

POLST Supports Care In Context of ERDs

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The *Ethical and Religious Directives for Catholic Health Care Services* begins its treatment of dying and death by affirming, “Christ’s redemption and saving grace embrace the whole person, especially in his or her illness, suffering and death. The Catholic health care ministry faces the reality of death with the confidence of faith.”¹ This grace-filled perspective is the yardstick that guides Christian responsibility in the time of transition from living to dying.

In June 2012, political columnist Joe Klein authored *Time* magazine’s lead story entitled “How to Die,” relating his personal experiences of the last five months of life for his mother and father.² Childhood sweethearts and now in their ninth decade of life, Klein’s parents were both suffering from dementia and other debilitating illnesses. Although haunted by the demons of dementia, Klein’s mother had “always” been painfully clear about her last wishes: “Just pull the plug. Let me die. I don’t want to be a vegetable.” As the primary caregiver, Klein saw himself as a “death panel” trying to handle heart-wrenching decisions about the care of his parents. How will I know when Mom is a “vegetable”? Klein wondered. At one point, he transferred his parents from fee-for-service Medicare to a private nursing home that used the Geisinger health care system,³ where he found physicians of “candor, humanity, and sanity” who helped him through the toughest decisions any of us will ever have to make. Knowing what his mother wanted did not make Klein’s decisions any easier, but not knowing what his father wanted severely complicated medical decision-making and his father’s last days. As harrowing as it was, Klein seemed to make appropriate decisions based on medical information and in his father’s best interest. His desire was to follow his parents’ wishes and to

allow them to die serenely and with dignity — in Klein’s words, “the very best you can hope for.”

Klein’s reflection demonstrates the importance of knowing what sort of medical intervention a loved one would want at life’s ending. He relied on previous conversations with his mother and on knowing his father’s values of hard work, family and independence in order to decide among treatment options. Others of us may rely on documents, advance directives and Physician Orders for Life Sustaining Treatment (POLST)

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that encapsulate our parents’ wishes. Such documents enable the helpful conversation that Klein might have had with his father before dementia set in. A POLST form may have relieved Klein of some of the burden of real-time decision-making by articulating what his parents would have wanted under life-threatening circumstances.



ADVANCE DIRECTIVES

Documents have been developed in the United States by which people can make known their end-of-life wishes in a clear and objective manner. Many states also allow people to appoint a surrogate or agent to make their health care decisions when they are unable to do so. An advance health care directive (also known as an advance directive or personal directive) is a legal document that allows one to specify what sort of medical intervention would be wanted, or it appoints someone to make these decisions when one is no longer able to make real-time choices due to illness or injury. Living wills and durable powers of attorney for health care are different types of

advance directives. A living will documents specific instructions regarding treatment options if one is terminally ill, permanently unconscious or in the final stages of a terminal illness.⁴ A durable power of attorney for health care or health care proxy appoints someone the future patient chooses — usually called a proxy, surrogate, representative or agent — to make these decisions when the patient is no longer able to do so for physical or cognitive reasons, or chooses not to do so even though capable.

People often are encouraged to have both a living will and a durable power of attorney for health care — which, for example in California, can be contained in a single document — as they can pro-

vide helpful guidelines to the family and health care team. At the same time, we often ask these documents to do more than they are designed to do. Many times surrogates and families are left wondering — as did Joe Klein — what exactly their loved one would want now, in a set of circumstances never anticipated. This is one reason for the appointment of a surrogate decision-maker who can make decisions in light of current circumstances and hopefully act as the patient

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would if capable, that is, make a substituted judgment.⁵ However, having an advance directive and a surrogate does little to prevent unwanted interventions — being taken to the emergency room, intubated, put on a ventilator and transferred to the intensive care unit (ICU), for example — in emergency situations. And, although many people are familiar with advance directives — 95 percent have heard of a living will — only 29 percent have a living will.⁶ Since as many as 40 percent of elderly adults may be incapable of making real-time, end-of-life decisions,⁷ knowing what their preferences are regarding medical intervention is increasingly important.

POLST

In order to know and follow patient values and wishes when the patient is unable to speak, and to better bridge the hypothetical and the real, the POLST program was initiated in 1991 under the leadership of the Center for Ethics and Health Care at the Oregon Health and Science University in Portland, Ore. The POLST form, as it became known in 1995, was “developed to translate advance directives into a physician's order that could be followed by clinicians directly when a patient is too sick to speak for him- or herself. It was created for patients for whom, due to their advanced illness, frailty, or status of being chronically or critically ill, it was impossible to decide in advance whether or not an intervention in response to a clinical event would carry a ‘reasonable hope of benefit’ or whether that intervention

would entail ‘excessive burden.’”⁸

POLST forms have assorted nomenclatures and variances in different states; for example, MOST (Medical Orders for Scope of Treatment), MOLST (Medical Orders for Life Sustaining Treatment) and TPOPP (Transportable Physician Orders for Patient Preferences).⁹ These documents are one-page physician orders that provide health care instructions for seriously ill persons who are nearing death. The use of a POLST form is appropriate for patients with serious illness, advanced frailty and a life expectancy of less than one year, and it facilitates informed decision-making about medical interventions at the ending of life.

A POLST form moves with the patient and is recognized in all care settings, from paramedics in the field to doctors in the ICU.¹⁰ It is a primary reference document for a

person of any age who lacks the capacity to make medical decisions and is in the final stages of life.

Because the POLST form does not take the place of an advance health care directive, it is still important to appoint a surrogate decision-maker. However, the POLST is an enforceable physician's order for one's health care reached after thorough discussion between the physician and patient or legally recognized surrogate decision-maker able to act on known patient preferences and wishes.¹¹ It makes treatment choices explicit for family members and caregivers. POLST preparation is voluntary, and the form must be signed by both the physician and patient or, when the patient lacks decision-making capacity, the legally recognized surrogate. Respect for a patient's dignity and reasonable autonomy are necessary conditions for patient-centered care and informed consent. Since the POLST form reflects a patient's wishes and is a medical order (unlike an advance directive), third parties should not be able to override it.

POLST provides specific treatment instructions with respect to four items: cardiopulmonary resuscitation (CPR), the level of medical intervention (ranging from comfort care at home to intensive hospital treatments), antibiotic use and feeding tubes and IV fluids, both long- and short-term.¹² POLST may be used to limit medical intervention or to indicate full treatment, including cardiopulmonary resuscitation, with comfort measures consistently provided. According to a National Quality Forum consensus report: “Com-

pared with other advance directive programs,¹³ POLST more accurately conveys end-of-life preferences and yields higher adherence by medical professionals. ... POLST and similar forms are designed to help health care professionals honor the treatment goals of their patients and ensure that physician orders are universal and transferable across care settings.”¹⁴

However, POLST involves more than just filling out a form. The POLST paradigm crafts a set of requirements and processes to govern how the form is to be used. The form constitutes a set of medical orders, and the process includes training of health care professionals across the continuum of care about the goals of the program as well as about the creation and use of the form. The process also includes a plan of ongoing monitoring of the program and its implementation.¹⁵

The POLST form is a uniform color within a state or region — it is uniquely identifiable and standardized. It accompanies the patient and is transferable and applicable across care settings.

The form is recommended for use by people who have advanced chronic progressive illness, by those who might die in the next year or by anyone who wishes to further his or her preferences for treatment. It requires a valid, dated signature from a physician, nurse practitioner or physician assistant, depending on the program.

People can use the form either to limit medical interventions or to clarify a request for all medically indicated treatments, including resuscitation — the POLST form provides explicit direction about resuscitation status if the patient is pulseless and apneic, as well as directions about other types of intervention that the patient may or may not want — ICU care or antibiotics, for example.

The POLST form should be used in such a way that is consistent with the Introduction in Part Three of the *Directives*: “Neither the health care professional nor the patient acts independently of the other; both participate in the healing process.” POLST is, therefore, a “validated way to help assure clinically appropriate care is delivered at the end of life, consistent with the Catholic moral tradition.”¹⁶

It is not accurate to understand POLST forms as elevating patient autonomy to an absolute right. Both patients and professionals work together in assessing the best medical treatment in terms of the patient’s clinical condition.¹⁷ It is not the

bright pink POLST form itself, but the conversation between physician and patient or, when the patient lacks capacity, the legally recognized surrogate, in support of the inherent dignity of the person, of *this* patient at *this* time of transition that is key. POLST is an occasion for serious conversation in support of the Catholic commitment to patient-centered care.

CRITIQUES

The POLST paradigm and form are not without critics. Some of this criticism is warranted, especially when the POLST form is not properly used. However, rather than merely discarding the use of POLST, as some suggest, potential misuses — such as not having face-to-face conversations with the patient, not requiring signatures from the patient or the surrogate and from the physician, or using POLST for someone who is medically stable with a life expectancy of years — should be corrected. The sage Latin axiom: *abusus non tollit usum* (abuse does not take away use) is applicable here.

Some critics wrongly believe that the use of POLST creates a “killing fields” mentality by persuading elderly people that their lives are futile. On this view, POLST is nothing more than a national effort to control death under the guise of compassion.¹⁸

Lisa Gasbarre Black, general counsel to the Diocese of Cleveland’s Catholic Charities Health and Human Services, believes for example, that POLST has a “corrosive effect on Catholic moral teaching, it attacks the sacredness of human life

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by hastening death, it mandates absolute conformance with a person’s end-of-life wishes, and contradicts Catholic doctrine.”¹⁹

E. Christian Brugger, D.Phil., who holds the J. Francis Cardinal Stafford Chair of Moral Theology at St. John Vianney Theological Seminary in Denver, is a vociferous opponent of POLST and has published two strongly condemnatory articles.²⁰ He specifically critiques Colorado’s MOST legislation on several grounds: first, that a patient does not need to be terminal for life-sustaining treatment to be withdrawn, opening the floodgates for any reasons whatsoever to end life, such

as living with a disability or a financial loss. Brugger asserts that MOST thus encourages euthanasia and fosters a false concept of autonomy. Second, the attending physician does not have to sign MOST, and the forms can be manipulated by non-physician facilitators. Third, the forms may not be kept up to date, and health care providers might act immediately to comply with outdated instructions, even despite family wishes. Fourth, the form itself is too simplistic and reduces complicated clinical decisions to a check-box format.

Brugger and his co-authors state that MOST and POLST forms “pose unacceptable risks to the well-being of patients and the ethical values of Catholic health care.” Consequently, he argues, Catholic health care institutions should refuse to accept MOST and POLST forms as they truly do not conform to “the full dignity of the human person.”²¹

The Wisconsin Catholic bishops find the risk of accidental or intentional euthanasia as a result of acting on a POLST “too grave to be acceptable” and encourage Catholics to avoid both the POLST form and the living will.²²

CATHOLIC HEALTH CARE

In the *Directives*, the Introduction of Part Five discusses issues surrounding care for the seriously ill and dying: “We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome.” Two extremes are to be avoided: “an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it, and ... the withdrawal of technology with the intention of causing death.”

The Wisconsin bishops helpfully point out that since we cannot predict the future, “it is difficult to determine in advance whether specific medical treatments, from an ethical perspective, are absolutely necessary or optional.”²³

However this is the problem that POLST, when properly used, is meant to address, specifically facilitating treatment choice not as a future possibility but in the here-and now context of terminal, life-limiting illness. POLST is a patient-centered process, respecting human dignity while acknowledging that death is an inevitable part of life.

For a proper implementation of POLST, the

Directives present these guidelines:

■ “Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers.” (No. 55)

■ “They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them.” (No. 55)

■ “In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment.” (No. 24)

■ “Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses capacity to make health care decisions.” (No. 25)

In light of these guidelines, it is appropriate for Catholic health care institutions to honor advance directives as long as they do not conflict with Catholic teaching, as Directive No. 24 states. POLST forms complement advance directives by converting an individual’s wishes regarding medical treatment into a medical order and providing guidance to surrogate decision-makers.

POLST forms must never be used as a type of assembly-line decision-making process with no regard for a patient’s or surrogate’s informed consent made in conjunction with a physician’s guidance and signature.

Even though some have warned Catholic health facilities of their “grave concerns” regarding the use of POLST, in themselves, advance directives and POLST not only do not contradict Catholic teaching but also facilitate communication, difficult decision-making and patient-centered care.²⁴

REFLECTIONS

“The inherent dignity of the human person must be respected and protected regardless of the nature of the person’s health problem or social status,” says Directive No. 23. “The respect for human dignity extends to all persons who are served by

Catholic health care.”

The appropriate use of the POLST paradigm demands clarity, therefore, in order to protect fundamental human dignity. Clarity in turn calls for transparency, enabling a patient and surrogate to “have access to medical and moral information and counseling so as to be able to form his or her conscience” (Directive No. 28). Information and counseling are necessary in order to facilitate the conversation that ensues, a conversation between patient and physician, and patient and family.

POLST ought not create a push to suicide or create a “killing fields” mentality. For this reason, it is essential that health care professionals explain and reiterate end-of-life treatments that are truly beneficial to the patient. POLST forms must never be used as a type of assembly-line decision-making process with no regard for a patient’s or surrogate’s informed consent made in conjunction with a physician’s guidance and signature.

The presence of a physician and patient- or surrogate-signed POLST in a patient’s chart represents a medical order which expresses the patient’s wishes for end-of-life treatment. In other words, a POLST directive enables medical professionals across health care settings to provide end-of-life interventions in light of the patient’s values and clearly expressed wishes.

In the literature on this subject, “treatment” is sometimes confused with “care.” End-of-life treatment may include, among other interventions, breathing machines (mechanical ventilation), kidney machines (dialysis), CPR (cardiopulmonary resuscitation), surgical interventions, various medications and antibiotics and feeding tubes (medically administered nutrition and hydration)²⁵ — all of which may impose excessive burdens during the transition from life to death.

Care represents an absolute clinical and moral obligation which brings to a patient physical, emotional, and spiritual comfort and solace. Care is never subjected to an ordinary/extraordinary analysis. While treatment might be proportionate or disproportionate and optional, care of a patient is *never* optional or disproportionate.

However, treatment can become over-treatment when a patient is kept alive with medical technologies well beyond what is medically and morally reasonable because of the fear that withholding or withdrawing medical intervention will

kill a patient. The *Directives* explicitly acknowledge that the duty to preserve life is not absolute — a patient may refuse disproportionate medical treatment when it offers no reasonable hope of benefit or entails a disproportionate burden or imposes excessive expense on the patient, family or the community, even if it results in death. (Directive No. 57)

Patient dignity is threatened if the POLST can be overridden by third parties. This provision in the law should be changed and surrogate override, in general, not permitted.

POLST is a voluntary form meant to reflect a terminal patient’s treatment preferences. POLST should not be used, then, for all patients but only for those who are living with advanced progressive illness or who have reached a terminal diagnosis. Another helpful aspect in properly following the POLST paradigm is the acknowledgment that comprehensive advance care planning is not something that can happen in a short interview with a patient during which the boxes on a POLST form are reviewed and checked.

Good advance care planning requires a shared understanding of the goals of treatment based on a particular patient’s medical trajectory.²⁶ Physicians, patients and family members must reach a shared understanding of patient goals of care, both medical and non-medical. We do not advance patient autonomy by giving authority to choices that originate in insufficient or mistaken information.²⁷

A patient (or surrogate) should first decide upon goals of care with a physician, and only then determine what specific interventions are appropriate to meet these goals. POLST is the last step in this discernment process. Good planning seldom results when the end-of-life discussion is started with, “Do you want everything done?”

A serious concern with the POLST law is raised by a provision that permits a legally authorized surrogate to override the previously expressed wishes of the patient, potentially undermining POLST’s purpose of enabling patients to receive end-of-life care consistent with their preferences. Certainly, a patient should be able to change his or

her treatment choices in light of changing health status and/or new information. The most recent preferences expressed by the patient should take precedence.

It may be appropriate for a legally-authorized surrogate and physician, after extensive conversation and based on patient values, to complete the initial POLST form for a patient who lacks the capacity to decide, but that should not translate into the ability of a surrogate to countermand an existing, properly executed POLST. Patient dignity is threatened if the POLST can be overridden by third parties. This provision in the law should be changed and surrogate override, in general, not permitted in Catholic facilities. The POLST form should be reviewed when there has been a profound change in a patient's health status or preferences, or when a patient is transferred between care settings.

CONCLUSIONS

POLST supports the Catholic commitment to human dignity and patient-centered care as long as certain parameters are kept central:

- A belief that God creates each of us for eternal life and that we are all precious gifts made in God's image and likeness

- Death is an inevitable part of life and has been redeemed by Christ

- An individual has the right in Catholic teaching to make medical treatment judgments based on the long-standing distinction between ordinary/proportionate and extraordinary/disproportionate medical intervention

- To the degree that a treatment prolongs life, cures, restores function, relieves symptoms, alleviates pain and engenders physical, psychological and spiritual well-being, to that degree is a treatment beneficial

- Simply because a treatment is beneficial, it is not mandatory if its burdens outweigh its benefits. It must be recognized that a given intervention may be burdensome to one patient but not to another in relatively identical medical circumstances

- A treatment is or becomes burdensome when it is financially costly, psychologically repugnant, unlikely to succeed, unlikely to provide great benefit, experimental, or difficult to administer²⁸

POLST is not for everyone. But for those who, like Joe Klein's parents, have reached life's ending and, unlike Klein's father, have clearly articulated their desires regarding medical intervention, the conversation and discernment process is simply

the very best that we can hope for our loved ones and ourselves. Catholic health care can — indeed, should — take the lead in patient-centered, ethically responsible end-of-life care. POLST, when done well and in line with the *Directives*, can help preserve human dignity during life's final transition.

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NOTES

1. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, D.C.: 2009), Introduction, Part Five.
2. Joe Klein, "How to Die," *Time* 179:23 (2012): 17-25.
3. Geisinger is an integrated health services organization widely recognized for its innovative use of the electronic health record and the development and implementation of innovative care models including Proven-Health Navigator, an advanced medical home model, and the ProvenCare program. The system serves more than 2.6 million residents throughout 44 counties in central and northeastern Pennsylvania. Geisinger's literature indicates that "in Pennsylvania, adults have the right to decide if they want to accept, reject or discontinue medical care or treatment."
4. American Bar Association Commission on Law and Aging, *Myths and Facts about Health Care Advance Directives*, www.americanbar.org/content/dam/aba/migrated/Commissions/myths_fact_hc_ad.authcheckdam.pdf.
5. See John Tuohey and Marian O. Hodges, "End of Life: POLST Reflects Patient Wishes, Clinical Reality," *Health Progress* 92:2 (2011): 60-64.
6. The Pew Research Center for The People and the Press, *More Americans Discussing and Planning End-of-*

- Life Treatment*, www.people-press.org, (2006), 2.
7. Maria J. Silveira, Scott Y. H. Kim and Kenneth M. Langa, "Advance Directives and Outcomes of Surrogate Decision-making before Death," *New England Journal of Medicine* 362:13 (2010): 1214.
 8. Tuohey and Hodges, 61.
 9. See www.ohsu.edu/polst/programs/sample-forms.htm.
 10. POLST forms carry the term "portability" because they travel with a patient to any point of treatment to assure that his or her wishes regarding life-sustaining treatment are followed.
 11. Ideally, a completed and signed POLST form is the result of a detailed discussion between physician and patient. If, however, the patient lacks decision-making capacity, a POLST form may be completed and signed after a discussion between the physician and legally recognized surrogate. Under no circumstance should a POLST be completed absent a thorough discussion with the physician or by anyone other than the physician and patient or surrogate.
 12. See Jason W. Manne, "A Critical Look at the Physician Orders for Life-Sustaining Treatment (POLST): What Are Its Weaknesses?" (master's thesis, Center of Bioethics and Health Law, University of Pittsburgh, 2007), 23-25.
 13. Properly speaking, POLST is not an advance directive but a component of the process of advance care planning. POLST never replaces an advance directive.
 14. National Quality Forum, "A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report," (Washington DC: 2006) 43-44.
 15. See www.POLST.org.
 16. Tuohey and Hodges, 64.
 17. See "A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Programs," *Journal of the American Geriatrics Society* 58:7 (2010): 1241-48.
 18. www.all.org/article/print/id/ODcxMw.
 19. Lisa Gasbarre Black, "The Danger of POLST Orders: An Innovation on the DNR," *Ethics and Medics* 35:6 (2010): 1-2.
 20. E. Christian Brugger, "A Critique of the National POLST Paradigm through an Analysis of Colorado's New MOST Legislation," *Linacre Quarterly* 78:2 (2011): 158-161, and (with others) "POLST and Catholic Health Care," *Ethics and Medics* 37:1 (2012): 1-4. For a helpful critique of these articles, see Ron Hamel, "POLST Under Fire," *Health Care Ethics USA* 20:1 (2012): 30-35.
 21. These latter two quotations come from Brugger in *Ethics and Medics*, 3.
 22. Catholic Bishops of Wisconsin, *Upholding the Dignity of Human Life: A Pastoral Statement on Physician Orders for Life-Sustaining Treatment (POLST) from the Catholic Bishops of Wisconsin*, [www.wisconsinatholic.org/WCC%20Upholding%20Dignity%20POLST%20State-ment%20FINAL%207-23.pdf](http://www.wisconsinatholic.org/WCC%20Upholding%20Dignity%20POLST%20Statement%20FINAL%207-23.pdf).
 23. Catholic Bishops of Wisconsin.
 24. Ron Hamel, "POLST Under Fire," 30.
 25. Michael Panicola et al., *An Introduction to Health Care Ethics: Theological Foundations, Contemporary Issues and Controversial Cases* (Winona, Minn.: Saint Mary's Press, 2007): 135.
 26. See Mary Catherine Beach and R. Sean Morrison, "The Effect of Do-not-Resuscitate Orders on Physician Decision-Making," *Journal of the American Geriatrics Society*, 50, 2057-2062.
 27. Jason W. Manne, master's thesis, 74.
 28. See Janet E. Smith and Christopher Kaczor, *Life Issues, Medical Choices* (Cincinnati: Servant Books, 2007), chapter 5.

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