

Physician orders for life-sustaining treatment – the new living will?

For years attorneys have included health care advanced directives (commonly called “living wills”) in their standard package of estate planning documents offered to clients. The effectiveness of living wills is now being questioned by some attorneys, who argue that they are rarely enforced, do little to affect patient care, and can even be dangerous. This article will examine the value and problems of living wills and introduce a new alternative – the Physician Order for Life-Sustaining Treatment (POLST).

Indiana law contains a form declaration of the living will at Ind. Code §16-36-4-10. In order for life-prolonging treatments to be withheld or withdrawn, the patient’s attending physician must certify that the patient has a “terminal

condition” as defined at Ind. Code §16-36-4-5. There is considerable doubt, however, as to how often physicians actually make such certifications. The statutory definition of “terminal condition” is vague, and physicians may be concerned about certifying as terminal a patient who may, in fact, recover. Without such certification, though, it is hard to determine what effect living wills, standing alone, actually have on patient care. Many attorneys and health care providers now emphasize the role of the health care representative or attorney-in-fact in making medical decisions, with the

living will being seen as providing loved ones, health care agents and health care providers invaluable information about a patient’s desires at the end of life.

Indiana law allows patients to appoint a health care agent in two ways – either in a stand-alone health care representative declaration or as part of a durable power of attorney. Ind. Code §§ 16-36-1-7; 30-5-5-16. If the attorney-in-fact under a durable power of attorney is to have the authority to terminate life-prolonging treatment, the document must include specific language required by statute. Ind. Code §30-5-5-17. Many attorneys therefore rely primarily on the decisions of the appointed health care agent instead of a living will because the agent is thought to have a better idea of the client’s wishes in an unanticipated situation. It is also believed that health care providers are more likely to heed the agent’s instructions. However, one study that attempted to find out how well a health care representative could predict a patient’s treatment preferences determined the representative was wrong about 30 percent of the time. This was found to be the case regardless of whether the representative was able to consult the patient’s living will. This study shows both the limitations of relying on health care representatives and of interpreting a patient’s preferences based on traditional advanced directives like the living will.

Clearly, even when a patient has both a health care agent and a living will in place, there can still be difficulty in ascertaining the patient’s wishes, particularly given the myriad situations in which such weighty decisions are often made. Consider, for example, an 89-year-old patient with Alzheimer’s,

unable to recognize family and needing assistance with all daily activities, who suffers from frequent urinary tract infections. The patient requires a transfer from the nursing home to the hospital each time for treatment with intravenous antibiotics. Given the patient’s condition, placement of the intravenous line is difficult, painful and exposes the patient to risks inherent to hospitalization and parenteral therapy. Now consider that this patient has a living will modeled after the Indiana statutory form. Is the patient’s dementia a “terminal condition” as defined by Indiana law, especially given that Alzheimer’s is progressive and fatal? Do the frequent hospital trips constitute “life prolonging treatment,” which the patient would have terminated given his/her desire for a certain quality of life?

Indiana’s statutory living will may not provide any help. The health care power of attorney, which gives an agent authority to withhold health care, is a better document but is still only as good as the communication between the agent and patient surrounding the granting of the power. The agent may be reluctant to terminate such treatments especially given the haste in which hospital transfers are often made. Is there a document the patient could have signed that would offer more specific guidance, one that would be understood and honored by health care providers, relatives and the courts? Many states have been trying to come up with a new solution to this problem, and they may have found one – the POLST.

The POLST (Physician Order for Life-Sustaining Treatment – sometimes called MOLST, Medical Order for Life-Sustaining Treatment) declaration offers an alterna-



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Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP or PA. These medical orders are based on the person's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name/ First/ Middle Initial _____
 Address _____
 City/ State/ Zip _____
 Date of Birth (mm/dd/yyyy) _____ Last 4 SSN _____ Gender M F

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
 Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNR (Allow Natural Death)
 When not in cardiopulmonary arrest, follow orders in B, C and D.

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
 Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.*
 Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital if indicated. Avoid intensive care.*
 Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*
 Additional Orders: _____

C ANTIBIOTICS
 No antibiotics. Use other measures to relieve symptoms.
 Determine use or limitation of antibiotics when infection occurs.
 Use antibiotics if medically indicated.
 Additional Orders: _____

D ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.
 No artificial nutrition by tube.
 Defined trial period of artificial nutrition by tube.
 Long-term artificial nutrition by tube.
 Additional Orders: _____

E REASON FOR ORDERS AND SIGNATURES
 My signature below indicates to the best of my knowledge that these orders are consistent with the person's current medical condition and preferences as indicated by discussion with:
 Patient Health Care Representative Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)
 Parent of Minor Court-Appointed Guardian
 Other _____

Print Primary Care Professional Name _____ Office Use Only _____
 Print Signing Physician / NP / PA Name and Phone Number _____
 Physician / NP / PA Signature (mandatory) _____ Date _____

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

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Information for Person Named on this Form Person's Name (print)

This voluntary form records your preferences for life-sustaining treatment in your current state of health. It can be reviewed and updated by your health care professionals at any time if your preferences change. If you are unable to make your own health care decisions, the orders reflect your preferences as best understood by your surrogate.

Signature of Person or Surrogate
 Signature _____ Relationship (write "self" if patient) _____

Opt Out Check box if you do not want this form included in the electronic POLST registry.

Contact Information
 Surrogate (optional) _____ Relationship _____ Phone Number _____ Address _____
 Health Care Professional Preparing Form (optional) _____ Preparer Title _____ Phone Number _____ Date Prepared _____
 PA's Supervising Physician _____ Phone Number _____

Directions for Health Care Professionals

Completing POLST

- Should reflect current preferences of persons with advanced illness or frailty. Encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form, refer to *Guidance for Health Care Professionals* at <http://www.ohsu.edu/polst/programs/docs/guidance.pdf>.

Sending to POLST Registry (Required unless "Opt Out" box is checked)

- For the POLST Registry, the following information on the other side of the form must be completed:
 - Person's full name
 - Date of birth
 - Section A
 - Physician / NP / PA Signature and date signed
- Send a copy of both sides of this POLST form to the POLST Registry.
 - FAX or eFAX: (503) 418-2161 Date _____/_____/_____
 or
 - Mail: Oregon POLST Registry
 Mail Code: CDW-EM Date _____/_____/_____
 3181 SW Sam Jackson Park Road
 Portland, OR 97239

Reviewing POLST
 This POLST should be reviewed periodically and if:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry as above (Required).
- If included in an electronic medical record, follow voiding procedures of facility/community.

PUT REGISTRY ID STICKER HERE:

For permission to use the copyrighted form contact the OHSU Center for Ethics in Health Care. Information on the POLST program is available online at www.polst.org or at polst@ohsu.edu.

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tive to the standard living will. POLST arose in Oregon in 1991 and has been adopted in at least seven states since. The POLST is more than just a "form" or "declaration" as it requires states to develop programs for implementation where the wishes of the patient will be carried out. At least 15 other states are in various stages of developing POLST programs. The goal of POLST is to provide concrete, written instructions for a patient's care that are easy for patients and surrogates to understand and for health care providers to follow.

Given its use for more than 10 years, there is now evidence that the POLST program is making a demonstrable difference in patient care in states where it has been adopted. A 2008 multi-state study sponsored by the National Institute of Nursing Research found that nursing home residents who had a completed POLST in their charts were 50 percent less likely to receive

life-sustaining treatments than those who did not. Even patients who had traditional living wills were significantly more likely than those with a POLST to receive unwanted medical interventions. One of the reasons for the success of the POLST program is the degree of communication it fosters between health care providers and patients/representatives. Doctors are encouraged to discuss specific scenarios and treatment options in detail, and patients and families have the chance to ask questions and make their wishes known. An added benefit of the POLST is its transportability – because it takes the form of an actual medical order, the POLST remains in the patient's chart and travels with the patient to whatever treatment setting the patient is in, whether that be the hospital, hospice, nursing home or even the patient's home in the community.

As its name indicates, the POLST declaration (or form) is an actual medical order signed by a patient's physician or other authorized health care provider. Unlike the typical living will, which often incorporates vague and legalistic language, the POLST form uses medical terminology and includes instructions for a variety of real-life medical situations. Each state implementing the POLST program has adopted its own form. The original Oregon form, for example, includes instructions for cardiopulmonary resuscitation, medical interventions, treatment with antibiotics and use of feeding tubes. The New York form goes even further, additionally including directions regarding future hospitalizations, transfers between medical facilities and intubation. With each form there is a detailed set of instructions for its use. The physician signing the form must indicate

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PROBATE & PROPERTY *continued from page 41*

that he or she has discussed it with the patient or the patient's authorized representative. Most states require that the patient or representative sign the form as well. Regular review of the patient's wishes is encouraged, and some states include a space on the POLST itself where the physician can document such reviews and note any changes. The form is typically required to be

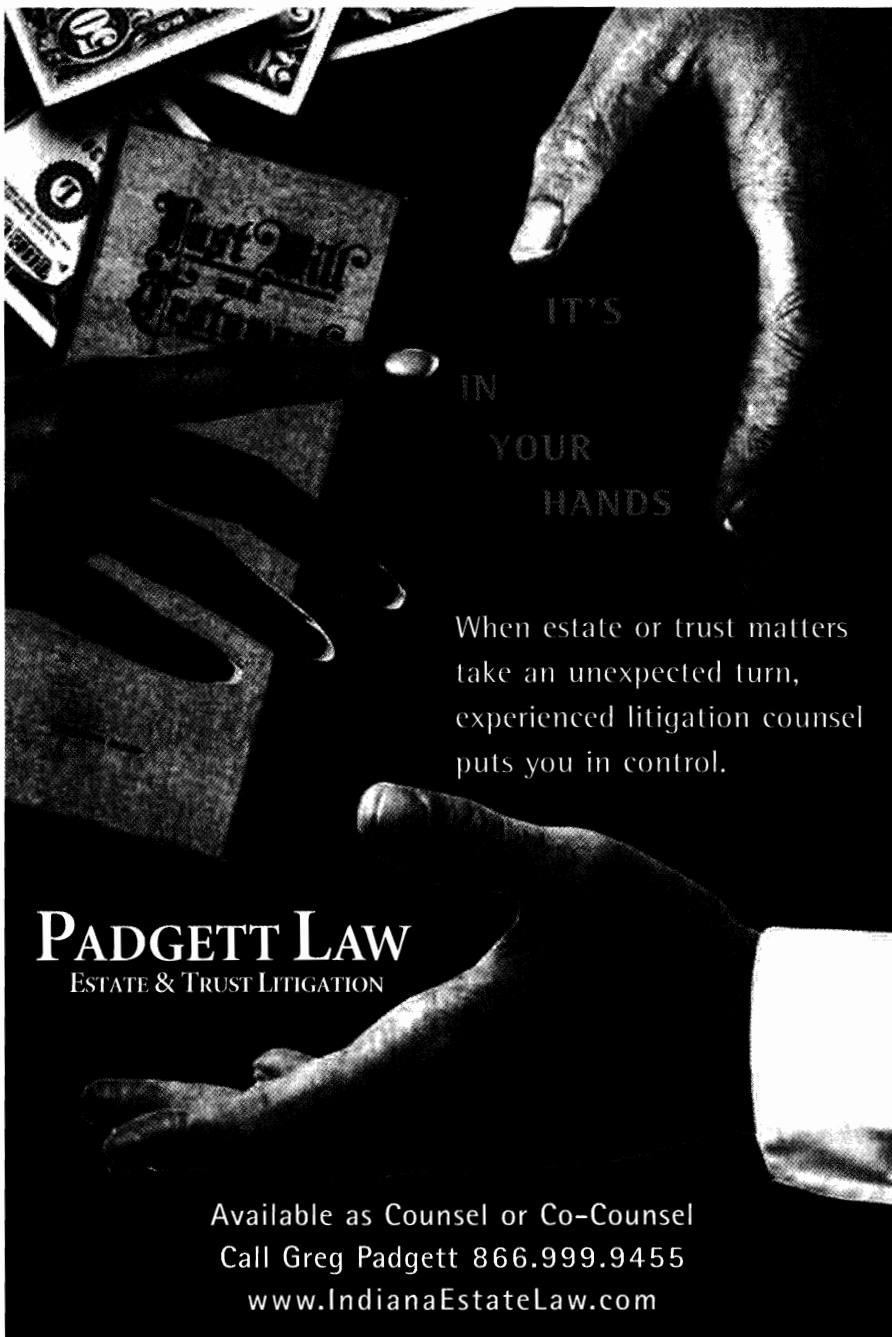
printed on brightly colored paper so it can easily stand out in the patient's chart. The Oregon POLST is provided with this article. (Several state forms can be reviewed at www.polst.org/programs.)

While the POLST program is now a proven success, it does have disadvantages. One of these is that

the POLST is designed primarily for patients who are terminally ill or suffering from other advanced medical conditions. It is not suitable for otherwise healthy individuals who wish to leave directions if a sudden medical incident occurs that significantly impacts their continuing quality of life. This highlights the continued need for a statutory living will scheme even when a POLST program has been implemented. In fact, all states encourage patients with a POLST to have a living will as well, and some require the health care provider to document on the POLST whether the patient has one.

When explaining the POLST to our Alzheimer's patient and health care representative above, the physician could have outlined various medical scenarios and treatment options so the patient and family could make an informed decision. If the physician had completed a POLST, the patient could have avoided further hospitalizations and treatment with antibiotics, and instead have received palliative care only, even if death were the result. The physician would have been encouraged to review the POLST regularly with the patient and family, and when it came time to implement the order, all persons involved in the patient's care would have clear directions to follow and would undoubtedly have a greater awareness and acceptance of the outcome.

What about Indiana? So far, a POLST program has not been introduced. A subcommittee of the Probate, Trust & Real Property Section of the State Bar, chaired by Indianapolis lawyer Diane Kennedy, is actively investigating the possibility of starting one here. Several hurdles need to be cleared before the state can jump on the POLST bandwagon. These include modifying or even eliminating



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Indiana's living will, do-not-resuscitate and health care representative/power-of-attorney statutes. This may even call for wiping the slate clean and starting with a whole new legal paradigm for medical decision-making in the state. Clearly, cooperation between the medical establishment, legal community, lawmakers and other stakeholders will be vital to making any policy and statutory changes in this area. One thing seems certain: Given our aging population, the need for an effective, legally enforceable method for communicating and then implementing end-of-life decisions is only going to increase. ☪

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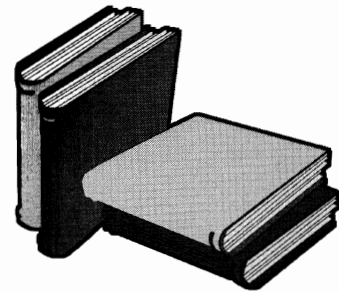
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