Subject: Recognition of Physician Orders for Life Sustaining Treatment (POLST) Forms (Resolution 20-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Peter H. Rheinstein, MD, JD, MS, Chair)

At the 2017 Annual Meeting, the House of Delegates referred Resolution 20-A-17, “Recognition of Physician Orders for Life Sustaining Treatment (POLST) Forms,” introduced by the Organized Medical Staff Section, which asked:

That our American Medical Association advocate with appropriate government, legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment forms completed in one state as valid and enforceable in other states; and

That our AMA create a universal Physician Orders for Life Sustaining Treatment form that would be valid and enforceable in all states.

The reference committee heard testimony unanimously in support of the intent of the resolution. Testimony highlighted the challenges of respecting the medical care orders of patients when they cross jurisdictional boundaries. However, testimony also emphasized that a universal POLST form may be impractical because POLST is one of many end-of-life care frameworks in use in the United States.

The reference committee agreed that reciprocity of physician orders between states is important, but noted myriad problems with a universal POLST form. The Reference Committee suggested that “model state legislation be crafted in order for [reciprocity] to be accomplished in a way that can realistically be implemented” and referred the resolution. This Board Report provides background and discussion of interstate recognition of POLST and provides a recommendation.

BACKGROUND

Physician Orders for Life Sustaining Treatment were created in the 1990s in the state of Oregon in response to concerns that Do Not Resuscitate Orders (DNRO) had certain inadequacies; chief among them was their inability to transfer to other facilities (nursing homes, hospitals, hospice, ER’s, etc.) as the patient moved [1,2]. POLST was created to improve “end-of-life care by overcoming many of the advance directives’ limitations. It is designed to convert patient preferences for life-sustaining treatment into immediately actionable medical orders” that then “can be followed by medical personnel regardless of the patient’s location” [3,4]. POLST has largely been successful, with studies showing greater effectiveness in care “delivered in accordance with patient wishes” and recent years have seen increased adoption of the program in states around the country [5]. POLST is increasingly becoming established, alongside advance directives, as an important end-of-life decision making tool.
However, a problem has emerged with the recognition of POLST as patients cross state lines. There is a lack of uniformity in how states recognize a POLST from other states. This creates uncertainty if a POLST originating in one state will be followed in another state. This uncertainty risks the proper adherence of a patient’s desires regarding life-sustaining treatment as they travel from one state to another.

STATE LAW

To be effective, a POLST program must be universally recognized and honored. While POLST in each state aims to achieve the same goal of honoring patient wishes during a medical crisis, each state has its own requirements and procedures for a valid POLST.

POLST currentlyexists at some level in all 50 states and Washington, DC. Sixteen states explicitly recognize out-of-state POLST: Colorado, Delaware, the District of Columbia, Georgia, Idaho, Illinois, Iowa, Maryland, Nevada, New Jersey, New York, Oregon, Rhode Island, Utah, Vermont and West Virginia. Only one state expressly limits reciprocity. In Oklahoma, an out-of-state form is only valid for 10 days after patient’s admission into an Oklahoma medical facility [6]. In states with statutes that are silent on reciprocity, accepted medical practice or custom may allow recognition of an out-of-state POLST absent statutory guidance.

There are four main statutory approaches taken to POLST reciprocity: states may honor a POLST if it complies with the originating state’s requirements, if it complies with the receiving state’s requirements, if it reasonably satisfies the receiving state’s requirements or if it complies with either the originating or receiving state’s requirements. State laws vary on approach [7].

ETHICAL ISSUES

The scope of Resolution 20-A-17 is focused on the portability of POLST across state lines. In this context, significantly relevant is the ethical force of autonomy in end-of-life decision making and how it is central to continual support of POLST. “The POLST process increases the likelihood that each person will receive the desired care and not receive undesired care” [2]. Indeed, studies have also shown POLST to be successful in the “honoring of patient preferences” [8]. The fundamental ethical principle of patient autonomy (the driving force behind POLST) is the reason why, despite ethical shortcomings that exist with any end-of-life decision making model, POLST remains a durable clinical decision making tool. Therefore, there is ethical impetus to see greater portability of POLST across states lines, as the more likely a POLST from one state is enforced and recognized by another state, the greater likelihood that a patient’s autonomy at the end-of-life will be respected.

RELEVANT AMA POLICIES

End-of-life decision making is a significant issue in the medical profession and in the field of bioethics. As such, the AMA is strongly supportive of the concept and has published its support for such measures. For example, Chapter 5 of the Code of Medical Ethics focuses on caring for patients at the end of life. This chapter of the Code has several opinions supporting the concept of advance care planning and withholding life-sustaining treatment [9,10,11,12]. The Code explains that “advance care planning is widely recognized as a way to support patient self-determination” and that a patient “has the right to decline any medical intervention or ask that an intervention be stopped, even when that decision is expected to lead to his or her death” [9,11].
The AMA has additionally shown its support for end-of-life decision making through numerous House Policies and Directives [13,14,15,16,17,18]. Policies have called for the AMA to encourage people to establish advance directives and explain that advance directives “are the best insurance for individuals that their interests will be promoted in the event they become incompetent” [13,14]. Also, the AMA has adopted a directive to endorse “The Uniform Health-Care Decisions Act,” a uniform law designed to help govern, simplify, and standardize advance directives [18]. AMA policy does not address issues of reciprocity across jurisdictions.

DISCUSSION

Resolution 20-A-17 would instruct the AMA to create a universal POLST form. Drafting a universal POLST form is fraught with challenges as different jurisdictions have different hierarchies, rules and statutes with regards to end-of-life care. A universal form will not work across all states, as some states may not be able to adopt such a form.

The reference committee’s recommendation to create model legislation that would enable POLST reciprocity between the states is a more workable solution. This approach was recognized by the National POLST Paradigm Task Force (NPPTF) legislative group. The group, an assembly of health law experts tasked with providing perspectives to POLST legal issues, offered solutions, among other things, to the problem of POLST portability across state lines. The group recommended the adoption of a “uniform law” that would offer reciprocity of POLST across state lines. The NPPTF legislative group notes:

While it is still under revision and not directly applicable to POLST, one potential source of guidance is the draft Inter-jurisdictional Recognition of Substitute Decision-Making Documents Act from the National Conference of Commissioners on Uniform States Laws [19]. If adapted to POLST, the reciprocity provisions in this Act would deem a POLST form valid if, when completed, it complied with the law of the jurisdiction where it was completed [7].

However, a uniform law from the National Conference of Commissioners on Uniform State Laws specifically with regards to POLST is not yet in existence and remains a theoretical solution to the problem of POLST portability. Until such uniform law is available for consideration, states may elect to enact legislation establishing reciprocity to address current problems with POLST compliance across jurisdictions.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 20-A-17, and that the remainder of this report be filed:

1. That our American Medical Association work with state medical associations to advocate with appropriate legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment forms completed in one state as valid and enforceable in other states; (Directive to Take Action) and

2. That our AMA draft model state legislation that will allow for reciprocity of POLST forms. (Directive to Take Action)

Fiscal Note: Modest—Between $1,000 and $5,000
REFERENCES


6. Okla. State 63 § 3105.3.


