

## The Catholic Medical Association's White Paper, "The POLST Paradigm and Form: Facts and Analysis"

*"From the Field" in this issue of HCEUSA is completely dedicated to POLST. The controversy over POLST continues. Most recently, Linacre Quarterly (May 2013) published an article, "The POLST Paradigm and Form: Facts and Analysis" (described by the authors as a "white paper") that levels serious charges against the POLST paradigm and POLST forms. The article has been widely disseminated and has served as the basis for active efforts to discredit POLST and to attempt to prevent its adoption in various parts of the country. While the article raises legitimate concerns, it is also flawed in a variety of ways. Fr. Tom Nairn, OFM, Ph.D., senior director for ethics at CHA, has conducted a very careful analysis of the article and its claims. That analysis is provided here in its entirety in the hopes that it might be of assistance to anyone having to address the content of the article.*

*In addition, we are publishing a Q & A on POLST that provides helpful information with regard to many of the concerns raised about POLST. With permission of the author, the Q & A has reformatted written testimony by Amy Vandenbroucke, JD, Executive Director, National POLST Paradigm Program, offered to the Senate Special Committee on Aging at a June 26, 2013 Hearing.*

*The White Paper may be accessed at <http://cathmed.org/assets/files/LNQ59%20FINAL.pdf>.*

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### An Analysis of Arguments

In the May 2013 issue of *The Linacre Quarterly* (Volume 80, 2), a working group of the Catholic Medical Association published a White Paper on the POLST paradigm and form. This White Paper has since been widely distributed, especially among Catholic bishops. This paper analyzes the arguments utilized in the White Paper.

## I. UNDERSTANDING OF POLST

The authors of the White Paper speak about the “POLST paradigm and form.” This phrase is used throughout the paper (see, for example, p. 105). Although the White Paper does not actually define the POLST paradigm, it explains that the paradigm has three aims:

- The first is advance care planning; the model requires a discussion on care options between POLST representatives and patients or their surrogates.
- The second is integrating patient preferences into physicians’ orders by recording them onto POLST forms. Each state adopts its own version of the form, but all forms share certain identical characteristics.
- The third is ensuring that the document “travels” with patients and remains applicable across all care settings. (p. 108)

In addition, the authors articulate seven requirements that they explain all endorsed programs must meet:

1. State or regional health care facilities and workers must recognize properly completed forms as current or (in some states standing) medical orders;
2. Training programs for POLST implementation must be instituted;
3. Forms should be recommended for persons who might die in the next year, who suffer from “chronic progressive illness and/or frailty,” or who are elderly “with strong, specific informed preferences” about their EOL options;
4. The signatures of patients or their surrogates on POLST forms are “strongly” recommended, but often not required, as “evidence that patients or their legal representatives agree with the orders on the form”;
5. POLST forms should be the preferred advance planning document in diverse health care settings (“e.g. emergency medical services, long-term care, and hospice”); their completion should be left voluntary; shared decision-making and patient wishes should govern their completion;
6. A plan should be developed for POLST implementation and ongoing evaluation;
7. “A single strong entity” should be identified who is willing to “accept ownership for the program” and is capable of implementing it.” (p. 106)

The White Paper’s source for the description of the aims of POLST is the work of Charles P. Sabatino. His own articulation of these aims, which he describes as “key tasks” (2010) or “core tasks” (2011), is as follows:

- POLST requires a health care professional to initiate a discussion with the patient (or the patient’s authorized surrogate) about key advanced illness treatment options in light of the

patient's *current* condition. The objective is to discern the patient's goals of care and preferences and the available care options.

- The patient's preferences are incorporated into medical orders, which are recorded on a highly visible, standardized form that is kept at the front of the medical order or with the patient if the patient lives in the community.
- Providers must ensure that the POLST form actually travels with the patient whenever he or she moves from one setting to another, thereby promoting the continuity of care and decision making. (This description of the three tasks appears in Sabatino and Karp, 3-4. The White Paper cites Sabatino (2010), p. 229, which expands upon and further explains each of these tasks.)

In their analysis of the evolution of POLST programs, Sabatino and Karp do give a brief definition of POLST:

In simplest terms, POLST is a tool for translating patients' goals of care into medical orders for a certain subset of patients – those with advanced, progressive illness and/or frailty. It represents a significant paradigm change in advance care planning policy by standardizing *providers'* communications prescribing a plan of care in a highly visible, portable way, rather than focusing solely on standardizing *patients'* communications. (p. 3)

They add:

In the broad framework of advance care planning, a key concept to understand is that POLST is not an advance directive like a living will or a durable power of attorney. Rather, it is an advance care planning tool that reflects the patient's here- and-now goals for medical decisions that may confront him or her and converts those goals into specific medical orders. (p. 4)

## II. ANALYSIS OF ARGUMENTS DEVELOPED IN THE PAPER

The following analysis treats the arguments developed in the White Paper. The authors often repeat the same or similar argument with slightly different nuances throughout the paper. This analysis groups the arguments under eighteen rubrics that attempt to illustrate what various arguments have in common. Under each rubric, one will find (a) the statement(s) from the White Paper, (b) the citation which the White Paper provides, (c) an analysis of the White Paper's use of its sources, and (d) additional comments.

### 1. AUTONOMY

#### *Statement(s):*

“Medical paternalism has been replaced by a culture of autonomy that values patient wishes in medical decision-making sometimes to a fault.” (p. 105)

“Advocates for patient autonomy argue that living will statutes were insufficient to ensure that patient care reflects patient preferences, especially in cases of advanced stage illness when critical decisions need to be made.” (p.107)

*References, sources:* Sabatino and Karp, (pp. 2-3); Brugger.

***Analysis of the White Paper’s use of sources:***

Implied in the White Paper (and more explicit in documents that it cites) is the understanding that behind the POLST paradigm is a “faulty and dangerous conception of autonomy,” (Brugger, p.161) which construes patient autonomy as free from any constraint.

***Additional comments:***

The *Ethical and Religious Directives* acknowledge that “neither the health care professional nor the patient acts independently of the other; both participate in the healing process” (Introduction, Part Three). The first core task of POLST is such interaction between the patient (or surrogate) and the professional. If such advance care conversations are properly executed, they are consistent with the ERDs and can be a safeguard against exaggerated patient autonomy.

It is striking that – although the issue of autonomy is brought up early in the document – an apparently more pressing issue for the White Paper is the possibility that the patient will be manipulated by the health care professional into requesting less than appropriate care.

**2. LIFE AS A FOUNDATIONAL GOOD**

***Statement(s):***

There “are foundational goods in human embodiment that must be respected in the free choices of patients and surrogates alike.” (p. 113)

***Analysis of the White Paper’s use of sources:***

Although there is no explicit citation, this statement arises from the Catholic moral tradition in general and, more specifically, from the Catholic tradition on the conserving of life. (Cronin)

***Additional comments:***

This is an important consideration. The POLST paradigm and form are simply tools that may be used well or poorly, that may be used for good or for ill. There is nothing inherent in the paradigm or form that is improper. Rather it is the way in which they are used that can become problematic or beneficial from the point of view of the Catholic moral tradition.

**3. USE OF FACILITATORS**

***Statement(s):***

“The POLST paradigm proposes that non-physician health care personnel . . . initiate advance care planning discussions with patients or surrogates. These ‘facilitators’ . . . act as front-line implementers of the POLST paradigm. Completed forms are then referred to clinicians for signatures.” (p. 111)

“Under the POLST paradigm, non-physician facilitators undertake [the] critical communications process: they approach patients, initiate POLST conversations, ‘assist in making informed end-of-life decisions,’ complete the POLST forms, and submit the forms to doctors for their signatures.” In some nursing homes, 72% of POLST forms were completed by facilitators and not physicians. (p. 117)

“Facilitator trainees, as non-physicians, have little or no preexisting knowledge regarding indications for and relative benefits and burdens of life sustaining treatments.” (p. 117)

*References, sources:* Sabatino and Karp, 24; Gunderson Lutheran, *Respecting Choices*; CANHR Policy Brief, 3.

*Analysis of the White Paper’s use of sources:*

The POLST paradigm does not *propose* the use of facilitators. What Sabatino and Karp explain is that “even though POLST is most directly tied to the physician’s role, every state’s POLST recognizes that other health care providers – such as nurse practitioners, physician assistants, other nurses and social workers – generally provide much if not most counseling and assistance in filling out POLST forms.” It then explains, “More often than not the physician role is to verify choices made and the process used with the patient and then sign off on the orders.” (Sabatino and Karp, p. 24).

The trained facilitator model that the White Paper describes is a program developed by Gunderson Lutheran Health System in La Crosse, Wisconsin. It has influenced POLST training in other states. The Appendix to this analysis describes the staged facilitation model used by Gunderson. According to this model, the facilitators work closely with the physician. Meetings between the facilitator, patient, and agent are in-depth meetings, and – especially in the “Last Steps” stage – there may be several advance care planning sessions. A physician cannot practically undertake such an in-depth conversation, but the physician or nurse practitioner does need to review the process with the patient. This is in fact what happens at Catholic hospitals that have initiated POLST and advance care planning. The White Paper gives no evidence that facilitators in fact have little knowledge of the burdens and benefits of life sustaining treatments.

*Additional comments:*

The use of auxiliary personnel in medical care settings has become commonplace. Regarding advance care planning, physicians have reported lack of time, skill and comfort for these sorts of conversations (see Hammes and Briggs, p. 47). Thus in many circumstances, auxiliary professionals are more adequately prepared to discuss end-of-life issues with patients than are physicians. The White Paper suggests that such personnel, “as nonphysicians, have little or no preexisting knowledge regarding indications for and relative benefits and burdens of life sustaining treatments” (p. 117). This statement is not adequate to the competence and training of these professionals. Furthermore, it does not adequately describe the actual collaborative relationship that exists and the importance of such professions in the end-of-life decisions. (See Adams et al.) Nevertheless, to the

extent that discussions with patients are not reviewed by a physician (in most states) or by a nurse-practitioner (in some states), this is an abuse of POLST.

The CANHR Policy Brief statement that 72% of POLST forms were completed by nonphysicians needs comment. The policy brief indicates that physicians did sign the forms but added that “physician participation in POLST completion appears to be tepid” (p. 3). The fact that a facilitator does the major work in participating in the dialogue with the patient or surrogate is not in itself a problem. Physicians, however, must be involved in the process. Simply to sign an already completed form without review is an abuse of POLST. This does not invalidate POLST but points to the need for education and training and for proper monitoring and evaluation. (Sabatino and Karp, pp. 19-20)

#### ***4. PHYSICIAN-PATIENT RELATIONSHIP***

##### ***Statement(s):***

There is a problem of the potential weakening of the doctor-patient relationship: “Deprived of the security of a personal relationship with the physician, the patient may seek comfort through instruments like POLST.” (p. 116)

##### ***Analysis of the White Paper’s use of sources:***

The White Paper gives no evidence that patients seek the comfort of POLST forms as an alternative to the security of a relationship with a physician. There is an issue here, but Sabatino and Karp describe it a *misperception* of POLST. They explain that POLST is a process and not merely a form. (p. 18) They give the example of New York that has defined an eight-step protocol, of which completing and signing the form is only one of the eight steps.

##### ***Additional comments:***

Although at the beginning of the White Paper the authors acknowledge that an aim of POLST is to increase advance care planning, (p. 108) the paper never really discusses the larger POLST paradigm and its context of advance care planning but seems to limit POLST to the form that is completed. This is at best a very truncated understanding of POLST.

To the extent that the authors’ criticism of POLST may be true in some circumstances, it seems that the remedy is to stress the importance of education about the goals and process of POLST. It is not simply a form to be filled out without appropriate training. If POLST is appropriately seen as a process within a larger context of advance care planning and not simply a form, the physician-patient relationship can actually be strengthened.

#### ***5. NECESSITY OF TERMINAL ILLNESS***

##### ***Statement(s):***

“Although POLST is said to be designed for use by terminally and chronically ill elderly, there is nothing in most POLST programs or state POLST laws that actually limit it to this population.” (p. 113)

“The POLST model legislation *annuls the requirement that a patient must be terminally ill* before he or she may direct the withholding or withdrawal of life-sustaining treatments.” (p. 113)

“POLST was originally conceived for patients clearly at the end of their lives, in controlled settings, for whom disabling life-threatening complications were anticipated. Such restrictive parameters for use of POLST can be replaced with looser limits or almost no limits, as borne out in various locations throughout the country.” (120; examples are given on p. 121.)

**References, sources:** Brugger, pp. 158-161; CANHR Policy Brief; Briggs, “Shifting the focus of Advance Care Planning,” *Innovations in End-of-Life Care*, 2003; Delaware MOLST Coalition.

***Analysis of the White Paper’s use of sources:***

Brugger’s article cites Colorado law on living wills “going back two decades” that limits proper compliance to use for a person in a terminal condition (p. 158). However, the U.S. Supreme Court has ruled in *Cruzan v. the Missouri Department of Health* (1990) that a person has a liberty interest under the Due Process Clause of the 14<sup>th</sup> Amendment in refusing unwanted medical treatment. It does not limit this liberty interest to persons with terminal illness.

***Additional comments:***

Beyond the legal perspective, the Catholic moral tradition regarding benefits and burdens is more nuanced than the White Paper indicates, and is not limited to terminal illness (See Cronin). Terminal illness as a moral pre-condition for assessing extraordinary means would preclude such traditional factors of moral teaching on end-of-life care as *vehemens horror*. The presence of chronic critical illness, advanced progressive disease, or frailty means that a person who technically may not be at an end-stage of a terminal condition may nevertheless face the prospect of a life-ending event.

The paper might also exhibit some confusion of POLST with the larger process of advance care planning (of which POLST is the final stage). Advance care planning is recommended for all adults, while POLST should be limited to those in the last stages of a chronic illness or the frail elderly (see the Appendix). However, to the extent that an expansion of POLST as described in the White Paper could occur, it would be an abuse and would contradict the articulated philosophy of POLST.

***6. MOVEMENT FROM END-OF-LIFE PLANNING TO THE COMPLETION OF POLST FORMS***

***Statement(s):***

“The goal of an end-of-life planning meeting can easily change from a thorough discussion of values, wishes, and options to merely completing the form.” (p. 116)

***Analysis of the White Paper’s use of sources:***

No evidence is given that this is the case. The White Paper indicates that POLST is a “paradigm” and not simply a form. Furthermore, it acknowledges (108) that one of the three aims of POLST is its inclusion in a larger advance care planning conversation. Advance care planning involves a

“process of understanding, reflection, and discussion. . . . This ideology is inherently and importantly different from merely the completion of advance directive documents.” (Hammes and Briggs, p. 90)

***Additional comments:***

The statement seems to reveal an incomplete understanding of POLST and advance care planning in general. As discussed earlier, descriptions of POLST place it in the context of advance care planning. Catholic health care institutions that have initiated advance care planning acknowledge not only the necessity but also the benefits of such a thorough discussion of values and beliefs in relation to clinical options.

**7. USE OF CHECK BOX LIST**

***Statement(s):***

“The POLST form offers a simple check box list of treatment options. Complex medical decisions are reduced to over simplified scenarios that do not reflect the nuances of actual medical practice.” The patient must pre-determine either to consent or reject. “Patients may make their choices weeks, months, or even years before choices will be carried out.” They do so not knowing “the exact nature of their [future] conditions or the range of reasonable treatment options.” Proper patient care cannot be reduced to a simple predetermined check list. (p. 114)

***Analysis of the White Paper’s use of sources:***

There are problems with the check box approach, and the authors are correct in stating that “proper patient care cannot be reduced to a simple predetermined check list.” However, the check list is possibly less problematic in the POLST form than in a living will. The philosophy behind POLST involves a “shift of emphasis from the completion of legal forms to an ongoing process of advance care planning. Advance care planning involves an iterative process of communication over time among the individual, the health care provider, the proxy, and others who may participate in the health care decision-making process to discern the individual’s priorities, values, and goals of care. Documentation remains important but as a tool *secondary to and supportive of* the communication process.” (Sabatino and Karp, p.2, my emphasis) Therefore, if the philosophy of POLST is respected, and the form is considered as part of advance care planning, the choices expressed result from dialogue between the patient and professional(s), reflect the patient’s current physical condition, and therefore more accurately reflect current treatment options than the check box of a living will.

***Additional comments:***

There are two aspects to the check box list of treatment options, (1) that of the person(s) executing the POLST and (2) that of the physicians and especially nonphysician emergency medical personnel who must interpret the form. As discussed in the analysis, checking the box in the first instance is supposed to be the result of a conversation between the professional and the patient or surrogate. It represents the appropriate option given current advance care planning related to the patient’s actual



medical condition. Typical procedures and policies for the implementation of POLST in health care facilities compare the patient's actual condition with the POLST order.

The second aspect involves especially emergency medical personnel. The check box design offers relatively clear guidance, although Sabatino and Karp indicate that EMS personnel believe that POLST still “offers too many choices, making it challenging to act on the scene” (p.18). The authors add that “the experience in successful POLST states has been that training modifies this perception” (p. 18). Others have observed that the check box format offers a helpful standardization, especially with the advent of electronic medical records.

## ***8. PATIENT SIGNATURE***

### ***Statement(s):***

POLST forms “may not require the patient's signature.” (p. 114)

### ***Analysis of the White Paper's use of sources:***

Most states in fact do require the patient's signature. Those that do not require the signature recommend it. New York recommends but does not require the patient's (or surrogate's) signature; it also recommends but does not require the signature of two witnesses. (Sabatino and Karp, p. 11)

### ***Additional comments:***

The White Paper acknowledges the normal response to this objection that traditional medical orders operate with only a clinician's signature, (p. 114) a response that the White Paper considers unsatisfactory.

Requiring the patient's signature in all states would likely strengthen POLST by serving as a safeguard ensuring that orders were not signed without the patient's or surrogate's knowledge and informed consent.

## ***9. NON-TREATMENT BIAS***

### ***Statement(s):***

“We have concerns with the verbiage used and the underlying psychology of the POLST form, which seem to carry a bias in favor of non-treatment.” (p. 115)

“Facilitator training scripts have been found to have inordinate emphasis on burdens of life sustaining treatments while dismissing the disadvantages and potential complications of rejection of treatments.” (p. 117)

***References, sources:*** *Respecting Choices*. Also cited: Washington State POLST (The White Paper objects to the term “prolonged,” which it maintains has negative connotations.) Wisconsin POLST (This POLST form substitutes the nomenclature “aggressive treatment” for “full treatment.”)

***Analysis of the White Paper's use of sources:***

It is not clear that the term “prolong” in fact biases the discussion. For example, the *Declaration on Euthanasia* favorably uses the term “prolongation.” Similarly, in 1981 the then Pope John XXIII Center (now NCBC) published the book entitled, *Moral Responsibility in Prolonging Life Decisions*.

The terms “aggressive therapies” or “aggressive interventions” also have a history in contemporary medicine and are not necessarily pejorative terms. The term “aggressive medical treatments” is used in *Evangelium Vitae*, par 65, and the *Catechism of the Catholic Church* actually speaks of “overzealous” treatment (par 2278).

Regarding the general question of bias in favor of non-treatment, no state requires that every section of the POLST form be completed. In most states there is an explicit presumption that sections left blank should be interpreted as the patient’s wanting full treatment in that area.

The White Paper also refers to the scripts that are part of the *Respecting Choices* program. The scripts and fact sheets do seem to emphasize the burdens of treatment for those in end-stage illness and the frail elderly.

***Additional comments:***

To the extent that such negative bias occurs, there is a problem. However, the White Paper does not establish that there is a bias in favor of non-treatment. In the population for whom the POLST is intended, there may likely be a valid decision against full treatment in favor of a more appropriate limited treatment. Such treatment would not be based on bias but on objective data. This would be in accord with Catholic moral principles. Hickman et al., for example, describe that, while there are a large number of nursing home patients who opted for only comfort care, the largest category indicated preference for limited care, which would seem appropriate considering this population. (p. 1246). Again, there is good reason why the smallest group would indicate full treatment (though this option in fact was also chosen).

Although some of the *Respecting Choices* scripts may appear to be biased in favor of non-treatment, the statements are also accurate descriptions of burdens. This emphasis on burdens is understandable given both the population in question and over-optimistic general perceptions of success that many patients have. For example the statement in the scripts regarding the relatively low success rate of CPR is important in light of the patients’ perceived success rate, often based on watching medical dramas. In Catholic facilities, however, facilitators need to be familiar with the *Ethical and Religious Directives* and to ensure that their communication with patients is in accord with Catholic moral teaching.

***10. SUSPICION REGARDING “UNWANTED TREATMENT”******Statement(s):***

The White Paper quotes Hickman: “POLST program’s association with less use of unwanted life-sustaining treatments in a large, geographically disparate sample is unprecedented.” It challenges this

assertion, asking that in light of “innovations of the POLST paradigm – facilitated informed consent, unwitnessed interviews, lack of patient signature – how can medical professionals be confident that treatments are truly unwanted?” (p. 120)

*References, sources:* Hickman et al., p. 1246.

*Analysis of the White Paper’s use of sources:*

What the study describes as innovations of the POLST paradigm are not necessarily part of the paradigm at all. Two of the three states studied by Hickman, et al. mandate patient signatures. Since the discussion deals with nursing homes, the “unwitnessed interviews” seems to refer to the CANHR Brief’s discussion that, contrary to California’s law requiring nursing homes to require that an ombudsman sign an advance directive form as witness, this is not the case with POLST (pp. 4-5). Facilitated informed consent has already been discussed under #2.

*Additional comments:*

There seems to be a suspicion throughout the White Paper that patients are led to make treatment choices contrary to their best interests. Yet little evidence is given for this. Terms like “can,” “may,” or “might” are used when such statements are made. The conclusion of the Hickman study states: “Study findings suggest use of the POLST program offers significant advantages over traditional methods to communicate treatment preferences in the nursing facility setting.” (p. 1247)

## ***11. MEDICALLY ASSISTED NUTRITION AND HYDRATION***

*Statement(s):*

“Every POLST form has a section dedicated to the refusal of nutrition and hydration. But Pope John Paul II clarified that the administration of nutrition and hydration, even by artificial means, ‘should be considered *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality.’ In all but cases when a patient is imminently dying or rare instances where food and water are no longer adequate to sustain bodily life or their administration causes excessive suffering, the decision to forego them would be wrongful.” (p. 113)

“The POLST gives the impression that patients who are fed and hydrated via technical means are being kept alive unnaturally.” (p. 115)

*References, sources:* Pope John Paul II, “On the ‘Vegetative State.’”

*Analysis of the White Paper’s use of sources:*

The 2004 Allocution was delivered at a conference on the persistent vegetative state, not end-of-life care. Pope John Paul II explains that medically administered nutrition and hydration is “in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering.” The distinctions articulated in Directive #58 of the *Ethical*

*and Religious Directives* are important in this context. In end-of-life care, medically assisted nutrition and hydration can be considered extraordinary means.

***Additional comments:***

The administration of medically assisted nutrition and hydration at end of life is more complicated – and exceptions regarding the use of medically assisted nutrition and hydration more common – than the White Paper indicates. Pope John Paul himself acknowledged that in individual cases medically assisted nutrition and hydration can be ineffective or excessively burdensome.

Regarding the statement on p. 115, the White Paper is correct in suggesting that “medically assisted” is a description that is less likely to be misinterpreted than “artificial.” It should be noted, however, that the language of “artificial” is not necessarily pejorative. In his 2004 Allocution, Pope John Paul did speak of water and food being provided “by artificial means” and continued “administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*.”

## **12. MANDATORY COMPLETION OF FORMS**

***Statement(s):***

“Proponents often imply that once a program is implemented, POLST forms are required, recognized and binding.” Furthermore, according to the proposed regulations around the Maryland MOLST, certain facilities “will be required to accept, update, and complete a MOLST form for each patient during the admission process.” (p. 122)

***References, sources:*** Maryland MOLST form; Oregon POLST; Maryland Department of Health and Mental Hygiene Regulations 10.01.21.04.

***Analysis of the White Paper’s use of sources:***

No state mandates that patients complete POLST forms (Fagerlin and Schneider, p. 11). Some states mandate that the forms/process must be *offered*, though patients are not required to have POLST/MOLST.

Maryland’s MOLST form went into effect January 1, 2013. It does state that in certain facilities a MOLST form must be completed. According to Regulation 10.01.21.04, however, “completing” means: “ (1) certifying, when applicable, the bases for the orders contained therein; (2) completing section one [on use of CPR] for all patients and only those sections two through nine of the form that are related to the patient’s current medical condition and wishes for care; and (3) signing and dating the MOLST form.” The form indicates in bold print that preparation of the MOLST form is voluntary. It also clearly states that if a patient or surrogate does not make any selection regarding CPR status, then CPR must be attempted.

It is correct that there is no place on the Maryland MOLST form for the signature of the patient, and, as suggested above, this is a problem. However, the physician or nurse practitioner must certify

that the form is a result of a discussion with and informed consent of the patient or surrogate. Furthermore, the form must be given to the patient or surrogate within 48 hours or earlier if the patient is discharged.

***Additional comments:***

If those offering POLST communicate that it is mandatory, this is an abuse of POLST. An implication of the White Paper is that the Maryland MOLST procedure is not voluntary and could be (legally) enacted without the patient's knowledge and/or consent. Although such an inference might be made by reading only the summary of the legislation, in viewing both the form and the actual regulations this is not the case.

In many states, POLST must be *offered* to all nursing home residents, but it is not mandatory for the patient to have a POLST form. Sabatino and Karp emphasize the importance of education and training, including monitoring and evaluation to counteract possible abuses. (pp. 19-20) It seems that proper education, monitoring and evaluation would rectify these abuses.

### ***13. MANDATORY COMPLIANCE WITH POLST ORDERS***

***Statement(s):***

Ten states have printed on top of POLST form: "First Follow These Orders, Then Contact Physician." Licensed health care professionals are placing their professional conduct at risk by carrying out orders that may not be appropriate for the patient. (p. 117)

In Maryland, "the law says that a facility must comply with all medical orders in a MOLST form regardless of whether the physician or nurse practitioner who signed the form has admitting privileges or is otherwise credentialed at the facility." (p. 122)

"The administrative rules in Oregon state that physicians and physician assistants must comply with POLST, even if the physician, physician assistant, or nurse practitioner who executed the form does not have admitting privileges at the facility where the patient is being treated." (p. 122)

***References, sources:*** The states mentioned are: Wisconsin, West Virginia, Tennessee, Washington, Pennsylvania, Minnesota, Louisiana, Hawaii, California, Colorado. See also Maryland's Department of Health and Mental Hygiene Regulations 10.01.21.04.

***Analysis of the White Paper's use of sources:***

According to Sabatino and Karp, a key barrier to implementation of patient's preferences is the implementation of an actionable plan that reflects those wishes. "These disconnects typically occur when the individual is in an advanced stage of illness when critical care decisions have to be made in crisis mode. Advance directives have not been effective in these situations for several reasons, including their frequent lack of availability when needed, their lack of clinical specificity with respect to here and now medical decisions, and their lack of integration into medical orders." (pp. 2-3) The

POLST form, as a medical order, is designed to be specific regarding what emergency services personnel should or should not initiate.

Sabatini and Karp also explain that in most states there is a pragmatic balancing of continuity of care goals with the hospital's quality of care goals: "The result generally is an expectation that POLST will be reviewed upon admission and either reaffirmed, revised, or revoked as appropriate. But if there is no time to review the orders due to the patient's condition, incapacity, or lack of available authorized surrogate, then orders can be followed, even if not signed by physician with admitting privileges." (pp. 17-18)

***Additional comments:***

The White Paper addresses the issue of compliance in the context of "respect for conscience." Sabatini and Karp explain that the question regarding admitting privileges deals with the portability of the form.

Many state laws offer immunity for providers; others indirectly give immunity by acknowledging the legality of the POLST document and therefore the need of medical personnel to follow it. According to Sabatino and Karp, "All the survey states except Minnesota provide immunity from civil or criminal liability and from disciplinary actions for complying with POLST orders and procedures." (p. 11) With respect to the circumstances of ascertaining a patient's wishes when there is no time to review the orders, following such orders is the most reasonable option for determining the patient's wishes and as such is an ethically-appropriate action to take.

***14. POLST OVERRIDES ADVANCE DIRECTIVES***

***Statement(s):***

"In some jurisdictions, POLST forms override all other advance directives, including the agent specified under a durable power of attorney." (p. 120)

***References, sources:*** Rev. John Tuohey, 2011 CHA webinar.

***Analysis of the White Paper's use of sources:***

According to Fagerlin and Schneider, their survey informants did not flag inconsistencies between POLST forms and advance directives as an issue. According to their study, POLST forms control decisions in three states; the most recent form in two states. (p.12) The CANHR Policy Brief, however, raises the issue that according to the wording of the legislation in California, a third party, such as the agent in a DPA, can execute a POLST form that is different from the wishes of the patient as expressed in the advance directive. (p. 4)

***Additional comments:***

Although the specific problem that the White Paper raises does not seem to be an actual problem, there is the possibility that a third party can overrule what the patient has specified. The CANHR

Policy Brief suggests a remedy for this by specifying that “the most recent treatment preferences expressed by the patient should prevail.” (p. 7)

### ***15. USE OF POLST IN NURSING HOMES***

#### ***Statement(s):***

“Nursing home residents with POLST forms are far more likely to have orders limiting life-sustaining treatments beyond ‘No CPR’ than those with conventional advance directives (98.1% v. 16.1%).” (p. 120)

***References, sources:*** Hickman, et al, p. 1244.

#### ***Analysis of the White Paper’s use of sources:***

The actual quote is: “When CPR orders were excluded from the analysis, residents with POLST forms had significantly more standing orders reflecting life-sustaining treatment preferences than non-POLST users (98.0% vs 16.1%  $P < .001$ ).” (p. 1244)

#### ***Additional comments:***

The Hickman study speaks of respecting patient preferences regarding life-sustaining orders, not the issuing of orders that limit life-sustaining treatments.

### ***16. COST SAVINGS/CONFLICT OF INTEREST***

#### ***Statement(s):***

“It seems reasonable to consider whether hospital-employed facilitators create a financial conflict of interest in their institution-appointed duties. Given that hospital Medicare reimbursement is a fixed price based on admission diagnosis, when patients agree to fewer life-sustaining treatments based upon conversations with negatively-biased facilitators, hospital costs decrease while profits increase. This is not to imply that administrators seriously ponder financial trade-offs for their clients, Nevertheless, significant cost savings have been achieved at the end of life with POLST/facilitator programs and may constitute a powerful driver for subscription in facilitator programs.” (p. 118)

***References, sources:*** Reinhardt, 2009; Gunderson Lutheran Health System, “Transforming Healthcare: Advance Care Planning.”

#### ***Analysis of the White Paper’s use of sources:***

The actual situation of hospital reimbursement is more complicated than the White Paper indicates. Uwe Reinhardt’s short blog entry itself is more nuanced than the White Paper suggests. Furthermore, the statement “when patients agree to fewer life-sustaining treatments based upon conversations with negatively-biased facilitators, hospital costs decrease while profits increase” contains several unexamined assumptions and is made without giving evidence.

Cost savings should be an appropriate goal for medical facilities. It demonstrates responsible stewardship of resources. The White Paper implies that *profits* drive the utilization of POLST. No

evidence is given. An important element of advance care planning programs such as *Respecting Choices* is improving quality outcomes. (See Hammes and Briggs, p.149-163)

***Additional comments:***

The White Paper's inference regarding conflict of interest is given as conjecture without evidence. The Catholic moral tradition acknowledges the cost of non-beneficial medical interventions as problematic. If advance care planning can both decrease costs and improve quality, it should be commended. Finally, the implication that cost savings would be realized as increased profits for a hospital does not follow from the facts, since part of the potential savings come from the fact that a patient would choose not to return to the hospital for end-of-life care.

Furthermore, the choice of limited care, palliative care, or hospice does not necessarily mean a quicker death. Studies have shown that appropriate palliative care increases survival rates in certain populations. The use of quality, appropriate care that does not needlessly expend health care resources is a moral driver here.

***17. INSTABILITY OF PATIENT CHOICES***

***Statement(s):***

"There is evidence that the stability of recorded [patient] decisions is low. Researchers have found that patient preferences change up to 77% of the time when questions are asked differently." Furthermore, "patients are frequently uncertain when their wishes are initially recorded (up to 45% of the time)." Answers to advance decision making documents are shaped by the way questions are asked. (p. 119)

***References, sources:*** Fagerlin and Schneider, p. 33; Sudore and Fried.

***Analysis of the White Paper's use of sources:***

The actual quote from Fagerlin and Schneider (p. 33) is: "In one study, '201 elderly subjects opted for the intervention 12% of the time when it was presented negatively, 18% of the time when it was phrased as in an advance directive already in use, and 30% of the time when it was phrased positively. Seventy-seven per cent of the subjects changed their minds at least once when given the same case scenario but a different description of the intervention.'" Fagerlin and Schneider do not want to eliminate all advance directives but to limit them to patients "whose medical situation is plain, crisis is imminent, preferences are specific, strong, and delineable, and who have special reasons to prescribe their care." (p. 30)

Similarly, Sudore et al. advocate a shift from "premature treatment decisions based on incomplete or hypothetical information" to health care decisions "based on a more comprehensive set of considerations, including the current clinical context, shifting and evolving goals, and patients' and surrogates' needs" p. 257). In fact, this is what POLST is attempting to do, and this is consistent with Catholic teaching on ethically proportionate and disproportionate means of sustaining life.



***Additional comments:***

The argument of Fagerlin and Schneider seems to favor POLST rather than argue against it. The conditions they describe are precisely those that serve as the basis for the philosophy of POLST. The quote from Fagerlin and Schneider seems to relate to the fact that answers are shaped by the way the question is asked rather than by the stability over time of the answers themselves. This demonstrates the importance of the role of advance care planning as opposed to simply filling out a form, be it a living will, durable power of attorney, or POLST.

Given the nature of POLST and its advance care planning context, there seems to be less chance of instability of patient decisions over time than with advance directives.

**18. CATHOLIC TEACHING ON ADVANCE DIRECTIVES*****Statement(s):***

Regarding advance directives in general, Directive #24 of the *Ethical and Religious Directives* “should not be read as an endorsement by the U.S. bishops of advance directives or advance decision making.” (p. 123)

***References, sources:*** *Ethical and Religious Directives for Catholic Health Care Services.*

***Analysis of the White Paper’s use of sources:***

The White Paper is technically correct. The concern expressed by the U.S. bishops has been to ensure that people execute advance directives according to Catholic teaching rather than to endorse advance directives themselves. This can be seen in the references to advance directives in the *Ethical and Religious Directives*. Having said this, it should also be noted that the bishops have in fact recommended that Catholics make use of advance directives. For example, in its *Pastoral Message on Growing Older Within the Faith Community*, the USCCB stated: “You may worry about being unable to communicate your desires regarding such serious matters as life support systems. Advance directives can help your loved ones know your wishes.”

***Additional comments:***

Directive 24 acknowledges that advance directives are morally acceptable in Catholic health care facilities provided that they do not contradict Catholic moral teaching. It needs to be emphasized, however, that POLST is not an advance directive. As Sabatino and Karp explain, “it is an advance care planning tool that reflects the patient’s here-and-now goals of medical decisions that may confront him or her today and converts those goals into specific medical orders.” (p. 4) It is dealing with the parameters of current, not future, care, and is supposed to be revised as care planning changes. Several POLST forms (though not all) indicate dates for review – often when the patient is transferred from one care setting to another.

### III. CONCLUDING COMMENTS

The many arguments put forth in the White Paper do not invalidate POLST. For this reason, this analysis does not evaluate the recommendations of the White Paper. (pp. 124-127)

Having said this, the current implementation of POLST is not without problems. Several of the arguments in the White Paper point to these problematic elements of the POLST paradigm but do not thereby invalidate the paradigm itself. It can be improved, however. Wenger et al. have shown that difficulties remain in interpreting POLST to make treatment decisions, in avoiding family disagreements regarding POLST directives, and in physician participation. (p. 54)

In order for a more beneficial implementation of POLST to occur, it seems that the following elements are needed:

- The target audience of POLST needs to be clear – those with advanced, progressive illness and/or frailty.
- The misunderstanding that POLST is another advance directive needs to be corrected.
- The quality of the advance care planning sessions that give rise to the POLST document is crucial. They should be seen as true dialogues between the health care professional and patient and/or surrogate. It may help if other family members were also present.
- Appropriate education and training are needed on all levels.
- Appropriate monitoring and evaluation need to be developed.
- A neuralgic element among many critics of POLST can be overcome by requiring the signature of patients or surrogates on POLST forms.

This analysis has been provided in the hope of continuing the discussion of the appropriateness of POLST and the process of advance care planning.

### APPENDIX: “*RESPECTING CHOICES*” STAGED APPROACH TO ADVANCE CARE PLANNING (ACP)

The facilitators that the White Paper mentions are part of Gunderson Health System’s *Respecting Choices* Program, which has expanded to several health care systems, including Catholic systems. The model incorporates three stages, each of which has specific training of facilitators. Thus, the training of professionals as facilitators is specific to the population that they will be serving in the appropriate stage of ACP. In the last stage, in which POLST forms are executed, nurses or social workers are employed. *Respecting Choices* describes the three stages in the following way:

- **First Steps** is appropriate for all adults, but ideally is initiated as a routine of care for those over 55. The goals of this stage of planning are to motivate individuals to participate; select

a qualified health care agent(s) appointed in a power of attorney for health care document; and provide instructions for goals of care in the event of a permanent, severe neurologic injury.

- **Next Steps** is initiated by health care providers caring for patients with chronic, progressive illness who are experiencing a decline in function, complications, or more frequent hospitalizations. The goal of this stage of ACP is to engage patients in understanding their illness progression and related treatment options, including benefits and burdens of life-sustaining treatment, and to prepare health care agent(s) to make decisions about goals of care in selected “bad outcome” scenarios.
- **Last Steps** is initiated as a component of quality end-of-life care for frail elders and those whose death in the next 12 months would not be a surprise. The goals of this stage of planning are to assist individuals or their designated health care agents to make timely, proactive, and specific end-of-life decisions (e.g., cardiopulmonary resuscitation, airway management, artificial nutrition, hospitalization) and convert these decisions into medical orders that can be followed throughout the health care continuum.

Thus, POLST is part, but only a part, of a regular, ongoing process of Advance Care Planning. Facilitators work closely with physicians and other care providers. (Hammes and Briggs, pp. 26-27, pp. 92-97)

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