POLST Orders Are Not Dangerous

In her article, "The Danger of POLST Orders: An Innovation on the DNR," Lisa Gasbarre Black cites several dangers she sees as inherent in the use of Physician Orders for Life-Sustaining Treatment (POLST).[1] I cannot comment on the Black's experience in Ohio, but her observations do not describe our nearly twenty years of POLST experience in Oregon Catholic health care. On the contrary, it has been our experience that, when informed by and executed in a manner consistent with sound medical practice, the *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*), and Church teaching, POLST orders protect the sacred value of human life by providing a greater opportunity for patients to make ethically sound medical decisions.

The original and ongoing purpose of POLST, and the manner in which it is used in Oregon Catholic health care, is to address the medical needs of a limited group of patients: those with *terminal* illness, those with *chronic and critical* illness, and those with *advanced* illness. That is to say, POLST orders are for those patients whose medical conditions are such that judgments can be made in advance about whether there is a "reasonable hope of benefit" from a given intervention or whether that intervention will entail "excessive burden."[2]

When the POLST order indicates that interventions such as cardio-pulmonary resuscitation or intubation are to be withheld, death is not hastened by forgoing ordinary means of preserving life. Rather, natural death is allowed to unfold because the patient's medical condition is such that it is known that the intervention would be extraordinary and thus morally optional. The result is clinically and morally good patient care at the end of life.

Examples of Proper Use

Black speaks of POLST orders being used for those who are "chronically *but not* terminally ill" who are hastening their deaths by forgoing "ordinary and proportionate means" of preserving life, that is, means that are routine.[3] This use may be true of the Ohio statute, but it is not the case in Oregon; and there would seem to be no reason why the use of POLST orders cannot be limited to situations in which death is not hastened by forgoing ordinary means of preserving life.

Suppose a patient's underlying medical condition, advanced chronic obstructive pulmonary disease, indicates that there is no reasonable hope of benefit from resuscitation in the event of pulmonary failure. In this case, a POLST order to refrain from such an intervention assures that the patient will not experience the "excessive burden" of this intervention at the end of life. At the same time, if there is reasonable hope of benefit for a different patient with a different advanced illness, a POLST order can assure that the intervention is applied despite the patient's otherwise fragile medical condition or family members objections that "mother really would not want this." As such, POLST orders are not unique from other medical orders for those with terminal illness, those with chronic and critical illness, or those with advanced illness who may or may not benefit from a clinical intervention when in the hospital. Where POLST orders are uniquely helpful is that they have standing outside a hospital facility, helping to assure that these patients will receive interventions for which there is reasonable hope of benefit and will not receive interventions that entail excessive burden at home or in an outpatient care facility.

This is especially important for patients on home/outpatient hospice who wish to receive only those medical interventions consistent with both their wishes and their overall medical conditions as natural death unfolds. If family or caregivers panic and dial 911—which happens more often than one might imagine—the emergency medical response team will have the authority to treat the dying person's symptoms and to not subject that patient to the "excessive burden" of the trauma of hospital transfer and the associated risk of dying en route when there is no reasonable hope that hospitalization can offer benefit.

Similarly, patients living at home or in a care facility and receiving palliative care because of chronically critical or advanced illness can receive medical interventions consistent with their wishes and medical condition in complex medical situations. For example, a patient with end-stage renal disease receiving dialysis may also suffer from advanced congestive heart failure for which cardio-pulmonary resuscitation would offer no reasonable hope of benefit in the event of sudden cardiac failure. Additionally, this same patient's POLST order may indicate that antibiotics should be used if there is reasonable hope of benefit, for instance, if the patient would recover from pneumonia and return to activities of daily living despite renal failure and congestive heart failure.

One need not be actively dying to determine, in light of one's overall medical condition, whether there may or may not be reasonable hope of benefit from an intervention in the face of a sudden catastrophic event. For patients with complex advanced or chronically critical illnesses, POLST orders allow both the pursuit of those interventions that offer reasonable hope of benefit and avoidance of those that will pose an excessive burden.

The POLST form is a set of a physician's orders *about* life-sustaining interventions. It is not, by definition, an order to *forgo* life-sustaining interventions. It is not Oregon's experience of POLST, nor would it seem inherent in POLST, that anyone be at risk of hastening death by forgoing beneficial interventions. As with all medical orders, POLST orders can be medically appropriate, ethically informed, and properly executed. In Oregon, POLST orders can provide an opportunity to comply with the *ERDs* by helping to assure that patients receive care that respects the clinical possibility and moral obligation to use ordinary or proportionate means of preserving life.

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Various POLST Safeguards

Black's article states: "POLST theory seeks to elevate patient autonomy to the level of an enforceable, legal right."[4] This is not our experience with the Oregon statute. Patient autonomy is certainly a factor with a POLST order but no more so than it is with any other physician's order requiring consent. Autonomy is important because consent is involved,[5] but it is not paramount. There will always be a subjective element to decisions about care, but subjective desires are in all settings necessarily constrained by the parameters of clinically objective facts. There is nothing unique about POLST orders that prevent them from being written in a way that is consistent with the *ERDs*.

Black also asserts that the POLST form "mandates compliance" by health care workers, including emergency responders.[6] This would seem to be an exaggeration. For reasons of professionalism, quality of care, and patient safety, medical orders are generally to be followed from the moment they are written. Just as an order for IV vancomycin cannot be ignored by medical professionals, so too POLST orders cannot be simply ignored. Having said this, no set of physician's orders is to be blindly followed. Because a physician's orders relate to a specific clinical scenario, it is possible that the actual facts as they unfold may impose new medical and ethical obligations not foreseen when the initial order was written.

In Oregon, POLST orders are periodically reviewed to make sure they are consistent with patients' dynamic medical conditions. Just as a physician will change an antibiotic order from methicillin to vancomycin upon determination that the patient has methicillin-resistant *Staphylococcus aureus*, so too a physician may determine that in the present situation a particular POLST order needs to be changed. Rather than suggest POLST orders "mandate compliance," it is perhaps more appropriate to say POLST orders "require professional compliance." As with all physicians' orders, POLST orders should be followed by health care professionals unless there are sound medical reasons for not doing so. In Oregon, we have not seen anything inherently dangerous in following or modifying POLST orders.

Is there a danger and risk of noncompliance with the *ERDs*? Any medical order can raise the specter of moral hazard—just as it can raise the specter of medical hazard. That risk is inherent in medicine itself and in our experience is not unique to POLST orders. The concerns raised about POLST orders can equally be said about state advance directive laws, popular end-of-life forms such as "Five Wishes," and even hospice programs in general. Medical situations will always carry some degree of moral hazard in so far as there are always medical and moral decisions that need to be made. Our Oregon Catholic health care experience suggests that POLST orders are not uniquely morally hazardous for the Catholic physician, the Catholic patient, nor Catholic health care, and eyeing POLST programs with undue suspicion or concern is likely more harmful to good patient care than it is helpful.

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[1] Lisa Gasbarre Black, "The Danger of POLST Orders: An Innovation on the DNR," *Ethics & Medics* 35.6 (June 2010): 1–2.
[2] US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), n. 56–57.
[3] Black, "Danger of POLST Orders, 2, emphasis added; and USCCB, *Ethical and Religious Directives*, n. 56.
[4] Black, "Danger of POLST Orders," 1.
[5] See USCCB, *Ethical and Religious Directives*, n. 26.
[6] Black, "Danger of POLST Orders," 1.

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