



REFLECTIONS ON THE GRAYING OF AMERICA: IMPLICATIONS OF PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

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ABSTRACT

This article examines historical developments in advance directives, including their benefits and their problems, and discusses in detail the newest form of advance directive, known as the POLST form, or Physician Order for Life-Sustaining Treatment. Against the backdrop of the author's personal experience with advance directives, this article examines whether or not the newest "kid on the block" improves our desire as a society to move towards more patient self-determination in end-of-life healthcare decisions, or whether it simply provides a clearer, less personal vehicle by which medical professionals can further avoid difficult discussions with patients and their surrogates when the end of life is near. This article concludes that although POLST forms may make treatment decisions easier for healthcare providers, there may be a disconnect between our laws approving such documentation and the reality of a patient's or patient's surrogate's own wishes at end-of-life.

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I. INTRODUCTION

As many statistics can attest, Americans are getting older.¹ How we cope as a society with that aging and how it affects our

¹ See U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: PERSONS 65 YEARS OLD AND OVER — CHARACTERISTICS BY SEX: 1990 TO 2010 tbl. 34 (2012), available at <http://www.census.gov/compendia/statab/2012/tables/12s0034.pdf>. The United States Census Bureau reports that in 1990, approximately 29.6 million people in the United States were age sixty-five or older. *Id.* In 2010, according to census data, that number had jumped to 38.6 million, an increase of about 9 million people. *Id.*

healthcare system and our healthcare implementation for individuals and classes of persons alike will become serious public policy issues over the next few decades. Especially during the last presidential election, issues of healthcare choice and implementation rose to the forefront of electoral politics.² As a society, we are at a monumental crossroads regarding issues pertinent to the graying of America, especially on the healthcare front. It is, however, the impact of and the decisions pertaining to particular individuals — most particularly end-of-life and other healthcare issues — that will affect each of us the most.

One such issue pertaining to healthcare choices of an individual is that of patient self-determination regarding care when one becomes seriously ill. Since the passage of the Patient Self-Determination Act in 1990,³ hospitals and other extended care facilities have urged patients to create and sign advance healthcare directives.⁴ Thousands of articles, both within the popular press as well as in legal and medical journals, have been written on this subject since that time. Many of these articles have explored and explained the purpose of such advance healthcare directives.⁵ Attorneys who practice in the area of estate planning have urged their clients to think about advance planning. In fact, it would be unusual today for an attorney not to advise a client that an advance

² See, e.g., David Blumenthal, 2012 – A Watershed Election for Health Care, 365 NEW ENG. J. MED. 2047 (2011). In this pre-election perspective, Dr. Blumenthal stated that “[t]he 2012 election will be the most important in the history of our health care system because it will determine whether the Affordable Care Act (ACA) is implemented or repealed.” *Id.* The issues discussed herein, while not directly impacted by the implementation of the ACA, nevertheless pertain to the broader issues of healthcare choices, health policy and implementation, and patient choice.

³ Patient Self-Determination Act of 1990, Pub. L. No. 101-508, 104 Stat 1388 (codified as amended in scattered sections of 42 U.S.C.).

⁴ See 42 U.S.C. § 1395cc(f)(1)(C) (2012).

⁵ See, e.g., Ruth F. Maron, *Who Has a Will to Live? Why State Requirements for Advance Directives Should Be Uniform(ly Revised)*, 24 REGENT U. L. REV. 169, 170 (2011) (examining advance directive legislation and advocating uniform standards for advance directives and other documents).

healthcare directive, a durable power of attorney, and a will constitute the most basic elements of good estate planning.⁶

However, advance healthcare directives and their derivatives⁷ can become extremely complicated from a personal, as well as an ethical, perspective, depending upon the form that they take and the intent that they have. A personal story can illustrate this point.

Fifteen years ago, my father, who was then eighty and wracked with Parkinson's disease and its sometimes-accompanying dementia, lay dying in a hospital bed in New Jersey. He was an intelligent man who had prepared, along with my mother, for the challenges at the end of his life. As part of that, both he and my mother had their lawyer prepare an advance healthcare directive in accordance with then-current New Jersey law. At that time, his "living will" stated, as many did, that he did not wish extraordinary measures used to keep him alive when it appeared that such measures would simply prolong his life. That document did not have many specific declarations in it, but it did say, very clearly, that he did not wish to receive a feeding tube as one of those extraordinary measures. And in that living will, he had specified that my mother should be his healthcare

⁶ However, despite the insertion of advance directives into the realm of medical decision-making, these types of documents are not without problems. For example, one problem of traditional advance directives is vagueness of instruction or information. Susan E. Hickman et al., *Hope for the Future: Achieving the Original Intent of Advance Directives*, in 35 HASTINGS CTR., IMPROVING END OF LIFE CARE: WHY HAS IT BEEN SO DIFFICULT? S26, S26 (Bruce Jennings et al. eds., 2005) [hereinafter HASTINGS CTR.]. Expressions often inserted into such documents such as "persistent vegetative state," "vegetable," and "close to death," for example, are not medically precise. *Id.* at S26-27. Once such documents are created, planning for death is seen as complete. "A systematic effort to reopen the conversation as a person's health declines is rarely made. The only repeated question that a patient might hear is, 'Do you have an advance directive?' as required by the Patient Self-Determination Act." *Id.* at S27.

⁷ The term "derivatives" in this article means documents such as Physician Orders for Life-Sustaining Treatment (POLST) forms, as well as similar forms with slightly different names currently in use in the United States, such as Medical Orders for Life-Sustaining Treatment (MOLST) form, as these forms are called in Maryland.

representative to make decisions regarding what medical treatments should be used when he could not voice his own opinion.

Cue in the daughter, who is me. Now, I never specifically talked with my father about that living will, or about his specific wishes, but I had read the document. My father's doctor came into his hospital room and told my mother and me that in order to give my father a fighting chance to survive, he needed to have a feeding tube inserted, and it needed to happen soon. My mother was, as you can imagine, a complete wreck when this man to whom she had been married for over fifty years was near death. She was completely incapable of making any decisions about his medical care. The decision fell to me. Despite my knowledge (and the doctor's knowledge) about the contents of my father's living will, and despite the fact that I was not his designated healthcare representative, I decided that the doctor should proceed with inserting the feeding tube and gave him permission to do so. My father died the next day, but I never regretted that decision.

Subsequently, when I had some very serious health issues a few years later, I drafted my own advance medical directive. In that document, I instruct my medical decision maker, who is my husband, that I do not wish extraordinary means used to keep me alive. However, I tempered my language in my living will with the wish that I wanted him to remember my Catholic faith and its tenets and that if there was any hope for my survival, I wanted to receive both food and nutrition in any dire situation. This just felt right to me, and it was a decision I reached through deep contemplation after my experience with my father. Likewise, when I redrafted my mother's living will, I inserted similar language just to reiterate the lesson that we had learned as a family unit when my father was so seriously ill.

Now a new generation of advance healthcare derivatives has arisen on the horizon of the medical care landscape. I call these new documents derivatives, because while they are not as elegant or lengthy as some living wills that I have seen or drafted, they nevertheless do contain information about the healthcare wishes of the person who completes them, at least at the time when the documents are drafted and formalized.⁸ These documents, known

⁸ Bear in mind that, as explained *infra* Section III, the persons who first developed these forms did not intend that they necessarily supplant lengthier

by various names, but most popularly identified as Physician Orders for Life-Sustaining Treatment (“POLST”) forms, have a singular purpose: to identify a person’s wishes with regard to specific types of treatments that could be used when a patient is in a life-or-death medical situation. As explained in further detail below, these documents can be extremely helpful to emergency personnel who have to make a quick determination about the administration of things such as CPR and related life-saving treatments and technologies. However, the documents leave no room for a change of heart by the individual if the person is incapable of verbally expressing his or her wishes to the rescue personnel. This is because the POLST form is what it says — it is a signed physician’s order that simply relays to rescue personnel what a doctor is ordering with respect to treatment for a particular individual. Those rescue personnel are bound by law to respect and follow that doctor’s order as written. Therein lies the ethical conundrum of the POLST document, and the issue most raised by those in opposition to its use. Whereas a living will or similar advance directive may express wishes that can guide a healthcare representative to make a principled, thoughtful decision as to a particular treatment within a particular occurrence, the POLST form provides no such guidance — it is simply a stark physician’s order, stated and signed at a particular point in time used to make determinations in all situations in which it is used. Like a photograph which memorializes an event, the POLST form memorializes an opinion from a particular moment; there is no further contemplation, no consideration of additional circumstances, no wavering from what is stated in the order.

The first part of this article provides a review of the advance medical directives movement generally, focusing upon that

forms such as living wills, but that they provide a more succinct enumeration of a person’s wishes for use by a medical team that has to make speedy decisions about appropriate and desired medical care in a medical emergency. In other words, by many, these are viewed as forms which simply effectuate the desires expressed in a document such as a living will. One author described the newer form as such: “POLST is not an advance directive; it is an advance care planning tool that reflects the patient’s here-and-now goals for medical decisions that, considering the patient’s current condition, could confront him or her in the immediate future.” Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 MILBANK Q. 211, 229 (2010), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2010.00596.x/pdf>.

movement's progress since the 1990 passage of the Patient Self-Determination Act. The second part provides an overview of the development of POLST, as well as what is known as the POLST paradigm. The third part provides some reflection upon some potential improvements primarily in the administration and effectuation of POLST, and discusses ethical decision-making and its relationship to the POLST paradigm. Finally, this article will conclude that despite the good that POLST documents can do, and the fact that they make treatment decisions much easier for first responders and healthcare providers, there is a disconnect here. Looking at such laws and such documents and a person's own wishes at a particular point in space and time should cause us, as individuals, to at least reflect upon our own views on end-of-life issues before we decide to use a POLST document for ourselves or our loved ones.

II. THE "ADVANCE" OF ADVANCE HEALTHCARE DIRECTIVES: A SIMPLE HISTORY

Although so-called living will statutes first appeared⁹ in the United States throughout the late 1970s and 1980s,¹⁰ they were not fully embraced by the medical profession¹¹ until the passage of the

⁹ In fact, as early as 1938, with the establishment of the Euthanasia Society of America, advocates pushed for various end-of-life approaches which would respect patients' wishes about dying. Milos D. Miljkovic et al., *From the Euthanasia Society to Physician Orders for Life-Sustaining Treatment: End-of-Life Care in the United States*, 19 *CANCER J.* 438 (2013).

¹⁰ See, e.g., Henry R. Glick, *The Right-to-Die: State Policymaking and the Elderly*, 5 *J. AGING STUD.* 283, 288-89 (1991). The author explains that while California, as an "early innovator" in this area of policy, passed the first living will bill in 1976, it was not until about 1984 when other states began enacting such laws. *Id.* at 289. By 1989, there were forty-one states with living will laws. *Id.*

¹¹ The movement towards patient self-determination was spurred in part when "awareness began to grow that the experience of dying . . . was often a horror." Bruce Jennings, *Preface to HASTINGS CTR.*, *supra* note 6, at S2, S2. This realization reflects the increasing technological capability in medicine and medical technology that can keep people alive longer through use of these new techniques. Some began to question whether this was really what the people kept alive would have wanted, since the quality of life after medical intervention might not be optimal. Reformers began to consider what could be done to change this paradigm, and they

Patient Self-Determination Act in 1990.¹² That statute made it mandatory for healthcare facilities to affirmatively provide written materials to their patients about advance healthcare directives when the patients entered a facility.¹³ If you have even been in a hospital within recent years, surely you recall being asked upon registration whether or not you have a living will and if you have named a healthcare representative. If you have taken neither of these steps, hospitals (and other healthcare facilities) will provide you with standard documentation that will enable you to complete these steps as soon as possible after your admission.¹⁴ This is the

realized that there were at least two steps that could be taken. First, laws could be used “to empower persons to dictate the terms of their own medical care at the end of life (via constitutional rights and legally authorized advance directives).” *Id.* This resulted in the proliferation of advance directive and living will statutes in the 1970s and 1980s. *See generally* Sabatino, *supra* note 8. Second, reformers realized that they could “enlist medicine to improve its skill at treating pain and suffering” in the form of palliative care and hospice-like treatment. Jennings, *supra* note 11, at S2.

¹² Patient Self-Determination Act of 1990, Pub. L. No. 101-508, 104 Stat 1388 (codified as amended in scattered sections of 42 U.S.C.).

¹³ In fact, the statute, enacted as part of the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, was in actuality an amendment to prior federal Medicare and Medicaid law. Sabatino, *supra* note 8, at 217. “This act was a fairly modest amendment . . . intended to encourage adults to think about and plan for health care decisions.” *Id.* It required that henceforth, all hospitals, skilled nursing facilities, home health agencies, hospices, and the like, which were certified as Medicare and Medicaid providers, would need to create and maintain policies about advance medical directives, provide written information to patients about such directives, note in a patient’s chart whether that patient has an advance healthcare directive, and further, strictly comply with state law regarding advance directives. *Id.* Additionally, such medical facilities and agencies would be required to educate staff and community on advance directives. *Id.* (citation omitted).

¹⁴ For example, Medstar Georgetown University Hospital, one of the largest and most respected hospitals in the Washington, D.C. area, provides a specific section on its website which explains advance healthcare directives to patients and also links to other websites with further information about the purpose and completion of such documents. *Advance Directives*, MEDSTAR GEO. U. HOSP., <http://www.medstargeorgetown.org/for-patients/patients-and-visitors/patient-information/advance-directives/#q={}> (last visited Mar. 30, 2015). In fact, that website, as is the case with many hospitals, provides an actual link to an “advance directive document” which meets the legal requirements of D.C., Maryland, and Virginia, prepared by the D.C. Hospital Association. *Advance Directive Document*,

Patient Self-Determination Act in action — assuring that patients in healthcare facilities receive the information mandated by the statute.¹⁵ Make no mistake about it, however — hospitals and other healthcare facilities seek to have such documentation on file not only to comply with the statute, but also to protect themselves from liability for any actions taken during medical treatment related to those documents.¹⁶

MEDSTAR GEO. UNIV. HOSP., <http://www.medstarhealth.org/content/uploads/sites/8/2014/09/advance-directive.pdf> (last visited Mar. 30, 2015). The document allows patients simply to initial next to their choices about healthcare treatments, and to sign the document and have it witnessed by two witnesses who attest that the author is of sound mind. *Id.* The sections of the document are divided into “My Durable Power of Attorney for Health Care;” “My Living Will;” and “Other Wishes.” *Id.* Interestingly, it is very clear in the available document that the instructions within the document apply in only two situations: one, a patient’s wishes if he or she has a terminal condition; and two, a patient’s wishes if he or she is in a persistent vegetative state. *Id.* In the “Instructions and Definitions” section of the document on the website, the following definitions appear:

Persistent Vegetative State: When a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person can’t think or respond.

Terminal Condition: An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment. Life-sustaining treatments will only prolong a person’s dying if the person is suffering from a terminal condition.

Id.

¹⁵ Note, however, that the Patient Self-Determination Act expressly forbids a healthcare provider from requiring a patient to complete any kind of advance directive. *See* 42 U.S.C. § 1395cc(f)(1)(C) (2014). Section 1395cc(f)(1)(C) of the Act states that a provider of services must not “condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.” *Id.* In the category of “medical providers want to be protected, too,” the statutory language continues with a statement that the provision set out above “shall not be construed as requiring the provision of care which conflicts with an advance directive.” *Id.* § 1395cc(f)(1)(E).

¹⁶ Dorothy D. Nachman, *Living Wills: Is It Time to Pull the Plug?* 18 *ELDER L.J.* 289, 292 (2011). As Nachman stated: “[o]ne of the challenges of creating effective end-of-life decision-making policy is that there are two distinct goals that such policies are designed to address: 1) protecting an individual’s right to

Prior to the passage of the Patient Self-Determination Act, however, policymakers and legislators throughout the United States had already begun the process of formalizing how advance medical decisions were to be made in this country.¹⁷ In 1976, California became the first state to pass a so-called living will statute.¹⁸ Other states followed suit. Within ten years, forty-one states had passed living will statutes,¹⁹ and full-scale consideration and debate about advance medical directives began in earnest.

Clearly, the passage of living will statutes was a step towards implementation of patient self-direction in medical care, primarily at the end of life. However, over a period of time, it became increasingly clear that while a living will could serve to provide some information to doctors and other medical professionals concerning a person's wishes about care, it was not enough. At that point, policymakers and legislators alike started looking at what legal vehicle could provide assistance when an individual was not competent or conscious to express his or her own wishes about medical care.²⁰ The model looked to was one

determine the nature and scope of their end-of-life care and 2) **protecting health care professionals from liability.**" *Id.* (emphasis added).

¹⁷ Another popular option for individuals is something known as The Five Wishes Form. This form, which meets legal requirements for advance directives in forty-two states, covers the following in a series of five wishes: 1) assignment of healthcare agent; 2) a living will; 3) matters of comfort care; 4) personal matters at the time of imminent death; and 5) matters that you want your loved ones to know, including how you wish to be remembered and final wishes regarding funeral or memorial plans. *Five Wishes*, AGING WITH DIGNITY, <http://www.agingwithdignity.org/five-wishes.php> (last visited Mar. 30, 2015).

¹⁸ Sabatino, *supra* note 8, at 213. In fact, the living will statutes both provided patients with a way to express their thoughts about end-of-life care, and protected medical professionals from potential liability in the absence of such a document. *Id.* "To individuals, it offered a standardized tool to express their wishes about life-sustaining treatment To physicians, the living will offered statutory immunity if they complied with the patient's wishes in good faith." *Id.* A further history of the modern movement can be found in *From the Euthanasia Society to Physician Orders for Life-Sustaining Treatment*. Miljkovic et al., *supra* note 9, at 438-39.

¹⁹ Sabatino, *supra* note 8, at 214.

²⁰ Attention to the plight of decision-making at the end of life came to a fevered pitch when the New Jersey Supreme Court decided the case of Karen Anne Quinlan in 1976. *In re Quinlan*, 355 A.2d 647 (N.J. 1976). In that case, the New Jersey

that had previously been used in a perhaps less emotional, business-like setting — the durable power of attorney.²¹ However, a document used to deal with financial and business situations would not be, in its most basic form, the most appropriate one to deal with potentially life-ending medical decisions. So at that time, a new document evolved which would eventually take shape as what is commonly known now as a durable power of attorney for healthcare.²²

California again created a law which promoted and allowed such documents to be used, passing a durable power of attorney for healthcare statute in 1983.²³ By the end of 1997, every state had

Supreme Court, in a lengthy, agonized decision authorized Ms. Quinlan's father, in consultation with the family and attending physicians, to order removal of a ventilator device, based partially on the fact that if Quinlan had been competent, surely she would have wanted to make a decision about whether to continue or not the use of the ventilator. *Id.* at 671. Under that theory, the court allowed Ms. Quinlan's father to make a decision about continuation or not of the ventilator unit, based upon what he believed her wishes to be. *Id.* The *Quinlan* case considered questions of religion, ethics, medicine, and criminality but ultimately found that if there was no reasonable possibility of Ms. Quinlan "ever emerging from her . . . comatose condition to a cognitive, sapient state" the family guardian and physicians should consult with the hospital's Ethics Committee and seek concurrence in discontinuance of life-saving care. *Id.* at 671-72. The court further stated that if the Ethics Committee agreed, the life-support system could be withdrawn without any civil or criminal liability on the part of any participant in that withdrawal. *Id.* at 672. Subsequent to the *Quinlan* decision, reformers and legislators alike started to work towards statutory solutions for similar problems, resulting in the creation of living will statutes. These documents could then express in writing a person's wishes for end of life care. As noted above, *supra* notes 15-18 and accompanying text, contemporary statutes generally address liability of medical personnel involved in any such decision.

²¹ A durable power of attorney allows an agent to continue to act on a person's behalf even after — or even if — the principal loses the capacity to delegate authority. See *Quinlan*, 355 A.2d at 672. The use of a durable medical power of attorney was actually propelled by the President's 1983 Commission for the Study of Ethical Problems in Medicine. Miljkovic et al., *supra* note 9, at 439. That group suggested looking to the Uniform Durable Power of Attorney Act for a model. *Id.*

²² See Miljkovic et al., *supra* note 9, at 438-39 (discussing the development of durable powers of attorney for healthcare).

²³ Sabatino, *supra* note 8, at 215.

enacted some type of healthcare power of attorney statute.²⁴ Thus, most states, by the end of the nineties, had passed legislation creating two distinct documents, which could be used by persons wishing to have greater control over end-of-life medical decision-making: the living will and the healthcare power of attorney.²⁵

Another type of related statute also began to emerge around the same timeframe as the living will and durable healthcare power of attorney laws. During the 1990s, statutes pertaining to so-called “Do Not Resuscitate” (“DNR”) orders and protocols began to pass through state legislatures.²⁶ By the turn of the century, at least forty-two states had established statewide DNR protocols.²⁷

As this area of law has progressed over the past twenty to thirty years, yet another series of legislation has emerged, focusing on who, in the absence of any other advance directive-type documents, can make decisions about end-of-life care for someone who is unable to do so for himself or herself.²⁸ Loosely patterned

²⁴ *Id.*

²⁵ In fact, in many states today, statutes which had once been separated, with one statute concerned with living wills and one concerned with healthcare powers of attorney, have been merged. The preferred document today provides both direction as to treatment and instructions as to a surrogate decision maker, should the creator of the document not be able to make decisions for himself or herself. *Id.* at 216-17.

²⁶ *Id.* at 215. These DNR protocols and orders mostly related to cardiopulmonary resuscitation (CPR), basic resuscitation, and heart stops in patients. *Id.* Today, DNR orders are very commonplace within the United States. “So deeply is DNR embedded in the patient choice paradigm that it could be called a ‘patient order’ not to attempt resuscitation that is given to the medical team.” Jeffrey P. Bishop et al., *Reviving the Conversation Around CPR/DNR*, 10 AM. J. BIOETHICS 61, 62 (2010).

²⁷ Sabatino, *supra* note 8, at 215. Interestingly, of those forty-two states, half had no medical preconditions for making the decision. The DNR decision had basically moved into the realm of any other patient-led medical decision. Charles P. Sabatino, *Survey of State EMS-DNR Laws and Protocols*, 27 J.L. MED. & ETHICS 297, 298 (1999).

²⁸ Sabatino, *supra* note 8, at 215. Probably legislation regarding this point emerged as a result of the Supreme Court’s decision in *Cruzan v. Director, Missouri Dept. of Health*. 497 U.S. 261 (1990). That 5-4 decision of the United States Supreme Court considered the fate of Nancy Beth Cruzan, who had

after distribution laws in intestate succession, these create a list of possible persons who can make medical decisions for a particular individual, including whether or not to use CPR in certain situations.²⁹ So the legislative trend towards patient self-determination in healthcare decision-making marches on, with emphasis upon individual wishes and desires regarding medical care.

III. POLST STATUTES AND THE POLST PARADIGM

A. THE DEVELOPMENT OF THE POLST PARADIGM

Advance directive documents were created to enable patients and families to take control of various medical decisions regarding medical treatment.³⁰ Despite the best efforts of reformers and legislators in some, if not many, instances, advance

sustained severe injuries in an automobile accident. *Id.* at 265. Her parents sought removal of artificial feeding and hydration equipment. *Id.* However, in the absence of clear and convincing evidence of Nancy's desires in this regard, the Supreme Court of Missouri refused authority of her parents to remove the equipment. *Id.* The United States Supreme Court considered whether Cruzan had a constitutional right to require the hospital to withdraw the equipment. *Id.* at 269. Ultimately, the Supreme Court upheld the decision of the Supreme Court of Missouri, finding no constitutional right here. *Id.* at 286-287. In rendering its decision the Court referenced the *Quinlan* case, *supra* note 20, and specifically noted that in the wake of that decision, cases such as this were exploding because of the advance of medical technology capabilities in extending life. *Cruzan*, 497 U.S. at 261.

²⁹ Sabatino, *supra* note 8, at 216. These statutes provide "a clear hierarchy of decision-making authority in the more conventional family constellations." *Id.*

³⁰ Keith E. Sonderling, *POLST: A Cure for the Common Advance Directive – It's Just What the Doctor Ordered*, 33 NOVA L. REV. 451, 451 (2009). It is interesting to note that, as stated in a recent article, there is a very substantial reason for this shift in focus to patient-centered direction of medical care. Miljkovic et al., *supra* note 9, at 438. "In 1949, 50% of all deaths occurred in hospitals and nursing homes; by 1980, that figure increased to approximately 80%." *Id.* That figure is surely higher today, thirty-five years later, considering the large development since the 1980s not only of nursing homes, but other types of domiciliary care facilities, including assisted living facilities.

directives have not been easy for medical professionals to use in practice. The reasons for this vary,³¹ but if you have ever read an advance directive such as a living will, you will observe that such documents tend to express a person's motivations for executing and having such a document. Furthermore, living wills also express religious and ethical understandings of the individual who is the author of the document. This is exactly what my own advance directives accomplish. Clearly, in a moment of emergency decision-making, however, such a document is too involved and too cumbersome to be used to make expedient decisions.³²

As a result, new models to effectuate the wishes of individuals in end-of-life medical care have begun to emerge.³³ The model that seems to be most popular — and certainly one of the most studied — is the POLST model.³⁴ As explained above, the POLST model actually creates a physician order — its title reflects that status — with the acronym POLST, standing for Physician Order for Life-Sustaining Treatment. That order is an “example of an actionable advance directive that is specific and effective

³¹ Miljkovic et al., *supra* note 9, at 438.

³² See *supra* Part II explaining the author's own decision-making process in executing a living will, and the types of things that she included in that document.

³³ These models, which developed because of problems with the traditional advance directives, include “Five Wishes,” “Let Me Decide,” “Respecting Choices,” and the POLST model. Hickman et al., *supra* note 6, at S27-S28. The Five Wishes document expresses a variety of wishes about many things pertinent to end of life and serious medical care, and also appoints a healthcare decision maker. *Id.* at S27. Information about this type of document can be found at www.agingwithdignity.org. *Id.* Let Me Decide is a Canadian program that considers a whole host of health care choices, ranging from levels of care to nutrition to cardiopulmonary resuscitation. *Id.* Information about this program is available at www.newgrangepress.com. *Id.* The Respecting Choices program stemmed from a community-planning program, which promoted written advance care directives, and also aggressively pushed for their placement in patient medical records. *Id.* The program itself, though, is much broader and contains a staff and physician education component, training in the use and preparation of the documents, and also specific “written protocols” for emergency personnel. *Id.* Information about this last program can be found at www.gundersenlutheran.com/eolprograms. *Id.* The POLST model is explained in greater detail *infra*.

³⁴ *Id.*

immediately.”³⁵ It serves as an actual medical document, which translates a patient’s end-of-life desires into a medical order. Accordingly, this type of a POLST, while not a substitute for what would be identified as an advance directive, is designed to bridge the gap to effectuate a person’s wishes as expressed in those traditional documents.³⁶ In essence, the POLST is a sort of a shorthand expression of the wishes that have been thought out in advance by an individual.³⁷ And such a shorthand version, stripped of the ethical, religious, or other thoughts of an individual, can provide emergency and other medical personnel quick and clear information about a person’s wishes regarding life-sustaining treatment in a critical medical situation.³⁸

The POLST form, which can differ from state to state, is essentially a physician’s order. It is meant to be used by patients who have serious illness and advanced frailty; the form is most appropriately used when a clinician would not be surprised if the patient died within the following year.³⁹ The form itself becomes

³⁵ *Id.*

³⁶ *Id.*

³⁷ Some commentators have noted that although the POLST paradigm has been recognized as valuable since it introduces a “systematic approach” to end-of-life treatment, there are still barriers to the establishment of POLST programs in some states. Susan E. Hickman et al., *The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Barriers to Implementation*, 36 J.L. MED. & ETHICS 119, 122 (2008).

³⁸ What exactly is different about the POLST form? It is more standardized and thus, in theory, it more effectively communicates a patient’s wishes. One commentator described it this way: “Physician orders for life-sustaining treatment represented a significant paradigm change, in that it standardized the providers’ communications prescribing a plan of care in a highly visible way, rather than focusing solely on standardizing patients’ communications.” Miljkovic et al., *supra* note 9, at 439.

³⁹ *See id.* at 44; *see generally* Hickman et al., *supra* note 37, at 120-21. In essence, and this is what the author believes might sometimes be lost in the implementation and use of POLST forms, the form is meant to reflect a patient or a patient surrogate’s feelings and determinations about the treatment options **in light of the patient’s current condition**. *See* Miljkovic et al., *supra* note 9, at 439 (emphasis added). In reality, and by observation, this may not be the case in how these forms are used. The author’s personal experience has been that the forms, required in the state of Maryland, were filled out simply to be part of a semi-

part of the medical records of a patient, and is meant to convey in simple form thoughts and desires of a patient — which might have even been expressed in a longer advanced directive such as a living will. In many states, the form is reproduced on a brightly colored paper, which is clearly prominent in an individual's healthcare record.⁴⁰ This is meant to reduce the incidences of medical personnel not being able to find, to interpret, or to ascertain the goals of a more complicated form of advance directive such as a living will.

The cornerstone of the POLST process is that patients are supposed to reach their decisions as noted on the POLST form (which is in essence a check-off form)⁴¹ in consultation with their medical providers.⁴² Although in theory this is a wonderful idea,

permanent medical record in a facility, and there seemed to be no effort to re-evaluate the information on the form (or for that matter to ascertain whether the patient or the patient surrogate had sufficient information with which to decode the form and fill it out so that it truly reflected personal wishes).

⁴⁰ See Hickman et al., *supra* note 37, at 120. The POLST program originated in Oregon, but has spread to a number of states over the last few years. See *id.* at 120-21; see also Miljkovic et al., *supra* note 9, at 439-40. Information about the POLST program can be found at www.polst.org.

⁴¹ Patricia A. Bomba et al., *POLST: An Improvement over Traditional Advance Directives*, 79 CLEV. CLINIC J. MED. 457, 462-463. What exactly does the POLST form do? Here is one description:

The POLST Form . . . provides instructions about resuscitation if the patient has no pulse and is not breathing. Additionally, the medical orders indicate decisions about the level of medical intervention that the patient wants or does not want, e.g., intubation, mechanical ventilation, transport to the hospital, intensive care, artificial nutrition and hydration, and antibiotics. Thus, POLST is outcome-neutral and can be used either to limit medical interventions or to clarify a request for any or all medically indicated treatments.

Id. Another view of the form states as follows: “[t]he P[OLST] form . . . is a way to translate the wishes of a patient with an advanced, progressive illness into physician orders that must be followed by emergency personnel and other health care providers across all settings of care.” Jenica Cassidy, *A Brief Survey of State POLST Form Distribution Practices*, 34 BIFOCAL 132 (2013).

⁴² See Bomba et al, *supra* note 41, at 459. When the POLST idea was in its infancy about twenty years ago, a group of health care professionals at the

the reality is that while patients and their families may look to medical professionals to initiate the difficult conversations that must ensue about health care choices in certain circumstances, often those discussions are just as difficult for medical professionals to initiate and have.⁴³ In many instances, these discussions never occur. Within the POLST paradigm, this is addressed, so that in the absence of a doctor-patient discussion, other trained healthcare workers might have these types of planning discussions with families and patients prior to completion of the POLST form.⁴⁴ In a perfect world, this will result in completion of the form in a way that is reflective of a particular patient's wishes.⁴⁵ Additionally, hopefully, the POLST process will

University of Oregon considered various problems that traditional advance directives had wrought, and "realized that physicians needed to be more involved in discussions with patients about end-of-life care and in translating the patient's preferences and values into concrete medical orders." *Id.*

⁴³ Some commentators have expressed the functioning of POLST, with regard to conversations between medical professionals and patients, in truly admirable ways. *Id.* These commentators state clearly that "[t]he aim [of POLST] is to improve the quality of care that seriously ill patients receive at the end of life." *Id.*

⁴⁴ *See generally* Hickman et al., *supra* note 6, at S29-30.

⁴⁵ Sonderling, *supra* note 30, at 453. "One of the most notable features of the POLST form is that it is not a complicated legal document, which can be difficult for caregivers to interpret. [Moreover] [v]arious studies demonstrate the effectiveness of the POLST Form in achieving the original intent of a patient's wishes." *Id.* (citations omitted). Clearly, the POLST form was intended to remedy issues remaining even after the widespread adoption of advance directives in the United States. *See generally* Marshall B. Kapp, *The Nursing Home as Part of the POLST Paradigm*, 36 *HAMLIN L. REV.* 151 (2013). "There are a myriad of serious problems with the legal status quo and the prevalent clinical practice that the legal climate helps to engender regarding the medical care of individuals with advanced, irreversible illness in the United States." *Id.* at 163. This is the crux of the issue here, as discussed *supra* Part II. On the one hand, advance directives aim to convey the values and wishes of a patient. On the other hand, especially in the assisted living and nursing home setting, the reality is that actual care provided to someone may not match up with those values and wishes. This is where the POLST form puts the pedal to the metal — it cuts through aspirational language and provides clear-cut treatment options. Moreover, because it is signed as a true physician's order, it requires follow-through within all medical settings, including assisted living and nursing home facilities. The bottom line is that "[h]ealthcare professionals ordinarily are used to, and reasonably comfortable with, respecting physicians' orders." *Id.* at 109.

proceed as a collaborative, shared, and informed medical decision-making occurrence.⁴⁶ To that end, the POLST process has a recommended eight-step protocol for completion of the requisite form.⁴⁷ That protocol provides for heavy involvement by the medical team in discussing and documenting medical decisions of the patient and his or her family.

Although this is a relatively new type of advance medical directive or derivative, studies show that the use of the POLST form both improves the documentation of a patient's wishes as well as the fulfillment of a patient's desires regarding medical care.⁴⁸ Furthermore, emergency medical workers have said that the use of the POLST form is quite useful in both expressing patient wishes and in helping those workers determine and decide which types of treatment they should provide to a particular patient.⁴⁹ These studies also show that POLST "more accurately conveys end-of-life care preferences for patients with advanced chronic illness and for dying patients" as compared to traditional advance directives.⁵⁰

⁴⁶ Bomba et al., *supra* note 41, at 460.

⁴⁷ *Id.* at 461-62. The eight-step POLST protocol is supposed to proceed as follows: (1) prepare for a discussion with the patient and the family; (2) determine not only the patient's prognosis, but also the patient's views and values in light of that prognosis; (3) further enlighten the patient and the patient's family (in small amounts, giving time for response); (4) engage in negotiation and reconciliation in order to seek common ground; (5) respond with empathy; (6) use the POLST form to review the elements of the form in use in the particular state, and help the family and the patient reconcile any issues with the form; (7) obtain the signed, written consent of the patient or his or her health care representative, as well as the physician's signature; and (8) review and revise the POLST form periodically. *Id.*

⁴⁸ *Id.* at 463 (internal citations omitted).

⁴⁹ *Id.*

⁵⁰ *Id.* at 464 (providing "[i]n summary, more than a decade of research has shown that the POLST Paradigm Program serves as an emerging national model for implementing shared, informed medical decision-making.").

B. MARYLAND: A CASE STUDY IN THE DEVELOPMENT OF THE POLST PROCESS

One of the more recent states to come “on line” with the POLST process is Maryland. Effective January 1, 2013, the Maryland version of the POLST form — the Maryland Medical Orders for Life Sustaining Treatment (“MOLST”) form — replaced the former Maryland Do Not Resuscitate (“DNR”) form.⁵¹ Although prior DNR forms are still valid and recognized by emergency medical workers in the state,⁵² the new forms are intended to replace the old DNR forms as the standard protocol for emergency services.

Maryland is a good case study for how the POLST/MOLST protocols have developed over time in various states. In 1993, the Maryland legislature passed the state’s Health Care Decisions Act.⁵³ That statute became effective on October 1, 1993,⁵⁴ and applies to individuals in every healthcare and community setting within the state of Maryland.⁵⁵ Generally, the Maryland Health

⁵¹ *Maryland Order for Life Sustaining Treatment (MOLST)*, MD. INST. FOR EMERGENCY MED. SERVS. SYS. (MIEMSS), <http://www.miemss.org/home/PublicInformation/DNRDoNotResuscitate/tabid/118/Default.aspx> (last visited Mar. 30, 2015) (announcing the change on its website and explaining the procedures for patients with and without MOLST forms).

⁵² *Id.*

⁵³ See Health Care Decisions Act of 1993, 1993 Md. Laws ch. 372 (codified as amended at MD. CODE ANN., HEALTH-GEN. § 5-601 to -618 (LexisNexis 2013)).

⁵⁴ See *id.* (stating “this Act shall take effect October 1, 1993.”); see generally *Maryland MOLST Guide for Health Care Professionals*, MD. MOLST TRAINING TASK FORCE (May 2012), <http://marylandmolst.org/docs/Guide%20for%20Patients%20and%20Caregivers%20May%202012.pdf>.

⁵⁵ See *Maryland MOLST Guide for Health Care Professionals*, *supra* note 54, at 3-4. As of July 1, 2013, all persons admitted to nursing homes, assisted-living programs, hospices, home health agencies and dialysis centers are required to have a completed MOLST form in their medical records. Miljkovic et al., *supra* note 9, at 441. This requirement of the State of Maryland, although well-intended from a healthcare point-of-view, is fraught with problems. For one, the Patient Self-Determination Act explicitly states that persons shall not be required to have any kind of advance directive (and not to condition treatment on the presence or absence of such a document in a patient’s medical file). See 42 U.S.C. § 1395cc(f)(1)(A)–(C); see also Sabatino, *supra* note 8 and accompanying text. Of

Care Decisions Act, as enacted in 1993, set the parameters for advance directives in the state. The law provides statutory authority for appointment of a healthcare agent to make healthcare decisions for an individual and for a living will document to set forth an individual's wishes regarding medical treatments when that individual is incapacitated.⁵⁶ The statute further provides for a certification process to determine when a patient is incapable of making an informed decision regarding treatment; at that point, a surrogate may act.⁵⁷ Under Maryland law, the treating physicians must engage in a specified certification that the individual being treated lacks the capacity to make healthcare decisions.⁵⁸ That physician determination must be recorded in writing in the individual's medical records.⁵⁹ At that point, the surrogate decision-maker — typically the healthcare agent named by the individual — may make decisions on the individual's behalf.⁶⁰ Healthcare practitioners must follow this

course, although the federal statute states this, the admission of a patient to a healthcare facility always includes at the least an inquiry about these forms. So it is questionable whether this Maryland requirement is even enforceable. Moreover, it is doubtful that in the rush of completing entrance forms to any kind of a healthcare facility that well-reasoned, thoughtful consideration would be made of the many different "options" presented to a patient or a surrogate on the POLST form.

⁵⁶ See *Maryland MOLST Guide for Health Care Professionals*, *supra* note 54, at 4-10. The Maryland statute, then, is a combination of different healthcare statutes, providing for both a written advance directive and an oral advance directive. MD. CODE ANN., HEALTH-GEN. § 5-601(b).

⁵⁷ See HEALTH-GEN. § 5-606; see also *Maryland MOLST for the Health Care Practitioner*, MD. MOLST TRAINING TASK FORCE (July 2013), <http://marylandmolst.org/docs/Maryland%20MOLST%20for%20the%20Health%20Care%20Practitioner%20PP.pdf> (providing a power-point presentation for healthcare professionals) [hereinafter "*Maryland MOLST*"].

⁵⁸ *Maryland MOLST*, *supra* note 57, at 6.

⁵⁹ *Id.*

⁶⁰ *Id.* at 7-9. As noted above, the healthcare agent is the appropriate decision maker in this instance. *Id.* at 20. Should there be no designated healthcare agent, or if for some reason the designee cannot act, then the statute provides that a surrogate decision-maker can be used. See *id.* at 7-8.; see also HEALTH-GEN. § 5-605. The Maryland Health Care Decisions Act further specifies a particular type

decision-making process or face reports to their licensing agencies.⁶¹

Following the development of the POLST form and the paradigmatic form in Oregon during the early 1990s, Maryland commenced work on the same topic in 1996.⁶² From 2003 until about 2011, a group known as the State Advisory Council on Quality Care at the End of Life (and its POLST subcommittee) worked with various stakeholders within Maryland, including the Maryland Attorney General's Office, the Maryland Institute of EMS Systems, the Board of Physicians, and the Office of Health Care Quality to study the POLST paradigm.⁶³ That process involved reviewing other states' experiences with the POLST process, reviewing the available literature about POLST, talking with individuals and groups in other states who had some experience with the POLST process to see what worked and what did not work, and reviewing training programs and tools.⁶⁴

and order in which the surrogate decision-maker can be consulted. HEALTH-GEN. § 5-605(a)(1)(2).

⁶¹ *Maryland's Health Care Decisions Act*, MARYLAND MOLST TRAINING TASK FORCE (Feb. 2014), <http://marylandmolst.org/docs/Health%20Care%20Decisions%20Act,%20Long%20Version,%20February%202014.pdf>, at 47-49. Note, however, that the Health Care Decisions Act protects the physician from criminal prosecution or civil liability for withholding or withdrawing health care in accordance with the Health Care Decisions Act. See HEALTH-GEN. § 5-609(a)(1) (stating "[a] health care provider is not subject to criminal prosecution or civil liability . . . as a result of withholding or withdrawing any health care under authorization obtained in accordance with . . . [the Maryland Health Care Decisions Act]."); see also *Maryland MOLST*, *supra* note 57, at 49.

⁶² See *MOLST's Journey in Maryland*, MD. MOLST TRAINING TASK FORCE (May 2012), <http://marylandmolst.org/docs/MOLST's%20Journey%20in%20Maryland%20PP%20May%202012.pdf> (documenting the Maryland journey to implementation and establishment of a POLST paradigm with a PowerPoint presentation) [hereinafter "*MOLST Journey*"].

⁶³ *Id.* at 11.

⁶⁴ *Id.* at 13-14. The State Advisory Council for Quality Care at the End of Life held its first meeting on April 25, 2003. See *Minutes from April 25th, 2003 Meeting of the State Advisory Council for Quality Care at the End of Life*, MD. ATT'Y GEN. (Apr. 25, 2003, 10:00 AM), <http://www.oag.state.md.us/Healthpol/SAC/mino42503.pdf>. At the meeting, Mr. Jack Schwartz, Director of Health Policy in the Office of the Maryland Attorney General, explained how the Council

Additionally, the working group reviewed the Maryland law, the historical use of the DNR form in the state, and such issues involving continuum of care and advance directives, decision-making capacity and its influence on state regulatory issues, as well as other issues related to end-of-life care.⁶⁵ That working group sought to replace the typically used DNR order and to implement use of the MOLST form.⁶⁶

When the MOLST amendments to the Health Care Decisions Act were finally introduced in the Maryland state legislature during the 2011 session, they were widely and definitively accepted. For example, House Bill 82 was ultimately passed 136-0; Senate Bill 203 was passed with a final vote of 45-0.⁶⁷ Since the passage of the MOLST amendments, various groups within state government have worked on implementing additional revisions to the Health Care Decisions Act to establish training protocols for individuals who would likely be advising others on the dynamics of the MOLST protocol and form.⁶⁸

As an illustration of how the actual form works, Maryland, again, is a good example. The Maryland MOLST form is divided into several parts. The first part certifies the basis for the orders in

originated, stating that after the passage of the Health Care Decisions Act in 1993, advisory groups from the Governor's office and the Attorney General's office were formed, but that they only lasted for short periods of time. *Id.* at 1. He also explained the difference between this Council and other groups for the first time that day by noting the Council "has a broad legislative mandate to provide ongoing oversight of issues related to quality care at the end of life." *Id.*

⁶⁵ *MOLST Journey*, *supra* note 62, at 15.

⁶⁶ *Id.* at 16. The objective of the MOLST form was that it not be so comprehensive as to confuse EMS workers and others in its use, and also so that the MOLST form would be recognized and treated as a medical order "across the continuum of care in all health care settings and in the community." *Id.* Additionally, the Council recognized that the Maryland version of the MOLST form would need to be used in facilities such as nursing homes and assisted living facilities, and that those facilities would need to have completed MOLST forms for all or mostly all of the patients therein. *Id.*

⁶⁷ *Id.* at 27-30.

⁶⁸ See generally marylandmolst.org and various sections on that website explaining the MOLST process.

the MOLST document, either as a result of discussions with the patient, patient's healthcare agent, guardian, or surrogate, or as a result of instructions in the patient's advance directive.⁶⁹ Additionally, on the first page of the form, there are several treatment options with respect to cardiopulmonary resuscitation (CPR), which can be checked off.⁷⁰ These options include "attempt CPR" or "no CPR," with the second category having an additional layer of options.⁷¹ The "attempt CPR" option includes any and all medical efforts that are indicated if either a cardiac or pulmonary arrest occurs.⁷² Under the "no CPR" option, the following three possibilities are listed: intubation, no intubation, or no CPR, but provide palliative and supportive care.⁷³ The first page of the form concludes with the signature of a physician, nurse practitioner, or physician assistant.⁷⁴ That signature converts the form into a physician's order. That first page is all that must be filled out in

⁶⁹ MD. MOLST TRAINING TASK FORCE, MARYLAND MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST), *available at* <http://marylandmolst.org/docs/MOLST%20MM3%202013%20FINAL%20PROPOSED%2072613%20POSTED%2021714-no-instructions.pdf> [hereinafter "MOLST ORDER FORM"]. For general information about the Maryland MOLST form, as well as a copy of the actual form currently in use, see *How Do I Plan for My Health Care?*, MD. MOLST-MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT, <http://marylandmolst.org> (last visited Mar. 30, 2015).

⁷⁰ See MOLST ORDER FORM, *supra* note 69. These treatment options are labeled clearly and in large type-font under the heading "CPR (Resuscitation) Status." *Id.* at 1.

⁷¹ *Id.* "Attempt CPR" includes, according to the form, "artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function." *Id.*

⁷² *Id.* That option also states that "[i]f the patient or authorized decision maker does not or cannot make any selection regarding CPR status," the "attempt CPR" option should be marked. *Id.*

⁷³ MOLST ORDER FORM, *supra* note 69, at 1. The intubate option includes intubation and artificial ventilation. *Id.* The no intubation option includes limited support by means of a CPAP or BiPAP machine. *Id.* With the palliative and supportive care only option, the patient is saying that passive oxygen in limited circumstances is acceptable, and that medications for pain relief may be administered. *Id.*

⁷⁴ *Id.*

the state of Maryland.⁷⁵ A copy of the first page of the Maryland MOLST form appears below:

MM 3 2013		Page 1 of 2	
Maryland Medical Orders for Life-Sustaining Treatment (MOLST)			
Patient's Last Name, First, Middle Initial		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
<p>This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.</p>			
<p>CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.</p> <p>I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:</p> <ul style="list-style-type: none"> <input type="checkbox"/> the patient; or <input type="checkbox"/> the patient's health care agent as named in the patient's advance directive; or <input type="checkbox"/> the patient's guardian of the person as per the authority granted by a court order; or <input type="checkbox"/> the patient's surrogate as per the authority granted by the Health Care Decisions Act; or <input type="checkbox"/> if the patient is a minor, the patient's legal guardian or another legally authorized adult. <p>Or, I hereby certify that these orders are based on:</p> <ul style="list-style-type: none"> <input type="checkbox"/> instructions in the patient's advance directive; or <input type="checkbox"/> other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records. <input type="checkbox"/> Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary. If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given. 			
<p>CPR (RESUSCITATION) STATUS: EMS providers must follow the <i>Maryland Medical Protocols for EMS Providers</i>.</p> <p><input type="checkbox"/> Attempt CPR: If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.</p> <p>[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]</p> <p>1 <input type="checkbox"/> No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.</p> <p><input type="checkbox"/> Option A-1, Intubate: Comprehensive efforts may include intubation and artificial ventilation.</p> <p><input type="checkbox"/> Option A-2, Do Not Intubate (DNI): Comprehensive efforts may include limited ventilatory support by CPAP or BIPAP, but do not intubate.</p> <p><input type="checkbox"/> No CPR, Option B, Palliative and Supportive Care: Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BIPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.</p>			
SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)			
Practitioner's Signature		Print Practitioner's Name	
Maryland License #	Phone Number	Date	

The second page of the MOLST form for Maryland states specifically that the selected methods of treatment are for “situations other than cardiopulmonary arrest.”⁷⁶ The treatment

⁷⁵ *Maryland MOLST*, *supra* note 57, at 42 (stating that Section 1, CPR status, must be completed on every MOLST form, and the remaining sections are only to be completed if the person completing the form desires to do so).

⁷⁶ *Id.* at 2. Oddly enough, the directions instruct the patient or patient representative to “[o]nly complete applicable items . . . [below], and only select one choice per applicable Section.” MOLST ORDER FORM, *supra* note 69, at 2. At first blush, this language would suggest that in reality, the form should be completed with respect to a particular place, time, and illness. In effect, however, it has not been the author’s experience that this is how the form is actually used in practice.

situations considered are the following: artificial ventilation, blood transfusions, hospital transfers, medical workups, use of antibiotics, artificially administered fluids and nutrition, and dialysis.⁷⁷ There is also a space on the form for “other orders.”⁷⁸ As with the first page, there is a space for a physician’s, nurse practitioner’s, or physician assistant’s signature, converting the second page into a physician’s order as well.⁷⁹ A sample of the second page of the Maryland form appears below:

⁷⁷ MOLST ORDER FORM, *supra* note 69, at 2.

⁷⁸ *Id.* Considered in the abstract, treatment decisions could each seem relatively easy. However, in the experience of the author, they are anything but simple. As an example, one item on page 2 of the form relates to antibiotics. The choices are:

- 6a. May use antibiotics (oral, intravenous, or intramuscular) as medically indicated;
- 6b. May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics;
- 6c. May use oral antibiotics when indicated for symptom relief or comfort;
- 6d. Do not treat with antibiotics.

Id. This is a very difficult decision for a surrogate. For example, my mother expressed broad wishes in her living will. She did not express any specific written wishes regarding the use of antibiotics, which are ubiquitous in the modern world. This broad language and lack of specificity in the instructions forced me, as her surrogate, to decide whether the administration of antibiotics was the right call for my mother given her circumstances, knowing that without antibiotics, a bacterial infection could spread quickly and kill her. Thus, in what seemed to be a relatively straightforward question laid a very difficult answer.

⁷⁹ MOLST ORDER FORM, *supra* note 69, at 2. In fact, the form indicates that a signature and date of a physician, nurse practitioner, or physician assistant are required “to validate order.” *Id.*

Patient's Last Name, First, Middle Initial		Date of Birth	Page 2 of 2 <input type="checkbox"/> Male <input type="checkbox"/> Female	
Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.				
2	ARTIFICIAL VENTILATION			
	2a.	May use intubation and artificial ventilation indefinitely, if medically indicated.		
	2b.	May use intubation and artificial ventilation as a limited therapeutic trial. Time limit _____		
	2c.	May use only CPAP or BiPAP for artificial ventilation, as medically indicated. Time limit _____		
	2d. Do not use any artificial ventilation (no intubation, CPAP or BiPAP).			
3	BLOOD TRANSFUSION			
	3a.	May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.		3b. Do not give any blood products.
4	HOSPITAL TRANSFER			
	4a.	Transfer to hospital for any situation requiring hospital-level care.		4b. Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise. Do not transfer to hospital, but treat with options available outside the hospital.
5	MEDICAL WORKUP			
	5a.	May perform any medical tests indicated to diagnose and/or treat a medical condition.		5b. Only perform limited medical tests necessary for symptomatic treatment or comfort. 5c. Do not perform any medical tests for diagnosis or treatment.
6	ANTIBIOTICS			
	6a.	May use antibiotics (oral, intravenous or intramuscular) as medically indicated.		6c. May use oral antibiotics only when indicated for symptom relief or comfort.
	6b.	May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.		6d. Do not treat with antibiotics.
	ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION			
7	7a.	May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.		7c. May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition. Time limit _____
	7b.	May give artificially administered fluids and nutrition, if medically indicated, as a trial. Time limit _____		7d. Do not provide artificially administered fluids or nutrition.
	DIALYSIS			
	8a.	May give chronic dialysis for end-stage kidney disease if medically indicated.		8b. May give dialysis for a limited period. Time limit _____
9	OTHER ORDERS			
	_____ _____ _____			
SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)				
Practitioner's Signature		Print Practitioner's Name		
Maryland License #		Phone Number		Date

The State of Maryland also provides its citizens and other readers with information about how to fill out the MOLST form for individuals making healthcare decisions for themselves or for their loved ones. For example, the Maryland MOLST Training Task Force (MMTTF) published several booklets to assist people in understanding both choices in medical treatments and in making plans for healthcare.⁸⁰ In these booklets, the MMTTF explains things like the CPR choice in a way that non-medical personnel can understand.⁸¹ These informational sources provide additional

⁸⁰ See, e.g., *Understanding Your Choices for Medical Treatments*, MD. MOLST TRAINING TASK FORCE (Aug. 2013), <http://marylandmolst.org/docs/Understanding%20Your%20Choices%20for%20Medical%20Treatments%20August%202013%20PP.pdf>; Md. MOLST Training Task Force, *supra* note 69. Additional booklets are available on the Maryland MOLST website at <http://marylandmolst.org>.

⁸¹ See, e.g., *How Do I Plan for My Health Care?*, MD. MOLST TRAINING TASK FORCE (Aug. 2013), <http://marylandmolst.org/docs/How%20Do%20I%20Plan%20for%20My%20Health%20Care%20August%202013.pdf>, at 3-6

background for an individual to assess choices to be made not only on the MOLST form, but just generally within the context of medical treatments. Therefore, these booklets can be invaluable to someone trying to decide what to do in making difficult healthcare choices, especially with respect to end-of-life care.⁸²

IV. ETHICAL AND EMOTIONAL ISSUES REGARDING USE OF MOLST/POLST FORMS

A. A FRAMEWORK FOR ETHICAL DECISION-MAKING IN THE POST-POLST WORLD

In considering how one goes about making ethical determinations in the post-POLST world of healthcare decision-making, it is useful to consider exactly what a POLST form addresses in its entirety. It is addressing the right to a natural death and a human being's right and ability to make decisions regarding how that death will occur. "The right to a natural death is one outstanding area in which the disciplines of theology, medicine and law overlap; or, to put it another way, it is an area in which these three disciplines convene."⁸³ The question then becomes: if these three disciplines are convening, then what exactly are they "convening" upon? Is it merely the right to have what has been termed a "natural death"? Or is it something more?

The discussion about a natural death comes easily to those involved in the hospice movement. This discussion first came about within the context of DNR orders. In a life-or-death

(explaining, for instance, how "CPR" works in layman's language and how it may or may not be effective, and also telling the reader not to "assume that CPR is as effective as it appears to be on television").

⁸² According to the Maryland protocol, all residents of nursing homes and assisted living facilities must execute a MOLST form, and it must be contained in a patient/resident medical record. See MD. CODE REGS. 10.01.21.04 (2013). This is separate and apart from any other advance directives that a patient may have in his or her medical file.

⁸³ *In re Quinlan*, 355 A.2d 647, 659 (N.J. 1976) (quoting a statement by Bishop Lawrence B. Casey in the amicus brief of the New Jersey Catholic Conference in the *Quinlan* case).

situation, a DNR order means that a medical professional will not resuscitate the patient if the patient arrests — nothing more and nothing less.⁸⁴ A DNR order, though, does not differentiate between a terminally ill patient and a potentially healthy individual who might find himself or herself in a situation of cardiac or pulmonary arrest. Rather, it merely tells medical professionals not to start CPR in a specific situation.⁸⁵ In fact, the DNR order only controls one part of the treatment for a patient.⁸⁶ It does not address other situations that might arise within the context of implementing that DNR order, or even in caring for a patient whom medical professionals think is in need of a DNR order, such as other medical interventions. In general, then, this would not appear to fully address the issue of “natural death.”

The hospice movement preaches that “allowing a natural death” means that only comfort measures are provided. The acronym “AND” (for “allowing a natural death”) in such a situation means that a patient is dying and “that everything that is being done for the patient — including the withdrawal of nutrition and hydration — will allow the dying process to occur with as much comfort as possible.”⁸⁷ In a Texas study done by several researchers comparing the use of DNR versus AND, the researchers involved found that a switch from the former term to the latter resulted not only in greater peace among family members about what would ensue, but also greater certainty to

⁸⁴ Chuck Meyer, *New Designation for Allowing a Natural Death (“A.N.D.”) Would Eliminate Confusion and Suffering When Patients Are Resuscitated Against Their Wishes*, HOSPICE PATIENTS ALLIANCE, <http://www.hospicepatients.org/and.html> (last visited Mar. 30, 2015).

⁸⁵ *Id.* “What it means is that we have simply changed the goal of treatment. But to patients and family members who are emotionally — not clinically — involved in the situation, this truth may not be apparent.” *Id.*

⁸⁶ Reverend Meyer asks whether a DNR order actually goes far enough in certain situations. In his opinion, “[f]or patients who are dying or in a terminal condition, the DNR order is not really appropriate because active, aggressive, life-sustaining treatment of any kind is not appropriate.” *Id.*

⁸⁷ *Id.* As a lifelong Catholic, the author hardly believes that this is what the Catholic Church anticipates as a “natural death.” It would be difficult to define where, in this scenario, medicine, ethics, and religion concur.

physicians and other medical professionals about the clear signals sent regarding care of a patient.⁸⁸ In patient-centered decision-making, though, this would seem to be a chicken-and-egg problem. On the one hand, providing greater certainty to medical professionals is a laudable matter. After all, doctors must know and act in accordance with the wishes regarding care expressed by patients and their surrogates. On the other hand, it seems unclear that even educated individuals would appreciate the difference here and understand what it is that they might be opting for by jettisoning a DNR order for something more extensive. This begs the question: is this merely a matter of semantics? It seems not to be. And this is where ethical decision-making can help pave the way.

Again, on the one hand, some commentators have stated that POLST forms are, on their face, immoral. The reasoning behind this view, according to these commentators, is that POLST forms are really a short-hand excuse for what some may view as physician-assisted suicide.⁸⁹ However, looking beyond a strictly religious viewpoint to the secular realm, and considering a person's legal rights, the United States Supreme Court has noted that competent adult patients can refuse intrusive treatment, "even if such refusal may hasten their dying."⁹⁰ Leaving aside the hysteria and the guilt that would come, especially for surrogates, from labeling all use of POLST forms as immoral, a patient or — more likely — a surrogate must have some methodology for

⁸⁸ S. S. Venneman et al., "Allow Natural Death" Versus "Do Not Resuscitate": *Three Words That Can Change a Life*, 34 J. MED. ETHICS 2 (2008), available at <http://jme.bmj.com/content/34/1/2.full>. The authors state that "[s]imply changing the title of the medical order from DNR to AND increased the probability of endorsement by all participants regardless of healthcare experience or lack thereof." *Id.* However, such a change would only really result in greater certainty about the plan of care by medical providers — not necessarily by a patient or a patient surrogate.

⁸⁹ Stanley A. Terman, *It Isn't Easy Being Pink: Potential Problems with POLST Paradigm Forms*, 36 HAMLINE L. REV. 177, 188-89 (2014). In fact, as noted in the Terman article, some Catholic bishops have urged all Catholics to avoid using such documents, programs, and materials. *Id.*

⁹⁰ *Id.* at 189 (internal citations omitted).

determining how to deal with the use of POLST forms.⁹¹ This is not a theoretical issue here — this is an actual, realistic scenario that occurs hundreds of times a day in the United States, for sure.

On the other hand, it would seem that in instances where a patient is in the throes of terminal illness — whether it is actual physical manifestation of illness or advanced dementia — one must consider certain basic principles of life and of morality. One of these principles is the principle of compassion. Should an individual's condition be so deteriorated that it is on the verge of being inhumane to prolong their suffering, the patient or the patient's surrogate must consider the principle of compassion in all medical decision-making regarding the individual.⁹² This is not to advocate for assisted suicide. This is simply to advocate for common sense in the face of a very real — and a very gut-

⁹¹ As noted above, *see supra* note 82, the state of Maryland now requires that patients, located in nursing homes and assisted living facilities, must have on file a MOLST form (the Maryland form of POLST) in order to remain in the facility. Thus, application of a strict moral mandate that such forms are not to be used would then leave a patient — and more significantly, a surrogate — with an untenable decision: in order to comply with statutory mandates, the form must be in place. If the patient or surrogate chooses not to use the form, the patient would have to be withdrawn from the facility. Surely this would not be viewed even by the strictest moralist as an appropriate decision for anyone to make. Moreover, as noted earlier in this article, the state of Maryland has basically “retired” its DNR form so that there is only one substitute to use — the MOLST form. A simpler decision may be had here, in that Maryland only requires that the first page of the MOLST form be completed for patients in facilities. That first page roughly corresponds to a DNR form, and doesn't dwell on the “nitty gritty” of other medical interventions, such as administration of antibiotics or whether or not to use other interventional medical techniques. So, in the instance of a deeply religious individual, whether Catholic or not, perhaps the answer is that only the first page of the form should be completed.

⁹² George P. Smith, II, *Gently into the Good Night: Toward a Compassionate Response to End-Stage Illness*, 22 TEMP. POL. & CIV. RTS. L. REV. 475, 477-78 (2013). Professor Smith states that “where one's quality of life is so severely diminished because of suffering, it is proper to advance an argument that necessitates reconfiguring or enhancing autonomy so that compassion becomes the operative bioethical principle in decision making at this level.” *Id.* at 477 (internal citations omitted). Additionally, he goes on to say that “compassion becomes the denominator in health care decisions for end-of-life care and directs that efforts should be undertaken which not only refrain from causing pain or suffering but relieve it as well.” *Id.* at 478 (internal citations omitted).

wrenching — scenario. The compassionate approach is one that makes sense in end-of-life decisions. It does not necessarily make such decisions any easier, but it certainly applies some rationality to the process. Most likely, if the author’s personal experiences are any guide, these decisions come at the end of a very long period of caregiving and decline in the health of a patient. Only when someone has walked in those shoes is that person qualified to evaluate another’s decision-making process. Additionally, the principle of compassion seems to be a good framework within which to wrestle the very difficult decisions that improvements in medical technology have wrought upon people in today’s world.⁹³

B. ADMINISTRATION AND EFFECTUATION OF POLST: WHICH COMES FIRST — EFFICIENCY OR PATIENT WISHES?

Finally, any discussion of the POLST paradigm would be incomplete without consideration of and emphasis upon the manner in which the POLST paradigm is effectuated within a particular jurisdiction. As noted above, within the state of Maryland, it appears, and is clearly documented on the Maryland MOLST website⁹⁴ that the forms are to be completed along with the guidance of a medical professional, explained and discussed fully with the patient and with a patient’s surrogate. Further, as noted earlier in this article, these forms are intended to be used with patients who are nearing end-of-life, and thus, their purpose is not to set in stone an approach to patient care, which would extend for many eons beyond their completion. However, in this endeavor, it seems that we as a society can do better: we can incorporate some safeguards into our statutes and regulations and into our best practices regarding use of POLST forms that would ensure that the forms are not only understood by all concerned, but that they are reviewed at regular intervals with the affected individuals and their surrogates.

⁹³ “Unquestionably, decisions in health care concerning the maintenance of life and the hastening of death often pose complicated moral questions” *Id.* at 483 (internal citation omitted). Moreover, “[b]est patient care, ideally, is adjusted to a patient’s changing medical condition.” *Id.* at 485 (internal citations omitted).

⁹⁴ See *How Do I Plan for My Health Care?*, *supra* note 69.

First, it would be wise to go beyond an aspirational goal that the forms are discussed and completed along with a medical professional. There are multiple ways in which to achieve this. We can pressure medical educators to include end-of-life counseling in medical education. We can attempt to require some type of education in end-of-life counseling as part of licensure requirements for various medical professionals within each state. We can require in our state healthcare statutes and regulations that some part of the POLST form affirmatively states that the form and its implications have been discussed with patients or with patient surrogates. These are not difficult things to incorporate into the POLST paradigm and would ensure that doctors or nurses actually explain the implications of each section of the form with those who will be most affected by it. It is no longer enough that medical professionals hide behind the shield of not wanting to do this — the proverbial horse is out of the proverbial barn in the advancement of medical technology, and because medical professionals are riding on the success of improvements in medical technology, so, too, they have an ethical duty to explain its ramifications more fully to patients.

Second, we should likewise incorporate into our state healthcare statutes and regulations a requirement that POLST forms be re-examined and completed again within a set period of time. This need not be particularly burdensome, but it could be an annual or biannual event, within which time the form would expire if not re-instituted. This would likewise present yet another opportunity for medical professionals to raise the sensitive issues of the POLST form with patients and patient representatives, in order to determine that they fully understand what it is that they are stating when the form is completed in its entirety.

These two steps would not be overly burdensome, and could actually go a long way in improving doctor-patient relations and in educating individuals as to the implications of modern medical technology. They would also move the POLST paradigm further along, from a rather cold, impersonal completion of a stark form to a more reasoned consideration of the meaning of end-of-life care, individual desires regarding that care, and a more compassionate view regarding implementation of those desires as expressed by both patient and patient surrogate. These steps would, in fact, help to merge the notions of advance directives that are more expressive of a person's actual wishes, such as a living will, with

the efficiency and exigency necessary when medical professionals need to act in an emergency.

V. CONCLUSION

Medical decision-making is never easy. Every medical decision is fraught with uncertainty, doubt, and fear. Moreover, coupling those emotions with having to make decisions on behalf of other persons simply compounds the issue. The POLST paradigm seems to have moved the needle a little bit further with respect to pinpointing, insofar as possible, exactly what types of medical interventions one would want, especially in end-of-life situations. Use of POLST forms surely allows emergency personnel to act rapidly and definitively with respect to the matters covered in the form. The POLST form also expresses a patient's wishes in a succinct and more certain format. These are all laudable improvements along the road to patient self-determination. However, we as a society must be very clear about where the POLST path is heading. We need to demand that jurisdictions more closely monitor both the initiation and use of POLST forms as well as the implementation of the process. We need to put some additional safeguards in place that will ensure that such forms continue to express a patient's wishes at a particular point in time. And through it all, we need to remember that compassion is the overriding moral compass that needs to guide us all in our endeavors in this regard.