

# National POLST: Legislative Guide

## Introduction

Under our system of government, the legal and regulatory framework for advance care planning is delegated to the states. This means each state establishes its own rules about what language is included in an advance directive and whether an out-of-state version of the document is valid. States have similar authority with POLST<sup>1</sup> forms but, unlike with advance directives, there is a national organization—National POLST—that promotes and educates on policies and guides created by of POLST Program leaders.<sup>2</sup>

Although implemented at the state level, POLST is not really a state program: it is a national movement and must consider patients coming into/out of the state wanting to use POLST. POLST exists to provide seriously ill and/or frail patients a tool to communicate their treatment preferences as they transition across care settings or travel throughout the United States. While not solely for emergencies, the POLST form is valuable in communicating to emergency personnel whether the patient wants CPR, advanced respiratory interventions and hospital transport. Therefore, the POLST form itself must be immediately recognizable to all EMS providers and healthcare professionals—and be able to be honored by all—in order to reach its full value to patients.

This Guide is intended to help state policymakers appreciate the role their state can play in helping patients and health care professionals use this important advance care planning tool. It addresses the legal/regulatory questions and issues that have been most recurrent among states implementing POLST Programs and provides preferred approaches to legal/regulatory questions that have been addressed in a variety of ways—by clinical consensus, by adoption of legislation or regulation, and sometimes by guidance from professional associations, states boards or departments of health or POLST leaders. This Guide uses the collective learned experience of states with POLST Programs to provide legislative tips, links to National POLST policies and guidance, strategies and other considerations.

Other POLST legal resources are available [here](#)<sup>3</sup>, including a [state regulatory/legislative comparison](#)<sup>4</sup>.

## Legislative Guide History

Drawing upon the experience of the states that implemented POLST prior to 2013, National POLST, with assistance from two individual members of the American College of Trust and Estate Counsel (ACTEC), convened a legislative working group to review the recurring policy, legislative and regulatory issues and the responses of states developing POLST Programs to those issues. The result of that process was the 2014 POLST Legislative Guide.<sup>5</sup> In 2019, the National POLST State Public Policy Committee updated it since, though all states have now established a POLST Program and made a determination on whether a

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<sup>1</sup> Different programs use different terms; for a full list of names, or to learn what POLST is called in your state, see [www.polst.org/map](http://www.polst.org/map)

<sup>2</sup> Current list of states actively participating in National POLST can be found here: <https://polst.org/plenary-members-state-pdf>

<sup>3</sup> <https://polst.org/resources/legal-and-policy>

<sup>4</sup> <https://polst.org/legislative-comparison-pdf>

<sup>5</sup> Authors of first Legislative Guide (2014) were Margaret Carley, Marilyn J. Maag, Thaddeus M. Pope, Charles P. Sabatino, Amy Vandenbroucke, and Robert B. Wolf.

legislative path is necessary, there are still considerable differences among legislation that could be reduced.<sup>6</sup>

## Key Definitions

“**emergency personnel**” includes first responders and emergency department staff

“**health care professional**” or “**provider**” means any health care professional involved in the POLST process acting with their scope of practice described or limited by license, certification or other method. These guidelines most frequently focus on [health care professionals who have authority to sign POLST forms](#); however, other health care professionals such as nurses, social workers, and chaplains may be part of the care team that supports the POLST process, even though they do not have authorization to execute the POLST medical order.<sup>7</sup>

“**POLST**” is the term now used as a generic identifier for portable medical orders; information about the evolution of the term can be found at [www.polst.org/logo](http://www.polst.org/logo). Throughout this document the generic reference of POLST will be used to refer collectively and individually to state initiatives of this kind and to such things as the POLST form, POLST conversation, POLST program.

“**surrogate**” is a substitute health-care decision-maker. This name for this person varies by state but includes health care agent, patient representative, proxy, etc. The term “surrogate” is used for consistency in this document to describe the person who consents or refuses to consent to some or all medical treatments for the patient who lacks decision-making capacity. We include the following in this definition:

1. an agent named in a legal document as the health care power of attorney<sup>8</sup> or health care proxy (also called a health care agent or representative);
2. a guardian or conservator of the person with health care decision-making powers, a court-appointed surrogate;
3. a surrogate recognized under state law;
4. any other similarly authorized decision-maker, regardless of the terminology used in a particular state; and
5. in the absence of anyone legally appointed, the individual identified by the facility to make decisions on behalf of the incapacitated patient.

Even when the patient appoints the surrogate, questions can still arise as to the extent of the surrogate’s authority. For more information see [Surrogate information](#).

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<sup>6</sup> Authors of the 2019 Legislative Guide revision were Amy Vandenbroucke, Jacob Dahlke, Paul Drager, Lorrie Griego, Cindy Munn, Bruce Smith, Karl Steinberg, and Pat Bomba.

<sup>7</sup> See #6 <https://polst.org/appropriate-use-pdf>

<sup>8</sup> Note, the term “durable power of attorney” refers to a document, not a person. A common error is referring to the agent or surrogate as the “power of attorney.” To be clear, the agent or surrogate *possesses* power of attorney because of the document, but they are *not* the power of attorney. Surrogates acting under a power of attorney are sometimes referred to as the “attorney-in-fact.”

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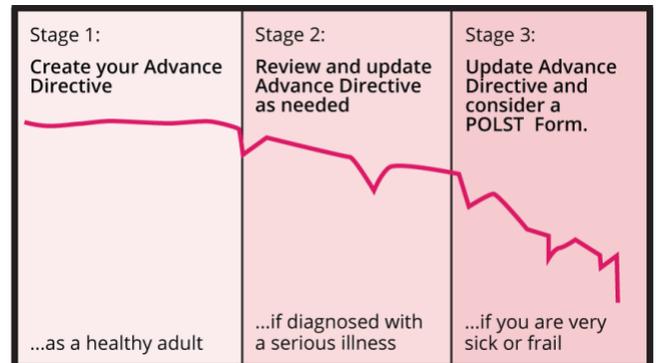
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## Issue 1: Understanding POLST

It is critical for lawmakers to understand and appreciate the operational differences in executing advance care planning documents and medical orders prior to passing any legislation or regulation.

### Issue 1A: What is POLST?

POLST is an approach to advance care planning for patients who are considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.<sup>9</sup> The POLST process emphasizes eliciting, documenting and honoring patients' preferences about the treatments they want to receive during a medical emergency or as they decline in health. These treatment preferences are documented by a provider in a portable medical order called a POLST form.



A POLST form is neither an advance directive nor a replacement for advance directives.<sup>10</sup> However, both advance directives and POLST forms are helpful advance care planning documents for communicating health care decisions when appropriately used. A POLST form consists of a set of medical orders that applies to a limited population of patients and addresses a limited number of critical medical decisions. It was designed to support patients throughout the healthcare continuum as they transition between health care settings (i.e., acute care, post-acute care, long-term care, home care, etc.).

The form is intended as a complement to advance directives in that it serves as a translational tool and a continuity of care assurance. It communicates patient treatment preferences to other providers, including emergency personnel, when the patient lacks the capacity to speak for him/herself. It is not solely for emergencies as it also provides guidance to:

- hospitals for creating in-hospital resuscitation status and other treatment order sets;
- post-acute and/or long-term care facilities to provide medical orders based on goals of care;
- facilities for transfer of care upon discharge; and
- other providers so they can align other treatments not covered by the POLST form they may offer or provide based on the patient's goals of care.

The success of POLST is deceptively simple. It requires:

1. personal, high-quality conversations between health care professionals and patients (or surrogates) about the patient's goals of care considering their current diagnosis, prognosis, and treatment options (including risks and benefits of each)<sup>11</sup>;
2. accurate translation by the health care professionals of those patient treatment preferences into medical orders on a POLST form;
3. the health care professional's ability to know that a POLST exists for a patient, and to easily locate a patient's POLST form when needed; and
4. the health care professional's knowledge about how to correctly interpret and follow POLST form orders, thereby enabling them to honor patient treatment preferences.

<sup>9</sup> <https://polst.org/guidance-appropriate-patients-pdf>

<sup>10</sup> For more information about how POLST forms differ from advance directives or how it fits into advance care planning, visit <https://polst.org/polst-advance-care-planning> and <https://polst.org/about/polst-and-advance-directives>

<sup>11</sup> <https://polst.org/appropriate-use-pdf> (see #3)

### Issue 1B: How do POLST forms differ from advance directives?

A POLST form is neither an advance directive nor a replacement for advance directives.<sup>12</sup> However, both advance directives and POLST forms are helpful advance care planning documents for communicating health care decisions when appropriately used. A POLST form consists of a set of medical orders that applies to a limited population of patients and addresses a limited number of critical medical decisions. The form is intended as a complement to advance directives in that it serves as a translational tool and a continuity of care assurance. There are several key differences between the two:

	POLST Form	Advance Directive
<b>Type of document</b>	Medical Order	Legal Document
<b>Who fills out the document?</b>	Health Care Professional (who can sign varies by state)	Individual/patient
<b>Who needs One?</b>	Any patient considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty	All competent adults
<b>What is communicated?</b>	Specific medical orders and patient's goals of care	General wishes about treatment and values and the surrogate
<b>Can emergency personnel follow the document?</b>	Yes	No
<b>Is the document voluntary?</b>	Yes	Yes
<b>Does it appoint a surrogate?</b>	No	Yes
<b>Can the surrogate complete, change or void the document?</b>	In most states, yes	No
<b>Ease in locating the document?</b>	Should be easy. Copy in medical record and, possibly, in a registry. Patient has original, usually brightly colored, and told to put on refrigerator or in medicine cabinet for emergency personnel to find	May be difficult. Depends on where patient keeps it and if they have: <ul style="list-style-type: none"> <li>• told someone where it is,</li> <li>• given it to their surrogate, or</li> <li>• given it to their health care professional to put in their medical record</li> </ul>
<b>Who is responsible for reviewing?</b>	The health care professional is responsible for periodically reviewing the POLST form with the patient or surrogate	It is up to the individual about how often it is reviewed and/or updated

Advance directives are legal documents executed by patients, often without any input from health care professionals. POLST forms are medical orders executed by authorized health care professionals after conversation with the patient or his/her surrogate. Shared decision-making discussions and advance

<sup>12</sup> For more information about how POLST forms differ from advance directives or how it fits into advance care planning, visit <https://polst.org/polst-advance-care-planning> and <https://polst.org/about/polst-and-advance-directives>

directives should be used to inform health care professionals in how to complete POLST medical orders but the two types of documents are distinct.

There are two common types of advance directives - an appointment of a surrogate (usually with delegated powers) and a healthcare treatment directive, which is commonly referred to as a living will. When these documents are executed in accordance with state laws governing them, they achieve legal status. Advance directives may provide general descriptions of types of treatments patients prefer or wish to avoid. It is not uncommon for those descriptions or instructions to require interpretation in order to adopt a treatment plan for the specific medical situation, especially as the condition(s) progress.

In contrast, a POLST form is a portable a set of medical orders that applies to a limited population of patients and addresses a set of important medical conditions and decisions. Since POLST is intended for patients considered to be at risk for a life-threatening clinical event due to their current life-limiting medical condition, which may include advanced frailty, the orders are completed with specific knowledge about treatment options that considered appropriate for the patient. POLST forms are not only for emergency personnel ,but may be used to guide hospital and facility personnel to create inpatient order sets, guidance for next care locations upon discharge, consideration of hospice enrollment, and other guidance on a patient's goals of care, aiding health care professionals in determining other treatments that may align with the patient's goals of care.

The preferences of patients as expressed in an advance directive may provide only limited assistance in many situations because they do **not**:

1. address the specific here-and-now medical circumstances of the patient;
2. get recorded in the medical record;
3. necessarily follow patients across care settings; and
4. provide guidance for changing conditions where medical orders and clinical protocols must adapt.

These limitations may be particularly evident when emergency first responders are called. First responders generally utilize all available medical rescue interventions, considered standard emergency response, absent a countervailing order by medical control or protocols honoring out-of-hospital Do-Not Resuscitate (DNR) orders or POLST forms. For most individuals, this is acceptable as the emergent episode in unexpected and unanticipated; fitting the definition of emergency response. For patients appropriate for POLST; however, the patient/surrogate and health care professional generally know what medical emergency will likely occur from the known life-limiting medical condition(s) and can decide upon appropriate responses should a medical crisis occur.

Advance directives are important for adults from the age of majority until death to provide guidance to health care decision-making. When the use of a POLST form becomes appropriate, the current advance directive (if it exists) should be reviewed and updated to ensure that the patient's preferences coincide with the patient's condition and that the surrogate is aware of the patient's instructions. If an existing advance directive appears to conflict with currently expressed values and preferences, efforts should be made to resolve the conflict and if appropriate, to complete a new advance directive that is concordant with current wishes and with any POLST form that is created.

A key component of advance care planning is thoughtful, facilitated advance care planning conversations between health care professional, the patient/surrogate and others (e.g., loved ones) involved in the care of the patient. In executing both the appointment of a surrogate and the execution of the advance

directive, the patient should involve, at a minimum, the surrogate in all aspects regarding preferences for treatments and values so as to prepare as fully as possible the surrogate in performing the significant duties that accompany the appointment as surrogate. This will help the surrogate prepare for and be more comfortable in making substitute decisions and best interest shared decisions when necessary.

The thoughtful appointment of a surrogate with delegated authority as prescribed in statute through an advance directive is the most valuable function, ensuring that someone with authority can speak for the person who no longer has decision-making capacity, particularly at the time a POLST form is completed, reviewed, and implemented. Appointment of a surrogate and engaging that individual in a discussion about values is the most crucial for any patient with capacity. The ability to have a continuing discussion around the review of a POLST is best assured if there is a surrogate to continue that conversation if and when the patient no longer has the ability to fully participate.

### Legislation Tip: Do not treat advance directives the same as POLST forms

Legal protections afforded to consumers and patients through advance directives serve to help ensure that vulnerable persons are authentically represented, and treatment preferences/instructions are honored. State laws often address witnessing or notary requirement for patients as individual decisions are not governed by licensure or certifications as are professionals. Requirements about the types of decisions surrogates can make may also be governed by statute, especially to protect persons who may be in need of representation (due to insufficient capacity or competency) by a guardian or conservator. Advance directive laws draw heavily from a legal transactional model that ties validity to formalities similar to those for creating wills, trusts, and other legal instruments.

POLST forms, in contrast, are medical orders usually governed by standard of care for licensed health care professionals subject to the professionals' code of conduct within the scope of practice. The actionable order sets should be concrete, clear, and concerned with the here-and-now. The model for decision-making for POLST is one of shared decision-making via direct engagement with health care professionals. Most formalities required of advance directives hinder rather than help such a model, because they cast the process into an implicitly adversarial context with an emphasis on legal formalities rather than good communication.

Legislation or regulation requiring that, in the event of a conflict, the more recently completed document between a POLST form and advance directive should followed during a medical crisis inappropriately conflates POLST forms and advance directives and may compromise patient autonomy. This is problematic because the requirement:

1. Ignores that these documents don't convey the same information to emergency personnel. A POLST form is a medical order that gives emergency personnel immediately actionable, specific medical orders to follow. Emergency responders cannot honor an advance directive: it is not a medical order, it is vague and it requires interpretation to develop a treatment plan.
2. Requires emergency personnel to spend critical time reviewing documents for completion dates while they are also providing the patient with standard care<sup>13</sup>, which may not be what the patient wanted.
3. Devalues POLST. The process for completing a POLST form gives it higher credibility in reflecting the most recent patient treatment wishes than an advance directive. POLST forms are credible

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<sup>13</sup> Standard of care or standard care is a legal term used to indicate the degree of care the average, prudent health care professional should exercise under the circumstances. In a medical emergency, it typically means doing everything medically appropriate and possible to attempt to save someone's life.

precisely because they are medical orders based on shared, informed decision making between patients and health care professionals based on the patient's current medical condition. POLST forms are created and documented in medical records by health care professionals. In contrast, advance directives are created by patients, often without health care professional assistance. A patient can complete one without any information about the choices and how the treatments may impact them; patients are also responsible for providing updated versions to their health care professionals and designated surrogates.

4. Causes confusion. Patients with good intentions likely are unaware that if they create or update an advance directive that conflicts with their POLST orders, it voids the previously executed POLST form. The patient and health care professional may both be unaware of the unintended consequence that the medical order—the POLST form—is now invalid.

### Issue 1C: How do POLST forms differ from Do-Not-Resuscitate (DNR) orders?

A DNR order (also known as a do-not-attempt resuscitation [DNAR] order, or an order to allow natural death [AND]) indicates that a health care professional has issued an order based on the patient's decision to forgo resuscitation in the event of a cardiac or respiratory arrest. By allowing patients to also affirm they **do** want a resuscitation attempt in the event of a cardiac arrest, POLST forms expand traditional DNR orders for patients in- and out-of-hospital settings who need more explicit order sets to ensure treatments match their conditions and honor their treatment preferences.

Some state laws regarding DNR orders only apply when the patient is not in an acute setting (out-of-hospital) and is limited to only those patients already in cardiac arrest or have stopped breathing. Patients who suffer from serious illness may not benefit from or desire full-resuscitation rescue attempts and therefore should have orders that address those situations that are short of a cardiopulmonary arrest. This step beyond DNR is the crux of POLST.

Neither a DNR order nor a POLST form with only Section A (the section providing orders about resuscitation) completed provides that more detailed time-sensitive, critical information. Additionally, the literature indicates not all people who agree to a DNR order want or can benefit from full-treatment interventions if they are in crisis. Section B of the POLST form provides select (limited) interventions and comfort-focused treatment that can be determined as appropriate along with "additional orders" to make them specific for each patient.<sup>14</sup> It is Section B that provides direction about treatment preferences to emergency personnel and other health care professionals in situations short of full cardiac and respiratory arrest. This section communicates the patient's treatment goals, which can help health care professionals align other treatment decisions not covered by the form to the patient's goals.

### Legislation Tip: Do not require DNR orders in addition to a POLST form

Requiring the use of an additional DNR order when the patient already has a POLST indicating a DNR preference is problematic for several reasons:

1. By increasing the administrative time and effort of completing two medical orders saying the same thing, an incentive may be created for the health care professional to not offer patients one, either or both, depriving the patient of their opportunity to share their more detailed treatment preferences using a POLST form.

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<sup>14</sup> A majority of individuals with DNR orders requested some other form of life-extending treatment. Hickman, S. E., Tolle, S. W., Brummel-Smith, K. and Carley, M. M. (2004), Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon Nursing Facilities: Beyond Resuscitation Status. *Journal of the American Geriatrics Society*, 52: 1424–1429. doi:10.1111/j.1532-5415.2004.52402.

2. It can create moral distress for first responders if they have a POLST form clearly indicating DNR orders, but they don't have the other required DNR order.
3. It creates additional work for patients and their caregivers to keep track of multiple documents.

### Issue 1E: How does POLST differ from Medical Aid In Dying?

A fundamental difference between POLST and medical aid in dying is the patient's intent. POLST is a medical order reflecting the patient's treatment wishes when they—at any age—are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty<sup>15</sup>. In contrast, medical aid in dying statutes reflect the patient's intent to deliberately end their life.

In contrast to POLST, medical aid in dying legislation only exists in some states. Under this legislation, a physician, at the request of a patient diagnosed as terminal, may write a prescription for a lethal amount of medication that the patient self-ingests with the intention of causing death. Patients may choose this practice only in states where medical aid in dying legislation or a court decision make this option available.

National POLST recognizes that allowing natural death to occur is not the same as providing a lethal prescription to intentionally cause death. Though a patient availing themselves of the medical aid in dying law in their state may also have a POLST form, neither National POLST nor any POLST Program or form allows medical aid in dying, nor does either authorize a health care professional to prescribe medication that would intentionally shorten life.

See National POLST's Policy on this topic at: <https://polst.org/dwd-pdf>

## Issue 2: Defining Patients Appropriate for POLST

### Issue 2A: Who is POLST intended for?

POLST is intended for patients—of any age—who are considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.<sup>16</sup> National POLST created guidance to help health care professionals identify appropriate patients.<sup>17</sup>

#### Legislation Tip: Do not limit patient access to POLST based on terminal diagnosis

Limiting POLST access to only those patients diagnosed as terminal is problematic for two reasons.

1. A terminal diagnosis is somewhat subjective and arbitrary. Health care professionals don't like diagnosing a patient as terminal and patients don't like hearing a terminal diagnosis, which may deprive some patients from appropriate POLST completion.
2. Requiring a terminal diagnosis ignores patients with advanced frailty<sup>18</sup> who are part of the intended POLST population. National POLST guidance includes patients who "have had multiple unplanned hospital admissions in the last 12 months, typically coupled with increasing frailty, decreasing function, and/or progressive weight loss." Clinically, though not meeting criteria for a terminal diagnosis<sup>19</sup>, these patients are appropriate for POLST.

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<sup>15</sup> <http://polst.org/guidance-appropriate-patients-pdf>

<sup>16</sup> <http://polst.org/guidance-appropriate-patients-pdf>

<sup>17</sup> <http://polst.org/guidance-appropriate-patients-pdf>

<sup>18</sup> indicating a combination of advanced chronic disease and/or advanced age with significant weight loss and functional decline

<sup>19</sup> For context, a terminal diagnosis as required for Medicare Hospice Benefit eligibility is a six-month-or-less life expectancy.

## Issue 2B: Why is it inappropriate for healthy patients to use POLST?

A fundamental component of the POLST process is the conversation between the patient and their health care professional(s) prior to the completion of a POLST form that is specific to that patient. POLST provides the opportunity for that patient to discuss *their* goals and values, to understand the benefits and burdens of treatment options available to them in the context of *their* specific medical condition, diagnosis, and prognosis. And to be a partner in making *their* treatment decisions. Healthy individuals cannot have such a specific conversation because they are healthy.

For individuals not yet diagnosed with serious life-limiting illness, using all available medical rescue measures is considered “standard care” during a trauma event or medical crisis. This is the default response and no POLST form is needed for the individual to receive it.

Additionally, there have been efforts to bring legislation<sup>20</sup> explicitly prohibiting a surrogate decision-maker from changing expressed treatment preferences for a patient who has lost decision-making capacity. As an example, if a healthy 55-year-old goes in for a colonoscopy and signs a form saying they would want standard care (i.e., all generally available interventions, including CPR and intubation) in the event of a complication—and subsequently loses decision-making capacity some years later (e.g., from advanced dementia), a surrogate would not be able to request DNR orders if the patient were diagnosed with widely metastatic cancer, short of obtaining a court order. Hence, completing a full-code POLST for a non-seriously-ill patient who merely wants standard care will create a potential or actual conflict later if a surrogate—however accurately and appropriately—requests a change in the treatment preferences. This represents yet another reason why POLST forms should not be completed for reasonably healthy individuals who want standard care, and who, like most people, want their surrogates to be able to speak for them (with or without an advance health care directive) in the event they lose decisional capacity.

## Issue 2C: Isn't a POLST form appropriate for every nursing home resident?

No. It is wrong to assume all residents in any healthcare or residential facility be deemed an appropriate candidate for POLST or be offered a POLST conversation or form. Doing so may result in offering a POLST discussion to a relatively healthy adult with acute convalescence who needs to be placed in a nursing home for a limited period of therapy before returning to the community with a goal of full recovery. Moreover, some nursing facilities essentially mandate POLST completion as part of the standard admission packet. This kind of policy, whether official or merely customary, violates the central tenet that POLST completion should always be voluntary.

Since the implementation of Centers for Medicare and Medicaid Services (CMS) guidance regarding residents' rights on refusal of care, advance care planning directives and the updated requirements of nursing homes to adopt policies dealing with cardiopulmonary resuscitation status, along with CPR-certified staff available at all times to respond, POLST forms have received considerable attention as a possible remedy. However, not all residents are appropriate for POLST, and the execution of a POLST document must be voluntary. These competing issues may pose challenges to facility personnel and POLST advocates. Other types of documentation memorializing patients' advance care planning conversations and treatment preferences can and should be used in place of POLST for those patients who are not appropriate for POLST.

Federal nursing facility regulations require that nursing home facilities conduct a “comprehensive assessment” upon resident admission. This assessment should include consideration of the

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<sup>20</sup> As an example, see California's proposed AB 937, <https://legiscan.com/CA/text/AB937/id/1559715>

appropriateness of POLST as part of advance care planning. But caution should be exercised to make sure POLST is not reduced to a checklist as part of the admissions process. It is critical that facilities offering POLST to appropriate residents implement policies and procedures to ensure that meaningful POLST conversations are occurring with an appropriately trained professional whenever a POLST form is offered or completed.

### **Issue 2D: Should specific medical preconditions be required for a POLST form?**

No; the preferred approach is for POLST to be available to anyone meeting the above clinical description. Where state law limits the types of decisions that individuals and their health care teams can enter into under advance directive statutes, clear distinctions between patient-initiated directives and health care professional-initiated medical orders should be carefully reviewed with policymakers and legislators. Distinctions should be clearly delineated so patients' rights and medical practice is not compromised.

Limitations in state law applicable to living wills should not be applied to a POLST Program, and these limitations on advance health care directives should also be reevaluated over time in light of the fundamental liberty interests of the patient to receive care and treatment that is consistent with their goals and values, honors their dignity, and avoids unwanted, intrusive and burdensome care.

For example, in order for a living will to be operational in Pennsylvania, the patient must be incompetent, and either must be permanently unconscious or be suffering from an end-stage medical condition, a term similar to "terminal condition", but without express or implied reference to prognosis. A POLST, however, is not an advance directive or a living will (one type of advance directive) but an actionable medical order addressing the patient's current condition. A living will, in contrast, is a directive or statement providing guidance about treatment decisions about future end-stage medical conditions or permanent unconsciousness. In some states' living will laws, restrictions on when a living will becomes effective may exist to address unintended consequences of medical instructions given by lay persons long before life-threatening circumstances are known.

State out-of-hospital DNR order statutes may contain medical preconditions for the issuance of out-of-hospital DNR orders.<sup>21</sup> Since POLST forms include an order to either attempt CPR or not attempt CPR, the presence of specific medical preconditions for such DNR orders under state law may create a barrier or inconsistency with respect to the POLST form. Further, in some states, state law dictates the details of out-of-hospital DNR orders and prohibits adding additional orders.<sup>22</sup>

## **Issue 3: Legislation is not Required to Establish POLST in a State**

### **Issue 3A: What federal legislation or regulation exists related to POLST?**

None. Under our system of government, advance care planning is delegated to the states. This means each state establishes its own rules about what specific language is included in an advance directive or POLST form and whether an out-of-state version of the document is valid. Unlike advance directives, however, there is a national organization—National POLST—that has established standards for POLST implementation.

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<sup>21</sup> Do Not Attempt Resuscitation (DNAR) and Allow Natural Death (AND) have emerged as preferred alternative terms to DNR, but the majority of state laws still use the term DNR.

<sup>22</sup> See *supra* note 2.

Although implemented at the state level, POLST is a national movement and state leaders should consider whether and how their laws, regulations and policies support patients coming into or leaving their state for care who want to use POLST.

A POLST form consists of a set of medical orders that applies to a specific population of patients and addresses a limited number of critical medical decisions. It was designed to support patients throughout the health care continuum as they transition between health care settings (i.e. acute care, sub-acute care, post-acute long-term care, home care, etc.). POLST forms communicate a limited number of critical medical decisions, namely the use of CPR and mechanical ventilation, to other health care professionals, including emergency personnel (EMS), when the patient lacks the capacity to speak for themselves. Not solely for emergencies, POLST forms also provide guidance to:

- hospitals for creating in-hospital resuscitation status and other treatment order sets;
- facilities for transfer care upon discharge; and
- other health care professionals. By providing goals of care statements, the POLST form assist other health care professionals coordinate treatments that align with the patient's preferences.

POLST form itself must be immediately recognizable to all EMS providers and healthcare professionals—and be understood and able to be honored by all—in order to reach its full value to patients.

### Legislation Tip: Follow National POLST Policies and Guidance

POLST is a grassroots movement started by health care professionals and that's why it is important to have state leaders participating in National POLST, helping build consensus about what *should* be required or encouraged related to POLST implementation. Through its governance body including state leaders, National POLST establishes standards for POLST implementation, including processes and forms, through consensus.

State legislation or regulations inconsistent with national POLST standards and guidance or that lack flexibility may potentially harm patients crossing state lines (into or out of the state) or who live on a state border and may prove counterproductive to the intent of POLST, possibly harming the overall movement.

Policymakers should understand the consequences to patients if deviating from or ignoring national policies or standards, including the real likelihood of patients unable to have their form—therefore treatment wishes—honored. There is no benefit in making POLST more difficult or confusing for patients and health care professionals to use.

### Issue 3B: Is legislation required to establish POLST?

No. Each coalition must evaluate both legislative and non-legislative approaches in light of the prevailing norms, statutes and political realities for an individual state. National POLST cautions POLST Programs to avoid assuming legislation will help ensure their success and advises careful consideration before pursuing a legislative strategy. Once legislation or regulations are enacted, they are difficult or impossible to remove. To whatever extent legislative and/or regulatory changes resolve barriers to adoption, it is important to build in flexibility in the program so that it can be responsive to changes in standards of care, innovations in clinical practice and quality initiatives.

An underlying principle is that the development of a POLST Program should be driven by clinical consensus with broad input from the field. The 2008 article, *The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation*, identifies some of the circumstances and issues that present challenges and barriers to

POLST and in some cases prompted legislative remedies.<sup>23</sup> To whatever extent legislative and/or regulatory changes resolve barriers to adoption, it is important to build in flexibility in the program so that it can be responsive to changes in standards of care, innovations in clinical practice and quality initiatives while avoiding unintended consequences of advances in shared decision-making<sup>24</sup> yet welcome broad-based input from the field.

### Issue 3C: When might POLST legislation be needed?

Legislation is needed if: (1) there are specific impediments existing in state law that pose legal barriers to POLST program implementation or (2) there are political or health practice realities that pose serious barriers to implementation.

For example, some states have legislated detailed state requirements for out-of-hospital DNR orders that do not permit other orders to be combined with a DNR order. Such a provision is a clear barrier to POLST. Some states restrict the use of out-of-hospital DNR protocols to certain medical diagnoses that are more restrictive than the criteria suggested by National POLST, and some states impose such significant limitations on surrogate consent to forgo life-sustaining treatments that the use of POLST for patients relying on surrogates may be challenging, but not impossible.

Political and health practice barriers are more difficult to assess and quantify objectively. They often require a judgment about the efficacy or consequences of proceeding with a legislative initiative versus non-legislative. For example, uniformity of a POLST Program statewide is important for success, but it may be achieved nonetheless by building clinical consensus using a standard of care approach, engaging health care professionals, facilities and systems throughout the state. Proceeding in that manner can ensure more thorough quality adoption while avoiding some of the concerns related to the inflexibility of legislation and the policy adoption hazards of implementing regulations. In these states, since POLST is a clinical program implemented by means of medical orders, boards governing the licensing and practice of health professionals exercise their authority over the practice of medicine.

Non-legislative approaches through clinical consensus have been successfully used in some states (e.g., Maine), providing greater flexibility in shaping and implementing their POLST Program, including more easily adapting the program to new best practices. Clinical consensus recognizes generally accepted medical practice standards, and to enable meaningful implementation, it is necessary to ensure recognition from the state department of health and/ or provider health licensing board(s).

Legislation that directs a uniform system may avoid inconsistency of practice across the state and enhance its acceptance. Similarly, health care professional confidence in using POLST is important. If concerns related to immunity and malpractice liability or protections from disciplinary sanctions abound then pursuing legislative immunity may become a priority. See *Issue 7D* for more discussion on legislative immunity provisions.

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<sup>23</sup> 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 119-40 (2008), available at [http://www.polst.org/educational\\_resource/the-polst-paradigm-to-improve-end-of-life-care-potential-state-legal-barriers-to-implementation](http://www.polst.org/educational_resource/the-polst-paradigm-to-improve-end-of-life-care-potential-state-legal-barriers-to-implementation).

<sup>24</sup> Jennifer Blumenthal-Barby et al., “Potential Unintended Consequences of Recent Shared Decision Making Policy Initiatives” 38:11, Health Affairs, 1876-1881 (Nov 2019)

### Issue 3D: Why doesn't National POLST offer model legislation?

Model POLST legislation previously provided proved ineffective as legislative approaches require substantial customization in most cases. The frameworks and complexities of each state's existing statutes governing health care decision-making (e.g., advance care planning or out-of-hospital medical orders) do not often follow a uniform format. Laws are often unique and require careful analysis of how POLST can fit within the existing framework if amendment and revision are necessary for accommodation.

## Issue 4: POLST Form Content and Creation

### Issue 4A: Why adopt the National POLST Form?

Standards are not enough to eliminate problematic variation among POLST forms. Form variation undermines the vision and unnecessarily limits the value of POLST, creating unnecessary administrative burdens and worries for the very patients and health care professionals POLST intends to help.

The National POLST form was created because a single form will make it easier, among other things:

- For health care professionals to recognize a POLST form and to correctly interpret and follow POLST form orders, thereby enabling them to honor patient treatment preferences;
- To conduct research and quality assurance activities, creating shared data for generalizable knowledge and ability to improve POLST; and
- To more broadly educate patients and health care professionals about POLST so the process and form are consistently understood and appropriately implemented everywhere.

Please read the [Form Guide](#) for more information about the creation of the form and its value to the POLST movement.

### Issue 4B: Should the POLST form language be put in statute?

No. Since POLST forms need to be periodically updated on a routine basis to incorporate new research or improved practices, POLST form details should not be dictated by statute or regulations. Even if legislation may be the best approach, neither elements of a POLST form nor specific form sections or language should be included in the legislation. National POLST recommends adopting the National POLST Form<sup>25</sup>, adopting a form substantially similar to the National POLST Form, or adopting a form consistent with National POLST form standards.<sup>26</sup>

If the state must be prescriptive about POLST form elements and language, and the National POLST Form is for some reason not acceptable, National POLST recommends granting authority to the State Health Department rather than dictating the specific elements of the form itself through legislation, to allow for flexibility to improve the document periodically.

### Issue 4C: How should a POLST form be created?

A study of established POLST Programs found that among the most important factors facilitating successful creation of a POLST Program was a core group of "physician champions" working with a

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<sup>25</sup> Available at [www.polst.org/national-form](http://www.polst.org/national-form)

<sup>26</sup> See Endorsement Application for POLST form standards: <https://polst.org/endorsement-application-pdf>

broadly inclusive task force or coalition.<sup>27</sup> The coalition should include representatives of the various organizations that contribute to end-of-life health care, including the state medical association, the state bar association, EMS providers, hospital associations, long-term care providers and professional societies, nurses' associations, hospice associations, the disability community, and other consumer groups, including faith-based organizations that are particularly concerned about patient protections.

Such a coalition also needs a statewide organization to serve as the "home" for POLST in that state. A viable organization is needed to provide the administrative and organizational support to the coalition. Examples of organizations include medical and hospital associations, a university or other educational facility, a hospice association, the state bar association, a governmental agency such as the state health department, or a non-profit with complementary mission affinity. Ultimately, when the POLST Program is implemented, this organization or some other agency or entity is necessary to provide ongoing management and oversight.

The state coalition should make use of the assistance and resources available through National POLST, which is responsible for, among other activities, coordinating education, advocacy, quality assurance and research, on a nationwide basis. Thus, each state's working group can learn from the experiences and insights of POLST programs and from the research done at the national level—and share their insights and experiences with National POLST for the benefit of other states' programs.

#### **Issue 4D: Must one uniform POLST form be used throughout the state?**

In order for POLST forms to be easily recognized, understood, and honored, it is important to have uniformity. National POLST has strongly recommended all states to have one form within a state to eliminate variations that cause confusion, misinterpretation, and interference with clinical adoption and acceptance of the form. In 2019, the National POLST form was released to try to eliminate such variation on a national scale.

The vision of National POLST is for uniformity and consistency in information, process, and appearances among all POLST programs and forms. Among other rationales, this helps facilitate portability for patients and reciprocity among the states. This is why a national POLST form was created and why there has been—and will continue to be—such emphasis on compliance with form element requirements and recommendations during the endorsement process<sup>28</sup> While variation is currently unavoidable, it is in the interest of all POLST Programs to be as consistent as possible to assure patients their wishes are truly portable across not only care setting but state lines.<sup>29</sup>

#### **Issue 4E: Who/what entity should be responsible for a state's POLST form?**

Responsibility should be delegated to a broad-based, inclusive working group, whose members provide input based on their experience, current research, and areas of expertise. The authority of such a coalition or oversight committee may be established by statute where necessary, with authority to convene and approve the POLST form and procedures through collaboration with the appropriate state

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<sup>27</sup> Charles P. Sabatino & Naomi Karp, *Improving Advanced Illness Care: The Evolution of State POLST Programs*, (AARP Public Policy Institute, April 2011), available at: <http://www.aarp.org/health/doctors-hospitals/info-04-2011/polst-04-11.html> (accessed Jan. 24, 2013).

<sup>28</sup> In 2017 National POLST adopted bylaws requiring a review of all endorsed states every 3 years. Part of the rationale for this was ensuring continued adherence to national form standards in the endorsement application, thereby helping limit reciprocity issues patients may face crossing state lines.

<sup>29</sup> For more information about the National Form see [www.polst.org/national-form](http://www.polst.org/national-form)

agency (e.g., department of health, department of aging, or medical licensing body). Two members of this group in each state should participate in National POLST’s Plenary Assembly.

#### **Issue 4F: How should the POLST form be made available?**

The POLST form should be made available to health care professionals through a standard approach to ensure quality and adherence to POLST Program guidelines.

National POLST strongly recommends that if the POLST form is available on a website, the form should have an instruction page clearly stating it is a medical order that must be completed by a health care professional or have a “sample” watermark on it with instructions on where to obtain a valid form, helping ensure patients do not erroneously print and complete the form on their own. Other good practices include West Virginia’s program that requires facilities to order their forms through a central location, and TPOPP in Kansas and Missouri that prohibits making the POLST form available online unless the signature portion is blocked out, rendering it invalid.

#### **Issue 4G: Should legislation or regulation mandate POLST form review?**

No; review of POLST forms should be fairly clear clinical norms and is best not fixed by a statutory schedule. In practice, most hospitals honor the POLST form that accompanies a patient until the patient is reassessed, treatment choices are discussed, and new orders are written. In emergency circumstances there may be no time to do a reassessment, in which case a valid POLST form should dictate treatment.

National POLST recommends that a POLST form be reviewed by the patient (or patient’s surrogate) and his/her health care professional periodically including when:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient’s health status; or
- (3) The patient’s goals of care and/or treatment preferences change.

This information is included under “instructions” on page 2 of the National POLST form.

Review of the patient’s POLST form upon discharge or transfer from one care setting to another is critical. When a patient is leaving a care setting, a health care professional should review the POLST form with the patient to: (i) confirm the orders are still accurate; (ii) update the POLST form to reflect new preferences or (iii) void the POLST form if the patient is no longer within the intended POLST population or for other reasons no longer wants a POLST form.

Periodic review with the passage of time is also highly advisable as an additional safeguard, as it helps ensure the POLST form still accurately documents the patient’s wishes for treatments as his/her medical condition progresses (or improves). While advance directives are often not updated, the surrogate’s appointed powers should, if at all possible, reflect the patient’s desire to have the surrogate assume decision-making authority as illness or frailty conditions progress and a surrogate is needed.

Health care professionals should also review POLST as part of other scheduled care plan reviews. For example, in nursing homes, there is already a federal requirement for review of care plans every three months, and states may have additional care plan review requirements.<sup>30</sup> POLST should be made an express part of care plan review. National POLST has provided templates facilities can consider to facilitate reviews.<sup>31</sup>

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<sup>30</sup> 42 C.F.R. 483.20(c).

<sup>31</sup> <https://polst.org/form-review-document-pdf>

### Legislation Tip: Do not put expiration dates or time limits on the validity of POLST forms

While it is clinically appropriate to review POLST orders at least once a year, even if none of the other triggering events for review listed above have occurred, creating an expiration date for a POLST form is strongly discouraged by National POLST. Expiration dates are unnecessarily burdensome, mostly for the patient, who has to keep track of the expiration, schedule an appointment with their health care professional prior to the expiration date, travel and pay for the appointment, all of which may be unnecessary if their treatment wishes are unchanged. Also, by allowing POLST orders to expire, it becomes likely that a patient’s treatment preferences will in fact not be followed if a new POLST is not created (or the expiring POLST renewed) in a timely manner—which goes against everything POLST stands for.

Even during COVID-19, expirations for POLST forms were discouraged. Instead, National POLST suggested health care professionals write something similar to “Orders reflect patient’s instruction during crisis standards of care (COVID-19)” to alert future health care professionals that the orders may not be accurate once the crisis standards of care are no longer in effect.<sup>32</sup>

**C. Additional Orders or Instructions.** These orders are in addition to those above (e.g., blood products, dialysis).  
[EMS protocols may limit emergency responder ability to act on orders in this section.]  
Orders reflect patient’s instruction during crisis standards of care (COVID-19).

## Issue 5: POLST Form Portability Among States

### Issue 5A: Are POLST forms portable across jurisdictions?

It depends on the form and jurisdiction. POLST form variation increases challenges to understanding, using and honoring POLST forms. Variations should be reduced as much as possible, and every state should work to minimize barriers to using out of state POLST forms.

National POLST recommends POLST Programs adopt the National POLST form to maximize portability. Failing that, POLST Programs should have a form meeting national form requirements, and any legislation should explicitly state that the National POLST form and any form meeting national form requirements will be valid and honored in the state.

### Issue 5B: What is the source of authority for recognition across jurisdictions and applicability of immunity?

Only a minority of states have a statute or regulation explicitly recognizing POLST forms from other states.<sup>33</sup> Therefore, the only “authority” for recognition across jurisdictions emanates from generally accepted medical practice, to the extent it acknowledges and respects existing medical orders. POLST is a written medical order, which is followed by the medical community to whatever extent that all medical orders are generally followed and implemented. When a patient moves from a hospital to a nursing home, or across state lines – from one jurisdiction to another, typically the physician assuming care will review the patient’s history and existing orders and update those orders as appropriate.

<sup>32</sup> <https://polst.org/crisis-standards-pdf>

<sup>33</sup> See e.g., Colo. Rev. Stat. Ann. § 15-18.7-104 (1)(a) (“Except as provided in [this statute], emergency medical service personnel, a health care provider, or a health care facility shall comply with an adult’s executed medical orders for scope of treatment form that: (I) Has been executed in this state or another state; (II) Is apparent and immediately available; and (III) Reasonably satisfies the requirements of a medical orders for scope of treatment form....”).

When a patient with a POLST form moves into a jurisdiction that does not utilize POLST forms, it becomes unclear whether the new physician is required to recognize the POLST orders and will be protected from liability for doing so. Legislation specifically mandating recognition of other states' POLST form or of the National POLST Form, and granting immunity from liability for doing so, may facilitate achievement of broader adoption of portability to protect patients when they travel and in reciprocity to reduce patient burden in needing to secure multiple POLST forms.

### **Issue 5C: Where there is variation of substantive POLST provisions or health decisions laws, which law applies (originating state or receiving state)?**

As explained in other portions of this Guide, a POLST Program may be created and implemented without legislation. Portability of POLST forms, however, is an area where legislation is helpful, because it can establish explicit reciprocity and recognition.

Most states recognize the face validity of an out-of-state advance directive, particularly in the naming of a surrogate, but implementation of such a directive may be impeded or its interpretation altered by the implementing state due to the receiving state's laws governing certain kinds of powers or directives.

States have taken three main approaches to POLST portability. States will honor the originating state's POLST form so long as it:

1. Complies with the law of the receiving state (e.g. Iowa,<sup>34</sup> New Jersey<sup>35</sup>).
2. Reasonably or substantially complies with the law of the receiving state (e.g. Colorado,<sup>36</sup> Idaho,<sup>37</sup> Utah<sup>38</sup>).
3. Complies with the law of the originating state (e.g. Rhode Island<sup>39</sup>).

The simplest solution, however, is for states to adopt the National POLST form and eliminate questions of form language compliance with state law.

### **Legislation Tip: Ways to eliminate POLST Form reciprocity or portability issues**

National POLST appreciates the support of the American Medical Association<sup>40</sup>, AMDA – The Society for Post-Acute and Long-Term Care Medicine<sup>41</sup>, and other national organizations to support reciprocity of advance care planning documents, including POLST. While helpful, reciprocity provisions do not help further the success of POLST for the following reasons:

1. Since POLST is a medical order that may be used in an emergency, it needs to be immediately recognizable. As of December 2017, there were 47 existing POLST forms to review, essentially, 47 variations of the same concept using 16 names and five different colors.<sup>42</sup> It is possible a first responder might not recognize an out-of-state POLST form for what it is, thus potentially providing unwanted treatment to a patient.
2. Even if the first responder recognized it as a POLST form, unless all states adopt reciprocity provisions, the responder and other health care professionals may be unsure if they are legally able to follow it.

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<sup>34</sup> Iowa Code § 39-4514.

<sup>35</sup> N.J. Stat. Ann. § 26:2H-134(c).

<sup>36</sup> Colo. Rev. Stat. Ann. § 15-18.7-104.

<sup>37</sup> Idaho Code § 39-4514.

<sup>38</sup> Utah Admin. Code R. 432-31-11.

<sup>39</sup> R.I. Gen. Laws 1956, §§ 23-4.11-2 & 23-4.11-12.

<sup>40</sup> <https://policysearch.ama-assn.org/policyfinder/detail/POLST?uri=%2FAMADoc%2Fdirectives.xml-D-85.992.xml>

<sup>41</sup> [https://bit.ly/AMDA\\_NationalPOLST](https://bit.ly/AMDA_NationalPOLST)

<sup>42</sup> <https://polst.org/form-guide-pdf>

If, however, states cannot adopt the National POLST Form and need to take one of the approaches to reciprocity above, legislators must recognize POLST will be undermined if clinicians are required to refer all questions about legal compliance to counsel. One way to avoid that is to build in a presumption of validity for POLST forms, regardless of origin. This kind of presumption is more common in state advance directive laws. For example, California’s advance directive law provides:

In the absence of knowledge to the contrary, a physician or other health care professional may presume that a written advance health care directive or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.<sup>43</sup>

In light of the variation in portability provisions, this is clearly an area where federal law could provide some resolution. For example, the Personalize Your Care Act of 2013<sup>44</sup> proposed bill provided that an advance directive validly executed outside the State in which such directive is presented “must be given effect by a health care professional of services or organization to the same extent as an advance directive validly executed under the law of the State in which it is presented.”<sup>45</sup> The bill had an express preemption clause that would preempt any state law with inconsistent portability provisions. Federal legislation could apply this same kind of mandate to POLST.

## Issue 6: POLST Form Execution

As with any other medical order, only health care professionals should fill out the POLST form.

### Issue 6A: Should POLST form completion be required?

No; it is a fundamental tenet of POLST that completion of a POLST form *always* be voluntary. The goal is to *offer* POLST conversations and forms to clinically appropriate patients, but it violates a patient’s right to self-determination and autonomy to require completion. National POLST will not endorse POLST Programs requiring completion of a POLST form, regardless of the patient population or care setting, without showing how voluntariness is preserved.

A requirement by healthcare facilities to *offer* POLST information to appropriate patients encourages widespread clinical implementation of POLST. This requirement parallels the long-standing duty under the Patient Self Determination Act to “provide written information . . . concerning . . . right to formulate advance directives.”<sup>46</sup> For example, Utah requires that hospitals, hospices, nursing, assisted living, and other facilities determine, on admission, whether each individual has a POLST.<sup>47</sup> These facilities must establish a process to determine which of those individuals without a POLST should be offered the opportunity to complete one.

National POLST has a policy on Incentives and Quality Assurance relative to form completion:

<https://polst.org/incentive-policy-pdf>

### Legislation Tip: Add Language Clarifying POLST is Voluntary

Many states have faced challenges with long-term care facilities (e.g., skilled nursing facilities and assisted living communities) making POLST forms a formal or virtual condition of admission. Including language

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<sup>43</sup> Cal. Probate Code §4676(b). Note that CA also has a presumption for DNR requests: Cal. Probate Code §4784.

<sup>44</sup> H.R. 1173, 113th Cong., 1<sup>st</sup> Sess. (2013) (Blumenauer, Ore.).

<sup>45</sup> Id., at § 5.

<sup>46</sup> 42 U.S.C. §§ 1395cc(f) & 1396a(w).

<sup>47</sup> Utah Admin. R. 432-31 (Oct. 1, 2011).

such as “a facility may not condition the provision of treatment on a patient having a POLST or any instruction relating to the administration, withholding or withdrawing life-sustaining procedures or artificially administered nutrition and hydration” can be helpful. This language (and other language to consider) was included in a 2020 bill introduced in Oregon.<sup>48</sup>

### **Issue 6B: Which health care professionals should be able to execute a POLST form?**

To maximize patient access to POLST, particularly in rural communities, National POLST recommends permitting physicians, advanced practice registered nurses [APRNs] (e.g., nurse practitioners [NPs] and clinical nurse specialists [CNS]), and physician assistants (PAs) to sign POLST forms.<sup>49</sup> Authorization to sign POLST forms must of course fit within state regulations and scope of practice rules.

When the first POLST Programs were starting, there were objections to authorizing anyone other than physicians to sign POLST forms. Once POLST was established and comfort levels within the medical profession were more secure, programs expanded authority to NPs and PAs to execute a POLST. Now the majority of states permit physicians, APRNs and PAs to sign.<sup>50</sup>

### **Issue 6C: Can any part of the POLST process be delegated to health care professionals who cannot sign a POLST form?**

Yes, POLST counseling and preparation can be delegated to a health care professional not authorized to sign a POLST Form. POLST is not an end in itself but the culmination of a process, and the quality of a POLST conversation is likely enhanced by a team approach. Multiple professionals may be involved in the process of helping a patient to clarify goals of care, but the signing physician, NP, or PA has the ultimate responsibility to confirm that the patient (or surrogate):

- understands the patient’s medical condition (diagnosis and prognosis);
- understands the patient’s available treatment options, the benefits and burdens of each, and how they fit into the patient’s goals of care; and
- is making a voluntary, informed choice before signing the form.

Other professionals, such as chaplains, social workers and nurses may help the patient explore and understand their values and goals of care. The process takes time and requires skills at facilitating a discussion.

California has developed a two-day training program on how to have the conversation, a program that has been adopted by Maine and Hawaii. There are a number of medical and nursing journal articles and curricula on this topic.<sup>51</sup> Many states have also used the Respecting Choices model<sup>52</sup> and other programs like Ariadne Labs, Vital Talk and Honoring Choices to educate health care professionals about POLST. Beyond health care professionals, there are others offering education on guides for engaging patients and families in these types of discussions.<sup>53</sup>

The reverse side of the National POLST form has space to identify the professional assisting with completion of the POLST form, ensuring accountability of the team responsible for the POLST process.

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<sup>48</sup> <https://olis.oregonlegislature.gov/liz/2020S1/Downloads/MeasureDocument/SB1606/Introduced>

<sup>49</sup> <https://polst.org/support-np-pa-signing-forms-pdf>

<sup>50</sup> <http://polst.org/state-signature-requirements-pdf>

<sup>51</sup> See, e.g., End-of-Life Nursing Education Consortium (ELNEC) project, a national education initiative to improve palliative and end-of-life care, <http://www.aacn.nche.edu/ELNEC>.

<sup>52</sup> <https://respectingchoices.org/about-us/>

<sup>53</sup> National POLST encourages all to work with them on the education materials and is working on creating standards for POLST education programs.

The most important element is the quality of the conversation, and the capability of the preparer to engage in and facilitate that conversation.<sup>54</sup> In some states, like Utah, the statute specifies the credentials of the persons who can have the conversations with the patient.<sup>55</sup> Regardless of who has or documents the conversation, when the physician or other authorized health care professional signs the orders, he or she has the responsibility to confirm that the treatment orders are appropriate and consistent with the patient's goals.

### Issue 6D: eSignatures

Due to the COVID-19 pandemic, laws and practices are quickly evolving and moving toward acceptance of verbal consent to POLST documented at a later time or in other ways (a preferred practice) and recognition of electronic signature which, up to now, have been recognized in very few states. The latter is likely to be addressed in legislation that addresses more than POLST. As of August 2020, the Uniform Law Commission is presently studying possible updates to the Uniform Health-Care Decisions Act and electronic signatures is one of the identified issues on the agenda.

Although historically advance care plans, advance directives and POLST forms alike, have required wet signatures, "the definition of writing and signature have been so transformed in so many spheres of business, health, and personal life that insisting on a wet signature is becoming archaic."<sup>56</sup> Specifically within health care, "electronic signatures are increasingly common in clinical setting for HIPAA notifications, prescribing drugs, and recording advance care planning conversations."<sup>57</sup>

Though explicit permission is preferred, even if the law is ambiguous, it makes good clinical sense to accept electronically signed POLST forms. Health care professionals have an obligation under common law and constitutional principles to honor the patient's clearly expressed treatment preferences: health care professionals are at risk if they ignore clearly expressed preferences, no matter how they are conveyed, unless there are concerns about ethical appropriateness or there are reasonable questions about their validity.<sup>58</sup> Therefore, even if a POLST form were invalid under state law because it was signed electronically, rather than with wet signatures, it still conveys a patient's expressed treatment preferences and other laws compel health care professionals to honor the document.

### Issue 7: Health care professional compliance with an in-state POLST form

Health care professionals must comply with POLST unless changed circumstances or new information dictate otherwise or state law prohibits compliance.

#### Issue 7A: Can health care professionals presume validity of a POLST form presented to them?

Parallel to the general rule for advance directives, health care professionals should be able to presume the validity of a completed POLST form. A health care professional who honors a POLST should not be subject to any sanctions as a result of his or her reliance on the POLST, so long as the health care professional believes "in good faith" both that the POLST is valid and that it has not been revoked. In this regard, reliance on a POLST form is equivalent to reliance on any other medical order.

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<sup>54</sup> See #4 <http://polst.org/appropriate-use-pdf>

<sup>55</sup> Utah Code Ann. §75-2a-106(2).

<sup>56</sup> Charlie Sabatino, personal communication, June 10, 2020.

<sup>57</sup> Charlie Sabatino, personal communication, June 10, 2020.

<sup>58</sup> Charlie Sabatino, personal communication, June 10, 2020.

### Issue 7B: Is explicit statutory immunity protection necessary?

As POLST is increasingly becoming the standard of practice for translating patients' treatment preferences into actionable medical orders, health care professionals are often protected under common law by compliance with generally accepted standards of practice in their area.

Many health care professionals across the country understandably seek explicit immunity for honoring instructions and medical orders. When they follow the orders on a properly completed POLST form in good faith, they want protection from criminal prosecution, civil liability, and disciplinary sanctions. Since health care professionals already have this immunity for following advance directives and surrogates under the laws of most states, some argue that it is anomalous *not* to have equivalent immunity language in a POLST statute or regulation.

Some states, like Maine, have been able to implement POLST solely through clinical consensus and without any explicit legislative or regulatory grant of immunity. As POLST is increasingly accepted as a standard of care by health care professionals in the state, common law protections strengthen but are not explicit.

In others, the lack of statutory protection may lead to health care professionals' reluctance to comply with POLST forms, which may deprive patients of the opportunity to receive medical treatment concordant with their goals and wishes. These health care professionals and facilities want to carry out patient wishes but they are risk-averse with respect to liability concerns, regardless of whether the fears are realistic. Consequently, depending on the medical culture in one's state, statutory immunity may be a critical factor to assuring that POLSTs are carried out.

### Issue 7C: Must the health care professional *signing* the POLST form be credentialed at the receiving hospital in order for the POLST form to be honored there?

A common question in the early days of POLST concerned the obligation of hospital physicians in the Emergency Department (ED) or upon admission, when receiving a patient with a POLST form that was signed by a health professional not credentialed by or without admitting privileges at the hospital. There was concern by the admitting or treating physician at the hospital as to whether to honor such POLST orders, stemming from a mistaken belief that an order signed by a physician or other qualified signor without admitting privileges is invalid at the hospital under federal Medicare law.

An examination of federal law and regulations provides no basis for that belief. Federal regulations provide only that the hospital's governing body must:

- Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff; ... and
- Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;<sup>59</sup>

Furthermore,

In accordance with hospital policy, the governing body must ensure that the following requirements are met:

- ... (4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that--

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<sup>59</sup> 42 C.F.R. §§ 482.12(a) (1) & (a) (5).

(i) Is present on admission or develops during hospitalization; ....<sup>60</sup>

Neither of these provisions prohibits recognition of a POLST form, any more than it precludes recognition of a state-recognized DNR order or prescription orders that accompany an arriving patient.

At the same time, federal law is very strong with respect to the hospital's obligation to honor patient direction of health decisions.

Standard: Exercise of rights.

- (1) The patient has the right to participate in the development and implementation of his or her plan of care.
- (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment.<sup>61</sup>

Finally, federal regulations require hospitals and medical personnel to comply with state law:

The hospital must be--

- (1) Licensed; or
- (2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.
- (3) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.<sup>62</sup>

CMS has never discussed POLST explicitly in its hospital regulations, manuals, or transmittals. Therefore, where POLST is permissible under state law as an appropriate clinical process for honoring patients' goals of care, it is fully consistent with federal rules. Perhaps more significantly CMS has recently acknowledged POLST (referring to "MOLST") as a positive example in recent changes to its Guidelines to Surveyors at F tag 684 ("Quality of Care") and F tag 578 ("Advance Directives") for nursing homes.<sup>63</sup>

The implementation of POLST also involves the concurrent clinical obligation to reassess the patient's condition and the medical plan of care whenever the patient's condition changes. This includes reassessment of POLST and its possible modification when appropriate.

Practically, if a patient presents with a POLST form at a hospital, an appropriate practice is for the receiving health care professional to discuss the POLST orders with the patient, acknowledging that a health care professional has previously spoken to the patient about his or her treatment wishes. The receiving health care professional then can reissue the orders or change them if the patient indicates such a change is now desired. If the patient is not capable of having this conversation with the receiving

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<sup>60</sup> 42 C.F.R. § 482.12 (c).

<sup>61</sup> 42 C.F.R. § 482.13(b).

<sup>62</sup> 42 C.F.R. §§ 482.11(b) & (c).

<sup>63</sup> CMS Manual System Pub. 100-07, State Operations, Provider Certification. Transmittal-ADVANCE COPY (September 27, 2012). SUBJECT: Revisions to Appendix PP – "Interpretive Guidelines for Long-Term Care Facilities -- F tag 155 (Advance Directives)," available at: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-47.pdf>; and F tag 309 (Quality of Care), available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-48.pdf>.

health care professional or circumstances otherwise prohibit the conversation then the health care professional should discuss the patient's condition and wishes with the surrogate, and POLST orders can likewise be reissued, or changed if appropriate.

If the patient's medical condition constitutes an emergency that precludes the receiving health care professional from discussing the POLST orders with the patient, the orders expressed on the POLST form are presumed to be valid and should be followed. If, thereafter, the patient stabilizes, POLST should be reviewed and confirmed, or adjusted if appropriate, according to hospital protocols. This review is done by a health care professional who has facility privileges. 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 is done prior to discharge.

## Issue 8: POLST Program (Administration, Monitoring, Evaluation)

### Issue 8A: What is an appropriate administrative structure needed to establish a POLST Program?

A clear lead entity or agency exists to administer the POLST Program, with four essential functions: ongoing education, research and monitoring, quality improvement, and participation in National POLST.

States have chosen quite different lead agencies with quite differing resources.<sup>64</sup> A successful program requires staff to answer questions, lead a state coalition for POLST implementation and participate in National POLST<sup>65</sup>. Additionally, the program should provide a continuous process of professional education, evaluation, and quality improvement. POLST Programs must also adapt to continuing improvements in medical treatment, technology, and health delivery.

### Issue 8B: How should a POLST Program be evaluated?

Because POLST is neither a static program nor self-implementing, an inclusive oversight group, consisting of representatives of the various organizations that contribute to advance care and end-of-life health care must provide input, over time, on how to make the POLST form and program more effective in the state. POLST Program leadership ideally includes the state medical association, the state bar association, EMS providers, hospitals, long-term care professional societies, nurses' associations, hospice associations, the disability community, and other consumer groups, including faith-based organizations that are particularly concerned about patient protections. This coalition will make suggested improvements to the POLST form and program based on the experiences and input of its various members, national policies and guidance, and national research and quality assurance information available.

Educating everyone involved in advance care planning on the purpose and proper use of POLST is critical to its widespread and effective implementation. Accordingly, the coalition should develop and implement a specific plan for initial and ongoing education in the use of POLST and effective counseling of patients and families. Large organizations, such as hospital systems and nursing home chains, may create their own training programs but should be encouraged to work with the state POLST Program (and, in effect, National POLST). Public education is also a necessity to better equip the public to participate effectively in decisions about advanced care planning.

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<sup>64</sup> See "POLST Program Home" <https://polst.org/wp-content/uploads/2015/07/POLST-Program-Development-Guide.pdf> (p. 17-25).

<sup>65</sup> In 2017, the new governance structure of National POLST encouraged all POLST Programs to participate in national POLST governance, including education, policy and guidance development, and creating and updating national POLST standards.

The coalition implementing a state’s POLST Program should implement a system for evaluating their POLST form (or participate in helping evaluate the National POLST form) and the POLST program, and for implementing changes and updates to both. To the extent that a data collection and monitoring system can be established to track usage of POLST, evaluation will be more effective. The National POLST Research & Quality Assurance Committee has created resources to help with quality assurance activities, available at: <https://polst.org/gatoolkits>

From time to time there may be a need to propose changes or updates to a state’s statute or regulations, if applicable. If the coalition is meeting regularly and has a plan for monitoring and evaluating the POLST program, then the coalition will be in a position to garner the evidence needed to bring about changes in the administrative rules or the state's statutes.

The coalition should make use of the assistance and resources available through and by National POLST, which is responsible for, among other activities, coordinating education, advocacy, and research, with regard to end-of-life health care, on a nationwide basis. Thus, each state's working group can learn from the experiences and insights of POLST programs and from the research done at the national level.

## Issue 9: POLST, Shared Decision-Making and Informed Consent

The most important part of the POLST process is that the patient understands what is meant by the form and agrees with the orders. Since the POLST form is a communication tool between health care professionals, it is intentionally drafted at a high health literacy level and not easily understood by patients.<sup>66</sup> Ultimately, as with any medical order, it is the responsibility of the health care professional signing the orders to ensure the patient understands and agrees to the treatments being ordered.

The terms “shared decision-making” and “informed consent” each have explicit meanings in healthcare. National POLST encourages using the shared decision-making (SDM) model for discussing and executing a POLST form. The intent of this section is not to override any state or federal definition, but to encourage any POLST process and conversation to be at the highest level of quality possible.

As noted in a 2004 *Annals of Internal Medicine* article, Whitney, et.al. wrote, “Informed consent is the legal process used to promote patient autonomy; shared decision making is a widely promoted ethical approach.<sup>67</sup>” This distinction underscores the need for a well-structured shared decision-making process to ensure more reliable and robust informed consent. POLST conversations between a patient and the health care professional should include all elements of informed consent to ensure patient understanding about diagnosis and prognosis; treatment options, including risks and benefits of each. Following agreement about those factors there should be concurrence or acknowledgment by the patient or surrogate that that treatment orders reflect the values and treatment preferences related to the goals of care. An opportunity for the patient and or family to ask questions is essential for both shared decision-making and informed consent to be successfully completed. The POLST form not only documents treatment decisions about resuscitation, but also conveys the specific appropriate interventions that should be executed if CPR is to be avoided. Simply put, medical orders should reflect the current goals of care.

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<sup>66</sup> National POLST created a tool to help patients interpret their orders: <https://polst.org/patient-guide-after-pdf>

<sup>67</sup> *Ann Intern Med.* 2004 Jan 6;140(1):54-9. A typology of shared decision making, informed consent, and simple consent. Whitney SN, McGuire AL, McCullough LB.

While unique for a medical *order*, obtaining the patient’s signature is a common practice for documenting informed consent for major medical decisions, although a signature does not guarantee informed consent. For POLST forms, obtaining the patient or surrogate signature (including electronic<sup>68</sup>), attestation or through witnessed verbal consent is how the majority of states<sup>69</sup> help confirm the patient is aware of having a POLST form. The National POLST form requires the patient (or surrogate) to sign the document, saying they understand it is voluntary and that they have discussed their treatment options and goals of care with the patient’s health care professional.<sup>70</sup> If the surrogate is making the decisions, they are additionally signing they agree the treatments are consistent with patient’s known treatment wishes.<sup>71</sup>

Circumstances may make a signature impractical where, for example, the patient is physically but not mentally impaired, or the surrogate’s discussion of POLST with the health care professional unavoidably takes place by phone. Thus, states currently using POLST have taken differing approaches to this issue.<sup>72</sup>

### Legislation Tip: POLST Forms Should Not Require Notaries or Witnesses

National POLST will not endorse any form requiring additional legal formalities such as witnessing or notarization, as this extra step: (i) is not needed for other medical orders; (ii) may be burdensome, especially in rural communities, depending on who may serve as a witness and how convenient a notary is to the location; and (iii) causes confusion between POLST and advance directives.

## Issue 10: Surrogate<sup>73</sup> Authority

A surrogate – including a health care agent or proxy, guardian, or default surrogate – who is recognized under state law to make health care decisions on behalf of a patient should be authorized to consent to a POLST if or when the patient lacks capacity to make health care decisions.

It is important to seek guidance from state laws related to surrogate eligibility and their decision-making authority. In most states, if the patient has not designated a surrogate, a state statute automatically appoints the patient’s spouse as the surrogate, sometimes referred to as a “default surrogate.” If there is no spouse, or if the spouse is not capable of acting as a surrogate, most states have a list of alternative possible surrogates, beginning with an adult child, a parent, a sibling and so forth, similar to the laws disposing of a person’s property where they have not signed a will. State law varies about when an individual is authorized to consent to or refuse to consent to some or all medical treatments and even who that individual is or can be; it is important to review all statutes related to surrogacy when implementing a POLST Program.

A surrogate appointed by a state statute has, in some states, the same authority to make health care decisions as one appointed by the individual, but in other states, that may not be the case. The state law may limit a default surrogate’s authority to refuse or terminate life sustaining treatment for the patient. Those limitations may limit the scope of orders on a POLST that the surrogate can agree to. For example, Arizona’s default surrogate law does not permit a default surrogate to consent to or approve the

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<sup>68</sup> The custom and practice of writing electronic medical orders is well established.

<sup>69</sup> Only 3 state forms do not require patient signature or attestation: Maryland, Minnesota and Oregon.

<sup>70</sup> <https://polst.org/national-polst-form-pdf>

<sup>71</sup> Id. See more information under “Patient or Patient Representative Signature” (pgs. 18-19) <https://polst.org/form-guide-pdf>

<sup>72</sup> Exceptions should be made for these circumstances or where the POLST is being completed to effectuate a living will that has become operational and a surrogate is unavailable.

<sup>73</sup> Reminder that “surrogate” is defined on page 2 of this guide.

permanent withdrawal of the artificial administration of food or fluid.<sup>74</sup> Therefore, a default surrogate could consent to a DNR option but not to the withholding of nutrition and hydration. POLST may still be utilized in that state, but with a more limited scope when default surrogates are involved.

Even when the patient appoints the surrogate through an advance directive, questions can still arise as to the extent of the surrogate's authority. Some states limit the right of an individual to delegate termination of life-sustaining treatment to a surrogate. For example, in Ohio, the attorney-in-fact 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. Additionally, there must be no reasonable possibility of the principal regaining the capacity to make informed health care decisions.<sup>75</sup> The POLST Program may be utilized in states with statutory limitations such as these. Physicians and other health care professionals should be familiar with the limitations currently in place in their states. The entire process does not have to be changed; rather, the POLST Program may be added to the picture, with surrogate decision-makers participating to the extent permitted under individual state law.

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 or healthcare directive 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 to the extent they apply to a particular decision, unless the advance directive and state law give authority to the surrogate to override the general directions in a living will.<sup>76</sup> A durable power of attorney for health care also may include limitations, put in place by the patient, on the surrogate's authority to make medical decisions. The surrogate must be aware of and act within the limitations established by the patient.

### **Issue 10A: A surrogate cannot sign an advance directive; why should they be able to sign a POLST form?**

An advance directive is a personal tool for exercising one's autonomy, enabling the individual to name a surrogate of his/her choice and give some degree of guidance for future medical decisions. Once the individual loses decisional capacity, a further direct expression of the patient's intent is no longer possible. Instead, the responsibility falls on the shoulders of the surrogate to consent to or refuse consent to medical decisions consistent with the values and wishes of the individual as best they can be discerned by the patient's advance directive or as otherwise known to the surrogate. For individuals with serious illness or frailty, several critical care decisions are highly likely and fairly imminent.

A POLST form is a medical order that translates or reflects the expressed wishes and known preferences and best interests of the patient into actionable medical orders. As the patient's condition progresses, the POLST form orders may be updated and changed; the advance directive remains as drafted.

While a discussion and confirmation of those expressions directly from the patient are preferred, that is not always possible if the patient lacks decision-making capacity. In those situations, health care professionals rely on a surrogate to act on behalf of the patient and participate in shared medical decision-making. It is incumbent on health care professionals to advocate for decisions that align with the patient's known goals, values, and treatment preferences, and are based on understanding the patient's current condition. Health care professionals work with surrogates to make decisions for the patient under

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<sup>74</sup> Ariz. Rev. Stat. § 36-3203(E).

<sup>75</sup> For example, Ohio Rev. Code § 1337.13.

<sup>76</sup> For example 20. Pa.C.S.A §5471.

this principle of substituted judgment. If or when a surrogate instead operates only on their own interpretation of the patient's best interests (when the preferences are not directly known but may be inferred), and in situations where it appears that the designated surrogate is not acting in accordance with the patient's known wishes, substituted judgment or best interests, then health care professionals should seek as necessary, assistance from an appropriate source, such as patient relations, risk management, or an ethics consultation service.

### **Issue 10B: Should there be restrictions on what a surrogate can agree to on a POLST form?**

In states where laws prohibit or make it difficult (by requiring a court order for approval for example), for a surrogate to change a POLST order, there is a serious potential unintended consequence in completing POLST forms for individuals not falling within the appropriate population if and when these patients lose decisional capacity. A POLST form completed for a healthy patient should order CPR and Full Treatment. If and when the patient has a new diagnosis of a serious illness but lacks decision-making capacity, a POLST ordering the same (CPR and Full Treatment) may no longer be appropriate. If the surrogate—acting in the best interest of the patient—advocates for either select or comfort-focused treatments, this may create a potential or actual conflict for the surrogate who is now “going against” the previously expressed treatment options that were in fact just for ordinary, default treatment.

### **Issue 10C: If a patient agreed to a particular treatment plan set forth in a POLST form, should a surrogate be allowed to change the plan later when the patient no longer has decisional capacity?**

When the power for decision-making is delegated by the patient and authority for determining future treatments rests with the surrogate, then the surrogate's authority to alter the treatment plan is clear. Surrogates have a fiduciary duty to comply with the patient's instructions and wishes. This question underscores a concern that a surrogate could undermine previously expressed wishes of the patient. Clinicians should always serve as advocates for the patient, especially those who cannot speak for themselves. The same question arises if the surrogate makes a decision regarding POLST that may appear inconsistent with a previously executed advance directive. Changing health status, however, may require applying or withholding/withdrawing treatments that have not been previously contemplated due to disease progression or other changes in condition. It is a concern that deserves thoughtful consideration. To categorically prohibit a surrogate from changing a POLST based on the changing condition of the patient would be likely to impede the effective management of the patient's condition, which is exactly what POLST is intended to do. POLST orders are expected to be reviewed and modified as necessary. Patients appropriate for POLST (see **Issue 3**) are certain to face changing medical conditions and ultimately declining function. POLST provides "clear and convincing" evidence of the patient's wishes. However, new circumstances require evaluation and consideration. Should a patient wish to restrict a physician from changing POLST medical orders based on a later request from a surrogate, the clinician should note such limitation(s) at the time it is put in place in the medical chart and on the POLST form.

Scenario 1: An 80-year-old woman with moderately severe heart failure works with her clinician to complete a POLST. She is awaiting the birth of her first great-grandchild and is hoping to enjoy quality time with the baby before she dies. She requests CPR in the event her heart and breathing stop; she has capacity to make such a medical decision. Subsequently, she suffers a massive cerebrovascular accident (a stroke) that causes her to lose her ability to make POLST decisions and from which she is not expected to recover; prognosis is less than 6 months. A palliative, comfort-focused approach is recommended by the health care team.

Review of POLST: The patient’s health care professionals and surrogate are aware that she will not attain her previously expressed goal for care and the focus of care shifts from longevity to comfort. Given her new medical condition and life expectancy, maintaining the previous medical order is neither applicable nor appropriate. Her clinician and her surrogate should revise her treatment goals and modify her POLST, reflecting her new health condition, including DNR and comfort-focused treatments.

Scenario 2: An 85-year-old woman with moderately severe heart failure works with her clinician to complete a POLST. She indicates she has lived a good life and prefers to allow a natural death at home; she has capacity to make such a medical decision. She seeks to age in place at home and requests a DNR order in the event her heart and breathing stop, along with selective interventions (including hospitalization) should her heart failure decompensate. Subsequently, she suffers a massive cerebrovascular accident (a stroke) that causes her to lose her ability to make POLST decisions and from which she is not expected to recover; prognosis is less than 6 months. A palliative, comfort-focused approach is recommended by the health care team.

Review of POLST: The patient’s health care professionals and surrogate are aware that she will not attain her previously expressed goal for care and the focus of care shifts from functionality to comfort. Given her new medical condition and life expectancy, her clinician and her surrogate can revise her POLST to reflect her new health condition, retaining her DNR order and changing selective treatments to comfort-focused treatments. Her surrogate should not request an order for CPR and full treatment in this clinical scenario as it would be contrary to the documented expressed wishes of the patient, and would also not be in her best interest.

Every surrogate assumes fiduciary duties when acting as the surrogate. These duties include but are not limited to duty of loyalty and duty of care. Surrogates should understand and educate themselves on their duties and consequences that may accompany any breach of those duties.<sup>77</sup> State POLST leaders may wish to establish reasonable safeguards to make certain that the surrogate is, at all times, acting to carry out the patient’s known wishes, substituted judgment, or if those are not reasonably available, then best interests. Examples of safeguards may include:

- (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 directive 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.

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<sup>77</sup> Fiduciary Principles in Surrogate Decision-Making, Nina A. Kohn, *The Oxford Handbook of Fiduciary Law*, Edited by Evan J. Criddle, Paul B. Miller, and Robert H. Sitkoff, 2019 DOI: 10.1093/oxfordhb/9780190634100.013.12

## Appendix 1: Legislation vs. Regulation

Public health laws and regulations have important consequences for the health of defined populations. The governmental process to effect change can be difficult to understand and navigate. It helps to work with a lobbyist and to understand the difference between laws and regulations. If you are trying to lobby to make changes to a law or regulation, know the work that would go into making those changes.

‘Law’ and ‘regulation’ are often used interchangeably but they differ. In short, laws (also called statutes) govern everyone equally and are passed through the legislative process. Since laws don’t include all the details people need to know in order to follow it, regulations are created. Regulations (also called rules) are created by an administrative agency that governs how the law will be implemented and enforced. For example, many states pass POLST legislation and then the department of health or public health creates rules providing more specifics about how to implement POLST (such as requiring POLST be included in emergency responder education), what the form needs to include, etc.

They are the same in that they go through formal—though different—processes before being finalized. The legislative process is longer and generally more cumbersome than the regulatory rule-making process. Additionally, the regulatory process is more flexible, and rules are easier to change than statutes, which is why this Guide strongly recommends, if specifics about POLST, such as the components and details of the form, need to be included in the process, that these items be modifiable within regulations as opposed to legislation.

Laws and regulations are both enforceable, meaning that there are negative consequences for failure to comply.