POLST
physician orders for life-sustaining treatment

Oklahoma Physician Orders for Life-Sustaining Treatment
Frequently Asked Questions (FAQs)

1. **What is OkPOLST?**

   OkPOLST stands for Oklahoma Physician Orders for Life-Sustaining Treatment. It refers to a physician's order that documents and directs a patient's medical treatment preferences when faced with life-limiting illnesses and irreversible conditions. The form represents a model program for end-of-life care. Many states have POLST forms and programs. For more information, please visit www.okpolst.org

2. **What is the mission of OkPOLST?**

   The mission of OkPOLST is to improve end-of-life care in Oklahoma by creating documents and programs that promote honoring the health care wishes and goals of care of those with life-limiting and irreversible conditions.

3. **How does the OkPOLST form ensure that patients receive the type of care they want?**

   The OkPOLST form represents the wishes and goals of care of the patient, and is translated into a physician's order that is readily available to other health care providers that may be involved in the patient's care. The information in the OkPOLST form is obtained from a conversation between the patient or his/her legal health care representative and his/her physician. Studies conducted in states that have similar documents available have revealed that among patients who have those documents, treatment preferences were honored 98 percent of the time, and no one received unwanted intubation, CPR, intensive care or feeding tubes. As a result, documents like the OkPOLST form have helped bridge the gap between what treatments the patient wants and what the patient receives.

4. **How does the OkPOLST form conform to specific cultural or religious beliefs?**

   Cultural and religious beliefs vary widely in regard to end-of-life care. There are many resources available to help patients determine if the OkPOLST form is right for them, based on their personal beliefs. Patients are also encouraged to discuss the form with their clergy or religious or spiritual leaders.

5. **Is the OkPOLST form a legal document?**

   No. It has the same legal standing as other physician's orders. The OkPOLST form is recommended as the standard of care to be used by Oklahoma health care providers to document a physician's orders directing a patient's medical treatment preferences when facing life-limiting and irreversible conditions.

6. **Does the OkPOLST form transfer across health care settings?**

   Yes. The form is designed to become part of the patient's medical record. It transfers with the patient across health settings, from home to hospital to long-term care facility or hospice care. When the patient transfers to a new health setting, the patient's original OkPOLST form should accompany him/her. In addition, a copy of the patient's OkPOLST form should be kept in the patient's medical record.

7. **How is the OkPOLST form identified?**

   The OkPOLST form is a standardized form that is printed on pink paper to ensure that it is easily identified by patients, their loved ones and their health care providers.

8. **Is a copy of the OkPOLST form as valid as the original?**

   Yes. The OkPOLST form can be copied. Photocopies and faxed copies of signed OkPOLST forms are considered valid. It is recommended that the copies be made on pink paper whenever possible to ensure that the form is easily identified. The copy must include the patient's most recent wishes. Patients are encouraged to keep copies of their OkPOLST forms in their possession and to let their families and/or physicians know where the form is kept in case it is needed.

9. **Is the OkPOLST form voluntary?**

   Yes. The form is completely voluntary.

10. **Is the OkPOLST form biased against treatment?**

    No. The OkPOLST form is not biased for or against treatment. It is non-judgmental, and it provides patients with the opportunity to choose and clearly state their own preferences for medical treatment when faced with a life-limiting and/or irreversible condition.

11. Who signs the OkPOLST form?

The OkPOLST form must be signed by the patient or his/her legal health care representative and the patient's physician to become valid. If the patient lacks decision-making capacity, the form may be signed by the patient's legal health care representative. Oklahoma statutes identify the legal health care representative to be a health care proxy named in an advance directive for health care, an attorney-in-fact named in a health care durable power of attorney or a court-appointed guardian.

12. Does the physician have to be licensed in Oklahoma to sign the OkPOLST form?

The physician must be licensed in Oklahoma, but is not required to be on the medical staff at the patient's treating facility.

13. Are the license numbers of the signing physician verified?

There is currently no process for validating the license numbers on the OkPOLST form, but contact information for the signing physician must be provided. As Oklahoma's physicians and health care facilities transition to electronic health records and a state-wide electronic health information exchange, this will become less of an issue.

14. Do all physicians have to honor the patient's OkPOLST form?

Yes. The OkPOLST form should be honored as an expression of a patient's end-of-life medical treatment preferences until such as time that a physician review s the OkPOLST form. The patient's physician is obliged to examine, assess and rewrite the orders any time the patient transfers to a new health care setting, as health status and goals of care may have changed. The physician may then issue new orders consistent with the most current information about the patient's health status, medical condition, treatment preferences and goals of care. The changes should also be documented in the patient's medical record.

15. Are there any repercussions for physicians who follow the orders set forth in a patient's OkPOLST form?

No. In some cases, physicians have been hesitant to follow OkPOLST orders without first reassessing the patient's wishes in his/her current clinical situation. However, the OkPOLST should be followed until a review is completed by the accepting health care professional. The OkPOLST form should be followed even if the physician who signed the form is not on the medical staff of the patient's treating facility.

16. Is there litigation in other states about POLST in terms of conflicts with other advance directive laws or conflicting information?

To date, there has been only one case filed in California and that case concerns an Emergency Room physician who did not honor the POLST form. This form has been used in many states since 1994 and has the ability to honor a patient's wishes across care settings. Currently, there are only seven states without a POLST program in any form of development: Alabama, Arkansas, Mississippi, Nebraska, South Dakota, Texas and Washington, D.C. There are 28 states in the process of developing POLST programs. The POLST forms used by each state are similar in that they are designed for use only by patients with serious advanced illnesses whose current health status indicates the need for standing medical orders. For more information about the POLST programs, please visit www.polst.org.

17. Are physicians compensated for discussing the OkPOLST form with their patients?

Discussing the plan of care is fundamental to all physician/patient relationships and is integral to medical care. Physicians are not specifically paid for having these conversation as they should be included as part of ordinary care for those with life-limiting illnesses. The time spent discussing the OkPOLST form with a patient should be counted in the visit level.

18. When will a state-wide registry be created to enable health care providers to determine who has an OkPOLST form?

In 2011, the federal government set a goal that all Americans would have electronic health records (EHRs) by 2014. Because OkPOLST is a physician order, it would be included in a patient's EHR. The OkPOLST Task Force is working with local health care information exchanges to create a state-wide registry. The registry will be a secure, confidential network that allows authorized providers to access a patient's EHR for the purpose of improving patient safety, quality of care and health outcomes.

19. Who is the OkPOLST form most appropriate for?

The OkPOLST form is useful for patients who are seriously ill with life-limiting and irreversible illnesses and whose life expectancy is less than one year or who are frail and elderly. It can be completed for any patient regardless of age.

20. Is it true that those who are appointed as guardians of intellectually or developmentally challenged individuals cannot execute the OkPOLST form on behalf of such individuals?

Under Oklahoma law, a guardian does not have the power to consent on behalf of the ward to withhold or withdraw life-sustaining procedures except with specific court authorization or as authorized by an advance directive executed pursuant to state law.

21. Who initiates the conversation about an OkPOLST form?

If the patient or the patient's legal health care representative wishes to complete an OkPOLST form, the patient's physician should be contacted. The physician should discuss treatment options including information about the patient's advance directive (if any) or other statements the patient has made regarding his/her wishes for end-of-life medical care and treatments. The benefits, burdens, efficacy and appropriateness of treatment and medical interventions should be discussed by the physician with the patient and/or the patient's legal health care representative.

Another member of the health care team such as a nurse or social worker may explain the OkPOLST form to the patient and/or the patient's legal health care representative. However, the physician is responsible for discussing treatment options with the patient or the patient's legal health care representative.

22. Is there a suggested way for health care providers to begin the conversation about the OkPOLST form?

The conversation may sound like this: "I'd like to talk with you today about what is going on with your medical condition which will help me understand how to best care for you or your family member. We will need to discuss the types of treatments available, what will work, what might work, and what will not work and what your goals of care are. After we have this discussion, we will be able to complete an OkPOLST form which is a physician's order that outlines the plan of care we discussed. This order will communicate this important information to other members of the health care team so they know how to best care for you during your illness. This form will transfer with you across care settings. The OkPOLST form can be rewritten at any time as long as it is represents your wishes and goals of care."

23. Is there a suggested way for family members to begin the conversation about the OkPOLST form?

The conversation may sound like this: "I'd like to talk with you about your illness and learn more about what your personal goals of care are and what types of treatment you want and don't want. It is important

for me to understand your wishes so that I can help to make sure those wishes are honored as your illness progresses or if you become unable to speak for yourself. After we discuss your wishes, we can use the OkPOLST form to record them so that we'll have a physician's order that will travel with you across health care settings. This form will ensure that your wishes are honored, and we can adjust it any time to reflect any changes in your wishes or condition."

24. Is there a suggested way for patients to begin the conversation about the OkPOLST form with their physicians or loved ones?

The conversation may sound like this: "I'd like to discuss my medical condition with you and share with you my goals of care. There are some treatments I do want and others that I don't want, and I'd like you to know what those are so there is no confusion later. It is also important to me that we discuss my personal and religious beliefs that affect my wishes for treatment. After we have this discussion, I would like you to record my wishes on an OkPOLST form, which will help to ensure that my wishes are honored as my condition progresses or if I become unable to speak for myself."

25. Is the OkPOLST form the same as an advance directive?

No. An advance directive, also known as a 'living will,' is a legal document that provides instructions specifying what types of treatment should be given to a person when that person becomes unable to make decisions or can no longer speak for him/herself. It only goes into effect if the patient loses the ability to make decisions. An advance directive can be very specific or very vague.

The OkPOLST form, however, is used as part of the health care planning process and is complementary to advance directives. It may also be used in the absence of an advance directive. In addition, the OkPOLST form is a physician's order that specifically outlines a patient's medical treatment wishes and goals of care. As a physician's order, it should be honored by all health care professionals, and it can be used to translate an advance directive into a physician's order. Also, because the OkPOLST form becomes part of the patient's medical record, it travels with the patient across health care settings. For reference purposes, those with questions about the difference between advance directives and the OkPOLST form may find the following chart helpful as it describes the primary differences between the two:

Advance Directive	POLST / OkPOLST
For anybody 18 years of age or older	For persons with advanced life-limiting illness and irreversible conditions at any age
Provides instruction for future treatment	Provides medical orders for current treatment
Appoints a health care proxy	Does not appoint a health care proxy
Does not guide emergency personnel	Guides action by emergency personnel, when available
Guides treatment decisions when available and the patient is incapacitated.	Guides treatment decisions, when available
Cannot be signed by a legal health care representative on behalf of an incapacitated person.	Can be signed by a capacitated patient or if incapacitated, by the patient's legal health care representative.

26. What is a health care durable power of attorney?

A health care durable power of attorney authorizes someone else (called an 'attorney-in-fact' or 'agent') to make decisions on behalf of the patient when the patient is no longer able to make decisions or speak for him/herself. The agent may only perform the tasks or make the decisions specifically authorized in the health care durable power of attorney document.

27. Is an advance directive or health care durable power of attorney required to complete an OkPOLST form?

An advance directive is not required to complete the OkPOLST form, but it can complement the OkPOLST form. When the patient is no longer able to make his/her own decisions, the OkPOLST form may be completed by a patient's legal health care representative named in an advance directive or by an attorney-in-fact named in a health care durable power of attorney or a guardian appointed under Oklahoma law.

28. Does an advance directive supersede the OkPOLST form?

In cases in which the patient's advance directive states different wishes than an OkPOLST form, the most recent expression of the patient's wishes is honored. The patient will receive life-sustaining medical treatment until additional information or clarification resolves the conflict. Ultimately, it is the responsibility of the attending physician to clarify any conflicts between the two documents.

29. How is a conflict between an advance directive and the OkPOLST form resolved?

a. If the OkPOLST form conflicts with the patient's previously-expressed health care instructions or advance directive, then, to the extent of the conflict, the most recent expression of the patient's wishes are honored.

b. If there are any conflicts or ethical concerns about the OkPOLST orders, appropriate hospital or health care facility resources – e.g., ethics committees, care conference, legal, risk management or other administrative and medical staff resources – should be utilized to resolve the conflict.

c. During conflict resolution, consideration should always be given to:

1) the attending physician's assessment of the patient's current health status and the medical indications for care or treatment;

2) the determination by the physician as to whether the care or treatment specified by OkPOLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and

3) the patient's most recently expressed preferences for treatment and the patient's treatment goals.

30. Do patients need an advance directive, an OkPOLST form and a health care durable power of attorney?

While all three forms are not required, it is recommended that patients with life-limiting and irreversible conditions have an advance directive that appoints a health care proxy or a health care durable power of attorney and an OkPOLST form directing a health care provider on his/her medical treatment preferences at the end of life.

31. Is the OkPOLST form reviewed regularly?

The OkPOLST form should be reviewed when the patient is transferred from one health care setting to another; when the patient experiences a significant change in condition; and/or when the patient's treatment preferences change. The OkPOLST form is designed to be a living document and should always reflect the patient's most recent wishes for medical treatment and goals of care.

32. Can an OkPOLST form be revoked?

Yes. The patient can revoke the OkPOLST form at any time

33. Does the OkPOLST form address the use of CPR?

Yes. The OkPOLST form addresses cardiopulmonary resuscitation, or CPR, in Section A. The orders specified in this section are applied only when the patient has no pulse and is not breathing, and do not apply to any other medical circumstances. If the patient wants CPR in this situation, those wishes are specified in this section, and full CPR measures will be performed. If the patient does not want CPR in this situation, he/she may choose the 'Do Not Resuscitate' option, which means CPR will not be performed and defibrillators will not be used. The patient should understand that comfort measures will always be provided if the 'Do Not Resuscitate' option is selected.

34. What does 'DNR' mean as stated in the OkPOLST form?

DNR stands for 'Do Not Resuscitate.' It means that no attempts will be made to restart the heart or breathing if the patient has no pulse or respiration.

35. What does 'Comfort Measures Only' mean as stated in the OkPOLST form?

'Comfort measures only' means that care and treatment provided will be for the purpose of enhancing comfort, controlling pain and symptoms and relieving the patient's suffering. Positioning and wound care will be used to relieve the patient's pain and suffering. The use of pain medication, oxygen, oral suction and manual treatment of airway obstruction will also be used as needed to ensure comfort. Measures such as Continuous Airway Pressure, or CPAP, which uses mild air pressure to keep the airways open, and Bilevel Positive Airway Pressure, or BiPAP, which is a breathing apparatus that helps the patient get more air into his/her lungs, may also be used to provide comfort.

36. What does 'Full Treatment' mean as stated in the OkPOLST form?

'Full treatment' refers to all appropriate life-sustaining treatments and may include the use of intubation, advanced airway intervention, mechanical ventilation, cardioversion, transfer to hospital, and use of intensive care, as indicated. It also means that in medical emergencies, 911 is called.

37. Does the OkPOLST form address the use of artificially administered nutrition and fluids?

Yes. The form includes a section that allows the patient to decide whether or not he/she wants nutrition and fluids by tube or IV. The form also allows the patient to state whether he/she would prefer a trial period, or if he/she wants long-term artificially administered nutrition and fluids.

38. On the OkPOLST form, a patient can choose not to receive artificially administered nutrition/hydration, but the form states that fluids and nutrition must be provided by mouth if medically feasible. What does this mean?

Food and water are provided by mouth whenever possible. This is clearly indicated in bold print in Section D of the OkPOLST form. If a patient is no longer able to eat and drink because of an illness from which he/she is not expected to recover, then continued discussions need to occur about the burden versus the benefit of feeding by tube or IV versus comfort care. Comfort care would include keeping the mouth and lips moist and providing food and water by mouth as tolerated. In some cases, to persist in providing artificially administered nutrition and hydration may become unduly burdensome for the patient and is not medically indicated.

39. What if the patient has special instructions that are not specifically included on the OkPOLST form?

The OkPOLST form provides additional orders or comments to be added in sections B, C and D. The patient may use these sections to relay special instructions, whatever those instructions may be.

40. Where can additional information about the OkPOLST form be found?

Additional information, including the OkPOLST form, and information for consumers, health care professionals and health care organizations, is available on the OkPOLST website at www.okpolst.org. A collaborative effort is underway to educate Oklahoma's health care providers, caregivers, social workers, religious leaders/organizations, patients and consumers about the OkPOLST form.