

Ethics Consultation and Quality

Ethics consultation is receiving increased attention of late. The October 2009 issue of *Cambridge Quarterly of Healthcare Ethics* contains a special section devoted to ethics consultation: “Coming of Age in Clinical Ethics Consultation: Time for Assessment and Evaluation.”

The first article is of particular interest. George Agich discusses “Why Quality Is Addressed So Rarely in Clinical Ethics Consultation.” At one point in the article he says: “Obviously, the kinds of questions or cases that are brought to ethics consultation services within certain institutions are structured by the nature of those institutions, the interests and concerns of those who request ethics consultations, as well as the overall clinical culture within which the service functions. Identifying the processes whereby cases and questions are brought to the ethics consultation service and the processes or procedures by which ethics consultants respond within each setting is a natural target for improving the quality of the services provided” (345).

Also addressing ethics consultation and quality, but with a different yet related focus, is an article in the fall 2009 issue of *The Journal of Clinical Ethics* (vol. 20, no. 3, pp. 220-226). The article, authored by Douglas Opel, Dena Brownstein, Douglas Diekema, Benjamin Wilfond, and Robert Pearlman, is titled “Integrating Ethics and Patient Safety: The Role of Clinical Ethics Consultants in Quality Improvement.” The authors observe that “Much of the attention on

quality in ethics has focused on improving the internal structures and processes within ethics consultation services, including the competencies of consultants themselves. However, in the wake of the proposal from the Institute of Medicine (IOM) that all care should be safe, effective, patient-centered, timely, efficient, and equitable, we challenge ethics consultants to look beyond the traditional confines of clinical ethics and contribute to this goal. This broader focus would act in conjunction with current efforts to improve the quality of practice *within* ethics consult services, but would strive primarily to improve the quality of health care provided *throughout the system*” (221). The remainder of the article goes on to discuss how this might be done.

Together with calls to improve ethics consultation with quality are tools for doing so. The second part of the VA’s Integrated Ethics program (“Preventive Ethics: Addressing Ethics Quality Gaps

on a Systems Level”) offers an approach and helpful tools for using ethics consultation for systemic change (see www.ethics.va.gov/integratedethics/index.asp). The VA has also developed ECWeb which is described as “a web-based tool that plays an important role in helping VHA achieve the goal of improving ethics quality within VA (see www.ethics.va.gov/integratedethics/ECWeb.asp). Mark Repenshek, along with Jeff Christiaansen from Harmony Technologies LLC, have also developed a tool for tracking ethics consults in view of quality improvement (see *Health Care Ethics USA*, 17, no. 1 [winter 2009]: 6-17). An update on this tracking system will appear in the winter 2010 issue of *Health Care Ethics USA*.

POLST (MOST, MOLST, POST)

The “Physician Orders for Life-Sustaining Treatment (POLST)” form has been in use since about 1995. It was first developed by a task force of health professionals at the Oregon Health Sciences University. From Oregon, it began to spread very gradually to other states and other parts of the country. Today the POLST form is used in Oregon, Washington, West Virginia, New York, California, Tennessee, and LaCrosse, Wisconsin. It is in various stages of consideration or implementation in several other states: Colorado, Georgia, Florida, Idaho, Iowa, Louisiana, Maine, Michigan, Nebraska, New Hampshire, Ohio, Texas, Utah, and in some areas of Kansas, Missouri, Minnesota, North Dakota, Pennsylvania, Wisconsin and Wyoming. In some states, these forms are known as MOST (Medical Orders for Scope of Treatment) or MOLST (Medical Orders for Life-Sustaining Treatment), or POST (Physician Orders for Scope of Treatment).

POLST is intended as a supplement to advance directives in the sense that it operationalizes patient wishes, turning them into actionable physician orders. As with advance directives themselves, the emergence and spread of POLST have generated concerns and even opposition from some sectors. It is viewed by some as contributing to hastening death, a back door to euthanasia. As one critic put it: “POLST originated in Oregon.... That should make it suspect....” Others have accused POLST of “reducing end-of-life issues to a form,” of placing too

much responsibility on the patient for determining treatments, and of allowing non-physicians to sign the form in place of a physician. In a few instances, diocesan officials have voiced opposition to POLST. Neither the literature nor the experience of those who have been using POLST bear out the concerns. (See the various studies in the literature at www.polst.org and HCEUSA, fall 2007, pp.8-10; for a recent discussion of POLST, see, Ronald Miller, “Physician Orders to Supplement Advance Directives: Rescuing Patient Autonomy,” *The Journal of Clinical Ethics* 20, no. 3 [fall 2009]: 212-219).

POLST forms, which are generally used for patients who are seriously or terminally ill, address four areas of patient care: 1) cardiopulmonary resuscitation; 2) the intensity of treatment; 3) antibiotics; and 4) medically administered nutrition and hydration. With regard to each of these, the patient can opt for “full” treatment or “no” treatment, or, with the exception of CPR, for something in between. POLST forms themselves do not skew patient decision making toward limiting or withdrawing treatment.

Among the primary drivers for POLST are the dual realities that only 15-20 percent of patients complete advance directives, and, among those who do, their directives are often not followed by physicians. POLST provides an opportunity for all patients who have advanced life-limiting disease and are likely to die within a year to express their wishes

regarding end-of-life care and to do so in a way that their wishes must be carried out by physicians. Crucial to the success of POLST are timely conversations between physician and patient in order to help the patient understand his/her medical condition and options for treatment/care, and to elicit and clarify the patient’s wishes. Quite possibly, this will not be accomplished in one conversation. The absence of such conversations would be of considerable concerns for a variety of reasons.

Can POLST be abused? Of course, like anything else. But the possibility of abuse is not sufficient justification for opposition. A more constructive approach is to do what can be done to ensure that POLST forms encourage conversations with the patient or the patient’s representative, document the basis for the orders, make provisions for appropriate signatures, provide for periodic review, revision, and revocation, and offer clear instructions to health professionals in the use of POLST. Systematically monitoring and studying the use of POLST in one’s facility(ies) could lead to improved implementation, an alleviation of concerns, or successfully addressing problems if they arise. Mere opposition to POLST, (as we have seen in some places), disregards patient self-determination, violates human dignity, promotes medically inappropriate and unwanted treatment at the end of life, contributes to medicalizing the dying process, and further entrenches the technological imperative.