

INVITED COMMENTARY

# The POLST Paradigm: Assessing Its Utility and Ethos

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The problem of POLST can be assessed at two levels: utility and ethos. In 2013, ten coauthors and I published a critique of its utility in a *White Paper* for the Catholic Medical Association.<sup>1</sup> We expressed solidarity with POLST proponents in working to overcome the real problems that POLST aims to address, problems associated with ensuring the rightful expression of patient preference in end-of-life care; effectively translating preferences into treatments; and safeguarding a consistent standard of care across care settings. At the same time, we argued that the simplistic form poses significant risks to good medical decision-making and good ethical decision-making, and that neither the form nor the paradigm is an adequate response to those problems.

## Utility

One of the more pressing concerns, which neither the essays of Edward Grant nor Lisa Anderson-Shaw (nor of any defender of POLST to date to my knowledge) adequately addresses, is with the intrinsically simplistic mode of medical decision-making represented on the form. The crude check-box format for designating treatment options reduces complex medical decisions to overly simplified scenarios that may not reflect the real-life complexity of end-of-life emergencies; and since these designations may be made weeks or months in advance of a crisis, the POLST encourages some patients—indeed tempts them—to make critical life-impacting decisions without all the facts, e.g., the precise details of the condition from which they will be suffering; the reasonable treatment options; and the risks/burdens and promises/benefits of each option. In short, POLST forces decision-making scenarios into a “one-size-fits-all” mold, a virtual “Procrustean bed,” ignoring the natural complexities, contingencies and diversity of unanticipated “in the moment” clinical decision-making.

Grant’s essay repeats several of our concerns, including the unreliability of the “death within a year” criterion;

the “ethical gray area” associated with decision-making in regard to the use/refusal of artificial nutrition and hydration; potential conflicts between POLST orders and other advanced medical directives; and the risk that, because the form’s directives may not be scrupulously updated, they will become “stale or ‘frozen in time.’” Nevertheless, he thinks that if the implementation of the POLST model is allowed “greater latitude and flexibility,” POLST would be “a step forward, and not a step back” in end-of-life care.<sup>2</sup> This seems to me doubtful.

Anderson-Shaw offers what she refers to as a “Christian response” to problems in end-of-life decision-making, but proposes no critical remarks at all on POLST. Her three case studies do illustrate certain problems, but hardly demonstrate that POLST is the best solution. For as many anecdotes as can be adduced for patients who have suffered unreasonable EOL treatments at the hands of overzealous loved ones, just as many can be found for elderly patients who have suffered under-treatment by clinicians and caregivers whose problematic ideas of autonomy and the “worth” of lives crippled by disability have inordinately influenced their caregiving.

## Ethos

POLST is not simply a form. It is, by design, a “paradigm,” a model for influencing the culture—ethos—of end of life care. So even if *ex hypothesi* the form’s utility could be improved by adding greater latitude and flexibility, the implemented paradigm still would act—and is acting—as a seedbed of values within U.S. healthcare. I will mention just two of several worries I have in this regard.

Neither Grant nor Anderson-Shaw expresses concern with the inevitable marginalization of the physician’s role in end-of-life counseling that POLST facilitates.<sup>3</sup> POLST defenders claim that the preeminent purpose of the paradigm is to invest the *informed preferences* of patients with clinical efficacy. But the paradigm entrusts the critical role of educating and counseling patients to non-physician “facilitators.” This means that information necessary to achieving truly informed consent in matters of life and death—about the likely course that diseases

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or other conditions will take, foreseen contingencies, benefits and burdens of available treatment options and their side-effects, etc.—is predominantly communicated by non-physicians: “More often than not the physician role [in the implementation of the POLST process] is to verify the choices made and the process used and then sign off on the orders.”<sup>4</sup>

For all our concern today with patient autonomy and informed consent, why is there not more apprehension about the marginalization of physicians? Should red flags not go up when POLST defenders say they want to “simplify” end-of-life decision-making? How can patients make truly informed decisions about care options without being counseled in the facts and complexities of medical situations? Should we not be working to overcome causes of the alienation of the doctor-patient relationship rather than multiplying them?

Both Grant and Anderson-Shaw make a point of noting that POLST is intended for patients who suffer from serious health conditions or life-limiting diseases. But *nothing* in the paradigm requires this. In fact, POLST model legislation ordinarily abrogates the decades old statutory requirement of Living Will laws that patients must be “terminally ill” before they are authorized to refuse life-sustaining treatment.<sup>5</sup> By situating refusal requests within the context of death and dying, the older laws implicitly operated from a reasonably limited notion of patient autonomy. The new statutes operate from a virtually unlimited notion of autonomy. When the paradigm was being debated in my home state, the lawyers for the Colorado MOLST coalition stated very clearly at the senate hearing that if their model legislation were enacted any competent adult may refuse life-sustaining measures at any time, for any reason.<sup>6</sup>

POLST literature speaks about “best practice,” “improved quality,” “reduction of errors,” “thoughtful planning,” and “respect for patients.” But what POLST *does* speaks louder than the mere repetition of words. “Best practice” *should* mean doing what is clinically indicated for patients *under their specific circumstances*. “Quality” should mean best practice *in action*. “Reduced error” should mean best practice in action without confusion, complications, or delay. And “thoughtful planning” should mean that patients ordinarily be assisted *by their physicians* to consider all relevant facts in light of all reasonable treatment options.

But none of these is the aim of the new paradigm. For POLST these positive pithy phrases can be reduced to a single supreme mega-value: *the right to refuse treatment without delay or complication across all care settings*.

Rather than entrenching Christian healthcare more deeply in the soil of secular values, we should find ways to implement the best possible care available for every patient at the times when he or she most needs it.

### Duties of the Dying and End-of-Life Instruments

To Christians, there is something incalculably more important at the end of life than being made comfortable. It is being assisted in every reasonable way possible to do and fulfill the work God has given to them to the end of their lives. Anderson-Shaw gestures in the direction of this theme with her insightful reference to Ephesians 2:10 and her “challenge” to Christian churches. But more needs to be said with respect to the developing of tools and processes for end-of-life decision-making.

What are the duties of dying Christians? . . . To put their earthly affairs in order; carry their crosses with patience; forgive those who need forgiveness and repent to those whom they’ve wronged; make due provision for their loved ones; direct that proper provision be made for their healthcare if their decision-making capacities erode; offer redeeming love to those around them; and set their eyes on heavenly glory.

Any tool, regimen or paradigm for end-of-life planning should be judged in light of how well it assists patients in carrying out these final duties.

- 1 Christian Brugger et al., “The POLST Paradigm and Form: Facts and Analysis (Catholic Medical Association White Paper),” *The Linacre Quarterly* 80, no. 2 (2013): 103–138.
- 2 Edward R. Grant, “Back to the Future? POLST and End-of-Life Law,” *Examining POLST*, supplement, *Dignitas* 22, no. 4 (Winter 2015): S8.
- 3 See the “Respecting Choices” website: <http://www.gundersen-health.org/respecting-choices/FAQs> and see question on “Why does Respecting Choices support the use of non-physician advance care planning facilitators?”
- 4 Charles P. Sabatino and Naomi Karp, “Improving Advanced Illness Care: The Evolution of State POLST Programs,” *AARP Public Policy Institute Research Report* (2011): 24, <http://assets.aarp.org/rgcenter/ppi/cons-prot/POLST-Report-04-11.pdf>.
- 5 I develop this criticism with respect to our legislation in Colorado in Christian Brugger, “A Critique of the National POLST Paradigm Through an Analysis of Colorado’s New MOST Legislation,” *The Linacre Quarterly* 78, no. 2 (May 2011): 157–171, esp. 158–161.
- 6 *Ibid.*, esp. 163.