

ETHICS & MEDICS

A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

POLST AND CATHOLIC HEALTH CARE

A new type of advance directive known as POLST (physician orders for life-sustaining treatment) is generating increasing concern in Catholic health care.¹ The one-page document is meant to convey patient preferences for life-sustaining treatments at the end of life. This essay sets forth several serious problems with the documents and recommends that Catholic health care institutions either refuse to accept them or, if the forms are already in use, revise POLST forms and policies to bring them in line with Catholic moral teaching.

The brightly colored POLST document consolidates on a single form patient care directives that were formerly dispersed over several forms and legal instruments. A POLST document includes a DNR order (“do not resuscitate”), an AND order (“allow natural death,” that is, refuse all treatments except comfort care), an order to withhold assisted nutrition and hydration, and, in some cases, a separate order to refuse all antibiotics. Each of the orders is executed simply by checking a box, similar to the process of filling out a “living will.”

The document’s most significant innovation is the signature of a physician (or a nurse practitioner or a physician’s assistant), making the POLST form an actionable medical order. This means that rather than stipulating a person’s preferences for treatment at some theoretical future point (as is the case with living wills), POLST restrictions apply the instant the order is signed, regardless of the patient’s condition or possible future medical condition (positive or negative). This distinction between living wills and POLST may very well be lost on patients who are familiar only with standard procedures for advance directives as opposed to doctor’s orders.

The POLST model was conceived in the early 1990s by medical ethics specialists associated with the Center for Ethics in Health Care at Oregon Health and Science University (OHSU).² The documents were first put into use in Oregon in 1995. Eleven states now actively endorse the POLST model, and another eighteen are in the process of developing POLST-model programs.³

Seven Ethical Problems with POLST

We are concerned about seven ethical problems that arise with POLST orders: (1) they may be implemented when the patient is not terminally ill, (2) no patient signa-

ture is required for their implementation, (3) no signature is required of a physician attending the patient when the orders are implemented, (4) the orders travel with patients from one health care facility to another, (5) the orders are effective immediately, (6) they are implemented by non-physician “facilitators,” and (7) they utilize a simplistic check-box format for directing complex decision making.

1. *May Be Implemented without Terminal Illness.* State laws authorizing the use of standard living wills go back to the 1980s. These laws exempt health care workers from liability under federal homicide laws when the workers are acting upon a validly expressed request to withhold or withdraw life-sustaining treatment from a patient who, in the judgment of one or two physicians, is suffering from a “terminal condition” or in a state of permanent unconsciousness. To our knowledge, all new state laws authorizing the use of POLST annul the requirement that a patient must be terminally ill before he or she may direct the withholding or withdrawal of life-sustaining treatments. In other words—and this is critically important for Catholic institutions—the laws that sanction the use of POLST authorize any adult patient to refuse any treatment at any time for any reason, whether or not the treatment is associated with end-of-life conditions. This is ethically problematic for several reasons.⁴ We will mention three.

First, the *Declaration on Euthanasia*, published May 5, 1980, by the Congregation for the Doctrine of the Faith, explains the criteria for the rightful refusal of medical treatments. The treatment is “extraordinary” (or “disproportionate”) and therefore not obligatory if the patient judges it to be either futile or excessively burdensome. The Congregation states that a correct judgment as to whether some proposed treatment is extraordinary requires “studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.”⁵ So making a morally good decision for the refusal of medical care requires a careful and detailed inquiry into particular facts related to the specific treatment options of a specific

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ARE THE TWO COMPATIBLE?*

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patient. The POLST model's one-size-fits-all approach to medical orders excludes this necessary process of inquiry.

Second, POLST sets up a conflict with Catholic teaching, clarified in 2004 by Pope John Paul II, that the administration of nutrition and hydration even by artificial means "should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality."⁶ This teaching was reaffirmed in 2007 by the Congregation for the Doctrine of the Faith⁷ and incorporated by the United States Catholic Conference of Bishops into the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)* in 2009.⁸

Because the POLST functions as an actionable medical order, directives to withhold assisted nutrition and hydration, as well as other orders to withhold morally "proportionate care," will legally bind Catholic health care agencies. The ERDs state that a Catholic institution "will not honor an advance directive that is contrary to Catholic teaching."⁹ Yet if Catholic institutions accept POLST orders and then refuse to carry them out, they will set themselves up for litigation.

Third, Catholic moral teaching condemns both suicide and euthanasia (so-called mercy killing). POLST documents permit any patient, whether terminally ill or not, to refuse all life-sustaining care, including routine antibiotics and even food and water; refusals can be made for any reason, including for the purpose (i.e., with the intention) of causing one's own death. Inevitably, the use of POLST documents will involve Catholic health care workers at times in facilitating euthanasia through the wrongful removal of life support.

2. *May Not Require Patient's Signature.* On the POLST forms used in Wisconsin, Oregon, and Montana, a doctor's signature is mandatory, but the signature of the patient (or surrogate) is merely *optional*, though recommended. Physicians in La Crosse, Wisconsin, have informed the authors of this essay that after several years of working with POLST forms, they have seen hundreds of completed documents with no patient (or surrogate) signatures. This lack of fully informed consent is ethically irresponsible and could be medically negligent.

3. *Do Not Require Signature of Attending Physician.* State DNR laws typically include requirements to protect patients: only the attending physician can write the order, and he or she must counsel the patient on the ramifications of DNR and document in the chart the medical condition that qualifies the patient for DNR. In contrast, many state POLST documents may be validly signed by *any* doctor, nurse practitioner, or physician assistant.

4. *Travel with Patients.* POLST forms travel with patients whenever they are transferred or discharged. Advocates consider this a strength of the POLST, since they believe it ensures continuity of care across institutions in accord with a patient's wishes. But if the documents are not regularly revised and updated in accord with changing clinical situations and wishes of the patients, then they risk ordering inappropriate or outdated measures. The

documents also require caregivers in new settings to follow orders issued by clinicians at other institutions, separating the health care providers from the "ordering" physicians.

Additionally, POLST forms usually contain a statement at the top in bold to the effect of "FIRST follow these orders, THEN contact physician." This requires that health care workers follow the orders even when they do not know and have not heard of the ordering physician. For example, a member of an emergency medical team may apply the orders of a physician he has never met to a patient he has never met.

5. *Effective Immediately.* This is a departure from living wills, which apply only when both of the following conditions occur: (a) the patient is incapable of making decisions *and* (b) the patient develops a serious clinical problem (e.g., a terminal, incurable, irreversible condition). The immunities granted by POLST legislation guarantee protection for a health care provider and the health care system, given the fact that "good faith" actions under POLST are not subject to criminal, civil, or disciplinary proceedings.¹⁰ In essence, a health care provider could potentially ignore conflicting directives from family, other directives, or even the expressed present wishes of the patient and avoid any liability simply by stating he was acting in good faith by following the POLST form.

6. *"Facilitated" by Non-physicians.* According to the National POLST Paradigm Task Force, a critical step for state implementation of POLST is the training of *non-physician facilitators*, such as health care personnel, nurses, social workers, admissions coordinators, and nursing home administrators. Facilitators routinely initiate POLST discussions with patients or family members, counsel patients and record their preferences, and refer completed POLST documents to physicians for signature.¹¹

There are numerous problems with this. First, these front-line implementers are not physicians. They have no experience evaluating patients with complicated medical problems. They have no previous understanding of medical indications for and benefits of life-sustaining treatments. They have no knowledge to determine when interventions are appropriate and ordinary care and when they are extraordinary and elective. Instead, trained facilitators rely on information obtained from a two- or three-day training session by the Respecting Choices program based in La Crosse, Wisconsin.

Second, based on a review of their statements and training materials, we have found that this program for facilitators is heavily fear-based, is biased in favor of refusing life-sustaining treatments, and emphasizes all possible burdens of accepting treatment while minimizing burdens associated with refusal of treatment. One of its training scripts reads:

To assist you in making this decision, I'd like to give you some examples of the side effects that can occur because of receiving artificial nutrition and hydration. First, the artificial nutrition that is delivered through tubes often moves out the stomach and slips into the lungs, causing pneumonia. This is called *aspiration*. The

artificial hydration that is delivered may also increase the amount of fluid the body has to absorb, causing extra fluid in the lungs, making it more difficult to breathe. The extra fluid also causes congestion in other parts of the body, causing pain and discomfort as well as the need to urinate more frequently.¹²

Another example is found in the program's fact sheet on tube feeding: "You may have fears about not getting food or water. You may think you will starve or be uncomfortable. This is not true. When food and water are not given, you will die naturally from your chronic illness. You will not feel hungry, and you will receive good care to make you comfortable."¹³ Though this may be true in some cases, one could hardly suppose that it will be true for all patients in all conditions. Some patients may indeed experience the pain of dehydration and starvation.

Third, the delegation of critical end-of-life discussions to facilitators deprives patients of the expertise, prior knowledge, and protective care of their primary care physician. Also, unlike living wills, the conversations with and decisions of facilitators require no witnesses. Last, facilitators actively solicit the cooperation of residents of nursing homes where 45 to 62 percent of the patients suffer from dementia.¹⁴ Since non-physician facilitators cannot diagnose dementia, the elderly whose agreements they facilitate may not be giving properly informed consent. As one La Crosse physician put it, "The elderly are notorious for being conned."

7. *Based on a Simplistic Checklist.* POLST orders exacerbate already existing problems with living wills by utilizing the simplistic check-box format. The information necessary for making a good judgment about what types of health care to accept and deny is complex and relies on factors that cannot be foreseen in advance. The check-box format of the POLST (and of living wills) cannot possibly account for all the medical contingencies that may arise at some future time when a patient loses consciousness. Germain Grisez comments on the limitations of living wills: "Any such directive will be so vague in some respects as to leave the judgment to care givers, and so specific in other respects as to allow many things a reasonable person might well refuse while perhaps excluding some things such a person would accept in certain circumstances."¹⁵

Discussion

Clearly there are unique, identifiable problems with the basic concept and implementation of the POLST model. From the perspective of good medical procedure, POLST, similar to a poorly written advance directive, is flawed because it disallows appropriate reflection based on actual events—that is, "in-the-moment medical decision making"¹⁶—and so binds the hands of doctors even when they have grounds for questioning its utility. Given this reality, the basis for advocacy of these documents should be seriously questioned.

POLST model promoters rely upon an exaggerated sense of patient "autonomy" much like that advanced by right-to-die advocates. Is it a mere coincidence that the POLST model is actively promoted by Compassion and

Choices, formerly the Hemlock Society?¹⁷ Is it a coincidence that the Center for Ethics in Health Care at OHSU is also the publisher of *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals*?¹⁸

Certainly these alone are not sufficient reasons to oppose implementation of the POLST paradigm. But when taken together with the aforementioned reasons, we believe a convincing argument is made that POLST forms and their model for implementation pose unacceptable risks to the well-being of patients and the ethical values of Catholic health care.

The national push for the implementation of the POLST paradigm seems also to be fiscally driven. Life support is costly. Increasing refusal orders for life-sustaining treatment saves medical expenses. Where the POLST model has been implemented, orders limiting life-sustaining treatments have significantly increased. For example, the implementation of POLST orders in La Crosse, Wisconsin,¹⁹ has earned La Crosse the dubious moniker of "Cheapest Place to Die" from *Good Morning America*.²⁰ In a critical commentary on POLST, The National Catholic Bioethics Center has expressed concerns that, under the Obama health care plan, Medicare and Medicaid benefits might become contingent on completion of POLST documents.²¹

The POLST paradigm is being rapidly implemented across the nation. Oregon has developed a statewide online POLST registry that emergency medical staff may access on the scene of a medical emergency.²² Some institutions recognize *only* POLST documents and ignore patients' wishes as expressed on other advance directives or by their legally designated proxy decision makers.²³

Given the risks that POLST documents pose to good in-the-moment medical decision making, good *moral* judgments in end-of-life care, and informed consent, we urge Catholic health care institutions to refuse to accept POLST forms. If already in use, the forms should be revised to make their use fully consistent with good health care practice and the full dignity of the human person. Whether such revisions can be accomplished seems doubtful. Indeed, the time has come for renewed reflection and articulation of how individuals may prepare and execute end-of-life directives that respect the dignity of human life and conform to Catholic moral teaching.

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Views expressed are those of individual authors and may advance positions that have not yet been doctrinally settled. *Ethics & Medics* makes every effort to publish articles consonant with the magisterial teachings of the Catholic Church.

- ¹In some states they are called MOLST (medical orders for life-sustaining treatment) or MOST (medical orders for scope of treatment). POLST, MOLST, and MOST documents are essentially the same.
- ²For a brief history of the POLST model, see POLST Paradigm, "History of the POLST Paradigm Initiative," www.ohsu.edu/polst/developing/history.htm.
- ³POLST Paradigm, "POLST State Programs," <http://www.ohsu.edu/polst/programs/state+programs.htm>.
- ⁴E. Christian Brugger, "A Critique of the National POLST Paradigm through an Analysis of Colorado's New MOST Legislation," *Linacre Quarterly* 78.2 (May 2011): 158–161.
- ⁵Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980), part IV. These norms are repeated in U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), nn. 56 and 57.
- ⁶John Paul II, Address to participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), original emphasis.
- ⁷Congregation for the Doctrine of the Faith, Responses to Certain Questions of the USCCB concerning Artificial Nutrition and Hydration (August 1, 2007), reprinted in *Ethics & Medics* 32.11 (November 2007): 1.
- ⁸USCCB, *Ethical and Religious Directives*, n. 58.
- ⁹*Ibid.*, n. 24.
- ¹⁰See, for example, Oregon State statute § 127.681 and New York State statute § 2994-gg.
- ¹¹National Program Office for Community-State Partnerships to Improve End-of-Life Care, "Focus: Oregon's POLST Program—Implementing End-of-Life Treatment Preferences Across Clinical Settings," *State Initiatives in End-of-Life Care* : 3 (April 1999), 3; available at www.practicalbioethics.org/FileUploads/SI_3.pdf; see also POLST Paradigm, "Approach to Implementation of a POLST Paradigm Program, n. 6," www.ohsu.edu/polst/developing/implementation-steps.htm.
- ¹²Respecting Choices, "Advance Care Planning: Facilitating the Process," in *Advance Care Planning: Facilitator's Manual*, 3rd ed. (La Crosse, WI: Gundersen Lutheran Medical Foundation, 2007), chapter 4.12, original emphasis.
- ¹³Respecting Choices, "Tube Feeding: What You Should Know," fact sheet, 2011.
- ¹⁴Fiona E. Matthews and Tom Denning, "Prevalence of Dementia in Institutional Care," *Lancet* 360.9328 (July 20, 2002): 225–226; J. Magaziner et al, "The Prevalence of Dementia in a Statewide Sample of New Nursing Home Admissions Aged 65 and Older: Diagnosis by Expert Panel," *Gerontologist* 40.6 (December 1, 2000): 663–672.
- ¹⁵Germain Grisez, *Difficult Moral Questions*, vol. 3, *The Way of the Lord Jesus* (Chicago: Franciscan Press, 1997), 208.
- ¹⁶Rebecca L. Sudore and Terri R. Fried, "Redefining the 'Planning' in Advance Care Planning: Preparing for End-of-Life Decision Making," *Annals of Internal Medicine* 153.4 (August 17, 2010): 256–262.
- ¹⁷See Compassion and Choices of Oregon Web site, <http://www.compassionoforegon.org/services/polst/>.
- ¹⁸Task Force to Improve the Care of Terminally-Ill Oregonians, *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals*, 1998, published online at <http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf>.
- ¹⁹Respecting Choices, "Multi-faceted Approaches to Advance Care Planning," news release, 2011, http://respectingchoices.org/news_upcoming_events/in_the_news/multi-faceted_approaches_to_advance_care_planning.
- ²⁰Kate Snow and Elizabeth Tribolet, "End-of-Life Lessons from the Cheapest Place to Die," *Good Morning America*, August 10, 2009, <http://abcnews.go.com/GMA/story?id=8250195&page=1>.
- ²¹Marie T. Hilliard, "The National Catholic Bioethics Center Responds to New Medicare Regulations Funding End-of-Life Care Discussions," December 29, 2010, <http://www.ncbcenter.org/page.aspx?pid=482&storyid1277=129&nsc1277=3>.
- ²²Oregon POLST Registry, <http://www.ohsu.edu/polst/programs/OregonPOLSTRegistry.htm>.
- ²³"Physician's Order Deemed Appropriate for Clarifying Patient Wishes," *Catholic Health World* 27.13 (August 1, 2011), <http://www.chausa.org/Content/wocolumn.aspx?pageid=4294969209>.

