

Reflections on the Use of the POLST Paradigm

(Editor's Note: In the last issue of Health Care Ethics USA, we invited those having experience with POLST to respond to the two articles by Brugger et al. discussed in that issue. Those responses follow.)

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Mr. G. was an 80-year-old retired dairy farmer who delighted in making toys for his great granddaughters. On weekends, he found joy in twirling his wife around the dance floor almost as much as he savored sitting quietly with her in the church where they were married 60 years before. When he began to be troubled by a nagging cough, he went to his family doctor. A whirlwind series of tests revealed that he had widely metastatic lung cancer. He was shuffled from medical to radiation oncologist, and presented with a variety of treatment options. Finally, bewildered and terrified, he sat again in his family physician's office. "I don't know what to do, doc. Help me figure this out." His doctor began by establishing a common understanding of his disease and its prognosis. The two of them discussed treatment options in light of that prognosis. Together, they explored what gave life meaning for Mr. G., what he still hoped to accomplish, and how he wanted to spend his remaining days. Together, they developed a philosophy of treatment, informed as much by statistics as by faith

and hope. As he had all his life, Mr. G. shouldered responsibility for his decisions, and insisted they be written down. At the end of their visit, Mr. G. and his physician filled out a POLST form, the "Physician Orders for Life Sustaining Treatment."

In the January issue of *Ethics and Medics*, Drs. Brugger et al. decry the POLST for prohibiting "any treatment at any time for any reason." In reality the antithesis of a "one size fits all approach," the POLST directive was created specifically for patients like Mr. G., who have advanced illness, or who are chronically, critically ill. In these patients, it is possible to predict what clinical interventions have a reasonable hope of benefit in a cardiopulmonary arrest or in a pre-arrest situation. We know, for example, that the in-hospital CPR success rate for cancer patients is about seven percent. In addition, we know that patients who survive a CPR attempt are at risk for its related complications, including permanent neurological and functional impairment. The POLST

allows chronically ill patients and health care providers to carefully consider the benefits and burdens of CPR in the event of cardiopulmonary arrest.

Next, particularly for patients who choose “no CPR” in an arrest, the POLST requires an evaluation of the medical care that might be used in a pre-arrest situation. Initiating a “detailed inquiry into the specific treatment options” available, health care providers typically discuss three categories or levels of treatment that might be employed. Rather than using a “simplistic check-box” to limit or restrict treatments, the POLST also directs physicians to employ reasonable interventions to prolong life. Mr. G., for example, wanted to live to see his grandson's college football debut, and was willing to undergo “full treatment” if there was hope he could be present for that milestone.

Drs. Brugger et al. are correct that a particular virtue touted by POLST supporters is its portability. It is particularly important in the home, where EMS personnel in our state are required to perform CPR unless there is a POLST. Even in those situations, however, the POLST form boldly states that “a person with capacity or the surrogate of a person without capacity can void the form and suggest alternate treatment.”

In addition, the POLST “should be reviewed every time a person is transferred from one care setting or care level to another, there is a substantial change in the person's health status, or the person's

treatment preferences change.” Rather than a static document that is executed once in a patient's disease trajectory, the POLST records a dynamic process of advance care planning that reflects a patient's changing medical situation, values and life goals.

Mr. G. completed his POLST in his physician's office, and revised it once when it became clear that his death was imminent. He expressed relief for the opportunity to understand his prognosis, which liberated him to make responsible and thoughtful preparations for dying that were consistent with his values and his faith. Accustomed to the rhythms of life on his dairy farm, he acknowledged death as part of “God's plan,” integral to a cycle of hope and renewal. With dignity and courage, unburdened by the fear of futile medical interventions, he was able to live fully for seven months. He died at home, in peace, surrounded by his family.

Brugger, Christian, et.al. “POLST and Catholic Health Care.” *Ethics and Medics* 37, no. 1 (2012).

Riesfield, Gary, et.al. “Survival in Cancer Patients Undergoing In-hospital Cardiopulmonary Resuscitation: A Meta-Analysis.” *Resuscitation* 71, no. 2 (2006): 152-169.

“POLST.” Washington State Forms, Washington State, WSMA.org. Washington State Medical Association. Web. 25 Mar. 2012.
<http://www.wsma.org/patients/polst.html>.

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Some of the current confusion regarding POLST may stem from a misuse of terminology. A POLST is a portable medical order and should be differentiated from advance care planning and advance directives. The experience over the past 22 years in La Crosse, Wis. is well-documented^{1,2,3,4} and may help make this clear.

In La Crosse the two main medical centers began working collaboratively in 1990 to support end-of-life planning conversations in the communities we serve through an education program called, “Respecting Choices.” The conversations are referred to as advance care planning and resultant decisions are most often recorded in the advance directive (AD) we recommend, the Durable Power of Attorney for Health Care (POA-HC). The medical centers ensure that all POA-HC are accessible in the patient’s medical record.^{1,2,3,4}

Efforts to make patient preferences known and honored were challenged in 1995 when the State of Wisconsin passed a law called, “Do-Not-Resuscitate (DNR) Bracelet Act.” The intention was to ensure that medical care provided in the emergency department and out-of-hospital settings was consistent with the patient’s desire and the attending physician’s authorization. Unfortunately,

this also meant that, by law, resuscitation was required by emergency medical systems (EMS) personnel unless the plastic bracelet housing a medical order was worn by the patient. Testing found that plastic bracelets become brittle, tearing the skin, and often cracked and give the appearance of having been tampered with making the medical order void. In addition, the presence of the bracelet attracted attention, breaching patient confidentiality.

This law created a need to translate advance planning preferences into a portable medical order which we refer to as Physician Orders for Life-Sustaining Treatment (POLST).

These distinctions are extremely significant in our community where people of all ages talk with their health care provider, family and loved ones about their beliefs and values and subsequent end-of-life preferences as their health status changes over their lifetime.

As patients gain clarity about end-of-life preferences, decisions are recorded in the POA-HC and stored in the medical record. The POA-HC allows patients to designate a person they trust, someone they have talked with, in addition to their health care provider, so that when the patient can no longer speak for him or herself, a caring, compassionate, knowledgeable person can participate in decision-making with the health care team.

Years of conversation with the primary health care provider, family members and loved ones and especially with the health care agent are reflected in the POA-HC. Only when chronic or terminal conditions are recognized or the patient achieves an advanced age and has tired of medical treatment, emergency room visits, intensive care unit and hospital stays will a provider with prescribing privileges write a medical order (POLST).

The conversation is paramount as it supports the development of an advance directive (AD) which in turn, as death becomes imminent, is translated into POLST.

Catholic health care has a unique opportunity to put the proper resources in place to provide a team of qualified health care practitioners to support both values-based reflection and proper interpretation of medical history, diagnosis and prognosis throughout our lives so that when persons realize they would prefer a natural, dignified death aligned with their values and beliefs, their wishes can be made known and unwanted care as well as cost can be avoided through the availability of clear medical orders.

NOTES

¹ Hammes, BJ, Rooney, BL. "Death and End-of-Life Planning in One Mid-Western Community." *Archives of Internal Medicine* 158, no. 4 (1998): 383-390.

² Hager, NL. "Advance Directives: One Community-Based Program Has a 95 Percent Success Rate." *Minnesota Physician: The Independent Medical Business Newspaper* 13, no. 7 (1999): 24-25.

³ Hammes, BJ, Rooney, BL., Gundrum, JD. "A Comparative, Retrospective, Observational Study of the Prevalence, Availability, and Specificity of Advance Care Plans in a County that Implemented an Advance Care Planning Microsystem." *Journal of the American Geriatrics Society* 58, no. 7 (July 2010):1249-1255.

⁴ Hammes, BJ, Rooney, BL, Gundrum, JD, Hickman, SE, Hager, N. "The POLST Program: A Retrospective Review of the Demographics of Use and Outcomes in one Community Where Advance Directives Are Prevalent." *Journal of Palliative Medicine* 15, no. 1 (January 2012):77-85.

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I read with dismay, the article in the Jan. 2012 issue of *Ethics and Medics*, regarding POLST and Catholic health care. Louisiana enacted the LaPOST (Louisiana Physician Order for Scope of Treatment) legislation in July 2010 with the support and collaboration of the Louisiana Conference of Catholic Bishops. The LaPOST Coalition is working to educate health care professionals as well as the clergy and community on its appropriate use. It is important to review the use of the LaPOST document in a patient scenario to understand the complexity of the decision making involved and the numerous adjustments in the document as the patient's disease progresses. The LaPOST document is the end result of

Careful conversations between a patient and their physician.

The case of Mr. Doe is a good example of how the POLST document can be employed to improve a patient's experience. Mr. Doe represents a 64-year-old man who presented to his physician with a 30 pound weight loss and a lump in his neck. He was evaluated and found to have head and neck cancer and it was hoped curative therapy would be successful. He had a PEG tube placed for nutritional support while he received combination chemotherapy and radiation therapy. The radiation therapy was difficult and he had difficulty swallowing. The use of the feeding tube was continued to supplement his oral diet.

Unfortunately, despite attempts at aggressive curative therapy, Mr. Doe's disease continued to progress. The patient understands that *he has a life limiting and irreversible disease* (which the LaPOST document requires). Numerous discussions were held by the physician and appropriate staff members with him and his wife regarding his goals for care. He wanted *no CPR* (DNR on section A) if his heart and breathing stopped (he died). He did want continued treatment of intercurrent illnesses as long as it maintained his current quality of life. This quality of life is decided by the patient. *Limited additional intervention* was selected in section B. He wanted to receive antibiotics and to continue his tube feedings—in this case in addition to his attempts at oral diet. (Section C and D) Several months later, Mr. Doe's disease had progressed such that he needed

assistance with all of his activities of daily living. The tumor had recurred in his neck and also involved the lungs and bones. He was being treated aggressively for pain and other symptoms and enjoyed time with his family and former coworkers. He continued to lose weight despite adequate calorie supplementation through his feeding tube.

As his disease progressed, the physician had a conversation with the patient and his wife, and a review of his LaPOST document led to a change in the document. The original document was voided and a new document completed. Based on the continued worsening of disease and declining functional status, the focus of his care became that of comfort. His LaPOST document now included DNR, comfort measures only, use of antibiotics if benefit is greater than the burden and discontinuation of the tube feeding when the burden is greater than the benefit. Three days before his death under the care of hospice, he was unresponsive, the tube feeding was discontinued as the liquid nutrition was not being digested, and he had an episode of aspiration causing shortness of breath. In conversation with the hospice physician and interdisciplinary team, the patient's wife requested that his wishes for comfort be honored. The patient died peacefully receiving the care that he and his physician and family felt was beneficial.

The authors Brugger, Pavela, Toffler, and Smith ask that the “forms should be revised to make their use fully consistent with good health care practice and the full dignity of the human person” —I think the

LaPOST document in its current form fulfills this promise without any need of revision.

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I respond to the article by Brugger et al. not as a health care professional who has employed POLST, but as someone who has had to deal with end-of-life issues in its absence, without its benefits. Health professionals have long recognized a lapse in the continuity of care of persons with chronic and progressive illness. After having held thoughtful conversations with inpatients who made informed decisions not to be intubated or to undergo CPR, we discharge them without an appropriate means to convey their decision to other caregivers and first responders.

I have counseled many troubled spouses and adult children whose loved one never anticipated the need for a new kind of order after leaving the hospital, expressing dismay when we advise them that a DNR order was only effective until the day of discharge. Thus, persons who never wanted extraordinary interventions end up receiving them, and surrogates end up having to make traumatic withdrawal decisions, so often stating, “We thought this decision had already been made.”

POLST, in part, attempts to ensure that the hospital is not the only place where people can have their previous decisions honored. The value of POLST arises from

a desire to address the inadequate continuity of care and communication experienced by patients and families. If further dialogue must occur to improve the documents, then let’s have that dialogue. But let’s not throw out the baby with the bath water. POLST serves valid purposes.

Catholic health care institutions have an obligation to *offer* interventions that may be of benefit to the patient; this does not obligate the patient to *accept* our interventions. Persons adhering to Catholic teaching have a moral obligation to use ordinary means to sustain life. No health care institution, Catholic or otherwise, can impose a treatment upon a competent patient, without consent. The mere existence of modern medical interventions does not automatically compel patients to accept them in every case and, to be certain, we should not presume to use them against the will of competent persons. It is our obligation to assess properly, seeking to understand a patient’s values and beliefs through dialogue and inquiry, and without our own agenda. It is our obligation to establish goals of care, provide evidence-based information regarding the risks, benefits, and possible complications of reasonable treatment options, as well as the options for continuing care should a comfort-focused plan of care be the decision of the patient. Health care institutions should have established protocols that may be pursued in instances where a surrogate’s decision-making appears to be in conflict with the patient’s wishes.

The suggestion that a person “commits suicide” by declining life-sustaining medical interventions is troubling. People do not die because a physician writes an order for “Do Not Resuscitate.” People die because they have a condition that is *life-threatening*. The suggestion that a physician is abetting a suicide if he or she orders “Do Not Resuscitate” on anyone other than a “terminally ill” person is equally problematic. A person with a very advanced-stage illness, who may have already been intubated and placed on a ventilator once, or even twice, and does not wish to undergo that experience again, would not be able to decide on a comfort approach to care, unless a physician indicates a prognosis limited to six months or less, by most definitions. There are many reasons why a person who is not deemed “terminal” might choose a conservative and comfort-focused approach to care. In certain disease processes, a comfort plan of care has even been demonstrated to have a more favorable prognosis than aggressive, curative treatment. The physicians I have worked with will acknowledge that patients with serious illness may survive a year or even several years, but are *at risk* for life-threatening complications that can occur at any time and can change a “non-terminal” prognosis to an “imminently terminal” prognosis – literally – in a heartbeat.

Do we reject the notion that there are people who believe “When it’s my time, it’s my time, and I want to die peacefully”? Have we abandoned the belief that some people come to terms with an advanced illness, and anticipate an

eternal peace with their Creator? Do we no longer accept that persons can feel at peace with a decision to let nature take its course in an illness, or that they can be just as stripped of their dignity by a medical team that has no regard for their medical or spiritual beliefs? Perhaps if we had been ensuring excellent care all along, there would not now be so many states seeking to legalize physician-assisted suicide.

As I child, I watched my grandmother care for my great-grandparents at the end of their lives, in their own beds, keeping them comfortable, though they were no longer inclined to eat and drink due to advanced illness, loss of appetite, and weakness. Was she acting unethically by not rushing them to the hospital and insisting on feeding tubes, against their wishes? She was doing what she had learned from her parents and grandparents. If generations cared for loved ones in this way, how is it now wrong? Does it mean that we place less value on human life if we care for loved ones while they pass peacefully, as they wish, surrounded by family, their pastor, and hospice caregivers? Do we not accept that the same God who was the architect of the human body and all its functions, including the means to heal wounds, fight infection, take in nutrients, recharge through sleep, and create new life, also divinely designed our bodies to do what they need to do at the end of life?

The inventions of modern medicine do not make us more obligated; they provide us more options. And we have lived long enough now to see both their usefulness in

saving and prolonging life, and the implications for patients and families who have never had discussions about these options. Our obligation is to have a quality conversation that will lead us to a plan of care that is ethically sound, legal in every regard, and reflects the personal wishes of the patient. POLST can be a useful tool in this regard.

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In their article, “POLST Documents Should Not Be Utilized in Catholic Healthcare,” Brugger, et al., identify seven “problems.” I differ strongly with seeing these as real problems for the following reasons:

- **Removing the requirement for terminal illness.**

Wisconsin statute qualifies patients with advanced but non-terminal disease if treatment is either futile or non-beneficial. If the statute does not require terminality, how can one refuse to honor the election of an individual who is non-terminal?

- **Removing the requirement for the patient’s signature.**

Many POLST implementations require the patient’s signature in order to

help make them portable. If non-signature invalidates a POLST DNR order, why doesn’t non-signature invalidate a hospital DNR order, which is generally not formally consented?

- **Removing the requirement for the attending physician’s signature.**

Many POLST implementations require the physician’s signature to help make them portable. If more physicians fly from “attending” to images and procedures, it may become all you can do to find the patient’s attending nurse practitioner.

- **Making the directive portable.**

This is a particularly unpersuasive objection since patients generally intend their election to be good until cancelled and are extraordinarily puzzled to be asked to re-document it whenever they cross a hospital threshold.

- **Making the directive an order.**

This is a particularly unpersuasive objection since patients can’t stop a code or rapid response team with a narrative filed in their chart.

- **Using non-physician facilitators.**

This is also

unpersuasive for those accustomed to working in a paradigm where the patient's election is informed by family, community, and society—including spiritual counselors.

- **Creating orders oversimplifies the potential subtleties of certain requests.** It is advance care planning which creates the narrative that captures the full subtlety of a patient's understanding, appreciation, reasoning, and intentionality. And it is the order that communicates that, and nothing is more deeply developed and widely implemented than POLST.

I do agree strongly with the authors' conclusion: "The time has come for a clear delineating and articulation of how individuals may prepare and execute an end of life directive that respects the dignity of human life and conforms to Catholic moral teaching." But in endorsing the language of LaPOST, I don't want this to degenerate to mere legalism. If someone comes in with another kind of POLST, that is still a good place to start the discussion.

We recently created a template for advance care planning in the electronic health record to address these concerns, including the following specific content:

- It identifies whether the patient is qualified by

terminality, futility, or lack of benefit (versus burden).

- It indicates whether the patient intends the directive to be good until cancelled, or to some other point.
- It lists who was involved in the discussion, and requires editing or co-signature by the physician if it was not of their creation.
- It remarks whether the POLST order captures the full subtlety of the patient's election.
- AND the POLST order would still require a patient/proxy signature and a physician signature.