POLST: A PORTABLE PLAN FOR CARE

A Physician Order for Life-Sustaining Treatment, better known as POLST[1], is a tool for translating a patient's goals and preferences for treatment into a medical order. In some ways, it can be seen as a successor to advance directives such as the living will or the durable power of attorney for health care.

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Recent months have witnessed a lot of Catholic writing about POLST, with some bishops and theologians critical of the POLST program[2] and others cautiously supportive.[3] This controversy has been helpful in raising some important issues regarding the conceptualization and implementation of the POLST paradigm in various states. The controversy might also be an occasion for Catholic health care ethicists to refocus the conversation from the relative advantages and disadvantages of POLST to what is probably the more important issue: the place of advance care planning in Catholic health care.

TRAJECTORIES OF ILLNESS

The past century has witnessed a significant change in the way people die in the United States. As Daniel Callahan, Ph.D., the founder of the Hastings Center for Bioethics, has written, most deaths in an earlier time were caused "by infectious disease, accident, or injury, they were faster and more intensive in their course, and more rapid in their lethal outcome." Callahan further explained that "the price of a longer life has been a sicker life," emphasizing that the chronic diseases of today "are slow to develop and slow to kill."[4]

In trying to analyze the deaths that result from chronic illness, researchers have described three distinct trajectories from onset of illness to death:

1. A relatively long plateau period of adequate functioning, followed by a short period of evident decline (typical of cancer). Most patients in this trajectory maintain relative comfort and functioning for a substantial period of time. However, once the illness becomes overpowering, the patient usually declines rapidly in the weeks and days immediately prior to death.

2. Long-term limitations and decline with intermittent exacerbations and sudden death (typical of organ system failure). Patients often live for a relatively long period of time and, especially at the beginning of the disease, experience minor limitations in everyday life. From time to time, however, the patient's condition overwhelms the body's reserves and leads to a worsening of serious symptoms. The patient often survives the episode but never quite recovers to the previous state of relative health. Episodes continue, with the patient experiencing further deterioration until the patient dies from a complication or exacerbation of the illness.

3. Prolonged diminishment (typical of dementia, disabling stroke or frailty). These patients are likely to die at older ages of either neurological failure or generalized frailty of body systems. These patients experience continuous decline and are likely to die in long-term care facilities.

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>
> — Daniel Callahan, Ph.D.

At the present time, approximately 20 percent of those who die have a course of decline consistent with the first trajectory, another 20 percent with that of the second, and 40 percent with that

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of the third. The last 20 percent are split between those who die suddenly and those whose deaths have not yet been classified.[5]

POLST AND ADVANCE CARE PLANNING

This change in the way people die has occasioned responses from the health care and legal professions. The 1980s and 1990s saw the development of the living will and durable power of attorney for health care, documents that enabled patients to make known their health care preferences when they could no longer speak for themselves. The past decade has witnessed the advent of POLST, a development in advance care planning aimed at standardizing the way in which the health care professional prescribes a plan of care in a visible, portable way, rather than standardizing the patient's communicating his or her treatment preferences.

Charles P. Sabatino, director of the American Bar Association's Commission on Law and Aging, explains that the POLST paradigm consists of three key tasks: (1) requiring that a health care professional initiate an advance care planning discussion with the patient or the patient's surrogate about key advanced illness treatment options in light of the patient's current medical condition; (2) incorporating the results of the advance care planning consistent with the patient's goals and preferences into a medical order, which is recorded in a highly visible way; and (3) ensuring 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.[6]

Although much of the debate around POLST has concerned the second point, it seems that the first point is the more important from both a medical and an ethical point of view. It emphasizes that the appropriate way to understand POLST is within the larger context of advance care planning and not to limit it to a routine form to be completed. Advance care planning includes a discussion or, more likely, a series of discussions, to help the patient or surrogate, and often the patient's family, to understand the patient's health care options in light of the current circumstances of his or her actual illness and the trajectories of chronic illness mentioned above. It further allows the health care professional to attend to the patient's values and beliefs in relation to the clinical options available. Such advance care planning demands listening on the part of both clinician and patient or surrogate.

Advance care planning is good medicine. As Thomas Smith, MD, and Joann Bodurtha, MD, MPH, wrote in the *Hastings Center Report*:

> We can scientifically lay to rest one of the death panel arguments — that asking patients and doctors to discuss difficult [end of life] issues will force people to die sooner. . . . [They are] almost universally accepted as a good measure of high-quality care and advocated as personal responsibility. . . . People who receive palliative care concurrently with curative care have less depression, better quality of life, and better communication, in addition to equal or better survival — and less distressed caregivers. People who talk with their doctors and nurses about death have no more anxiety and depression and better quality of care. People whose spiritual needs are addressed by the medical team have better satisfaction, fewer in-hospital deaths, more hospice use, and better quality of life scores.[7]

Such quality end-of-life care, however, involves moving from regarding POLST as documentation — filling out a legal form — to appreciating that it is communication. As such, the POLST form is secondary to and supportive of the more important, ongoing process of advance care planning.[8]

Advance care planning also is good ethics. Such planning moves beyond both physician paternalism and a simplistic notion of patient autonomy. Both health care professional and patient have a role to play in the process; both speak and both listen. Thus the philosophy behind advance care planning echoes the *Ethical and Religious Directives for Catholic Health Care Services* which state that “neither the health care professional nor the patient acts independently of the other; both participate in the healing process.”[9]

There are valid arguments to be made, both pro and con, regarding POLST. Appropriate education, monitoring and evaluation remain important. However, it is better advance care planning that will lead to more medically and ethically appropriate end-of-life care.

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NOTES

1. Different states use different nomenclature to refer to this document. Though most use the acronym POLST (Physician Order for Life-Sustaining Treatment), some states have used the following terms: MOLST (Medical Order for Life-Sustaining Treatment), POST (Physician Order for Scope of Treatment), MOST (Medical Order for Scope of Treatment), COLST (Clinical Orders for Life-Sustaining Treatment), SMOST (Summary of Medical Order for Scope of Treatment), TPOPP (Transportable Physician Order for Patient Preference) or SAPO (State Authorized Portable Order). When the term POLST is used in this article, it can refer to any of the above.
2. See, for example, Christian Brugger, et al., “The POLST Paradigm and Form: Facts and Analysis,” *The Linacre Quarterly* 80, no. 2 (May 2013): 103-138. http://cathmed.org/assets/files/LNQ59%20FINAL.pdf. See also, “Upholding the Dignity of Life: A Pastoral Statement on Physician Orders for Life-Sustaining Treatment (POLST) from the Catholic Bishops of Wisconsin.” www.wisconsincatholic.org/WCC%20Upholding%20Dignity%20POLST%20Statement%20FINAL%207-23.pdf.
3. See, for example, “The Final Journey: Information from the Catholic Bishops of Louisiana on End-of-Life Decisions,” http://lhcqf.org/page-flip/The-Final-Journey/. See also, Thomas Nairn, “The Catholic Medical Association’s White Paper, ‘The POLST Paradigm and Form: Facts and Analysis,’” *Health Care Ethics USA* 21, no. 3 (Summer 2013): 17-36.
4. Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (New York: Simon and Schuster, 1993), 43.
5. Joanne Lynn and David M. Adamson, *Living Well at the End of Life: Adapting Health Care to Serious Chronic Illness in Old Age*, (Santa Monica, Calif.: RAND Health, 2003): 9.
6. See Charles P. Sabatino, “The Evolution of Health Care Advance Planning Law and Policy,” *The Milbank Quarterly* 88, no. 2 (2010): 229. See also, Charles P. Sabatino and Naomi Karp, “Improving Advanced Illness Care: The Evolution of State POLST Programs.” *AARP Public Policy Institute Report* (2011): 3-4.
7. Thomas J. Smith and Joann N. Bodurtha, “The ‘Good Planning Panel,’” *The Hastings Center Report* 43, no. 4 (July-August 2013): 31.
8. Sabatino and Karp, 2.
9. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition (Washington, D.C.: USCCB, 2009), Introduction to Part Three.

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