The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation

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The Physician Orders for Life-Sustaining Treatment (POLST) Paradigm is designed to improve end-of-life care by converting patients' treatment preferences into medical orders that are transferable throughout the health care system. It was initially developed in Oregon, but is now implemented in multiple states with many others considering its use. Accordingly, an observational study was conducted in order to identify potential legal barriers to the implementation of a POLST Paradigm. Information was obtained from experts at state emergency medical services and long-term care organizations/agencies in combination with a review of relevant state law. Legal analysis of survey responses and existing laws identified several potential state legal barriers to a POLST Paradigm implementation. The most potentially problematic barriers are detailed statutory specifications for out-of-hospital DNR (do not resuscitate) protocols (n = 9 states). Other potential barriers include limitations on the authority to consent to forgo life-sustaining treatments (n = 23 states), medical preconditions (n = 15), and witnessing requirements (n = 12) for out-of-hospital DNR protocols. State leaders interested in the development of a POLST Paradigm Program are advised to work with legal counsel to address the potential legal barriers identified in this study.

It is widely agreed that advance directives have failed to achieve their "admirable purpose" of helping patients retain control over end-of-life treatment,[1] and researchers have identified numerous reasons for this failure. Most people do not complete advance directives,[2] and when they do, they often fail to understand the form's language and the implications of their decisions.[3] Patients' goals and preferences for care may change over time, but their advance directives are rarely revisited,[4] and proxy decision makers, appointed by patients to make decisions on their behalf upon incapacitation, often do not understand the patients' wishes.[5] Furthermore, advance directives are frequently unavailable when needed,[6] or health care providers may not know about the directives or may not think they apply to the patient's situation.[7] Even when they are available, the language is often too vague to provide helpful guidance.[8] As a result, advance directives typically do not affect patient care.[9]

The POLST (Physician Orders for Life-Sustaining Treatment) Program was originally developed in Oregon to improve end-of-life care by overcoming many of the advance directives' limitations. It is designed to convert patient preferences for life-sustaining treatments into immediately actionable medical orders. The centerpiece of the program is a standardized, brightly colored form that provides specific treatment orders for cardiopulmonary resuscitation, medical interventions, artificial nutrition, and antibiotics. It is completed based on conversations among health care professionals with the patient and/or the appropriate proxy decision makers, in conjunction with any existing advance directive for incapacitated patients. The POLST form is recommended for persons who have

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advanced chronic progressive illness, who might die in the next year, or who wish to further define their preferences for treatment. There are now programs based on the POLST paradigm in West Virginia and Washington, as well as parts of Wisconsin, Pennsylvania, and New York. Although the form's content and name vary slightly depending on the location (e.g., Physician Orders for Scope of Treatment, or POST in West Virginia, Medical Orders for Scope of Treatment, or MOLST in New York), all share the same core elements with similar form design.[10] Programs based on these same core elements are referred to as "POLST Paradigm Programs," and the forms are referred to as "POLST Forms" (see Figure 1 for a sample).

The POLST Form is designed to transfer across treatment settings, so it is readily available to medical personnel, including emergency medical technicians (EMTs), emergency physicians, and nursing facility staff, for example. The POLST Paradigm Program relies upon teamwork and coordinated systems to ensure preferences are honored throughout the health care system.[11] Research suggests the POLST form accurately represents patient treatment preferences the majority of the time[12] and that the treatments provided at the end of life match the orders on the form.[13] EMTs report that the POLST form provides clear instructions about patient preferences, and is useful when deciding which treatments to provide.[14] In contrast to the single intervention focus of out-of-hospital DNR orders, the POLST form provides patients with the opportunity to document treatment goals and preferences for interventions across a range of treatment options, thus permitting greater individualization.[15]

In its 2006 consensus report, the National Quality Forum observed that "…compared with other advance directives programs, POLST more accurately conveys end-of-life preferences and yields higher adherence by medical professionals." The National Quality Forum and other experts have recommended nationwide implementation of the POLST Paradigm.[16] However, state legislative processes used to create advance directives and out-of-hospital DNR protocols may complicate efforts to achieve the goal of national implementation. Most state laws stipulate specific requirements for the use of out-of-hospital DNR orders and advance directives that are designed to uphold the rights of adults to forgo medical treatment.[17]

A national study was undertaken to identify potential legal barriers to the implementation of POLST Paradigm Programs through the examination of state statutes (formal, codified laws enacted by state legislative bodies that require a legislative vote to change) and regulations (rules developed by state administrative offices authorized by the legislature to clarify or implement statutes) relevant to end-of-life treatment decisions. This article reports the results of this study and identifies common problematic statutes and regulations that may need to be changed prior to an individual state implementing a POLST Paradigm Program.

Methods

Overview

Interviews were conducted between October 2005 and May 2006 with state emergency medical services (EMS) and long-term care (LTC) expert informants. These informants were the initial source of information regarding state law. An independent legal review of each state's law was also conducted to validate responses, supplement information, and clarify inconsistencies in the informants' responses. The goal was to identify current state laws that could be potential barriers to implementing a POLST Paradigm Program. This study was reviewed and approved by the West Virginia University Institutional Review Board for the Protection of Human Subjects prior to its conduct.

Participants

Participants were individuals who were expected to understand relevant state law by virtue of their professional roles. The affiliation of the actual informant in each state varied, reflecting different governmental and organizational environments. EMS informants were primarily state EMS directors and/or their designees identified from online profiles of state EMS agencies. LTC informants were either lawyers affiliated with state LTC advocacy organizations or state agency leaders. These individuals were identified through state chapters of the American Health Care Association, the American Association of Homes and Services for the Aging, state long-term care ombudsman offices, and other professional long-term care advocacy groups.

Survey

The EMS survey instrument contained questions about state statutes and regulations pertaining to EMTs regarding the following: (1) out-of-hospital DNR orders; (2) DNR order forms; (3) unique DNR identifiers (e.g., bracelets, identification tags, necklaces); (4) do-not-hospitalize orders; (5) out-of-hospital orders for other medical treatments (e.g., intubation or intravenous fluids); and (6) the use of POLST Paradigm Programs. The LTC survey instrument contained questions about state statutes and regulations pertaining to nursing facilities regarding the following: (1) DNR orders; (2) do-not-hospitalize orders; (3) artificial nutrition and hydration; (4) orders to limit

other life-sustaining interventions (e.g., antibiotics or other medications, intubations); and (5) the use of POLST Paradigm Programs.

Procedures

Potential participants were contacted by phone one to two weeks after an introductory letter, and a copy of the survey was sent by mail or email. Appointments were scheduled with individuals who agreed to participate, and individuals who declined participation were asked to help identify other potentially appropriate informants. Participants were interviewed via telephone by one of three trained law student research assistants, and each was asked to provide citations, hard copies, or web links to relevant information. On occasion, more than one informant was interviewed (either separately or together) to obtain complete information about the state. Some spontaneously completed the survey and returned it by email or fax. If needed, the research assistants contacted these informants by phone to clarify responses or obtain additional information.

Survey responses were reviewed and used to create state summary profiles. In the process of creating these profiles, the researchers noted discrepancies between the responses provided by the EMT and LTC informants. Informants were re-contacted and provided with a copy of the state profile to review and verify the accuracy of their responses. State profiles were corrected if needed based on feedback from the informants. In combination with this process, a review was conducted of relevant state law to fill in and verify the accuracy of responses. Reviews were first conducted by a law student research assistant (JN), then by a legal consultant, and finally by a lawyer (CPS). Any remaining discrepancies were resolved in favor of the primary legal source. Preliminary analysis of the profiles led to the identification and review of the following areas of law that are potentially relevant to POLST Paradigm Programs: (1) living will provisions; (2) durable power of attorney for health care provisions; (3) default surrogate provisions; (4) guardianship provisions; and (5) out-of-hospital DNR protocols. State profiles were subjected to a statutory and regulatory analysis to identify barriers to POLST Paradigm Programs evident in any of these legal sources.

Results

The following percentages are all based on n = 51, and references to "states" include the District of Columbia. Survey responses were obtained from EMS informants, representing n = 38 states (a 75 percent response rate), and LTC informants, representing n = 42 states (an 82 percent response rate). Thirty-three states (65 percent) had both EMS and LTC informants, and four states (eight percent) had neither. Table 1 contains a summary of potential legal impediments to implementation of a POLST Paradigm Program for each state, based upon the survey data and the legal analysis. State-specific details, including state code citations, are available in the Appendix.

Limitations on Consent to Forgo Life-Sustaining Treatment

Twenty-three states (45 percent) impose explicit limitations on substituted consent to forgo life-sustaining treatments via their advance directive or default surrogate laws. These limitations either focus on all life-sustaining interventions, including DNR and artificial nutrition and hydration, or on only artificial nutrition and hydration. Most limitations are diagnostic preconditions and vary by state. They include language such as "terminal condition," "permanent unconsciousness," and "end-stage condition." Definitions of these preconditions vary in regards to the complexity of the certification procedures required, with the most restrictive requiring documentation by a second physician specialist. Additional medical certifications and/or evidentiary requirements were identified in four states (eight percent). One of the most stringent states is Oklahoma, which expressly denies any substitute decision maker the right to provide substituted consent to forgo artificial nutrition and hydration unless at least one of five specific preconditions are met (see Appendix). Twenty-seven states (53 percent) imposed some level of restriction on withholding or withdrawing treatments, as in the case of a pregnant patient.

Medical Preconditions and Witnessing Requirements

In many states, the authority to give substituted consent is determined by the category of the decision maker. All states (100 percent) permit a pre-identified agent (also known as a health care proxy, durable power of attorney for health care, medical power of attorney, health care agent, or authorized surrogate) or a legal guardian to make decisions about life-sustaining treatment for an incapacitated person. The agent's authority is limited in 12 states (24 percent) by medical precondition requirements, and in one state (Iowa) by the requirement that a witness be present when an agent consents to forgo treatment. Guardians are often called upon by the courts to make decisions for incapacitated persons, including decisions about life-sustaining treatment. The authority for guardians to make such decisions is limited in 12 states (24 percent) by medical or other preconditions, and in two states (District of Columbia and Iowa) by witnessing requirements similar to those described above.

Default Surrogate Provisions

Many states have default surrogate laws that identify permissible decision makers for patients who are unable to speak for themselves and have no legally authorized agent or guardian. Typically, these states grant decision-making authority to default surrogates based on their relationship to the patient, using a kinship hierarchy that typically starts with the spouse. Thirty-nine states (76 percent) permit default surrogates to make end-of-life decisions, and 20 states (51 percent) impose medical preconditions. The District of Columbia, Iowa, and Montana also impose witnessing requirements for decisions by default surrogates. Fourteen states (27 percent) have no legal provisions regarding a default surrogate's ability to determine to forgo life-sustaining treatments on behalf of an incapacitated patient when no pre-identified agent exists.

Out-of-Hospital DNR Protocol Barriers

The introduction of a POLST Paradigm Program may also be complicated by existing out-of-hospital DNR protocols that are incompatible with the POLST Paradigm. Out-of-hospital DNR protocols exist by statute or regulation in all but four states: Minnesota, Mississippi, Missouri, and North Dakota. In the 47 states (92 percent) with out-of-hospital DNR protocols, 42 authorize the protocols by statute, and five (Alabama, Maine, Massachusetts, Nebraska, and Oregon) authorize by regulation. Three elements of out-of-hospital DNR protocols were identified as potential barriers to a POLST Paradigm Program: (1) detailed statutory form specifications for DNR identification; (2) applicability of the protocol only to certain medical conditions; and (3) witnessing requirements.

Detailed Statutory Form Specifications. Six states (Indiana, Kansas, Michigan, Oklahoma, Pennsylvania, and Texas) prescribe detailed statutory form specifications for out-of-hospital DNR orders, and two states (Rhode Island and District of Columbia) require that a specific bracelet or necklace be used, rather than a form. In addition, Arkansas expressly precludes the withholding of treatments (other than CPR) under its out-of-hospital DNR statute. Thirty-three states (65 percent) with statutory out-of-hospital DNR protocols have form requirements that are deemed minimal or moderate. These states may require some modifications for the POLST Paradigm Program, but the protocols do not necessarily preclude implementation. As noted above, four states lack out-of-hospital DNR protocols, and five states have protocols that derive solely from regulations. Regulatory protocols are easier to alter than statutory protocols, and therefore are not considered to be a potential barrier to implementation.

Medical Preconditions. The presence of specific medical preconditions for out-of-hospital DNR protocols limit which patients are eligible to use programs based on the POLST Paradigm. The nature of medical preconditions vary by state and are defined in a manner similar to the medical preconditions noted under the authority to consent to forgo life-sustaining treatments. Medical preconditions for out-of-hospital DNR orders were present in 15 states (29 percent).

Witnessing Requirements. Most out-of-hospital DNR forms require the signature of the patient along with the attending physician or another specified supervising health care provider. However, 12 states (24 percent) also require the signature of one or two witnesses to effectuate the order.

Discussion

The POLST Paradigm has been recognized as a valuable innovation for improving end-of-life care because it includes a systematic approach for ensuring patients' treatment preferences are honored by converting these preferences into medical orders. However, the findings of this study suggest that there are potential legal barriers to the implementation of a POLST Paradigm Program in many states. The most potentially problematic legal barriers are highly detailed statutory out-of-hospital DNR form specifications and/or identifiers, such as bracelets. Other potential barriers include legally defined medical preconditions, witnessing requirements, limitations on substituted consent for withholding life-sustaining treatments, including artificial nutrition and hydration, and the absence of default surrogate provisions.

Out-of-hospital DNR laws and protocols first began to take root in the early 1990s. These protocols were developed to ensure that a patient's wishes regarding resuscitation were translated into medical orders that would be recognized and complied with across health care settings. By 2006, all but four states had developed such protocols. Ironically, these protocols may inadvertently constrain a similar process that would apply to a greater range of decisions about life-sustaining treatments. The exact nature of the barrier and the ease of modifiability depend on the state-specific details of these mandates, including whether they are written as statute, as regulation, or as mere guidelines.

Medical preconditions for out-of-hospital DNR orders do not necessarily prevent the use of a POLST form, but they would have to be met and documented as part of a POLST Paradigm Program. Medical preconditions have the potential to significantly limit the utility of the program because they narrow the population of patients who are eligible by restricting the form's use to patients with "terminal illness," "per-

manent unconsciousness," or other similar conditions, as defined by the precondition language. Medical preconditions could also create additional procedural complexities that would limit the utility of a POLST Paradigm Program. For example, some medical preconditions require that two specially qualified physicians certify the precondition, which could be problematic in settings where multiple physicians are not readily available. Witnessing requirements can create a similar kind of challenge. Finally, limits on substituted consent do not preclude the possibility of using the POLST Paradigm, but may restrict the types of life-sustaining treatments eligible for substituted consent. In the states where the POLST Paradigm is currently in use statewide, there are no medical preconditions, witnessing requirements, or limits on substituted consent.

Default surrogate provisions are useful, but not necessary, for a successful POLST Paradigm Program. In states without default surrogate provisions, use of a POLST Paradigm Program is not precluded, but may be limited to decision making by the patient, designated agent, or guardian, depending on the state's law. Consequentially, this may restrict the number of individuals eligible to use POLST forms, and may ultimately limit the utility of the program for individuals who do not engage in any type of advance planning prior to incapacitation (i.e., acute illness or progressive neurological diseases such as Alzheimer's dementia). Conversely, in practice, most states permit family members to determine treatment for incapacitated patients without advance directives, even in the absence of laws authorizing default surrogate provisions, unless there is a disagreement about how to proceed.

Several states have overcome potential legal barriers to successfully implement a POLST Paradigm Program through regulatory and legislative processes. It may be possible for a state with fewer potential legal barriers to implement a POLST Paradigm Program within its existing laws, as Oregon, Washington, and Wisconsin have done. One benefit of this approach is the freedom to make modifications to the program as needed. This course of action may not be feasible or desirable for states with more complex legal barriers, or for states with no legal provisions regarding such end-of-life treatments, as those states would likely need to legislate every provision of the POLST Paradigm Program, making the process complicated, lengthy, and possibly contentious.

An unanticipated finding of this study was the difficulty that some administrators, legal experts, and other key state contacts had in interpreting the relevant state law regarding decision making for seriously ill patients and nursing home residents. In a few cases, simple misunderstanding of the laws became apparent during the direct review and analysis of the laws themselves. Many informants identified these errors when asked to review the state profiles reflecting their responses. Other informants were unclear about how the interrelation of multiple laws affects options and procedures. For example, an informant might be familiar with only one area of the law, such as advance directive laws, and then answer questions in reference only to those laws when other areas of law, such as out-of-hospital DNR laws or default surrogate laws, may be equally or more relevant in a given situation.

Legal analysis confirmed the varying complexity and scope of end-of-life care laws. It was determined that a minimum of five different sets of legal provisions are relevant to POLST Paradigm Program implementation: (1) living wills; (2) durable powers of attorney for health care; (3) default surrogate provisions; (4) guardianship law; and (5) out-of-hospital DNR protocols. These findings highlight the need for coalitions interested in developing POLST Paradigm Programs to include a variety of legal experts and regulatory authorities to ensure the Program complies with all applicable state regulations and statutes, since an individual's or professional's breadth of knowledge regarding the applicable state law can be limited.

The interpretation and application of these findings must take into account several factors. First, the regulations in some states list more than one set of preconditions for withholding life-sustaining treatment including artificial nutrition and hydration. However, if one of the preconditions permits withholding life-sustaining treatments when the burdens of treatment outweigh the benefits, then the preconditions were not identified as barriers, since this kind of calculus represents a fairly common, flexible approach to health care decision making. Nevertheless, if there is disagreement about whether the precondition applies in a specific situation, then this "flexibility" ultimately may become a barrier. Second, the findings do not reflect a number of legal limitations implicit or virtually universal in state law. For example, there are typically provisions that permit EMTs to attempt resuscitation despite the presence of a DNR order under certain conditions, such as a large-scale accident with mass casualties, an accident unrelated to the patient's "terminal condition," or a conflict between documented orders and family members' directives at the scene. EMTs may also disregard DNR orders to avoid verbal or physical confrontation, or when a physician directs otherwise. Third, the findings do not reflect the procedural elements that are typical in state law. These include certifying the patient's incapacity or medical precondition, certifying that the treatment is not nec-

essary for comfort care, and requiring notice to the patient or family before an action is taken. Fourth, the findings do not identify differences in state decision-making standards. Most states prescribe some version of a *substituted judgment* and *best interest* standard for decision making, but some are more restrictive by requiring evidence of the patient's actual wishes or by setting a higher burden of proof (clear and convincing). Fifth, the authority of guardians to make health care decisions is generally determined by the appointing court, so variations of that restriction are not included in the chart unless the guardianship law imposes a specific limitation or ban, or the law simply does not identify the guardian as a surrogate decision maker for health care. Finally, even if a state has approved out-of-hospital DNR orders, this usually does not preempt within-facility protocols, even where the out-of-hospital DNR order form is described as "mandatory." An examination of facility regulations, such as nursing homes and assisted living facilities, was not included in this study.

This legal review found that most advance directive laws, and many out-of-hospital DNR laws, do not preempt or change any existing rights regarding health care decision-making authority or responsibility. Rather, they are complimentary with existing laws and prescribe one, but not the only, legal pathway to end-of-life treatments. The primary advantage of following state law is that participants are immune from prosecution, disciplinary action, and civil action for their conduct in compliance with the statute. Florida law provides an example of non-preemption language:

> The provisions of this chapter are cumulative to the existing law regarding an individual's right to consent, or refuse to consent, to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor, competent or incompetent person, or a patient's family may have under the common law, Federal Constitution, State Constitution, or statutes of this state.[18]

Although health care providers undoubtedly value this immunity, most of their day-to-day clinical activity has no such legal protection. Thus, if providers conclude that the POLST Paradigm is clinically appropriate, and there is no existing law that expressly prohibits its implementation, then the above conclusions may be sufficient to proceed. The barriers identified in this study are relevant only if states determine that the existing laws designed for out-of-hospital orders and advance directives apply to POLST Paradigm Programs.

Conclusion

This review of state laws identified several potential statutory and regulatory barriers to a national implementation of the POLST Paradigm Program. The most potentially problematic barriers are highly detailed state requirements for out-of-hospital DNR orders that are incompatible with the requirements for a POLST form. Other barriers, such as witnessing requirements, will have a significant impact on the complexity and cumbersomeness of implementing a POLST Paradigm Program, but do not absolutely preclude its use. States interested in developing a POLST Paradigm Program will need to review the compatibility of their existing laws with the POLST Program, and amend or adopt accordingly. States should strive to ensure the POLST form remains simple to use and maintains the goal of helping patients retain control over their end-of-life treatment.

Note

After the completion of data collection and the legal analysis in December 2006, the following states passed or enacted legislation which is not included in the Table and Appendix and which established the use of a POLST Paradigm Program: Hawaii, Idaho, North Carolina, and Tennessee.

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Table 1

Potential Statutory Barriers to Use of a POLST Paradigm Program

STATE	Lack Default Surrogate Provisions	Medical or Other Preconditions for Forgoing Treatment[1]				Detailed statutory out-of-hospital DNR form or identifier	Medical Preconditions for out-of-hospital DNR	Witnessing Requirements for out-of-hospital DNR
		Default Surrogate	Agent	Guardian	Witnessing Required to Forgo LST			
Alabama		●	●	●				
Alaska		●	●	●				
Arizona		●						●
Arkansas		●				●[2]		
California								
Colorado		●						
Connecticut		●[3]	●[3]					
Delaware		●					●	
D.C.					●[4]	●[5]		
Florida		●	●					
Georgia							●	
Hawaii								●
Idaho							●	
Illinois		●		●				●
Indiana						●	●	●
Iowa		●[6]	●[6]	●[6]	●[6]		●	
Kansas				●[7]		●		●
Kentucky		●	●	●				●
Louisiana		●	●	●			●	●[8]
Maine		●						
Maryland		●						
Massachusetts	●							
Michigan		●				●		●
Minnesota	●							
Mississippi								
Missouri	●							
Montana		●	●	●	●[9]		●	
Nebraska	●		●				●	
Nevada		●					●	
New Hampshire	●							
New Jersey								
New Mexico								
New York**	●[10]						●	●
North Carolina		●[11]		●[11]				
North Dakota								

STATE	Lack Default Surrogate Provisions	Medical or Other Preconditions for Forgoing Treatment[1]				Detailed statutory out-of-hospital DNR form or identifier	Medical Preconditions for out-of-hospital DNR	Witnessing Requirements for out-of-hospital DNR
		Default Surrogate	Agent	Guardian	Witnessing Required to Forgo LST			
Ohio		●	●	●				
Oklahoma	●		●	●		●		●
Oregon*		●	●	●				
Pennsylvania**	●					●	●	
Rhode Island	●					●[12]	●	
South Carolina							●	
South Dakota								
Tennessee								
Texas						●		●
Utah*							●	●
Vermont	●							
Virginia								
Washington*								
West Virginia*								
Wisconsin**	●						●	
Wyoming								
Total Potential Barriers:	**12**	**20**	**12**	**12**	**3**	**9**	**15**	**12**

NOTE: Agent = *person formally appointed by the patient to serve as a health care agent;* Guardian = *any court-appointed decision maker with authority over health decisions;* Default Surrogate = *any decision maker authorized by law in the absence of an agent or guardian.* DNR = *Do Not Resuscitate. See the Appendix for detailed information about state statutes and regulations as well as information about restrictions about withholding and withdrawing treatments for pregnant women.*

**States with statewide POLST Paradigm Program at time of survey.*

***States with regional POLST Paradigm Programs at time of survey.*

1. Limitations in state law vary in whether the limitations apply to all life-sustaining treatments or only to artificial nutrition and hydration. See Appendix for further information about specific states.
2. Arkansas: Restricts withholding of other life-sustaining treatments in the out-of-hospital DNR order.
3. Connecticut: Limitation is on physicians and does not specifically apply to default surrogate, agent, or guardian
4. One witness required for consent by default surrogate and guardian, but not agent.
5. District of Columbia: Requires use of a bracelet.
6. Iowa: Medical preconditions and witnessing of consent to forgo apply if no living will with relevant provisions.
7. Kansas: Preconditions are not applicable if there is an advance directive with provisions relevant to forgoing life-sustaining treatment.
8. Louisiana: Two witnesses are required for Living Will which is the basis for the out-of-hospital DNR order.
9. Montana: Two witnesses required for consent to forgo by a designated surrogate only.
10. New York: Default surrogate statute applies only to out-of-hospital DNR orders.
11. North Carolina: Preconditions only for "comatose" patients.
12. Rhode Island: Requires use of a bracelet.

Appendix

Legal Barriers to Use of the "Physician Orders for Life-Sustaining Treatment" (POLST) Paradigm

KEY TO TERMS:

AD: Advance Directive; includes living wills (LW) and durable power of attorney (DPA) for health care forms (also known as health care proxy appointments).

Agent: person formally appointed by the patient to serve as a health care agent.

ANH: Artificially supplied nutrition and hydration (e.g., food and water through tubes); does not include spoon feeding.

DNR: Do not resuscitate

DS: Default Surrogate: person or persons identified by state law with authority to act as surrogate decision maker for an individual if there is no agent or guardian.

EMS: Emergency medical services

Forgoing: withholding or withdrawing.

Guardian: Any court-appointed decision maker with authority over health decisions.

LST: Life-sustaining treatment; the definition varies by state but almost always includes cardiopulmonary resuscitation (CPR).

N/A: not applicable because state does not have type of law at issue, e.g., no DNR protocol or no DS, no advance directive statute.

OHDNR: Out-of-Hospital DNR orders; also referred to as EMS-DNR Orders, Comfort Care Orders, or CPR Directives. The term does not include rules for DNR orders for hospitals or other health care facilities.

Patient: adult to whom treatment decision applies.

Substituted consent: consent for certain types of medical treatment when patient is not able to consent himself/herself.

Witness: usually adult and with decision-making capacity. Eligibility requirements for serving as a witness are not spelled out in the Table.

Note: *Cells shaded in pink indicate a substantial potential barrier to implementation of a POLST Paradigm Program. Appendix updated to January 2007.*

State & Citation Key	Who may consent to forgoing LST including DNR	Statute Expressly non-exclusive (1) OHDNR (2) AD	OHDNR Order Statutory and Regulatory Provisions				Advance Directive and Default Surrogate Statutes	
			OHDNR Order Provisions	Out-of-Hospital DNR Provision Barriers to POLST			Substituted Consent Limitations/Barriers to POLST	
				Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
Alabama Ala. Code (AC) Ala. Admin. Code (AAC)	Patient, agent, guardian, DS AC 22-8A-11	(1) OHDNR N/A because regulation-based OHDNR (2) AD AC 26-1-2(g)(9) [DPA] & 22-8A-9(d) [LW]	Regulations/ Guidelines: AAC 420-2-1-.19	No Statute Regulations only AAC 420-2-1-.02(38) & 420-2-1-.19(1)	None listed	None listed	Pregnancy limitation. AC 22-8A-4(c) Medical precondition: For agent, guardian, and DS, patient must be in "terminal condition" or be "permanently unconscious." AC 22-8A-2	None listed
Alaska Alaska Stat. (AS) Alaska Admin. Code (AAC) Also: K. Kirk , 22 *Alaska L. Rev.* 213 (2005)	Patient, agent, guardian, DS 13.52.030	(1) OHDNR Not Addressed (2) AD Not Addressed	Statute: AS 13.52.065 Regulations/ Guidelines: 7 AAC 16.010 7 AAC 16.020 7 AAC 16.090	Defers to regulations AS 13.52.065(c) & 13.52.065(d); 7 AAC 16.010(d)1	None listed	None listed	Pregnancy limitation. AS 13.52.055 For agent and DS, patient must be in a "terminal condition" or have "permanent unconsciousness." AS 13.52.045, 13.52.390(36) Guardian may not consent to forgo LST, but not required to oppose forgoing LST. AS 13.26.150(e)	None listed
Arizona Ariz. Rev. Stat. Ann. (ARS)	Patient, agent or guardian ARS 36-3251(D)	(1) OHDNR Not Addressed (2) AD Not Addressed	Statute: ARS 36-3251	Statutory form – Simple ARS 36-3251(B) & (C)	None listed	Yes; one witness. ARS 36-3251(B) and Op. Atty. Gen. No. 197-005.	None listed	DS cannot make decisions to "withdraw" ANH ARS 36-3231(D) DS also not listed as authorized to consent to OHDNR 36-3251(D).

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			OHDNR Order Provisions	Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
Arkansas Ark. Code Ann. (AC) Code of Ark. Rules (CAR)	Regulations refer only to "Patient or Health Care Proxy or Legal Guardian" as authorized signors. OHDNR. CAR 007 28 006 (5)	(1) OHDNR AC 20-13-905(e) (2) AD AC 20-17-210 [LW]	Statute: AC 20-13-901 to 20-13-908 Regulations/ Guidelines: CAR 007 28 006	Defers to regulations AC 20-13-901, 20-13-906; CAR 007 28 006; But restricts w/holding other treatments via OHDNR AC 20-13-901(5)(C)	None listed	None listed	Pregnancy limitation. AC 20-17-206(c) For DS, patient must be in "terminal condition." AC 20-17-203	None listed
California Cal. Probate Code (CPC) Cal. Health & Safety Code (CHSC) Cal. Code Regulations. (CCR) Cal. EMS Authority (EMSA) guidelines	Patient, Agent, Guardian, DS. EMSA #111 (1993), *Guidelines for EMS Personnel Regarding Do Not Resuscitate (DNR) Directives*	(1) OHDNR CPC 4786 (2) AD Not Addressed	Statute: CPC 4780 to 4786	Prescribes minimal form contents Cal CPC 4780, 4783	None listed	None listed	None listed	None listed
Colorado Colo. Rev. Stat. Ann. (CRS) Colo. Code. Regulations (CCR)	Patient, agent, guardian, DS CRS 15-18.5-103(3)	(1) OHDNR CRS 15-18.6-103 (1) (2) AD CRS 15-14-506 (4)(a) [DPA]	Statute: CRS 15-18.6-104 Regulations/ Guidelines: 6 CCR 1015-1(4)	Prescribes moderate form contents CRS 15-18.6-103 6 CCR 1015-1(4.4)	None listed	None listed	None listed	DS cannot consent to forgoing ANH unless "the attending physician and a second independent physician trained in neurology or neurosurgery certify in the patient's medical record that the provision or continuation of artificial nourishment or hydration is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning." CRS 15-18.5-103(6)
Connecticut Conn. Gen. Stat. Ann. (CGS) Conn. Agencies Regulations (CAR)	Patient, agent, guardian, DS 19a-570(8); 19a-571	(1) OHDNR Not Addressed (2) AD Not Addressed	Statute: CGS 19a-580d CAR 19a-580d-1 to 19a-580d-9	Prescribes minimal form contents Regulations must address use of bracelets CGS 19a-580 CAR 19a-580d-1, 19a-580d-2, 19a-580d-4	None listed	None listed	Pregnancy limitation. CGS 19a-574 Limitation on physician: [Not clear whether this affects authority of agent, guardian, or surrogate]: In order to forgo a "life support system," patient must have a "terminal condition" or be "permanently unconscious." CGS 19a-571(a) Further…"If the attending physician does not deem the incapacitated patient to be in a terminal condition or permanently unconscious, beneficial medical treatment including nutrition and hydration must be provided." CGS 19a-571	None listed

Appendix continued on next page

State & Citation Key	Who may consent to forgoing LST including DNR	Statute Expressly non-exclusive (1) OHDNR (2) AD	OHDNR Order Statutory and Regulatory Provisions				Advance Directive and Default Surrogate Statutes	
			OHDNR Order Provisions	Out-of-Hospital DNR Provision Barriers to POLST			Substituted Consent Limitations/Barriers to POLST	
				Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
Delaware Del. Code Ann. (DC) Code of Delaware Regulations (CDR)	Patient, agent, guardian, DS 16 DC 2507	(1) OHDNR Not Addressed (2) AD Not Addressed	Statute: 16 DC 9706(g) 16 DC 9706(h) Regulations/ Guidelines: CDR 40 700 061	Prescribes moderate form contents 16 DC 9706(g)(1)(a) & 9706(h) CDR 40 700 061(5.0)	Yes "terminal illness." 16 DC 9706(h)(1); CDR 40 700 061 (1.0); 40 700 061 (3.1); 40 700 061 (3.3.1)	None listed	Pregnancy limitation. 16 DC 2503(J) For DS, patient must be in "terminal condition" or be "permanently unconscious." 16 DC 2501(r), 16 DC 2507(b)(6)	None listed
District of Columbia D.C. Code (DCC)	Patient, agent, guardian, DS DCC 21-2210	(1) OHDNR Not Addressed (2) AD DCC 7-629 [LW]	Statute: DCC 7-651.01 to 7-651.17	Prescribes moderate form contents Bracelet/ necklace required DCC 7-651.01(8), 7-651.02(b), 7-651.03, 7-651.04	None listed	None listed	For DS and guardian, at least one witness must be present whenever these people grant, refuse or withdraw consent on patient's behalf. DCC 21-2210	None listed
Florida Fla. Stat Ann. (FS) Fla. Admin. Code Ann. (FAC)	Patient, agent, guardian, DS FS 765.401	(1) OHDNR Not addressed (2) AD FS 765.106 [combined act]	Statute: FS 401.45(3)	Defers to regulations FS 401.45(3) FAC 64E-2.031	None listed	None listed	Pregnancy limitation for agent or DS, FS 765.113 For agent and DS, patient must have an "end-stage condition," be in a "persistent vegetative state," or have a "physical condition [that] is terminal." FS 765.305, 765.401(3)	None listed
Georgia Georgia Code Ann. (GC)	Patient, agent, guardian, DS 31-39-2(3) 31-39-4©	(1) OHDNR GC 31-39-9(a) (2) AD GC 31-36-4 [DPA] and § 31-32-11 [LW]	Statute: GC 31-39-6.1	Statutory form – Simple GC 31-39-6.1	Yes Agent, guardian, DS, or physician can consent to DNR for "candidate for nonresuscitation" defined as patients 1) with medical condition that can "reasonably be expected to result in the imminent death of the patient," 2) in a "noncognitive state with no reasonable possibility of regaining cognitive function, or 3) CPR would be "medically futile." GC 31-39-2(3), 31-39-2(4), 31-39-4	None listed	None listed	None listed
Hawaii Hawaii Rev. Stat. (HRS)	Patient, agent, guardian, DS HRS 327E-2 and E-5	(1) OHDNR Not addressed (2) AD Not Addressed	Statute: HRS 321-229.5; HRS 321-23.6	Prescribes minimal form contents HRS 321-229.5(a) & 321-23.6	None listed (as of 2006 amendment) to 321-229.5(a) & 321-23.6(a)	Yes Two witnesses HRS 321-229.5(a)(2) & 321-23.6(a)(2)	None listed	None listed

State & Citation Key	Who may consent to forgoing LST including DNR	Statute Expressly non-exclusive (1) OHDNR (2) AD	OHDNR Order Statutory and Regulatory Provisions				Advance Directive and Default Surrogate Statutes	
				Out-of-Hospital DNR Provision Barriers to POLST			Substituted Consent Limitations/Barriers to POLST	
			OHDNR Order Provisions	Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
Idaho Idaho Code (IC) Idaho Admin. Code (IAC)	Patient, agent, guardian, DS IC 39-4503	(1) OHDNR IC 56-1032 (2) AD IC 39-4508 [combined act]	Statute: IC 56-1021 to 56-10335 Regulations/ Guidelines: IAC 16.02.03.400	Defers to regulations IC 56-102(6) & 56-102(7), IAC 16.02.03.400	Yes "Terminal condition" IC 56-1021(12), 56-1023	None listed	Pregnancy limitations. IC 39-4501(2)	None listed
Illinois Ill. Comp. Statutes (ILCS) Ill.Admin. Code (IAC)	Patient, agent, guardian, DS DNR. 755 ILCS 40/65; 77 IAC 515.380(e)	(1) OHDNR 755 ILCS 40/65(c) & (e) (2) AD 755 ILCS 35/9 (d) [LW] & 755 ILCS 45/4-3[DPA]	Statute: 210 ILCS 50/3.30 210 ILCS 50/3.57	Defers to regulations 755 ILCS 65 IAC 515.380(e) & 77 IAC 515.380(f)	None listed	Yes Two witnesses. 755 ILCS 40/65	For guardian and DS, patient must be in "terminal condition," have "permanent unconsciousness," or have an "incurable or irreversible condition." 755 ILCS 40/10, 40/20(b) and 40/25(a).	None listed
Indiana Ind. Code Ann. (IC)	Patient, agent, guardian, DS IC 16-36-5-9, 16-36-5-11	(1) OHDNR Not addressed (2) AD IC 16-36-4-17(e) [LW]	Statute: IC 16-36-5-1 to 16-36-5-28	Statutory form – Detailed IC 16-36-5-7, 36-5-15, 16-36-5-17	Yes "Terminal condition" or "medical condition" such that if CPR "would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death." IC 16-36-5-8; 16-36-5-10. Also Pregnancy limitation in OHDNR. IC 16-36-5-14	Yes Two witnesses. IC 16-36-5-2 16-36-5-11	None listed	None listed
Iowa Iowa Code Ann (IC) Iowa Admin Code (IAC)	Patient, agent, guardian, DS IC144A.7 IAC 641-142.5b	(1) OHDNR IC 144A.11(5) (2) AD IC 144B.12 [DPA] and 144A.11 [LW]	Statute: IC 144A.7A to 144A.10 Regulations/ Guidelines: IAC 641-142.1 to 641-142.9 App. B	Prescribes minimal form contents IC 144.7A IAC 641-142.1 641-142.3 641-142.9 App. A 641-142.9 App. B	Yes "Terminal condition." IC 144.7A(3)(d), IAC 641-142.1	None listed	Pregnancy limitation. IC 144A.6, 144A.7(3) For Agent, guardian, or DS, if patient has no living will, then patient must be in "terminal condition" IC144A.7(1) and there must be a witness present at the time decision is made. IC 144A.7(3)	None listed

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				Out-of-Hospital DNR Provision Barriers to POLST			Substituted Consent Limitations/Barriers to POLST	
			OHDNR Order Provisions	Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
Kansas Kan. Stat. Ann. (KS) Kan. Admin. Regulations. (KAR)	Patient, agent, guardian KS 65-4943 KS 59-3018 No DS statute	(1) OHDNR Not addressed (2) AD KS 65-28, 108(d) [LW]	Statute: KS 65-4941 to 65-4948 Regulations/ Guidelines: KAR 109-14-1	Statutory form – Detailed KS 65-4942 65-4941(e) 65-4946 KAR 109-14-1	None listed	Yes One witness who meets statutory qualifications. KS 65-4941(b), 65-4942, 65-4943	Pregnancy limitation for living will. KS 65-28,103(a) Guardian limited to circumstances where ward has a health care advance directive with provisions relevant to forgoing life-support or where the ward is certified as being terminal or in persistent vegetative state.	None listed
Kentucky Ky. Rev. Stat. Ann. (KRS)	Patient, agent, guardian, DS KRS 311.631 Ky Bd of EMS, Emergency Medical Services Do Not Resuscitate (DNR) Order (Instructions)	(1) OHDNR KRS 311.637(5) (2) AD KRS 311.637(5) [combined act]	Statute: KRS 311.623	Defers to regulations KRS 311.623(3)	None listed	Yes Notarized or two witnesses KRS 311.623(3) and Ky Bd of EMS, Emergency Medical Services Do Not Resuscitate (DNR) Order (Instructions)	Pregnancy limitation. KRS 311.629(4) For guardian and DS, patient must be permanently unconscious, in persistent vegetative state, or "when inevitable death is expected … within a few days." Woods v. Ky. Cabinet for Human Resources, 142 S.W. 3d 24, 42 (Ky. 2004)	For Agent, Guardian & DS, forgoing ANH permitted only: (a) When inevitable death is imminent…or (b) When a patient is in a permanently unconscious state if the grantor has executed an advance directive authorizing the withholding or withdrawal of artificially-provided nutrition and hydration; or (c) When the provision of artificial nutrition cannot be physically assimilated by the person; or (d) When the burden of the provision of artificial nutrition and hydration itself shall outweigh its benefit." KRS 311.629, 311.631
Louisiana La. Rev. Stat. Ann. (LRS)	LRS Patient, Agent, Guardian, DS, (authorized to sign Declaration permitting DNR order) LRS 40:1299.58.5	(1) OHDNR LRS 1299.58.10(C) (2) AD LRS1299.58. 10(C) [LW]	Statute: LRS 40:1299.58.2 40:1299.58.3(D) 40:1299.58.7(E)	Bracelet/necklace required (But process is expressly nonexclusive) LRS 40:1299.58.2(7) & 40:1299.58.3(D)	Yes "Terminal and irreversible condition." (includes "continual profound comatose state") LRS 40:1299.58.2(12) 40:1299.58.2(15)	Yes Two witnesses required on the Declaration (living will). DNR order is issued based on the Declaration and LRS 40:1299.58.2(16) 40:1299.58.3	For Agent, Guardian, DS, patient must be in "in terminal and irreversible condition" or "comatose." LRS 1299.58.5	None listed
Maine Me. Rev. Stat. Ann (MRS)	Patient, Agent, Guardian, DS MRS 5-802(b) 5-805	(1) OHDNR N/A because regulation-based OHDNR (2) AD Not Addressed	Regulations/ Guidelines: Me. EMS Prehospital Treatment *Protocols* (Eff. July 1, 2005)	No statute Regulations only *Protocols* (Eff. July 1, 2005)	None listed	None listed	For DS, patient must be "terminally ill" or in a "persistent vegetative state." MRS 18-A, 5-805	None listed
Maryland Md. Health-Gen. Code Ann. (MHGC)	Patient, Agent, Guardian, DS MHGC 5-602, 5-605, *Protocol*	(1) OHDNR MHCG 5-616 (2) AD MHGC 5-616(a) [combined act]	Statute: MHGC 5-608 Regulations/ Guidelines: Md. Inst. for EMS Systems, *Md. Medical Protocols for EMS Providers* (9/1/06)	Defers to regulations *Protocol* p. 150	None listed	None listed	For DS, patient must be a "terminal condition," "persistent vegetative state," or "end-stage condition" MHGC 5-606(b)	None listed

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			OHDNR Order Provisions	Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
Massachusetts Mass. Gen. Laws (MGL)	Patient,Agent Guardian *Protocol* Definitions (6), (9) & (10) No DS Statute	(1) OHDNR N/A because regulation-based OHDNR (2) AD Not Addressed	Regulations/ Guidelines: MA Dept. of Public Health, *Comfort Care/ DNR Order Verification Protocol*, in EMS Pre-Hospital Treatment Appendix (Eff. 7/1/06)	No statute Regulations only *Protocol*	None listed	None listed	None listed	None listed
Michigan Mich. Comp. Laws Ann. (MCL)	Patient, Agent, Guardian, DS But OHDNR Act refers only to Patient and Agent. MCL 333.1053(a)	(1) OHDNR MCLA 333.1066 (2) AD MCL 333.5660 & 333.5652 [DPA]	Statute: MCL 333.1052 to 333.1067 MCL 333.20919(1)(c) See also MCL 333.1055, 1056 which provides a DNR order for adherents of spiritual healing	Statutory form – Detailed MCL 333.1052(c) 333.1052(d) 333.1053, 333.1054 333.1057	None listed	Yes Two witnesses MCL 333.1053, 333.1054	Pregnancy limitation for agent. MCL 700.5509(d)[For DS, patient must have a terminal illness. MCL 333.5653(a), 333.5655(b)	None listed.
Minnesota Minn. Stat. Ann. (MS)	Form refers only to Patient or "Responsible Party" No DS Statute	(1) OHDNR N/A (2) AD MS 145C.10 (e) [DPA] & MS 145B.17 [LW]	None identified	N/A	N/A	N/A	Pregnancy limitation – advance directives. MS 145B.13, 145C.10(g)	None listed
Mississippi Miss. Code Ann. (MC)	Patient, Agent, Guardian, DS MC 41-41-203(c) and (h) 41-41-211 41-41-213	(1) OHDNR N/A (2) AD Not Addressed	None identified	N/A	N/A	N/A	None listed	None listed
Missouri Mo. Rev. Stat. (MRS) Mo. Code Regulations. Ann. (MCR)	Patient, Agent, Guardian MRS 404.710(10), 404.714(5) & (7) No DS Statute	(1) OHDNR N/A because regulation-based OHDNR at local level (2) AD MRS 459.055 [LW]	None statewide. Local EMS medical directors have responsibility for establishing DNR protocols. Regulations/ Guidelines: 19 MCR 30-40.303(2)(c), 30-40.303(3)(c), 19 MCR 30-40.333(7)	N/A	N/A	N/A	Pregnancy limitation in living will. MRS 429.025	None listed

Appendix continued on next page

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				Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
Montana Mont. Code Ann. (MC) Mont. Admin. Rules (MAR)	Patient, Agent, Guardian, DS MC 59-9-103 and -106	(1) OHDNR MC 50-10-104 (5) (2) AD MC 50-9-205 [combined act]	Statute: MC 50-10-101 to -107 Regulations/ Guidelines: MAR 37.10.101 to .105	Defers to regulations MC 50-10-101(6) 50-10-103(1) 50-10-107 MAR 37.10.101 37.10.104 37.10.105	Yes. "Terminal condition" [as defined by MC 50-9-102] or in condition that physician or advanced practice registered nurse has documented as grounds for DNR or in patient's file. 50-10-101(6)	None listed	Pregnancy limitation. MC 50-9-106(6) For agent, guardian, and DS, patient must be in "terminal condition." MC 50-9-103(1) & (4), -105(1), and -106(1)(a). For DS, consent to forgo life support requires two witnesses. MC 50-9-106(a)(1).	None listed
Nebraska Neb. Rev. Stat. Ann. (NRS)	Patient, Agent NRS 30-3403 and -3418 No DS Statute	(1) OHDNR N/A because regulation-based OHDNR (2) AD NRS 30-3401 [DPA] & 20-402 & 20-412 [LW]	Regulations/ Guidelines: Nebraska EMS Model Protocols www.hhs.state.ne.us/crl/rcs/ems/protocols.pdf (*Protocol*)	No statute Regulations only *Protocol*, pp. v-vi.	Yes "Terminal condition" or "persistent vegetative state." *Protocol*, p. v	None listed	Pregnancy limitation for LW and DPA NRS 20-408, 30-3417(1)(b) For agent, patient must (a) have a "terminal condition," or in a "persistent vegetative state" NRS 30-3418	None listed
Nevada Nev. Rev. Stat. (NRS) Nev. Admin. Code (NAC)	Patient, Agent, DS NRS 450B.520 NRS 449.626, But OHDNR consent limited to patient or agent NRS 450B.520 (2)(b)	(1) OHDNR NRS 450B.590 (2) AD NRS 449.680 [LW]	Statute: NRS 450B.400 to 450B.590 Regulations/ Guidelines: NAC 450B.950 to 450B.960	Prescribes minimal form contents NRS 450B.410 450B 500 450B.505 NAC 450B.955 & .960	Yes "Terminal condition" or attending physician has issued DNR order for patient, with patient's written approval and documents grounds for order in medical record. NRS 450B.410, .420, .470, & .510,	None listed	Pregnancy limitation for living will and DS. NRS 449.624(4) & .626(6) For DS, patient must be in "terminal condition" NRS 449.626(1)(a)	None listed
New Hampshire N.H. Rev. Stat. Ann. (NHRS) N.H. Code Admin. R. Ann. (NHCAR)	Patient, Agent NHRS 137-J:26 No DS Statute	(1) OHDNR NHRS 137-J25(II) (2) AD NHReS 137-J:10 (IV) [combined act]	Statute: NHRS 137-J24 to 137-J:33 (Eff. 1/1/07) Regulations/ Guidelines: NHCAR Saf-C 5922.02 (Eff. after 7/1/07)	Statutory form – Simple NHRS 137-J26(V) & 137-J:33	None listed	None listed	Pregnancy limitation on agent consent. NHRS 137-J:5(V)(c)	None listed

State & Citation Key	Who may consent to forgoing LST including DNR	Statute Expressly non-exclusive (1) OHDNR (2) AD	OHDNR Order Statutory and Regulatory Provisions				Advance Directive and Default Surrogate Statutes	
				Out-of-Hospital DNR Provision Barriers to POLST			Substituted Consent Limitations/Barriers to POLST	
			OHDNR Order Provisions	Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
New Jersey N.J. Stat. Ann. (NJS) N.J. Admin. Code (NJAC)	Patient, Agent, Guardian, DS *Guidelines* p. 5 No DS Statute (but case law affirms family decision-making)	(1) OHDNR NJS 26:2H-68(c) (2) AD Not Addressed	Statute: NJS 26:2H-68(c) NJAC 10:8, 10:42A, & 10:42 (for institutionalized and persons under public guardianship) Regulations/ Guidelines: *NJ Do Not Resuscitate (DNR) Orders Outside of the Hospital – Guidelines* developed by the Med. Society of NJ	No statute Regulations only *Guidelines* developed by the Medical Society of NJ	None listed	None listed	None listed	None listed
New Mexico N.M. Stat. Ann. (NMS) N.M. Admin. Code (NMAC) [CS: looks like only patient and agent can consent to a DNR order. 7.27.6.8(A)]	Patient, Agent, guardian, DS NMAC 7.27.6(I) 27-7A-1(U), 27-7A-5	(1) OHDNR Not addressed (2) AD Not Addressed	Statute: NMS 24-10B-4(I) Regulations/ Guidelines: NMAC 7.27.6	Defers to regulations NMAC 7.27.6.8 & 7.27.6.9	None listed	None listed	None listed	None listed
New York N.Y. Pub. Health Law (NYPHL), N.Y. Comp. Codes R. & Regulations (NYCRR)	Patient, Agent, guardian, DS NYPHL 2964(3)(iv) & 2965 No DS statute, *except* for OHDNR orders.	(1) OHDNR: Not addressed (2) AD Not Addressed	Statute: NYPHL 2960 to 2979, especially 2961, 2977 Regulations/ Guidelines: 10 NYCRR 800.90	Defers to regulations NYPHL 2977(6) 10 NYCRR 800.90	Yes For DS and guardian only, patient must have a "terminal condition," be "permanently unconscious," "resuscitation would be medically futile," OR "resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient." NYPHL 2965(3)(c)	Yes Two witnesses, only if Guardian or DS consent NYPHL 2964(2), 2965(4), 2977(4).	(Only for OHDNRs)	Indirect limit on Agent: If patient's wishes about ANH "are not reasonably known and cannot with reasonable diligence be ascertained, the agent shall not have the authority to make decisions regarding these measures." NYPHL 2982(2)

Appendix continued on next page

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North Carolina N.C. Gen. Stat. (NCGS)	Patient, Agent, Guardian, DS NCGS 90-21.17 & 90-322	(1) OHDNR: NCGS 90-21.17(a) (2) AD NCGS 32A-15 (b) [DPA] & N.C. Gen. Stat. § 90-320(b) [LW]	Statute: NCGS 90-21.17 Attorney General advisory opinion recognizes non-statutory DNR orders. 1997 WL 858260 (N.C.A.G.), dated 12/22/97.	Prescribes minimal form contents NCGS 90-21.17(a) & (c)	None listed	None listed	Very narrow limitation: Medical preconditions (terminal condition or PVS) to forgo life support, for patients who are comatose and have no living will. NCGS 90-322.	None listed
North Dakota N.D. Cent. Code (NDCC)	Patient, Agent, Guardian, DS NDCC 23-06.5-03, 23-06.5-02(4),	(1) OHDNR N/A (2) AD NDCC 23-06.5-13 (7) [combined act]	None identified	N/A	N/A	N/A	Pregnancy Limitation. NDCC 23-06.5-09(5)	None listed [There is a provision that limits w/h or w/d of ANH, but only if the person has an advance directive that does not give direction with respect to ANH. NDCC 23-06.5-09(6)]
Ohio Ohio Rev. Code Ann. (ORC) Ohio Admin. Code (OAC)	Patient, Agent, Guardian, DS ORC 1337.13(B), 2133.08	(1) OHDNR: ORC 2133.24(C)(3) (2) AD Not Addressed	Statute: ORC 2133.21 to 2133.26. See 2133.23 Regulations/ Guidelines: OAC 3701-62-01 to 3701-62-14	Defers to regulations ORC 2133.21 OAC 3701-62-01(H), 3701-62-04, and Apps. A, B, and C	None listed	None listed	Pregnancy limitation. ORC 2133.08(G), 1337.13(D) For agent, guardian, and DS, patient must be in "terminal condition" or be "permanently unconscious." ORC 1337.13(B), 2133.08	Pregnancy limitation. ORC 2133.08(G), 1337.13(D) For agent, guardian, and DS, patient must be in "terminal condition" or be "permanently unconscious." ORC 1337.13(B), 2133.08
Oklahoma Okla. Stat. Ann. (OS)	Patient, Agent, Guardian OS tit. 63, 3131.4(B)(3) & 3131.3(11). No DS Statute	(1) OHDNR OS tit. 63, 3131.11 (2) AD OS tit. 63 § 3101.12 (E) [combined act]	Statute: OS tit. 63, 3131.1 to 3131.15	Statutory form – Detailed OS tit. 63, 3131.5 & 3131.12	None listed	Yes Two witnesses with additional limitations. OS tit. 63, 3131.5 & 3131.12	Pregnancy limitation. 63 OS 3101.8 [CS: not on SCC]	No authority to forgo ANH except where: 1. Physician knows patient gave "informed consent" to forgo ANH; 2. Court finds clear & convincing evidence that the patient gave "informed consent" to forgo; 3. Patient has statutory advance directive authorizing forgoing of ANH; 4. ANH will cause "severe, intractable, and long-lasting pain" or is not medically possible; 5. Patient is in final stage of terminal illness or injury, but exception overridden if forgoing ANH "would result in death from dehydration or starvation rather than from the underlying terminal
Oregon Or. Rev. Stat. (ORS) Or. Admin. Rules (OAR) Voluntary POLST protocol available at <www.ohsu.edu/polst/state/or.shtml>	Patient, Agent, Guardian, DS ORS 127.510, 127.535, 127.540, 127.635	(1) OHDNR N/A because regulation-based OHDNR (2) AD ORS 127.560(1) [combined act]	Regulations/ Guidelines: POLST protocol & OAR 847-035-0030(b)	No statute Regulations only *POLST* form *POLST protocol*	None listed	None listed	For agent, guardian, and DS, the patient must: 1) have a "terminal illness," 2) be "permanently unconscious, or 3) "LST will not benefit the patient and will cause permanent and severe pain; or 4) the patient has a progressive, advance, fatal illness (described further) ORS 127.540(6) & 127.635	For agent, guardian or DS to forgo ANH, the person: 1) Had stated while capable "clearly and specifically" that s/he would have refused ANH; 2) Has an appointed health care agent ("representative") with authority re ANH; 3) Is permanently unconscious. 4) Has a terminal condition. 5) Has an advanced progressive fatal illness; or 6) ANH "is not medically feasible or would itself cause severe, intractable or long-lasting pain"; ORS 127.580

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			OHDNR Order Provisions	Statutory OHDNR Form Requirements	Medical Preconditions for OHDNR Orders[1]	Witnessing Req's for OHDNR Consents	Consent Limits on Forgoing Life-Sustaining Treatment	Consent Limits Specific to Forgoing ANH
Pennsylvania Pa. Cons. Stat. (PCS) Pa. Admin Code (PAC)	Patient, Agent, Guardian 20 PCS 5456, 5460, 5461, PAC1051.11 & 1051.12 No DS Statute	(1) OHDNR PCS 5421 (2) AD PCS 5421 & 5423 [combined act];	Statute: 20 PCS 5421 & 5481 to 5488 Regulations/ Guidelines: 20 PAC 1051.1 to 1051.101	Statutory form – Detailed 20 PCS 5484 PAC1051.22(c)	Yes "Terminal condition" or "permanently unconscious" PCS 5484 PAC 1051. 11(a) and 1051.22(a)	None listed	Pregnancy limitation. 20 PCS 5429 PAC1051.61	None listed
Rhode Island R.I. Gen. Laws (RIGL)	Patient, Agent, RIGL 23-4.10-5. Authority of guardian not addressed No DS Statute	(1) OHDNR RIGL 23-4.11-10(e) (2) AD RIGL 23-4.11-10(e) [LW] & 23-4.10-9(e) [DPA]	Statute: RIGL 23-4.11-1 to -15, but specifically -14	Bracelet/ necklace required RIGL 23-4.11-2(11) & 23-4.11-14	Yes Terminal condition RIGL 23-4.11-2(11) & (13) and 23-4.11-14	None listed	Pregnancy limitation. RIGL 23-4.10-5(c), 23-4.11-6(c)	None listed
South Carolina S.C. Code (SCC) S.C. Code of Regulations (SCCR) [CS: person who can consent set forth in SCC 44-78-24; SCCAR 1402]	Patient, Agent, guardian, DS SCC 44-78-24, 44-66-30	(1) OHDNR Not Addressed (2) AD Not Addressed	Statute: SCC 44-78-10 to 44-78-65 Regulations/ Guidelines: SCCR 1400 to 1600	Statutory form – Simple SCC 44-78-30 SCCR 1402(G) & 1403(D)	Yes "Terminal condition." SCC 44-78-15(6), 44-78-20; SCCR 1408	None listed	Pregnancy limitation. SCC 44-77-70 & 62-5-504(G) for advance directives	None listed
South Dakota S.D. Codified Laws (SDCL) S.D. Admin. Rules (SDAR)	Patient, Agent, guardian, DS SDCL 59-7-2.5, 34-12C-2 & -3 34-12F-2	(1) OHDNR Not addressed (2) AD SDCL 34-12D-18 [LW]	Statute: SDCL 34-12F-1 to 34-12F-8 Regulations/ Guidelines: SDAR 44:05:06	Bracelet/ necklace required (But process is expressly nonexclusive) SDAR 44:05:06 SDCL 34-12F-1 & -3	None listed	None listed	Pregnancy limitation for advance directives. SDCL 34-12D-10 & 59-7-2.8	Minimal potential barrier: Agent may forgo ANH only if at least one of several alternative conditions are met, one of which is a "benefits" vs. "burdens" test. SDCL 59-7-2.7
Tennessee Tenn. Code Ann. (TC) Tenn. Comp. R. & Regulations (TCRR) Dept. of Health *FAQ's* re use of POST form: www2.state.tn.us/health/Boards/AdvanceDirectives/FAQ_POST.htm	Patient, Agent, Guardian, DS TC 68-11-224(a)(2) 68-11-1803(b) 68-11-1806	(1) OHDNR TC 68-11-224(g) (2) AD Not Addressed	Statute: TC 68-11-224 Regulations/ Guidelines: Physicians Orders for Scope of Treatment (POST) recognized in facility–specific regulations: TCRR 1200-8-1 thru 1200-8-35.	Defers to regulations TC 68-11-224(c), 68-11-224(e)(5)	None listed	None listed	None listed	Minimal potential barrier: For DS, ANH can only be forgone when it "is merely prolonging the act of dying and the patient is highly unlikely to regain capacity to make medical decisions." TC 68-11-1806(e)

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Texas Tex. Health & Safety Code Ann. (THSC) Tex. Admin. Code (TAC)	Patient, Agent, Guardian, DS THSC 166.039 166.039 166.082 166. 088	(1) OHDNR THSC 166.05 (2) AD THSC 166.051 [combined act]	Statute: THSC 166.081 to 166.101 Regulations/ Guidelines: 25 TAC 157.25 See also EMS Web page materials, available at <www.tdh.state.tx.us/hcqs/ems/dnrhome.htm>	Prescribes detailed form contents THSC 166.081, 166.083, 166.089, 166.102; 25 TAC 157.25(c)(2) & 157.25(h)	None listed	Yes 2 witnesses THSC 166.082(b), 166.083, 166.088(d), 25 TAC 157.25(h)	Pregnancy limitation THSC 166.049, 166.098 25 TAC 157.25(g)	None listed
Utah Utah Code Ann. (UC) Utah Admin. Code (UAC)	Patient, Agent, Guardian, DS UC 75-2-1105 75-2-1105.5 75-2-1106 75-2-1107	(1) OHDNR UC 75-2-1117(4) (2) AD UC 75-2-1117(4) [combined act]	Statute: UC 75-2-1105.5 Regulations/ Guidelines: UAC R. 426-100-1 to 426-100-5 POLST protocol UAC R.432-31-1 to -3	Defers to regulations UC 75-2-1105.5 UAC R. 426-100-2 & POLST form UAC R.432-31-3	Yes "Terminal condition." UC 75-2-1105.5(1)(a) UAC R. 426-100-3(1) None listed for POLST	Yes 2 witnesses UC 75-2-1105.5(4) & (5) None listed for POLST	Pregnancy limitation UC 75-2-1109	None listed
Vermont Vt. Stat. Ann. (VS)	Patient, Agent, Guardian 18 VS 9708 No DS Statute	(1) OHDNR Not addressed (2) AD Not Addressed	Statute: 18 VS 9701, 9708 Regulations/ Guidelines: Dept. of Health *Proposed Rule* available at <http://healthvermont.gov/regulations/advance_directive.aspx> (as of 11/06)	Prescribes moderate form contents 18 VS 9701(6) & 9701(7) [*Proposed Rule* Includes bracelet and POLST form]	None listed	None listed	None listed	None listed
Virginia Va. Code (VC) Va. Admin. Code (VAC)	Patient, Agent, Guardian, DS VC 54.1-2983 54.1-2986 54.1-2987.1(A)	(1) OHDNR VC 54.1-2987.1(F) (2) AD VC 54.1-2992 [combined act]	Statute: VC 54.1-2982, 54.1-2987.1 Regulations/ Guidelines: 12 VAC 5-66-10 to 5-66-80 Office of EMS guidance available at <http://vdh.virginia.gov/OEMS/Files_page/files.asp#DNR>	Defers to regulations VC 54.1-2987.1(c) 12 VAC 5-66-40 & -50	None listed	None listed	None listed	None listed

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Washington Wash. Rev. Code Ann. (WRC)	Patient, Agent, Guardian, DS WRC 11.94.010 & 7.70.065	(1) OHDNR Not addressed (2) AD Not Addressed	Statute: Yes. WRC 43.70.480 Regulations/ Guidelines: POLST recognized under WA State Dept. of Health *EMS Provider Protocols for Do Not Resuscitate Orders* (rev'd 3/03)	Defers to regulations *EMS Provider Protocols for Do Not Resuscitate Orders* (rev'd 3/03)	None listed	None listed	None listed	None listed
West Virginia W.Va. Code Ann. (WVC) W.Va. Code St. R. (WVCSR)	Patient, Agent, Guardian, DS WVC 16-30-6 16-30-8 16-30C-3(n) 16-30C-6(e)	(1) OHDNR WVC 16-30C-12 (2) AD WVC16-30-16 (a) [combined act]	Statute: WVC 16-30C-1 to 16-30C-16 Regulations/ Guidelines: WVSCR 64-48-11	Statutory form, but also accepts POLST Paradigm (POST) WVC 16-30C-3(k), 16-30C-6(f), 16-30C-7, 16-30C-13	None listed	None listed	None listed	None listed
Wisconsin Wis. Stat. Ann. (WS) Wis. Admin. Code (WAC)	Patient, Agent, Guardian WS 155.05, 154.225 No DS Statute	(1) OHDNR WS 154.11(4). (2) AD WS 154.11(4) [LW]	Statute: WS 154.17 to 154.29 Regulations/ Guidelines: WAC HFS 125.01 to 125.05	Defers to regulations WS 154.19 & 154.27 WAC HFS 125.04 & 125.05	Yes 1) Patient has terminal condition 2) CPR would not work, or 3) Pain and harm outweighs possibility of CPR success. WS 154.17(4)	None listed	Pregnancy limitation for DNR WS 154.19 And an agent's authority must be explicit. WS 155.20(6)	None listed
Wyoming Wyo. Stat. (WS) Wyo. Rules & Regulations (WRR)	Patient, Agent, Guardian, DS WS 35-22-202 35-22-403 35-22-406 35-22-407 3-2-202(a) (iv)	(1) OHDNR WS 35-22-203(a) (2) AD Not Addressed	Statute: WS 35-22-201 to 35-22-208 Regulations/ Guidelines: WRR ch.5, § 12 & 15	Prescribes moderate form contents WS 35-22-203	None listed	None listed	None listed	None listed

CAUTION: *The descriptions and limitations listed in this chart are broad characterizations for comparison purposes and not as precise quotations from legislative language.© American Bar Association (ABA) Commission on Law and Aging 2007. The ABA acknowledges The West Group for providing access to online legal research.*

1. Medical preconditions refer to those required by statute, not any preconditions the patient, agent, guardian, or DS has imposed by choice.

Figure 1

A Sample POLST Paradigm Form from Oregon

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders
for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First Name/ Middle Initial	
Date of Birth	

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

B *Check One*

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C *Check One*

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if life can be prolonged.

Additional Orders: _____

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

E

REASON FOR ORDERS AND SIGNATURES

Discussed with:
☐ Patient
☐ Parent of Minor
☐ Health Care Representative
☐ Court-Appointed Guardian
☐ Other:_____

My signature below indicates these orders are consistent with the person's preferences, if known. See medical record for further documentation.

Print Physician/NP/PA Name and Phone Number ( )	Office Use Only
Physician/NP /PA Signature (mandatory) / Date	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED