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Editorial

Standardizing Protection of Patients' Rights From POLST to MOELI (Medical Orders for End-of-Life Intervention)

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To better align treatment desired with treatment received, and to codify this in law, the Patient Self-Determination Act of 1990 gave patients the right to decide what they were willing to have done to their bodies by creating an advance directive (AD), to have these decisions recorded in their medical records, and to be represented by surrogates if they cannot speak for themselves by creating a Durable Attorney for Health (DPOA).¹ To increase the likelihood that a wish expressed becomes a wish honored, Oregon developed the first Physician Orders for Life-Sustaining Treatment (POLST) to implement the law. New York² and many other states followed suit, pursuing a painstaking course in which POLST-type programs were proposed, negotiated, and enacted. Across venues, the POLST program has developed with a variety of names, such as POLST, MOLST, MOST, TPOPP, and IPOST, LaPOST, and POST. All have the goal of using a semi-structured process to help patients articulate their end-of-life (EOL) treatment preferences and to produce documents that translate their requests into a set of medical orders.

Coordinated by the National POLST Paradigm Task Force (NPPTF), the paradigm was a groundbreaking step toward ensuring protection of patient liberties. Recent reviews of multiple studies^{3,4} have offered considerable support for the program. Even critics of the paradigm acknowledge that it ensures patient autonomy, optimizes communication, minimizes use of unwanted interventions, simplifies decision making, facilitates transfers between providers and institutions, promotes consistency across health care settings, and decreases the cost of unwanted EOL care.⁵ Despite its apparent value, however, the POLST paradigm has been underutilized by patients and misunderstood by providers.⁶ Even trained providers using current iterations of the form produce documents that are often difficult to interpret in a crisis; contain confusing and/or contradictory requests, for example, resuscitation paired with comfort care^{7,8}; are outdated when applied⁹; and/or are heeded inconsistently.¹⁰

Although significant progress has been made by conforming to local laws, cultures, and medical systems in the 47 jurisdictions that address the POLST to some extent,¹¹ constitutional and ethical rights transcend state boundaries and can be recognized nationally. Because of the compromises in different jurisdictions, the programs differ in important ways, so patients in one state may have different

requirements and opportunities than those receiving service elsewhere. A nationally standardized paradigm would uniformly protect patients' rights regardless of where they live, and make it possible to undertake national evaluative and training programs.

From POLST to MOELI

The various iterations of the POLST have merit, but improvements are needed to address their shortcomings. While keeping its 2-page format, we propose multiple changes that build on and enhance the valuable POLST platform. Unlike the POLST, which is copyright-protected in some jurisdictions, our revised protocol is an open-source document that can be copied in whole or in part to facilitate its widespread adoption.

Title

Because many states allow advanced practice nurses and qualified physicians' assistants to sign and enter the form in patients' medical records, several states have already replaced "Physician" with "Medical" or "Provider." In addition, "Life Sustaining Treatment" implies that the form is intended to guide only those treatments that *prolong* life without encompassing the goals of patients who might not want this outcome. To solve both problems, we suggest changing the name to the more inclusive and accurate "Medical Orders for End-of-life Intervention" (MOELI).

Header

The header reminds providers about the scope and limitations of the form and offers guidelines for its use.

A. Reason for Creating the MOELI

The POLST paradigm is generally offered to patients with life expectancies not exceeding 12 months due to a terminal illness and/or extreme frailty. We propose extending the paradigm to those 80 or older. Because rates of dementia increase exponentially starting about age 65, with the risk doubling every 5 years,^{12,13} there is a reasonable chance that 80-year-olds will suffer the start of undetected insidious cognitive decline resulting in their loss of the capacity to initiate, reflect on, or engage in creating a living will. As Steinberg¹⁴ wisely observed, it is important for any person who might develop dementia to make EOL decisions while having the capacity to do so. Extending

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Medical Orders for End-of-life Intervention (MOELI)

MOELI is a set of medical orders that guide medical treatment based on a person's current medical condition. **** It is voluntary. ****MOELI supplements but does not replace a living will. ****Patient and/or legal surrogate must participate in its completion, jointly when possible. **** Patients can accept or refuse treatment as long as they have capacity; MOELI used only when patients cannot decide for themselves. ****Before acting in these orders providers must verify the patient's health status, ie. frailty, diagnosis, and life expectancy.**

Patient name: Last _____ First _____ Middle _____

Date of birth: _____ Last 4 #SSN _____ Gender: M F Other (specify) _____

A. Reason for MOELI 80 or older Extremely frail Death likely in 12 months
Terminal illness(es) (specify) _____

<p>B. MOELI discussed with:</p> <p>____ Patient> ____ Spouse> ____ Domestic partner> ____ Other (who?)> ____ Legal guardian.....> ____ Parent of a minor.....> Use* for participants who have DPOAH If patient did not participate, reason: _____</p>	<p>C. Legal capacity, health literacy, numeracy</p> <p>____ Yes ____ No ____ Not assessed ____ Yes ____ No ____ Not assessed ____ Yes ____ No ____ Not assessed ____ Yes ____ No ____ Not assessed ____ Yes ____ No ____ Not assessed ____ Yes ____ No ____ Not assessed</p>	<p>D. Does patient have a living will? ____ Yes ____ No If yes: Date: _____ Was it document discussed in creating the MOELI? ____ Yes ____ No If living will exists, attach it to, and forward with this MOELI. If no, did you encourage patient to create one. ____ Yes ____ No ____ N/A</p>
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E Patient's goal

I wish to live as long as possible. Please prolong my life using all reasonably practical means.
 I wish to live a meaningful life. Please use life supports as long as I am able to communicate and think clearly and my pain is controlled.
 I wish to experience a natural death. Please do not use artificial means to prolong my life.

F. Cardiopulmonary Resuscitation (CPR)

DO resuscitate any time my heart stops beating
 DO resuscitate only if my heart stopped due to a temporary, correctable event
 DO NOT resuscitate or use defibrillator under any circumstance: Always allow natural death.

G. Medical Intervention

Full Treatment to prolong life by all medically effective means. Includes transfer to hospital or skilled nursing facility, resuscitation, ventilation, hydration and nutrition by tube, dialysis, all forms of breathing assistance, antibiotics and all other recommended procedures, drugs, and surgery.
 Always For a trial period of: _____

Limited Treatment to treat medical conditions that avoids burdensome methods. Includes transfer to hospital or skilled nursing facility, resuscitation, fluids and nutrition by tube, and medication including antibiotics and other drugs to relieve pain and symptoms, noninvasive breathing aids, but no surgery
 Always For a trial period of: _____

Comfort-focused treatment to maximize comfort. Includes medication to relieve pain and suffering, breathing enhanced with oxygen, suctioning and other means of clearing airways, and positioning for comfort. Does not include resuscitation or other life-prolonging procedures such as fluids and food by tube or dialysis. May include transfer to a hospital or skilled nursing facility if needed for comfort including pain relief.

Additional orders on reverse: Yes No

H. OPTIONAL I hold blameless any provider who honors the requests herein in a manner that meets the community standard of care, and I direct my healthcare representative to do the same. (Patient's initials): _____

I. Signatures. MOELI is valid only if signed by provider and patient and/or participating surrogate

Name of person who helped patient complete MOELI if other than provider below: _____

Provider	Patient	Surrogate
I verify that this documents reports patient's wishes that I checked for completeness and consistency. Print Name: _____ Signature: _____ ____ Physician ____ ARNP ____ NP ____ PA-C Date _____ Phone _____ e-mail _____	Print Name: _____ Signature: _____ Date _____ Phone _____ e-mail _____	DPOAH? ____ Yes ____ No Legal Guardian? ____ Yes ____ No Signer understands and agrees to represent patient's preferences. Name: _____ Signature: _____ Date _____ Phone _____ e-mail _____

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed MOELI forms are legal and valid.

For more information visit: *List contact information for issuing organization*

J. Additional Orders		Conditions, if any including duration in days of any trials
1. Defibrillation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Mechanical respiration	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Nutrition by tube	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Fluids by tube	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	

7. Transfer to hospital Whenever suggested Only for brief management of treatable problem Only if essential to relieve pain/discomfort

8. Other

K. Review of this MOELI form

1. This MOELI should be reviewed periodically, and always when:
 - a. Declarer is transferred from one care setting or one care level to another, or
 - b. There is a substantial change in the declarer’s health status, or
 - c. The declarer’s treatment preferences change, or
 - d. If it has been in effect for one year.
2. A competent adult patient, or the surrogate of a declarer who is not competent, can void this form and request alternative treatment
3. To void this form draw a line through “MEDICAL ORDERS” and write “VOID” in large letters.
4. Any changes require a new MOELI

Review Date	Reviewer/Phone and/or e-mail.	Reason: Transfer, Changed health status, Routine review, Other	Review Outcome
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New form completed

L. Instructions for Completing the MOELI

1. Verify declarer is 80 or older, extremely frail, and/or is expected to die within 12 months. Specify the illness(es) if any
2. List all participants in discussion of this MOELI, ideally declarer and proxy, and attest to participants’ legal capacity.
3. Evaluate all participants’ legal capacity and health literacy to make certain that they understand the meaning of all medical terms and the likely consequences of all decisions
4. At declarer’s request, include selected relatives in the discussion to facilitate family-centered decision making
5. Review any existing living wills or MOELIs. The MOELI implements but does not replace living wills.
6. Solicit and record declarer’s goals regarding length and quality of life
7. Explain and record declarer’s resuscitation preference
8. Explain and record declarer’s type of intervention preference
9. Explain optional waiver to protect providers who honor the expressed requests
10. Obtain required signatures and assurances
11. Review requests for specific interventions in Section J. and *check for completeness and consistency of all requests.*
12. Record dates that MOELI has been reviewed, if any.

M. Using the MOELI

1. Any incomplete section implies full treatment for this section.
2. The MOELI is valid in all community and institutional settings until replaced by new medical orders.
3. This MOELI is a set of medical orders that replaces all previous orders. Destroy all earlier orders.
4. This MOELI and attached documents should be transferred with declarer when changing providers or institutions.

N. Space for logo and contact information of issuing organization.

Fig. 1. Medical Orders for End-of-Life Intervention

the paradigm to those 80 and older preserves the right of many to make EOL plans while they can articulate their values and preferences.¹⁵

Nature of Illness

The POLST Legislative Guide and Form Requirements clearly state that POLSTs should be used for patients who have a “serious advanced illness.”¹⁶ Designating what this illness is (if it exists) creates a context for the order and is also useful information for emergency workers who have no prior knowledge of the patient.

B. Participants

Listing the names of all participants increases the likelihood that the MOELI will be the product of collaboration. In addition to those named, it is useful to include providers who will deliver the EOL care to increase the likelihood that the patients’ requests will be honored. **Patient.** Because the MOELI is designed to help patients make their goals and preferences medical realities, their participation is critical, even if they prefer to delegate decision making to others.¹⁷ **Spouse or domestic partner.** The MOELI process assumes that if acceptable to the patient, any life partner should have the privilege of participating in EOL discussions regardless of legal status. Including **surrogates** makes them “partners” who are likely to support rather than disrupt subsequent EOL decisions. A 2006 review of multiple studies found that 33% of surrogates’ depictions of patients EOL preferences were inaccurate, even if the wishes had been discussed.¹⁸ Recently, it was found that only 21% of surrogates accurately predicted whether Veterans would consider severe physical disability, severe cognitive disability, and/or severe pain would constitute a state “worse than death.”¹⁹ Accuracy and understanding can be increased when surrogates participate in creating the documents.

Evaluation of Capacity

Many state POLST forms do not address decision-making capacity. Because it is a legal-medical document, everyone who signs the document should have the capacity to understand the meaning of the decisions and their likely consequences.²⁰ MOELI explicitly recognizes this requirement.

Health Literacy and Numeracy

Understanding requires sufficient health literacy, defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make basic health decisions.”²¹ It also requires numeracy, defined as “the ability to access, use, interpret, and communicate mathematical information and ideas.”²² Patients who do not understand the meaning of words like “resuscitation” and “artificial nutrition” or phrases like “a 10% chance of improvement” will be limited in information exchange, deliberating, and deciding.²³ Noting both of these abilities increases acceptance of the MOELI.

D. Discussion of Living Wills

Placing discussion of an existing living will near the start the document reminds providers that the process should begin by referencing the patient’s AD if one has been executed. MOELIs implement but do not replace 3-part living wills,²⁴ that is, Personal (goal and value) Statement, AD, and DPOA.

E. Stipulation of Patient’s Goals

Traditional advance care planning has been described as a process that relies “too much on objective presentation of the risks and

benefits of alternative treatments and insufficiently on ... what matters to patients, such as remaining independent, being pain free, or living as long as possible.”²⁵ The POLST Legislative Guide refers to the importance of basing medical decisions on patients’ goals,¹⁶ and the National POLST Paradigm Fundamental Policy Principles 1, 3, and 4 all stress the importance of goals.²⁶ Yet only 4 of the currently used state POLST forms even mention goals. Goal discussion helps patients articulate the way they would like to die as the ultimate expression of the meaning of their lives and it breaches the gap between technical medical decisions and their human essence.²⁵ Therefore, it is as important for providers to discuss goals as it is to discuss central line placement or a surgical procedure.²⁷

F. Cardiopulmonary Resuscitation

All POLSTs ask all patients to make CPR/DNR choices, without differentiating between those who are terminally ill versus essentially healthy people who unexpectedly suffer cardiac or pulmonary arrest.²⁸ Some patients may want resuscitation regardless of their condition or the risks it entails, whereas others do not want it under any circumstances. Both of these groups are well served by the traditional dichotomous choice. Other patients, however, want resuscitation if the arrest is the result of a treatable traumatic event, for example, hypothermia, an adverse drug reaction, or anaphylactic shock. By providing this “middle” option for resuscitation, the MOELI helps overcome some patients’ fear that they will be allowed to die even when their condition is reversible. This also reduces uncertainty for emergency workers.

G. Preferred Type of Care

POLST forms have been criticized for being biased toward less invasive interventions.²⁹ The order of presentation matters, because patients are more likely to choose the first option presented.³⁰ Of the POLSTs available for review, 22 list comfort care first, 8 list full treatment first, and 1 does not address scope of treatment. The MOELI places full treatment first to help overcome the perception that such a document implicitly biases patients toward less treatment. It also attempts to avoid bias by using neutral language, and seeks to overcome inconsistent instructions, for example, by avoiding pairing DNR and full treatment.³¹

H. Hold Blameless Provision

Issue 10A in the POLST Legislative Guide¹⁶ notes that many health care professionals across the country want more explicit reassurance that they will not be sued for honoring patients’ choices. Fear of being sued reduces acceptance of ACP in general, and it significantly inflates medical costs.³² The nonmandatory statement included in the MOELI is intended to reassure providers by creating a “safe harbor”³³ in the form of a moral contract of mutual trust between providers, patients, and their survivors. Although not a guarantee, this provision should reduce the likelihood of litigation.

I. Signatures

Preparers. These forms are often completed with the help of facilitators^{6,34,35} with varying backgrounds, for example, community health advisors, chaplains, social workers, or psychologists. Their names should be recorded in case the validity of the document is challenged or a subsequent provider needs help in resolving uncertainties. Preparers are also asked to verify that the form conveys the wishes of the named patient, and that they are complete and internally consistent, both of which have been problems on some POLSTs.⁷ **Providers.** Because MOELIs are medical orders, they must be signed by a physician, ARNP, or PA-C who is authorized to enter orders in patients’ medical records. In addition to identifying their profession, providers are also asked to certify their belief that the MOELI accurately reflects the patient’s wishes. **Patients.** In some jurisdictions,

patient signature is recommended but not required as is common for DNR orders. This is inconsistent with the principle of shared decision making that underlies this paradigm. **Surrogates** are asked to verify that they are named in the patient's DPOAH and to accept responsibility for fulfilling their duties.

J. Elaboration of Treatment Requests

The POLST Legislative Guide¹⁶ stipulates that the form should stipulate “patients’ goals for the use of cardiopulmonary resuscitation (CPR) and *other medical interventions* [italics added],” and that decisions should be “concrete [and] clear.” This is important because ADs are often faulted for not giving physicians enough guidance for ordering critical EOL interventions.³⁶ This section clarifies the desired components of scope of treatment requests, adding considerations for their use. Examples are the possible request for palliative sedation to unconsciousness to manage intractable pain or the use of artificial nutrition for “comfort feeding only.”³⁷ Rather than arbitrarily selecting a small sample of the options, the MOELI lists the 6 most common EOL measures. Item 8 addresses hospital transfers for patients living in the community, assisted living facilities, and/or nursing homes. Because “it is well known that a hospital transfer can do more harm than good,”³⁸ it is important to allow patients the opportunity to refuse transfer when practical.

K. Scheduled Review

Periodic review is extremely important because patients’ preferences and preferences may change over time in response to age, circumstance, and health status.

L. Presentation Guide

This section serves as an outline for meetings with patients and surrogates to complete a MOELI. Because training in ACP is still neglected in medical education, this concise “user manual” guides providers in its use.

M. General Instructions

This section addresses some legal requirements and stresses the need to preserve them in a way that avoids their being forgotten, including the need for providers to include the form in patients’ electronic and hard copy medical records.

Conclusion

The MOELI is offered as an upgrade to the POLST paradigm. It fills in some gaps in the original, increases the range of patients who can use it, and reframes some critical elements. We hope that it stimulates discussions that will motivate various POLST organizations to collaborate in creating a standardized national form. Its adoption would have to be followed by the creation of multiple cultural adaptations that go beyond mere translation. It is also necessary to develop a national evaluative database, mobilize institutional policies and resources that support use of the paradigm, and to increase educational efforts that train health care professionals and the general public in its use as the optimal way to make sure that the care received is the care desired.

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Letter to the Editor

Proposed POLST Replacement Creates More Problems than it Solves

To the Editor:

We appreciate Drs Richard Stuart and Stephen Thielke's praise for the POLST (Physician Orders for Life-Sustaining Treatment) Paradigm and their effort to "upgrade" the POLST form in their editorial, "Standardizing Protection of Patients' Rights from POLST to MOELI (Medical Orders for End-of-Life Intervention)."¹ The primary goal of the POLST Paradigm is to align patient preferences with the treatments provided through the use of a standardized medical order form. The National POLST Paradigm Task Force (NPPTF) maintains standards for POLST Paradigm programs that reflect the accumulated wisdom of leaders from programs across the country.² There are now robust programs in 23 states and national standards that most states are working to implement.

The NPPTF has developed a process for ongoing review of standards built on more than 20 years of experience and encourages the integration of research and quality assurance activities to continue to improve the model. Indeed, POLST standards for procedures, forms, and best practices have changed over the years, based on experience, feedback, and evidence from research.³ The authors identify many important challenges facing the POLST Program. Unfortunately, the untested MOELI concept appears to solve none of the issues identified by the authors and may instead increase the likelihood of confusion. We have concerns about the practicality, feasibility, and appropriateness of the following ideas proposed by the authors:

- (1) Creating a nationally standardized MOELI form: Although the authors acknowledge that variability among state POLST forms is due to differences in state laws and regulations, they seem unaware that their proposed MOELI form faces substantial legal barriers from those same variations.⁴ It is unclear why the authors think MOELI's legislative pathway would be different or easier than the experiences of state POLST programs or have a different outcome.
- (2) Expanding the MOELI-eligible population of patients to everyone over age 80: The NPPTF promotes the use of the POLST Paradigm for seriously ill or frail patients for whom death would not be unexpected because the orders, once signed, become the active plan of care. Focusing on this population ensures that health care professionals can initiate specific and detailed shared decision-making conversations about current diagnosis, prognosis, treatment options, the likely effect those treatments will have on that patient (eg, what will most likely happen if cardiopulmonary resuscitation is attempted), and identify the patient's goals of care. Conversations with this level of specificity are not possible (or appropriate) with an otherwise healthy patient, irrespective of age. Health care professionals should recommend the standard of care to healthy patients rather than encourage them to consider limitations on treatments without knowing the context of the decisions they are being asked to make.
- (3) Increased complexity of MOELI: The authors criticize POLST as "easily misunderstood" and "difficult to interpret," yet propose a form that is more complicated and more confusing. MOELI introduces the potential for conflicts with its "additional orders" menu of treatment options that permits selection of treatments that are incompatible, making interpretation unnecessarily difficult. For example, the MOELI would make it possible to request full treatment and refuse mechanical respiration, or decline resuscitation and elect use of defibrillation. It also requires emergency medical technicians (EMTs) to judge in the field whether a patient's cardiac arrest is a temporary, correctable event, a determination that is both infeasible and outside the scope of practice for EMTs. The MOELI has the potential to create confusion by introducing a very different form with fields of unclear value, such as a checklist to document assessments of numeracy and literacy. All these changes would require entirely new educational efforts in states where POLST programs are already established and functioning well. Additionally, there have been more than 30 research studies on POLST that have supported quality improvement activities, some of which have led to the removal of sections the authors propose be added back in. Discarding POLST in favor of the complicated MOELI would require starting anew to develop new educational materials and build the evidence base.
- (4) Inclusion of a liability waiver that patients could choose not to sign: The optional section containing a "hold blameless" clause is highly problematic and concerning. Almost all states already have immunity provisions in their state laws that protect from liability health care professionals who complete or honor these orders in good faith. The MOELI waiver of liability draws unnecessary attention to potential liability and away from good care. In states without immunity provisions, it may not be enforceable.

We appreciate that Drs Stuart and Thielke sought to stimulate discussion about the POLST form so that, as they suggest, institutional resources and educational efforts will be mobilized to ensure that the treatment patients receive at the end of life is the treatment they want. Clinicians, researchers, and policymakers interested in improving the POLST Paradigm model are encouraged to work collaboratively with their respective state POLST programs. Information about these programs and the NPPTF can be found at www.polst.org.

Acknowledgement

Submitted on behalf of the National POLST Paradigm Task Force.

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Letter to the Editor

Ethical and Practical Ways in Which MOELI (Medical Orders for End-of-Life Intervention) Advance the Physician Orders for Life-Sustaining Treatment (POLST) Program

To the Editor:

We are pleased that Hickman et al,¹ some of whom have done much of the heavy-lifting throughout the development of the Physician Orders for Life-Sustaining Treatment (POLST) program, offered their appraisal of our MOELI.² They question the value or feasibility of 7 of our 16 suggested changes; we hope that their silence on the remaining 9 means that they either agree with our suggestions, or at least see no major problems with their implementation. We are surprised by the tone of some of their objections, because all of our recommendations are consistent with the policies and guidelines of the National POLST Paradigm Task force (NPPTF) documents, and many of our suggestions directly implement its prescriptions. We are fully committed to the paradigm as a way to protect patient autonomy in making decisions about end-of-life (EOL) care, and we believe that the MOELI does a better job of doing so than any of the protocols currently endorsed by the NPPTF.

1. National Standardization

Hickman et al remind us that 23 states have robust POLST programs. Sadly, that means that despite years of effort, 27 states do not. Existing programs have 15 different names, from COLST (Clinical Order for Life-Sustaining Treatment) to WyoPOLST (Wyoming POLST),³ and differ markedly in content. Therefore, the NPPTF vision seeks “consistency of process”: “If you are traveling to another state, it is a good idea to take your Advance Directive and your POLST Form with you.”⁴

By far the most defensible and practical response to these problems is to create nationally standardized protocols and processes around end-of-life care. We agree with Hickman et al that doing so would require overcoming substantial legal barriers and treading a difficult legislative pathway. However, these challenges are no different than those encountered in various states in which, as we have noted, conflicts among “local laws, cultures, and medical systems” abound.² We believe that rather than trying to slay 27 dragons while continuing to placate the 23 already in tow, it makes much more sense to concentrate energy on achieving a single national program. If successful, all patients in America could uniformly exercise their right to self-directed care without regard to local interests. A national training program could be created in keeping Principle 5 of NPPTF’s “Fundamental Policy Principles.”⁵

Spearheaded by the NPPTF or similar entities, a national standard could be created through the collaboration of governmental body, such as the Centers for Medicare & Medicaid Services (CMS), and nongovernmental organizations, such as AARP, American Medical Association (AMA), and the American Bar Association.

2. Eligibility Based on Age, and Standards of Care

We appreciate the acknowledgment by Hickman et al of the importance of identifying patients’ goals of care. Unfortunately, very few of the existing state protocols provide adequate (or any) space for goal statement, an omission that the MOELI corrects.

Hickman et al correctly point out that the current POLST paradigm is intended for patients who are extremely frail, extremely ill, and/or expected to survive less than 1 year. We propose widening eligibility to those 80 and older. Hickman et al contend that “conversations at this level of specificity are not possible (or appropriate) with an otherwise healthy patient.” However, for many years, a strong national effort has encouraged everyone 18 or older to complete advance directives that include exactly this content, in writing. Surely a “healthy” patient should not be denied the opportunity to express values and preferences around the end of life? Our hope is that extending the MOELI to those 80 and older, who voluntarily choose to use it, will accord them the option of specifying the scope of EOL care they want while they retain the capacity to do so. Waiting in order to complete this process until a patient is “unhealthy” to the point of losing capacity may lead patients to suffer prolonged, invasive, often stressful interventions that they fervently would have hoped to avoid.

3. Neutrality About Scope of Treatment

Hickman et al suggest that “health care professionals should recommend the standard of care to healthy patients rather than encourage them to consider limitations on treatments without knowing the context of the decisions they are being asked to make.” We are unsure of what they mean by “standard of care”: in many circumstances it could involve routine aggressive treatment that many patients might not want. The risk of this outcome is exposed in POLST’s title, “Life-sustaining Treatment,” which tacitly recognizes only one approach to EOL care (sustaining life), without considering other desirable outcomes that may be more consistent with patients’ preferences and values, for example, treatment aimed at preserving their comfort, clarity of thought, and ability to communicate while moving toward a natural death. We propose that the ultimate standard of care should be that which patients choose for themselves. That is why we use “End-of-Life Treatment” in the title of our form. Also, because NPPTF has encouraged advanced registered nurse practitioners (ARNPs) and certified physician assistants (PA-Cs) to also sign the orders,⁶ we switched from “Physician” to “Medical” orders. As a result, our working title

is “Medical Orders for End-of Life Treatment” (MOELI). There may be a more succinct and descriptive name and acronym, but we have not heard it yet. In response to its first contact with the MOELI, one state organization contemplated switching the name of its program from POLST to MOST, “Medical Order for Scope of Treatment.”

4. Increased Complexity

Hickman et al suggest that the MOELI increases complexity and includes unclear material. We recognize that the processes of making EOL care decisions are intrinsically complicated and rife with apparent paradoxes and contradictions. We acknowledge that there is no simple and straightforward means to elicit and document all the details that would be needed for EOL care across various treatment settings. Any final, written products are bound to be the result of compromise. One of the authors correctly noted elsewhere that many state forms are “either worded too generally or include multiple choice options that may not adequately address the complex clinical circumstances you face in the future,”⁷ and other authors stated that “advance directives have failed to achieve their ‘admirable purpose’ of helping patients retain control over end-of-life treatment.”⁸ We designed the MOELI as an effort to achieve better outcomes by avoiding as much of this complexity as possible.

A recurring problem with the POLST forms is that most include only 2 of the 5 types of procedures that normally comprise aggressive EOL care, forcing providers to guess whether the patient would have chosen any of the remaining 4. This exposes patients to the risk of undergoing the type of “extraordinary and excessively burdensome” treatments that NPPTF is committed to helping them avoid.⁹ The MOELI seeks to correct this deficiency by including all 6 of the classes of EOL interventions. It is thus designed to reduce that uncertainty about interventions while allowing patients to stipulate, in a less templated fashion, whether, and if so how and when, they would like each to be used. This is consistent with the National POLST Paradigm¹⁰ that stipulates that the form must provide space for “Other Orders” (Item 7C) and “Additional Orders” (Item 8). As is true for many POLST forms, the MOELI records these longer-term interventions on the back of the form so they do not delay or confuse first responders.

Inconsistencies between the procedures requested, for example, a do not resuscitate (DNR) order paired with aggressive treatment, have been observed in completed POLST forms and are likely to appear in any EOL forms. We believe that these problems are due to flaws in the decision-making process (ie, how thoughtfully an individual can reason about hypothetical situations) rather than the complexity of the decisions themselves, or the inability of a form to record values and preferences. If the challenge were impossible, no effort would be made to document EOL decisions until they were manifest. The EOL planning process is geared at mitigating this problem. Because EOL documents are not self-administered, but are rather the product of compassionate discussion with patients and/or their surrogates, any significant inconsistencies could be attributable to facilitator error. This error can be corrected by adequate training, and any expressed inconsistencies would provide an opportunity for further discussion.

5. Conforming CPR/DNR Orders to Patients’ Preferences

Hickman et al indicate that 3 resuscitation levels proposed in the MOELI would be “infeasible and beyond the scope of practice of EMTs.” We acknowledge that the uncertainty of medical status in emergency settings can make it difficult to follow through on specific plans of action. Yet we maintain that additional

information would, on balance, help emergency personnel perform their duties with greater confidence. For example, in keeping with a recommendation by the NPPTF that orders on the POLST be based on “specific knowledge of a patient’s specific disease,”¹¹ the MOELI (but not most POLST forms) identifies the patient’s terminal illness (if any) as an orientation point for emergency and hospital workers. Beyond that, first responders always assess the situation when preparing to act, including questions about events that could have suppressed heartbeat and/or respiration. First responders are obligated to honor DNR orders when presented. However, consultation with emergency response agencies validates the importance of emergency personnel asking whether the patient has recently started a new drug, overused prescribed or street drugs, eaten a new food (eg, oysters in one recent case seen by one of us), or suffered an insect or animal bite. These questions can be answered quickly while aid personnel prepare the patient for CPR and/or defibrillation. Allowing a patient to die when one of these correctable events had occurred would certainly not be beneficent, and might constitute malpractice. Parenthetically, it is also useful to suggest that patients complete Step 5 of the 6-Steps Living Will¹² that lists information including diagnosis, allergies, provider names, current medications, etc as an aid to first responders and institution-based providers who may not be familiar with their conditions.

There is an added advantage of adding the middle resuscitation option. During our experience facilitating the creation of advance directives, we encountered a number of patients who were reluctant to engage in advance care planning because they felt it was insensitively black-and-white. During discussions of the wider range of resuscitation options, we were able to help them to understand that a DNR order is not a “do not care” order but rather one that includes palliative care measures that often are quality-of-life enhancing and life-prolonging.

6. Verifying Capacity for Informed Consent

Hickman et al object to our reminder that facilitators should evaluate patients’ and surrogates’ decision-making capacity, including their health literacy and numeracy. We did not create this requirement; we merely remind clinicians of their ethical obligation to assess it, as stressed in NPPTF’s Fundamental Policy Principles that “POLST Paradigm Forms should always reflect informed consent.”⁵ As attorneys and ethicists know, documents created by individuals who lack capacity do not meet the “informed consent” standard and therefore should not be honored. It is a legitimate concern that facilitators may need additional training in capacity assessment. We have created a protocol to guide the process¹³ that can efficiently be included in training and paradigm updates.

7. Safe Harbor Provision

Hickman et al object to the effort in the MOELI to create a good faith bond between patients and providers by including a liability waiver. They state that doing so “draws unnecessary attention to potential liability.” Fear of malpractice litigation abounds in health care, and is a cause of overtreatment.^{14,15} It is doubtful that the language on the MOELI could possibly add more fuel to that raging fire. In fact, the POLST Legislative Guide³ identifies liability concern as a major deterrent to health care professionals’ use of the paradigm, and states that providers want more explicit protection. In order to address this critical issue, our optional waiver is intended to allay apprehension by creating a good-faith contract between

patients, their surrogates, and the professionals upon whom they rely for implementation of their wishes.

Conclusion

We developed the MOELI based on the POLST paradigm. Hickman et al, leaders in the field, have concerns about “the practicality, feasibility, and appropriateness of following [our] ideas.” These are empirical questions best answered by research and field-testing of various approaches. They remind us “there have been more than 30 research studies on POLST.” Unfortunately, few of these studies have provided clear answers to the issues that we have raised. As Hickman et al observed elsewhere,¹⁶ the findings of many of the studies may not be generalizable because so much of the research was conducted using a largely homogeneous white population in Oregon, where the POLST has been vigorously supported for years. We published the MOELI as an open source document, in which we have no financial interest, in the hope that Hickman et al, and many others whose dedication and research have brought the paradigm this far, will collaborate with us on efforts to assess its effectiveness and improve the process of using it in its entirety or any of its elements. Meanwhile, the MOELI is available for clinical and research use given Sabatino's¹⁷ observation that most states do not require use of a particular form, although many require witnessing. We all share a deep commitment to finding the best possible way to assure that the EOL treatment patients want is the EOL treatment they receive.

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