



Back to the Future? POLST and End-of-Life Law

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The “POLST Paradigm”¹ represents the latest development in the four-decade American enterprise of legislating standards for the care of terminally ill and permanently incapacitated patients.² Near the outset of this enterprise, the late lawyer and scholar Dennis J. Horan said of the 1976 California living will statute (“Natural Death Act”) that it “adds officious burdens to the death bed, encumbers medical decisions with unnecessary additional consultations and creates rather than clarifies legal problems.”³ Horan was equally skeptical of the New Jersey Supreme Court’s opinion that same year in the case of Karen Quinlan.⁴ The court, he noted, relied unnecessarily and unwisely on the constitutional right of privacy, whereas existing common-law principles (such as the right to refuse medical treatment) would have provided a sufficient and more effective basis for its decision.⁵ More recently, Professor Lois Shepherd echoed Horan’s conclusion, if not his precise analysis. Proposing that we put an end to end-of-life law, she concludes (as did Horan) that end-of-life treatment decisions should be treated, in law and clinical practice, like other important medical treatment decisions. The corpus of specialized rules and procedures developed in recent decades “may have been useful and even necessary at some point in the development of the law and ethics in this area, but their value has diminished and it is time to let them pass.”⁶

POLST—the common acronym for Physician Orders for Life-Sustaining Treatment—promises to address these dilemmas. The POLST paradigm purports to compensate for the failure of myriad statutes and court cases to produce, in a critical mass of cases, reliable and actionable indicators of a patient’s intentions regarding care at the end of life.⁷ Ostensibly, POLST is designed to complement, not replace, mechanisms such as living wills, appointment of healthcare surrogates, and advance medical directives (AMDs). Yet, the literature supporting POLST unambiguously promotes the paradigm as

a superior form of advance care planning. Unlike these prior mechanisms, the bright-colored, one sheet POLST form is the “order” of a physician (or, in some states, a nurse practitioner or physician assistant), in clear, direct language, which is immediately actionable. Recourse to POLST will thus alleviate concerns over applying the boilerplate language in a “form” living will, interpreting the generalized instructions in a “customized” advance directive, or seeking approval at every stage (or at every facility transfer) from an appointed surrogate who may, or may not, understand an incapacitated patient’s prior wishes.⁸ If POLST is not explicitly designed to replace the mechanisms created by existing end-of-life law, it is certainly intended to establish a more sound path toward effective end-of-life decision-making. Before examining whether POLST can live up to this ambition, a brief “POLST Primer” is warranted.

A Primer on POLST

The POLST paradigm was designed in the early 1990s to translate into actionable medical orders a patient’s wishes regarding three potential treatment options at the end of life: (1) cardio-pulmonary resuscitation (CPR); (2) intubation and ventilator support; and (3) artificially administered nutrition. Originally, the paradigm also included antibiotics as a fourth treatment option, but this has been dropped in many POLST forms. The paradigm was developed by the Center for Ethics in Health Care at Oregon Health & Science University, together with representatives of stakeholder healthcare organizations.

Shortly thereafter, POLST proponents from Oregon and a handful of other states formed the National POLST Paradigm Task Force (NPPTF). The NPPTF determines whether POLST initiatives in other states qualified as “endorsed” POLST programs, or merely as “developing” programs. A state program may reach “endorsed” status—and thus lay full claim to representing the POLST Paradigm—only if it adheres to NPPTF standards (including the specifics of the POLST form), has addressed relevant legal and regulatory issues, and has developed strategies for dissemination and ongoing evaluation of the program within the state.⁹ Seventeen states have

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“endorsed” programs, two of which (Oregon and West Virginia), have achieved “mature” status. Twenty-eight other states have programs in various stages of development.¹⁰ While there are slight variations in the POLST form from state to state, the basic structure does not vary. Using the Oregon POLST form as an example, Section A calls for a yes/no decision on the use of CPR if the patient is in cardiopulmonary arrest (no pulse or respiration). Section B, titled “Medical Interventions,” is designed to guide treatment decisions in other acute situations. It provides three options: (1) “comfort measures only,” (2) “limited additional interventions” or “selective treatment” (to exclude intubation/ventilation and ICU care), and (3) “full treatment” (to include intensive care). Section C indicates the patient’s preferences for the use of artificially assisted nutrition if the patient loses the capacity to take food and fluids by mouth. Three options are offered: long-term tube feeding; a defined trial period of tube feeding (which may be specified by additional orders on the form); and no tube feeding.

As noted, POLST is designed to complement, not to replace, existing provisions for AMDs, including the appointment of healthcare surrogates. While any adult can execute an advance directive, POLST is recommended only for a patient with a serious health condition or frailty, whose healthcare provider “would not be surprised” if the patient died within 12 months.¹¹ AMDs, according to the paradigm, are intended to guide “future” treatment, while POLST is concerned with “current” treatment. A POLST form may be revoked at any time and, according to the paradigm’s guidelines, should be revisited whenever there is a significant change in the patient’s condition and at time of transfer to another healthcare setting. The legal foundation for POLST varies from state to state. Most states with POLST programs have amended their state codes pertaining to AMDs and/or to do-not-resuscitate orders (DNR) to implement POLST,¹² but not all potential conflicts with state laws on AMDs and DNR have been resolved.¹³

According to the paradigm, a properly-completed POLST form constitutes a contemporaneous recording of patient wishes that is (1) immediately actionable because it is signed by a physician or other provider, (2) easy to follow because it is on a single-page, brightly-colored, standardized form, (3) more comprehensive than a traditional DNR because of the other treatment options it addresses, and (4) transportable from institution to institution, or from institution to home.¹⁴ Proponents also contend that POLST serves patient autonomy better than traditional forms of AMDs because (1) the form is created after a discussion between the patient and provider when a serious condition has arisen, and thus addresses

current, specific needs, not a hypothetical scenario that may be years off; (2) under POLST protocols, the form should be revised whenever there is a significant change in the patient’s condition; (3) the form will travel with the patient, and thus (unlike an AMD that may be in a home safe or lawyer’s office) be available when a decision regarding life-sustaining treatment needs to be made; (4) the form is written in precise medical language and signed by a provider, and thus will more likely be honored by other providers when the patient is transferred; and (5) POLST is not subject to the variances, limitations, and formal requirements that afflict current state laws on AMDs and surrogate appointments.¹⁵ Deviance from the requirements of the POLST paradigm would place at risk these lofty objectives. While states frequently amend laws and regulations to accommodate and implement the POLST paradigm, their latitude in doing so is constrained by the mandates enforced by NPPTF. Legislative changes to the structure of the POLST form,¹⁶ its status as an “order,” or its portability jeopardize the state’s ability to achieve “endorsed” POLST status.¹⁷ While allowing for minor variations in implementation, POLST is a one-size-fits-all paradigm, implementation of which is zealously guarded by NPPTF.

With this brief background, we can consider POLST’s influence on end-of-life decision-making, its relationship to existing legal standards regarding the provision and withdrawal of life-sustaining treatment, and whether the superseding authority intended for the POLST form is appropriate, particularly in non-emergency settings.

POLST and Current End-of-Life Standards

To the first issue, the POLST paradigm proposes a clear answer: if correctly followed, POLST is intended to—and will—change the manner in which end-of-life treatment decisions are made.¹⁸ According to one expert, POLST reflects a growing consensus away from a legalistic, “transactional” model of advance care planning (embodied in living wills and AMDs) toward a patient-centered “communication” model that emphasizes an iterative process of decision-making that focuses on goals of care in light of the patient’s current medical condition and personal beliefs and values.¹⁹ A core premise of POLST is that completion of the form is based on the voluntary, informed consent of the patient. However, the paradigm also anticipates that all patients in the target POLST population—those whose death within a year would not be a “surprise”—will be given the opportunity to complete a POLST form.²⁰ For the most part, POLST does not aim to reach this objective through mandates, such as the “mandatory offer” of an opportunity to complete an advance directive required by the federal Patient

Self-Determination Act. The vast majority of POLST states do not require that hospitals and other institutions offer POLST to certain categories of patients. Consistent with the paradigm's standards, those that do emphasize participation in POLST is strictly voluntary.²¹ In this way, POLST may be said to adopt a “soft” carrot-and-stick incentive to more open discussion and decisions on end-of-life treatment options.

The Uniqueness of POLST?

No one denies the laudable goal of detailed physician-patient consultations, built on the principles of informed consent, suitable to the clinical situation of the patient. Yet, is the POLST form the most suitable “carrot” to reach that goal? The format seems to require a particular structure to those discussions, steered toward reaching a “yes” or “no” decision on the listed treatment options—options that may be of limited relevance to a given patient's circumstances, and to the exclusion of options that may be far more relevant. Completion of the form, in the rigid format dictated by NPPTF, is the *sine qua non* of the entire POLST paradigm. NPPTF no doubt intends that any discussion of end-of-life treatment would be tailored to an individual patient's needs. Patients also may decline to respond to any of the options on the form, and may use other instruments, including non-POLST medical orders and AMDs to communicate preferences on other aspects of treatment. But only the POLST orders appear on bright pink card stock, signifying their intended priority and precedence over other patient or provider directives. The underlying intent is manifest—to get as many patients as possible to decide among these options, and to make those decisions actionable as a matter of clinical practice and law. The POLST paradigm is transparent on these points: not enough patients currently state their preferences regarding these core measures of life-sustaining treatment, and of those that do, the lack of enforceability undermines those preferences.

One can readily understand POLST's objective to simplify and “empower” patient choices—particularly on the utilization of CPR and intubation/ventilation, and particularly if the patient has been discharged from acute care to a skilled nursing facility, hospice, or home. A patient who has consented to entry of a DNR order and has chosen to return home for the duration of a terminal illness should be confident that paramedics who may be summoned by a 911 call will not override that order. (The same is true for the discharged patient who desires to be resuscitated, perhaps until death is more imminent.) The availability, clarity, and prominence of a POLST form are

suited to the type of split-second decision that must be made in such a circumstance. The same would be true of a patient discharged to a skilled-nursing facility; the POLST form could limit emergency calls and transfers to acute care that run counter to the desires of the patient.

However, POLST's inclusion of “artificially administered” or “medically assisted” nutrition seems less justified, especially given the breadth of the target POLST population (anyone whose death within a year would not be a “surprise”). Few if any decisions to institute tube feeding are undertaken as an emergency measure. (Although POLST is not entirely clear on this point, we can assume that “artificial nutrition by tube” refers to mechanisms such as a PEG tube and does not include

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use of IV fluids to relieve dehydration.) The inclusion of tube feeding brings POLST into an ethical gray area, as some religious and ethical authorities view the refusal or cessation of tube feeding as tantamount to euthanasia. POLST proponents contend that the range of options on the form accounts for these controversies, and forces no one, patient or provider, to act contrary to conscience; they cite as evidence that some Catholic hospitals participate in POLST.²² But conflict remains. A pastoral letter from the Catholic bishops of Wisconsin concluded that the POLST form “oversimplifies” end-of-life treatment decisions, and, in reference to cessation of tube feeding, may authorize acts that are tantamount to euthanasia.²³ The National Catholic Bioethics Center likewise concluded that Catholic institutions should not accept POLST forms.²⁴ Even setting aside the particular objections in Roman Catholic moral teaching, POLST holds no particular advantage over “ordinary” provider orders or advance directives in guiding decisions whether or not to place a feeding tube. Furthermore, the contemporaneous assent of a duly-appointed surrogate, reflecting the desires stated by the patient in an AMD or in private, may be a far more reliable and ethically appropriate basis on which to base a decision on assisted feeding. POLST instructions may simply repeat the wishes stated in an AMD or conveyed by a surrogate. But they could conceivably conflict—meaning that the process of completing the POLST form should include inquiry into whether

the patient has an AMD and/or has appointed a surrogate, as well as informing the surrogate of the decisions reflected on the POLST form. While the POLST paradigm recommends such a comprehensive approach to discussions with the patient, the form retains its authority whether or not the recommendation is followed. This example illustrates POLST's complex and unresolved relationship with key aspects of existing end-of-life law.

The POLST form is most suited to genuine emergencies and “in the moment” treatment decisions, particularly where existing law requires the use of aggressive life-sustaining treatment.²⁵ The most common scenario involves emergency medical services (EMS) personnel, required by law and protocol to perform aggressive and invasive life-sustaining measures on patients in cardio-pulmonary arrest. All aspects of the POLST form—the standard format, the bright paper, and the clear physician’s

“...the further the distance from a genuine emergency, the weaker the case for POLST as opposed to other forms of directing patient care, and the greater the potential for conflict with existing laws.”

orders—are necessary and sufficient to notify emergency personnel not to apply such measures, or to apply them if the POLST form so indicates. Even here, however, POLST may come into conflict with existing rules on out-of-hospital DNR orders. Virtually all states have adopted protocols for such orders (outside the context of POLST) that may include, depending on the state, both formal and substantive requirements, such as a certification by two physicians that the patient meets a qualifying precondition such as terminal illness or permanent unconsciousness.²⁶ POLST proponents view such requirements as “barriers” to the implementation of POLST;²⁷ another perspective might view POLST as undermining safeguards established to protect vulnerable patients and to err on the side of life.²⁸

POLST proponents emphasize that “normal” physician-patient conversations reduced to “standard” physician orders are not a viable alternative to POLST during emergency situations.²⁹ However, the further the distance from a genuine emergency, the weaker the case for POLST as opposed to other forms of directing patient care, and the greater the potential for conflict with existing laws. For example, if an assisted living resident or nursing home patient has executed an advance directive

and/or appointed a health care surrogate, what is the need of a POLST form on questions such as the appropriate level of medical intervention or the use of tube feeding? The POLST form, it is argued, is both more contemporary and actionable—but the same would be true of standard physician or provider orders recorded on a medical chart; such orders would also have the virtue of being more detailed and nuanced than the stark, simplistic choices on the POLST form.

POLST & Conflicting Forms

Another difficulty is which advance care form should control—the potentially more detailed AMD, or the more recent and simplistic POLST form? The POLST form attempts to address this prospect by emphasizing (repeatedly, and in bold type) that POLST complements an advance directive, does not replace it, and that both

documents should be examined to ensure consistency. Short of perfect implementation of the POLST paradigm, this will not always be done. What then? State laws differ in their approach to resolving this issue. Some stipulate that the POLST form prevails, others that the AMD prevails. Still others require that the most recently completed document prevails; among this group, California allows a more recent POLST form endorsed by a surrogate to prevail, while New Jersey and Colorado

stipulate that only the most recent patient-created document can prevail.³⁰ The very fact that states see the need to enact such provisions demonstrates that the potential conflict between POLST and other mechanisms such as AMDs is genuine, not speculative.

The authority of a surrogate to complete or override a POLST form also varies from state to state. Healthcare surrogates can be appointed or recognized in several ways: through court-appointed guardianship; through designation by a competent adult of a durable power of attorney for health care (or similar document) under state law; and, in all but a handful of states, through recourse to a “default” list of surrogates designated by statute.³¹ Some POLST forms recognize a fourth category, a person recognized by the physician as someone who would act and make decisions in the incompetent patient’s best interests. The legal authority of this fourth category of surrogates is not as certain as those of the other three, but likely reflects the practical reality when a treatment decision must be made and a formally-appointed surrogate is not available. Surrogates complete over one-third of POLST forms, but some states limit their ability to revoke or modify a POLST form previously completed by the patient when competent.³² Such

restrictions may block the “iterative” process that is part of the POLST paradigm, raising the risk that the POLST form becomes stale or “frozen in time.”

Finally, the assertion that POLST is intended not to replace AMDs, but to complement them, does not withstand scrutiny. POLST literature typically asserts the superiority of the POLST form over current advance directive and surrogate arrangements, and proposes a template for physician-patient consultation that would render AMDs obsolete.³³ The assertion that POLST is not an “advance directive” is even more risible. There are obviously differences between the POLST form and existing AMDs—the AMD, in most states, can be customized in ways the POLST form cannot; the AMD may be executed by any adult, whether young and perfectly healthy or elder and infirm; the AMD is subject to different procedural formalities than POLST; and the AMD is not a physician order. However, the core similarities trump these differences. POLST, like an AMD, is a legal means to communicate patient preferences about contingent future treatment decisions that provides legal immunity to those who in good faith act upon those preferences. The purported distinction between “future” (set forth in AMDs) and “current” (set forth in POLST) treatment directives is blurred by the fact that POLST is not limited to patients with a terminal illness or in imminent danger of death. The pool of patients who *may* die within a year’s time is not defined with particularity, and may overlap significantly with the pool of patients for whom preparation of an advance directive and appointment of a surrogate, all under existing law, would be prudent.

The fact that POLST “ramps up” the statement of patient preferences to the status of physician orders also does not bring POLST outside the ambit of an advance directive. POLST effectively converts into a single step the two-step process of incorporating the preferences stated by a patient, a surrogate, or in an AMD into standard medical orders. Equally tenuous is the claim that the POLST form is a medical order, not (like an AMD), a legal instrument. NPPTF requires specific adjustments to state law in order for a POLST program to be “endorsed,” and in response, laws specifically designed to give legal effect to POLST orders tantamount to that of AMDs have been enacted in virtually every state where the paradigm is implemented. POLST, because of its status as a medical order, is a different form of legal instrument from an AMD, but its effect—to record patient preferences for future treatment and provide immunity to those who follow them—is based on the same core principles animating the course of legislation in this area for four decades.

POLST, therefore, is an evolution of, not a departure

from, the long process of actualizing patient preferences in a format that will provide a legal “safe harbor” for those who rely on those preferences. If POLST becomes the dominant paradigm to guide treatment decisions for the terminally and chronically ill, there would be less need to prepare an AMD, save for appointing a healthcare surrogate who, if the need arises, could authorize completion of the POLST form. This would comport with the consensus among many experts that the appointment of a reliable surrogate is the most important element of advance care planning,³⁴ and that such planning should be based on shared communication and shared responsibility between patients, providers, and family members or other surrogate decision-makers.

POLST: Summary of Benefits and Limitations

In its ideal form, the POLST paradigm offers many advantages over the mechanisms previously enacted under the umbrella of “end-of-life law.” The “transactional” model embodied in living wills and other forms of AMDs is a defensible starting point for discerning patient values and wishes, but has proven largely ineffective in guiding specific decisions in the clinical setting. In addition, preparation of an AMD in an attorney’s office, often many years before it would come into effect, is a weak indicator of patient preference.³⁵ In contrast, the POLST paradigm’s objective that the process commence, not with the presentation of the POLST form, but with a detailed discussion of the patient’s condition, prognosis, and goals for treatment, is virtually unassailable—as is the expectation that a completed POLST form be revisited when conditions change or the patient is transferred.³⁶ However, short of failure to attain “endorsed” status, there is no mechanism to inform these “musts” within the POLST paradigm, and compliance will inevitably vary.³⁷ Moreover, the *raison d’être* of the paradigm is the entry of physician’s orders, and not just any physician’s orders, but POLST-compliant orders as defined by NPPTF. Thus, the structured discussions and iterative process mapped out by the paradigm are not ends in themselves, but means to an end.

This would not be a problem if the “end” were more broadly defined to obtain patient-physician (or surrogate-physician) agreement on medical orders appropriate to the patient’s present condition, prognosis, values, and preferences. Neither POLST, nor virtually any other aspect of current end-of-life law (save for those provisions allowing personal appointment of a surrogate) is required for this end to be achieved. A patient’s right to consent to or refuse medical treatment is secured by common-law, as recognized in numerous state court decisions as well as by the United States Supreme Court.³⁸

Proponents of POLST make a persuasive case that a standardized form is needed to guide the actions of emergency responders. Yet, even here, some caution must be exercised lest POLST becomes a default mechanism for limiting life-sustaining treatment. The case for the necessity of POLST falters when applied to non-emergency situations. Much of *that* case—and it is not negligible—

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rests on POLST’s practical impact. Published research, while notable for its common authorship by proponents of the paradigm,³⁹ indicates that the paradigm resulted in lower incidence of unwanted CPR, ventilator support, and transfer to intensive care.⁴⁰ In a 2010 study focused on nursing home residents, POLST was reportedly more effective than “traditional practices” in limiting unwanted life-sustaining treatment, particularly those medical interventions addressed by Section B of the standard POLST form.⁴¹ Laudable as they may be, these results do not establish the necessity of POLST; presumably missing in the case of non-POLST patients were clear directives on issues such as hospitalization. POLST may fill this gap, but clearly stated “standard” medical orders should be just as effective.

Conclusion

POLST’s growing acceptance signifies recognition that the enterprise of legislating end-of-life law has failed to achieve satisfactory results. Proponents will likely argue that no other mechanism has achieved such widespread acceptance as an alternative to “traditional” methods of effectuating patient preferences. POLST nevertheless risks falling into the same traps as its predecessors. The regimented POLST form is reminiscent of early living wills and standard form AMDs; this necessarily limits its applicability to patients whose treatment dilemmas cannot be reduced to simple “yes” or “no” responses to CPR, hospitalization, and assisted feeding. POLST also manifests the unfounded assumption that special rules and procedures—in copious quantity and exacting detail—are required to permit the withdrawal or withholding of life-sustaining medical treatment. Under current (non-POLST) law, providers are sometimes reluctant to make such decisions unless an AMD is available; in the future, they may be reluctant to act without the execution of a POLST form. For any variety of reasons, a patient in the “POLST pool” may be reluctant to, or simply

delay, authorizing a POLST form to be executed. Does that patient thereby risk being over-treated? Finally, POLST may perpetuate the most regrettable dynamic in our end-of-life law: the search for a talismanic statement (“I would never want to live that way”), document (living will), or other indicator allowing those who actually *make* the decisions about life-sustaining treatment for an incapacitated patient to believe that the decision is not theirs, but that of the patient. This dynamic is the flip side of our understandable desire to honor patient autonomy. However, autonomy is not an absolute value, and it risks becoming distorted and fetishized if used to diminish the responsibilities we bear in treating the incapacitated.

POLST, to the extent it elicits current patient preferences based on the patient’s current condition, is an improvement on what has gone before. Its proponents and overseers (NPPTF), however, should recognize its built-in limitations and, in response, permit greater latitude and flexibility in its implementation. Only then is POLST likely to be a step forward, and not a step back, into the future.

- 1 Thaddeus Mason Pope and Melinda Hexum, “Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment,” *Journal of Clinical Ethics* 23, no. 4 (2012): 353.
- 2 Charles P. Sabatino and Naomi Karp, “Improving Advanced Illness Care: The Evolution of State POLST Programs,” *AARP Public Policy Institute* (2012): 2. Accessible at <http://assets.aarp.org/rgcenter/ppi/cons-prot/POLST-Report-04-11.pdf>
- 3 Dennis J. Horan, “Editor’s Comment on the Living Will,” in *Death, Dying, and Euthanasia*, ed. Dennis Horan and David Mall (Washington, DC: University Publications of America, 1977), 369.
- 4 *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).
- 5 Dennis J. Horan, “The Quinlan Case,” in *Death, Dying, and Euthanasia*, 525–534.
- 6 Lois Shepherd, “The End of End-of-Life Law,” *North Carolina Law Review* 92, no. 1693 (2014): 1748.
- 7 Pope and Hexum, “Legal Briefing,” 354.
- 8 Susan E. Hickman et al., “The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation,” *Journal of Law, Medicine, & Ethics* 36, no. 1 (2008): 119.
- 9 See National POLST Paradigm, *About the National POLST Paradigm*, <http://www.polst.org/about-the-national-polst-paradigm/> (accessed August 18, 2015). See also Pope and Hexum, “Legal Briefing,” 355, and Amy Vandenbroucke et al., “POLST: Advance Care Planning for the Seriously Ill,” *Bifocal* 36, no. 4 (2015): 91.
- 10 The National POLST website includes an interactive map including information on the status of POLST programs in each state. See <http://www.polst.org/programs-in-your-state/>.
- 11 Written testimony of Amy Vandenbroucke before Senate Special Committee on Aging, on June 26, 2013, “Renewing the Conversation: Respecting Patients [sic] Wishes and Advance Care Planning,” 113th Cong., 10. This testimony can be accessed

- at http://www.aging.senate.gov/imo/media/doc/03_Vandenbroucke_6_26_13.pdf (accessed August 18, 2015).
- 12 National POLST Paradigm Program, *POLST Program Legislative Comparison*, February 15, 2015, <http://www.polst.org/wp-content/uploads/2015/03/POLST-Leg-Chart-2-15-15.pdf> (accessed August 18, 2015).
 - 13 Hickman et al., “The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care,” 119.
 - 14 Pope and Hexum, “Legal Briefing,” 354.
 - 15 *Ibid.* See also Patricia A. Bomba, Marian Kemp, and Judith S. Black, “POLST: An Improvement Over Traditional Advance Directives,” *Cleveland Clinic Journal of Medicine* 79, no. 7 (2012): 457–464.
 - 16 Oregon stipulates that “the form must not be altered in **any way**” (their emphasis), and must be printed back to back on “65# Cover Ultra Pink card stock,” and for good measure, suggested retailers are offered for obtaining the required paper. <http://static1.square-space.com/static/52dc687be4b032209172e33e/t/542ec715e4b0fc638df2bc56/1412351765576/2014.10.02+Printing+POLST+instructions.pdf> (accessed August 18, 2015).
 - 17 Amy Vandenbroucke, Executive Director of the National POLST Program, testified before a U.S. Senate committee in 2013 that states which modify the POLST form, require patients to be in a “terminal” condition, or mandate completion of POLST forms cannot achieve “endorsed” POLST status (“Renewing the Conversation,” 10).
 - 18 Mason and Hexum, “Legal Briefing,” 354.
 - 19 Sabatino and Karp, “Improving Advanced Illness Care,” 2–3.
 - 20 Vandenbroucke, “Renewing the Conversation,” 10.
 - 21 Pope and Hexum, “Legal Briefing,” 362–63. Maryland and Utah are among the minority of states that require “mandatory offer” of POLST to patients for whom it is suitable.
 - 22 Vandenbroucke et al., “POLST: Advance Care Planning,” 94.
 - 23 The Catholic Bishops of Wisconsin, “Upholding the Dignity of Human Life: A Pastoral Statement on Physician Orders for Life-Sustaining Treatment (POLST),” <http://www.wisconsinatholic.org/WCC%20Upholding%20Dignity%20POLST%20Statement%20FINAL%207-23.pdf> (accessed August 18, 2015). See also Rev. Javier I. Bustos, “Our Lives on a Bright-Colored Form: A Statement on the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm in the State of Wisconsin,” last modified September 8, 2011, <http://www.archmil.org/ArchMil/Resources/COMM/OurLivesonaBright-ColoredForm.pdf> (accessed August 18, 2015).
 - 24 E. Christian Brugger, Stephen L. Pavela, William L. Toffler, and Franklin Smith, “POLST and Catholic Health Care: Are the Two Compatible?” *Ethics and Medics*, 37, no. 1 (January 2012), 1–4.
 - 25 Vandenbroucke et al., “POLST: Advance Care Planning,” 94.
 - 26 Hickman et al., “The POLST Paradigm,” 122–123.
 - 27 *Ibid.*
 - 28 Stanley A. Terman, “It Isn’t Easy Being Pink: Potential Problems with POLST Paradigm Forms,” *Hamline Law Review*, 36, no. 2 (2013): 207–209.
 - 29 Vandenbroucke et al., “POLST: Advance Care Planning,” 94.
 - 30 Pope and Hexum, “Legal Briefing,” 362.
 - 31 Edward R. Grant, “Advance Medical Directives in the Era of Health Care Reform: Who Decides?” *Dignitas* 20, no. 4 (2013): 1, 4.
 - 32 Pope and Hexum, “Legal Briefing,” 361.
 - 33 For example, in her Senate testimony, Vandenbroucke highlighted the “key differences” between the POLST form and an advance directive chiefly by noting that only the latter “needs interpretation,” “communicates general wishes,” and is not “generally available when needed.” The POLST form, by contrast, is “immediately available,” communicates “specific” medical treatments, and is “easy to locate” (“Renewing the Conversation,” 5). Another commentator asserts that POLST “more accurately conveys end-of-life care preferences for patients with advanced chronic illness and for dying patients than traditional advance directives and yields higher adherence by medical professionals.” Bomba, Kemp, and Black, “POLST,” 464.
 - 34 Shepherd, “The End of End-of-Life Law,” 1726–1727.
 - 35 Angela Fagerlin and Carl E. Schneider, “Enough: The Failure of the Living Will,” *Hastings Center Report* 34, no. 2 (2004): 30.
 - 36 Sabatino and Karp, “Improving Advanced Illness Care,” 2–3.
 - 37 Sabatino and Karp have identified a number of barriers to proper implementation of the paradigm, including misperception that POLST is “just another routine form,” that the POLST process is cumbersome and time-consuming, and even that emergency medical personnel find the POLST form confusing because of the number of options presented on the form (Sabatino and Karp, “Improving Advanced Illness Care,” 18).
 - 38 *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990); See also Grant, “Advance Medical Directives,” 4.
 - 39 See Susan E. Hickman et al., “A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program,” *Journal of the American Geriatrics Society*, 58, no. 7 (2010): 1241–1248; Susan E. Hickman et al., “Use of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in the Hospice Setting,” *Journal of Palliative Medicine* 12, no. 2 (2009): 133–141; Terri A. Schmidt et al., “The Physician Orders for Life-Sustaining Treatment Program: Oregon Emergency Medical Technicians Practical Experiences and Attitudes,” *Journal of the American Geriatrics Society* 52, no. 9 (2004): 1430–1434; and Susan E. Hickman et al., “Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon Nursing Facilities: Beyond Resuscitation Status,” *Journal of the American Geriatrics Society*, 52, no. 9 (2004): 1424–1429.
 - 40 Sabatino and Karp, “Improving Advanced Illness Care,” 6–7.
 - 41 Hickman et al., “A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities,” 1241–1248.