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Sarah Catherine Spillers

Brittany Lamb

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Is the POLST Model Desirable for Florida?

Sarah Catherine Spillers, BS, Brittany Lamb, BS

ABSTRACT

Florida has one of the largest and most rapidly growing elderly populations in the nation. Although advances in medicine are allowing physicians to extend the lives of elderly patients, advances must simultaneously be made in the end-of-life care arena to ensure that the comfort and quality of life of elderly patients is maintained. This paper argues that use of a Physician Orders for Life Sustaining Treatment (POLST) form in Florida would be effective in increasing the accuracy of translating patients' end-of-life wishes into treatment orders, in ensuring the consistency of treatment across settings, and in improving health care provider compliance with patient preferences. It will be demonstrated that present concerns in Florida are essentially the same as those which previously existed in other states that have successfully implemented POLST programs.

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Background

According to the U.S. Department of Health and Human Services (2010), the population of persons 65 years and older is expected to more than double in the United States by 2040. The rapid growth of the elderly population will require health care professionals to provide these patients with quality end-of-life care, including access to reliable, effective, and accurate advance directives.

Unfortunately, current forms of advance directives are ineffective at accurately translating patients' wishes for end-of-life care into the treatment they ultimately receive. A significant portion of the population does not have any form of advance directive, and those who have them often are not treated according to their wishes due to the forms' vague or inaccurate language (Hickman et al., 2010). Further, many advance directives are restricted to particular medical interventions, such as do-not-resuscitate (DNR) orders. Although these forms are only applicable in certain situations, health care providers often make assumptions about patients' wishes regarding other treatments based on the presence of these forms (Hickman et al., 2010).

Florida has one of the largest and most rapidly growing elderly populations in the nation (Campbell, 2010). Although advances in medicine are allowing physicians to extend the lives of elderly patients, advances must simultaneously be made in the end-of-life care arena to ensure that the comfort and quality of life of elderly patients is maintained. This paper argues that use of a Physician Orders for Life Sustaining Treatment (POLST) form in Florida would be effective in increasing the accuracy of translating patients' end-of-life wishes into treatment orders, in ensuring the consistency of treatment across settings, and in improving health care provider compliance with patient preferences.

It will be demonstrated that present concerns in Florida are essentially the same as those which previously existed in other states that have successfully implemented POLST programs. Part I discusses the inadequacies of current forms of advance directives. Part II provides an overview of the reasons for the initial development of the POLST form, and explains how implementation of POLST in other states has remedied the concerns that led to the form's development. This part also explores the various implementation strategies used by each state with an endorsed POLST program. Part III provides evidence of poor end-of-life care in Florida. Part IV suggests the implementation of POLST in order to correct these inadequacies, and recommends an optimal strategy for achieving implementation of POLST in Florida.

Part I: Problems with Current Forms of Advance Directives

Respect for patient autonomy is a core principle of medical ethics. Patients have the right to make their own medical decisions, including accepting or refusing treatment. It is the role of physicians to inform patients of all possible treatment options and their accompanying risks. This principle should be carried into honoring patients' end-of-life treatment preferences. Thus far, advance directives are not measuring up to the task.

The use of advance directives has been strongly encouraged in the United States since the passage of the Patient Self Determination Act (PSDA) in 1990. The act mandates that health care facilities give patients information regarding the advance directive laws in their state, making it known that patients have the right to document their preferences. The PSDA also requires facilities to ask about, document, and honor any advance directives currently in force for a patient. However, it is unclear whether the PSDA has increased the use of advance directives.

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A study of nursing homes in ten states investigated chart documentation of advance directives before and after implementation of the PSDA. The study determined that after the PSDA was implemented, there was only a small increase in the documentation of living wills (Teno et al., 1997). Although the PSDA might have increased awareness of advance directives, they are still criticized for several shortcomings.

First, advance directives are still not widely used. Recent studies have estimated that their use by adults in the United States ranges only from 5% to 15% (Kirschner, 2005; Sabatino, 2007). Many people report they do have preferences about medical care if they are unable to make decisions, but simply have not put them into writing. Others do not complete advance directives because they feel “too healthy” to do so, do not know where to obtain the forms, or are unfamiliar with the forms (Fagerlin & Schneider, 2004). Further, many patients do not have advance directives because their health care providers fail to discuss end-of-life treatment. For example, “Ms. B,” a 71 year old, suffered from a stroke leaving her unable to speak or swallow, but retained her mental faculties. Her sister recalled the following in an interview:

She could answer yes or no questions by shaking her head. The hardest part was that I knew she was suffering. She was always thirsty. She would fight people to get to a sink and constantly motioned for water. She was resuscitated several times and I never understood why. When I asked the [hospital] staff, they said they had to do everything they possibly could to keep her alive. It was hard for me to watch. I knew she was suffering and I felt powerless to stop it (Personal communication, June 2011).

Ms. B had no advance directive making her end-of-life treatment preferences known, and was subjected to this treatment for a year before she passed away. Physicians must be more proactive in addressing the difficult topic of end-of-life care with patients, and must encourage patients to document their treatment preferences to prevent unwanted treatment.

Advance directive use has remained low even in populations where death should not come as a surprise. Teno and colleagues (2004) conducted an extensive study using Medicare data that confirms low use of advance directives in nursing homes across the United States. In 2001, use of advance directives in terminally ill nursing home residents was 45.4%, only slightly better than the 36.4% found in all nursing home residents. Florida’s statistics are

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slightly higher than the U.S. average, with 56.1% of terminally ill nursing home residents having an advance directive, compared to 39.6% for all nursing home residents. Documentation of physicians’ orders such as DNRs was much higher. Across the United States, 74.2% of terminally ill nursing home residents had a DNR in place, and in Florida, 66.7% had one. However, the study revealed that individuals were unlikely to document their desires to forego life-sustaining treatments other than CPR. For example, only 15% of terminally ill nursing home residents in the U.S. documented their desire to forgo artificial nutrition, and only 9% did so in Florida.

It is difficult to make end-of-life treatment decisions for patients who have not documented their wishes in writing, but challenges arise even when patients have filled out a form. Advance directives have been attacked for using unclear language which can be hard to interpret in emergency situations. The forms are commonly drafted by attorneys with little understanding of medical procedures, and the resulting vague, unclear language of the forms often leaves a patient’s wishes up for interpretation. Health care providers have noted that living wills are particularly unhelpful because they are infrequently updated, and often do not accurately reflect patients’ changing medical conditions (Fagerlin & Schneider, 2004). Physicians attempting to interpret forms that are unclear, inapplicable, or out-of-date may opt to avoid perceived potential liability by disregarding the patient’s advance directive and providing the maximum available treatment.

Lack of transferability between health care providers is a problem for both advance directives and physicians’ orders such as DNRs. For example, if a nursing home resident has an advance directive declining attempts at resuscitation, the form may not accompany the patient or may be disregarded by EMTs called to the nursing home or by physicians at a hospital to which the patient is transferred. This problem is evident in the case of Dr. S, a retired physician who died in his home. As his wife recalled, “[h]e did not want to eat that morning. He just wanted to sit in his recliner. I came to check on him a while later and he didn’t seem to be breathing. I called his physician, and he told me to call the paramedics” (Personal communication, July 2011). Mrs. S. notified the 911 operator that her husband had a DNR and did not wish to be resuscitated, and the operator assured her that the EMTs would not do so. However, Mrs. S. recalled that “[t]hey moved him to the floor even though I was yelling at them not to do anything to him.”

The EMTs explained to Mrs. S that they were simply following protocol, but nonetheless called Dr. S’s physician to inquire about his DNR. The

physician confirmed that Dr. S had a DNR in place, but the EMTs had in the meantime determined that Dr. S. “lack[ed] electrical activity,” and thus did not resuscitate him. Mrs. S stated in an interview that given the opportunity, she would have done things differently: “It was a high stress situation. There was no time to wade through documents. Everyone should keep their DNR on hand.” Although Dr. S had a DNR, which is a physician’s order and thus not considered an advance directive, the unwillingness of the EMTs to honor the document illustrates the lack of transferability of all current forms of documentation of patients’ end-of-life preferences.

The utility of advance directives is limited, as they commonly do not include preferences related to life-sustaining treatments other than CPR (Hickman et al., 2010). Advance directives are drafted to apply to hypothetical medical emergencies which may or may not eventually occur. If a situation occurs that is not provided for by a patient’s advance directive, the document provides little to no assistance to physicians in determining the patient’s preferred care plan. This can lead to patients being subjected to a significant amount of unwanted medical treatment and expense. Consideration of more care options than just resuscitation is desirable to ensure that health care providers have documentation of the patient’s preferences for a broad variety of medical situations and that the patient’s preferences will be honored.

It is common for elderly patients to have a DNR order on file, as attempts to resuscitate this age group are usually futile, especially in those with a chronic illness (Cadogan, 2010). Medicare data for 1992-2005 was analyzed to determine the number of beneficiaries over the age of 65 who had undergone CPR in U.S. hospitals. Of the 433,985 patients who received CPR, only 18% survived to be discharged. The rate of survival after CPR in this age group has not changed since 1992. However, the data show that the proportion of in-hospital deaths preceded by CPR has increased, while the proportion of survivors discharged to their homes, rather than another health care facility, has decreased. The CPR survival rate was found to be lower in patients who were male, older, had more coexisting conditions, or were admitted from a skilled nursing facility (Ehlenbach, Barnato, Curtis, & Kreuter, 2009).

These data illuminate the ineffectiveness of CPR for elderly patients. Few elderly patients survive resuscitation attempts, and even fewer return to their previous functional level, with most returning to health care facilities instead of their homes (Ehlenbach, et al., 2009). DNR orders are therefore an important tool that can protect patients

from being subjected to resuscitation attempts, which are likely to leave them in a worsened state if they survive.

However, having only a DNR order might alter the way a patient is treated by health care providers. A survey performed by Beach and Morrison (2002) studies this possibility. Three patient cases were sent to physicians along with surveys asking for physician agreement level regarding several possible clinical interventions. All three cases either did or did not include a DNR order. In each of the patient scenarios, if a DNR order was present, physicians either agreed or strongly agreed to initiate fewer interventions unrelated to CPR. Another study found a 30% lower rate of hospitalization in Missouri nursing home patients who had a lower respiratory infection and a DNR order form compared to those without a DNR (Zewig, Kruse, Binder, Szafara, & Mehr, 2004).

The above studies suggest that some physicians provide less treatment to patients with DNR orders. However, DNR orders are not applicable to patient treatment unless the patient has no pulse and is not breathing. Health care providers should therefore refrain from making assumptions about patients’ wishes based solely on their CPR status, as possessing a DNR order does not imply that a patient desires no other life-sustaining treatments. A study performed in Oregon nursing facilities, 71% of which use the POLST form for at least half of their patients, found that the majority of patients with DNR orders indicated on the POLST form a choice to receive some other form of life-extending treatment. For example, a patient who had a DNR order listed in Section A of the POLST form (Cardiopulmonary Resuscitation) chose in Section B (Medical Interventions) that they wished to receive full treatment and to be taken to the Intensive Care Unit if needed (Figure 1). Conversely, nearly half the patients with orders for resuscitation on the POLST form documented in another section of the form that they did not wish to receive full treatment (Hickman, Tolle, Brummel-Smith, & Carley, 2004). Because of varying patient preferences, there is a clear need for a form that incorporates patients’ CPR wishes with those for hospitalization and other life-sustaining treatments.

The POLST form is a more uniform, comprehensive, and portable method of documentation of patients’ end-of-life treatment desires. Although the POLST form is not intended to replace advance directives executed by patients, it corrects many of the inadequacies of current forms and intends to lessen the discrepancy between a patient’s end-of-life care preferences and the

Figure 1. Oregon POLST Form

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.</p> <p><i>Guidance for Health Care Professionals.</i> http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf.</p>	Patient Last Name:	Patient First Name	Middle Int.	
	Date of Birth: (mm/dd/yyyy)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
	Address: (street / city / state / zip)			
A <i>Check One</i>	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 <i>Check One</i>	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 <i>Check One</i>	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: <i>recommended</i> 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: <i>required</i> Signer Phone Number: Signer License Number: (optional) Physician / NP / PA Signature: <i>required</i> Date: <i>required</i> Office Use Only			
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY © CENTER FOR ETHICS IN HEALTH CARE, Oregon Health & Science University, 3181 Sam Jackson Park Rd, UHN-86, Portland, OR 97239-3098 (503) 494-3965				

treatment(s) eventually provided by the patients' health care providers.

Part II: Development of the POLST Form

Efforts to develop the POLST form were initiated in Oregon in the early 1990s. Under the guidance of the Center for Ethics in Health Care at the Oregon Health and Sciences University, doctors, nurses, emergency personnel, and members of ethics committees convened to discuss the shortfalls of existing advance directives and to determine how to provide improved end-of-life care to patients with advanced critical illness. Over several years, a form was developed which documented patients' end-of-life treatment preferences and converted them into doctors' orders. It was created to allow critically ill patients to decide in advance of a clinical event whether to allow health care providers to perform various medical interventions (Spann, 1999). The POLST form addresses a variety of treatment interventions, including CPR, artificial nutrition, intravenous (IV) fluids, resuscitation, intubation, hospitalization, ICU care, and the use of antibiotics. The POLST form thus allows the patient to express greater detail about desired end-of-life treatment than is possible in traditional advance directives, and offers health care providers significantly increased guidance about how to treat patients in an expanded set of medical situations.

The Oregon POLST Task Force aimed to eliminate the confusion of health care providers by providing them with a uniform order sheet with standard medical terminology that could be quickly understood, in place of varying attorney-drafted forms which were often incomprehensible to health care providers due to their vague or inaccurate language. Creating a form with increased transferability was another central goal of the Task Force. Because the POLST form constitutes a physician's order, it is more portable and is recognized by health care providers in all treatment settings to which a patient may be transferred, from private residences to nursing homes, ambulances, and hospitals. The Oregon POLST form provides immunity from criminal and civil liability to emergency medical technicians (EMTs) who comply with POLST orders, ensuring that a patient's treatment goals will not be disregarded when they are transferred from one care setting to another (Spann, 1999).

POLST also requires a discussion between doctor and patient about the patient's end-of-life care preferences. Aside from the form's conversion of the patient's preferences into doctors' orders, the form promotes discussions about the end of life, a topic frequently avoided by health care providers. The POLST form prevents avoidance of this difficult

topic, and ensures that patient's wishes are heard, documented, and acted upon. Such a conversation would have been beneficial for Mrs. C, an 82-year old woman who was undergoing dialysis treatments for kidney failure. In an interview, Mrs. C's daughter recalled the day she drove her mother to her doctor's office to repair her "clogged" dialysis port. Before returning home, Mrs. C complained of feeling nauseous and hot. The doctor ran several tests, but later cleared Mrs. C to leave. Mrs. C complained that she still felt unwell while getting into the car. As her daughter recollected:

Then she made a sound and I knew something was wrong. She coded in my Jeep and died right then. They worked on her doing CPR at the doctor's office for two hours, and then for four hours more in the ICU at the hospital. She laid in the hospital for a week on an IV. She looked swollen because of all the fluid they put in her. She was hooked up to a bunch of machines (Personal communication, June 2011).

Mr. A, a 53-year old man, would also have benefitted from his physician's assistance in documenting his end-of-life treatment preferences. His stepdaughter explained in an interview that Mr. A crashed several times while undergoing bypass surgery:

They had to shock him back each time. His body didn't handle the surgery well. He wasn't breathing on his own and when he woke up he was on a ventilator. He pulled through and recovered. Afterwards he told us he never wanted to be on a ventilator again. He felt like it was too far in his chest and that it was killing him.

Three years later, while shopping in J.C. Penney, Mr. A had a heart attack. A respiratory therapist was in the store and administered CPR, but Mr. A had no pulse for thirty minutes. He was transported to the cardiac ICU and put on a ventilator. As Mr. A's stepdaughter recalled:

The next day the doctors were trying to convince my mother that she should take him off the ventilator. The decision to take him off the machine was very hard on her. We felt that since he had pulled through the bypass there was a chance he could pull through this, but it was very important to us that his wishes were followed. If he had an advance directive

signed they probably still would have done CPR in J.C. Penney, since it was a public place, but when he got to the hospital they might not have put him on the ventilator.

Although physicians' tendency to avoid discussing end-of-life issues with patients may spare patients and their families from having difficult conversations, it is evident from the above accounts that avoiding these topics can be detrimental in the long run. The POLST form provides an avenue for physicians to commence these discussions with patients, and completion of the form allows patients to avoid costly, unnecessary, and undesired medical treatment.

The effectiveness of the POLST form in improving patient end-of-life care has been researched through surveys and pilot programs. Studies conducted in Oregon following the initial creation of the POLST form determined that many health care providers were eager to use it (Spann, 1999). More recent multistate surveys of hospice staff have shown that POLST is effective for initiating difficult conversations regarding end of life treatment goals and for successfully preventing unwanted medical treatment (Hickman et al., 2009). In a study of 180 Oregon nursing home residents, the researcher's goal was to determine how well treatment preferences were honored for residents whose POLST forms indicated that they did not desire resuscitation and wished for transfer to the hospital only if comfort measures failed. Consistent with their wishes, none of the patients received CPR, ICU care, or were put on a ventilator. Thirteen percent of the subjects, however, (24) were hospitalized. Yet, 85% of those hospitalized were transferred because the nursing home could not provide adequate comfort care to prevent suffering. The other 15% represented cases in which the POLST form was overridden by either the patient or a family member, resulting in hospitalization to extend the patient's life (Tolle, 1998).

Hickman and colleagues' study of hospice staff opinions of POLST (2009) found that the overwhelming majority of participants supported use of the form. Hospice staff reported that the form was useful in preventing unwanted resuscitation by EMS (97%), serves as a helpful mechanism for initiating a conversation about end-of-life treatment preferences (96%), and helps ensure patient treatment preferences are honored (94%). The study also reported that hospice staff members feel more comfortable knowing what to do when a POLST form is available (93%). After conducting chart reviews, researchers found that patient preferences were followed 98% of the time when a POLST form was in place. Patients with orders for comfort care

only (Section B) were less likely to be hospitalized than patients with orders for limited or full medical interventions. It is therefore evident that POLST is effectively reducing unwanted hospitalization of elderly patients.

Studies have also shown that the POLST Task Force's goal of transferability is being achieved by the form: in the abovementioned study which followed 180 Oregon nursing home residents for a year, 94% of the participants had their POLST form in their record at the end of the study. Of the 11 who did not, two died while in the hospital, and the hospital correctly kept their forms (Tolle, 1998). Increased transferability of the POLST form over other common forms of advance directives has also been documented through the acceptance of the form by Oregon EMTs. Oregon EMTs typically favor the use of the POLST form, and in a study to determine EMTs' attitudes towards POLST, 80% of participants expressed the wish that more patients would use the form (Schmidt, 2004). Although EMTs have expressed reluctance to withhold resuscitation if a patient does not have an official state-approved advance directive (Marco, 2002), surveys of Oregon EMTs demonstrated that when patients had a POLST form, it changed the method of treatment in 45% of cases (Schmidt, 2004).

Other states concerned with the adequacy of current forms of advance directives in achieving quality end-of-life care took notice of the effectiveness of the Oregon POLST form, and began to use the Oregon model in developing their own forms. Fifteen states have successfully endorsed POLST programs and 21 states have programs in development, including Florida (POLST Paradigm Program Contact List by State, 2011). States with endorsed programs have used various strategies to achieve utilization of the POLST form.

To avoid the delay and uncertainty entailed in attempting to pass POLST legislation and the scrutiny of the Oregon legislature, the Oregon POLST Task Force opted to implement the form through voluntary health care provider compliance and subsequent regulatory recognition of POLST. Because the legally defined scope of practice for EMTs did not explicitly cover POLST forms, Oregon EMTs were reluctant to comply with them, fearing that they would be held liable for failing to resuscitate patients without DNR orders. The Oregon Task Force persuaded EMTs to comply with POLST forms through the promulgation of regulations stating that EMTs should comply with POLST forms in the same manner as a DNR order and providing EMTs with immunity from liability for compliance with a POLST form (Or. Admin. R. § 847-035-0030(6), 2008).

Several states, such as West Virginia, North Carolina, Maryland, Idaho, Vermont, and New York,

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have enacted legislation recognizing POLST forms (W. Va. Code § 16-30-3(u), 2008; N.C. Gen. Stat. § 90-21.17, 2007; MD. Code Ann., Health—Gen. § 5-608.1, 2008; Idaho Code Ann. §§ 39-4512A-39-4512C, 2008; 18 V.S.A. §§ 9719, 9709(b)(5), 2005; NY PHL §§ 2994-dd – 2944-gg, 2010). Other states have followed Oregon’s approach, initially encouraging voluntary compliance with POLST forms and subsequently achieving regulatory recognition of the form’s validity. For example, Washington began pilot programs in two counties, and the Washington Department of Health later adopted the POLST form based on its interpretation of two state statutes that impliedly authorized its approval of a POLST program (Wash. Rev. Code § 43.70.480 (2008); Wash. Rev. Code § 18.71.210 (2008)). Similarly, states such as Utah, Tennessee, Wisconsin, and Hawaii have passed legislation impliedly delegating authority to state health departments to develop and implement POLST programs (Utah Admin. Code R. 432-31-2, 2008; Utah Admin. Code R. 432-31-4(1), 2008; Utah Admin. Code R. 426-100-6, 2008; Tenn. Code Ann. § 68-11-224(i)(1), 2008; Tenn. Code Ann. § 68-11-1805, 2008; Wis. Stat. § 154.03, 2007; Haw. Rev. Stat. §321-23.6, 2008). Although the specifics of the POLST form vary from state to state (Sabatino & Karp, 2011), each state with an endorsed POLST program has implemented the form in an effort to improve end-of-life care.

Because Florida has one of the largest and most rapidly growing elderly populations in the nation (Campbell, 2010), concerns regarding the uniformity, portability, and vagueness of current forms of advance directives can be expected to steadily increase. The state’s significant elderly population necessitates that health care providers devote increased attention to accurately documenting and complying with patients’ end-of-life treatment preferences. The implementation of a POLST program in Florida will correct the inadequacies of current advance directives and improve end-of-life care for elderly patients.

Part III: Issues in Florida

Seventeen percent of Florida’s population is 65 years or older (Kaiser Family Foundation, 2009). This is the highest percentage in the nation aside from West Virginia, which also has a 17% elderly proportion but a significantly smaller overall population. Florida also has the sixth highest hospital care intensity index in the nation, based on inpatient days and inpatient physician visits among chronically ill Medicare beneficiaries in the last two years of life (Commonwealth Fund, 2009). Florida’s rate is 1.177, far above the best state’s (Utah’s) rate of 0.509. A 2007 survey found that Florida had the second highest percentage of decedents spending

seven or more days in an intensive care unit during the last six months of life, at 23.1% (Dartmouth Atlas, 2007). The national average was 15.2%. These data suggest that elderly patients in Florida are being subjected to a high and likely unnecessary amount of hospitalization and treatment. The implementation of a POLST program would likely reduce this rate by ensuring that elderly individuals with advanced critical illness receive only those medical interventions they desire.

Florida physicians may be satisfied with forms of advance directives currently in use. For physicians who devote little attention to patient end-of-life care, satisfaction with the status quo may be due in part to the unlikelihood of courts holding health care providers liable for failure to comply with patients’ advance directives. Without a liability incentive to encourage them to honor patients’ end-of-life treatment goals, physicians may disregard patients’ advance directives in favor of performing a broad spectrum of medical interventions which may sustain the patient’s life but impinge upon the patient’s comfort.

Physicians may also be relying on patients’ families to decide the amount of treatment a patient should receive. Without proper education regarding a family member’s health status and the futility of life-sustaining treatments for patients with certain conditions or in certain age groups, families may opt for the maximum amount of life-sustaining treatment for their loved ones. In a conversation with an experienced ICU nurse, it was explained that the elderly patients seen in the ICU are often those who have “fallen through the cracks:”

These patients, and in many cases their families, were not well educated about the limited chance of recovery [after] the patient is admitted to the ICU. Families have all the power when a patient can’t speak for [himself or herself]. Even if the patient has an advance directive, if they can’t speak for themselves and the family says they want everything done for them, you still have to follow the family’s desires. I have never worked for a doctor who ignored the family (Personal communication, July 2011).

Although patients and their families have sued health care providers for performing life-sustaining measures in conflict with the patient’s advance directive, they have not prevailed unless the intervention performed by the health care facility *caused* the patient’s death (Scheible v. Joseph L. Morse Geriatric Center, Inc., 2008; Kush v. Lloyd, 1992).

Although some health care providers may be satisfied with current forms of advance directives, it is evident from several sources—the unwillingness of courts to hold health care providers liable for failure to comply with patients' wishes, statistics revealing a high hospital intensity index during patients' end stages of life, and the support of numerous Florida organizations for POLST implementation efforts—that widespread problems with end-of-life care exist in Florida, and that patients' end-of-life treatment preferences are not being sufficiently protected. These insufficiencies may be remedied through the implementation of the POLST form.

Part IV: Recommendations for Implementation of POLST in Florida

Implementation of a POLST program would be beneficial in Florida due to the state's large and growing elderly population, the state's poor performance related to end-of-life care, and lack of compliance with current forms of advance directives. State policymakers must carefully consider which POLST implementation strategy would be most effective.

At first glance, the legislative route seems to be the optimal approach to POLST implementation in Florida, as legislation recognizing POLST would be the most comprehensive and uniform approach to ensuring that the form is recognized in all health care facilities and health care providers are immunized from liability for compliance with a POLST form. However, legislation recognizing POLST was rejected in 2006, (H.B. 1017, 2006; S. 2572, 2006) and it is unclear whether the concerns that prevented its passage then have subsided.

House Bill 1017 and Senate Bill 2572 would have recognized the POLST as a type of advance directive under Chapter 765 of the Florida Statutes. The legislation would have required the Florida Department of Health to design and post a POLST form on its website, and would have required the signature of both a licensed health care professional and the patient. If Florida policymakers wish to pursue implementation of POLST through legislation, the bills could be reintroduced to amend Chapter 765 of the Florida Statutes, in hopes that the concerns that prevented the 2006 legislation from passing have dissipated in the past five years. Alternatively, POLST legislation could be reintroduced to amend Chapter 401 of the Florida Statutes, with the goal of obtaining recognition of the POLST as an alternative to or enhancement of the DNR order.

However, the scrutiny of the Florida legislature may prevent the bill from being passed in the manner intended by its proponents. The legislature may demand revisions to the POLST form that are

inimical to ensuring that patients' end-of-life treatment preferences are honored. The length of time that would likely be required to implement POLST through legislation is also undesirable. For these reasons, it is advisable that Florida pursue implementation of POLST through a strategy similar to Oregon's, starting with a period of educational efforts and encouraging voluntary use of POLST forms in health care facilities statewide. This should be followed by regulatory recognition of POLST to reassure health care providers of the validity of the forms, as well as to reassure them of their immunity from liability for good faith compliance with POLSTs. A pilot study has recently been initiated in a few Florida hospitals to introduce physicians and patients to POLST forms, gauge their responsiveness to POLST, and test the effectiveness of the forms in improving end-of-life care. Physicians who are participating in the study and initiating conversations based on the POLST form report that the form "is a good template for conversation. Patients really like it" (S. Bagatell, personal communication, June 29, 2011). Data from this pilot study will be beneficial in persuading additional Florida health care providers and facilities to offer and honor POLST forms. Ideally, the hospitals, hospice providers, and EMTs currently using the POLST form in pilot programs will be influential in spreading awareness of the benefits to their colleagues across the state.

POLST experts tasked with educating health care providers must collectively agree upon issues such as signature requirements for the POLST form, color requirements, the validity of copies of original forms, and whether the form must be periodically reviewed to ensure consistency with a patient's changing medical condition. They must also address how health care providers should handle conflicting instructions in a patient's POLST and advance directives, whether to honor POLST forms executed out of state, and whether minors with advanced illnesses may use POLST forms. Agreement on these issues is necessary prior to beginning extensive educational efforts to ensure that POLST forms are offered and honored in a consistent manner.

Although the ideal situation would be voluntary use of the POLST form by health care providers, it is inevitable that the form will encounter some degree of resistance. Health care providers have expressed fear of liability for compliance with POLST orders, concerned that their failure to provide the full spectrum of medical interventions for a patient will lead to sanctions even if the withdrawal or withholding of interventions is in accordance with the patient's POLST order. Providers commonly refuse to withdraw or withhold interventions even if a patient

has specified a treatment preference using a traditional advance directive explicitly recognized under Florida law (Birdwell, 2005). Because POLST is not explicitly recognized under Florida law, providers are even more cautious about offering or honoring the POLST form.

It may be argued that POLST is already permissible under current Florida law, as neither Chapter 765 nor 405 seem to pose any significant barrier to its adoption. However, the tendency of health care providers to be risk-averse will likely necessitate the promulgation of regulations specifically recognizing POLST as a valid instrument for documenting patients' end-of-life treatment preferences and affirming health care providers' immunity from liability for good faith compliance.

Because the support of EMS providers is crucial in ensuring that patients receive their preferred treatment while being transferred between settings of care and in ensuring that POLST forms accompany the patient during those transfers, it will likely be necessary to gain the support of the EMS community to make POLST a reality in Florida. The addition of language to Section B of the POLST form may be necessary to address several of the concerns that have been expressed by EMTs.

One concern that has been expressed is that 911 will be used for purposes other than emergency medical care and transportation if patients have a POLST form that directs health care providers not to transport the patient, but to provide comfort measures only. EMTs are concerned that time that could be devoted to patients who wish to be transported and to receive the full panoply of medical interventions will instead be devoted to providing the most basic forms of comfort care to patients, such as bathing or repositioning (S. Bagatell, personal communication, June 29, 2011). This concern may be overcome by adding language to Part B of the POLST form stating "EMTs provide comfort care only according to local EMS protocol." Concern has also been expressed that POLST forms will complicate the procedures normally followed by EMS providers. For example, if a patient's POLST states the wish to be transferred to a specific hospital under any circumstances, this may interfere with the protocol normally undertaken by EMTs. This concern may be overcome by adding language to Part B of the POLST form stating "Transfer to hospital per local EMS protocol."

Future Directions

Despite the passage of the PSDA, patients, families, and health care providers remain dissatisfied with current forms of advance directives. Implementation of the POLST form in Florida will

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<http://health.usf.edu/publichealth/fphr/index.htm>

improve end-of-life care by providing a more uniform, transferable, and comprehensive method of documenting patients' treatment preferences. Florida's implementation strategy should consist of educational efforts in which health care providers are encouraged to voluntarily comply with POLST orders. This period of education and voluntary compliance should be followed by the passage of regulations to reassure health care providers of the validity of POLST forms, as well as to reassure them of their immunity for good faith compliance with POLST orders.

The leaders of pilot programs currently underway in Florida hospitals must compile data illustrating the effectiveness of the POLST form in improving compliance with patients' end-of-life treatment goals. These data must be shared with other hospitals, nursing homes, and hospice centers statewide and their participation in POLST efforts must be encouraged. Finally, other states must follow Florida's example and consider the inadequacies of their current forms of advance directives, as the nation as a whole would benefit from use of the POLST form.

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Sarah Catherine Spillers (scspillers@gmail.com) is J.D. candidate at the Florida State University College of Law, Tallahassee, FL. Brittany Lamb (bal06c@med.fsu.edu) is a medical student at the Florida State University College of Medicine, Tallahassee, FL. This paper was submitted to the *FPHR* on August 21, 2011, revised and resubmitted, and accepted for publication on November 7, 2011. Copyright 2011 by the *Florida Public Health Review*.