The National Catholic Bioethics Center

Provider Orders for Life-Sustaining Treatment (POLST)

Prepared by the Ethicists of the NCBC
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"In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored. … While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community."
— USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed., nn. 24 and 32.

❖ Summary ❖

- A POLST is a medical order that specifies whether life-sustaining treatment is to be used or withheld for a specific patient in various circumstances. It carries the signatures of the health care provider and sometimes the patient. It differs from a do-not-resuscitate order and a traditional advance directive in that it is actionable from the moment it is signed by the health care provider, even if the patient is still competent and is not terminally ill.
- One reason given for use of the POLST and similar instruments is the avoidance of futile or unwanted treatment. Even without POLST, however, patients are never obligated to submit to health care procedures whose burdens outweigh therapeutic benefits.
- Decisions about forgoing life-sustaining treatment should be made at the time and in the circumstances in which the decisions are needed (not years ahead), and they should be made by the patient or the patient's surrogate in consultation with the patient's attending physician, in line with the patient's known wishes and best interest (not by health care workers who are strangers to the patient but have access to his POLST).
- The details of a patient's medical condition at a specific time need to be considered when such decisions are made, including the imminence of anticipated death, the likely risks and side effects of treatment, the suffering treatment is likely to cause, and the expense to the patient's family and community.
- An optimal advance directive is written in very general terms. Instead of specifying treatment, it designates a health care proxy or surrogate who will make decisions if the patient is incompetent, someone who knows the will of the patient and the teachings of the Catholic Church.

Problems Inherent in the POLST

- A POLST can be used to deny ordinary care and beneficial treatment for patients who are chronically but not terminally ill, are elderly and frail, or are in a persistent vegetative state. These patients, who might otherwise be expected to live for years, may be denied antibiotics or assisted nutrition and hydration in violation of ERDs 32, 56, 57, and 58.
- A number of POLST forms do not require a patient signature for implementation. Thus, nothing other than the notes of the facilitator or the originating physician show that the POLST is consistent with the will of the patient.
- A number of forms do not require the signature of the health care provider who is attending the patient when the orders are implemented. Thus, regardless of the provider's opinion about appropriate care, he or she may be bound to follow a POLST that was signed by another provider.

- The orders travel with patients from one health care facility to another. Thus, the agency treating the patient may be bound to follow a POLST drawn up under different circumstances, regardless of the patient's current health status.
- Orders are effective immediately, even if the patient remains competent and is not experiencing an end-stage disease; if the patient is incompetent and the family requests treatment with a proportionate benefit, the wishes of the family may be ignored.
- Orders can be developed with the patient by "facilitators" who are not licensed health care providers. Thus, necessary conversations between physician and patient about crucial medical decisions may not occur.
- POLST orders utilize a simplistic check-box format for directing complex decision making. Thus, persons may be refusing proportionately beneficial antibiotics, assisted nutrition and hydration, and other forms of health care long before their proportionate benefit can be ascertained.

❖ FAQ ❖

Question 1. What is the difference between an advance directive and a POLST?

Reply: An advance directive is a legal document that allows a person to identify a proxy or surrogate decision maker and express his wishes about receiving or forgoing health care, including life-sustaining treatment, in the event that he is no longer able to communicate such wishes. An optimal advance directive is written in general terms that identify principles on which a surrogate is to base decisions, made with the assistance of a physician, in the specific health care situation encountered by the patient.

A POLST is a medical order about receiving or forgoing life-sustaining treatment that takes effect from the moment the health care provider signs it, even if the patient is competent and not terminally ill.

Question 2. Why is the designation of a health care proxy or surrogate morally preferable to use of a POLST?

Reply: Unless death is imminent, it is virtually impossible to compare the benefits and burdens of treatment before a patient has encountered a specific health care situation. Thus, pre-signed checklists of treatments to be received or withheld are not helpful for making decisions based on the best interest of the patient and consistent with the patient's wishes. A well-informed proxy who knows the patient, understands the values held by the patient, and respects the natural moral law can provide a far better understanding of how the patient's wishes are to be respected than can a general checklist that is not tied to any specific patient care situation.

Question 3. Can a POLST form be modified to be consistent with ERDs 24 and 32?

Reply: Some forms allow a person to indicate the conditions under which specific treatments are to be administered or withheld. But the significant problem with such an approach is the inability to identify ahead of time every treatment that might be available and every circumstance in which it might be received or forgone. The problem inherent in the orders is that they are actionable from the moment they are signed; they are not a blueprint for health care decision making in which the patient (when competent), the family, and the health care providers work together to determine the best medical course of action in the real-life situation encountered by the patient.

Question 4. Is there a clinical situation in which a POLST could be helpful in directing health care decisions?

Reply: When a person is terminally ill and death is anticipated from the underlying disease, and not from the withholding of life-sustaining treatment, it could be helpful to have actionable orders to prevent the initiation of futile or disproportionately burdensome treatment.

❖ Resources ❖

Lisa Gasbarre Black, "The Danger of POLST Orders: An Innovation on the DNR," *Ethics & Medics* 35.6 (June 2010): 1–2. Reproduced by permission.

E. Christian Brugger et al., "POLST and Catholic Health Care: Are the Two Compatible?," *Ethics & Medics* 37.1 (January 2012): 1–4. Reproduced by permission.

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