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Catholic Health Association of the United States

TALKING POINTS REGARDING POLST

Prepared by Fr. Thomas Nairn, OFM, PhD, Senior Director, Ethics, Catholic Health Association in collaboration with the Supportive Care Coalition Ethics and Church Relations Committee

There has been controversy recently within the Catholic Church concerning Physician Orders for Life-Sustaining Treatment (POLST). Some of this can be traced to misunderstandings regarding what POLST is and for whom POLST is intended. The following talking points are meant to help avoid these misunderstandings. Key messages to emphasize regarding POLST are:

- POLST is a tool for translating patients' goals for treatment into medical orders regarding a current progressive illness.
- POLST is intended for those patients with serious advanced, progressive illness and/or frailty and not for the general population.
- POLST is not an advance directive.
- POLST is not simply a form for a health care professional to complete but rather a part of a larger advance care planning process comprised of conversations between the patient or surrogate and the health care professional.
- Although some bishops have supported POLST and others have opposed it, when POLST is properly executed in a Catholic health care facility, it is consistent with Catholic moral teaching.
- POLST legislation in some particular states can diverge from the general POLST paradigm. The National POLST Paradigm Task Force offers a website that explains which state programs are endorsed by the organization and which are not, giving an explanation for non-endorsement.

1. What is POLST? POLST stands for "Physician Order for Life-Sustaining Treatment."[1] It is a tool for translating a patient's goals for treatment into an actionable medical order within the context of advance care planning. It standardizes the way in which the *health care professional* prescribes a plan of care in a visible way that is portable among health care institutions, rather than focusing on standardizing the *patient's* communicating his or her treatment preferences by means of an advance directive.

2. For whom is POLST intended? POLST is intended for patients with serious advanced, progressive illness and/or frailty, whose physician would not be surprised if they were to die within the year.

3. Is POLST an advance directive like a Living Will? POLST is not an advance directive. Advance directives are executed by any competent adult and express the patient's preferences regarding future treatment in instances where the patient can no longer speak for himself or herself. An advance directive in the form of a durable power of attorney also names an agent who will transmit the patient 's preferences when the patient is no long able to do so. POLST is meant for persons with advanced progressive illness and/or frailty. The POLST form reflects the patient's here-and-now goals for medical decisions that will likely need to be confronted in the relatively short term and converts those goals into a medical order. POLST can build on an advance directive but it can also function in the absence of an advance directive.

4. Why do some professionals think that POLST is necessary, especially for a person who already has an advance directive? Even with advance directives, there has frequently been a disconnect between patient preferences and the implementation of those preferences by health care personnel, especially in crisis situations for individuals in an advanced stage of illness. Reasons why advance directives have not been effective include: lack of availability of the directive, lack of specificity, and the inability to contact the agent of the durable power of attorney for healthcare. POLST was developed to help resolve this disconnect by integrating the patient's goals for treatment into a medical order.

5. How many states have adopted POLST? Are all POLST forms alike? Currently POLST is used in over twenty states and being developed in more than twenty more. POLST forms vary somewhat from state to state, both in nomenclature (see end note #1) and in content. Several states explicitly recognize out-of-state versions of POLST, while only one state (North Carolina) expressly limits validity to in-state forms. Most states do not address this issue.

6. What does the POLST form contain? POLST forms vary somewhat from state to state. However they generally contain at least three sections: The first section states whether or not cardio-pulmonary resuscitation should be initiated on a patient who is not breathing and has no pulse. This is followed by a section listing treatment options when a patient does have a pulse and/or is breathing. The options range from full treatment, through limited interventions, to comfort measures only. Many POLST forms also have sections regarding the administration of antibiotics and medically administered nutrition and hydration. The form is signed by a physician or (in some states) by a nurse practitioner and, in most states, by the patient or surrogate. Some states do not require the patient's or surrogate's signature but do recommend it. Most state forms also provide a section regarding the review and possible change of the content of the form.

7. Should all adults have a POLST document? POLST is not meant for everyone. It is meant only for those with advanced, progressive illness and/or frailty. A few states, however, are less restrictive in their definition regarding who is eligible for POLST. Some states have mandated that all long term care facilities request that their residents or their surrogates complete POLST forms. Even in these situations, completion of POLST remains voluntary.

8. What is the "POLST paradigm"? Is it simply completing the POLST form? The POLST paradigm encompasses more than the completion of the POLST form. Charles P. Sabatino, Director of the American Bar Association's Commission on Law and Aging, explains that the POLST paradigm consists of three key tasks:

- POLST requires a health care professional to initiate a discussion with the patient (or the patient's authorized surrogate) about key advanced illness treatment options in light of the patient's *current* condition. The objective is to discern the patient's goals of care and preferences and the available care options.

- The patient's preferences are incorporated into medical orders, which are recorded on a highly visible, standardized form that is kept at the front of the medical record or with the patient if the patient lives in the community.

- Providers must ensure that the POLST form actually travels with the patient whenever he or she moves from one setting to another, thereby promoting the continuity of care and decision making. [2]

9. How does POLST relate to advance care planning? The appropriate way to understand POLST is within the context of advance care planning and not to limit it to a form to be completed. Advance care planning includes a discussion or more likely a series of discussions to help the patient, surrogate, and often the patient's family to understand and reflect upon care options, given the current circumstances of the patient's illness or aging. Such discussions should include the patient's values and beliefs in relation to the clinical options. The execution of the POLST form is important, but it is secondary to and supportive of the advance care planning process.[3] If properly engaged, the philosophy behind advance care planning echoes the Catholic *Ethical and Religious Directives* which states that "neither the health care professional nor the patient acts independently of the other; both participate in the healing process."[4]

10. Does the POLST document need the signature of the patient, like an advance directive does? Is the lack of a signature a problem? Most states require the patient's or surrogate's signature. Those that do not require the signature recommend it. New York state recommends but does not require the patient's (or surrogate's) signature and also recommends but does not require the signature of two witnesses. The rationale for some states' not requiring a patient's signature is that the document is a medical order and, like other medical orders, should require only the clinician's signature. Requiring the patient's signature, however, can serve as a safeguard to ensure that the orders were executed with the patient's or surrogate's knowledge and informed consent.

11. Can the POLST document be voided or revised? The patient or surrogate can void the form at any time and request alternative treatment. A form is usually voided by writing "VOID" across the form in large letters, but the process can vary from state to state. The POLST form should be reviewed and updated as needed based on changes in the patient's medical condition and/or treatment preferences. At a minimum, the POLST should be reviewed:

- When the patient is transferred from one care setting or level of care to another,
- When there is a substantial change in the patient's health status,
- When the patient's primary care physician changes.

Many POLST forms have a specific section to document such reviews.

12. Has the Catholic Church endorsed POLST? Although some bishops and Catholic conferences have supported POLST and others have voiced opposition to POLST as developed in their respective states, most bishops in the U.S. have neither endorsed POLST nor opposed it.

13. Is POLST consistent with Catholic moral teaching? The question of whether or not the POLST form and paradigm are consistent with Catholic moral teaching depends upon the content of the POLST form used in a particular state. However, it should be noted that the POLST paradigm and form are simply tools that may be used well or poorly, for good or for ill. The 2009 edition of the *Ethical and Religious*

Directives for Catholic Health Care Services makes no explicit mention of POLST. Nevertheless, there is nothing inherent in the paradigm or form in general that is necessarily improper from the point of view of Catholic morality. Rather it is the way in which they are used that can become beneficial or problematic from the point of view of the Catholic moral tradition. The range of answers in most POLST forms – and the character of the advance care planning given in Catholic health care facilities – allows patients to make choices consistent with Catholic moral teaching.

14. Does the fact that the form is an actionable medical order create a problem from the point of view of Catholic morality? Some Catholic bishops and moral theologians have objected that the POLST form spells out in advance the specific treatments to be provided the patient at a time in the future. They maintain that the physician cannot know at the time of the writing of the order whether these treatments would be appropriate from an ethical point of view.

This can be true regarding the way POLST has been established in a few particular states. Part of this concern, however, might stem from a misunderstanding of the POLST paradigm itself. The POLST form is not an advance directive. Rather, it communicates specific medical treatments based on the patient's current state of health. Those treatments that are agreed upon in advance care planning sessions between the health care professional and the patient and/or surrogate are stated in the POLST form and signed by the health care professional as a medical order. Changes in the patient's condition call for further advance care planning sessions. As the condition of the patient changes, the POLST form needs to be updated. Therefore if the POLST paradigm is followed, it should not create an ethical problem.

15. Does the fact that POLST uses a check box format create an ethical problem? There is a particular reason for the check box format. It allows emergency services personnel to: (1) follow medical orders in the field because they are trained to find information in an instant and (2) incorporate the specified procedures in their scope of practice. The check box design therefore offers the relatively clear guidance that EMS personnel are looking for.

16. Can POLST be abused? As with any process or form, POLST can be abused. Probably the greatest danger is to regard POLST as just another form to be completed and separate it from advance care planning, which is essential in properly executing the POLST paradigm. Some health care professionals may execute POLST forms for patients who are not appropriate candidates for POLST. Especially in some long term care facilities, POLST might be treated as mandatory rather than voluntary – or, in some states, health care personnel may be unclear on what aspects of POLST are mandatory in long term care facilities and what are not. Finally, EMS personnel may not be properly trained in interpreting the POLST form. These abuses have led some commentators to reject the POLST paradigm itself. Although this may be an over-reaction, it does indicate that those who are involved with POLST must be vigilant in monitoring and evaluating its implementation. Furthermore, since POLST legislation or practice in a particular state may or may not reflect this general POLST paradigm, Catholic health care professionals ought to investigate possible ethical shortcomings in the way POLST is implemented in their particular state. The National POLST Paradigm Task Force offers a website that explains which state programs are endorsed by the organization and which are not, giving an explanation for non-endorsement.[5]

[1] Different states use different nomenclature: POLST (Physician Order for Life-Sustaining Treatment), MOLST (Medical Order for Life-Sustaining Treatment), POST (Physician Order for Scope of Treatment), MOST (Medical Order for Scope of Treatment), COLST (Clinical Orders for Life-Sustaining Treatment), SMOST (Summary of Medical Order for Scope of Treatment), TPOPP (Transportable Physician Order for Patient Preference) or SAPO (State Authorized Portable Order). When the term POLST is used in these talking points, it can refer to any of the above.
[2] See Charles P. Sabatino, "The Evolution of Health Care Advance Planning Law and Policy," *The Milbank Quarterly* 88, 2 (2010): 229; see also Charles P. Sabatino and Naomi Karp, "Improving Advanced Illness Care: The Evolution of State POLST Programs." *AARP Public Policy Institute Report* (2011): 3-4.
[3] See Sabatino and Karp, 2.
[4] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition (Washington, DC: USCCB, 2009), Introduction to Part Three.
[5] See http://www.polst.org/programs-in-your-state/

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