

END OF LIFE

POLST Reflects Patient Wishes, Clinical Reality

BY FR. JOHN TUOHEY, Ph.D. and MARIAN O. HODGES, MD

The case of Sarah is a good starting point: Sarah is a 95-year-old, frail woman living in a retirement home. She has hypertension and osteoporosis, and she has been slowly losing weight. She has discussed code status with her doctor and has asked for “Do Not Attempt Resuscitation” (DNAR), which is marked in her chart.

One afternoon, the staff finds her down, unresponsive and cyanotic in the hallway. They immediately call 911. The emergency technicians arrive and perform cardiopulmonary resuscitation. Sarah is intubated, and she gets back a weak pulse, with blood pressure of 80. She is still unrespon-

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sive. She is taken to the emergency room where her son meets them, having been called by the retirement home’s staff. He turns to the emergency room physician and says, “She did not want this. Please stop. She wanted a peaceful, natural death. Not this.”

Or consider Peter: Peter is a 53-year-old man with severe multiple sclerosis and end-stage cardiomyopathy from hypertension and diabetes. He has had recurrent hospital admissions for congestive heart failure. Each time, he is treated and returned to the intermediate-care facility where he lives because of his impaired functional status

from his multiple sclerosis.

After this last hospitalization, the doctors talk with Peter and his family about his heart disease. The patient says he is sick of being in the hospital and would rather have his quality of life maximized at the facility where he lives. He does not want hospice because he does not “think he is ready.” He agrees to “Do Not Attempt Resuscitation” status. His daughter, Brenda, age 30, agrees with this plan. She has seen him so uncomfortable in the hospital, and she knows his time is limited. The intermediate-care facility supports the plan, and the manager says they have provided excellent care at end of life for other residents.

One Saturday, Peter has increased difficulty breathing, and his weight is up by 10 pounds. He is mildly agitated and mildly cyanotic. The weekend staff does not know Peter well and do not feel comfortable caring for him at the facility without emergency-room evaluation. They call Brenda for her input, but she is at her son’s football game and does not hear the cell phone in her purse. The staff sends Peter to the emergency room, where he is evaluated to be in respiratory failure and is urgently intubated. They saw his DNAR in the

notes from his last admission, but he could not tell them if that is what he wants now, and his family is unavailable. An hour later, they reach Brenda; when she arrives at the hospital, she sees her dad hooked up to the ventilator, still unresponsive, and she sighs. "This is what he was trying to prevent," she says.

We can change the names, pathologies and the circumstances, but the question remains the same: What to do when the care plan already under way is one the patient didn't want and isn't likely to be of benefit?

ADVANCE DIRECTIVES FALL SHORT

The best approach, of course, is to make sure it never begins, but sometimes a missed phone call or a missed DNAR chart note is all it takes to start the unwanted journey.

Although widely advocated for their usefulness,¹ advance directives or living wills are not generally helpful in these types of cases. Aside from evidence that an advance directive often is not followed in any setting,² this document typically addresses a hypothetical, medically catastrophic event that may happen sooner or later, or maybe never. As a result, the patient's wishes can be left open to interpretation depending

on circumstances.³ These documents generally speak to a limited number of situations, such as when the patient is imminently dying, suffering in the last stages of advanced progressive illness or permanently unconscious, and they do not necessarily preclude initiating interventions. This is a good thing for the young person who suddenly has a heart attack. This is not good for those patients whose chronically critical illness or whose advanced illness or frailty makes it unreasonable to think

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an intervention can offer benefit.

Even when there is a DNAR order in a patient's chart, that order may not be found quickly enough if a patient is rushed to the hospital, or the emergency medical technicians may disregard it if they are not confident the

patient had decided on a care plan that took into account this *specific* event in light of his or her health condition.

In short, for patients like Sarah and Peter, something more is needed to assure a way to follow *Ethical and Religious Directives for Catholic Health Care Services No. 57* in forgoing by withholding interventions that will not be beneficial and that does not limit forgoing to withdrawing interventions only after they have imposed excessive burden. This "something more" can be the Physician's Order for Life-Sustaining Treatments (POLST).

THE MOVE TO POLST

The POLST program began in 1991 with the development of a medical order sheet under the leadership of the Center for Ethics in Health Care at the Oregon Health and Sciences University. This form 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 herself. It was created for patients for whom, due to their advanced illness, frailty or status of being chronically critically ill, it was possible 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."

Key elements of this physician order sheet are:

- Legal standing for emergency medical technicians, who are otherwise obligated to resuscitate any patient they are called to see

- Portability, so it would travel with the patient to any point of care in the system to assure that his or her wishes regarding life-sustaining treatment would not be lost in transition

- A greater appreciation that a patient's wishes regarding end-of-life care is more than simply documenting "code status."⁴ In addition to indicating CPR or DNAR when a patient has no pulse and is not breathing, the order sheet addresses the benefit or burden



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of various levels of medical interventions such as IV fluids, hospital admission, ICU care, intubation outside the context of apnea, as well as the use of antibiotics and medically administered nutrition and hydration.

In 1995, this order sheet became what is known today as the POLST, a portable tool that specifies the patient's wishes regarding beneficial and burdensome treatment at end of life and that, as a physician's order, is transferable throughout the health care system. If Sarah in the above case had a POLST indicating "Do Not Attempt Resuscitation," the emergency technicians would not have intubated her and the care team at the hospital would not have received a patient already started on an unwanted, burdensome treatment that could not benefit her. What's more, her son would have been spared finding her in the emergency room on a mechanical ventilator against her wishes, deprived of the chance to die naturally at home.

STUDIES SHOW ADVANTAGES

The effectiveness of the POLST for this patient population has been studied and reported in some recent publications. Among them, a 2009 telephone survey of hospice staff in Oregon, Wisconsin and West Virginia reported 96 percent of those interviewed described the POLST as an effective tool for initiating conversations about care preferences, and 97 percent said it prevented burdensome resuscitation.⁵

Leaders in the palliative care field also have written of POLST usefulness, particularly in the way it can translate a discussion of a patient's values into explicit medical orders that can assure those values are acted upon.⁶

The most recent and thorough study, published in 2010, used 90 Medicaid-eligible nursing facilities in Oregon, Wisconsin and West Virginia to compare the effectiveness of communicating patient preferences by way of a POLST with the more traditional documentation in a patient's chart or medical record. The study examined records of more than 1,700 living and deceased nursing home residents aged 65 and older with a minimum of a 60-day stay. The researchers found that patients with a POLST were more likely to have expressed more detailed life-sustaining preferences than simply decisions about CPR. Patients with a POLST were more likely to have

POLST AND PATIENT AUTONOMY

The literature regarding POLST makes heavy use of the expression "patient wishes." Many articles point out a POLST is better able to assure "patient wishes" than are other tools. This may lead some to see the POLST as exaggerating patient autonomy. Some raise concerns about patient choice of medically assisted suicide and euthanasia.⁹ Patient autonomy is certainly a factor with a POLST order, but no more so than it is with any other physician's order requiring patient/surrogate consent. Respecting patient autonomy is important because consent¹⁰ is involved, but subjective desires in health care are necessarily constrained by the parameters of clinically objective facts and professionalism.

Patients whose medical condition does not warrant a particular POLST order cannot get it simply because they want it. Decision-making with regard to a POLST form should be done, as with any other physician's order, in a way that is consistent with the Introduction in Part III of the *Directives*: "Neither the health care professional nor the patient acts independently of the other; both participate in the healing process." In this sense, the exaggeration of patient choice is less likely with a POLST than with an advance directive, which a patient can fill out alone, without regard to anyone else.

With the POLST form, autonomy is respected through the patient's informed consent to receive or forgo an

intervention based on the reasonable hope of benefit or excessive burden associated with it. In addition, because they relate to a physician's order in a specific clinical scenario, it is possible that the actual scenario as it unfolds may impose new medical and ethical obligations not foreseen when the initial order was written. POLST orders, like all orders, need to be periodically reviewed to make sure they are consistent with a patient's dynamic medical condition. Although a patient may want some particular intervention, it can happen that the clinical situation makes this desire impossible to fulfill in a beneficial and nonburdensome way.

— John Tuohy and Marian Hodges

their overall preferences actually documented as medical orders, helping to assure their preferences would be followed. Finally, patients with POLST orders restricting treatments at end of life were found to be accompanied with less use of life-sustaining treatments compared to those patients with similar wishes but more traditional end-of-life documentation.

The study supports previous conclusions that a POLST offers significant advantages over traditional methods to communicate preferences by both initiating a broader discussion of likely interventions at the end of life and by assuring those preferences are documented as medical orders.

POLST AND CATHOLIC TEACHING

There has been some concern about the compatibility of the POLST with Catholic teaching about the end of life. A June 2010 essay raised this issue in *Ethics & Medics*, a publication of the National Catholic Bioethics Center.⁷ The essay speaks of a variety of “dangers of POLST orders,” among them that the POLST is wrongly used for patients who are “chronically *but not* terminally ill” (emphasis added), and who are “hastening their death” by forgoing “ordinary and proportionate means of preserving” life, which the author defines as means that are “routine.”

These concerns have been addressed elsewhere,⁸ but as they are serious, some comment is appropriate here as well. The purpose of the POLST is to address the anticipated medical needs of a specific group of patients that includes the *terminally* ill, but the POLST is also appropri-

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ate for those who are *chronically critically* ill and for those with *advanced* illness. 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. Especially for all these patients, a more thorough discussion of care beyond simply questions of CPR/DNAR is necessary, as is documentation of the care plan as a

medical order to assure appropriate interventions are delivered or forgone.

Consider, for example, a patient with advanced chronic obstructive pulmonary disease (COPD). If that patient’s underlying medical condition

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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, and no one is ethically obligated to try some intervention on the thought that it might delay death. As noted above, *Directive No. 57* allows forgoing by *withholding*, not only forgoing by *withdrawing* what is likely to be nonbeneficial or burdensome.

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.”

POLST orders are perhaps most uniquely helpful in that they have standing outside a hospital facility, helping to assure that a patient being cared for at home or elsewhere will receive interventions for which there is reasonable hope of benefit and not receive interventions that entail excessive burden. This is especially important for nonhospitalized patients who suffer a sudden medical event and the family or caregivers dial 911. The POLST gives the emergency technicians medical orders to follow that are consistent with the patient’s wishes and condition.

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.

The central ethical tenet that informs our Catholic moral tradition is the inherent dignity of the person, grounded in our relatedness to the image and likeness of God. Respect for this dignity is essential in every personal encounter and expressed differently in each encounter. In Catholic health care's encounter with those who are terminally ill, chronically critically ill or suffering with advanced illness, this expression of respect for dignity takes on the look of care that provides genuine benefit in the real-time situation and avoids the unnecessary medical "touch" of non-beneficence or burdensomeness. This lies at the foundation of the *Directives* on end-of-life care. In order to respond appropriately to our patients in these settings, it is incumbent upon us to find validated tools that improve the effectiveness not only of our care, but also of our respect for dignity in the way we deliver care.

The POLST is just such a tool. It provides a validated way for medical orders, prudently reflecting both patient wishes and clinical reality, to assure that these vulnerable patients are only benefitted, never subjected to futile care and certainly never burdened.

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NOTES

1. Daniel P. Sulmasy, "The Last Word: The Case for Catholic Advance Directives," *America*, (Nov. 29, 2010), http://www.americamagazine.org/content/article.cfm?article_id=12585.
2. Henry S. Perkins, "Controlling Death: The False Promise of Advance Directives," *Annals of Internal Medicine* 147, no. 1 (2007): 51-57.
3. Joan M. Teno et al., "Do Advance Directives Provide Instructions that Direct Care?" *Journal of the American Geriatrics Society* 45 (1997): 508-512.
4. Mary Catherine Beach, R. Sean Morrison, "The Effect of Do-Not-Resuscitate Orders on Physician Decision-Making," *Journal of the American Geriatrics Society* 50 (2002): 2057-61; Steven C. Zwig et al., "Effect of Do-Not-Resuscitate Orders on Hospitalization of Nursing Home Residents Evaluated for Lower Respiratory Infections," *Journal of the American Geriatrics Society* 52 (2004): 51-8.
5. Susan E. Hickman et al., "Use of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in the Hospice Setting," *Journal of Palliative Medicine* 12 (2009):133-41.
6. Diane Meier, Larry Beresford, "POLST Offers Next Stage in Honoring Patient Preferences," *Journal of Palliative Medicine* 12 (2009):291-95.
7. Lisa Gasbarre Black, "The Danger of POLST Orders: An Innovation on the DNR," *Ethics & Medics* 35 (June 2010):1-2.
8. John F. Tuohey, "POLST Orders Are Not Dangerous but Effective Devices for End-Of-Life Care," *Ethics & Medics* 35 (October 2010):3-4.
9. Sulmasy, "The Last Word."
10. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition (Washington, DC: USCCB Publications, 2009) No. 26: "The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment."

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