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Questioning POLST: Practical and Religious Issues

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The Physician Orders for Life Sustaining Treatment (POLST) is a one-page transferrable medical chart insert designed to facilitate physician–patient communication about a patient's wishes at the end of life. The document as a chart addition is in widespread use today, but various criticisms have been leveled at POLST, the most serious being that POLST creates a slippery slope to illicit active euthanasia. This article examines the criticisms and finds that they fit two categories, the first being practical implementation problems. These problems are correctable given more and better training of medical care staff. The second and more serious ethical charge is that POLST contributes to a culture that is moving toward endorsing euthanasia, but this is difficult to justify given POLST's history, the intentions of those who have designed and implemented it, and the lack of any evidence that POLST does, or even could in present form, serve such an end. The analysis offered will propose that the more serious ethical criticism is actually grounded in a particular sectarian religious perspective, so that the criticism that POLST is euthanasia-bound fails to meet the requirements of a reasonable universalizable ethical perspective.

L'Ordonnance du médecin pour un traitement de maintien des fonctions vitales (ORLST) est un feuillet d'information médicale transférable d'une page conçu pour faciliter la communication médecin–patient au sujet des souhaits d'un patient en fin de vie. Le document sous forme de tableau est largement utilisé aujourd'hui, mais diverses critiques ont été formulées à POLST, la plus grave étant que POLST crée une pente glissante vers une euthanasie active illicite. Cet article examine les critiques et constate qu'elles entrent dans deux catégories, la première étant les problèmes pratiques de mise en œuvre. Ces problèmes peuvent être corrigés grâce à une meilleure formation du personnel médical. La deuxième accusation éthique, plus grave, est que POLST contribue à une culture qui s'oriente vers l'euthanasie, mais elle est difficile à justifier étant donné l'histoire de POLST, les intentions de ceux qui l'ont conçue et mise en œuvre et l'absence de toute preuve que POLST sert, ou pourrait même, sous sa forme actuelle, une telle fin. L'analyse proposée proposera que la critique éthique la plus sérieuse est en fait fondée sur une perspective religieuse sectaire particulière, de sorte que la critique selon laquelle POLST est liée à l'euthanasie ne répond pas aux exigences d'une perspective éthique universelle raisonnable.

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Introduction

Medical care at the end of life is burdened by patients being unfamiliar with advance directives and uninformed about their right to withhold or withdraw care or to state their care preferences. Although those who do have living wills are more likely to opt for limited or comfort care, only 26% of American adults have an advance directive, with the most cited reason for this low number being lack of awareness.¹ Having an advanced directive does not simply eliminate problems, however, for despite being recognized as “important tools for providing care in keeping with patients’ wishes,” advance directives are often not available when needed or honoured consistently when available.² Many health care professionals go further in their criticisms to offer that “advance directives have failed to achieve their ‘admirable purpose’ of helping patients retain control over end-of-life treatment.”³ Even those who affirm the value of advance directives are concerned that the health care system needs to do more to ensure that providers have the “time, space and reimbursement to conduct the time-consuming discussions necessary to plan appropriately for the end of life.”⁴ The reference to “discussions” that may be “time-consuming” is worthy of consideration. If patient unawareness is a significant part of the problem with advance directives being effective and useful, it follows that at least some of the problems with end-of-life care

1. JK Rao et al, “Completion of Advance Directives Among U.S. Consumers” (2014) 46:1 American J Preventive Medicine 65 at 68, DOI: <10.1016/j.ame.Pre.2013.09.008>.

2. MJ Silveira, SYH Kim & KM Langa, “Advance Directives and Outcomes of Surrogate Decision Making before Death” (2010) 362 N Eng J Med 1211 at 1218, DOI: <10.1056/NEJMsa.0907901>.

3. SE Hickman et al, “The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation” (2008) 36:1 JL Med & Ethics 119 at 119, DOI: <10.1111/j.1748-720x.2008.00242.x>.

4. Silveira, *supra* note 2.

centers on communication issues, and that would include communication between physicians and patients.

In 1991, a task force made up of health care professionals at the Center for Ethics in Health Care at the Oregon Health & Science University, recognizing that physicians needed to be more involved in discussions with patients about end-of-life care, developed an instrument designed to translate patient wishes into functional medical orders. They created POLST, an acronym for “Physician Orders for Life-Sustaining Treatment.” POLST is an information and communications tool that functions to engage physicians and patients in direct conversation about medical care at the end of life. The aim of POLST was not to limit health treatment but to “improve end-of-life care by converting patients’ treatment preferences into medical orders that are transferable throughout the health care system.”⁵ Its purpose was to elicit, record and honour patient wishes for care at the end of life or in critical illness situations where patients may be moving from one health care setting to another. The National POLST Paradigm information page declares that POLST “helps patients get the medical treatments they want, [and] avoid the medical treatments they do not want, when they are seriously ill or frail. It’s about helping people live the way they want until they die.”⁶

POLST is a printed single back-to-back sheet of brightly colored paper that can be placed in the patient’s chart. The form asks for ordinary identification data—name, gender, address and date of birth, then asks for a check in boxes that deal with cardiopulmonary resuscitation, medical interventions, and artificially administered nutrition. The form then asks for documentation of the patient-physician discussion and requires a medical professional to attest to an understanding with the patient that the medical orders articulated in POLST are consistent with the patient’s “current” medical condition and preferences. The backside of the form specifies the voluntary nature of POLST. It also gathers contact information about the health care professional and any surrogate, states directions for health care professional use of the form, and provides information about the state registry, procedures for reviewing patient preferences if they change and instructions for voiding POLST.⁷ The form is to be signed by the patient and physician (or another health care professional); and the signatures indicate that an “in depth” discussion has taken place about the patient’s

5. Hickman, *supra* note 3.

6. National POLST Paradigm, “About POLST,” (n.d.), online: <polst.org/about/>.

7. The Oregon POLST form, revised 2018, online: <static1.squarespace.com/static/52dc687be4b032209172e33e/t/5a4bc5d024a694a258e09544/1514915281928/2017.12.28+Printing+POLST+instructions.pdf>.

diagnosis, prognosis, treatment options and goals of care. The document, which is to be updated every two or three years, has legal force but it is framed in a moral context as a “promise by health care professionals to honor” the patient’s wishes for end-of-life care.⁸ In 1995, Oregon led the way in being the first state to put POLST into effect, and the form used in Oregon has been revised as recently as 2018.

The original Oregon Health and Science University task force that devised POLST created a “Paradigm Program” that other states could adapt to their particular laws and regulations. The paradigm, which is today known under 14 different names including MOLST, MOST or POST, has been widely adopted in different jurisdictions. Today in the United States, 23 states have endorsed the POLST Paradigm; another 24 are in various stages of developing the Paradigm for implementation; and four states have developed a POLST form but in ways the National POLST Paradigm Task Force (NPPTF) considers non-conforming. (Maryland, for instance, fails to inform patients that POLST is always voluntary.) One state and the District of Columbia are not yet at the developing stage.⁹

The POLST document is designed for patients who have a life expectancy of less than a year, although persons of advanced age who wish to sign a POLST may do so. A POLST document is voluntary and revocable at any time. It requires that qualified and trained health care professionals, which includes physicians, physician assistants, nurse practitioners and social workers, participate in the end-of-life care discussions with patients and their family members and surrogates. Specifics regarding end-of-life care are indicated on POLST forms—feeding tube options, resuscitation efforts and the degree of allowable medical intervention if the patient has a pulse and is breathing—and it functions as a transferable medical order that emergency medical staff can use to guide treatment. POLST is different from an advance directive. An advance directive is, like POLST, a legal document, and it may guide treatment after a medical emergency but it does not function as a medical order in emergency situations; and state laws may mandate life-saving interventions even with an advance directive. POLST, however, allows emergency care staff to withhold medical intervention if that is what the patient indicated on the POLST form. POLST is an accompaniment to, not a replacement for, an advance directive. Many states have a POLST registry for recording a patient’s

8. Patricia Bomba, Marian Kemp & Judith Black, “POLST: An Improvement over Traditional Advance Directives” (2012) 79:7 *Cleveland Clinic J Medicine* 457 at 459.

9. National POLST Paradigm, “State Programs,” (n.d.), online: <polst.org/wp-content/uploads/2018/04/2018.04.11-POLST-Program-Status.pdf>.

treatment instructions, and thus the patient's wishes as recorded on the form are available and easily accessible in ways advance directives are not.

Because it deals with life and death decision-making, POLST is of moral interest, and ethical questions have been raised about the POLST initiative. Such questions deserve a hearing and require evaluation, and my purpose here is to examine those questions, particularly as they present a challenge to the moral propriety of using POLST. Some of the moral questions concerning POLST have arisen from the experiences of medical professionals in the field who have run into problems using POLST, but more theoretical issues have been provoked as well, including the view that POLST condones or even authorizes euthanasia. I will argue that the concern for euthanasia arises from a specific context of inquiry, which turns out to be religious or theological. Examining the issue in this context will point out not only that religion continues to play an important role in bioethics, but that cultural context—including religious beliefs and commitments—is an important variable in establishing, and thus qualifying, how one proceeds to determine questions about moral meaning in the field of bioethics. That cultural context will inevitably frame how one questions, evaluates and then draws ethical conclusions about POLST as an instrument of medical intervention at the end of life.

Moral questions around practical implementation are, for some, reasons for condemning POLST, yet for POLST defenders these criticisms are actually indicators of success. That POLST has been criticized for successfully resolving some of the very problems it was hoped it would resolve is, of course, a curious situation, but the question that must be asked is whether implementation problems render POLST problematic from an ethical point of view. The POLST Paradigm is in widespread use today and this provides an empirical indicator that moral challenges to POLST have not proven sufficiently convincing to medical practitioners that a move to cease using POLST has gathered support. Ethical questions have arisen; they deserve attention; and it is appropriate to begin an examination of these issues by inquiring into the intentions of those who devised POLST. What good were they seeking to realize?

I. The moral intent of POLST: The good of patient care

POLST was developed to correct a recognized problem with end-of-life medical care, namely, communications between physicians and patients. Such communications are necessary for informed decision-making and the exercise of autonomy, a bedrock principle in bioethics. Yet research has indicated that patients and families prefer to avoid conversations about

medical care. One study indicated that 70% of patients surveyed preferred to have physicians or family members make medical decisions for them,¹⁰ and this may be due in part to lack of awareness about medical options. In order to consent to treatment and engage in informed decision-making patients should understand the following: diagnosis and prognosis, the various care options available to them, and their right to accept or refuse those options. In the United States, the *Patient Self-Determination Act of 1990* inscribed this moral understanding into law.

Advance directives like the living will were available at the time POLST was conceived, but as “general statements of patients’ preferences need[ing] to be carried out through specifications in medical orders when the need [arises],”¹¹ they have been problematic. It has already been shown that most adults do not have advance directives. When needed they are often not available, and they do not transfer with the patient from one health care setting to another. Advance directives do not immediately translate into medical orders, and they can often lack the kind of specificity that would be needed in emergency situations. Other problems have surfaced with advance directives, including these: that patients often fail to understand the advance directive form; that the language of the advance directive form may be confusing; and that advance directives do not adapt to changes in patient preferences for care. In a moment of medical crisis, proxy decision-makers may not understand the patient’s wishes or, if they do, they may still not abide by the advance directive—it is not an easy thing for a friend or family member to take responsibility for a decision that will in all likelihood lead to death. Another issue is that health care professionals may not know about the advance directive or they may believe that in the medical situation they are facing the advance directive does not apply. Given these problems, researchers have concluded that “advance directives typically do not affect patient care.”¹²

POLST was intended to serve the good end of patient care. It was designed to enable informed patient-centered decision-making while engaging medical professionals directly with patients. POLST emphasized teamwork and system coordination on the part of health care professionals, and it aimed at honouring the autonomous exercise of

10. CM Puchalski et al, “Patients who want their family and physician to make resuscitation decisions for them: observations from SUPPORT and HELP. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment. Hospitalized Elderly Longitudinal Project” (2000) 48:5 Supplement J American Geriatrics Society S84 at S89, DOI: <10111/j/1532-5415/2000.tb03146x>.

11. Bomba, *supra* note 8 at 458.

12. *Ibid.*

practical reasonableness, which is a basic or foundational good of life. Moreover, POLST intended to correct the flawed and inadequate advance directives system and improve patient-centered care at the end of life.

In the two decades it has been in use, POLST has proven to be a valuable addition to end-of-life care. POLST has been credited with helping patients and physicians decide on specific plans and treatment options and more individualized patient care. The National Quality Forum reported in 2006 that "...compared with other advance directive programs POLST more accurately conveys end-of-life preferences and yields higher adherence by medical professionals," and the Forum went on to recommend nationwide implementation of POLST.¹³ An American Bar Association review of POLST concluded:

Clinical experience and research demonstrate that advance care directives are not sufficient to ensure that care goals of patients with serious advanced illnesses will be honored unless a POLST form is also completed.¹⁴

II. *Moral problems I: Intention v. Implementation*

In that it aimed to advance the good end of honouring patients and respecting their decision-making authority, POLST seems ethically sound at the level of design and intentionality. POLST, however, has provoked controversy and has its detractors. Several issues have been raised about POLST, some more serious than others, and these issues do affect how one is to assess the moral meaning of POLST.

Critics of POLST have raised practical problems concerning implementation that begin with the actual POLST form itself. According to a survey conducted by the California Advocates for Nursing Home Reform (CANHR), physicians often do not have the very physician-patient interaction POLST was supposed to foster. The survey indicated that 72% of POLSTs for long-term nursing home residents were completed by nurses, nurses aides or other non-physicians, so that physician participation is not what it was supposed to be. Sometimes chaplains, hospital employees or social workers engage patients and fill out the form, which then leads to questions about how well medical knowledge is being conveyed and understood in discussions with patients. The CANHR policy statement pointed out that the form allows that persons signing for patients when

13. Hickman, *supra* note 3 at 14.

14. Amy Vandenbroucke et al, "POLST: Advance Care Planning for the Seriously Ill" (2015) 36:4 *Bifocal* 91 at 92-93, online: <www.americanbar.org/content/dam/aba/publications/bifocal/BIFOCALMarch-April2015.authcheckdam.pdf>.

patients cannot sign the form themselves includes “other,” so that anyone could potentially be a signatory to the form. Not only does “this fact leave patients vulnerable to massive abuse,” but in California this provision is inconsistent with the state law that requires POLST signatories to be limited to “patients with capacity, or legally recognized health care decision makers.”¹⁵

Another problem that has been noted by critics of POLST pertains to advance directives. The POLST form and procedures do not require any cross checking with advance directives, and, furthermore, inconsistencies and actual conflicts can arise between an advance directive and POLST. Additionally, critics have charged that there is little data available to indicate that what is captured on the POLST form accurately reflects a patient’s true treatment wishes.¹⁶ POLST forms can be so written that they actually mandate certain kinds of treatment, and two-thirds of POLST Paradigm forms use the language of “must” or “always” around feeding. Some patients might want to forego any assistance in eating or taking in fluids, but Minnesota, for example, mandated that “Oral fluids and nutrition must always be offered if medically feasible.” There was a check box on the form next to that statement and it was printed pre-checked to prevent any other choice from being made. In April, 2017 a revised form was issued correcting this problem.¹⁷ POLST forms have been criticized for not allowing space for opening discussion of treatment options like “Palliative Sedation to Unconsciousness,” since some patients might choose unconsciousness-inducing sedation as an option.

Surveys show that as many as 78% of physicians mistake living wills for Do Not Resuscitate (DNR) orders, so another criticism leveled at POLST is that a high likelihood exists that a POLST form could be similarly misinterpreted. The danger, of course, is that a patient might want a life sustaining treatment but then not receive it. Where resuscitation was at issue, however, the evidence is that a high consistency obtains between POLST orders and treatment, but a lower consistency is noted between treatment and orders in situations where the patient actually wanted other kinds of life-sustaining treatment.¹⁸

15. California Advocates for Nursing Home Reform (CANHR), “CANHR Policy Brief: Physician Orders for Life Sustaining Treatment (‘POLST’)—Problems and Recommendations” (n.d.) at 3, online: <www.canhr.org/reports/2010/POLST_WhitePaper.pdf>.

16. Stanley A Terman, “It Isn’t Easy Being Pink: Potential Problems with POLST Paradigm Forms” (2013) 36:2 Hamline L Rev 177 at 193.

17. *Ibid* at 194.

18. *Ibid* at 203-204.

The forms have also been criticized for lack of clarity. In California the question has arisen whether EMTs should send patients to hospitals if they are handed a POLST that says “comfort care.”¹⁹

POLST makes possible a documented medical order transferability that advance directives do not, but this very feature has proved problematic for some. POLST allows for the transfer of the medical order so that it may be acted upon in another facility, and it is this feature of POLST that creates continuity of care. Critics, however, have charged that transferability has actually interfered with end-of-life decision-making. The argument has been made that the POLST document may have been signed and decided on prior to a health care crisis so that when an emergency arises, the document can be used as a treatment directive like a DNR, thereby suppressing the possibility that a comatose or otherwise incapacitated patient would choose an intervention to extend life. One researcher has argued, “There is a risk with POLST that life-sustaining medical treatments will be forgone when the patient would have wanted them had he or she been able to communicate.”²⁰

One organization critical of POLST (and discussed in more detail below) has raised several ethical issues, and, even if not well documented, they merit attention. They include the following concerns:

- POLST has been handed out too early in some cases and in others seems not to be time-bounded, with New Jersey, for example, allowing POLST to be given on the expectation of a five year rather than a one-year life expectancy;
- few patients have family physicians with whom they can have extended conversations about end of life and the POLST form;
- incidents of practical coercion have been identified and some patients have been mistakenly told that they *must* fill out a POLST form;
- boxes on the form have been incorrectly checked;
- no witnesses are required for POLST as with advance directives;
- POLST goes into effect regardless of the mental status of the patient; and

19. CANHR, *supra* note 15 at 3.

20. Jason W Manne, *A Critical Look at The Physician Orders For Life-Sustaining Treatment (Polst): What Are Its Weaknesses?* (Master’s Thesis, University of Pittsburgh, 2008), online: <d-cholarship.pitt.edu/9805/>.

- the POLST form can be signed by a medical professional who may not have privileges at a facility where the patient has been moved.²¹

These several concerns about POLST fall under the general heading of “practical problems,” “implementation problems” and even “safety problems.” These various criticisms admittedly raise morally relevant issues. It is not obvious, however, what is at issue. Are the criticisms pointing out that the very problems POLST was designed to correct—human fallibility, insufficient training leading to misunderstanding and procedural mistakes—are continuing even with POLST, or is some more foundational question about the moral meaning of POLST at stake?

Since there is confusion about how POLST differs from advance directives, living wills and DNR orders, it would seem appropriate to point out that POLST requires training and education. Where there is confusion or misunderstanding between various kinds of end-of-life documents or orders, health care professionals have an ethical obligation to gain clarity about the differences. It would seem that education and training are solutions to implementation problems. The fact that there are human failures to act consistently with the paradigm directions for POLST seems to be a problem of professional responsibility rather than a problem with the ethical status of POLST itself.

The other critical issues raised seem to lend themselves to similar kinds of practical responses. Given that POLST does not supplant an advance directive, commitment to making sure that these documents are working together when both are available would seem to be a natural step and a professional responsibility. A Washington State study undertaken in long-term nursing homes showed that where POLST was used, patient wishes were followed in over 90% of cases, and when POLST was placed in a chart along with an advance directive, treatment was congruent between the two documents in all cases.²² Care, education and training are the solutions to most of the implementation problems attributed to POLST. And on the issue raised about transferability, the criticism raised focuses not only on the concern that autonomy may be overridden as a patient moves and the medical situation changes, but on the point that POLST makes medical orders transferrable. This criticism overlooks the fact that frustration with the non-transferability of advance directives

21. Patients Rights Council, “POLST: Important Questions and Answers” (n.d.), online: <www.patientsrightscouncil.org/site/polst-important-questions-answers/>.

22. J.L. Meyers et al, “Use of the Physician Orders for Life-Sustaining Treatment (POLST) Form to Honor the Wishes of Nursing Home Residents for End of Life Care: Preliminary Results of a Washington State Pilot Project” (2004) 30(9) *J of Geron Nur* 37.

was a driving force behind the development of POLST in the first place. Advance directives, as already noted, have not served their purpose well, and the lack of transferability was a major factor leading to the creation of the POLST corrective.

Regarding some of the other criticisms, that POLST forms allow some “other” to sign for the patient, meaning potentially anyone, appears to be a legitimate flaw in the form and this ethical challenge should lead to a change in the form. There is no evidence that this has led to anything looking like widespread abuse, but it does create a potential for abuse and thus should be addressed. Given that POLST is meant to increase patient-physician interaction and communication, it seems most reasonable to prohibit non-medical persons from signing on behalf of physicians. Also, because witnesses to the patient signature are not required (as in advance directives), it is possible that an order could be written against the patient’s wishes, which is to say that a surrogate decision-maker could seek to hasten a patient’s death by signing for the patient. Rather than pointing to some problem with POLST as the cause of wrongdoing, however, it seems more relevant to point out that the person who would do such a thing is acting unethically and the wrongness of such an act would be confirmed in any moral perspective. It is worth noting Stanley Terman’s comment: “To my knowledge, no data are available regarding whether dying is hastened more frequently because POLST forms make it easier to write such orders.”²³ On the concern about mental status, we would do well to remember that physicians are obligated in informed consent discussions about advanced directives to attest that patients have not lost capacity and are not impaired in making judgments. We can extend this qualification to POLST to say that, morally speaking, physicians are not obligated to comply with a patient request for treatment or non-treatment if either option would be ineffective, non-beneficial, contrary to accepted health care standards or if it presents a conscience conflict for the physician.²⁴

POLST proposed to enhance patients’ interaction with their medical caregivers; and it was directed at a communication problem with physicians. Accordingly, it would be appropriate to involve physicians in the POLST communication process as originally intended. POLST should not be out of sync with state law, as in the case in California noted above, and clarity should be provided to emergency workers like EMTs who are confused about what to do when POLST indicates non-treatment or comfort care. If an emergency medical technician reads a POLST form indicating a

23. Terman, *supra* note 16 at 191.

24. *Ibid* at 192.

patient's wish not to be hospitalized, the EMT should not transport—again, this is an education issue and goes to issues in training. The ethics issue here is one of accepting the responsibilities of educational and training requirements of medical care professionals. The ethics concern about coercion raised by critics is of the utmost seriousness, but rather than this being a problem with POLST it points to a prospective wrongful act—even a criminal act—on the part of a caregiving agent. From a moral point of view—and altogether aside from the POLST document—*any* coercion used in presenting the POLST option to a patient constitutes an unconscionable moral breach as well as a violation of professional practice standards. If medical practitioners unintentionally misrepresent POLST and suggest to a patient that it is not voluntary, then that too is cause for more training and better education of caregivers rather than a problem with POLST itself. POLST can certainly be implicated in wrongdoing, but when it is, it does not seem reasonable to blame the document as the cause of the wrongdoing, since that result arises either from unintended errors or is more appropriately located in an agent's willingness to violate established and clearly understandable ethical norms.

POLST engages the bioethics principles of autonomy and beneficence. The POLST objective to support and honor patient directions for informed end-of-life instructions to medical staff speaks to the autonomy principle of respect for persons; and beneficence is served as medical professionals engage POLST as an instrument to promote patient care and well-being. Medical care in certain instances where POLST was used has established that quality of care was compromised with infringements on autonomy and beneficence. Analyzing the criticisms, however, leads to the conclusion that questions raised about POLST due to implementation problems do not point to POLST as an authorizing source for actions leading to harm of patients. Furthermore, the implementation issues discussed do not seem to provide justification for curtailing or abandoning POLST on moral grounds. Still, where medical care has fallen short and POLST has been in some way implicated in subverting autonomy or leading to harms contrary to beneficent patient care, corrections are in order and certainly need to be addressed.

III. *Moral problems II: Religion's ethical concerns*

It is not only medicine, law and ethics that have an abiding interest in the end-of-life issues so central to POLST, but religion as well, and religious authorities have indicated serious misgivings about POLST. That POLST is creating an opportunity for patients to exercise their decision-making capabilities in ways that can lead directly to death invites evaluation of

POLST in light of religiously framed ethical standards. At issue is whether and how POLST affirms the value of life, a preeminent consideration for many religious people because they understand life to be a sacred value due to its status as a gift from God. Accordingly, religiously grounded ethical viewpoints can hold that medical professionals should not be the ones who decide on issues of life or death. They are, in a religious context, finite human beings of limited understanding, and the ultimate questions of life and death transcend the field of medicine. People of faith who affirm this view would hold that physicians and other medical care professionals who employ instruments like POLST are engaging with patients in decision-making efforts about life and death when those issues do not appropriately belong to them but to God—and to those authorized to interpret the divine will in such matters. The theistic religions of the Western traditions value life, and while my focus here will be on Roman Catholic Christianity, we can find the high value placed on life, God's authority over life and death, and trepidation about medicine encroaching into divine space in other Western religions. Islam, for instance, holds to the belief that life and death are given by God, and it cautions that "Medicine...displaces God and empowers humanity to take charge of its destiny, to seek to overcome suffering rather than to passively accept it as a divinely ordained fate. Religion emphasizes the finitude of human life and reminds humanity not to defy God's will to take a life at a predetermined time known to God alone."²⁵ Many other theists in the West, including Jews and Christians, hold a similar view. It could be argued that if a patient and medical professionals invoke POLST to assist a patient in a decision to die, such an act is allowing POLST to be implicated in a self-deceptive claim of authority to determine life and death. Western theological perspectives could even lend support to the idea that for humans to assume decision-making authority when ultimate issues are at stake constitutes an act of defiance against the divine will—medical practitioners can claim no access to the divine will through the resources of modern science and medicine.

The role that religion can play in providing a framework for a moral critique of POLST can be seen in the seven objections to POLST listed in the previous section. Those objections present as ethical concerns, but they were advanced within a normative framework of theological commitment through the Roman Catholic-centered Patients' Rights Council. That context is important for understanding and weighing the criticisms. Roman Catholic criticisms of POLST are particularly important because of the

25. Abdulaziz Sachedina, *Islamic Biomedical Ethics: Principles and Application* (New York: Oxford University Press, 2009) at 80.

21% of Americans who identify with that Church body and because of the significant role Roman Catholicism plays in American life and culture.²⁶ Not only does religion, Roman Catholicism in particular, play a serious role in the ethical assessment of POLST, but the most serious objections to POLST, objections that go beyond implementation problems and errors, come mainly from Roman Catholic ethicists and Church leaders. Analyzing the ethics of POLST in the context of Roman Catholic teaching, however, must begin by noting that POLST itself supports the decision of any Roman Catholic patient to refuse POLST on religiously framed (or any other) grounds.

1. *Relevant background issues in roman catholic moral theology*

POLST is an option in medical care, a patient-centered instrument that patients are free to engage or not engage. Because it is non-coercive and champions autonomy, it is fair to view POLST as respecting patients' moral and religious beliefs. For example, it allows Catholics to make decisions consistent with the United States Conference of Catholic Bishops *Ethical and Religious Directives for Catholic Health Care Services* and ensures that those decisions will be honored in an emergency and across care transitions.²⁷ The Conference of Catholic Bishops' statement does not mention POLST in its end-of-life section, but that statement includes concerns such as those in paragraph 57, which seems consistent with POLST objectives: "A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community."²⁸ This statement reflects prior teachings in the Church. Pope Pius XII in his "Address to an International Congress of Anesthesiologists" in 1957 said that "there is no obligation to have recourse in all circumstances to every possible remedy and that, in some specific cases, it is permissible to refrain from their use." He went on to say that a doctor

...can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission. ...[I]f it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully

26. Pew Research Center, "Religious Landscape Study," online: <www.pewforum.org/religious-landscape-study/>.

27. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Bishops Ethical and Religious Directives for Catholic Health Care Services*, 5th ed (2009), online: <www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

28. *Ibid* at 31.

insist that the doctor should discontinue these attempts and the doctor can lawfully comply.²⁹

This position, which Pope Pius XII was careful to dissociate from any condoning of euthanasia, seems to conform to central POLST objectives: physicians and patients discussing treatment and end-of-life plans, and patients exercising autonomy in making clear their wishes for end-of-life medical care and involvement (i.e., the patient “gives [the doctor] permission”).

Pope Francis has also offered comments on end-of-life issues:

The *Catechism of the Catholic Church* makes this clear: ‘The decisions should be made by the patient if he is competent and able’ (loc. cit.). The patient, first and foremost, has the right, obviously in dialogue with medical professionals, to evaluate a proposed treatment and to judge its actual proportionality in his or her concrete case, and necessarily refusing it if such proportionality is judged lacking. That evaluation is not easy to make in today’s medical context, where the doctor-patient relationship has become increasingly fragmented and medical care involves any number of technological and organizational aspects.³⁰

In response to his call for “dialogue with medical professionals” and in his analysis that the “doctor-patient relationship has become increasingly fragmented” Francis advances a view that seems consistent with POLST objectives. Elsewhere in his end-of-life statement to the World Medical Association held at the Vatican in November, 2017, Francis notes that “advances in therapies, surgeries, technologies and other medical interventions” have made it possible “to extend lives by ways that were inconceivable in the past.” He goes on to say that “Greater wisdom is called for today, because of the temptation to insist on treatments that have powerful effects on the body, yet at times do not serve the integral good of the person.” A concern for autonomy and beneficence runs through the papal statement, and Francis remarks that “it is morally licit to decide not to adopt therapeutic measures, or to discontinue them, when their use does not meet that ethical and humanistic standard that would later be called ‘due proportion’ in the use of remedies.” With Francis giving sanction to the withdrawal of “overzealous treatment,” which may be harmful to patients physically and spiritually, Francis encourages discussions between care-

29. Pope Pius XII, “Address to an International Congress of Anesthesiologists” *L’Osservatore Romano* (24 November 1957), reprinted online: <www.lifeissues.net/writers/doc/doc_31resuscitation.html>.

30. Jim Fair, “Pope Francis Addresses End of Life Issues” *Zenit* (16 November 2017), online: <zenit.org/articles/pope-francis-addresses-end-of-life-issues/>.

givers and patients and their families, one commentator observing that “Pope Francis stressed the primary role of the patient in making treatment decisions.”³¹

POLST has not been a specific topic for papal comment, but the POLST form allows health care professionals to work with patients (or their surrogates) to order treatments patients want and to refuse treatments patients consider “extraordinary” or excessively burdensome, and the Catholic directives as enunciated by Pius XII and Pope Francis clearly endorse this respect for autonomy. Like the Catholic directives, the POLST form requires that “ordinary” measures to improve the patient’s comfort and food and fluid by mouth, as tolerated, always be provided.³²

2. *Objections to POLST from roman catholic leaders and ethicists*

Despite an apparent congruence between POLST objectives and what Roman Catholic Church teaching allows in end-of-life decision making, the argument has been made that POLST inserts illicit euthanasia into the regular order of medical practice. This is clearly the most serious criticism of POLST. However, POLST nowhere in the actual form or in any statements by those who created the document gave evidence of intending or endorsing active euthanasia. Euthanasia is universally prohibited by law in the United States, and POLST nowhere equates natural death with direct and intentional killing. The POLST form also makes no allowance for physician assistance in dying or physician assisted suicide. Despite these clear prohibitions on what can be done with respect to aid to the dying, Roman Catholic ethicist E. Christian Brugger has argued that POLST is more dangerous than it appears. Brugger’s argument is that the POLST form allows patients to refuse any treatment for any reason with the consequence that completing the form opens a slippery slope to physician assisted suicide, hence to a form of euthanasia.³³ The fear that POLST can by implication lead to euthanasia was also expressed in a statement by a group of Wisconsin Bishops, who wrote:

It is difficult to determine in advance whether specific medical treatments, from an ethical perspective, are absolutely necessary or optional. These decisions depend on factors such as the benefits, expected outcomes, and the risks or burdens of the treatment. A POLST oversimplifies these decisions and bears the real risk that an indication may be made on it to withhold a treatment that, in particular circumstances, might be an act of

31. *Ibid.*

32. Vandenbroucke, *supra* note 14 at 91-94.

33. E Christian Brugger, “A Critique of the National POLSD Paradigm through an Analysis of Colorado’s New MOST Legislation” (2011) 78:2 *Linacre Quarterly* 157, DOI: <10.1179/002436311803888410>.

euthanasia. Despite the possible benefits of these documents, this risk is too grave to be acceptable.³⁴

The Bishops' statement concludes by saying,

Due to the serious and real threats to the dignity of human life that POLST and all similar documents present, we encourage all Catholics to avoid using all such documents, programs, and materials. The POLST form should not be regarded as the standard model for designating treatment preferences.³⁵

Not only the Wisconsin Bishops but the Bishops in Minnesota, the National Catholic Bioethics Center, and the Catholic Medical Association have all attacked POLST on similar grounds. Their concern is that POLST inevitably encourages euthanasia. This is a dramatic accusation, but the clearly stated objectives in POLST make no allowance for active euthanasia or physician assisted suicide, and the form provides no evidence for such a charge. Any coercive and illicit killing of a patient at the hands of medical professionals and caregivers, as stated above, would no doubt meet with strong resistance from the medical community and law enforcement authorities; and the motives for such acts cannot be reasonably associated with patients signing a POLST form. The fear that POLST could slide into authorizing or otherwise enabling the illicit killing of a patient via active euthanasia actually provokes another question: Is a slippery slope from POLST to euthanasia the actual issue of concern? After considering certain other criticisms that Roman Catholic ethicists have raised about POLST, I shall offer a response to that question.

Another criticism of POLST is that it fails to provide conscience clauses to protect facilities and practitioners. Yet another concern is that POLST opens up treatment and care options to patients as if those treatment options, which could lead to death, were morally neutral. The reasons for raising these concerns is not obvious from simply examining the POLST document or investigating the intentions of those who created it. The clearest response to these objections is to note that POLST nowhere insists that physicians uncomfortable with POLST violate conscience clauses, and the criticism that options for treatment are presented as if they are morally neutral overlooks the ethical reality that no delivery of

34. Diocese of Madison, "Bishops Urge Against use of POLST Medical Forms" *Catholic Herald* (26 July 2012), online: <www.madisoncatholicherald.org/news/around-diocese/3341-polst.html>.

35. *Ibid.*

medical services to patients is ever morally neutral.³⁶ Medical treatment always involves motivated and intentional actions, and in the field of ethics any action is subject to ethical scrutiny.

Roman Catholic teaching does not oppose end-of-life or advanced care planning, but it does insist that such planning be conformed to Catholic teaching. This points to what may be the real issue driving the charge that POLST is euthanasia-friendly. Some Roman Catholic Church leaders have condemned POLST because it runs counter to a specific Catholic instruction, namely, that for end-of-life planning *Catholics are required to identify a Catholic proxy*. Church leaders have pointed out that advance directives allow for the appointment of a decision-making proxy or surrogate, and the concern is to keep that proxy within the folds of the Church. As the Wisconsin Bishops said,

We encourage all persons to use a durable power of attorney for health care. For those who are age 18 or older, completing this document allows you to appoint a trusted person to make health care decisions on your behalf if a situation arises in which you cannot make these decisions for yourself. It is important to discuss your wishes and Catholic teaching with the person whom you appoint and to choose someone who will make health care decisions based on these principles.³⁷

The Catholic proxy issue is one major concern about how Catholics are to regard end-of-life decision making, and the proxy issue seems directed at advance directives rather than POLST. Advance directives are legal documents that do not provide treatment orders, whereas the POLST form gives emergency health care professionals medical orders to follow—emergency care professionals following an advance directive must attempt to save a life—and only an advance directive can identify and secure a surrogate and doing so involves a legal process. POLST forms ask for surrogate information but otherwise have no authority to designate a surrogate. POLST is a medical order that tells medical care professionals patient wishes when patients cannot speak for themselves. The proxy issue, when aimed at POLST, appears directed at the wrong target.

The Catholic Medical Association and other Roman Catholic critics have also expressed concern that POLST could not be restricted to the terminally ill. Allowing, say, the frail elderly, to use POLST to specify

36. Jean McCarthy, "Wisconsin Bishops Warn against POLST End of Care Document" *Life Site* (26 July 2012), online: <www.lifesitenews.com/news/Wisconsin-bishops-warn-against-polst-end-of-care-document>.

37. *Ibid.*

treatment plans in a medical crisis, could, according to this criticism, serve to hasten a loss of life outside of a pressing life-and-death situation, and this could conceivably turn POLST into a means for effecting euthanasia. Defenders of POLST would not accept the conclusion that POLST leads to euthanasia, but they could be expected to welcome the prospect that the frail elderly might employ POLST to make decisions about end-of-life care. From the start, the developers of POLST understood that the POLST process could benefit elderly persons who wanted to avoid unwanted medical interventions in a medical crisis. POLST supporters do not accept that pre-emptive action on the part of the elderly constitutes a moral violation and would, on the contrary, hold that engaging the elderly in POLST discussions prior to a medical crisis is not only not objectionable from a moral point of view but is, rather, an exemplification of autonomous decision making.

Roman Catholic Church leaders and ethicists have raised yet another objection to POLST, this one concerning the theological commitment to affirming the value of life. A main concern of the Wisconsin Bishops and others was that POLST interferes with how some in the Church want to direct end-of-life decision making. The Bishops argued that end-of-life decision-making must be vested in a proxy who knows the patient's wishes and is charged with decision making in accordance with an advance directive that itself embodies Catholic values. Given that Catholic teaching, as noted above, supports patients who reject overly aggressive or "overzealous" treatment, withholding care is sanctioned when treatment is disproportionately burdensome—the Bishops do not deny this. What is objectionable, however, is that the patient's family or caregivers could find the life of a patient so burdensome that they would turn to POLST as a way to reject the gift of life. This in turn provokes the prospect of active euthanasia. To permit a medical intervention leading to this end would, the Bishops say, constitute a paradigm shift with respect to life values. And if POLST actually authorized such interventions or allowed caregivers to euthanize a patient in order to rid themselves of a burden, the Bishops would be right to raise an ethics alarm.

This objection, however, expresses a fear that is so far from being realized in practice that it cannot be used to justify rejection of the POLST process. POLST does not advocate any such paradigm shift in end-of-life respect for life values—and for caregivers to kill a person because he or she has been reduced to a burden would constitute an illicit direct and intentional killing. Such a killing would amount to murder under current law. The Bishops advocate reasserting the authority of the proxy in order to prevent this unwelcome but also unlikely prospect, but making the

move toward “Catholicizing” the proxy then runs counter to another of the core problems POLST was designed to address. POLST, recall, allows for treatment decisions to be made in the present circumstances of a patient’s medical condition—that is one of its advantages. The fact that POLST orders can be put into effect quickly is a benefit over against the problem that a proxy may not be available in a crisis moment to offer direction to a medical care team. Furthermore, proxy or surrogate decision-makers make mistakes, and as one defender of POLST has put it, “surrogates are frequently and wildly inaccurate when making decisions about life-sustaining treatments.”³⁸ (This is the reason surrogates complete the POLST form as well as the patient.) POLST seeks to avoid the problems that proxies presented in the advance directive experience.

The Catholic evaluation of POLST advances stout resistance to what some Catholic faithful regard as an encroachment of anti-life values. Despite the criticisms advanced by those concerned about POLST from the point of view of Roman Catholic teaching, however, the fact is that Catholic health care ethics have, in general, embraced POLST. For instance, Catholic health systems in Oregon universally reject that state’s path breaking *Death with Dignity* law and its provisions for physician assistance in dying, yet in Oregon “all Catholic health systems use and honor POLST forms....”³⁹ This does not render these criticisms from within the Roman Catholic tradition of moral theology “strawman” arguments easily dispensed with, for they are real concerns from exceedingly concerned individuals pledged to the life values of their faith tradition. They are arguments and positions that can be addressed, however, and the fact that POLST is used widely in Catholic hospitals undermines any claim that POLST is subverting the value of life as understood by Roman Catholics. Such claims represent worries about abuse, but those worries are directed at theoretical or hypothetical possibilities rather than actual instances of abuse.

Because the Catholic ethical critique of POLST—that POLST leads inevitably to euthanasia via a slippery slope—can itself be challenged, refuted and even deemed unsupportable, something else is at issue. My view is that behind the criticism of POLST is distress at the prospect of the Church losing its authority in end-of-life decision making. The criticism of POLST advanced by some Church leaders appears to be motivated by a refusal to allow the government or medical professionals to supplant

38. Thaddeus Pope, “Dangerous Catholic Attack on POLST” *Bioethics.net* (19 July 2013), online: <www.bioethics.net/2013/07/dangerous-catholic-attack-on-polst>.

39. Vandenbroucke, *supra* note 14 at 94.

Church authority in the ethical arena of life-and death decision making. Again, religious people will in various traditions and belief systems hold that life-and-death decisions are too important to leave to medical professionals, well-intentioned though they may be. The faith perspective would hold that such decisions are made appropriately in the context of the ultimate values that transcend the resources of modern medicine. These ultimate values belong to God and then by extension to the Church, for the Church claims to have access to knowledge of the divine will, which it is then committed to serving. On the basis of this understanding, a larger ethical issue then arises, for this perspective concerning ultimate values then allows Church teachings and directives to themselves be examined for ethical soundness. Those religiously framed teachings and guidelines should be examined alongside non-Church related guidelines, such as POLST, that reflect the values of a broader society and claim standing in both the professional medical community and in government authorizations for medical care. The case can then be made that examining Church teaching themselves alongside secular ethical action guides leads to this conclusion: that Roman Catholic Church teachings on various life-related issues are grounded in a religious metaphysics and ethical framework that is sectarian. As such these criticisms are grounded in and supported by a non-rational faith context that transcends what is ordinarily available to reasonable persons in a non-sectarian context of decision making. I would suggest that this is the case with respect to POLST.

My view is that sectarian views ought not be followed in those settings and jurisdictions where secular law and best practices medical science govern the process of decision making.⁴⁰ Given a commitment to this foundation, the view that POLST is condoning active euthanasia seems unwarranted and even unreasonable. Were POLST to be criticized for condoning patient-authorized *passive* euthanasia—if by that one means a patient is refusing interventions with knowledge that doing so may hasten death—then that criticism is not so far-fetched. The problem on this point is that *any* act of refusing medical intervention to sustain life when a patient no longer wants aggressive treatment would fit under such a description, including actions by those Catholics who, in conformity to Church teaching, want to stop treatment to die a natural death. Control of decision-making and insisting on the primacy of Church authority in decision-making seem to me to be the core issues at stake in the Catholic criticism of POLST.

40. Lloyd Steffen, *Ethics and Experience: Moral Theory from Just War to Abortion* (Lanham, Md: Rowman and Littlefield, 2012) at 173-194.

Conclusion

POLST is a sheet of paper. It is a colorful piece of paper and easily found in a patient's chart. More importantly from an ethical point of view, however, is that POLST is a corrective to a major continuing problem in the medical field—communications between health care professionals and patients. POLST provided a response to that problem. In its over two decades of use in the medical field, POLST has proven to be a successful addition to communications and to the advance directive process.

POLST has been criticized and some of the problems identified warrant criticism. For the most part, however, those criticisms do not impugn the ethical propriety of POLST. Most of the problems raising concerns have been anecdotal, incidental and the result of identifiable instructional rather than intractable systemic failures. The curiosity, of course, is that POLST has at times suffered from the very communications problems that POLST was created to address. It is thus important when examining the moral meaning of POLST to discern that the most feared problems, like those attached to euthanasia, do not practically arise, and the practical problems that have arisen, being the result of human failures, are correctable. The most serious charge against POLST, namely, that it provides the permission slip for active euthanasia, is unfounded, and like most slippery slope arguments, this one too appears when thought comes to an end. The grounds for connecting POLST to euthanasia are most reasonably located in a religious or ideological point of view that can and should be identified as a sectarian rather than a rationally universalizable ethical perspective.

POLST is a communications tool that addresses a communication problem. It honors patient autonomy and provides a means for medical professionals to provide beneficent patient-centered care. It recognizes that medical culture can deliver over-aggressive treatment to patients who do not want such care and whose medical condition may not warrant it, then offers a practical corrective. It respects autonomy and is a reminder that the move to emphasize autonomy in bioethics was in response to the hegemonic encroachment of a clinical medical culture that did not involve patients in decisions about their own care.

The clinic has its own culture and values.Clinical practice is often thought to have an implicit ethos that varies among medical specialties or particular healthcare professions, their 'standard of care.' And, because healthcare professionals are highly educated and respected, they are probably likely to assume that others share these values or to overvalue the worth of their treatments. The doctrine of informed consent [so vital a part of autonomy] evolved to safeguard us from the imposition of this

clinical culture on patients.⁴¹

POLST serves autonomy. It has not put an end to challenges in end-of-life decision-making, but it has contributed positively to a more holistic end-of-life health care effort. Even if it is too bold to suggest that POLST might, finally, contribute to the possibility of patient growth at the end of life, at least it can be said with more assurance that POLST creates an opportunity for the medical profession to approach the dying with greater respect for patient dignity.

41. Mark Kuczewski & Patrick J McCruden, "Informed Consent: Does it Take a Village? The Problem of Culture and Truth Telling," (2001) 10:1 *Cambridge Quarterly of Healthcare Ethics*; reprinted in Carol Levine, *Taking Sides: Clashing Views on Controversial Bioethical Issues*, 12th ed. (Dubuque, Iowa: McGraw-Hill, 2008) at 38.

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