# POLST: Advance Care Planning for the Seriously Ill

Advance care planning helps ensure patient treatment preferences are documented, regularly updated, and respected. There are two documents used to record these preferences: advance directives and Physicians Orders for Life-Sustaining Treatment (POLST) forms.[1] These two documents differ in many ways; however, they can work together in approaching end-of-life planning.

This article addresses their differences and clarifies misconceptions about POLST and its relationship to advance directives.

## Clarification of POLST Paradigm Program

The National POLST Paradigm Program Task Force (NPPTF) was convened to establish quality standards for POLST programs and to assist states in program development. The NPPTF endorses states adhering to POLST Program tenets; currently there are 16[2]. Endorsement means: (i) the program and its form adhere to NPPTF standards; (ii) the program has addressed legal and regulatory issues associated with POLST and; (iii) the program has developed strategies for ongoing implementation and state-wide dissemination of the POLST program and quality assurance. States not endorsed may still use POLST terminology (or something similar) in developing their programs but they have not shown they meet the NPPTF's established standards.

## Advance Directives and POLST Forms

There are two types of advance directives, which can standalone or be combined: living wills and health care proxy[3]. Living wills identify types of treatment a patient wants or does not want if they are terminally ill or in a vegetative state and lack decision-making capacity. A health care proxy document identifies a surrogate to make decisions when the patient lacks decision-making capacity. All competent adults should be encouraged to have an advance directive.

POLST is not an advance directive but an actionable medical order, although not in the traditional sense. POLST is only for seriously ill patients for whom their health care professional (HCP) would not be surprised if they died in the next year.[4] It would be inappropriate for a HCP to complete a POLST form for a patient who is outside the intended POLST patient population.[5]

### Complementary Documents

Neither form supplants the other; they complement each other. Most importantly, both encourage needed advance care planning conversations among loved ones to understand a patient's goals of care and treatment preferences so they can be honored when the patient is unable to speak for him/herself. It is only through

these ongoing conversations, and revisions of both documents as necessary, that either can ensure patient treatment desires are honored.

Both documents are only as good as the conversation and information shared prior to completing them. POLST creates the opportunity to have a more specific advance care planning conversation than is likely to occur with an advance directive.

POLST is not just a piece of paper but also the culmination of a shared decision-making process between the patient and his/her HCP. The HCP identifies and discusses the patient's specific diagnosis, prognosis, and treatment options (including the benefits and burdens of each). The patient shares his/her values, beliefs and goals of care. Using all that information, the HCP and patient work together to make decisions about desired treatment. The HCP completes the POLST, documenting the decisions; it is only after this conversation that the HCP signs the POLST.

The advance directive not only identifies the surrogate to stand in the patient's shoes when the patient lacks capacity but provides guidance for the surrogate and HCP on desired treatment. The longer patients, surrogates, loved ones and HCPs have engaged in advance care planning conversations, the more likely the parties will be able to ensure a patient's wishes are identified and honored.

The POLST Paradigm Program requires HCPs to be trained in conducting shared decision-making discussions with patients and families so POLST forms are properly completed; states must show evidence of education to this point in order to be endorsed. The POLST Paradigm Program expects these conversation to occur and strongly recommends that all POLST forms require documentation affirming this conversation took place through documenting patient or surrogate signature, attestation or consent.

### Similarities

Both are voluntary. Both document patient treatment preferences and goals of care; the living will captures this information, as does Section B of the POLST.

### Key Differences

Unfortunately, confusion about these two documents persists, leading some individuals to consider only one of them while ignoring the potential benefit of the other. Clinical experience and research demonstrate that advance care directives are not sufficient to ensure that care goals of patients with serious advanced illnesses will be honored unless a POLST form is also completed.[6]

The salient differences between these documents are presented in the Table.[7]

### Completion of Document

Completion of an advance directive does not require assistance by a HCP; individuals can complete them on their own. Signatures required to make an advance directive valid vary by state but usually include the signature of the patient and a witness/es (some states require notarization of advance directive forms).

POLSTs are completed and signed by HCPs; states with POLST Programs provide on-going education to HCPs on how to properly complete POLST forms.

### Language of Document

Advance directives generally have language that may not be understood by the general public and does not clearly define treatment options. Consequently, a patient's advance directive may be vague and not easily interpreted. As a result, when reviewing an advance directive for treatment options, the HCP and surrogate may be required to speculate what the patient would have wanted in the specific medical circumstance.

POLSTs have specific language about treatment options so they are easily interpreted and followed. POLST turns patient treatment preferences and goals of care documented in an advance directive into medical orders that may be followed in an emergency.

### Timing of Document Completion

While both document future treatment preferences, advance directives can be completed at any time since they document general wishes for an unspecified future medical crisis.

POLST documents specific wishes based on specific knowledge of a patient's specific disease (and its progression). While the specifics of exactly what will happen as the disease progresses is unknown, the prognosis and understanding of the disease progression are known and the universe of possibilities is restricted.

### Ease of Modification or Revocation

Modification or revocation of an advance directive usually requires compliance with state law or regulation, as well as obtaining new signatures from multiple individuals (see Signatures above). A key tenet of the POLST program is that POLST forms must be easily modified or revoked to allow patients to change treatment decisions as their disease progresses. Consequently, POLST forms are created to be easily modified or revoked.

### Accountability

If the advance directive is poorly written, confusing, contradictory, or not signed by all required parties, it may be invalid or not followed without anyone being accountable for such errors.

As a medical order, only those professionals with training should complete a POLST form with the patient or surrogate and, further, the HCP with authority to sign medical orders is responsible for reviewing the POLST prior to signing to ensure the orders are consistent with the decisions reached during the shared decision-making process. The signing HCP is accountable for the POLST orders.

### Document Review During a Medical Crisis

In a medical crisis, emergency medical service (EMS) personnel institute cardiopulmonary resuscitation and other life support measures unless they have medical orders to the contrary. As medical orders, POLST forms are followed in times of crisis by EMS personnel in accordance with protocol, and by treating health care professionals, including physicians. Since a POLST form is brightly colored and included in a patient's medical record, it is easily located.

Advance directives are not medical orders so EMS personnel cannot follow them; instead, they are generally reviewed (if they can even be located) once the patient has been transported to the health care facility.

## Final Comments on POLST

Some POLST opponents have stated that conversations with patients and their HCPs suffice for advance care planning, but conversation alone is not a viable alternative to a POLST. During emergencies, EMS personnel follow protocols. They cannot follow requests from surrogates, interpret advance directives, and they generally do not have time to identify and call the patient's HCP to ask for orders.

The POLST form is patient-centered and honors patients' moral and religious beliefs. For example, it allows Catholics to make decisions consistent with the United States Conference of Catholic Bishops Ethical and Religious Directives for Catholic Health Care Services, 5th ed. (2009) and ensures that those decisions will be honored in an emergency and across care transitions. The POLST form allows HCPs to work with the patient (or his/her surrogate) to order treatments the patient wants and to ensure that treatments the patient considers "extraordinary" and/or excessively burdensome not be provided. Further, the POLST form requires that "ordinary" measures to improve the patient's comfort and food and fluid by mouth, as tolerated, always be provided.[8]

POLST recognizes that allowing natural death to occur is not the same as killing. Euthanasia is illegal in every state, and POLST forms do not allow for active euthanasia or physician-assisted suicide. In Oregon, where POLST was developed and where there exists an assisted suicide law, all Catholic health systems use and honor POLST forms but not the assisted suicide law.

| | POLST Paradigm Form | Advance Directive |
|---|---|---|
| **Type of Document** | Medical Order | Legal Document |
| **Who Completes the Document** | Health care professional (which health care professional can sign varies by state) | Individual |
| **Who Should Have One** | Any seriously ill or frail individual (regardless of age) whose health care professional wouldn't be surprised if he/she died in the year | All competent adults |
| **What Document Communicates** | Specific medical orders | General treatment wishes |
| **Can this Document Appoint a Surrogate Decision-Maker?** | No | Yes |
| **Surrogate Decision-Maker Role** | Can engage in discussion and update or void form if patient lacks capacity | Cannot complete |
| **Can Emergency Personnel Follow this Document?** | Yes | No |
| **Ease in Locating / Portability** | Patient has original; a copy is in patient's medical record.<br><br>A copy may be in a state registry (if state has one). | No set location. Individuals must make sure surrogates have most recent version. |
| **Periodic Review** | Health care professional responsible for reviewing with patient or surrogate. | Patient is responsible for periodically reviewing. |

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[1] The names of similar forms in different states vary: MOLST (Medical Orders for Life-Sustaining Treatment); MOST (Medical Orders for Scope of Treatment); POST (Physician Orders for Scope of Treatment); La POST (Louisiana Physician Order for Scope of Treatment); COLST (Clinical Orders for Life-Sustaining Treatment); IPOST (Iowa Physicians Orders for Scope of Treatment); SMOST (Summary of Physician Orders for Scope of Treatment); TPOPP (Transportable Physician Order for

Patient Preference). Program names vary among the states overseeing these forms as well. These different state coalitions are referred to as POLST Paradigm Programs.

[2] California, Colorado, Georgia, Hawaii, Idaho, Louisiana, Montana, New York, North Carolina, Oregon, Pennsylvania, Tennessee Utah, Washington, West Virginia, and Wisconsin (only regionally endorsed).

[3] The name of the "health care proxy" document varies among states but includes: decision-maker, durable power of attorney for health care, health care agent, health care decision maker, health care proxy, health care representative, health care surrogate, legal health care representative, legal medical decision maker, substitute decision maker, surrogate, power of attorney for health care, and proxy.

[4] Moss A., et al., "Utility of the 'Surprise' Question to Identify Dialysis Patients with High Morbidity," *Clin J Am Soc Nephrol* 3 (2008):1379-1384. See also Moss AH, Lunney JR, Culp S, Auber M, Kurian S, Rogers J, Dower J, Abraham J., "Prognostic Significance of the 'Surprise' Question in Cancer Patients," *J Palliat Med* 13 (2010): 837-840.

[5] If a health care professional inappropriately or improperly completes a POLST, it should be considered a medical error, reportable to a medical board or other review group, just like any other inappropriate medical order.

[6] Hickman, SE, CA Nelson, NA Perrin, AH Moss, BJ Hammes, and SW Tolle, "A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices versus the Physician Orders for Life-Sustaining Treatment Program," *Journal of the American Geriatrics Society*, 58(7) (2010): 1241-1248. See also Hickman SE, CA Nelson, AH Moss, SW Tolle, NA Perrin, BJ Hammes, "Consistency between Treatment Provided to Nursing Facility Residents and Orders on the Physician Orders for Life-Sustaining Treatment Form," *Journal of the American Geriatrics Society* 59.11 (2011): 2091-2099. See also Bomba, P.A., Kemp, Marian, Black, Judith, "POLST: An Improvement over Traditional Advance Directives," *Cleveland Clinic Journal of Medicine* 79.7 (July 2012): 457-464.

[7] Bomba, P.A., Kemp, Marian, Black, Judith, "POLST: An Improvement Over Traditional Advance Directives," *Cleveland Clinic Journal of Medicine* 79.7 (July 2012): 457-464.

[8] Request for Endorsement Program Status Form, http://www.polst.org/wp-content/uploads/2014/05/POLST-Endorsed-Status-Application.pdf, January 5, 2015. See also Catholic Bishops of New York State, "Now and at the Hour of Our Death, A Catholic Guide to End of Life Decision Making" (2011). See also Louisiana Conference of Catholic Bishops, "The Final Journey, Information from the Catholic Bishops of Louisiana on End of Life Decisions", May 2013.