

POLST Signature Requirements: Responding With Compassion While Ensuring Informed Consent

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Abstract

The majority of states require the signature of a surrogate decision maker on a POLST form for a patient who lacks decisional capacity. While commendable in its intention to ensure informed consent, in some cases this may lead the surrogate to feel that they are signing their loved one's "death warrant," adding to their emotional and spiritual distress. In this paper we argue that such a signature should be recommended rather than required, as it is neither a sufficient nor necessary condition of informed consent. Additional steps—such as requiring the attestation and documentation of the signing health care professional that verbal consent was fully informed and voluntary—can achieve the ultimate goal of respecting patient autonomy without adding to the surrogate's burden.

Keywords

POLST, signature, autonomy, advance care planning, surrogate

Key message

Recommending—but not mandating—surrogate signature on a POLST form ensures informed consent while sparing surrogates undue burden.

Case Description

Jimmy is an 84-year-old male with Stage IV heart disease and moderate dementia, who was recently hospitalized with hematochezia found to be due to metastatic colon cancer. Prior to the onset of dementia, he had completed an Advance Directive stating that he did not want "heroic measures" if he was terminally ill, strongly preferring to die at home. He also named his wife of 51 years, Mary, as his health care proxy.

Mary expresses a wish to take him home and focus entirely on his comfort. The discharging physician recommends a Portable Orders for Life-Sustaining Treatment (POLST[®]) form specifying no CPR and a goal of comfort. His wife agrees that is what Jimmy would want, but then the physician asks her to sign the POLST form.

"Do I have to?" she asks.

The physician nods, as this conversation is taking place in one of the over 30 states where a patient or surrogate signature is required for a POLST form to be legally valid.

Mary stares at the form.

The physician reaches out and touches Mary's arm. "It's really Jimmy's decision, and he's already made it. He just needs you to be his voice now."

"It just feels like I'm signing his death warrant."

"I'm so sorry for all you're going through."

"Isn't there any other way?"

The physician points to the word "Required" on the signature line.

"I'm afraid not," he says.

Discussion

It is vital to avoid mistaking the process of obtaining informed consent with its documentation. The process involves communicating risks, benefits, and alternatives, and assuring that the decision-maker has sufficient decision making capacity (DMC) and is acting voluntarily. Documentation of the process might include a progress note in a hospital chart, or in certain

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circumstances the patient or surrogate's signature on a consent form. Thus physicians do not "consent patients"; rather, patients (or their appropriate surrogates) provide informed consent. Nor should a signed piece of paper be referred to as "the consent," since it merely represents—or, at least, should represent—tangible evidence that the process of informed consent has occurred.

It is also crucial to recognize that, while appropriately ingrained in the practice of modern medicine, the requirement of informed consent—based on the principle of autonomy—is a fairly recent development. The first modern legal precedent dates from just over a century ago,¹ initially focusing on accepting intervention and only expanding to include refusal of potentially life-sustaining treatments in the 1970s.²

Even now, signed consent is the exception rather than the rule in health care. The sheer volume of decisions that are made regarding a particular patient's treatment make signed consent impractical in most situations. To require a patient/surrogate signature for every modification of a patient's medication, each prescription, and every lab test ordered would be unbearably cumbersome. Verbal consent suffices in the vast majority of situations, even in intimate contexts (such as a digital rectal exam) or for low-risk invasive procedures (such as venipuncture).

There are 3 exceptions to this rule. The first is in the context of clinical research, given the distinct goal (i.e., contributing to generalizable knowledge, as opposed to improving the health of an individual patient) which is often misunderstood by potential subjects³ and heightens the risk of exploitation.⁴ The second involves interventions that are multi-faceted (such as hospital admission, for which there is generally a "blanket consent" for expected treatment) or particularly complex (such as bone marrow transplantation). Signed documentation can serve as both a helpful reminder of what was discussed as well as confirmation that requisite information was, indeed, provided. The third exception applies to most invasive procedures—such as essentially any surgical intervention—which by definition involve some degree of risk and discomfort, and gave rise to the seminal court cases that established the legal requirement of informed consent.^{1,5}

Cardiopulmonary resuscitation (CPR) is a clinical intervention that is neither particularly complex nor does it—at least in the case of Basic Life Support—represent an invasive procedure, which is one "in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice."⁶ Despite this, a majority of states deem the signature of the patient or surrogate to be "required" (e.g., California,⁷ Indiana,⁸ and Utah⁹) or "mandatory" (e.g., Colorado,¹⁰ Washington,¹¹ and West Virginia¹²) on their state's POLST Paradigm[®] form, in order for CPR or other life sustaining treatments to be withheld or to avoid returning to the hospital for additional treatment.

One obvious reason for such a requirement is that the stakes are extremely high: if a patient experiences complete cardiopulmonary failure, in the absence of CPR they will not survive.¹³ (It should also be noted that even with CPR, they are

still unlikely to survive.¹⁴) This is also the case, however, following the failure of other organs such as the kidneys, yet the signature of the patient/surrogate is not required to withhold dialysis. Why should signed consent be required to forgo one form of life-prolonging treatment but not another?

The question, of course, is not whether informed consent is required, but what degree of *verification* of that consent is sufficient. Renal failure evolves over time, allowing the medical team to verify understanding and confirm goals. Cardiopulmonary arrest, on the other hand, is immediate and often unforeseen, permitting no opportunity for remedy should a misunderstanding exist. The signature of the patient or surrogate could reasonably be viewed as an insurance policy, to make absolutely certain that the limitation of treatment comports with the patient's wishes.

As far as insurance policies go, though, patient signatures on consent forms come up short.¹⁵ Even after signing, patients often still don't appreciate the risks, benefits, and alternatives of the procedure described on the form.¹⁶ This is particularly true of POLST forms, as illustrated by a study from California (a state which requires patient or surrogate signature on POLST forms) which revealed that while almost all nursing home residents have a POLST form, most surrogates do not remember having had an advance care planning discussion or signing the POLST.¹⁷

Yet even if a signed form is not a sufficient condition for informed consent, it still provides another layer of evidence that the patient or their surrogate has opted to forgo CPR and other medical treatments. All other things being equal, that is a valid point; but all other things are *not* equal, especially when the patient lacks DMC and consent must be obtained from a surrogate decision-maker. Acting as a patient's surrogate decision maker is a sacred and awesome responsibility, often requiring the surrogate to subjugate their own feelings as they authorize treatment plans that acknowledge that they are losing the person they love. Even when patients make their wishes as explicit as Jimmy did, surrogates still wrestle with the agonizing choice of "whether I should" consent to limitation of treatment.

Not surprisingly, after making a momentous decision to limit treatment, over one-third of surrogates report serious symptoms—including stress, doubt, and guilt over the decisions they've made—which in some cases can last for years.¹⁸ In one study, 82% of family members who took part in end-of-life decision making had subsequent symptoms of post-traumatic stress disorder,¹⁹ findings which cross racial and ethnic boundaries.²⁰ Signing a DNR order specifically—thereby expanding beyond the question of "whether I should" to concretizing the memory "that I *did*" sign a document that prevented my loved one from receiving treatment that had a chance of extending their life—has been found to "raise many negative emotions including guilt, ambivalence, and conflict."²¹

One might reply, though, that CPR is unique. Prior to providing every other medical intervention, consent must be obtained, either in the form of patient/surrogate agreement or "presumed consent" in emergent situations when the patient or

surrogate is not able to render a decision. CPR, on the other hand, is automatically administered *unless* the patient/surrogate has declined in advance.

Further, the POLST is the only clinician medical order set that a patient or surrogate is ever asked to co-sign. In every other context, a patient-signed form reviews the risks, benefits, and alternatives of a proposed intervention, with the implementation of that intervention occurring independently and authorized solely by the clinician. Perhaps the *sui generis* nature of CPR invalidates comparisons to recognized categories where written consent is required.

Yet even if one sets aside the eloquent critiques of CPR exceptionalism,²² the alternative is to return to the core principle which gave rise to the concept of informed consent in the first place: patient autonomy. (Or, more broadly and appropriately, respect for persons—whether they possess DMC or not.²³) Patients have the right to decide which medical treatments to accept and which to refuse, and when a patient lacks DMC their appropriate surrogate may exercise that right on their behalf. The question at hand is not whether informed consent is required for limitation of treatment. Respect for autonomy demands that it be, and when the stakes are as high as they are with potentially life-sustaining treatment, in-depth discussion and clear documentation of the health care professional order is certainly warranted.

Given those stakes, one would want to ensure that the directive to forgo CPR is crystal clear, in order to optimally respect the patient's values and provide reliable guidance to first responders. But the POLST form itself accomplishes that through check boxes indicating appropriate treatments. Clarity of direction is not the concern, but rather verification of appropriate authorization.

But even that is already addressed without requirement of patient or surrogate signature. Even in states where such a signature is only recommended, identification of the person providing consent—and their relationship to the patient, if applicable—is requisite, as is the name and signature of the ordering health care professional.

The patient or surrogate should, of course, be offered the opportunity to sign the POLST form, should they wish to. In many cases this may not be an obstacle or a cause for increased psychological suffering, perhaps even offering a sense of closure or tangible reassurance that the patient's comfort will be a priority.²¹ Yet *requiring* the surrogate's signature on the POLST form runs the risk of compounding the surrogate's pain and complicating their grief. Lest there be any doubt of this, one need only note the study where less than 5% of patients or surrogates opted to sign a POLST when their signature was optional.²⁴

This is also—and perhaps especially—true in pediatrics. While no large-scale studies have been conducted regarding the emotional burden of asking parents to sign POLST orders for their terminally ill child, anecdotal reports indicate that parents often find this act a source of profound anguish. This has prompted some children's hospitals to revise their inpatient

code status requirements, to eliminate the need for parental signature.

Surrogate signature has already been shown to not be a sufficient condition for ensuring informed consent, but neither is it a necessary condition. For even if the handful of states that currently do not require that signature on physical POLST forms (e.g., Maryland²⁵ and Tennessee²⁶) are written off as outliers, there are compelling counter-examples in the states which do. In the context of the COVID-19 pandemic and the increase in virtual visits several states (e.g., Pennsylvania²⁷) have begun to establish exceptions to their POLST signature requirements, if the appropriate decision-maker is not physically present for the conversation (and may not have access to technology that would allow remote signing). If convenience and efficiency are compelling reasons to forgo a surrogate's signature on a POLST form, how can minimizing psychological harm not be?

Alternatives to mandatory surrogate signature—such as 2 witnesses' attestation that verbal consent was fully informed and voluntary (which is an alternative in New York²⁸) or the more straightforward attestation of the health care professional signing the form that Oregon has used for nearly 30 years—prioritizes informed consent without mistaking the process for the paper that describes it, and without forcing a surrogate like Mary who is honoring their loved one's wishes to feel like they are signing that patient's death warrant.

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References

1. *Schloendorff v. Society of New York Hospital*. Vol. 211 N.Y. 125, 105 N.E. 921914.
2. *In re Quinlan*, 70 10 (N.J. 1976); Natural Death Act, 7, California Health and Safety Code § 7185-95, 1 Stat. (1976).
3. Henderson GE, Churchill LR, Davis AM, et al. Clinical trials and medical care: defining the therapeutic misconception. *PLoS Med*. 2007;4(11):e324. doi:10.1371/journal.pmed.0040324
4. Kirkwood K. On the exploitation of research subjects. *J Clin Res Bioeth*. 2012;3(138):10-4172. doi:10.4172/2155-9627.1000138
5. *Salgo v. Leland Stanford Jr. University Board of Trustees* (154 Cal. App. 2d 560; 317 P.2d 170).
6. CMS Manual System. Medicare National Coverage Determinations. Published 2009. Accessed April 9, 2020. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R101NCD.pdf>

7. 2008 Cal. Legis. Serv. Ch. 266 (A.B. 3000), eff. Jan. 2008, amends Cal. Probate Code §§4780–4788.
8. Ind. Code Ann. §§ 16-36-6-1- -20. Approved May 7, 2013.
9. Utah Code Ann. §75-2a-106, plus definition at §75-2a-103(17), enacted in 2007 as part of a comprehensive advance directive statute (eff. Jan. 1, 2008).
10. Colo. Rev. St. Ann. §15–18.7-101 to -110. Approved May 26, 2010.
11. Rev. Code Wash. Ann. §43.70.480 amendment in 2000.
12. Amendment to WV Code §16-30C-1 to -16 (DNR law); and 16-30 -1 to 25 (Health Care Decisions Act) specifically § 16-30- 3(u), -5, -10, -13(d), and -25. Enacted 2002.
13. Conceivably, a precordial thump or immediate defibrillation could restore spontaneous circulation without need for chest compressions. See Cave DM et al. Part 7: CPR techniques and devices: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*. 2010;122(18): S720-8.
14. Mozaffarian D, Benjamin EJ, Go AS, et al. Heart disease and stroke statistics—2015 update: a report from the American Heart Association. *Circulation*. 2015;131(4): e29-322.
15. Cocanour CS. Informed consent: it's more than a signature on a piece of paper. *Am J Surg*. 2017;214(6):993-997.
16. Kinnersley P, Phillips K, Savage K, et al. Interventions to promote informed consent for patients undergoing surgical and other invasive healthcare procedures (Review). *Cochrane Database Syst Rev*. 2013;(7):CD009445.
17. Stephens CE, Hunt LJ, Bui N, Halifax E, Ritchie CS, Lee SJ. Palliative care eligibility, symptom burden, and quality-of-life ratings in nursing home residents. *JAMA Intern Med*. 2018; 178(1):141-2.
18. Wendler D, Rid A. Systematic review: the effect on surrogates of making treatment decisions for others. *Ann Intern Med*. 2011; 154(5):336-346.
19. Azoulay E, Pochard F, Kentish-Barnes N, et al. Risk of post-traumatic stress symptoms in family members of intensive care unit patients. *Am J Respir Crit Care Med*. 2005;171(9): 987-994.
20. Braun UK, Beyth RJ, Ford ME, McCullough LB. Voices of African American, Caucasian, and Hispanic surrogates on the burdens of end-of-life decision making. *J Gen Intern Med*. 2008;23(3): 267-274.
21. Handy CM, Sulmasy DP, Merkel CK, Ury WA. The surrogate's experience in authorizing a do not resuscitate order. *Pall Supp Care*. 2008;6(1):13-19.
22. Tomlinson T, Brody H. Futility and the ethics of resuscitation. *JAMA*. 1990;264(10):1276-1280.
23. Lysaught MT. Respect: Or, how respect for persons became respect for autonomy. *J Med Phil*. 2004;29(6):665-680.
24. Hickman SE, Nelson CA, Smith-Howell E, et al. Use of the Physician Orders for Life-Sustaining Treatment Program for patients being discharged from the hospital to the nursing facility. *J Pall Med*. 2014; 17(1): 43-9.
25. Health Care Decisions Act—"Medical Orders for Life-Sustaining Treatment" Form. Repealing and reenacting parts of the Health Care Decisions Act § 5-602(f)(3) and (4) 5-608, 5-609, 5-617, 5-619, and 19-344(f); Adding to § 5-608.1. Effective date: October 1, 2011.
26. Tenn. Code. Ann. § 68-11-224, amended by TN LEGIS 254 (2013). Approved April 19, 2013.
27. "Patient or surrogate verbal consent," Pennsylvania Orders for Life-Sustaining Treatment May 2020 newsletter.
28. New York Department of Health: General Instructions for the Legal Requirements Checklists for Adult Patients and Glossary. Accessed April 9, 2020. https://www.health.ny.gov/professionals/patients/patient_rights/molst/docs/general_instructions_and_glossary.pdf