POLST: Honoring Wishes at the End of Life

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POLST is an acronym for Physicians Orders for Life Sustaining Treatments. The POLST form allows persons with serious medical conditions to document their advance decisions for life-prolonging treatments as clear, specific written medical orders, which will be honored in all settings. Oregon was the first state to implement a POLST program in the mid 1990s. Since then, several states have implemented or are developing similar programs. The National POLST Paradigm Task Force was formed to help in the development, education, and research of POLST and POLST-like programs across the country. Key elements of POLST paradigm forms include:

- immediately actionable signed medical orders on a standardized form
- orders that address a range of life-sustaining interventions (e.g., CPR, intubation, mechanical ventilation, intravenous medications, antibiotics, medically administered nutrition and hydration)
- a brightly colored, clearly identifiable form
- portability across treatment settings

The federally legislated Patient Self Determination Act of 1991 spawned advance directive statutes in all states. These generally are of two types: personal living wills or directives, and proxy directives (DPOAH). Both types are signed by patients and express their wishes for treatments for very serious medical conditions if they become unable to make those decisions themselves. Polls show that patients and physicians strongly support advance directives, and all fifty states have statutory support for them. Unfortunately, the literature consistently shows that only 15 to 20 percent of patients complete some form of advance directive; of those completed, physicians often do not honor them; and patients with advance directives receive no measurably different care than patients without them at the end of life1. Additionally, the care patients receive in hospitals and nursing homes, as well as from emergency medical responders, is determined by physician orders. For patients' wishes to be honored in these settings, they must be written as physician orders. Even where advance directives may be honored directly, a written confirmation of the patient's medical condition, and concurrence with the wishes by a physician, is required.

The POLST concept was originally developed in Oregon with the goal of ensuring that a patient's wishes regarding end-of-life care are honored when the patient is unable to speak for herself or himself. The first version of the form was implemented in 1995. By 1998, early research confirmed that patients with POLST forms received the care they wanted and did not receive the care they did not want. In a study of 180 nursing home residents requesting comfort care measures only, transfer to hospital only if comfort measures fail, and do not resuscitate (DNR) orders, only 2 percent were hospitalized to extend their lives, and none were resuscitated against their wishes2.

By 2000, the Regional Ethics Network of Eastern Washington (RENEW), aware of the discouraging results with advance directives, and of the promising results in Oregon with the POLST, obtained a grant from the Washington State Medical Association (WSMA) to collaborate with the Washington State Hospital Association (WSHA), the Department of Health (DOH), and the Department of Social and Health Services (DSHS) to pilot the POLST in two counties in eastern Washington. DSHS, regulator of nursing homes, was particularly concerned that POLST would accurately reflect patients' wishes, and this led to our form differing from Oregon's by requiring the patient's or his/her legal surrogate's signature along with the physician's. Within six months of the pilot3, DSHS notified the nursing homes statewide that they could develop policies for using POLST and POLST-like forms, and DOH replaced the previously approved pre-hospital DNR form with the POLST. Educational and promotional efforts have been ongoing. These include: DOH training for EMS responders in all counties in the state; WSMA publications and workshops targeting physicians as well as providing a

POLST video and tools on its website, www.wsma.org; the provision of sample hospital policies and procedures, training videos, and webcasts by the Association of Washington State Hospital Association (WSHA) for effective POLST form use in hospitals; collaboration in all these efforts with a statewide broad-based community action coalition (Washington End-of-Life Consensus Coalition).

Who should have a POLST? The form is designed for persons with an advanced life-limiting disease who already know what treatments they wish to accept or refuse. Most people, including those with stable medical conditions, should fill out advance directives instead of POLST, expressing their wishes for what they want and do not want for medical treatments if they develop a life-threatening or life-limiting condition and are unable to speak for themselves. Physicians are encouraged to discuss the POLST with anyone whom they anticipate dying within a year. An excellent opportunity for initiating a POLST is when a patient with advanced disease is being discharged from the hospital. If a patient is known to want to limit any life sustaining treatments from this point on, whether that information is obtained directly from him/her or from advance directives and surrogates, a POLST should be filled out and accompany the patient to his/her next setting.

How is the POLST used? Here is one example: Marilyn, a woman in her fifties with metastatic ovarian cancer and

POLST: Select Bibliography

The articles listed here may be helpful for furthering your understanding of POLST.

Baumrucker, S. "Physician Orders for Scope of Treatment: An Idea Whose Time Has Come." *American Journal of Hospice and Palliative Care* 21 (2004): 247-248.

Cantor, M., and R. Pearlman. "Advanced Care Planning in Long-Term Care Facilities." *Journal of the American Medical Directors Association* 5, Supplement (March/April 2004): S73-S80.

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Hanson, L., and M. Ersek. "Meeting Palliative Care Needs in Post-Acute Care Settings 'To Help Them Live Until They Die'." *Journal of American Medical Association* 295 (2006): 681-687.

Hickman, S., B. Hammes, A. Moss, and S. Tolle. "Hope for the Future: Achieving the Original Intent of Advance Directives." *Hastings Center Report Special Report* (November-December 2005): S26-30.

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Lee, M., K. Brummel-Smith, J. Meyer, N. Drew, and M. London. "Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program." *Journal of the American Geriatrics Society* 48 (2000): 1219-1225.

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Tolle, S., and V. Tilden. "Changing End-of-Life Planning: The Oregon Experience." *Journal of Palliative Medicine* 5 (April 2002): 311-317.

Tolle, S., V. Tilden, P. Dunn, and C. Nelson. "A Prospective Study of the Efficacy of the Physician Orders for Life Sustaining Treatment." *Journal of the American Geriatrics Society* 46, no. 9 (1998): 1097-1102.

Vanpee, D., and C. Swine. "Scale of levels of care verses DNR orders." *Journal of Medical Ethics* 30 (August 2004): 351-352.

undergoing her first course of chemotherapy, filled out her POLST with her physician and chose DNR in Part A. However, she still wanted full treatment for any other medical emergencies, and so indicated on Parts B, C, and D. She did well for over a year, and when her disease relapsed, she chose to have another aggressive course of chemotherapy. At this time she changed her POLST to indicate that she wanted no intubation or mechanical ventilation in addition to no CPR, but would still want other medical life-prolonging treatments initiated if necessary. Her disease progressed and she was home with hospice care. She developed headaches, severe nausea, vomiting, and dehydration. As she was unrelieved at home, she was transported to the hospital and resuscitated with fluids, medications, and change in pain treatment, per her POLST. Her cognition improved, but brain metastases were found, and she elected a brief course of palliative radiation therapy, which relieved her acute symptoms. However, it was clear that she was terminally ill, as other critical metastases were found. At this point, she changed her POLST one more time to reflect her goals of complete comfort care at home, and she was transferred back home where she died peacefully a few days later.

A POLST paradigm program is more than a form, and we emphasize this in all our educational efforts with health care professionals and the public. Thoughtful and timely conversations within families and with health care professionals are necessary for helping people determine their wishes for treatment under specific circumstances and for appropriately completing their advance directive documents and POLST4. Overcoming the obstacles to these conversations remains the greatest challenge to successful implementation of programs to honor wishes of people facing serious illness near the end of their lives. We have been fortunate in Washington to have exceptional collaboration between state, regional, and local organizations who share this common goal.

Similar efforts are underway in many states. Differences in each state's legal statutes and regulations may require different approaches, such as revised legislation, to fully implement a POLST paradigm program. Further information about POLST paradigm programs, including getting started in your state, and a compilation of published research on POLST, can be found at www.polst.org.

NOTES

1. The SUPPORT Principle Investigators, "A Controlled Trial to Improve Care for Seriously III Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)," *Journal of the American Medical Association* 274, no. 20 (November 22/29, 1995):1591-1598.
2. SW Tolle et al, "A Prospective Study of the Efficacy of the Physician Order Form for Life-Sustaining Treatment," *Journal of the American Geriatrics Society,* 46, no. 9 (September 1998): 1097-1102.
3. JL Meyers et al, " PHYSICIAN ORDERS for Life-Sustaining Treatment Form: Honoring End-of-Life Directives for Nursing Home Residents," *Journal of Gerontological Nursing* 30, no. 9 (September 2004): 37-46.
4. JA Tulsky, " Beyond Advance Directives: Importance of Communication Skills at the End of Life," *Journal of the American Medical Association* 294, no. 3 (July 20, 2005): 359-365.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders
for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First Name/ Middle Initial	
Date of Birth	

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ Resuscitate/CPR ☐ Do Not Attempt Resuscitation (DNR/no CPR)

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

B *Check One*

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C *Check One*

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if life can be prolonged.

Additional Orders: _____

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

E

SUMMARY OF MEDICAL CONDITION AND SIGNATURES

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Health Care Representative ☐ Court-Appointed Guardian ☐ Other:_____	**Summary of Medical Condition**	
Print Physician/ Nurse Practitioner Name	MD/DO/NP Phone Number	Office Use Only
Physician/ NP Signature (mandatory)	Date	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Signature of Person, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature (optional)	Name (print)	Relationship (write "self" if patient)

Contact Information

Surrogate (optional)	Relationship	Phone Number	
Health Care Professional Preparing Form (optional)	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications.

POLST must be signed by a physician or nurse practitioner to be valid. Verbal orders are acceptable with follow-up signature by physician or nurse practitioner in accordance with facility/community policy.

Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POLST

This POLST should be reviewed periodically and if:

(1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person's health status, or

(3) The person's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.

The Oregon POLST Task Force

The POLST program was developed by the Oregon POLST Task Force. The POLST program is administratively housed at Oregon Health & Science University's Center for Ethics in Health Care. Research about the safety and effectiveness of the POLST program is available online at <**www.polst.org**> or by contacting the Task Force at <**polst@ohsu.edu**>.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

 Form developed in conformance with Oregon Revised Statute 127.505 et seq September 2004