

How POLST Can Improve End-of-Life Decision-Making

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The Problems With Living Wills

“Living Wills are getting a black eye”, acknowledges Charles Sabatino, a contributing author of the popular “Five Wishes” Living Will form and director of the ABA’s Commission on Law and Aging.

In fact, in professional commentary on Living Wills, it is hard to find much support for Living Wills. Here are a sampling of the titles of published articles (mostly in medical journals) commenting on the problems with Living Wills: “Enough: The Failure of the Living Will,” “The Illusion of Patient Choice in End-of-Life Decisions,” “The Dangers of Directives or the False Security of Forms,” and “Confronting the ‘Near Irrelevance’ of Advance Directives”.² This suggests that conventional boiler-plate Living Wills have had relatively little success in guiding end-of-life decision making.

Tim Takacs, Elder Law Attorney and founder of the Life Care Planning Law Firms Association, wrote on the National Academy of Elder Law Attorneys (NAELA) listserv,

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² See, e.g. Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 *The Hastings Center Report* 30-42 (March-April 2004); Peter H. Ditto, et. al, *Advance Directives as Acts of Communications*, 161 *Arch. Intern. Med.* 421-430 (2001); E.J. Larson and T.A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 *Wake Forest L. Rev.* at 278 (1997); J. Teno et. al, *Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention*, 45 *J. of the Am. Geriatr. Society* 500-507 (1997); David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 *JAMA* 2101-2104 (1992); Diane E. Hoffmann, Sheryl I. Zimmerman & Catherine J. Tompkins, *The Dangers of Directives or the False Security of Forms*, 24 *J. of Law, Medicine & Ethics* 5 (1996); Rebecca Dresser, *Confronting the ‘Near Irrelevance’ of Advance Directives*, 5 *J. Clin. Ethics* 55-56 (Spring 1994).

It has been years since I drafted a Living Will for a client. In fact, I won't do it even if a client wants one. I used to be an advocate for Living Wills, until clients told me stories of how health care providers were misinterpreting them. I have two nurses and a social worker (former hospital discharge planner) on my staff and none of us would ever risk our lives by having a Living Will.

An article in The New York Times on November 28, 2006, by Jane E. Brody³, further reports on the risk that Living Wills can be misinterpreted. In the article, she makes an alarming observation after reading a book entitled *Understanding Your Living Will*⁴, written by Emergency Room Doctor Ferdinando L. Mirachi:

Dr. Mirachi has studied how health professionals interpret living wills and found that the overwhelming majority think they mean that the patient wants to be treated as D.N.R. (Do Not Resuscitate), when in fact aggressive life-saving interventions could restore some patients to their previous state of health.

Indeed, Dr. Mirachi himself states in his book:

Patients die in hospitals every year because of medical staff misinterpretations of Living Wills. This can occur if patients with Living Wills are automatically treated as DNR – a medical code status that means Do Not Resuscitate. The problem is, in some cases the patients should initially have been treated aggressively and, if they had been, would likely have survived.

This news should be distressing for Elder Law Attorneys. What it means is that no matter how carefully we draft Living Wills for clients and how much time we spend educating them and their families, the medical profession may pre-judge the Living Will to mean something it is not. It means that in many cases, the Living Will when it reaches the hospital will be DOA (“dead on arrival”).

³ *Medical Due Diligence: A Living Will Should Spell Out the Specifics*, Jane E. Brody, New York Times (Nov. 26, 2007).

⁴ Ferdinando L. Mirachi, D.O., *Understanding Your Living Will*, Addicus Books, Inc. (2006).

Another major defect in Living Wills discussed by Dr. Mirachi is the lack of specifics. He writes:

Living Will forms and other templates can rob you of the chance to select individual treatments and record your specific wishes. This lack of specifics can create problems when health care personnel try to determine your code status or your treatment instructions. Many of the boilerplate forms – available on the Internet, from social service agencies, or from an attorney’s office – are not created with a physician’s input. They don’t use certain language or address situations that would be familiar to health care workers who must read and understand your Living Will.

Boilerplate Living Wills may leave out entire classes of treatments and they usually do not address code status at all. These poorly written or incomplete forms force health care workers to rely only on your health care proxy, if you have one, or turn to your loved ones, who may not be ready or able to address their questions.

Keep in mind that Living Wills originated from the legal environment of court decisions and State laws. Unfortunately, their legalistic or transactional approach is out of touch in the medical environments where decision-making counts.⁵ The legal requirements in executing Living Wills are overly formalistic. Too many States require statutory forms and legalistic wording in Living Wills. The formality requirements vary so much from State-to-State that people who have Living Wills are fearful of their nonrecognition in other States. The effort to adopt the 1993 Uniform Health Care Decisions Act has been limited to only a few States and therefore has failed to achieve Living Will and Health Care Power of Attorney uniformity among the States.⁶ As a result, the goal of honoring the patient’s end-of-life and emergency treatment wishes – the chief objective of Living Wills – is not being achieved as it should.

⁵ Charles P. Sabatino, *A Shifting Legal Landscape: From a Transactional Approach to a Communications Approach*, paper presented at 2008 NAELA Advanced Elder Law Institute, Kansas City, MO.

⁶ See Charles P. Sabatino, *De-Balkanizing State Advance Directive Law*, 13(1) Public Policy & Aging Report 1 (National Academy on an Aging Society, Winter 2008).

There is no disagreement that the use of a Health Care Power of Attorney is preferred over a Living Will. One reason why this is true is because a Living Will, which attempts to predict the future, cannot cover every possible medical situation whereas the flexible authority of the appointed agent can address almost every future medical situation. It is the author's belief that it is better to have a Living Will and/or an end-of-life values statement supplement a Health Care Power of Attorney so that the appointed health care agent has official guidance on what the patient's wishes are.

Efforts to Improve Living Wills

Despite the problems with Living Wills, Dr. Mirachi feels that they are still valuable tools. To improve the relevance of Living Wills, he recommends the use of a new kind of Living Will which includes specific code status and physician input.

Elder Law Attorney David McGuffey also weighed in on the NAELA listserv. David agrees there are problems with Living Wills, but similarly feels they should not be abandoned. He writes:

Despite the horror stories, I find living wills helpful. The absence of clear direction, however, can also have damaging consequences. I was sitting in an ethics board meeting yesterday for a local health care provider and one of the cases the board reviewed concerned a family where futile care was being demanded. The patient has a host of problems and was in a vegetative state, but the family refused to authorize removal of the ventilator. Clear directions concerning the patient's end of life wishes would have made the decision making process easier.

Further efforts to improve Living Wills have come from a paradigm switch – from the transactional approach to a communications approach of “advance care planning”.⁷ Advance care planning includes not only preparation of living wills and health care POAs, but also communications

⁷ Lauren G. Collins, Susan M. Parks, Laraine Winter, *The State of Advance Care Planning: One Decade after Support*, 23 Am. J. Palliat. Care 378-384 (2006).

with family members and physicians about what may happen in the future. In this process, the client's values and goals of care are discerned, put into written form, explained to the appointed proxy or proxies, and adequately disseminated.

The Advent of POLST

An even more promising effort to improve the relevance of Living Wills has come from the adoption of POLST or Physician's Order on Life Sustaining Treatment.

POLST is a one or two page form in **medical code language** – using a check-the-box format. POLST contains the patient's wishes on end-of-life (EOL) decisions, such as CPR, level of emergency interventions, use of antibiotics, and use of artificial nutrition and hydration. The POLST form is signed by the patient and his/her physician – after a significant physician-patient discussion. The patient's Living Will can serve as a basis to fill out the POLST form.

The POLST form is printed on bright colored (usually orange, yellow or pink) hard copy paper and is incorporated into a prominent place in the patient's medical record – wherever the record travels. The POLST form is usually created at or near the time when an acute or serious chronic condition develops and, therefore, has a greater chance of being relevant to the specific medical situation at hand.

Since a POLST form is signed by a physician, it has a much greater chance of being complied with by healthcare providers than a conventional boiler-plate Living Will. Since a POLST form is written in medical code language, it has a much greater chance of being understood by healthcare providers.

Since the POLST form is highly visible, portable, and travels with the patient's medical records, it has a greater chance of being available at the time an end-of-life decision is to be made.

It is easy to see why POLST is a great improvement over a conventional Living Will. POLST is not perfect. It only covers the most

common of medical situations. There will always be a gap. This is where the appointed agent under the health care POA comes in.

POLST was first adopted in the early 1990s by Oregon. Since then, the States of Washington, Wisconsin, West Virginia, Idaho, Maryland, New York, North Carolina and Tennessee have adopted POLST statutes or nonstatutory collaborative protocols either Statewide or in sections of States.

POLST initiatives have started in parts of other States as well.⁸

Positive research results on the use of POLST in Oregon have been reported.⁹ On August 11-12, 2008, the American Bar Association adopted the following Resolution:

The American Bar Association urges federal, state, tribal and territorial legislative bodies, governmental agencies and health care providers to establish and support decision-making protocols to ensure that the wishes, including those expressed in any prior advance directive, of those who have advanced chronic progressive illnesses are appropriately translated into visible and portable medical orders such as “Physicians Orders for Life-Sustaining Treatment” or “POLST,” that address higher probability medical contingencies, including hospitalization, cardiopulmonary resuscitation, artificial nutrition and hydration, antibiotics and ventilation.

In Wisconsin, POLST has been adopted as a nonlegislative protocol by at least one hospital system.¹⁰ The author would like our Elder Law Section to consider supporting POLST Statewide. We will need to research Wisconsin’s substantive law on advance directives to determine whether legislation is needed. Wisconsin’s DNR statute may or may not contain sufficient authority to implement POLST by regulation.¹¹

⁸ National POLST Paradigm Initiative reports POLST programs in parts of Georgia, Kansas, Missouri, New Mexico, Utah, Washington, West Virginia, New York, Pennsylvania, and Michigan’s Jackson County. Information on POLST developments in all states is available at <http://www.polst.org>.

⁹ Susan E. Hickman, Susan W. Tolle, Kenneth Brummen-Smith & Margaret M. Carley, *Use of the POLST (Physician Orders for Life-Sustaining Treatment) Program in Oregon Nursing Facilities: Beyond Resuscitation Status* 52 J. Amer. Geriatrics Soc. 1424-1429 (2004); Terri A. Schmidt, Susan E. Hickman, Susan W. Tolle & H. S. Brooks, *The Physician Orders for Life-Sustaining Treatment (POLST) Program: Oregon Emergency Medical Technicians’ Practical Experiences and Attitudes*, 52 J. Amer. Geriatrics Soc. 1430-1434 (2004). Additional literature is summarized at <http://www.polst.org> (accessed Nov. 14, 2007).

¹⁰ POLST.org, POLST paradigm forms, Wisconsin, at <http://www.ohsu.edu/polst/docs/wisconsin.pdf>.

¹¹ Wis. Stat. § 154.03 (2007).

How Physicians and Attorneys Can Work Together

Gone are the days when an attorney spends a few minutes at the end of a long estate planning meeting to briefly explain and sign a Living Will. Attorneys must realize that just helping clients write a conventional boilerplate Living Will may be a disservice. Physicians also need to get more involved in assisting patients with end-of-life decision-making and preparing POLST forms. Physicians and attorneys need to work together to educate the patient/client and involved loved ones on the risks of establishing a conventional Living Will, initiate the communication process, and secure participation of other professionals in the POLST process. The key objective is to help ensure that the client/patient's wishes on end-of-life and emergency treatment are honored. The ultimate goals are to increase the chances of saving life or achieving good death, in accordance with the client's wishes and values.