American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved April 2017

Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Treatment (POLST)

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The ethical principle of respect for patient autonomy and the legal principle of patient self-determination, gives individuals the right to make their own health care decisions. Advance directives and Do-Not-Resuscitate (DNR) documents were designed to allow people the opportunity to express their treatment preferences for situations when they cannot communicate those preferences themselves. Unfortunately, clinicians may not be able to honor those wishes because the documents are either unavailable or the wording is too vague or value based to apply to specific conditions encounters. As a result, emergency physicians may in good faith initiate or withhold treatments that are contrary to a patient's wishes.[1]

Physician Orders for Life-Sustaining Treatment (POLST) are portable medical orders designed to help health care professionals honor and implement the treatment wishes of their patients in any setting. POLST helps physicians, nurses, long-term care facilities, hospices, home health agencies, emergency medical services, hospitals, and other health care professionals to:

- Promote patient autonomy by documenting treatment preferences and converting them into medical orders;
- Clarify specific patient treatment preferences, minimize confusion;
- Facilitate appropriate treatment by emergency personnel; and
- Enhance the Health Insurance Portability and Accountability Act (HIPAA) compliant transfer of patient records between health care professionals and health care settings. [1]

The POLST form is not intended to replace a living will or health care power of attorney form. Rather, the POLST form is designed to implement patient wishes by translating the patient's treatment wishes into medical orders, centralizing information, facilitating record keeping, and ensuring transfer of appropriate information among health care professionals and across care settings. [1]

When Should a POLST be Used?

A POLST form is primarily intended for seriously ill or frail patients who have an advanced chronic or progressive life-limiting illness. POLST orders may also be used by patients who are at risk for impaired decision-making capacity and by anyone with strong treatment preferences.[2]

Different states have adopted different names and acronyms for POLST-type orders, including Physician Orders for Scope of Treatment (POST), Medical Orders for Scope of Treatment (MOST), and Medical Orders for Life-Sustaining Treatment (MOLST); these orders all share the same core elements with similar form and design. A National POLST Paradigm Task Force and Office coordinates state-specific efforts to adopt and disseminate these orders, and the order set with these specified set of common elements are referred to as POLST Paradigm orders.[3]

Specific Orders:

POLST Paradigm order forms differ among the states that have adopted them—the order of the sections or the options within a section may be different—but all of them include a number of essential elements. Orders commonly address four different medical treatments or services, in Sections A-C.[4]

- Section A addresses Cardiopulmonary Resuscitation (CPR)
- Section B addresses Medical Interventions
- Section C addresses Medically Administered Fluids and Nutrition

Sections A and B are outlined in red as those sections are POLST relevant in emergency situations and need to be easily identified.

Many states also include a section on "Goals of Care." Patient goals of care should provide guidance to medical professionals filling out a POLST form and to those interpreting a POLST form, as they provide important information that can translate patient preferences and values into medical orders that are more easily understood and specific enough to apply to most medical encounters.

A final section provides information on who discussed and agreed to the orders with the health care professional, followed by fields for the name, signature, date, and phone number of the physician (MD/DO), physician assistant, or nurse practitioner issuing the order, and fields for the name and signature of the patient or the patient's legally authorized representative.

Section A – CPR

These orders apply only to the circumstance in which a person experiences cardiopulmonary arrest, which means that the person has no pulse and is not breathing. This section does not apply to any other medical circumstances. If

a patient is in respiratory distress but is still breathing or has a pulse, a first responder or emergency physician should refer to sections B and C for corresponding orders.[4]

Beware of the possibility of the completion of POLST forms with contradictory orders—for example, if the patient wants CPR in Section A, but wants limited interventions only in Section B. The performance of CPR requires full treatment, and resuscitation protocols involve intubation to secure a patient's airway and support breathing. If the patient does not want full treatment including intubation and mechanical ventilation in an intensive care unit (ICU), then the patient should not receive CPR. Patients and families sometimes misunderstand CPR. Patient education regarding invasive treatments, ramifications, and expectations is essential to optimal communication regarding patient wishes.[1]

In contrast to these inconsistent POLST orders, some patients may not desire CPR if they experience a cardiac arrest, but they may still reasonably desire ICU care for serious illness or elective intubation for respiratory failure without cardiac arrest. This choice may be a rational one, as ICU care may provide a patient significant benefit, even if, despite those benefits, the patient would choose to avoid CPR given its low likelihood of benefit.

Section B – Medical Interventions

These orders apply to emergency medical circumstances when a person has not experienced cardiopulmonary arrest; in other words, these orders are for a person who has a pulse and/or is breathing.

Full Scope of Treatment:

If full treatment by emergency personnel or other appropriate health care professionals is indicated and desired, the "Full Scope of Treatment" box is checked. Treatment includes use of advanced airway interventions such as endotracheal intubation, mechanical ventilation, central venous line placement, vasopressor support, and electrical therapies such as defibrillation, cardioversion, and pacing. If the patient is not already at the hospital, transfer to the hospital and use of intensive care may be indicated.

Limited Additional Interventions:

This option is for patients who prefer to receive basic medical treatments for reversible conditions or exacerbations of underlying disease with the goal of restoring the patient to his/her current state of health.[4] It directs that medical treatment, antibiotics, IV fluids, and cardiac monitoring be used as indicated for secondary or incidental complications such as pneumonia, but that intubation and mechanical ventilation be omitted. This option does allow the use of less invasive airway support such as bilevel positive airway pressure (BiPAP) or continuous positive airway pressure (CPAP), and it directs that appropriate comfort measures be provided.[1]

Section B also has an area to indicate "Other Instructions." This may be helpful to clarify other interventions as appropriate for individual patients.

Comfort Measures:

Selection of this option indicates a desire for only those interventions that enhance comfort through symptom management. The use of medication by any route, positioning, wound care, and other measures to relieve pain and suffering is appropriate. The use of oxygen, suction, and manual treatment of airway obstruction should be administered as needed for comfort. [1,4]

Hospitalization should be avoided when the "Comfort Measures" option is selected. Patients should only be transferred to a hospital if comfort needs cannot be met adequately in the current location. In some cases, hospice care and outpatient palliative care may be appropriate to consider. Sometimes more specific instructions may be recorded in "Other Instructions."[4]

Section C – Medically Administered Fluids and Nutrition

These orders pertain to a person who cannot take fluids and food by mouth. Oral fluids and nutrition always should be offered to a patient if medically feasible. Section C of the POLST form requires a single choice among three options for tube feedings, including fluids and nutrition provided via intravenous (IV), nasogastric (NG) or percutaneous endoscopic gastrostomy (PEG) routes.[4]

Long-Term artificial nutrition by tube if indicated – A patient (or his/her representative) may decide to receive IV fluids if indicated. When this box is checked, IV fluids should be administered whenever clinically indicated.

Defined trial period of artificial nutrition by tube – A patient (or his/her representative) may prefer to receive IV fluids for a defined trial period when clinically indicated. For example, a patient may desire a brief trial of IV hydration if they become dehydrated. In this case, the IV fluids would be a temporary intervention with the goal of treating a potentially reversible acute illness over a few days to a week.

No artificial nutrition – A patient (or his/her representative) may prefer to forgo the use of medically provided fluids and nutrition. Again, oral fluids and nutrition always should be offered to a patient if medically feasible and desired by the patient.

"Other Instructions" allows for further clarification in this section as well.[1]

Final Section – Discussed with and Agreed by: Signatures

The signatures section of the POLST form must be completed. The persons or class of persons who can issue or consent to POLST orders varies from

state to state, but should be listed on the POLST form. If the patient is an adult and is able to make and communicate health care decisions, then the patient is the only person who can consent to the physician issuing the orders of the POLST form. The patient's signature of consent may be required for the form in some states, with a few having a requirement for a witness for the signature or the conversation. If the patient is a minor, then a parent or guardian may consent to the physician's completion of a POLST form. Some states may currently limit use of POLST to patients 18 years of age or older.[4]

If the patient is an adult who no longer has the capacity to make and communicate health care decisions, the POLST form may be discussed with and agreed to by the legally authorized representative of the patient, as indicated by the form.[4]

Signature of the Appropriate Decision-Maker:

The National POLST Paradigm Task Force strongly recommends evidence that the patient or the patient's representative has reviewed the form and agrees that the orders reflect the patient's preferences.[3]

If the patient has the capacity to make and communicate health care decisions, he or she must agree to the orders. When the patient lacks the capacity to make or communicate health care decisions, then the appropriate patient representative signature should be present and is sometimes required by law to sign the form, depending on the state in which it is being signed. In situations where the patient representative cannot be physically present to sign the form, some states allow the medical provider to discuss the details over the phone with the appropriate patient representative.

Healthcare Professional Signature:

Since the form is the issuance of a medical order, the signature of a health care professional is mandatory. Which group of healthcare professionals can sign a properly filled out POLST form varies by state, and may include physicians, nurse practitioners, and physician assistants. Without this signature, the orders in the POLST form are not valid. The date and printed name of the health care professional should be provided. Social workers, and chaplains may initiate a discussion and educate a patient about POLST, but the signature must be that of the practitioner who is issuing the order.

Back Side of the POLST Form

The back page of the POLST form generally provides space for contact information. Fields for the patient's name and birth date (on every page for accuracy in case the form is faxed on individual pages), the health care professional who signed the document, the patient's representative or surrogate, the relationship to the patient, and phone numbers. This allows health care professionals to attempt early contacts with this person when the patient's health status changes.

Explanations for use of the form and provisions for reviewing or revoking the form may also appear.

Revoking the POLST Form

A patient with decision making capacity or the patient's representative (if the patient lacks capacity) can revoke the POLST when faced with new information or changes to the patient's condition and request alternative treatment based on known preferences of the patient or, if unknown, the patient's best interests.

Depending on the state, a POLST form may also be revoked in a number of ways including destruction, putting a line through the front page and writing void on the form, or by indicating in the review section on the back that POLST orders have been revoked.

POLST Orders that are not Medically Feasible or are Inconsistent

POLST forms provide significant additional guidance that is not contained in portable DNR orders and advance directives for honoring patient treatment preferences and communicating those preferences in a clear manner to medical personnel. However, a small number of POLST forms will reflect patient preferences and order sets that may not be medically feasible or may be logically inconsistent. For example, "attempt resuscitation" and "comfort measures only" are inconsistent with one another. Some POLST forms might require more interpretation than time allows during an emergency (eg, attempt CPR, but limit interventions).[5,6]

If emergency healthcare personnel are presented a POLST form like this, and time allows, the provider should describe the problem and seek clarification from the patient, provided the patient has decision-making capacity. If the patient lacks capacity, however, every effort should be made to contact the medical provider or the patient's representative, in order to clarify the patient's end-of-life care preferences and goals of care. Those efforts may fail, however, or the patient's medical condition may be such that there is not enough time to seek clarification. In such circumstances, the provider should, in good faith, act in light of expressed patient values (e.g. specified in an advance directive) if available; when expressed patient values are not available, the provider should act in the patient's best interests based upon his or her own medical judgment.[6]

Legal Protection for Emergency Physicians Honoring POLST Medical Orders

Although most states have either an established or developing POLST program, many have not yet provided explicit statutory protection of physicians who honor patient wishes in good faith through a POLST form (as is frequently provided for in the setting of pre-hospital DNR orders and advance directives). As a result, many physicians are concerned about the

legal liability involved in using the forms. Even in those states without explicit statutory protection, however, physicians are protected by common law when they follow generally accepted standards of practice in their area.[3] Furthermore, the federal government takes a strong position on the hospital's obligation to honor patient decisions concerning their care.[7] Finally, we are not aware of a single suit brought against a physician who followed the wishes of a patient as documented by a POLST form in the more than 10 years of its use, while there has been at least one suit against an emergency physician for not following a POLST form.[6,8]

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