

POLST

POLST (“Physician Orders for Life-Sustaining Treatment”) began in Oregon in 1995 in response to 1) seriously ill patients receiving treatments that were *not* consistent with their wishes; 2) problems that arose when a patient was transferred from one care setting to another, and; 3) the reality that so many seriously ill people lack advance directives. POLST addresses these challenges by converting an individual’s treatment preferences into a physician’s order.

Approximately 10 states have adopted POLST and a good number more are considering its adoption. In a few states, there has been some rather strong opposition to POLST from some segments of the community. Two recent articles in *Ethics and Medics* capture well some of the major concerns with POLST as well as a response to them (Lisa Black, “The Danger of POLST Orders: An Innovation on the DNR,” *Ethics and Medics* 35, no. 6 [June 2010]:1-2; Rev. John Tuohey, “POLST Orders Are Not Dangerous,” *Ethics and Medics* 35, no. 10 [October 2010]: 3-4) . The major concerns with POLST orders seem to be the following. POLST:

- Elevates patient autonomy to an enforceable, legal right and mandates absolute conformance to an individual’s choice;
 - Attacks the value of human life by allowing individuals to hasten their own deaths on the basis of their subjective, personal intentions;
 - Provides opportunities for patients and physicians to act in noncompliance with the ERDs and church teaching.
- While these concerns should prompt vigilance with regard to POLST orders, they do not carry the day and, in fact, may even be misleading. In contrast, here are a few considerations when thinking about POLST (some of these reflect or are influenced by John Tuohey’s article):
- POLST, as Father Tuohey points out, is a physician’s order *about* life-sustaining treatment and not an order to *forgo* life-sustaining treatment. POLST forms are not biased toward refusing or withdrawing treatment, but rather allow for a full range of options from receiving treatment to refusing treatments to receiving some and refusing others.
 - Drawing up a POLST form provides an opportunity to develop a care plan that is consistent with the patient’s wishes and takes account of the patient’s medical condition. With POLST there is a better chance of

- treatment appropriate to the patient's condition and in accordance with the patient's wishes.
- POLST provides protection for patients, especially for those outside the hospital, not to receive treatments that are inappropriate or that are contrary to their wishes. POLST forms are portable from one care setting to another.
 - Autonomy is not absolute. Decisions are made in conjunction with a medical professional and within the context of the patient's medical reality. Health professionals need not sign a POLST order with which they disagree or which are inconsistent with the ERDs.
 - Drawing up a POLST document is the result of conversations and not a unilateral decision of patients. While it reflects the patient's preferences, it is not entirely subjective. Furthermore, the Catholic tradition recognizes the right of the patient or the patient's surrogate to make treatment decisions (see the "Declaration on Euthanasia" and Part Three of the *Ethical and Religious Directives*)
 - A Catholic hospital need not comply with any request in a POLST order that is contrary to hospital policies or to the ERDs
- which would probably be quite rare. There are very few things at the end of life that are contrary to the ERDs and some of these are illegal.
- There is nothing in POLST (either in concept or practice) that is contrary to the ERDs or to the 500+ year Catholic tradition regarding end-of-life decisions. The tradition has long held that it is morally permissible to withhold or withdraw interventions that are deemed extraordinary or disproportionate based on an assessment of their benefits and burdens to a particular patient and his/her medical condition.
 - POLST can be a means of respecting human life and human dignity. Some seem to believe that the only way to respect human life is by prolonging it. This is not the Catholic tradition. There are times when respecting life and human dignity calls for no longer interfering with the dying process and subjecting the individual to medical interventions that are at best harmful.
- Might POLST orders be abused? Of course, like anything else. But it hardly seems plausible that the instances of abuse would be so great as to outweigh the great good that can be achieved for patients through their use. Furthermore, there is no evidence of abuse in those states where POLST has been employed. In fact, there

seems to be sufficient experience with POLST to feel confident that it can be a useful tool for patients and their clinicians (see Susan Hickman, et. al., “A Comparison of Methods to Communicate Treatment Preferences in Nursing

Facilities: Traditional Practices versus the Physician Orders for Life-Sustaining Treatment Program,” *Journal of the American Geriatrics Society* [2010]) without significant abuse. What seems critical to the success of POLST is adequate preparation of those clinicians who will be leading the process and signing the orders.

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