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Guidelines for Emergency Physicians on the Interpretation of Portable Medical Orders

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Therapy (POLST)”

The ethical principles of patient autonomy and right of a patient to make decisions about their medical care are grounded in the due process clause of the 14th amendment. Portable medical orders are an attempt to these principles and rights. Advance directives, living wills, and Do-Not-Resuscitate (DNR) documents are designed to allow individuals with the opportunity to express their treatment preferences in situations when they cannot communicate those preferences themselves. Unfortunately, clinicians may not be able to honor such wishes because these documents are either unavailable or contain ambiguous language. As a result, emergency physicians may in good faith initiate or stop treatments that are contrary to a patient’s wishes.¹

Portable medical orders are designed to help health care professionals honor and implement the treatment wishes of patients, especially in outpatient settings and during acute emergency medical care. POLST is one prominent kind of portable medical order, but the description can apply to other portable medical orders in general as well. Portable medical orders help physicians, nurses, long-term care facility personnel, hospice staff, home health agency care providers, emergency medical services professionals, hospital workers, and other health care professionals to:

- Promote patient autonomy by documenting treatment preferences and converting them into medical orders;
- Clarify patient treatment preferences unambiguously with specificity;
- Facilitate value-concordant treatment; and
- Ensure a patient’s expressed treatment wishes are taken into account by all health care professionals across the different settings of health care delivery.¹

Portable medical orders forms are not intended to replace a living will or health care power of attorney. Rather, they are designed to implement patient wishes by translating the patient’s treatment wishes into medical orders, centralizing information, facilitating record keeping, and ensuring transfer of

appropriate information among health care professionalism and across care settings.¹

When Should a Portable Medical Order be Used?

A POLST form is primarily intended for seriously ill or frail patients who have an advanced chronic or a progressive life-limiting illness. POLST orders may also be used by patients who are at risk for impaired decision-making capacity and by anyone with strong treatment preferences.²

Different states have adopted different names and acronyms for POLST-type orders, including Physician Orders for Scope of Treatment (POST), Medical Orders for Scope of Treatment (MOST), and Medical Orders for Life-Sustaining Treatment (MOLST); these orders all share the same core elements with similar form and design. Their names can vary by state, but we will refer to portable medical orders as POLST for the purpose of these Guidelines. A National POLST Paradigm Task Force and Office coordinates state-specific efforts to adopt and disseminate these orders, and the order set with specified set of common elements are referred to as POLST Paradigm orders.³

Specific Orders:

POLST Paradigm order forms differ among the states that have adopted them - such as the order of the sections or the options within a section may be different - but all of them discuss treatment preferences regarding a number of essential medical treatments or services.⁴

- Cardiopulmonary Resuscitation (CPR) Medical Interventions such as intubation
- Medically Administered Fluids and Nutrition
- Signatures Confirming the Orders/Wishes

CPR and medical interventions sections are relevant in emergency situations and need to be easily identified. Many states also include a section on “Goals of Care” that is typically free text. Patient goals of care should provide guidance to medical professionals filling out a POLST form and to those interpreting a POLST form, as they provide important information that can translate patient preferences and values into medical orders that are more easily understood and specific.

CPR

These orders apply only to the circumstance in which a person experiences cardiopulmonary arrest, ie, the individual has no palpable pulse or noticeable breathing activity. This section does not apply to any other medical circumstances. If a patient is in respiratory distress but is still breathing or has a pulse, a first responder or emergency physician should refer to other sections for guidance.⁴

Beware of the possibility of the completion of POLST forms with potentially contradictory orders—for example, if the patient wants CPR, but does not want intubation. Patients and families sometimes misunderstand CPR. Hence, patient education regarding invasive treatments, ramifications, and expectations is essential to optimal communication regarding patient wishes prior to translating wishes into POLST. The performance of CPR requires resuscitation protocols that involve intubation to secure a patient’s airway and support their breathing. If the patient does not want aggressive full treatment including intubation and mechanical ventilation in an intensive care unit (ICU), then the patient should not receive CPR.¹

In contrast to such inconsistent POLST orders, some patients may not desire CPR if they experience a cardiac

arrest, but they may still reasonably desire ICU care for serious illness or elective intubation for respiratory failure without cardiac arrest. This choice may be a rational one, as ICU care may provide a patient significant benefit, even if, despite those benefits, the patient would choose to avoid CPR given its low likelihood of benefit.

Medical Interventions

These orders apply to emergency medical circumstances when a person has not experienced cardiopulmonary arrest; in other words, these orders are for a person who has a pulse and/or is breathing.

Full Scope of Treatment:

If full aggressive treatment by emergency personnel or other appropriate health care professionals is indicated and desired, the “Full Scope of Treatment” box is checked. Treatment includes use of advanced airway interventions such as CPR, endotracheal intubation, mechanical ventilation, central venous line placement, vasopressor support, and electrical therapies such as defibrillation, cardioversion, and pacing. If the patient is not already at the hospital, transfer to the hospital and use of intensive care may be indicated.

Selective/ Limited Additional Interventions:

This option is for patients who prefer to receive medical treatments for reversible conditions or exacerbations of underlying disease with the goal of restoring the patient to his/her usual state of health.⁴ It directs that medical treatments such as antibiotics, IV fluids, cardiac monitoring and similar therapies be used as indicated for secondary or incidental complications such as pneumonia, but that intubation and mechanical ventilation be omitted. This option does allow the use of less invasive airway support such as bilevel positive airway pressure (BiPAP), continuous positive airway pressure (CPAP), high flow nasal cannula and it directs that appropriate symptom management for measures be provided.¹

This section can also have an area to indicate “Other Instructions.” This may be helpful to clarify other interventions as appropriate for individual patients.

Comfort-Focused/ Symptom Treatment:

Selection of this option indicates a desire for interventions that focus on comfort through symptom management. Medications by any route, positioning, wound care, and other measures are to optimize patient comfort. The use of oxygen, suction, and manual treatment of airway obstruction should be administered as needed for comfort.^{1,4}

Patients should be admitted to a hospital if needs cannot be met adequately in the current location. If symptoms can be controlled, then possible discharge with symptom management should be considered. Also, if the focus is comfort, hospice care and palliative care consultation may be appropriate. Sometimes more specific instructions may be recorded in “Other Instructions.”⁴

Medically Administered Fluids and Nutrition

These orders pertain to a person who cannot take fluids and food by mouth. Oral fluids and nutrition always should be offered to a patient if medically feasible. Most POLST forms require a single choice among three options for tube feedings, including fluids and nutrition provided via intravenous (IV), nasogastric (NG) or percutaneous endoscopic gastrostomy (PEG) routes.⁴

Long-Term artificial nutrition by tube if indicated – A patient (or his/her representative) may decide to receive IV fluids if indicated. When this box is checked, IV fluids should be administered whenever clinically indicated.

Defined trial period of artificial nutrition by tube – A patient (or his/her representative) may prefer to receive IV fluids for a defined trial period when clinically indicated. For example, a patient may desire a brief trial of IV hydration if they become dehydrated. In this case, the IV fluids would be a temporary intervention with the goal of treating a potentially reversible acute illness over a few days to a week.

No artificial nutrition – A patient (or his/her representative) may prefer to forgo the use of medically provided fluids and nutrition. Again, oral fluids and nutrition always should be offered to a patient if medically feasible and desired by the patient.

“Other Instructions” allows for further clarification in this section as well.¹

Discussed with and Agreed by: Signatures

The signatures section of the POLST form **MUST** be completed. The persons or class of persons who can issue or consent to POLST orders varies from state to state but should be listed on the POLST form. If the patient is an adult and is able to make and communicate health care decisions, then the patient is the only person who can consent to the physician issuing the orders of the POLST form. The patient’s signature of consent may be required for the form in some states, with a few having a requirement for a witness for the signature or the conversation. If the patient is a minor, then a parent or guardian may consent to the physician’s completion of a POLST form. Some states may currently limit use of POLST to patients 18 years of age or older.⁴

If the patient is an adult who no longer has the capacity to make and communicate health care decisions, the POLST form may be discussed with and agreed to by the legally authorized representative of the patient, as indicated by the form.⁴

Signature of the Appropriate Decision-Maker:

The National POLST Paradigm Task Force strongly recommends evidence that the patient or the patient’s representative has reviewed the form and agrees that the orders reflect the patient’s preferences.³ Some states have a section for a patient to name their health representative or surrogate if/when the patient was to lose decision capacity.

If the patient has the capacity to make and communicate health care decisions, he or she must agree to the orders. When the patient lacks the capacity to make or communicate health care decisions, then the appropriate patient representative signature should be present and is sometimes required by law to sign the form, depending on the state in which it is being signed. In situations where the patient representative cannot be physically present to sign the form, some states allow the medical provider to discuss the details over the phone with the appropriate patient representative.

Health Care Professional Signature:

Since the form is the issuance of a medical order, the signature of a health care professional is mandatory. Which group of health care professionals can sign a properly filled out POLST form varies by state, and may include physicians, nurse practitioners, and physician assistants. Without this signature, the orders in the POLST form are not valid. The date and printed name of the health care professional should be

provided. Social workers, and chaplains may initiate a discussion and educate a patient about POLST, but the signature must be that of the practitioner who is issuing the order.

Additional Sections of the Portable Medical Order Form

Additional sections of the POLST form generally provide space for contact information. Most included fields are the patient's name and birth date (on every page for accuracy in case the form is faxed on individual pages), the health care professional who signed the document, the patient's representative or surrogate, the relationship to the patient, and phone numbers. This allows health care professionals to attempt early contacts with this person when the patient's health status changes. Explanations for use of the form and provisions for reviewing or revoking the form may also appear.

Revoking the Portable Medical Order Form

A patient with decision making capacity or the patient's representative (if the patient lacks capacity) can revoke the POLST when faced with new information or changes to the patient's condition and request alternative treatment based on known preferences of the patient or, if unknown, the patient's best interests.

Depending on the state, a POLST form may also be revoked in a number of ways including destruction, putting a line through the front page and writing void on the form, or by indicating in the review section on the back that POLST orders have been revoked.

Portable Medical Orders that are not Medically Feasible or are Inconsistent

POLST forms provide significant additional guidance for honoring patient treatment preferences and communicating those preferences in a clear manner to medical personnel. However, a small number of POLST forms might reflect patient preferences and order sets that may not be medically feasible or are logically inconsistent. For example, a form selecting "attempt resuscitation" and "comfort measures only" is inconsistent. Some POLST forms might require more interpretation than time allows during an emergency (eg, attempt CPR, but limit interventions).^{5,6}

If emergency health care personnel are presented with a POLST form with inconsistent treatment wishes and time allows, the provider should describe the inconsistency and seek clarification from the patient (provided the patient has decision-making capacity), the medical provider who signed the form or the patient's representative or surrogate, to clarify the patient's care preferences. If these efforts fail to clarify or the patient's medical condition may be such that there is not enough time to seek clarification, then provider should, in good faith, act in light of expressed patient values (eg, specified in an advance directive) if available; when expressed patient values are not available, the provider should act in the patient's best interests based upon his or her own medical judgment.⁶

Legal Protection for Emergency Physicians Honoring Portable Medical Orders

Although most states have either an established or developing POLST program, some have not yet provided explicit statutory protection for physicians who honor patient wishes in good faith through a POLST form (as is frequently provided for in the setting of pre-hospital DNR orders and advance directives). In those states without explicit statutory protection, physicians are protected under common law when they follow generally accepted standards of practice in their area.³ It should be noted that in most states, there is no legal immunity for following DNR orders in the inpatient setting; however, most physicians, including ED physicians, honor those orders, nonetheless. Furthermore, the federal government takes a strong position on the hospital's obligation to honor patient decisions concerning their care.^{6,7,8}

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