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END-OF-LIFE CARE: HOW POLST FORMS CAN FIX A BROKEN SYSTEM

By Michael Gottlieb

I. Introduction

Nobody likes to talk about death. Maybe that is the reason a striking number of people fail to utilize advanced medical directives leaving their end-of-life treatment preferences as an unfortunate mystery. In any case, our system of end-of-life treatment needs reform. We spend an extremely disproportionate number of health care dollars on the last few months of patients' lives. What makes this all the more alarming is the research suggesting that many of these patients would have preferred to be left alone, at least to a certain extent. These problems can be greatly alleviated by shifting from the current system of advanced directives to a system that embraces the use of POLST forms.

II. History of End-of-Life Care

Under current law, patients are entitled to make their own health care decisions, but to do so the patient must be competent.¹ Most of the controversy surrounding end of life care is related to treatment for incompetent patients.

The current, most common approach to treatment for incompetent patients involves the use of advanced medical directives.² There are two types of advanced directives. The first type is known as a health care proxy, a person designated by any competent adult to make decisions for them regarding such things as providing or withholding life sustaining treatment.³ The second

¹ See, e.g., Ky. Rev. Stat. Ann. § 311.631 (West).

² See, e.g., N.Y. Comp. Codes R. & Regs. tit. 10, § 400.21.

³ See *id.*

type of advanced directive is a living will. This is a document executed by an individual, while they are competent, directing the providing or withdrawal of life sustaining treatment in specific circumstances.⁴

III. Problems with the Current System

A. Cost

As a nation, we spend an astounding percentage of our health care dollars on end of life care, particularly the last year of patients' lives. In 2006, the percentage of Medicare payments attributable to the last year of patients' lives was 25.1 percent.⁵ One can argue that this is acceptable and that there is great value in doing everything possible to prolong patients' lives even where some costly and invasive treatment turns out to be futile. However, this argument is complicated by the fact that most end of life care is funded by Medicare. Medicare covers 97 percent of Americans 65 years of age or over.⁶ As a joint, societal program, many Americans feel it unjust that the solvency of Medicare is threatened by costly and invasive treatment administered at the tail end of patients' lives. The controversy is furthered by research suggesting that such treatment often prolongs patients' lives to a minimal extent and, in any case, does little to enhance quality of life.⁷

⁴ See *id.*

⁵ See G. F. Riley and J. D. Lubitz, "Long Term Trends in Medicare Payments in the Last Year of Life," *Health Services Research* 45, no. 2 (2010): 565-576.

⁶ See Andersen, R., Lion, J., and Anderson, O.W.: *Two Decades of Health Services: Social Survey Trends in Use and Expenditure*, Cambridge, MA. Ballinger Publishing Co., 1976.

⁷ See Anne M. Wilkinson, Ph.D.; Janet Heald Forlini, J.D. (FNaa1), *Medicaring: Quality End-of-Life Care*, 2 J. Health Care L. & Pol'y 268, 272 (1999).

B. Patients' Preferences for End-of-Life Treatment are often Unrealized

Perhaps more prominent than the issue of cost is the research suggesting that the care many receive at the end of their lives is not aligned with how they prefer to be treated.⁸ This is significant because it means that our current system of advanced directives is not working very well. As a result, patient autonomy is being violated. It is also significant in how it relates to the previously mentioned issue of cost. Not only does end of life care account for such a drastic percentage of health care costs, it is likely that much of this treatment is administered to unwilling patients. What can be gathered from here is that these two issues (i.e. cost and autonomy) are interrelated and can be solved through one mechanism. If costly end-of-life care is limited to those patients who desire it, we would have lower overall costs. At the same time, we would have greater respect for patient autonomy.

There are various reasons as to why advanced directives have fallen short of their goal in allowing patients to retain control of their end of life treatment. The following are the most often cited explanations.

1. Too Few People Utilize Advanced Directives

According to an AARP poll, as of 2007 only 29 percent of Americans actually completed a living will or a health care proxy document.⁹ When controlling for people over 60 the rate jumps to 51 percent¹⁰ but this still leaves millions of Americans unaccounted for.

⁸ See S.B. Hardin Y.A Yusufaly, "Difficult end-of-life treatment decisions: do other factors trump advanced directives?" *Archives of Internal Medicine* 164 (2004): 1531-1533; H. S. Perkins, "Controlling Death: The False Promise of Advance Directives," *Annals of Internal Medicine* 147, no. 1 (2007): 51-57.

⁹ AARP Bulletin Poll: "Getting Ready to Go," *Executive Summary*. (AARP 2008). Available at http://assets.aarp.org/rgcenter/il/getting_ready.pdf (accessed November 22, 2012).

¹⁰ See *id.*

2. *Advanced Directives offer Little or Confusing Guidance*

Research suggests that the guidance provided for by advanced directive forms is inadequate and confusing to patients. One such study asked a sample of elderly volunteers to complete an advanced directive and then compared the completed forms to their verbally expressed desires for end-of-life treatment. A whopping 41 percent of respondents completed the forms in a manner inconsistent with their verbally articulated preferences.¹¹

3. *Patients' Preferences Changing Over Time*

Studies show that while patients' end of life preferences are likely to change over time, it is unlikely that their completed advanced directives will be revisited.¹² This is a particularly interesting challenge because rather than the issue stemming from a lack of adherence to the advanced directive, in this case adherence to the advanced directive is the problem.

4. *Health Care Proxies Often Do Not Understand Patients' Wishes*

The purpose of appointing a health care proxy is for the proxy to make health care decisions for the patient where the patient is incapacitated- presumably the decisions that the patient would have made. However, research suggests that this is often not the case. One study concludes that surrogates predict patients' end of life care preferences with only 68 percent accuracy.¹³

¹¹ See D. E. Hoffmann, S. I. Zimmerman, and C. J. Tompkins, "The Dangers of Directives or the False Security of Forms," *Journal of Law, Medicine & Ethics* 24, no. 1 (1996): 5-17.

¹² See A. Fagerlin and C. E. Schneider, "Enough: The Failure of the Living Will," *Hastings Center Report* 34, no. 2 (2004): 30-42.

¹³ See D. I. Shalowitz, E. Garrett-Mayer, and D. Wendler, "The Accuracy of Surrogate Decision Makers: A Systemic Review," *Archives of Internal Medicine* 166, no. 5 (2006): 493-497.

One can argue that this problem with advanced directives is overstated as the patient does not necessarily expect the proxy to understand the patient's preferences for every possible scenario with 100 percent accuracy. This viewpoint likely views the health care proxy as more of a delegation with the patient deferring to the proxy's judgment. However, it is still disconcerting that in 32 percent of cases, patients' preferences went unrealized.

5. *Physicians are often Unaware of Completed Directives*

Studies show that even when patients complete advanced directives, physicians are often unaware that the directive even exists. One study concluded that amongst patients who had completed living wills, their medical charts contained accurate information about the living will only 16 percent of the time.¹⁴ This may be a result of patients relying on family members or health care agents to produce the directive when needed.¹⁵ Furthermore, patients may give their advanced directive to a particular physician and then receive end-of-life care from an entirely different physician who is unaware that any directive exists.¹⁶

6. *Advanced Directives do not Significantly Affect Patient Care Even when the Physician Knows the Directive Exists*

Research suggests that completing an advanced directive often does not influence how a patient will be treated even when the physician is aware of the directive.¹⁷ This is perhaps the most alarming of all problems associated with advanced directives. This is not a result of

¹⁴ See R.S. Morrison, E. Olson, K.R. Mertz, and D.E. Meier, *The Inaccessibility of Advance Directives on Transfer from Ambulatory to Acute Care Settings*, *Journal of the American Medical Association*, 274(6)(1995):478-482.

¹⁵ See Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 *MILBANK Q.* 211, 221-224 (2010).

¹⁶ See *id.*

¹⁷ See Hardin and Yusufaly, *Supra* Note 8; J. M. Teno, M. Stevens, S. Spernak, and J. Lynn, "Role of Written Advance Directives in Decision Making: Insights from Qualitative and Quantitative Data," *Journal of General Internal Medicine* 13, no. 7 (1998): 439-446.

physicians purposefully disregarding the directive but rather (incorrectly) determining that the directive does not apply to the patient's particular situation.¹⁸

IV. POLST Forms as a Solution

In response to the limitations and problems associated with advanced directives, fourteen states have embraced the use of POLST (Physician Orders for Life-Sustaining Treatment) forms along with national coordination efforts administered through the Center for Ethics in Health Care at the Oregon Health & Science University.¹⁹ Originally developed in Oregon, a POLST form converts the patient's end of life care preferences into a medical order written by a physician with the concurrence of the patient instructing other health care providers (such as emergency personnel) how to treat the patient under specific circumstances.²⁰ The form is standardized and brightly colored, and completed with instructions particularly regarding the providing or withholding life sustaining treatment.²¹ While the states vary in their approach to implementation of the POLST program, a look at Idaho's statutory provisions illustrate what a POLST form is and how the program is intended to work.

Idaho actually refers to the form as a POST form which stands for Physician Orders for Scope of Treatment.²² While Idaho's approach to the program is fairly representative of the POLST forms emerging across the country, the difference in name is an example of subtle differences that exist between different states' programs.

¹⁸ See *id.*

¹⁹ Physician Order for Life Sustaining Treatment Paradigm available at [Http://www.ohsu.edu/polst](http://www.ohsu.edu/polst).

²⁰ Susan E. Hickman, Charles P. Sabatino, Alvin H. Moss, Jessica Wehrle Nester, *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).

²¹ See *id.*

²² Idaho Code Ann. § 39-4512A (West).

Idaho's statute describes a POST form as a health care provider order signed by the patient as well as a physician, physician's assistant, or advanced practice nurse.²³ The form can be signed by the patient's surrogate instead of the patient provided that the form is not contrary to the patient's last expressed wishes.²⁴ The form is effective from the date of execution until it is suspended or revoked.²⁵

In regard to the completion of the POST form, Idaho's statute provides that the physician, physician's assistant or advanced practice nurse should upon the request of the patient or surrogate assist in the completion of the form.²⁶ This includes discussing the form's content, ramifications, and treatment options.²⁷ Upon completion of the form, the patient should be provided with a copy.²⁸

Idaho's statute also specifies when the POST form should be reviewed by the physician, physician's assistant or advanced practice nurse. This includes every time the physician, PA or APN examines the patient (or at least every seven days for patients who are hospitalized), every time the patient is transferred from one health care setting to another, any time there is a substantial change in the patient's health status, and any time the patient's treatment preferences change.²⁹ It should be noted that "failure to meet these review requirements does not affect the POST form's validity or enforceability."³⁰

²³ See id.

²⁴ See id.

²⁵ See id.

²⁶ See id.

²⁷ See id.

²⁸ See id.

²⁹ See id.

³⁰ See id.

In regard to compliance, Idaho's statute requires health care providers and emergency medical personnel to comply with a POST form when presented with one or when a patient is wearing a POST identification device.³¹ Furthermore,

Health care providers and emergency medical services personnel shall make reasonable efforts to inquire as to whether the patient has completed a physician orders for scope of treatment (POST) form and inspect the patient for a POST identification device when presented with a situation calling for artificial life-sustaining treatment not caused by severe trauma or involving mass casualties and with no indication of homicide or suicide.³²

As one can observe from Idaho's statute, the POLST (or in Idaho's case, POST) paradigm is a significant shift from the old system of advanced directives. Because the POLST form is filled out by the physician and is a medical order, many of the problems associated with advanced directives do not exist. Upon revisiting some of the previously mentioned problems associated with advanced directives, one can see how the POLST paradigm is an effective solution.

A. More people will utilize POLST Forms than Advanced Directives

While many people do not take advantage of advanced directives, it is likely that the POLST paradigm will have far more successful enrollment. The reason for this is that the POLST form is filled out by the physician rather than the patient. As such, the physician can encourage the patient to partake in the POLST program during a routine visit. Some states have gone so far as to require physicians to offer patients a POLST option as will be later discussed.

³¹ Idaho Code Ann. § 39-4512B (West).

³² Idaho Code Ann. § 39-4512C (West).

B. *POLST Forms Provide Clarity Rather Than Confusion*

While advanced directives have been shown to confuse patients and distort their end-of-life care preferences, POLST forms can all but guarantee elimination of this problem. The reason is simply because the patient will not be expected to complete the POLST form alone. It is a team effort between the patient and the doctor (or in some states, physician's assistant or advanced practice nurse). Even if the patient is confused by some of the form's language, the physician will explain to the patient in clear and understandable terms what her options are, and complete the form accordingly. Furthermore, even if the patient takes the liberty of completing the form without a doctor's assistance, the form is not valid without the doctor's signature. A conscious doctor will not sign a POLST form until she is certain that the patient understands precisely the terms of the completed form.

C. *Patients' Changing Preferences will be Reflected in the POLST Form*

As mentioned, one of the problems with advanced directives is that patients rarely revisit their directives regardless of whether their end-of-life care preferences change.³³ This is obviously problematic as it renders the advanced directive outdated and divorced from the patient's true treatment preferences. In contrast, POLST forms will remain up-to-date and reflect patients' *current* treatment preferences. A look back at Idaho's POST statute reveals why:

The attending physician, APPN or PA shall review the POST form: (a) Each time the physician, APPN or PA examines the person, or at least every seven (7) days, for persons who are hospitalized; and (b) Each time the person is transferred from one (1) care setting or care level to another; and (c) Any time there is a substantial change in the person's health status; and (d) Any time the person's treatment preferences change.³⁴

³³ See *Supra* Note 12.

³⁴ See *Supra* Note 22.

To be fair, the POLST program is not foolproof in regard to the issue of patients' changing preferences. For one, not every state lays out review procedures explicitly as does Idaho. Additionally, even in Idaho's system, there is still the possibility for a patient's POST to not reflect a recent change in patient's preferences. For instance, if between physician visits, a patient changes their preferences regarding life-sustaining treatment and shortly thereafter slips into a comatose state, the patient will likely receive the treatment specified in the POST form which may not reflect the recent change. However, this scenario is a rarity and Idaho's approach goes a long way in ensuring that patients' forms are updated and reflect their current end-of-life care preferences.

D. POLST Forms Do Not Rely On Proxies

An understated benefit of the POLST program is a shift away from the approach of patients designating health care proxies. The reason this is a positive shift is because research proves that health care proxies all too often do not fully understand patients' true preferences.³⁵ Perhaps the reason that appointing proxies has been the most common form of communicating end-of-life care preferences is because of its simplicity. However, POLST forms offer patients a similar dose of simplicity without relying on a third-party to understand their health care preferences. Because no proxy is needed there is no problem of proxies misunderstanding patients' preferences.

E. Health Care Providers will Likely Know of an Existing POLST Form

As compared with advanced directives, health care providers will more likely be aware of an existing POLST form. This is especially true if the POLST form is made part of the patient's

³⁵ See *Supra* Note 13.

electronic medical records. An alternative proposal for storage and retrieval is the “form under the refrigerator magnet” method. These proposals will be explored further later on.

F. POLST Forms will Likely Affect Patient Care

POLST forms are more likely than advanced directives to affect patient care. The reason for this is that much of the ambiguity associated with advanced directives does not apply to POLST forms. Since the forms are filled out by a health care provider, the language is clear enough to make the patient’s treatment preferences understandable to the future treating physician. Furthermore, there is the potential to include standardized language to be used in the POLST form into legislation as will be discussed later.

V. Policy Questions and State Responses

Fourteen states currently have adopted the POLST paradigm to various degrees. In alphabetical order, they are California, Colorado, Hawaii, Idaho, Louisiana, Montana, New York, North Carolina, Oregon, Pennsylvania, Tennessee, Utah, Washington and West Virginia.³⁶ Additionally, many other states are in the process of developing POLST programs including Minnesota and Vermont.³⁷ This paper will focus solely on the POLST programs of California, Hawaii, Idaho, Minnesota, New York, North Carolina, Oregon, Tennessee, Utah, Vermont, Washington and West Virginia, because on these twelve states was done a substantial amount of research.³⁸

³⁶ See *Supra* Note 19.

³⁷ See *id.*

³⁸ C.P. Sabatino & N. Karp, *Improving Advance Illness Care: The Evolution of State POLST Programs*, Washington, DC: AARP Public Policy Institute, No. 2011-01 (2011).

While this paper continuously refers to the program as POLST, not every state which has adopted a version of the program employs this terminology. Idaho (as mentioned) and West Virginia refer to the program as POST for Physician Order for Scope of Treatment.³⁹ Additionally, New York, North Carolina, and Vermont also have a slight variation utilizing the terms MOLST (Medical Orders for Life-Sustaining Treatment),⁴⁰ MOST (Medical Orders for Scope of Treatment)⁴¹ and COLST (Clinicians Orders for Life-Sustaining Treatment)⁴² respectively. For the sake of consistency, this paper will refer to the form as POLST regardless of the state being discussed.

Implementing a POLST paradigm requires a host of policy questions to be addressed. Many states which have adopted the POLST paradigm have addressed these policy questions but have answered them in various ways as is often the case. Consequently, some differences in approach have emerged amongst the POLST states.

A. Necessity of Enacting Legislation

The first policy question is whether legislation is even necessary to launch a POLST program. Notably, some of the states which have made the shift did so without legislation. These states include Oregon, the pioneer of the entire program, as well as Minnesota. They developed the program through clinical consensus along with subsequent regulatory recognition of POLST's as a standard of care.⁴³ The remaining POLST states authorize some form of legislation but do so in various ways. For example, New York incorporates the POLST

³⁹ Idaho Code Ann. § 39-4512A (West); W. Va. Code Ann. § 16-30-25 (West).

⁴⁰ N.Y. Pub. Health Law § 2994-d (McKinney).

⁴¹ N.C. Gen. Stat. Ann. § 90-21.17 (West).

⁴² 12-5 Vt. Code R. § 15.

⁴³ *See Supra* Note 38.

legislation into their existing do-not-resuscitate provision⁴⁴ while North Carolina includes it into their medical malpractice code section.⁴⁵

To best achieve the goals of the POLST program, some form of legislation should be enacted in each state. The reason for this is simply to increase physician compliance with POLST forms. As mentioned, one of the primary problems associated with advanced directives is physician's disregarding existing directives in various circumstances.⁴⁶ Enacting legislation serves as a tool to increase physician compliance- it lends validity to the POLST form and will likely cause physicians to think twice before disregarding the form's instructions. This is especially true if the form mandates physician compliance in specific circumstances.

B. Duty to Offer POLST Option to Patients

Another policy question is whether health care providers should be required to offer patients a POLST option. Currently, two states, Tennessee and Utah, have such a requirement with Utah establishing policies to determine who is appropriate for POLST's.⁴⁷ This is a difficult issue as there are plausible cases to be made on each side. On one hand, doctors may not appreciate a legal mandate imposed on them and it is critical for doctors to embrace the system in order for it to work properly. On the other hand, without a legal requirement, POLST forms may suffer the fate of under-utilization experienced with advanced directives. This possibility may be more likely if doctors' interests are at odds with POLST forms such as widespread use of the forms resulting in more limited end-of-life treatment and thus lowering doctor reimbursements.

⁴⁴ See *Supra* Note 40.

⁴⁵ N.C. Gen. Stat. Ann. § 90-21.17 (West).

⁴⁶ See *Supra* Note 17.

⁴⁷ See *Supra* Note 38.

A reasonable approach would be to strongly encourage physicians to offer patients the POLST option but to fall short of making it a legal requirement. Additionally, patients should be encouraged to ask their doctor about the POLST option. Doctors will ultimately see the value in using the form and presumably they can be trusted to take care of their patients. If over time enrollment in the POLST program does not appear to be satisfactory then this issue can be revisited.

C. Duty to Comply with POLST Form

Regardless of whether states require physicians to offer patients a POLST option, there is the question of whether doctors should be required to comply with a POLST form if one does in fact exist. Nine states currently require compliance- California, Hawaii, Idaho, New York, Oregon, Tennessee, Vermont, Washington and West Virginia.⁴⁸ (Tennessee actually requires that the POLST form accompany the patient upon transfer or discharge.⁴⁹)

It is essential that states mandate physicians to comply with POLST forms. As mentioned, one of the key shortcomings of advanced directives is physicians' non-compliance. Shifting from the advanced directive model to the POLST as a required medical order is integral to the program's success. An additional question is whether there should be a penalty for health care providers who fail to comply with an existing POLST form. At the very least, physicians who administer life-sustaining treatment on a patient in conflict with an existing POLST form should be regarded as having administered treatment without having received informed consent.

⁴⁸ See *Supra* Note 38.

⁴⁹ See *id.*

D. Authority to Write/Sign POLST Form

A somewhat controversial policy issue which must be addressed is whether the legal authority to write POLST's should apply exclusively to physicians or whether it should be extended to other medical professionals such as nurses and physicians' assistants. There are arguments to be made on both sides of this issue. Extending the authority to non-physicians can be beneficial in increasing enrollment in the POLST program. On the other hand, doctors presumably have a stronger ability to communicate to patients what their options are and transmit patients' preferences to the POLST form. Clear language in the POLST form as well as proper guidance to the patient are both key to the program's success.

In six states, physicians are required to write (or at least sign) the POLST form. These states include California, Hawaii, Idaho, New York, Tennessee, and West Virginia.⁵⁰ The remaining states allow for nurse practitioners or physicians' assistants to sign which include Minnesota, North Carolina, Oregon, Utah, Vermont and Washington.⁵¹

It is probably best that legal authority to write and sign POLST's be limited to physicians. It is unlikely that satisfactory enrollment in the POLST program turns on allowing the forms to be completed by non-doctors. Most people have a primary care physician and if doctors are on-board they will assist in prompting and encouraging their patients to complete a POLST form. Leaving this responsibility to doctors will likely guard against the unclear language that plays a large role in the ineffectiveness of advanced directives.

⁵⁰ *See id.*

⁵¹ *See id.*

E. Immunity for Complying with a POLST Form

Another interesting policy question is whether health care providers should be granted immunity from civil or criminal liability for complying with POLST forms. With the exception of Minnesota, all of the mentioned states grant such immunity⁵² and for good reason. Lack of immunity would be a huge hindrance on the main goal of the POLST program: aligning patients' end-of-life care preferences with their actual end of life treatment. Physicians are trained to err on the side of providing life-sustaining treatment. Without immunity, they may exercise such caution even when presented with a POLST form instructing them otherwise for fear that the form is not entirely accurate. It is a big step for a physician to withhold life-sustaining treatment and immunity from liability is necessary for that step to be accomplished.

F. POLST Conflict with Advanced Directive

A complicated policy question which must be addressed by each state prior to implementing the POLST program is what happens when a POLST form conflicts with an advanced directive. Ideally, patients will not complete a POLST forms in a manner inconsistent with a prior advanced directives. However, whenever dealing with multiple forms there is the risk for conflict so steps must be taken to avert uncertainty.

The issue of inconsistent initiatives elicited wide divergence amongst the POLST states. In Idaho, North Carolina, and Utah, the POLST form governs.⁵³ In California and Washington, the most recently completed form governs.⁵⁴ In Tennessee, the advanced directive controls.⁵⁵ New York and West Virginia deal with inconsistencies by applying the substituted judgment/best

⁵² *See id.*

⁵³ Idaho Code Ann. § 39-4512A (West); Utah Code Ann. § 75-2a-106(7) (West); *See Supra* Note 19.

⁵⁴ Cal. Prob. Code § 4781.4 (West).

⁵⁵ *See Supra* Note 38.

interest standard.⁵⁶ Sadly, the remaining four states- Hawaii, Minnesota, Oregon and Vermont- do not at all consider the issue of inconsistency.

While the California/Washington approach may seem most logical, the Idaho/North Carolina/Utah approach (i.e. POLST governing) is most in line with the goals of the POLST paradigm. This is simply because it is beneficial to shift away from the advanced directive model, known to fall short of accomplishing patients' end of life care goals, and toward the POLST system which has a greater likelihood for success. If the advanced directive is to govern even in a case where it was completed more recently, it would discourage a shift away from the advanced directive model. Therefore, it is preferable for the POLST form to govern in all cases.

G. Incomplete POLST Forms/Presumption of Treatment

In some cases, a patient will fill out a POLST form only partially leaving some sections blank. Indeed, no state requires every section of the form to be completed since patients at the time of being presented the form may not be ready to decide on all of the options.⁵⁷ The question thus arises as to how incomplete sections of an existing POLST form should be treated.

Sound public dictates a presumption of full life-sustaining treatment where patients' preferences are unclear and incomplete sections of a POLST form should be treated no differently. This is the approach taken by most of the POLST states with New York and Vermont serving as the two exceptions.⁵⁸

Some may object to a presumption of maximum end of life treatment citing the disproportionately high costs as well as unduly invasive treatment that often times is

⁵⁶ W. Va. Code Ann. § 16-30-5 (West).

⁵⁷ See *Supra* Note 38.

⁵⁸ See *id.*

unsuccessful in extending patients' lives for more than a short period of time. However, the goal of the POLST program is for patients' treatment preferences to become known. If successful, guesswork will not need to be relied upon except in the rarest of circumstances. The true problem being addressed is not that of invasive end-of-life treatment generally but invasive end of life treatment interfering with patient autonomy. It should therefore not be necessary to presume anything less than maximum treatment in cases of uncertainty. If successful, the POLST program will make such cases rare exceptions.

H. Out of State Recognition of POLST Forms

Another more technical question involves state recognition of POLST forms from other states. Five of the mentioned POLST states expressly recognize POLST forms from other states- Idaho, New York, Oregon, Utah and West Virginia⁵⁹ (though West Virginia's recognition may be limited to DNR orders). North Carolina is the one state which explicitly denies recognition to out-of-state versions of POLST Forms.⁶⁰ The remaining six POLST states- California, Hawaii, Minnesota, Tennessee, Vermont and Washington- unfortunately do not address the issue of out-of-state POLST forms.

For proper adherence to POLST forms it is important that states recognize out-of-state versions. Lack of recognition of these forms will likely lead to the very confusion and uncertainty that plagued advanced directives. True, this scenario is limited to cases where one finds themselves outside of their home state but such an occasion is frequent enough that it is necessary for each state to address the issue.

⁵⁹ Idaho Code Ann. § 39-4514 (West); Or. Admin. R. 847-010-0110; Utah Admin. Code r. R432-31-11; W. Va. Code Ann. § 16-30C-15 (West).

⁶⁰ *See Supra* Note 41.

I. Storage and Retrieval of POLST Form

Some final policy considerations concern the storage and retrieval of POLST forms. A common proposal is the “form under the refrigerator magnet” method which suggests that all patients keep their POLST form on their refrigerator. This would allow medical personnel to know exactly where to find it in case of an emergency. This proposition has merit but is insufficient. Many emergencies take place outside of a patient’s home which could render the POLST form inaccessible when needed.

Many propose that POLST forms be made part of patients’ medical records.⁶¹ In simpler times this would just mean having the POLST form serve as the cover sheet of the patient’s medical records. However, as physicians and hospitals transition from paper towards electronic medical records, the question arises as to whether POLST forms be made part of patient’s electronic records.

It is preferable that POLST forms be made part of patient’s electronic medical records. The transition from paper to electronic records benefits the POLST program as it makes it more likely that physicians will be made aware of existing POLST forms. It further decreases the likelihood of POLST forms being lost or misplaced. It should be noted that incorporating POLST forms into patients’ electronic medical records will likely implicate the legal issues that apply to electronic medical records generally.⁶²

⁶¹ See Charles P. Sabatino, *National Advance Directives: One Attempt to Scale the Barriers*, 1 NAT’L ACAD. OF ELDER L. ATT’YS J. 131, 153 (2005); T.A. Schmidt, *The Physician Orders for Life-Sustaining Treatment Program: Oregon Emergency Medical Technicians’ Practical Experiences and Attitudes*, 52 J. AM. GERIATRICS SOC’Y 1430, 1431 (2004).

⁶² See, e.g., Blake Carter, *Electronic Medical Records: A Prescription for Increased Medical Malpractice Liability?* 13 VAND. J. ENT. & TECH. L. 385 (2011).

Some may fear that an electronic version of the POLST form could result in situations where the form is inaccessible. The concern here is that patient may have an emergency in their home or anywhere outside of a health care setting, and the attending practitioner will administer treatment without access to the patient's electronic medical records. This concern, while well intended, is unfounded. Inclusion of patients' POLST forms into their electronic medical records does not preclude the patient from maintaining a hard copy. Therefore, even if medical personnel find themselves in a patient's home unable to access the patient's medical records, they can still retrieve the original POLST form or a copy. Including the form into the patient's electronic medical records only serves to increase access to the form and make it more likely that personnel will discover the form in the course of emergency treatment.

In addition to incorporating POLST forms into patients' electronic medical records, to help facilitate access to the POLST form, doctors should be allowed to rely on copies or faxes of the original document. Indeed this is the rule in all POLST states except North Carolina.⁶³ West Virginia requires copies to be photocopied onto pink paper, the color of the original POLST form.⁶⁴

VI. Legal Impediments to Enacting POLST Legislation

For those states yet to enact POLST legislation there are several legal barriers which may slow the process. It is likely that some existing legislation will need to be amended to allow for a successful transition to the POLST paradigm.

⁶³ See *Supra* Note 38.

⁶⁴ See *id.*

A. Limitations on Consent to Forgo Life-Sustaining Treatment

Twenty-three states currently carry explicit limitations on substituted consent to forgo life-sustaining treatment.⁶⁵ Oklahoma for example expressly denies a decision maker the right to provide substituted consent to forgo life sustaining treatment unless a host of conditions are met including that

In the reasonable medical judgment of the incompetent patient's attending physician and a second consulting physician, artificially administered hydration or artificially administered nutrition will itself cause severe, intractable, and long-lasting pain to the incompetent patient or such nutrition or hydration is not medically possible; or in the reasonable medical judgment of the incompetent patient's attending physician and a second consulting physician: (a) the incompetent patient is chronically and irreversibly incompetent, (b) the incompetent patient is in the final stage of a terminal illness or injury, and (c) the death of the incompetent patient is imminent.⁶⁶

Limitations on consent to forgo life-sustaining treatment can obviously be impediments to enacting POLST legislation. Therefore, it is imperative for states that have such legislation to make the proper amendments that would allow for the legal implementation of the POLST paradigm. This does not necessarily require states to completely scale back their limitations on substituted consent to forgo life-sustaining treatment. They can simply include into their legislation exceptions for POLST forms which would allow for the forms to govern the withholding of life-sustaining treatment.

B. Do Not Resuscitate Orders

⁶⁵ See *Supra* Note 20.

⁶⁶ Okla. Stat. Ann. tit. 63, § 3080.4 (West).

Forty-seven states contain Do Not Resuscitate (DNR) protocols posing another legal obstacle for implementation of POLST legislation.⁶⁷ It seems counterintuitive for DNR protocols to serve as a barrier to POLST's. DNR's after all are meant to protect patients against unwanted life-sustaining treatment much like the POLST program. However, many of the DNR protocols contain medical preconditions which limit the use of the order to patients with specific conditions such as "terminal illness," or "permanent unconsciousness."⁶⁸ Furthermore, some medical preconditions require two qualified physicians to certify the precondition.⁶⁹

In addition to requiring medical preconditions, many DNR forms contain witnessing requirements. Applicable in twelve states, this means that the DNR order cannot be effectuated if it does not contain the signature of one or two witnesses.⁷⁰ This is in addition to the general requirement for the order to contain the signature of the patient and attending physician.

For proper implementation of POLST legislation, DNR protocols need to be scaled back or rendered inapplicable to POLST forms. Medical preconditions (as well as witnessing requirements) are counter to the goals of the POLST system. POLST forms are not meant to be limited to patients with a specific kind of ailment; they are a tool to allow individuals to have their end of life treatment preferences respected regardless of the circumstances.

VII. National Accountability

In light of the fact that so much divergence exists across the POLST states, a question that is bound to arise is whether the public would be better served with a national POLST form. The National Quality Forum as well as other experts has recommended nationwide

⁶⁷ See *Supra* Note 20.

⁶⁸ See *id.*

⁶⁹ See *id.*

⁷⁰ See *id.*

implementation of the POLST paradigm.⁷¹ However, while experts laud the widespread use of POLST forms, they seem to be content with variation among the states as opposed to a national form. As one author put it, "...consideration of the trends among the states and the ways in which various methods of implementation reflect or run counter to the overall good of deliberative democracy will assist those advocating the widespread use of POLST in determining which method they may wish to pursue."⁷²

It is not necessary to develop a national POLST form for the program to be successful. In fact, a national form may even produce some negative consequences. The primary goal of the POLST program is to align patients' end-of-life care preferences with their end-of-life treatment. The variation that exists amongst the POLST states simply represents multiple ways of achieving that goal. It is possible that the flexibility afforded to the states in carrying out the specifics of the POLST form increases the likelihood that the states- and perhaps even the physicians- will embrace the POLST program.

Rather than a national POLST form, what *would* be useful is data analysis comparing the various POLST states. While there is plenty of research analyzing the overall success of POLST forms, there is little research determining how some state approaches fair in contrast to other states. This would be extremely useful to states that are considering joining the POLST paradigm. As it stands, these states do not have a national paradigm to turn to but rather a hodgepodge of various state approaches. While the variety of approaches is good, it gives states

⁷¹ See National Quality Forum, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report*, 2006, at 43; S. J. Baumrucker, Editorial, "Physician Orders for Scope of Treatment: An Idea Whose Time Has Come," *American Journal of Hospice and Palliative Medicine* 21, no. 4 (2004): 247-248; Laura C. Hanson & Mary Ersek, *Meeting Palliative Care Needs in Post-Acute Care Settings*, 295 *J.A.M.A.* 681, 681-86 (2006).

⁷² See Kathy L. Cerminara, J.D., LL.M., J.S.D. & Seth M. Bogin, B.A., M.S.Ed., *A Paper About A Piece of Paper Regulatory Action As the Most Effective Way to Promote Use of Physician Orders for Life-Sustaining Treatment*, 29 *J. Legal Med.* 479, 481 (2008).

little guidance regarding adopting a particular approach. Therefore, a research committee should be designated with comparing the effectiveness of the POLST forms amongst the various POLST states. This will assist new-member states in joining the POLST program and making educated decisions regarding which particular approach to adopt.

VIII. Results of POLST Programs

The results of active POLST program have been encouraging. As early as 2006, the National Quality Forum in its consensus report observed that POLST forms convey patients' end of life preferences more accurately than do advanced directives.⁷³ In addition, POLST forms have been shown to result in higher adherence by medical professionals as compared with advanced directives.⁷⁴ One study shows compliance with POLST forms in specific circumstances as high as 91 percent.⁷⁵

IX. Conclusion

Death is as sad as it is inevitable. It is something we fail to think about until it is very close. Many people push off decisions regarding how they want to be medically treated at the end of their life. In some unfortunate cases, the patients' decisions about treatment preferences are not made or not expressed in time for health care providers to treat them accordingly.

As a society, it behooves us to ensure that our citizens die with dignity. Different people may have different ideas about what it means to die with dignity. But at the very least, most can agree that it means providing people with autonomy with respect to their end-of-life care. It also

⁷³ National Quality Forum, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report*, 2006, at 43.

⁷⁴ *See id.*

⁷⁵ *See* M.A. Lee, K. Brummel-Smith, J. Meyer, N. Drew, M.R. London, *Physician orders for life-sustaining treatment (POLST): outcomes in a PACE program. Program of All-Inclusive Care for the Elderly*, *J Am Geriatr Soc.* 48(10)(2000):1219-1225.

means creating an environment which encourages people to make the difficult decisions about end-of-life care and assists them in the process. Most importantly, it means ensuring that when a person expresses preferences regarding end-of-life treatment, those preferences are respected.

As a society, we have long recognized a person's right to decide for themselves their end-of-life treatment. Far from something new, this idea is rooted in the advanced directive framework. In theory, advanced directives acknowledge that a person is entitled to decide their end-of-life treatment. The problem with advanced directives is that they simply do not work. Patients often fail to utilize advanced directives.⁷⁶ In cases where advanced directives *are* completed, physicians often fail to comply with them.⁷⁷

The POLST paradigm is a proven response to the shortcomings of advanced directives. It is not a shift in societal viewpoint for its goals are similar to those of advanced directives. The POLST form is designed to allow people to make their own end-of-life decisions. However, in contrast to advanced directives, the POLST form produces high enrollment as well as a significant increase in physician compliance.

Many states have seen the value in adopting the POLST program. Some variation in approach exists between these states but the heart of the program is consistently applied. The differences that exist are not problematic as they reflect some level of flexibility within the POLST program.

It is important for states which have not yet done so to adopt the POLST paradigm. States which currently utilize POLST forms have seen excellent results. Physicians' assistance in completing the forms will result in higher POLST enrollment as compared with advanced

⁷⁶ See *Supra* Note 9.

⁷⁷ See *Supra* Note 8.

directives. Further, physicians are more likely to be aware of an existing POLST form than an advanced directive and are more likely to comply with its instructions.⁷⁸ Advanced directives have been shown to be insufficient and there is little reason not to embrace the POLST program.

It is not important for every state to adopt the program in exactly the same way. However, it is important for every state to get on board with the premise of the POLST form. When such forms are commonplace throughout the nation, the true goals of the POLST program will have been achieved.

⁷⁸ See *Supra* Note 73; See *Supra* Note 75.