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POLST: A Cure for the Common Advance Directive - It's Just What the Doctor Ordered

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KEITH E. SONDERLING*

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I. INTRODUCTION

For years, the legal and medical communities have fused their knowledge in an attempt to honor the decision of individuals regarding their life-sustaining treatment and end-of-life care. In 1914, Justice Cardozo laid the foundation for patients to take control over their own health care decisions when he stated that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”¹ Today, patients and their families are often presented with a host of medical options concerning life-sustaining treatment and end-of-life care. Developed as tools for

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1. *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

patients and their families to take control of these difficult medical decisions, advance directives specify the care and treatment patients wish to receive or refuse.² Advance directives also identify individuals authorized to make treatment decisions if the patient is incapacitated.³ Both the medical and legal communities advocate the use of advance directives as a way for “each patient to shape the course of his or her medical care,” especially when patients are unable to communicate their own preferences.⁴

Unfortunately, due to a variety of obstacles, the original intent of advance directives often is not accomplished.⁵ In an attempt to correct the problems associated with advance directives, health care professionals, attorneys, and bioethicists have worked together, developing new forms of documentation to enhance traditional advance directives and effectively implement patients’ wishes concerning end-of-life care.⁶ One such model is the Physician Orders for Life-Sustaining Treatment (POLST) form.⁷ The POLST form is a medical document designed to translate a patient’s end-of-life care desires “into actual physician orders.”⁸ Heralded as “revolutionary,”⁹ “unique,”¹⁰ and a “progressive” advance directive,¹¹ the POLST form does not replace traditional advance directives, but does convert existing advance directives into written medical orders, which attending caregivers can easily understand.¹² Surveys demonstrate that medical professionals are concerned about administering end-of-life care, and they have asked for in-

2. SUSAN E. HICKMAN ET AL., THE HASTINGS CTR., HOPE FOR THE FUTURE: ACHIEVING THE ORIGINAL INTENT OF ADVANCE DIRECTIVES, IMPROVING END OF LIFE CARE: WHY HAS IT BEEN SO DIFFICULT? S26 (2005) [hereinafter HICKMAN ET AL., HASTINGS CTR. REPORT].

3. *Id.*

4. See Joan M. Teno et al., *Do Advance Directives Provide Instructions That Direct Care?*, 45 J. AM. GERIATRICS SOC’Y 508, 508 (1997).

5. See HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S26. Traditional forms of advance directives include the living will and the designation of a health care surrogate. *Id.*

6. See *id.* at S27.

7. *Id.* at S28.

8. Washington State Medical Association, Physician Orders for Life-Sustaining Treatment POLST Form, *available at* http://www.wsma.org/patient_resources/polst.cfm#faq (last visited Feb. 21, 2009) [hereinafter WSMA].

9. Ron Wyden, *Steps to Improve Quality of Life for People Who Are Dying*, 6 PSYCHOL. PUB. POL’Y & L. 575, 577 (2000).

10. Charles P. Sabatino, *Survey of State EMS-DNR: Laws and Protocols*, 27 J.L. MED. & ETHICS 297, 298 (1999) [hereinafter Sabatino, *Survey*].

11. Susan E. Hickman et al., *A Viable Alternative to Traditional Living Wills*, 34 HASTINGS CTR. REP. 4, 5 (2004) [hereinafter Hickman et al., *Viable Alternative*]. Although the authors refer to the POLST form as an example of an advance directive, the POLST form is a new model of medical documentation designed to enhance and eventually replace existing advance directives. See *id.*

12. See WSMA, *supra* note 8.

creased care planning and better documentation of treatment desires.¹³ One of the most notable features of the POLST form is that it is not a complicated legal document, which can be difficult for caregivers to interpret.¹⁴

Various studies demonstrate the effectiveness of the POLST form in achieving the original intent of a patient's wishes.¹⁵ However, Florida, whose advance directives statutes are considered to be contemporary guidelines for other states,¹⁶ in 2006 failed to pass House Bill 1017, which would have created a POLST form.¹⁷ Almost three years later, the political and social issues that plagued the passage of House Bill 1017 have diminished. As the state with the largest population of elderly residents as well as significant populations of persons with AIDS and heart disease,¹⁸ Florida has a vested interest in strengthening and enhancing its current advance directive laws. Accordingly, Florida must follow the lead of other states that have taken a proactive approach to the development and implementation of POLST initiatives.

It was surprising, in the wake of the national attention that Florida and the subject of end-of-life decision making received surrounding Terri Schiavo's end-of-life care,¹⁹ that the Florida Legislature did not pass the proposed POLST legislation.²⁰ Supporters of the bill believe that the legislation failed for a number of reasons, including the legislature's reluctance to deal with controversial end-of-life legal issues in the wake of the Terri Schiavo legal battle.²¹ The timing of book releases by Terri's parents and husband,²² as

13. See HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S26–S27.

14. See *id.* at S28.

15. See *id.*

16. Theodore P. Gustitus, Note, *A Comparative View of Advance Health Care Directives in Florida and North Carolina*, 11 QUINNIAC PROB. L.J. 163, 165 (1997) (comparing Florida's contemporary approach with North Carolina's traditional approach to statutory construction of advance directive laws).

17. H.B. 1017, 2006 Leg., Reg. Sess. (Fla. 2006) (identical to S. 2572, 2006 Leg., Reg. Sess. (Fla. 2006)).

18. Act effective Oct. 1, 1999, ch. 99-331, § 1, 1999 Fla. Laws. The legislature also found that Florida has the third highest population of individuals with AIDS, as well as the fourth highest rate of deaths "from heart disease and chronic obstructive pulmonary disease in the nation." *Id.* at 3455.

19. See Kathy L. Cerminara, *Tracking the Storm: The Far-Reaching Power of the Forces Propelling the Schiavo Cases*, 35 STETSON L. REV. 147, 147 (2005). Terri Schiavo, gained national attention in 2005 due to the conflict between her husband and her parents regarding her life-sustaining care desires. *Id.*

20. H.B. 1017, 2006 Leg., Reg. Sess. (Fla. 2006). House Bill 1017 died in health care regulation committee on May 6, 2006. *Id.* Senate Bill died on May 5, 2006. S-2572, 2006 Leg., Reg. Sess. (Fla. 2006).

21. See, e.g., Cerminara, *supra* note 19, at 147.

well as then Governor Jeb Bush's reluctance to make changes to the advance directive laws during his final term have also been identified as factors contributing to the failure of the bill.²³ Additionally, in 2005, the Florida Senate Committee on Health Care reviewed Florida's advance directive statutes and recommended no changes be made to the current law.²⁴

House Bill 1017 would have required the Florida Department of Health to create a POLST form and to make the form available on its website.²⁵ The proposed bill also would have required both a licensed health care professional and the patient to complete and sign the POLST form and to place the completed form in the patient's medical record.²⁶ Under House Bill 1017, the POLST form would have been a type of advance directive pursuant to chapter 765 of the *Florida Statutes*.²⁷ As this article will demonstrate, the POLST form serves to promote the intent and effectiveness of advance directives by clearly documenting a patient's end-of-life treatment decisions as a physician's order.

Accordingly, new POLST legislation should be reintroduced pursuant to chapter 401 of the *Florida Statutes*, authorizing the use of the POLST form as a written medical order to be used as an alternative to, replacement for, or enhancement of, the Do Not Resuscitate Order. Part II of this article describes the history, the purpose, and the effectiveness of the POLST form. Additionally, this section presents an analysis of those states that have implemented POLST legislation or are in the process of developing a POLST form. Part III of this article analyzes Florida's advance directive laws. This section also distinguishes the POLST form from Florida advance directives. Part IV of this article addresses problematic issues associated with Florida's advance directives and demonstrates how the POLST form attempts to resolve these issues. Part V discusses how the POLST form satisfies advance directive reforms suggested by the medical, legal, and bioethical communi-

22. See generally MICHAEL SCHIAVO, TERRI: THE TRUTH (2006) (detailing husband's account of the legal debate); MARY & ROBERT SCHINDLER ET AL., A LIFE THAT MATTERS: THE LEGACY OF TERRI SCHIAVO—A LESSON FOR US ALL I (2006). Terri Schiavo's husband and parents released their books on March 27, 2006. David Sommer, *Characters in Schiavo Case Live in Its Wake*, TAMPA TRIB., Mar. 29, 2006, at 8.

23. See Maya Bell, *Bush Drops End-of-Life Push—Legislators Not Willing to Reopen Schiavo Debate*, SUN-SENT., Apr. 13, 2006, at 12B.

24. The Florida Senate Interim Project Report 2006-137, Committee on Health Care, Review Procedures for Sustaining and Safeguarding Written and Oral Advance Directives and Purpose Methods for Increasing Floridians' use of Written Advance Directives (Nov. 2005), available at http://www.flsenate.gov/data/Publications/2006/Senate/reports/interim_reports/pdf/2006-137he.pdf.

25. H.B. 1017, 2006 Leg., Reg. Sess. (Fla. 2006).

26. See *id.*

27. *Id.*

ties. This section also briefly details potential problems of the form's implementation. Part VI concludes with a recommendation to the Florida Legislature for the reintroduction of POLST legislation as a medical order under chapter 401 of the *Florida Statutes* and not as an advance directive under chapter 765.

II. PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

An overview of the POLST form is presented in Part A of this section. The origin and history of the form is outlined in Part B. The purpose of each section of the POLST form is reviewed in Part C. Part D provides statistical evidence demonstrating the effectiveness of the form. Part E details the use of the POLST paradigm in various states throughout the nation.

A. Overview

Physician Orders for Life-Sustaining Treatment is a medical order form known by the acronym "POLST."²⁸ "The form is an example of an actionable advance directive that is specific and effective immediately."²⁹ This makes the POLST form the most efficient advance planning mechanism for patients with terminal or life-threatening conditions.³⁰ The form "is a short summary of treatment preferences . . . [which] centralizes information, facilitates record keeping, and ensures transfer of appropriate information among health care providers."³¹ The physician documents the patient's treatment and care decisions on the form.³² The neon colored form serves as the "cover sheet to the [patient's] medical record."³³ The information contained in the form will be followed in the same manner as other physician orders.³⁴ As part of the medical record, "the POLST form travels with the patient" between health care settings.³⁵ Accordingly, the receiving health care provider

28. HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S28.

29. *Id.*

30. See Maureen Henry, *Update on End-of-Life Issues in Utah*, 19 UTAH B. J. 6, 9 (2006).

31. See WASHINGTON STATE DEP'T OF HEALTH, POLST PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT iii (2003) [hereinafter WASHINGTON].

32. 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) [hereinafter Sabatino, *National*].

33. *Id.* at 153; see Terri A. Schmidt et al., *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).

34. WSMA, *supra* note 8.

35. Sabatino, *National*, *supra* note 32, at 153.

has the appropriate information and documentation regarding the patient's end-of-life requests, "thus, promoting continuity of care decisions."³⁶

The most important and unique aspect of the POLST form is that it translates end-of-life discussions between patients and their doctors into actual treatment decisions.³⁷ The form is a clearly recognizable "set of physician orders" that health care providers must follow.³⁸ POLST documentation provides clarity to health care providers and a sense of comfort to patients ensuring that their treatment preferences will be properly interpreted and implemented.³⁹ Unlike advance directives, which merely document a patient's end of life care decisions, the POLST form clearly translates a patient's requests into specific written medical orders.⁴⁰ These orders are understandable and executable by all health care providers, even those who are unfamiliar with the individual patient.⁴¹ Because it is a medical order signed by a physician, "it is immediately actionable without further interpretation."⁴² The POLST form clarifies treatment desires, which reduces confusion for the attending health care provider, especially in emergency situations.⁴³ As part of the patient's medical record, the POLST form is intended to travel with the patient upon transfer to another care setting.⁴⁴ POLST documentation is particularly helpful to receiving health care providers who are unfamiliar with the patient, such as emergency room physicians or paramedics.⁴⁵ These health care providers are often first responders who are in a position to administer life sustaining treatments to incapacitated patients.⁴⁶ The POLST form allows the receiving medical facility or health care provider to follow specif-

36. *Id.*

37. WSMA, *supra* note 8.

38. *Id.*

39. *See id.*

40. *See* HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S28.

41. *See* Hickman et al., *Viable Alternative*, *supra* note 11, at 5.

42. *Id.*

43. *See* WSMA, *supra* note 8.

44. Jim Newman, *Converting Patient Wishes into Medical Orders*, OHSU Studies Program, MED. NEWS TODAY.COM, Oct. 12, 2005, <http://www.medicalnewstoday.com/medicalnews.php?newsid=31884>.

Because the POLST form travels with a person from nursing home, to hospital to other health care settings, they are particularly useful in cases where input about health care options is immediately needed. For instance, if a seriously ill person is incapacitated when paramedics arrive, the form provides the emergency medical technicians with orders for treatments that are consistent with patient preferences.

Id.

45. Milton Zadina & Lisa Weber-Devoll, *A New Era in Advance Directives*, 5 NEB. MED. 10, 10 (2006).

46. *See id.*

ic doctor's orders regarding the patient's end-of-life wishes.⁴⁷ The POLST form also eliminates the need for redundant questioning regarding life-sustaining treatment wishes because it provides pertinent information related to the requirements of the Patient Self Determination Act (PSDA).⁴⁸ Currently, there is no other form that streamlines the documentation process related to life sustaining treatment decisions and end-of-life care in this manner.⁴⁹

Although the design of the POLST form is intended to efficiently and effectively expedite a patient's end-of-life medical care, the most important goal of the form is to ensure "that treatment wishes are honored in the event that a patient is unable to speak for him or herself."⁵⁰ Unlike advance directives, which are often created by patients and their attorneys, the POLST form is designed to facilitate discussion between the physician and the patient concerning a wide range of end-of-life care options specifically tailored to a patient's current medical condition.⁵¹ This physician-patient dialogue results in a POLST form clearly documenting the patient's end-of-life treatment decisions as standardized physician's orders.⁵² Typically, these orders include the patient's desires in relation to such life-sustaining measures as resuscitation, antibiotic use, and food and fluid administration.⁵³ The POLST form is modified according to changes in the patient's condition and desires, thus ensuring that the form accurately reflects the patient's wishes.⁵⁴ In addition to providing clarity to the patient's health care providers, the POLST form provides definitive direction to family members and significant others.⁵⁵ Accordingly, the burden of life-sustaining treatment options and decisions that often plague family members in times of crisis can be reduced by the knowledge that the POLST form documents a clear articulation of the patient's treatment wishes, which will be carried out as standardized physician's orders.⁵⁶

47. WSMA, *supra* note 8.

48. *Id.*

49. *Id.*

50. Erin B. Furlong, *Legal Trends in End-of-Life Health Care Decision-Making*, 27 BIFOCAL 21, 26 (2005).

51. *See* Sabatino, *National*, *supra* note 32, at 153.

52. WSMA, *supra* note 8.

53. Hickman et al., *Viable Alternative*, *supra* note 11, at 5.

54. *See* Zadina & Weber-Devoll, *supra* note 45, at 10.

55. *See id.*

56. *See id.*

B. *Origin*

In 1990, various Oregon ethics committees convened to discuss problems associated with Oregon's advance directive law.⁵⁷ Committee members consisted of doctors, nurses, and emergency personnel who were concerned about the difficulties patients and their families encountered when dealing with end-of-life decisions.⁵⁸ The committee raised additional concerns regarding the inadequacy of Do Not Resuscitate Orders (DNRO), especially upon the transfer of patients to and from health care facilities.⁵⁹ Identifying a need for a new type of DNRO or advance directive that would summarize a patient's end-of-life preferences as a portable physician order led to the creation of the POLST Task Force.⁶⁰ Over the next five years, the POLST Task Force developed a form which converted end-of-life treatment preferences into written medical orders, known as the Physician Orders for Life-Sustaining Treatment form.⁶¹

In an attempt to escape legislative scrutiny, impacting the comprehensiveness of the newly created form, the POLST Task Force decided to "bypass the Oregon State Legislature" and recommended voluntary rather than mandated use of the POLST form.⁶² The POLST Task Force was also successful in persuading the Oregon Board of Medical Examiners to modify its administrative rules, which defined how emergency medical technicians (EMTs) should comply with DNROs.⁶³ With strong support from the EMT community, amendments to administrative rules provide that EMTs should comply with the POLST form in the same manner as a DNRO.⁶⁴ Additionally, this ruling provided immunity to EMTs from liability for good faith compliance with the POLST form.⁶⁵

57. See Jeri Spann, *Implementing End-of-Life Treatment Preferences Across Clinical Settings*, STATE INITIATIVES IN END-OF LIFE CARE, at 1, 3 (National Program Office for Cmty.-State P'ships to Improve End-of-Life Care, Issue 3, 1999), available at http://www.rwjf.org/files/publications/other/State_Initiatives_EOL3.pdf.

58. See Susan W. Tolle et al., *A Prospective Study of the Efficacy of the Physician Order Form for Life-Sustaining Treatment*, 46 J. AM. GERIATRICS SOC'Y 1097, 1098 (1998).

59. See *id.*

60. See *id.*

61. *Id.*

62. Spann, *supra* note 57, at 1-2. Circumventing the Oregon legislature prevented alterations to the form and allowed the task force to effectively expedite the implementation of the POLST form. See *generally id.*

63. *Id.* at 2.

64. See *id.*

65. See *id.*

Between 1992 and 1995, the POLST Task Force focused on finalizing the form through extensive research and a test pilot program.⁶⁶ The pilot study showed that health care providers were eager to use this form.⁶⁷ By 1995, health care providers were utilizing the form throughout Oregon, and in 1996, modifications made the form more patient-friendly.⁶⁸ Since the modifications, the POLST Task Force distributed over one million forms to nursing homes, hospices, and hospitals throughout the state.⁶⁹ Consequently, in 2002, the majority of Oregon medical facilities used the POLST form.⁷⁰ In November 2004, the task force again modified the form to enhance its clarity and utility.⁷¹ The success of the Oregon POLST program serves as an impetus and model for other states.

C. *The Form*

The Oregon POLST form is a two-sided document printed “on bright pink card stock.”⁷² The top of the form includes a standard Health Insurance Portability and Accountability Act (HIPAA) statement,⁷³ which allows each health care provider to legally disclose the form to other receiving health care providers.⁷⁴ The upper-right corner of the form contains the patient’s name and date of birth.⁷⁵ The form instructs the receiving health care provider to follow the documented orders and contact the patient’s listed physi-

66. See Spann, *supra* note 57, at 2.

67. See *id.*

68. See *id.* The 2004 modifications included eliminating confusing statutory language and complicated medical terminology, and creating questions regarding medical options requiring only a yes or no response. See generally WASH. PUB. HOSP. DIST.S., SUMMARY OF CHANGES TO THE POLST FORM—Nov. 2004 (2004) <http://www.awphd.org/EndOfLife/TableofPOLSTFormChanges2004.pdf>.

69. POLST, History of the POLST Paradigm Initiative, <http://www.ohsu.edu/ethics/polst/developing/history.htm> (last visited Feb. 21, 2009) [hereinafter History of the POLST].

70. See *id.*

71. See generally WASH. PUB. HOSP. DIST.S., *supra* note 68.

72. Melinda A. Lee et al., *Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program*, 48 J. AM. GERIATRICS SOC’Y 1219, 1220 (2000).

73. See CENTER FOR ETHICS IN HEALTH CARE, POLST FORM (2008), <http://www.ohsu.edu/ethics/polst/programs/documents/POLST.August.2008.sample.pdf> [hereinafter POLST FORM].

74. See generally Health Insurance Portability & Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified in scattered sections of the U.S.C.). The Health Insurance Portability and Accountability Act of 1996 is a federal law containing administrative, technical, and regulatory mandates regarding the organization and documentation of medical records and health information. See generally *id.* Criminal and civil penalties can be imposed for violations. *Id.* at § 217; 45 C.F.R § 150.305 (2008).

75. See POLST FORM, *supra* note 73.

cian or nurse practitioner.⁷⁶ The form also notifies the health care provider to administer full treatment in the event any section is left blank.⁷⁷

Divided into five treatment sections, the front page contains information regarding: Cardiopulmonary Resuscitation (CPR), Medical Interventions, Antibiotics, Artificially Administered Nutrition, and Reason for Orders and Signatures.⁷⁸ The CPR section is similar to a DNRO, instructing the health care provider regarding treatment if the patient “has no pulse and is not breathing.”⁷⁹ The patient has the choice to be resuscitated or not to be resuscitated.⁸⁰ If the patient is breathing or has a pulse, the Medical Interventions section applies.⁸¹ The patient may choose Comfort Measures Only, which includes food, fluids, medical measures to relieve pain and suffering, other limited interventions, including oxygen, cardiac monitoring, and manual treatment of obstructed airways.⁸² A patient may also choose Full Treatment, including “mechanical ventilation and cardioversion.”⁸³ Under the Antibiotics section, the patient may choose to receive no antibiotics, limited antibiotics, or all antibiotics that are medically indicated.⁸⁴ The Artificially Administered Nutrition section is applicable when the patient is unable to take food or liquid by mouth.⁸⁵ The patient may decline tube feedings, or may request a trial period for a specified number of days, or choose to receive long-term artificial nutrition.⁸⁶ The final section, identified as the Reason for Orders and Signatures, documents with whom the patient discussed his or her final treatment preferences.⁸⁷ Both the patient and physician must sign the bottom of the front page.⁸⁸ A designated surrogate may sign on behalf of the incapacitated patient.⁸⁹ The back of the form contains an option for a guardian, surrogate, or other contact person to be notified, as well as instruc-

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. See POLST FORM, *supra* note 73.

81. See *id.*

82. *Id.* This option prevents transfers to another medical facility if the current location is adequate. See *id.* This option does transfer the patient to the hospital, but avoids the intensive care unit, if possible. See *id.*

83. POLST FORM, *supra* note 73.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

88. POLST FORM, *supra* note 73.

89. *Id.*

tions on the form's use and revision.⁹⁰ The back of the form also contains a chart documenting the form's previous modifications.⁹¹

D. *Effectiveness*

Since its inception in the mid 1990s, the POLST form has been “[o]ne of the most studied systems of advance care planning.”⁹² Various studies show that the POLST form is effective in ensuring one of its primary goals, which is the prevention of unwanted life-sustaining treatment.⁹³ Generally, the research has concluded that emergency medical providers who are responsible for administering treatment regularly follow and can easily interpret the POLST form in situations where life-sustaining treatment is required.⁹⁴

After being widely used throughout Oregon, researchers conducted studies to determine the effectiveness of the form.⁹⁵ The first study, by Susan Tolle, was conducted over a one-year period, of 180 nursing home residents who had completed a POLST form. It was designed to assess the actual implementation of the documented orders and the level of comfort care administered.⁹⁶ All of the patients requested not to be resuscitated and asked to be transferred to a hospital only if the requested comfort measures could not be provided in the nursing home.⁹⁷ Of these patients, none were resuscitated or received ventilator support.⁹⁸ Most importantly, the study found adherence to the form in 98% of the cases.⁹⁹ Furthermore, the high degree of the form's portability across health care settings was evidenced by the finding of the proper location of the form in 94% of the patient's records.¹⁰⁰ The most widely credited finding of the study is that POLST orders are followed regularly and result in “low rates of transfer for aggressive life-extending treatments” and “high levels of comfort care.”¹⁰¹ Tolle credited these positive outcomes to several aspects of the form's design.¹⁰²

90. *Id.*

91. *Id.*

92. HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S28.

93. *See* Spann, *supra* note 57, at 3.

94. *See id.*

95. *See, e.g.*, Tolle et al., *supra* note 58, at 1097.

96. *Id.* at 1098.

97. *Id.*

98. *Id.* at 1097.

99. *See id.*

100. Tolle et al., *supra* note 58, at 1100.

101. *Id.* at 1097.

102. *See id.* at 1101.

Following Tolle, Melinda A. Lee conducted a study of fifty-eight patients in an Oregon nursing home “[t]o evaluate whether terminal care was consistent with” the patient’s POLST form.¹⁰³ The study revealed that 98% of the participants had completed a POLST form.¹⁰⁴ Results of the study indicated that “care was consistent with POLST instructions regarding CPR for 91% of participants, antibiotics for 86%, IV fluids for 84%, and feeding tubes for 94%.”¹⁰⁵ Additionally, only one patient’s form was missing and only two forms were completed improperly.¹⁰⁶ In conclusion, Lee found that the POLST form “shows promise as a tool for promoting that patients’ preferences regarding end of life care are carried out.”¹⁰⁷

A third study, by Terri A. Schmidt, evaluated the attitudes and practical experiences of EMTs regarding their use of the POLST form in multiple care settings.¹⁰⁸ The study indicated that 75% of the EMTs readily located the POLST form.¹⁰⁹ Furthermore, EMTs reported proper completion of 87% of the forms and adherence to orders in 90% of the forms.¹¹⁰ Most importantly, 93% of the EMTs surveyed thought “the POLST form was useful in determining which treatments to” administer.¹¹¹ Most significantly, this study found that EMTs modified their standard treatment plan pursuant to a patient’s preferences as documented on the POLST form.¹¹² Overall, the “[f]indings suggest that the . . . POLST program is effective in providing instructions to EMTs regarding life-sustaining treatments.”¹¹³

These studies demonstrate that the POLST form is a patient and provider-friendly planning tool which clearly documents life-sustaining and end-of-life treatment decisions in a form that is readily accessible and easily inter-

Several features appear to add to the effectiveness of the POLST form. The form has been standardized statewide, which enhances [the] recognition and respect on transfer. The shocking pink color of the form makes it hard to ignore. The orders to limit life sustaining treatment are clearly stated, . . . making them easy to locate. The form contains *physician* orders about specific medical treatments in language acceptable and understandable to nursing home staff, home hospice, covering physicians, and emergency medical services. The form’s specific language requiring that comfort measures must be provided is designed to encourage attention to pain and suffering.

Id.

- 103. Lee et al., *supra* note 72, at 1219.
- 104. *Id.* at 1222.
- 105. *Id.*
- 106. *See id.* at 1221.
- 107. *Id.* at 1224.
- 108. *See* Schmidt et al., *supra* note 33, at 1430.
- 109. *See id.* at 1433.
- 110. *See id.* at 1432.
- 111. *Id.*
- 112. *See id.* at 1434.
- 113. Schmidt et al., *supra* note 33, at 1434.

preted by a variety of health care providers.¹¹⁴ Finally, these studies show that the POLST form “offer[s] insight[] that health care systems should not ignore. It is time to make sure that patients get what they want, [and] not just what we think they need.”¹¹⁵

E. *Use in Other States*

Due to success in Oregon, POLST paradigm programs are spreading rapidly.¹¹⁶ Many states simply use the Oregon form, while other states use modified versions of the Oregon form.¹¹⁷ The following provides a policy analysis of those states that pioneered and enacted original POLST legislation.¹¹⁸ Washington State implemented a POLST form replacing the state’s EMS-No-CPR form.¹¹⁹ Additionally, Washington State, like Oregon, altered its administrative code, protecting emergency medical service providers from liability for following the POLST form in good faith.¹²⁰ Similarly, West Virginia passed legislation in 2002 codifying their own version of the POLST form, known as the “physician’s orders for scope of treatment (POST).”¹²¹ Recognized as a Do Not Resuscitate Order (DNRO), the POST form provides legal protection to health care providers for good faith compliance.¹²²

Utah has also enacted POLST legislation.¹²³ Added to the Personal Choice and Living Will Act, the POLST form in Utah has in effect replaced

114. See Lee et al., *supra* note 72, at 1224; Schmidt et al., *supra* note 33, at 1434; Tolle et al., *supra* note 58, at 1097.

115. Michael D. Cantor, *Improving Advance Care Planning: Lessons from POLST*, 48 J. AM. GERIATRICS SOC’Y 1343, 1344 (2000).

116. See POLST, POLST State Programs, <http://www.ohsu.edu/ethics/polst/programs/state+programs.htm> (last visited Feb. 21, 2009) [hereinafter POLST State Programs]. In 2004, a National POLST Paradigm Initiative program was created to assist the development of POLST programs around the country. See POLST, History of the POLST Paradigm Initiative, <http://www.ohsu.edu/ethics/polst/developing/history.htm> (last visited Feb. 21, 2009) [hereinafter History of the POLST]. Other states developing POLST forms include Wisconsin, Idaho, Tennessee, Minnesota, Texas, and Main. POLST State Programs, *supra* note 115.

117. See History of the POLST, *supra* note 116.

118. For a detailed national analysis of current POLST legislation, pilot programs, and other initiatives see generally Kathy L. Cerminara & Seth M. Bogin, *A Paper About a Piece of Paper: Regulatory Actions as the Most Effective Way to Promote Use of Physician Orders for Life-Sustaining Treatment*, 29 J. LEGAL MED. 479 (2008).

119. See WASHINGTON, *supra* note 31, at 7. The EMS-No-CPR notifies the EMS of the patient’s request not to be resuscitated. See *id.*

120. See WASH. REV. CODE § 43.70.480 (2009).

121. W. VA. CODE § 16-30-25 (2008).

122. See *id.* The statute requires a physician’s signature to become effective. See *id.*

123. See Henry, *supra* note 30, at 9.

the DNRO form.¹²⁴ Additionally, Utah EMTs are permitted to honor the POLST form and health care providers are required to make an effort to determine if the patient has a POLST form.¹²⁵ In 2004, Maryland enacted, what is now called, the Instructions on Current Life-Sustaining Treatment Options (ICLTO) form.¹²⁶ The ICLTO form requires a provider's review of the form upon a patient's arrival from another health care facility.¹²⁷ Unlike the POLST form, the ICLTO is not recognized as an official medical order.¹²⁸ The form is only the physician's summary of the patient's wishes, or of an existing advance directive.¹²⁹ In May of 2006, Hawaii enacted legislation which charged the Hawaii Department of Health with developing and implementing a POLST program.¹³⁰ The POLST form will replace Hawaii's current system of bracelets and necklaces used to notify emergency personnel of the existence of an advance directive.¹³¹

Finally, in November 2006, the Pennsylvania House of Representatives passed Senate Bill 628, establishing a task force to create and test the POLST form in nursing homes throughout the state.¹³² These legislative enactments demonstrate that other state lawmakers have recognized the value of POLST. Yet despite the enactment of contemporaneous POLST legislation in other states, Florida has failed to successfully enact its own POLST initiative.

III. ADVANCE DIRECTIVES IN FLORIDA

The successful utilization of the POLST form in other states provides Florida with a frame of reference for its incorporation into Florida law. This section will detail Florida's advance directive law and will distinguish the POLST form from these advance directives.

With rapid advances in medical technology, health care providers are able to sustain life for extended periods of time.¹³³ Very often, health care providers and family members must make decisions without information

124. See UTAH CODE ANN. § 75-2a-106 (Supp. 2008).

125. See *id.*

126. See MD. CODE ANN., HEALTH-GEN. § 5-608.1(d) (LexisNexis 2005). At its inception this form was named the Parents Plan of Care (PPOC), however, the name of the form was changed to Instructions on Current Life-Sustaining Treatment Options (ICLTO) in 2007. MD. CODE ANN., HEALTH-GEN. § 5-608.1(d) (LexisNexis Supp. 2008).

127. MD. CODE ANN., HEALTH-GEN. § 5-608.1(d).

128. See Furlong, *supra* note 50, at 26.

129. *Id.*

130. See H.B. 3126, 23d Leg., Reg. Sess. (Haw. 2006).

131. *Id.*

132. See S.628, 2005 Leg., Reg. Sess. (Pa. 2006).

133. See The Florida Senate Interim Project Report 2006-137, *supra* note 24, at 1.

regarding the level of care the patient actually wanted to receive.¹³⁴ Efforts to alleviate these life and death decision making situations began in the 1970s, when medical professionals began asking their patients to state the level of care they wished to receive in the event of their incapacitation.¹³⁵ Today, through the use of advance directives, patients effectuate their “own choice, thereby honoring self-determination even when individuals no longer possess the capacity for self-determination.”¹³⁶ An advance directive is “[a] legal document explaining one’s wishes about medical treatment if one becomes incompetent or unable to communicate.”¹³⁷ It can also be “[a] document that takes effect upon one’s incompetency and designates a surrogate decision-maker for healthcare matters.”¹³⁸ Currently, every state has at least one type of advance directive codified into law.¹³⁹

The *Florida Statutes* chapter 765 codifies Florida’s health care advance directive laws.¹⁴⁰ In 2002, the Last Acts Initiative rated Florida’s advance directive statute as one of the best in the nation.¹⁴¹ This recognition resulted from years of public and professional input finally leading to the enactment of the Life-Prolonging Procedures Act of Florida of 1984.¹⁴² The Florida Legislature decided that “every competent adult has [a] right of self-determination . . . [and] the right to choose or refuse medical treatment.”¹⁴³ Under Florida law, an advance directive is a “witnessed written document or oral statement in which instructions are given by a principal or in which the principal’s desires are expressed concerning any aspect of the principal’s

134. *See id.*

135. *Id.*

136. ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISION MAKING* § 7.01, at 7-16 (2006). Advance directives have four general purposes: To preserve the autonomy of the patient’s degree of control over medical care when that person lacks the ability to do so; to avoid recourse to the judicial process, when there is confusion about the patient’s wishes; to protect health care professionals from civil and criminal liability by following the patients wishes in good faith; and to reduce medical costs, by not administering unwanted medical treatment. *Id.* at 7-16, 7-18–7-19.

137. BLACK’S LAW DICTIONARY 57 (8th ed. 2004).

138. *Id.*

139. MEISEL & CERMINARA, *supra* note 136, at 7-7.

140. FLA. STAT. § 765 (2008).

141. LAST ACTS, MEANS TO A BETTER END: A REPORT ON DYING IN AMERICA TODAY 11 (2002), <http://www.rwjf.org/files/publications/other/meansbetterend.pdf>. The study rated the “quality of state advance directive laws” in 2002. *Id.* Florida was one of seven states to receive an “A” rating. *Id.*

142. *See generally* Meta Calder, *Chapter 765 Revisited: Florida’s New Advance Directives Law*, 20 FLA. ST. U. L. REV. 291 (1992) (detailing the history of Florida’s advance directive law).

143. FLA. STAT. § 765.102(1).

health care.”¹⁴⁴ Pursuant to the statute, advance directives include, but are “not limited to, the designation of a health care surrogate, a living will, or anatomical gift.”¹⁴⁵ Although not officially listed as an advance directive under chapter 765, the durable power of attorney is considered an advance directive.¹⁴⁶ House Bill 1017, Florida’s failed POLST legislation, would have added the POLST form as a type of advance directive under chapter 765.¹⁴⁷

A. *Living Will, Health Care Surrogate Designation, Durable Power of Attorney*

Florida law defines a living will as a witnessed document or “oral statement made by the principal” (patient) that expresses “instructions concerning life-prolonging procedures.”¹⁴⁸ A competent adult may create a living will at any time.¹⁴⁹ Typically, a living will contains information regarding a person’s desire to receive or withhold treatment in the event of a terminal illness, an end-stage medical condition, or “a persistent vegetative state.”¹⁵⁰ The statute requires that the living will be signed in front of two witnesses, one of whom cannot be related to the principal.¹⁵¹ Once completed, it is the principal’s responsibility to notify the health care provider of the existence of a living will.¹⁵² If the principal is incapacitated, any person may provide notification to the health care provider, so that the living will is made part of the medical record.¹⁵³ Under the Patient Self-Determination Act (PSDA), federal law requires that federally funded medical facilities inform incoming patients of their right to make a living will, and inquire

144. FLA. STAT. § 765.101(1). “Principal’ means a competent adult executing an advance directive and on whose behalf health care decisions are to be made.” *Id.* § 765.101(14).

145. *Id.* § 765.101(1).

146. See FLA. STAT. § 709.08; see also FLA. STAT. § 401.45.

147. H.B. 1017, 2006 Leg., Reg. Sess. (Fla. 2006).

148. FLA. STAT. § 765.101(11)(a), (b) (2008). “Life-prolonging procedure’ means any medical procedure, treatment, or intervention . . . which sustains [or] restores . . . a spontaneous vital function.” *Id.* § 765.101(10).

149. FLA. STAT. § 765.302(1) (2008).

150. *Id.* “‘Terminal condition’ means [an injury] or illness from which there is no . . . probability of recover[ing] . . . without treatment, can be expected to cause death.” FLA. STAT. § 765.101(17). “‘End-stage condition’ means an irreversible condition [which] treatment of the condition would be ineffective.” *Id.* § 765.101(4). “‘Persistent vegetative state’ means a permanent and irreversible condition of unconsciousness . . .” *Id.* § 765.101(12).

151. FLA. STAT. § 765.302(1).

152. *Id.* § 765.302(2).

153. *Id.*

whether that patient has executed such a document.¹⁵⁴ Once the health care provider has received the living will, a change or revocation will only be effective when communicated directly to the health care provider.¹⁵⁵ A properly executed living will “establishes a rebuttable presumption of clear and convincing evidence of the principal’s wishes.”¹⁵⁶

Although the POLST form is not a substitute for a living will, it is a supplement to this type of advance directive.¹⁵⁷ In effect, the POLST form translates a patient’s wishes regarding life-sustaining treatment and end-of-life care, including resuscitation measures, antibiotic administration, and the administration of nutrition into standard medical orders.¹⁵⁸ Health care professionals can easily interpret and implement POLST orders, which “surmounts the disconnect between [the living will] and the functioning of [the] health care systems.”¹⁵⁹

A second type of advance directive under Florida law is the designation of a health care surrogate.¹⁶⁰ This is a written document that designates a person to whom the principal has given the legal authority to make medical decisions in the event the principal is incapacitated.¹⁶¹ These decisions are based upon what the surrogate “believes the principal would have” wanted if they were able to speak for themselves.¹⁶² The procedure for naming a health care surrogate is similar to that of creating a living will. Two adults must witness the execution of the document.¹⁶³ Once completed and delivered to the surrogate, the surrogate designation form, like the living will, creates “a rebuttable presumption of clear and convincing evidence of the principal’s [desire regarding the] designation of the surrogate.”¹⁶⁴ However, the surrogacy does not commence until the attending physician finds and documents

154. See 42 U.S.C. § 1395cc (2000).

155. FLA. STAT. § 765.104(3) (2008).

156. FLA. STAT. § 765.302(3); see also *In re Guardianship of Browning*, 543 So. 2d 258, 273 (Fla. 2d Dist. Ct. App. 1989) (holding surrogate’s decision “to forego life-sustaining treatment [must be supported by] clear and convincing evidence”).

157. See Sabatino, *National*, *supra* note 32, at 153.

158. See POLST FORM, *supra* note 73.

159. Sabatino, *National*, *supra* note 32, at 153.

160. See FLA. STAT. § 765.202 (2008).

161. See *id.* § 765.202(1).

162. FLA. STAT. § 765.205(1)(b) (2008).

163. *Id.* § 765.202(1). If the principal cannot sign, he or she may direct that another “sign the principal’s name” in front of the witnesses. *Id.* The statute states that the surrogate cannot be a witness to the signing of the document, and at least one of the witnesses cannot be a blood relative or spouse. *Id.* § 765.202(2). Additionally, the document can name an alternative surrogate. *Id.* § 765.202(3).

164. *Id.* § 765.202(7).

the principal's lack of capacity to make health care decisions.¹⁶⁵ If at any time the principal regains capacity, the surrogate's authority ceases.¹⁶⁶

An alternative to the designation of a health care surrogate is the designation of a durable power of attorney.¹⁶⁷ Although the durable power of attorney does not appear under Florida's advance directive statute, it functions in the same manner as an advance directive.¹⁶⁸ Under the durable power of attorney, principals can designate individuals to serve as their attorneys-in-fact.¹⁶⁹ Relating to health care, an attorney-in-fact is given full authority to "make all health care decisions on behalf of the" incapacitated patient.¹⁷⁰ Under Florida law, the attorney-in-fact can be any competent person over the age of eighteen.¹⁷¹ The document must be in writing, it must clearly identify the person being appointed as the attorney-in-fact, and it must state that authority is conferred upon the principal's incapacitation.¹⁷² Once completed, the attorney-in-fact has the same power as the health care surrogate.¹⁷³

The POLST form is useful to both the health care surrogate and the attorney-in-fact.¹⁷⁴ POLST forms reduce the need for much of the critical health care decision making that is required of the health care surrogate or attorney-in-fact.¹⁷⁵ If the incapacitated patient has not completed a POLST form, the surrogate or attorney-in-fact can communicate with the health care provider regarding the completion of the form.¹⁷⁶ Under the Summary of Goals section of the POLST form, the physician will document that the health care surrogate or attorney-in-fact has completed the form on behalf of the patient.¹⁷⁷

165. See FLA. STAT. § 765.204(2)–(3) (2008). If a question regarding capacity arises, another physician must evaluate the principal, and if in agreement, record a similar finding of incapacity. *Id.* § 765.204(2).

166. See *id.* § 765.204(3).

167. See FLA. STAT. § 709.08(1) (2008).

168. See *id.*

169. *Id.*

170. *Id.* § 709.08(7)(c).

171. *Id.* § 709.08(2).

172. See FLA. STAT. § 709.08(1). The statute also requires that the document be signed in front of two witnesses. *Id.*

173. See *id.* In addition to the living will and health care surrogate, section 765 of the *Florida Statutes* provides guidelines for the donation of body organs as an anatomical gift. FLA. STAT. § 765.510 (2008).

174. See POLST FORM, *supra* note 73.

175. See *id.*

176. See *id.*

177. See *id.*

B. *Do Not Resuscitate Orders*

Do Not Resuscitate Orders (DNRO), established under Chapter 401 of the *Florida Statutes*, are prepared in advance to memorialize a person's life-sustaining treatment wishes.¹⁷⁸ A DNRO is a physician's order signed by both the doctor and the patient.¹⁷⁹ The DNRO authorizes health care providers to withhold or withdraw resuscitation in the event that an individual needs to be resuscitated.¹⁸⁰ Generally, emergency medical service personnel must "resuscitate a patient to the point of stabilization of vital signs."¹⁸¹ The DNRO allows the patient to choose not to receive resuscitation in the event of cardiac or pulmonary arrest.¹⁸² Produced by the Florida Department of Health, the DNRO form must "be printed on yellow paper."¹⁸³ A DNRO is generally used by patients who suffer from a terminal condition, an end-stage condition, or are in persistent vegetative states.¹⁸⁴

Although the DNRO and the POLST form are both medical orders, there are significant differences between these two directives. The POLST form requires a discussion between the patient and the health care provider regarding different levels of treatment, including, but not limited to, resuscitation.¹⁸⁵ The orders on the POLST form must also be reviewed periodically.¹⁸⁶ On the other hand, the DNRO, pursuant to the patient's wishes, only informs the health care provider not to resuscitate.¹⁸⁷ As it has in many other states, the POLST form could replace the DNRO in Florida.¹⁸⁸ The POLST form would provide greater detail and specification for patient care desires, while still fulfilling the purpose of the DNRO.¹⁸⁹

IV. PROBLEMS WITH ADVANCE DIRECTIVES

The purpose of an advance directive is to allow an individual to control decisions related to life-sustaining treatments and end-of-life care.¹⁹⁰ Unfor-

178. FLA. STAT. § 401.45(3)(a) (2008).

179. *Id.*

180. *Id.*

181. 15 JEROME IRA SOLKOFF, *FLORIDA ELDER LAW* § 26:54 (2006 ed.).

182. FLA. ADMIN. CODE R. 64J-2.018 (2008).

183. *Id.* at r. 64J-2.018(2)(a). A miniature copy of the DNRO form is available, which the EMSs must honor. *Id.* at r. 64J-2.018(2)(b).

184. *See* FLA. STAT. § 765.101 (2008).

185. *See* POLST FORM, *supra* note 73.

186. Sabatino, *National*, *supra* note 32, at 153.

187. *See* FLA. ADMIN. CODE R. 64J-2.018.

188. *See* POLST State Programs, *supra* note 116.

189. *See* POLST FORM, *supra* note 73.

190. *See* Sabatino, *National*, *supra* note 32, at 151-52.

tunately, research over the past several decades has demonstrated that current statutory advance directives have not produced their intended results.¹⁹¹ Often, patients lose their ability to ensure that their end-of-life care preferences are honored.¹⁹² Many legal and health care professionals believe “[s]ystematic efforts are urgently needed to improve advance care planning and end-of-life care.”¹⁹³ The American Medical Association stresses that “[m]ore rigorous efforts in advance care planning are required in order to tailor end-of-life care to the preferences of patients so that they can experience a satisfactory last chapter in their lives.”¹⁹⁴ This section will detail the problems associated with current advance directives, as well as demonstrate how the POLST form represents “[p]romising new models” which can “move us closer to achieving the original intent of advance directives.”¹⁹⁵

Studies have found that only 18% of Americans have completed advance directives.¹⁹⁶ Even if efforts are made to educate the public regarding the need for advance directives, simply having an advance directive does not guarantee that it will be followed.¹⁹⁷ Often advance directives raise “more questions for doctors than the document answers,” and may force doctors to make treatment choices against the patient’s desires.¹⁹⁸ Additionally, patients

191. HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S26.

192. *Id.*

193. Karl A. Lorenz & Joanne Lynn, Editorials, *Oregon’s Lesson for Improving Advance Care Planning*, 52 J. AM. GERIATRICS SOC’Y 1574, 1575 (2004).

194. Code of Medical Ethics § 2.225 (AMA Council on Ethical and Judicial Affairs 2004–05).

195. HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S26.

196. Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, HASTINGS CTR. REP. 30, 32 (2004). “People widely say they want a living will. . . . [d]espite this, and despite decades of urging, most Americans lack them.” *Id.* “Few individuals provide explicit oral or written instructions regarding their intent to refuse medical treatment should they become incompetent.” *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 289 (1989) (O’Connor, J., concurring). “Physicians should encourage their patients to document their treatment preferences or to appoint a health care proxy with whom they can discuss their values regarding health care and treatment.” Code of Medical Ethics § 8.081. *See also* CAROL KROHM & SCOTT SUMMERS, *ADVANCE HEALTH CARE DIRECTIVES: A HANDBOOK FOR PROFESSIONALS* 51–54 (2002) (stating various reasons why most people do not create an advance directive).

197. *See* R. Sean Morrison et al., *The Inaccessibility of Advance Directives on Transfer from Ambulatory to Acute Care Settings*, 274 J. AM MED. ASS’N 478, 478 (1995).

198. April Frawley Birdwell, *For Advance Directives, a Picture’s Worth a Thousand Words*, U. OF FLA. NEWS, July 18, 2005, <http://news.ufl.edu/2005/07/18/videowill>. Doctors tend to make more conservative treatments when unable to interpret an advance directive. *Id.*

are under the false assumption that after writing their advance directives, planning is complete.¹⁹⁹

A. *What Does It Say?*

Generally, standard advance directives assume that at some point an individual “would prefer to die rather than continue” on life support.²⁰⁰ Advance directives are often completed by patients and their lawyers who are unfamiliar with the specific treatments administered during life threatening medical situations and terminal illnesses.²⁰¹ Unfortunately, these advance directives do not detail the various medical conditions that may arise, thus leaving the health care provider and family to decide what the patient would have wanted under these circumstances.²⁰² One study showed that out of 4804 patients with advance directives, only ninety provided specific instructions that the health care provider could follow.²⁰³ Often, when patients write their advance directives, they are written in layman’s terms, thus leading to vague and confusing instructions.²⁰⁴ Researchers attribute this lack of clarity to the unpleasantness of the subject and the lack of adequate information regarding the types of treatment available.²⁰⁵ Advance directives are often created under urgent circumstances, which “trigger[s] emotional and existential turbulence, enhancing the likelihood of unstable decisions,”²⁰⁶ leading to “technically inaccurate statements,” which are medically impossible to honor.²⁰⁷ Essentially, the health care provider and family is in the same position as if the patient had never created an advance directive.²⁰⁸ Accordingly,

199. See Vicki Joiner Bowers, Comment, *Advance Directives: Peace of Mind or False Security?*, 26 STETSON L. REV. 677, 719–20 (1996).

200. See Teno et al., *supra* note 4, at 508.

201. See Fagerlin & Schneider, *supra* note 196, at 33.

202. See *id.*

203. Teno et al., *supra* note 4, at 511. “Even if all of [the advance directives] had been noted and had been rigorously followed, the effects upon the overall population would have been imperceptible.” *Id.*

204. See *id.* (stating examples of vague and confusing instructions). See also Bowers, *supra* note 199, at 719 (discussing vague and ambiguous terms used in advance directives); Fagerlin & Schneider, *supra* note 196, at 34.

205. See Fagerlin & Schneider, *supra* note 196, at 34. The research also revealed that most “people are functionally illiterate, and most of the literate cannot express themselves clearly in writing.” *Id.*

206. Am. Med. Assoc. Council on Ethical & Jud. Affairs, *Optimal Use of Orders Not to Intervene and Advance Directives*, 4 PSYCHOL. PUB. POL’Y & L. 668, 670 (1998).

207. Teno et al., *supra* note 4, at 511.

208. See *id.*

many researchers believe that advance directives cannot “effectively direct care decisions for seriously ill adults.”²⁰⁹

Even with clearly documented advance directives, a survey of Florida doctors revealed that physicians felt uncomfortable and reluctant to decide a patient’s fate simply by “relying on a legal document.”²¹⁰ One study concluded that overall, advance directives “do not influence the level of medical care” and found that 25% of the patients studied received care “inconsistent with their living will.”²¹¹ Additionally, problems associated with reading and interpreting advance directives may lead health care providers to interpret documents in the light of their own preferences.²¹² At times, doctors simply ignore advance directives because they are reluctant to prematurely declare that a patient is in an end-stage of a terminal illness which would require reliance on an advance directive.²¹³ Consequently, by the time the physician actually determines that the patient has reached the threshold of imminent death, the advance directive is often regarded as no longer applicable.²¹⁴

By converting a patient’s wishes into actionable medical orders, the POLST form avoids problematic issues relating to vagueness and lack of clarity of instructions commonly associated with traditional advance directives.²¹⁵ Like any medical order, the attending health care provider can quickly read and interpret the POLST form and successfully implement the instructions.²¹⁶ Unlike advance directives prepared by attorneys, the POLST form is completed by patients and their physicians, and is drafted using appropriate medical terminology in a standard medical order format.²¹⁷ Therefore, both the physician and the patient have an increased level of confidence that care will be administered in accordance with the patient’s wishes.²¹⁸ The standard medical order format provides clarity and guidance to health care providers who may be unfamiliar with the patient to whom they are providing care.²¹⁹ The POLST form removes barriers associated with traditional

209. *Id.* at 508.

210. *See* Birdwell, *supra* note 198.

211. Fagerlin & Schneider, *supra* note 196, at 36.

212. *See id.* at 35–36.

213. Morrison et al., *supra* note 197, at 481.

214. Fagerlin & Schneider, *supra* note 196, at 36.

215. *See* Sabatino, *National*, *supra* note 32, at 153.

216. *See* HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S28.

217. *Id.*

218. *See id.*

219. Zadina & Weber-Devoll, *supra* note 45, at 10.

advance directives including unclear legal jargon that is difficult to interpret, especially in emergency situations.²²⁰

B. *Where Is It?*

In addition to containing clear and specific instructions, the advance directive must be readily accessible to health care providers.²²¹ Most advance directives are completed years before being actually needed, consequently their “existence and location may vanish in the mists of time.”²²² A study found that half of all advance directives created often remain in the lawyer’s office.²²³ As many as 62% of the study’s patients failed to provide their advance directives to their doctors.²²⁴ Upon admission to a health care facility, most patients are too overwhelmed and nervous “to recall and mention their advance directives.”²²⁵ The study also discovered that only 16% of reviewed patients’ charts actually contained an advance directive form.²²⁶ Other studies have found that patients often believe that their condition is not serious enough to mention the existence of their advance directive.²²⁷ Fear of early withdrawal of treatment is also identified as a reason why patients are hesitant to mention the existence of an advance directive.²²⁸ The increase in patient transfers between health care facilities has also added to problems asso-

220. See 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, 119 (2008) [Hickman et al., *The POLST*]. “[T]he wording of the standard living will may impede decision-making and lead to decisions contrary to a patient’s true preferences if” there are no discussions between patient and doctor. Teno et al., *supra* note 4, at 511.

221. See David Martin, *Using Implantable Devices to Improve End-of-Life Care*, 91 AM. J. CARDIOLOGY 583, 583 (2003).

222. Fagerlin & Schneider, *supra* note 196, at 35.

223. See *id.*

224. *Id.*

225. *Id.* See Morrison et al., *supra* note 197, at 481 (finding responsibility for identifying advance directives are delegated to clerks who are untrained to deal with “these types of discussions”). See also Am. Med. Assoc. Council on Ethical & Jud. Affairs, *supra* note 203, at 670 (stating inquiry to existing advance directives “was assigned to the medical student or nurse”).

226. Fagerlin & Schneider, *supra* note 196, at 35.

227. Morrison et al., *supra* note 197, at 481.

228. *Id.*

ciated with current advance directives.²²⁹ Unfortunately, advance directives “often fail to accompany” patients when they are transferred.²³⁰

Unlike the lack of portability of traditional advance directives, the POLST form serves as the cover sheet for the patient’s medical record.²³¹ Easily recognized when transferred across health care settings, the POLST form is reviewed upon the patient’s admission to the receiving medical facility.²³² In those states that use the POLST form, “providers have committed to ensuring that the POLST form travels with the patient whenever transfers from one setting to another are made, thus, promoting continuity of care decisions.”²³³ Because the form is placed on top of the medical record, the health care provider is alerted to the fact that the patient has an advance directive, eliminating the need to ask as required under the PSDA.²³⁴ However, to comply with the PSDA, the health care provider must still ask patients whether the POLST form belongs to them.²³⁵ Additional efforts were made by the POLST form developers to ensure that the form would not “become buried in the [medical] record.”²³⁶ For instance, to increase visibility, the POLST form is printed on brightly colored neon paper.²³⁷ Clearly, the POLST form is designed to address the availability and portability issues that plague traditional advance directives.²³⁸

C. *Things Change*

“Unlike most legal documents which gain credence over time, directives tend to lose credibility. The greater the time span or change in circumstances between the directive’s creation and its implementation, the greater the uncertainty that the previous and present desires are identical.”²³⁹ Writ-

229. See Foundation for Healthy Communities, Physician Orders Regarding Treatment (PORT) Program, Fact Sheet (2005), available at http://www.healthynh.com/fhc/initiatives/performance/eol/PORT_FACT_SHEET_SEAcoast.pdf.

230. See Tolle et al., *supra* note 58, at 1098. But see Raymond L. Parri, *If I Call 911, Is My Living Will Any Good? The Living Will v. the DNRO*, 70 FLA. B. J. 82, 84 (1996). Most states recommend that a copy of advance directives should be made available to the EMT as they transport a patient from one facility to another, and while in the home, the advance directive should be near the patient at all times. *Id.*

231. Sabatino, *National*, *supra* note 32, at 153.

232. *Id.*

233. *Id.*

234. See WSMA, *supra* note 8.

235. See HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S27.

236. Furlong, *supra* note 50, at 26.

237. See Sabatino, *National*, *supra* note 32, at 153.

238. See WSMA, *supra* note 8.

239. Bowers, *supra* note 199, at 719–20.

ten well before a person becomes terminally ill, most advance directives only address hypothetical possibilities for the future, which rarely occur.²⁴⁰ With the passage of time and life changes, very often a patient's personal preference regarding life-sustaining treatments and end-of-life care may change.²⁴¹ Because a "decision made at age thirty may be different from a decision one would make at age eighty,"²⁴² it is unlikely that one could create an advance directive that accurately reflects changes in personal feelings.²⁴³ Moreover, with advances in medical technology, of "paramount concern is the possibility that medical practice will change between the time of making the directive and [its] implementation."²⁴⁴ For example, vaccinations and cures may become available for diseases considered terminal at the time of the drafting of the advance directive.²⁴⁵ Unfortunately, advance directives are rarely reviewed or updated.²⁴⁶

In contrast to a traditional advance directive, the POLST form addresses the issue of medical advances and personal changes impacting one's life-sustaining treatment and end-of-life care wishes.²⁴⁷ Through its requirement of periodic review and updates, the form ensures the patient's wishes are current and accurately documented.²⁴⁸ Specifically, the back of the form lists instructions regarding its review.²⁴⁹ Consequently, the POLST form accurately documents the patient's wishes in light of his or her most current personal and medical circumstances.²⁵⁰

240. *Id.*

241. *Id.*

242. *Id.*

243. *Id.*

244. Bowers, *supra* note 199, at 719–20.

245. See ALAN MEISEL, *THE RIGHT TO DIE* 350 (1989).

246. See HICKMAN ET AL., *HASTINGS CTR. REPORT*, *supra* note 2, at S27. "Once advance directives are completed, planning is typically considered finished. A systematic effort to reopen the conversation . . . is rarely made. The only repeated question that a patient might hear is, 'Do you have an advance directive?' as required by the Patient Self-Determination Act." *Id.*

247. See Bowers, *supra* note 199, at 719.

248. See Sabatino, *Survey*, *supra* note 10, at 299.

249. POLST FORM, *supra* note 73. The POLST form specifies that a review should be completed when: "The person is transferred from one care setting or care level to another, or [t]here is a substantial change in the person's health status, or [t]he person's treatment preferences change." *Id.*

250. See Sabatino, *Survey*, *supra* note 10, at 298–99.

D. *The Surrogate's Burden*

Patients who designate health care surrogates often neglect to provide information regarding their specific health care treatment preferences.²⁵¹ Although a study demonstrated that seventy percent of surrogates correctly predicted their principal's preferences, the burden of surrogacy is still significant.²⁵² Even when the patient has left general guidance regarding his or her end-of-life care, studies have shown those statements are often unclear and confusing.²⁵³ Lacking information concerning the patient's health care wishes often results in stress and anxiety that leaves surrogates "overwhelmed with their own concerns and [they cannot] effectively advocate for the patient."²⁵⁴ Furthermore, some surrogates are not readily available for immediate decision making.²⁵⁵ Finally, in fear of potential litigation from the patient's family members, some physicians are cautious when dealing with surrogates.²⁵⁶

Because of its intent and design, the POLST form can serve as a valuable planning tool for the patient and the health care surrogate.²⁵⁷ If the form is completed prior to the patient's incapacitation, it will provide the surrogate with detailed instruction and guidance regarding the principal's current and future treatment preferences.²⁵⁸ In fact, the surrogate may assist the patient and physician in completing the form.²⁵⁹ In the event that a patient becomes incapacitated, a health care surrogate may complete a form on behalf of the patient, which "should remove much of the burden of medical decision making from a family's shoulders in a time of crisis."²⁶⁰ Additionally, the POLST form's periodic review requirement allows surrogates to update the treatment preferences in light of the patient's current condition.²⁶¹

251. See Fagerlin & Schneider, *supra* note 196, at 35–36.

252. *Id.* at 36.

253. Teno et al., *supra* note 4, at 511.

254. Fagerlin & Schneider, *supra* note at 196, at 37.

255. *Id.* at 36.

256. *Id.* at 37 ("[D]octors intent on avoiding litigation may realize that the only plausible plaintiffs are families.").

257. See Milton Zadina & Lisa Weber-Devoll, *A New Era in Advance Directives*, 5 NEB. MED. 10, 10 (2006).

258. *Id.*

259. *Id.*

260. *Id.*

261. See, e.g., 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), available at <http://www.agingwithdig nity.org/Natform.pdf>.

V. POLST: IS IT THE ANSWER?

Clearly, problems associated with advance directives significantly impact patients, their families, and the legal and health care communities.²⁶² However, most health care providers, legal professionals, and bioethicists believe “the initial goal of advance directives was laudable and is worth preserving.”²⁶³ Numerous studies on advance directives “demonstrate that in the right system, the rate of advance care planning can be high, clinically important, available,” and effective.²⁶⁴ Fortunately, there are promising new models which move us closer to achieving the original intent of advance directives.²⁶⁵ Health care providers have requested a model that converts traditional advance directives into “specific, immediately actionable medical orders that transfer with the patient throughout the health care system.”²⁶⁶ This section will demonstrate how the POLST form represents a model that fulfills recommendations regarding advance directive reforms.

Hickman identified several factors that would contribute to the creation of successful advance directives.²⁶⁷ First, patients and their doctors should develop advance directives which include individualized medical plans.²⁶⁸ This allows patients to define what is acceptable rather than simply stating that they wish to refuse or to receive treatment.²⁶⁹ The POLST form satisfies this recommendation because it is a medical order individualized to the patient’s desires completed by patients and their health care providers.²⁷⁰ Additionally, in contrast to the DNRO and a living will, which Hickman states “simply list[] the right to refuse treatment,” the form provides the patient with a variety of treatment options.²⁷¹ The second factor contributing to a successful advance directive is portability.²⁷² The directive must be easily transferred across patient settings and provide medical instructions in “specific language that is actionable in all settings.”²⁷³ The POLST form also fulfills this recommendation.²⁷⁴ Unlike advance directives, the POLST form

262. See HICKMAN ET AL., THE HASTINGS CTR. REPORT, *supra* note 2, at S26.

263. *Id.*

264. Hickman et al., *Viable Alternative*, *supra* note 11, at 5.

265. HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S26.

266. Hickman et al., *Viable Alternative*, *supra* note 11, at 5.

267. See HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S28–30.

268. *See id.* at S28.

269. *See id.*

270. *See id.*

271. *Id.*

272. HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S28.

273. *Id.*

274. *See id.*

is a clearly documented physician's order, which serves as a cover sheet to the patient's medical record and must accompany the patient during transfer.²⁷⁵ Furthermore, the form is generally created by a state's department of health, ensuring its standardization, so it is easily recognized by the transferring and receiving medical facilities.²⁷⁶ According to Hickman, the final recommendation of a stringent periodic review represents "the most crucial element[] of [a] more successful advance directive program[]."²⁷⁷ Once again the form fulfills this recommendation by requiring regular review and updates of a patient's POLST form.²⁷⁸

The American Medical Association (AMA) has also suggested advance directives reforms which are satisfied by the POLST form.²⁷⁹ For example, the AMA suggests that physicians receive immunity from malpractice when honoring patient's wishes found in statutory documents.²⁸⁰ States which have enacted POLST legislation have amended their statutes and administrative codes providing immunity to health care providers who, in good faith, follow the POLST form.²⁸¹ Additionally, the POLST form clearly follows the AMA suggestion that advance directives be created on worksheet-type documents to ensure treatment can be recorded and "applicable to medical decisions."²⁸² The form also provides an understandable standard medical format and allows for an accurate interpretation of the patient's wishes.²⁸³ The POLST form clearly conforms to the AMA's suggestion that advance directives ensure reasonable confidence in the patient and the provider.²⁸⁴ Like Hickman, the AMA has also suggested that advance directives be readily accessible, periodically updated, and easily transferable.²⁸⁵ The POLST form clearly conforms to these suggestions.

Although the POLST form fulfills many of the recommended advance directive reforms, it is important to note that the success of the POLST form

275. *See id.*

276. *See id.*

277. HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S30.

278. *See id.* at S30.

279. *See, e.g.*, Code of Medical Ethics § 2.225 (AMA Council on Ethical and Judicial Affairs 2004–05).

280. *See id.* at 101.

281. *See id.*

282. *Id.*

283. *See* Kathy L. Cerminara & Seth M. Bogin, *A Paper About a Piece of Paper: Regulatory Actions as the Most Effective Way to Promote Use of Physician Orders for Life-Sustaining Treatment*, 29 J. LEGAL MED. 479, 484 (2008).

284. *See* HICKMAN ET AL., HASTINGS CTR. REPORT, *supra* note 2, at S28.

285. *See* Code of Medical Ethics § 2.225 (AMA Council on Ethical and Judicial Affairs 2004–05).

is contingent upon statewide education programs.²⁸⁶ According to Susan W. Tolle, part of the success of Oregon's POLST program may be traced to a five-year statewide education effort, as well as the fact that Oregon provides more end-of-life care funding than any other state.²⁸⁷ Tolle, expressed concern that other states may not achieve the same success rates without such a fully supported state system.²⁸⁸

States must also be prepared for new dilemmas resulting from the POLST form.²⁸⁹ For instance, if a conflict exists between a POLST form and a previously completed advance directive, the most recent form generally takes priority, but in an emergency situation the physician may ignore the POLST form if the existing advance directive provides for more aggressive life-sustaining treatment.²⁹⁰ Although this situation is not common, it can potentially open the door to future litigation.²⁹¹

V. CONCLUSION

The POLST form is a valuable planning tool that effectively translates a patient's end-of-life decisions into standardized, clearly defined medical orders, thus eliminating many problems associated with traditional advance directives. Although House Bill 1017 previously would have amended chapter 765 of the *Florida Statutes*, that POLST legislation was not enacted. It is imperative that Florida now enact new legislation under the appropriate Florida statute.

Although the POLST form can be used as an advance directive, it is more likely that the legislature would approve the POLST form as an alternative or replacement to the DNRO under chapter 401 of the *Florida Statutes*. Accordingly, the POLST form should be re-introduced pursuant to chapter 401 of the *Florida Statutes*. As this article demonstrates, unlike advance directives, the POLST form is a document included in the patient's medical record that clearly memorializes the patient's treatment care decisions and end of life wishes into actionable standardized physician's orders. The

286. Tolle et al., *supra* note 58, at 1101.

287. *See id.*

288. *See id.*

289. *See, e.g.*, Hospice Foundation of America (HFA), Living With Grief: Ethical Dilemmas at the End of Life, Questions and Answers, <http://www.hospicefoundation.org/teleconference/2005/qa.asp> (last visited Feb. 21, 2009).

290. *See id.*

291. *See id.* Although conflicts between POLST forms and previously executed advance directives could be a potential source of future litigation, this "problem is not common in Oregon or in other states using the POLST" form. *Id.*

POLST form may be used in conjunction with advance directives, effectively translating the patient's treatment care wishes into actionable medical orders.

Many states that have successfully enacted POLST legislation have done so by authorizing the POLST form as an alternative or replacement to the existing DNRO form. Enacting such legislation would not require amending chapter 765, which the legislature has been hesitant to reform because of political, religious, and social reasons. Accordingly, because the POLST form is a medical order, like the DNRO, and not a traditional advance directive, new POLST legislation should be introduced under chapter 401 of the *Florida Statutes*.

Finally, to ensure the proper development and implementation of the POLST form, the Florida Department of Health should initiate a statewide POLST program. Efforts to educate the public and the medical and legal communities regarding the purpose and practical use of the POLST form should be diligently implemented. Pilot programs in a variety of health care settings will provide relevant and reliable data and findings regarding the utility of the form in practical health care settings. Results of the pilot program can be used to modify the POLST form in accordance with the identified needs and requirements of Florida patients, their physicians, and Florida law. Ultimately, Florida's enactment of POLST legislation under chapter 401 of the *Florida Statutes* will prove that the form is the cure for the common advance directive.