Beyond Medical Advance Directives: Implementing the POLST (Physician Orders for Life-Sustaining Treatment) Paradigm in Florida

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Every state, including Florida, has enacted laws intended to help critically ill medical patients maintain a degree of personal autonomy or self-determination regarding decisions about the initiation, continuation, withholding, or withdrawal of various medical interventions, even at a time when the patient no longer has sufficient present cognitive or emotional capacity to rationally make and communicate his or her own choices.\(^1\) Florida Statutes Chapter 765 establishes a mechanism for currently decisionally capable adults to execute health care advance directives in the form of designating a health care surrogate or agent, making a living will instructing on future desired treatment, or providing a post-mortem anatomical gift such as an organ for transplantation. Florida Statutes Chapter 709 authorizes a capable adult to execute a durable power of attorney, which is the functional equivalent of creating a health care surrogate. Florida Statutes § 401.45(3)\(^2\) empowers a physician to write a Do Not Resuscitate Order (DNRO) on the Department of Health Yellow form, with the concurrence of the patient or surrogate, for a critically ill patient who is not anticipated to recover from a cardiac arrest.

However, experience with advance directives over the last couple of decades has led to the identification of several significant problems.\(^3\) The most salient of these problems include: the reluctance of many people to use the available legal tools in a timely fashion; the paucity of practical guidance, or the confusing guidance, provided by advance directive forms for patients filling them out and medical professionals trying to apply them in clinical scenarios; patients’ care goals and preferences often changing over time; the frequent ignorance of the surrogate or health care agent regarding the real care preferences of the patient; the fact that, even when providers know that an advance directive exists (and such knowledge cannot always be assumed), the advance directive frequently does not significantly alter the patient’s course of treatment\(^4\) or may even exacerbate the clinical situation.\(^5\)
Growing frustration with the inherent limitations of existing instruments for promoting the prospective autonomy of critically ill patients who may become decisionally incapacitated has led many attorneys, health care providers, and commentators to advocate as the next step in the evolution of health care advance planning law and policy the use of POLST (Physician Orders for Life-Sustaining Treatment) forms. Unlike a traditional advance directive executed by a patient while still decisionally capable, POLST entails a medical order written by a physician (and with the concurrence of the patient or surrogate) instructing other health care providers such as emergency medical squads about the treatment of a critically ill patient under specific factual situations. Approximately a dozen states have formally implemented the POLST Paradigm, with national coordination efforts being administered through the Center for Ethics in Health Care at the Oregon Health & Science University. Many more states are in the process of developing their own versions of POLST.

There is an array of legal impediments in the various states to successful adoption and fulfillment of the POLST paradigm. In Florida, an informal working group of interested attorneys, health care and human services providers, professional associations, and academics has come together under the coordinating umbrella of the Florida State University Center for Innovative Collaboration in Medicine & Law to identify and explore possible strategies for pushing forward acceptance and implementation of the POLST Paradigm in this jurisdiction. In the coming months, this group will need to grapple with a myriad of legally tinged strategic choices about how best to achieve the objectives of POLST.

Needed Legal Changes?
The initial set of strategic issues asks about what changes, if any, in current Florida law are necessary to authorize and/or encourage attending physicians to write POLSTs for appropriate patients and to authorize and/or encourage other health care professionals to respect and implement those POLSTs. One potential route (involving the most complex and controversial political ramifications)\textsuperscript{13} would be to propose legislative enactment of new, explicit statutory language. Such statutory language could be integrated into Chapter 765, as was unsuccessfully attempted with House Bill 1017 during the 2006 legislative session,\textsuperscript{14} creating a new and different type of advance directive; alternatively, the legislature could be asked to amend Fla. Stat. § 401.45 to authorize physicians’ orders pertaining to the withholding of specified other kinds of medical interventions besides cardiopulmonary resuscitation (CPR). Either as an alternative strategy to legislation or as a supplement implementing the statutory change, explicit regulatory modifications could be sought to clarify the POLST-related rights and responsibilities of affected parties.\textsuperscript{15} This approach would necessitate identifying which state agency(ies) would have relevant jurisdiction and ways to assure inter-agency coordination and cooperation in the administration of POLST oversight.

A third potential strategy would bypass legislation and regulation in favor of action predicated on clinical consensus. This approach would entail obtaining explicit agreement from the relevant state agencies that current state statutes and regulations already permit physicians to write, patients and surrogates to agree to, and other health care providers to implement POLSTs, with the emphasis of change agents being placed on professional and public education rather than on trying to amend the law. The clinical consensus strategy would rely mainly on the “Preservation of existing rights” clause found in Florida’s advance directive statute:

The provisions of this chapter [765] are cumulative to the existing law regarding an individual’s right to consent, or refuse to consent, to medical treatment and do
not impair any existing rights or responsibilities which a health care provider, a
patient, including a minor, competent or incompetent person, or a patient’s family
may have under the common law, Federal Constitution, State Constitution, or
statutes of this state.\textsuperscript{16}

The argument would be that current common and constitutional law already protects the
liberty rights of patients to make contemporaneous and prospective medical decisions and
to secure the assistance of their physicians in effectuating those liberty rights by, for
example, documenting a POLST instructing other health care providers on behalf of the
patient.

\textbf{Drafting and Policy Issues}

Assuming that either a statutory or regulatory change strategy is pursued to promote the
POLST Paradigm in Florida, a myriad of policy questions will need to be addressed in the
legislative or rule-making drafting stage. In looking for guidance elsewhere, there is a wide
divergence among other states regarding how they have resolved these questions.\textsuperscript{17}

For instance, decisions will need to be made about the specific content of the adopted
POLST form and whether that content should be incorporated into statute or regulation or only
described in broad terms. Typical POLST forms in use elsewhere contain separate sections
dealing with: CPR attempts; medical interventions (full treatment versus comfort measures
only); use of antibiotics; administration of artificially administered nutrition and hydration;
reason for the orders (documenting the physician’s conversations with the patient and/or
surrogate); and signatures. A Florida POLST form might comport or deviate from this particular
structure. If a new statute or regulation does incorporate specific POLST form content, a
question arises whether the explicitly approved form must be used by the physician in order for
the POLST to be considered valid or, alternatively, whether a somewhat deviating but comparable form would be legally acceptable.

A further legal and policy drafting question is whether to require health care providers to offer the POLST option to patients. If so, which specific providers would be covered? Should the requirement encompass all patients or only certain categories? What timing requirements (e.g., at the time of admission to a health care institution, as now specified in the Patient Self-Determination Act),\textsuperscript{18} if any, should be delineated? What is the penalty for provider non-compliance? Another, likely very politically contentious, issue relates to who, beside physicians, should be granted the legal power to write POLSTs. Should this authority be extended, for example, to nurses or physicians’ assistants?\textsuperscript{19}

A different strategic conundrum concerns the extent of the authority that a new statute or regulation ought to grant surrogates to consent to a POLST on behalf of a patient who lacks enough present cognitive and emotional capacity to decide and speak personally about medical treatment concerns. The desire to facilitate the writing of POLSTs, even when concurrence must come from a surrogate instead of the patient, must be balanced against the need to protect decisionally compromised patients from surrogates who, unfortunately,\textsuperscript{20} may not be worthy of such trust.

One of the largest impediments to successful POLST implementation elsewhere has been health care providers’ anxieties about the risk of possible lawsuits brought against them by disgruntled family members.\textsuperscript{21} Overcoming that vastly exaggerated but strongly and sincerely held apprehension will be vital to achieving successful POLST implementation. Thus, the good faith legal immunity provisions necessarily built into any new statutes and/or regulations must be drafted carefully, balancing encouragement of provider compliance with POLSTs against the
need for some form of accountability for the actors involved. On a related note, should provider compliance with a valid POLST be mandated? If so, what is the proper range of sanctions for a failure to comply with the mandate?

Other operational issues also need to be resolved in the legislative or regulatory drafting stage. May a provider rely, in withholding certain kinds of treatment, on copies or faxes of the POLST document? Must those copies or faxes be printed on paper of a particular color and/or size so as to be identifiable readily? Alternatively, must the original document be available? If there is a material conflict between the physician’s instructions in a patient’s POLST and that patient’s own earlier written advance directive, which document governs? What about POLST forms with some sections not completed? In the absence of a totally completed POLST form, should there be a presumption that maximum aggressive medical intervention must be rendered? Finally (although this enumeration of issues does not purport to be comprehensive), there is the matter of portability of the POLST as a patient travels between different jurisdictions. Should Florida legislation or regulation state that Florida providers may (or must) recognize and implement POLSTs validly executed in other jurisdictions, in return for reciprocal respect for Florida-drafted POLSTs by the other jurisdictions?

**Storing and Retrieving POLST Forms**

Let us assume that the working group is successful in achieving legal recognition in Florida of the POLST Paradigm, educating physicians (and any other authorized health care providers) to discuss POLST possibilities with patients and their surrogates and to write a POLST when appropriate and agreed to, and convincing health care providers to implement their patients’ valid POLSTs if and when the forms can be found in a timely manner and the
designated circumstances have materialized. At that point, an additional set of legally tinged policy and practice issues would emerge concerning the storage and retrieval of POLST forms so that they are readily available when needed.

One obvious, straightforward way to handle the storage and retrieval issue is the proverbial “form under the refrigerator magnet” method, with its equally obvious problem of inaccessibility of the document if an emergency situation involving the patient occurs outside of the patient’s home. To avoid that frequent, foreseeable operational shortcoming, other options must be considered.

As physicians, hospitals, and other health care facilities move steadily in their documentation from paper toward electronic medical records, it is desirable that a patient’s electronic medical record include the POLST, if one exists. Doing so, though, will implicate all of the potential legal issues that might apply to electronic medical records generally.²²

In addition to encouraging the incorporation of POLST forms into individual patients’ electronic medical records, the Florida working group eventually will need to consider establishing, either through legislative and/or regulatory recognition (and an accompanying appropriation of public funds) or through some type of voluntary arrangement, the creation of a central registry to facilitate both immediate form retrieval and quantitative research on the effectiveness of the POLST mechanism. Several other states are at various stages of planning or implementing such central registries, and a taxonomy of associated legal issues has already begun to emerge.

Most fundamentally, should submission of every written POLST form to the central registry be required? Who (the physician, the patient, and/or others) would be mandated to submit? If submission were not required, then who (if anyone) would be permitted to submit a
POLST to the registry? What immunity from criminal and civil liability or other legal protections for POLST submitters should be embedded in statute or regulation? What penalties, if any, should be imposed on mandated submitters who fail to comply with submission requirements? Who should be granted access to the data compiled within the POLST registry, and under what conditions? What specific procedures should be imposed to assure that the registry complies with the confidentiality and data security requirements of the Health Insurance Portability and Accountability Act (HIPAA) and state law regarding personal health information?

Additional challenges arising in the development and implementation of a POLST registry mechanism would include quality control processes for maximizing the accuracy (i.e., the correct form for the correct patient) and timeliness of information entered into and stored within the registry. Potential questions pertaining to the civil liability of individuals and/or entities negligently entering data into or maintaining a registry need to be anticipated and dealt with proactively; these questions would involve, for instance, determining who would have standing to sue, defining the applicable standards of care, and delineating damages for breach of duty.

**Policy Issues for Health Care Institutions**

Besides the sort of public policy issues outlined above that may need to be addressed through the development of legislation and/or regulation, moving forward in promoting the POLST Paradigm to enhance patient autonomy and improve the quality of medical treatment for the critically ill will require individual health care providers (most notably, hospitals, nursing homes, rehabilitation facilities, and assisted living facilities) to confront several interrelated
internal policy questions, ideally in a proactive stance. Specifically, despite a statutory or regulatory overlay, each institutional health care provider will likely retain substantial discretion about how POLSTs written by physicians for patients they serve are to be reconciled and integrated with existing institutional bylaws and protocols regarding the treatment of critically ill persons.

For example, will the institutional provider presently caring for a particular patient recognize and act upon a POLST signed by a physician who earlier cared for that patient in the community or in another institutional provider, but who does not have active admitting and treating privileges within the current provider? Conversely, will the provider limit its recognition of POLSTs to those that are written by physicians who are members of that provider’s medical staff? In a connected vein, even if state law were to permit non-physicians to write POLSTs in consultation with patients or their surrogates, would any particular institutional health care provider elect to recognize and implement a POLST written by a non-physician?

**Conclusion**

Evidence has been produced in other jurisdictions that the POLST Paradigm is an effective way to move beyond the limitations of the advance medical directives approach to enhancing the self-determination of individual patients and improve the quality of available medical care during times of critical illness. Florida has been categorized as a “developing” POLST state, and robust, earnest discussion—as briefly summarized here—has begun to take place about the contours and details of competing legal, public policy, and institutional strategies for propelling this jurisdiction forward. This challenge presents an opportunity for productive
interprofessional collaboration in which the contributions of legal expertise to the delivery of excellent medical care will be essential.
Notes

1 Fla. Stat. § 765. 102 (legislative findings and intent).

2 Implemented by Fla. Admin. Code r. 64B8-9.016.


5 Lesley S. Castillo, Brie A. Williams, Sarah M. Hooper et al., Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care, 154 ANNALS INTERN. MED. 121 (2011).


7 See Sabatino, supra Note 4.

8 Some states vary the terminology slightly. For example, some states call their POLST-equivalent a MOLST (Medical Order for Life Sustaining Treatment), POST (Physician Order for Scope of Treatment), MOST (Medical Order for Scope of Treatment), or COLST (Clinical Order for Life-Sustaining Treatment).

9 Http://www.ohsu.edu/polst.


17 See Sabatino & Karp, supra Note 10.


24 Fla. Sta. § 456.057 (7), (8), & (11).