POLST AND HEALTH CARE DIRECTIVES – WHAT TO DO UNTIL THE LAWYER ARRIVES. ©

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I. INTRODUCTION

Edward Winter, was a patient who had initially been admitted to the hospital for chest pain. Before his illness, Mr. Winter had witnessed his wife's deterioration after receiving emergency resuscitation. Consequently, he discussed his desire not to receive extraordinary life-sustaining treatment with his physician following admission, a wish that was reflected in a "No Code Blue" order entered on his chart. Despite this indisputably clear instruction, a nurse defibrillated Mr. Winter when he suffered ventricular fibrillation. Within a few days, he suffered a stroke that paralyzed his right side, but he went on to live for approximately two more years. In his complaint, Mr.Winter alleged that the nurse's actions constituted battery and negligence, causing him pain, suffering, and emotional distress, as well as medical and other expenses.[2] After significant litigation the Ohio Supreme Court ruled that Ohio would not recognize "wrongful life" claims. If the claim had survived (no pun intended) the damages for future care would have been in the millions.

In a slightly different context our Washington Supreme Court has rejected a claim for damages for the unexpected "wrongful birth" of a **healthy** child.[3] Our Court has not ruled out a claim for damages for the "wrongful birth" or "wrongful life" of a sick or congenitally disabled child. A

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[1] I hasten to point out that I am not a medical doctor. My undergraduate degree at Gonzaga University was in Basic Medical Sciences (Premed) so I know just enough about medicine to be dangerous. My opinions ore offered as a lawyer relying on my Juris Doctorate training.

[2] *Anderson v. St. Francis-St. George Hosp., Inc.,* 77 Ohio St. 3d 82, 82, 671 N.E.2d 225, 226 (1996)

[3] *McKernan v. Aasheim*, 102 Wn.2d 411, 419–20, 687 P.2d 850, 855 (1984)("We believe that it is impossible to establish with reasonable certainty whether the birth of a particular healthy, normal child damaged its parents. Perhaps the costs of rearing and educating the child could be determined through use of actuarial tables or similar economic information. But whether these costs are outweighed by the emotional benefits which will be conferred by that child cannot be calculated. The child may turn out to be loving, obedient and attentive, or hostile, unruly and callous. The child may grow up to be President of the United States, or to be an infamous criminal. In short, it is impossible to tell, at an early stage in the child's life, whether its parents have sustained a net loss or net gain.

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recent Washington case ended in a $50,000,000 in just such a case.[4] No Washington appellate court has yet considered a claim for "wrongful life" in the context of a Health Care Directive, but it is coming.[5] These claims have had mixed success in other states.

There is certainly a risk to a practitioner for ignoring a medical care directive, if the prolonged life is a difficult and expensive one. This article will address the issue and the care provider's options when faced with a medical care directive.

II. THE HEALTH CARE DIRECTIVE

The :"medical care directive", sometimes referred to as the "advance care directive", exists in a number of different forms, including but not limited to (1) Physician Orders for Life-Sustaining Treatment (POLST) forms; (2) living wills;[6] (3) durable powers of attorney for health care; (4) Do Not Resuscitate orders (DNR) and CODE/NO CODE orders. Living wills and durable powers of attorney generally give an individual the right to make the end-of-life medical decisions. Sometimes the form specifies generally the parameters of the authority. The POLST (a/d/a MOLST) form is the most specific form in regards to end-of-life medical treatment and the preferred from by most practitioners.[7]

The POLST (Physician Orders for Life-Sustaining Treatment) Program was originally developed in Oregon to improve end-of-life care. It is designed to convert patient preferences for life-sustaining treatments into immediately actionable medical orders. The centerpiece of the program is a standardized, brightly colored form that provides specific treatment orders for cardiopulmonary resuscitation, medical interventions, artificial nutrition, and antibiotics. The POLST form is generally recommended for persons who have advanced chronic progressive illness, who might die in the next year, or who may wish to further define their preferences for treatment. There are now programs based on the POLST paradigm Washington as well as a number of other states.

Advance directives have become an important aspect of planning for the future, allowing each person to decide in advance about the medical care that he or she wishes to receive in case of

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[4] https://www.seattletimes.com/seattle-news/50m-awarded-over-birth-defect-test-said-baby-would-be-ok/

[5] However, in *McNabb v. Dep't of Corr.*, 163 Wn.2d 393, 411, 180 P.3d 1257, 1267 (2008) our Supreme Court concluded that a state prisoner has a limited right to refuse artificial means of nutrition and hydration. The State's interests in orderly administration of the prison system, preservation of life, prevention of suicide, and maintenance of the ethical integrity of the medical profession outweigh the prisoner's right to starve himself to death.

[6] The term "Living Will" was coined many years ago to describe a document that specifies whether a person wants to receive life-sustaining treatment in the event that he or she is dying from a terminal illness or is in a coma from which there is no reasonable hope of recovery. In 1979, the legislature adopted the new title of "Directive to Physicians" for such a document. This statute was then amended and retitled in 1992, using the title of "Health Care Directive," because the document was intended to advise not only the attending physician but also other health care professionals regarding the wishes of the principal regarding future medical decisions.

[7] If more than one care directive exists the safest procedure is to follow the form that is most medically specific. Although if the forms are seemingly inconsistent the practitioner is faced with a dilemma that will required legal advice beyond the purview of this article.

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terminal illness or coma, or cardiac or respiratory failure, and to prepare legal documents so that a surrogate may make these decisions if personally unable to do so. The term "Advance Directives" typically refers to a variety of legal documents intended to allow an individual to make decisions in advance as to the medical treatment that he or she wishes to receive in the future; specify how decisions are to be made on his or her behalf, if necessary; and direct the medical establishment to follow these decisions. Although each type of document is meant to have a specific use and meaning, actual practice has sometimes resulted in a lack of certainty as to how these documents are to be prepared and applied.

A Health Care Directive is prepared in advance to inform all medical personnel as to the actions that should be taken in case of a terminal illness or coma and statutorily becomes effective only when a physician determines that a terminal condition exists, or two physicians find that the patient is in a coma. A Health Care Directive is a "springing" document that must be activated by the physician at the time when the specified condition develops. A Health Care Directive is an advance instruction of intent as to orders the physician is asked to give if certain situations (a terminal condition or coma) develop in the future.

A Do Not Resuscitate (DNR) Form is prepared cooperatively by an individual and physician as an advance order by the physician that, if the individual experiences cardiac or respiratory failure, cardiopulmonary resuscitation (CPR) is or is not to be attempted. A physician order for the decided-upon action is provided in advance so that medical personnel will respond according to the advance order.

A Durable Power of Attorney for Health Care allows an individual to appoint someone else to make medical care decisions, in case of personal inability to make such decisions. An agent is given certain powers to "stand in" for the ill person.

A health care directive is signed by the principal as an expression of intent and preference but becomes effective only when a physician makes a determination of a medical condition that causes the directive to be placed into effect. The physician thus must decide if and when the condition for springing the document have been satisfied and enter an appropriate order. A health care directive is intended to allow an individual the right to decide, in advance, to refuse medical treatment in the event that he or she is determined by one physician to be in a terminal condition or by two physicians to be in a persistent vegetative state (coma). **Thus, the physician remains the individual who determines when and how a health care directive will be activated**, based on the intent of the individual and intervention by the physician using his or her own criteria. The statutes provide limited guidance to the physician; they provide only that the document should become effective only if the individual is expected to die within a reasonable period of time within reasonable medical judgement.[8]

Many persons other than physicians are often involved in matters involving terminal illnesses and comas. Hospitals, skilled nursing facilities, and adult family homes all encounter such situations; however, they are often not sure how to respond when a health care directive has been prepared in advance. In some cases, a physician may be willing to specify the specific terms and conditions

[8] RCWA § 70.122.030

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under which the directive is to be viewed as effective and prepare an advance order that, if these conditions arise, the health care directive is to be viewed as in effect and there to be no action taken to artificially prolong the life of the patient. This requires an advance decision by the physician. If the physician is unwilling to provide such an advance order, then the logistics of decision making at the time may become quite complex, and it is difficult to assure that the wishes of the principal are respected. Further complicating such decisions is an awareness that the medical condition of individuals may improve and decline over time, and the interpretation of such changes is medically complex. Unfortunately, this is a predictable collision of medicine and law, for which there is no clearly acceptable answer.

III. THE WASHINGTON PROTOCOL FOR HEALTH CARE DIRECTIVES

Washington has codified the care directive rules. The legislature found that the prolongation of the process of dying for persons with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient. The legislature further found that physicians and nurses should not withhold or unreasonably diminish pain medication for patients in a terminal condition where the primary intent of providing such medication is to alleviate pain and maintain or increase the patient's comfort. This was the overriding basis for the statute. However, the legislature also found that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining treatment where the patient having the capacity to make health care decisions has voluntarily evidenced a desire that such treatment be withheld or withdrawn. Despite this schizophrenic view the legislature recognized the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person's right to control his or her health care may be exercised by an authorized representative who validly holds the person's durable power of attorney for health care.

RCW 70.122 et. seq. is an attempt by lawmakers to establish protocols for medical professionals regarding end-of-life decisions. An individual may choose to prepare a health care directive in order to specify that if he or she is dying, artificial means are not to be used to extend his or her life. The statutes recognize the right of **an adult person** to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or a permanent unconscious condition. **However, a health care directive does not allow a physician or other health care provider to assist in suicide**. By statutory requirements, a copy of the directive is to be made a part of the patient's medical records.[9]

The statute provides an exemplar for a Health Care Directive but any reasonable modification is acceptable. The statutory preferred form provides, in pertinent part:

[9] RCWA 70.122.040.

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I [Patient], having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

I DO want to have artificially provided nutrition and hydration.
I DO NOT want to have artificially provided nutrition and hydration.

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.
(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Signed.....
City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

Witness.....

Witness.....

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In my opinion, if the statutory directive is not utilized, then at a minimum the directive must provide that it takes effect only upon the permanent unconsciousness of the patient or if the patient's condition is terminal. These minimum terms are defined in the statute but may not fit nicely into medical terms. [10]

A "Permanent unconscious condition" means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state. In this circumstance, if a proper directive exists, the physician can withhold or with draw "live sustaining treatment."

A "Terminal condition" means an incurable and irreversible condition caused by injury, disease, or illness that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying. In this circumstance, the patient can be conscious and even communicative. Unless the patient revokes the directive the physician can carry it out. This may create an awkward situation. Certainly, if the patient is communicative the provider should reaffirm that he or she wants to carry out the directive. If the patent does not indicate a desire to revoke the directive then the directive should be honored.

It is important to note that prior to withholding or withdrawing life-sustaining treatment, the diagnosis of **a terminal condition** must be made by **the attending physician.** The diagnosis of a **permanent unconscious state** must be made **by two physicians**. The findings must be charted and made a permanent part of the patient's medical records.

The provider may withhold or withdraw "life sustaining treatment" which is defined as any medical or surgical intervention that uses mechanical or other artificial means, **including artificially provided nutrition and hydration**, to sustain, restore, or replace a vital function, which, when applied to a qualified patient, would serve only to prolong the process of dying. "Life-sustaining treatment" shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain. Providers often balk at withholding nutrition or hydration but the law allows it.

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[10] It is widely agreed that advance directives have failed to achieve their "admirable purpose" of helping patients retain control over end-of-life treatment, and researchers have identified numerous reasons for this failure. Most people do not complete advance directives; Patients' goals and preferences for care may change over time, but their advance directives are rarely revisited; and proxy decision makers, appointed by patients to make decisions on their behalf upon incapacitation, often do not understand the patients' wishes. Furthermore, advance directives are frequently unavailable when needed, or health care providers may not know about the directives or may not think they apply to the patient's situation. See, Susan E. Hickman, Charles P. Sabatino, Alvin H. Moss, Jessica Wehrle Nester, The Polst (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation, 36 J.L. Med. & Ethics 119 (2008)

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Remember that withholding of life sustaining treatment only applies to a "qualified patient." A "Qualified patient" means an adult person who is a patient diagnosed in writing:

(a) to have a terminal condition diagnosed by the patient's attending physician, who has personally examined the patient, **or**

(b) a patient who is diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards diagnosed by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.

You must me an adult (over 18) to legally sign a care directive. Minors, regardless of their mental acuity, cannot have a directive. The directive must be signed by the patient and witnessed by two adults not related to the patient. Remember that you cannot be a witness to the signing of the directive if you are the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient. The directive or a copy thereof, can and should be made part of the patient's medical records retained by the attending physician and a copy should be forwarded by the custodian of the records to the health facility when the withholding or withdrawal of life-support treatment is contemplated.

A care provider has a duty to determine if a care directive exists. He or she should make a reasonable inquiry of other care providers and family members to determine if a directive exists. The provider should never assume that a directive exists or take the word of another about what is contained in the directive. The provider does not need to have the original directive if he or she can reasonably determine that a copy is a reasonable facsimile. If the health care provider does not have access to the directive he or she should proceed as if the directive did not exist.

A health care directive may be revoked at any time by the declarer (patient) **without regard to the declarer's mental state or competency** by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in the declarer's presence and by the declarer's direction.

(b) By a written revocation of the declarer expressing his or her intent to revoke, signed, and dated by the declarer.

(c) By a verbal expression by the declarer of his or her intent to revoke the directive.

(d) In the case of a directive that is stored in the health care declarations registry by an online method established by the department of health.[11]

It is important to note that the directive cannot be revoked by any other person of family member. Furthermore, normally the directive cannot be ignored or overridden by the attorney-in-fact designated in the durable health care power of attorney. However, this can create a dicey

[11] Be aware that because of budget limitations the registry was discontinued in 2011.

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situation. I am aware anecdotally of a case where the patient was unconscious and it was determined by two physicians that he would not regain consciousness. He had an enforceable health care directive. His wife, who was also his health care attorney-in-fact refused to accept the diagnosis and insisted on life sustaining and even lifesaving treatment. The patient recovered and resumed a relatively normal life style. While the physician would have been within the law to withhold lifesaving treatment it was fortunate that he did not. .

Any physician or health care provider who participates in good faith in the withholding or withdrawing of life-sustaining treatment, in accordance with a health care directive, is immune from legal liability **unless otherwise negligent**. This includes any civil or criminal liability and any professional sanctions. The statute does not define "otherwise negligent." However, it does provide that you are not liable if you do not have actual knowledge of the existence of a health care directive or if in good faith you rely upon the validity of the health care declaration and the declaration is subsequently found to be invalid.

You should make every effort to carry out the terms of the directive once you have seen it. You should not withhold life sustaining treatment if you are not certain of the terms of the directive. **Ignoring the directive or implementing a directive that you have not seen or are reasonably certain exists could be considered negligence**.

Often, a provider may be aware of the directive but at the critical time some family members insist on utilizing heroic measures. In effect, they are asking you to ignore the directive. If the directive provides otherwise, it well could be negligence (i.e. malpractice) to ignore the directive and follow the wishes of the family. In that case you could leave yourself open for a "wrongful life" claim. Giving in to the often misguided wishes of the family members could expose you to significant legal liability.

You can opt-out of the directive protocol. However, to do so you must inform the patient or patient's authorized representative of the existence of any policy or practice that would preclude the honoring of the patient's directive at the time the physician or facility becomes aware of the existence of such a directive. If the patient, after being informed of such policy or directive, chooses to retain the physician or facility, the physician or facility with the patient or the patient's representative shall prepare a written plan to be filed with the patient's directive that sets forth the physician's or facilities' intended actions should the patient's medical status change so that the directive would become operative. The physician or facility has no obligation to honor the patient's directive if they have complied with the opt-out provisions, including compliance with the written plan required under this subsection.

If you or other staff members have an ethical or religious objection to carrying out the terms of the directive you may decline to participate in the care plan. However, in that case, other members of your practice, who do not object, should be assigned to carry out the directive. The law prohibits your employer or professional organization from discriminating against you because of your good faith refusal to participate in end-of-life care to which you object.

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The withholding or withdrawal of life-sustaining treatment from a qualified patient pursuant to the patient's directive in accordance with the provisions of the law shall not, for any purpose, constitute a suicide or a homicide.

If the **patient** is capable of making health care decisions and indicates that he or she wishes to die at home, the patient shall be discharged as soon as reasonably possible. The health care provider or facility has an obligation to explain the medical risks of an immediate discharge to the qualified patient. If the provider or facility complies with the obligation to explain the medical risks of an immediate discharge to a qualified patient, there shall be no civil or criminal liability for claims arising from such discharge. The law is not clear regarding a request to die at home by an attorney-in-fact or family member. In my opinion, it would be reasonable for the provider to honor the wishes of the attorney-in-fact if the power of attorney provides such authority. Likewise, if there are no immediate health concerns about a transfer to home a provider could discharge the patient to home. .

The bottom line is to identify and review the directive, chart your findings and carry out the directive to the best of your ability.

IV. POLST FORMS[12]

Curiously, the health care directive statute does not reference the POLST form. This may be the result that the POLST form was developed by the medical community and not the legislature. Often the patient will have a medical care directive which provides more general directions and a POLST form that prescribes more detailed orders. The two are normally compatible but the POLST form provides more specific directions to the physician.[13] The POLST form must be read in conjunction with the health care directive and durable health care power of attorney. If the POLST form and directive are inconsistent then the safest course of action is to follow the most aggressive treatment plan selected. For example if the directive provides for no life sustaining treatment but the POLST provides for full treatment and the patient cannot provide you direction on what to do, then provide full treatment.

The physician should go over the POLST form with the patient and chart the visit. Utilize the form recommended by Washington State Medical Association (WSMA). A copy of that form is included in the appendix to this paper.

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[12] For a comprehensive and up-to-date list of POLST research, please visit the national POLST website, www.polst.org

[13] In 2015, the Department of Health's Nursing Care Quality Assurance Commission issued an advisory opinion and FAQ document clarifying that nursing assistants and other non-credentialed UAP (unlicensed assistive personnel) may honor a no-CPR order indicated in a patient's POLST. This change in guidance will hopefully make it possible for more bedside caregivers to honor patient decisions to refuse CPR. Find the opinion and FAQ on the DOH Nursing Commission webpage at https://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission

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Here is a list of POLST (and other advance care directives) "dos and don'ts"" for clinicians recommended by WSMA.[14]

> DO remember to sign and date the form. Signatures of both clinician and patient (or surrogate) are required.
>
> DON'T pre-sign forms for facility settings.
>
> DO be aware that, while POLST can be signed by surrogates, it is best if the POLST agrees with the patient's prior directives or if the patient signs the document themselves.
>
> DON'T send the form home with a patient to fill out on their own. If a patient wants to show the form to their family or surrogate decision-makers, DO set up an appointment to have them review it with you for final decisions and signatures.
>
> DO make sure that the patient understands the treatment options at each level of care.
>
> DO discuss the non-emergency medical treatment preferences (Section D) and indicate if the patient has preferences that would limit either use of antibiotics or artificial nutrition.
>
> DO recognize that a patient wishing DNR for cardiopulmonary arrest might still want full treatment. This can be indicated by checking DNAR in Section A and Full Treatment in Section B. In general, CPR in Section A should always link with Full Treatment in Section B, since CPR frequently includes intubation and ICU care.
>
> DO consider introducing POLST to Alzheimer's patients while they can consider and sign the documents themselves. Discuss "down the road" scenarios thoroughly, so that patients can opt to amend prior documents to properly instruct their families about what future choices might be.
>
> DO work with administrators in facilities where you are an attending or serve as medical director to ensure that there is a timely process for discussing and completing POLST.
>
> DO be aware that, while Medicare requires health care institutions to ask about advance care planning documents, it prohibits them from compelling or requiring patients have these forms/
>
> POLST, nursing assistants and other caregivers

[14] https://wsma.org/POLST#dos

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V. SPECIAL RULES FOR NURSING HOMES

.Nursing homes are subject to specific administrative requirements related to health care directives. These special rules are codified in the Washington Administrative Code section WAC 388-97-0280. A nursing home is required to thoroughly understand each resident's wishes regarding advance directives, both on admission and through periodic review. The nursing home is required to determine if any advance directives have previously been prepared, or if the resident wishes to prepare such directives, and if any surrogates are authorized to make medical decisions on behalf of the resident. All decisions are to be documented in the medical record. Informed consent is required with respect to all directives, first by the resident, if possible, then by any surrogate.

The Department of Social and Health Services (DSHS) requires that written procedures must be developed by every nursing home to assure compliance with advance directive statutes and has developed procedure development guidelines that may be used to assure compliance with the statutory requirements. The Washington Health Care Association (WHCA) and the Washington Association of Housing and Services for the Aging (WAHSA) have developed sample materials that may be used or adapted by nursing homes.

Nursing homes are required to determine, on admission and on a quarterly basis, whether residents are able to prepare an advance directive, whether they wish to prepare such a directive, and whether they wish to change a prior directive. The standard advance directive forms include both health care directive- and DNR-related decisions. By drawing upon presumed scope-of-practice authority, DSHS has concluded that registered nurses, nurse practitioners, and physician assistants can also sign such forms.

Under the regulations "Advance directive" means any document indicating a resident's choice with regard to a specific service, treatment, medication or medical procedure option that may be implemented in the future such as power of attorney, health care directive, limited or restricted treatment cardiopulmonary resuscitation (CPR), do not resuscitate (DNR), and organ tissue donation.

The nursing home must:

(a) Document in the clinical record whether or not the resident has an advance directive;

(b) Not request or require the resident to have any advance directives and not condition the provision of care or otherwise discriminate against a resident on the basis of whether or not the resident has executed an advance directive;

(c) In a language and words the resident understands, inform the resident in writing and orally at the time of admission, and thereafter as necessary to ensure the resident's right to make informed choices, about:

(i) The right to make health care decisions, including the right to change his or her mind regarding previous decisions;

(ii) Nursing home policies and procedures concerning implementation of advance directives; and

(d) Review and update as needed the resident advance directive information:

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(i) At the resident's request;
(ii) When the resident's condition warrants review; and
(iii) When there is a significant change in the resident's condition.

When the nursing home becomes aware that a resident's health care directive is in conflict with facility practices and policies which are consistent with state and federal law, the nursing home must:

(a) Inform the resident of the existence of any nursing home practice or policy which would preclude implementing the health care directive;

(b) Provide the resident with written policies and procedures that explain under what circumstances a resident's health care directive will or will not be implemented by the nursing home;

(c) Meet with the resident to discuss the conflict; and

(d) Determine, in light of the conflicting practice or policy, whether the resident chooses to remain at the nursing home:

(i) If the resident chooses to remain in the nursing home, develop with the resident a plan in accordance with chapter 70.122 RCW to implement the resident's wishes. The nursing home may need to actively participate in ensuring the execution of the plan, including moving the resident at the time of implementation to a care setting that will implement the resident's wishes. Attach the plan to the resident's directive in the resident's clinical record; or

(ii) If, after recognizing the conflict between the resident's wishes and nursing home practice or policy the resident chooses to seek other long-term care services, or another physician who will implement the directive, the nursing home must assist the resident in locating other appropriate services.

If a terminally ill resident, in accordance with state law, wishes to die at home, the nursing home must:

(a) Use the informed consent process as described in WAC 388-97-0260, and explain to the resident the risks associated with discharge; and

(b) Discharge the resident as soon as reasonably possible.

Again and curiously, the rules for nursing homes refer to health care directives but do not mention POLST forms. It would be a good practice to discuss both the health care directive and POLST form with the nursing home resident when complying with these rules.

VI. CONCLUSION

For the most part health care directives and POLST forms do not create conflicts in the practice of medicine. This is largely because the directives are rarely utilized in health care decisions for a variety of reasons. Although the issue has garnered media attention and has brought the importance of advance directives to the public's attention, a number of physicians still disregard a patient's last wishes for fear of legal reprisal or simply due to a lack of communication between

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patient and health care provider.[15] There is no need to fear health care directives and every reason to enforce them in Washington In fact, the failure to honor health care directives could subject the medical care provider to malpractice clams. As long as the directives are documented in the chart and at the time of implementing the directive the physician should feel assured that he or she will not incur any adverse liability for carrying out the directive. Careful communication with the patient and family members during treatment and at the time of making the end-of-life health care decisions will eliminate most concerns. While I understand that sometimes these allowed treatment protocols go against the grain of a physician's instinct to "save the patient" under Washington law the patient's desires trump those of the physician.

[15] One survey found that only 36% of individuals with advance directives had mention of this fact in their medical records and less than 1% actually had the document filed with their chart. The study concluded that advance directives fail to have a significant effect on orders regarding resuscitation. Holly Fernandez Lynch et al.,Compliance with Advance Directives: Wrongful Living and Tort Incentives, 29J. Legal Med. 133, 138 (2008).

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TIDBITS RELATED TO THE TOPIC

Other POLST resources

Washington State Department of Health
Office of Community Health Systems
EMS & Trauma Section
(360) 236-2841, (800) 458-5281
https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/PhysiciansOrdersforLifeSustainingTreatment

Washington State Hospital Association
(206) 281-7211
http://www.wsha.org/our-members/projects/end-of-life-care-manual/section-6-physician-orders-for-life-sustaining-treatment-polst/

National POLST Paradigm
c/o Emmer Consulting, Inc.
208 I Street NE Washington DC 20002
www.polst.org

For a more detailed discussion of 'Wrongful Life" suits I suggest reading Nicole Marie Saitta, Samuel D. Hodge, Jr., *Wrongful Prolongation of Life-A Cause of Action That Has Not Gained Traction Even Though A Physician Has Disregarded A "Do Not Resuscitate*" Order, 30 Temp. J. Sci. Tech. & Envtl. L. 221 (2011)

A real life example of the liability that a physician may face when dealing with health care directives is set out in *HCA, Inc. v. Miller*, 36 S.W.3d 187, 190 (Tex. App. 2000),aff'd, 118 S.W.3d 758 (Tex. 2003).In that case, Karla Miller unexpectedly entered the hospital because of premature labor. The doctors noted that, if she delivered at that time, the child could be severely impaired because the fetus was only 23 weeks old.2 The parents instructed the physicians that no heroic measures should be undertaken to resuscitate their child. Nevertheless, the baby was born that night, and life- sustaining measures were used to keep the newborn alive, leaving her mentally and physically challenged. The parents filed suit against the health care providers, and the jury awarded over fifty-nine million dollars for ignoring what was tantamount to a "Do Not Resuscitate" order. This victory was short-lived, however, when the appellate court reversed the decision, stating that "a health care provider is not liable in tort for administering urgently needed life-sustaining medical treatment to a newborn infant contrary to pre-birth instructions of parents not to do so."

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In “Wrongful Prolongation of Life-A Cause of Action That Has Not Gained Traction Even Though A Physician Has Disregarded A "Do Not Resuscitate" Order, 30 Temp. J. Sci. Tech. & Envtl. L. 221, 224–26 (2011) the following excerpts provide interesting insight to the problems faced by end of life decisions. (Footnotes have been omitted)

“Advance Directives: The Lessons of Karen Ann Quinlan and Terry Schiavo
Advance directives and prolongation of life questions are not foreign to the courts. This topic became a public issue in 1976 with the tragic case of Karen Ann Quinlan. A father sought guardianship of his 21-year-old daughter who was in a persistent vegetative state. Mr. Quinlan wanted to discontinue all extraordinary procedures necessary to sustain his daughter's life. The New Jersey Supreme Court, reliant on the physician's statement that there was no reasonable possibility of Karen ever emerging from her comatose state, agreed that life- support systems could be withdrawn on the basis of her right to privacy without criminal or civil liability. In this case, the court began to address questions concerning “prolongation of life” and noted the paucity of legislation in this area, a recurrent theme cited by the courts in subsequent years. The court also noted a difference between the self-infliction of deadly harm and self-determination against artificial life support in the face of certain death. Ultimately, this litigation paved the way for future courts to issue declaratory or injunctive relief against health care providers who refuse to carry out advance directives, and it has led to the enactment of state statutes that aim to protect a patient's right to die while upholding a physician's obligation to prolong life.

These issues were again prominently brought to the public's attention in 2005 with the Terry Schiavo litigation, which addressed the issue of a woman being kept alive on artificial life support. The patient's husband disagreed with Terry's parents over the removal of their daughter's food, fluids, and medical treatment. The parents alleged that the husband was violating their daughter's rights, and they sought a temporary restraining order to reverse his decision to withhold the patient's medical treatment. Throughout the proceedings, both parties argued over what they believed were the patient's intentions concerning artificial life support, though no concrete document regarding her wishes existed. The fierce debate that ensued reawakened the public's interest in advance directives. For instance, the National Hospice and Palliative Care Organization (NHPCO) received over 900 calls and 2,000 emails during the pending of the litigation from individuals interested in state-specific advance directives so they could avoid the controversy that was taking place in the Schiavo matter. Two weeks following Mrs. Schiavo's death, NHPCO had more than 200,000 downloads from its website for advance directives.”

“Some individuals have been quite emphatic in making their end-of-life decisions known, with one eighty-year old woman tattooing “Do Not Resuscitate” on her chest to reinforce the living will she had hanging on her refrigerator.”

“A natural question arises as to why physicians would resuscitate individuals with DNR orders. One reason may be the lack of communication between patient/care providers and the subsequent hospital/doctor, and this problem is only compounded when individuals are transported between facilities, nursing homes, and hospitals, often without the accompanying paperwork. As one physician noted:

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> Lack of communication about the wishes of the patient in a time of medical crisis is the main cause for unintentionally bypassing "do not resuscitate"/ "do not intubate" orders. In these cases, the patient suddenly collapses from a heart attack or stroke. Often, a cardiac or respiratory arrest occurs at night when neither the family nor the patient's physician is on site. In these cases, the person is witnessed to collapse or is found unresponsive and a "code" is instantly called. At that moment, everyone comes running nurses, any available physicians, respiratory therapists to start resuscitation efforts. The intent is to save the life. In the haste to come to the aid of the patient, the DNR/DNI status may not be appreciated, especially if the medical event occurs at the start of a shift before the nursing staff has become familiar with all of their patients. The DNR status may not be identified until the hospital chart is reviewed or a family member is called. By then, the patient may have been resuscitated and stabilized. Some hospitals circumvent this situation by designating the resuscitation status directly on the patient identification wrist band at the time of admission to the hospital."

"Why Are Advance Directive Ignored?

Communication errors may be one reason why doctors fail to adhere to a patient's advance directives. However, the fear of reprisal from family members when following such instructions weighs heavily on doctors' minds. While statutes exist to protect physicians in these situations, this does not always insulate them from lawsuits. Some doctors, therefore, err on the side of human life when making decisions about resuscitation and other life saving measures, thereby ignoring a living will and adhering to the belief that they might be subject to a damages lawsuit.

This is what happened in Allore v. Flower Hospital where the patient's living will was ignored by his health care providers despite their awareness of its existence. Under the terms of the living will, the patient wanted "no life-sustaining treatment" in the event of a terminal condition or "permanently unconscious state." After being repeatedly admitted to the hospital for pulmonary problems associated with asbestosis, he was intubated and mechanically ventilated because Allore's advance directive was unknown to the treating physicians. In fact, the patient's chart read, "In the event of cardiac standstill, ventricular fibrillation or respiratory arrest, resuscitation measures are to be initiated immediately using ACLS protocols," measures which directly contradicted the patient's wishes. Unfortunately, Mr. Allore's repeated hospitalizations caused his end-of-life directions to be miscommunicated in the shuffle of paperwork and changing of physicians. In a subsequent lawsuit, the estate was barred from recovering damages for the wrongful prolongation of life. The court noted that since the "harm" was the benefit of life, it would not provide compensation. The only damages allowed were those related to the alleged battery for the resuscitation efforts against the patient's wishes. Thus, the recovery of medical costs and pain and suffering could not be awarded since they related to the wrongful prolongation of the decedent's life and not a direct result of a battery or negligence. Allore was decided under the doctrine of implied consent, a policy which protects physicians when providing treatment in emergencies "without the specter of liability for lack of consent." This policy is not applicable when an advance directive exists since an individual has already made a choice regarding life-sustaining measures. However, a physician can still act within means of a standard of care, especially when an advance directive is not clearly known within the means. In this regard, the

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court recognized that there was no evidence that the attending physician was aware of Allore's refusal of treatment, and since he signed a consent form for treatment when admitted to the hospital, "no issue of material fact existed as to implied consent on the part of Frank Allore to the patient's intubation and ventilation."

"Allore might seem like an isolated incident of ignoring a patient's wishes, but it is not."

As research has shown, "medical care at the end of life is often inconsistent with patient choice even when the patient has made a choice known." Other studies have revealed that the medical profession's ambivalence toward advance directives often leads to their failure to comply with these orders for several reasons: (1) the fear of liability; (2) the perception that directives interpose an unnecessary additional control over, and interfere with, the physician's professional actions; and (3) the perception that directives implicitly question the physician's judgment of the patient's best interests. This last factor lends itself to the moral extremism that some physicians may feel. As noted:

> In rare instances, a health care provider may have a powerful personal moral bias that all life is worth saving and that everything possible should be done for every patient. All through their training, "physicians-to-be" are taught that life is precious and they are to do everything to their best ability to improve the life of their patients. At the conclusion of medical school, some take the Oath of Hippocrates (". . .I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. . .") to affirm this commitment. In some cases, disease becomes a challenge and if a patient dies, the physician perceives themselves as a failure. In these situations, the physician may exceed their boundaries and intentionally ignore the DNR/DNI order.

Despite possible feelings of moral obligations, physicians are ultimately required to assess the degree of severity of the patient and treat the person accordingly. This, in and of itself, may affect a physician's prescribed course of treatment."

"While a patient may have a DNI [do not intubate] order on the chart, they may develop a treatable pneumonia or other respiratory difficulty responsive to antibiotics or other medications. In these cases of a reversible respiratory problem, intubation and ventilatory support may be necessary to buy time until the medications have time to work. Thus, while the intubation is contrary to the DNI request, it is temporary and does not represent a long term commitment. This decision and its reasoning must be discussed with the patient and/or the family."

"While overly cautious resuscitation might have been the practice in the past, a recent study found "do-not-resuscitate" orders to be an independent risk factor for poor surgical outcome.101Hadiza Kazaure, Sanziana Roman & Julia A. Sosa,High Mortality in Surgical Patients with Do-Not-Resuscitate Orders, 146 Archives of Surgery 8 (2011) available at http://archsurg.amaassn.org/cgi/content/abstract/146/8/922 (last visited Dec. 27, 2011). The researchers concluded that surgical patients with DNR orders sustain postoperative complications, with 1 in 4 dying within 30 days of surgery. In fact, people with DNR orders may be twice as likely to die soon after surgery regardless of the procedure or health status of the individual before the operation. Some attribute this statistic to the overall poorer health of this population, but the

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Director of Clinical Ethics at Stanford's Center for Biomedical Ethics claims these directives "subconsciously affect how doctors and nurses treat patients. For example, they order fewer tests and don't enter the patient's room as often."Jennifer Warner, DNR Orders May Affect Surgical Outcomes, WebMD, April 18, 2011, - http://www.webmd.com/palliative-care/news/20110418/dnr-orders-may-affect-surgical-outcomes."

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

Date of Birth ____ ____ ____

Last 4 #SSN (optional) ____ ____ ____ ____

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A — Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

Check One

☐ **Attempt Resuscitation/CPR**

When not in cardiopulmonary arrest, go to part B.

☐ **Do Not Attempt Resuscitation/DNAR (Allow Natural Death)**
Choosing DNAR will include appropriate comfort measures.

B — Medical Interventions: Person has pulse and/or is breathing.

Check One

☐ **FULL TREATMENT - primary goal of prolonging life by all medically effective means.**
Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

☐ **SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures.**
Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **COMFORT-FOCUSED TREATMENT - primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

Additional Orders: (e.g. dialysis, etc.) _____

C — Signatures:

The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Guardian with Health Care Authority ☐ Spouse/Other as authorized by RCW 7.70.065 ☐ Health Care Agent (DPOAHC)	PRINT — Physician/ARNP/PA-C Name	Phone Number
	✗ Physician/ARNP/PA-C Signature ***(mandatory)***	Date ***(mandatory)***
PRINT — Patient or Legal Surrogate Name		Phone Number
✗ Patient or Legal Surrogate Signature ***(mandatory)***		Date ***(mandatory)***

Person has: ☐ Health Care Directive (living will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 8/2017

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

WASHINGTON

WSMA Washington State Medical Association
Physician Driven Patient Focused

Washington State Department of Health

See back of form for non-emergency preferences ▶

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient and Additional Contact Information (if any)

Patient Name (last, first, middle)	Date of Birth	Phone Number
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number

D Non-Emergency Medical Treatment Preferences

Antibiotics:

☐ Use antibiotics for prolongation of life.
☐ Do not use antibiotics except when needed for symptom management.

Medically Assisted Nutrition:

Always offer food and liquids by mouth if feasible.

☐ No medically assisted nutrition by tube.
☐ Trial period of medically assisted nutrition by tube. (Goal: _____)
☐ Long-term medically assisted nutrition by tube.

Additional Orders: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

✗ Physician/ARNP/PA-C Signature	Date
✗ Patient or Legal Surrogate Signature	Date

Directions for Health Care Professionals

Completing POLST

- Completing a POLST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their surrogate and medical provider based on the person's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

NOTE: A person with capacity may always consent to or refuse medical care or inverventions, regardless of information represented on any document, including this one.

SECTIONS A AND B:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment."

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

OVER ▶