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POLST: An Emerging Model for End-of-Life Care Planning

By Patricia Bomba and Charles P. Sabatino

Patient preferences for care at the end of life are not consistently followed, despite the presence of legal documents completed in accordance with state law. Further, studies have shown that most patients either do not have advanced directives or, for those patients who do, the directives do not adequately provide health care professionals with explicit instructions for making critical decisions.

A decade of research has shown that an emerging national model, the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program, more accurately conveys end-of-life care preferences for patients with serious, chronic, life-limiting conditions, and is followed by medical professionals because POLST contains medical orders. The POLST Paradigm Program enables physicians and other health care professionals to discuss and convey the wishes of patients with serious life-limiting illness who have a life expectancy of less than one year, or anyone interested in further defining their end-of-life care wishes. While the POLST Paradigm Program is known by different names in different states, *e.g.*, West Virginia's *Physicians Orders for Scope of Treatment* or "POST" and New York's *Medical Orders for Life-Sustaining Treatment* or "MOLST," all endorsed programs share common core elements.

POLST is outcome-neutral and may be used either to limit medical interventions or to clarify a request for all medically indicated treatments. POLST provides explicit direction about cardiorespiratory resuscitation status if the patient has no blood pressure, no pulse, and no respirations. Additionally, the medical orders provide direction about other types of life-sustaining treatment that the patient may or may not want—for example, decisions about transport, ICU care, antibiotics, artificial nutrition, intubation and mechanical ventilation. Key features of the program include education, training and a quality improvement process.

This article explains the genesis of POLST, its current status in state health decisions policy, and its prospects as a model for all states. [An opposing view of the POLST approach appears on page 5.]

State Statutory Law

The first health care advance directive law—a living will act—was passed by California in 1976. Since then, every state has enacted one or more health care advance directive statutes. Most have at least two statutes, one establishing a "living will" type directive, the other establishing a proxy or durable power of attorney for health care. The spread of advance directive legislation did not lead to uniformity of law. Indeed, formalities and other requirements vary to such an extent that no single comprehensive advance directive form can possibly meet the statutory requirements in every state.

During the 1990s, however, states began moving toward simplification by combining these laws into comprehensive advance directive acts. Today, about half the states have comprehensive or combined advance directive statutes, which at a minimum cover living wills and proxies in the same law. The most comprehensive ones also recognize the authority of default surrogate decision-makers in the absence of an advance directive.

One of the drivers in the trend toward simplification has been the sizeable research literature detailing a lack of effectiveness of traditional legalistic advance directive tools when individuals are seriously ill and lose decisional capacity. Studies show that conventional advance directives have been confusing, often clinically irrelevant, and produce little impact on end-of-life decision making. *See, e.g.* Angela Fagerlin & Carl E. Schneider, "Enough: The Failure of the Living Will," 34 *The Hastings Center Report* 30-42 (March-April 2004).

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

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

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

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As law and practice move toward the less standardized, more flexible, communications approach of advance care planning, questions remain as to whether more flexibility in communication will have any greater impact on actual treatment decisions than do standardized advance directive forms. Knowing the patient's wishes and goals of care better does not guarantee that those wishes and goals will actually be translated into quality end-of-life care congruent with the wishes. Virtually every practitioner knows of too many cases in which medical turns of events result in unwanted suffering for patients and family.

Role of POLST in Advance Care Planning

The POLST Paradigm Program is designed to enhance the process of determining the goals of care for patients with serious, chronic, life-limiting conditions and then to bridge the gap between patient goals and preferences and the actual plan of care as reflected in medical orders. The POLST paradigm begins with the recognition that what really happens to patients in hospitals and other health care settings normally depends on physician orders and routinized clinical procedures. Patients' advance directives (or their spoken wishes) and their surrogates' voices often get lost in the regimented hustle and bustle of clinical convention.

The POLST paradigm is characterized by three key elements:

(1) ***Effective communication of patient wishes:*** The use of POLST requires a discussion between the health care provider and patient or surrogate about goals of care and potential life-sustaining treatment options. The target patient population has advanced progressive chronic conditions and may die in the next year. The objective is to discern patient goals for care, and in turn have goals guide the choice of intervention, in light of the patient's current medical condition, prognosis and the available care options as explained by the treating health care provider. Since the POLST is completed in consultation with a physician when the patient's life expectancy is less than a year, it provides better proof that the patient holds a firm and settled commitment to withholding or terminating life supports under the circumstances that actually exist when the decision whether to withhold or terminate life-sustaining treatment must be made.

(2) ***Documentation of medical orders on a brightly colored form:*** Patient wishes are incorporated into medical orders that are recorded on a unique, visible POLST form (bright pink in Oregon and New York; bright green in West Virginia) that serves as a cover

sheet to the medical record. In a patient's home, it is generally posted on the refrigerator. The treating physician reviews and modifies the form periodically as needed. The uniquely designed form is the hallmark of the POLST paradigm. It covers several key decisions that are of high probability for seriously chronically ill patients. This is where the POLST paradigm differs from out-of-hospital Do-Not-Resuscitate (DNR) protocols that exist in virtually every state. DNR protocols provide a decision-making process, doctor's order, and patient identification process exclusively for decisions about cardio-pulmonary resuscitation. POLST addresses a broader range of treatment scenarios.

(3) ***Promise by health care professionals to honor these wishes:*** The POLST process helps to ensure that physicians, nurses, health care facilities, and emergency personnel will honor the patient's wishes for life-sustaining treatment in the patient's present condition. Health care providers must ensure that the POLST form travels with the patient whenever transfers from one setting to another are made, thus, promoting continuity of care and decision making. Periodic review of the orders is required and documented each time the person is hospitalized; each time the person is transferred from one care setting to another; any time there is a substantial change in the person's health status; and any time the person's treatment preferences change.

POLST is not an advance directive in the conventional sense, but rather a set of medical orders signed by a physician (or a nurse practitioner in some states) that reflect the patient's *here-and-now* goals for medical decisions that could confront the patient in the immediate future. It complements one's advance directive, but for those patients who have no advance directive, it can also function in the absence of a directive if the patient has decisional capacity, or if state law provides a default surrogate for patients without an appointed proxy. (The core requirements for a POLST protocol, as stated by the national POLST Paradigm Initiative, can be found at *http://www.ohsu.edu/ethics/polst/developing/core-requirements.*

Medical Evidence Base

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

In another study, emergency medical technicians in Oregon reported that the POLST form provides clear instructions about patient preferences and is useful when deciding which treatments to provide.

Congress Waives Distribution Requirements for 2009

President Bush has signed legislation that will temporarily suspend the penalty for seniors who fail to take the required minimum distribution from IRA and employer retirement accounts in 2009.

But the penalty freeze, which is part of the Worker, Retiree, and Employer Recovery Act of 2008, did not affect required distributions for 2008, which had to be made by December 31, 2008. Congress had expected the Treasury Department and the Internal Revenue Service to come up with a solution, but the agencies decided not to change the rule for 2008. This meant that taxpayers will be hit with a double whammy for 2008 because the required withdrawals are based on a percentage of what the IRA and 401(k) portfolios were worth at the end of 2007, when the Dow Jones Industrial Average was still well into five digits.

Replication of National Model

The National Quality Forum and other experts have recommended nationwide implementation of the POLST Paradigm. Since Oregon's pioneering development of the POLST form in the early 1990s, a total of nine states have taken legislative or regulatory steps to implement POLST-like protocols and parts of several other states have done so on a local basis, although the name of the protocol varies. (For a table outlining POLST initiatives around the country, go to: *http://www.elderlawanswers.com/Resources/ArticleAtty.asp?id=7375&Section=9&state=*)

The POLST Paradigm Program has the advantage of being fairly adaptable in the face of variable state law. For example, it has been implemented with detailed legislation (as in West Virginia), without legislation through provider collaboration (as in Oregon), and with a combination of provider collaboration, regulation and legislation in New York.

It is important to understand that the POLST paradigm does not change state health decisions law regarding the definition of capacity to make health care decisions, persons authorized to consent to health care on behalf of an incapacitated patient, and the standard

Clifton B. Kruse, Jr., Moral Beacon and Mentor to Elder Law Attorneys, Dies at 74

Clifton B. Kruse, Jr., a revered elder law attorney who was admired as much for his courtliness and generosity to fellow practitioners as for his masterly grasp of the law, died December 30, 2008, in Colorado Springs, Colorado. He was 74. The cause was complications from Alzheimer's disease.

For many in the field, Kruse set the standard for all that an elder law attorney can and should be. Arizona elder law attorney Robert Fleming wrote in a tribute, "In my third of a century of elder law practice I have never met another lawyer who managed to pull together sophistication, heartfelt empathy, intellectual rigor and courtly manner in the same fashion Clifton Kruse projected. He did it, to all appearances, effortlessly. He was a friend and mentor to many in the elder law community (I count myself among those legions)."

Kruse was the eighth President of the National Academy of Elder Law Attorneys, serving from 1995 to 1996. He was inducted as a Fellow in 1993 and served on the Board of Directors from 1991 through 1997.

Writing in a message to NAELA members, the organization's current president, Craig C. Reaves, characterized Kruse as "a consummate gentleman. Always impeccably dressed, always gracious towards others, always with time to answer a question, no matter how busy he was. Clif was a beacon for how to act honestly, ethically and professionally as a lawyer."

Born July 16, 1934, Kruse was an ordained Methodist Minister and prison chaplain. He received his Juris Doctorate degree from Washburn University School of Law in 1963 and was the founding member of Kruse and Lynch, P.C.

Kruse's treatise *Third-Party and Self-Created Trusts*, now in its third edition, remains the primary reference resource on its topic. Displaying his warmth and humanity was another book, *Selma's Cat and Other Things That Matter*, a collection of encounters with clients culled from Kruse's more than 40 years of practice. The stories convey just how difficult, heartrending, but ultimately rewarding the job of an elder law attorney can be—and how it often takes a master humanitarian and emotional tactician like Kruse to meet the challenge.

In addition to his NAELA affiliations and awards, Kruse was a Fellow of the American College of Trust and Estate Counsel and a former vice president of the Colorado Bar Association, which gave him the Award of Merit, its highest honor for outstanding contributions to the legal profession and the association.

Kruse is survived by his wife of 52 years, Carolyn; sisters Thelma Kruse and Linda Lynch; his children Angela Kruse and Stephen Kruse; two grandchildren and six great-grandchildren.

A memorial service was held January 3, 2009, in Colorado Springs. In lieu of flowers the family suggests donations to the Pikes Peak Hospice, 825 E. Pikes Peak Avenue, Suite 600, Colorado Springs, CO 80903, or the Humane Society of the Pikes Peak Region, 610 Abbott Lane, Colorado Springs, CO 80905.

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of decision-making an agent or surrogate must follow. It operates within those parameters. However, states interested in developing a POLST program need to review the compatibility of existing laws with the POLST program and follow, amend, or adapt accordingly. A recent study of potential barriers to POLST implementation found that the most common barrier was the existence of highly detailed state requirements for out-of-hospital DNR orders. DNR statutes or regulations are sometimes so narrowly focused on DNR orders that they may preclude addressing a broader range of clinical interventions as is done by the POLST form.

The New York Experience

The New York experience provides an instructive example of state policy moved from a focus solely on DNR orders to POLST. New York's MOLST Program was one of several projects developed and implemented by the Community-Wide End-of-life/Palliative Care Initiative, a health care and community collaborative based in Rochester. MOLST was adapted from Oregon's POLST and integrated New York State Public Health Law, including formal requirements for capacity determination and review/renewal requirements for DNR orders.

Prior to the MOLST, New York's non-hospital DNR Law (PHL § 2977) required use of a "standard form" issued by the Department of Health; by contrast, hospital-based DNR orders could be on any form. The "standard form" is a one-page form with little detail beyond instruction not to resuscitate. A non-hospital DNR can be honored *only* if the patient is in *full* cardiopulmonary arrest. If the patient is *not* in full cardiac or respiratory arrest, *full* treatment must be provided. Do-Not-Intubate orders were *not* covered in the non-hospital DNR law.

MOLST began as a voluntary program in 2003. In 2005, MOLST was approved by New York State Department of Health for use in all health care facilities, although not for community care. At the same time, legislation was enacted to permit a pilot demonstration for community use in two counties. The MOLST pilot was successful, and positive attributes and benefits were found to outweigh any potential risks. In the pilot counties, MOLST is well-recognized and trained professionals can read it and understand its intent. With completion of the pilot, MOLST was made permanent and statewide by legislation signed by Gov. David Paterson in July 2008. MOLST can be now used in the community as DNR and DNI orders throughout New York State.

Role of Elder Law Attorneys

Elder law attorneys can play a major role in encouraging clinical and policy leaders to develop a POLST paradigm program in their state. Case examples of clients whose clearly articulated wishes were not appropriately translated into their care plan can be most compeling. Many chronically ill elders and their families have encountered unpleasant surprises when their medical needs abruptly changed—surprises that should be of no surprise had someone looked at their medical status and discussed goals of care and likely scenarios.

In addition, the American Bar Association endorsed the POLST paradigm in August 2008, so the policy weight of a significant portion of the legal profession is behind the movement. The bar's role is also important in making sure a POLST program actually operates meaningfully as intended. With poor training, inadequate resources, and insufficient evaluation, the process can regrettably morph into another systematic trampling of patient autonomy. But of course, that is true of any best-laid plans. Ultimately, the key to successful implementation is the sound commitment of medical professionals, institutions, regulators, and insurers to the optimal functioning of POLST.

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