



CEDARS-SINAI MEDICAL CENTER

## **Frequently Asked Questions AB 3000: Physician Orders for Life-Sustaining Treatment**

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### **1) What is POLST?**

**POLST**, which stands for "Physician Orders for Life-Sustaining Treatment," is a physician's order that outlines a plan of care reflecting both the patient's preferences concerning care at life's end and the physician's clinical judgment based on a thorough medical evaluation of the



patient's condition While POLST has been around for years in other parts of the country, the California Assembly passed explicit legislation about POLST (AB 3000 [Statutes 2008, Chapter 266]) in 2008, and that legislation went into effect on January 1, 2009. While this legislation does not require that healthcare providers use the POLST form, it does requires that all healthcare providers honor patients' POLST forms.

## **2) How does POLST help the patient?**

- Documents a patient's wishes for life-sustaining treatment in the form of a physician order.
- Streamlines the transfer of patient records between facilities.
- Clarifies treatment intentions and minimizes confusion about patient preferences.
- Complements a patient's Advance Healthcare Directive.
- Assists physicians, nurses, emergency personnel and health care facilities in promoting patient autonomy.
- Optimizes comfort care of patients.
- Allows orders to be reviewed and changed periodically as indicated by patient values and medical circumstances.

## **3) How does POLST help healthcare providers?**

- Ensures readily available information about the patient's treatment preferences.
- Provides a system for communicating the physician's medical orders for the patient to other care facilities.
- Is an effective instrument that prevents unwarranted treatments and helps ensure that medically indicated treatments desired by the patient are provided.
- Provides a practical way to assemble patient information on a double-sided form.
- Allows periodic review and changing of orders as indicated by patient values and medical circumstance.

## **4) What is the POLST form?**

The POLST form, which is preferably to be printed on heavy stock bright pink paper, provides default orders in the event a patient become seriously ill. Specifically, the POLST form contains information about:

- use of CPR,
- preferred scope of medical interventions in general,
- use of artificially administered nutrition.

In emergency situations, the orders contained on a POLST form are to be used to direct medical care until further orders can be decided upon and written.

## **5) Why should a POLST form be completed?**

In general, POLST both helps patients and their healthcare professionals to discuss and develop concrete plans that accurately reflect patients' preferences concerning end of life care and then succinctly and clearly convey those plans to other healthcare professionals, facilities, and emergency personnel.

## **6) When should a POLST form be completed?**

Ideally, a POLST form is completed when the prospect for a patient having significant health



decline is more likely than not, but before the patient is acutely ill. For many, this means at that point when it would not be surprising if the patient died within the next year. Hence, a POLST form may be completed when a patient is diagnosed with a terminal illness, experiences a significantly compromising illness, or becomes frail. A POLST form may be completed as part of a regular medical appointment, at any point in which end-of-life planning is appropriate, or as part of discharge planning from the hospital. Per the latter, completing a POLST would be appropriate for any patient who, while in CSMC, has DNAR status, has been seen by the Palliative Care team, is being discharged to hospice, is being discharged to a long-term care facility, or has metastatic or end-stage organ disease. Legally, a POLST form may be completed for any patient at any time, regardless of the patient's current health status.

### **7) What is the procedure for completing a POLST form?**

In general, a POLST is to be completed by the patient's physician (or by a healthcare provider who has undergone special training about how to complete a POLST and who works with the patient's physician) in conjunction with a thorough conversation with the patient regarding the patient's current and future health conditions and associated treatment preferences. After such conversation, both the patient and the physician must sign the POLST.

More specifically, the procedure for completing a POLST form may be initiated by either the physician or the patient. If a patient expresses interest in completing a POLST form to a healthcare provider other than the patient's physician, the patient's physician should be contacted. A healthcare provider such as a nurse or social worker who has undergone training about POLST can explain the POLST form to the patient, however, the physician is responsible for reviewing the various treatment options on the POLST form with the patient. The physician should also talk with the patient about the patient's advance directive (if any) or other statements the patient has made regarding his or her wishes for end of life care and treatments. In addition, the benefits, burdens, efficacy and appropriateness of various treatment and medical interventions should be discussed as well.

After all appropriate discussions, the completed POLST form is signed. The physician should document in the patient's medical record that a POLST form has been completed.

### **8) When is a POLST form actually utilized?**

The POLST form may be utilized when a patient is at home, in a long-term care facility, in transit between locations, or as a directive when a patient arrives at an Emergency Department or is admitted into an acute care facility.

### **9) What if a patient can no longer communicate her/his wishes for care or is incapable of signing the POLST form?**

Family members, or other legally recognized decision-makers for the patient, may speak on behalf of a patient if they are familiar with the patient's preferences. A healthcare professional can complete the POLST form based on family members' or legally recognized decision-makers' understanding of the patient's wishes. And a family member or legally recognized decision maker can sign the POLST form in the patient's stead.



**10) Where should a patient’s POLST form be kept?**

If a patient lives at home, the original pink POLST form should be kept where emergency responders can find it. If a patient lives at a long-term care facility, the POLST form will be kept in the patient’s chart. When a patient arrives at the hospital, a copy of the original pink POLST form should be made and used to establish initial orders. The patient’s physician might also keep a copy. The original form itself, however, is to remain with a patient regardless of where the patient is located.

**11) What should be done when a patient arrives in the ED or is admitted into the hospital with a POLST form?**

There are four general steps that should to be taken:

- Confirm with the patient, if possible, or with the patient’s legally recognized healthcare decision-maker if the patient lacks decision-making capacity, that the POLST form in hand has not been voided or superseded by a subsequent POLST form or other kind of healthcare directive.
- Make a copy of the POLST form and place it in the patient’s medical record along with documentation that the patient has a POLST form. Return the original POLST form to the patient or the patient’s legally recognized decision-maker.
- Notify the physician currently treating the patient of the existence of the POLST form and the information contained on it.
- Follow the directives contained on the POLST form as a valid physician order until the physician currently treating the patient reviews the POLST form and incorporates the content of the POLST into the care and treatment plan of the patient, as appropriate.

**12) Can the directives contained on a POLST form be changed?**

There are three ways in which a POLST may be altered:

- The patient, if he or she has capacity to make healthcare decision, may
  - revoke a POLST form and complete a new POLST form,
  - request treatment that differs from what is ordered on the POLST form but not otherwise revoke the POLST, or
  - revoke the POLST form and not complete a new one.

Such changes may be made by the patient at any time and in any manner that communicates his or her intent.

- The legally recognized healthcare decision-maker for a patient lacking capacity to make healthcare decisions may request a modification of the patient’s POLST based on consultation with the physician who is, at that time, the patient’s treating physician.
- The physician who is, at the time, treating the patient may, after having conducted an evaluation of the patient and, if possible, having consulted with the patient (or the patient’s legally recognized healthcare decision-maker if the patient lacks capacity to make healthcare decisions), issue new orders consistent with the patient’s current health status and goals of care.

**13) Are there other circumstances in which a POLST can be disregarded?**

Yes. If fulfilling the instructions on a POLST form would entail providing medically ineffective healthcare or healthcare that is contrary to generally accepted healthcare standards, the POLST



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may be disregarded. In addition, if there is reasonable doubt concerning the authenticity of the POLST form, it may also be disregarded.

**14) Are the orders contained within a patient's POLST still applicable when the patient comes to our ED or is admitted to our institution but the physician who signed the POLST is not a member of our medical staff?**

Yes. The only exceptions for abiding by a POLST are those stated above.

**15) Are there legal risks associated with following the orders contained within a POLST?**

No. The California legislature included in the legislation governing POLST the explicit statement that any healthcare provider who honors a POLST is protected from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction as a result of his or her reliance on the information contained within a POLST as long as the healthcare provider:

- believes in good faith that action or decision is consistent with the information contained within the POLST, and
- has no knowledge suggesting that the POLST-related action or decision would be inconsistent with the patient's preferences.

**16) Should a POLST be reviewed, and if so, how often?**

Yes. The POLST form should be reviewed by a physician periodically, if:

- the patient is transferred from one facility to another,
- there is a significant change in the patient's health status (improvement or deterioration),
- the patient's treatment preferences change.

**17) Does the POLST form replace traditional Advance Directives?**

No. Although the POLST form complements an Advance Directive, it is not intended to replace that document.

**18) If a patient has a POLST form and an Advance Directive that conflict, which takes precedence?**

In most cases, the more recent document would be followed.

**19) Where can one learn more about POLST?**

General information is available from the California Coalition for Compassionate Care ([www.finalchoices.org](http://www.finalchoices.org)) or from the National POLST Paradigm Initiative Task Force ([www.polst.org](http://www.polst.org)).

For additional information, please contact the  
**Palliative Care Team at 310-423-9520 or the  
Center for Healthcare Ethics at 310-423-9636.**