The POLST Paradox: Opportunities and Challenges in Honoring Patient End-of-Life Wishes in the Emergency Department

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Physician Orders for Life-Sustaining Treatment forms convert patient wishes into physician orders to direct care patients receive near the end of life. Recent evidence of the challenges and opportunities for honoring patient end-of-life wishes in the emergency department (ED) is presented. The forms can be very helpful in directing whether cardiopulmonary resuscitation and intubation are desired in the first few minutes of a patient's presentation. After initial stabilization, understanding the intent of end-of-life orders and the scope of further interventions requires discussion with the patient or a surrogate. The emergency medicine provider must be committed both to honoring initial resuscitation orders and to the conversations required to narrow the gap between ED care and patient wishes so that people receive care best aligned with their wishes. [Ann Emerg Med. 2019;73:294-301.]

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INTRODUCTION

Physician Orders for Life-Sustaining Treatment (POLST) Paradigm documents (hereafter referred to as POLST forms) are a portable order set created and signed by the provider and patient or surrogate to direct current care across settings in the last stages of life. Some version of POLST forms is currently available in all 50 states.[1] This is in contrast to standard written advance directive documents, such as a Living Will or a Medical Durable Power of Attorney, in which patients express wishes for future situations. Cardiopulmonary resuscitation (CPR) directives, when signed by a physician, address only an actual cardiopulmonary arrest. The Medical Durable Power of Attorney is extremely useful but does not convey values and wishes, and the Living Will is applicable only under the narrow circumstances of a terminal or persistent vegetative state. Although the rate of advance directive completion (Living Will, Medical Durable Power of Attorney, or both) has increased to approximately 70% among older adults, there is little evidence that advance directive completion has influenced hospitalization or inhospital death rates.[2] On the other hand, POLST forms do influence care. For instance, POLST orders are associated with significantly decreased odds of attempted resuscitation in the field and increased odds of out-of-hospital death for patients who request "comfort measures only."[3,4]

Half of older adults visit the ED in the last month of their lives.[5] And more than half of people are not able to participate in decisionmaking near the end of their lives, according to a 2015 Institutes of Medicine report.[6] POLST documents are meant to give guidance and protection to emergency medical services (EMS), residential retirement facilities, nursing homes, the ED and inpatient settings so that health care providers can most closely respect people's diverse end-of-life wishes. The promises and challenges in honoring POLST documents in the ED setting have become clearer since the last *Annals* review of this topic in 2014.[7]

Background

In 1995, Oregon became the first state to use a form that would translate patient wishes into actionable orders to be honored across health care settings. POLST forms serve to supplement written advance directives by expressing directions for current care. The form is designed for several specific groups of people: those who are near enough to the end of their lives that the likely trajectory for their death is known (usually in the last 6 to 12 months of a severe chronic disease that will be life ending), those who are very elderly and frail, and those who have already or are likely to lose decisional capacity as their condition worsens.[8,9] POLST forms are more useful than CPR directives in that they describe important broader end-of-life treatment choices than just whether to receive CPR attempts. For example, some patients may not want to go to the ICU; they may not want intubation. Or it may be very important to them that those and other aggressive measures be attempted to

give them more time before they die. These can all be described within the POLST document.

POLST forms are state based, but most are authorized through the national POLST Paradigm Task Force, established in 2004.[1] Currently, some version of the POLST form has been endorsed or is "in development" in 46 states (plus the District of Columbia); 5 states have nonconforming alternatives. Each state has its own slight variations in format and content, as well as different acronyms: POLST, Physician Orders for Scope of Treatment, Medical Orders for Scope of Treatment, Medical Orders for Life-Sustaining Treatment, and Clinician Orders for Life Sustaining Treatment.[10] The form is signed by the patient or surrogate and provider, and copies are kept by the patient and in the medical chart. In some states, a central electronic registry allows emergency access to the patient's POLST orders.[11] The form is typically on bright-colored cardboard paper to make it easier to locate both by EMS and in the printed medical chart. In many electronic health records, a scanned version is present, although ease of access is variable.[12] Facsimiles or copies are honored. As of April 2018, the 5 states with nonconforming programs were Maryland, Nebraska, Vermont, Massachusetts, and Connecticut. Oregon, the original developer of POLST forms, withdrew from the National POLST Paradigm organization in 2017 over conflict-of-interest policy differences. The latest status of POLST form endorsement in each state, and reasons why a few programs are judged "nonconforming" to the national organization, are available through the national Web site: http://www.polst.org.

POLST forms are meant to document a robust "informed consent" discussion between a provider and patient or surrogate and are signed by both the provider and the patient or representative. Patients with decisional capacity can overrule previous POLST expressions. But if the patient lacks decisional capacity, providers are protected when they honor POLST orders, either by a state's specific statutes or because POLST forms have become the standard of medical care in that state or community, as affirmed by a recent American College of Emergency Physicians (ACEP) policy statement.[13] Forms can (and should) be periodically renewed, updated, or changed, and the most recent form is the one that should be honored. Most state statutes require providers to respect POLST forms unless they have a "good faith" belief that the POLST is invalid.[13,14]

Despite state-based idiosyncrasies, several components of state POLST forms are common to all nationally "certified" or endorsed programs. The following sections are depicted in Figure 1 and are present in all conforming states[1]:

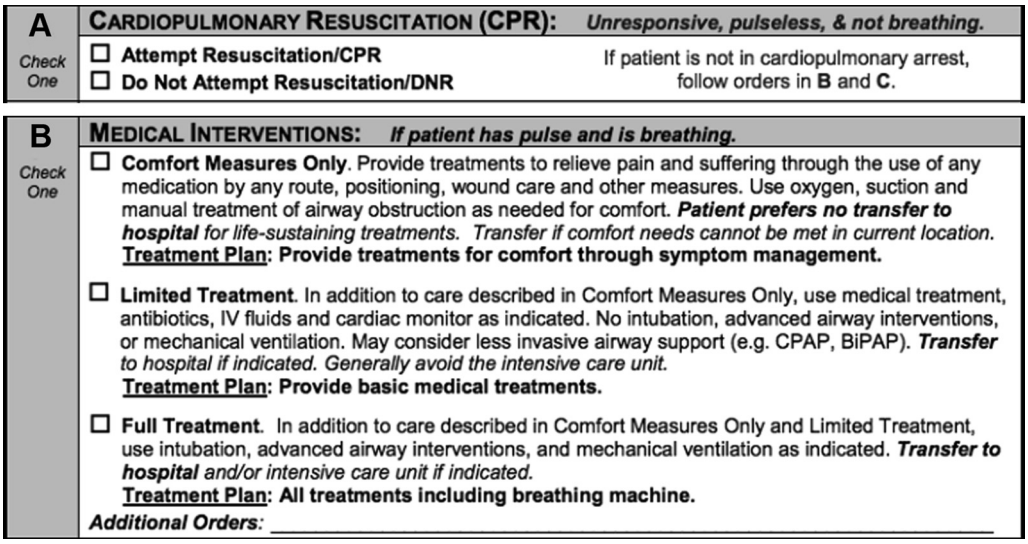
- CPR attempts (section A): yes or no.
- Level of care desired (section B): Most states include 3 basic categories:
  - Full treatment: no limitations on medical interventions, including intensive care, intubation, and other invasive tests and treatments
  - Limited (or selective) interventions: consideration of simple treatments and admission, but avoidance of ICU transfer, heroic procedures, surgery, and intubation
  - Comfort-focused care, defined as addressing pain and suffering, managing other symptoms, and transferring or admitting to the hospital only if unable to manage symptoms at residence

In some state POLST forms, the documentation of intubation and respiratory support wishes may be separated from section B and include some combination of no intubation, noninvasive respiratory support only, or intubation, either short or long term.[14]

The following additional elements of the POLST form are sometimes specified in state-based forms. Because many states continue to revise and clarify ambiguous wording, emergency physicians must be aware of the particulars of the current form for the state in which they work.

- Hydration, nutrition: some states include a section with options related to artificial hydration or nutrition (long-term feeding tubes, short-term trial only, or no feeding tube). Some states also specify whether intravenous fluids should be used for rehydration.
- Antibiotics: options may include no antibiotics, use for symptom control only, trial of use, or use for full spectrum of situations.

The advantages of POLST forms are that they clarify a range of treatment decisions near the end of life and relieve some of the stress of surrogate decisionmaking.[7,14] They can also better ensure that medical care occurs according to patient wishes over potential family objections. POLST orders are currently the best way for people approaching death to limit interventions such as transport to the hospital, admission, or unwanted aggressive treatments designed to extend life that may not be aligned with their wishes. They can also be used to affirm desire for continued aggressive medical care. Provisions should be shared with family or friends who may be involved in end-of-life care. These orders may also protect providers from liability for doing less than "everything" at a time when providers may feel compelled to initiate all interventions to extend life.[13] This "do everything" approach can be a particular risk in the ED, where providers often have little information about patient wishes or underlying medical prognosis and no previous relationship with their patients.



A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *Unresponsive, pulseless, & not breathing.*

☐ **Attempt Resuscitation/CPR**
☐ **Do Not Attempt Resuscitation/DNR**

If patient is not in cardiopulmonary arrest, follow orders in **B** and **C**.

B Check One — **MEDICAL INTERVENTIONS:** *If patient has pulse and is breathing.*

☐ **Comfort Measures Only**. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Provide treatments for comfort through symptom management.

☐ **Limited Treatment**. In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment**. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

Figure 1. POLST form elements, sections A and B.[1]

EVIDENCE FROM THE RECENT LITERATURE

Several years of experience have now been reported from such states as Oregon and West Virginia, where tracking and accountability have been robust. For this article, a review was performed of the resources compiled by the National POLST Paradigm Task Force and PubMed references to POLST for the past 5 years, with emphasis on recent data reports and lessons important to emergency medicine providers.

Demographics

The first large published experience came from Oregon's 2012 30,000-registrant database.[15] Their experience, as well as experiences reported from other more recent reports, highlights several lessons important to emergency physicians:

- A significant number of patients filling out POLST documents do want CPR attempts, although the incidence varies significantly according to different studies. Although many people use the POLST form to express their wish to avoid the default of attempted resuscitation, approximately one third of people filing POLST forms in the 2012 Oregon database expressed a wish for resuscitation attempts. In Maryland, 32% of white patients and 62% of nonwhite patients wanted CPR attempts.[16] A recent California nursing home study showed that 53.2% of residents wanted resuscitation attempts,[17] although only 20% wanted CPR attempts according to a recent West Virginia report.[18]
- Half or more of "no CPR" patients still want some level of medical intervention beyond comfort care. Both Oregon and West Virginia databases emphasize this point: providers cannot predict a patient's nonarrest wishes by knowing their CPR status, something that is often misunderstood.[13,15,18]
- Greater than 40% of all patients with POLST forms, according to several reports, convey a wish for some kind of "middle ground" choice in their care near the end of life: neither "no CPR/comfort care only" nor "CPR and full treatment."[15,18]

POLST Completion and Consistency

Experience with POLST completion has led to some changes in what options patients can choose. In Oregon, entries into the state database that indicate "yes, CPR/comfort care" are no longer accepted in their registry because they are considered incompatible.[15] In West Virginia, "yes, CPR/limited care" is also not accepted, although it is possible to imagine limited scenarios in which patients might want an attempted quick reversal of a cardiac arrest but not an extended resuscitation that involves intubation and ICU care.[11]

Recent reports also indicate that the trends for POLST preferences may be changing because both patients and physicians have more experience with the form and the conversations that must accompany it. In a West Virginia study of registrants from 2016 to 2017, 79% of patients completing a POLST form with their providers requested no CPR attempts.[18] In other reports from West Virginia and Oregon registry data (2012 to 2013), the percentage of the total people requesting "full interventions" decreased to less than 10%, whereas the percentage of POLST participants requesting "comfort measures only" increased

to greater than 50%.[19] However, even among patients with advanced cancer in a recent West Virginia study, 6% have POLST forms requesting full interventions.[20]

A persistent concern of providers is the quality of POLST completion. In some reports, a majority of forms are filled out by a social worker or nurse and cosigned by a physician.[21] This could be helpful because the quality of POLST documentation is only as good as the conversations that precede it. Nursing and social work team members may be able to take more time and have more skills at discussing options with patients, particularly if they are palliative care specialists. However, if physicians are just signing the documents pro forma, provider and patient understanding may be less than ideal. It is the physician's responsibility, even if just signing off on the document, to have a conversation and assure everyone that this truly represents the patient's wishes. A pilot study of nursing home residents and representatives indicated that preferences expressed in interviews did not necessarily reflect previous POLST orders, although directed discussions resolved these fairly easily.[22] In addition, one nursing home study in Los Angeles found that almost one third of POLST forms lack at least one signature (provider or patient/representative) or had what was considered inconsistent requests (eg, CPR but comfort or limited interventions).[23] A recent ED study by Clemency et al[24] documented similar problems involving incomplete forms. Of 100 forms that they reviewed, two thirds had at least one blank section and almost half had no treatment guidelines (section B), although all had the CPR option completed, and 82% had intubation instructions. On the other hand, a recent much larger study of "inconsistencies" in Oregon and West Virginia pushed back at the claims of Clemency et al,[24] finding a less than 10% incidence of discrepancies.[11] Oregon has mandated entry of POLST forms into the statewide registry, virtually eliminating inconsistent care pathways and ensuring that all aspects of the form are completed.[11]

POLST Order Adherence and Barriers

Only 6.4% of patients with POLST "comfort measures only" orders died in the hospital according to an Oregon report versus 44.2% of those wanting full treatment and 34.2% of patients not having POLST forms.[25] In Oregon's EMS experience, 94% of patients with POLST documents indicating "no CPR" had resuscitation stopped or withheld before hospital admission, according to a 2014 review.[3] Mirarchi et al,[26,27] in The Realistic Interpretation of Advance Directives (TRIAD) VI and VII studies, demonstrated that out-of-hospital providers and emergency physicians are often confused, particularly with POLST forms that are in these middle ranges of choices. Clemency et al[24] echoed this frustration in their series of 100 POLST documents for patients presenting to an ED in New York State, arguing that many POLST forms did not describe clear aggressive or clear comfort-based choices and decried the fact that that confusion leads to default resuscitation. Supporting a discussion-based approach to clarifying POLST wishes, one recent report noted that 20% of patients revised even their POLST preferences over time, often in verbal discussions in the final setting of their care, which can be in the ED.[28]

Another significant barrier to the ED's honoring of patient wishes is access to the POLST form. A California survey of 70 emergency physicians indicated that only 31% were confident that they could locate advance care planning information in the electronic health record. This was despite the fact that they believed that code status orders, Medical Durable Power of Attorney information, and POLST forms were frequently very useful.[12] In a small study from a Level 1 Iowa ED, only half of the 18 patients having a POLST form arrived in the ED with it. Of those 9, EMS personnel were aware of only 3 of the forms during transport.[29] On the other hand, electronic state-based POLST registries, such as those in Oregon (mandated) and West Virginia (voluntary), have markedly improved the ability of EMS and EDs to rapidly know the substance of POLST orders and have also improved the completeness and clarity of POLST forms in their states.[11]

POLICY AND LEGAL CONSIDERATIONS

Emergency medicine leadership is committed to improving end-of-life care and recognizes the need to align the ED response to an urgent downturn near the end of life with patients' wishes when possible. ACEP has articulated the emergency medicine commitment to POLST forms and provided guidance for interpretation in a recent policy statement.[13] On the legal front, not only ACEP but also the American Medical Association have affirmed provider legal protections for honoring POLST wishes and the need to overcome legal fears.[30] Either through explicit statutory protection or common law of accepted standards of practice, the 2017 ACEP policy statement asserts the "hospital's obligation to honor patient decisions concerning their care."[13]

There is growing discussion of the idea that failure to honor valid POLST forms may leave providers legally liable and should be considered a medical error.[13,31] Courts increasingly are saying that the will of the patient or agent, not the will of the provider, should control the type of care received. Recent legal cases are starting to assert that

providers are not immune from penalties for initiating unwanted treatment when patient wishes are clear. Several cases of failure to honor advance directives or do-not-resuscitate orders have upheld the principle that was expressed by one judge: "….[U]nless health care providers…face consequences for ignoring or failing to follow a patient's directives, the public policy favoring these directives stands to be undermined."[32]

AN APPROACH TO THE POLST FOR EMS AND THE ED

Although POLST documents have not provided the definitive answer to end-of-life care and our ability to honor people's end-of-life wishes, the aspects of POLST documents that are important to EMS and in the ED should not be dismissed. Figure 2 outlines a basic strategy for using POLST orders to greatest benefit in the EMS and ED settings.

EMS responders should respond positively to patients who present with POLST forms, without arguing about whether transport is indicated. It must be assumed if 911 is called that the situation overwhelms individuals in attendance. POLST documents should be rapidly reviewed to determine whether a no-CPR or no-intubation order is present. When less invasive means of stabilizing the patient are available, such as noninvasive ventilator support, these can be helpful in getting the patient to the ED. The ED should support the EMS providers and should receive these patients with respect, embracing the responsibility to review patient wishes and orders and to work through unclear patient choices for managing the situation at hand.

Most important for the initial ED approach to the patient near the end of life is knowing whether the patient wants attempts at CPR. Equally useful is documentation of whether the patient wishes intubation. In the first minutes of an emergency ED presentation, knowledge of patient wishes about these 2 interventions can be invaluable. In the ED, orders for receiving or not receiving CPR should be honored. Likewise, clear orders for no intubation or limitations on respiratory support should also be honored for a patient with a POLST form. Of course, when a valid POLST form indicates limitations on interventions, providing symptom relief remains paramount.[7,13,32]

After the emergency response, options contained in the POLST form require clarification. Indeed, one of the major concerns about interpreting POLST orders is that the intent behind many of the intermediate options may not be clear. If the crisis can be stabilized, there is no substitute for discussions between the care team and the patient or representative. The POLST document can provide a useful trigger or prop for a thoughtful discussion of how aggressive the patient wants treatment to be in this particular situation.

1) Support EMS and welcome patients/families needing ED help near the end of life.
2) Honor POLST orders concerning CPR and airway management when these are accessible and appear valid.
3) Use the POLST information to engage in discussion with patient/family in regard to wishes and intent after the initial crisis is stabilized.
4) Consider disposition strategies that align with patient wishes in POLST forms.
5) Clarify or prime patient/family for difficult intervention questions that will need review with the admitting team, and document issues that have been broached or made clear in the ED.

Figure 2. Recommendations for how providers should integrate POLST documents into ED care.

Less than 60% of patients opt for one of the most clear-cut combinations of POLST choices, namely, no CPR and comfort-focused care, or CPR with full treatment.[15] The rest choose intermediate treatment options. As Schmidt et al[15] pointed out: "POLST is not about limits on treatment. It is a method of recording and honoring patients' preferences…." Intermediate choices are not necessarily contradictory. For instance, some people may want attempts at CPR, but want providers to stop if such attempts do not immediately reverse the arrest and would require intubation, an ICU admission, or use of multiple life-support interventions (an option not accepted in some states).[11] Comfort care may require admission to the hospital to control symptoms or use of parenteral antibiotics to treat a symptomatic urinary tract infection or cellulitis.[21] A recent ACEP Ethics Committee statement argued that even an ICU admission may be appropriate for a patient who wishes some limitations on interventions near the end of life if some specialized interventions reflect the patient's goals and preferences.[33] As Mirarchi and Yealy[34] pointed out, "end of life and critical illness are not always the same." In the ED, the direction of care often requires conversation about intent and goals with the patient or surrogate.

One useful approach has been proposed by Mirarchi et al[26]: "the resuscitation pause," depicted in Figure 3. Several important issues are highlighted in this mnemonic.

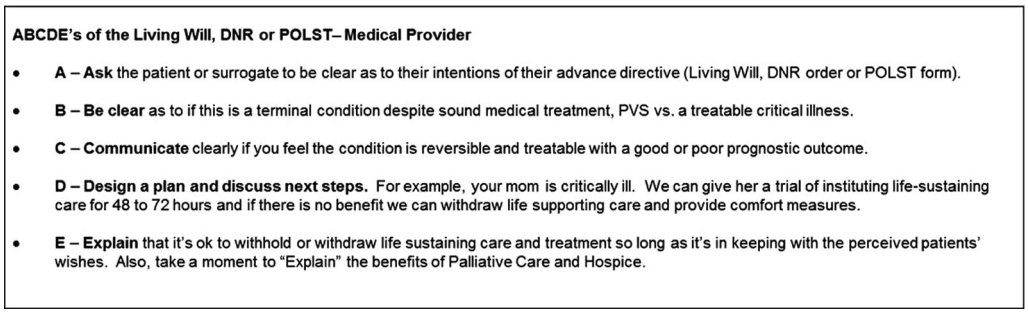


Figure 3. Resuscitation pause. Duplicated with permission from F. Mirarchi.[26]

If the patient can speak for himself or herself, it is crucial to explore the intentions behind his or her Living Will, CPR directive, or even POLST form. If possible, providers should state whether they assess the overall condition of the patient to be terminal and explore whether this patient would want some more time if the acute condition is treatable. When prognosis is unclear, it is important to acknowledge that and prepare the patient and family for possible decisions to come.

The emergency physician is often in a unique position to formulate an action plan with patients or surrogates, as suggested by Mirarchi et al.[26] Broaching the concept of, for instance, a time-limited trial or of revisiting interventions started in the ED may help the admitting team to later suggest stopping interventions that are not successful in restoring the patient to an acceptable quality of living. Or the ED providers can preview upcoming discussions and consultations and affirm the team's commitment to honoring patient wishes. Many families are also helped by an explanation that withdrawing unwanted or ineffective treatments is as ethically valid as withholding them, and maybe more so.[26,35]

The other aspect of "orders" found in the POLST documentation that can be useful in the ED is in regard to disposition: deciding where patients should go after the ED evaluation is complete. Do they wish to avoid hospitalization or the ICU? Do they wish to return to their residence if the acute issue can be resolved or managed through the ED encounter? Do they want admission if it might extend their life a bit more? Can they be safely cared for in their residence?

Finally, the ED role includes good documentation and robust communication with admitting teams. The electronic health record note should include topics broached, who was present, and what wishes and intent might have been clarified by the ED team. Palliative care consultation can and should be initiated when appropriate from the ED, as the Choosing Wisely commitment for emergency medicine has spelled out.[36] If the patient is in hospice, the hospice service should be notified before consideration of admission because the hospice team can sometimes facilitate alternative dispositions and needs to approve of any hospital admission for their patients.[37]

POLST forms have been found to work best when created with a patient's provider in an office visit, looking ahead to expected downturns that might trigger a 911 call and possible admission to the hospital. The other most useful scenario is institutional settings such as nursing homes, in which POLST orders may prevent unwanted transportation to the hospital or admission.[38] Although successes for EMS and ED highlight the utility of POLST orders, Oregon and other commentators emphasize the complexity of end-of-life care and the need for POLST completion to be one piece in a coordinated network of communication and action if patient end-of-life care is to be improved.[38,39]

CONCLUSION

POLST forms are an important step for allowing people near the end of life to translate their wishes into orders. For some individuals, this is a way to avoid unwanted resuscitation, artificial ventilation, or hospitalization. For others, it affirms their desire for full interventions to extend life. POLST orders are most helpful in the initial minutes of an ED presentation when they clarify choices of CPR or no CPR and intubation or no intubation. Beyond this, these orders should point the way toward conversations about complex decisions for which patient or surrogate values vary widely and may not be clear from a written document alone. After the initial assessment, often the only way to understand what patients want is to take the POLST form into the room (these days, it may be the virtual form), show that emergency providers want to understand what is important to their patients, and start an important conversation to jointly strategize about how to best care for them.

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Images in Emergency Medicine

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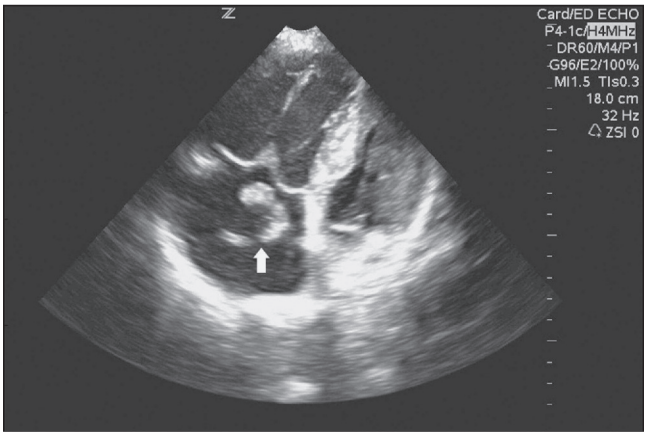

"Elderly Female With Syncope" by Byrne, Czuczman, and Hwang, July 2011, Volume 58, #1, pp. 105, 115.