

Ethics of POLST

Archdiocese of San Francisco

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POLST – Physician (Provider) Orders for Life-Sustaining Treatment

Other names:

1. MOLST – Medical Orders for Life-Sustaining Treatment
2. MOST – Medical Orders for Scope of Treatment
3. POST – Physician Orders for Scope of Treatment
4. TPOPP – Transportable Physician Orders for Patient Preferences

What is POLST?

1. POLST is an actionable medical order signed by a qualified clinician that authorizes the medical treatment(s) a patient chooses to receive, or not receive, at the end of life.
2. POLST is a portable document that travels with the patient and applies across multiple health care settings, including hospitals and long-term care facilities.
3. Important: POLST is a medical order, it is not an advance directive document (power of attorney or living will). When healthcare providers (including EMTs) see the POLST form, they are expected to implement its instructions just as they would if ordered to do so by a qualified clinician.

Rationales for POLST (argued by POLST supporters)

1. The process:
 - a. POLST provides a means for patients to more easily communicate end-of-life (EOL) treatment preferences across care settings.
 - b. Conversations surrounding the POLST form—as well as the process of completing it—fosters shared EOL decision-making among (1) patient and proxy, (2) patient and clinician, and (3) patient and family members.
 - c. POLST standardizes and simplifies EOL documentation, there is one single form rather than multiple advance directive documents.
 - d. POLST offers more specific treatment options than do other advance directives
2. For the patient:
 - a. POLST promotes patient autonomy in EOL decision-making
 - b. POLST honors a patient's values, beliefs, wishes, and goals concerning EOL care
 - c. POLST seeks to minimize unwanted EOL treatments—and prevent overaggressive EOL care—when the patient does not want it
 - d. As a standing medical order, POLST integrates patient EOL wishes into the physician's orders. As such, it allows physicians to more easily understand and respect a patient's EOL treatment wishes.
 - e. Because POLST is portable, it provides consistency in the patient's EOL care across different health care settings.

NCBC's concerns with POLST

1. Some patients are given a POLST form at admission to a hospital or skilled care facility and are asked to complete it without being provided any information or direction. These patients may feel pressured to complete the POLST as a condition for admission or treatment.
2. Medical decisions are moral decisions. The checkbox format of the standard POLST form may undermine critical evaluation of the moral principles involved in a patient's health care situation and it may short-circuit complex decision-making.
3. A major concern with the standard POLST form is that it can be completed by a "trained facilitator" instead of a clinician. While it may be appropriate for a facilitator to conduct initial advance-care-planning *conversations*, these individuals should not be directly involved in making treatment *decisions*. The NCBC believes that such involvement encroaches on—and could interfere with—the traditional physician–patient relationship. The clinician, who could be a physician, physician assistant, or advance practice registered nurse, has the medical knowledge to understand and order treatment options that are in the patient's best interests. As such, the NCBC insists that a clinician, not a facilitator, discusses the various treatment options with the patient and surrogate, aids the patient in making appropriate treatment decisions, completes the POLST form to accurately document these decisions, and signs it.
4. Standard POLSTs state there should be a periodic review of the form, but many do not specify how often this should occur. The NCBC recommends that the form be reviewed, at minimum, every six months. The review helps to ensure that the POLST addresses any changes in the patient's medical condition and/or treatment preferences.
5. As a medical order, the POLST may compel clinicians and institutions to provide (or not-provide) medical interventions that violate the clinician's conscience or that in the clinician's medical judgment are contrary to the patient's best interests. It may also compel institutions to violate their policies and/or medical guidelines, in particular the *Ethical and Religious Directives*. POLST forms and legislation must incorporate clear and robust conscience protections for both health care professionals and institutions.
 - "not interfere with a transfer" vs. "facilitate a transfer"
6. Catholic teaching maintains that an individual has a moral obligation to accept treatments deemed ordinary but may forgo those deemed extraordinary (see "NCBC sample POLST" Section B). The standard POLST form does not address, let alone adequately distinguish between, ordinary and extraordinary means. It assumes that all medical interventions are morally neutral.
7. Catholic teaching maintains that, in principle, nutrition and hydration even by medically assisted means (feeding tube) is morally obligatory (ERDs, n. 58). Standard POLST forms allow patients to categorically refuse nutrition and hydration, a direct violation of Church teaching.
8. POLST may undermine informed consent. Directives 26 and 27 of the ERDs state that informed consent is an essential aspect of health care decision making. To properly consent to or refuse a medical intervention, one must have full knowledge about the nature of the intervention and its benefits, risks, side-effects, consequences, costs, and alternatives. As such, medical decisions—which are moral decisions—generally should be

made “in the moment,” that is, at the actual time the intervention needs to be implemented and when the patient or surrogate has full knowledge of all relevant medical facts and can consult with the attending physicians. In contrast, the standard POLST form allows patients and surrogates to make treatment decisions about a future medical condition for which they may not have sufficient knowledge or have not adequately consulted with their physician(s). Stated differently, the future-looking POLST offers no guarantee that a patient’s consent to treatment (or non-treatment) will be informed by the concrete circumstances of his or her medical condition *at the time the treatment needs to be implemented*. In fact, a completed POLST may “lock in” treatment decisions that are medically inappropriate.

9. POLST may override a surrogate’s decision-making authority. Patients have the legal and moral right to designate a surrogate (or proxy) decision-maker to make medical decisions on their behalf in the event they lose decision-making capacity (ERDs nos. 24 & 25). This designation is normally accomplished by completing a Power of Attorney for Health Care (POA-HC) form. However, POLST does not require that health care providers consult with the surrogate, family members, or loved ones before implementing its orders. In addition, depending on local laws and circumstances, the POLST may take precedence over the POA-HC. This creates a situation where a pre-signed POLST can override, even negate, a surrogate’s decision-making authority. The NCBC maintains that the well-informed surrogate who knows the patient and his/her values, understands the patient’s present medical condition, and respects both the natural law and Church teaching can far better determine how a patient’s wishes should be respected than can a general checklist that is not tied to any specific patient care situation.

NCBC Guidelines for Completing POLST, from “A Catholic Guide to POLST”

If you are thinking about completing a standard POLST form or have been asked by a health care provider to complete one, please keep the following guidelines in mind:

1. The POLST form is appropriate only for and should be completed only by patients who have been diagnosed with a terminal illness, defined as when death is anticipated within six months.
2. Completing a POLST form is OPTIONAL. Patients or surrogates are under no obligation to complete the form, and health care providers cannot compel a patient or surrogate to complete a POLST as a condition for receiving treatment.
3. Physicians are under *no obligation* to complete a POLST for their patients, and no physician can be forced to sign a patient’s POLST contrary to his or her medical judgment or rightly formed conscience.
4. The POLST form is not an advance directive. If a POLST is completed, both the patient and the surrogate should ensure that the treatment decisions indicated on the POLST are consistent with those indicated on the patient’s advance directives (Power of Attorney for Health Care or Living Will) if they exist. *The legally designated surrogate should have final decision-making authority over the patient’s care, regardless of whether a POLST has been completed.*

5. Patients and surrogates can use the POLST form to indicate that the most comprehensive treatment shall be provided or that all indicated forms of life support shall be used to conserve life.
6. A patient or surrogate must sign the POLST form for it to be valid. This signature affirms that what is indicated on the form accurately communicates the patient's treatment preferences.
7. If a POLST is completed, it should be reviewed, at minimum, every six months. This review helps ensure that that the form addresses any changes in the patient's medical condition and/or treatment wishes.
8. Patients and surrogates can alter or revoke a POLST at any time to meet changing medical conditions and treatment preferences.

NCBC Resources on POLST

1. "Guide to POLST," *Catholic Health Care Ethics: A Manual for Practitioners*, 3rd edition (Philadelphia, PA: The National Catholic Bioethics Center, 2020), 24.11–24.19.
2. "A Catholic Guide to POLST" – NCBC Store