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

NCBC GUIDE TO COMPLETING THE POLST FORM

NCBC Ethicists

POLST (Physician Orders for Life-Sustaining Treatment) is an actionable medical order signed by a qualified clinician that authorizes medical treatments that a patient chooses to receive or not receive at the end of life. POLST is a portable document that travels with the patient and applies across multiple health care settings, including hospitals and long-term care facilities. When health care providers see the POLST form, they are expected to implement its instructions just as they would if ordered to do so by a qualified clinician. There are other documents that, despite having different names, serve the same function. These include MOLST (Medical Orders for Life-Sustaining Treatment) and POST (Physician Orders for Scope of Treatment).

Why an NCBC Guide to POLST?

POLST forms are becoming more widely used, and in some states they are the primary means by which patients communicate end-of-life treatment choices. The National Catholic Bioethics Center (NCBC) offers this *Guide to POLST* because, as explained below, we have numerous concerns with both the POLST paradigm and many of the state-approved POLST forms currently in use.[1] To address these concerns, we have devised this guide to help patients make end-of-life treatment decisions that are consistent with the Catholic health care tradition as expressed through the *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*). It is important to note that the NCBC's decision to issue this guide should not be viewed as an endorsement of the POLST movement. Instead, we recognize that the increasing influence of POLST has created the need for educational materials that will help patients document end-of-life treatment choices in ways that are consistent with Catholic moral teaching.

Concerns with POLST

The POLST paradigm has gained significant support because it encourages advance-care planning and fosters shared decision making among patients, their health care providers, and their loved ones with regard to end-of-life care. While POLST can be used for these good ends, there are serious concerns with it as well.

Who Should Complete a POLST?

The National POLST Paradigm Task Force states that POLST is appropriate for patients "with serious illness or frailty, whose health care professional would not be surprised if they died within one year."[2] This language raises a red flag. "Serious illness" and "frailty" are never defined on a standard POLST form, and practically no guidance is offered on how to apply these terms in a clinical setting—other than to say that the clinician "would not be surprised" if the patient died within the next year. This ambiguous language may lead to confusion and possibly even abuse. In light of this, the NCBC advises that its POLST form is appropriate only for patients who have been diagnosed with a terminal illness, defined as when death is anticipated within six months.

Facilitator versus Clinician

Another 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 trained facilitator to conduct initial advance-care-planning *conversations*, these individuals should not be directly involved in making treatment *decisions*. We believe that such involvement encroaches on—and could interfere with—the traditional physician–patient relationship. For this reason, we do not include a space on the NCBC POLST for a facilitator signature.

The clinician, who could be a physician, physician assistant, or certified registered nurse practitioner, has the medical knowledge to understand and order treatment options that are in the patient's best interests. For this reason, 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.

Mandatory Review

Standard POLST forms state that there should be a periodic review of the form, but many do not specify how often this should occur. The NCBC POLST recommends that the form be reviewed, at minimum, every six months. This review helps to ensure that the POLST addresses any changes in the patient's medical condition and treatment wishes. Boxes are provided to record the date of the most recent review as well as the signature of the qualified

clinician. If a patient is transferred to another facility, experiences a significant change in health, or updates treatment preferences, a new POLST should be completed.

Informed Decision Making

The final and most important concern with the standard POLST form is that it can undermine informed decision making. The standard POLST allows patients to make treatment decisions regarding a future medical condition about which they may not have sufficient knowledge. Stated differently, the future-looking POLST offers no guarantee that a patient's consent to treatment or nontreatment will be informed by the concrete circumstances of his or her medical condition *at the actual time the treatment needs to be implemented*. The completed POLST may thus "lock in" treatment decisions that are medically inappropriate. For example, a patient may decide to refuse antibiotics even though they are easily supplied and in a future illness would be clearly beneficial.

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 treatment, one must have full knowledge about the nature of the treatment and its benefits, risks, side effects, consequences, costs, and alternatives. For this reason, medical decisions—which are moral decisions—generally should be made "in the moment," that is, at the actual time the treatment needs to be implemented and when the patient or surrogate has full knowledge of all relevant medical facts.

In sum, the POLST paradigm and form represent one response to the challenge of treating patients in accord with their wishes at the end of life. To bring clarity and certainty to a range of decisions that patients often do not consider in advance, the POLST form was designed to be simple, clear, and authoritative. Unfortunately, as we have demonstrated, these qualities can create problems of their own. If patients are going to use POLST to document their end-of-life treatment choices, great care must be taken in both the form's completion and its implementation.

POLST and Advance Directives

POLST is different from and should not be confused with other more familiar advance-directive documents such as the living will and the health care proxy. (The NCBC has published a separate *Catholic Guide to End-of-Life Decisions* that more fully explains both documents; it is available on the NCBC website.)

The living will is a legal document that patients use to indicate their treatment preferences should they become incapacitated and unable to direct their own care. If there is a medical crisis, family members and health care providers review the document to see what the patient directs should be done or not done. This is not a medical order, so if the indicated treatment preferences are contrary to the patient's overall well-being or if they violate Church teaching, they will not be followed (see directive 24 of the *ERDs*). This may not be true of POLST. POLST is a medical order, so even if it commands actions that are inappropriate or harmful to the patient, there is an expectation that it will be followed.

The health care proxy, or durable power of attorney for health care, is a legal document that patients use to designate another person to make medical decisions on their behalf and in their best interests in the event that they lose decision-making capacity. This designated person is called a surrogate or proxy. When this document is in force, health care providers will consult with the surrogate about the best course of action based on information relayed to the surrogate by the patient. The POLST form, in contrast, does not require that health care providers consult with the surrogate, family members, or loved ones before implementing the order.

In accord with directive 25 of the *ERDs*, the NCBC advises its clients that, in situations where patients are not able to direct their own care, a family member or loved one is in the best position to make effective ethical decisions on their behalf. As such, Catholics are best advised to choose a surrogate who can be trusted to follow Catholic teaching in making end-of-life treatment decisions. This POLST guide does not alter that advice. The NCBC recommends that every adult should legally designate a health care proxy in accord with his or her state laws for establishing a surrogate decision maker. To be clear, the surrogate is *not* designated through the POLST form, but through a state-recognized health care proxy or a similar document such as the durable power of attorney for health care. The NCBC also recommends that the designated surrogate be granted final decision-making authority over the patient's care, regardless of whether a POLST has been completed.

Finally, it is important to note that the POLST form complements but does not replace the patient's advance directives. POLST should be viewed as the instrument that "activates" the treatment preferences the patient has indicated through the health care proxy or living will. If a POLST is completed, the patient should thus make certain that the surrogate has a copy of the form. In addition, both the patient and the surrogate must ensure that the treatment decisions indicated on the POLST form are consistent with those indicated on the health care proxy or living will, if one exists.

Guidelines for the Standard POLST Form

If you are thinking about completing a standard POLST form or have been asked by a heath 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. 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.

4. Physicians are under *no obligation* to complete a POLST form 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.
5. Patients and surrogates can use a 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. Patients and surrogates can alter or revoke a POLST form at any time to meet changing medical conditions and treatment preferences.

The NCBC Sample POLST Form

To address the concerns that we identified above, the NCBC has drafted a sample POLST form grounded in the Catholic health care tradition. This document differs from and improves upon standard POLST forms. The NCBC's sample POLST was drafted to be used by organizations and indivudals who are dealing with the many challenges posed by standard POLST forms, including but not limited to those who are engaged in legislative efforts and those who desire an advance-care-planning tool that is in accord with Catholic moral teaching. The NCBC's sample form is available by emailing info@ncbcenter.org.

Section A: Cardiopulmonary Resuscitation (CPR)

This section is similar to that of the standard POLST form, and it applies *only* in situations where the patient is unresponsive, has no pulse, and is not breathing.

If one checks the box "CPR/Attempt Resuscitation," medical personnel will attempt to restart the heart following a cardiac arrest (heart stoppage) and reestablish pulmonary function (breathing). Methods include airway management, chest compressions, and cardioversion. If one checks the box "DNR/Do Not Attempt Resuscitation," medical personnel will not attempt to do so, but rather will allow natural death to occur. Catholic teaching permits a patient to have a DNR (do-not-resuscitate) order when it is appropriately geared toward his or her medical condition. For example, patients who are in very ill health or who are very aged often will not benefit from resuscitation efforts. In fact, CPR can cause them grave injury. In these cases, CPR may be declined on the grounds that it constitutes an extraordinary means of treatment.

It is important for the patient and surrogate to know that if any section of the POLST form is not completed, the patient will receive the most comprehensive treatment for that section. For example, if section A is left blank, medical personnel will provide the patient with full CPR and resuscitation efforts.

Section B: Medical Interventions

This section of the NCBC sample POLST form looks similar to that of the standard POLST, but its focus is somewhat different. Section B addresses situations where a patient does not need CPR but experiences a medical emergency and is unable communicate his or her health care wishes. This section presents three general directions for care.

Comfort measures are designed to keep patients as comfortable as possible (see directive 61 of the *ERDs*). These measures include routine prescriptions and medications to control pain and other symptoms. Generally speaking, if the "Comfort Measures" box is checked, the patient will not be transported to the hospital.

The option to specify limited additional interventions allows patients to distinguish between ordinary and extraordinary means of care. The *ERDs* define ordinary means of care as any treatment that, in the patient's or surrogate's judgment, offers a reasonable hope of benefit and does not entail excessive burden. *Ordinary means of care are morally obligatory* (see directive 56 of the *ERDs*). Examples include the standard treatments for a medical condition, intravenous fluids to provide nutrition and hydration, and the monitoring of heartbeat and respiration. An extraordinary means of care is any treatment that, in the patient's or surrogate's judgment, does not offer reasonable hope of benefit or imposes an excessive burden. *Extraordinary means of care are not morally obligatory* (see directives 32 and 57 of the *ERDs*).Examples include treatments that have harmful side effects, are highly invasive, or entail significant discomfort or excessive cost. It is important to note that the determination of burden refers to the use of a particular medical intervention, not to the perceived quality of the patient's continued life.

It is also important to note that the determination of whether a particular treatment is ordinary or extraordinary is made by the patient or surrogate in consultation with the health care provider, not by the health care provider alone. The NCBC POLST form includes space for patients to include treatment instructions based on their specific medical conditions. Generally speaking, a patient who checks the "Limited Additional Interventions" box will be transported to the hospital.

Full treatment authorizes the use of any and all available treatments to preserve life. Patients who check the "Full Treatment" box will be transported to the hospital.

Regardless of the medical intervention chosen, comfort measures must *always* be provided. If section B is left blank, the patient will receive full treatment.

Sections C and D: Antibiotics and Medically Assisted Nutrition and Hydration

The NCBC has significantly modified these sections of the standard POLST form to make them consistent with Catholic moral teaching. Many standard POLST forms offer patients the option of declining antibiotics. The sample NCBC POLST does not. In most cases, antibiotics constitute an ordinary means of care. These medications are highly effective in treating infection, and they can be easily administered in pill or liquid form, including intravenously.

Many standard POLST forms also offer patients the option of declining medically assisted nutrition and hydration (a feeding tube), but again, the sample NCBC POLST does not. In accord with directive 58 of the *ERDs*, providing nutrition and hydration by either natural or medically assisted means is consistent with basic human care. It is, in

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principle, ordinary and thus morally obligatory. Medically assisted nutrition and hydration becomes extraordinary and thus not morally obligatory when one of the following conditions is met:

1. The patient's body is unable to assimilate nutrition or hydration. Evidence of this can include bloating or persistent diarrhea.
2. The provision of assisted nutrition and hydration constitutes an excessive burden to the patient. Examples of this include aspiration pneumonia, recurring infection at the site of the feeding tube, and a non-decisional patient continually removing the tube. Again, it is important to note that that determination of burden refers to the use of a particular medical intervention—in this case, medically assisted nutrition and hydration—not to the perceived quality of the patient's continued life.
3. Death is imminent because of the patient's underlying medical condition. In this case, withholding or withdrawing nutrition and hydration does not result in starvation or dehydration. Therefore, it does not cause or intentionally hasten death.

If any of these conditions exists, it is permissible for the patient, surrogate, or qualified clinician to withhold or withdraw medically assisted nutrition and hydration.

Overall, the sample NCBC POLST does not offer the option of declining either antibiotics or assisted nutrition and hydration in advance, because the question of whether their provision is appropriate for a particular patient most often cannot be answered at the time the POLST form is completed. Such decisions need to be made "in the moment" and with full knowledge of all relevant medical facts. The NCBC does not rule out the possibility that these treatments may be legitimately declined at some future point. However, it seeks to ensure that the appropriateness of a treatment is determined by the clinician and the legally responsible decision makers at the actual time such a decision needs to be made, not at the time the POLST form is completed. Given that antibiotics and assisted nutrition and hydration are not aspects of emergency medical care, there is almost always time to make deliberate, informed decisions about them. One should not rule out their possibility in advance.

Signatures

Signatures are essential to complete a valid POLST. The physician, physician assistant, or certified registered nurse practitioner who completes the POLST form must print and sign his or her name in the appropriate spaces, indicate a contact telephone number, and date the form. The clinician's signature attests that he or she has informed the patient of available treatment options and will provide care consistent with the treatment options indicated on the form. The patient or the surrogate (if the patient cannot sign) must sign and print his or her name in the appropriate spaces and indicate the relationship to the patient (if the surrogate). A signature attests that the patient or surrogate has been informed of what is documented on the POLST form and that this documentation accurately communicates the patient's treatment preferences.

A Valuable Resource

The *NCBC Guide to POLST*, along with the NCBC sample POLST, can address and ultimately overcome the concerns associated with many standard POLST forms. It can aid individuals in making ethically acceptable end-of-life treatment decisions. In addition, it can assist organizations in formulating advance-care-planning tools that are consistent with Catholic teaching. The NCBC remains willing to assist in the implementation of this guide and its sample POLST form as needed.

Notes

1. See National POLST Paradigm, accessed April 16, 2018, http://polst.org/.
2. "About the National POLST Paradigm," National POLST Paradigm, accessed April 16, 2018, http://polst.org/about-the-national-polst-paradigm/.

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