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Law

Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment

Thaddeus Mason Pope and Melinda Hexum

ABSTRACT

This issue's "Legal Briefing" column covers recent legal developments involving POLST (physician orders for life-sustaining treatment.)¹ POLST has been the subject of recent articles in *JCE*.² It has been the subject of major policy reports³ and a recent *New York Times* editorial.⁴ And POLST has been the subject of significant legislative, regulatory, and policy attention over the past several months. These developments and a survey of the current landscape are usefully grouped into the following 14 categories:

1. Terminology
2. Purpose, function, and success
3. Status in the states
4. Four legal routes of implementation
5. Which professionals can authorize POLST?
6. Is the patient's signature required?
7. Can surrogates consent to for incapacitated patients?
8. If a POLST conflicts with an advance directive, which prevails?
9. Is offering POLST mandatory?

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10. What are the duties of healthcare providers?
11. What is the role of electronic registries?
12. What is the role of the federal government?
13. International adoption
14. Court cases

1. TERMINOLOGY

While the POLST paradigm is established or developing in almost every U.S. state, it goes by at least 14 different names.⁵ For the sake of clarity, this article will use the acronym POLST, as it is the acronym used by most states. Even among these states, POLST stands for three different terms. In most of the states, POLST stands for physician orders for life-sustaining treatment.⁶ In Minnesota and Montana, it stands for provider orders for life-sustaining treatment.⁷ In Pennsylvania, POLST stands for Pennsylvania orders for life-sustaining treatment.⁸

The remaining states use 11 additional acronyms. Two are similar to POLST. Vermont uses COLST (clinical orders for life-sustaining treatment);⁹ Delaware, Maryland, Massachusetts, New York, Ohio, and Rhode Island use MOLST (medical orders for life-sustaining treatment).¹⁰

Four other acronyms focus on scope of treatment rather than on life-sustaining treatment. Idaho, Indiana, South Carolina, Tennessee, Vir-

ginia, and West Virginia use POST (physician orders for scope of treatment).¹¹ Louisiana uses LaPOST (Louisiana physician order for scope of treatment).¹² Alaska, Colorado, Kentucky, New Mexico, and North Carolina use MOST (medical orders for scope of treatment).¹³ Iowa uses IPOST (Iowa physician orders for scope of treatment).¹⁴ Nevada uses SMOST (summary of physician orders for scope of treatment).¹⁵

Four final acronyms are far more different.¹⁶ Kansas and Missouri use TPOPP (transportable physician order for patient preference).¹⁷ Utah calls its POLST a death with dignity order.¹⁸ Illinois legislated that POLST “may be referred to” as the department of public health uniform DNR advance directive.¹⁹ The Veterans Health Administration refers to POLST as SAPO (state authorized portable orders).²⁰

2. PURPOSE, FUNCTION, AND SUCCESS

Both law and practice support a presumption that each patient will receive aggressive interventions to prolong her/his life as long as possible. Patients can rebut this presumption and decline treatment, even if that choice hastens their death. But many patients lack the capacity to make healthcare decisions at the end of life. For decades, many medical and legal experts have looked to the advance directive as a central mechanism to assure that patients are treated in accordance with their preferences.

Unfortunately, the advance directive has had very limited success.²¹ There are several reasons. First, many patients have not completed one. And most of the advance directives that have been completed are unavailable when needed. Moreover, even if available, advance directives must be reduced to medical orders. But advance directives are often vague, leaving providers uncertain as to how the instructions apply to a patient’s current clinical circumstances. For example, take the phrase, “if I am close to death”: does that mean within weeks, or within hours? Furthermore, even once orders are written, they do not travel outside an institution.

POLST helps address these problems.²² Meant to supplement, not replace, traditional

advance directives for patients expected to die within the next year, POLST has several advantages. First, it is signed by the healthcare provider. There is no need for interpretation and translation, because POLST is an immediately actionable medical order. Second, since POLST is on a single-page, standardized form, it is easy to follow. Third, unlike DNR (do-not-resuscitate) orders, POLST addresses not just CPR (cardiopulmonary resuscitation), but an entire range of life-sustaining interventions, such as IV (intravenous) fluids, antibiotics, a feeding tube, and artificial breathing. Fourth, POLST is transportable. It is a brightly colored, clearly identifiable form that remains in the patient’s chart and travels with the patient from hospital, to nursing home, to ambulance, to the patient’s home. POLST is recognized and honored across all these different treatment settings.²³

POLST protects and promotes patient autonomy better than advance directives in at least four ways. First, POLST is usually created with a healthcare provider at or near the time when an acute or serious chronic condition develops. It addresses the patient’s current situation, not a possible future scenario. Consequently, it has a greater chance of being more informed and more relevant to the specific medical situation at hand. Second, since the POLST form is highly visible, portable, and travels with the patient’s medical records, it is more likely available when a decision must be made. Third, since it is written in precise medical language on a standardized form, it is better understood. Fourth, since POLST is signed by a provider, it has a greater chance of compliance by other providers.

While documentation is the centerpiece, POLST is more than a form, it is a tool providing a framework for end-of-life care conversations between patients, families, and healthcare providers. Providers are encouraged to discuss specific scenarios and treatment options. Patients and families have the chance to ask questions and make their wishes known.²⁴ In short, it gives patients more control of end-of-life care. A universal medical order honored across care facilities, POLST changes how end-of-life treatment is provided. Healthcare providers know immediately what patients do and do not want,

and they can provide treatment and care consistent with those preferences.²⁵

3. STATUS IN THE STATES

Since its inception, POLST has become a national phenomenon. As of September 2012, at least 46 U.S. states or communities had a POLST program of some form.²⁶ A program can roughly be classified as either “endorsed” or “developing,” based on the degree to which it has implemented the core elements of POLST and established itself within the state or community. Because there is considerable variation within these classifications, healthcare and other professionals involved in end-of-life decision making must pay careful attention to the progress and status of the POLST program in their own state and community.

Origin of POLST

In the early 1990s, the Center for Ethics in Health Care at Oregon Health & Science University (OHSU) brought together representatives from stakeholder healthcare organizations to develop a portable form that translated patients’ preferences regarding life-sustaining treatment into medical orders. This form was ultimately named POLST.²⁷ POLST was first released for use in Oregon in 1996. The evidence base that Oregon established regarding the efficacy of POLST facilitated its refinement and clinical acceptance within Oregon and encouraged its spread across the U.S.²⁸ The POLST form and procedures from Oregon’s efforts provided a paradigm for other states.

A handful of other states were quick to adopt Oregon’s POLST model. As early as 1997, leaders of local health systems in western Wisconsin adopted POLST as an alternative to the state’s statutorily established DNR program.²⁹ By the early 2000s, support emerged for POLST and POLST pilot programs in New York,³⁰ Pennsylvania,³¹ Washington,³² and West Virginia.³³

In 2004, POLST leaders within these five states, as well as Oregon, became the original members of the National POLST Paradigm Initiative Task Force (NPPTF).³⁴ NPPTF was formed to facilitate the development of POLST

programs in other states and to further policy development and research related to POLST.

Endorsed POLST Programs

For the sake of gaining a big-picture understanding of the status of POLST programs across the country, it is helpful to break them down by their relative maturity. In this respect, the classification of programs as “endorsed” or “developing” is a good starting point. For a state or community program to be given “endorsed” status by NPPTF, the program must meet a set of specific requirements.³⁵ Some of the criteria relate to the core elements of POLST. Most visibly, NPPTF requires a standardized form that allows a patient to request or limit treatment in four categories covered by the form: (1) CPR, (2) intensity and location of other life-sustaining treatment, (3) antibiotics, and (4) artificially administered nutrition. The standardized form must transfer across healthcare settings and it must constitute medical orders.

The “endorsed” program criteria also relate to whether a form is implemented in a manner consistent with the aims of the POLST paradigm (for example, requiring safeguards to ensure that POLSTs are based on patient preferences). To earn “endorsed” status, a program must be sustainable; for example, there must be an entity willing and able to accept leadership of the program. And there must be a plan for ongoing evaluation. As of September 2012, 15 states had programs classified as “endorsed.” These include Oregon and the early adopters, New York, Pennsylvania, Washington, West Virginia, and Wisconsin, as well as California, Colorado, Hawaii, Idaho, Louisiana, Montana, North Carolina, Tennessee, and Washington.³⁶

A few states, including Oregon, West Virginia, New York, and California stand out as relatively more established. These four states have already achieved broad clinical acceptance of POLST and have ensured its continued expansion and evolution. Use of POLST is particularly well documented in Oregon and West Virginia, whose POLST programs have been the subject of published research reporting that the vast majority of nursing facilities or hospices in the states use POLST.³⁷ Although California’s

POLST program is relatively young, its efforts have achieved broad dissemination of POLST in a short period, despite the challenges posed by the geographic size of the state and the heterogeneity of the state's population.³⁸

These four states have also made significant efforts to ensure the continued expansion and refinement of their POLST programs. They provide regular, ongoing training of physicians, and have made available extensive educational resources, including training curricula, instructional guides, and video tutorials.³⁹ This promotes further penetration of POLST into clinical practice and encourages its use consistent with the goal of honoring patient preferences. Moreover, these four states have ensured the sustainability and refinement of their programs both through the maintenance of effective statewide and local coalitions and through significant financial support.⁴⁰

In contrast, other endorsed programs have not reached the same level of establishment. For example, Tennessee's Board for Licensing Health Facilities adopted rules for POST and a POST form in 2005, but, as of 2010, Tennessee POST still lacked a "true home or program" and was largely unfunded. This poses significant challenges to widespread implementation.⁴¹ Similarly, Hawaii's POLST program was legislatively recognized in 2009, but its adoption by healthcare facilities and professionals has been slow, despite the education efforts of a strong, statewide end-of-life coalition.⁴²

Developing POLST Programs

Reflecting the relative newness of POLST, the majority of states⁴³ or communities⁴⁴ (29 altogether) have POLST programs that are classified as "developing." This classification is applied to programs that are not so established as to meet the criteria for "endorsed" programs, but have started to lay the necessary groundwork for implementation of POLST. These criteria include: (1) leadership by an effective local or statewide coalition, (2) involvement of key stakeholders, and (3) development of a standardized form that will comply with the form requirements for an endorsed program.⁴⁵

The POLST programs classified as "developing" represent a spectrum of stages of devel-

opment. Some have already laid the groundwork for effective implementation of POLST. They have created a standard form, secured the approval of key stakeholders, and addressed legal or practical barriers to implementation.

Massachusetts is a good example of a program that has already addressed most of these elements. It developed a standard form with the input of stakeholders and experts,⁴⁶ and it conducted a legislatively authorized demonstration program in Worcester.⁴⁷ Then, Massachusetts authorized EMTs (emergency medical technicians) to honor MOLST forms,⁴⁸ and initiated a statewide MOLST expansion plan.⁴⁹ As of April 2012, Massachusetts MOLST expanded statewide. Healthcare institutions and professionals were on notice they should: (1) honor MOLST forms, (2) implement MOLST policy, and (3) use the training and supplemental materials provided on the Massachusetts MOLST website.⁵⁰

Iowa is another example of a relatively advanced developing program. Iowa first conducted legislatively authorized pilot programs. It followed the pilots, in 2012, with legislative establishment of POLST on a permanent, statewide basis.⁵¹ The Iowa Department of Public Health published a statewide (IPOST) form.⁵²

In contrast to Massachusetts and Iowa, other states have programs that are just starting to get off the ground.⁵³ For example, in 2011, a New Mexico task force developed a POLST form for regional pilot programs, scheduled to start in 2012, but the form is not yet officially recognized by the New Mexico Department of Health or EMS [emergency medical services] Bureau.⁵⁴ In Ohio, POLST advocates are in the process of trying to change complicated state DNR laws, which present a legal barrier to implementation of POLST outside healthcare facilities.⁵⁵

4. FOUR LEGAL ROUTES OF IMPLEMENTATION

The most effective strategy for development of a POLST program depends on each state's unique circumstances, including: (1) existing laws relating to end-of-life healthcare decision making, (2) political climate, and (3) attitudes toward POLST within the medical and broader

community. Accordingly, different states and regions have taken four different legal approaches to implementation. First, many states have authorized POLST by statute. Second, other states have authorized POLST by administrative regulations. Third, some states rely on only informal guidelines and clinical consensus. Fourth, POLST advocates have frequently taken an incremental approach.

Statutory Recognition of POLST

Using either statutes or regulations to establish POLST helps ensure the form and program will be uniform throughout a state. Moreover, statutory recognition of POLST has three additional advantages. First, legislation can amend existing state laws that conflict with or limit the utility of POLST. Legal barriers include: (1) detailed out-of-hospital DNR form requirements, (2) medical preconditions for out-of-hospital DNRs, and (3) lack of default surrogates.⁵⁶

Second, legislation is the most authoritative way to immunize healthcare providers from criminal prosecution, civil liability, or disciplinary sanctions for their actions complying with POLST.⁵⁷ This can be helpful to achieve the support of, and participation by, healthcare professionals.⁵⁸ The experiences of advocates indicates it is “important to health care professionals that POLST statutes assure them that they will be immune from liability for acting in good faith based on the orders contained within a POLST form.”⁵⁹

Third, authorizing POLST by statute better clarifies its legal status.⁶⁰ While a state’s existing healthcare decision laws might be interpreted as broad enough to permit use of POLST, its explicit recognition by the legislature makes it clear that POLST is consistent with state law. This encourages risk-averse healthcare providers to adopt POLST, and such legal clarity can make it more likely that POLST will withstand legal challenges in the courts.⁶¹ Also, a statute permits Veterans Health Administration (VHA) facilities in a state to use POLST, since they can do so only if “authorized by state law.”⁶²

States with POLST statutes. There are 18 states with statutes authorizing POLST: California, Colorado, Georgia, Hawaii, Idaho, Illinois, Iowa, Louisiana, Maryland, New Jersey, New

York, North Carolina, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, and West Virginia.⁶³ These POLST statutes vary in the level and type of detail provided. At one end of the spectrum are states like Louisiana whose statutes specify much of the actual text to be used in a POLST form.⁶⁴ At the other end of the spectrum are states like Georgia, Illinois, New York, Pennsylvania, and Tennessee, whose statutes are chiefly concerned with authorizing a state health department or other regulatory body to establish a POLST form and procedures.⁶⁵ In Pennsylvania, for example, the 2006 statute simply authorizes the establishment of an “advisory commission” to determine the advisability of a “standardized form containing orders . . . that detail . . . life-sustaining wishes.” The department of health formed a Patient Life-Sustaining Wishes Committee that developed a form approved by the department in October 2010. Similarly, New Jersey delegated the development of a form to a federally designated patient safety organization.⁶⁶

Many states, however, use legislation to establish some minimum requirements for a POLST form and procedures, leaving room for flexible implementation and evolution of a POLST program.⁶⁷ For example, California’s statute recognizes POLST as a valid medical order but it does not specify the POLST form. Instead, it requires in general terms that the form provide standardized directions to healthcare providers regarding resuscitative and other life-sustaining measures.⁶⁸ California’s statute focuses on other key issues like: (1) distinguishing POLST from advance directives,⁶⁹ (2) ensuring patient protections,⁷⁰ (3) clarifying the role of a legally recognized decision maker,⁷¹ (4) establishing provider immunity,⁷² and (5) mandating the applicability of POLST across all healthcare settings.⁷³

Other states statutorily provide more detail regarding the POLST form, but with enough generality to allow the form to evolve without amending state law. For example, West Virginia’s POST statute requires the state form provide: (1) a physician’s orders relating to CPR, level of medical intervention, antibiotics, and hydration and nutrition; (2) a physician’s signature; (3) a place to indicate whether a patient

has an advance directive or appointed decision maker; (4) the signature of the patient or patient's representative; and (5) documentation of any review of the form's orders.⁷⁴

Recent POLST legislation. Seven of the 18 states with POLST statutes enacted them within the past two years: Georgia, Iowa, Illinois, Maryland, New Jersey, Rhode Island, and Vermont.⁷⁵ Georgia simply added immunity for acting in good faith in accordance with a POLST.⁷⁶ Illinois's statute is very brief, directing the Illinois Department of Health to develop a standard form that meets the "minimum requirements to nationally be considered a POLST."⁷⁷ Maryland, Iowa, New Jersey, and Rhode Island provide more detailed requirements.⁷⁸ While Vermont's 2005 Advance Directive Statute created a DNR/COLST form, use of this form was only recommended. In 2011, to ensure better uniform implementation of POLST, Vermont enacted the Hospice and Palliative Care Act, which requires that healthcare providers use the standard form issued by the Vermont Department of Health.⁷⁹

Recent efforts to pass POLST legislation. The pool of states with POLST legislation will likely continue to grow in the next few years, given the number of states with developing POLST programs and ongoing and increasingly well-organized efforts of POLST advocates. In addition to the six states that enacted POLST legislation in the past two years, several states introduced and considered POLST bills.

In early 2012, POLST legislation was introduced in Indiana, Kentucky, and Wyoming, but none of the three bills made it out of committee.⁸⁰ The bills would have authorized the development of a standard POLST form and provided basic guidelines for its use and content. Washington introduced legislation that, if enacted, would have provided immunity for action "in accordance with the directions contained in a [POLST] form."⁸¹ Ohio has repeatedly failed to pass legislation that would replace the state's DNR forms with POLST.⁸² Even though POLST advocates have not introduced legislation in Ohio since the 2009-2010 session, the Midwest Care Alliance is reportedly still working to get a POLST bill re-introduced and adopted by the Ohio legislature.⁸³

Administrative Regulation of POLST

While statutory establishment of POLST provides clear benefits, the statutory route is not always feasible or necessary. Where POLST would be consistent with existing state law, regulations can, like statutes, assure uniformity of POLST forms or procedures across the state. At the same time, a regulatory approach allows POLST advocates to avoid the lengthy and uncertain legislative process.⁸⁴ Regulations are generally easier to enact and change than statutes. Regulations provide greater flexibility and are less likely to attract a heated political debate.⁸⁵ States use regulations in two ways. Some states use them instead of statutes. Other states use them to supplement POLST-specific statutes.

Regulations in states without POLST statutes. Regulations have been used to promote POLST in states without explicit statutory recognition. Regulations in these states are promulgated pursuant to general statutes that broadly recognize a health agency's authority to oversee healthcare facilities, emergency medical services, and/or DNR forms. For example, Tennessee has a statute authorizing the Tennessee Board for Licensing Health Facilities to develop "universal do-not-resuscitate orders." A UDNR is defined as "a written order that applies regardless of the treatment setting and that is signed by the patient's physician that states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted."⁸⁶ Interpreting this statute to permit development of a form that addresses life-sustaining treatments other than resuscitation, the Tennessee Board for Licensing issued formal regulations in 2005, establishing a statewide POLST form and procedures for its use in licensed healthcare facilities.⁸⁷

More recently, Delaware issued regulations to replace its pre-hospital advance care directive form with MOLST. The Delaware EMS agency developed a MOLST form and protocol. It provided detailed rules to guide its implementation, including: (1) methods to identify a patient with a MOLST, (2) procedures for revoking a MOLST, and (3) requirements for periodic review of the form.⁸⁸ But due to concern over whether the regulations were consistent

with the governing statutes, in November 2012, the Delaware Department of Health and Social Services instructed all healthcare providers to “refrain from further use” of MOLST.⁸⁹

Like Delaware, Oregon also has no statute explicitly addressing POLST. And like Delaware and Tennessee, Oregon used a regulatory agency to promote POLST. While Delaware used its EMS agency, Oregon used its board of medical examiners.⁹⁰ Specifically, Oregon BME used its authority to oversee the scope of practice of EMTs to amend the agency’s rules, allowing first responders to follow the orders on a POLST.⁹¹

Regulations in states with POLST statutes. While states like Tennessee, Delaware, and Oregon use regulations in the absence of a POLST statute, other states use regulations to supplement an existing statute. In these states, agency regulations play a critical role in fleshing out the details of a POLST form and program.⁹² In many states, including California, Illinois, Iowa, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Utah, and Vermont, the POLST form must be approved by a health department or other regulatory body.⁹³ POLST forms are currently awaiting development or final approval by health departments or related entities in states that recently adopted POLST legislation, including Illinois, Maryland, and New Jersey.⁹⁴ In contrast, Iowa, which enacted POLST legislation in 2012, has already published its IPOST form.⁹⁵

POLST Programs Developed Primarily Through Clinical Consensus

While most POLST programs are defined by statutes and/or regulations, nongovernmental organizations (NGOs) play a major role in implementation.⁹⁶ In most states, guidelines and supplemental educational materials have been developed and made available by health professional organizations or end-of-life coalitions. Particularly notable are West Virginia’s Center for End-of-Life Care, New York’s Community-Wide End-of-Life/Palliative Care Initiative, California’s Coalition for Compassionate Care, Hawaii’s Kokua Mau coalition, and the Washington State Medical Association.⁹⁷

In some states, NGOs have sought to implement POLST primarily or solely through reli-

ance on clinical consensus. Advocates in these states aim to establish POLST as the standard of care.⁹⁸ While developing a POLST program with the support of neither legislation nor regulation can result in inconsistency, it provides flexibility for a program to adapt to clinical needs without constraint by regulatory or legislative processes.⁹⁹

This approach was effective in Oregon and is being used in Kentucky, Michigan, Nebraska, and Nevada.¹⁰⁰ Perhaps the most notable use of the clinical consensus approach is in Kansas, Maine, Minnesota, Missouri, and North Dakota.¹⁰¹ While Oregon did selectively seek changes in regulations to allow POLST to be effective (for example, to permit EMTs to honor POLST orders), the Oregon Health & Science University Center for Ethics largely relied on a “grassroots approach” to integrate POLST into the standard of medical care. This entailed: (1) using a train-the-trainer model to initially educate health professionals about use of the form, (2) facilitating research to demonstrate the efficacy of POLST, and (3) providing for ongoing POLST education and program refinement.¹⁰² POLST is now the standard of medical care in Oregon, and is used by nearly all the state’s hospice and nursing facilities.

Minnesota and Maine have also met with a degree of success implementing POLST solely through clinical consensus. Minnesota’s standardized POLST form, developed by an interdisciplinary task force endorsed by the state’s EMS regulatory board, has already been adopted by key health systems in the Twin Cities area and greater Minnesota.¹⁰³ Maine has also been successful, achieving geographically widespread, although sporadic, use of POLST by way of outreach and education, as well as the involvement of healthcare systems.¹⁰⁴

Incremental Approach to Implement POLST

A number of states found it necessary or useful to take an incremental approach to implementing POLST.¹⁰⁵ California, Iowa, Massachusetts, New York, North Carolina, and West Virginia are notable examples of states that used such an approach successfully. Such strategies frequently begin with pilot programs. They then use the evidence base from such programs to

take POLST statewide, through legislation, regulation, or expanded clinical acceptance.¹⁰⁶

For example, use of POLST in New York outside healthcare facilities ultimately required legislation because of conflicts with state DNR laws.¹⁰⁷ New York passed legislation in 2008, permitting use of MOLST in all settings on a permanent, statewide basis. Such legislation was facilitated by earlier step-wise progression: (1) voluntary use by hospital and nursing facilities in the Rochester region in 2003, (2) state department of health approval for use of MOLST within healthcare facilities in 2005, (3) legislatively established pilot programs to test nonhospital use of the form.¹⁰⁸

Similarly, Iowa enacted legislation in 2012, authorizing use of the Iowa POST form throughout the state.¹⁰⁹ This was facilitated by earlier legislatively authorized pilot programs in Cedar Rapids and Jones County.¹¹⁰ These local projects reported to an advisory council that made recommendations to the state legislature.

5. WHICH PROFESSIONALS CAN AUTHORIZE POLST?

Legal concerns surrounding POLST do not end once a POLST program is established. It takes years for a POLST program to become fully implemented.¹¹¹ Even established POLST programs continually evolve and can raise issues concerning how POLST fits within a state's existing framework of healthcare laws. This and the following sections (5 to 12) highlight the eight most troublesome legal questions raised by POLST.¹¹²

As a form containing medical orders, POLST universally requires a healthcare professional's signature to be valid.¹¹³ The question remains, however, whether to expand the authority to sign a POLST form beyond physicians. POLST programs have taken two different approaches. At least nine states have limited authority to physicians: California, Georgia, Hawaii, Illinois, Kansas, Missouri, Nevada, New York, Tennessee, and West Virginia,¹¹⁴ but the larger trend is to extend authority to other health professionals. At least 14 states extend authority to sign a POLST to nurse practitioners (NPs), advanced practice nurses, and physician assistants (PAs):

Colorado, Iowa, Idaho, Maryland, Massachusetts, Minnesota, Montana, New Jersey, North Carolina, Oregon, Rhode Island, Utah, Vermont, and Washington.¹¹⁵

There are three main rationales for the trend toward expansion of signing authority. First, in rural, geographically isolated areas, physicians can be a rarity, making the question of which healthcare professionals can authorize a POLST an issue of accessibility. This issue was a significant concern in Alaska, where many rural and village communities have no physicians available.¹¹⁶ Utah's original POLST statute authorized only physicians. But amendments in 2007 and 2008 expanded authorized signers to include NPs and PAs. Rural access likely motivated 2012 amendments to Idaho's POST law to permit NPs and PAs to sign.¹¹⁷

Second, just as physicians are often unavailable in rural areas, they are often a rarity in long-term care facilities.¹¹⁸ A recent survey reports, "more than one third of [more than 16,000 U.S.] nursing homes reported difficulty in obtaining physician participation in POLST completion and having physicians sign the POLST."¹¹⁹

Third, extension of authority to sign acknowledges the reality that nonphysicians (nurses, social workers, advanced care planning facilitators) are more likely than physicians to actually engage patients in a discussion about end-of-life care.¹²⁰ This issue is recognized not only by expanded signing authority in many states, but also by the presence of an additional box on several state POLST forms to identify the professional who helped prepare the form. POLST forms in California, Hawaii, Iowa, Minnesota, North Carolina, and Utah have a place to indicate the identity of the preparer, while still requiring the signature of an authorized healthcare professional to be valid.¹²¹

6. IS THE PATIENT'S SIGNATURE REQUIRED?

The core objective of POLST is to ensure that a patient's preferences for end-of-life care are respected. To that end, many of NPPTF criteria for an "endorsed" POLST program relate to patient protections. Notable among these is the documentation of the patient's consent by

signature.¹²² Similarly, some Roman Catholic bishops and theologians are concerned that the lack of a patient's signature raises grave concerns as to whether a POLST accurately reflects and protects the patient's wishes.¹²³

In fact, the majority of states require the signature of the patient or, if the patient lacks capacity, the patient's legal representative. Montana, for example, provides that "a form lacking the patient or legal decision maker signature . . . is invalid,"¹²⁴ but this is not universal. At least four states, Minnesota, New York, Oregon, and Wisconsin, strongly recommend that a POLST be signed by the patient, but fall short of requiring it.¹²⁵ New York permits verbal consent with two witnesses. Vermont requires a patient signature except when CPR would be "futile."¹²⁶

Most state POLST programs lack a related safeguard often required of advance directives. In California, for example, advance directives completed by long-term care residents are not effective "unless a patient advocate or ombudsman . . . signs the advance directive as a witness."¹²⁷ California and other states require an extra signature "to recognize that some patients in skilled nursing facilities are insulated from a voluntary decision making role, by virtue of the custodial nature of their care, so as to require special assurance that they are capable of willfully and voluntarily executing an advance directive." No such safeguard is required for POLST. On the other hand, increasing safeguards entails costs and can increase the risk of error. For example, lack of qualified witnesses could mean that far fewer POLSTs are completed.

7. CAN SURROGATES CONSENT FOR INCAPACITATED PATIENTS?

Closely connected to the requirement of a patient's signature is the question of whether a surrogate can consent to a POLST for a patient who lacks decision-making capacity. Surrogates complete about 30 to 40 percent of POLSTs.¹²⁸ Recognizing the importance of this issue, NPPTF recommends that POLST programs permit surrogates to complete POLSTs for incapacitated patients.

But NPPTF acknowledges this is complicated by state laws governing surrogates and healthcare decision making.¹²⁹

A number of states impose certain limitations on the scope of surrogate authority.¹³⁰ For example, some states require the satisfaction of certain medical preconditions like the diagnosis of a "terminal condition."¹³¹ Others, like California and Minnesota, authorize a "legally recognized healthcare decision maker" to consent to a POLST on behalf of a patient who lacks capacity, but fail to fully define who qualifies as a legally recognized decision maker¹³² or to specify who can serve as a surrogate if the patient has not appointed one ahead of time.¹³³

States vary in the limits that they place on the authority of a surrogate regarding POLST.¹³⁴ The language of many POLST statutes or regulations in many states would automatically permit a surrogate to revoke or modify a patient-created POLST. There is substantial logic to this approach. POLSTs are supposed to be reviewed periodically and updated: (1) if there is a substantial change in a patient's health status, (2) if a patient's treatment preferences change, or (3) if a patient is transferred from one treatment setting or care level to another. Indeed, 24 percent of POLSTs are rewritten to reflect a patient's changed circumstances, primarily for more comfort-focused care.¹³⁵ Often, a POLST must be updated after a patient loses capacity.

But some states, like New Jersey and Tennessee, prohibit a surrogate from altering or revoking a patient-created POLST form unless expressly authorized to do so by the patient.¹³⁶ The New Jersey MOLST form provides a place for a patient to indicate this authorization.¹³⁷ Other states impose far narrower limitations. Rhode Island requires that a "recognized health care decision maker" of a patient who lacks capacity consult with the "MOLST qualified health care provider" prior to requesting modification of the patient's MOLST.¹³⁸ Other states, like Delaware, have limited the authority of surrogates to revoke a POLST in emergency situations, recognizing the difficulty involved in identifying authorized decision makers under such circumstances.¹³⁹ Still other states, like Utah and New York, impose special process re-

quirements for legal surrogates to consent to POLST forms on behalf of the mentally ill, the developmentally disabled, or minors.¹⁴⁰

Thus, while POLST programs almost universally permit legal surrogates to complete, modify, or revoke a POLST on behalf of a patient lacking decision-making capacity,¹⁴¹ states face different challenges regarding the question of surrogate authority and handle it in different ways. This makes it important for healthcare professionals to be aware of the specific laws or rules in their state.

8. IF A POLST CONFLICTS WITH AN ADVANCE DIRECTIVE, WHICH PREVAILS?

Another important question is, which form prevails, should the orders in a POLST conflict with a patient's advance directive? States that addressed this issue in POLST statutes, regulations, or guidelines have generally taken one of three approaches, directing: (1) a POLST form prevails over an advance directive;¹⁴² (2) an advance directive prevails over POLST;¹⁴³ or (3) the most recently completed document prevails.¹⁴⁴ Other states have not explicitly addressed the question of what happens when a POLST and an advance directive conflict.¹⁴⁵

Failure to address the issue of conflicting forms creates uncertainty for healthcare professionals and patients. Efforts to address the problem of conflicting forms have created additional concerns. One concern raised by California's POLST law is that the "latest in time" rule to resolve a conflict between a POLST and a previously created healthcare instruction, in combination with the ability of a legally authorized representative to complete a POLST on behalf of an incapacitated patient, creates a situation in which a third party can override a patient's previously expressed treatment preferences.¹⁴⁶

States with more recently adopted POLST statutes, including Colorado¹⁴⁷ and New Jersey,¹⁴⁸ seem to have avoided this problem by specifically stating that the most recent *patient-completed* document will control in the event of a conflict. So a surrogate-completed POLST could not contradict a patient's advance directive.¹⁴⁹ Unfortunately, this seems overbroad in that it would also preclude a surrogate-com-

pleted POLST from contradicting not only the patient's advance directive, but also an earlier patient-completed POLST. The VHA is more flexible: the most recent document controls "unless there is sufficient reason to conclude that the more recent information does not actually reflect the patient's current preferences."¹⁵⁰

9. IS OFFERING POLST MANDATORY?

A number of states require hospitals or long-term care facilities to offer POLST to certain groups of patients. This requirement parallels the duty under the Patient Self-Determination Act (PSDA) to "provide written information . . . concerning . . . right to formulate advance directives."¹⁵¹ For example, Maryland requires that completion of its MOLST form be offered to patients in assisted living and nursing facilities, hospices, home health agencies, and dialysis centers, as well as to hospital inpatients being transferred to long-term care.¹⁵² Utah requires a similar range of facilities to determine, on admission, whether each individual has a POLST. These facilities must determine which individuals without a POLST should be offered the opportunity to complete one.¹⁵³

Such requirements encourage widespread clinical implementation of POLST, but surveys of states and facilities implementing POLST raise concerns that healthcare facilities, especially nursing homes, misinterpret "mandatory offer" to mean all residents must have a POLST form.¹⁵⁴ To be sure, completion of POLST is not the same as dictating a particular treatment plan. POLST accommodates varying treatment preferences. Even if completion were required, patients and residents could complete POLST any way that they wanted. Nearly one-quarter of patients completing POLSTs chose "full treatment." Many choosing DNAR (do not attempt resuscitation) on their POLST want other kinds of treatment like hospitalization, antibiotics, and artificial nutrition and hydration.¹⁵⁵

Still, requiring completion arguably undermines the premise that a POLST is based on the voluntary, informed consent of a patient.¹⁵⁶ Accordingly, no state requires that a patient complete a POLST form.¹⁵⁷ Nevertheless, these concerns about confusing "offer" and "com-

plete” have led multiple states, particularly those like Iowa and Colorado that have recently adopted POLST legislation,¹⁵⁸ to mandate that completion of a POLST cannot be a condition of receiving healthcare services or insurance.¹⁵⁹ North Carolina requires that its official MOST form contain, in bold, directly over the signature line, the statement, “You are not required to sign this form to receive treatment.”¹⁶⁰ Rhode Island provides, “The MOLST is a voluntary option for qualified patients. No patient is required to elect a MOLST.”¹⁶¹ These clarifications are similar to those regarding advance directives in the federal PSDA¹⁶² and in the healthcare decisions acts (HCDAs) of many states.¹⁶³ Indeed, PSDA and HCDA prohibitions are directly applicable in states where POLST qualifies as an advanced directive.

10. WHAT ARE THE DUTIES OF HEALTHCARE PROVIDERS?

While it is not mandatory for a patient to complete a POLST, many states have imposed duties on healthcare providers with regard to POLST. First, as noted above, some states have mandated that certain healthcare facilities offer POLST to patients. Second, many, if not most, states have explicitly imposed a duty on healthcare providers to comply with orders communicated by a POLST.¹⁶⁴

This duty to comply raises questions regarding: (1) the obligations of a healthcare professional who objects to the withholding of life-sustaining treatment on policy, moral, or religious grounds; (2) the obligations of healthcare providers to respect POLSTs signed by physicians without admitting privileges to a particular facility; and (3) the obligations of providers to respect POLSTs created in other states.

States have addressed the first by requiring that healthcare professionals who are unwilling to comply with a POLST take all reasonable steps to transfer a patient to another physician or facility.¹⁶⁵ States have addressed the second issue by making it clear that a POLST must be honored, regardless of the admitting privileges of the signing physician.¹⁶⁶ Facilities worried about compliance with Joint Commission medical staff standards can review the

POLST and write new orders on admission.¹⁶⁷ States have addressed the third issue with reciprocity provisions, expressly recognizing that there is a duty to comply with POLSTs completed in other states, provided that the forms comply with the laws of the treating state.¹⁶⁸

It should be noted that even in the absence of a statute or regulations explicitly imposing a duty on healthcare providers to comply with a POLST, they may still have such a legal duty if the POLST paradigm has become the standard of medical care in that state or community. Notably, North Carolina does not expressly state that a healthcare provider has a duty to comply with POLST, but its immunity statutes will not apply to healthcare professionals who refuse to comply with POLST, despite knowing of the form’s existence.¹⁶⁹

11. WHAT IS THE ROLE OF ELECTRONIC REGISTRIES?

While the development and use of electronic POLST registries is primarily a question of organization and funding, rather than a legal question, the movement toward registries is a growing trend that merits attention. Because paper POLST forms can be difficult to locate in emergency situations, around 25 percent of POLST forms are not immediately available.¹⁷⁰ Electronic repositories of POLST forms have the potential to increase the efficacy of POLST by facilitating the communication of POLST orders across healthcare settings. Registries can be particularly useful in allowing first responders to quickly determine a patient’s treatment preferences during medical emergencies, situations in which time is critical. Quick access to a POLST can make a difference in whether a patient’s preferences are respected. In one study, POLST orders changed the treatment plan for 45 percent of patients.¹⁷¹

For example, Oregon developed a statewide electronic registry that operates in conjunction with the state’s 24-hour trauma communication center, allowing EMTs and emergency departments to, with a phone call, determine whether a patient has a POLST and what orders are contained within the form.¹⁷² Oregon’s registry is large and well established. Since its creation in

2009,¹⁷³ the registry has received 135,000 POLST forms and the call center has received nearly 2,000 POLST-related emergency calls.¹⁷⁴

At least five other states, including Idaho, Montana, New York, Utah, and West Virginia, have electronic POLST registries in varying stages of development.¹⁷⁵ While these registries share the same goal of increasing the accessibility of POLST forms, they differ in a number of respects. First, only some have been implemented statewide (Oregon, Idaho, West Virginia). Second, only a few permit electronic completion of POLST forms (New York, Utah). Third, only some state registries also contain non-POLST advanced directives and other healthcare documents (Idaho, West Virginia).¹⁷⁶

Oregon is the only state that mandates the submission of completed POLST forms to the registry, unless the patient opts out.¹⁷⁷ This mandate not only permits Oregon's registry to comply with HIPAA (Health Insurance Portability and Accountability Act) guidelines, but also ensures that enough POLSTs are submitted for the registry to be useful, both in terms of emergency accessibility and in terms of data for POLST research and quality assurance.¹⁷⁸

The trend toward registries is likely to continue to expand. As of September 2012, California was in plans to develop and test a POLST registry.¹⁷⁹ Other states, such as Montana and Vermont, do not specifically have a POLST registry, but already have an advanced directive or DNR registry that could potentially be extended to POLST.¹⁸⁰ And more registries are coming online. Michigan, for example, authorized a "peace of mind registry" in 2012.¹⁸¹

12. WHAT IS THE ROLE OF THE FEDERAL GOVERNMENT?

As the previous discussion has illustrated, POLST is largely a matter of state law and policy. However, the federal government also has a role to play in POLST. Three examples illustrate the potential for the federal government to encourage POLST implementation: (1) HITECH (Health Information Technology for Economic and Clinical Health Act) and electronic health records, (2) Medicare and voluntary advance care planning, and (3) VHA policy.

HITECH and Electronic Health Records

The HITECH Act of 2009 seeks to facilitate more widespread adoption of electronic health records (EHR),¹⁸² a tool that has the potential to make POLST more effective. Under HITECH, hospitals and physicians can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and utilize that technology to achieve "meaningful" healthcare objectives.¹⁸³ While HITECH and its regulations do not explicitly refer to POLST, they incentivize greater use and development of technology that can help address the patient care goals of POLST, increasing its accessibility and facilitating monitoring and evaluation of the POLST process.¹⁸⁴

Medicare and Voluntary Advance Care Planning

Early forms of the bill that would become the Affordable Care Act contained a provision that would have reimbursed physicians under Medicare for periodically consulting with patients about advance care planning and discussing POLST, where available and applicable.¹⁸⁵ But political backlash (involving talk of "death panels") ultimately forced the removal of this provision.¹⁸⁶

Still, the March 2010 enacted version of the ACA did authorize "annual wellness visits" under Medicare.¹⁸⁷ So, through regulations, the U.S. Department of Health and Human Services authorized Medicare coverage of POLST conversations as an element of this "annual wellness visit."¹⁸⁸ But this also proved controversial.¹⁸⁹ So the regulation was rescinded just six weeks later.¹⁹⁰ More recently, U.S. Representative Earl Blumenauer (D-Oregon), the proponent of the (ultimately eliminated) POLST language in the original ACA, introduced new legislation, the Personalize Your Care Act of 2011.¹⁹¹ This bill would provide Medicare and Medicaid coverage for POLST conversations and grants to develop POLST programs.

Veterans Health Administration

While the VHA has its own advance directive, VHA facilities must honor advance directives and POLSTs that are valid under state law.¹⁹² When presented with a SAPO (state-au-

thorized portable order), VA clinicians have two basic obligations. First, they must act in accordance, write corresponding orders, and scan the SAPO into the electronic health record. Second, they must encourage and educate the veteran regarding completion of a SAPO on discharge.¹⁹³

13. INTERNATIONAL ADOPTION

While primarily a U.S. program, POLST has been spreading to other countries. For example, NPPTF and Respecting Choices have been consulting with policy makers in Brazil and Singapore.¹⁹⁴ POLST has been implemented somewhat in Germany.¹⁹⁵ And POLST has been particularly popular in Canada and Australia.

Canada

A 2008 Health Canada report notes that “some Canadian jurisdictions are exploring or using the POLST model.”¹⁹⁶ Indeed, POLST is being used by Canadian healthcare systems in at least four of its 10 provinces. For example, Fraser Health in British Columbia is using a MOST.¹⁹⁷ Hamilton Health Services in Ontario is using POST.¹⁹⁸ Alberta Health Services is using a “goals of care designation order.”¹⁹⁹ And, in March 2012, the Regina Qu’Appelle Health Region in Saskatchewan implemented MVLST (“my voice for life sustaining treatment”).²⁰⁰

Australia

While developed independently from NPPTF, the Australian state of Queensland has implemented a program quite similar to POLST. The acute resuscitation plan (ARP), a pink form of medical orders, was piloted in 2009, and was rolled out across the state in 2010.²⁰¹ But while consent should be obtained, there is no patient signature requirement, and the ARP instructions expressly recognize a process by which patient choices can differ from those in the ARP. While allied health professionals can be involved with completing an ARP form, it must be signed by the “most senior medical officer available.”

14. COURT CASES

While POLST is relatively new to most U.S. jurisdictions, there has already been some liti-

gation and regulatory enforcement. There have been four types of cases. First, families have sought damages for healthcare providers’ failure to comply with a POLST. Second, families have sought judicial permission to override a POLST. Third, there have been several cases involving forged POLSTs. Fourth, there have been cases involving uninformed POLSTs.

Failure to honor POLST

Most POLST statutes require healthcare providers to honor POLST, unless they have a good faith belief that the POLST is invalid. In late 2011, Compassion & Choices filed the first lawsuit seeking to enforce this legal duty, *DeArmond v. Permanente Medical Group*.²⁰² In this case, a young woman named Emily DeArmond had been ill her entire life due to brain cancer. In August 2010, her mother completed a POLST for her, ordering “do not intubate.” In November 2010, Miss DeArmond was found in bed, unresponsive, by her mother. An ambulance transported Miss DeArmond to Kaiser Medical Center, where an emergency room physician intubated her despite the known POLST.

The DeArmond family filed a lawsuit for damages in the Superior Court of Orange County, California. The complaint alleges causes of action for: (1) neglect of a dependent adult, (2) intentional infliction of emotional distress, (3) negligent infliction of emotional distress, (4) deceptive and unfair trade practices, (5) violation of the Health Care Decisions Act, and (6) violation of the California Consumer Legal Remedies Act. In May 2012, the court granted Kaiser’s petition to compel arbitration of the dispute. While the DeArmond family may still prevail on the merits, it will be without the publicity or transparency that normally attends litigation.

Excuse from POLST Compliance

In *Zornow*, a New York court excused compliance with a patient’s MOLST.²⁰³ Joan M. Zornow, 93, had advanced Alzheimer’s and was living in a nursing home. Her daughter, Carole Zornow, applied to be appointed her guardian. Carole Zornow and her siblings disagreed about their mother’s wishes and a previously enacted MOLST. Relying heavily on Joan Zornow’s Roman Catholic faith, the court found clear and

convincing evidence that she would have wanted most life-sustaining interventions. Consequently, in a poorly reasoned and widely criticized opinion, the court revoked all of the orders in her MOLST, except the DNAR order. The court ruled that no “blanket directives” should be used for Mrs. Zornow, because it could never be confidently determined that any treatment decision therein would be consistent with Roman Catholic moral theology.

Forged POLST

In the past two years, there have been several high-profile cases involving forged advance directives. In 2011, a Minnesota court found that Lana Barnes had criminally altered the advance directive of her husband, Albert Barnes.²⁰⁴ She had been demanding treatment that healthcare providers at numerous facilities had determined was inappropriate and non-beneficial. In fact, Mr. Barnes had specifically rejected such treatment in his 1993 advance directive. But his wife had cut, pasted, and recopied the document to omit those instructions. Moreover, Mr. Barnes's entire 1993 advance directive had been revoked by a 1994 advance directive in which he appointed his son, instead of his wife, as his healthcare agent.

While Lana Barnes altered an advance directive to indicate a patient's preference to continue treatment, Susan Elizabeth Van Note altered an advance directive to indicate a patient's preference to stop treatment. In September 2012, a Kansas City grand jury indictment was unsealed, alleging that Van Note, a Kansas estate planning attorney, forged her father's name to an advance directive. In 2010, William Van Note was shot and stabbed in his home. Ms Van Note soon showed up at the hospital with an advance directive stating that her father did not want prolonged treatment to keep him alive. Accordingly, doctors and nurses stopped their lifesaving efforts, and the patient died. Ms Van Note is alleged to have committed the shooting and stabbing.

More recently, several cases have involved allegations of a forged POLST. *Krela v. Kryla* is eerily similar to the Van Note case. A son alleges that his stepmother poisoned his father and that she forged a POLST to facilitate this

plan.²⁰⁵ The case is still in the preliminary motions phase. In *Scottrade v. Davenport*, the former girlfriend of the decedent disputed an online brokerage's distribution plan.²⁰⁶ She claimed that the other beneficiaries murdered the decedent and forged a POLST to facilitate this plan and the destruction of evidence. But the court found these claims to be frivolous. Finally, in *Costello v. University of Washington Medical Center*, the plaintiff claimed that the patient's POLST had been “fraudulently presented.”²⁰⁷ That case was dismissed because it was filed after the statute of limitations.

Uninformed POLST

While POLST has proven a tremendous tool for protecting and promoting patient autonomy, there remains significant concern with potential abuse. Patient advocates are concerned that POLST may be implemented in a coercive and manipulative manner, such that the resulting POLST does not reflect the patient's preferences and values. Indeed, there is some evidence to ground such concerns. In 2010, the California Department of Public Health sanctioned Crethaven Nursing Home in Santa Cruz regarding its use of POLST. Based on interviews, observation, and clinical record review, the CDHP found the facility in violation. It had failed to ensure that the attending physician obtained residents' informed consent prior to completing POLSTs.²⁰⁸

CONCLUSION

POLST helps patients. It documents a patient's wishes for life-sustaining treatment in the form of a medical order. It streamlines the transfer of patient records between facilities. It clarifies treatment intentions and minimizes confusion about patient preferences. It assists physicians, nurses, emergency personnel, and healthcare facilities in promoting patient autonomy. It optimizes comfort care of patients.

Because the POLST paradigm is well organized and well publicized, it is driving other related reforms. Most notable is greater attention to advance care planning. Not only are more POLSTs being completed, but more advance directives and advance care planning discus-

sions are being completed. Furthermore, at a legal level, POLST has prompted re-examination of long-latent gaps in healthcare decisions laws, such as the lack of default surrogate rules. When physicians, lawyers, and others get together to discuss POLST, these related concerns receive attention and salience.

NOTES

1. This article focuses on legal issues intrinsic to POLST. Other commentators have already examined extrinsic legal obstacles to adopting POLST. S.E. Hickman, C.P. Sabatino, A.H. Moss, J.W. Nester, "The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation," *Journal of Law, Medicine, and Ethics* 36, no. 1 (2008): 119-40. Nor does this article discuss related issues pertaining to advance directives, surrogate decision making, or out-of-hospital DNAR orders.

2. R. Miller, "Physician Orders to Supplement Advance Directives: Rescuing Patient Autonomy," *The Journal of Clinical Ethics* 20, no. 3 (Fall 2009): 212-9; T. Pope, "Legal Briefing: Advance Care Planning," *The Journal of Clinical Ethics* 20, no. 4 (Winter 2009): 289-96.

3. C.P. Sabatino, *Improving Advanced Illness Care: The Evolution of State POLST Programs* (Washington, D.C.: AARP, 2011).

4. "Care at the End of Life," editorial, *New York Times*, 25 November 2012, at SR10.

5. POLST goes by even more names other countries. See section 13 above.

6. Alabama, California, Florida, Georgia, Hawaii, Illinois, Indiana, Maine, Michigan, Nebraska, New Hampshire, New Jersey, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Washington, Wisconsin, and Wyoming.

7. Minnesota Medical Association, "POLST Communications," <http://www.mnmed.org/Key-Issues/POLSTCommunications/tabid/3291/Default.aspx>, accessed 10 December 2012; Montana Board of Medical Examiners, "POLST," http://bsd.dli.mt.gov/license/bsd_boards/med_board/polst.asp, accessed 10 December 2012.

8. Aging Institute of UPMC Senior Services, "Professionals in Aging: Pennsylvania Orders for Life-Sustaining Treatment (POLST)," <http://www.aging.pitt.edu/professionals/resources-polst.htm>, accessed 10 December 2012.

9. 18 Vt. Stat. Ann. § 9708.

10. "Program Description for: Connecticut,"

<http://www.ohsu.edu/polst/programs/connecticut.htm>, accessed 10 December 2012; 16 Del. Admin. Code 4304-1.0-14.0; Md. Code. Ann., Health-Gen. § 5-608.1; 2008 Mass. Acts, ch. 305, sec. 43; N.Y. Department of Health, Bureau of Emergency Medical Services, "Policy Statement 11-02 (1 March 2011); "Program Description for: Ohio," <http://www.ohsu.edu/polst/programs/documents/OHProgramDescription.pdf> (27 October 2008); R.I. Code § 23-4.11-2(10).

11. Idaho Code § 39-4512A; Ind. H.B. 1114 (2012); M.A. O'Rourke et al., "Physician Order for Scope of Treatment (POST) in South Carolina (SC)," *Journal of Clinical Oncology* 30 (2012): Suppl. 34, abstract 21; Tenn. Comp. R. and Regs. 1200-08-01-.13; "Program Description for: Virginia," <http://www.ohsu.edu/polst/programs/documents/developing-stateform-Virginia-5-29-12.pdf>, accessed 10 December 2012; W. Va. Code § 16-30-25.

12. La. Rev. Stat. Ann. § 40:1299.64.2(5).

13. "Program Description for: Alaska," <http://www.ohsu.edu/polst/programs/documents/AKProgramDescription.pdf> (5 December 2008); Colo. Rev. Stat. Ann. § 15-18.7-104; Ky. S.B. 217, 2012 Leg., Reg. Sess. (2012); Program Description for: New Mexico," <http://www.ohsu.edu/polst/programs/documents/NMdevelopingstateform.pdf> (23 January 2012); N.C. Gen. Stat. Ann. § 90-21.17.

14. Iowa Code § 144D.1-4.

15. Nevada Center for Ethics and Health Policy, "An Introduction to the Nevada SMOST," http://www.unr.edu/ncehp/spost_summary.html, accessed 10 December 2012.

16. Still other similar acronyms have some currency. K.B. Newport et al., "The 'PSOST': Providers' Signout for Scope of Treatment," *Journal of Palliative Medicine* 13, no. 9 (2010): 1055-8. But PSOST has a narrower mission than POLST. It is an internal tool for smooth transitions on nights and weekends.

17. "Transportable Physician Orders for Patient Preferences (TPOPP)," <http://www.practical-bioethics.org/initiatives/transportable-physician-orders.html>, accessed 10 December 2012.

18. Utah Bureau of Emergency Medical Services, "Life with Dignity/POLST/DNR," <http://www.health.utah.gov/ems/polst>, accessed 10 December 2012.

19. 20 Ill. Comp. Stat. § 2310-600(b-5).

20. Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook*, § 1004.04 (25 October 2012).

21. C.P. Sabatino, "The Evolution of Health Care Advance Planning Law and Policy," *Milbank Quarterly* 88, no. 2 (2010): 211-39; L.S. Castillo et al., "Lost in Translation: The Unintended Consequences of

Advance Directives Law on Clinical Care," *Annals of Internal Medicine* 154, no. 2 (2011): 121-8; K.E. Sonderling, "POLST: A Cure for the Common Advance Directive—It's Just What the Doctor Ordered," *Nova Law Review* 33, no. 2 (2009): 451-80; M.B. Kapp, "The Nursing Home as Part of the POLST Paradigm," *Hamline Law Review* 36, no. 2 (2013); H.S. Perkins, "Controlling Death: The False Promise of Advance Directives," *Annals of Internal Medicine* 147, no. 1 (2007): 51-7; A. Fagerlin and C.E. Schneider, "Enough: The Failure of the Living Will," *Hastings Center Report* 34, no. 2 (2004): 30-42.

22. P.A. Bomba, M. Kemp, and J.S. Black, "POLST: An Improvement over Traditional Advance Directives," *Cleveland Clinic Journal of Medicine* 79, no. 7 (2012): 457-464; C. Spillers and B. Lamb, "Is the POLST Model Desirable for Florida?" *Florida Public Health Review* 8 (2011): 80-90.

23. For detailed explanations of POLST (customized for clinician, lawyer, and patient audiences in multiple languages), see the extensive training resources on the California, New York, Oregon, and West Virginia program websites. Coalition for Compassionate Care of California, "POLST—Physician Orders for Life-Sustaining Treatment: For Health Care Providers," <http://www.capolst.org/?for=providers>, accessed 10 December 2012; Compassion and Support at the End of Life, "Medical Orders for Life-Sustaining Treatment—Professionals," http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center, accessed 10 December 2012; Center for Health Care Ethics, Oregon Health and Science University, "Oregon POLST Information for Health Care Professionals, POLST," <http://www.ohsu.edu/polst/programs/OregonHealthCareProfessionals.htm>, accessed 10 December 2012; West Virginia Center for End-of-Life Care, "Information about Completing Effective Advance Directives and POST Forms," <http://www.wvendoflife.org/POST>, accessed 10 December 2012.

24. P.A. Bomba, "Landmark Legislation in New York Affirms Benefits of a Two-Step Approach to Advance Care Planning Including MOLST," *Widener Law Review* 17, no. 2 (2011): 475-500.

25. B.J. Hammes et al., "The POLST Program: A Retrospective Review of the Demographics of Use and Outcomes in One Community Where Advance Directives Are Prevalent," *Journal of Palliative Medicine* 15, no. 1 (2012): 77-85; S.E. Hickman et al., "The Consistency Between Treatments Provided to Nursing Facility Residents and Orders on the Physician Orders for Life-Sustaining Treatment Form," *Journal of the American Geriatrics Society* 59, no. 11 (2011): 2091-9; S.E. Hickman et al., "A Comparison of Methods to Communicate Treatment Preferences

in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program," *Journal of the American Geriatrics Society* 58, no. 7 (2010): 1241-8; S.E. Hickman et al., "Use of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in the Hospice Setting," *Journal of Palliative Medicine* 12, no. 2 (2009): 133-41; M.A. Lee et al., "Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program," *Journal of the American Geriatrics Society* 48, no. 10 (2000): 1219-25; S.W. Tolle, V.P. Tilden, C.A. Nelson and P.M. Dunn, "A Prospective Study of the Efficacy of the Physician Order Form for Life-Sustaining Treatment," *Journal of the American Geriatrics Society* 46, no. 9 (1998): 1097-102.

26. See Center for Ethics in Health Care, Oregon Health and Science University, "POLST State Programs," <http://www.ohsu.edu/polst/programs/state+programs.htm> (September 2012). Maryland also has a legislatively established MOLST program that is not registered with the National POLST Paradigm program. Md. Code. Ann., Health-Gen. § 5-608.1 (West 2012); "Maryland MOLST," <http://marylandmolst.org/>, accessed 10 December 2012. Four other states (Alabama, Arkansas, Oklahoma, and South Dakota) also have no POLST program affiliated with NPPTF. But, like Maryland, some of these states have been developing a POLST program.

27. Center for Ethics in Health Care, Oregon Health and Science University, "History of the POLST Paradigm Initiative," <http://www.ohsu.edu/polst/developing/history.htm>, accessed 10 December 2012.

28. See Sabatino, note 3 above, p. 15.

29. "Program Description for: Wisconsin," <http://www.ohsu.edu/polst/programs/documents/WIProgramDescription.pdf> (28 July 2005).

30. "Program Description for: New York," <http://www.ohsu.edu/polst/programs/documents/NYProgramDescription082908FINAL.pdf> (29 Aug. 2008).

31. "Program Description for: Pennsylvania," http://www.ohsu.edu/polst/programs/documents/ProgramDescriptionPA_END.pdf (1 November 2010).

32. See Sabatino, note 3 above, pp. 45-6.

33. *Ibid.*, 49.

34. See note 27 above.

35. Center for Health Care Ethics, "Program Requirements," <http://www.ohsu.edu/polst/developing/core-requirements.htm> (26 April 2012).

36. See note 27 above.

37. S.E. Hickman et al., "Use of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in the Hospice Setting," *Journal of Palliative Medicine* 12, no. 2 (2009): 133-41, 135,

reporting that 100 percent of hospices in Oregon and 85 percent of hospices in West Virginia used POLST. The vast majority of these hospices (92 percent in Oregon and 73 percent in West Virginia) had POLST forms for more than half of their patients.

38. N.S. Wenger et al., "Implementation of Physician Orders for Life Sustaining Treatment in Nursing Homes in California: Evaluation of a Novel State-wide Dissemination Mechanism," *Journal of General Internal Medicine* (10 August 2012); DOI: 10.1007/s11606-012-2178-2. Only 18 months after POLST was introduced in the state, 81 percent of responding nursing homes had completed a POLST with a resident and that 54 percent of nursing home residents had a completed POLST; 69 percent of responding nursing homes also reported receiving a patient with a completed POLST from another care venue, suggesting that use of POLST in California is spreading across healthcare settings.

39. See Sabatino, note 3 above, p. 41; see note 23 above.

40. See Sabatino, note 3 above, p. 36; D.M. Zive and T.A. Schmidt, *Pathways to POLST Registry Development: Lessons Learned* (2012) (describing the efforts of California, New York, Oregon, and West Virginia to develop and fund electronic POLST registries in effort to reduce barriers to use of POLST in emergency situations and generate data for research and monitor/evaluation).

41. See Sabatino, note 3 above, pp. 47-8; "Program Description for: Tennessee," <http://www.ohsu.edu/polst/programs/documents/TNProgramDescription.pdf> (6 February 2009).

42. See Sabatino, note 3 above, p. 45; "Program Description for: Hawaii," <http://www.ohsu.edu/polst/programs/documents/HIPProgramDescription.pdf> (26 October 2009).

43. Alaska, Arizona, Connecticut, Delaware, Florida, Illinois, Iowa, Indiana, Maine, Massachusetts, Michigan, Nebraska, New Hampshire, New Jersey, New Mexico, Ohio, South Carolina, Texas, and Vermont.

44. Kansas, Minnesota, Missouri, Nevada, North Dakota, and Wyoming.

45. "Program Requirements," <http://www.ohsu.edu/polst/developing/core-requirements.htm>, accessed 10 December 2012.

46. "Program Description for: Massachusetts," <http://www.ohsu.edu/polst/programs/documents/MAPProgramDescription.pdf> (10 May 2010).

47. 2008 Mass. Acts, ch. 305, sec. 43 (directing the establishment of a POLST pilot program, which would facilitate recommendations for establishment of a statewide MOLST program). The Massachusetts MOLST website also provides links to the reports

and recommendations based on the demonstration program experience. "About MOLST in Massachusetts," <http://www.molst-ma.org/about>, accessed 10 December 2012.

48. Massachusetts Dept. of Publ. Health, Office of Emergency Medical Services, "Emergency Medical Services Pre-Hospital Treatment Protocol," <http://www.mass.gov/eohhs/provider/guidelines-resources/clinical-treatment/public-health-oems-treatment-protocols.html> (10th ed., 1 March 2012).

49. Massachusetts Dept. of Publ. Health, "Circular Letter DHCQ 12-3-560," http://www.molst-ma.org/sites/molst-ma.org/files/DHCQ_560.pdf (20 March 2012).

50. "MOLST Expansion Throughout Massachusetts Has Begun," <http://www.molst-ma.org/health-care-professionals>, accessed 10 December 2012.

51. Iowa H.F. 2165, codified as Iowa Code § 144D.1-4 (West, 2012).

52. Iowa Dept. of Publ. Health, "Iowa Physician Orders for Scope of Treatment Form," <https://idph.state.ia.us/IPOST/Form.aspx> (25 June 2012). The IPOST website also provides a links to guidelines for completion and use of IPOST. <https://idph.state.ia.us/IPOST/Form.aspx>, accessed 10 December 2012.

53. A number of states have fledgling POLST programs that still have to address legal barriers to POLST implementation. See, e.g., Program Descriptions for South Carolina, Florida, Kansas, Missouri, and North Dakota.

54. "Program Description for: New Mexico," <http://www.ohsu.edu/polst/programs/documents/NMdevelopingstateform.pdf> (23 January 2012).

55. "Program Description for: Ohio," <http://www.ohsu.edu/polst/programs/documents/OHProgramDescription.pdf> (27 October 2008); D. Cluxton and M. Sweterlisch, "Getting Acquainted with MOLST," (22 February 2011), <http://206.21.86.11/SiteObjects/B6766D956ACCF782F13938BE01AD760/MOLSTHandouts.pdf>, accessed 10 December 2012. POLST advocate, the Midwest Care Alliance, "continues to work on draft legislation to replace DNR law in Ohio with Medical Orders for Life Sustaining Treatment (MOLST). We are working with the many stakeholders involved to reach consensus on legislative language before the bill can be introduced. To that end, a stakeholder meeting has been scheduled for September 25, 2012." Midwest Care Alliance, "Pulse," http://www.ohpco.org/aws/MCA/pt/sd/news_article/62980/_PARENT/layout_details/false (4 September 2012). Bills introduced in earlier sessions had been defeated. Ohio H.B. 601 (2008); Ohio H.B. 241 (2009).

56. See Hickman et al., note 1 above, pp. 121-2

(noting that existing state laws can impose a number of barriers to implementation of POLST, including limits on the authority of surrogate decision makers, lack of default surrogate laws, medical preconditions or witnessing requirements for withholding of life-sustaining treatment, and detailed out-of-hospital DNR laws). While most of these barriers, particularly medical preconditions or lack of default surrogate provisions, are not an absolute bar, they can limit the utility of POLST or make implementation of POLST more difficult.

57. Ga. H.B. 247 (2011), enacted as 2012 Ga. Act 580, codified at Ga. Code Ann. § 29-4-18(k)(3).

58. See Hickman et al., note 1 above, p. 124 (stating that the primary advantage of ensuring that there is a statutory basis for POLST is that healthcare professionals will be “immune from prosecution, disciplinary action, and civil action for their conduct in compliance with the statute.”).

59. K.L. Cerminara and S.M. Bogin, “A Paper about a Piece of Paper: Regulatory Action as the Most Effective Way to Promote Use of Physician Orders for Life-Sustaining Treatment,” *Journal of Legal Medicine* 29, no. 4 (2008): 479-503, 500.

60. La. Atty. Gen. Op. 08-0289 (26 November 2007). Notably, due to concern over whether new MOLST regulations were consistent with governing EMS statutes, the Department of Health and Social Services instructed all healthcare providers to “refrain from further use” of MOLST. Letter from K.T. Rattay, Director, Division of Public Health, Delaware Department of Health and Social Services (14 November 2012), <http://www.medsocdel.org/Portals/1/In%20the%20News/MOLST%20Form%20Letter%20111412.pdf>, accessed 10 December 2012.

61. See Cerminara and Bogin, note 59 above, pp. 500-1 (noting both that courts respect statutes in a way they do not respect administrative regulations, due to the fact that administrative agencies derive their power from the legislature, and that statutory establishment should ensure that POLST complies with applicable state law, limiting “potential misunderstandings and ambiguities”).

62. *VHA Handbook* 1004.04 §§ 3(f) and 7(a).

63. Cal. Prob. Code §§ 4780-86 (West 2012) (adopted 2009); Colo. Rev. Stat. Ann. § 15-18.7 (West 2012) (adopted 2010); Ga. Code Ann. § 29-4-18(k)(3) (West 2012) (adopted 2012); Haw. Rev. Stat. §§ 327K-1 to K-4 (West 2012) (adopted 2009); Idaho Code Ann. §§ 39-4512 to -4514 (West 2012) (adopted 2006); 20 Ill. Comp. Stat. Ann. § 2310/2310-600(b-5) (West 2012) (adopted 2011); Iowa Code Ann. § 144D.1-4 (West 2012) (adopted 2012); La. Rev. Stat. Ann. § 1299.64.1-6 (2012) (adopted 2010); Md. Code Ann., Health-Gen. § 5-608.1 (West 2012) (adopted 2011);

N.C. Gen. Stat. Ann. § 90-21.17 (West 2012) (adopted 2007); N.J. Stat. Ann. § 26:2H-130 to -140 (West 2012) (adopted 2011); N.Y. Pub. Health Law § 2994-dd(6) (McKinney 2012) (adopted 2010, although 2008 legislation permitted statewide use of MOLST across healthcare settings); 20 Pa. Cons. Stat. Ann. § 5488 (adopted 2006); R.I. Gen. Laws Ann. § 23-4.11-3.1 (West 2012) (adopted 2012); Tenn. Code Ann. § 68-11-224 (West 2012) (adopted 2004; creates a “universal DNR” law that does not explicitly authorize POLST, but permits regulations that do); Utah Code Ann. § 75-2a-106 (West 2012) (adopted 2008); Vt. Stat. Ann. tit. 18, §§ 9701, 9707, 9709 (West 2012) (adopted 2005, amended 2011); W. Va. Code § 16-30-25 (West 2012) (adopted 2002).

64. See La. Rev. Stat. Ann. § 40:1299.64.2(8).

65. Ga. Code Ann. § 29-4-18(l); 20 Ill. Comp. Stat. Ann. § 2310/2310-600(b-5); N.Y. Pub. Health Law § 2994-dd(6); 20 Pa. Cons. Stat. Ann. § 5488; Tenn. Code Ann. § 68-11-224; Sabatino, note 3 above, p. 10.

66. N.J. S.2197, enacted as 2011 Pub. Laws Ch. 145, codified as N.J. Stat. Ann. § 26:2H-130 to -140. A Wyoming bill similarly would have delegated the details. Wyo. H.B. 75 (2012).

67. “Simplicity and economy of language are also highly recommended to retain sufficient clinical flexibility to make continuing improvements to the program.” Center for Ethics in Health Care, Oregon Health and Science University, “Considering Legislation: When Selected Regulation Change is Not Enough,” <http://www.ohsu.edu/polst/resources/legalissues.htm>, accessed 10 December 2012.

68. Cal. Prob. Code § 4780(a)(2)(B)(3).

69. Cal. Prob. Code § 4780(c) (directing that “the health care provider, during the process of completing the Physician Orders for Life-Sustaining Treatment form, should inform the patient about the difference between an advance health care directive and the Physician Orders for Life-Sustaining Treatment form”).

70. See, e.g., Cal. Prob. Code § 4780(c) (requiring that the form be completed based on patient preferences and signed both by the physician and the patient or the patient’s legally-recognized decision-maker); Cal. Prob. Code § 4783(a) (requiring the following language be included on the form: “by signing this form, the legally recognized health care decision maker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form”).

71. See, e.g., Cal. Prob. Code § 4780(b) (authorizing a legally recognized healthcare decision maker to execute a POLST on behalf of a patient if the pa-

tient lacks capacity or has authorized the decision maker to do so on his/her behalf); Cal. Prob. Code § 4781.2 (requiring a legally recognized health care decision maker to consult with the patient's physician before attempting to modify the patient's POLST).

72. Cal. Prob. Code § 4782.

73. Cal. Prob. Code § 4785.

74. W. Va. Code § 16-30-25(b)(1)-(5).

75. Ga. H.B. 247 (2011), enacted as 2012 Ga. Act 580, codified at Ga. Code Ann. § 29-4-18(k)(3); Ill. H.3134 (2011), codified at 20 Ill. Comp. Stat. Ann. § 2310/2310-600(b-5); Iowa H.F. 2165 (2012), codified at Iowa Code Ann. § 144D.1-.4; Md. H.B. 82, enacted as Md. 2011 Acts Ch. 434, codified at Md. Code Ann., Health-Gen. § 5-608.1; N.J. S.2197, enacted as 2011 Pub. Laws Ch. 145, codified at N.J. Stat. Ann. § 26:2H-130 to -140; R.I. H.B. 7735 and S.B. 2361 (2012), enacted as Pub. Laws 187 and 199, codified at R.I. Gen. Laws Ann. § 23-4.11-3.1; Vt. H. 201, enacted as 2012 Acts 60, codified at 18 Vt. Stat. Ann. § 9708.

76. In 2010, Georgia had enacted a statute instructing the "Department of Public Health [to] develop and make available a Physician Order for Life-sustaining Treatment, a specific form voluntarily executed by a patient and his or her authorized representative and a physician which provides directions regarding end of life care." 2010 Ga. Laws, Act 616, codified at Ga. Code Ann. § 29-4-18(l).

77. 20 Ill. Comp. Stat. Ann. § 2310/2310-600(b-5) (West 2012). The Illinois Department of Health is expected to approve a proposed form in early 2013.

78. Iowa Code Ann. § 144D.1-.4; Md. Code Ann., Health-Gen. § 5-608.1; N.J. Stat. Ann. § 26:2H-130 to -140; R.I. Gen. Laws Ann. § 23-4.11-3.1.

79. Vt. Stat. Ann. tit. 18, § 9708(b). Vermont healthcare facilities and residential care facilities "may document DNR/COLST orders in the patient's medical record in a facility-specific manner when the patient is in their care," but are required to use the Department of Health-issued form for patients who are not admitted to healthcare/residential care facilities or who are transferred from such facilities. Vt. Stat. Ann. tit. 18, § 9708(c).

80. Ind. H.B. 1114 (2012); Ky. S.B. 217, 2012 Leg., Reg. Sess. (2012); Wyo H.B. 75, 61st Leg., Budget Sess. (2012).

81. Wash. H.B. 2462 (2012).

82. Ohio H.B. 241, 128th Gen. Assembly (2009); Ohio H.B. 601, 127th Gen. Assembly (2008).

83. Midwest Care Alliance, "Networks and Task Forces," <http://www.ohpco.org/aws/MCA/pt/sp/networks>, accessed 10 December 2012; Midwest Care Alliance, see note 55 above.

84. See Cerminara and Bogin, note 59 above, pp. 496-97.

85. See Cerminara and Bogin, note 59 above, pp. 497-8 (noting that issuance of regulations requires some public disclosure through notice and opportunities for comment, but also recognizing that administrative actions attract less public attention, permitting POLST advocates to avoid heated political battles).

86. Tennessee authorizes the development and use of "universal do-not-resuscitate orders," which the statute defines as "a written order that applies regardless of the treatment setting and that is signed by the patient's physician that states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted." Tenn. Code Ann. § 68-11-224(e)(6). An opinion of the attorney general interpreted this statute to permit the Board for Licensing Health Facilities to promulgate a POST form, which addresses life-sustaining treatments that go beyond CPR. See Sabatino, note 3 above, pp. 47-8 (citing Atty. Gen. Op. No. 05-093, 13 June 2005).

87. Tenn. Comp. R. and Regs. 1200-08-01-.13 & -.15; 1200-08-06-.13 & -.15; 1200-08-10-.13 & -.15 (2012).

88. 16 Del. Admin. Code 4304-1.0 – 14.0 (2012) (adopted 2012).

89. Letter from K.T. Rattay, Director, Division of Public Health, Delaware Department of Health and Social Services (14 November 2012), <http://www.medsocdel.org/Portals/1/In%20the%20News/MOLST%20Form%20Letter%20111412.pdf>, accessed 10 December 2012.

90. See Cerminara and Bogin, note 59, above, p. 493.

91. Ore. Admin. R. § 847-035-0030(6) (2012).

92. See Sabatino, note 3 above, p. 10.

93. See note 63 above, for California, Iowa, Illinois, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Utah, and Vermont's POLST statutes authorizing regulatory bodies to develop and/or approve POLST forms or procedures.

94. Chicago End-of-Life Care Coalition, "IDPH Uniform DNR Advance Directive and the Evolution of POLST Illinois," <http://www.cecc.info/resource-links/physicians-order-for-life-sustaining-treatment-polst>, accessed 10 December 2012; New Jersey Hospital Association, "DHSS Selects NJHA to Lead New Jersey's POLST Initiative," <http://www.njha.com/html/DailyMessage.aspx?id=13733>, accessed 10 December 2012; "10.01.21 Medical Orders for Life-Sustaining Treatment (MOLST) Form—Procedures and Requirements," Maryland Register 39, no 16 (10 Aug.

2012); Maryland MOLST, http://marylandmolst.org/pages/molst_form.htm, accessed 10 December 2012.

95. Iowa Dept. of Pub. Health, "IPOST Form and Guidance," <http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=1EC05976-26E1-4950-B60B-02CABD2A4A66> (25 June 2012); <http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=4162F2B4-7E54-4717-B5EA-F3F60A72C6DF>, accessed 10 December 2012.

96. See Sabatino, note 3 above, p. 10.

97. These websites contain guidelines and supplemental materials to facilitate POLST implementation: <http://www.wvendoflife.org/POLST>, accessed 10 December 2012; http://www.compassionandsupport.org/index.php/for_patients_families/molst, accessed 10 December 2012; <http://www.capolst.org/>, accessed 10 December 2012; <http://www.wsma.org/POLST>, accessed 10 December 2012; <http://kokuamau.org/polst>, accessed 10 December 2012.

98. POLST is well-established in Lacrosse, Wisconsin, but not in the rest of the state. Unfortunately, the Wisconsin Medical Society decided not to include POLST in a statewide program to encourage advance care planning. In light of opposition from Roman Catholic bishops in the state, the Medical Society determined that POLST is too much of a "lightning rod." A. Johnson, "End-of-Life Medical Care Initiative Prompts Worries about Abuse," *Milwaukee Sentinel-Journal* (17 October 2012).

99. See Hickman, note 1 above (acknowledging that most day-to-day activity of health care providers does not have explicit statutory protection).

100. Hospice of the Bluegrass, "Kentuckians Deserve the MOST," <http://www.hospicebg.org/most.html>, accessed 10 December 2012; J. Ard, "Rule Making or Legislation: Test Cases from Health Care," *State Bar of Michigan Administrative Law Journal* 35 (2009): 2-7; J. Wilson, "End-of-Life Wishes," *Columbus Telegram*, 25 March 2005; Nevada Center for Ethics and Health Policy, "An Introduction to the Nevada SMOST," http://www.unr.edu/ncehp/spost_summary.html, accessed 10 December 2012.

101. See Cerminara and Bogin, note 59 above, p. 488; Center for Practical Bioethics, "Transportable Physician Orders for Patient Preferences (TPOPP)," <http://www.practicalbioethics.org/initiatives/transportable-physician-orders.html>, accessed 10 December 2012; "Program Description for: Minnesota," <http://www.ohsu.edu/polst/programs/documents/MNProgramDescription.pdf> (11 March 2010); "Program Description for: Maine," http://www.ohsu.edu/polst/programs/documents/MaineDevelopingProgramDescription_INFO-1docmmc2011.pdf (7 July 2011); Maine Hospice Council, [\[hospicecouncil.org/polst/\]\(http://hospicecouncil.org/polst/\), accessed 10 December 2012; "Program Description for: North Dakota," <http://www.ohsu.edu/polst/programs/documents/NDProgramDescription.pdf> \(30 December 2008\).](http://maine</p></div><div data-bbox=)

102. Center for Health Care Ethics, Oregon Health and Science University, "History of the POLST Paradigm Initiative," <http://www.ohsu.edu/polst/developing/history.htm>, accessed 10 December 2012.

103. Minnesota Medical Association, "POLST Communications" <http://www.mnmed.org/KeyIssues/POLSTCommunications/tabid/3291/Default.aspx>, accessed 10 December 2012; L. Vawter and E. Ratner, "The Need for POLST: Minnesota's Initiative," *Minnesota Medicine* 93, no. 1 (2010): 42-46, <http://www.minnesotamedicine.com/CurrentIssue/ClinicalRatnerJan2010/tabid/3294/Default.aspx>.

104. "Program Description for: Maine," http://www.ohsu.edu/polst/programs/documents/MaineDevelopingProgramDescription_INFO-1docmmc2011.pdf (7 July 2011).

105. The AARP report, which surveyed 12 states with POLST programs, found that the use of a "deliberately incremental strategy" was one of the three most frequently identified variables that facilitated successful implementation of POLST. See Sabatino, note 3 above, p. 13.

106. See Sabatino, note 3 above, pp. 13, 44-50. For example, the California POLST was developed and piloted in 2007-2008. It was authorized in 2008 and went in effect in 2009. Cal. A.B. 3000 (2008), enacted as Chapter 266, codified as Cal. Prob. Code § 4780. Illinois enacted a POLST statute in 2011. Ill. H.B. 3134, enacted as Ill. Pub. Acts 97-0382, codified at 20 Ill. Comp. Stat. § 2310-600(b-5). In late 2012, a task force submitted a draft form to the Illinois Department of Public Health. Once the form is approved, POLST will be piloted in two or three communities before a statewide rollout. See Chicago End-of-Life Coalition, note 94 above.

107. See Sabatino, note 3 above, pp. 14, 38-31; "Program Description for: New York," <http://www.ohsu.edu/polst/programs/documents/NYProgramDescription082908FINAL.pdf> (29 Aug. 2008).

108. See Sabatino, note 3 above, pp. 45-6. P.A. Bomba and C.P. Sabatino, "POLST: An Emerging Model for End-of-Life Planning," *ElderLaw Report* 50, no. 7 (2009): 1-5; D. Meier and L. Beresford, "POLST Offers Next Stage in Honoring Patient Preferences," *Journal of Palliative Medicine* 12, no. 4 (2009): 291-295.

109. Iowa H.F. 2165, codified at Iowa Code Ann. § 144D.1-.4.

110. "IPOST: The Report of the Patient Au-

tonomy in Health Care Decisions Pilot Project,” (2010), <https://idph.state.ia.us/IPOST/Resources.aspx>, accessed 10 December 2012.

111. See Sabatino, note 3 above.

112. Other legal issues about which there is more uniformity include: (1) whether copies are as valid as originals, (2) whether out-of-state POLST forms will be given reciprocity, and (3) whether providers have legal immunity for adhering to POLST orders in good faith.

113. See Center for Health Care Ethics, Oregon Health and Science University, “Program Requirements,” <http://www.ohsu.edu/polst/developing/core-requirements.htm> (26 April 2012) (specifying that the treatment preferences communicated by a POLST form “require[] a medical order that needs signature by a health care professional”).

114. Cal. Prob. Code § 4780(c); “Georgia POLST Form,” <http://www.dph.ga.gov/POLST/>, accessed 10 December 2012; Haw. Rev. Stat. Ann. § 327K-1, K-2; Illinois Department of Public Health (IDPH), “Uniform Do-Not-Resuscitate (DNR) Advance Directive: Guidance for Health-Care Providers and Professionals,” www.idph.state.il.us/public/books/guide_hcpp.htm, accessed 10 December 2012; “Transportable Physician Orders for Patient Preferences (TPOPP),” <http://www.practicalbioethics.org/initiatives/transportable-physician-orders.html>, accessed 10 December 2012 (Kansas and Missouri); Nevada Center for Ethics and Health Policy, “An Introduction to the Nevada SMOST,” http://www.unr.edu/ncehp/spost_summary.html, accessed 10 December 2012; N.Y. Pub. Health Code § 2994dd; Tenn. Code Ann. § 68-11-224; Tenn. Comp. R. and Regs. 1200-08-01-.13 and -.15; 1200-08-06-.13 and -.15; 1200-08-10-.13 and -.15 (2012); W.Va. Code Ann. § 16-30-25; West Virginia Center for End-of-Life Care, “Using the POST Form: Guidance for Healthcare Professionals” (2012). Proposed legislation in Indiana would also have limited signing authority to physicians. Ind. H.B. 1114 (2012).

115. Colo. Rev. Stat. Ann. § 15-18.7-104; Idaho Code Ann. § 39-4512A(1); Iowa Code Ann. § 144D.2(c); Massachusetts Dept. of Publ. Health, “Circular Letter DHCQ 12-3-560,” http://www.molst-ma.org/sites/molst-ma.org/files/DHCQ_560.pdf (20 March 2012); Md. Code Ann., Health-Gen. § 5-608.1; Minn. Med. Assn., “FAQ: The POLST Form,” <http://www.mnmed.org/LinkClick.aspx?fileticket=FGvy4%2f9Ibco%3dandtabid=3291> (January 2010); Montana Board of Medical Examiners, “POLST,” http://bsd.dli.mt.gov/license/bsd_boards/med_board/polst.asp, accessed 10 December 2012; N.C. Gen. Stat. Ann. § 90-21.17(c); N.J. Stat. Ann. § 26:2H-134; Ore. Admin. R. § 333-270-0030; Ore. Rev. Stat.

§ 127.663(6); R.I. Gen. Laws §§ 23-4.11-2(12), 23-4.11-3.1(d)(1); Utah Code Ann. § 75-2a-106(2); Vt. Stat. Ann., tit. 18 §§ 9701(5) and 9708(d); Washington State Medical Association, “POLST,” <http://www.wsma.org/POLST>, accessed 10 December 2012.

116. “Program Description for: Alaska,” <http://www.ohsu.edu/polst/programs/documents/AKProgramDescription.pdf>, accessed 5 December 2012.

117. See Zive and Schmidt, note 40 above, p. 18. Idaho S.B. 1294, enacted as 2012 Idaho Laws Ch. 302, codified at Idaho Code Ann. § 39-4512A(1).

118. S.C. Zweig, L.L. Popejoy, D. Parker-Oliver and S.E. Meadows, “The Physician’s Role in Patients’ Nursing Home Care,” *Journal of the American Medical Association* 306, no. 13 (2011): 1468-1478; J.L. Meyers et al., “Physician Orders for Life-Sustaining Treatment Form: Honoring End-of-Life Directives for Nursing Home Residents,” *Journal of Gerontological Nursing* 30, no. 9 (2004): 37-46.

119. See Wenger et al., note 38 above.

120. California Advocates for Nursing Home Reform, “Physician Orders for Life Sustaining Treatment: Problems and Recommendations” (2010), 3, 6.

121. Coalition for Compassionate Care of California, “California POLST Form,” <http://www.capolst.org/>, accessed 10 December 2012; Kokua Mau, “Hawaii POLST Form,” <http://www.kokuamau.org/professionals/polst>, accessed 10 December 2012; Iowa Dept. of Pub. Health, “IPOST Form,” <http://www.idph.state.ia.us/IPOST/Form.aspx>, accessed 10 December 2012; Minn. Med. Ass’n, “FAQ: The POLST Form,” <http://www.mnmed.org/LinkClick.aspx?fileticket=FGvy4%2f9Ibco%3dandtabid=3291>, accessed 10 December 2012; North Carolina Medical Society, “Using the MOST Form—Guidance for Healthcare Professionals,” http://www.ncmedsoc.org/pages/public_health_info/end_of_life.html, accessed 10 December 2012; Utah Commission on Aging, “POLST: Utah Physician Order for Life-Sustaining Treatment: A Life With Dignity Order,” <http://health.utah.gov/hflcra/forms/POLST/AdvanceDirectiveProviderGuide2011.pdf>, accessed 10 December 2012. While facilitators arguably do an even better job than physicians, their role remains controversial.

122. Center for Health Care Ethics, Oregon Health and Science University, “Program Requirements,” <http://www.ohsu.edu/polst/developing/core-requirements.htm> (26 April 2012).

123. “Upholding the Dignity of Human Life: A Pastoral Statement on POLST from the Catholic Bishops of Wisconsin,” (July 2012), <http://WisconsinCatholic.org>, accessed 15 December 2012; E.C.

Brugger, "A Critique of Colorado's New MOST Legislation," *Linacre Quarterly* 78, no. 2 (2011): 58-61. But other Roman Catholic thought leaders more strongly support POLST. R. Hamel, "POLST under Fire," *Healthcare Ethics USA* 20, no. 1 (2012): 30-5; G.D. Coleman and M.R. McLean, "POLST Supports Care in Context of ERDs," *Health Progress* 93, no. 6 (2012): 58-65.

124. Montana Board of Medical Examiners, "Using the Montana POLST Form: Guidance for Healthcare Professionals," http://bsd.dli.mt.gov/license/bsd_boards/med_board/polst.asp (30 June 2011).

125. See Sabatino, note 3 above, pp. 29, 33.

126. 18 Vt. Stat. Ann. § 9708(d)(3)(A)-(B).

127. Cal. Prob. Code § 4675.

128. B.J. Hammes et al., "The POLST Program: A Retrospective Review of the Demographics of Use and Outcomes in One Community Where Advance Directives Are Prevalent," *Journal of Palliative Medicine* 15, no. 1 (2012): 1-9.

129. See Center for Health Care Ethics, note 26 above.

130. T.M. Pope, "Legal Fundamentals of Surrogate Decision Making," *Chest* 141, no. 4 (2012): 1074-81; T.M. Pope, "Comparing the FHCDA to Surrogate Decision Making Laws in Other States," *NYSBA Health Law Journal* 16, no. 1 (2011): 107-11.

131. See Hickman, note 1 above, p. 121.

132. See California Advocates for Nursing Home Reform, note 120 above, p. 4; see Hickman, note 1 above, p. 122 (noting that 14 states, as of 2008, did not have default surrogate laws, which identify decision makers for patients who are incapacitated and have not previously authorized a legal healthcare decision maker).

133. See Sabatino, note 3 above, p. 35.

134. Vermont is seeking to resolve uncertainty by directing the Department of Health to promulgate rules on the authority of non-agent, non-guardian decision makers. Vt. H.201 (2011), enacted as 2011 Vt. Act 60, codified at Vt. Stat. Ann. § 9708.

135. S.E. Hickman et al., "The Consistency Between Treatments Provided to Nursing Facility Residents and Orders on the POLST Form," *Journal of the American Geriatrics Society* 59, no. 11 (2011): 2091-9.

136. Tennessee End-of-Life Partnership, "POLST and Surrogate Information," <http://endoflifecaretn.org/information-about-post-and-appointment-of-a-surrogate/>, accessed 10 December 2012.

137. N.J. Stat. Ann. § 26:2H-135.

138. R.I. Gen. Laws §§ 23-4.11-2(12) and 23-4.11-3.1(d)(1).

139. 16 Del. Admin. Code § 4304-7.2.

140. N.Y. Pub. Health L. § 2994-b; Utah Code

Ann. § 75-2a-106(4).

141. See Sabatino, note 3 above, pp. 29, 34 (finding that all twelve states surveyed permitted surrogates to consent to POLST on behalf of an incapacitated patient).

142. See, e.g., Idaho Code Ann. § 39-4512A(2); N.C. Gen. Stat. Ann. § 90-21.17; Utah Code Ann. § 75-2a-106(7).

143. See, e.g., Iowa Code Ann. § 144D.4(1)-(3) (a POST form shall not supersede a Declaration Relating to Use of Life-Sustaining Procedures, durable power of attorney for healthcare, or an out-of-hospital DNR order); Md. Code Ann., Health-Gen. § 5-608.1(c)(3)(ii) ("the 'Medical Orders for Life-Sustaining Treatment' form shall be consistent with [. . .] any known advance directive of the patient if the patient is incapable of making an informed decision."); W. Va. Code § 16-20-5(b).

144. See, e.g., Cal. Prob. Code § 4781.4; Colo. Rev. Stat. Ann. § 15-18.7-110; Ind. H.B. 1114 (2012); N.J. Stat. Ann. § 26:2H-135.

145. See, e.g., N.Y. Pub. Health Code § 2994-d(4)-(5) (the conflict issue is not expressly addressed, but surrogates are obligated to follow patient's known wishes, followed by patient's best interests, with additional preconditions for decision making related to end-of-life care listed in subsection 5—thus, a surrogate-completed POLST may not trump a patient-completed advance directive except under certain conditions). Minnesota, Hawaii, Oregon, Vermont have not expressly addressed the issue. See Sabatino, note 3 above, pp. 30, 35.

146. California Advocates for Nursing Home Reform, note 120 above, p. 4; Cal. Prob. Code §§ 4780(c) and 4781.4 (West 2012). The danger is substantially mitigated by two features of healthcare decisions laws. First, surrogates must make treatment decisions consistent with the patient's preferences and best interests. Second, healthcare providers face liability for complying with surrogate decisions that they know deviate from this standard. See Pope, note 130 above.

147. Colo. Rev. Stat. Ann. § 15-18.7-110 (specifying that the most recent document controls in the event of a conflict between POLST and a prior health care directive, but with the qualification that a surrogate, advanced practice nurse, or physician assistant may not revoke prior healthcare/CPR directive that was completed by the patient).

148. N.J. Stat. Ann. § 26:2H-135 (specifying that the "more recent directive from the patient" will be honored in the event of conflicting healthcare instructions).

149. Of course, foreseeing the need to update the POLST to be consistent with current health sta-

tus, the patient could, in his or her advance directive, specifically grant the surrogate permission to revoke or modify a POLST.

150. *VHA Handbook* 1004.04 § (5)(b)(2)(a).

151. 42 U.S.C. § 1395CC(f)(1); 42 C.F.R. §§ 482.13(a) and 489.102(a).

152. Md. Code Ann., Health-Gen. § 5-608.1(c)(1)(ii)(1)-(2).

153. Utah Admin. Code § 432-31-4(2)(b)-(c).

154. See Sabatino, note 3 above, p. 18; see California Advocates for Nursing Home Reform, note 120 above, p. 6 (analyzing California's POLST laws, and reporting the results of a survey of long-term care Ombudsman regarding POLST: "While the POLST form is voluntary, health care facility staff members often tell patients that their services are contingent on POLST completion. As stated before, 73% of Ombudsman reported that POLST is 'always' or 'often' presented to long-term care residents as mandatory").

155. E.K. Fromme et al., "POLST Registry Do-Not-Resuscitate Orders and Other Treatment Preferences," *Journal of the American Medical Association* 307, no. 1 (2012): 34-5; S.E. Hickman et al., "A Comparison of Methods of Communicating Treatment Preferences in Nursing Facilities: Traditional Practices versus the POLST," *Journal of the American Geriatrics Society* 58, no. 7 (2010): 1241-8; S.E. Hickman, S.W. Tolle, K. Brunnelswitch, and M.M. Carley, "Use of a POLST Program in Oregon Nursing Facilities," *Journal of the American Geriatrics Society* 52, no. 9 (2004): 1424-9.

156. See Center for Health Care Ethics, Oregon Health and Science University, "Program Requirements," <http://www.ohsu.edu/polst/developing/core-requirements.htm> (26 April 2012) (requirement number 7 for endorsed programs specifies that "Completion of the form and the decisions recorded on it should be voluntary and based on shared medical decision making").

157. See Sabatino, note 3 above, p. 18.

158. Iowa Code Ann. § 144D.4(6); Colo. Rev. Stat. Ann. § 15-18.7-108.

159. Idaho Code Ann. § 39-4514(8)(a)-(b); La. Rev. Stat. Ann. § 1299.64.1(B)(2); Ore. Rev. Stat. § 127.672; Vt. Stat. Ann. tit. 18 § 9709(e).

160. N.C. Gen. Stat. Ann. § 90-21.17(c).

161. R.I. Gen. Laws § 23-4.11-3.1(h).

162. 42 C.F.R. § 489.102(a)(3) ("Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.").

163. Cal. Prob. Code § 4677 ("A health care provider, health care service plan, health care institution, disability insurer, self-insured employee wel-

fare plan, or nonprofit hospital plan or a similar insurance plan may not require or prohibit the execution or revocation of an advance health care directive as a condition for providing health care, admission to a facility, or furnishing insurance.").

164. See, e.g., Cal. Prob. Code § 4781.2; Colo. Rev. Stat. Ann. §15-18.7-104(1)(a); Haw. Rev. Stat. Ann. § 327K-2; Idaho Code Ann. §§ 39-4512B and 39-4513(5); Iowa Code Ann. § 144D.3(5) (specifies that health care providers unwilling to comply with POLST orders on policy/religious beliefs/moral convictions shall take all reasonable steps to transfer patient); Md. Code Ann., Health-Gen § 5-608.1(f); N.J. Stat. Ann. §§ 26:2H-134(a) and 139; Ore. Admin. R. 847-010-0110; R.I. Gen. Laws § 23-4.11-3.1(c)(1); W. Va. Code Ann. §§ 16-30-12, 16-30-10, 16-30C-7.165; T.M. Pope, "Legal Briefing: Conscience Clauses and Conscientious Refusal," *The Journal of Clinical Ethics* 21, no. 2 (2010): 163-80.

166. E.g., Colo. Rev. Stat. Ann. § 15-18.7-104(1)(b); Iowa Code Ann. § 144D.3(2); Md. Code Ann., Health-Gen § 5-608.1(f).

167. Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH) §§ MS.03.01.03 (formerly MS.2.20) ("The management and coordination of each [patient]'s care, treatment, and services is the responsibility of a practitioner with appropriate privileges."), MS.05.01.03 (formerly MS.3.20).

168. E.g., Colo. Rev. Stat. Ann. § 15-18.7-104; N.J. Stat. Ann. § 26:2H-134(c).

169. N.C. Gen. Stat. § 90-21.17(d); see Sabatino, note 3 above, p. 30.

170. A 2004 Oregon study found that 25 percent of surveyed EMTs reported difficulty locating a POLST form the last time they treated a patient with a POLST. T.A. Schmidt, S.E. Hickman, S.W. Tolle, and H.S. Brooks, "The Physicians Orders for Life-Sustaining Treatment Program: Oregon Emergency Medical Technicians' Practical Experiences," *Journal of the American Geriatrics Society* 52, no. 9 (2004): 1430-4, 1432.

171. See Schmidt et al., note 170 above.

172. See Zive and Schmidt, note 40 above, p. 24.

173. Ore. Rev. Stat. Ann. § 127.663-.681.

174. See Zive and Schmidt, note 40 above, p. 26; Oregon POLST Registry, "Nov. 2012 Monthly Update," <http://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/PhysicianOrdersforLifeSustainingTreatment/Pages/index.aspx>, accessed 15 December 2012.

175. *Ibid.*, pp. 16-32.

176. *Ibid.*, pp. 11, 17-32, 39.

177. Or. Rev. Stat. Ann. § 127.663-.681; see Zive

and Schmidt, note 40 above, p. 23.

178. See Zive and Schmidt, note 40 above, pp. 22-23, 26.

179. *Ibid.*, p. 16.

180. Mont. Code Ann. § 50-9-501; Montana DOJ, "End of Life Registry and Advance Health Care Directives," <https://doj.mt.gov/consumer/end-of-life-registry/>, accessed 10 December 2012; Vermont Dept. of Health, "Vermont Advance Directive Registry," <http://healthvermont.gov/vadr>, accessed 10 December 2012.

181. Mich. S.B. 723 (2012), enacted as 2012 Mich. Pub. L. No. 179.

182. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, tit. XIII (2009); DHHS, Office of the National Coordinator for Health Information Technology, "HealthIT.hhs.gov Information Related to the American Recovery and Reinvestment Act of 2009," http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_learn_about_hitech/1233 (21 June 2012).

183. See Sabatino, note 3 above, p. 25.

184. See Sabatino, note 6 above, p. 25 (acknowledging that the utility of EHR for facilitating evaluation, monitoring, or research of the POLST process will depend on the ability to enter POLST data into an electronic form, rather than simply scanning the form into a repository).

185. H.R. 3590, § 1233, 111th Cong. (2009).

186. See Sabatino, note 21 above, pp. 211, 232.

187. Pub. L. No. 111-148, § 4103.

188. DHHS, "Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011," 75 *Fed. Reg.* 73,170 (29 November 2010).

189. R. Pear, "U.S. Alters Rule on Paying for End-of-Life Planning," *New York Times*, 4 January 2011; Letter from Rep. Fred Upton to Sec. Kathleen Sebelius (14 March 2011).

190. DHHS, "Medicare Program: Amendment to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011," 76 *Fed. Reg.* 1366 (10 January 2011).

191. H.R. 1589, 112th Cong., 1st Sess. (2011).

192. 38 *C.F.R.* § 17.32.

193. *VHA Handbook* § 1004.04 (25 October 2012).

194. Email from Bill Pfunder to Thaddeus Pope (26 November 2012); R.K.P. Chang et al., "Sowing Seeds and Building Collaborations: Challenges Faced and Learning Points on Starting Systemic Advance Care Planning in a Hospital in Singapore," *BMJ Supportive and Palliative Tertiary Care* 2, no. 2 (2012): 201-2.

195. J. In der Schmitten et al., "A Complex Regional Intervention to Implement Advance Care Planning in One Town's Nursing Homes: Protocol of a Controlled Inter-Regional Study," *BMC Health Services Research* 11, no. 14 (2011): 1-9; C.H. Wiese et al., "[The Göttingen Palliative Emergency Card: Improvement of Emergency Medical Care for Ambulatory Palliative Care Patients: The "Yellow Card for Rescue Services]," *Deutsche Medizinische Wochenschrift* [German Medical Weekly] 133, no. 18 (2008): 972-6.

196. Health Canada, "Implementation Guide to Advance Care Planning in Canada: A Case Study of Two Health Authorities" (2008), hc.sc.gc.ca/hcc.sss/pubs/palliat/2008_ace_guide_eesl/index_eng.php, accessed 15 December 2012.

197. Fraser Health, "Policy: Medical Orders for Scope of Treatment (MOST) and Advance Care Planning (ACP)" (13 June 2012); email from Doris Barwich to Thaddeus Pope, 4 December 2012.

198. Email from Professor John You to Thaddeus Pope, 5 December 2012.

199. Alberta Health Services, "Advance Care Planning and Goals of Care Resources," <http://www.albertahealthservices.ca/3917.asp>, accessed 10 December 2012.

200. Regina Qu'Appelle Health Region, "About Advance Care Planning," http://www.rqhealth.ca/programs/advanced_care_planning/index.shtml, accessed 10 December 2012.

201. Queensland Health, "Resuscitation Planning," http://apps.health.qld.gov.au/acp/Public_Section/Resuscitation_Planning/resuscitation_planning3.aspx, accessed 10 December 2012.

202. No. 30-2011-00520263-CV-PO-CJC (Orange County Sup. Ct., Cal., filed 3 November 2011).

203. No. 1017263, 2010 WL 6860446 (Monroe County, N.Y., 23 December 2010).

204. *In re Barnes*, No. 27-GC-PR-111-16 (Hennepin County Probate Ct., Minn., 4 February 2011).

205. *Krela v. Kryla*, No. 6:12-CV-01089-TC (D. Ore., filed 18 January 2012).

206. *Scottrade v. Davenport*, No. 90-CV-11-3-BLG-RFC, 2012 WL 2019679 (D. Mont., 5 June 2012).

207. *Costello v. University of Washington Medical Center*, No. 11-2-15367-3 SEA (King County Sup. Ct., Wash. 2011) (Order granting defendant's motion to dismiss), affirmed, No. 67840 (Wash. App., 24 September 2012).

208. CDPH, Licensing and Certification Division, "Statement of Deficiencies and Plan of Correction, Survey of Cresthaven Nursing Home, No. CA-070000038" (22 December 2009).