur during delivery of care. Someone available and legally

¹⁸³ See *id.* § 5471.

¹⁸⁴ See Bernard J. Hammes et al., *A Comparative, Retrospective, Observational Study of the Prevalence, Availability, and Specificity of Advance Care Plans in a County that Implemented an Advance Care Planning Microsystem*, 58 J. AM. GERIATRICS SOC'Y 1249, 1252 (2010).

empowered to participate in and consent to a care plan and orders as needed is very important, not just once, but probably a number of times.

This underscores the importance of having as much guidance and communication about care preferences as possible when appointing a health care agent or proxy. The POLST program is not a substitute for an advance health care directive. Rather, the POLST program complements the advance health care directive for appropriate patients. Every competent adult needs an advance health care directive.

4. Immunity May be Demanded by Medical Providers

Clinical practices that commonly use and honor the POLST program can provide immunity for health care professionals because the POLST program becomes a part of the generally accepted medical practice standard of care. This standard of care should protect all health care professionals, including doctors, hospitals, and EMS personnel. Due to the importance of the orders contained in a POLST form and the general framework of protection provided to the health care community within advance directive and out-of-hospital DNR order statutes, it would not be surprising that the medical community may want to see immunity officially sanctioned.

This immunity can be done, as it was in Oregon, by professional regulatory changes that acknowledge the obligation of health care professionals to comply with life-sustaining treatment orders documented by a POLST form executed by a physician, nurse practitioner, or physician assistant, and the need for corresponding immunity from criminal prosecution, civil liability, or professional discipline.¹⁸⁵ POLST was broadly instituted and accepted for a number of years in Oregon before these regulatory changes were made, so in a sense the regulations were more an affirmation of the POLST paradigm as the recognized medical standard within the state than a creation of that standard.

If health care professionals need this immunity because of its importance to the medical community, a statute rather than a regulation is probably the best way to accomplish this immunity where the development of POLST is occurring differently from its birth and unique history in Oregon. The immunity provisions contained in the Model Act provide a helpful starting point:

(b) A health care professional or institution acting in good faith and in accordance with generally accepted

¹⁸⁵ OR. ADMIN. R. 847-010-0110(1), 847-035-0030(6) (2014).

health care standards applicable to the health care professional or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for complying with a POLST form and assuming that the orders therein were valid when made and have not been revoked or terminated.

(c) An individual acting as agent, guardian, or surrogate under [reference advance directive law and guardianship law] is not subject to civil or criminal liability or to discipline for unprofessional conduct for signing a POLST form and thereby consenting to POLST in good faith.¹⁸⁶

In states that have an out-of-hospital DNR order statute, it should contain an immunity provision providing a successful combination of POLST with the existing out-of-hospital DNR order statute.

D. Policy and Procedural Questions for Consideration

Designing and implementing a POLST paradigm program involves many and varied policy, procedural, and drafting questions.

1. *Medical Professional Involvement*

a. *Who Can Sign a POLST Order?*

In most states, a physician, nurse practitioner, or physician's assistant can sign a POLST order, consistent with their general scope of practice rules. Arguments can be made in favor of requiring a physician to sign the POLST order because of the seriousness of the orders in end-of-life situations, but no reason exists for different requirements for an in-hospital DNR order and a POLST order. The more serious question is who has the conversation with the patient that culminates in the POLST orders? The argument in favor of the physician having this conversation is that the physician is the one in the best position to discuss the potential outcomes of the medical treatments as applied to a particular patient. The quality of the conversation governs the effectiveness of the entire process, strengthening the argument to engage the most capable medical professional. The argument on the other side is that a quality conversation requires significant time, and spending the time necessary (particularly in the long-term care setting) is difficult for the physician.

¹⁸⁶ See *infra* Appendix 3, § 4(b)-(c).

Under present Medicare reimbursement policies, Medicare does not compensate for such conversations with the exception of the initial Medicare physical examination. Efforts to provide medical reimbursements continue, but until they are successful, the lack of any reimbursement policy is a significant barrier to physician involvement in advance health care planning for both advance directives and POLST.

b. Can POLST Counseling and Preparation be Delegated in Part to a Nonphysician?

Counseling and preparation of the POLST form can be delegated to a well-trained health care professional such as a nurse, a physician's assistant, or even a social worker. But adequate training, both as to knowledge and to the practiced skills of having that conversation, is critical. Having a training curriculum that provides the person having that conversation with the requisite knowledge of the law, the medical issues and treatments covered by the POLST, and treatment issues that apply to the patients with whom they are going to be having the conversation is critical to a POLST program. Training modules are available from a variety of sources nationally, the best known of which is the Respecting Choices program by the Gunderson Health System in La Crosse, Wisconsin, where online and on-site training can be obtained with a high level of experience and sophistication.¹⁸⁷ If enough professionals with adequate background and training are already available in a state, a state-specific training program can be developed to integrate state law and local practices by using well-respected leaders whose knowledge and influence can favorably impact the program.¹⁸⁸ The importance of a quality conversation regarding end-of-life care choices cannot be overstated. The executive director of the ABA Commission on Law and Aging describes it as "the beating heart and Achilles' heel"¹⁸⁹ of POLST and indeed of all advance health care planning and health care decision-making.

¹⁸⁷ See *Respecting Choices*, *supra* note 17.

¹⁸⁸ For example, Pennsylvania is currently developing its own training program using a train-the-trainer model with the help of a Supporting Innovation in POLST Paradigm Expansion and Dissemination Grant.

¹⁸⁹ Telephone Conference, Legislative Work Group of National POLST Paradigm Task Force (statement of Charles P. Sabatino, Exec. Dir., ABA Comm'n on Law and Aging).

2. *How is Informed Consent Documented?*

a. *Signature of Patient or Surrogate Required*

All medical orders require that they be issued by a licensed health care professional within their scope of practice. But the patient does not sign most medical orders apart from an initial consent to treatment and more specific surgical consents. The patient or the patient's surrogate is always recommended and usually required to sign the POLST order. The reason for this requirement is very simple—to document that a conversation occurred and that the patient consented to the order. While not all states with POLST programs require the patient's signature to document the consent of the patient, the Task Force strongly recommends a patient's signature (or electronic equivalent) making it part of the minimum requirements for a POLST order except under circumstances in which consent is obtained, but the signature cannot be obtained.¹⁹⁰

b. *Should There be Exceptions to the Requirement of a Signature?*

When discussing the POLST order with the patient and obtaining contemporaneous consent is not possible, but the POLST order is completed following clear instructions set out in a living will that has been made operational, there should be no problem with providing an exception to the general requirement of a patient or patient surrogate signature.

When the conversation occurs with a mentally competent patient who is not physically able to sign, or when the conversation is held with a surrogate by telephone, the signature requirement should bend to the purpose for the signature. When the inability to sign the POLST is due to physical but not mental disability, a third party could sign the POLST at the patient's request and direction. This alternative would be similar to processes used for advance directives, in which generally someone not affiliated with the health care provider signs the person's name.¹⁹¹

c. *Should Other Safeguards Such as Witnessing and Notarization be Required or Recommended in a Medical Setting?*

The formalities of witnessing and notarization that are used in a legal setting are safeguards intended to protect the client from being taken

¹⁹⁰ See discussion *infra* Part VII.D.2.b.

¹⁹¹ See, e.g., 20 PA. CONS. STAT. § 5452(b) (2014).

advantage of or improperly influenced when signing legal documents. They are appropriate in these settings to convey a sense of importance and solemnity to the legal document to be signed and to be sure that the signature really is the signature of the client. The safeguards in the medical setting are no less protective but are not intended to be legalistic. The ideal setting for the execution of a POLST document is in the presence of the attending physician, the patient, and the patient's health care agent or other surrogate if they have one. This setting is the ideal and with the physician, the surrogate and the patient, no further safeguards are either necessary or appropriate. The witness requirement typically guards against forgery. Forgery of a POLST patient or surrogate's signature is highly unlikely, particularly in the presence of a physician or other health care professional; whereas forgery does happen to other legal documents, particularly those governing the management or distribution of a person's property at death, such as a financial power of attorney, a will, or trust. The sensitivity of the subject matter would also press against a witness requirement, as the need for private, candid, and highly personal communication is particularly great in this context.

d. Authority of Surrogates—How Much Power, How Much Leeway?

The authority of a health care agent or other surrogate to make health care decisions should generally follow state law. The question of how much power and how much discretion a patient wishes to give to a health care agent is an important one that should be addressed in the advance directive, but no reason exists for having a different requisite authority to sign a POLST document than for a surrogate to make health care decisions generally, reflecting life-sustaining treatment decisions. The POLST form is merely the final documentation of the health care decision. The health care discussion and decision-making process is the most important element of POLST.

3. What Medical Treatments and Decisions Should be Included in a POLST Form?

A POLST form should always contain the treatments covered in the first two sections of the Oregon POLST form.¹⁹² The first section is necessary to serve as the order with respect to resuscitation when the patient has no pulse or is not breathing. Clearly, these emergency orders

¹⁹² See *infra* Appendix 1.

must be included to indicate the code status of the patient. In this respect the POLST order is no different from a standard DNR order, except, it allows for an affirmative resuscitation order, indicating a patient's wish to be considered a full code. This reflection of an affirmative choice is very important and a far better indication of patient intent than a default to a full code because a DNR order has not been signed.

The second section of the Oregon POLST form deals with perhaps the most important decisions reflected in the order, both as to the frequency with which the orders are needed and individual patient preferences. It gives the patient the choice of full treatment, including cardioversion, intubation and ventilation, or any other medical means necessary to preserve life. A second choice is for limited interventions, which includes all care needed for comfort. Limited interventions include IV fluids and cardiac monitor, but do not include the most aggressive treatments such as intubation, advanced airway interventions, or mechanical ventilation. This choice authorizes transfer to a hospital, but avoids intensive care if possible. The third choice is to only provide comfort care. Medication, positioning, and other measures would be provided to relieve pain and suffering, but transfer to a hospital is not indicated unless the best comfort care cannot be provided adequately in the current medical setting.

Studies from the Oregon POLST Registry confirm that while most patients completing a POLST elect DNR for Section A, slightly more than one half of those who elect DNR on Section A do not elect "Comfort Care Only" on Section B.¹⁹³ This study validates the conclusion that if the patient wishes are properly reflected, DNR should never be taken to mean "Do-Not-Treat." This study also confirms the conclusion that a POLST form includes important treatment orders in Section B that are typically not included in a standard DNR order and should help eliminate a "spillover" inference from a DNR order that a patient who wishes a DNR order may want to have comfort care only. In many cases, the patient may in fact want considerably more, including a desire to be sent to the hospital for significant medical treatment. That question is particularly important in the long-term care setting, where a patient after a number of hospitalizations may, in some cases, simply want to be treated in their current setting and in others wish acute care where otherwise indicated.

¹⁹³ See sources cited *supra* note 116.

Medically supplied nutrition and hydration preferences should always be included in a POLST form. These treatments have always engendered more differences of opinion than other advanced life support because nutrition and hydration can be viewed as a more basic provision of care and, therefore, morally obligatory. The Supreme Court in the *Cruzan* decision held that medically supplied nutrition and hydration was medical care, and as such, a patient or a patient surrogate could refuse it under the proper conditions.¹⁹⁴ However, the extraordinary, protracted, and divisive litigation involving Terri Schiavo highlights the controversy surrounding the appropriate use of medically supplied nutrition and hydration. If Schiavo had executed an advance directive or a POLST form that addressed this issue, most of the issues revolving her care would have been resolved.¹⁹⁵ There remain clear differences in perspective with respect to medically supplied nutrition and hydration between conservatives in the Jewish and Catholic communities, which are focused upon the sanctity of life and the importance of patient protection, while others are more focused upon patient freedom as a core value. The current Oregon POLST form separately provides for medically supplied “nutrition” but does not include hydration in this separate section. IV fluids are indicated in the “Limited Interventions” choice in Section B of the form. It provides for three basic alternatives for medically supplied nutrition: the choice of refusing medically supplied nutrition, a trial period of medically supplied nutrition, or long-term medically supplied nutrition. As is the case in other parts of the POLST form, additional orders may provide some customization of the orders to take into account finer choices that may be made by the patient and physician.

In making the more detailed design choices on the POLST form, the drafters may wish to consider the order of the alternatives to counter arguments that the POLST form introduces a bias by including comfort care and no medically supplied nutrition by tube as the first choices listed on the form. The careful reader may note that the Oregon POLST form uses the term “artificial nutrition,” while in this Article the term usually employed is “medically supplied” nutrition or hydration. The word “artificial” has a negative and off-putting connotation, as opposed to

¹⁹⁴ See *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 279 (1990).

¹⁹⁵ Not all the issues would have been resolved because much of the argument centered around whether her husband or parents should make decisions about her care. Protracted litigation addressed the exact nature of her medical condition; whether she was in a permanent vegetative state or a minimally conscious state. But if her wishes had been clear, the proper result would have followed.

“medically supplied nutrition,” which does not carry that negative overlay. While such nutrition may or may not be a good idea in a specific circumstance, the authors’ find it best to use neutral terms in all documents intended to objectively reflect patient intent. One may also notice that the Oregon form uses the phrase “Allow Natural Death” next to the choice for “Do-Not-Resuscitate.” Both terms are accurate, but they are likely to evoke very different emotional reactions.

The POLST form covered the use of antibiotics until several years ago, but the form is no longer included in the recommended form. The reason that antibiotics were removed from the form is that antibiotics can be used for such a wide variety of uses that may address palliative, curative, or life preserving needs. The great variety and usefulness of antibiotics in such a wide range of circumstances make a checklist response less useful. Antibiotics to address a painful wound infection or a urinary tract infection is likely to be highly desirable in virtually every instance, whereas the patient may not desire intravenous antibiotics, which must be administered in a hospital setting to address pneumonia or another systemic infection. Studies of the compliance with POLST orders reveal that the former antibiotics section of the POLST reflected the lowest correlation with clinical treatment.¹⁹⁶ The inference to be drawn from this is that the use of antibiotics is too varied to be helpfully covered in a simple form. Consequently, that section has been removed from the Oregon POLST form.

4. *Should a POLST Ever be Required?*

a. *For a Patient to Sign or Have a POLST?*

The completion of a POLST form, like the completion of an advance health care directive, should always be voluntary. Advance planning and POLST are all about personal freedom, and that freedom, like so many others, must include the freedom not to exercise it. The voluntary nature of all advance planning tools is a core value that must be strongly guarded. In most, if not all states, neither medical care nor health insurance may be conditioned upon the completion of an advance directive.¹⁹⁷ While it would be very helpful if everyone completed a health care power of attorney and health care treatment instructions, the importance of the freedom to choose overrides the utility of requiring these helpful documents.

¹⁹⁶ See *Consistency Between Treatments and POLST Orders*, *supra* note 3, at 2097.

¹⁹⁷ See *supra* note 120 and accompanying text.

The same value may be even more critical for the POLST form because the POLST form is an immediately effective medical order that is not conditional upon the later occurrence of an end-stage medical condition or permanent unconsciousness, as is the typical living will. In a long-term care setting, institutions have a great advantage if they can use one form for medical orders to reflect code status and other critical medical orders. But the whole decision-making process is designed to be voluntary, and that must include the process itself. What then should an institution using POLST do when the patient refuses to sign the POLST form to indicate consent even though an agreement exists as to the orders reflected on the POLST? If the POLST form requires the signature of the patient with the few exceptions noted above, the use of the POLST form without a patient signature undermines the consensual process and the safeguard of the signature itself. Consequently, institutional procedures may encourage the use of the POLST form for all patients for whom the form is appropriate, but if the patient does not wish to engage in the POLST discussion or refuses to sign, the physician should not use the POLST form to document the physician's orders.

b. For an Institution to Use or Offer a POLST?

Requiring healthcare facilities to offer POLST to the patients for whom the form is appropriate encourages widespread clinical implementation of POLST. Several states require that hospitals or long-term care facilities offer POLST to certain groups of patients. This requirement parallels the long-standing duty under the Patient Self Determination Act to "provide written information . . . concerning . . . an individual's right to formulate advance directives."¹⁹⁸ For example, Utah requires that hospitals, hospices, nursing, assisted living, and other facilities determine, on admission, whether each individual has a POLST form.¹⁹⁹ These facilities must then determine which of those individuals without a POLST form should be offered the opportunity to complete one. POLST is not for everyone and is typically limited to patients with advanced illness or frailty.

By contrast, Maryland requires health care facilities to both offer and actually complete a POLST form for all admitted nursing home

¹⁹⁸ See Patient-Self Determination Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388-1115 (codified as amended at 42 U.S.C. § 1395cc(f)(1)(A)(i) (2006)).

¹⁹⁹ See UTAH ADMIN. CODE r. 432-31-4 (2014).

patients.²⁰⁰ That is, even a healthy patient admitted to a nursing facility for short term rehabilitation after a knee replacement would be required to complete a POLST form. This requirement is over inclusive on two levels. First, this categorical approach results in POLST being offered to patients and residents for whom the form is not intended. Second, Maryland mandates not only the offering but also the use of POLST. This mandate can cause concern as to the overuse of the POLST form and undermine the core value of voluntary health care decision-making.

c. Should an Institution be Required to Honor a POLST?

A requirement that all licensed health care facilities and providers honor a POLST form virtually requires the addition of immunity for honoring a POLST form. It may also be necessary to provide protection for health care institutions, providers, and employees who cannot in good conscience follow a particular POLST order. Pennsylvania's statute with respect to living wills and health care agents is typical of a parallel conscience exception.

(a) Notification by attending physician or health care provider—If an attending physician or other health care provider cannot in good conscience comply with a living will or health care decision of a health care agent or health care representative or if the policies of a health care provider preclude compliance with a living will or health care decision of a health care agent or health care representative, the attending physician or health care provider shall so inform the principal if the principal is competent or the principal's health care agent or health care representative if the principal is incompetent.

(b) Transfer—The attending physician or health care provider under subsection (a) shall make every reasonable effort to assist in the transfer of the principal to another physician or health care provider who will comply with the living will or health care decision of the health care agent or health care representative.

(c) Employee or staff member of health care provider.

²⁰⁰ See MD. CODE REGS. 10.01.21.04 (2013).

(1) An employee or a staff member of a health care provider may not be required to participate in the withholding or withdrawal of life-sustaining treatment.

(2) A health care provider that is an employer may not discharge or in any other manner discriminate against its employee or staff member as a result of informing the employer of the employee's choice not to participate in the withholding or withdrawal of life-sustaining treatment.

(3) A health care provider that is an employer may require its employee or staff member to express in writing the wishes or unwillingness of the employee or staff member as set forth in this subsection.

(d) Liability—If transfer under subsection (b) is impossible, the provision of life-sustaining treatment to a principal may not subject an attending physician or a health care provider to criminal or civil liability or administrative sanction for failure to carry out either the provisions of a living will or a health care decision of a health care agent or health care representative.²⁰¹

5. *When Should a POLST Form be Reviewed and a New POLST Form Completed?*

The Task Force recommends that a POLST form order be reviewed periodically and specifically when:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status; or
- (3) The patient's . . . treatment preferences change.²⁰²

A POLST form that is more than 1-year old should always prompt review, since one or more of these changes would almost certainly have occurred within that time period. If a patient presents a POLST form, regardless of whether the prescribing health professional is credentialed by

²⁰¹ 20 PA. CONS. STAT. § 5424 (2014).

²⁰² LEGISLATIVE GUIDE, *supra* note 47.

the hospital, the appropriate practice is for the admitting physician to discuss the POLST orders with the patient, acknowledging that a physician or other health professional has previously spoken to the patient about his or her wishes. The admitting physician then reissues the orders, or changes them if the patient indicates such a change is now desired.

The practical challenge occurs when the patient is not capable of having this conversation with the admitting physician or circumstances do not allow the desired conversation. In this circumstance, if the patient has a legally authorized surrogate available and time permits, the physician should discuss the patient's condition and wishes with the surrogate, and a POLST form can likewise be reissued or changed.

If the medical situation is an emergency which precludes the attending physician from discussing the POLST orders with the patient or the patient's surrogate, the orders expressed on the POLST form are valid and should be followed. If, thereafter, the patient stabilizes, a physician who has facility privileges should review and adjust the POLST form accordingly because this stabilization represents a substantial change in the person's health. In all cases, the attending physician should ensure that the orders on the POLST form, as revised if necessary, become active hospital chart orders and that a new POLST form is completed prior to discharge.

The passage of time by itself may also strongly suggest a review of a POLST order to determine if it should be revised. A state policy suggesting or requiring periodic review may be helpful to address concerns that a POLST order may no longer appropriately express the patient's current wishes. In Pennsylvania, for example, the POLST orders are suggested for a review at least once a year even if none of the other triggering events have occurred.²⁰³ It is highly advisable that a POLST form be reviewed at least once a year in all cases, that the review be documented in some manner, and the POLST form be modified and reissued if necessary. In a long-term care facility setting, review of the POLST form at care conferences, which occur every three months, would help insure that the documentation of medical decision-making is up to date. The POLST form itself could provide space to document the review.

²⁰³ See discussion *supra* Part III.C.3.

6. *How Should a Patient with a POLST Form from Another State be Treated? Are they Portable?*

The POLST program results in written medical orders to be followed by the medical community in the same manner as all medical orders are followed and implemented. When a patient moves from a hospital to a nursing home, or across state lines—from one jurisdiction to another, typically a physician will review the patient's history and existing orders and update those orders. When a patient with a POLST form moves into a jurisdiction that does not utilize POLST forms, the state will not likely require the new physician to recognize the POLST orders and the physician may not be immune from liability for doing so. Legislation specifically addressing recognition of other states' POLST forms and granting immunity from liability for doing so would be very helpful.

Most or all states already honor, to some degree, each other's documents relating to health care decision-making, such as living will declarations and health care proxies or powers of attorney. Pennsylvania's statute provides as follows:

(b) Living will executed in another state or jurisdiction—A living will executed in another state or jurisdiction and in conformity with the laws of that state or jurisdiction shall be considered valid in this Commonwealth, *except to the extent that the living will executed in another state or jurisdiction would allow a principal to direct procedures inconsistent with the laws of this Commonwealth.*²⁰⁴

While this sounds as though it grants reciprocity, it provides a substantive limitation in the italicized language. Thus, for a living will from another state or jurisdiction to be valid in Pennsylvania, it could not direct the withdrawal of care necessary to preserve life unless the patient were in an end-stage medical condition or permanently unconscious. It also qualifies the recognition to a living will executed in another state or jurisdiction “in conformity with the laws of that [other] state or jurisdiction.”²⁰⁵

²⁰⁴ 20 PA. CONS. STAT. § 5446(b) (emphasis added).

²⁰⁵ *Id.* How a physician in Pennsylvania can be expected to know whether a patient presenting an Arkansas living will has a document which is in conformity with the laws of Arkansas is unclear.

Reciprocity is similarly developing with regard to medical orders included within POLST forms. The states have taken four main approaches to POLST portability. First, some states will honor the originating state's POLST form so long as it complies with the law of the receiving state—Iowa²⁰⁶ and New Jersey.²⁰⁷ Second, some states will honor the originating state's POLST form so long as it just reasonably or substantially complies with the law of the receiving state—Colorado,²⁰⁸ Idaho,²⁰⁹ and Utah.²¹⁰ Third, some states honor the originating state's POLST form so long as it complies with the law of the originating state—Rhode Island.²¹¹ Fourth, some states will honor the originating state's POLST form so long as it complies with either the law of the receiving state or the law of the originating state—Maryland²¹² and West Virginia.²¹³

In light of this variation, portability is an area where a uniform law adopted by most or all states utilizing the POLST program could be helpful. It would be particularly helpful in suggesting a uniform approach from those noted above after studying the alternatives and applicable policy considerations. In all events, states should honor, to the extent possible, any authentic expression of a patient's intent regardless of the form of that expression.

7. *Consider Special Situations—Minors and Persons with Developmental Disabilities*

In most states, whether by statute or the application of case law, the POLST form can be applied to minors with life-limiting illnesses.²¹⁴ With minors, as with those with severe developmental disabilities, decisions will typically be made by a guardian or a default surrogate under state law. However, a minor or a person with a developmental disability may have health care decision-making capacity, and even if

²⁰⁶ See IOWA CODE § 144D.3-(1) (2014).

²⁰⁷ See N.J. STAT. § 26:2H-134(c) (2014).

²⁰⁸ See COLO. REV. STAT. § 15-18.7-104(1) (2013).

²⁰⁹ See IDAHO CODE ANN. § 4514(7) (2011 & 2013).

²¹⁰ See UTAH ADMIN. CODE r. 432-31-10 (2014).

²¹¹ See R.I. GEN. LAWS § 23-4.11-12 (Supp. 2012).

²¹² See MD. CODE ANN., HEALTH GEN. § 5-617 (LexisNexis 2009 & Supp. 2012).

²¹³ See W. VA. CODE ANN. § 16-30C-15 (LexisNexis 2011). Actual reference in the statute is to DNR, while POLST is not mentioned. Presumably, POLST would be honored also.

²¹⁴ See *infra* Appendix 2 for specifics in states with a POLST program.

they do not have legal capacity to make a health care decision, their preferences and values should be taken into account to the extent possible. There may be more significant limitations on the use of the POLST form if the patient has never been able to indicate his or her desires for end-of-life care or been able to appoint an agent who might have the highest level of legal authority under state law.²¹⁵ Some states, such as New York, have special procedures and checklists for minors²¹⁶ and highly detailed requirements and procedures for those with developmental disabilities.²¹⁷

8. *Creating, Administering, and Improving a POLST Paradigm Program*

The easiest place to begin the examination of the steps necessary to start a successful POLST program in a state is the National POLST website. There, in relatively simple terms, the process is outlined in the following steps:

(1) Do a needs assessment. Is the system by which patients' wishes are identified, documented, and respected working well? Do patients who are seriously ill get the care they want, and not the care they do not want? If they want to receive comfort care at home or in a long-term care facility, are they able to obtain it in those settings, or are they being transported to the hospital? This assessment should be done with EMS, ED physicians and nurses, and social workers in long-term care facilities

²¹⁵ For example, in Pennsylvania, even the parents who were the court appointed guardians of their never competent, severely disabled adult child had no power to decline care necessary to preserve life because he was not in an end-stage medical condition nor permanently unconscious. See *In re D.L.H.*, 2 A.3d 505, 506 (Pa. 2010). For an illustrative approach to these special issues under Oregon law, see OR. POLST TASK FORCE, PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST): USE FOR PERSONS WITH SIGNIFICANT PHYSICAL DISABILITIES, DEVELOPMENTAL DISABILITIES AND/OR SIGNIFICANT MENTAL HEALTH CONDITION WHO ARE NOW NEAR THE END OF LIFE (2013), available at http://www.polst.org/wp-content/uploads/2013/03/POLSTPersonswithDisabilitiesLongDocument.Final_.pdf.

²¹⁶ See MOLST: MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT: LEGAL REQUIREMENTS CHECKLISTS FOR MINOR PATIENTS AND GLOSSARY, N.Y. DEP'T OF HEALTH (2012), available at http://www.health.ny.gov/professionals/patients/patient_rights/molst/docs/checklist_minor_patients.pdf. The checklist outlines capacity determination, clinical standards, notifications, and other legal requirements exist.

²¹⁷ See N.Y. Surr. Ct. Proc. Act § 1750-b (McKinney 2013).

and hospitals. Generally speaking, an honest assessment will find a significant need for improvement.²¹⁸

(2) Assemble a core working group. This should be a group of physicians and other health care professionals who have become knowledgeable about POLST with a strong desire to improve the process of establishing and implementing patient wishes.²¹⁹

(3) Assemble a task force with broad representation. Just as communication and dialogue is the critical underpinning of all advance care planning and health care decision-making, also critical is that a POLST program begin with broad and inclusive representation to share views, goals, and concerns so that all points of view can be heard and respected in the ongoing process. This begins with the formation of a task force that includes representatives from a wide and inclusive group of constituencies. These should include EMS, emergency department physicians and nurses, the state department of health, department of aging, state hospital association, state bar association, state hospice association, and religious organizations with health care expertise, such as the state Catholic health association, and the state department of public welfare. In addition, the task force should include advocacy groups for the disabled community and minorities. Representation with broad expertise in the provision of health care is absolutely necessary to a well-designed program. Equally important are strong representatives whose primary concern is patient safety and protection of the most vulnerable as well as those whose primary concern is the protection of patient freedom.²²⁰

(4) Consider a pilot project. A pilot project within an area showing particular interest in POLST will help identify issues and barriers and confirm that POLST will benefit the public within the state. The issues, barriers, and medical culture vary from state to state, so a pilot project can be helpful in confirming the benefit of POLST and identifying issues to address.²²¹

(5) Address the legal issues for the particular state. At this stage, decisions need to be made as to the general approach to a state-wide

²¹⁸ See IMPLEMENTATION STEPS AND MATERIALS: APPROACH TO IMPLEMENTATION OF A POLST PARADIGM PROGRAM, NAT'L POLST (2013), available at www.polst.org/wp-content/uploads/2013/11/Implementation-Steps-and-Materials.pdf.

²¹⁹ See *id.*

²²⁰ See *id.*

²²¹ See *id.*

POLST program. Should it be done by clinical consensus, regulation, or legislation? These issues were discussed in detail in this Article.²²²

As these initial steps are completed, participants will need to address at least the following issues:

(1) Where should the POLST program be maintained? The POLST program has been maintained and housed in a variety of settings: in a university setting, as in the Oregon Health & Science University, in a state department of health or aging, in a state medical society, and in a state bar association. The best place to maintain the POLST program will vary from state to state. However, making sure that the site is viewed by all concerned as a broad representation of the people of the state, rather than a particular constituency that views the POLST program as important, is critical. While a medical society, a hospital association, or a bar association may be satisfactory sites for the POLST program, a state agency such as the health department or the department of aging may be preferable because of their public representative role. A university setting is also favorable if the university is one broadly identified with the entire state, rather than a geographic or political portion of the state. Trust and credibility are extremely important, particularly in this highly sensitive and important area of health care decision-making at the end of life.

(2) How do we best evaluate the POLST program? Studies based upon family surveys as well as surveys of medical professionals are the primary tools to determine whether the POLST program is achieving its goals. Obviously, the patient cannot provide the responses directly in this instance, but surveys done in a sensitive manner after a patient's death will give us very valuable information about whether the family believes that the patient's wishes were elicited, respected, and carried out properly. Health care professionals directly involved in the process such as EMS personnel, emergency room physicians and nurses, medical directors of long-term care facilities, and social workers at hospitals and long-term care facilities should be fruitful sources for survey responses. The primary focus should be on the patient and the patient's family as the ones most directly affected, but the breadth and depth of experience of the health care professionals will provide a richer set of responses for analysis.

A continuing oversight task force or committee is critical to gather and analyze data, monitor procedures, and respond to suggested changes to improve the form, process, and education. This oversight committee or task force must be broadly representative as described above and must

²²² See *id.*; see also discussion *supra* Part VII.

have the authority to respond so that the program can be based upon experience and evidence, and so that there can be continuous quality improvement. Such authority would most likely have to come either from a legislative or regulatory grant of power. The oversight committee should recommend changes to the form or required process in a state, but a state agency, such as the department of health or department of aging, should approve and implement the recommendations. This procedure may not be necessary in a state such as Oregon, where the program began as a clinical consensus and is housed at an appropriate state university setting, but may be the best alternative in states which opt for some form of legislation. Revisions in the form and process should not require statutory change, which will inevitably impede progress and flexibility to address changing technologies and evidence-based recommendations.

(3) Integration with electronic medical records. The POLST form and advance directives must be integrated with electronic medical records as the conversion process continues to build and advance. Just as the Patient Self-Determination Act of 1990²²³ required that a patient's advance directive be made a part of the medical record, so it must be made a part of the patient's *electronic* medical record. The ability to retrieve these advance directives despite this federal statute has been very poor, particularly where the advance directive was placed in the medical records in past admissions. Changing this trend is critical so that advance health care directives and the POLST form are brought forward in the electronic medical records of the patient, making them readily accessible. The Task Force has issued a formal statement making this recommendation.²²⁴ A centralized state registry for both advance health care directives and the POLST form would be best. Seven states have implemented such a registry²²⁵ and it provides numerous and significant benefits, but it also involves significant expense, and funding is always an issue. Of course, the proper use of our health care treatment resources

²²³ See Pub. L. No. 101-508, § 4206, 104 Stat. 1388 (codified as amended at 42 U.S.C. § 1395cc(f) (2006)).

²²⁴ See NAT'L POLST PARADIGM TASK FORCE, RECOMMENDATIONS FOR ELECTRONIC HEALTH RECORDS AND PHYSICIANS ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) PARADIGM FORMS (2012), available at <http://www.polst.org/wp-content/uploads/2013/11/2012-Recommendations-for-EMR.pdf>.

²²⁵ See Diana M. Zive & Terri A. Schmidt, PATHWAYS TO POLST REGISTRY DEVELOPMENT: LESSONS LEARNED, NAT'L POLST PARADIGM TASK FORCE (2012), available at <http://www.polst.org/wp-content/uploads/2012/12/POLST-Registry.pdf>.

that consume currently almost 17.6% of our national gross domestic product²²⁶ ultimately dwarfs the expenditure that seeks to make sure that we all get the care we want and do not get the care we do not want when it matters (and costs) most.

4). **How about an “App” for that?** A centralized statewide electronic registry for the POLST and advance directives would be very valuable where the resources, support and funding for such a project can be found. In the meantime, an ABA project by their Commission on Law and Aging may allow individuals and families to take matters into their own hands by making their health care wishes electronically available using their My Health Wishes smartphone application.²²⁷ The basic version is free, while the “Pro” version for \$3.99 allows you to store information for any number of individuals, and can include all relevant contact information for health care proxies, as well as digital copies of advance health care directives or POLST documents.²²⁸ In addition, names and contact information for all physicians and specialists, prescriptions and medical conditions can be kept in an easily accessible form with click-to-call or click-to-email these documents that never seem to be readily available when we need them.²²⁹ A family project to update this emergency information so that every family member has access to every other family member’s important medical documents could be extremely valuable and might encourage the type of early intergenerational conversations that should occur in the context of healthy advance care planning.

(5) How can the necessary education be accomplished? Education of the professional medical community and of the public concerning POLST and advance care planning generally is a great and continuing task. In the context of POLST, one of the greatest challenges is to ensure that those who are given the responsibility of interpreting and implementing advance health care directives and the POLST form understand the law as it applies to these two important tools and understand the distinctions between them. Who has the power to make a medical decision for a patient

²²⁶ See Jason Kane, *Health Costs: How the U.S. Compares With Other Countries*, PBS NEWS HOUR (Oct. 22, 2012, 10:30 AM), <http://www.pbs.org/newshour/rundown/2012/10/health-costs-how-the-us-compares-with-other-countries.html>.

²²⁷ Paula Span, *The Documents You Need, When You Need Them*, THE NEW OLD AGE BLOG: N.Y. TIMES (Apr. 24, 2014, 1:02 PM), <http://nyti.ms/1f7G750>.

²²⁸ See *id.*; see also *My Health Care Wishes App*, A.B.A., http://www.americanbar.org/groups/law_aging/MyHealthCareWishesApp.html (last visited Aug. 1, 2014).

²²⁹ See *id.*

when the patient cannot make the decision? What if any limitations are there to the powers of a surrogate decision maker?

The medical professional must know how the POLST form, advance health care directives, and medical decision-making work under their own state's laws to properly guide the process for the patient and the patient's family. The public must fundamentally understand that an advance directive appointing a health care agent is an exercise of one of their most important and personal freedoms. Every adult should exercise that freedom. And we must as a society become more mature and more candid in our talk with each other, with our families, and with our health care providers about death and dying. The goal remains to live as well as we can, as long as we can. When the time comes, with the best available medical judgment and guided by our personal religious and moral beliefs, we hope to make decisions that allow us to die in the setting that best reflects our beliefs and our humanity.

APPENDIX 1

OREGON POLST FORM CURRENTLY IN USE

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT			
Physician Orders for Life-Sustaining Treatment (POLST)			
<p>Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. For more information on Oregon POLST visit: www.orpolst.org</p>		Patient Last Name:	Patient First Name
		Middle Init.	
Date of Birth: (mm/dd/yyyy)		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Address: (street / city / state / zip)			
A Check One	CARDIOPULMONARY RESUSCITATION (CPR): <i>Patient has no pulse and is not breathing.</i> <input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR When not in cardiopulmonary arrest, follow orders in B and C.		
B Check One	MEDICAL INTERVENTIONS: <i>If patient has pulse and/or is breathing.</i> <input type="checkbox"/> Comfort Measures Only (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.</i> Treatment Plan: Maximize comfort through symptom management. <input type="checkbox"/> Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). <i>Transfer to hospital if indicated. Generally avoid the intensive care unit.</i> Treatment Plan: Provide basic medical treatments. <input type="checkbox"/> Full Treatment In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. <i>Transfer to hospital and/or intensive care unit if indicated.</i> Treatment Plan: Full treatment including life support measures in the intensive care unit. Additional Orders: _____		
C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible.</i> <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. <input type="checkbox"/> Long-term artificial nutrition by tube. Additional Orders: _____		
D	DOCUMENTATION OF DISCUSSION: <input type="checkbox"/> Patient (Patient has capacity) <input type="checkbox"/> Health Care Representative or legally recognized surrogate <input type="checkbox"/> Parent of minor <input type="checkbox"/> Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.) <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other: _____		
Signature of Patient or Surrogate Signature: <u>recommended</u> Name (print): _____ Relationship (write "self" if patient): _____			
This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box <input type="checkbox"/>			
E	SIGNATURE OF PHYSICIAN / NP / PA My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.		
Print Signing Physician / NP / PA Name: <u>required</u>		Signer Phone Number:	Signer License Number: (optional)
Physician / NP / PA Signature: <u>required</u>		Date: <u>required</u>	Office Use Only
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. SUBMIT COPY TO REGISTRY <small>© CENTER FOR ETHICS IN HEALTH CARE, Oregon Health & Science University, 3181 Sam Jackson Park Rd, UHN-88, Portland, OR 97239-3098 (503) 494-3965</small>			

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT			
Information for patient named on this form PATIENT'S NAME: _____			
<p>The POLST form is always voluntary and is usually for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Oregon Advance Directive is recommended for all capable adults, regardless of their health status. An Advance Directive allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself.</p>			
Contact Information			
Surrogate (optional):	Relationship:	Phone Number:	Address:
Health Care Professional Information			
Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:
PA's Supervising Physician:		Phone Number:	
Primary Care Professional:			
Directions for Health Care Professionals			
Completing POLST			
<ul style="list-style-type: none"> • Completing a POLST is always voluntary and cannot be mandated for a patient. • Should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of an Advance Directive. • Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. • Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid. • A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to <i>Guidance for Health Care Professionals</i> at http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf. 			
Sending to Oregon POLST Registry (Required unless "Opt Out" box is checked)			
<p>For the Oregon POLST Registry the following must be completed:</p> <ul style="list-style-type: none"> • Patient's full name • Date of birth • Section A • MD / DO / NP / PA signature • Date signed 		<p>Send a copy of both sides of this POLST form to the Oregon POLST Registry.</p> <p><u>FAX or eFAX:</u> 503-418-2161</p> <p>or</p> <p><u>Mail:</u> Oregon POLST Registry CDW-EM 3181 SW Sam Jackson Park Rd. Portland, OR 97239</p> <p><u>Registry Phone:</u> 503-418-4083</p> <p>*Please allow up to 10 days from receipt for processing into the Registry. Mailed confirmation packets may take four weeks for delivery.</p>	
		<p>Date Submitted _____ / _____ / _____</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <p>MAY PUT REGISTRY ID STICKER HERE:</p> </div>	
Reviewing POLST			
<p>This POLST should be reviewed periodically and if:</p> <ul style="list-style-type: none"> • The patient is transferred from one care setting or care level to another, or • There is a substantial change in the patient's health status, or • The patient's treatment preferences change, or • The patient's primary care professional changes. 			
Voiding POLST			
<ul style="list-style-type: none"> • A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment. • Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid. • Send a copy of the voided form to the POLST Registry as above (required). • If included in an electronic medical record, follow voiding procedures of facility/community. 			
<p>For permission to use the copyrighted form contact the OHSU Center for Ethics in Health Care. Information on the POLST program is available online at www.orpolst.org or at polst@ohsu.edu.</p>			
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. SUBMIT COPY TO REGISTRY			

APPENDIX 2

**POLST PROGRAM LEGISLATIVE COMPARISON
AS OF JANUARY 1, 2014 PREPARED AND REPRODUCED WITH
PERMISSION BY THE ABA COMMISSION ON LAW AND AGING AND THE
NATIONAL POLST PARADIGM TASK FORCE**

	1. California	2. Colorado	3. Georgia
Terminology	Physician Orders for Life-Sustaining Treatment (POLST)	Medical Orders for Scope of Treatment (MOST)	Physician Orders for Life-Sustaining Treatment (POLST)
Placement in the State Code	CAL. PROB. CODE §§ 4780-4785 (West 2009)	COLO. REV. ST. § 15-18.7-101 to -110 (2013)	GA. CODE ANN. § 29-4-18 (Supp. 2013)
Regulations/ Guidelines	None	None	None
Entity Responsible for Development/ Approval of POLST	Emergency Medical Services Authority	Colorado Advance Directives Consortium	Department of Public Health
Provider Signature Required (Preauthorization by a Physician May be Required for Nonphysicians)	Physician	Physician, Nurse Practitioner, or Physician Assistant	Yes
Patient Signature Required?	Yes	Yes	Yes
Surrogate Signature Permitted? (Agent/Default/ Guardian)	Yes	Yes	Yes
Applicable to Minors	Yes	No	Yes
Patient Limitations	None	None	None
Other Execution Requirements?	No	No	No
Exclusive DNR Form?	No	No	No
Immunity Provided?	Yes	Yes	Yes
Duty to Offer POLST?	No	Not addressed	No
Duty to Comply?	Yes, with limited exceptions	Yes	No
Original vs. Copies/Faxes?	Original pink; copies valid	On Wausau Astrobrights Vulcan Green; copies valid	Yes
Conflicts with AD Addressed?	Most recent controls	Most recent controls	No
Presumption if Section of Form Left Blank	Full treatment	Not addressed	Full treatment
Out-of-State POLST Recognized?	Not addressed	Yes	Not addressed

	4. Hawaii	5. Idaho	6. Illinois
Terminology	Physicians Orders for Life-Sustaining Treatment (POLST)	Physician Orders for Scope of Treatment (POST)	Physician Orders for Life-Sustaining Treatment (POLST)
Placement in the State Code	HAW. REV. STAT. ANN. § 327K-1 to K-4 (LexisNexis 2013)	IDAHO CODE ANN. § 39-4501 to -4515 (2011 & Supp. 2013)	20 ILL. COMP. STAT. 2310-600(b-5) (2012)
Regulations/ Guidelines	None	Idaho Emergency Medical Services Guideline	Guidance Document for Illinois Health Care Professionals and Providers
Entity Responsible for Development/ Approval of POLST	Department of Health	Department of Health and Welfare	Department of Public Health
Provider Signature Required (Preauthorization by a Physician May be Required for Nonphysicians)	Physician	Physician, Advanced Practice Professional Nurse, or Physician Assistant	Physician
Patient Signature Required?	Yes	Yes	Yes
Surrogate Signature Permitted? (Agent/Default/ Guardian)	Yes	Yes	Yes
Applicable to Minors	Yes	Yes	Yes
Patient Limitations	None	None	Death or loss of decisional capacity within the next year would not be unexpected
Other Execution Requirements?	No	POST is completed by provider on a password protected web page	Witness over the age of 18 must sign also
Exclusive DNR Form?	No	No	Yes
Immunity Provided?	Yes	Yes	Yes
Duty to Offer POLST?	No	No	No
Duty to Comply?	Yes, with limited exceptions	Yes, with limited exceptions	Yes
Original vs. Copies/Faxes?	Original lime green preferred, but no color requirements; copies are valid	Yes	Bright pink paper recommended or stored in a bright envelope; copies valid
Conflicts with AD Addressed?	Not addressed	Yes, but if signed by surrogate decision maker, not contrary to the person's last known expressed wishes or directions	POLST is not intended to replace Power of Attorney
Presumption if Section of Form Left Blank	Full treatment	Full treatment	Absent POLST, required to attempt to save life
Out-of-State POLST Recognized?	Not addressed	Yes	Not specifically addressed, but Illinois POLST forms not intended to be recognized in other states because of their voluntary nature

	7. Indiana	8. Iowa	9. Louisiana
Terminology	Physician Order for Scope of Treatment (POST)	Iowa Physician Orders for Scope of Treatment (IPOST)	Louisiana Physician Order for Scope of Treatment (LaPOST)
Placement in the State Code	IND. CODE §§ 16-36-6-1 to -6-20 (2013)	IOWA CODE §§ 144D.1 -10.4 (2014)	LA. REV. STAT ANN. § 40:1299.64.1 to .64.6. (2010)
Regulations/ Guidelines	None	IPOST Coalition Guidance for Healthcare Providers	LA. ADMIN CODE tit. 48, §§ 201-211 (2011)
Entity Responsible for Development/ Approval of POLST	Department of Health	Department of Public Health	Department of Health and Hospitals
Provider Signature Required (Preauthorization by a Physician May be Required for Nonphysicians)	Physician	Physician, Advanced Registered Nurse Practitioner, Physician Assistant, or Facilitator	Physician
Patient Signature Required?	Yes	Yes	Yes
Surrogate Signature Permitted? (Agent/Default/ Guardian)	Yes	Yes	Yes
Applicable to Minors	Yes	No	Yes
Patient Limitations	Must be a "qualified person" as defined in the statute	Must be a "qualified person" as defined in the statute	Must be a "qualified person" as defined in the statute
Other Execution Requirements?	No	No	When completing a new LaPOST form, the old form must be properly voided
Exclusive DNR Form?	No	Yes	No
Immunity Provided?	Yes	Yes	Yes
Duty to Offer POLST?	No	No	No
Duty to Comply?	Yes	No	Yes
Original vs. Copies/Faxes?	Print on bright pink paper recommended; Fax, paper, or electronic copies valid	No color requirement, but the form must be easily distinguishable	Print on gold color paper; copies valid
Conflicts with AD Addressed?	No	POST form does not supersede DNR form nor power of attorney	Not in practice, the most recent document is considered valid
Presumption if Section of Form Left Blank	None, but provider has obligation to follow known preferences, or in absence, patient's "best interests" prevail	Full treatment	Full treatment
Out-of-State POLST Recognized?	Not addressed	Yes	Not addressed

	10. Maryland	11. Minnesota	12. Montana
Terminology	Medical Orders for Life-Sustaining Treatment (MOLST)	Provider Orders for Life-Sustaining Treatment (POLST)	Provider Orders for Life-Sustaining Treatment (POLST)
Placement in the State Code	MD. CODE ANN., HEALTH-GEN. § 5-608.1 (LexisNexis 2009 & Supp. 2012)	None Voluntary consensus process	None
Regulations/ Guidelines	MD. CODE REGS. 10.01.21.01 to .21.07 (2013)	Endorsement of POLST form by Emergency Medical Services Regulatory Board	MONT. ADMIN. R. 37.10.101, .104, .105 (2008)
Entity Responsible for Development/ Approval of POLST	Department of Health and Mental Hygiene in conjunction with the Maryland Institute for Emergency Medical Services Systems and the State Board of Physicians	Minnesota Medical Association hosts a self-selected, open membership, interdisciplinary, statewide Steering Committee (voluntary consensus process)	Department of Public Health and Human Services and Board of Medical Examiners
Provider Signature Required (Preauthorization by a Physician May be Required for Nonphysicians)	Physician, Nurse Practitioner, or Physician Assistant	Physician, Nurse Practitioner, or Physician Assistant	Physician, Nurse Practitioner, or Physician Assistant
Patient Signature Required?	No, but when health care facility completes the form, it must offer the patient to participate	No, but recommended	Yes
Surrogate Signature Permitted? (Agent/Default/ Guardian)	No	Yes	Yes
Applicable to Minors	Yes	Yes	No
Patient Limitations	Not applicable where primary diagnosis is psychiatric or related to pregnancy, or where patient is a minor unlikely to require life-sustaining treatment	None	None
Other Execution Requirements?	No	No	No
Exclusive DNR Form?	Honoring existing EMS DNR order forms, but will only use MOLST forms going forward	No	No
Immunity Provided?	Yes	Orders consistent with a health care directive for instructions of a surrogate	Yes
Duty to Offer POLST?	Yes	No	No
Duty to Comply?	Yes	No	No
Original vs. Copies/Faxes?	No color requirement for original; copies and electronic format valid	No color requirement for original; copies valid	On terra green (light lime green); copies valid
Conflicts with AD Addressed?	Except in cases of medical ineffectiveness, a MOLST form must be consistent with wishes of competent patient, and if incompetent, consistent with any known advance directive	POLST form documents justification for orders (for example, AD, patient stated preference, proxy instruction, or best interest)	Advance directive or health care power of attorney prevails
Presumption if Section of Form Left Blank	None	Not addressed	Not addressed
Out-of-State POLST Recognized?	Yes	Not addressed	Not addressed

	13. Nevada	14. New Jersey	15. New York
Terminology	Physician Orders for Life-Sustaining Treatment (POLST)	Practitioner Orders for Life-Sustaining Treatment (POLST)	Medical Orders for Life-Sustaining Treatment (MOLST)
Placement in the State Code	NEV. REV. STAT. §§ 449-691 to -697 (2013)	N.J. STAT. §§ 26:2h-129 to -140 (2014)	N.Y. PUB. HEALTH LAW § 2994-dd(6) (McKinney 2014)
Regulations/Guidelines	None	N.J. Hospital Association and Department of Health, POLST Guidance for N.J. Healthcare Professionals	Department of Health MOLST Legal Requirements Checklist
Entity Responsible for Development/Approval of POLST	Board of Health	Department of Health through the N.J. Hospital Association Institute for Quality and Patient Safety	Community-wide End-of-life/Palliative Care Initiative
Provider Signature Required (Preauthorization by a Physician May be Required for Nonphysicians)	Physician only	Attending Physician or Advanced Practice Nurse	Physician only
Patient Signature Required?	Yes	Yes	No, but informed consent is required
Surrogate Signature Permitted? (Agent/Default/Guardian)	Yes	Yes	Yes
Applicable to Minors	Yes	Yes	Yes
Patient Limitations	None	None	None
Other Execution Requirements?	No	No	Separate signatures required for CPR instruction and for other life-sustaining treatments
Exclusive DNR Form?	No	No	No
Immunity Provided?	Yes	Yes	Yes
Duty to Offer POLST?	Yes	Not addressed	No
Duty to Comply?	Yes	Yes	Yes
Original vs. Copies/Faxes?	Must be "uniquely identifiable" having a "uniform" color; copies and faxes not addressed	Original recommended; copies valid	Pink original is preferred; copies, fax and electronic representation are valid
Conflicts with AD Addressed?	Most recently controls; DNR prevails if identification is on the patient when need for life resuscitating treatment arises (unless patient is pregnant)	More recent verbal or written directive prevails	None; section may be crossed out with notation "decision deferred"
Presumption if Section of Form Left Blank	None	Full treatment	No
Out-of-State POLST Recognized?	Yes	Yes	Yes

	16. North Carolina	17. Oregon	18. Pennsylvania
Terminology	Medical Order for Scope of Treatment (MOST)	Physician Orders for Life-Sustaining Treatment (POLST)	Pennsylvania Orders for Life-Sustaining Treatment (POLST)
Placement in the State Code	N.C. GEN. STAT. § 90-21.17 (2013)	OR. REV. STAT. § 127-663-684 (2013)	None
Regulations/ Guidelines	Division of Health Service Regulation, Emergency Medical Services MOST Educational Program	OR. ADMIN. R. 847-010-0110 (2014)	Standard POLST form
Entity Responsible for Development/ Approval of POLST	Department of Health and Human Services	Oregon POLST Task Force through the Center for Ethics in Health Care at Oregon Health & Science University	Coalition for Quality at the End of Life (CQEL)
Provider Signature Required (Preauthorization by a Physician May be Required for Nonphysicians)	Physician, Physician Assistant, or Nurse Practitioner	Physician, Physician Assistant, or Nurse Practitioner	Physician, Physician Assistant, or Nurse Practitioner
Patient Signature Required?	Yes	No, but strongly recommended	Yes
Surrogate Signature Permitted? (Agent/Default/ Guardian)	Yes	Yes	Yes
Applicable to Minors	Yes	Yes	Yes
Patient Limitations	None	None	None
Other Execution Requirements?	If approval is oral, surrogate must sign a copy of the form and return it for entry into the medical record; original must note signature "on file"	No	No
Exclusive DNR Form?	No	Yes, outside of health care facilities	No
Immunity Provided?	Yes	Yes	Not addressed
Duty to Offer POLST?	No	No	Not addressed
Duty to Comply?	Yes, unless provider fails to comply with actual knowledge of the form's existence	Yes	Not addressed
Original vs. Copies/Faxes?	Pink original	Pink original; copies valid	Print on pulsar pink card stock recommended; copies valid
Conflicts with AD Addressed?	Yes, MOST forms "may suspend any conflicting directions in patient's AD"	No	Any current AD, if available, must be reviewed
Presumption if Section of Form Left Blank	Full treatment	Full treatment	Full treatment
Out-of-State POLST Recognized?	None	Yes	None

	19. Rhode Island	20. Tennessee	21. Utah
Terminology	Medical Orders for Life-Sustaining Treatment (MOLST)	Physician Orders for Scope of Treatment (POST)	Life with Dignity Order (LWDO) or Physician Order for Life-Sustaining Treatment (POLST)
Placement in the State Code	R.I. GEN. LAWS §§ 23-4-11-2 to -4-11-3.1 (Supp. 2012)	TENN. CODE ANN. § 68-11-224 (2013)	UTAH CODE ANN. §§ 75-2a-103 (17), -2a-106 (2014)
Regulations/Guidelines	23-4.11 R.I. CODE R. § 3 (2013)	Board for Licensing Health Care Facilities adopted Physician Orders for Scope of Treatment (POST) in requirements for each type of facility	UTAH ADMIN. CODE r. 432-31-3 (2014)
Entity Responsible for Development/Approval of POLST	Department of Health	Board for Licensing Health Care Facilities	Department of Health
Provider Signature Required (Preauthorization by a Physician May be Required for Nonphysicians)	Physician, Registered Nurse Practitioner, or Physician Assistant	Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist	Physician, Advance Practice RN, Physician Assistant or other specified health professionals acting under supervision
Patient Signature Required?	Yes	No, but optional signature line included in approved form	Yes
Surrogate Signature Permitted? (Agent/Default/Guardian)	Yes	Yes	Yes
Applicable to Minors	Yes	Yes	Yes
Patient Limitations	Limited to "qualified patient" as defined in statute	None	None
Other Execution Requirements?	No	No	No
Exclusive DNR Form?	No	No	No
Immunity Provided?	Yes	Yes	Yes
Duty to Offer POLST?	No	No, but if patient has a DNR order at time of discharge, facility "shall complete a POST form"	Yes
Duty to Comply?	Yes, with limited exceptions	Form must accompany patient on transfer or discharge	No, but facilities have a duty to transfer copy of POLST with the patient
Original vs. Copies/Faxes?	Yes	Approved copies are valid	Copies valid
Conflicts with AD Addressed?	Not addressed	Not addressed	POLST controls
Presumption if Section of Form Left Blank	Not addressed	Full treatment	Full treatment
Out-of-State POLST Recognized?	Yes	Not addressed	Yes

	22. Vermont	23. Washington	24. West Virginia
Terminology	Clinician Orders for Life-Sustaining Treatment (COLST)	Physician Orders for Life-Sustaining Treatment (POLST)	Physician Orders for Scope of Treatment (POST)
Placement in the State Code	VT. STAT. ANN. tit. 18, §§ 9701(6), 9708, 9719 (2013)	WASH. REV. CODE § 43.70.480 (2014)	W. VA. CODE ANN. § 16-30-25 (LexisNexis 2011)
Regulations/ Guidelines	13-140-66 VT. CODE R. § V (2013)	Standard POLST form	W. Va. Center for End-of-Life Care: Using the POST Form Guidance for Healthcare Professionals
Entity Responsible for Development/ Approval of POLST	Department of Health	Department of Health, Office of Emergency Medical Services & Trauma System (OEMSTS)	Department of Health & Human Resources
Provider Signature Required (Preauthorization by a Physician May be Required for Nonphysicians)	Physician or Osteopath, Advance Practice RN, or Physician Assistant	Physician, Nurse Practitioner, or Physician Assistant	Physician
Patient Signature Required?	No, but informed consent is required	Yes	Yes
Surrogate Signature Permitted? (Agent/Default/ Guardian)	Yes	Yes	Yes
Applicable to Minors	No	Yes	None
Patient Limitations	None	None	None
Other Execution Requirements?	Patient's clinician must sign the DNR part of the form separately from the other medical interventions. If patient is in a health care facility, clinician must certify that the facility's DNR policy has been followed.	No	No
Exclusive DNR Form?	Not within facility, but required in community	No	No
Immunity Provided?	Yes	Yes	Yes
Duty to Offer POLST?	Yes	No	No
Duty to Comply?	Yes	Yes	Yes
Original vs. Copies/Faxes?	Original any color; copies valid per instructions	Green original (a downloadable original can be printed on green stock); copies valid	Bright pink original; copies must be pink
Conflicts with AD Addressed?	Not addressed	Most recent controls	Expressed directives control
Presumption if Section of Form Left Blank	No presumption	Full treatment	Full treatment
Out-of-State POLST Recognized?	Yes	Not addressed	Not addressed for POST

APPENDIX 3

MODEL POLST PARADIGM PROGRAM LEGISLATION

The following statutory language is taken from early Model Legislation authored by the National POLST Paradigm Task Force. This language could be helpful for states considering legislation. However, the authors suggest readers to reference the full discussion of legislative and regulatory issues in the National POLST Paradigm Task Forces POLST Legislative Guide and a full study of the statutes as outlined in Appendix 2.

SECTION 1. Findings.

The Legislature finds and declares the following:

- (a) The Physician Orders for Life Sustaining Treatment (POLST) [or other name chosen by the state] form complements an advance directive by taking the individual's wishes regarding life-sustaining treatment, such as those set forth in the advance directive, and converting those wishes into medical orders.
- (b) A POLST form is particularly useful for individuals who are frail and elderly or who have a chronic, progressive medical condition, (clinician would not be surprised if the patient died within in the next year), or a terminal illness.

SECTION 2. Definition.

A "Physician Orders for Life-Sustaining Treatment (POLST) Program" guides the process of evaluation and communication between a patient or other legally authorized medical decision maker and health care professionals. It ensures that the individual understands the decisions he or she is making, and it converts the individual's goals and preferences for care into a set of medical orders on a form that is portable and complied with by all health professionals across care settings.

SECTION 3. POLST Form and Procedures.

The State Department of Health [use name of appropriate state agency] shall designate a statewide working group of [number] individuals representing physicians, nurse practitioners, physicians assistants, hospitals, long-term care facilities, hospice, state and local emergency medical services providers, and patient advocates to develop a POLST form and process and educational and evaluation methodologies for approval by the Department.

SECTION 4. Reliance on Authority of POLST Form.

(a) If an individual with a POLST form is transferred from one health care facility to another, the health care facility initiating the transfer shall communicate the existence of the POLST form to the receiving facility prior to the transfer. The POLST form shall accompany the individual to the receiving facility and shall remain in effect. The POLST form shall be reviewed by the treating health care professional and one of three actions shall be taken:

- (1) The POLST form shall remain in effect;
- (2) The POLST form shall be voided and a new form completed; or
- (3) The POLST form shall be voided without a new form being completed.

(b) A health care professional or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care professional or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for complying with a POLST form and assuming that the orders therein were valid when made and have not been revoked or terminated.

(c) An individual acting as agent, guardian, or surrogate under [reference advance directive law and guardianship law] is not subject to civil or criminal liability or to discipline for unprofessional conduct for signing a POLST form and thereby consenting to POLST in good faith.

SECTION 5. Revocation of Consent to POLST Form.

(a) An individual may revoke his or her consent to all or part of a POLST form at any time and in any manner that communicates an intent to revoke.

(b) An agent, guardian, or surrogate may revoke his or her consent to all or part of a POLST form at any time and in any manner that communicates an intent to revoke.

(c) A health care professional, agent, guardian, or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health care professional and to any health care institution at which the patient is receiving care.

SECTION 6. Implementation.

No later than the first day of [month], [year], the Secretary of the State Department of Health [use name of appropriate state entity] shall implement the statewide distribution of standardized POLST forms.

