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Portable Medical Order Sets (POLST®): Ethical and Legal Landscape

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By Professor Sharona Hoffman

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I. Introduction

Anyone who has observed the dying of a loved one or who has thought about medical care in the final months of life may be concerned about end-of-life care. How can individuals ensure that their care fits their needs and preferences if they cannot express these because of dementia, confusion, or other frailties? Some worry that they will receive care that is painful and aggressive in the last stages of disease even though they would prefer comfort care only. By contrast, others worry that physicians will withhold therapeutic care because they assume that such care is unwanted by patients who are near death.

Reassurance can come in the form of POLST. POLST has traditionally been an acronym for "physician orders for life-sustaining treatment," but the National POLST Paradigm now defines it as "a portable medical order form."[1] A POLST form is a tool that can help actualize patients' wishes for end-of-life care because it consists of a set of medical orders that are integrated into the patient's medical record. The POLST concept, however, raises significant ethical and policy concerns.

This article describes and assesses POLST. Focusing on patient autonomy, the article analyzes POLST benefits and risks. In addition, it surveys the laws and regulations that govern POLST.

II. What Is a POLST Form?

A POLST form consists of medical orders indicating a patient's wishes regarding life-saving medical interventions. POLST forms vary from state to state; however, they commonly allow patients to indicate whether they want to receive treatments such as the following that are listed by the Patients Rights Council:

- Cardiopulmonary resuscitation (CPR)
- Antibiotics
- Artificially administered nutrition and fluids
- Blood transfusions
- Dialysis
- Future hospitalization
- Comfort measures only (which orders that even non-invasive curative medical treatment should not be provided)[2]

POLST forms translate patient preferences into actionable medical orders because they are signed by a health care professional and become part of the patient's medical record.[3] Significantly, they are portable and accompany patients across care settings, thus making them applica-

1 National POLST Paradigm, *POLST Frequently Asked Questions (FAQ)*, http://www.polst.org/wp-content/uploads/2016/04/2016.04.03-POLST-FAQs.pdf (last updated February 17, 2016); National POLST Paradigm, *Names of POLST Programs*, https://polst.org/programs-in-your-state/ (accessed May 1, 2019); National POLST Paradigm, *What Is POLST?*, https://polst.org/professionals-page/ (accessed May 1, 2019).

2 Patients Rights Council, *POLST: Important Questions & Answers* (2015), http://www.patientsrightscouncil.org/site/polst-important-questions-answers; *see e.g.* Ind. St. Dept. of Health, *Indiana Physician Orders for Scope of Treatment (POST)* (2018), http://polst.org/wp-content/uploads/2018/07/2018.07.01-Indiana-POST-form-SAMPLE.pdf; Natl. POLST Paradigm, *Resource Library,* http://polst.org/resources/resource-library/?resource_type_url=Forms (providing links to other POLST forms) (all three sources accessed Feb. 13, 2019).

3 *Momentum to Better Respect Patients' End-of-Life Wishes "Growing Every Day,"* 29 Med. Ethics Advisor 37, 37 (2013); Natl. POLST Paradigm, POLST Legislative Guide 5 (approved Feb. 28, 2014), http://polst.org/wp-content/uploads/2017/02/2014.02.20-POLST-Legislative-Guide-FINAL.pdf (accessed Feb. 13, 2019).

ble everywhere, including at hospitals and nursing homes.[4]

POLST forms are designed for seriously ill or frail individuals. The National POLST Paradigm characterizes these individuals as those:

- Whose health care professional would not be surprised if they died within 1-2 years; or
- Who are at an increased risk of experiencing a medical emergency based on their current medical condition and who wish to make clear their treatment preferences, including about CPR, mechanical ventilation, ICU; or
- Who have had multiple unplanned hospital admissions in the last 12 months, typically coupled with increasing frailty, decreasing function, and/or progressive weight loss.[5]

It is critically important that patients or their authorized surrogates have one or more thorough conversations about end-of-life treatment wishes with trained personnel[6] before POLST forms are signed.[7] It must be clear that the patient or surrogate understands different treatment options and has distinct preferences.

The concept of POLST, now often called the POLST paradigm,[8] was developed in the early 1990s at the Oregon Health & Science University Center for Ethics in Health Care. In 2004, the National POLST Advisory Panel (later called the National POLST Paradigm Task Force and now simply the National POLST Paradigm) was established to formulate quality standards for POLST forms and to help states develop POLST programs.[9]

POLST forms consist of check boxes that clinicians mark to indicate whether patients desire certain types of medical interventions. Traditionally, POLST forms were one-page, double-sided, brightly colored documents that were placed at the front of patients' medical records.[10] Today, the forms are often integrated into patients' electronic health records, ideally using a prominent, unique POLST tab.[11] Some states have established POLST registries to which POLST forms can be submitted so that physicians and emergency care providers can easily access them from a centralized database.[12]

4 Charlie Sabatino, *POLST: Avoid the Seven Deadly Sins,* 39 Bifocal 60, 60 (2018), http://polst.org/wp-content/uploads/2018/04/2018.04.25-POLST-Avoid-The-7-Deadly-Sins.pdf (accessed Feb. 13, 2019)

5 Natl. POLST Paradigm, *National POLST Paradigm: Intended Population & Guidance for Health Care Professionals,* https://polst.org/wp-content/uploads/2019/01/2019.01.14-POLST-Intended-Population.pdf (last revised January 14, 2019).

6 *See infra* nn. 27–29 and accompanying text for a discussion of the various professionals who may conduct such a conversation.

7 Natl. POLST Paradigm, *Appropriate POLST Paradigm Form Use Policy*, https://polst.org/wp-content/uploads/2018/04/2018.04.27-Appropriate-Use-of-POLST-Paradigm.pdf (last updated Apr. 27, 2018).

8 Natl. POLST Paradigm, *About the National POLST Paradigm*, http://polst.org/about-the-national-polst-paradigm (accessed Feb. 13, 2019).

9 Patients Rights Council, *supra* n. 2.

10 *Id.*

11 Natl. POLST Paradigm, *Recommendations for Integrating Physicians Orders for Life Sustaining Treatment (POLST) Forms with Electronic Health Records* (approved Aug. 25,2016),http://polst.org/wp-content/uploads/2017/04/2016.08.25-Recommendations-for-Integrating-POLST-Paradigm-Forms-with-EHRs.pdf (accessed Feb. 13, 2019).

12 Off. of the Natl. Coord. for Health Info. Tech., *Electronic End-of-Life and Physician Orders for Life-Sustaining Treatment (POLST) Documentation Access through Health Information Exchange (HIE) 5*, https://www.healthit.gov/sites/default/files/topiclanding/2018-07/POLSTRegistryKnowledge.pdf (accessed Feb. 13, 2019).

In various states, POLST are called by different names. These include POST (physician orders for scope of treatment), MOLST (medical orders for life-sustaining treatment), and MOST (medical orders for scope of treatment).[13]

III. Benefits of POLST

A. Goals and Outcomes

All adults are encouraged to complete advance directives, consisting of a living will and a health care power of attorney.[14] However, only about one-third of individuals have done so.[15] Moreover, some individuals have advance directives that were written decades ago and do not necessarily reflect their current wishes. Consequently, POLST forms, which are filled out toward the end of life, are an important tool for effectuating patients' care preferences.[16] The forms can be used in the absence of advance directives or as an adjunct to them (though confusion may arise if they contradict wishes that are clearly expressed in existing advance directives).[17]

Without explicit instructions regarding end-of-life care or a trusted individual who has been appointed as the decision-maker, patients may be subject to unwanted and even tormenting care. For example, patients with late-stage cancer who can no longer articulate their wishes may be treated aggressively with difficult therapies, fed artificially, intubated, and have their dying process protracted significantly even if they would prefer to receive comfort care only. In addition, some patients may be denied desired life-prolonging treatments because doctors wrongly assume that a patient with end-stage illness would decline such interventions.

POLST portability is particularly valuable. It enables all medical facilities in which a patient is treated to learn of the patient's wishes if he or she is unable to communicate them.

Studies confirm the benefits of POLST. For example, a three-state study of 90 nursing homes showed that people with a POLST form who indicated they wanted "comfort measures only" experienced a lower rate of unwanted hospitalizations.[18] Another study, which reviewed the medical records of 300 patients who participated in a POLST program and died in 2015, found that 290 of these patients received care that was consistent with the care listed on their POLST forms.[19] Of these patients, 19 percent revised their wishes as their circumstances changed.[20]

A 2015 review of POLST literature concluded that "POLST orders reflect-

13 National POLST Paradigm, *Names of POLST Programs*, https://polst.org/programs-in-your-state/ (last accessed May 1, 2019); Patients Rights Council, *supra* n. 2.

14 Sharona Hoffman, *Aging with a Plan: How a Little Thought Today Can Vastly Improve Your Tomorrow* 41–48 (Praeger 2015).

15 Kuldeep N. Yadav et al., *Approximately One in Three U.S. Adults Completes Any Type of Advance Directive for End-of-Life Care,* 36 Health Affairs 1244, 1244 (2017).

16 John E. Jesus et al., *Physician Orders for Life-Sustaining Treatment and Emergency Medicine: Ethical Considerations, Legal Issues, and Emerging Trends*, 64 Annals Emerg. Med. 140, 140 (2014).

17 *See infra* n. 58 and accompanying text for a discussion of state laws that address such conflicts.

18 *Id.*

19 Jennifer Hopping-Winn, *The Progression of End-of-Life Wishes and Concordance with End-of-Life Care*, 21 J. Palliative Med. 541, 541 (2018) (finding that only three patients received care that was inconsistent with their wishes and seven did not have enough data in their charts to determine whether their care reflected their preferences).

20 *Id.* at 542–543.

Table 1. Comparison of POLST Forms and Advance Directives[24]

	POLST Form	**Advance Directive**
Type of document	Medical order	Legal document
Who completes?	Health care professional (who can sign varies by state: https://polst.org/wp-content/uploads/2019/03/2019.03.06-Signature-Requirements-by-State.pdf)	Individual
Who needs one?	Any patients considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.	All competent adults
Is completion voluntary?	Yes	Yes
Appoints a surrogate?	No	Yes
Can patient's surrogate complete, change or void?	In most states	No
What is communicated?	Specific medical orders	General wishes about treatment wishes
Can emergency personnel follow?	Yes	No
Ease in locating	Should be easy. Patient has original. Copy is in medical record. Copy may be in a registry (if state has a registry).	May be difficult. Depends on where individual keeps it and if they have told someone where it is, given a copy to surrogate, or to health care professional to put in his/her medical record.
Periodic review	Health care professional is responsible for reviewing with patient or surrogate upon: • transfer to a new facility; • when there is a substantial change inpatient's medical condition; or • when patient's goals of care or treatment preferences change.	Up to the individual about how often it is reviewed and/or updated.

ing decisions to withhold interventions are usually honored and that treatments are largely consistent with orders."[21] However, because of limitations of the studies that have been conducted, only weak evidence exists regarding whether POLST forms accurately reflect patient wishes.[22] Thus, in some cases, clinicians may have checked boxes on a patient's POLST form without verifying (a) that the patient understood the concept of POLST and the treatment options listed on the form and (b) that the patient made thoughtful choices about these options. Health care providers were generally enthusiastic about POLST forms and found them

21 Susan E. Hickman et al., *Use of the Physician Orders for Life-Sustaining Treatment Program in the Clinical Setting: A Systematic Review of the Literature*, 63 J. Am. Geriatrics Soc'y 341, 347 (2015).

22 *Id.* at 348.

helpful in making treatment decisions. However, they cited a variety of problems, such as difficulty understanding and explaining the form and challenges associated with transferring POLST across care settings.[23]

B. POLST Forms vs. Advance Directives

POLST forms can be easily confused with advance directives, but the two are quite different. Advance directives (consisting of a living will and health care power of attorney) are safeguards that all adults, regardless of age, should have. By contrast, a POLST form is useful only near the end of life and addresses an individual's current medical circumstances. In addition, advance directives can be signed at any location, whereas POLST forms are signed at medical facilities by health care professionals. Table 1 offers further comparison.[24]

IV. POLST Concerns: Does the POLST Paradigm Adequately Promote and Protect Patient Autonomy?

Personal autonomy is the ability to act independently in a manner that is "free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice."[25] The POLST paradigm is intended to promote patient autonomy by ensuring that patients' health care preferences are followed. However, ethicists and patient advocates have questioned the degree to which patient autonomy is truly safeguarded in the POLST context. Do POLST forms faithfully record patients' wishes? Do patients always understand the forms' contents and implications? Are POLST forms reviewed periodically and amended promptly in case patients' preferences evolve? Sections III(A)–(D), which follow, analyze several objections to the POLST paradigm related to patient autonomy.

A. Patient Comprehension and Voluntariness

Critics assert that the POLST paradigm does not include sufficient safeguards to ensure that POLST forms reflect patients' true wishes and are signed voluntarily. For example, there is little oversight concerning the quality of POLST conversations that patients should have with their health care providers. Commentators have noted that POLST forms are at times signed without a sufficiently comprehensive discussion of the patient's goals and priorities.[26]

The POLST paradigm does not require the patient's attending physician to discuss POLST with the individual or to sign the POLST form.[27] Instead, a nurse practitioner or physician assistant can often sign the form.[28] Unfortunately, these

23 *Id.* at 347.

24 Natl. POLST Paradigm, *supra* n. 5, tbl. at https://polst.org/wp-content/uploads/2019/05/2019.04.30-POLST-vs-ADs-chart.pdf (accessed Feb. 13, 2019).

25 Patricia A. King et al., *Law, Medicine and Ethics* 46 (Foundation Press 2006).

26 Sabatino, *supra* n. 4, at 61.

27 Natl. POLST Paradigm, *Signature Requirements for a Valid POLST Form by State* (last updated Dec. 14, 2018), https://polst.org/wp-content/uploads/2019/01/2018.12.14-Signature-Requirements-by-State.pdf (accessed Feb. 14, 2019).

28 Natl. POLST Paradigm, *National POLST Paradigm Task Force Supports Nurse Practitioners and Physician Assistants Signing POLST Paradigm Forms*, https://polst.org/wp-content/uploads/2017/04/2016.12-NPPTF-Supports-Nurse-Practitioners-and-Physician-Assistants-Signing-POLST-Paradigm-Forms.pdf (approved Dec. 15, 2016); Patients Rights Council, *supra* n. 2; see e.g. Ctr. for End-of-

clinicians may not be as familiar with the patient as the attending physician. Moreover, the person who actually discusses POLST with the patient and fills out the form does not have to be a trained health care professional at all. Rather, he or she can be a chaplain, social worker, or other person who serves as a "facilitator."[29] Although these individuals may have ample time and patience to discuss POLST details, they may not have the scientific knowledge required to explain the medical implications of particular treatment decisions. Thus, at the very least, facilitators who are not health care providers should be required to undergo training regarding end-of-life decision-making.

Some states do not mandate that the patient sign the POLST form.[30] In other states, the patient's signature is required, but the form does not state that by signing the form, the patient is affirming that he or she thoroughly discussed treatment choices with a health care professional or facilitator.[31] Notably, as a rule, POLST forms do not require the signature of witnesses who observe patients signing the document and could attest to the patients doing so knowingly and voluntarily.[32]

The check-box format of POLST forms is also vulnerable to criticism. Some consider the format too simplistic for the very complex decision-making entailed in end-of-life care.[33] POLST forms aim to be unambiguous and concise; thus, they do not leave space for explanations related to various contingencies and unusual circumstances that may arise.[34] For example, some patients may prefer comfort measures only at the end of life but want antibiotics or IV fluids if they suffer from an easily treatable infection several months before they are expected to die.

B. Timing of Implementation

Another concern is that POLST may be implemented prematurely.[35] In fact, the orders are effective immediately, as soon as the forms are signed.[36] The National POLST Paradigm provides in part that POLST forms are appropriate for "[p]atients with serious life-limiting medical condition or advanced frailty … whose health care professional would

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Life Care, Robert C. Byrd Health Sci. Ctr. of W.Va. U., *West Virginia Physician Orders for Scope of Treatment (POST)* (2017), http://polst.org/wp-content/uploads/2018/02/2017-West-Virginia-POST-Form-pink.pdf (accessed Feb. 14, 2019).

29 Robert B. Wolf et al., *The Physician Orders for Life-Sustaining Treatment (POLST) Coming Soon to a Health Care Community Near You,* 49 Real Prop. Tr. & Est. L.J. 71, 112 (2014); Natl. POLST Paradigm, POLST & Advance Directives, http://polst.org/advancecare-planning/polst-and-advance-directives (accessed Feb. 13, 2019).; Patients Rights Council, *supra* n. 2.

30 Natl. POLST Paradigm, *supra* n. 27.

31 Stanley A. Terman, *It Isn't Easy Being Pink: Potential Problems with POLST Paradigm Forms,* 36 Hamline L. Rev. 177, 182 (2013); *see e.g.* Iowa Physician Orders for Scope of Treatment (IPOST) (2012), http://idph.iowa.gov/Portals/1/Files/IPOST/FORM%20GUIDANCE%20-%20IPOST%20Revised%206%2025%2012%20SAMPLE.pdf (accessed May 30, 2019).

32 Terman, *supra* n. 31, at 182.

33 E. Christian Brugger et al., *POLST and Catholic Health Care,* 37 Ethics & Medics 1, 3 (2012).

34 *See e.g.* Ctr. for Ethics in Health Care, Or. Health & Sci. U., *Oregon POLST* (2019), http://polst.org/wp-content/uploads/2019/01/2019-Oregon-POLST-Form-Sample.pdf (accessed May. 28, 2019).

35 Wolf et al., *supra* n. 29, at 102. Some states explicitly require that POLST forms be filled out only by patients with a terminal illness. *See infra* n. 55 and accompanying text.

36 Patients Rights Council, *supra* n. 2.

not be surprised if they died within 1-2 years."[37] Some patients who fall into this category may live several years longer. If such patients require antibiotics to treat an infection but the antibiotics are withheld because of their POLST forms, these patients may be robbed of significant time during which they could still enjoy a high quality of life.

Moreover, there is no mandate that patients or their surrogates review POLST forms with a trained professional periodically or before a significant treatment decision is implemented (e.g., antibiotics are given or withheld). Some forms provide spaces for indicating that they underwent such review and were subsequently retained or voided. However, these reviews *are not required at any time*, let alone at specific intervals or treatment junctures.[38]

Because the orders go into effect immediately, no signature is required for verification from either the patient or the attending physician at the time an order is implemented (e.g., a life-saving treatment is given or withheld). This is true even when the patient or surrogate is able to provide a signature quickly and the circumstances are not emergent. For example, the North Carolina form states explicitly, "When the need occurs, first follow these orders, then contact physician."[39] Consequently, little if any effort may be made to verify that the patient's preferences have not changed.

Frail and ill patients may experience many changes in their health status.[40] These patients may improve temporarily and wish to have more aggressive treatment to prolong their lives. They may also modify their views about end-of-life care as they come closer to death. It is extremely important, therefore, to encourage patients to review and update their POLST forms as appropriate.[41]

C. Incentives to Promote POLST

Health care facilities may promulgate financial or other incentives to encourage physicians to pursue POLST with their patients.[42] From an institutional perspective, POLST forms are very appealing because they eliminate uncertainty about the course of treatment for patients at the end of life and provide caregivers with clear instructions and perhaps liability protection.

On the other hand, incentives may threaten patient autonomy because they can motivate health care providers to pressure patients to sign a POLST form. If incentives are based on the number of POLST forms signed, clinicians could be tempted to have briefer conversations with patients in order to move quickly to the next individual. To safeguard the integrity of the POLST paradigm, health care

37 Natl. POLST Paradigm, *supra* n. 7.

38 *See e.g.* Ctr. for End-of-Life Care, *supra* n. 28. *But see*, National POLST Paradigm Task Force, *POLST Legislative Guide*, National POLST Paradigm, https://polst.org/wp-content/uploads/2017/02/2014.02.20-POLST-Legislative-Guide-FINAL.pdf (approved Feb. 28, 2014). The guidance recommends that POLST be reviewed periodically and especially under the following circumstances:
- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's goals of care and/or treatment preferences change.

39 N.C. Dept. of Health & Human Servs., *Medical Orders for Scope of Treatment (MOST)* (2014), http://polst.org/wp-content/uploads/2018/01/2014-NC-MOST.pdf (accessed Feb. 14, 2019).

40 Sabatino, *supra* n. 4, at 62.

41 *Id.*

42 *Id.*

institutions should avoid establishing any form of incentive to promote POLST.[43]

D. Religious Concerns

Many religious adherents believe that human beings have a duty to preserve their own lives.[44] Some religious authorities are uncomfortable with POLST forms because they enable patients to establish medical orders to withhold life-saving treatments. Thus, the National Catholic Bioethics Center on Health Care and the Life Sciences issued a paper in which it argued that POLST forms "pose unacceptable risks to the well-being of patients and the ethical values of Catholic health care."[45] Indeed, in some cases, patients whose doctors encourage them to sign POLST forms may sign a form despite being unsure of whether there is a conflict between the orders on the form and their religion.

One solution is to include an explicit statement on the POLST form about religious beliefs for patients who indicate that religion is important to them. During the POLST discussion, patients could be asked whether they have religious beliefs that may be relevant to end-of-life care. If patients are uncertain, they can be urged to speak with their clergy, after which they can include a specific statement regarding religious doctrine in the "additional orders" or "other instructions or clarification" section of the POLST form.[46] Dr. Stanley Terman, a POLST expert, suggests some helpful language. The patient could assert, "If I reach an advanced stage of dementia (as detailed in my living will), then I DO want to receive tube feeding indefinitely, since I am Catholic." In the alternative, the patient could state, "If I reach an advanced stage of dementia (as detailed in my living will), then I DO NOT want to receive tube feeding, even though I am Catholic."[47]

V. State Law

The majority of states use POLST forms either statewide or in pilot programs.[48] Thirty states and the District of Columbia address POLST by statute;[49] of

43 *Id.;* Natl. POLST Paradigm, *National POLST Paradigm: Appropriate POLST Paradigm Form Use Policy* (updated Apr. 27, 2018), http://polst.org/wp-content/uploads/2018/04/2018.04.27-AppropriateUse-of-POLST-Paradigm.pdf (accessed Feb. 14, 2019).

44 *See e.g.* Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Holy *See* (May 5, 1980), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html (accessed Feb. 14, 2019) (stating that "believers see in life … a gift of God's love, which they are called upon to preserve and make fruitful.").

45 Brugger et al., *supra* n. 33, at 3.

46 *See e.g.* Ctr. for Ethics in Health Care, Or. Health & Sci. U., *Oregon POLST* (2019), http://polst.org/wp-content/uploads/2019/01/2019-Oregon-POLST-Form-Sample.pdf (2019) (accessed March 8, 2019); Utah Dept. of Health, *Provider Order for Life-Sustaining Treatment (POLST): Utah Life with Dignity Order* (2016), http://polst.org/wp-content/uploads/2018/01/2016-UT-POLST.pdf (accessed Feb. 14, 2019).

47 Terman, *supra* n. 31, at 187.

48 *See* Natl. POLST Paradigm, *National POLST Paradigm: POLST Adoption by State* (as of Apr. 2018), http://polst.org/wp-content/uploads/2018/04/2018.04.24-State-POLST-Adoption-Map.pdf (accessed Feb. 14, 2019).

49 The states are Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Mississippi, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, and Wyoming. See Natl. POLST Paradigm, *POLST Program Legislative Comparison* (as of Apr. 1, 2018), https://polst.org/wp-content/

these, 20 states have added regulations or other guidance.[50] One state, Montana, addresses the use of POLST by regulation but has no POLST statute.[51] The 19 states that do not use POLST forms have neither statutes nor regulations or other official guidance on POLST, but many have established POLST programs by voluntary consensus or practice.[52]

Some state POLST programs vary in significant ways.[53] For example, 26 states and the District of Columbia allow POLST forms for minors, while four explicitly prohibit this.[54] Some states place other restrictions on the availability of POLST, such as only permitting patients with an advanced illness to complete a POLST form.[55] Many states recognize out-of-state POLST forms, but a large number are silent on the matter, and Oklahoma deems out-of-state forms valid for only 10 days after a patient's admission to an Oklahoma medical facility.[56]

Maryland has adopted a unique approach by making its POLST program mandatory under some circumstances. POLST forms must be completed for patients served by assisted living programs, home health agencies, hospices, kidney dialysis centers, or nursing homes, and for those being transferred from one hospital to another or to one of these institutions.[57]

Most states with POLST legislation or regulations recognize that POLST forms may contradict existing advance directives. The majority establish that the most recently executed instrument takes precedence over older documents.[58] Detailed information about POLST legislation and regulations appears on the National POLST Paradigm website.[59]

VI. Conclusion

POLST forms can be greatly beneficial to patients and health care providers. They can assure patients that their treatment preferences will be honored at the end of their lives and offer clinicians clear guidance about their patients' course of treatment.

However, the POLST paradigm also raises significant concerns for ethicists and patient advocates. To address these concerns, medical facilities should ensure that patients or their surrogates have one or more thorough conversations with a

uploads/2019/04/2019.04.02-POLST-Legislative-Comparison-Chart.pdf (accessed Apr. 24, 2019).

50 *See id.* The states are California, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Nevada, New Jersey, Oregon, Rhode Island, Tennessee, Utah, Vermont, West Virginia, and Wyoming.

51 *See id.*

52 *See id.* The states are Alabama, Alaska, Arizona, Florida, Kansas, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Mexico, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, and Wisconsin.

53 Natl. POLST Paradigm, *National POLST Paradigm Program Designations* (as of Nov. 2018), http://polst.org/programs-in-your-state (accessed Feb. 14, 2019).

54 *Id.* The rest of the states have not addressed this issue.

55 *See* Natl. POLST Paradigm, *supra* n. 48.

56 *Id.*

57 Md. MOLST Training Task Force, *Maryland MOLST FAQs* 1 (Aug. 2018), http://www.marylandmolst.org/docs/Maryland_MOLST_FAQs.pdf (accessed Feb. 14, 2019).

58 Natl. POLST Paradigm, *supra* n. 48. Exceptions include Idaho (if the POLST was signed by a surrogate), Iowa (POLST does not supersede do not resuscitate (DNR) orders or power of attorney), Kentucky (living will prevails), North Carolina (POLST form may state that it suspends conflicting advance directives), Utah (POLST always controls), and West Virginia (advance directive always controls).

59 Natl. POLST Paradigm, *supra* n. 53.

qualified expert about the nature and content of POLST forms. Patients or their surrogates should also be asked to review POLST forms periodically or at important treatment junctures to ensure that they accurately indicate current care preferences.

In addition, because POLST forms leave little if any space for narrative explanations, all patients should have an advance directive (consisting of a living will and health care power of attorney) that furnishes greater detail about their end-of-life wishes. Advance directives should be included in electronic health records and be referenced in POLST forms so that clinicians know they exist. Also, renewed efforts should be made to encourage American adults to complete advance directives.

All states should have laws that address POLST and detail POLST requirements. They should also undertake educational initiatives to ensure that health care providers and the public at large are knowledgeable about the POLST paradigm.

With appropriate safeguards, POLST forms can fulfill their promise of consistently promoting patient autonomy and welfare, thus serving as a valuable component of end-of-life care.