

POLST: Making Sure Patients Get What They Want

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INTRODUCTION

In stark contrast to the legislative developments in the Louisiana Capitol, a bill is awaiting Illinois Governor Pat Quinn's signature that would expand a health care paradigm being hailed as the "best kind of end-of-life care that has come along." The bill is an effort to improve upon an already successful medical order called physician orders for life-sustaining treatment (POLST). Specifically, it is an attempt to bridge the noticeable gap that exists between the number of patients who would rather die at home and the actual one-third of patients who have that wish realized.

The POLST paradigm was developed in order to improve the quality of care afforded to seriously ill patients by giving them the opportunity to direct the path that their care will take at the end of life. It is a legal document that specifies what care will be carried out in an emergency medical situation, and it is filled out by the patient, in consultation with their physician, and signed both by the patient and the physician. It is generally only appropriate for patients suffering from an advanced stage of terminal illness or whose prognosis indicates that they have approximately one year left to live, for the patient's current health status points to the need for standing medical orders. The key component of the paradigm is thoughtful conversations between health care providers, patients, and their families and friends to determine what life-sustaining treatments fall in line with their personal values, beliefs, and goals.

Although one might confuse POLST with an advance directive, which is designed to help healthy people make their end-of-life decisions known to loved ones in the event of serious illness or injury, POLST is actually a complementary tool. Signing such an order is highly encouraged for the target patient population due to clinical experience and research demonstrating that advance directives are not sufficient by themselves in ensuring that patients' preferences in health care are respected and honored. The most recent high-profile case of Casey Kasem provides a striking example. A significant advantage in having POLST is that the order is completely portable, becoming a part of the patient's medical record, thus reducing the risk of unwanted or ineffective care. However, it must be noted that POLST does not replace an advance directive, as it does not substitute for naming a health care agent or durable power of attorney for health care.

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ANALYSIS

POLST has already been available in Illinois for over a year, and its use throughout the country has been steadily increasing over the past twenty years, beginning with its introduction in Oregon in 1991. Today, almost all states employ POLST, with the forms varying in their language and structure from state to state. A recent study conducted in Oregon also found that POLST is successful, finding that the end-of-life preferences for patients only seeking comfort care were honored and only 6 percent of such patients died in the hospital.¹ Conversely, 34 percent of patients without a POLST order died in the hospital.

Yet, POLST is not just about limiting the kind of life-sustaining measures that should be implemented; it can also be used to ensure that a patient's wish for aggressive care is also fulfilled. So long as the patient and the physician engage in a dynamic conversation wherein the patient is adequately presented with the diagnosis, prognosis, treatment alternatives, and the burdens and benefits associated with life-sustaining treatment, then the patient's informed decision must be respected regardless of the preferred course of treatment.

As mentioned above, the bill presented to Gov. Pat Quinn is an expansion of the already existing POLST form in Illinois. It includes the opportunity to discuss additional treatment options that were not present in the previous form, such as IV solutions, feeding tubes, pain medications, and hospice. It allows for physician's assistants, nurses, and senior medical residents to sign the POLST, in addition to physicians, which accurately reflects the fact that these health care providers are often the ones most likely to have the time to talk and discuss varying options with patients. It also provides three general options for their end-of-life care:

- Comfort measures avoiding transfers to hospitals;
- limited interventions of basic medical treatments and transfers to hospitals if indicated but avoiding intensive care;
- and full treatment including a transfer to a hospital or intensive care unit.

Critics of the bill and POLST itself have voiced issues concerning the validity and relevance of seriously ill patients' advance choices, especially when taking into consideration the possibility of patients changing their minds. Furthermore, opponents often cite the inherent power imbalance that exists between patients and their physicians, stating that POLST is not "protective enough" and is "more about withholding treatment" than patient autonomy.

CONCLUSION

These concerns are not unique to POLST, as similar arguments have been made in regards to advance directives. This is why continuous conversation must take place between health care providers and their patients and their families. A form is just a filled out piece of paper. It carries no weight if the necessary concentration is not given to (1) the prerequisite conversation and (2) the professional duty placed upon health care providers to honor the requests that come out of that conversation. Only then can the filled out piece of paper become actionable, hopefully resulting in the kind of delicate care that seriously ill Illinois patients deserve.

¹ Fromme, E. K., Zive, D., Schmidt, T. A., Cook, J. N. B. and Tolle, S. W. "Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon". *Journal of the American Geriatrics Society*. doi: 10.1111/jgs.12889