

# Iowa Physician Orders for Scope of Treatment (IPOST)

## Q&A from a Catholic Perspective

*Editor's Note: The following document was prepared by Janine Marie Idziak, Ph.D., Director, Bioethics Resource Center, Loras College and Consultant for Health Care Ethics and Life Issues, Archdiocese of Dubuque in collaboration with others (see below) in conjunction with POLST developments in Iowa. This Q and A about IPOST might be helpful to various sectors of the Catholic health care ministry as well as diocesan leaders and committees that are currently or will soon be dealing with proposals to enact POLST. It is being published here with the permission of the author.*

*In 2008 Iowa Legislative House File #2539 authorized a pilot project for IPOST in Cedar Rapids (Linn County). In 2010 the pilot project was expanded to Jones County as a rural (vs. urban) area. A new chapter for the Iowa Code was proposed in the 2012 session of the Iowa legislature, 144D Physician Orders for Scope of Treatment. This legislation was passed, signed into law by the governor, and went into effect on July 1, 2012.*

### SECTION I General Information about IPOST

*Please review the IPOST form available at <https://idph.state.ia.us/IPOST/Form.aspx>*

#### What is the purpose of IPOST?

It is a tool to help ensure that a patient's end-of-life health care treatment choices are *communicated* and *honored* from one health care setting to another (hospital, nursing home, home care, hospice, EMTs).

#### How is IPOST different from an advance directive (living will, durable power of attorney for health care)?

An advance directive is a *general expression of an individual's wishes* regarding medical

treatments. IPOST is *an actual medical order* for using or forgoing medical treatments. Directives given in a living will and/or durable power of attorney for health care are used in completing the IPOST form. IPOST is a way of turning the wishes expressed in advance directives into actual orders for patient care. Thus IPOST is a complement to advance directives.

Any adult who is mentally competent can execute an advance directive, including people who are healthy. IPOST is intended for use only by a limited population: persons who are terminally ill, persons with a chronic critical medical condition, and the frail elderly.<sup>1</sup>

**Does IPOST negate or supersede advance directives?**

Chapter 144D Physician Orders for Scope of Treatment of the Iowa Code respects the provisions of a living will (Chapter 144A) and the force of a durable power of attorney for health care (Chapter 144B):

*“Physician orders for scope of treatment form” or “POST form” means a document containing medical orders which may be relied upon across medical settings that consolidates and summarizes an individual’s preferences for life-sustaining treatments and interventions and acts as a complement to and does not supersede any valid advance directive. (Chapter 144D.1)*

If an individual is a qualified patient as defined in section 144A.2, the individual’s declaration executed under chapter 144A shall control health care decision-making for the individual in accordance with chapter 144A. ...A POST form shall not supersede a declaration executed pursuant to chapter 144A. (Chapter 144D.4)

If an individual has executed a durable power of attorney for health care pursuant to chapter 144B, the individual’s durable power of attorney for health care shall control health care decision-making for the individual in accordance with chapter 144B. A POST form shall not supersede a durable power of attorney for health care executed pursuant to chapter 144B. (Chapter 144D.4)

**Is IPOST unique to Iowa?**

IPOST was developed based on the national Physician Order for Life-Sustaining Treatment (POLST) paradigm. This national model is being instituted state by state, but *with some variations among states*. Thus the IPOST project must be judged on its own merits.

**Is IPOST part of the federal health care reform law (Patient Protection and Affordable Care Act)?**

No. IPOST is an independent project.

**Why is legislation needed to establish IPOST?**

Legislation will ensure that the IPOST medical order is valid in multiple locations across the continuum of care; otherwise, the order may only be valid in a specific location and expire when the patient moves from one setting to another. (See Chapter 144D.3) Legislation can also help define what is allowable to order and prevent inappropriate orders that could lead to euthanasia or assisted suicide. (See Chapter 144D.4)

**Is IPOST simply an experiment? How do we know that IPOST will work if it is established legislatively?**

IPOST was “field tested” through two pilot projects conducted and evaluated in urban (Linn County) and rural (Jones County) areas. Two reports on these pilot projects were submitted to an IPOST State Advisory Council. As stated in the January 2012 report:

## FROM THE FIELD

A plan was created to evaluate the IPOST community process to assure that the procedures created produced the effective community program that was desired. Evaluation was to audit to assure that the IPOST documentation was present, complete, and compatible with other advance directives and followed. The evaluation leaders used process evaluation by the local committees, documentation audits by designated evaluators and satisfaction surveys to assess provider, interviewer and family acceptance of the initiative.<sup>2</sup>

On the basis of the success of these pilot projects, the State Advisory Council recommended that IPOST be made available statewide.<sup>3</sup>

**Thus far IPOST has been a pilot project in two counties in Iowa. When IPOST is instituted statewide, will executing an IPOST form be mandatory for eligible patients?**

While using the IPOST form may be recommended, it is not be mandatory. The IPOST form is an *option* that eligible patients can use. (See Chapter 144D.4)

**How is an IPOST form executed?**

In collaboration with a physician/advanced registered nurse practitioner/physician assistant, a specially-trained health care professional assists the patient or his/her proxy decision maker in conversations that build an understanding of a patient's values and goals of care. The IPOST form is then completed, and must be signed by both the patient/proxy

decision maker and the physician/advanced registered nurse practitioner/physician assistant.

**Can an IPOST form be changed?**

Yes. The IPOST form should be reviewed periodically and a new IPOST completed when the person's treatment preferences change. Review may also occur when the person is transferred from one care setting or care level to another.

## SECTION II IPOST and Catholic Health Care

**Has Catholic health care had input into the IPOST project?**

A 2008 Iowa Legislative House File (#2539) authorized a pilot project for IPOST in Cedar Rapids (Linn County). This pilot project has been led by staff from both Mercy Medical Center and St. Luke's Hospital in Cedar Rapids. In 2010 the pilot project was expanded to Jones County as a rural (vs. urban) area. The co-director of the Linn County pilot project from Mercy in Cedar Rapids has also been involved with the pilot project in Jones County, and serves as well on the state IPOST Advisory Council.

The director of the Bioethics Resource Center at Loras College, who also serves as Consultant for Health Care Ethics and Life Issues for the Archdiocese of Dubuque, has served on the committees for the IPOST pilot projects in both Linn and Jones counties.

**What medical treatments are included on the IPOST form?**

IPOST has three sections regarding categories of medical treatment:

**A) CARDIOPULMONARY RESUSCITATION (CPR)**

- CPR/Attempt Resuscitation
- DNR/Do Not Attempt Resuscitation

**B) MEDICAL INTERVENTIONS - Person has a 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. Patient prefers no 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, cardiac monitor, oral/IV fluids and medications as indicated. Do not use intubation, or mechanical ventilation. May consider less invasive airway support (BiPAP, CPAP). May use vasopressors. Transfer to

hospital if indicated. May include critical care.

- **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes critical care.

Additional Orders:

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**C) 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.

**According to Catholic moral teaching, when should a medical treatment be used and when is it permissible to forgo (that is, withhold or withdraw) a medical treatment?**

Based on Vatican documents, the *Ethical and Religious Directives for Catholic Health Care Services* from the United States Conference of Catholic Bishops states:

A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a

reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community. (Directive 56)

A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community. (Directive 57)<sup>4</sup>

**Can IPOST be used in a way that is consistent with Catholic teaching on using and forgoing medical treatment?**

Yes. IPOST is not only about forgoing medical treatments; it allows someone to elect to have cardiopulmonary resuscitation, and/or artificially administered nutrition, and/or the full range of additional medical interventions described above. If a medical treatment is judged to be “ordinary” (offering a reasonable hope of benefit and not entailing an excessive burden) for a particular patient and hence to be morally obligatory for him/her, the IPOST form allows the patient to choose to have it. Similarly, the IPOST form allows a patient to forgo a treatment that is “extraordinary” (not offering a reasonable hope of benefit or entailing an excessive burden) in his/her case.

The goal of IPOST is to determine which medical treatments are *appropriate for the patient given his/her medical condition*. In this regard, Catholic health care ethicist Fr. John Tuohy, Ph.D. and Marian Hodges, MD have offered these reflections about the national POLST project: “Key here is that the POLST is a physician’s order *about* life-sustaining interventions, not an order simply to *forgo* them. Especially for patients with

complex medical conditions or chronically critical illness, some interventions may offer reasonable hope of benefit, others may not. POLST orders allow for pursuing the interventions that do and avoiding the ones that will pose an excessive burden. POLST is a validated way to help assure clinically appropriate care is delivered at the end of life, consistent with the Catholic moral tradition.”<sup>5</sup>

**In particular, can IPOST be used in a way that is consistent with Church teaching on assisted nutrition and hydration (a.k.a. artificially administered nutrition, tube feeding)?**

Based on Vatican documents, the *Ethical and Religious Directives for Catholic Health Care Services* from the United States Conference of Catholic Bishops states:

In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the “persistent vegetative state”) who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be “excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed.” For instance, as a patient draws close to inevitable death from an underlying

progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort. (Directive 58)<sup>6</sup>

The IPOST form includes the two options indicated in the *Ethical and Religious*

*Directives*:

- Long-term artificial nutrition by tube.
- No artificial nutrition by tube.

Thus the IPOST form can be completed in a way that is consistent with Church teaching on assisted nutrition and hydration.

**What are some questions and concerns about the national POLST paradigm (of which IPOST is one instance) that have been voiced within the Catholic community?**

- POLST gives too much importance to patient autonomy.
- POLST can be used to hasten the death of persons who are chronically but not terminally ill.
- POLST is not a good tool for end-of-life discussions.
- POLST can be used as a mechanism for cost containment in health care rather than for the welfare of patients.
- POLST is a step on the way to allowing euthanasia.

Each of these points will be considered, as well as replies to these questions and concerns.

**Does POLST/IPOST give too much importance to patient autonomy?**

“Autonomy” refers to self-determination, that is, the prerogative to direct the course of one’s own life. In a medical context, patient autonomy refers to a patient is participating in medical treatment decision making and even having the prerogative to make the final decision about using or forgoing a medical treatment.

In an article which appeared in *Ethics and Medics* from the National Catholic Bioethics Center, Lisa Gasbarre Black criticized POLST programs (of which IPOST is one instance) as focusing too much on patient autonomy, “elevat[ing] [it] to the level of an enforceable, legal right.” (7)

POLST statutes lower the legal standard of respecting and protecting life to a diminished level that mandates absolute conformance with an individual’s choice...

The POLST philosophy is that a patient’s wishes are paramount. Those wishes may negate established protocols for life-sustaining treatment or conflict with conventional standards for end-of-life or life-sustaining care. Those wishes may also defy Catholic moral teachings on euthanasia.

Pope John Paul II warns that the POLST-type philosophy contradicts Catholic doctrine: “The roots of the contradiction between the solemn affirmation of human rights and their tragic denial in practice lies in a notion of freedom which exalts the isolated individual in an absolute way, and gives no place to solidarity, to openness to others and service to

them.” POLST truly “exalts the isolated individual in an absolute way” by legislating that patient autonomy becomes the mandated standard for medical care of patients who are chronically or terminally ill or who face imminent death if not treated.<sup>8</sup>

Black’s objection has been addressed by Fr. Touhey and Dr. Hodges. They acknowledge that “the literature regarding POLST makes heavy use of the expression ‘patient wishes’” and that “many articles point out a POLST is better able to assure ‘patient wishes’ than are other tools.”<sup>9</sup> However, they point out that, while “patient autonomy is certainly a factor with a POLST order,” it is “no more so than it is with any other physician’s order requiring patient/surrogate consent.”<sup>10</sup> They also point out that “subjective desires in health care are necessarily constrained by the parameters of clinically objective facts and professionalism.”<sup>11</sup>

It should also be noted that a role for patient autonomy is recognized in the *Ethical and Religious Directives for Catholic Health Care Services*:

The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching. (Directive 59)

The free and informed health care decision of the person or the person’s surrogate is to be followed so long as it does not contradict Catholic principles. (Directive 28)<sup>12</sup>

As previously indicated, a patient’s choices in completing an IPOST form can (and should) be guided by the principles of Catholic moral teaching on using/forgoing medical treatments.

Moreover, Fr. Touhey takes issue with the accuracy of Black’s assertion that “the POLST form ‘mandates compliance’ by health care workers.”<sup>13</sup>

This would seem to be an exaggeration. For reasons of professionalism, quality of care, and patient safety, medical orders are generally to be followed from the moment they are written. Just as an order for IV vancomycin cannot be ignored by medical professionals, so too POLST orders cannot be simply ignored. Having said this, no set of physician’s orders is to be blindly followed. Because a physician’s orders relate to a specific clinical scenario, it is possible that the actual facts as they unfold may impose new medical and ethical obligations not foreseen when the initial order was written.<sup>14</sup>

**The POLST/IPOST form can be used not only by patients who are terminally ill but also by patients who suffer from a chronic critical illness. Does the use of IPOST illegitimately hasten the death of these patients?**

Another concern about the POLST project articulated by Lisa Gasbarre Black is that “POLST orders [are] being used for those who are ‘chronically *but not* terminally ill who are hastening their deaths by forgoing

‘ordinary and proportionate means’ of preserving life, that is, means that are routine.”<sup>15</sup>

Fr. Touhey and Dr. Hodges have again responded to this concern:

...the POLST is also appropriate for those who are *chronically critically ill* and for those with *advanced* illnesses. Although not terminally ill, these patients have an overall medical condition that gives insight into medical events that may happen for which an intervention can be judged in advance to offer reasonable hope of benefit or excessive burden.

Consider, for example, a patient with advanced chronic obstructive pulmonary disease (COPD). If that patient’s underlying medical condition means there is no reasonable hope of benefit from pulmonary resuscitation in the event of anticipated respiratory failure, a POLST order to forgo resuscitation means the patient won’t have to experience the excessive burden of such intervention at the end of life. One does not need to be terminally ill to judge the absence of benefit for this patient population.

At the same time, if a different COPD patient’s condition indicates a “reasonable hope of benefit” from attempted pulmonary resuscitation, a POLST order can assure that the intervention will be applied despite that patient’s otherwise fragile medical state or in spite of family members’

objections that “Mother really would not want this.”<sup>16</sup>

### Is POLST/IPOST a flawed tool for end-of-life discussions?

That the POLST paradigm is not a good tool for end-of-life discussions has been argued by Marie Hilliard, director of bioethics and public policy at the National Catholic Bioethics Center:

“The issue is not whether a discussion by a health care practitioner with a patient on end-of-life care issues is a good. It is a good. Encouraging providers to have truly informing discussions with patients on this issue is also a good. The problem that arises in real patient care situations is that such federally reimbursed discussions too often become formula based with a check-off list agreed to, and signed off on, by both patient and practitioner leading to the antithesis of true informed consent. An increasingly common document used for this purpose is a Physician’s Orders for Life Sustaining Treatment, known as a POLST or Medical Orders for Life Sustaining Treatment, known as MOLST... a patient could complete a POLST/MOLST form before any of the facts that would be appropriate to such decision-making were in play. These orders might indicate the patient did not want life sustaining treatment, which under specific circumstances could simply be an antibiotic, a blood transfusion, or proportionately beneficial assisted nutrition and hydration.



We can do better as a country than to encourage persons months and years before they face health care crisis to sign away care. Health care and end-of-life care discussions are a good, but if they become boiler plate check-off lists that culminate in the signing of a POLST/MOLST form they become the antithesis of true informed consent.”<sup>17</sup>

As previously indicated, the IPOST form is not intended for use in advance by people who are healthy, but only by a limited population of persons with medical conditions: persons who are terminally ill, persons with a chronic critical medical condition, and the frail elderly. Further, even when an IPOST form has been executed, it is intended for periodic review and amendment as needed. Thus it is not true to say that an IPOST would be completed “months and even years before” the person executing it would face health care crises or that a person would complete the form “before any of the facts that would be appropriate to such decision-making were in play.”

Nor is it accurate to describe the process of completing IPOST forms as “boiler plate check-off lists” that are “the antithesis of true informed consent.” Rather, the 2012 IPOST Report describes the process in this way: “Program integrity is achieved through...stringent adherence to a standardized training for those people who will be interviewing families and individuals to fill out their IPOST form. This is not a program in which you are given a form to fill out, this is a program where a qualified, and trained interviewer works with you to move

through the form deliberating options and documenting wishes and choices.”<sup>18</sup>

### **Is POLST/IPOST being promoted as a mechanism for cost containment in health care?**

This concern has been raised by William Saunders in an address to the International Association of Catholic Bioethicists: “There is no question that rising health care costs, particularly for the elderly and chronically ill, is a significant concern. End-of-life care is expensive, and the widespread use of POLST forms is certainly a cost-containment measure. Concerns arise, however, if patients are being pressured into making decisions about end-of-life care based on personal or societal financial concerns rather than what is in their best interests.”<sup>19</sup>

Cost containment may or may not be a result of the IPOST project; in any case it is not the *intent* of the project. Patients have the right to choose their course of treatment, including those procedures which might increase the cost of their care. There is no requirement or suggestion that the least expensive option be chosen.

### **Is POLST/IPOST a step on the way to allowing euthanasia?**

Among those who have voiced this concern about the POLST paradigm is E. Christian Brugger, a moral theologian at Denver’s archdiocesan seminary.<sup>20</sup> Brugger contends that POLST is paving the way for legally sanctioned euthanasia by omission.<sup>21</sup> Brugger states: “The POLST-type law grants adults the civil right to direct healthcare professionals to

remove life-sustaining procedures when those procedures are not futile and when the burden imposed by them would be offset by a reasonable hope of recovery. It juridically extends the ordinary context for refusal of life-support to include the motive of bringing about death. Without using the term, the new law authorizes euthanasia.”<sup>22</sup>

Thus it is very significant that Chapter 144D.4 of the Iowa Code contains the following stipulation: “This chapter shall not be construed to condone, authorize or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.”

**Does IPOST contain protections for vulnerable populations such as people who are disabled?**

Marie Hilliard, director of bioethics and public policy at the National Catholic Bioethics Center, has voiced concerns about the potential impact of POLST on the disabled:

“Additionally, there are legitimate concerns about what Medicare regulations and requirements might be developed and if they might be made contingent upon completion of advanced directives and POLST/MOLST forms. Certain populations are particularly at risk in such situations. One continually hears of pressures on persons with disabilities and their families to forego life-sustaining health care treatments. If the federal reimbursement program (Medicare) has incentives that can be interpreted as fostering more POLST/MOLST form completions, the

implications for persons with disabilities and the elderly are significant.”<sup>23</sup>

There are protections in IPOST for persons with disabilities. First, the mere fact that someone has a disability does not qualify the person to execute an IPOST form. Further, the patient himself/herself if competent (or an appropriate proxy decision maker acting in the interests of the patient) is involved in completing the IPOST form. Finally, Chapter 144D.4 of the Iowa Code contains this stipulation: “A health care provider, hospital, health care facility, health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital plan shall not require any person to execute a POST form as a condition of being insured for, or receiving, health care services.”

**Could an IPOST form be executed in a way that is inconsistent with the teaching of the Catholic Church on using/forgoing medical treatments?**

This is a theoretical possibility. For example, someone might refuse artificially-administered nutrition under any circumstances, which is not in accord with Church teaching.

However, it should be noted that this problem is not unique to IPOST. In executing a durable power of attorney for health care, someone could give instructions to his/her proxy decision maker e.g., for a blanket refusal of assisted nutrition and hydration, or for a blanket refusal of kidney dialysis independent of its benefits and burdens in a particular case. Nevertheless, the fact that someone could give instructions to a proxy decision maker that is not in accord with Catholic teaching is not

taken as a reason why the durable power of attorney for health care should not be executed by Catholics, or as a reason why this document should not exist at all. As Catholic health care ethicist Fr. Touhey has commented, “Our Oregon Catholic health care experience suggests that POLST orders are not uniquely morally hazardous for the Catholic physician, the Catholic patient, nor Catholic health care, and eyeing POLST programs with undue suspicion or concern is likely more harmful to good patient care than it is helpful.”<sup>24</sup>

It should be noted that there are some safeguards for what a patient can request on an IPOST form. First of all, the form must be signed by specific categories of health care professionals (viz., physician or advanced registered nurse practitioner or physician assistant) who will bring their own professional expertise to reviewing the choices of the patient. Second, according to the Chapter 144D of the Iowa Code, IPOST “shall not be construed...to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.”

To ensure that Catholics know how to complete IPOST in accord with Church teaching, a booklet *Completing IPOST Guidance from the Catholic Moral Tradition* has been developed by the Medical-Moral Commission of the Archdiocese of Dubuque, Iowa. This booklet is available at <http://www.arch.pvt.k12.ia.us/RespectLife/index.html> > Life-Sustaining Treatments.

### Is there *conscience clause* protection for a Catholic health care facility which judges that it cannot honor a particular IPOST form on ethical grounds?

Chapter 144D.3 of the Iowa Code includes this provision: “A health care provider, hospital or health care facility that is unwilling to comply with an executed POST form based on policy, religious beliefs, or moral convictions shall take all reasonable steps to transfer the patient to another health care provider, hospital, or health care facility.”

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#### Notes

1. Code of Iowa Chapter 144D.1, definition of “patient.”
2. *IPOST January 2012 The Report of the Iowa Patient Autonomy in Health Care Decisions Project*, Appendix no. 2 Evaluation Report. Available at [http://www.idph.state.ia.us/hcr\\_committees/common/pdf/patient\\_autonomy\\_pilot/pilot\\_report\\_2012.pdf](http://www.idph.state.ia.us/hcr_committees/common/pdf/patient_autonomy_pilot/pilot_report_2012.pdf).
3. *Ibid.*, p. 2 Abstract.
4. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed. (2009), available at <http://www.usccb.org>.
5. Fr. John Tuohey and Marian Hodges, “POLST Reflects Patient Wishes, Clinical Reality” *Health Progress* (March-April 2011): 60-64 at 63-4.
6. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed. (2009), available at <http://www.usccb.org>.
7. Lisa Gasbarre Black “The Danger of POLST Orders: An Innovation on the DNR,” *Ethics and Medics* 35/6 (June 2010), quoted in William L. Saunders, “POLST: Ethical Considerations for Catholic Health Care Providers and Patients,” presented at the meeting of the International Association of Catholic Bioethicists, Philadelphia, July 2011. Available at <http://www.iacbweb.org/Readings/Saunders2011.pdf>.
8. *Ibid.*
9. Tuohey and Hodges, “POLST Reflects Patient Wishes, Clinical Reality,” p. 62.
10. *Ibid.*

11. *Ibid.*
12. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed. (2009), available at <http://www.usccb.org> .
13. John F. Tuohey, "POLST Orders Are Not Dangerous," *Ethics and Medics* 35/10 (October 2010): 3-4 at 4.
14. *Ibid.*
15. *Ibid.*, p. 3.
16. Tuohey and "POLST Reflects Patient Wishes, Clinical Reality," p. 63.
17. Marie T. Hilliard, "The National Catholic Bioethics Center Responds to New Medicare Regulations Funding End-of-Life Care Discussions," available at <http://www.ncbcenter.org/page.aspx?pid=482&storyid1277=129&nscs1277=3> .
18. *IPOST January 2012 The Report of the Iowa Patient Autonomy in Health Care Decisions Project*, "The IPOST Standard and Model."
19. William L. Saunders, "POLST: Ethical Considerations for Catholic Health Care Providers and Patients," p. 23, presented at the meeting of the International Association of Catholic Bioethicists, Philadelphia, July 2011. Available at <http://www.iacbweb.org/Readings/Saunders2011.pdf> .
20. "Moral theologian warns of dangers of POLST documents in end-of-life care" (August 25, 2011)
21. *Ibid.*
22. *Ibid.*
23. Hilliard, "The National Catholic Bioethics Center Responds to New Medicare Regulations Funding End-of-Life Care Discussions."
24. "Is there a danger and risk of noncompliance with the ERDs [*Ethical and Religious Directives for Catholic Health Care Services*]? Any medical order can raise the specter of moral hazard---just as it can raise the specter of medical hazard. That risk is inherent in medicine itself and in our experience is not unique to POLST orders. The concerns raised about POLST orders can equally be said about state advance directive laws, popular end-of-life forms such as "Five Wishes," and even hospice programs in general. Medical situations will always carry some degree of moral hazard so far as there are always medical and moral decisions that need to be made. Our Oregon Catholic health care experience suggests that POLST orders are not uniquely morally hazardous for the Catholic physician, the Catholic patient, nor Catholic health care, and eyeing POLST programs with undue suspicion or concern is likely more harmful to good patient care than it is helpful." Tuohey, "POLST Orders Are Not Dangerous," p. 4.