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The Physician Orders for Life-Sustaining Treatment (POLST) Coming Soon to a Health Care Community Near You

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I. Introduction

Advance health care directives, including durable health care powers of attorney and living wills, are part of the standard bill of fare for estate planners, along with durable financial powers of attorney, wills and trusts. This article discusses an end-of-life planning tool that is less well known in the estate-planning community – a physician order designed to elicit and record a patient's end of life treatment preferences, referred to in some jurisdictions (and in this article) as POLST.[1] The wide acceptance and spread of the POLST has gone largely unnoticed by estate and trust and elder law practitioners, despite its purpose to implement their clients' care wishes when the client is dying or near death, traditionally a focal point of their professional efforts. This article is intended to remedy that lack of awareness.

A POLST program serves different purposes from those of the living will declaration and the power of attorney for health care. A living will declaration puts into writing the declarant's wishes as to life-sustaining treatment if, at some point in the future, the declarant is termi-

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

nally ill, in an end-stage medical condition, or in a permanently unconscious state. The living will declaration applies in the future, and goes into effect only if the declarant is no longer able to make health-care decisions. A health care power of attorney gives a surrogate the authority to make health-care decisions, but again it typically takes effect only if the principal is unable to make decisions. By contrast, POLST programs are designed to elicit and to honor the medical treatment goals of persons with advanced progressive illness or frailty by creating a medical order that is immediately effective.[2]

POLST orders also differ from do-not-resuscitate (DNR) orders, which are focused only on preventing resuscitation. DNR orders do not communicate affirmative orders to attempt resuscitation for those individuals who desire all possible interventions.[3] A POLST program allows patients to document their choices about the level of intervention the patients want, currently, as they live out the final phase of their lives. The orders always address cardiopulmonary resuscitation (CPR), and importantly also can address other end-of-life health care issues, such as the level of medical intervention desired in an emergency, the use of artificially supplied nutrition and hydration, the use of antibiotics, and the use of ventilation.[4]

A POLST program is valuable because of the standardization and consistency it creates.[5] Ideally, a POLST form should move with the patient wherever the patient goes, from home to hospital to skilled nursing facility to long term care facility, so that care is provided in a consistent fashion and so that the patient's end-of-life health care decisions can be re-evaluated and updated as needed.[6] DNR orders typically vary from one setting to another, because each hospital or care facility has preferred to create and use its own form, so traditional DNR orders are effective only within that health care facility. The end-of-life care of patients and the patients themselves have suffered from this lack of con-

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2 *See* Patrick M. Dunn et al., *The POLST Paradigm: Respecting the Wishes of Patients and Families*, ANNALS OF LONG-TERM CARE, Sept. 2007, at 33, 33-39.

3 *See* Susan E. Hickman et al., *The Consistency Between Treatments Provided to Nursing Facility Residents and Orders on the Physician Orders for Life-Sustaining Treatment Form*, 59 J. AM. GERIATRICS SOC'Y 2091, 2091 (2011).

4 *See id.*

5 *See id.*; Susan E. Hickman et al., *A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program*, 58 J. AM. GERIATRICS SOC'Y 1241, 1241-42, 1246-47 (2010).

6 *See generally* Marshall B. Kapp, *The Nursing Home as Part of the POLST Paradigm*, 36 HAMLINE L. REV. 151, 152-53 (2013) (taking the position that "the mechanisms. . .for enforcing personal care values and preferences follow individuals across and throughout the care continuum" and concluding that the "POLST. . .should be an integral facet of ideal nursing home care.").

sistency, and due to differences in multiple DNR forms, duplication of orders, and impaired communication of the patients' wishes.

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

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

II. History of POLST

During the 1990s, there was much discussion in the United States about end-of-life care reform, which had begun in the 1970s, but remained ineffective in many respects. In a Hastings Center Special Report published in 2005, a group of authors published a compilation of essays summarizing the flaws in the end-of-life reform process that had been underway for at least two decades.[7] The authors discussed the need for systemic changes, the concept of autonomy, and emphasized the importance of improved communication and understanding.[8] Studies and reports such as this one validated the concerns which had already encouraged the State of Oregon to move forward, and other states to follow suit.

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[7] *See* Bruce Jennings, *Preface* to *Improving End of Life Care: Why Has It Been So Difficult?*, Hastings Center Rep., Nov.-Dec., Supp. 2005 at S2, S4 (Bruce Jennings et al. eds.).

[8] *See id*. at S2, S4.

A. Development in the State of Oregon

POLST started in the State of Oregon in 1991 as the result of the observation of clinical ethics leaders that patients' preferences regarding life sustaining treatment, as embodied in advance directives, frequently were not found or not transferable and, therefore, not honored.[9] The decision was made, in the State of Oregon, to implement a system to honor patients' values and wishes regarding their end-of-life medical treatment. Beginning in 1990, a task force developed, revised, pilot-tested, and ultimately released a POLST form for use throughout the State of Oregon.[10] In 1999, the administrative rules in Oregon were changed to provide that First Responders or EMTs would respect patients' wishes, including choices regarding life-sustaining treatments reflected in a POLST. Over time, it became accepted practice to allow minors with terminal illness to participate in the POLST program, and to allow nurse practitioners and physicians' assistants to sign POLST medical orders. In 2008, the Oregon POLST form was modified to include a section for the special concerns of persons with disabilities. In 2009, legislation was passed creating a statewide registry of POLST forms in Oregon, permitting access to the forms as needed, including by providers of emergency medical care.[11] There are now over one million POLST forms distributed in Oregon, and the use of POLST is the accepted medical standard of care.[12] The Oregon POLST form is used by almost all hospices and nursing homes in the state.[13] The POLST form currently in use in Oregon is attached, with permission.[14]

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9 *See POLST*, OR. HEALTH & SCI. UNIV. SCH. OF MED., http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-programs/polst.cfm (discussing the history of POLST in the state of Oregon) (last visited Feb. 22, 2015). Although POLST began in Oregon, it spread quickly to the states of New York, Pennsylvania, Washington, West Virginia, and Wisconsin. *See History*, NAT'L POLST, http://www.polst.org/about-the-national-polst-paradigm/history (last visited Feb. 22, 2015).

10 *See* Charles P. Sabatino & Naomi Karp, *Improving Advanced Illness Care: The Evolution of State POLST Programs*, 2011 AARP PUB. POLICY INST. 47, *available at* http://assets.aarp.org/rgcenter/ppi/cons-prot/POLST-Report-04-11.pdf. The form was created by a task force that implemented POLST through a grassroots approach. *See id.*

11 *See Oregon POLST History*, POLST OREGON, http://www.or.polst.org/history/ (last visited Feb. 22, 2015); *see also* OR. ADMIN. R. 847-035-0030(6) (2013); OR. REV. STAT. ANN. §§ 127.666, 127.675 (West Supp. 2014).

12 *See 20,000 Oregonians Enroll in Oregon POLST Registry,* OR. HEALTH & SCI. UNIV. SCH. OF MED. (July 9, 2010), http://www.ohsu.edu/xd/education/schools/school-of-medicine/about/polst-7810.cfm.

13 Dana M. Zive & Terri A. Schmidt, *Pathways to POLST Registry Development: Lessons Learned*, 2012 NATIONAL POLST PARADIGM TASK FORCE 26, *available at* http://www.polst.org/wp-content/uploads/2012/12/POLST-Registry.pdf.

14 *See infra* Appendix 1.

B. Development in La Crosse, Wisconsin

While the POLST paradigm was developing in Oregon, the leaders of major health organizations in La Crosse, Wisconsin decided to focus on end-of-life planning and decision-making.[15] Like the state of Oregon, the community of La Crosse, Wisconsin has taken on a leadership role in effectively using both advance directives and POLST forms.

In 1991, the La Crosse health organizations launched a unique program to increase the use and effectiveness of advance directives. They used printed materials and videos to educate the community and they trained the staff of their organizations as well. The community of La Crosse decided to establish the use of advance directives as a routine standard in the process of health care decision-making. The goal of their program was to create consistent practices throughout their community.[16] Community leaders and health care leaders supported the program. A study conducted from 1995 to 1996 found that advance directives were written by 85% of persons who died in La Crosse. The study also found that 95% of those advance directives actually were found in the medical records and typically were followed by family members and physicians.[17]

By clinical consensus, the community of La Crosse started using POLST forms in 1997, as no legislation in Wisconsin authorized the use of the forms.[18] In a follow-up study of the La Crosse community, researchers reviewed medical record and death certificate data of persons who died from 2007 to 2008. The researchers concluded that "POLST can be a highly effective program to ensure that patient preferences are known and honored in all settings. [Powers of attorney for health care] are valuable because they identify appropriate surrogates when patients are incapacitated."[19]

The leaders of the La Crosse end-of-life health care projects developed a curriculum known as *Respecting Choices*®.[20] Their work in this

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15 *See* Bernard J. Hammes & Brenda L. Rooney, *Death and End-of-Life Planning in One Midwestern Community*, 158 ARCHIVES OF INTERNAL MED. 383, 383-84, (1998), *cited in History/Overview*, GUNDERSEN HEALTH SYS., http://www.gundersenhealth.org/respecting-choices/about-us/history-and-overview (last visited Feb. 22, 2015).

16 *See id.*

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

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

19 *Id.* at 77.

20 *See* GUNDERSEN HEALTH SYS., *supra* note 15.

area over the past 20 years has led them to the conclusion that a three-step approach to choices about end-of-life health care is most effective:[21] (1) First Step: Adult signs Living Will Declaration and Durable Power of Attorney for Health Care; (2) Next Step: As adult ages, agent and family members become more involved and are prepared to act; (3) Last Step: POLST paradigm implemented.[22]

The goal in utilizing POLST is to facilitate discussion and shared health care decision-making within families and with their health care professionals. The La Crosse community uses trained "facilitators for all stages of advance care planning, including POLST."[23]

C. Nationwide Development

There is now a nationwide movement focusing on improving the end-of-life health care process. By the beginning of 2011, approximately one quarter of the states had adopted POLST by statute, regulation or clinical consensus and most of the other states were considering it.[24] The following maps reflect the accelerating adoption of POLST programs between 2006 and March 2015, with a total of sixteen states meeting the standards of an endorsed program described in Part II.D, *infra*.[25] Different states' programs are known by various names, including MOST (Medical Orders for Scope of Treatment), MOLST (Medical Orders for Life-Sustaining Treatment), and POST (Physician Orders for Scope of Treatment).[26]

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21 *See Respecting Choice® Advance Care Planning*, GUNDERSEN HEALTH SYS., http://www.gundersenhealth.org/respecting-choices (last visited Feb. 22, 2015).

22 *Stages of Planning*, GUNDERSEN HEALTH SYS., http://www.gundersenhealth.org/respecting-choices/about-us/stages-of-planning (last visited Feb. 22, 2015).

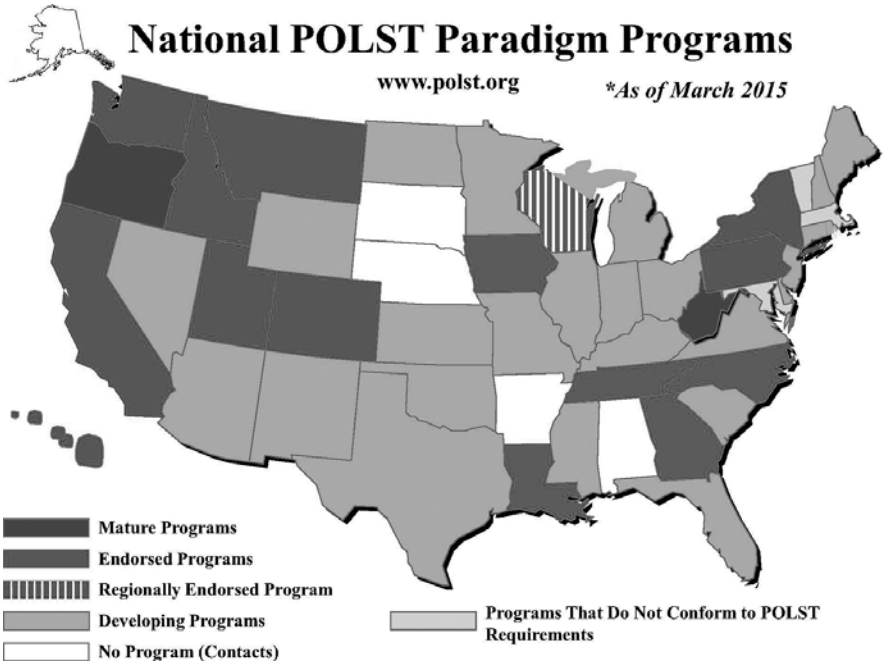
23 Sabatino & Karp, *supra* note 10, at 24.

24 *Id.* at 26.

25 These maps were provided by the National POLST Paradigm Task Force. For the most current information see the interactive map available at http://www.polst.org/programs-in-your-state/ (last visited March 14, 2015).

26 Sabatino & Karp, *supra* note 10, at v. See Appendix 1, *infra*, for an example of a POLST form. The actual forms used vary from state to state. See Appendix 2, *infra*, for a table comparing important characteristics of POLST programs in all states with an established program as of February 15, 2015.

NATIONAL POLST PARADIGM PROGRAMS—2006



D. The National POLST Paradigm Task Force

The National POLST Paradigm Task Force (NPPTF) was created to provide information and guidance to the organizations that are pursuing the process of implementing POLST in their various states. The NPPTF was convened by the Center for Ethics in Health Care at Oregon Health & Science University.[27] The NPPTF has developed standards for a successful program drawn from the experiences of successful state programs and based upon requirements thought necessary for a successful program. A program can be endorsed by the NPPTF as meeting these standards.[28] Each state with an endorsed program provides one member to serve on the NPPTF, which includes committees that consist of members from both endorsed and developing POLST programs.[29] The NPPTF's objectives are to (1) facilitate the development, implementation, and evaluation of POLST Paradigm Programs in the U.S.; (2) educate the public and health care professionals regarding the POLST Paradigm; (3) support, perform and fund research related to end-of-life care; and (4) improve the quality of end-of-life care.[30]

III. How POLST Works

The most frequently cited clinical standard for determining if a POLST form is appropriate for a patient is the "surprise" question.[31] If a patient's physician and other caregivers would not be surprised if the patient died within the next year, then that person should have a conversation, or a series of conversations, about end-of-life care and should consider completing a POLST form. It is important to note that this group is intended to include more than just those patients with an end stage medical condition or a terminal condition. Persons who are of advanced age or considerable frailty, or both, may want to specify the level of care they prefer.

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27 Sabatino & Karp, *supra* note 10, at 3.

28 *Id.* For a list of NPPTF endorsement requirements, see *Request for Endorsement of State POLST Program*, Nat'l POLST (May 16, 2014), http://www.polst.org/wp-content/uploads/2014/05/POLST-Endorsed-Status-Application.pdf.

29 *See National POLST Paradigm Task Force (NPPTF)*, Nat'l POLST, http://www.polst.org/about-the-national-polst-paradigm/national-task-force/ (last visited March 14, 2015).

30 *See Renewing the Conversation: Respecting Patients' Wishes and Advance Care Planning: Hearing Before the S. Spec. Comm. on Aging*, 113th Cong. 8-9 (2013) (Written Testimony of Amy Vandenbroucke, Executive Director, NPPTF), http://www.aging.senate.gov/imo/media/doc/03_Vandenbroucke_6_26_13.pdf.

31 *See*, *e.g.*, Alvin H. Moss et al., *Prognostic Significance of the "Surprise" Question in Cancer Patients,* 13 J. Palliative Med. 837, 837-38 (2010); Alvin H. Moss, et al., *Utility of the "Surprise" Question to Identify Dialysis Patients with High Mortality,* 3 Clinical J. Am. Soc'y Nephrology 1379, 1379, 1381-82 (2008).

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

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

To create a written document that clearly and accurately reflects the patient's wishes, the health care professionals have to start with an open and frank discussion of the patient's current medical condition, the likely progression of the patient's medical condition, the treatment alternatives, the likely outcomes of those treatment alternatives, the level of intervention that is available, and the level of intervention the patient wants. This discussion is primarily the physician's responsibility, but a trained facilitator may work with the physician to explore the patient's personal values, priorities, and goals of care, given the medical facts.

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

Effective discussion results in written medical orders documented on a POLST form accurately expressing the patient's choices. The medical orders are reviewed and updated, as all medical orders are reviewed and updated. If a patient and a patient's physician complete a POLST

form and later the patient, the physician, or both, decide it may be appropriate to change the medical orders, an updated POLST form can be completed. If a patient does not have the mental capacity to participate in the POLST process, an agent acting under a power of attorney for health care may participate in the discussion – the initial discussion and/or follow-up discussions – and sign the POLST form on the patient's behalf. The agent may take these steps only to the extent authorized by state law and the power of attorney document itself. If a patient does not have the mental capacity to participate in the POLST process and has not signed a power of attorney for health care, then the patient's default surrogate may be authorized to participate in the process on behalf of the patient, depending upon the applicable provisions of state law.[32]

A. *The Medical Treatments Covered by POLST*

The medical treatments covered by POLST vary slightly from state to state, and presumably they will change over time as medical treatments change and improve, and as empirical evidence of the usefulness of including or excluding specific treatments becomes available.[33] The treatments addressed tend to fall into three categories.

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

The next section of the POLST (generally section B) addresses the next level of medical interventions. The patient decides the desired level of medical intervention. The patient may choose the full treatment available, including steps such as intubation, ventilation, cardioversion, advanced airway techniques, and transfer to a hospital's intensive care unit. Alternatively, the patient may prefer limited interventions, such as the use of antibiotics and other medical treatments, but generally wants to avoid more invasive forms of treatment and the intensive care unit. The third general category is the choice of comfort care only. It is im-

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32 *See*, *e.g.*, N.Y. PUB. HEALTH LAW § 2994-d (McKinney 2012); WASH. REV. CODE ANN. § 7.70.065 (West Supp. 2014).

33 To review the POLST forms currently used by various states, see *Resource Library*, NAT'L POLST, http://www.polst.org/educational-resources/resource-library (last visited March 14, 2015). Many states have created websites to explain POLST and to make their forms available statewide. For example, see Coalition for Compassionate Care of California, *California POLST Forms*, CAPOLST.ORG, http://capolst.org/polst-for-healthcare-providers/forms/ (last visited Feb. 22, 2015) for the California POLST forms, and see Washington State Medical Association, *Physician Orders for Life-Sustaining Treatment*, WSMA.ORG (Apr. 2014) http://www.wsma.org/doc_library/ForPatients/EndOfLifeResources/POLST/POLST_Master_final_2014.pdf for the Washington POLST form.

portant to note that a POLST form can always be used to provide additional orders – whatever is desired and appropriate considering the unique needs and desires of each patient.

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

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

Unless state law imposes limitations through statutes or regulations, a surrogate recognized under state law may consent to a POLST on behalf of a patient when the patient has lost the capacity to make health care decisions.[34] The surrogate may be an agent or a proxy appointed by the patient through a power of attorney for health care, a court-appointed guardian, or a default surrogate given authority by a statute.[35]

For as long as a patient is able, the patient has the freedom to make health care decisions. The patient may decide to sign a living will and designate an agent who will make health care decisions when the principal cannot. At some point in time, however, the patient may lose the ability to understand his or her medical condition and to evaluate the options that are available. The ability of another person to step in and make decisions becomes critical. The surrogate carries out the patient's wishes, as expressed in the patient's living will, but frequently must participate in a broader shared decision-making process relating to the patient's care plan. Because POLST involves medical orders regarding a

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34 *See*, *e.g.*, TENN. CODE ANN. § 34-6-204(b) (2007); W. VA. CODE. ANN. § 16-30-8 (West 2008).

35 *See*, *e.g.*, OHIO REV. CODE §§ 1337.12, 2111.02, 2133.08 (West 2005) (governing the appointment of an agent under a durable power of attorney for health care, the appointment of a guardian, and the priority of persons who may consent to the withholding or withdrawal of life-sustaining treatment when the patient cannot and there is no agent or guardian in place).

patient's care, the patient must be mentally competent in order to give informed consent to those orders. If the patient no longer can give informed consent, then state surrogacy law applies to these decisions.[36]

Ideally, a surrogate is selected by the patient and authorized by a power of attorney for health care, or similar document, to act on the patient's behalf.[37] If the patient has not designated an agent or proxy, then state law typically includes a default statute.[38] The statutes typically list family members of the patient, in priority order, who will assume the role of surrogate. For example, if the patient has a spouse, then the spouse will act as surrogate and engage in the decision-making process. If the patient is not married, then the patient's adult children will serve as surrogate. Most default statutes continue designating family members to act as surrogates in priority order.[39]

State law varies greatly on the issue of the surrogate's authority.[40] In some states, the surrogate, whether designated by the patient personally or serving under a default statute, has the same authority to make health care decisions as the patient. Some states limit a surrogate's authority to withhold or withdraw life-sustaining treatment for the patient. Some states place greater limitations on a default surrogate serving with statutory authority than on a surrogate designated by the patient.[41] These limitations may affect the POLST decision-making process and limit the nature of the POLST form (i.e., medical orders) the surrogate may sign on behalf of the patient.

It is important to note that a POLST program may be adopted in states with statutory limitations on a surrogate's authority.[42] The limitations were put in place by state legislatures, often after many hearings and hard-fought compromise, to protect patients' lives and guard against abuse. The statutory limitations on decision-making authority have been in place in many states for 20 years or more. Physicians and other health care professionals are familiar with the limitations currently in place. The entire process does not have to be changed; rather, a POLST program may be added to the picture, with surrogate decision-makers participating to the extent permitted under state law.

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36 *See* NAT'L POLST PARADIGM TASK FORCE, POLST LEGISLATIVE GUIDE 17 (2014) [hereinafter LEGISLATIVE GUIDE], http://www.polst.org/wp-content/uploads/2014/02/2014-02-20-POLST-Legislative-Guide-FINAL.pdf.

37 *See*, *e.g.*, W. VA. CODE ANN. § 16-30-4.

38 *See*, *e.g.*, *id.* § 16-30-8.

39 *See*, *e.g.*, *id.*

40 *See infra* Appendix 2.

41 *See* LEGISLATIVE GUIDE, *supra* note 36, at 16-19.

42 *See id.* at 17-18.

> In addition to statutory limitations on a surrogate's decision-making authority, a surrogate's authority also may be limited by the patient's own directions. A living will may provide several specific choices by the declarant with regard to his or her end-of-life medical care. A surrogate is expected to follow and implement those directives . . . . A durable power of attorney for health care [or the POLST form itself] also may include limitations, put in place by the principal, on the surrogate's authority to make medical decisions.[43]

Thus, communication, early on, between the patient and surrogate is important. The surrogate must know and understand the patient's choices.[44]

Because the patient's medical condition and functioning are always changing – especially towards the end of life – the surrogate decision-maker may need to consult with the physician about modifying or reversing a previous decision and completing a new POLST form on behalf of the patient. The NPPTF recommends that each state consider establishing reasonable safeguards to make certain that the surrogate is, at all times, acting to carry out the patient's wishes.

Examples of safeguards are: (1) a requirement that a surrogate engage in further consultation with the treating physician before authorizing a change to the patient's POLST; (2) a requirement that the patient's advance directives be consulted, if available; (3) a requirement that good faith efforts be made to act consistently, at all times, with the patient's known wishes; and (4) a requirement that the reasons for any change in the patient's POLST be documented.[45]

C. How the POLST Relates to Advance Health Care Directives

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

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43 *Id.* at 18.
44 *Id.*
45 *Id.* at 19.

FIGURE 1 KEY COMPARISON OF ADVANCE DIRECTIVES AND POLST PARADIGM[46]

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

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

Both in theory and clinical practice there are no strict medical preconditions applicable to the completion of a POLST form. The POLST program addresses the patient's current goals of care and results in medical orders to implement those goals.[47] While the POLST is not appropriate and necessary for everyone, it should not harm anyone completing the form properly because it allows for the direction of full medical treatment for anyone desiring full treatment.

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46 *Id.* at 8.

47 However, as noted *supra* in Part III, the POLST program is intended to apply to a person who is experiencing advanced illness or frailty – e.g., if the patient's physician would not be surprised if the patient were not alive one year from now. *See* sources cited *supra* note 31.

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

The need for an advance health care directive is essentially universal. Advance health care directives are prepared most frequently for older adults, and it is certainly true that older adults are more likely to encounter the need for a health care agent and a living will sooner, rather than later. But it is unwise to think of these documents, the planning process and the conversation they reflect as something that can wait until a person is a senior citizen.

In fact, the most notorious and difficult cases involving the rights of patient self-determination involved young women. Karen Ann Quinlan was twenty-one years of age in 1975 when she fell into a persistent vegetative state.[48] Nancy Beth Cruzan was twenty-five at the time of her accident in 1983.[49] Teresa Marie Schiavo was twenty-six at the time of her cardiac arrest in 1990.[50] It was no doubt their youth that made their cases all the more difficult for the courts of law and the court of public opinion.

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

2. *Advance Directives Across the Life Cycle*

Advance health care planning should be discussed across the generations by all age groups, as they are all potentially affected. Parents should realize that once their children become adults, they may have no rights to access health care information or to make health care decisions

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48 *See In re* Quinlan, 355 A.2d 647, 653-54 (N.J. 1976).

49 *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 266 (1990).

50 Kathy Cerminara & Kenneth Goodman, *Schiavo Timeline, Part 1*, U. MIAMI, ETHICS PROGRAMS, http://www.miami.edu/index.php/ethics/projects/schiavo/schiavo_timeline/ (last visited Feb. 22, 2015).

for their child who is in an accident or suddenly falls ill. Unmarried adult children should realize that the parents who have protected them since birth may be helpless if they land in a hospital somewhere far from home. While most states provide a default medical decision-maker with some ability to speak for a patient if they have no health care power of attorney and are incompetent, those default decision-makers may not be the ones desired by the patient. This is particularly true for single adults, unmarried couples and the non-traditional family. Further, in many states the default decision-maker may not have the same authority to make medical decisions for the patient as would a health care agent,[51] so it behooves all of us to protect ourselves and our families by having proper advance health care directives in place. Properly viewed, an advance health care directive should be as common and immediate a rite of passage for a young person as registering to vote or indicating on their drivers' license whether they would wish to be an organ donor. We need to normalize discussions about death and dying and achieve a level of "existential maturity" as described by noted medical ethicist Linda Emanuel.[52]

Initially, advance health care directives are best completed when a person is healthy and there is no time pressure. This allows for the beginning of thoughtful reflection on the choice of a health care agent and how aggressively the person wishes to be treated if they were to become very ill. Like all planning, it is best to start the conversation early, and that conversation needs to take place with spouses, parents, and children. The conversation can begin with the patient and their doctor or more frequently the client and their lawyer, but communication must also begin with the health care agent. The agent at the very least needs to know they are being appointed and they need to have a copy of the document appointing them as agent to make sure they understand it.

Even more importantly the agent needs to understand what the patient wants, their goals and values. Estate planning attorneys tend to

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51 For example, in Pennsylvania, a health care agent can exercise all of the powers of the principal, but a default surrogate, called a health care representative, may only decline care necessary to preserve life if the patient is in an end-stage medical condition or is permanently unconscious. 20 PA. CONS. STAT. ANN. §§ 5456(a), 5462(c) (West 2012).

52 *See* Judith Johnson, *How's Your Existential Maturity?,* THE HUFFINGTON POST (Jun. 24, 2012, 5:12 AM), http://www.huffingtonpost.com/judith-johnson/existential-maturity-_b_1447249.html (quoting Linda Emanuel) ("Existential maturity (is) a kind of peaceful acceptance of mortality and of the relationship between generations of life that mitigates the pain of our transience by allowing an understanding of how we can die without entirely ceasing to exist."). Linda Emmanuel is a pioneer and leading authority on advance directives, health care decision-making, and medical futility. She coauthored and published the first case specific advance medical directive in Linda L. Emanuel & Ezekiel J. Emanuel, *The Medical Directive: A Comprehensive Advance Care Document*, 261 J.AM. MED. ASS'N. 3288 (1989).

think of planning in terms of the legal documents and the legal entities and relationships produced by those documents, while particularly with advance health care directives, it is the conversation and communication that is the key. Most of the documents produced by estate planners are drafted with a specific intent to protect against a potential risk of harm from an adverse event or adverse party, whether that adverse party might be a taxing authority, a creditor or claimant, or someone seeking to upset an estate plan. That is why estate planners work so hard at drafting language that is legally clear and which will not be misinterpreted.[53] It is also the reason so many legal documents are much longer than clients would prefer. Estate planners want to make it as certain as possible that the client's intent is expressed clearly and precisely. Advance health care directives are fundamentally different in this respect, as there really are no parties whose interests should be adverse to the client. The important point is simply that the client's wishes need to be conveyed clearly and effectively to their health care agent and to their doctor so that their wishes will be carried out.

As time passes, the patient may develop more significant medical conditions that require management, the patient may feel less able to make their own medical decisions, and the decisions may become more difficult. It is appropriate and very helpful for the health care agent to become more involved with the patient's current care even though the patient may still be making their own health care decisions. For the agent to be prepared to make those decisions when needed, the agent will need to generally understand the underlying medical conditions of the patient and the medications and treatments the patient is receiving. This means that the agent will need to be a part of a continuing care conversation with the patient and the patient's doctor. This helpful measure is authorized by the patient's consent, or a more formal HIPAA authorization.[54]

3. *POLST Decision-Making in Context*

In contrast to the universal need for every competent adult to have an advance directive or living will, the POLST is appropriate for a much more limited group of patients – those patients with serious advanced illness or frailty whose clinicians would not be surprised if the patient died within the next year. It is critically important to recognize that despite the efficacy and usefulness of the POLST, it in no way dimin-

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[53] Unfortunately, clarity and certainty to a reviewing court or taxing authority will generally have an inverse relationship with clarity to a client or others tasked with interpreting the estate planner's work product.

[54] *See* 45 C.F.R § 164.508 (2013).

ishes the need for the advance health care directive.[55] It is the advance health care directive which appoints the health care agent to continue the conversation and to be part of the decision-making after the patient is no longer able to take part in that conversation.

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

(1) When a patient is transferred from a hospital to a skilled nursing facility to a long-term care facility, the POLST form is intended to travel with the patient and be honored at the new facility. However, this setting will inevitably involve a change in the capabilities of care, and may often imply a change in condition. When this happens, the POLST form should be reviewed to see if it is still appropriate and easily applied in the new setting.

(2) Whenever a patient's condition changes significantly, whether for the better or for the worse, the POLST form should be reviewed to see if it still appropriately reflects the patient's wishes. Most often this will occur as a patient's medical condition becomes more serious, and the patient may decide that less aggressive care is appropriate. On the other hand, a POLST form completed within the context of a very serious medical condition may no longer be appropriate if the patient has made a significant recovery.[56]

(3) Since the POLST form is intended to reflect the patient's current wishes, any change in those wishes should be respected. The POLST is never intended to be irrevocable, and state law typically pro-

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55 *See* Stanley A. Terman, *It Isn't Easy Being Pink: Potential Problems with POLST Paradigm Forms,* 36 HAMLINE L. REV. 177, 184 (2013).

56 This is not as rare as it might seem, as one of the authors experienced while acting as a health care agent for a patient for whom a POLST was completed during a grave acute illness from which the patient recovered. Subsequently, the patient returned to her long-term care facility, where two years later she celebrated her 100th birthday. Her recovery required a review and revision of her POLST form.

tects broadly the patient's ability to change or revoke the POLST, an advance directive, or an out-of-hospital DNR order.[57]

While there is no broadly recognized time period, the passage of which should trigger a review of the POLST form, the authors suggest that a review at least once a year is appropriate. For a patient in a skilled nursing or long-term care facility, care conferences will typically occur every three months and a brief review of the POLST form can be easily incorporated into the facility's procedures so as to screen for a change in the patient's condition or preferences which might warrant a more detailed review between the patient or their surrogates and a healthcare professional.[58] One recent research article makes a strong case for the involvement of a certified nurse practitioner for at least some of these care conferences at which the POLST is reviewed.[59]

Because both advance health care planning and the POLST are most effective when they reflect a continuing conversation, it is critical that when the patient is unable to continue that conversation directly, because of illness or incapacity, a properly empowered and informed surrogate decision-maker continues that conversation. When a review of a POLST form is required for one of the reasons discussed above, a surrogate decision-maker – preferably a healthcare agent appointed by the patient – should be kept informed and participate with the doctor in the review process.

When a response to an emergency situation is required, the POLST must be followed first even before discussion with the patient's physician.[60] But where there is time for such a discussion, both the patient's physician and the patient's health care agent should be kept informed so that patient care continues to reflect the patient's wishes as accurately as possible.

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57 *See infra* Appendix 1.

58 Frequent questions at professional seminars often reflect concern that a POLST may be applied without sufficient thought at a much later date under different circumstances that do not justify the POLST treatment choices. This is a valid concern that must be addressed by thoughtful application of the POLST process that never allows the existence of a POLST form to discourage active and thoughtful medical decision-making.

59 *See* Gerald A. Hartle, David G. Thimons & Joseph Angelelli, *Physician Orders for Life Sustaining Treatment in U.S Nursing Homes: A Case Study for CRNP Engagement in the Care Planning Process*, 2014 NURSING RES. & PRAC., at 2, 3. Almost one quarter of the POLST form orders were changed after a care conference in which a CRNP was present. *See id.*

60 Because CPR and intubation must be applied immediately to be effective, there is no time for even the briefest of delays for consultation and discussion.

IV. The Role of the Estate Planner

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

The estate planner should inform clients about the POLST during the estate planning process as part of the discussion about health care decision-making and advance directives. The clients need to know that if there is a substantial decline in their medical condition or a significant medical diagnosis, they should review their advance directive to be sure it continues to reflect their wishes. If the situation is serious, they should know that the POLST is a tool available to them and their doctor to try to ensure that their wishes are carried out properly in light of their new current medical condition. The estate planner should consider giving clients written resource materials about the POLST and how it fits in with the advance directives prepared in the estate planning process.[61]

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

The estate planner should know how a POLST should be completed. Ideally, the POLST is the result of a meaningful conversation about the patient's medical condition, treatment options, and preferences. Where the patient has appointed a health care agent, the agent

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61 Educational information may be made easily available on the web. *See*, *e.g.*, Marian Kemp, *POLST in Action in Pennsylvania*, YouTube (Feb. 12, 2013), http://www.youtube.com/watch?v=kncf8BZXbFk, (prepared in partnership with the Oregon POLST Task Force and adapted to accurately reflect Pennsylvania law).

should participate in the conversation even if the patient is still capable of making medical decisions. The agent may help express the patient's current wishes based on the patient's goals, values and religious faith. A health care agent can make sure that the patient's advance health care directive is available for review and discussion. Just as importantly, the agent's participation in the conversation will help him or her understand as well as possible, through a first-hand discussion with both the doctor and the patient, what the patient may want in terms of care. This discussion is all the more valuable because it is as close as possible to the time when such decisions about care must be made; this is when the health care agent needs to be present to talk with the doctor, ask the right questions, and get the answers.

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

The estate planner may know when the POLST form should be reviewed. If the estate planner knows that a POLST form has been completed, they may suggest review when necessary to make sure that the patient care documents continue to reflect the patient's wishes, given any changes in setting or condition.[62] The estate planner in this position is serving more as a trusted family advisor than as a technical legal advisor, but the importance of that role should never be underestimated. Nothing is more important, or strengthens relationships more, than being there for the client's family in times of crisis.

The estate planner may be needed to be sure the patient's wishes are carried out within the context of existing laws, the patient's advance health care directive, and the POLST order form. In some cases, the

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[62] See *supra* Part III.C.3 for a discussion on when it may become necessary to review a POLST form.

estate planner may be required to enforce the patient's rights so that their wishes under the law are respected:

> Attorneys who work with their clients' health care professionals can play an important role. They can help ensure that existing laws are followed so patients and their families receive the necessary information to make informed decisions about treatment and care. Attorneys can ensure that health care proxies are completed, and that when patients have decision-making capacity, they communicate their wishes to loved ones and health care professionals. This will help make certain that desired treatment is provided, unwanted and harmful treatment is not provided, and the expressed wishes of patients or directions of their health care agents or surrogates are respected. Attorneys should think about possible remedial legislation and work to facilitate such legislation. There are many opportunities for involvement.[63]

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

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

The POLST, on the other hand, has emerged from the scientific, medical, and clinical world. The wide acceptance and spread of the POLST is not well known to the majority of estate and trust and elder law practitioners. It is very important to the POLST's proper functioning that it fit within state laws governing living wills, health care powers

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63 David C. Leven, *Health Justice Denied or Delayed at the End of Life: A Crisis Needing Remedial Action,* 58 N.Y.L. SCH. L. REV. 403, 415 (2013-2014); *see also* Kathryn Tucker, *Elder Law: Counseling Clients Who Are Terminally Ill,* 37 WM. MITCHELL L. REV. 109, 120 (2010). Both of these articles discuss the inadequacies of the current approach to severe pain management in certain cases. *See* Leven, *supra*, at 411; Tucker, *supra*, at 120. Leven in his article discusses palliative sedation ("the use of sedative medications to relieve extreme suffering") to unconsciousness and voluntarily stopping eating or drinking (VSED) as "last resort" options to treat intractable pain at the end of life to shorten the process of dying where there are no other alternatives to relieve patents' suffering. *See* Leven, *supra*, at 411.

of attorney, out-of-hospital DNR statutes, guardianship, and health care decision-making laws generally. This requires estate and trust petitioners and elder law practitioners to become familiar with the POLST and its objectives, assess its risks and benefits, and that lawyers take a seat at the table when the POLST is being proposed so that it fits properly within state and federal jurisprudence.

V. The Constitutional Context of the POLST

Any consideration of the federal constitutional protections afforded to a POLST regime must begin (and, for the time being at least, end) with the United States Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*.[64] The specific legal issue presented in *Cruzan* was the constitutionality of an en banc decision of the Missouri Supreme Court that held that Missouri state law required "clear and convincing" proof of an incompetent individual's wishes *not* to receive apparently futile life-prolonging treatment as a prerequisite to the discontinuation of such measures.[65] The Missouri Supreme Court's divided decision was in stark contrast to an, even then, overwhelming majority of state appellate court decisions in their treatment of individuals (such as Nancy Cruzan) whose medical condition had been deemed to be "a persistent vegetative state."[66]

As discussed at length in the *Cruzan* decision (and noted briefly *infra*), state courts have struggled for some years to provide a rationale for sustaining the constitutional right of an individual to refuse medical treatment. The resulting jurisprudence, while inconsistent in its reasoning, has generally favored a patient's (or his or her surrogate decision-maker's) determination to refuse treatment. Connecticut, for example, began its modern judicial analysis of the issue in *Foody v. Manchester Memorial Hospital*, which focused on the distinction between "ordinary" and "extraordinary" treatment.[67] The court held in *Foody* that the parents of an adult daughter with multiple sclerosis who was hospitalized in a "semi-comatose condition" could obtain permanent injunctive relief prohibiting further treatment.[68] In *McConnell v. Beverly Enterprises-Connecticut, Inc.*, the Connecticut Supreme Court's opinion provides a strong rationale, derived from both constitutional and common law sources, for patient self-determination,[69] which has defined

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

65 *See id.* at 267-69 (citing Cruzan v. Harmon, 760 S.W.2d 408, 415, 426 (Mo. 1988) (en banc)).

66 *See, e.g.*, *Cruzan*, 497 U.S. at 347-48 (Stevens, J., dissenting).

67 Foody v. Manchester Mem'l Hosp., 482 A.2d 713, 719 (Conn. Super. Ct. 1984).

68 *See id.* at 716, 721-22.

69 *See* McConnell v. Beverly Enters.-Conn., Inc., 553 A.2d 596, 603 (Conn. 1989).

Connecticut law since that time: "The right to refuse medical treatment is a right rooted in this nation's fundamental legal tradition of self-determination."[70] Other states have an equally mixed jurisprudence, and as will be seen, that approach, on a national level, is encouraged by Justice O'Connor's concurrence in *Cruzan*.

The U.S. Supreme Court's *Cruzan* decision comprises not only Chief Justice Rehnquist's opinion for the Court, but two separate concurring and two separate dissenting opinions. It is Justice O'Connor's relatively brief concurrence, however, that is generally viewed as establishing the constitutional principle for which *Cruzan* is known: "[T]he liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment . . . ."[71]

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

> Today's decision, holding only that the Constitution permits a State to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment . . .Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, in the first instance.[72]

Yet, with the exception of Justice Scalia, who would remove all "right to die" cases from the federal courts in favor of a purely state-sourced jurisprudence,[73] all the then-members of the U.S. Supreme Court were united in their view that, under either a privacy-liberty rationale such as that relied upon in the seminal New Jersey decision of *In re*

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70 *Id.* at 601.

71 *Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring).

72 *Id.* at 292 (citation omitted).

73 *See id.* at 293 (Scalia, J., concurring).

Quinlan,[74] or the venerable (if sometimes criticized) New York "informed consent" doctrine of *Schloendorff v. Society of New York Hospital*,[75] or both, a competent individual, absent a showing of a specific compelling contrary public interest, has a right to refuse medical treatment.

> "On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient's competency to make a rational and considered choice."[76]

While much of the majority opinion in *Cruzan* may be dicta – Nancy Cruzan was understandably incapable of expressing her own wishes and there was some (minimal) controversy over what her personal wishes really were – that dicta is clearly decisive for the constitutional validity and enforceability of a POLST, properly executed in accordance with local law. Indeed, as Justice O'Connor states in her concurring opinion, the reasoning of the *Cruzan* majority essentially mandates such validity and enforceability.[77]

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

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

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74 *See In re* Quinlan, 355 A.2d 647, 664 (N.J. 1976).

75 *See* Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

76 Cruzan, 497 U.S. at 273 (quoting *In re* Conroy, 486 A.2d 1209, 1225 (N.J. 1985)).

77 *See id.* at 292 (O'Connor, J., concurring).

A separate issue is the ability of a surrogate to use a POLST form for an individual who is incapable of making informed medical decisions. This issue remains, for now, within the "laboratory" of the states. Since every state now allows medical treatment decisions to be delegated to a duly appointed agent or surrogate, the constitutional force of the interests at stake weighs strongly in favor of compliance with a POLST. In those states which limit the power of a third party to direct the withholding or withdrawal of life support, the authority of a third party (e.g., a default surrogate) to execute a POLST will be limited consistently with state law in the absence of an explicit judicial broadening of the principles set forth in *Cruzan*.[78]

VI. Concerns, Criticisms And Fears Surrounding The POLST

Criticisms and concerns have been raised, particularly within the Catholic community, about the POLST's scope, safeguards, effect, and implementation. Those criticisms and concerns deserve examination. It is important to understand, give weight to, and take into account those concerns to the extent possible within the context of the design, process, and implementation of a POLST program. While some of the issues raised are more fundamental than others, they should all be understood and reflected upon by those wishing to either advance a POLST program, or consider legislation that would address POLST within their home state. An exposition of these concerns were surveyed in *Ethics & Medics*[79] and much more thoroughly and rigorously set forth by the Catholic Medical Association in a White Paper, published in the *Linacre Quarterly*.[80] Most recently, a very rigorous point-by-point analysis of the White Paper was authored by Father Tom Nairn, Senior Director of Ethics for the Catholic Health Association.[81] This analysis agrees with some of the concerns expressed in the White Paper, but ultimately con-

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78 *Cf. id.* at 286-87 (Rehnquist, C.J., majority opinion) (specifically rejecting any constitutional basis for surrogate decision-making in the absence of evidence of a patient's own wishes).

79 See generally Christian Brugger et al., *POLST and Catholic Health Care: Are the Two Compatible?*, 37 Ethics & Medics, no. 1, Jan. 2012, at 1, 1 ("set[ting] forth several serious problems with the [POLST] documents").

80 *See generally* Christian Brugger et al., *The POLST Paradigm and Form: Facts and Analysis,* 80 Linacre Q. 103, 105 (2013), *available at* http://www.maneyonline.com/doi/pdfplus/10.1179/0024363913Z.00000000027 (taking the position "that the use of POLST forms will create unacceptable risks from both good medical . . . and ethical decision-making" while "recogniz[ing] that POLST might offer some benefits to some patients").

81 *See generally* Tom Nairn, *The Catholic Medical Association's White Paper, "The POLST Paradigm and Form: Facts and Analysis"*, Health Care Ethics USA, no. 3, 2013, at 17, *available at* http://www.chausa.org/docs/default-source/hceusa/the-catholic-medical-association%27s-white-paper-the-polst-paradigm-and-form—-facts-and-analysis.pdf?sfvrsn=2.

cludes that the arguments do not invalidate the arguments for the POLST.[82] They do, however, expose valid areas of concern. Ultimately, the importance of these concerns, particularly those which are theological in nature, is properly left to the reader.

A. The POLST May Be Implemented When The Patient Is Not Terminally Ill

Most state laws authorizing living wills address the medical conditions – typical of the high profile cases that prompted legislative action, such as terminal illness, permanent unconsciousness, or permanent vegetative state – found in the seminal *Quinlan*, *Cruzan*, and *Schiavo* cases. These medical situations made their way into our laws as medical conditions required for a living will to become operative. They are not typically incorporated into the POLST process, nor into statutes authorizing a POLST program. The constitutionality of these medical limitations, as they relate to living wills or the POLST, is questionable in light of each person's fundamental liberty interest in controlling one's own medical care as announced in *Cruzan*.[83]

The fundamental right of the patient under the Constitution and the doctrine of informed consent simply does not square with a bright-line boundary covering only terminal illness or permanent unconsciousness. A ninety-five-year-old resident of a long-term care facility may well be medically stable but may not wish to have aggressive medical care imposed in light of the resident's age and frailty. Certainly, a DNR order for such a resident would raise no eyebrows in the presence or absence of a POLST form. The really well-informed resident might well be aware that the efficacy rate for CPR under such circumstances is less than five percent, and the probability of real "success" in such circumstances is essentially nonexistent.[84] Accordingly, the resident may well consider resuscitation to be both inappropriate and burdensome. Because a DNR order or a POLST form addressing the situation is the decision of the patient, relative to the patient's present condition and as

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[82] *Id.* at 34.

[83] *See supra* Part V.

[84] *See* Michael Gordon, *Cardiopulmonary Resuscitation in the Frail Elderly: Clinical, Ethical and Halakhic Issues*, 9 ISR. MED ASS'N. J. 177, 178 (2007); *see also* David E. Weissman & Charles F. von Gunten, *Fast Fact #24: Discussing DNR Orders – Part 2*, CENTER TO ADVANCE PALLIATIVE CARE, https://www.capc.org/fast-facts/24-discussing-dnr-orders-part-2 (last updated Mar. 2009). The frail, elderly patient simply does not possess the biological reserves to withstand the CPR process, and the arrest is most typically the final pathway to death as a result of co-morbidities. Gordon, *supra* at 178. Dr. Gordon argues that, even from a traditional religious perspective, the current presumption of resuscitation in the absence of a DNR order may be ethically questionable for this portion of the population. *Id.* at 178-79.

agreed between the patient and the doctor, the limitations on triggering a living will should not be imposed on a patient's present medical care choices as a matter of law.

The United States Conference of Catholic Bishops provide:

> A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a realistic hope of benefit or do not entail an excessive burden or impose excessive expense on the family or the community.
>
> A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.[85]

As a matter of Catholic moral teaching, Dr. E. Christian Brugger, Professor of Moral Theology at Saint John Vianney Theological Seminary, and coauthors argue that the POLST is ethically problematic for several reasons: Dr. Brugger's first objection is that "making a morally good decision for the refusal of medical care requires a careful and detailed inquiry into particular facts related to the specific treatment options of a specific patient. The POLST model's one-size-fits-all approach to medical orders excludes this necessary process of inquiry."[86] To the contrary, a POLST form allows the patient to express that which is "proportionate" in "the patient's judgment," and the burdens to be considered include those to "the family or the community,"[87] which appear far more favorable and liberal to patient freedom than the positions espoused by Dr. Brugger.

Dr. Brugger's second objection is that nutrition and hydration, even by artificial means, "'should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is

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85 U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 31 (5th ed. 2009) (paragraph numbers omitted) (citing Sacred Congregation for the Doctrine of the Faith, Vatican, *Declaration on Euthanasia*, VATICAN.VA (May 5, 1980), pt. IV, *available at* http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html).

86 Brugger et al., *supra* note 79, at 1-2 (quoting St. Pope John Paul II, Address to the International Congress on Life Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas (Mar. 20, 2004)).

87 *Cf.* U.S. CONFERENCE OF CATHOLIC BISHOPS, *supra* note 85 (taking the position that there is a moral obligation to preserve life using "proportionate means" as opposed to means that are "disproportionate" to their expected efficacy or burden on "the family or community").

seen to have attained its proper finality.'"[88] Since a POLST form would allow a patient to direct the withholding or withdrawal of medically supplied nutrition or hydration, it may be objectionable, particularly where the patient may be in a permanently unconscious state – a circumstance in which the Catholic Church considers medically supplied nutrition and hydration to be morally obligatory.

> Catholic moral teaching condemns both suicide and euthanasia . . . . POLST documents permit any patient, whether terminally ill or not, to refuse all life-sustaining care, including antibiotics and even food and water . . . for the purpose of causing one's own death. Inevitably, the use of POLST documents will involve Catholic health care workers at times in facilitating euthanasia through the wrongful removal of life support.[89]

Father John F. Tuohey and Marian O. Hodges differ on this point and others because the POLST does not direct the withdrawal of care; rather, it merely permits the withdrawal of care.

> Key here is that the POLST is a physician's order *about* life-sustaining interventions, not an order simply to *forgo* them. Especially for patients with complex medical conditions or chronically critical illness, some interventions may offer reasonable hope of benefit, others may not. POLST orders allow for pursuing the interventions that do and avoiding the ones that will pose an excessive burden. POLST is a validated way to help assure clinically appropriate care is delivered at the end of life, consistent with the Catholic moral tradition.[90]

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

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

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88 Brugger et al., *supra* note 79, at 2 (quoting St. Pope John Paul II, Address to the International Congress on Life Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas (Mar. 20, 2004)).

89 *Id.*

90 John F. Touhey & Marian O. Hodges, *End of Life, POLST Reflects Patient Wishes, Clinical Reality*, HEALTH PROGRESS, Mar.-Apr. 2011, at 60, 63-64; *see also* Nairn, *supra* note 81, at 20.

> no hope of benefit or that are excessively burdensome. Determining what is ordinary and extraordinary consists in an assessment of the means – cost, availability, etc. – and the benefits and burdens upon this patient in this particular situation. It is not clear that one must be terminal, whatever that means in this day and age.
>
> For example, an active and relatively healthy 87-year-old woman with poor circulation in her legs is told by her physician that she needs a double amputation. She refuses because, for a number of reasons, this surgery and a loss of her legs are seen to be excessively burdensome. Or take the patient who has undergone dialysis three times per week for the last six years and declines further dialysis because it has become too burdensome. While the patient will die without dialysis, he is not strictly speaking terminal at the time of the decision. Or the patient who develops a rare cancer for which there is an experimental treatment available at considerable cost in a foreign country for a lengthy period of time. The individual refuses because seeking such treatment would impose excessive burdens on the individual and her family. She is not strictly speaking terminal at the time of her decision. Having said this, however, if we are dealing with "life-sustaining treatments," then, in the vast majority of cases, we will be dealing with patients who had a life-threatening condition.[91]

Regardless of the outcome of this theological debate, the mere fact that a patient could utilize a POLST form to carry out a personal health care decision that conflicts with a particular moral and religious tradition is not a valid reason to reject it as a tool for effectuating patient wishes as a matter of law and clinical practice. The POLST form does not in any event mandate any particular decision. It merely permits the exercise of an individual's free will. It is up to the individual to apply his or her own goals of care, values, and religious beliefs into health care decision-making. Our society is multicultural, with citizens of widely divergent religious perspectives and the firmly established right to select any one or none at all. POLST, in short, is an empowering tool intended to reflect patient wishes in accordance with constitutional and legal principles. The fact that it can be used to effectuate a patient's wishes inconsistently with a particular moral tradition is not a valid criticism if it can also reflect a choice consistently with that moral tradition.

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91 Ron Hamel, *POLST Under Fire,* 20 HEALTH CARE ETHICS USA, no. 1, 2008, at 30, 33-34, *available at* http://www.chausa.org/docs/default-source/general-files/2f04a948aa0a4109a63a2ee0b25509ad1-pdf.pdf?sfvrsn=0; *see also* Nairn, *supra* note 81, at 22-23.

Further, there is a significant distinction between the individual's right to refuse medical care and the administration of medical care directed at hastening death to shorten a period of suffering that cannot otherwise be relieved. The affirmative application of medical care to assist a patient in this way, now generally referred to as "aid in dying," is neither endorsed by the POLST paradigm nor facilitated by the POLST form. It is expressly legal only in the states of Oregon and Washington by statute[92] and in Montana by a decision of the Montana Supreme Court.[93] A thorough discussion of the development, history and results in these three states can be found in the writings of Kathryn L. Tucker, a forceful advocate of patient choices at the end of life.[94]

B. A Patient's Signature May Not Be Required

While all states require the signature of a physician or other healthcare professional, several states adopting a POLST program do not require a patient's signature.[95] Of course, physicians' orders typically do not require a patient's signature, but there are good reasons for requiring a patient's signature on a POLST form. The most important reason is to be sure that there has been a discussion and conversation with the patient or the patient's legal representative. There may be valid concerns about requiring a signature, particularly for a patient's legal representative. A patient's surrogate may be afraid or discouraged from making a decision by the formality of their signature on behalf of the patient.[96] But the better approach clearly is to require a patient or legal representative signature as a safeguard.

Without some assurance that the POLST is a result of a meaningful conversation between the patient, or the patient's legal representative, and a healthcare professional (preferably an attending physician) nothing corroborates the POLST form as representative of an informed patient decision. The NPPTF recommends that the signature of either the

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92 *See generally* OR. REV. STAT. §§ 127.800-897 (2003 & Supp. 2010) (comprising the Oregon Death with Dignity Act); WASH. REV. CODE §§ 70.245.010-.904 (Supp. 2010) (comprising the Washington Death with Dignity Act).

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

94 *See*, *e.g.*, Tucker, *supra* note 63; Kathryn L. Tucker, *When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life,* 33 WHITTIER L. REV. 109 (2011). One interesting finding is that the Death with Dignity Act in Oregon has "galvanized improvements in end-of-life care and benefited all terminally ill Oregonians." Tucker, *supra* at 120. One can understand how the existence and exercise of this option might spur further efforts to provide better options in palliative and end-of-life care.

95 *See infra* Appendix 2, rows 5-6.

96 There is a certain finality and gravity about signing an order limiting care, which is not inappropriate but can be more off-putting than a conversation with the doctor.

patient or the legal representative of the patient be required.[97] States considering the POLST would do well to follow that recommendation. While a patient signature does not insure that a proper informed discussion took place, it does prove that there was at least some interchange with the patient or the patient's legal representative. As discussed later in this article, provisions can be made which are also recommended for signature equivalents where necessary, such as a witnessed verbal consent, or electronic signature.[98]

C. The POLST May Be Driven by Fiscal Concerns

Dr. Brugger correctly points out that high-tech life sustaining treatment is expensive and suspects that fiscal considerations are behind much of the impetus to adopt the POLST.[99] He notes that the highly successful implementation of the POLST in La Crosse, Wisconsin earned La Crosse the dubious distinction of "Cheapest Place to Die" from Good Morning America.[100] Reducing expensive care that is ultimately not desired by an informed patient is likely to save money. It hardly makes sense, however, to criticize the POLST if it produces better and less expensive end-of-life care, just as long as the decisions reached are the result of a patient choice that is medically well informed. The POLST form is merely the endpoint of the informed consent process; it is not the process itself.

We may well ultimately reach a point of limiting expensive end-of-life care where the results are not justified. The harsh reality is that about thirty-three percent of the total cost of healthcare in America is incurred in the last year of life.[101] To the extent that we can have better care that is cheaper as well, we should clearly pursue it. But patient freedom is very important, and we must be vigilant, as always, for conflicts of interest in the informed consent process. Conflicts of interest are a real concern to be considered and will likely become a greater concern as time goes on and the financial pressures of cost control within our health care system increase. This concern may be most strongly felt within the disability community and minority populations who, with some cause, may feel most vulnerable and least trusting of the

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97 *See* LEGISLATIVE GUIDE, *supra* note 36, at 16.

98 *See infra* Part VIII.D.2.

99 *See* Brugger et al., *supra* note 79, at 3.

100 *Id.*; *see also* Kate Snow & Elizabeth Tribolet, *Good Morning America: End-of-Life Lessons from the Cheapest Place to Die,* ABCNEWS.GO.COM (Aug. 10, 2009), http://abcnews.go.com/GMA/story?id=8250195&page=1.

101 Kate Snow & Elizabeth Tribolet, *supra* note 100.

health care system when it must balance cost against the extension of their lives.[102]

D. POLST May Be "Too Effective" And May Discourage "In The Moment" Thoughtful Medical Decision-Making

Pennsylvania's POLST form, for example, says, "FIRST follow these orders. THEN contact physician . . . ."[103] This, it could be argued, would discourage a physician from considering changing the order to better suit the patient's current condition and medical treatment alternatives. However, this language is included because the first section of the POLST deals with emergency situations[104] – for which there is no time to consult with a physician – and should therefore not be read as discouraging thoughtful consideration and reconsideration of the most medically appropriate treatment. There is a danger in any form of order or advance directive that it will be followed without thought. There is danger also that the fact that a patient has a living will may prompt a medical provider to conclude that the patient does not desire important or life sustaining care, thus failing to consider that the operation of a living will is dependent upon certain specified conditions, most typically a terminal condition, end-stage medical condition, or a state of permanent unconsciousness.

A similar "spillover" effect can occur as a result of a patient having a DNR order. The assumption may be made that because there is a DNR order, the patient does not want relatively full medical care short of CPR. This assumption is unjustified and inaccurate, and in this respect the POLST can be of significant benefit in avoiding the unwanted limitation of care and encouraging more effective expressions of care decisions, particularly in the context of long term care residents. As a result of a detailed study of the POLST forms used in Oregon, where an electronic registry has been implemented, it was noted that while 72.1% of the patients completing a POLST included DNR under section A "only half of these forms opted for 'Comfort Measures Only' in "[s]ection B . . . ."[105] This data both strengthens the argument that patients with a DNR order do not necessarily wish to limit other significant care, and makes a powerful argument for the POLST itself, which

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102 *See* INSTITUTE TO ENHANCE PALLIATIVE CARE, *The Task Force for Quality at End-of-Life, End-of-Life Care In Pennsylvania: Final Report and Recommendations*, 48-51 (2005).

103 PA. DEP'T OF HEALTH, PENNSYLVANIA ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) (2010), http://www.polst.org/wp-content/uploads/2013/01/POLST-Form.pdf.

104 *See id.*

105 OR. POLST REGISTRY, OREGON POLST REGISTRY ANNUAL REPORT 18 (2011).

allows an expression for limited interventions and transfer to a hospital even though resuscitation is not desired.[106]

Within the context of long term care facilities, the questions raised by section B of the POLST are really important in carrying out patient and family wishes, as it deals directly with whether the patient wishes to be hospitalized or desires the most aggressive medical care, along with the resultant burdens and intrusions customarily applied in an intensive care unit.[107] A patient may have had their fill of hospitals and aggressive medical care and may wish to receive the best care possible without hospitalization, unless hospitalization is necessary to treat a fracture or other acute injury. Hospitalization might be required, even if "Comfort Care Only" is selected, when necessary to treat a fracture or other acute injury, because comfort could not be maintained in the long-term care setting without some acute care treatment.[108]

E. The POLST May Dictate Choices Weeks, Months Or Even Years Before The Choices Are To Be Carried Out

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

> The forms are completed prior to the time that many people know the exact nature of their conditions or the range of reasonable treatment options. In other important areas of life (e.g. investing), people are ill advised to make consequential decisions without knowing all the facts. But the POLST paradigm invites patients to make the most consequential decision of their lives before many facts are even possibly knowable: What precise ailment will I be suffering from? What treatment alternatives will be available? What probability of medical benefit does each offer? What burdens are associated with each? . . . A POLST form is a blunt and inadequate instrument that is as likely to do damage as good for people at vulnerable moments of life.[109]

Dr. Brugger's concerns, however, are general – applicable to any healthcare directions given in advance by whatever means expressed. The POLST is the least susceptible to this argument of any directions given in advance simply because the POLST form is an explicit medical order immediately effective with reference to the patient's *current condition,* rather than a hypothetical future condition, which is usually the

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106 *See infra* Appendix 1.
107 *See supra* Part III.A.
108 *See infra* Appendix 1.
109 Brugger et al., *supra* note 80, at 114 (footnote omitted).

case with a living will addressing a future terminal illness or permanent unconsciousness. In this context, the argument goes towards how frequently a POLST form should be reviewed and updated, rather than whether there should be a POLST form at all, since the primary premise behind the POLST paradigm is that the agreed-upon orders reflect the patient's current medical condition, treatment options, and probable benefits and burdens of those treatments.

F. POLST May Be Forced On Patients

Concerns have been expressed that the POLST may, in effect, be forced upon patients. This is a valid concern if institutional policy requires the execution of a POLST form, even though a POLST form itself gives a patient the freedom to decide with their doctor to opt for full treatment, for comfort measures only, or anything in between. Documentation of patient wishes for resuscitation code status indicating whether they desire full CPR efforts in the event of a crisis is generally required under existing regulations for skilled nursing facilities, and guidance from the Centers for Medicare and Medicaid Services (CMS) "provides that 'failure to obtain and implement orders related to life-sustaining treatments' is the highest level deficiency: 'Level 4: Immediate Jeopardy to Resident Health or Safety.'"[110] However, the execution of an advance directive or other order governing the limitation of care is not required. In fact, requiring an advance health care directive or a medical order such as the POLST is against the law in most states and is not the best policy for any state. Pennsylvania's statute is an example:

> A health care provider, a health care service plan, a health maintenance organization, an insurer issuing disability insurance, a self-insured employee welfare benefit plan, a nonprofit hospital plan and a Federal, State or local government sponsored or operated program may not:
>
> (1) Require an individual to execute an advance health care directive or order or to designate or disqualify a health care representative as a condition for being insured for or receiving health care services.
>
> (2) Charge an individual a different rate or fee whether or not the individual executes or has executed an advance health

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

> care directive or order or designated or disqualified a health care representative.[111]

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

G. Physician Signature May Not Be Required And "Facilitators," Rather Than the Attending Physician, May Be the Ones To Have the Conversation With the Patient

This concern covers two related questions. First, who is the medical professional entitled to sign the POLST form? Second, but likely more importantly, who is the one who actually has the conversation with the patient? The most important part of the POLST process is the conversation where the patient is informed of the medical treatment choices and the likely course of his or her illness. The concern is that a person who is specially trained as a facilitator of these conversations may not be equipped to give the necessary medical guidance or may be incapable of making a decision as to whether the patient is sufficiently competent to have that conversation.[112] This concern has the greatest weight where the patient's medical condition is uncertain or unusual, since the facilitator may not be able to properly inform the patient of the likely outcomes for his or her personal situation and the appropriate treatment options.[113] Where the medical condition is more common and the course more predictable, such as in the case of chronic obstructive pulmonary disease, congestive heart failure, or end-stage renal failure, it is likely that such a facilitator may well have substantial experience to guide a patient very well in the conversation. And the facilitator may have a very precious resource that is in shorter supply for the physician – time – the time to have an unhurried conversation about something very important and very personal.[114] The further unfortunate truth is that not all doctors are very good at having this conversation about care

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111 20 PA. CONS. STAT. ANN. § 5428 (West Supp. 2014).

112 *See* Brugger et al., *supra* note 79, at 2.

113 *See id.* at 2-3.

114 *However*, they will only have that precious time if this critical task is respected by health care employers eager to increase employee productivity. It should not be assumed

at the end of life. However, as Dr. Brugger points out, the American Medical Association counsels physicians to be directly involved in the process of informed consent.[115]

> In the communications process, you, as the physician providing or performing the treatment and/or procedure (not a delegated representative), should disclose and discuss with your patient:
>
> • The patient's diagnosis, if known;
>
> • The nature and purpose of a proposed treatment or procedure;
>
> • The risks and benefits of a proposed treatment or procedure;
>
> • Alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance);
>
> • The risks and benefits of the alternative treatment or procedure; and
>
> • The risks and benefits of not receiving or undergoing a treatment or procedure.
>
> In turn, your patient should have an opportunity to ask questions to elicit a better understanding of the treatment or procedure, so that he or she can make an informed decision to proceed or to refuse a particular course of medical intervention.[116]

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

The related question, of which medical professionals are authorized to sign the form, is also important and is more likely to be included in a statute or regulation even though it is the conversation that is most important. It is after all awkward at best to legislate or regulate a conversation. The POLST form is just the end product of that conversation.

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that a facilitator would have more time for this conversation. The employer must *give* the facilitator that time.

115 *See* Brugger et al., *supra* note 80, at 117.

116 Memorandum from the American Medical Association on Informed Consent, Presented to the Nevada State Senate Committee on Health and Human Services by Assemblyman James Ohrenschall as Exhibit M (May 7, 2013), *available at* http://www.leg.state.nv.us/Session/77th2013/Exhibits/Senate/HHS/SHHS1054M.pdf.

California, Louisiana, New York, Tennessee and West Virginia require a physician's signature.[117] Colorado, Hawaii, Idaho, Iowa, Maryland, New Jersey, North Carolina, Rhode Island, Utah, Vermont and Washington, by statute, more broadly allow others such as a Certified Nurse Practitioner, Advanced Practice Nurse or Physician's Assistant, to sign the POLST.[118] Montana and Oregon do so by regulation.[119] Pennsylvania's statutory committee recommended this broader approach, while Minnesota did so by clinical consensus alone.[120]

A qualified health care professional must always sign the POLST as a medical order, but the conversation is the most important part of the process. The health care professional must empathetically inform the patient about the health care choices that relate to their care, and listen to the patient's goals, values, and preferences in this process. In the opinion of the authors, a POLST form is best completed in the context of a full discussion with the patient, the patient's primary or attending physician, and the patient's surrogate. This conversation should guide the treatment choices and the orders that reflect those choices.

H. "Steering" Decisions in POLST

Another criticism leveled at the POLST is that the structure and wording of the POLST form and the manner in which it may be explained to patients is intended to influence the patient towards the with-

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117 *See* CAL. PROB. CODE § 4780(c) (West 2009); LA. ADMIN. CODE. tit. 48, § 207(B) (2011); N.Y. PUB. HEALTH LAW § 2994-dd(1), (6) (McKinney Supp. 2014); TENN. CODE. ANN. § 68-11-224 (2013) (allowing for the signature of duly licensed non-physician medical personnel in very limited circumstances); W. VA. CODE ANN. § 16-30-25(b)(2) (West 2008).

118 *See* COLO. REV. STAT. ANN. § 15-18.7-103(1)(i) (West 2011); HAW. REV. STAT. §§ 327K-1 to 327K-2(a) (West 2014); IDAHO CODE ANN. § 39-4512A(1) (Supp. 2014); IOWA CODE ANN. § 144D.2(1)(d) (West 2013); MD. CODE ANN., HEALTH-GEN. § 5-608.1(b)(2) (West Supp. 2013); N.J. STAT. ANN. § 26:2H-134(b)(3) (West Supp. 2014); N.C. GEN. STAT. § 90-21.17(c) (2013); R.I. GEN. LAWS §§ 23-4.11.2(12), 23-4.11.2(b)(1)(iii) (Supp. 2013); UTAH CODE ANN. § 75-2a-106(3)(a) (LexisNexis Supp 2013); VT. STAT. ANN. tit. 18, §§ 9701(5), 9708(e)(1) (West Supp. 2014); WASH. REV. CODE ANN. §§ 70.122.030, 70.122.051 (West 2014).

119 *See* MONT. ADMIN. R. 37.10.101 and 37.10.104 to .105 (2014); OR. ADMIN. R. 847-010-0110 (2014) (requiring facilities to honor POLST even though the signer, who may be a nurse practitioner or physician assistant in addition to physicians, is not on the facility medical staff); *see also* OR. ADMIN. R. 847-035-0030 (2013) (requiring emergency medical services personnel to honor POLST); Sabatino & Karp, *supra* note 10, at 10.

120 *See Introduction to the POLST Form*, UPMC.COM, http://www.upmc.com/Services/AgingInstitute/partnerships-and-collaborations/Documents/POLST-Introduction-to-the-POLST-Form.pdf.; 20 PA. CONS. STAT. ANN. § 5488 (West 2014) (directing the Pennsylvania Department of Health to establish a committee to determine the advisability of using POLST forms); Sabatino & Karp, *supra* note 10, at v.

drawal of care.[121] The choices presented in section B of the POLST form itself present the "Comfort Measures Only" and "Limited Additional Intervention" (no artificial nutrition) options before the "Full Treatment" option,[122] which prompts some to wonder whether the order of choices is intended to influence the way the form is completed. This criticism isn't silly, as there is evidence that presenting a choice first on a form does tend to influence responses.[123] But the criticism ignores the fact that the resuscitation choice is the first listed choice in section A at the top of the form.[124] Further, the default choice if no decision is made within a particular section of the POLST form is full treatment.[125] In those respects the POLST is slanted towards full medical treatment, which in any event is the general default within our health care system. Whether full treatment is the best default choice to reflect actual patient preferences, it is certainly well established and the most protective.[126] More importantly, the POLST is not filled out by the patient, but by a health care professional for whom the order of choice should have no significance.

But the discussion, rather than the form, is most important, and it is the integrity of the discussion to which most attention should be paid. With a POLST, just as with an advance health care directive, the process and the form should reflect and effectuate patient wishes, not influence them for or against additional medical care. It is extremely important to be sensitive to the fact that the way in which information and, particularly, questions involving care are presented may significantly influence patient responses.

While the effectuation of properly informed patient choices is very important, the "properly informed" part of the equation should never be ignored. While patient autonomy has become a very strong medical value in recent years, the input of the medical professional should not be ignored. Why, after all, do we go to the doctor in the first place? Obviously, we go to the doctor to get the doctor's professional opinion. If a doctor, overly concerned with patient autonomy, asks, "Well, what would you like me to do?" or "What are you looking for?" the rational patient's answer ought properly to be the following: "I am looking for

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121 *Cf.* Scott D. Halpern et al., *Default Options in Advance Directives Influence How Patients Set Goals for End-Of-Life Care*, 32 HEALTH AFF. 408 (2013).

122 *See infra* Appendix 1.

123 *See* Halpern et al., *supra* note 121.

124 *See infra* Appendix 1.

125 *See infra* Appendix 1.

126 Halpern et al. argue that this presumption should be reversed. *See* Halpern et al., *supra* note 121 at 413-14. The authors based their presumption upon their experience with actual well-informed patients. *Id.* However, such a shift would provoke widespread controversy and concern.

your professional guidance and judgment." A doctor's primary function is to guide and give direction on medical matters, and if substantial and burdensome medical care will be ineffectual or against the patient's best interests, the doctor ought to advise the patient accordingly. If this is undesirable "steering," one must bear in mind that, after all, someone has to steer, and it is helpful if the one steering knows how to drive! There must be room for both professional judgment and guidance and patient freedom in these most critical and meaningful conversations.

VII. Statutory, Regulatory, Policy and Procedural Questions for States Considering a POLST Program[127]

A coalition can successfully adopt and implement a POLST program without state legislation through clinical consensus.[128] Broad clinical consensus will establish a generally accepted medical practice standard for the state, which allows for flexibility and is the fundamental basis for assessing proper medical care. Establishing clinical consensus helps to protect the medical provider from liability and encourages consistency in practice. However, recognition by some means of state medical board or health, human service, health care licensing, or licensing department is necessary to enable meaningful implementation.

If the state legislative process is involved each time the POLST program is modified or improved, then refinements, even when there is agreement, will be slower and more difficult to implement. Oregon is an example of a state that adopted the use of POLST through clinical consensus and then improved the POLST program over time as the need for modification became apparent.[129] Even in a state without legislation formally adopting POLST, a state-level organization (such as a

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127 Most of the topics for this concluding section – intended to give guidance to attorneys, healthcare professionals, and legislators who wish to implement a POLST program – coincide with the task of a legislative working group for the NPPTF, which included two of the authors of this article, Marilyn J. Maag and Robert B. Wolf, together with Charles P. Sabatino, Executive Director of the ABA Commission on Law and Aging; Thaddeus M. Pope, Director of the Hamline University Health Law Institute and Professor of Law at Hamline University School of Law; Margaret Murphy Carley, former Executive Director of the NPPTF; and Amy Vandenbroucke, Executive Director of the NPPTF and Consultant to the Oregon POLST Task Force. Therefore, there is a significant overlap in the discussion of issues, ideas, and phrasing of responses from Part VII of this article and the working group product, the NPPTF Legislative Guide. The statements and opinions expressed in this article are, however, the sole responsibility of the authors of this article and should not be attributed to the NPPTF unless otherwise indicated herein. The NPPTF Legislative Guide can be found on the NPPTF website. *See* Legislative Guide, *supra* note 36.

128 *See id.* at 8-9.

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

state health department, medical board, or health decisions coalition) or a university-based ethics center must take on responsibility for convening a task force of interested and affected organizations to study, deliberate and make recommendations for the adoption of a POLST program, circulate a POLST form to be used statewide, and provide information, such as on a website, about the POLST program and the POLST form.

In those states where the POLST program is initiated by clinical consensus, legislation relating to POLST still may be prudent for a specific purpose. For example, in Oregon, legislation was adopted specifically to create a statewide registry of POLST forms.[130]

In some states, there are legislative barriers to POLST, and therefore the state must adopt legislation in order to open the door to effective use of POLST.[131] The most common barriers relate to out-of-hospital DNR orders and surrogate decision-making.[132] For example, a state's statutes may not permit a DNR order to be combined with other medical orders or may allow the use of an out-of-hospital DNR order only in limited circumstances.[133] These barriers may interfere with the implementation of POLST in that state. Statutory limitations on a surrogate's ability to make medical decisions relating to a patient's end-of-life medical care may complicate the implementation of POLST in a state.[134] However, it is possible, and perhaps even essential and wise, to adopt the POLST program in a state while leaving existing statutory limitations on surrogate medical decisions in place where they are deemed necessary to protect against patient abuse.

Where legislation is not required, the proponents of a POLST program in a particular state may choose or prefer legislation for reasons discussed in more detail below.[135] Legislation can be used to create a statewide uniform system, which, in addition to instituting consistency, can be studied and improved.[136] Additionally, legislation may be used to provide legal immunity to health care professionals who make the POLST program available to their patients.[137]

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130 *See* OR. REV. STAT. ANN. § 127.666 (West Supp. 2014).

131 *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).

132 *See id.* at 119, 122.

133 *See id.*

134 *See id.* at 121.

135 *See infra* Part VII.A.2.

136 *See*, *e.g.*, LA. REV. STAT. ANN. §§ 40:1299.64.1to 64.6 (West 2008) (creating the Louisiana Physician Orders for Scope of Treatment, Louisiana's version of POLST).

137 *See* Sabatino & Karp, *supra* note 10, at 17.

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

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

The American Bar Association (ABA) Commission on Law and Aging and the NPPTF prepared a legislative chart that may provide useful comparisons for states considering the implementation of a POLST program.[138] The chart contains information on important characteristics and references that pertain to the twenty-six states that either have legislation concerning the POLST, or have implemented the POLST without specific authorizing legislation. Many of the statutes and POLST programs are discussed in this section of the article.

Oregon, where the POLST was initially developed, adopted the POLST paradigm through voluntary health care professional consensus.[139] This consensus was later supported by targeted changes in professional board regulations applicable to physicians, physician assistants, nurse practitioners, and first responders.[140] The regulatory changes acknowledge the obligation of these health care professionals to comply with life-sustaining treatment orders executed by a physician, nurse practitioner, or physician assistant, and additionally provide for immunity from criminal prosecution, civil liability or professional discipline.[141] This approach of clinical consensus followed by flexible regulatory support has enabled the Oregon POLST Task Force to modify the POLST form and implementation program periodically as lessons are learned, without having to re-navigate the complexities and politics of the legislative process.[142] As noted earlier, Oregon did enact

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138 *See infra* Appendix 2.

139 *See* Sabatino & Karp, *supra* note 10, at v.

140 *See infra* Appendix 2.

141 *See* OR. ADMIN. R 847-010-0110 (2013) (requiring all health care professionals to respect the life-sustaining treatments of any physician, physician assistants, or nurse practitioner); *see also*, OR. ADMIN. R. 847-035-0030 (2013).

142 *See* Sabatino & Karp, *supra* note 10, at 3.

a statute several years ago to create a POLST registry,[143] but that law merely enhances documentation and access to POLST; the legislation was not necessary for the creation and initial implementation of Oregon's POLST program. Whether created by consensus, law or regulation, POLST programs need the flexibility to evolve over time through a process of evidence-based research, quality improvement processes, and clinical experience.

1. *Arguments Opposing a Statute*

Even for those readers less cynical than American poet John Godfrey Saxe,[144] the legislative process is cumbersome and the legislation itself is often very detailed, which makes it an inflexible approach. This is true in part because drafters must take into account not only the situations they have actively in mind to which the legislation is primarily addressed, but in addition, every situation that might be addressed by the language that is used. This is an issue with all legal documents, lest the drafter's intent be misconstrued and harm result because of the document, such as with a will or a trust. But drafting a will or trust is actually a much simpler task because the drafter actually knows, for the most part, the situation and the people the document is intended to address. But a statute has no such boundaries. Statutes must, by nature, be very detailed and specific to cover all of the situations intended without covering any of those situations not intended to be covered. Those efforts, however, reduce the flexibility of their application to specific situations.

Mandatory statutory forms are seldom a good idea, but language and form are often mandated with a statutory approach. If a form is set forth as required by the statute, it will be very difficult to change when needed, each time exposing itself to a legislative process that may take a number of years, and each time taking some risk that the statute or the form may be changed in a way that causes more harm than good. Even where an example form is clearly labeled as non-mandatory, often it may be interpreted as mandatory by private parties or a state agency so as to produce this inflexibility even when the statute does not express or intend that result.[145]

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143 *See* OR. REV. STAT. ANN. § 127.666 (West Supp. 2014) (allowing the Oregon Health Authority to establish a statewide national registry for the collection and dissemination of POLST).

144 John Godfrey Saxe once said, "Laws, like sausages, cease to inspire respect in proportion as we know how they are made." *An Impeachment Trial*, UNIV. CHRON. (Univ. of Mich.), Mar. 20, 1869, at 4, *available at* http://babel.hathitrust.org/cgi/pt?id=mdp.39015080034658;view=1up;seq=170.

145 In Pennsylvania, for example, a sample form for advance directives, which passed in 1992, was essentially required by state agencies for a number of years, despite the fact that the statutory form was not intended to be mandatory. As a result, the current stat-

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

Ideally, the forms and procedures used within a POLST program will be continuously reviewed, with input from the field, health care professionals, patients, and families, to judge the effectiveness of the form and the process that is used to produce and implement the form. This review is best undertaken by a relatively small group of people with expertise in the field, responding to the clinical evidence of how effective the form is shown to be in helping patients and health care professionals.

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

2. *Arguments Favoring a Statute*

On a day-to-day basis, physicians and other health care professionals issue countless orders and prescriptions for which there is no statutory immunity. They are protected only by their fulfillment of generally accepted medical practice standards. But the history of end of life care has been written differently. Technological advances enabled doctors and hospitals to maintain life in a manner that merely prolonged the

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ute added the following language: "A Commonwealth agency that licenses health care providers or regulates health care may not prescribe a mandatory form of advance health care directive." 20 PA. CONS. STAT. ANN. § 5433(a)(2) (West Supp. 2014).

process of dying or maintained the patient in a permanently unconscious state. Advance health care directives were developed in response to this prolonging, and at that time, the concept of withholding or withdrawing such care was novel, even though constitutionally protected. As a result, advance directive laws and out-of-hospital DNR statutes uniformly protect health care professionals from criminal or civil liability or disciplinary sanctions. Consequently, many healthcare professionals across the country want this more explicit reassurance for following a POLST. While they may not need it, they want statutory immunity. When they follow the orders in a POLST in good faith, they want protection from criminal prosecution, civil liability, and disciplinary sanctions. Health care providers may well contend that if they have this protection for following an advance health care directive, they should also have that same protection for following a POLST.

The State of Washington is illustrative. Current Washington law affords immunity only to EMTs.[146] But legislative testimony in early 2013 demonstrated that emergency room and long-term care providers are reluctant to comply with POLST orders declining treatment.[147] These clinicians and facilities want to carry out patient wishes, but they are fearful of the legal risk. Whether or not this fear is grounded, it is real and can lead providers to disregard patient wishes. Consequently, statutory or regulatory immunity can be a critical factor to assuring that patient wishes embodied in a POLST are carried out.

For a POLST program to be successful, institutions and health care providers must uniformly recognize and honor the POLST form. In order for the form to be readily honored, accepted, and consistently applied, it needs to be the same form in all respects, including wording, layout, and color. Anything else will cause delay in implementation and will increase the possibility that the form will be misread or misapplied. Having a statute that prescribes the form of the POLST would produce that uniformity. Better still, a statute might authorize or direct the state's department of health to design, approve, and promulgate a form of the POLST with the help and guidance of a broadly representative statewide committee. The committee could review and revise both the form and the process from time to time based upon feedback on what works effectively and what does not. The work and recommendations of the statewide committee can be subject to the approval of that state's health department or other suitable agency, such that the result of that collaboration will have checks and balances as well as flexibility. With-

146 *See* WASH. REV. CODE. ANN. § 18.71.210 (West 2009).

147 *See* H.R. 63-1000, 1st Reg. Sess., at 3 (Wash. 2013), *available at* http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bill%20Reports/House/1000-S.E%20HBR%20APH%2013.pdf.

out a statute to encourage or require providers to honor the form and a process and hosting entity to design, approve, and revise the form, promulgate procedures, and educational materials to health care providers and the public, it will be a challenge to avoid having multiple versions of the POLST form. States may need to encourage structure through legislation to produce the most effective and beneficial POLST program.

A statute that requires health care providers to honor the POLST would obviously cause the POLST to be utilized much more quickly and uniformly. And a statute or health department regulation, which requires medical providers to accept the POLST and provide immunity for those accepting it, would encourage use of the POLST within a state much more quickly than anything else. In this regard, a requirement that a POLST be accepted is not the same as a requirement that a POLST be used or even offered to a patient. Those are separate and important policy questions to be addressed. Even more importantly, from a policy standpoint, neither the POLST, nor an advance health care directive, should be required as a condition of care or for the issuance of insurance to a patient. But a valid advance health care directive is enforceable. The health care provider does not have the option to ignore these documents; health care providers should be required to follow a POLST order.

B. Model Act or Uniform Law

The NPPTF's POLST Legislative Guide (Legislative Guide[148]) took the place of the Model POLST Paradigm Program Legislation (Model Act[149]) on the NPPTF website because "the frameworks and complexities of each state's health care . . . laws" are such that "[e]very legislative approach requires customization to work in any particular state."[150] Although the Legislative Guide may provide more adaptable guidance, the Model Act is a helpful starting point for wording in those states considering legislation. While some language from this short Model Act could be very useful in crafting legislation, state health care decision-making law must fit together as a unified, consistent whole. Consequently, individual state law pertaining to living wills, health care powers of attorney, guardians, default health care decision-makers, and out-of-hospital DNR orders should be considered to make sure that all of the laws which touch upon health care decision-making fit together properly.

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148 See *supra* note 36 for the URL at which the Legislative Guide can be found.
149 See *infra* Appendix 3 for the Model Act.
150 *Cf.* LEGISLATIVE GUIDE, *supra* note 36, at 1.

Recognition of a POLST order executed out of state should be provided, at the very least, with respect to execution formalities of the POLST form itself, some of which will undoubtedly vary from state to state. Non-recognition of out-of-state forms is a problem similarly encountered with respect to advance health care directives. Out-of-state recognition is particularly important in major medical centers geographically close to adjacent states, such as Philadelphia, where patients are frequently drawn from New Jersey or Delaware, or Pittsburgh, where patients are frequently drawn from West Virginia or Ohio. Should this portability apply only to execution formalities? Can the provider presume a POLST form from another state is valid? How does the provider know whether to regard an out-of-state POLST form as properly executed if signed by a surrogate? This issue may require further study and perhaps a future Uniform Law project.[151]

C. State Specific Considerations and Barriers Are Critical

Interested parties and their advisors wishing to implement a POLST program in their state must examine the framework of their state's health care decision-making law to identify issues, considerations, and barriers to the implementation of a POLST program. Susan E. Hickman coauthored an article that identifies state law barriers that exist in a number of states.[152] A review of these issues and potential barriers may suggest a helpful reexamination of state laws addressing living wills, out-of-hospital DNR order statutes, and health care decision-making generally. Some of these barriers may require resolution by statutory change, while some may only limit the usefulness of the POLST in certain situations and for certain patients, but do not fundamentally interfere with the implementation of a POLST program. There are many less fundamental decisions involved in the successful design of a POLST form and implementation of a successful POLST program. This article focuses upon those issues and barriers the authors believe to be most fundamental to the POLST and most frequently encountered in state law and policy.

1. *State law limitations on advance directives*

Simply stated, POLST is designed for persons with serious advanced illness or frailty whose clinicians would not be surprised if they died within the next year. This is not intended, however, to be a bright

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151 *See infra* Part VII.D.

152 Hickman et al., *supra* note 131, at 119, 121-22.

line distinction of terminal illness or permanent unconsciousness.[153] Rather, POLST is intended to be a flexible approach reflecting clinical judgment and differences in patient preferences. The preferred approach is for the POLST to be available to anyone meeting the above clinical description. Where state law limits the freedom of an individual and his or her physician to use a living will or out-of-hospital DNR order, further analysis and consideration is necessary for POLST to fit comfortably within state law.

State law may impose medical preconditions on the operation of advance health care directives, which may cause confusion relative to POLST but should not fundamentally interfere with the functioning of POLST. For example, for a living will to be operative in Pennsylvania, the patient must be incompetent and must be either permanently unconscious or suffering from an end-stage medical condition[154] – a term very similar to "terminal condition" but without any express or implied reference to a time frame for life expectancy. A physician or other health care professional unfortunately is rarely involved in the process of preparing and signing a living will, and thus executing a living will lacks an important part of the informed decision-making process and must, by its nature, be more conditional and speculative. A POLST form, however, is not a living will, nor an advance health care directive. A POLST form is a medical order, signed by the physician or other authorized health care professional, and effective immediately, taking into account the patient's current condition and intended to reflect the patient's contemporaneous shared decision-making.

POLST forms document "in the moment," shared health care decision-making and reflect the informed consent necessary for medical treatment. Where the POLST is completed with the health care professional while the patient is competent and able to participate fully in the health care decision-making process, the rationale for any limitation of the patient's rights to an end-stage medical condition does not exist. The execution of a POLST is thus an effectuation of the patient's constitutional, common law, and statutory rights reflecting informed consent.[155] Limitations on a patient's rights to say yes or no to medical care, particularly where it is intrusive or burdensome, should be reconsidered. Why, for example, should a very elderly but competent patient not be able to say "no" to intubation or resuscitation, even if the patient is not suffering from an end-stage medical condition? Should the pa-

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153 At least two studies have shown that, while not perfect, this test has proved to be a practical one that can be reasonably made and applied by clinicians. *See* sources cited *supra* note 31.

154 20 PA. CONS. STAT. ANN. § 5443(a) (West Supp. 2014).

155 *See supra* Part IV.

tient not be able to document that by an express written health care instruction such as a living will?

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

2. *Out-of-hospital DNR Order statutes*

An out-of-hospital DNR order is much more closely related to the POLST than a living will. A POLST form always includes an order to either attempt resuscitation or not attempt resuscitation. A POLST form is specifically designed to be portable and effective outside of a hospital. Consequently, it is a form that is intended to literally operate as an out-of-hospital DNR order when that is the choice made on the POLST form, but there are two critical differences: First, the POLST form gives the patient a choice as to resuscitation, whereas the out-of-hospital DNR order is issued only when the patient's choice to not be resuscitated is confirmed by the medical order. This would seem to support the argument for broader availability of the POLST, since the POLST does not mandate the limitation of care and allows the patient to express the desire for full treatment. Second, the POLST form covers a much broader range of choices and preferences than DNR orders.[156] Specific medical preconditions for the issuance of such DNR orders are present under the law in 15 states; this creates a barrier or inconsistency with respect to the POLST.[157] Further, in six states, state law dictates the details of out-of-hospital DNR orders, the wording of which is inconsistent with the POLST form.[158]

The statutes' inconsistency is somewhat ironic in that they were intended to expand patients' rights to control their medical care should they suffer an arrest outside of a hospital where they might appropriately have a DNR order. DNR orders in a hospital setting have been available as a matter of clinical practice for virtually as long as CPR.

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156 These additional preferences are what give POLST forms their greatest benefit, as many patients who opt for DNR orders want significant medical care apart from resuscitation. Those preferences should not be ignored, and that danger is inherent to a form that only covers resuscitation.

157 *See* Hickman et al., *supra* note 131, at 122.

158 *See id.*

The use of a DNR order in the hospital setting is based upon proper clinical judgment and the informed consent of the patient or the patient's surrogate health care decision-maker. There is no express medical precondition, nor should there be, apart from the shared informed decision-making of the physician and the patient or surrogate. The out-of-hospital DNR order statutes grew out of the need for emergency medical service (EMS) providers to have clear direction and protection when their life-saving protocols would be inappropriate. An out-of-hospital DNR order, necklace, or bracelet provides clear communication and safe authority to the EMS providers.

An example of how an out-of-hospital DNR statute can be a challenge, but not an insurmountable barrier, to an effective POLST program may be helpful. Pennsylvania has an out-of-hospital DNR statute making an order, bracelet, or necklace available to a patient through their attending physician when the patient has an end-stage medical condition or is permanently unconscious with a living will directing non-resuscitation.[159] Faced with the alternatives of either only permitting the use of POLST forms in the context of an end-stage medical condition (thereby resulting in inconsistent and inflexible language in the order), or leaving the existing out-of-hospital DNR order form as a parallel standalone form, a statewide advisory committee, tasked by statute to study the need for and advisability of a POLST form, opted to recommend the latter approach. However, the committee's recommended ideal approach was to pass legislation that would allow the POLST form and out-of-hospital DNR order to be combined, without the medical preconditions for the issuance of a POLST.[160] In the meantime, EMS providers in Pennsylvania must inform a medical command physician of the existence and content of a POLST form and rely upon the orders of the medical command physician regarding resuscitation to determine whether non-resuscitation is appropriate.

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

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159 *See* 20 PA. CONS. STAT. ANN. §§ 5483-5484 (West 2005 & Supp. 2014).

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

3. *Medical preconditions or limitations to decisions of health care surrogates*

Ideally, health care decisions are the product of a shared decision-making process, with the full participation of the patient, the patient's physician, and perhaps other health care professionals. This full participation requires that the patient have the mental capacity to understand their condition, understand the benefits and burdens of the proposed course of treatment, and understand any possible alternative treatments. Inevitably, many or even most patients will at some point reach a point where someone else will need to make one or more health care decisions for them.

State law often allows a surrogate, in the form of an agent under a health care power of attorney, a guardian, or a default surrogate, to make decisions for the patient when the patient is no longer able to do so. Some states, however, limit the right of an individual to delegate termination of life sustaining treatment to a surrogate.[161] For example, in Ohio, the agent acting under a power of attorney for health care may refuse or withdraw informed consent to life-sustaining treatment only if the principal is in a terminal condition or a permanently unconscious state. In addition, there must be no reasonable possibility of the principal regaining the capacity to make informed health care decisions.[162]

Where there is no health care agent appointed by the patient or a guardian appointed by the court, most states provide for a default surrogate, generally selected from a priority list similar to the laws disposing of a person's property where there is no will. In some states, the default surrogates have the same authority to make health care decisions as they would if they were appointed by the individual, but in others, their authority is more limited, particularly with reference to their authority to withhold or withdraw life sustaining treatment. The latter states' limitations may limit the choices for the completion of the POLST form by a surrogate.[163] For example, state law may preclude a default surrogate from consenting to a POLST order indicating DNR for a ninety-five-year-old long term care resident, even though the patient may well have desired it, because the patient, though very elderly, is not in an end-stage medical condition or permanently unconscious.

These limitations on the power of surrogates to make health care decisions for an incapacitated patient may interfere with the effectiveness of the surrogate's ability to effectuate the patient's intent. However, these state law limitations are not unique to the POLST program.

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161 *See supra* Part III.B.

162 *See* OHIO REV. CODE ANN. § 1337.13 (West 2004 & Supp. 2014).

163 *See*, *e.g.*, 20 PA. CONS. STAT. ANN. § 5461(b) (West Supp. 2014).

Where state law limits the surrogate's authority, it may be limited with respect to an ordinary in-hospital DNR order or an out-of-hospital DNR order, as well as any other medical orders that would limit life-sustaining treatment.[164] Note that a POLST program may be adopted and utilized in a state with statutory limitations on a surrogate's authority. While such limitations on surrogate decision-making may be thought to be unhelpful, they are not a barrier to the implementation of a successful POLST program. This is important if the removal of those limitations is not permitted, as a matter of policy and political reality, in a discussion in which the appropriate constituencies are balancing patient freedom and patient protection. A POLST program can still be implemented while respecting those limitations on surrogate authority. Limitations on the ability of a surrogate to agree to a POLST may constitute an impediment to health care decision-making in general and to a POLST program in particular, but they do not preclude the implementation of a beneficial POLST program.

In addition to statutory limitations on a surrogate's decision-making authority, a surrogate's authority also may be limited by the patient's advance health care directive or living will, the latter of which expresses the patient's choices regarding, specifically, his or her end-of-life medical care. A surrogate is expected to follow and implement those directives unless the document gives the agent leeway to vary or even overrule the patient's instructions. Pennsylvania, for example, provides an option in its sample form for the patient to require the agent to either follow the instructions, or treat them as guidance only, thereby allowing the agent to have the final say.[165] A durable power of attorney for health care also may include limitations, put in place by the principal, on the surrogate's authority to make medical decisions. The surrogate must be aware of, and act within the limitations established by, the principal.[166]

A POLST form is a particularly useful tool for individuals with serious advanced illness or frailty when critical care decisions are highly likely or fairly imminent, and in many or perhaps even most of these cases, the patient may not be well enough to speak for himself or herself. In a La Crosse, Wisconsin health system with widespread use of POLST, a study of deceased patients found that 67% of deceased patients had a POLST form, and the average time that the last POLST form was completed was only 4.3 months before death.[167] These are patients for whom a crisis care plan is needed in the form of medical

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164 *See* Hickman et al., *supra* note 131, at 122-23.
165 *See* 20 PA. CONS. STAT. ANN. § 5471 (Supp. 2013).
166 *See id.*
167 Bernard J. Hammes et al., *supra* note 17, at 1252.

orders, so that there are no unwanted surprises in care delivery. It is very important for there to be someone available and legally empowered to participate in and consent to a care plan and orders as needed, and not just once, but very probably several times.

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

4. *Immunity may be demanded by medical providers*

Immunity for health care professionals may be provided by clinical practice, as the POLST is commonly used and honored and therefore becomes a part of the generally accepted medical practice standard of care. This standard of care should protect all health care professionals, including doctors, hospitals and emergency medical service personnel. However, because of the importance of the orders contained in a POLST form and the general framework of protection provided to the health care community within advance directive and out-of-hospital DNR order statutes, it would, however, not be surprising that the medical community may want to see that immunity officially sanctioned.

This can be accomplished, as it was in Oregon, by professional regulatory changes that acknowledge health care professionals' obligation to comply with a duly executed POLST form and provide for corresponding immunity from criminal prosecution, civil liability, and professional discipline.[168] POLST was broadly instituted and accepted for a number of years in Oregon before these regulatory changes were made, so in a sense, the regulations were more an affirmation of the POLST paradigm as Oregon's recognized medical standard than a creation of that standard.

Where POLST is implemented differently than through unique grassroots efforts resulting in clinical consensus as it was in Oregon, granting such immunity, if needed because of its importance to the medical community, is probably best accomplished by statute rather than regulation. The immunity provisions contained in the Model Act provide a helpful starting point:

> (b) A health care professional or institution acting in good faith and in accordance with generally accepted health-care standards applicable to the health care professional or institution is not subject to civil or criminal liability or to discipline

168 *See* OR. ADMIN R. 847-010-0110, 847-035-0030(6) (2013).

> for unprofessional conduct for complying with a POLST form and assuming that the orders therein were valid when made and have not been revoked or terminated.
>
> (c) An individual acting as agent, guardian, or surrogate under [reference advance directive law and guardianship law] is not subject to civil or criminal liability or to discipline for unprofessional conduct for signing a POLST form and thereby consenting to POLST in good faith.[169]

In states where there is an out-of-hospital DNR order statute, a section providing statutory immunity is best provided within that statute if the POLST can be successfully combined with the existing out-of-hospital DNR order statute.

D. Policy and Procedural Questions to Be Considered

There are many varied policy, procedural, and drafting questions involved in designing and implementing a POLST paradigm program.

1. *Medical professional involvement*

a. *Who can sign a POLST order?*

In many states a physician, nurse practitioner, or physician's assistant can sign a POLST form consistently with their general scope of practice rules.[170] In light of the seriousness of the orders in end-of-life situations, there are arguments to be made in favor of requiring that a POLST form be signed by a physician, but there is no reason for the requirement to be any different than it would be for an in-hospital DNR order. Determining who will have the conversation with the patient that culminates in the POLST orders is an important consideration. The argument in favor of this conversation being with the physician is that the physician is in the best position to discuss medical treatments' potential outcomes and tailor those conversations to a particular patient. The quality of the conversation governs the effectiveness of the entire process, which supports the argument that the most capable medical professional be engaged. The opposing argument is that significant time is required for a quality conversation, and it is often difficult for physicians to find that required time, particularly in the long term care setting. Under present Medicare reimbursement policies, such conversations are not compensated, with the exception of the initial Medicare physical examination.[171] Efforts to provide medical reimbursements continue, but

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

170 *See supra* Part IV.G.

171 *See* Robert A. Burt, *The End of Autonomy*, in *Improving End of Life Care: Why Has It Been so Difficult?*, HASTINGS CENTER REP., *supra* note 7, at S13.

until they are successful, the lack of any reimbursement policy is a significant barrier to physician involvement in advance health care planning, for both advance directives and the POLST.

b. *Can POLST counseling and preparation be delegated in part to a non-physician?*

Counseling and preparation of the POLST form can be delegated to a well-trained health care professional such as a nurse, physician's assistant, or even a social worker. But adequate training, both as to knowledge and to the practiced skills of having that conversation, is critical. A POLST program should include a training curriculum to provide sufficient knowledge of the relevant law and medical treatments to care providers so they can effectively discuss these issues with patients in the process of completing POLST forms. Training modules are available from a variety of sources nationally, the best known of which is the Respecting Choices® program by the Gundersen Health System in La Crosse, Wisconsin, offering online and on-site training with a high level of experience and sophistication.[172] If enough professionals with adequate background and training are already available in a state, a state-specific program of training can be developed that can integrate state law and local practices, using well-respected leaders whose knowledge and influence can favorably impact the program.[173] The importance of a quality conversation regarding end-of-life care choices cannot be overstated. It has been described as "the beating heart and Achilles' heel" of the POLST and indeed of all advance health care planning and health care decision-making.[174]

2. *How is informed consent documented?*

a. *Signature of patient or surrogate required*

All medical orders require that they be issued by a licensed health care professional within their scope of practice. But most medical orders are not signed by the patient, apart from an initial consent to treatment and more specific surgical consents. It is always recommended and usually required that the patient or the patient's surrogate sign a

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172 *See Certification*, GUNDERSEN HEALTH SYS., http://www.gundersenhealth.org/respecting-choices/certification (last visited Feb. 22, 2015).

173 For example, Pennsylvania is currently developing its own training program using a train-the-trainer model with the help of a Supporting Innovation in POLST Paradigm Expansion and Dissemination Grant. Oregon Health & Science Univ., Subaward Agreement Amendment (Sept. 2013) (on file with author).

174 Telephone Conference with Charles P. Sabatino, Exec. Dir., ABA Comm'n on Law and Aging (using this description to emphasize the importance of the conversation regarding end-of-life choices).

POLST form. The reason for this is very simple – to document that a conversation occurred and that the patient consented to the order. While not all states with POLST programs require the consent of the patient to be documented by the patient's signature, a patient's signature (or electronic equivalent) is strongly recommended by the NPPTF and should be part of the minimum requirements for a POLST except under circumstances in which consent is obtained, but the signature cannot be obtained.[175]

b. *Should there be exceptions to the requirement of a signature?*

Where it is not possible to discuss the POLST with the patient and obtain contemporaneous consent, and the POLST is completed by following clear instructions set out in an operational living will, there should be no problem with providing an exception to the general requirement of a patient or patient surrogate signature.

Where the conversation occurs with a mentally competent patient who is not physically able to sign, or where the conversation is held with a surrogate by telephone, the signature requirement should bend to the signature's purpose. When the inability to sign the POLST is due to physical but not mental disability, a third party could sign the POLST at the patient's request and direction. This would be similar to processes used for advance directives, in which generally a third party not affiliated with the health care provider signs the person's name.[176]

c. *Should other safeguards such as witnessing and notarization be required or recommended in a medical setting?*

The formalities of witnessing and notarization that are used in a legal setting are safeguards intended to protect the client from being taken advantage of or improperly influenced when signing legal documents. They are appropriate in these settings to convey a sense of importance and solemnity to the legal document and to be sure that the signature really is the signature of the client. The safeguards in the medical setting are no less protective, but they are not legalistic. The ideal setting for the execution of a POLST document is in the presence of the attending physician, the patient, and the patient's health care agent or other surrogate if they have one. This is the ideal, and with the physician, surrogate, and patient, no further safeguards are either necessary or appropriate. The requirement of witnessing typically guards against

175 *See* LEGISLATIVE GUIDE, *supra* note 36, at 16.

176 *See, e.g.*, 20 PA. CONS. ANN. § 5452(c)(2) (West Supp. 2014).

forgery. It is highly unlikely that a POLST patient or surrogate signature would be forged, particularly in the presence of a physician or other health care professional, whereas forgery of other legal documents is more likely – particularly those governing the management or distribution of a person's property, such as a financial power of attorney, will, or trust. The sensitivity of the subject matter would also press against a witnessing requirement, as the need for private, candid, and highly personal communication is particularly great in this context.

d. *Authority of surrogates—how much power—how much leeway?*

The authority of a health care agent or other surrogate should generally follow state law with respect to health care decision-making. The question of how much power and how much discretion a patient wishes to give to a health care agent is an important one that should be addressed in an advance directive, but there is no reason the authority to sign a POLST form should be any different from a surrogate's authority to make health care decisions that generally reflect life-sustaining treatment decisions. The POLST form is merely the end-point documentation of the health care decision. The health care discussion and decision-making process is the primary concern.

3. *What medical treatments and decisions should be included in the POLST?*

A POLST form should always contain the treatments covered in the first two sections of the Oregon POLST form.[177] Section A is necessary to serve as the order with respect to resuscitation where there is no pulse or breathing. Clearly, these emergency orders must be included to indicate the resuscitation code status of the patient, and in this respect the POLST is no different from a standard DNR order, except, importantly, it allows for the patient to indicate that they want full resuscitation efforts to be made. This reflection of an affirmative choice is very important and a far better indication of patient intent than a default to a full resuscitation code because a DNR order has not been signed.

Section B of the Oregon POLST form deals with perhaps the most important decisions reflected in the order, both as to the frequency with which the orders are needed and individual patient preferences. Section B gives the patient three options for how medical care providers can administer medical interventions. The form offers the choices of "Full Treatment" (including intubation, advanced airway interventions, mechanical ventilation, or other medical means necessary to preserve

177 *See infra* Appendix 1.

life), "Limited Additional Interventions" (only including care needed for comfort such as intravenous (IV) fluids and cardiac monitor, and allowing the transfer to a hospital, provided that the intensive care unit is generally avoided), and "Comfort Measures Only" (restricting the use of medication, positioning, and other measures to relieving pain and suffering, and allowing for the transfer to a hospital only if the best comfort care cannot be provided adequately in the current medical setting).[178]

Studies from the Oregon POLST Registry confirm that while most patients completing a POLST form elect DNR for section A, slightly more than one half of those who elect DNR on section A do not elect "Comfort Care Only" on section B, confirming the conclusion that if the patient wishes are properly reflected, DNR should never be taken to mean "Do-Not-Treat."[179]

This finding also supports the conclusion that a POLST form, which includes important treatment orders in section B that are typically not included in a standard DNR order, should help eliminate a "spillover" inference that a patient who wishes a DNR order may want to have comfort care only. In many cases, the patient may in fact want considerably more, including a desire to be sent to the hospital for significant medical treatment. That question is particularly important in the long term care setting where a patient, after a number of hospitalizations, may in some cases simply want to be treated in their current setting, and in other cases may wish acute care when otherwise indicated.

Preferences as to medically supplied nutrition and hydration should always be included in a POLST form. These treatments have always engendered more differences of opinion than other advanced life support because nutrition and hydration can be viewed as a more basic provision of care and therefore morally obligatory. The Supreme Court in the *Cruzan* decision held that medically supplied nutrition and hydration are medical care, and as such, could be refused by a patient or a patient surrogate under the proper conditions.[180] Yet the extraordinary, protracted, and divisive litigation involving Terri Schiavo highlights the remaining debate over the appropriate use of medically supplied nutrition and hydration. If Terri Schiavo had executed an advance directive or a POLST that addressed this issue, most of the issues involving her care would have been resolved.[181] There remain clear differences in

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178 *See infra* Appendix 1.

179 *See* OR. POLST REGISTRY, *supra* note 105 (citing Erik K. Fromme et al., *POLST Registry Do-Not-Resuscitate Orders and Other Patient Treatment Preferences*, Research Letter, 307 J AM. MED. ASS'N 34 (2012)).

180 *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279 (1990); *see also supra* Part V.

181 This is not to say *all* issues would have been resolved; much of the argument centered around who should make decisions about her care as between her husband and

perspective with respect to medically supplied nutrition and hydration between conservatives in the Jewish and Catholic communities, who are focused on the sanctity of life and the importance of patient protection, and others who are more focused on patient freedom as a core value. The current Oregon POLST form provides an option for medically supplied nutrition separately from hydration, with the option for IV fluids also indicated separately in the "Limited Interventions" choice in section B. As to medically supplied nutrition, the Oregon POLST form provides for three basic alternative choices – refusing medically supplied nutrition, a trial period of medically supplied nutrition, or long term medically supplied nutrition. As is the case in other parts of the POLST form, additional orders may provide some customization to take into account more nuanced choices that may be made by the patient and physician.[182]

In making the more detailed design choices on the POLST form, the drafters may wish to consider the order of the alternatives, in response to arguments that the POLST form introduces a bias by including the options for both "Comfort Measures Only" and "Limited Additional Intervention" prior to "Full Treatment."[183] The careful reader may note that section C of the Oregon POLST form uses the term "artificial nutrition," while this article uses the term "medically supplied" when referring to nutrition or hydration. The word "artificial" has a negative and off-putting connotation, while "medically supplied" does not carry the same negative overlay. While such nutrition may or may not be a good idea in a specific circumstance, the authors' view is that all documents intended to objectively reflect patient intent should use neutral terms.

Until several years ago, the Oregon POLST form contained a separate section for addressing the use of antibiotics, which allowed the patient to opt out of treatment with antibiotics.[184] This separate section was removed from the form because antibiotics can be used to address palliative, curative, or life preserving needs. The usefulness of antibiotics in such a wide range of circumstances makes a checklist response less appropriate, though antibiotics is still retained in the description of potential treatments under the choice of "Limited Additional Interventions." Antibiotics used to address a painful wound infection or a

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her parents, and there was protracted litigation addressing the exact nature of her medical condition focusing on whether she was in a permanent vegetative state or a minimally conscious state. *See generally* Bush v. Schiavo, 885 So.2d 321 (Fla. 2004). But if her wishes had been clear, the proper result would likely have followed.

182 *See infra* Appendix 1.

183 *See infra* Appendix 1.

184 *See* OR. POLST REGISTRY, *supra* note 105 at 10.

urinary tract infection are likely to be highly desirable in virtually every instance, whereas a patient may not desire IV antibiotics that must be administered in a hospital setting to address pneumonia or yet another systemic infection. Studies of the compliance with POLST orders reveal that the former antibiotics section of the POLST form reflected the lowest correlation with clinical treatment.[185] The inference to be drawn from this is that the use of antibiotics is too varied to be covered effectively in a simple form. Consequently, that separate section has been removed from the Oregon POLST form.

4. *Should a POLST ever be required?*

a. *For a patient to sign or have a POLST?*

The completion of a POLST form, like the completion of an advance health care directive, should always be voluntary. Advance planning and the POLST are all about personal freedom, and that freedom, like so many others, must include the freedom not to exercise it. The voluntary nature of all advance planning tools is a core value that must be strongly guarded. In most if not all states, neither medical care nor health insurance may be conditioned upon the completion of an advance directive.[186] While it would be very helpful if everyone completed a health care power of attorney and health care treatment instructions, the importance of the freedom to choose overrides the utility of requiring these helpful documents.

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

185 *See* Hickman et al., *supra* note 3, at 2097.

186 *See*, *e.g.*, *supra* note 111 and accompanying text.

not use the POLST form to document the physician's orders unless it is simply used to indicate that the patient refused to have the discussion or refused to sign the POLST form and full treatment is required.

b. *For an institution to use or offer a POLST?*

Requiring healthcare facilities to offer POLST to the patients for whom it is appropriate encourages widespread clinical implementation of POLST. Several states require that hospitals or long term care facilities offer POLST to certain groups of patients. This requirement parallels the long-standing duty under the Patient Self Determination Act to "provide written information . . . concerning . . . an individual's right to formulate advance directives."[187] For example, Utah requires that hospitals, hospices, nursing, assisted living, and other facilities determine, on admission, whether each individual has a POLST.[188] These facilities must then determine which of those individuals without a POLST form should be offered the opportunity to complete one. POLST is not for everyone and is typically limited to patients with advanced illness or frailty.

By contrast, Maryland requires healthcare facilities to both offer and actually complete a POLST form for all admitted nursing home patients.[189] Therefore, a healthy patient admitted to a Maryland nursing facility for short-term rehabilitation after a knee replacement would be required to complete a POLST form. This categorical approach is over-inclusive on two levels: First, it results in POLST forms being offered to patients and residents for whom they are not intended. Second, Maryland mandates not only the offering but also the use of POLST forms, which can cause the POLST form to be overused and undermines the core value of voluntary health care decision-making.

c. *Should an institution be required to honor a POLST?*

A requirement that all licensed health care facilities and providers honor a POLST form fits well with a provision of immunity for honoring a POLST form; if a state statute or regulation requires or provides one, it should also provide the other. It may also be necessary to provide protection for health care institutions, providers, and employees who cannot in good conscience follow a particular POLST order but are required to do so by statute. Pennsylvania's statute with respect to living wills and health care agents is typical of such a parallel conscience exception:

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187 *See* Patient Self-Determination Act of 1990, Pub L. No. 101-508, § 4206, 104 Stat. 1388-115 (codified as amended at 42 U.S.C. § 1395cc(f)(1)(A)(i) (2011)).

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

189 *See* MD. CODE REGS. 10.01.21.04 (2014).

(a) Notification by attending physician or health care provider. – If an attending physician or other health care provider cannot in good conscience comply with a living will or health care decision of a health care agent or health care representative or if the policies of a health care provider preclude compliance with a living will or health care decision of a health care agent or health care representative, the attending physician or health care provider shall so inform the principal if the principal is competent or the principal's health care agent or health care representative if the principal is incompetent.
(b) Transfer. – The attending physician or health care provider under subsection (a) shall make every reasonable effort to assist in the transfer of the principal to another physician or health care provider who will comply with the living will or health care decision of the health care agent or health care representative.
(c) Employee or staff member of health care provider. –
(1) An employee or a staff member of a health care provider may not be required to participate in the withholding or withdrawal of life-sustaining treatment.
(2) A health care provider that is an employer may not discharge or in any other manner discriminate against its employee or staff member as a result of informing the employer of the employee's choice not to participate in the withholding or withdrawal of life-sustaining treatment.
(3) A health care provider that is an employer may require its employee or staff member to express in writing the wishes or unwillingness of the employee or staff member as set forth in this subsection.
(d) Liability. – If transfer under subsection (b) is impossible, the provision of life-sustaining treatment to a principal may not subject an attending physician or a health care provider to criminal or civil liability or administrative sanction for failure to carry out either the provisions of a living will or a health care decision of a health care agent or health care representative.[190]

5. *When should a POLST be reviewed and a new POLST completed?*

[T]he NPPTF recommends that a POLST form be reviewed periodically and specifically when:

190 20 PA. CONS. STAT. ANN. § 5424 (West Supp. 2014).

•The patient is transferred from one care setting or care level to another, or

•There is a substantial change in the patient's health status, or

•The patient's treatment preferences change.[191]

A POLST form that is more than one year old should be reviewed, since one or more of these changes would almost certainly have occurred within that time period. If a patient presents a POLST form, regardless of whether the prescribing health professional is credentialed by the hospital, the appropriate practice is for the admitting physician to discuss the POLST orders with the patient, acknowledging that a physician or other health professional has previously spoken to the patient about his or her wishes. The admitting physician then reissues the orders or changes them if the patient indicates such a change is desired.

A practical challenge occurs when the patient is not capable of having this conversation with the admitting physician. If the patient has a legally authorized surrogate available and time permits, the physician should discuss the patient's condition and wishes with the surrogate and subsequently change or reissue a POLST form accordingly.

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

The passage of time by itself may also strongly suggest a review of a POLST form to determine if it should be revised. A state policy suggesting or requiring periodic review may be helpful to address concerns that a POLST form may no longer appropriately express the patient's current wishes. Pennsylvania's POLST form, for example, suggests that the POLST be reviewed at least once a year even if none of the other triggering events listed above have occurred.[192] It is highly advisable in all cases that a POLST form is reviewed at least once a year, the review is documented in some manner, and the POLST is modified or reissued if necessary. In a long-term care facility setting, POLST forms can be reviewed at care conferences, which must occur at least every three

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191 LEGISLATIVE GUIDE, *supra* note 36, at 23.

192 *See* PA. DEP'T OF HEALTH, *supra* note 103.

months[193] and this would help insure that the documentation of medical decision-making is up to date. The POLST form itself could provide space to document review.

6. *How should a patient with a POLST from another state be treated? Are they portable?*

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

Most, if not all, states already honor, to some degree, each other's documents relating to health care decision-making, such as living will declarations and health care proxies or powers of attorney. Pennsylvania's statute provides as follows:

> (b) Living will executed in another state or jurisdiction. – A living will executed in another state or jurisdiction and in conformity with the laws of that state or jurisdiction shall be considered valid in this Commonwealth, *except to the extent that the living will executed in another state or jurisdiction would allow a principal to direct procedures inconsistent with the laws of this Commonwealth.*[194]

While this sounds as though it grants reciprocity, the italicized language provides a substantive limitation. Thus, for a living will from another state or jurisdiction to be valid in Pennsylvania, it could not direct the withdrawal of care necessary to preserve life unless the patient were in an end-stage medical condition or permanently unconscious. It also qualifies the recognition of a living will executed in another state or jurisdiction as one that has been executed "in conformity with the laws of that other state or jurisdiction."[195]

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193 *See* 42 C.F.R. § 483.20(c) (2015).

194 20 PA. CONS. STAT. ANN. § 5446(b) (West Supp. 2014) (emphasis added).

195 *Id.* It is not clear how a physician in Pennsylvania can be expected to know whether a patient presenting an Arkansas living will has a document that is in conformity with the laws of Arkansas.

Reciprocity is similarly developing with regard to medical orders included within POLST forms. The states have taken four main approaches to POLST portability: First, some states will honor the originating state's POLST form so long as it complies with the law of the receiving state (e.g., Iowa and New Jersey[196]). Second, some states will honor the originating state's POLST form so long as it either reasonably or substantially complies with the law of the receiving state (e.g., Colorado, Idaho, and Utah[197]). Third, some states honor the originating state's POLST so long as it complies with the law of the originating state (e.g., Rhode Island[198]). Fourth, some states will honor the originating state's POLST so long as it complies with either the law of the receiving state or the law of the originating state (e.g., Maryland, West Virginia[199]).

In light of these variations, portability is clearly an area where a uniform law adopted by most or all states utilizing the POLST program could be helpful. In all events, states should honor, to the extent possible, any authentic expression of a patient's intent regardless of the form of that expression.

7. *Consider special situations—minors and persons with developmental disabilities*

In most states, whether by statute or the application of case law, the POLST can be applied to minors with life-limiting illnesses.[200] With minors, as with those with severe developmental disabilities, decisions will most typically be made by a guardian or default surrogate under state law. However, a minor or person with a developmental disability may have health care decision-making capacity, and even if they do not have legal capacity to make a health care decision, their preferences and values should be taken into account to the extent possible. There may be more significant limitations on the use of POLST if the patient has never been able to either indicate their desires for end-of-life care or appoint an agent with the highest level of legal authority under state

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196 *See* IOWA CODE ANN. §§ 144D.3-(1) (West 2014); N.J. STAT. ANN. § 26:2H–134(c) (West Supp. 2014).

197 *See* COLO. REV. STAT. ANN. § 15–18.7-104(1) (West 2011); IDAHO CODE ANN. § 39-4514(7) (2014); UTAH ADMIN. CODE r. 432-31-10(4) (2014).

198 *See* R.I. GEN. LAWS § 23-4.11-12 (2008).

199 *See* MD. CODE ANN., HEALTH-GEN. § 5-617 (West 2014); W. VA. CODE §16-30C-15 (West 2014). The text of the West Virginia Statute only references DNR orders. W. VA. CODE §16-30C-15. Presumably, POLST would be honored also even though it is not mentioned.

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

law.[201] Some states, such as New York, have special procedures and checklists for minors and highly detailed requirements and procedures for those with developmental disabilities.[202]

8. *Creating, administering, and improving a POLST paradigm program*

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

(1) Perform a needs assessment. Is the system by which patients' wishes are identified, documented, and respected working well? Do patients who are seriously ill get the care they want and not the care they do not want? If they want to receive comfort care at home or in a long-term care facility, are they able to do so, or are they being transported to the hospital? This assessment should be done with EMS, emergency department (ED) physicians and nurses, and social workers in long-term care facilities and hospitals. Generally speaking, an honest assessment will find a significant need for improvement.[203]

(2) Assemble a core working group. This should be a group of physicians and other health care professionals who are knowledgeable about POLST and have a strong desire to improve the process of establishing and implementing patient wishes.[204]

(3) Assemble a task force with broad representation. Just as communication and dialogue are the critical underpinnings of all advance

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201 For example, in Pennsylvania, even the parents who were the court-appointed guardians of their never-competent, severely disabled adult child have no power to decline care necessary to preserve life because he was not in an end-stage medical condition, nor was he permanently unconscious. *See In re* D.L.H., 2 A.3d 505, 515 (Pa. 2010). For an illustrative approach to these special issues under Oregon law, see OR. POLST TASK FORCE, PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST): USE FOR PERSONS WITH SIGNIFICANT PHYSICAL DISABILITIES, DEVELOPMENTAL DISABILITIES AND/OR SIGNIFICANT MENTAL HEALTH CONDITION WHO ARE NOW NEAR THE END OF LIFE (2013), http://www.polst.org/wp-content/uploads/2013/03/POLSTPersonswithDisabilitiesLongDocument.Final_.pdf.

202 *See* N.Y. DEP'T OF HEALTH, MOLST: MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT: LEGAL REQUIREMENTS CHECKLISTS FOR MINOR PATIENTS AND GLOSSARY (2012), http://www.health.ny.gov/professionals/patients/patient_rights/molst/docs/checklist_minor_patients.pdf (outlining capacity determination, clinical standards, notifications, and other legal requirements for minors); N.Y. SURR. CT. PROC. ACT § 1750-b (McKinney Supp. 2014).

203 *See* IMPLEMENTATION STEPS AND MATERIALS: APPROACH TO IMPLEMENTATION OF A POLST PARADIGM PROGRAM (2013), http://www.polst.org/wp-content/uploads/2013/11/Implementation-Steps-and-Materials.pdf.

204 *See id.*

care planning and health care decision-making, it is critical that a POLST program begin with broad and inclusive representation to share views, goals, and concerns so that all points of view can be heard and respected in the ongoing process. This begins with the formation of a task force that includes representatives from a wide and inclusive group of constituencies. These should include EMS, ED physicians and nurses, the state department of health, state department of aging, state hospital association, state bar association, state hospice association, and religious organizations with health care expertise, such as the state Catholic health association, and the state department of public welfare. In addition, advocacy groups for the disabled community and minorities should be included. Representation with broad expertise in the provision of health care is absolutely necessary to a well-designed program. It is equally important to have strong representatives whose primary concern is patient safety and protection of the most vulnerable, and others whose primary concern is the protection of patient freedom.[205]

(4) Consider a pilot project. A pilot project within an area showing particular interest in the POLST will help to identify issues and barriers and to confirm that POLST will benefit the public within the state. The issues, barriers, and medical culture vary from state to state, so a pilot project can therefore be helpful in confirming the benefit of POLST and identifying issues to address.[206]

(5) Address the particular state's relevant legal issues. At this stage, decisions need to be made as to the general approach to implementing a state-wide POLST program. Should it be done by clinical consensus, regulation, or legislation?[207] These issues were discussed in detail in this article.[208]

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

(1) Where should the POLST be maintained? The POLST has been maintained and housed in a variety of settings, such as a university, state department of health or aging, state medical society, and state bar association. The best place to maintain the POLST will vary from state to state, but it is very important that the site be viewed by all concerned as broadly representing the people of the state, rather than a particular constituency to which the POLST is viewed as important. While a medical society, hospital association, or bar association may be satisfactory sites for the POLST, a state agency such as the health department or department of aging may be preferable because of their roles as repre-

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205 *See id.*
206 *See id.*
207 *See id.*
208 *See supra* Parts VII to VII.C.

sentatives of the public as a whole. A university setting is also favorable if the university is one broadly identified with the entire state, rather than a geographic or political portion of the state. Trust and credibility are extremely important, particularly in this highly sensitive and important area of health care decision-making.

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

A continuing oversight task force or committee is critical to gather and analyze data, monitor procedures, and respond to suggested changes to improve the form, process, and education. This oversight committee or task force must be broadly representative, as described above, and must have the authority to respond so that the program can be based upon experience and evidence, and so that there can be continuous quality improvement. Such authority would most likely have to come either from a legislative or regulatory grant of power. Changes to the form or required process in a state would be best recommended by this oversight committee, but implemented with the approval of a state agency such as the department of health or department of aging. This may not be necessary in a state such as Oregon, where the program began by clinical consensus and is housed at an appropriate state university setting, but may be the best alternative in states that opt for some form of legislation. Revisions in the form and process should not require statutory change, which would inevitably impede progress and the flexibility to address changing technologies and evidence-based recommendations.

(3) Integrate POLST with electronic medical records. The POLST and advance directives must be integrated with electronic medical records as the conversion process continues to build and advance. Just as the Patient Self-Determination Act of 1990 required that a patient's

advance directive be made a part of the patient's records,[209] so must it be made a part of the patient's *electronic* medical records. The ability to retrieve these advance directives, despite this federal statute, has been very poor, particularly where the advance directive was placed in the medical records in past admissions. It is critical that this be changed so that advance health care directives and POLST forms are brought forward in the electronic medical records of the patient and are readily accessible. The NPPTF has issued a formal statement making this recommendation.[210] A centralized state registry for both advance health care directives and the POLST would be best. Seven states have implemented such a registry,[211] and there are numerous and significant benefits to such a registry. However, there is also significant expense involved, and funding is always an issue. While the proper use of our health care treatment resources, which consume currently almost 17.6% of our national gross domestic product,[212] is important, making sure that everyone gets the care they want and do not get the care they do not want when it matters (and costs) most should be our primary goal.

(4) How about an "App" for that? A centralized statewide electronic registry for the POLST and advance directives would be very valuable where the resources, support, and funding for such a project can be found. In the meantime, a project by the ABA Commission on Law and Aging may allow individuals and families to take matters into their own hands by making their health care wishes electronically available using their My Health Wishes smartphone application.[213] The basic version is free, while the "Pro" version, for $3.99, allows you to store information for any number of individuals, and can include all relevant contact information for health care proxies, as well as digital copies of

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209 *See* Patient Self-Determination Act of 1990, Pub L. No. 101-508, § 4206, 104 Stat. 1388-115 (codified as amended at 42 U.S.C. § 1395cc(f)(1)(A)(i) (2011)).

210 *See* NATIONAL POLST PARADIGM TASK FORCE, RECOMMENDATIONS FOR ELECTRONIC HEALTH RECORDS AND PHYSICIANS ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) PARADIGM FORMS (2012) http://www.polst.org/wp-content/uploads/2013/11/2012-Recommendations-for-EMR.pdf.

211 For a discussion of the POLST registry development in these seven states, see DANA M. ZIVE & TERRI A. SCHMIDT, NAT'L POLST PARADIGM TASK FORCE, PATHWAYS TO POLST REGISTRY DEVELOPMENT: LESSONS LEARNED (2012), *available at* http://www.polst.org/wp-content/uploads/2012/12/POLST-Registry.pdf.

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

213 *See* Paula Span, *The Documents You Need, When You Need Them*, Blog Entry in *The New Old Age*, N.Y. TIMES (Apr. 24, 2014), http://newoldage.blogs.nytimes.com/2014/04/24/the-documents-you-need-when-you-need-them/?_r=0.

advance health care directives or POLST documents.[214] In addition, names and contact information for all physicians and specialists, prescriptions, and medical conditions can be kept in an easily accessible form, with click-to-call or click-to-email options for these contacts and documents that never seem to be readily available when we need them.[215] A family project to update this emergency information so that every family member has access to every other family member's important medical documents could be extremely valuable and might encourage the type of early intergenerational conversations that should occur in the context of healthy advance care planning.

(5) How can the necessary education be accomplished? Educating the professional medical community and the public about POLST and advance care planning generally is a great and continuing task. In the context of POLST, one of the greatest challenges is to ensure that those who are given the responsibility of interpreting and implementing advance health care directives and POLST forms understand how the law applies to these two important tools and the legal distinctions between them. Who has the power to make a medical decision for a patient when the patient cannot make the decision? What, if any, limitations are there to the powers of a surrogate decision-maker?

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

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214 *See id.*; *My Health Care Wishes App*, A.B.A., http://www.americanbar.org/groups/law_aging/MyHealthCareWishesApp.html (last visited Feb. 22, 2015).

215 *See My Health Care Wishes App*, *supra* note 214.

APPENDIX 1
OREGON POLST FORM CURRENTLY IN USE[216]

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient Last Name:	Patient First Name:	Patient Middle Name:	Last 4 SSN: ☐☐☐☐
Address: (street / city / state / zip):		Date of Birth: (mm/dd/yyyy) _____ /_____ /_____	Gender: ☐ M ☐ F

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***Unresponsive, pulseless, & not breathing.***

☐ **Attempt Resuscitation/CPR**
☐ **Do Not Attempt Resuscitation/DNR**

If patient is not in cardiopulmonary arrest, follow orders in **B** and **C**.

B *Check One*

MEDICAL INTERVENTIONS: ***If patient has pulse and is breathing.***

☐ **Comfort Measures Only**. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Provide treatments for comfort through symptom management.

☐ **Limited Treatment**. In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment**. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible.***

☐ Long-term artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ No artificial nutrition by tube.

Additional Orders (e.g., defining the length of a trial period): _____

D *Must Fill Out*

DOCUMENTATION OF DISCUSSION: (REQUIRED) ***See reverse side for add'l info.***

☐ Patient (If patient lacks capacity, must check a box below)

☐ Health Care Representative (legally appointed by advance directive or court)
☐ Surrogate defined by facility policy or Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion- see reverse side)

Representative/Surrogate Name: _____ Relationship: _____

E

PATIENT OR SURROGATE SIGNATURE AND OREGON POLST REGISTRY OPT OUT

Signature: ***recommended***	This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box: ☐

F *Must Print Name, Sign & Date*

ATTESTATION OF MD / DO / NP / PA (REQUIRED)

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

Print Signing MD / DO / NP / PA Name: ***required***	Signer Phone Number:	Signer License Number: *(optional)*
MD / DO / NP / PA Signature: ***required***	Date: ***required***	Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION E

216 OR. HEALTH & SCIENCE UNIV., CTRS. FOR ETHICS & HEALTH CARE, PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (2014), http://www.polst.org/wp-content/uploads/2014/10/2014.10.02-Oregon-POLST-Form-FINAL.pdf.

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information for patient named on this form **PATIENT'S NAME:** _____

The POLST form is **always voluntary** and is usually for persons with serious illness or frailty. POLST records your wishes for medical treatment in your current state of health (states your treatment wishes if something happened tonight). Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. No form, however, can address all the medical treatment decisions that may need to be made. An Advance Directive is recommended for all capable adults and allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself. Consider reviewing your Advance Directive and giving a copy of it to your health care professional.

Contact Information (Optional)

Health Care Representative or Surrogate:	Relationship:	Phone Number:	Address:

Health Care Professional Information

Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:
PA's Supervising Physician:		Phone Number:	
Primary Care Professional:			

Directions for Health Care Professionals

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- An order of CPR in Section A is incompatible with an order for Comfort Measures Only in Section B (will not be accepted in Registry).
- For information on legally appointed health care representatives and their authority, refer to ORS 127.505 - 127.660.
- Should reflect current preferences of persons with serious illness or frailty. Also, encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by MD/DO/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to *Guidance for Health Care Professionals* at www.or.polst.org.

Oregon POLST Registry Information

Health Care Professionals:

(1) You are ***required*** to send a copy of both sides of this POLST form to the Oregon POLST Registry unless the patient opts out.

(2) The following sections must be completed:
- Patient's full name
- Date of birth
- MD / DO / NP / PA signature
- Date signed

Registry Contact Information:

Phone: 503-418-4083
Fax or eFAX: 503-418-2161
www.orpolstregistry.org
polstreg@ohsu.edu

Oregon POLST Registry
3181 SW Sam Jackson Park Rd.
Mail Code: CDW-EM
Portland, Or 97239

Patients:
Mailed confirmation packets from Registry may take four weeks for delivery.

MAY PUT REGISTRY ID STICKER HERE:

Updating POLST: A POLST Form only needs to be revised if patient treatment preferences have changed.

This POLST should be reviewed periodically, including when:
- The patient is transferred from one care setting or care level to another (including upon admission or at discharge), or
- There is a substantial change in the patient's health status.

If patient wishes haven't changed, the POLST Form does not need to be revised, updated, rewritten or resent to the Registry.

Voiding POLST: A copy of the voided POLST must be sent to the Registry unless patient has opted-out.

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry (**required** unless patient has opted out).
- If included in an electronic medical record, follow voiding procedures of facility/community.

For permission to use the copyrighted form contact the OHSU Center for Ethics in Health Care at orpolst@ohsu.edu or (503) 494-3965. Information on the Oregon POLST Program is available online at **www.or.polst.org** or at **orpolst@ohsu.edu**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

APPENDIX 2
POLST PROGRAM LEGISLATIVE COMPARISON AS OF FEBRUARY 15, 2015[217]

POLST Program Legislative Comparison - as of 2/15/2015

		1. California ☼	2. Colorado ☼	3. Connecticut
1	**Terminology**	Physician Orders for Life-Sustaining Treatment (POLST)	Medical Orders for Scope of Treatment (MOST)	Medical Orders for Life-Sustaining Treatment (MOLST)
2	**Placement in the state code**	2008 Cal. Legis. Serv. Ch. 266 (A.B. 3000), eff. Jan. 2008, amends Cal. Probate Code §§4780 – 4785 (part of the state Health Care Decisions Statute).	Colo. Rev. St. Ann. §15–18.7 -101 to -110. A separate Article titled "Directives Concerning Medical Orders for Scope of Treatment." Approved May 26, 2010.	Conn. Gen. Stat. §§ 14-5(1)(a)-(h) enacted May 28, 2014.
3	**Regulations/ Guidelines**	None.	None.	None.
4	**Entity responsible for development/ approval of POLST**	Emergency Medical Services Authority~§4780(a)(2)(B)	Colorado Advance Directives Consortium.	The Commissioner of Public Health may establish an advisory group of healthcare providers and consumer advocates to make recommendations regarding the pilot program.
5	**Provider signature required**	Physician~§4780(c) ~	Physician, Nurse Practitioner, Physician Assistant~§ 15–18.7-103	Physician- Advanced Practice Registered Nurse - Physician Assistant § 14-5(1)(c)
6	**Patient signature required?**	Yes~§4780(c)	Yes. ~§ 15–18.7-103	Yes § (1)(d)
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes~§4780(b) & ©	Yes. ~§ 15–18.7-103	Yes § (1)(d)
8	**Applicable to minors**	Yes, case law authority	No.	Not addressed
9	**Patient Limitations**	None	None	Patient must have been "determined by a physician to be approaching the end stage of a serious, life-limiting illness or is in a condition of advanced, chronic progressive frailty"

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POLST Program Legislative Comparison - as of 2/15/2015

		1. California ☼	2. Colorado ☼	3. Connecticut
10	**Other execution requirements?**	No Form has box to identify health Care professional assisting in preparation.	No.	None
11	**Exclusive DNR form?**	No, §4780(a)(2) & (e)	No.	No.
12	**Immunity provided?**	Yes, § 4782	Yes.	Not addressed
13	**Duty to offer POLST?**	No	Not addressed. ~	Participation by the institution is voluntary
14	**Duty to comply?**	Yes, with limited exceptions, §4781.2(a)	Yes.~§ 15–18.7-104	.Not addressed
15	**Original vs. Copies/faxes?**	Original pink. Copies are valid.	On Wausau Astrobright Vulcan Green. Copies valid.	Not addressed
16	**Conflicts with AD addressed?**	Most recent controls, §4781.4	Most recently executed shall take precedence. §15–18.7-110(2)	Not addressed
17	**Presumption if section of form left blank**	Full treatment	Not addressed.	Not addressed
18	**Out-of-state POLST recognized?**	Not addressed	Yes. § 15–18.7-107(1)(l)	Not addressed
19	**Web page for additional resources**	Coalition for Compassionate Care of California: www.capolst.org	http://www.coloradoadvancedirectives.com	None
20	**Additional Notes**			Because the law calls for a pilot program, not statewide implementation, it only directly affects people who live in the areas chosen by the state Department of Public Health for the pilot. The department is considering running the pilot in two areas: one urban and one rural. The program ends in 2016)

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POLST Program Legislative Comparison - as of 2/15/2015

		4. Georgia ☼	5. Hawaii ☼	6. Idaho ☼
1	**Terminology**	Physician Orders for Life-Sustaining Treatment (POLST)	Physicians Orders for Life-Sustaining Treatment (POLST)	Physician Orders for Scope of Treatment (POST)
2	**Placement in the state code**	Mandate for Dept. of Public Health to develop POLST inserted in provision on "Temporary medical consent guardian." Ga. Code Ann., § 29-4-18(i) [Enacted 6-3-10 by Ga. Legis. 616 (2010)]	Haw. Rev. Stat. § 327K-1 thru K-4 to the state's health code, enacted July 15, 2009.	Idaho Code Ann § 39-4501 to -4515, specifically § 39-4512A ~ Enacted 2007. ~ Eff. July 1, 2007. Part of comprehensive "Medical Consent and Natural Death Act." Last Amend July 1, 2012.
3	**Regulations/ Guidelines**	None as of April 2013. Dept. of Public Health approved POLST form.	None.	Guidelines published by the EMS Bureau, Idaho Department of Health and Welfare: http://healthandwelfare.idaho.gov/Medical/EmergencyMedicalServices/PhysicianCommission/PhysicianOrdersforScopeofTreatmentPOST/tabid/807/Default.aspx
4	**Entity responsible for development/ approval of POLST**	Department of Public Health	Department of Health, § 327K-4	Idaho Department of Health and Welfare, § 39-4512A(6)
5	**Provider signature required**	Yes	Physician, § 327K-1 and K-2	Physician, Advanced practice professional nurse, or Physician Assistant. § 39-4512A(1)
6	**Patient signature required?**	Yes	Yes, § 327K-1 and K-2	Patient or surrogate signature required. § 39-4512A(1)
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes. Ga. Code Ann., §31-9-2	Yes. § 327K-1 and K-2	Yes, § 39-4504.
8	**Applicable to minors**	Yes. Ga. Code Ann., §31-9-2, 31-32-5	Yes.	Yes, § 39-4504
9	**Patient Limitations**	None	None	None

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POLST Program Legislative Comparison - as of 2/15/2015

		4. Georgia ☼	5. Hawaii ☼	6. Idaho ☼
	Other execution requirements?	None	No. Form has box to identify healthcare professional assisting in preparation.	POST is completed by provider on password protected interactive web page: www.sos.idaho.gov/general/hcdr.htm
10				
11	**Exclusive DNR form?**	No. See §31-39-4(a)	No	No
12	**Immunity provided?**	Yes, §29-4-18 and §31-32-10	Yes, § 327K-3	Yes, § 39-4513
13	**Duty to offer POLST?**	No	No	No, but duty to ask if the person or the surrogate decision maker has a POST and to provide one if requested § 39-4512C & 39-4512A(3).
14	**Duty to comply?**	No	Yes, with limited exceptions, § 327K-2	Yes, with limited exceptions § 39-4512B & 39-4513(5)
15	**Original vs. Copies/faxes?**	Yes. Indicated on the POLST Form	Original lime green preferred, but no color requirements. Copies are valid.	Yes, § *39-4514(9)(b)*
16	**Conflicts with AD addressed?**	No	Not addressed	Yes, § 39-4512A(2). But if signed by surrogate decision maker, not contrary to the person's last known expressed wishes or directions: 39-4512A(1).
17	**Presumption if section of form left blank**	Full treatment	Full treatment	Full treatment
18	**Out-of-state POLST recognized?**	Not addressed	Not addressed	Yes, § 39-4514(6)
19	**Web page for additional resources**	www.dph.ga.gov/POLST	Kokua Mau: www.kokuamau.org/professionals/polst	Idaho Quality of Life Coalition: http://idqol.org
20	**Additional Notes**			POST identification jewelry authorized,§ 39-4514(5)(c); 39-4502(15).

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POLST Program Legislative Comparison - as of 2/15/2015

		7. Illinois	8. Indiana	9. Iowa ☼
1	**Terminology**	Physician Orders for Life Sustaining Treatment (POLST) Paradigm Program	Physician Order for Scope of Treatment (POST)	Iowa Physician Orders for Scope of Treatment (IPOST)
2	**Placement in the state code**	20 ILCS § 2310-600(b-5) revising the Illinois Department of Public Health's (IDPH) Uniform DNR Advance Directive. Eff. Jan. 1, 2012.	Ind. Code Ann. §§ 16-36-6-1 - -20. Approved May 7, 2013.	Iowa Code Ann. §§ 144D.1 – 4 Added by Acts 2012 (84 G.A.) ch. 1008, H.F. 2165, § 5. Amended by Acts 2012 (84 G.A.) ch. 1133, S.F. 2336, § 95.
3	**Regulations/ Guidelines**	The POLST Illinois Task Force developed a guidance document (August 2013) at: http://www.cecc.info/resource-links/physicians-order-for-life-sustaining-treatment-polst	None as of Aug. 2013.	Created as part of the Patient Autonomy in Health Care Decisions Pilot project created pursuant to 2008 Iowa Acts, chapter 1188, section 36, as amended by 2010 Iowa Acts, chapter 1192, section 58,as amended by 2010 Iowa Acts, chapter 1192, section 58. Eff. July 1, 2013.
4	**Entity responsible for development/ approval of POLST**	Illinois Department of Public Health	Indiana State Department of Health, §16-36-69. See: http://www.in.gov/isdh/25880.htm.	Iowa Department of Public Health.. See: www.idph.state.ia.us/hcr_committees/common/pdf/patient_autonomy_pilot/patient_autonomy_pilot_report.pdf
5	**Provider signature required**	Physician only	Physician, § 16-36-6-8(a)	Yes. Physician, Advanced Registered Nurse Practitioner, and Physician Assistant, I.C.A. § 144.D.2(1)(c).
6	**Patient signature required?**	Yes	Yes. § 16-36-6-8(b)(2)	Yes, I.C.A. § 144.D.2(1)(b)
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes	Yes, a representative of the qualified person may sign. § 16-36-6-7	Yes, I.C.A. § 144.D.2(1)(b)
8	**Applicable to minors**	Yes	Yes. § 16-36-6-7	No
9	**Patient Limitations**	Death or loss of decisional capacity within the next year would not be unexpected.	Must be a "qualified person" defined as having either (1) an advanced chronic progressive illness; (2) an advanced chronic progressive frailty; (3) a condition caused by injury, disease or illness from which there could be no recovery and death will occur within a short period of time; or (4) a medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful. §16-36-6-5.	Must be a "qualified patient" defined as "a patient who has executed a declaration or an out-of-hospital do-not- resuscitate order… and who has been determined by the attending physician to be in a terminal condition." §144A.2(11)

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POLST Program Legislative Comparison - as of 2/15/2015

		7. Illinois	8. Indiana	9. Iowa ☼
10	**Other execution requirements?**	Witness over the age of 18 must sign also	No	"If preparation of the form was facilitated by an individual other than the patient's physician, advanced registered nurse practitioner, or physician assistant, the facilitator shall also sign and date the form." § 144.D.2(1)(d)
11	**Exclusive DNR form?**	Yes	No	Yes, §144A.3, see also 144D.4(3)
12	**Immunity provided?**	Yes	Yes, § 16-36-6-16(a)	Yes, § 144.D.3(4)
13	**Duty to offer POLST?**	No	No	No
14	**Duty to comply?**	Yes	Yes. Exceptions listed under § 16-36-6-15(a)(1)-(5).	No - "may comply" § 144D.3(2), (5)
15	**Original vs. Copies/faxes?**	Bright pink paper recommended or stored in a bright envelope, copies valid.	Print on bright pink paper recommended. Facsimiles, paper, or electronic copies valid. § 16-36-6-10(b)	No color requirement, but "The form shall be easily distinguishable." § 144.D.2(1)(f)
16	**Conflicts with AD addressed?**	POLST is not intended to replace Power of Attorney	Not addressed.	POST form does not supersede DNR form nor power of attorney. §144D.4(1)-(2). Related law: §144A.7 (discussing procedure in absence of DNR form).
17	**Presumption if section of form left blank**	Absent POLST, required to attempt to save life	None, but provider has obligation to follow known preferences, or in absence, patient's "best interests" prevail.	Full treatment § 144.D.2(1)(g)
18	**Out-of-state POLST recognized?**	Not specifically addressed, but Illinois POLST forms not intended to be recognized in other states because of their voluntary nature.	Not addressed.	Yes, § 144.D.3(1)
19	**Web page for additional resources**	Chicago End-of-Life Care Coalition: http://www.cecc.info/resource-links/physicians-order-for-life-sustaining-treatment-polst	www.iupui.edu/~irespect/docs/INPOSTguidanceHCPJune2013.pdf This guidance book provides information to health care providers about how to use the Indiana POST program.	http://www.idph.state.ia.us/hcr_committees/common/pdf/patient_autonomy_pilot/patient_autonomy_pilot_report.pdf
20	**Additional Notes**			

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POLST Program Legislative Comparison - as of 2/15/2015

		10. Louisiana ☼	11. Maryland	12. Minnesota
1	**Terminology**	Louisiana Physician Order for Scope of Treatment (LaPOST)	Medical Orders for Life–Sustaining Treatment (MOLST)	Provider Orders for Life Sustaining Treatment (POLST)
2	**Placement in the state code**	40 La. Codes Stat § 40:1299.41..	Health Care Decisions Act--"Medical Orders for Life– Sustaining Treatment" Form. Repealing and reenacting parts of the Health Care Decisions Act § 5–608, 5–609, 5–617, 5–619, and 19–344(f); Adding to § 5–608.1. Effective date: October 1, 2011	None. Voluntary consensus process
3	**Regulations/ Guidelines**	La. Admin Code. tit. 48, pt. I, § 201 thru §211. Eff. June 2011.	Code of Md Regulations (COMAR) 10.01.21.01 through -.07, effective Jan. 1, 2013.	Endorsement of POLST form by Emergency Medical Services Regulatory Board, meeting minutes of 9/11/09, available at: http://www.emsrb.state.mn.us/minutes/20090911-7.pdf
4	**Entity responsible for development/ approval of POLST**	Department of Health and Hospitals	Department of Health and Mental Hygiene, in conjunction with the Maryland Institute for Emergency Medical Services Systems and the State Board of Physicians, 5-608.1(b)(1)(i) and (ii): The "Medical Orders for Life–Sustaining Treatment" form and the instructions for its completion and use shall be developed in consultation with: (1) The Office of the Attorney General; (2) The State Board of Nursing; (3) The State Advisory Council on Quality Care at the End of Life; and (4) Any other individual or group the Department determines is appropriate.	Minnesota Medical Association hosts a self-selected, open membership, interdisciplinary, statewide Steering Committee (voluntary consensus process)
5	**Provider signature required**	Physician, §207(B)	Physician, Nurse Practitioner, and Physician Assistant	Physician (MD/DO), Nurse Practitioner, and Physician Assistant (when delegated)
6	**Patient signature required?**	Yes. §207(A)	No. When health care facility completes the form, it must offer the patient to "participate." § 608.1(c)(2)(i). Option to decline is included on form.	No, but recommended
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes. §207(A)	No (Same rule as above).	Yes.
8	**Applicable to minors**	Yes. No age limit as long as a patient has a life limiting and irreversible condition. Anyone authorized by law who can speak for them can complete a LaPOST document	Yes. Parents may authorize.	Yes, being used by at least one pediatric hospital.
9	**Patient Limitations**	Must be a "qualified patient," i.e. "having a life-limiting and irreversible condition" § 1299.64.2(11) defined as "a continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness which within reasonable medical judgment would usually produce death within six months, herein. §1299.64.2(6)	Not applicable where primary diagnosis is psychiatric or related to pregnancy, or where patient is a minor unlikely to require life-sustaining treatment. COMAR10.01.21.02	None

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		10. Louisiana ☼	11. Maryland	12. Minnesota
	Other execution requirements?	When completing a new LaPOST form, the old LaPOST form must be properly voided. §209(C)-(D)	No.	No
10				
11	**Exclusive DNR form?**	No	Existing EMS DNR order forms approved by MIEMSS and the Board of Physicians never expire. Going forward, they will only be using MOLST forms but will continue to honor existing EMS DNR order forms.	No
12	**Immunity provided?**	Yes. §1299.64.5, 201B(2),	Yes. Health-General § 5-609(b) and COMAR 10.01.21.07	Under advance directive law,immunity exists when orders consistent with legal health care directive and/or instructions of legally appointed surrogate decision maker
13	**Duty to offer POLST?**	No	Not only a duty to offer, but a duty to complete MOLST for residents of nursing homes, assisted living programs, kidney dialysis centers, home health agencies, and hospices. Hospitals must complete the form to patients that will be transferring to one of these health care facilities or to another hospital. "Competing completing at least the certification section and the CPR section. COMAR 10.01.21.04	No
14	**Duty to comply?**	Yes. If patient has document, must comply unless new knowledge?	Yes, including hospitals, Health-General § 5-608.1(f)	No – Health care directive law provides immunity for short term provision of life prolonging therapy, even against instructions in legal health care directive (& therefore despite POLST).
15	**Original vs. Copies/faxes?**	Print on gold color paper. Copies valid.	No color requirement for original. Copies and electronic format valid. COMAR 10.01.21.05	No color requirement for Original. Copies are valid.
16	**Conflicts with AD addressed?**	Not addressed. In practice, most recent document is considered valid	Except in cases of medical ineffectiveness, a MOLST form must be consistent with wishes of competent patient, and if incompetent, consistent with any known advance directive. If more than one MOLST, the later in time controls, but duty to attempt resolution of conflicts through discussion.	POLST form documents justification for orders (e.g. AD, patient stated preference, proxy instruction, or best interest)
17	**Presumption if section of form left blank**	Full treatment. §207C(3).	No. But if emergency treatment is needed, Health-General §5-607 authorizes that treatment be provided if consent cannot be obtained.	Not addressed
18	**Out-of-state POLST recognized?**	Not addressed	Yes. Health-General § 5-617.	Not addressed
19	**Web page for additional resources**	http://www.lhcqf.org/lapost/	www.marylandmolst.org	MN Med. Society: www.polstmn.org www.mnmed.org/KeyIssues/POLSTCommunications/tabid/3291/Default.aspx http://coa.umn.edu/MAGEC/POLST/index.htm
20	**Additional Notes**		Any individual may request completion of MOLST. COMAR10.01.2104H	

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		13. Mississippi	14. Montana ☼	15. Nevada
1	**Terminology**	Physician Orders for Sustaining Treatment (POST).	Provider Orders for Life-Sustaining Treatment (POLST)	Physician Orders for Life– Sustaining Treatment (POLST)
2	**Placement in the state code**	Miss. Code. Ann. § 41 -41 -302 - 303, eff July 1, 2014.	None, but regulations adopted pursuant to the general rule-making authority granted under the Rights of the Terminally Ill Act, Mt Code Ann. At § 50-9-110.	NEV. REV. STAT. ANN. §449.600 (added to state's living wills statute).
3	**Regulations/ Guidelines**	None	Mont. Admin. Rule § 37.10.. And MCA § 101, .104, and .105.	None as of December 2013. State Board of Health adopted POLST form.
4	**Entity responsible for development/ approval of POLST**	The State Board of Medical Licensure shall promulgate a standard POST form.	Department of Public Health and Human Services and Board of Medical Examiners	State Board of Health; approved by the Governor, §15
5	**Provider signature required**	Physician § 41 -41- 302(h)(i)	Physician, Nurse Practitioner, and Physician Assistant	Physician only, §16
6	**Patient signature required?**	The signature of the patient or the patient's representative is required; .	Yes	Yes. 3 §449.626
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes, however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record as soon as practicable and "on file" must be written on the appropriate signature on this form	Yes	Yes, a representative may sign. §449.626
8	**Applicable to minors**	Yes, § 41 -41- 302€(ii)	No	Yes. § 449.626
9	**Patient Limitations**	None.	None	Prwegnancy limitation, §449.695

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		13. Mississippi	14. Montana ☼	15. Nevada
	Other execution requirements?	None	No	No
10				
11	**Exclusive DNR form?**	Yes	No	No
12	**Immunity provided?**	Yes, except for purposeful acts. § 41 - 41- 303	Yes	Yes. § 449.630
13	**Duty to offer POLST?**	No	No, but An attending physician, attending advanced practice registered nurse, or other health care provider who is unwilling to comply with this chapter shall take all reasonable steps as promptly as practicable to transfer care of the declarant to another physician, advanced practice registered nurse, or health care provider who is willing to do so. Mont. Code Ann. § 50-9-203	Not addressed
14	**Duty to comply?**	Yes	No	Yes. § 449.617
15	**Original vs. Copies/faxes?**	Not addressed	On terra green (light lime green). Copies valid.	Must be "uniquely identifiable" having a "uniform" color; copies/faxes not addressed. § 15
16	**Conflicts with AD addressed?**	Not addressed.	Advance directive or health care power of attorney prevails.	Document executed most recently is valid; A do-not-resuscitate identification prevails if it is on the person of the patient when need for life resuscitating treatment arises (unless patient is pregnant). § 18
17	**Presumption if section of form left blank**	Not addressed	Not addressed	None. § 449.640
18	**Out-of-state POLST recognized?**	Not addressed	Not addressed	Yes. § 449.690
19	**Web page for additional resources**	None	http://bsd.dli.mt.gov/license/bsd_boards/med_board/polst.asp	
20	**Additional Notes**	None		Pregnancy limitation, § 20

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		16. New Jersey	17. New York ☼	18. North Carolina ☼
1	**Terminology**	Practitioner Orders for Life-Sustaining Treatment (POLST)	Medical Orders for Life-Sustaining Treatment (MOLST)	Medical Order for Scope of Treatment (MOST)
2	**Placement in the state code**	Physician Orders for Life-Sustaining Treatment Act. N.J.S.A. 26:2H–129 thru 140. Approved Dec. 20, 2011. Freestanding Act, part of Health Facilities provisions.	A 2008 amendment to DNR provision of the Pub Health Law § 2977(13) (DNR law), eff.7/8/08 , permitting use of an alternative form to the state DNR form, as approved by DOH. MOLST is the ONLY form approved by DOH and thus, DOH approval permitted MOLST to be used statewide in all settings; in 2010 this provision was replaced by a section of the Family Health Care Decisions Act, PHL §2994-dd(6), eff. 6/1/10.	NC Gen. Stat. § 90-21.17, Eff. October 1, 2007, a section under the Medical Malpractice Actions article, recognizing "Portable do not resuscitate order and Medical Order for Scope of Treatment."
3	**Regulations/ Guidelines**	None. Guidance publication provided by the NJ Hospital Association at www.njha.com/quality-patient-safety/advanced-care-planning/polst	Form approved by Dept. of Health and EMS practice changed to allow EMS to follow DNR, DNI, and MOLST orders, effective 7/8/08. www.nyhealth.gov/professionals/patients/patient_rights/molst	Dept. of Health and Human Services, Office of EMS, adopted a MOST form and procedure, eff. January 1, 2008: www.ncdhhs.gov/dhsr/EMS/dnrmost.html
4	**Entity responsible for development/ approval of POLST**	NJ Dept. of Health through NJHA Institute for Quality and Patient Safety	MOLST created by the Community-wide EOL/Palliative Care Initiative, Rochester, NY. Development, implementation, legislative advocacy and health policy change was led by Excellus BCBS, leader of the Initiative, in collaboration with DOH, and multiple collaborating partners. Statewide implementation now rests with the MOLST Statewide Implementation Team, with leadership supported by Excellus BlueCross BlueShield, per Compassion and Support.	Dept. of Health and Human Services, Division of Health Service Regulation. (Sell forms for 4 cents each).
5	**Provider signature required**	Attending Physician or Advanced Practice Nurse, 2H-134(b)(3)	Physician only.	Physician (MD/DO), Physician Assistant, Nurse Practitioner
6	**Patient signature required?**	Yes. 2H-134(b)(2)	No, but informed consent is required. Verbal consent permitted. Two witnesses are always recommended. One witness may be the physician.	Yes
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes. 2H-134(b)(2)	Yes, by health care agent, PHL surrogate, minor's parent/guardian, or §1750-b surrogate. Verbal consent permitted. Two witnesses are always recommended. One witness may be the physician.	Yes
8	**Applicable to minors**	Yes, minors may have POLST with parental or guardian consent.	Yes Capacity determination, clinical standards, notifications & other legal requirements exist, per DOH Checklist for Minor Patients: http://www.health.ny.gov/professionals/patients/patient_rights/molst/docs/checklist_minor_patients.pdf	Yes
9	**Patient Limitations**	None, but "recommended for use on a voluntary basis by patients who have advanced chronic progressive illness or a life expectancy of less than **five years**, or who otherwise wish to further define their preferences for health care;" (definition of POLST)	None.	None

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		16. New Jersey	17. New York ☼	18. North Carolina ☼
10	**Other execution requirements?**	No	Separate signatures required for CPR instruction and for other life-sustaining treatments, as DOH regulations mandate ascertaining if a patient has made a decision regarding resuscitation instructions on the day of admission to a nursing home, while recognizing patients may not be ready to complete the entire MOLST form initially. EMS protocols align with cardiac and/or pulmonary arrest (page 1) and cardiac and/or pulmonary insufficiency (page 2.) Capacity determination, clinical and surrogate standards, notifications, and other legal requirements vary based on who makes decisions and where made. These vary for adult and minor patients and are outlined in checklists found: www.health.ny.gov/professionals/patients/patient_rights/molst. The §1750-b process must be followed for persons with developmental disabilities who lack medical decision-making capacity before the MOLST can be completed. Review and renewal of MOLST is required by NYSPHL, and if there is a care transition, a change in health status or change in goals for care	(1) If patient representative approves orally, must then sign a copy of the form and return it for entry into med record. Original must note signature "on file." (2) Form has box to identify health care. professional assisting in preparation.
11	**Exclusive DNR form?**	No	No	No
12	**Immunity provided?**	Yes. § 26:2H-138	Yes, PHL §2994-o, Family Health Care Decisions Act	Yes, 90-21.17(d)
13	**Duty to offer POLST?**	Not addressed in law.	No	No
14	**Duty to comply?**	Yes. 26H-134(a)	Yes	No, but immunity provision does not apply if provider fails to comply with actual knowledge of the form's existence.
15	**Original vs. Copies/faxes?**	Original recommended; copies also valid (in NJ Guidelines for implementation)	Pink original is preferred. Copies, fax and electronic representation are legal and valid orders.	Pink original must be used.
16	**Conflicts with AD addressed?**	More recent verbal or written directive prevails.§ § 26:2H-135(c).	Not specifically addressed but surrogates are obligated to follow patient's known wishes; otherwise best interests.	Yes, MOST form "may suspend any conflicting directions in patient's AD.90-21.17 C
17	**Presumption if section of form left blank**	Full treatment	No. Section may be crossed out with notation "Decision Deferred"	Full treatment
18	**Out-of-state POLST recognized?**	Yes. § 26:2H-134(4)	Yes	Not addressed
19	**Web page for additional resources**	www.njha.com/quality-patient-safety/advanced-care-planning/polst and www.goalsofcare.org/polst-form	Dept. of Health: www.nyhealth.gov/professionals/patients/patient_rights/molst Also see Compassion and Support (multiple resources): CompassionAndSupport.org	NC Medical Society: www.ncmedsoc.org/pages/public_health_info/end_of_life.html
20	**Additional Notes**	Physician and Advance Practice Nurse education in end-of-life care required (Section 14(a), 15 (a) of law)	Physician and APN education in end-of-life care required (§14(a), 15 (a) of law). NY has created eMOLST, a secure web-based application that allows enrolled users to complete the eMOLST form and MOLST Chart Documentation Form (goals for care discussion and legal requirements). The forms are created as pdf documents that can be printed for the patient and a paper-based medical record, stored in an EMR and become part of the NYS eMOLST registry.	

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		19. Oregon ☼ (Mature)	20. Rhode Island	21. Pennsylvania ☼
1	**Terminology**	Physician Orders for Life-Sustaining Treatment (POLST)	Medical Orders for Life-Sustaining Treatment (MOLST)	Pennsylvania Orders for Life-Sustaining Treatment (POLST)
2	**Placement in the state code**	No statute from inception in 1991 until 2009 Oregon POLST Registry Act, Or. Rev. Stat. Ann. §127-663 to -684, eff. June 26, 2009, which defined POLST. And created a POLST registry.	R.I. Gen. Laws §23-4.11-3.1 and 23-4.11-2 (10) (part of the state Living Will Statute, §23-4.11-1 to -15). Defines MOLST as another type of "Declaration" eff. June 11, 2012.	No statute.
3	**Regulations/ Guidelines**	OAR 847-035-0030(6), a Medical Bd. regulation requiring EMS personnel to honor POLST; and OAR 847-010-0110 (Medical Bd. regulation), requiring physicians, nurse practitioners, and physician assistants to honor POLST even if the signer is not on the facility medical staff. Registry rules are at OAR 333-270-0030 to -0080. Guidance for professionals: www.oregonpolst.org/sample-policies	Rules and Regulations Pertaining to Medical Orders for Life-sustaining Treatment, R23-4.11-MOLST. See: www.pcmhri.org/files/uploads/Rules%20and%20Regulations%20Pertaining%20to%20Medical%20Orders%20for%20Life%20Sustaining%20Treatment.pdf	Secretary of Health approved a standard form called Pennsylvania Order for Life-Sustaining Treatment for use in Pennsylvania. October 24, 2010
4	**Entity responsible for development/ approval of POLST**	Oregon POLST Task Force through the Center for Ethics in Health Care at Oregon Health & Science University	Dept. of Health~§ 23-4.11-3.1 www.health.ri.gov/lifestages/death/about/medicalordersforlifesustainingtreatment	Coalition for Quality at the End of Life (COEL)
5	**Provider signature required**	Physician, Nurse Practitioner, Physician Assistant, Or. Admin. Rule 333-270-0030	Physician (MD/DO), Registered Nurse Practitioner, Physician Assistant, 23-4.11-2(12)	Physician, Physician Assistant, Nurse Practitioner (CRNP)
6	**Patient signature required?**	No, but strongly recommended	Yes, 23-4.11-3.1(b) and (c).	Yes
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes, ORS 127.635 (default surrogate consent law)	Yes, 23-4.11-3.1(b) and (c).	Yes
8	**Applicable to minors**	Yes	Yes	Yes
9	**Patient Limitations**	None	Limited to "Qualified patient" i.e., one in a terminal condition. 23–4.11–2(16), but defined very broadly as an "incurable or irreversible condition that, without the administration of life sustaining procedures, will, in the opinion of the attending physician, result in death." 23–4.11–2(20).	None

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		19. Oregon ☼ (Mature)	20. Rhode Island	21. Pennsylvania ☼
	Other execution requirements?	No. Form has box to identify health care. professional assisting in preparation.	No	No
10				
11	**Exclusive DNR form?**	Outside of health care facilities, yes.	No, 23-4.11-3.1(b)	No
12	**Immunity provided?**	Yes, Or. Rev. Stat. 127.555 (advance directive law) as interpreted by OAR 847-010-0110	Yes, 23-4.11-8	Not addressed
13	**Duty to offer POLST?**	No	No	Not addressed
14	**Duty to comply?**	Yes, OAR 847-010-0110	Yes, with limited exceptions, 23-4.11-3.1(c)	Not addressed
15	**Original vs. Copies/faxes?**	Pink original. Copies valid	Yes	Print on pulsar pink card stock recommended. Copies valid
16	**Conflicts with AD addressed?**	No	Not addressed	Any current AD, if available, must be reviewed
17	**Presumption if section of form left blank**	Full treatment	Not addressed	Full treatment
18	**Out-of-state POLST recognized?**	Yes, OAR 847-010-0110 is interpreted to support compliance with out-of-state forms. See: www.oregonpolst.org/wp-content/uploads/2013/02/OregonPOLSTTaskForceReciprocityStatementFinal.pdf	Yes, § 23-4.11-12	Not addressed
19	**Web page for additional resources**	OR Health Sciences at: www.orpolst.org/	www.health.ri.gov/lifestages/death/about/medicalordersforlifesustainingtreatment. Also	The Aging Institute of UPMC Senior Services and the University of Pittsburgh -- www.aging.pitt.edu/professionals/resources-polst.htm
20	**Additional Notes**	Oregon POLST Registry became available for statewide use in late 2009. The law does not require a patient to have a POLST form, but if completed, the signing health care professional must submit to the Registry, unless patient opts out. See: www.oregonpolst.org/oregon-polst-registry		See also: http://www.polst.org/wp-content/uploads/2013/01/POLST-Education.pdf

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		22. Tennessee ☼	23. Utah ☼	24. Vermont
1	**Terminology**	Physician Orders for Scope of Treatment (POST)	Life with Dignity Order (LWDO) – generic term. Physician Order for Life-Sustaining Treatment (POLST) is the only DOH approved LWDO.	Clinician Orders for Life-sustaining Treatment (COLST)
2	**Placement in the state code**	Tenn. Code. Ann. § 68-11-224, amended by TN LEGIS 254 (2013), approved April 19, 2013.	Utah Code Ann. §75-2a-106, plus definition at §75-2a-103(17), enacted in 2007 as part of a comprehensive advance directive statute (eff. Jan. 1, 2008).	2005 revisions to Advance Directive law included rulemaking for COLST, at 18 V.S.A. § 9719. A 2009 amendment added a definition, §9701(6); and in 2011 specifications for COLST, §9708.
3	**Regulations/ Guidelines**	Board for Licensing Health Care Facilities adopted Physician Orders for Scope of Treatment (POST) in requirements for each type of facility. See Tenn. Comp. R. & Regs. 1200-08-01-.15 (Appendix I) for Hospitals. Similar provision applies to other facilities: http://www.state.tn.us/sos/rules/1200/1200-08/1200-08-01.20120402.pdf (Appendix 1) Also see: http://health.state.tn.us/Boards/AdvanceDirectives See also FAQs: http://health.state.tn.us/AdvanceDirectives/FAQ_POST.htm	Utah Admin. R. 432-31. Regulation eff. Feb. 25, 2010: www.rules.utah.gov/publicat/code/r432/r432-031.htm. Form: http://health.utah.gov/hflcra/forms/POLST/POLSTForm2010.pdf	Vt. Admin. Code 12-5-15:1, particularly 12-5-15: Appendix B. See: http://healthvermont.gov/news/2011/063011_DNR-COLST.aspx Also see: http://healthvermont.gov/regs/ad/dnr_colst_instructions.pdf
4	**Entity responsible for development/ approval of POLST**	Board for Licensing Health Care Facilities	Department of Health, 75-2a-106(10). See http://health.utah.gov/ems/polst	Vermont Dept. of Health. See
5	**Provider signature required**	Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist (For the non-physicians, extensive prerequisites must be met).	Physician, Advance Practice RN, or Physician Asst (w/in scope supervisory agreement). Also provides that other specified health professionals acting under the supervision of the above may "prepare" the LWDO. Form includes box for preparer signature, also. 75-2a-106(2)	Physician or Osteopath, Advance Practice RN, or Physician Assistant
6	**Patient signature required?**	Not required in statute, but optional signature line included in approved form.	Yes, 75-2a-106(3)	Informed consent required, but signature is optional. Informed consent not required physician and 2nd clinician have "determined that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest." 9708(d)(3)
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes	Yes, 75-2a-106(3)	Yes, 9708(f)
8	**Applicable to minors**	Yes, 68-11-224	Yes, 75-2a-106(3), but If patient is a minor and POLST calls for forgoing LST, 2 physicians must certify that it is "in the best interest of the minor." §75-2a-106(4)	No
9	**Patient Limitations**	None	None	None

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		22. Tennessee ☼	23. Utah ☼	24. Vermont
10	**Other execution requirements?**	No	Form has box to identify health care. professional assisting in preparation.	Patient's clinician must sign the DNR part of the form separately from the other medical interventions. If patient is in a health care facility, clinician must certify that the facility's DNR policy has been followed. 9708(a)(4)1
11	**Exclusive DNR form?**	No	No R432-31-11	Not within facility, but required in community. 9708(b) and (c)
12	**Immunity provided?**	Yes~68-11-224	Yes, both for complying and for providing LST in contravention of the POLST, 75-2a-106(6)	Yes, §9713
13	**Duty to offer POLST?**	No, but if patient has a DNR order at time of discharge, facility "shall complete a POST form"	Yes, must establish policies to determine who is appropriate for POLST and offer. R432-31-4	Yes
14	**Duty to comply?**	Form must accompany patient on transfer or discharge.	No. But facilities have duty to transfer copy of POLST with patient	Yes, 9708(i)
15	**Original vs. Copies/faxes?**	Approved form notes that copies are valid.	Copies valid.	Original any color. Copies valid per instructions.
16	**Conflicts with AD addressed?**	Not addressed	POLST controls, 75-2a-106(7)	Not addressed.
17	**Presumption if section of form left blank**	Full treatment	Full treatment	No presumption.
18	**Out-of-state POLST recognized?**	Not addressed	Yes, R432-31-11	Yes, 18 V.S.A. §9708(k)
19	**Web page for additional resources**	http://endoflifecaretn.org	UT Center on Aging Provider Guide at http://aging.utah.edu/programs/utah-coa/directives/provider.php, and , https://health.utah.gov/ems/polst/	Vermont Ethics Network: http://vtethicsnetwork.org/colst.html
20	**Additional Notes**	Physician's verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.	DOH developing web page for electronic registry. Also referred to as "A Life with Dignity Order"	If DNR order issued, clinician shall authorize the issuance of DNR identification (bracelet) §9708(h)

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		25. Washington ☼	26. West Virginia ☼ (Mature)
1	**Terminology**	Physician Orders for Life-Sustaining Treatment (POLST)	Physician Orders for Scope of Treatment (POST)
2	**Placement in the state code**	Rev. Code Wash. Ann. § 43.70.480 amendment in 2000 mandated DOH develop EMS guidelines – including "a simple form that shall be used statewide" - for persons with signed writings requesting no "futile emergency medical treatment."	Amendment to WV Code §16-30C-1 to -16 (DNR law); and 16-30-1 to 25 (Health Care Decisions Act) specifically § 16-30-3(u), -5, -10, -13(d), and -25. Enacted 2002.
3	**Regulations/ Guidelines**	The Dept. of Health developed the form and program in conjunction with the Washington State Medical Assn: http://www.wsma.org/POLST	Guidelines -- provided by the WV Center for End-of-Life Care at: www.wvendoflife.org/POST and www.wvendoflife.org/MediaLibraries/WVCEOLC/Media/professional/POST-Manual-2012-complete.pdf
4	**Entity responsible for development/ approval of POLST**	The Dept. of Health, Office of Emergency Medical Services & Trauma System (OEMSTS)	Development: Dept. of Health & Human Resources/ Management: The West Virginia Center for End-of-Life Care.
5	**Provider signature required**	Physician, Nurse Practitioner, or Physician Assistant	Yes, physician. § 16-30-25
6	**Patient signature required?**	Yes	Yes, § 16-30-25
7	**Surrogate signature permitted? (Agent/Default Surrogate/Guardian)**	Yes	Yes
8	**Applicable to minors**	Yes	None
9	**Patient Limitations**	None	None

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		25. Washington ☼	26. West Virginia ☼ (Mature)
	Other execution requirements?	Form has box to identify health care. professional assisting in preparation.	No
10			
11	**Exclusive DNR form?**	No	No
12	**Immunity provided?**	Yes, statute interpreted to provide for EMS responders. Rev. Code Was. Ann.Y3 §18.71.210	Yes
13	**Duty to offer POLST?**	No	No
14	**Duty to comply?**	Yes, by EMS as the accepted standard of care	Yes, §16-30-12 and 16-30-10 and §16-30C-7
15	**Original vs. Copies/faxes?**	Green original (a downloadable original can be printed on green stock). Copies valid.	Bright Pink Original. Copies must be pink
16	**Conflicts with AD addressed?**	Most recently completed form takes precedence.	The person's expressed directives control. 16-30-5(b
17	**Presumption if section of form left blank**	Full treatment	Full treatment
18	**Out-of-state POLST recognized?**	Not addressed	Yes, DNR §16-30C-15 Not addressed for POST
19	**Web page for additional resources**	WA State Medical Assn at http://www.wsma.org/POLST	WV Center for EOL Care: www.wvendoflife.org/POST
20	**Additional Notes**		Can be filed with WV e-Directive Registry. See: www.wvendoflife.org/e-Directive-Registry

☼ indicates program is endorsed by the National POLST Paradigm Task Force
ABA Commission on Law Aging

Appendix 3
Model POLST Paradigm Program Legislation

(The following statutory language is taken from early Model legislation authored by the National POLST Paradigm Task Force and thought by the authors of this article to be helpful language for states considering legislation. However, reference to the full discussion of legislative and regulatory issues as contained in this article, attention to the National POLST Paradigm Task Force POLST Legislative Guide available on the website at www.POLST.org., and a full study of the statutes referenced in the Chart of Legislation (*supra* Appendix 2) is strongly suggested.)

SECTION 1. Findings.

The Legislature finds and declares the following:

(a)The Physician Orders for Life Sustaining Treatment (POLST) [or other name chosen by the state] form complements an advance directive by taking the individual's wishes regarding life-sustaining treatment, such as those set forth in the advance directive, and converting those wishes into medical orders.

(b)A POLST form is particularly useful for individuals who are frail and elderly or who have a chronic, progressive medical condition, (clinician would not be surprised if the patient died within in the next year), or a terminal illness.

SECTION 2. Definition.

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

SECTION 3. POLST Form and Procedures.

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

SECTION 4. Reliance on Authority of POLST Form.

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

(1) The POLST form shall remain in effect;

(2) The POLST form shall be voided and a new form completed; or

(3) The POLST form shall be voided without a new form being completed.

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

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

SECTION 5. Revocation of Consent to POLST Form.

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

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

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

SECTION 6. Implementation.

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