



Of Proxies and POLSTs: The Good and the Bad in End of Life Planning

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Planning for end of life situations is important. We should put in place an *advance directive* before our health takes a serious turn for the worse and we are no longer able to indicate our own wishes or make our own decisions. Advance directives can be of two types: living wills and health care agents.

The best approach is to choose a health care agent (a.k.a. a “proxy” or a “durable power of attorney for health care”). Our agent then makes decisions on our behalf when we become incapacitated. We should designate in writing who our health care proxy will be. The National Catholic Bioethics Center (<http://www.ncbcenter.org>) and many individual state Catholic Conferences offer helpful forms that can be used to designate our proxy. Copies of our completed health care proxy designation forms should be shared with our proxy, our doctors, nurse practitioners, hospice personnel, family members and other relevant parties.

In addition to choosing a health care proxy, some individuals may also decide to write up a living will in which they state their wishes regarding end of life care. Living wills raise concerns, however, because these documents attempt to describe our wishes about various medical situations before those

situations actually arise, and may end up limiting choices in unreasonable ways. Given the breathtaking pace of medical advances, a person’s decisions today about what care to receive or refuse may not make sense at a later time point. In the final analysis, it is impossible and unrealistic to try to cover every medical situation in a living will, and it is preferable to have a proxy, a person we trust, who can interact with the hospital and the health care team, weigh options in real time, and make appropriate decisions for us as we need it.

A new type of living will known as a “POLST” form — a tool for advance planning — also raises concerns. The POLST form (which stands for Physician Orders for Life Sustaining Treatment) is a document that establishes actionable medical orders for a patient’s healthcare. The form is typically filled out with the help of trained “facilitators” — usually not physicians — who ask questions about patients’ health care wishes, and check boxes on the form that correspond to their answers. The facilitators receive training that can lead them to paint a rather biased picture of treatment options for patients, emphasizing potential

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negative side effects while side-stepping potential benefits or positive outcomes.

POLST forms thus raise several significant moral concerns:

1. The approach encouraged by the use of POLST forms may end up skewed toward options of non-treatment and may encourage premature withdrawal of treatments from patients who can still benefit from them.
2. Filling out a POLST form may preclude a proxy from exercising his or her power to protect the rights of the patient, since the form sets in motion *actual medical orders that a medical professional must follow*. As a set of standing medical orders, the POLST approach is inflexible. Many POLST forms begin with language like this: “First follow these orders, then contact physician or health care provider.” Straightforwardly following orders created outside of a particular situation may be ill-advised, improper and even harmful to the patient.
3. In some states, the signature of the patient (or his or her proxy) is not required on the POLST.

After the form has been filled out, it is typically forwarded to a physician (or in some states to a nurse practitioner or a physician’s assistant) who is expected to sign the form. Thus, in some states, a POLST form could conceivably be placed into a patient’s medical record without the patient’s knowledge or informed consent. In a recent article about POLST forms in the *Journal of Palliative Medicine*, approximately 95% of the POLST forms sampled from Wisconsin were not signed by patients or by their surrogates. Fortunately, in some other states like Louisiana, the patient’s signature or the signature of the proxy is mandatory for the form to go into effect.

The implementation of a POLST form can thus be used to manipulate patients when they are sick and vulnerable, and can even lead to mandated orders for non-treatment in a way that constitutes euthanasia. The POLST template represents a fundamentally flawed approach to end of life planning, relying at its core on potentially inappropriate medical orders and dubious ap-

proaches to obtaining patient consent.

Notwithstanding the pressure that may be brought to bear on a patient, no one is required to agree to the implementation of a POLST form. Patients are free to decline to answer POLST questions from a facilitator, and should not hesitate to let it be known that they instead plan to rely on their proxy for end of life decision making, and intend to discuss their healthcare options uniquely with their attending physician.

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