

Health Care Ethics USA

A resource for the Catholic health ministry

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POLST Under Fire

The POLST paradigm has come under fire in two recent articles. This has directly resulted in a few church leaders expressing to CEOs of Catholic health care facilities in their dioceses their grave concerns about the use of POLST in those facilities. Needless to say, this is causing considerable consternation where POLST is already being employed as well as among those who are actively planning to implement its use.

The first article, “A Critique of the National POLST Paradigm through an Analysis of Colorado’s New MOST Legislation,” appeared in the May 2011 issue of *Linacre Quarterly*. The second, “POLST and Catholic Health Care,” appeared in the January 2012 issue of *Ethics and Medics*. Both articles are by E. Christian Brugger (and, in the case of the *Ethics and Medics* article, by Brugger and three colleagues) who teaches at the Saint John Vianney Theological Seminary in Denver, Colo.

What are Brugger’s concerns? First, his concerns about Colorado’s MOST.

- The Colorado MOST legislation does not require that the patient be in a terminal condition in order for life-sustaining treatment to be withdrawn. “[T]here is no requirement in the law that the refusal of life-sustaining care must be limited to end-of-life conditions” (159). Consequently, some patients, he believes, will choose to bring about their own death, even when the treatment offers hope of recovery. Their decision is based on burdens not associated with the treatment. He writes: “Perhaps the thought of living with some disability, or with some grave loss, say, a relational loss ... or financial loss, is repugnant to them: ‘Living like this,’ they judge, ‘is too burdensome.’ The burden in this case is not imposed by some medical treatment from which they wish and seek to be free through refusing it; the burden is living under some state of affairs from which death can free them” (161). This, he says, is nothing short of suicide.
- Furthermore, and closely related to this, the Colorado MOST legislation does not employ benefit and burden criteria to determine the appropriateness of decisions to refuse treatment, nor does it distinguish between killing and letting die or between rightful and wrongful intentions. Consequently, “it empowers health-care professionals to remove life-preserving treatment from patients for whom they are not futile and for whom in many cases the burden would be offset by a reasonable hope of recovery. It therefore juridically extends the normative context of intentionality to include the removal or withholding of life support for purposes of death. Without using the term, the new law authorizes euthanasia” (161).
- A faulty notion of autonomy underlies MOST as well as the national POLST

paradigm. Brugger observes that a faulty notion of autonomy has become increasingly operative in health care over the past forty years. As he explains: “It understands autonomy as freedom from constraint. Not only should my capacity for free and deliberate choice be respected, but *what* I choose should be respected *because* I have chosen it and not in virtue of the kind of choice it is” (162). He goes on to conclude that this notion of human agency is exemplified in the philosophy underlying MOST: “respecting choice and liberty—and hence autonomy—means respecting *what* I choose” (162). There are no limits to this notion of autonomy. Patients can refuse life-sustaining treatment whenever they want and for whatever reason and health care facilities must comply with morally problematic medical orders.

Brugger concludes from all this that “since other forms of advance directives are available to patients for expressing their rightful will in end-of-life care, it is advisable that Catholic institutions refuse to accept MOST-type documents as valid” (166). He further notes that “one central provision of the MOST document is to order that artificially administered food and water be withheld. Ordinarily, this provision could not rightly be carried out by a Catholic institution” (166). Finally, he claims that “by removing the requirement of terminal illness, it [Colorado’s HB 1122] authorizes doctors to carry out the intentions of their patients for death. It is naïve to think that some

patients, especially those with an exaggerated conception of autonomy and a repugnance for some disability or limitation, will not order their self-killing through the removal of life-sustaining care, and that some doctors, sharing their philosophical views, will not be willing to execute their order” (167).

In their article in *Ethics and Medics*, Brugger et al. identify seven ethical problems with POLST. They are as follows:

- POLST orders may be implemented when the patient is not terminally ill. “The laws that sanction the use of POLST authorize any adult patient to refuse any treatment at any time for any reason, whether or not the treatment is associated with end-of-life conditions” (1). The authors explain that this is ethically problematic for three reasons. First, the POLST model’s one-size-fits all approach to medical orders excludes... a careful and detailed inquiry into particular facts related to the specific treatment options of a specific patient” (2, 1). Second, POLST orders set up a conflict with the church’s teaching on artificially administered nutrition and hydration. If a Catholic health care facility refuses to carry out an order contrary to church teaching, there is the possibility of litigation. And, third, because POLST permits refusal of treatment for any reason, “the use of POLST documents will involve Catholic health care workers at times in facilitating euthanasia through the wrongful removal of life support” (2).

- No patient signature is required for implementation of POLST orders. “This lack of fully informed consent is ethically irresponsible and could be medically negligent” (2).
- No signature is required of a physician attending the patient when the orders are implemented. “[M]any state POLST documents may be validly signed by *any* doctor, nurse practitioner or physician assistant” (2).
- The orders travel with patients from one health care facility to another; “[I]f the documents are not regularly revised and updated in accord with changing clinical situations and wishes of the patients, then they risk ordering inappropriate or outdated measures” (2). Furthermore, they can also separate the immediate health care providers from the “ordering” physician.
- The orders are effective immediately. Because “good faith” actions are not subject to criminal, civil, or disciplinary proceedings under POLST, “a health care provider could potentially ignore conflicting directives from family, other directives, or even the present expressed wishes of the patient and avoid any liability simply by stating he was acting in good faith by following the POLST form” (2).
- POLST forms are implemented by non-physician “facilitators.” “Facilitators routinely initiate POLST discussions with patients or family members, counsel patients, and record their preferences, and refer completed POLST documents to physicians for signature” (2). The authors explain that this is problematic for three reasons: 1) the facilitators are not physicians and rely on information from a 2-3 day training session; 2) training materials are biased in favor of refusing life-sustaining treatments and emphasize the burdens of accepting treatment; 3) use of facilitators deprives patients of the expertise and the personal knowledge of their physicians.
- POLST forms utilize a simplistic check-box format for directing complex decision making. This format “cannot possibly account for all the medical contingencies that may arise at some future time ...” (3).

These concerns lead the authors to conclude that “POLST forms and their model for implementation pose unacceptable risks to the well-being of patients and the ethical values of Catholic health care” (3). For this reason, they “urge Catholic health care institutions to refuse to accept POLST forms. If they are already in use, the forms should be revised to make their use fully consistent with good health care practice and the full dignity of the human person” (3).

Brugger and his colleagues have levied very serious and damaging charges against the POLST paradigm. Those charges merit extensive comment, but only a few general observations will be made at this time. We invite others, especially those who have experience with POLST, to comment on these charges in future issues of *HCEUSA*.

Supporters of POLST will likely be inclined to dismiss the Brugger et al. critique and, to some extent, with good reason. There is much in their analyses that is mistaken, without foundation, or exaggerated. However, supporters of POLST would do well to take a second look at the POLST paradigm and POLST forms in light of the Brugger critiques. This can be an opportunity to improve POLST, instead of discarding it as Brugger and his colleagues advocate. There seems to be some merit, for example, in the authors' concerns about patient/surrogate signatures, attending physician signatures, and who assists patients in determining their wishes about life-sustaining treatment.

Having said that, there are several troubling aspects of the articles that deserve mention. First, the authors' focus is on POLST *forms*—two in particular, Colorado and Wisconsin. While there is great similarity among POLST forms, they are not all identical. To dismiss the POLST paradigm entirely on the basis of the forms used by two states seems to be an over-reach.

It also seems to be an excessive reaction to dismiss POLST entirely on the basis of concerns about forms. While the forms are important, what is more important is how POLST is implemented in practice. The authors would have done well to consult extensively with those who deal directly with POLST—patients/surrogates, family members, and health professionals—in order to understand and assess user's experience. Would they really have found the abuse

that they suggest? Would they have found significant numbers of patients choosing to end their lives for illicit reasons and physicians going along with their requests? While this undoubtedly can happen (and probably does in some relatively few instances), it can occur without POLST and it is unlikely that POLST encourages it.

The authors seem to discount the fact that the vast majority of people do not want to die and that the vast majority of physicians and other health professionals are committed to preserving life when possible. They appear to ascribe intentions to others that simply are not present. Nor do they take account of the culture in Catholic health care organizations that has been shaped by the church's teaching on the duty to preserve life and the limits to that duty. Both articles reflect a fundamental mistrust of patients, health professionals, and Catholic health care.

A second concern is the notion that one must be terminal in order to forsake life-sustaining treatment. Is this really the Catholic tradition? What seems to be central in the tradition and in the Church's teaching is that one has a moral obligation to use ordinary means to sustain one's life, but there is no obligation to use extraordinary means—means that offer little or no hope of benefit or that are excessively burdensome. Determining what is ordinary and extraordinary consists in an assessment of the means—cost, availability, etc.—and the benefits and burdens upon this patient in this particular situation. It is not clear

that one must be terminal, whatever that means in this day and age.

For example, an active and relatively healthy 87 year-old woman with poor circulation in her legs is told by her physician that she needs a double amputation. She refuses because, for a number of reasons, this surgery and the loss of her legs are seen to be excessively burdensome. Or take the patient who has undergone dialysis three times per week for the past six years and declines further dialysis because it has become too burdensome. While the patient will die without dialysis, he is not strictly speaking terminal at the time of the decision. Or the patient who develops a rare cancer for which there is an experimental treatment available at considerable cost in a foreign country for a lengthy period of time. The individual refuses because seeking such treatment would impose excessive burdens on the individual and her family. She is not strictly speaking terminal at the time of her decision. Having said this, however, if we are dealing with “life-sustaining treatments,” then, in the vast majority of cases, we will be dealing with patients who have a life-threatening condition.

Related to this, the authors state that POLST sets up a conflict with church teaching regarding artificially administered nutrition and hydration. The only thing the POLST form does is ensure a discussion of ANH (as well as other treatment options) with the patient and the documentation of the patient’s wishes. What is critical from a Catholic moral perspective is not the form, but the discussion with the patient. It is

incumbent upon those discussing with the patient to inform the patient of what may and may not be done in a Catholic facility, if that is necessary. The author’s statement about ANH is misleading, but more seriously it reflects a larger problem throughout their critique of POLST. They fail to take sufficient account of the fact that POLST is the end-point in a process. That process consists in one or more face-to-face conversations with the patient about his or her treatment preferences at this point in his or her medical condition. The POLST form summarizes, documents, and operationalizes those wishes. And it is not a static end-point. As the patient’s condition changes, additional conversations may be needed and, possibly, changed preferences and new documentation.

A third concern related to the above is the authors’ claim that the POLST paradigm is contrary to church teaching. There is nothing in the POLST paradigm itself that is contrary to church teaching. *How* POLST is employed in a particular situation could be, but that is true of any patient decision and medical order. Even without POLST, patients might decide and physicians write an order for something that is inconsistent with church teaching. In such situations, the Catholic health care organization needs to inform the patient or surrogate that it cannot comply with the patient’s wishes (Directives 24, 28).

Contrary to what the authors claim, POLST is not a “refusal document.” POLST forms permit patients to request

as well as refuse treatment and, in fact, they default to the provision of treatment if a particular section is not completed. So, if anything, they are biased toward treatment. And one would hope that in a Catholic health care organization, the Catholic moral tradition around end-of-life issues will inform conversations between health professionals and patients and their families. What are clearly contrary to church teaching at the end of life are PAS and euthanasia. Neither is legal in most states, and neither is

permitted or performed in Catholic facilities.

There is much more to be said about these two articles. We invite others to contribute their reflections and experiences and we will publish what we can in future issues of HCEUSA. In the meantime, readers might consider taking a look at the Louisiana POLST form.

RH

Editor's note: We invite our readers to respond to the claims made in these articles, especially readers who have experience with POLST. Please keep responses to about 500 words. Responses may be emailed to ethics@chausa.org.

“Festschrift” in Honor of Jack Glaser

We would like to honor our colleague Jack Glaser in the next issue of HCEUSA by assembling reflections from ethicists in the ministry on how Jack influenced them, what impact he had on them, and his contributions to the Catholic health ministry. Submissions should be relatively brief, approximately 150-300 words. Please email to rhamel@chausa.org