

CANHR POLICY BRIEF

PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT ("POLST")

PROBLEMS AND RECOMMENDATIONS

A SPECIAL REPORT BY:

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HOPE:

“A POLST is particularly useful for individuals who are frail and elderly or who have a compromised medical condition, a prognosis of one year of life, or a terminal illness.” (AB 3000 (2008) Section 1(f))

REALITY:

Seventy-three percent (73%) of surveyed Ombudsman report that nursing homes residents are erroneously told POLSTs are mandatory, regardless of their health condition, “always” or “often.”

Executive Summary

The POLST form has exploded into the consciousness of California health care providers. The meteoric rise of POLST as part of advance health care planning has been the result of a well-organized and coordinated effort to sell the POLST form’s considerable benefits. The greatest benefit is that POLST is meant to inspire a conversation – a conversation between physicians and other health care providers with their patients who are at the end of their lives. However, POLST has caused deep concerns among many health care consumer advocates who publicly wonder if POLST is doing more harm than good for Californians.

This policy analysis is devoted to assessing POLST – from the good to the bad to the ugly. The analysis begins with an overview of the positive features of POLST as an advance care planning tool. The discussion then shifts to the considerable problems that POLST presents, from the form itself to its statutory foundation and subsequent implementation. The analysis concludes with a lengthy list of recommendations for eliminating or reducing some of the POLST problems.

As part of its analysis, CANHR conducted a survey of Long-term Care Ombudsman regarding the POLST in practice. The survey revealed a very disturbing level of misrepresentation and misuse of POLST such that one wonders if the forms are in fact causing more harm than good. The forms certainly have their place as a useful advance health care planning tool. The problem is the good intentions of the POLST form’s proponents have not addressed the troublesome realities of a health care profession that often leaves patients groping for information to elucidate their options. In short, POLST fails to recognize that for many patients, the health care system is simply not interested in a conversation.

POLST Background

Physician Orders for Life Sustaining Treatment (“POLST”) are physician order forms on which a patient indicates preferences regarding end-of-life care such as resuscitative measures and other life-sustaining treatment. Those preferences are then used to direct the patient’s care in the event they lose capacity to communicate their preferences at some future time. The primary purpose of POLST, therefore, is to ensure that patients receive end-of-life care consistent with their preferences.

Oregon was the first state to adopt POLST in 1991 and since that time, the form has been established or is being developed in over twenty-five states.¹ In California, POLST began as a seven community pilot project in 2007 and has been used statewide since January 1, 2009. Statewide use began with the adoption of Assembly Bill Number 3000 (“AB 3000”) which amended and added Probate Code sections 4780-4785 - the entirety of the POLST law.

The Advantages of POLST

1. PATIENTS' PREFERENCES ARE FORMALIZED AT AN APPROPRIATE TIME.

POLST forms are designed for completion when a patient is frail and elderly or terminally ill.² Thus, the expression of the patient's wishes need not rely on conjecture about end-of-life scenarios when the principal is relatively healthy and does not have a terminal condition; but rather can be based on medically-informed expectations. The preferences selected should be considerably more educated and give providers a more accurate picture of the patient's desires.

2. THIRD PARTIES MAY GUIDE CHOICES WHEN THE PATIENT HAS NOT MADE DOCUMENTED PREFERENCES.

A third party may execute a POLST on behalf of the patient if the patient has lost the capacity to do so.³ This feature allows for advance direction of treatment even when patients have not documented their wishes. Since a small minority of the population has completed AHCDs, POLST provides a method to express and document patients' wishes when they otherwise could not.⁴

3. READER-FRIENDLY FORM.

POLST is a mere two page form. As such, POLST does not seem daunting and implicitly encourages patients to complete it. Other advance directive forms are typically significantly longer. For example, the "Five Wishes" directive, a comprehensive form meant to meaningfully and plainly address end-of-life care decisions, offers forty-seven separate choices. The brevity of the POLST form tends to persuade patients or their legal representatives to complete it.

4. POLST MUST BE SIGNED BY A PHYSICIAN.

The requirement that a physician sign the form is important for three reasons. First, it forces physicians to be part of the end-of-life care planning process, giving patients an opportunity to ask questions and receive expert information to make more informed choices. Second, the requirement should assure that forms are filled out correctly and signed by appropriate parties since

the physician is not supposed to sign the POLST form until such actions have taken place. Third, a physician's signature gives the form the primacy of a medical order. As a medical order, unlike AHCDs, health care facilities and staff can follow a POLST's directions without reservation.

5. DETAILED INFORMATION ON THE FORM.

POLST contains more specific information about end-of-life care options than the standard AHCD, therefore offering better accuracy regarding patients' true care preferences.

6. EASILY IDENTIFIABLE.

The POLST form is printed on #65 stock, pink paper, rendering it instantly recognizable in a patient's medical chart.

7. STANDARDIZED FORM.

The POLST form is standardized. Thus, health care workers will presumably have great familiarity with the form and have confidence in adhering to its directions. This familiarity should minimize patient and family confusion in filling out or amending the form.⁵

8. POLST WILL BE AVAILABLE WHEN AHCDs MAY NOT BE.

POLST forms are meant to be included in a patient's medical chart and transported with the patient any time they move to a new health care provider. AHCDs may also be included in the patient's chart, but were not designed to travel with the patient to new providers. Thus, POLSTs should be more readily available to inform physicians' treatment orders.

POLST Problems

Problems with the POLST Form

1. THERE ARE NO LIMITS ON WHO CAN SIGN ON BEHALF OF THE PATIENT.

Any of the following parties may sign a POLST form for a patient: (1) the patient him or herself; (2) parent of minor; (3) health care representative; (4) court-appointed conservator; and (5) other.

The inclusion of “other” as a signatory allows any person at all to direct end-of-life care for patients. This bears repeating: including “other” as a signatory permits *anyone* to make critical life and death decisions on behalf of patients. This fact leaves patients vulnerable to massive abuse and is entirely inconsistent with POLST law. California Probate Code Section 4780(1) limits POLST signatories to patients with capacity, or legally recognized health care decision makers.

2. NO REQUIREMENT THAT AHCD BE CHECKED FOR CONSISTENCY.

Although it is certainly the case that physicians should check patients’ AHCDs for consistency with POLST forms, they do not always do so. This is problematic because: (1) AHCDs help to advise proper implementation of POLST, and (2) consistency or lack thereof between AHCDs and POLSTs would help determine whether the POLST form is accurate.

3. POLST FORM HAS NARROWER RULES FOR REVOCATION THAN POLST LAW.

The POLST form states that patients wishing to revoke a POLST form may do so by: (1) executing a verbal or written advance directive, (2) executing an entirely new POLST form, or (3) writing “VOID” across the POLST form. However, under Probate Code Section 4780(d), any time a patient chooses to revoke a POLST form and effectively communicates that intent, the POLST form is revoked. Therefore, the form is inconsistent with the law and misleads patients.

4. LACK OF CLARITY.

While end-of-life care choices in POLSTs may be clear in some instances, they are not consistently easy to understand. For example, part B of POLST presents three potential medical interventions: (1) “comfort measures,” (2) “limited additional interventions,” and (3) “full treatment.” These terms could have multiple meanings in multiple situations. As lawyer and medical doctor Jason W. Manne questions, “what do these terms mean in terms of actual medical procedures performed by doctors?”⁶ As one California Long-term Care Ombudsman (“Ombudsman”) reports, “POLST format does not display the choices clearly and simply when staff need to use it. . . . EMT’s are confused about what ‘comfort care’ means . . . should the patient even be sent to the hospital if the POLST says ‘comfort care?’ ”⁷

5. PHYSICIANS SIGN THE FORM BUT DO NOT ACKNOWLEDGE HAVING CONVERSATION.

Physicians are required to sign POLST forms, but there is no place to indicate whether the end-of-life care choices were discussed with their patients. Thus, the form appears to guarantee basic physician-patient interaction; in practice, however, physician participation is exhausted by simply signing a previously prepared form. POLSTs are supposed to be the result of a reflective, iterative, process, marked by ample conversation with a physician. In a survey of Ombudsman programs conducted by CANHR, more than 72% of POLSTs for residents of long-term care facilities were completed by nurses, nurses’s aides, or other nonphysicians.⁸ In light of such data, physician participation in POLST completion appears to be tepid.

Problems with the POLST Law

1. THIRD PARTIES PERMITTED TO OVERRIDE PREVIOUSLY EXPRESSED WISHES OF A PATIENT.

The primary purpose of POLST is to ensure that end-of-life care is delivered in a manner consistent with the patient’s wishes. The form is designed to record the patient’s preferences and then direct providers accordingly. Unfortunately, the POLST law permits third parties to override

prior expressions of a patient's preferences, undermining the primary purpose of POLST and setting California privacy law and advance health care decision making on their heads. For example, E.H. from Fairfield, California, reports that his friend wrote an AHCD directing that he receive all treatment necessary to prolong his life.⁹ The friend's son (and, it should be noted, his heir) nonetheless later signed a POLST directing his father receive comfort care only. His father passed away soon after.

The insidious proposition that third parties may override the previously expressed wishes of a patient comes from two provisions of AB 3000. The first provision is Probate Code Section 4780(c), allowing a "legally authorized representative" to sign a POLST on behalf of an incapacitated patient. That provision is innocuous enough until one considers a second provision, found in Probate Code Section 4781.4, which states in the event of a conflict between POLST and any other previous health care instruction, the latest in time prevails. Thus, the POLST law gives third party "representatives" the ability to countermand a patient's prior expressions of treatment preferences and make treatment decisions with which the patient has expressly disagreed.

Patients' rights to express their treatment preferences in advance are grounded in federal and state constitutional law, namely the right of privacy and bodily autonomy. Once a patient has documented his or her preferences, the only person who may override those decisions is the patient. The POLST law, therefore violates basic constitutional law principles and undermines its own stated purpose of promoting patient self-determination. Even if third parties were constitutionally able to overrule a patient's express health care preferences, there are compelling policy reasons for avoiding it. In a Shalowitz, Garret-Mayer, and Wendler 2006 study, surrogates wrongly predicated patients' treatment preferences 32% of the time. In matters of life and death, 68% must be seen as a failing grade.

2. WHO IS A "LEGALLY RECOGNIZED HEALTH CARE DECISION MAKER" ANYWAY?

POLST law allows "legally recognized health care decisionmaker[s]" to sign a POLST and make end-of-life care decisions on behalf of a patient who lacks capacity.¹⁰ The law, however, does not define what a legally recognized health care decisionmaker is.

A "POLST Model Policy" developed by the California Coalition for Compassionate Care cites various case and statutory law to define "legally recognized decisionmaker," but is not able to provide a definitive understanding of the term.¹¹ The cited case law is *Cobbs v. Grant*.¹² But the *Cobbs* decision merely states that parents may make treatment decisions for their children.¹³ In unbinding *dicta*, the *Cobbs* court says that a patient's "closest relative" may decide for the patient but does not define the term or explain who decides if family members are in disagreement.¹⁴ The POLST Model Policy also cites various statutes that give health care decision making authority to agents operating under a power of attorney, persons orally designated by a patient, and court-appointed conservators.¹⁵

A "legally recognized health care decisionmaker" certainly includes surrogates who are properly designated through procedures authorized in the Probate Code. However, the majority of patients have no such surrogate, leaving the identity of a potential representative much less certain. Family members seem to have some authority via *Cobbs*, another case called *Barber v. Superior Court*, and Probate Code Section 4716. Nonetheless, there is no provision for who among family members is "the closest" or how to resolve intra-family conflicts. All of this uncertainty is compounded by the fact that the POLST form allows any person, a.k.a. "other," to sign a POLST on behalf of the patient.

3. LONG-TERM CARE OMBUDSMAN ARE NOT REQUIRED TO WITNESS POLST FORM SIGNING IN NURSING HOMES.

Under California Probate Code Section 4675(a), AHCDs executed in skilled nursing facilities require an Ombudsman sign as a witness.

This is because nursing home residents are “insulated from a voluntary decisionmaking role, by virtue of the custodial nature of their care, so as to require special assurance that they are capable of willfully and voluntarily executing an advance directive.”¹⁶ This same special assurance should be provided when POLST forms are signed. Many reports of POLST abuses and problems have come from skilled nursing facilities.¹⁷

Problems with POLST Implementation

1. MISUNDERSTANDING THAT POLST SOMEHOW REPLACES AHCD.

In the preamble to AB 3000, the legislature declares:

“The Physician Orders for Life Sustaining Treatment (POLST) form **complements** an advance directive by taking the individual’s wishes regarding life-sustaining treatment, such as those set forth in the advance directive, and converting those wishes into a medical order.” [emphasis added]

However, in practice, POLST is often used in place of an advance directive. Seventy-three percent of surveyed Ombudsman reported that POLST is represented to patients as replacing an AHCD “always” or “often.”

2. POLST FORM IS NOT USED PRIMARILY FOR PERSONS WITH TERMINAL ILLNESS.

One of the selling points of POLST is that the form was meant to reflect patients’ treatment preferences closer in time to their end-of-life care, when they are likely to know what will cause their deaths.¹⁸ Despite this intention, some providers have been giving out POLSTs to practically all patients, healthy or ill, with health care directives or not. According to Hickman, Tolle, et al., 92% of all nursing home patients in Oregon were given POLST in 2004. In California, 73% of surveyed Ombudsman report that residents of nursing homes are erroneously told POLSTs are mandatory, without regard to their health condition, “always” or “often.” POLST is not meant for younger, healthy persons. And, importantly, POLST forms do not expire – meaning patients may be held to

their choices many years after their preferences have changed.

3. ACCOMPANYING HANDOUTS MAY MANIPULATE PATIENT CHOICES.

Many times, POLST forms will be accompanied by handouts meant to sway patient decisions. For example, on the POLST form, CPR is an available option. However, accompanying handouts describe how survivors of CPR may have broken ribs and brain damage and that those revived may only survive a short period of time afterwards. The handouts are clearly intended to convince patients or their representatives to forego CPR.¹⁹

4. PHYSICIANS COMPLETE AND SIGN “ADVISORY POLSTs.”

Another POLST implementation problem is that physicians will sometimes fill out and sign POLST forms without a patient’s or surrogate’s consent. These physicians claim that these forms are only advisory and not binding.²⁰ Despite such caveats, the presence of a physician-signed POLST in a patient’s medical chart is likely going to dictate care, regardless of whether a patient has signed. Any effort to use the POLST in a manner other than to preserve the patient’s express wishes is illegal and unfair to the patient.

5. THE FORM IS TRANSFERRED BETWEEN AND AMONG INSTITUTIONS.

Because POLST is meant to travel with the patient between and among institutions, there may be problems of physicians who are not credentialed at a particular health care facility giving enforceable orders.

6. POLST FORMS SOMETIMES LACK A PHYSICIAN’S SIGNATURE.

An Ombudsman from a northern California program reported that patients’ files frequently contain POLST forms that are missing the physician’s signature. POLST forms that lack a physician signature are not legal or enforceable and should not be made part of a patient’s record until they are properly signed.

7. “HEALTH CARE PROFESSIONALS” RATHER THAN DOCTORS EXPLAIN THE FORM.

Despite the fact that doctors are supposed to explain the form to patients, non-physician “health care professionals” – such as social workers, care assistants, or even people who work in a facility business office – are often left to do so. In long-term care facilities, a staggering 57% of all POLSTs are believed to be completed by non-health care professionals such as admission coordinators and business managers.²¹ While these persons may possess some basic knowledge of health care, they are not experts in medicine and the issues of end-of-life care. Thus, many important choices on the form and their implications may be inaccurately explained or not explained at all, leading to violations of patients’ basic rights to give informed consent prior to medical treatment. Overall, allowing undefined health care professionals to review the form with the patient contributes to undermining the purpose of POLST: to accurately reflect the treatment preferences of the patient.

In a recent case in Santa Cruz, a nursing home was subjected to enforcement action by the state Department of Public Health for using POLST procedures that failed to ensure that physicians had discussed end-of-life care options with their patients; in fact, the facility’s procedures discouraged such conversations.²² The facility was found to have a clipboard stacked with POLST forms in various stages of completion. Upon further investigation, the facility was found to be mailing partially completed POLST forms to resident representatives for signature. Once the forms were returned, the facility submitted them to the relevant physicians for signature. The facility was treating the forms as part of an assembly-line of end-of-life care, with no regard for deliberation or informed consent.

HOPE:

“[POLST] would require a health care provider to explain the form.” (AB 3000 (2008) Preamble)

REALITY:

In nursing homes, 57% of all POLSTs are believed to be completed by non-health care professionals such as admission coordinators and business managers.

8. THE FORM IS OFTEN PRESENTED AS MANDATORY.

While the POLST form is voluntary, health care facility staff members often tell patients that their services are contingent on POLST completion. As stated before, 73% of Ombudsman reported that POLST is “always” or “often” presented to long-term care residents as mandatory.

9. PATIENTS WITH CAPACITY ARE IGNORED.

One Long-term Care Ombudsman in Los Angeles reports that multiple nursing homes have a standard practice of having POLSTs signed by resident family members, regardless of whether the resident has capacity to make health care decisions. This observation is reinforced by the fact that 59% of surveyed Ombudsman found that POLSTs were signed by third parties, *even when the resident had capacity*, “often” or “sometimes.”

10. NON-ENGLISH FORMS ARE USELESS.

Physicians will only honor forms filled out in English, even though the form has been translated in many languages. So, while patients may fill out a POLST in their native language, they are useless unless they find someone to translate it to English. Non-English POLSTs may give a false sense of security to non-English speakers so not only are they non-binding but actually may discourage practical advance direction of care.

Recommendations for Improving the POLST Form²³

1. ADD A STATEMENT THAT POLSTs ARE VOLUNTARY.

While a POLST form is meant to be voluntary, health care providers will often present POLST as mandatory. The simplest solution is to add a prominent statement, perhaps in bold, that POLST is voluntary and health care services are not contingent upon completion. Another alternative is to change the law to add penalties for providers who claim otherwise.

2. ADD A STATEMENT THAT POLST DOES NOT REPLACE AHCD.

POLST forms do not replace AHCDs. The POLST law makes this very clear. Yet, in practice, POLST has tended to crowd out AHCDs with some providers actually claiming that POLST has replaced AHCDs. A statement in bold across the top of each side of the POLST form – saying something to the effect of “POLST does not replace AHCD” – would help resolve this practice.

3. REMOVE “OTHER” FROM POTENTIAL SIGNATORIES AND REQUIRE PATIENT INCAPACITY BEFORE ANY THIRD PARTIES MAY SIGN ON BEHALF OF THE PATIENT.

Under POLST, only a “legally recognized decisionmaker” may sign on behalf of a patient. While this term remains undefined, it certainly does not include “other.” “Other” should be deleted from the options. In addition, third party signatures should be prohibited unless the patient lacks capacity to sign the POLST him or herself.

4. CHECK FOR CONSISTENCY WITH AHCD.

Providers should be strongly encouraged to check consistency between AHCDs and POLSTs. Comparing a POLST to a pre-existing AHCD would enhance decision making by identifying mistakes and more fully informing patients’ preferences. To deal with this, the form should instruct health care professionals to check for consistency with any advance directives.

5. MODIFY FORM REVOCATION REQUIREMENTS TO MATCH THE LAW.

The law allows patients to revoke POLST forms at any time, in any fashion.²⁴ The form, however, lists only a few methods of revocation. This inconsistency should be resolved by amending the form to reflect the law.

6. CLARIFY THE CHOICES IN THE FORM.

POLST advocates should work with physicians and patients to clarify the unclear parts of the POLST form. For example, “comfort care” could be better defined while terms like “intubation” and “cardioversion” should be defined or removed, unless there is some guarantee that doctors will always be available to explain these terms.

7. REQUIRE THE SIGNATURE OF THE PERSON ALLEGING THE CONVERSATION.

Since one of the primary purposes of POLST is to insure that each patient or representative has a discussion with a physician or other health care professional about end-of-life preferences, the discussion should be acknowledged on the form. The physician who signs the form should have to indicate whether they had a conversation with the patient. If they did not, the health care professional who did have the conversation should have to sign the form and select their profession from a limited menu of approved health care professions.

Suggested Changes in POLST Law

1. MOST RECENT DOCUMENT COMPLETED BY THE PATIENT SHOULD PREVAIL

Under the POLST law, the most recent document prevails when an AHCD conflicts with a POLST. Patients’ privacy rights, however, dictate that the most recent treatment preferences expressed by *the patient* should prevail. When patients themselves fill out two documents, the most recent one should prevail. However, a patient’s documented wishes should not be overwritten by a third party executing a POLST on the patient’s behalf. If POLSTs are meant to reflect a patient’s wishes, third parties should not be able to override them simply by completing a new POLST form.

2. CLARIFY “LEGALLY RECOGNIZED DECISIONMAKER.”

The law should clarify who constitutes a “legally recognized decisionmaker.” Because the form includes a category of “other,” such a decision maker potentially includes anyone at all. The law should be amended to at least provide a cursory definition that limits potential representatives in a manner consistent with established California health care law. The definition should clarify whether family members, without express designation by the patient or a court, are included as “legally recognized decisionmaker[s].”

3. REQUIRE PHYSICIANS EXPLAIN THE CHOICES.

The law currently allows “health care professionals” rather than physicians to explain the POLST form. The form is littered with technical terminology – some of which non-expert “health care professionals” may have a difficult time with. With decisions as important as whether one will be left to die, informants should be qualified physicians. No substitute for an adequate informant should be accepted. At the very least, the term “health care professional” should be defined so that unqualified people are excluded from consideration.

4. REQUIRE A WITNESS IN NURSING HOMES.

A witness to a POLST signing should be present for two reasons. First, a witness can assure a physician conversed with the patient. Second, a witness can assure the physician’s information was conveyed objectively and the patient or representative signed voluntarily – with the opportunity to make decisions. A witness requirement could be limited to situations where inordinate pressure exists to have POLSTs completed, such as when the patient is a resident of a skilled nursing facility. In those situations, the Ombudsman program could be utilized as the witness, as they are with AHCDs.

Suggested Changes in POLST Implementation

1. DIRECT THAT IF A PATIENT LACKS CAPACITY AND HAS PREVIOUSLY APPOINTED A SURROGATE, ONLY THAT SURROGATE MAY SIGN FOR THE PATIENT.

If a patient appoints a surrogate to make decisions for him or her, the patient has clearly expressed a trust and preference for that particular surrogate. Therefore, when a patient has appointed a surrogate and subsequently loses capacity to express treatment preferences, POLST completion should be limited to the appointed surrogate. In such cases, no other third parties should be allowed to complete a POLST, unless the appointed surrogate expressly abrogates their position.

2. GIVE ONLY TO TERMINALLY ILL PATIENTS.

POLST’s history and law make clear that POLST forms are only supposed to be given to frail, elderly, or terminally ill patients. However, in practice, some providers have given the form to practically all patients. Providers should be discouraged from this practice. Patients who are not frail, elderly, or terminally ill should be encouraged to complete AHCDs, which would not only satisfy the goal of POLST policy but also the federal Patient Self-Determination Act (“PSDA”), which was designed to increase the use of AHCDs nationwide.

3. SHOULD ONLY ACKNOWLEDGE FORMS SIGNED BY A PHYSICIAN.

A form not signed by a practicing physician is not legal should not be acknowledged or included in a patient’s medical records. Health care providers confronted with forms not signed by physicians should refuse to accept the forms until they include a physician’s signature.

4. USE SUPPLEMENTAL HANDOUTS THAT CONTAIN BALANCED INFORMATION.

Many times, handouts given with POLSTs prevent patients from choosing care options most reflective of their true preferences. The handouts seem intended to scare patients about some of their potential choices. Providers who elect to continue

providing handouts should ensure they present all reasonable information regarding each POLST form option. This objective handout would leave the patient to decide for him or herself – rather than the handout making the decision for the patient.

5. DON'T ALLOW "ADVISORY FORMS."

"Advisory forms" - forms filled out and signed by a physician only – are not legal and should not be allowed. Since these forms are not binding, their existence can only cause harm. Physicians are precluded by law from substituting their treatment choices for those of their patients.

6. USE FORMS WITH BOTH ENGLISH AND OTHER LANGUAGES.

Non-English POLSTs, like English POLSTs, should be honored. It seems perfectly reasonable to include accompanying English text in all foreign language forms so that they may be read by both the patient and health care providers. Such a form would eliminate the need for a translator and guarantee that any POLST form signed by the patient would be immediately binding.

7. PUT AHCDs IN THE CHART.

If AHCDs, like POLST forms, were available in the patient's medical records, the two could more easily be used in collaboration with one another. Providers should be re-acquainted with the federal PSDA and give AHCDs their rightful place in the advance directive document hierarchy.

Conclusion

The POLST form represents a positive development in advance care planning in many ways. It presents a reader-friendly form to inform important end-of-life decisions. Unlike AHCDs, the form requires medical personnel to sign the form and consult with the patient. The form is standardized and instantly identifiable and gives patients affirmative choices in choosing end-of-life care. However, POLST is far from perfect.

POLST is imperfect in regard to the: (a) makeup of the form, (b) substance of the law, and (c) implementation. In those regards, recommendations have been made. Some of those recommendations, such as dealing with non-English forms and handouts intended to inform end-of-life care decisions, are relatively insignificant and merely advisory. However, most recommendations, such as revising the law to prevent unconstitutional disregarding of patients' express wishes, are quite serious and must be immediately addressed by the legislature and POLST advocates. Otherwise, a potential rift between providers and their patients will emerge, characterized by lawsuits, mistrust, and ultimately, a failure to meet the stated goals of POLST.

Notes

- 1 See “POLST,” Center for Ethics in Health Care, Oregon Health & Science University. Copyright 2008, <http://www.ohsu.edu/polst/programs/state+programs.htm> (POLST is established statewide in California, North Carolina, Oregon, Tennessee, Washington, and West Virginia. It is established in part of the state in Wisconsin. It is being developed statewide in Alaska, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Louisiana, Maine, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, Ohio, Texas, and Utah. It is being developed in part of the state in Kansas, Missouri, Minnesota, Nevada, New York, North Dakota, Wisconsin, and Wyoming.)
- 2 AB 3000, Section 1(f), *Declaration of Legislative Intent*; see also, Susan E. Hickman, et. al., *A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program*, *Journal of the American Geriatric Society*, Vol. 58 (2010), pp. 1241-1248, at 1241.
- 3 Cal. Probate Code §§ 4780(b) and 4780(c)
- 4 A 2006 poll from the Pew Research Center found 29% of Americans have completed an AHCD. *More Americans Discussing – and Planning – End-of-Life Treatment*, The Pew Research Center, January 5, 2006, <http://people-press.org/reports/pdf/266.pdf>. This finding is consistent with many other polls and studies finding AHCD completion in 20-30% of the population.
- 5 Cal. Probate Code § 4782(b) does not require that POLST be standardized, but does require that it be “approved by the Emergency Medical Services Authority.” In practice, the form is standardized. Further, The California Coalition for Compassionate Care (“CCCC”) has created one duplicated form used statewide. This is especially important to note when the standardized form is easily accessible both in any medical institution and on-line on www.finalchoices.org. CCCC’s “Model Policy” (2009) refers to the form as “standardized.” AHCDs, on the other hand, tend not to be standardized, although Probate Code Section 4701 provides a base form.
- 6 Jason W. Manne, *A Critical Look at the Physician Orders For Life Sustaining Treatment (POLST): What Are Its Weaknesses?*, University of Pittsburgh, 1, 41 (2007).
- 7 An Ombudsman from a northern California program
- 8 For more on the Ombudsman POLST survey, contact CANHR.
- 9 E.H. called CANHR for assistance and shared his story.
- 10 See “Documents associated with AB 3000 in the 2007-2008 Session,” <http://www.leginfo.ca.gov/bilinfo.html> (Nothing in the legislative history sheds any light on what the “legally recognized health care decisionmaker” is.)
- 11 *Model Policy for Skilled Nursing Facilities, Physicians Orders for Life Sustaining Treatment (POLST)*, California Coalition for Compassionate Care (2009).
- 12 8 Cal.3d. 229, 244 (1972).
- 13 See *Ballard v. Anderson* (1971) 4 Cal. 3d 873, 883, *Doyle v. Giuliucci* (1965) 62 Cal.2d 606, *Bonner v. Moran* (1941) 126 F.2d 121 (all these cases stand for the principle that parents may consent for their children).
- 14 See *Cobbs*, 8 Cal.3d. at 244.
- 15 *Supra* Note 11; see also, Cal. Probate Code §§ 4671, 4711, 1880.
- 16 Cal. Probate Code § 4675.
- 17 Based on CANHR’s call and email volume as well as the Ombudsman survey previously discussed.
- 18 *Supra* Note 2; See also, Charles P. Sabatino, *The Evolution of Health Care Planning Law and Policy*, *The Milbank Quarterly*, Vol. 88, No. 2, p. 230: “The relevant population for POLST is persons with advanced chronic progressive illness, those who might die in the next year, or anyone else wishing to further define their preferences of care . . . POLST comes at the later stages.”
- 19 For a sample handout, please contact CANHR.
- 20 CANHR’s Ombudsman survey found that 58% of Ombudsman had seen advisory POLSTs in long-term care facilities, with 21% claiming they are observed “always” or “often.”
- 21 *Supra* Note 8.
- 22 California Department of Public Health, *Deficiency Issued During Survey #FGPS11*, 12-22-2009.
- 23 The POLST form is actually in the midst of a revision. A new form has been proposed to the Emergency Medical Services Authority (“EMSA”). Some of the recommendations made in this paper have been included in the draft form. EMSA is expected to make its decision on a new form later this year.
- 24 Cal. Probate Code § 4780.



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