

**AMERICAN BAR ASSOCIATION****ADOPTED BY THE HOUSE OF DELEGATES****AUGUST 11-12, 2008****RECOMMENDATION**

RESOLVED, That the American Bar Association urges federal, state, tribal, and territorial legislative bodies, governmental agencies, and health care providers to establish and support decision-making protocols to ensure that the wishes, including those expressed in any prior advance directive, of those who have advanced chronic progressive illnesses are appropriately translated into visible and portable medical orders such as “Physicians Orders for Life-Sustaining Treatment” or “POLST,” that address higher probability medical contingencies, including hospitalization, cardiopulmonary resuscitation, artificial nutrition and hydration, antibiotics, and ventilation.



## REPORT

This recommendation urges policymakers and health care providers to ensure that the wishes of individuals with advanced chronic progressive illness are elicited and translated into a language that health care systems understand, i.e., doctor's orders. The recommended protocol, known as "Physicians Orders for Life-Sustaining Treatment" and by other names, focuses on here-and-now, high-probability, critical decisions rather than theoretical decisions that could occur in the distant future. It does not eliminate the need for health care advance planning and advance directives. Rather, it complements advance care planning by ensuring that care plans addressing a high probability set of life-support interventions for seriously ill patients are discussed, informed by the patient's wishes, and reflected in a highly visible set of medical orders that follow the patient across care settings, and are adjusted to the patient's current health care conditions as needed.

### I. Background: The Landscape of State Health Decisions Legislation

State statutory law addressing surrogate decision making and the use and recognition of advance directives has been the predominant feature of law and regulation affecting health care decision-making over the last 30 years. These laws include advance directive statutes, default surrogate statutes, out-of-hospital do-not-resuscitate order provisions, organ donation laws, and guardianship laws. Among these, health care advance directives have become *the* central legal tool in virtually every state as a way to make one's health care wishes known and assure they are honored.

The first health care advance directive law – a living will act – was passed by California in 1976.<sup>1</sup> Since then, every state has enacted one or more health care advance directive statutes. Most have at least two statutes, one establishing a "living will" type directive; the other establishing a proxy or durable power of attorney for health care. The spread of advance directive legislation did not lead to uniformity of the law. Indeed, formalities and other requirements vary to such an extent that no single comprehensive advance directive form can possibly meet the statutory requirements in every state. One group – Aging with Dignity, Inc. – sought to create a truly national advance directive form in 1998, called *Five Wishes*, and could meet the statutory requirements, by their own estimation, in only 33 states when they introduced the form that year. This Balkanization is a problem at least to the extent that it confuses the public and deters them from advance planning, and to the extent that it leads providers and the public embrace the myth that the only valid advance directive is a statutory one.

During the 1990's, states began moving toward simplification by combining these laws into comprehensive advance directive acts. By mid-2000, about eighteen states had comprehensive or combined advance directive statutes<sup>2</sup>, which at a minimum, cover living wills and proxies in the same law. The most comprehensive ones also recognize the authority of default surrogate decision-makers in the absence of an advance directive.

<sup>1</sup> See California Natural Death Act, Cal. Health & Safety Code §§ 7185-7195 (West 1991).

<sup>2</sup> AL, AZ, AC, CT, DE, FL, HI, KY, ME, MD, MN, MS, NJ, NM, OK, OR, VA, WV. A complete summary chart of state health care power of attorney and combined advance directive laws, updated annually by the ABA Commission on Law and Aging, is available on the internet at <http://www.abanet.org/aging/update.html>.

The primary model for a flexible combined advance directive and default surrogate law is the *Uniform Health-Care Decisions Act*.<sup>3</sup> The *Uniform Act* was promulgated as a national model by the National Conference of Commissioners on Uniform State Laws in 1993, and given recognition by the American Bar Association in 1994. The Act establishes very simple rules for recognizing almost any kind of written or oral statement as an advance directive, although the states that have adopted the *Uniform Act* have commonly added to the Act's baseline requirements.<sup>4</sup> The Act includes a comprehensive, sample form with options for instructions, appointment of an agent, organ donation, and the naming of a primary physician. In addition, the Act covers surrogate or family/friend decision making for persons who do not have an advance directive.

Encouraged by the Uniform Act and by a growing literature detailing a lack of effectiveness of traditional legalistic advance directive tools, state law has been in a gradual but constant state of flux, moving incrementally toward a more flexible approach that more strongly emphasizes an ongoing process of communication. An ample body of research, summarized by Fagerlin and Schneider and others, reveals that conventional advance directives have been confusing, often clinically irrelevant, and producing little impact on end-of-life decision making.<sup>5</sup>

State law and policy have begun to embrace the concept of *advance care planning*, described by the Institute of Medicine as follows:

[A]dvance care planning is a broader, less legally focused concept than that of advance directives. It encompasses not only preparation of legal documents but also discussions with family members and physicians about what the future may hold for people with serious illnesses, how patients and families want their beliefs and preferences to guide decisions..., and what steps could alleviate concerns related to finances, family matters, spiritual questions, and other issues that trouble seriously ill or dying patients and their families.<sup>6</sup>

<sup>3</sup> See <http://www.law.upenn.edu/bl/ulc/fnact99/1990s/uhcda93.htm>. For a descriptive review of the Uniform Act, see Charles P. Sabatino, "The New Uniform Health-Care Decisions Act: Paving a Health Care Decisions Superhighway?" 53 *Maryland Law Review* 101 (1994).

<sup>4</sup> According to the NCCUSL, the Uniform Act has been adopted in whole or in part in Alabama, Delaware, Hawaii, Maine, New Mexico, and Mississippi. See NCCUSL's web site at: [http://www.nccusl.org/nccusl/uniformact\\_factsheets/uniformacts-fs-uhcda.asp](http://www.nccusl.org/nccusl/uniformact_factsheets/uniformacts-fs-uhcda.asp).

<sup>5</sup> See, e.g. Angela Fagerlin & Carl E. Schneider, "Enough: The Failure of the Living Will," 34 *The Hastings Center Report* 30-42 (March-April 2004); Peter H. Ditto, et. al., "Advance Directives as Acts of Communication," 161 *Arch. Intern. Med.* 421-430 (2001); E.J. Larson and T.A. Eaton, "The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act," 32 *Wake Forest L. Rev.* at 278 (1997); J. Teno et al., "Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention," 45 *J. of the Am. Geriatr. Society* 500-507 (1997); David Orentlicher, "The Illusion of Patient Choice in End-of-Life Decisions," 267 *JAMA* 2101-2104 (1992); Diane E. Hoffmann, Sheryl I. Zimmerman & Catherine J. Tompkins, "The Dangers of Directives or the False Security of Forms," 24 *J. of Law, Medicine & Ethics* 5 (1996); Rebecca Dresser, "Confronting the 'Near Irrelevance' of Advance Directives," 5 *J. Clin. Ethics* 55-56 (Spring 1994).

<sup>6</sup> Institute of Medicine, Committee on Care at the End of Life, *Approaching Death: Improving Care at the End of Life* (Marilyn J. Field & Christine K. Cassel, eds., Natl. Acad. Press 1997).

One small measure of change towards a communications paradigm is a trend toward the statutory recognition of oral advance directives documented in the patient's record. Prior to the 1993 Uniform Health-Care Decisions Act, no state recognized oral advance directives. Today, 14 states recognize some form of oral directive,<sup>7</sup> an option provided for in the Uniform Health-Care Decisions Act. The Act provides that an oral "instruction" documented in the record is valid. Furthermore, the Act recognizes an orally designated "surrogate" where the appointment is personally communicated to the supervising health care provider.<sup>8</sup>

A few of these 14 states recognize only oral instructional directives but not orally designated surrogates.<sup>9</sup> Two states require witnesses as a prerequisite to validity.<sup>10</sup> Permitting oral directives affirms the form of communication most likely to occur between physician and patient and provides one marker of state flexibility in advance planning.

## II. POLST Translates Patient Wishes into Appropriate, Portable Medical Orders

As law and practice move toward the less standardized, more flexible, communications approach of *advance care planning*, questions remain as to whether more flexibility in communication will have any greater impact on actual treatment decisions than do standardized advance directive forms. The underlying task still remains: determining patients's wishes and goals of care and ensuring that the patient receives quality end-of-life care congruent with their wishes. An emerging strategy called POLST began in Oregon and it has had a positive impact in bridging this gap between patient goals and preferences – expressed directly, through an advance directive, or by a proxy – and the actual plan of care as reflected by physician orders.

What happens to patients in hospitals and other health care settings normally depends on physician orders and standard clinical procedures. A small but growing number of states have recognized that patient wishes and goals, no matter how communicated, must be methodically factored into medical orders if we are to ensure that they receive care congruent with their wishes and goals. Moreover, a process to ensure the continuity of that care across care settings is needed. In the early 1990s, Oregon experimented with a protocol for seriously chronically ill patients, called *Physicians Orders for Life-Sustaining Treatment*, or POLST.<sup>11</sup> There are several ways to describe the POLST process, but relevant to this review are three key tasks it aims to accomplish.

<sup>7</sup> Alaska Sta. §13.52.010(a) and 13.52.030(c) (West 2007); Cal. Prob. Code §§4623 and 4711 (West 2007); Conn. Gen. Stat §19a-578 (West 2007); 16 Del. Code §2507(b) (West 2007); Fla. Stat. Ann. §§765.101(1) and 765.101(11)(a) (West 2007); Haw. Rev. Stat. §327E-3 and §327E-5 (2007); La. Rev. Stat. Ann. 40:1299.58.3(3) (West 2007); 18-A Me. Rev. Stat. Ann. §5-802(a) (West 2007); Md. Health-Gen. Code Ann. §5-602(d)(1) (West 2007); Miss. Code Ann. §§41-41-205(1) and 41-41-211 (West 2007); N.M. Stat. Ann. §§24-7A-2(A) and 24-7A-5 (West 2007); Tenn. Code Ann. §68-11-1803 and –1806 (West 2007); Va. Code Ann. §54.1-2982 and 54.1-2983 (West 2007); Wyo. Stat. Ann. §35-22-403(a) (2007).

<sup>8</sup> Uniform Health-Care Decisions Act §5. *See, e.g.* N.M. Stat. Ann. §§24-7A-2(A) and 24-7A-5 (West 2007).

<sup>9</sup> *See e.g.* Conn. Gen. Stat §19a-578 (West 2007); Fla. Stat. Ann. §§765.101(1) and 765.101(11)(a) (West 2007); La. Rev. Stat. Ann. 40:1299.58.3(3) (West 2007); 18-A Me. Rev. Stat. Ann. §5-802(a) (West 2007).

<sup>10</sup> *See e.g.* Md. Health-Gen. Code Ann. §5-602(d)(1) (West 2007); Va. Code Ann. §54.1-2982 and 54.1-2983 (West 2007).

<sup>11</sup> Susan W. Tolle *et al.*, "A Prospective Study of the Efficacy of the Physician Order Form for Life-Sustaining Treatment," 46 *J. Am. Geriatr. Soc.* 1 (1998).

(1) The use of POLST requires a discussion between the health care provider and patient or surrogate about high-probability end-of-life care treatment options. The target group are patients with advanced progressive chronic conditions. The objective is to discern the wishes of the patient in light of his or her current condition and the available care options as explained by the treating health care provider. This is the point at which one's advance directive can impact the clinical decision-making process most directly when the patient is unable to speak for himself or herself. The patient's instructions must be understood and factored into the decisionmaking, and/or the patient's proxy must be accorded the delegated authority of the patient.

(2) The patient's wishes are incorporated into doctor's orders to the extent medically appropriate and the doctor's orders are recorded on a unique, visible (bright pink in Oregon) POLST form that serves as a cover sheet to the medical record. It is reviewed and modified periodically as needed. The uniquely designed form is the hallmark of the POLST paradigm. It covers several key decisions that are common for seriously chronically ill patients. This is where the POLST paradigm differs from out-of-hospital Do-Not-Resuscitate protocols that exist in virtually every state.<sup>12</sup> DNR protocols provide a decision-making process, doctor's order, and patient identification process exclusively for decisions about cardio-pulmonary resuscitation. The POLST paradigm expands that model to address a set of clinical decisions, including CPR, that are of a higher probability for seriously chronically ill patients. For example, the Oregon and Washington forms address: CPR; the level of medical intervention desired in the event of emergency (comfort only/do not hospitalize; limited; or full treatment); use of antibiotics; and the use of artificial nutrition and hydration. An annotated sample front side of the Washington POLST form is provided as *Figure 1*. The POLST process helps to ensure that physicians, nurses, health care facilities, and emergency personnel will honor the patient's wishes for life-sustaining treatment in the patient's present condition.

(3) Health care providers must ensure that the POLST form travels with the patient whenever transfers from one setting to another are made, thus, promoting continuity of care decision making. And periodic review of the orders, and adjustment if needed, is required and documented on the form itself.

POLST is not an advance directive, but it is an advance care planning tool that reflects the patient's *here-and-now* goals for medical decisions that could confront the patient in the immediate future.<sup>13</sup> It builds upon one's advance directive, but for those patients who have no advance directive, it can also function in the absence of a directive if the patient has decisional capacity, or if state law provides a default surrogate for patients without an appointed proxy.

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<sup>12</sup> Out-of-hospital DNR protocols exist by statute or regulation in every state except Minnesota, Mississippi, and North Dakota. Susan E. Hickman, Charles P. Sabatino, Alvin H. Moss, & Jessica Wehrle Nester, "The POLST (Physician Orders for Life-sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation" 31 J. Law, Med. & Ethics 119, 122 (Spring 2008).

<sup>13</sup> The core requirements for a POLST protocol, as stated by the national POLST Paradigm Initiative can be found at < <http://www.ohsu.edu/polst/corereqs.shtml> >.

An important characteristic of POLST is that it is outcome neutral. It is not focused only on stopping medical interventions. It provides options for declining treatment, requesting aggressive treatment, and for gradations in between.

A growing literature supports the efficacy of the POLST approach in honoring and communicating patient's wishes.<sup>14</sup> For example, in a chart review study conducted in nursing facilities in two eastern Washington counties approximately 6 months after implementation of the POLST program in Washington State, POLST forms were found in 21 charts at these facilities. Chart reviews and analysis of interviews with staff and residents/surrogates found evidence that the POLST form accurately conveyed treatment preferences 90% of the time. Most charts contained documentation regarding an informed consent process (76%) and there was evidence that resident's wishes were honored in a majority of cases (90%). When patients had advance directives in their charts, the POLST form was congruent with the advance directive 100% of the time.<sup>15</sup>

In another study, emergency medical technicians in Oregon reported that the POLST form provides clear instructions about patient preferences, and is useful when deciding which treatments to provide.<sup>16</sup> In contrast to the single intervention focus of out-of-hospital do-not-resuscitate (DNR) orders, the POLST form provides patients the opportunity to document treatment goals and preferences for interventions across a range of treatment options, thus permitting greater individualization.<sup>17</sup>

The National Quality Forum and other experts have recommended nationwide implementation of the POLST Paradigm.<sup>18</sup> Since Oregon's development of the POLST form, a total of eight states have taken legislative or regulatory steps to implement POLST-like protocols and parts of several other states have done so on a local basis, although the name of the protocol

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<sup>14</sup>Patrick Dunn, et al, "A Method to Communicate Patient Preferences about Medically Indicated Life-sustaining Treatment in the Out-of-Hospital Setting," 44 *J. Am. Geriatr Soc.* 785–791 (1996); M.A. Lee et al., "Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program - Program of All-Inclusive Care for the Elderly," 48 *J. Am. Geriatr. Soc.* 1343–1344 (2000); Susan W. Tolle, et al., "A Prospective Study of the Efficacy of the Physician Order Form for Life-Sustaining Treatment," 46 *J. Am. Geriatr. Soc.* 1097–1102 (1998).

<sup>15</sup> J. L. Meyers et al., "Use of the Physician Orders for Life-Sustaining Treatment (POLST) Form to Honor the Wishes of Nursing Home Residents for End of Life Care: Preliminary Results of a Washington State Pilot Project." 30 *J. of Gerontological Nursing* 37-46 (2004).

<sup>16</sup> Terri A. Schmidt et al., "The Physician Orders for Life-Sustaining Treatment Program: Oregon Emergency Medical Technicians' Practical Experiences and Attitudes," 52 *J. Am. Geriatr. Soc.* 1430–1434 (2004)..

<sup>17</sup> Susan E. Hickman et al., "Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon Nursing Facilities: Beyond Resuscitation Status," 52 *J. Am. Geriatr. Soc.* 1424–1429 (2004).

<sup>18</sup> National Quality Forum, A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report, 2006, at 43. A. Kellerman & J. Lynn, "Withholding Resuscitation in Prehospital Care," 144 *Annals of Internal Medicine* 692-693 (2006); L. C. Hanson & M. Ersek, "Meeting Palliative Care Needs in Post-Acute Care Settings," 295 *JAMA* 681-686 (2006); D. Casarett, J. Kapo, & A. Caplan, "Appropriate Use of Artificial Nutrition and Hydration – Fundamental Principles and Recommendations," 352 *New England J. of Medicine* 2607-2612 (2005); International Liaison Committee on Resuscitation, American Heart Association, European Resuscitation Council, "Interdisciplinary Topics," 112 *Circulation* 100-108 (Supplement 2005); S. J. Baumrucker, Editorial, "Physician Orders for Scope of Treatment: An Idea Whose Time Has Come," 21 *Am. J. of Hospice and Palliative Med.* 247-248 (2004).

varies. West Virginia calls it *Physicians Orders for Scope of Treatment* or “POST”; New York calls it *Medical Orders for Life-Sustaining Treatment* or “MOLST.”<sup>19</sup> **Table 1** summarizes the legislative and regulatory actions these eight states have taken to institute some version of POLST.

In many ways, the POLST protocol represents a sea change in advance care planning policy by making key provider communications reflecting the plan of care highly visible and clinically routine and coupling elicitation of treatment preferences and goals with orders for care, rather than focusing solely on standardizing patient communications. The POLST paradigm has the additional advantage of being fairly adaptable in the face of variable state law. For example, it has been implemented both with detailed legislation (as in West Virginia<sup>20</sup>) and without legislation through provider collaboration (as in Oregon<sup>21</sup>).

A recent study of potential legal and regulatory barriers to POLST identified several potential barriers to a national implementation of the POLST paradigm program.<sup>22</sup> The most potentially problematic barriers were highly detailed state requirements for out-of-hospital DNR orders that are so narrowly focused on DNR orders as to be incompatible with addressing a broader range of clinical interventions as is done by the POLST form. Other barriers, such as witnessing requirements in state law, have a significant impact on the complexity and cumbersomeness of implementing a POLST program, but do not absolutely preclude its use.<sup>23</sup> Another state law variation that makes a difference is the authority of default family surrogates where the patient has named no health care agent. In states where this is clearly recognized, surrogate consent on a POLST form is permissible. In states where the authority of a default surrogate is limited or unclear, states will at least have to clarify how surrogate consent will apply to POLST.<sup>24</sup> A POLST program can be implemented without permitting default surrogate consent, but it will limit the number of cases in which POLST can be used.

It is important to understand that the POLST paradigm does not change state health decisions law regarding the definition of capacity to make health care decisions, who is authorized to consent to health care on behalf of an incapacitated patient, and the standard of decision-making an agent or surrogate must follow. It operates within those parameters. However, with respect to the array of other potential legal issues identified in the study, states interested in developing a POLST program will need to review the compatibility of existing laws with the POLST program and follow, amend, or adapt accordingly.

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<sup>19</sup> For more about the WV form, see <[http://www.hsc.wvu.edu/chel/ad\\_forms/WVHA\\_POST\\_form\\_disc.htm](http://www.hsc.wvu.edu/chel/ad_forms/WVHA_POST_form_disc.htm)>, 2007); see also, [http://www.hsc.wvu.edu/chel/wvi/faq\\_post.htm](http://www.hsc.wvu.edu/chel/wvi/faq_post.htm). The National POLST Paradigm Initiative reports POLST programs in parts of Georgia, Kansas, Missouri, New Mexico, Utah, Washington, West Virginia, Wisconsin, New York, and Pennsylvania. Information on POLST development is also available at <<http://www.polst.org>>.

<sup>20</sup> W. Va. Code Ann. §16-30-1 to -25 (West 2007).

<sup>21</sup> See Patrick Dunn et al., “A Method to Communicate Patient Preferences About Medically Indicated Life-Sustaining Treatment in the Out-of-Hospital Setting,” 44 *J. Am. Geriatr. Soc.* 785-791(1996).

<sup>22</sup> Susan E. Hickman, Charles P. Sabatino, Alvin H. Moss, & Jessica Wehrle Nester, *The POLST (Physician Orders for Life-sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation* 31, *J. Law, Med. & Ethics* 119 (Spring 2008).

<sup>23</sup> *Id.*

<sup>24</sup> *Id.* See Table 1 and Appendix.

### **III. Contents of the Recommendation**

This recommendation urges the state, territorial, and federal governments, as well as health care providers, to establish and support decision-making protocols such as POLST in order to ensure that the wishes of those who have advanced chronic progressive illness are appropriately translated into visible and portable medical orders that address higher probability medical contingencies such as hospitalization, cardiopulmonary resuscitation, artificial nutrition and hydration, antibiotics, and ventilation. POLST is an evolving and malleable protocol, so the recommendation is not intended to promote a highly detailed set of specifications for such protocols. Moreover, the recommendation does not specify whether states should enact specific legislation or solely rely on regulatory strategies or provider consensus strategies. As noted above, the legal landscape is different in every state and must be reviewed in each state.

An instructive benchmark for any effort to establish a POLST protocol are ten core requirements, defined by a national POLST Paradigm Initiative Task Force and available at: <http://www.ohsu.edu/polst/corereqs.shtml> .

The core requirements listed are:

1. The POLST form constitutes a set of medical orders
2. The process includes training of health care professionals across the continuum of care about the goals of the program as well as the creation and use of the form
3. Use of the form is recommended for persons who have advanced chronic progressive illness, those who might die in the next year or anyone wishing to further define their preferences of care
4. The form requires a valid Physician (Nurse Practitioner or Physician Assistant accepted depending upon program) signature and date of signature
5. The form may be used either to limit medical interventions or to clarify a request for all medically indicated treatments including resuscitation
6. The form provides explicit direction about resuscitation status if the patient is pulseless and apneic
7. The form also includes directions about other types of intervention that the patient may or may not want. For example, decisions about transport, ICU care, antibiotics, artificial nutrition, etc.
8. The form accompanies the patient, and is transferable and applicable across care settings (i.e. Long term care, EMS, hospital)
9. The form is uniquely identifiable, standardized, uniform color within a state/region
10. There is a plan for ongoing monitoring of the program and its implementation

The Task Force also lists the following issues as matters to be handled by states in different ways depending on state law and local preferences.

1. Ideally, a surrogate should be able to make decisions about treatment choices for a patient without decision-making capacity, but states have varying laws regarding surrogates and decision making.
2. Some states may recognize the form as the only out-of-hospital DNR form; in others there may be other means of DNR ID as well. Use of the form is always voluntary.
3. Ideally, states would accept forms completed in other states (reciprocity).

## **IV. Need for ABA Action**

The ABA stands in a unique position as a major spokesperson for the legal profession in the United States. Where legal barriers stand in the way of the individual's right to have his or her reasonable expectations about quality end-of-life care known and respected, the ABA best serves the public and its own Goal III, "To provide ongoing leadership in improving the law to serve the changing needs of society."

States, territories, health care providers, and the federal government all have important roles in establishing and supporting POLST type protocols. While most efforts have been at the state legislative level, it is appropriate to call on federal as well as state officials to take appropriate action to support the states. Congress and Centers for Medicare and Medicaid Services ("CMS") have a direct role in health care standard setting. Congress and/or CMS can, for example, require providers who participate in the Medicare and Medicaid programs to develop protocols to translate chronic care patients' care goals into easily identifiable, portable, and reviewable medical orders that follow the patient across care settings, consistent with state law. Such protocols could address resuscitation status and other key interventions that the patient may or may not want, such as decisions about transport, ICU care, antibiotics, and artificial nutrition. Such a mandate would push the field forward, yet give states considerable leeway in developing their own version of a POLST type protocol.

## **V. Related ABA Policy**

The ABA has been active in the promotion of health care decision-making policies that promote the individual's decision-making autonomy and quality end-of-life care. In 1989, the House of Delegates adopted policies to encourage the use and recognition of durable powers of attorney for health care. In 1990, the House adopted a policy to support the right of competent individuals to consent to or refuse suggested medical interventions and to recognize that an appropriate surrogate may exercise this right on behalf of an incompetent individual. The ABA also actively supported passage of the Patient Self-Determination Act in 1990, the federal law that promotes information and education on advance directives. In 1994 the ABA recognized a new Uniform Health-Care Decision-Making Act, promulgated by the National Conference of Commissioners on Uniform State Laws.

In 1999 the ABA, through its Commission on Legal Problems of the Elderly, released a national survey of State Emergency Medical Services Do-Not Resuscitate Protocols in order to provide a clear comparative baseline for policy development.

In July 2000 the ABA adopted a resolution urging state, federal, and territorial governments to remove legal impediments to quality pain and symptom management, and to support a right to effective pain and symptom evaluation, management, and ongoing monitoring as part of basic medical care. In furtherance of this policy, the ABA petitioned the Health Care Financing Administration (now CMA) in 2001 to make clear that the Patient Self-Determination Act should be interpreted to require disclosure of a patient's right to effective pain and symptom management.

This current policy recommendation is in accord with past and present ABA policy and serves to move the policy field forward to the next critical step— that of translating patient wishes into visible, effective, and portable medical orders addressing end-of-life medical contingencies most likely to be faced by seriously chronically ill patients in the here and now.

Respectfully submitted,

Joseph D. O'Connor, Chair  
August 2008



Figure 1. Sample POLST Form from Washington State

Actual size is 8.5 x 11 inches. Reverse of form not shown.

The form is always a bright color.

The POLST form converts patient treatment wishes into medical orders.

In any section left unmarked, the highest level of treatment must be provided.

Decisions about the use or limitation of antibiotics may be decided in advance or on a case-by-case basis.

A brief summary of the patient's health status gives other providers a context for these orders.

A discussion about treatment preferences is required when completing the POLST form.

A physician must sign the POLST form, but the form may be completed by a nurse, social worker or other health care team member. In Oregon, it may also be signed by a nurse practitioner. The person who prepares the form is encouraged to sign the back of the POLST (not shown).

Copyright promotes the use of a standardized version of this form.

The original form should accompany the patient on transfer and remain with the patient where they reside.

### Physician Orders for Life-Sustaining Treatment (POLST)

This is a Physician Order Sheet. Based on patient/resident wishes and medical indications, it summarizes any Advance Directive. Any part not completed indicates full treatment for that part. When need for resuscitation occurs, first follow these orders, then contact physician. The purpose of Parts B, C, and D are to provide physician orders on end of life care as patients move through the various health care settings. Notify physician of any significant change in medical condition.

	Last Name of Patient/Resident
	First Name/Middle Initial of Patient/Resident
	Patient/Resident Date of Birth

#### Physician Orders for Life-Sustaining Treatment

<b>Part A</b> check one box only	<b>Resuscitation.</b> Patient/resident has no pulse and is not breathing. For all other medical circumstances, refer to "Part B, Medical Interventions." <input type="checkbox"/> Resuscitate <input type="checkbox"/> Do Not Resuscitate (DNR)								
<b>Part B</b> check one box only	<b>Medical Interventions.</b> Includes Emergency Medical Services. Patient/resident has pulse and/or is breathing. <input type="checkbox"/> <b>Comfort Measures Only.</b> Oral and body hygiene, reasonable efforts to offer food and fluids orally. Medication, positioning, wound care, warmth, appropriate lighting and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient/resident. Transfer only if comfort measures fail. <input type="checkbox"/> <b>Limited Interventions.</b> All care above and consider oxygen, suction, treatment of airway obstruction (manual only). <input type="checkbox"/> <b>Advanced Interventions.</b> All care above and consider oral/nasal airway, bag-mask/demand valve, monitor cardiac rhythm, medication, IV fluids. <input type="checkbox"/> <b>Full Treatment/Resuscitation.</b> All care above plus CPR, intubation and defibrillation. <input type="checkbox"/> <b>Other Instructions:</b>								
<b>Part C</b> check one box only	<b>Antibiotics (notify physician of new infection)</b> <input type="checkbox"/> No antibiotics except if needed for comfort <input type="checkbox"/> No invasive (IM/IV) antibiotics <input type="checkbox"/> Full Treatment <input type="checkbox"/> <b>Other Instructions:</b>								
<b>Part D</b> check one box only	<b>Artificially Administered Fluids and Nutrition.</b> Oral fluids and nutrition must be offered if medically feasible. <input type="checkbox"/> No feeding tube/IV fluids (provide other measures to assure comfort) <input type="checkbox"/> No long term feeding tube/IV fluids (provide other measures to assure comfort) <input type="checkbox"/> Full Treatment <input type="checkbox"/> <b>Other Instructions:</b>								
<b>Part E</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>Discussed with:</b> <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Agent of Durable Power of Attorney <input type="checkbox"/> Court-appointed Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Specify)</td> <td style="width: 50%;"><b>The Basis for These Orders Is: (circle all that apply)</b> <input type="checkbox"/> Patient's request    <input type="checkbox"/> Patient's known preference <input type="checkbox"/> Patient's best interest    <input type="checkbox"/> Medical futility</td> </tr> </table>	<b>Discussed with:</b> <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Agent of Durable Power of Attorney <input type="checkbox"/> Court-appointed Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Specify)	<b>The Basis for These Orders Is: (circle all that apply)</b> <input type="checkbox"/> Patient's request <input type="checkbox"/> Patient's known preference <input type="checkbox"/> Patient's best interest <input type="checkbox"/> Medical futility						
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Physician Name (print)</td> <td style="width: 30%;">Physician Signature (mandatory)</td> <td style="width: 10%;">Phone</td> <td style="width: 20%;">Date</td> </tr> <tr> <td colspan="2">Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)</td> <td colspan="2">Date</td> </tr> </table>		Physician Name (print)	Physician Signature (mandatory)	Phone	Date	Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)		Date	
Physician Name (print)	Physician Signature (mandatory)	Phone	Date						
Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)		Date							

Revised 12/2/01

ORIGINAL FORM MUST ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED




Table 1. POLST States

State	Statute	Regulation/Guideline
<p><b>Idaho</b> Idaho Code Ann § 39-4501 to -4515</p> <p>Enacted 2007. Eff. July 1, 2007</p>	<p>Comprehensive "Medical Consent and Natural Death Act" incorporated Physicians Orders for Scope of Treatment (POST)</p>	<p>Guidelines published by the EMS Bureau, Idaho Department of Health and Welfare: <a href="http://www.healthandwelfare.idaho.gov/site/3344/default.aspx">http://www.healthandwelfare.idaho.gov/site/3344/default.aspx</a></p>
<p><b>Maryland</b> Md. Code Ann. [Health-Gen.] §5-601 to –618, specifically, 5-602(f); 5-608.1; 5-619; and 19-344</p> <p>Enacted 2004 (changed name of form in 2007)</p>	<p>Comprehensive Health Care Decisions Act, incorporated "Instructions on Current Life-Sustaining Treatment Options" (the Maryland version of POLST)</p>	<p>Guidelines: Md. Inst. for EMS Systems. See: <a href="http://www.miemss.org/home/PublicInformation/DNRDoNotResuscitate/tabid/118/Default.aspx">http://www.miemss.org/home/PublicInformation/DNRDoNotResuscitate/tabid/118/Default.aspx</a></p>
<p><b>New York</b> N.Y. Pub. Health Law § 2977 (13) (McKinney 2007) Amendment to DNR Statute Oct. 11, 2005</p> <p>Statewide use Jan. 2006</p>	<p>Provision in Out-of-hospital DNR law permitted a pilot program in two counties, Monroe and Onondaga., using "Medical Orders for Life-Sustaining Treatment" (MOLST)</p>	<p>MOLST was developed in two counties. See: <a href="http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center">http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center</a></p> <p>The form was subsequently approved in January 2006 by the NYS Department of Health (NYSDOH) for use as an institutional DNR in ALL health care facilities throughout New York State. See: <a href="http://www.health.state.ny.us/professionals/nursing_home_administrator/docs/dcl_molst.pdf">http://www.health.state.ny.us/professionals/nursing_home_administrator/docs/dcl_molst.pdf</a></p> <p>It is not yet approved for use in community settings, except in the two pilot counties.</p>
<p><b>North Carolina</b> NCGS § 90-21.17, Eff. October 1, 2007,</p>	<p>Amended DNR statute to recognize "Medical Orders for Scope of Treatment" (MOST)</p>	<p>Dept. of Health and Human Services, Office Of Emergency Medical Services, adopted a MOST form and procedure, Implementation date January 1, 2008: <a href="http://www.ncdhhs.gov/dhsr/EMS/dnrmost.html">http://www.ncdhhs.gov/dhsr/EMS/dnrmost.html</a></p>
<p><b>Oregon</b></p>	<p>No statute was</p>	<p>Or. Admin. Rule 847-035-0030 (6).</p>

State	Statute	Regulation/Guideline
No statute Voluntary program since 1991	needed. Developed through consensus process.	Emergency Medical Technicians, First Responders and Supervision Physicians Scope Of Practice ... (6) An Oregon-certified First Responder or EMT, acting through standing orders, shall respect the patient's wishes including life-sustaining treatments. Physician supervised First Responders and EMTs shall request and honor life-sustaining treatment orders executed by a physician or a nurse practitioner, if available. A patient with life-sustaining treatment orders always requires respect, comfort and hygienic care. See: <a href="http://www.ohsu.edu/polst/state/or.shtml">http://www.ohsu.edu/polst/state/or.shtml</a>
<b>Tennessee</b> Tenn. Code. Ann. § 68-11-224  2004 amendment	Amended DNR law to create "universal DNR statute" Does not specifically address POLST, but regulations do.	Board for Licensing Health Care Facilities adopted Physicians Orders for Scope of Treatment (POST) to implement universal DNR statute. See: <a href="http://health.state.tn.us/Boards/AdvanceDirectives/">http://health.state.tn.us/Boards/AdvanceDirectives/</a>
<b>Washington</b> RCWA 43.70.480  Enacted 2000	Amended Dept. of Health/EMS statute to mandate guidelines – including "a simple form that shall be used statewide" - for EMS response to persons with signed writings requesting no "futile emergency medical treatment."	The Department of Health, Office of Emergency Medical Services & Trauma System (OEMSTS) developed the POLST form and program in conjunction with the Washington State Medical Association (WSMA) : <a href="http://www.wsma.org/patient_resources/polst.cfm">http://www.wsma.org/patient_resources/polst.cfm</a>
<b>West Virginia</b>  Amendment to WVC §§16-30C-1 to -16 (DNR law); and §§16-30-1 to -25 (Health Care Decisions Act) Specifically §§16-30-3(u); 16-30-5; and 16-30-25)  Enacted 2002	Do Not Resuscitate Act and Health Care Decisions Act amendment incorporates "Physicians Orders for Scope of Treatment" (POST)	Guidelines: Provided by the WV Center for End-of-Life Care at: <a href="http://www.hsc.wvu.edu/chel/wvi/forms.html">http://www.hsc.wvu.edu/chel/wvi/forms.html</a> and <a href="http://www.hsc.wvu.edu/chel/wvi/pdf/POSTManual2007comp.pdf">http://www.hsc.wvu.edu/chel/wvi/pdf/POSTManual2007comp.pdf</a>

Prepared by the ABA Commission on Law and Aging, April 2008.

GENERAL INFORMATION FORM

Submitting Entity: Commission on Law and Aging.

Submitted By: Joseph D. O'Connor, Chair.

1. Summary of Recommendation(s).

Urges policymakers and health care providers to ensure that the wishes of individuals with advanced chronic progressive illness are elicited and translated into a language that health care systems understand, i.e., doctor's orders. The recommended protocol, known as "Physicians Orders for Life-Sustaining Treatment" and by other names, focuses on here-and-now, high-probability, critical decisions rather than theoretical decisions that could occur in the distant future. It does not eliminate the need for health care advance planning and advance directives. Rather, it complements advance care planning by ensuring that care plans addressing a high probability set of life-support interventions for seriously ill patients are discussed, informed by the patient's wishes, and reflected in a highly visible set of medical orders that follow the patient across care settings, and are adjusted to the patient's current health care conditions as needed.

2. Approval by Submitting Entity.

The resolution was approved at the regular meeting of the Commission on Law and Aging on January 18, 2008. Co-sponsors as of June 3, 2008, include the Section on Real Property, Trust and Estate Law, the Commission on Mental and Physical Disability Law, and the Senior Lawyers Division.

3. Has this or a similar recommendation been submitted to the House or Board previously?  
No

4. What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?

This recommendation builds upon and is consistent with current ABA policy, which supports:

- The use and recognition of durable powers of attorney for health care (1989).
- The right of competent individuals to consent to or refuse suggested medical interventions and the right of an appropriate surrogate to exercise this right on behalf of an incompetent individual (1990).
- The Uniform Health-Care Decision-Making Act (1994), promulgated by the National Conference of Commissioners on Uniform State Laws.

5. What urgency exists which requires action at this meeting of the House?

There is no current proposed federal legislation specifically addressed by this recommendation, although several members have expressed an interest. State legislatures have been actively considering POLST-type protocols, and so far, a total of eight states have taken legislative or regulatory steps to implement POLST. Parts of several other states have done so on a local basis.

6. Status of Legislation. (If applicable.)  
None pending at this time.
  
7. Cost to the Association. (Both direct and indirect costs.)  
None.
  
8. Disclosure of Interest. (If applicable.)  
Not applicable.
  
9. Referrals.  
  - Standing Committee on Government Affairs
  - Standing Committee on Medical Professional Liability
  - Commission on Domestic Violence
  - Commission on Homelessness and Poverty
  - Commission on Mental and Physical Disability Law
  - Center for Human Rights
  - Government and Public Sector Lawyers Division
  - Senior Lawyers Division
  - Young Lawyers Division
  - Special Committee on Bioethics and the Law
  - Section of Family Law
  - Section of General Practice, Solo and Small Firm
  - Section of Health Law
  - Section of Individual Rights and Responsibilities
  - Section of Real Property, Probate, and Trust Law
  - Section of Administrative Law and Regulatory Practice
  - Section of Science and Technology Law
  - Section of State and Local Government Law
  - Section of Tort, Trial and Insurance Practice
  - Government and Public Sector Lawyers Division
  
10. Contact Person. (Prior to the meeting.)  
 Charles Sabatino, Director, Commission on Law and Aging  
 740 15<sup>th</sup> Street NW, Washington DC, 20005  
 Phone: 202-662-8686. Cell : 202-390-8446  
 E-mail : SabatinoC@staff.abanet.org
  
11. Contact Person. (Who will present the report to the House.)  
 Joseph D. O'Connor, Chair, Commission on Law and Aging  
 E-mail: [joc@lawbr.com](mailto:joc@lawbr.com)  
 Cell : 812-322-1637

## EXECUTIVE SUMMARY

**1. Summary of the Recommendation.**

This resolution Urges policymakers and health care providers to ensure that the wishes of individuals with advanced chronic progressive illness are elicited and translated into a language that health care systems understand, i.e., doctor's orders. The recommended protocol, known as "Physicians Orders for Life-Sustaining Treatment" and by other names, focuses on here-and-now, high-probability, critical decisions rather than theoretical decisions that could occur in the distant future. It does not eliminate the need for health care advance planning and advance directives. Rather, it complements advance care planning by ensuring that care plans addressing a high probability set of life-support interventions for seriously ill patients are discussed, informed by the patient's wishes, and reflected in a highly visible set of medical orders that follow the patient across care settings, and are adjusted to the patient's current health care conditions as needed.

**2. Summary of the issue that the recommendation addresses.**

Health care decision-making law and practice in the last 15 years have moved toward a more flexible, communications approach of *advance care planning*; yet the research has shown that too often patient's wishes are still not known or adequately factored into medical decisions near the end of life. Even for individuals who have executed health care advance directives, patients' wishes and goals too often do not get translated into well thought-out care plans backed by medical orders. A small but growing number of states have recognized that patient wishes and goals, no matter how communicated, must be methodically factored into medical orders if we are to ensure that patients receive care congruent with their wishes and goals. In the early 1990s, Oregon experimented with a protocol for seriously chronically ill patients, called *Physicians Orders for Life-Sustaining Treatment*, or POLST. The protocol requires three steps. First, the treating health care provider must initiate a discussion with the patient or surrogate about a range of appropriate end-of-life care treatment options. The patient's advance directive, if one exists, is an important focus of the discussion. The objective is to discern the wishes of the patient in light of his or her *current* condition. Two, the patient's wishes must be incorporated into a set of standardized doctor's orders that are recorded on a unique, visible (brightly colored) form that serves as a cover sheet to the medical record and is reviewed periodically. And three, providers must ensure that the POLST form travels with the patient whenever transfers from one setting to another are made, thus, promoting continuity of care decisions.

**3. Please explain how the proposed policy position will address the issue.**

In most states, the POLST approach necessitates a legislative or regulatory change. Currently, a total of eight states have taken legislative or regulatory steps to implement POLST. This recommendation urges all states to take the necessary steps. As the federal government considers the applicability of POLST to Medicare and Medicaid providers, this recommendation puts the ABA on record in support of moving forward to that end.

**4. Summary of any minority views or opposition that have been identified.**

None to date.