

PEER-REVIEWED ORIGINAL RESEARCH

Overcoming Legal Impediments to Physician Orders for Life-Sustaining Treatment

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Abstract

The Physician Orders for Life-Sustaining Treatment (POLST), otherwise known as the POLST paradigm, represents the next generation in end-of-life (EOL) planning for certain patients who wish to exercise prospective control over their own medical treatment in their final days. As is true for any physician treatment orders, a POLST is written in consultation with the patient or patient's surrogate. There are a number of practical impediments to widespread adoption and implementation of the POLST paradigm in medical practice. One of these impediments has to do with some physicians' anxiety about potential negative legal repercussions they might suffer for writing or following a patient's POLST; this is the focus of the present article. After describing the POLST paradigm and physicians' anxieties about it, this article argues that the feared potential negative legal consequences of writing or following a patient's POLST are not well founded. Instead of succumbing to legal and ethical paralysis, resulting in the failure to integrate the POLST paradigm robustly into practice, physicians should feel comfortable under current and developing law to write and honor POLSTs for appropriate patients. This article explains the basis for such physician comfort.

Introduction

The topic of end-of-life (EOL) medical care arises more frequently today in discussions about clinical practice and health policy than it did in the past. Specifically, criticisms of the current state of aggressively overmedicalized dying in the United States are once again emerging from a variety of quarters, along with forceful calls for substantial improvements in the kind and quality of medical and supportive care provided to patients approaching or living through the final stages of life [1, 2].

At least since enactment of the federal Patient Self-Determination Act (PSDA) in 1990, health care professionals, patients and their advocates, family members, and public policy makers have looked hopefully to [advance medical planning documents](#), particularly instruction (living will) and proxy (durable power of attorney) directives, as the primary mechanism for recording individual preferences and effectuating personal

autonomy in the EOL context [3]. In many cases, this strategy has worked well enough to ensure that medical care of dying patients comports closely with those patients' known or imputed values and wishes [4]. However, one study of 9,105 adult patients found that an intervention to improve [EOL decision making](#) improved neither care quality nor outcomes [5]. Even when a patient has created a legally authorized advance planning document in a timely manner, for a number of reasons the advance directive might not be honored by caregivers in precisely the circumstances envisioned by the patient [6]. Thus, there is a growing consensus that achieving progress in the experience of dying in America requires an evolution involving the development and implementation of a next generation of planning tools [7].

The POLST Paradigm

Fortunately, a next-generation EOL planning mechanism already has been invented, although it has not yet been fully implemented even for eligible patients. The Physician Orders for Life-Sustaining Treatment, or POLST (with terminology varying slightly among states) [8], unlike the traditional advance directive executed by a patient while still decisionally capable, entails a medical order written by a physician (with the concurrence of the patient or surrogate decision maker) instructing other health care professionals (such as emergency medical squads) about the treatment of a seriously ill or extremely frail patient. POLST originated in 1991, when a group of leading medical ethicists in Oregon, finding that patient preferences for [EOL care](#) were not consistently honored, convened a group of stakeholders who developed a new tool for honoring patients' EOL treatment wishes. In 2004, the National POLST Advisory Panel, later known as the National POLST Paradigm Task Force, convened to establish quality standards for POLST paradigm forms and programs to assist states in developing the POLST paradigm [8]. More than 16 states have formally implemented the POLST paradigm through legislation or regulation, but at least 45 states have some health care professionals and institutions that are using POLST for some patients [9].

Unlike advance directives, which are advisable for every adult who is decisionally capable of creating one, regardless of current physical health status, only a specific subset of the adult population is properly eligible for physicians' writing of a POLST, namely, for frail elderly patients or those with advanced chronic illness whose deaths within the next year or two would not surprise those persons' physicians. Thus, the POLST paradigm is not intended or proposed to replace advance directives for the large percentage of adults who do not meet eligibility criteria.

For those patients for whom a POLST is appropriate, it has demonstrated advantages as a supplement to traditional advance directives executed by the patient. For example, the POLST paradigm, through a structured discussion, combines the patient's deeply held values and the physician's expertise about medical means through which to achieve those values. The POLST allows for precision in EOL care instructions, which are recorded

on a POLST form to try to minimize need for interpretation in particular cares. The POLST form can also follow a person across different care settings. The most important advantage suggested by research is that health care professionals are more likely to honor POLSTs in practice than patient-written living wills or the expressed preferences of [patient-appointed surrogates](#) [10]. Therefore, although much more research needs to be conducted before firm conclusions can be drawn [11], it appears at this point that POLSTs are more likely than advance directives to influence EOL care in a direction consistent with a patient's autonomy [12]. Many more states, such as Florida [13], are in the process of developing and integrating into practice their own versions of POLST.

Impediments to POLST Adoption

If POLST is such a great idea, one might ask, why don't we just do it for appropriate patients? There are several impediments, including a resistance to change and ignorance on the part of key actors (including physicians, emergency medical personnel, hospital and nursing facility administrators, and other health care professionals) regarding the advantages of POLST for responding to patients at the EOL. There also is political and ideological resistance by a few groups that attempt to characterize POLST as a pretext for denying treatment to vulnerable persons or for actively hastening their deaths [14]. This misperception has been carefully rebutted by advocates of POLST who explain that POLST is, in fact, a tool for effectuating the autonomy of appropriate patients and thus protecting them from either unwanted medical interventions or the lack of desired interventions [9].

One additional barrier to broader adoption and implementation of the POLST paradigm, though, is physicians' anxiety about potential negative legal repercussions for purposely withholding or withdrawing any form of life-sustaining medical treatment in the absence, or sometimes even in the presence, of legislation or regulation in physicians' own jurisdiction that explicitly grants physicians immunity against criminal, civil, or disciplinary sanctions associated with a decision to withhold or withdraw life-sustaining medical intervention, including under POLST participation [15-17]. As one experienced professor of health law and medical ethics has observed,

While unlikely to be a conscious factor, physicians also collude in the denial of death because they prefer not to be sued. To avoid litigation, they could justify performing unnecessary or futile care at the end of life out of an unjustified fear that a dissatisfied patient may file a medical malpractice claim.... A general fear of being sued might explain aggressive care at the end of life [18].

For example, studies have demonstrated that physicians are dissuaded from following the provisions in valid advance directives out of fear of possible litigation from family members [19]. As explained by one legal scholar:

Historically, physicians have been reluctant to be involved in medical interventions that hasten a patient's death. They are concerned that facilitating or failing to forestall death will get them into legal trouble. Yet, there is a strong public policy interest in honoring patient autonomy and permitting individuals to forgo life-sustaining treatment when they determine that the burdens outweigh the benefits. Accordingly, the healthcare decisions acts of most states grant physicians immunity for complying with advance directives. Similar immunity is provided to encourage compliance with the newer Physician Orders for Life-Sustaining Treatment ("POLST") [20].

Some states initially promoted POLST through a process called clinical consensus [21]. This approach entails obtaining explicit assurance from relevant state agencies that extant state statutes and regulations already permit physicians to write, patients and surrogates to agree to, and other health care professionals to implement POLSTs. In the clinical consensus model, POLST proponents concentrate on trying to change behavior by educating health professionals and the public about the virtues of the POLST tool for appropriate patients rather than on embarking on the potentially politically treacherous, unpredictable, and often uncontrollable course of trying to amend the law. However, following the establishment of clinical consensus among health care professionals, legislative and regulatory routes to POLST implementation eventually have been followed in almost all the states with mature POLST programs, largely to assuage physicians' and emergency responders' lingering [legal anxieties](#) [21]. Put differently, medical professionals have demanded explicit immunity provisions, preferably in statute [22]. In the author's experience over the past six years promoting implementation of the POLST paradigm in Florida, physicians and emergency medical personnel throughout the state have consistently indicated support for the idea but reluctance to embrace it in practice without the existence of express statutory immunity against civil, criminal, and disciplinary actions based on the physician's effectuating the patient's autonomous treatment choices. Additionally, the author has heard complaints from many patients (and their family members) about their personal physician's refusal to write requested POLSTs for them without the assurance of clear statutory immunity protecting the physician against malpractice actions, criminal prosecutions, and disciplinary sanctions.

Implementing POLST in the Absence of Explicit Legal Authority

Nevertheless, progress in states that have not yet enacted legislation or promulgated regulations explicitly authorizing POLST should not be delayed until the complexities and pitfalls of the political and administrative processes have been successfully navigated by a jurisdiction's POLST proponents, an endeavor that could take several more years. It is important for physicians in states developing or considering developing plans to implement POLST to understand that, contrary to their legal apprehensions—

apprehensions permeating the EOL atmosphere generally—knowledgeable commentators hold that there actually is no valid legal reason to refrain from writing and honoring POLSTs in appropriate circumstances and following conversation with, and agreement from, a patient or surrogate [21].

Constitutional [23] and common (judge-made) law [24], on both the federal and state levels, already protects the individual's liberty and privacy rights, which include rights of adult patients with decision-making capacity to make both contemporary and prospective medical decisions and to secure voluntary assistance from their physicians in effectuating those rights. These liberty and privacy rights extend to choices to withhold or withdraw different forms of life-sustaining medical treatments [25]. State statutes—even when advance directive legislation contains purportedly restrictive language concerning applicability—do not and cannot infringe upon a patient's constitutional right to be protected against insufficiently justified state interference with bodily integrity [26]. Legal research reveals no case in which any physician has been prosecuted, civilly sued, or professionally disciplined for writing a POLST; nor have any emergency medical personnel or other health care professionals been prosecuted, sued, or professionally disciplined for honoring a POLST. However, families increasingly are initiating legal action against physicians and other health care professionals for subjecting patients to [unwanted medical interventions](#) at the end of life, and courts are responding favorably to those legal actions [27, 28].

What is needed on a national scale is to reproduce the path followed by most of the states with presently endorsed or mature POLST programs, namely, the development of pilot or demonstration exercises leading to clinical consensus among a state's medical practitioners. Through such projects, the viability and benefit of POLST approaches to EOL care can be demonstrated and documented. In the presence of a broad clinical consensus among practicing medical professionals, a state's legislature or relevant administrative agencies consequently would be asked merely to codify prevailing clinical practices.

Admittedly, this strategy of reproducing established and successful POLST programs requires the mustering and exhibition of moral courage by clinicians—but with the understanding that legal risks really range somewhere between nonexistent and extremely minimal. Clinicians' moral courage can be supplemented or enhanced by a recent change in Medicare regulations that provide a mechanism for paying physicians to counsel patients about EOL planning [29]. Although the actual impact of this change in payment policy on physician behavior remains to be seen [30], given what I've argued here, this new incentive under the Healthcare Common Procedure Coding System (HCPCS) can be seen as national policy-level support for more robust integration of POLST-inspired care management.

Such moral courage, in the sense of physicians being willing to effectuate patient wishes by writing a POLST and other health professionals' being willing to honor and implement the POLST, should be encouraged by medical and other health care professional organizations. What these organizations need to do is not only endorse immunity-specifying legislation and regulation (although that is an important component of the overall strategy) but also create, disseminate, and educate people—fellow clinicians, administrative colleagues, patients, and patients' loved ones—about clinical practice guidelines pertaining to the writing and honoring of patients' POLSTs. Until this happens, unfortunately, physicians might not be able to rely on the many other health care professionals who work together when caring for patients to honor a POLST for a particular patient.

Conclusion

In sum, physicians who care for patients approaching the end of life have a valuable—but thus far seriously underutilized—tool available in the POLST paradigm to help them express respect for a patient's autonomy. They should not hide behind exaggerated or inaccurate anxieties about supposed legal risk as an excuse for not doing more to enhance the quality of the dying experience for patients who depend so much upon them for a humane death that accords with their wishes for EOL care.

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