June 23, 2014

Dear Dean:

The Florida State University Center for Innovative Collaboration in Medicine and Law has just completed a project funded by a grant from the Retirement Research Foundation and administered through the Oregon Health & Science University. The purpose of this project was to develop and disseminate to applicable Florida professional educational institutions a comprehensive set of materials that may be utilized by individual institutions in educating students and professional practitioners in Florida about planning for and facilitating clinically and ethically appropriate medical decision making by and on behalf of very seriously ill patients. Primary emphasis was placed on developing and disseminating teaching materials relating to POLST (Physician Orders for Life-Sustaining Treatment). Additional information and materials about POLST, both nationally and specifically in Florida, may be found at the POLST tab of the Center website, http://med.fsu.edu/medlaw/POLST.

We invite you to please share these materials with interested faculty members at your own institution for use in their teaching activities. We would be happy to speak with any of your faculty members who would consider incorporating these and other POLST-related materials into your institutional curriculum. Thank you for your help in distributing these materials.

Sincerely,

Marshall B. Kapp, J.D., M.P.H.
Director, Center for Innovative Collaboration in Medicine and Law

Kenneth Brummel-Smith, M.D.
Charlotte Edwards Maguire Chair and Professor, Department of Geriatrics

Enclosures
The 2013 Florida Statutes

Title XXIX
PUBLIC HEALTH

Chapter 401
MEDICAL TELECOMMUNICATIONS AND TRANSPORTATION

401.45 Denial of emergency treatment; civil liability.—

(1)(a) Except as provided in subsection (3), a person may not be denied needed prehospital treatment or transport from any licensee for an emergency medical condition.

(b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.

(2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

(3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient’s physician is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient’s physician and by the patient or, if the patient is incapacitated, by the patient’s health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

(b) Any licensee, physician, medical director, or emergency medical technician or paramedic who acts under the direction of a medical director is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct, as a result of the withholding or withdrawal of resuscitation from a patient pursuant to this subsection and rules adopted by the department.

(c) The department, in consultation with the Department of Elderly Affairs and the Agency for Health Care Administration, shall develop a standardized do-not-resuscitate identification system with devices that signify, when carried or worn, that the possessor is a patient for whom a physician has issued an order not to administer cardiopulmonary resuscitation. The department may charge a reasonable fee to cover the cost of producing and distributing such identification devices. Use of such devices shall be voluntary.

(4) Any licensee or emergency medical technician or paramedic who in good faith provides emergency medical care or treatment within the scope of their employment and pursuant to oral or written instructions of a medical director shall be deemed to be providing emergency medical care or treatment for the purposes of s. 768.13(2)(b).
(5) The department shall adopt and enforce all rules necessary to implement this section.

History.--s. 26, ch. 73-126; s. 3, ch. 76-168; s. 1, ch. 77-174; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 24, 25, 27, ch. 82-
402; s. 13, ch. 83-196; ss. 26, 36, ch. 92-78; s. 8, ch. 99-331; s. 5, ch. 2000-295.
The 2013 Florida Statutes

Title XLIV  CIVIL RIGHTS  Chapter 765  HEALTH CARE ADVANCE DIRECTIVES

765.202  Designation of a health care surrogate.—

(1) A written document designating a surrogate to make health care decisions for a principal shall be signed by the principal in the presence of two subscribing adult witnesses. A principal unable to sign the instrument may, in the presence of witnesses, direct that another person sign the principal’s name as required herein. An exact copy of the instrument shall be provided to the surrogate.

(2) The person designated as surrogate shall not act as witness to the execution of the document designating the health care surrogate. At least one person who acts as a witness shall be neither the principal’s spouse nor blood relative.

(3) A document designating a health care surrogate may also designate an alternate surrogate provided the designation is explicit. The alternate surrogate may assume his or her duties as surrogate for the principal if the original surrogate is unwilling or unable to perform his or her duties. The principal’s failure to designate an alternate surrogate shall not invalidate the designation.

(4) If neither the designated surrogate nor the designated alternate surrogate is able or willing to make health care decisions on behalf of the principal and in accordance with the principal’s instructions, the health care facility may seek the appointment of a proxy pursuant to part IV.

(5) A principal may designate a separate surrogate to consent to mental health treatment in the event that the principal is determined by a court to be incompetent to consent to mental health treatment and a guardian advocate is appointed as provided under s. 394.4598. However, unless the document designating the health care surrogate expressly states otherwise, the court shall assume that the health care surrogate authorized to make health care decisions under this chapter is also the principal’s choice to make decisions regarding mental health treatment.

(6) Unless the document states a time of termination, the designation shall remain in effect until revoked by the principal.

(7) A written designation of a health care surrogate executed pursuant to this section establishes a rebuttable presumption of clear and convincing evidence of the principal’s designation of the surrogate.

History.—s. 3, ch. 92-199; s. 8, ch. 94-183; s. 49, ch. 96-169; s. 1797, ch. 97-102.
The 2013 Florida Statutes

Title XLIV
CIVIL RIGHTS

Chapter 765
HEALTH CARE ADVANCE DIRECTIVES

765.302 Procedure for making a living will; notice to physician.—

(1) Any competent adult may, at any time, make a living will or written declaration and direct the providing, withholding, or withdrawal of life-prolonging procedures in the event that such person has a terminal condition, has an end-stage condition, or is in a persistent vegetative state. A living will must be signed by the principal in the presence of two subscribing witnesses, one of whom is neither a spouse nor a blood relative of the principal. If the principal is physically unable to sign the living will, one of the witnesses must subscribe the principal’s signature in the principal’s presence and at the principal’s direction.

(2) It is the responsibility of the principal to provide for notification to her or his attending or treating physician that the living will has been made. In the event the principal is physically or mentally incapacitated at the time the principal is admitted to a health care facility, any other person may notify the physician or health care facility of the existence of the living will. An attending or treating physician or health care facility which is so notified shall promptly make the living will or a copy thereof a part of the principal’s medical records.

(3) A living will, executed pursuant to this section, establishes a rebuttable presumption of clear and convincing evidence of the principal’s wishes.

History.—s. 4, ch. 92-199; s. 1147, ch. 97-102; s. 25, ch. 99-331.
The 2013 Florida Statutes

Title XLIV  Chapter 765
CIVIL RIGHTS  HEALTH CARE ADVANCE DIRECTIVES

765.304  Procedure for living will.—
(1) If a person has made a living will expressing his or her desires concerning life-prolonging procedures, but has not designated a surrogate to execute his or her wishes concerning life-prolonging procedures or designated a surrogate under part II, the attending physician may proceed as directed by the principal in the living will. In the event of a dispute or disagreement concerning the attending physician’s decision to withhold or withdraw life-prolonging procedures, the attending physician shall not withhold or withdraw life-prolonging procedures pending review under s. 765.105. If a review of a disputed decision is not sought within 7 days following the attending physician’s decision to withhold or withdraw life-prolonging procedures, the attending physician may proceed in accordance with the principal’s instructions.
(2) Before proceeding in accordance with the principal’s living will, it must be determined that:
(a) The principal does not have a reasonable medical probability of recovering capacity so that the right could be exercised directly by the principal.
(b) The principal has a terminal condition, has an end-stage condition, or is in a persistent vegetative state.
(c) Any limitations or conditions expressed orally or in a written declaration have been carefully considered and satisfied.

History.—s. 4, ch. 92-199; s. 10, ch. 94-183; s. 27, ch. 99-331.
The 2013 Florida Statutes

Title XLIV  CIVIL RIGHTS
Chapter 765  HEALTH CARE ADVANCE DIRECTIVES

765.303  Suggested form of a living will.—
(1)  A living will may, BUT NEED NOT, be in the following form:

```
Living Will

Declaration made this    day of  , (year), I, , willfully and voluntarily make known my desire that my
dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare
that, if at any time I am incapacitated and
    (initial) I have a terminal condition
    or (initial) I have an end-stage condition
    or (initial) I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is
no reasonable medical probability of my recovery from such condition, I direct that life-prolonging
procedures be withheld or withdrawn when the application of such procedures would serve only to
prolong artificially the process of dying, and that I be permitted to die naturally with only the
administration of medication or the performance of any medical procedure deemed necessary to provide
me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression
of my legal right to refuse medical or surgical treatment and to accept the consequences for such
refusal.

In the event that I have been determined to be unable to provide express and informed consent
regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to
designate, as my surrogate to carry out the provisions of this declaration:

Name:
Address:

    Zip Code:

Phone:
   
   I understand the full import of this declaration, and I am emotionally and mentally competent to
   make this declaration.

Additional Instructions (optional):

(Signed)
Witness
(2) The principal’s failure to designate a surrogate shall not invalidate the living will.

History.—s. 4, ch. 92-199; s. 35, ch. 99-6; s. 26, ch. 99-331; s. 12, ch. 2000-295.
The 2013 Florida Statutes

Title XLIV
CIVIL RIGHTS

Chapter 765
HEALTH CARE ADVANCE DIRECTIVES

765.305 Procedure in absence of a living will.—
(1) In the absence of a living will, the decision to withhold or withdraw life-prolonging procedures from a patient may be made by a health care surrogate designated by the patient pursuant to part II unless the designation limits the surrogate’s authority to consent to the withholding or withdrawal of life-prolonging procedures.

(2) Before exercising the incompetent patient’s right to forego treatment, the surrogate must be satisfied that:
(a) The patient does not have a reasonable medical probability of recovering capacity so that the right could be exercised by the patient.
(b) The patient has an end-stage condition, the patient is in a persistent vegetative state, or the patient’s physical condition is terminal.

History.—s. 4, ch. 92-199; s. 28, ch. 99-331; s. 13, ch. 2000-295.
The 2013 Florida Statutes

Title XLIV  Chapter 765  View Entire Chapter
CIVIL RIGHTS  HEALTH CARE ADVANCE DIRECTIVES

765.107  Construction.—
(1) This chapter shall not be construed to repeal by implication any provision of s. 766.103, the Florida Medical Consent Law. For all purposes, the Florida Medical Consent Law shall be considered an alternative to provisions of this section.

(2) Procedures provided in this chapter permitting the withholding or withdrawal of life-prolonging procedures do not apply to a person who never had capacity to designate a health care surrogate or execute a living will.

History.—s. 2, ch. 92-199; s. 20, ch. 99-331.
The 2013 Florida Statutes

<table>
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<td>HEALTH CARE ADVANCE DIRECTIVES</td>
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**765.101 Definitions.**—As used in this chapter:

1. “Advance directive” means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal’s desires are expressed concerning any aspect of the principal’s health care, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of this chapter.

2. “Attending physician” means the primary physician who has responsibility for the treatment and care of the patient.

3. “Close personal friend” means any person 18 years of age or older who has exhibited special care and concern for the patient, and who presents an affidavit to the health care facility or to the attending or treating physician stating that he or she is a friend of the patient; is willing and able to become involved in the patient’s health care; and has maintained such regular contact with the patient so as to be familiar with the patient’s activities, health, and religious or moral beliefs.

4. “End-stage condition” means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

5. “Health care decision” means:
   a. Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures and mental health treatment, unless otherwise stated in the advance directives.
   b. The decision to apply for private, public, government, or veterans’ benefits to defray the cost of health care.
   c. The right of access to all records of the principal reasonably necessary for a health care surrogate to make decisions involving health care and to apply for benefits.
   d. The decision to make an anatomical gift pursuant to part V of this chapter.
   e. “Health care facility” means a hospital, nursing home, hospice, home health agency, or health maintenance organization licensed in this state, or any facility subject to part I of chapter 394.
   f. “Health care provider” or “provider” means any person licensed, certified, or otherwise authorized by law to administer health care in the ordinary course of business or practice of a profession.
   g. “Incapacity” or “incompetent” means the patient is physically or mentally unable to communicate a willful and knowing health care decision. For the purposes of making an anatomical gift, the term also includes a patient who is deceased.
   h. “Informed consent” means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks...
and hazards inherent in the proposed treatment or procedures, and to make a knowing health care
decision without coercion or undue influence.

(10) “Life-prolonging procedure” means any medical procedure, treatment, or intervention,
including artificially provided sustenance and hydration, which sustains, restores, or supplants a
spontaneous vital function. The term does not include the administration of medication or performance
of medical procedure, when such medication or procedure is deemed necessary to provide comfort care
or to alleviate pain.

(11) “Living will” or “declaration” means:
(a) A witnessed document in writing, voluntarily executed by the principal in accordance with s.
765.302; or
(b) A witnessed oral statement made by the principal expressing the principal’s instructions
concerning life-prolonging procedures.

(12) “Persistent vegetative state” means a permanent and irreversible condition of unconsciousness
in which there is:
(a) The absence of voluntary action or cognitive behavior of any kind.
(b) An inability to communicate or interact purposefully with the environment.

(13) “Physician” means a person licensed pursuant to chapter 458 or chapter 459.

(14) “Principal” means a competent adult executing an advance directive and on whose behalf
health care decisions are to be made.

(15) “Proxy” means a competent adult who has not been expressly designated to make health care
decisions for a particular incapacitated individual, but who, nevertheless, is authorized pursuant to s.
765.401 to make health care decisions for such individual.

(16) “Surrogate” means any competent adult expressly designated by a principal to make health
care decisions on behalf of the principal upon the principal’s incapacity.

(17) “Terminal condition” means a condition caused by injury, disease, or illness from which there is
no reasonable medical probability of recovery and which, without treatment, can be expected to cause
death.

History.—s. 2, ch. 92-199; s. 3, ch. 94-183; s. 46, ch. 96-169; s. 16, ch. 99-331; s. 3, ch. 2001-250; s. 131, ch. 2001-277; s.
104, ch. 2006-1; s. 28, ch. 2006-178.
64J-2.018 Do Not Resuscitate Order (DNRO) Form and Patient Identification Device.

(1) An emergency medical technician or paramedic shall withhold or withdraw cardiopulmonary resuscitation:

(a) Upon the presentation of an original or a completed copy of DH Form 1896, Florida Do Not Resuscitate Order Form, December 2004, which is incorporated by reference and available from the department at no cost, or, any previous edition of DH Form 1896; or

(b) Upon the presentation or observation, on the patient, of a Do Not Resuscitate Order patient identification device.

(2) The Do Not Resuscitate Order:

(a) Form shall be printed on yellow paper and have the words “DO NOT RESUSCITATE ORDER” printed in black and displayed across the top of the form. DH Form 1896 may be duplicated, provided that the content of the form is unaltered, the reproduction is of good quality, and it is duplicated on yellow paper. The shade of yellow does not have to be an exact duplicate;

(b) Patient identification device is a miniature version of DH Form 1896 and is incorporated by reference as part of the DNRO form. Use of the patient identification device is voluntary and is intended to provide a convenient and portable DNRO which travels with the patient. The device is perforated so that it can be separated from the DNRO form. It can also be hole-punched, attached to a chain in some fashion and visibly displayed on the patient. In order to protect this device from hazardous conditions, it shall be laminated after completing it. Failure to laminate the device shall not be grounds for not honoring a patient’s DNRO order, if the device is otherwise properly completed.

(3) The DNRO form and patient identification device must be signed by the patient’s physician. In addition, the patient, or, if the patient is incapable of providing informed consent, the patient’s health care surrogate or proxy as defined in Section 765.101, F.S., or court appointed guardian or person acting pursuant to a durable power of attorney established pursuant to Section 709.08, F.S., must sign the form and the patient identification device in order for them to be valid.

(4) An emergency medical technician or paramedic shall verify the identity of the patient who is the subject of the DNRO form or patient identification device. Verification shall be obtained from the patient’s driver license, other photo identification, or from a witness in the presence of the patient.

(5) During each transport, the EMS provider shall ensure that a copy of the DNRO form or the patient identification device accompanies the live patient. The EMS provider shall provide comforting, pain-relieving and any other medically indicated care, short of respiratory or cardiac resuscitation.

(6) A DNRO may be revoked at any time by the patient, if signed by the patient, or the patient’s health care surrogate, or proxy or court appointed guardian or person acting pursuant to a durable power of attorney established pursuant to Section 709.08, F.S. Pursuant to Section 765.104, F.S., the revocation may be in writing, by physical destruction, by failure to present it, or by orally expressing a contrary intent.

Specific Authority 381.0011, 401.45(3) FS. Law Implemented 381.0205, 401.45, 765.401 FS. History—New 11-30-93, Amended 3-19-95, 1-26-97, Formerly 10D-66.325, Amended 2-20-00, 11-3-02, 6-9-05, Formerly 64E-2.031.
Patient’s Full Legal Name: __________________________ Date: __________________________
(Print or Type Name)

PATIENT’S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

☐ Surrogate
☐ Court appointed guardian
☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

(Applicable Signature) __________________________
(Print or Type Name) __________________________

PHYSICIAN’S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient’s cardiac or respiratory arrest.

(Signature of Physician) __________________________
(Date) __________________________
(Telephone Number (Emergency)) __________________________

(Print or Type Name) __________________________
(Physician’s Medical License Number) __________________________

DH Form 1896, Revised December 2004
DECLARACIÓN DEL PACIENTE

Sobre la base del consentimiento informado, yo, quien suscribo, por medio de la presente ordeno que no me proporcione RCP.
(Si este documento no está firmado por el paciente, marque la casilla pertinente):

- Responsable del sujeto
- Apoderado (ambos, según se definen en el Capítulo 765 de los Estatutos de Florida)
- Poder de duración indeterminada para fines de atención médica (de acuerdo con el Capítulo 709 de los Estatutos de Florida)

(Firma correspondiente) (Fecha) Número telefónico (Emergencia)

DECLARACIÓN DEL MÉDICO

Yo, quien suscribo, un médico licenciado de acuerdo con el Capítulo 458 o 459 de los Estatutos de Florida, soy el médico del paciente anteriormente mencionado. Por medio de la presente, ordeno que no se proporcione resucitación cardiopulmonar (ventilación artificial, compresión torácica, intubación endotraqueal y desfibrilación) al paciente en caso de que éste sufra un paro cardíaco o respiratorio.

(Firma del médico) (Fecha) Número telefónico (Emergencia)

FORMULARIO 1896 DEL DEP. DE SALUD, revisado en diciembre de 2004

DECLARACIÓN DEL MÉDICO

Yo, quien suscribo, un médico licenciado de acuerdo con el Capítulo 458 o 459 de los Estatutos de Florida, soy el médico del paciente anteriormente mencionado. Por medio de la presente, ordeno que no se proporcione resucitación cardiopulmonar (ventilación artificial, compresión torácica, intubación endotraqueal y desfibrilación) al paciente en caso de que éste sufra un paro cardíaco o respiratorio.

(Firma del médico) (Fecha) Número telefónico (Emergencia)

FORMULARIO 1896 DEL DEP. DE SALUD, revisado en diciembre de 2004

DECLARACIÓN DEL PACIENTE

Esto es el formulario está destinado únicamente a la circulación. Los proveedores de servicios médicos de emergencia y el personal médico sólo deben acatar la versión en inglés del presente formulario: "División de Operaciones Médicas de Emergencia, Oficina de Traumatología"
Learning Objectives for Teaching POLST in Medical Education

1. Appreciate the actual and perceived legal environment surrounding end of life medical care in Florida and elsewhere

2. Be familiar with opportunities (such as advance medical directives and Physician Orders for Life-Sustaining Treatment) for improving the quality of end of life medical care while reducing the physician’s legal liability

3. Understand the difference between the POLST paradigm and advance medical directive approaches and the relative strengths and problems with each strategy

4. Incorporate potential end of life medical decisionmaking mechanisms into clinical practice
Bibliography: Teaching About POLST in Medical Education, With Emphasis on Florida
Prepared by Marshall B. Kapp & Ken Brummel-Smith, Florida State University
Support: Oregon Health & Sciences University/Retirement Research Foundation


Castillo, Leslie S., Brie A. Williams, Sarah M. Hooper et al., Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care. ANNALS INTERNAL MEDICINE 154:121-128 (Jan. 18, 2011)


Kapp, Marshall B., Beyond Medical Advance Directives: Implementing the POLST (Physician Orders for Life-Sustaining Treatment) Paradigm in Florida. FLORIDA BAR HEALTH LAW SECTION NEWSLETTER XXVI (1):10-13 (Fall 2011)

Kapp, Marshall B., The Nursing Home as Part of the POLST Paradigm. HAMLINE LAW REVIEW 36(2):151-175 (Spring 2013)


Wilson, Caroline J., Jeffrey Newman, Sharon Tapper, et al., *Multiple Locations of Advance Care Planning Documentation in an Electronic Health Record: Are They Easy to Find?* JOURNAL OF PALLIATIVE MEDICINE 16(9):1089-1094 (Sept. 2013)
Goals of Medicine Near the End of Life

- Improving quality of care and quality of life for people with advanced, irreversible illness
- Assuring that care complies with patient wishes and values
- Utilizing values-enforcing mechanisms that follow the patient throughout the care continuum

Present Care of Patients with Advanced, Irreversible Illness

- Decisionally capable patients—Autonomy
  - Cruzan (U.S. Supreme Court 1990)—liberty right
  - Common law informed consent right

- Decisionally incapable patients
  - Advance directives, Florida Statutes chap 765
  - Federal Patient Self-Determination Act (1990) requires inquiry and opportunity for advance planning

- Instruction directives (Living Wills), F.S. § 765.202
- Surrogate (agents) appointment, F.S. § 765.202; Durable power of attorney, F.S. chapter 706, is functional equivalent. May withhold or withdraw life-prolonging treatment if:  
  - No reasonable probability of patient recovering capacity  
  - End-stage condition, terminal, or PVS
  - Substituted judgment (How much evidence?)  
  - Best Interests standard

- Do Not Resuscitate (DNR) Orders
  - Florida Statutes § 401.45(3)
  - Implemented by Fla. Admin. Code r. 64B8-9.016
> Default statute, F.S. § 765-401, authorizes a "proxy."
  - Spouse
  - Adult child(ren)
  - Parent
  - Adult sibling(s)
  - Close relative
  - Close friend
  - Clinical social worker selected by ethics committee

> Guardianship
  - Ad hoc, default, bumbling through

---

**Problems with the Status Quo**

- Patients without directives
- Interpretation and application disagreements
- Document portability
- Inadequate enforcement mechanisms
- Surrogates or Proxies disagree, won't decide, make decisions based on conflicts of interest

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**POLST Alternative**

> Background
  - Nomenclature varies
  - Definition
    - Physician order, *not* an advance directive
  - National movement, [www.polst.org](http://www.polst.org)

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**Advantages over advance directives**

- Combines the patient's expertise on values and the physician's expertise of medical means to achieve those values. Structure for discussion (*not* just a form).
- Follows the person across care settings
  - More likely to be honored
  - Allows for more precision, less need for interpretation

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**Florida POLST Status and Strategy**

- [http://med.fsu.edu/medlaw/POLST](http://med.fsu.edu/medlaw/POLST)
- Legal alternatives
  - Legislation
  - Regulation
  - Clinical consensus
Clinical consensus
- Fla. Stat. § 765.106 Preservation of existing rights—The provisions of this chapter are cumulative to the existing law regarding an individual’s right to consent, refuse to consent, to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor, competent or incompetent person, or a patient’s family may have under the common law, Federal Constitution, State Constitution, or statutes of this state.

Drafting/Policy Questions for Statutory or Regulatory Revisions
- Form content? Specified in law?
- Which specific medical interventions should be listed as options?
- Require statement of reasons for the POLST for this patient?
- Must the approved form be used?
- Must POLST be offered? To which patients?

Who (besides physicians) may write a POLST?
- Who (besides physicians) may discuss a POLST with the patient?
- Must patient or surrogate consent be documented on the form by signature?

Extent of surrogates’ authority to consent to POLST on behalf of a patient lacking decisional capacity?
- Immunity for providers for following a POLST?
- Penalties for provider non-compliance?
- Originals vs. Copies/Faxes?
- Conflicts between POLST and advance directives?

Policy Questions for Institutions
- How does POLST fit with institutional by-laws and protocols?
- Recognition of POLST signed by physician without privileges in that institution?
- Recognition of POLST signed by non-physician?

- Who has access?
- Confidentiality and security of data? HIPAA compliance?
- Quality control, timeliness, updating of data? Liability for inaccurate data entry?
Discussion
Advance Care Planning

Doctoring 103
Florida State University College of Medicine
4/8/2014

Objectives
- Determine the difference between advance care planning (ACP) and "Advance Directives"
- Describe the 5 steps in ACP
- Define "Living Will," and "Health Care Surrogate"
- Describe role of the "Advance Care Plan," the "5 Wishes," and the POLST

Advance Care Planning Goals
- Identify patient goals and values
- Ensure that care meets those goals and values
- Educate patient and surrogate about the role of the surrogate
- Strengthen the Dr-patient relationship
- Prevent later family battles

Ultimate goal: support the patient’s self-determination

Not Just for Elderly Folks

These people were all your age!

Evidence For ACP
- Patients want to talk about it with their family
- Patients expect the doctor to bring it up
- Best done in the outpatient setting
- Best done in stages
- Physicians can bill for the time
- Saves health care expenditures

Definitions
- Advance care planning - a series of discussions and decisions about future health care desires
- Advance directives – methods to ensure these desires are respected
  - Written instructions
  - Naming a proxy or surrogate
- Physician orders
Getting at Goals & Values

- What is most important to you?
- What experiences have you had with serious illness or death?
- Can you imagine health experiences that are worse than death?
- Is it important for you to:
  - Live as long as possible even if it means suffering?
  - Try treatments but stop if you are suffering?
  - Focus on quality of life, even if your life is shorter?
- Have you changed your mind over what matters most in life?

Advance Directive Forms

- Florida Living Will
- 5 Wishes
- Project Grace form

These forms instruct others how a patient wants to be treated

Florida Living Will

- A expression of wish to die naturally if:
  - Terminal condition
  - End-stage condition
  - Persistent vegetative state
- No reasonable hope for recovery
- Problems:
  - Vague terms (terminal, life-prolonging)
  - Two physicians must document state

Google: FL Living will form

Project Grace Form

- Illness/conditions with little or no chance of recovery
- Treatment choices in different conditions
- Naming of a health care surrogate
- Problems:
  - Varied state requirements

www.ProjectGrace.org

5 Wishes

- One stop shopping - surrogate, medical directives, values
  - Accepted in most states
- Problems
  - Cost - $5
  - May not exactly fit all state laws
  - Medical directives vague

http://www.agingwithdignity.org/five-wishes.php

Surrogates and Proxies

- Health care surrogate - someone expressly designated by the patient to make health care decisions
- Proxy - someone who has not been expressly designated
- Durable power of attorney for health care - essentially the same as a surrogate

Note: these are reversed in other states

FL Statutes 765
Proxy – Legal Sequence

1. Legal guardian
2. Spouse
3. Adult child(ren)
4. Parent(s)
5. Adult sibling(s)
6. Adult relative
7. Close friend
8. Outside clinical SW

FL Statutes 765

Physician Orders

- Do Not Resuscitate Order
  - DNRO
  - the “Yellow Form”
  - Used in FL
- Physician Orders for Life-Sustaining Treatment
  - POLST
  - the “pink form”
  - Used in 16 states, 33 more evaluating

DNRO vs. POLST

- DNRO
  - CPR
  - DNR
- POLST
  - CPR
  - DNR
  - Level of care
    - Comfort
    - Limited
    - Full treatment
  - Artificial nutrition

Steps in Advance Care Planning

- Introduce the topic
- Engage in structured discussions
- Document the patient’s preferences
- Review and update the directives
- Apply it when needed including orders
- Introduce, discuss, document, order, and update

Ref. EPEC

Introduce the Topic

- Make it routine
- Ask what they know
- Explain the goals of the discussion
- Provide materials
- Watch for comfort or discomfort
- Involve family and surrogate

Structured Discussion

- Role of the surrogate
  - Role is to say what the patient would have said.
  - Therefore, needs to know what patient’s goals and values are!
  - The surrogate is not to say what he or she herself wants.
  - The surrogate has to agree to agree.
- Role of the doctor – ensure the surrogate is being authentic
Structured Discussion

- Elicit the patient's values and goals
  - 5 questions
- Provide patient and surrogate education*
  - Correct common misconceptions
    - Can’t talk on a ventilator
    - Artificial nutrition doesn’t prolong life in dementia
    - Success rate of CPR

*Making Medical Decisions For Someone Else

Structured Discussion

- Assist patient in completing an advance directive form
  - Living will
  - 5 Wishes
  - Project Grace form
- Decide when a DNRO (Yellow form) or POLST form is needed
  - Would you be surprised if this patient died in the next year?

Document the Preferences

- Put copies in the medical record
- Patient completes a surrogate form
  - Patient and surrogate sign
- Give copies to others
  - Family, lawyer, clergy
- Physician completes an order form
  - Physician and patient sign it

Review and Update

- When should you review it?
  - Divorce, marriage, major life events
  - After reflection following a major illness
  - Routinely?
- When must it be updated?
  - Death or incapacity of surrogates
  - Surrogate changes
Learning Objectives
The student will be able to:
1. State the 5 questions used to identify patient goals and values
2. Describe the difference between advance care planning (ACP) and “Advance Directives”
3. Describe the 5 steps in ACP
4. Describe the role of the “Health Care Surrogate”
5. Describe the difference between an advance directive and physician orders for end-of-life care

Small Group Learning Objectives
The student will be able to:
1. Discuss at least 1 strength and 1 limitation for each of 3 common advance directive forms
2. Discuss at least 2 examples of explanations for personal choices surrounding advance care planning
3. Demonstrate the ability to formulate and use at least 1 statement to initiate an advance care planning discussion
4. Demonstrate the ability to formulate and use at least 1 statement to clarify the patient’s values and goals
5. Discuss the difference between advance directives and the POLST form.

Student Advance Preparation
- Read D103 Learning Objectives Week – 14.
- Become familiar with the following advance directive forms posted on Blackboard. Select one form to complete that would best convey your personal wishes. Complete the form in writing and bring with you to Small Group.
  - Living Will
  - Five Wishes
  - Advance Directive document
- Review Physician Orders for Life Sustaining Treatment (POLST) form
Schedule and Brief Agenda
9:00 – 10:30 OR 10-30 – 12:00 Small groups meet:
   I. Reflections on large group activity (10 min)
   II. Today’s agenda and learning objectives ( 2 min)
   III. Discussion of personal advance directive document (35 min)
   IV. Role play #1 (15 min)
   V. Role play #2 (15 min)
   VI. Feedback and closing reflections (10 min)

Small Group Learning Objectives
The student will be able to:
1. Discuss at least 1 strength and 1 limitation for each of 3 common advance directive forms
2. Discuss at least 2 examples of explanations for personal choices surrounding advance care planning
3. Demonstrate the ability to formulate and utilize at least 1 statement to initiate an advance care planning discussion
4. Demonstrate the ability to formulate and utilize at least 1 statement to clarify the patient’s values and goals
5. Discuss the difference between advance directives and the POLST form.

Note: Many students will find this content emotionally charged. It often stirs up memories (recent and/or remote). While it can be very powerful if these issues are discussed, some students may be reluctant to share. Please be “tuned in” to quiet learners and encourage but do not push participation for this session.

I. Reflections on large group activity (10 min)

II. Review agenda and learning objectives (2 min): present today’s learning objectives and agenda

III. Discussion of advance directives (35 min, learning objectives 1, 2, and 5): Students have prepared for the session completing one of the three documents listed below for themselves. They were told to bring their completed document to the small group session. Selection of a document to complete was based on their personal preference for a form that would best convey their treatment preferences.

   1. Living Will
   2. Five Wishes
   3. Project Grace form

They were also told to review the POLST form (item 4 below) and be prepared to discuss how their doctor would use it to reflect the advance plans, if they had a life-threatening illness.

Discussion:
   Conduct a quick survey with show of hands: how many selected the Five Wishes, how many the Project Grace form, how many the Living Will?
Have each student state what form s/he selected and discuss why s/he chose that document.
What does the student see as the pros and cons of the document chosen?
What was it like to answer the questions?
Did they actually answer the questions according to what they believe?
How did they decide who would be their surrogate?
How do they think it would feel to discuss their choices with a potential surrogate?
Does this feel like just an assignment or is there any part of the exercise that feels real to them?

If anyone suggests these are just for old people, you might remind them how the famous cases involving advance directives that reached the Supreme Court were young patients about their age. None of them (Karen Ann Quinlan, Nancy Cruzan, or Terri Schiavo) had written advance directives.

Review each of the forms as follows:

**Living will**
- How do they define “terminal condition?” “End-stage condition?” “Persistent vegetative state?”
- What would they say to a patient who asked for a definition?
- What do they think the limitations of this document are? (vague terms, no clear statement of particular wishes)
- What might be the benefits? (expresses a sentiment about care, maybe if Terri Schiavo had filled one out the long battle could have been avoided)

**Five Wishes** – (page 7, medical treatments)
- What is “close to death” or “a short period of time”? How would you determine that with a patient?
- What is “life support?”
- How “severe” would brain damage have to be to check this?
- What condition might they use in the fourth category (bottom right on page 7)?

**Project Grace form**
- How do you know when a person is “not capable of making my healthcare decisions?” How do you determine when the person has an “end stage condition?”
- What does “irreversible mental illness” mean?
- What did the student answer about “things that give my life quality” section?

Ask them to review the POLST form and consider how they would want Sections A through D completed, given the information they filled out in their advance directive and their personal preferences.

**The Physician Orders for Life Sustaining Treatment (POLST) form**
- How does this differ from the others? *(Answer: this is a set of doctor’s orders, not a patient generated document. This is for now, not the future. It is not an advance directive.)*
- Is there any lack of clarity in the definitions?
- What if a patient said they wanted DNR (section A) but also wanted “Full Treatment” in section B?
- What is their understanding of sections C and D?
IV. Role Play #1 - Initiating an advance care planning discussion (15 min, learning objective 3):

Students divide into pairs. Since one role-play patient is male and the other female, it might help to have male/female pairs where possible.
One student plays the medical student instructed by her/his preceptor to bring up the discussion of advance care planning. The patient, Mr. Cummings, is coming in for a routine follow-up visit.

The other student plays the patient, Mr. Cummings, a 55-year old computer salesperson with diabetes and mild hypertension, that is otherwise in good health.

Allow about 5 minutes for 5 pairs to conduct simultaneous role play.

Debrief the session and explore examples of phrases used to bring up the topic; good explanations for why this issue should be addressed; areas of difficulty or needs for clarification.

Remind students that research shows patients and physicians feel that advance directives are important to discuss, each party is waiting for the other to bring it up (if he/she thought it was important it would be mentioned). Both parties can get nervous or uncomfortable about having these conversations. What strategies will the students use to get over their discomfort?

V. Role Play #2 – clarifying goals and wishes for treatment (15 min, learning objective 4):

Students remain in pairs and reverse roles:

The student that played the patient in role-play #1 now plays the medical student seeing an office patient for his/her preceptor. The nurse tells the medical student that the patient, Mrs. Downs, said she wants to talk because she doesn’t want “any heroic measures.” The medical student’s task is to clarify the patient’s values and goals.

The patient, Mrs. Downs, is an 81 year old with osteoarthritis, hypertension, and cataracts. She is mentally competent, independent and lives alone.

Allow about 5 minutes for 5 pairs to conduct simultaneous role play.

Debrief the session and explore the language used to describe “heroic measures”. There are many words and phrases that might be used to say the same thing; and sometimes the same words are used to mean different things. “No heroics” could refer to: no CPR; no CPR and no intubation; no CPR, intubation, blood transfusions, antibiotics, food or water, etc. The Advance Care Plan illustrates that there are many options from which one could choose to accept or limit care.

Explore students’ reaction to the request for no heroics.
   - Does it bother them the patient asking does not have a terminal disease diagnosis (like cancer)?
   - Would they feel differently if the patient did have a terminal disease?
   - Does it make any difference what terminal disease (cancer or AIDS)?
   - Would they feel differently if this patient were 51 years old?
VI. Feedback and Closing reflections for today’s session (10 min)

Consider having the participants answer the following questions:
  i. What did we learn today?
  ii. What are some of the possible future applications of what we learned today?
  iii. What can we do to improve the learning process?

**Student Advance Preparation**
- Read D103 Learning Objectives Week – 14.
- Become familiar with the following advance directive forms posted on Blackboard. Select one form to complete that would best convey your personal wishes. **Complete the form in writing and bring with you to Small Group.**
  - Living Will
  - Five Wishes
  - Project Grace Form
- Review Physician Orders for Life Sustaining Treatment (FL POLST) form.

**Facilitator Advance Preparation**
- Read D103 Learning Objectives Week.
- I encourage you to and select one form to complete that would best convey your personal wishes.
  - Living Will
  - Five Wishes
  - Project Grace form
- Review Physician Orders for Life Sustaining Treatment (FL POLST) form
- **Print and bring to Small Group: 5 copies of each page of ACP role play cases D103-2013**
Beyond Medical Advance Directives: Implementing the POLST (Physician Orders for Life-Sustaining Treatment) Paradigm in Florida

By Marshall B. Kapp, Director, Florida State University Center for Innovative Collaboration in Medicine & Law, Tallahassee, FL*

Every state, including Florida, has enacted laws intended to help critically ill medical patients maintain a degree of personal autonomy or self-determination regarding decisions about the initiation, continuation, withholding, or withdrawal of various medical interventions, even at a time when the patient no longer has sufficient present cognitive or emotional capacity to rationally make and communicate his or her own choices. Florida Statutes Chapter 765 establishes a mechanism for currently decisionally capable adults to execute health care advance directives in the form of designating a health care surrogate or agent, making a living will instructing on future desired treatment, or providing a durable power of attorney, which is the functional equivalent of a capability adult to execute a durable power of attorney, making a living will instructing on future desired treatment, or providing a durable power of attorney, which is the functional equivalent of a health care advance planning law and policy. The use of POLST (Physician Orders for Life-Sustaining Treatment) forms. Unlike a traditional advance directive executed by a patient while still decisionally capable, POLST entails a medical order written by a physician (and with the concurrence of the patient or surrogate) instructing other health care providers such as emergency medical squads about the treatment of a critically ill patient under specific factual situations. Approximately a dozen states have formally implemented the POLST Paradigm, with national coordination efforts being administered through the Center for Ethics in Health Care at the Oregon Health & Science University. Many more states are in the process of developing their own versions of POLST. There is an array of legal impediments in the various states to successful adoption and fulfillment of the POLST paradigm. In Florida, an informal working group of interested attorneys, health care and human services providers, professional associations, and academics has come together under the coordinating umbrella of the Florida State University Center for Innovative Collaboration in Medicine & Law to identify and explore possible strategies for pushing forward acceptance and implementation of the POLST Paradigm in this jurisdiction.

In the coming months, this group will need to grapple with a myriad of legally tinged strategic choices about how best to achieve the objectives of POLST.

Needed Legal Changes?
The initial set of strategic issues asks about what changes, if any, in current Florida law are necessary to authorize and/or encourage attending physicians to write POLSTs for appropriate patients and to authorize and/or encourage other health care professionals to respect and implement those POLSTs. One potential route (involving the most complex and controversial political ramifications) would be to propose legislative enactment of new, explicit statutory language. Such statutory language could be integrated into Chapter 765, as was unsuccessfully attempted with House Bill 1017 during the 2006 legislative session, creating a new and different type of advance directive; alternatively, the legislature could be asked to amend Fla. Stat. § 401.45 to authorize physicians’ orders pertaining to the withholding of specified other kinds of medical interventions besides cardiopulmonary resuscitation (CPR). Either as an alternative strategy to legislation or as a supplement implementing the statutory change, explicit regulatory modifications could be sought to clarify the POLST-related rights and responsibilities of affected parties. This approach would necessitate identifying which state agency(ies) would have relevant jurisdiction and ways to assure inter-agency coordination and cooperation in the administration of POLST oversight.

A third potential strategy would bypass legislation and regulation in favor of action predicated on clinical consensus. This approach would entail obtaining explicit agreement from the relevant state agencies that current state statutes and regulations already permit physicians to write, patients and surrogates to agree to, and other health care providers to implement POLSTs, with the emphasis of change agents being placed on professional and public education rather than on trying to amend the law. The clinical consensus strategy would rely mainly on the “Preservation of existing rights” clause found in Florida’s advance directive statute:

The provisions of this chapter [765] are
cumulative to the existing law regarding an individual’s right to consent, or refuse to consent, to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor, competent or incompetent person, or a patient’s family may have under the common law, Federal Constitution, State Constitution, or statutes of this state.\(^{15}\)

The argument would be that current common and constitutional law already protects the liberty rights of patients to make contemporaneous and prospective medical decisions and to secure the assistance of their physicians in effectuating those liberty rights by, for example, documenting a POLST instructing other health care providers on behalf of the patient.

**Drafting and Policy Issues**

Assuming that either a statutory or regulatory change strategy is pursued to promote the POLST Paradigm in Florida, a myriad of policy questions will need to be addressed in the legislative or rule-making drafting stage. In looking for guidance elsewhere, there is a wide divergence among other states regarding how they have resolved these questions.\(^{17}\)

For instance, decisions will need to be made about the specific content of the adopted POLST form and whether that content should be incorporated into statute or regulation or only described in broad terms. Typical POLST forms in use elsewhere contain separate sections dealing with: CPR attempts; medical interventions (full treatment versus comfort measures only); use of antibiotics; administration of artificially administered nutrition and hydration; reason for the orders (documenting the physician’s conversations with the patient and/or surrogate); and signatures. A Florida POLST form might comport or deviate from this particular structure. If a new statute or regulation does incorporate specific POLST form content, a question arises whether the explicitly approved form must be used by the physician in order for the POLST to be considered valid or, alternatively, whether a somewhat deviating but comparable form would be legally acceptable.

A further legal and policy drafting question is whether to require health care providers to offer the POLST option to patients. If so, which specific providers would be covered? Should the requirement encompass all patients or only certain categories? What timing requirements (e.g., at the time of admission to a health care institution, as now specified in the Patient Self-Determination Act),\(^{18}\) if any, should be delineated? What is the penalty for provider non-compliance? Another, likely very politically contentious, issue relates to who, beside physicians, should be granted the legal power to write POLSTs.

Should this authority be extended, for example, to nurses or physicians’ assistants?\(^{19}\)

A different strategic conundrum concerns the extent of the authority that a new statute or regulation ought to grant surrogates to consent to a POLST on behalf of a patient who lacks enough present cognitive and emotional capacity to decide and speak personally about medical treatment concerns. The desire to facilitate the writing of POLSTs, even when concurrence must come from a surrogate instead of the patient, must be balanced against the need to protect decisionally compromised patients from surrogates who, unfortunately,\(^{20}\) may not be worthy of such trust.

One of the largest impediments to successful POLST implementation elsewhere has been health care providers’ anxieties about the risk of possible lawsuits brought against them by disgruntled family members.\(^{21}\)

Overcoming that vastly exaggerated but strongly and sincerely held apprehension will be vital to achieving successful POLST implementation. Thus, the good faith legal immunity provisions necessarily built into any new statutes and/or regulations must be drafted carefully, balancing encouragement of provider compliance with POLSTs against the need for some form of accountability for the actors involved. On a related note, should provider compliance with a valid POLST be mandated? If so, what is the proper range of sanctions for a failure to comply with the mandate?

Other operational issues also need to be resolved in the legislative or regulatory drafting stage. May a provider rely, in withholding certain kinds of treatment, on copies or faxes of the POLST document? Must those copies or faxes be printed on paper of a particular color and/or size so as to be identifiable readily? Alternatively, must the original document be available? If there is a material conflict between the physician’s instructions in a patient’s POLST and that patient’s own earlier written advance directive, which document governs? What about POLST forms with some sections not completed? In the absence of a totally completed POLST form, should there be a presumption that maximum aggressive medical intervention must be rendered? Finally (although this enumeration of issues does not purport to be comprehensive), there is the matter of portability of the POLST as a patient travels between different jurisdictions.

Should Florida legislation or regulation state that Florida providers may (or must) recognize and implement POLSTs validly executed in other jurisdictions, in return for reciprocal respect for Florida-drafted POLSTs by the other jurisdictions?

**Storing and Retrieving POLST Forms**

Let us assume that the working group is successful in achieving legal recognition in Florida of the POLST Paradigm, educating physicians (and any other authorized health care providers) to discuss POLST possibilities with patients and their surrogates and to write a POLST when appropriate and agreed to, and convincing health care providers to implement their patients’ valid POLSTs if and when the forms can be found in a timely manner and the designated circumstances have materialized. At that point, an additional set of legally tinged policy and practice issues would emerge concerning the storage and retrieval of POLST forms so that they are readily available when needed.

One obvious, straightforward way to handle the storage and retrieval issue is the proverbial “form under the refrigerator magnet” method, with its equally obvious problem of inaccessibility of the document if an emergency situation involving the patient occurs outside of the patient’s home. To avoid that frequent, foreseeable operational shortcoming, other options must be considered.

As physicians, hospitals, and other health care facilities move steadily in their documentation from paper toward electronic medical records, it is desirable that a patient’s electronic medical record include the POLST, if one exists. Doing so, though, will implicate all of the potential legal issues that might apply to electronic medical records generally.\(^{22}\)

In addition to encouraging the incorporation of POLST forms into individual patients’ electronic medical records, the Florida working group...
eventually will need to consider establishing, either through legislative and/or regulatory recognition (and an accompanying appropriation of public funds) or through some type of voluntary arrangement, the creation of a central registry to facilitate both immediate form retrieval and quantitative research on the effectiveness of the POLST mechanism. Several other states are at various stages of planning or implementing such central registries, and a taxonomy of associated legal issues has already begun to emerge.

Most fundamentally, should submission of every written POLST form to the central registry be required? Who (the physician, the patient, and/or others) would be mandated to submit? If submission were not required, then who (if anyone) would be permitted to submit a POLST to the registry? What immunity from criminal and civil liability or other legal protections for POLST submitters should be embedded in statute or regulation? What penalties, if any, should be imposed on mandated submitters who fail to comply with submission requirements? Who should be granted access to the data compiled within the POLST registry, and under what conditions? What specific procedures should be imposed to assure that the registry complies with the confidentiality and data security requirements of the Health Insurance Portability and Accountability Act (HIPAA)\(^{23}\) and state law\(^{24}\) regarding personal health information?

Additional challenges arising in the development and implementation of a POLST registry mechanism would include quality control processes for maximizing the accuracy (i.e., the correct form for the correct patient) and timeliness of information entered into and stored within the registry. Potential questions pertaining to the civil liability of individuals and/or entities negligently entering data into or maintaining a registry need to be anticipated and dealt with proactively; these questions would involve, for instance, determining who would have standing to sue, defining the applicable standards of care, and delineating damages for breach of duty.

**Policy Issues for Health Care Institutions**

Besides the sort of public policy issues outlined above that may need to be addressed through the development of legislation and/or regulation, moving forward in promoting the POLST Paradigm to enhance patient autonomy and improve the quality of medical treatment for the critically ill will require individual health care providers (most notably, hospitals, nursing homes, rehabilitation facilities, and assisted living facilities) to confront several interrelated internal policy questions, ideally in a proactive stance. Specifically, despite a statutory or regulatory overlay, each institutional health care provider will likely retain substantial discretion about how POLSTs written by physicians for patients they serve are to be reconciled and integrated with existing institutional bylaws and protocols regarding the treatment of critically ill persons.

For example, will the institutional provider presently caring for a particular patient recognize and act upon a POLST signed by a physician who earlier cared for that patient in the community or in another institutional provider, but who does not have active admitting and treating privileges within the current provider? Conversely, will the provider limit its recognition of POLSTs to those that are written by physicians who are members of that provider’s medical staff? In a connected vein, even if state law were to permit non-physicians to write POLSTs in consultation with patients or their surrogates, would any particular institutional health care provider elect to recognize and implement a POLST written by a non-physician?

**Conclusion**

Evidence has been produced in other jurisdictions that the POLST Paradigm is an effective way to move beyond the limitations of the advance medical directives approach to enhancing the self-determination of individual patients and improve the quality of available medical care during times of critical illness. Florida has been categorized as a “developing” POLST state, and robust, earnest discussion—as briefly summarized here—has begun to take
place about the contours and details of competing legal, public policy, and institutional strategies for propelling this jurisdiction forward. This challenge presents an opportunity for productive interprofessional collaboration in which the contributions of legal expertise to the delivery of excellent medical care will be essential.

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Endnotes
1 Fl. Stat. § 765.102 (legislative findings and intent).
2 Implemented by Fla. Admin. Code r. 64B8-9.016.
5 Lesley S. Castillo, Brie A. Williams, Sarah M. Hooper et al., Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care, 154 ANNALS INTERN. MED. 121 (2011).
7 See Sabatino, supra Note 4.
8 Some states vary the terminology slightly. For example, some states call their POLST-equivalent a MOLST (Medical Order for Life Sustaining Treatment), POST (Physician Order for Scope of Treatment), MOST (Medical Order for Scope of Treatment), or COLST (Clinical Order for Life-Sustaining Treatment).
9 http://www.ohsu.edu/polst.
17 See Sabatino & Karp, supra Note 10.
24 Fla. Sta. § 456.057 (7), (8), & (11).
Is the POLST Model Desirable for Florida?

Sarah Catherine Spillers, BS, Brittany Lamb, BS

ABSTRACT

Florida has one of the largest and most rapidly growing elderly populations in the nation. Although advances in medicine are allowing physicians to extend the lives of elderly patients, advances must simultaneously be made in the end-of-life care arena to ensure that the comfort and quality of life of elderly patients is maintained. This paper argues that use of a Physician Orders for Life Sustaining Treatment (POLST) form in Florida would be effective in increasing the accuracy of translating patients' end-of-life wishes into treatment orders, in ensuring the consistency of treatment across settings, and in improving health care provider compliance with patient preferences. It will be demonstrated that present concerns in Florida are essentially the same as those which previously existed in other states that have successfully implemented POLST programs.

Florida Public Health Review, 2011; 8, 80-90.

Background

According to the U.S. Department of Health and Human Services (2010), the population of persons 65 years and older is expected to more than double in the United States by 2040. The rapid growth of the elderly population will require health care professionals to provide these patients with quality end-of-life care, including access to reliable, effective, and accurate advance directives.

Unfortunately, current forms of advance directives are ineffective at accurately translating patients’ wishes for end-of-life care into the treatment they ultimately receive. A significant portion of the population does not have any form of advance directive, and those who have them often are not treated according to their wishes due to the forms’ vague or inaccurate language (Hickman et al., 2010). Further, many advance directives are restricted to particular medical interventions, such as do-not-resuscitate (DNR) orders. Although these forms are only applicable in certain situations, health care providers often make assumptions about patients’ wishes regarding other treatments based on the presence of these forms (Hickman et al., 2010).

Florida has one of the largest and most rapidly growing elderly populations in the nation (Campbell, 2010). Although advances in medicine are allowing physicians to extend the lives of elderly patients, advances must simultaneously be made in the end-of-life care arena to ensure that the comfort and quality of life of elderly patients is maintained. This paper argues that use of a Physician Orders for Life Sustaining Treatment (POLST) form in Florida would be effective in increasing the accuracy of translating patients’ end-of-life wishes into treatment orders, in ensuring the consistency of treatment across settings, and in improving health care provider compliance with patient preferences.

It will be demonstrated that present concerns in Florida are essentially the same as those which previously existed in other states that have successfully implemented POLST programs. Part I discusses the inadequacies of current forms of advance directives. Part II provides an overview of the reasons for the initial development of the POLST form, and explains how implementation of POLST in other states has remedied the concerns that led to the form’s development. This part also explores the various implementation strategies used by each state with an endorsed POLST program. Part III provides evidence of poor end-of-life care in Florida. Part IV suggests the implementation of POLST in order to correct these inadequacies, and recommends an optimal strategy for achieving implementation of POLST in Florida.

Part I: Problems with Current Forms of Advance Directives

Respect for patient autonomy is a core principle of medical ethics. Patients have the right to make their own medical decisions, including accepting or refusing treatment. It is the role of physicians to inform patients of all possible treatment options and their accompanying risks. This principle should be carried into honoring patients’ end-of-life treatment preferences. Thus far, advance directives are not measuring up to the task.

The use of advance directives has been strongly encouraged in the United States since the passage of the Patient Self Determination Act (PSDA) in 1990. The act mandates that health care facilities give patients information regarding the advance directive laws in their state, making it known that patients have the right to document their preferences. The PSDA also requires facilities to ask about, document, and honor any advance directives currently in force for a patient. However, it is unclear whether the PSDA has increased the use of advance directives.
A study of nursing homes in ten states investigated chart documentation of advance directives before and after implementation of the PSDA. The study determined that after the PSDA was implemented, there was only a small increase in the documentation of living wills (Teno et al., 1997). Although the PSDA might have increased awareness of advance directives, they are still criticized for several shortcomings.

First, advance directives are still not widely used. Recent studies have estimated that their use by adults in the United States ranges only from 5% to 15% (Kirschner, 2005; Sabatino, 2007). Many people report they do have preferences about medical care if they are unable to make decisions, but simply have not put them into writing. Others do not complete advance directives because they feel “too healthy” to do so, do not know where to obtain the forms, or are unfamiliar with the forms (Fagerlin & Schneider, 2004). Further, many patients do not have advance directives because their health care providers fail to discuss end-of-life treatment. For example, “Ms. B,” a 71 year old, suffered from a stroke leaving her unable to speak or swallow, but retained her mental faculties. Her sister recalled the following in an interview:

She could answer yes or no questions by shaking her head. The hardest part was that I knew she was suffering. She was always thirsty. She would fight people to get to a sink and constantly motioned for water. She was resuscitated several times and I never understood why. When I asked the hospital staff, they said they had to do everything they possibly could to keep her alive. It was hard for me to watch. I knew she was suffering and I felt powerless to stop it (Personal communication, June 2011).

Ms. B had no advance directive making her end-of-life treatment preferences known, and was subjected to this treatment for a year before she passed away. Physicians must be more proactive in addressing the difficult topic of end-of-life care with patients, and must encourage patients to document their treatment preferences to prevent unwanted treatment.

Advance directive use has remained low even in populations where death should not come as a surprise. Teno and colleagues (2004) conducted an extensive study using Medicare data that confirms low use of advance directives in nursing homes across the United States. In 2001, use of advance directives in terminally ill nursing home residents was 45.4%, only slightly better than the 36.4% found in all nursing home residents. Florida’s statistics are slightly higher than the U.S. average, with 56.1% of terminally ill nursing home residents having an advance directive, compared to 39.6% for all nursing home residents. Documentation of physicians’ orders such as DNRs was much higher. Across the United States, 74.2% of terminally ill nursing home residents had a DNR in place, and in Florida, 66.7% had one. However, the study revealed that individuals were unlikely to document their desires to forego life-sustaining treatments other than CPR. For example, only 15% of terminally ill nursing home residents in the U.S. documented their desire to forgo artificial nutrition, and only 9% did so in Florida.

It is difficult to make end-of-life treatment decisions for patients who have not documented their wishes in writing, but challenges arise even when patients have filled out a form. Advance directives have been attacked for using unclear language which can be hard to interpret in emergency situations. The forms are commonly drafted by attorneys with little understanding of medical procedures, and the resulting vague, unclear language of the forms often leaves a patient’s wishes up for interpretation. Health care providers have noted that living wills are particularly unhelpful because they are infrequently updated, and often do not accurately reflect patients’ changing medical conditions (Fagerlin & Schneider, 2004). Physicians attempting to interpret forms that are unclear, inapplicable, or out-of-date may opt to avoid perceived potential liability by disregarding the patient’s advance directive and providing the maximum available treatment.

Lack of transferability between health care providers is a problem for both advance directives and physicians’ orders such as DNRs. For example, if a nursing home resident has an advance directive declining attempts at resuscitation, the form may not accompany the patient or may be disregarded by EMTs called to the nursing home or by physicians at a hospital to which the patient is transferred. This problem is evident in the case of Dr. S, a retired physician who died in his home. As his wife recalled, “He did not want to eat that morning. He just wanted to sit in his recliner. I came to check on him a while later and he didn’t seem to be breathing. I called his physician, and he told me to call the paramedics” (Personal communication, July 2011). Mrs. S. notified the 911 operator that her husband had a DNR and did not wish to be resuscitated, and the operator assured her that the EMTs would not do so. However, Mrs. S. recalled that “they moved him to the floor even though I was yelling at them not to do anything to him.”

The EMTs explained to Mrs. S that they were simply following protocol, but nonetheless called Dr. S’s physician to inquire about his DNR. The

http://health.usf.edu/publichealth/fphr/index.htm
physician confirmed that Dr. S had a DNR in place, but the EMTs had in the meantime determined that Dr. S. “lack[ed] electrical activity,” and thus did not resuscitate him. Mrs. S stated in an interview that given the opportunity, she would have done things differently: “It was a high stress situation. There was no time to wade through documents. Everyone should keep their DNR on hand.” Although Dr. S had a DNR, which is a physician’s order and thus not considered an advance directive, the document illustrates the lack of transferability of all current forms of documentation of patients’ end-of-life preferences.

The utility of advance directives is limited, as they commonly do not include preferences related to life-sustaining treatments other than CPR (Hickman et al., 2010). Advance directives are drafted to apply to hypothetical medical emergencies which may or may not eventually occur. If a situation occurs that is not provided for by a patient’s advance directive, the document provides little to no assistance to physicians in determining the patient’s preferred care plan. This can lead to patients being subjected to a significant amount of unwanted medical treatment and expense. Consideration of more care options than just resuscitation is desirable to ensure that health care providers have documentation of the patient’s preferences for a broad variety of medical situations and that the patient’s preferences will be honored.

It is common for elderly patients to have a DNR order on file, as attempts to resuscitate this age group are usually futile, especially in those with a chronic illness (Cadogan, 2010). Medicare data for 1992-2005 was analyzed to determine the number of beneficiaries over the age of 65 who had undergone CPR in U.S. hospitals. Of the 433,985 patients who received CPR, only 18% survived to be discharged. The rate of survival after CPR in this age group has not changed since 1992. However, the data show that the proportion of in-hospital deaths preceded by CPR has increased, while the proportion of survivors discharged to their homes, rather than another health care facility, has decreased. The CPR survival rate was found to be lower in patients who were male, older, had more coexisting conditions, or were admitted from a skilled nursing facility (Ehlenbach, Barnato, Curtis, & Kreuter, 2009).

These data illuminate the ineffectiveness of CPR for elderly patients. Few elderly patients survive resuscitation attempts, and even fewer return to their previous functional level, with most returning to health care facilities instead of their homes (Ehlenbach, et al., 2009). DNR orders are therefore an important tool that can protect patients from being subjected to resuscitation attempts, which are likely to leave them in a worsened state if they survive.

However, having only a DNR order might alter the way a patient is treated by health care providers. A survey performed by Beach and Morrison (2002) studies this possibility. Three patient cases were sent to physicians along with surveys asking for physician agreement level regarding several possible clinical interventions. All three cases either did or did not include a DNR order. In each of the patient scenarios, if a DNR order was present, physicians either agreed or strongly agreed to initiate fewer interventions unrelated to CPR. Another study found a 30% lower rate of hospitalization in Missouri nursing home patients who had a lower respiratory infection and a DNR order form compared to those without a DNR (Zewig, Kruse, Binder, Szafara, & Mehr, 2004).

The above studies suggest that some physicians provide less treatment to patients with DNR orders. However, DNR orders are not applicable to patient treatment unless the patient has no pulse and is not breathing. Health care providers should therefore refrain from making assumptions about patients’ wishes based solely on their CPR status, as possessing a DNR order does not imply that a patient desires no other life-sustaining treatments. A study performed in Oregon nursing facilities, 71% of which use the POLST form for at least half of their patients, found that the majority of patients with DNR orders indicated on the POLST form a choice to receive some other form of life-extending treatment. For example, a patient who had a DNR order listed in Section A of the POLST form (Cardiopulmonary Resuscitation) chose in Section B (Medical Interventions) that they wished to receive full treatment and to be taken to the Intensive Care Unit if needed (Figure 1). Conversely, nearly half the patients with orders for resuscitation on the POLST form documented in another section of the form that they did not wish to receive full treatment (Hickman, Tolle, Brummel-Smith, & Carley, 2004). Because of varying patient preferences, there is a clear need for a form that incorporates patients’ CPR wishes with those for hospitalization and other life-sustaining treatments.

The POLST form is a more uniform, comprehensive, and portable method of documentation of patients’ end-of-life treatment desires. Although the POLST form is not intended to replace advance directives executed by patients, it corrects many of the inadequacies of current forms and intends to lessen the discrepancy between a patient’s end-of-life care preferences and the
**Figure 1. Oregon POLST Form**

<table>
<thead>
<tr>
<th><strong>HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS &amp; ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Orders for Life-Sustaining Treatment (POLST)</strong></td>
</tr>
<tr>
<td>Follow these orders until orders change. These medical orders are based on the patient’s current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. Guidance for Health Care Professionals: <a href="http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf">http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf</a></td>
</tr>
<tr>
<td>Patient Last Name:</td>
</tr>
<tr>
<td>Date of Birth: (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Last 4 SSN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>A</strong></th>
<th><strong>CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check One</td>
<td></td>
</tr>
<tr>
<td>☐ Attempt Resuscitation/CPR</td>
<td></td>
</tr>
<tr>
<td>☐ Do Not Attempt Resuscitation/DNR</td>
<td></td>
</tr>
<tr>
<td>When not in cardiopulmonary arrest, follow orders in B and C.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>B</strong></th>
<th><strong>MEDICAL INTERVENTIONS: If patient has pulse and/or is breathing.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>check One</td>
<td></td>
</tr>
<tr>
<td>☐ Comfort Measures Only (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.</td>
<td></td>
</tr>
<tr>
<td>☐ Limited Additional Interventions in addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. Treatment Plan: Provide basic medical treatments.</td>
<td></td>
</tr>
<tr>
<td>☐ Full Treatment In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. Treatment Plan: Full treatment including life support measures in the intensive care unit. Additional Orders:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>C</strong></th>
<th><strong>ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check One</td>
<td></td>
</tr>
<tr>
<td>☐ No artificial nutrition by tube.</td>
<td></td>
</tr>
<tr>
<td>☐ Defined trial period of artificial nutrition by tube.</td>
<td></td>
</tr>
<tr>
<td>☐ Long-term artificial nutrition by tube.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>D</strong></th>
<th><strong>DOCUMENTATION OF DISCUSSION:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Patient (Patient has capacity)</td>
<td>☐ Health Care Representative or legally recognized surrogate</td>
</tr>
<tr>
<td>☐ Parent of minor</td>
<td>☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)</td>
</tr>
<tr>
<td>☐ Court-Appointed Guardian</td>
<td>☐ Other</td>
</tr>
</tbody>
</table>

Signature of Patient or Surrogate

Signature: [recommended]

Name (print): __________

Relationship (write "self" if patient):

This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box ☐

<table>
<thead>
<tr>
<th><strong>E</strong></th>
<th><strong>SIGNATURE OF PHYSICIAN / NP / PA</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s current medical condition and preferences.</td>
<td></td>
</tr>
</tbody>
</table>

Print Signing Physician / NP / PA Name: [required]

Signer Phone Number: __________

Signer License Number: (optional)

Physician / NP / PA Signature: [required]

Date: [required]

Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRRED OR DISCHARGED. SUBMIT COPY TO REGISTRY

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**Florida Public Health Review, 2011; 8:80-90.**

[http://health.usf.edu/publichealth/fphr/index.htm](http://health.usf.edu/publichealth/fphr/index.htm)
Part II: Development of the POLST Form

Efforts to develop the POLST form were initiated in Oregon in the early 1990s. Under the guidance of the Center for Ethics in Health Care at the Oregon Health and Sciences University, doctors, nurses, emergency personnel, and members of ethics committees convened to discuss the shortfalls of existing advance directives and to determine how to provide improved end-of-life care to patients with advanced critical illness. Over several years, a form was developed which documented patients’ end-of-life treatment preferences and converted them into doctors’ orders. It was created to allow critically ill patients to decide in advance of a clinical event whether to allow health care providers to perform various medical interventions (Spann, 1999). The POLST form addresses a variety of treatment interventions, including CPR, artificial nutrition, intravenous (IV) fluids, resuscitation, intubation, hospitalization, ICU care, and the use of antibiotics. The POLST form thus allows the patient to express greater detail about desired end-of-life treatment than is possible in traditional advance directives, and offers health care providers significantly increased guidance about how to treat patients in an expanded set of medical situations.

The Oregon POLST Task Force aimed to eliminate the confusion of health care providers by providing them with a uniform order sheet with standard medical terminology that could be quickly understood, in place of varying attorney-drafted forms which were often incomprehensible to health care providers due to their vague or inaccurate language. Creating a form with increased transferability was another central goal of the Task Force. Because the POLST form constitutes a physician’s order, it is more portable and is recognized by health care providers in all treatment settings to which a patient may be transferred, from private residences to nursing homes, ambulances, and hospitals. The Oregon POLST form provides immunity from criminal and civil liability to emergency medical technicians (EMTs) who comply with POLST orders, ensuring that a patient’s treatment goals will not be disregarded when they are transferred from one care setting to another (Spann, 1999).

POLST also requires a discussion between doctor and patient about the patient’s end-of-life care preferences. Aside from the form’s conversion of the patient’s preferences into doctors’ orders, the form promotes discussions about the end of life, a topic frequently avoided by health care providers. The POLST form prevents avoidance of this difficult topic, and ensures that patient’s wishes are heard, documented, and acted upon. Such a conversation would have been beneficial for Mrs. C, an 82-year old woman who was undergoing dialysis treatments for kidney failure. In an interview, Mrs. C’s daughter recalled the day she drove her mother to her doctor’s office to repair her “clogged” dialysis port. Before returning home, Mrs. C complained of feeling nauseous and hot. The doctor ran several tests, but later cleared Mrs. C to leave. Mrs. C complained that she still felt unwell while getting into the car. As her daughter recollected:

Then she made a sound and I knew something was wrong. She coded in my Jeep and died right then. They worked on her doing CPR at the doctor’s office for two hours, and then for four hours more in the ICU at the hospital. She lay in the hospital for a week on an IV. She looked swollen because of all the fluid they put in her. She was hooked up to a bunch of machines (Personal communication, June 2011).

Mr. A, a 53-year old man, would also have benefitted from his physician’s assistance in documenting his end-of-life treatment preferences. His stepdaughter explained in an interview that Mr. A crashed several times while undergoing bypass surgery:

They had to shock him back each time. His body didn’t handle the surgery well. He wasn’t breathing on his own and when he woke up he was on a ventilator. He pulled through and recovered. Afterwards he told us he never wanted to be on a ventilator again. He felt like it was too far in his chest and that it was killing him.

Three years later, while shopping in J.C. Penney, Mr. A had a heart attack. A respiratory therapist was in the store and administered CPR, but Mr. A had no pulse for thirty minutes. He was transported to the cardiac ICU and put on a ventilator. As Mr. A’s stepdaughter recalled:

The next day the doctors were trying to convince my mother that she should take him off the ventilator. The decision to take him off the machine was very hard on her. We felt that since he had pulled through the bypass there was a chance he could pull through this, but it was very important to us that his wishes were followed. If he had an advance directive
signed they probably still would have done CPR in J.C. Penney, since it was a public place, but when he got to the hospital they might not have put him on the ventilator.

Although physicians’ tendency to avoid discussing end-of-life issues with patients may spare patients and their families from having difficult conversations, it is evident from the above accounts that avoiding these topics can be detrimental in the long run. The POLST form provides an avenue for physicians to commence these discussions with patients, and completion of the form allows patients to avoid costly, unnecessary, and undesired medical treatment.

The effectiveness of the POLST form in improving patient end-of-life care has been researched through surveys and pilot programs. Studies conducted in Oregon following the initial creation of the POLST form determined that many health care providers were eager to use it (Spann, 1999). More recent multistate surveys of hospice staff have shown that POLST is effective for initiating difficult conversations regarding end of life treatment goals and for successfully preventing unwanted medical treatment (Hickman et al., 2009).

In a study of 180 Oregon nursing home residents, the researcher’s goal was to determine how well treatment preferences were honored for residents whose POLST forms indicated that they did not desire resuscitation and wished for transfer to the hospital only if comfort measures failed. Consistent with their wishes, none of the patients received CPR, ICU care, or were put on a ventilator. Thirteen percent of the subjects, however, (24) were hospitalized. Yet, 85% of those hospitalized were transferred because the nursing home could not provide adequate comfort care to prevent suffering. The other 15% represented cases in which the POLST form was overridden by either the patient or a family member, resulting in hospitalization to extend the patient’s life (Tolle, 1998).

Hickman and colleagues’ study of hospice staff opinions of POLST (2009) found that the overwhelming majority of participants supported use of the form. Hospice staff reported that the form was useful in preventing unwanted resuscitation by EMS (97%), serves as a helpful mechanism for initiating a conversation about end-of-life treatment preferences (96%), and helps ensure patient treatment preferences are honored (94%). The study also reported that hospice staff members feel more comfortable knowing what to do when a POLST form is available (93%). After conducting chart reviews, researchers found that patient preferences were followed 98% of the time when a POLST form was in place. Patients with orders for comfort care only (Section B) were less likely to be hospitalized than patients with orders for limited or full medical interventions. It is therefore evident that POLST is effectively reducing unwanted hospitalization of elderly patients.

Studies have also shown that the POLST Task Force’s goal of transferability is being achieved by the form: in the abovementioned study which followed 180 Oregon nursing home residents for a year, 94% of the participants had their POLST form in their record at the end of the study. Of the 11 who did not, two died while in the hospital, and the hospital correctly kept their forms (Tolle, 1998). Increased transferability of the POLST form over other common forms of advance directives has also been documented through the acceptance of the form by Oregon EMTs. Oregon EMTs typically favor the use of the POLST form, and in a study to determine EMTs’ attitudes towards POLST, 80% of participants expressed the wish that more patients would use the form (Schmidt, 2004). Although EMTs have expressed reluctance to withhold resuscitation if a patient does not have an official state-approved advance directive (Marco, 2002), surveys of Oregon EMTs demonstrated that when patients had a POLST form, it changed the method of treatment in 45% of cases (Schmidt, 2004).

Other states concerned with the adequacy of current forms of advance directives in achieving quality end-of-life care took notice of the effectiveness of the Oregon POLST form, and began to use the Oregon model in developing their own forms. Fifteen states have successfully endorsed POLST programs and 21 states have programs in development, including Florida (POLST Paradigm Program Contact List by State, 2011). States with endorsed programs have used various strategies to achieve utilization of the POLST form.

To avoid the delay and uncertainty entailed in attempting to pass POLST legislation and the scrutiny of the Oregon legislature, the Oregon POLST Task Force opted to implement the form through voluntary health care provider compliance and subsequent regulatory recognition of POLST. Because the legally defined scope of practice for EMTs did not explicitly cover POLST forms, Oregon EMTs were reluctant to comply with them, fearing that they would be held liable for failing to resuscitate patients without DNR orders. The Oregon Task Force persuaded EMTs to comply with POLST forms through the promulgation of regulations stating that EMTs should comply with POLST forms in the same manner as a DNR order and providing EMTs with immunity from liability for compliance with a POLST form (Or. Admin. R. § 847-035-0030(6), 2008).

Several states, such as West Virginia, North Carolina, Maryland, Idaho, Vermont, and New York,

Because Florida has one of the largest and most rapidly growing elderly populations in the nation (Campbell, 2010), concerns regarding the uniformity, portability, and vagueness of current forms of advance directives can be expected to steadily increase. The state’s significant elderly population necessitates that health care providers devote increased attention to accurately documenting and complying with patients’ end-of-life treatment preferences. The implementation of a POLST program in Florida will correct the inadequacies of current advance directives and improve end-of-life care for elderly patients.

Part III: Issues in Florida

Seventeen percent of Florida's population is 65 years or older (Kaiser Family Foundation, 2009). This is the highest percentage in the nation aside from West Virginia, which also has a 17% elderly proportion but a significantly smaller overall population. Florida also has the highest hospital care intensity index in the nation, based on inpatient days and inpatient physician visits among chronically ill Medicare beneficiaries in the last two years of life (Commonwealth Fund, 2009). Florida's rate is 1.177, far above the best state's (Utah's) rate of 0.509. A 2007 survey found that Florida had the second highest percentage of decedents spending seven or more days in an intensive care unit during the last six months of life, at 23.1% (Dartmouth Atlas, 2007). The national average was 15.2%. These data suggest that elderly patients in Florida are being subjected to a high and likely unnecessary amount of hospitalization and treatment. The implementation of a POLST program would likely reduce this rate by ensuring that elderly individuals with advanced critical illness receive only those medical interventions they desire.

Florida physicians may be satisfied with forms of advance directives currently in use. For physicians who devote little attention to patient end-of-life care, satisfaction with the status quo may be due in part to the unlikelihood of courts holding health care providers liable for failure to comply with patients’ advance directives. Without a liability incentive to encourage them to honor patients’ end-of-life treatment goals, physicians may disregard patients’ advance directives in favor of performing a broad spectrum of medical interventions which may sustain the patient's life but impinge upon the patient’s comfort.

Physicians may also be relying on patients’ families to decide the amount of treatment a patient should receive. Without proper education regarding a family member's health status and the futility of life-sustaining treatments for patients with certain conditions or in certain age groups, families may opt for the maximum amount of life-sustaining treatment for their loved ones. In a conversation with an experienced ICU nurse, it was explained that the elderly patients seen in the ICU are often those who have “fallen through the cracks.”

These patients, and in many cases their families, were not well educated about the limited chance of recovery [after] the patient is admitted to the ICU. Families have all the power when a patient can’t speak for [himself or herself]. Even if the patient has an advance directive, if they can’t speak for themselves and the family says they want everything done for them, you still have to follow the family’s desires. I have never worked for a doctor who ignored the family (Personal communication, July 2011).

Although patients and their families have sued health care providers for performing life-sustaining measures in conflict with the patient’s advance directive, they have not prevailed unless the intervention performed by the health care facility caused the patient’s death (Scheible v. Joseph L. Morse Geriatic Center, Inc., 2008; Kush v. Lloyd, 1992).
Although some health care providers may be satisfied with current forms of advance directives, it is evident from several sources—the unwillingness of courts to hold health care providers liable for failure to comply with patients’ wishes, statistics revealing a high hospital intensity index during patients’ end stages of life, and the support of numerous Florida organizations for POLST implementation efforts—that widespread problems with end-of-life care exist in Florida, and that patients’ end-of-life treatment preferences are not being sufficiently protected. These insufficiencies may be remedied through the implementation of the POLST form.

Part IV: Recommendations for Implementation of POLST in Florida

Implementation of a POLST program would be beneficial in Florida due to the state’s large and growing elderly population, the state’s poor performance related to end-of-life care, and lack of compliance with current forms of advance directives. State policymakers must carefully consider which POLST implementation strategy would be most effective.

At first glance, the legislative route seems to be the optimal approach to POLST implementation in Florida, as legislation recognizing POLST would be the most comprehensive and uniform approach to ensuring that the form is recognized in all health care facilities and health care providers are immunized from liability for compliance with a POLST form. However, legislation recognizing POLST was rejected in 2006, (H.B. 1017, 2006; S. 2572, 2006) and it is unclear whether the concerns that prevented its passage then have subsided.

House Bill 1017 and Senate Bill 2572 would have recognized the POLST as a type of advance directive under Chapter 765 of the Florida Statutes. The legislation would have required the Florida Department of Health to design and post a POLST form on its website, and would have required the signature of both a licensed health care professional and the patient. If Florida policymakers wish to pursue implementation of POLST through legislation, the bills could be reintroduced to amend Chapter 765 of the Florida Statutes, in hopes that the concerns that prevented the 2006 legislation from passing have dissipated in the past five years.

Alternatively, POLST legislation could be reintroduced to amend Chapter 401 of the Florida Statutes, with the goal of obtaining recognition of the POLST as an alternative to or enhancement of the DNR order.

However, the scrutiny of the Florida legislature may prevent the bill from being passed in the manner intended by its proponents. The legislature may demand revisions to the POLST form that are

http://health.usf.edu/publichealth/fphr/index.htm
has specified a treatment preference using a traditional advance directive explicitly recognized under Florida law (Birdwell, 2005). Because POLST is not explicitly recognized under Florida law, providers are even more cautious about offering or honoring the POLST form.

It may be argued that POLST is already permissible under current Florida law, as neither Chapter 765 nor 405 seem to pose any significant barrier to its adoption. However, the tendency of health care providers to be risk-averse will likely necessitate the promulgation of regulations specifically recognizing POLST as a valid instrument for documenting patients’ end-of-life treatment preferences and affirming health care providers’ immunity from liability for good faith compliance.

Because the support of EMS providers is crucial in ensuring that patients receive their preferred treatment while being transferred between settings of care and in ensuring that POLST forms accompany the patient during those transfers, it will likely be necessary to gain the support of the EMS community to make POLST a reality in Florida. The addition of language to Section B of the POLST form may be necessary to address several of the concerns that have been expressed by EMTs.

One concern that has been expressed is that 911 will be used for purposes other than emergency medical care and transportation if patients have a POLST form that directs health care providers not to transport the patient, but to provide comfort measures only. EMTs are concerned that time that could be devoted to patients who wish to be transported and to receive the full panoply of medical interventions will instead be devoted to providing the most basic forms of comfort care to patients, such as bathing or repositioning (S. Bagatell, personal communication, June 29, 2011). This concern may be overcome by adding language to Part B of the POLST form stating “EMTs provide comfort care only according to local EMS protocol.” Concern has also been expressed that POLST forms will complicate the procedures normally followed by EMS providers. For example, if a patient’s POLST states the wish to be transferred to a specific hospital under any circumstances, this may interfere with the protocol normally undertaken by EMTs. This concern may be overcome by adding language to Part B of the POLST form stating “Transfer to hospital per local EMS protocol.”

Future Directions

Despite the passage of the PSDA, patients, families, and health care providers remain dissatisfied with current forms of advance directives. Implementation of the POLST form in Florida will improve end-of-life care by providing a more uniform, transferable, and comprehensive method of documenting patients’ treatment preferences. Florida’s implementation strategy should consist of educational efforts in which health care providers are encouraged to voluntarily comply with POLST orders. This period of education and voluntary compliance should be followed by the passage of regulations to reassure health care providers of the validity of POLST forms, as well as to reassure them of their immunity for good faith compliance with POLST orders.

The leaders of pilot programs currently underway in Florida hospitals must compile data illustrating the effectiveness of the POLST form in improving compliance with patients’ end-of-life treatment goals. These data must be shared with other hospitals, nursing homes, and hospice centers statewide and their participation in POLST efforts must be encouraged. Finally, other states must follow Florida’s example and consider the inadequacies of their current forms of advance directives, as the nation as a whole would benefit from use of the POLST form.

Acknowledgements

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Hypothetical Case 1—Mr. V

Mr. V, an 86-year-old man with advanced dementia, has resided in a sectarian nursing home for the past three years. A month ago, Mr. V stopped eating and a nasogastric tube was inserted to provide nutrition and hydration. He is bedridden and incontinent, and lies in a nearly fetal position. He appears to be in discomfort and, although he is in wrist restraints, he attempts to pull at the NG tube. He has several co-morbidities.

Mr. V’s only known relative is his cousin Joe. Joe asked that the NG tube be discontinued. Fifteen years ago, while Mr. V and Joe were watching a football game on TV together, Mr. V said, “You know, if I ever get senile like my neighbor, I hope you shoot me.” This was the only known time that Mr. V had indicated his wishes to anyone regarding his future medical treatment. The nursing home refused to honor Joe’s request for discontinuation of the NG tube, citing religious beliefs as expressed in the facility’s written policy statement. The nursing home medical director, who also serves as Mr. V’s attending physician, concurs with the facility, saying that she refuses to “starve” Mr. V to death.

How should this situation be managed? Should, and could, have advanced health care planning taken place and how would such planning help in the current management of the situation? Should, and could, the POLST paradigm have been included in planning for Mr. V? What are the limits or barriers to pursuing the POLST paradigm in Mr. V’s case?

Image the same set of facts, except that now Mr. V is a 26-year-old man with severe traumatic brain injury suffered in a motorcycle accident. How would that change your management of this situation? How would the change in facts affect the advisability, feasibility, and usefulness of advance health care planning? Would Mr. V have been an appropriate POLST candidate in this situation?
Hypothetical Case 2—Mrs. L

Mrs. L is an 85-year-old severely demented widow who was admitted to a nursing home from a hospital about two years ago. She had been hospitalized for treatment of a hip fracture incurred in an automobile accident when she was still driving. She now also suffers from chronic lymphocytic leukemia and hypertension. Before the hospitalization that led to her present nursing home admission, Mrs. L had lived in an apartment with a sister with whom she has maintained close contact.

Mrs. L seemed to do well in the nursing home, even though her dementia became progressively more severe. She paces and talks to herself a lot. She periodically needs blood transfusions to control her leukemia. During these transfusions, Mrs. L cannot understand what is happening and sometimes vigorously resists the procedure despite the best efforts of facility staff, who are dismayed by her consternation, to calm her. Before administering the transfusion, it has become necessary to give her a sedative and then physically hold her in bed while the procedure is begun. Otherwise, Mrs. L would remove the transfusion apparatus. The nurse had become quite upset with the whole situation but was too intimidated to raise the issue of possible discontinuation of the transfusions with Mrs. L’s physician, who was strongly committed to the transfusion plan.

Two years before the accident that began this chain of events, Mrs. L. had gone to a legal aid office and executed advance medical directive in the form of a Living Will. This document stated, among other things, “If I become unable to make and express my own treatment wishes, I do not want medical interventions that prolong my life if I have an incurable or irreversible medical problem that is not terminal, but which inflicts upon me severe or progressive physical and/or mental deterioration and loss of ability to function normally.”

Would the existence of a POLST help Mrs. L and/or her family and health care team? What would be the advantages (or disadvantages) of having a POLST available in this case in addition to the Living Will? Is Mrs. L even a proper candidate for a POLST? At what point (if any) should a conversation with her about the possibility of a POLST been initiated? By whom? What specific instructions about treatment should be indicated on a POLST written for Mrs. L?
Hypothetical Case 3

Mr. M is an 80-year-old man readmitted to a nursing home after being hospitalized for seizures (status epilepticus). He retains a tracheostomy with oxygen to trach collar but no longer needs a ventilator to breathe. Prior to the hospitalization, he resided at the nursing home for six months. He is dependent on others for help with activities of daily living because of a prior stroke. He has a history of diabetes and hypertension. His wife and daughter are actively involved in his care, but his other two children are not.

A POLST form had been completed at the nursing home, with Mr. M’s agreement, prior to the hospitalization. Because Mr. M’s physician was writing a POLST, Mr. M did not execute an advance medical directive. The POLST instructed that Mr. M should not be fed through a gastrostomy tube. Nevertheless, a g-tube was placed during his recent hospitalization and he arrived at the nursing home with orders to continue tube feeding. All the orders on the POLST form indicated that all life-prolonging measures other than the g-tube (for example, cardiopulmonary resuscitation, ventilator, blood products, and antibiotics) should be implemented if needed.

Nursing home staff is convinced that Mr. M does not want to be fed through a tube, that his health is steadily deteriorating, and that he is “tired” and ready to die. They believe his wife and involved daughter have pressured him to tacitly accept the g-tube. Currently, Mr. M appears alert but only responds to questions by nodding, when he responds at all. The nursing home staff, though, strongly believes that he had the capacity to make decisions about his own care at the earlier time that the POLST was written for him. They are concerned that he is now receiving tube feedings in violation of his POLST.

What is the role of Mr. M’s attending physician in this case? The role of the nursing home Medical Director? What can/should the attending physician and/or Medical Director do? How could this situation have been avoided?
Mr. R is an 81-year-old hospitalized man with pneumonia and advanced dementia. He also has advanced metastatic prostate cancer. During the diagnostic process, Mr. R was discovered to be suffering from a leaking aortic aneurism and bilateral muscle abscesses. The abscesses were drained. He was started on a course of antibiotics and given a blood transfusion. The primary issue now is whether to perform surgery to repair the aneurism.

Mr. R’s dementia makes him rather unconnected mentally to his surroundings and to other people. Although he usually appears comfortable, his discomfort as a result of his most recent medical difficulties was demonstrated by his behavior and agitated reactions to clinical procedures.

In the opinion of the medical team, surgically repairing Mr. R’s aneurism will reduce his risk of a fatal rupture but would leave his declining mental status unchanged. His pain will be increased postoperatively and the risk of death during surgery may run as high as 30%. Mr. R is unable to participate meaningfully in a discussion about his treatment options. He has no interested and available family members or friends.

Could a POLST have anticipated and effectively planned for this set of circumstances? At what point should a POLST conversation have been initiated, and by whom? What should have been the content of a timely written POLST for Mr. R?