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MEMORANDUM
TO: NRLC Board of Directors
State Legislative Directors, NRLC State Affiliates
FROM: Burke J. Balch, J.D., Director
Jennifer Popik, J.D., Legislative Counsel
Robert Powell Center for Medical Ethics
DATED: January 25, 2014
RE: HOW SHOULD THE PRO-LIFE MOVEMENT DEAL WITH POLST?

Background: From Living Wills Through Surrogate Decision-Making to the Will to Live

In the 1970's most in the pro-life movement publicly opposed enactment of "living will" legislation, arguing that it would chip away at the then-existing presumption for life-saving medical treatment, and pointing out the vagueness of the language of most versions– especially the way in which seemingly harmless terms living will forms used were open to a variety of interpretations that could expand the denial of treatment they authorized far beyond the intent of those who signed them.

The pro-life movement lost that fight, and "living wills" became recognized in almost every jurisdiction; meanwhile, by the 1990's the "quality of life" ethic had so completely displaced the pre-existing "equality of life" or "sanctity of life" ethic virtually throughout the health care professions that it was clear that the presumption had shifted to favor denial of treatment, instead of its provision, for older people and people with significant disabilities. Moreover, court after court and then state legislature after state legislature had adopted standards authorizing, through "surrogate" decisionmaking, withholding of treatment and, later, food and fluids from older people and people with disabilities who had never signed living wills or otherwise rejected life-saving measures.

Consequently, the pro-life movement recognized that it was now essential to *promote* advance directives that would allow people to express their choice *for* life-saving medical treatment, food, and fluids. In 1992, the Board of Directors of the National Right to Life Committee adopted language for the "Will to Live," which created a pro-treatment presumption (variable by the signer in certain circumstances such as imminent and inevitable death) and allowed designation of a trusted "health care agent" to make health care decisions, in accordance with the Will to Live directions, whenever the signer became unable to make them for herself or himself. Other pro-life groups promulgated their own versions of protective advance directives.

The Coming of POLST

Starting with Oregon in 1991 but with dramatic expansion over the last five years, many medical organizations have promoted, and many states have enacted legislation authorizing, documents variously called POLST or POST(Physician Orders for Life-Sustaining Treatment) or MOLST or MOST (Medical Orders for Life-Sustaining Treatment). [Because of the variety of

nomenclature used, this memo will employ the term "POLST-type documents" or sometimes just "POLST."] The central POLST concept is to have a one sheet document that itself constitutes an immediately effective medical order, with standardized wording and a series of checkoffs to give directions for such things as whether or not to provide resuscitation, antibiotics, nutrition and hydration, and specific levels of general medical care.

Unlike an advance directive, which is a general expression of the patient's wishes to guide health care decisions should the patient become incapable of making health care decisions in the future, a POLST gives directions that are immediately applicable to the patient, whether the patient is presently capable or incapable of making health care decisions. While an advance directive is effective indefinitely (although it may be revoked or rewritten), a POLST is intended to be reviewed and potentially rewritten whenever the patient's condition undergoes a substantial change. In addition, a POLST generally must be reviewed periodically (and the review must be documented on the form) in order for it to remain effective.

It is understandable that some in the pro-life movement are currently taking a position similar to that the pro-life movement took with regard to the living will when it was first proposed – they advocate outright opposition to POLST-type forms. Consider, however, the following facts: as of January 1, 2014, 20 states had explicitly authorized some form of POLST by statute, while two others had done so by regulation.[1] More importantly, POLST-type programs are presently under way in *all but seven states (and D.C.)*.[2] **The practical reality is that in the absence of governmental regulation, medical groups in any state can themselves develop and implement a POLST-type form without legislative sanction, and that this has either already occurred or is in process in 22 states.** Because physicians necessarily have the authority to write medical orders for their patients, it is hard to envision a practical way that a state legislature could formulate, or that it realistically would adopt, a law *forbidding* the use of POLST-type forms.

Instead, what pro-life state groups with sufficient legislative support **can** do is to promote legislation that *regulates* POLST-type forms – and ideally specifies their content in such a way as to maximize the possibility of their use as pro-life documents while attempting to minimize the danger that patients and surrogates will be mislead into agreeing to denial of treatment they would in fact want. Failure to adopt a regulatory approach – either by simply ignoring or by instead just declaring opposition to POLST – will simply leave the construction and implementation of POLSt-type forms in the hands of the medical profession, and often of those elements of the medical profession most anxious to facilitate rejection or denial of life-preserving treatment, food, and fluids.

A PRO-LIFE REGULATORY APPROACH TO POLST-TYPE FORMS

While it is not practical to ban POLST-type forms, it is feasible to regulate their content and use with the objectives described above. To begin, in each section of the form, the full treatment option should be listed first, with the lowest level of treatment last. In addition, pro-life advocates should strive to ensure that the state POLST-type form:

1. **Uses accurate terminology.** As a starting point, unlike many standard advance directive forms that are written on the assumption they are to be used predominately to reject

treatment, existing POLST-type forms are written in such a way as to give the option of directing the provision, not just the rejection, of each category of treatment covered. Their proponents generally describe these forms as intended neutrally to implement the treatment preferences of the patient. It is possible for pro-life advocates to cite this structure and stated intent to argue for changing terminology that describes treatments in a negative way. While a number of examples could be given, two should suffice to illustrate the point:

• "Life-prolonging" as an adjective used to describe treatment connotes the dragging out of imminently expiring life; "Life-preserving" is preferable as an accurate descriptor without the off-putting negative implications. (Though less desirable than "life-preserving", the word "life-sustaining" is preferable to "life-prolonging".)

• "Artificial nutrition and hydration" (or "artificially administered nutrition and hydration") is an inaccurate and off-putting way of describing what properly could be called "medically-administered nutrition and hydration." First, the nutrition and hydration that may be supplied by a tube is no less "natural" than that which is supplied by a fork or spoon. Second, administration by a feeding tube is no more "artificial" than the use of a drinking straw to sip from a soda or a milk shake, or indeed the use of a fork or spoon. Straws and tableware are not found in "nature" – they must be manufactured "artifically." The term "artificial" is not put forth as a common adjective to describe CPR, or antibiotics, or any other form of medical treatment; it is inconsistent to insist on its used to describe assisted feeding. The term "medically administered" accurately and neutrally covers the fact that a surgical incision is used to create the stoma or opening through which a stomach feeding tube is placed or to insert a catheter into a blood vessel for TPN, and that trained medical personnel insert nasogastric tubes.

2. **Prevent the use of POLSTs to supersede, rather than implement, advance directives.** The statutes in a number of states provide that a later-executed POLST-type form supersedes any conflicting instruction in an advance directive. In the case of a patient who is currently incapable of making health care decisions, this allows the surrogate legally authorized to execute a POLST to violate the treatment preferences the patient herself or himself set forth, while competent, in the advance directive. There is grave danger in such states that medical professionals could successfully pressure relatives or other surrogates to reject treatment the patient may have directed be provided in a Will to Live or other advance directive.

As recognized by the Pennsylvania, West Virginia, and Washington forms, a POLST-type form should be seen as a supplement to, not a replacement for, an advance directive, because 1) an advance directive can be more comprehensive, complex, and nuanced and 2) an advance directive can contemplate different levels of treatment for different potential conditions. In contrast, a POLST form is designed to apply only to the patient's current condition, and is explicitly intended to be reviewed and potentially rewritten whenever there is a substantial change in the patient's condition. Indeed, a POLST form is most appropriate in providing a standardized, at-a-glance, easily comprehensible summary of the most salient directions applicable, especially in an emergent situation, *in accordance with* the patient's advance directive. [Of course, if the patient is competent, she or he is free to choose POLST options at variance with his or her advance directive – but would be well advised also to rewrite the advance directive since should he or she subsequently become incompetent, the advance directive would prevail.]

For these reasons, a POLST-type form should always indicate whether there is an advance directive for the patient, and if so, then when the POLST is being executed by a health care agent or surrogate because the patient is currently incapable, a certification should be required (preferably in a separately signed paragraph) that the POLST is in accord with the advance directive.

3. **Provide adequate detail in describing treatment alternatives.** Particularly for levels of treatment that are less than full treatment, it is important to spell out what treatment *should* be provided. For example, when a DNR is checked, levels of medical intervention below full should make clear that even though resuscitation has been rejected, difficulty breathing should be treated by such measures as noninvasive bi-level positive airway pressure, a bag valve mask, and the use of oxygen, suction, and manual treatment of airway obstruction. For another example, even when hospitalization is rejected, the modifier should be added "unless comfort needs cannot be met in the patient's current location (e.g., hip fracture)." Because of the wide variety of POLST-type forms in use in various states, it is often possible to cite precedent from one or another form for a phrasing that will minimize the extent to which treatment is to be withheld in a given option.

If possible, the nutrition/hydration options should include the alternative of total parenteral nutrition (TPN) as the top choice, both because that is an accepted form of feeding when the digestive tract is inadequately functioning, and because listing it as the top option makes tube feeding an intermediate option, which may incline more individuals to choose it.

4. **Ensure treatment pending transfer if health care provider unwilling to comply with POLST directive for treatment.** Probably the gravest threat patients now face is involuntary euthanasia in the form of denial of life-preserving treatment, food, or fluids against the expressed wish of the patient (or the patient's surrogate). Early pro-life successes in obtaining statutory requirements of treatment pending transfer in a number of states have been followed by a dearth of success in other states in the face of medical opposition. However, statutes regulating POLST-type forms provide an opportunity to write the requirement of treatment pending transfer into the forms. Where this can be achieved, it will be a dramatically important accomplishment whose significance should never be underestimated.

Attached to this memorandum is a sample of how a bill regulating a POLST-type form could be drafted. It must be emphasized, however, that any such bill needs to be carefully crafted in light of the other statutory provisions (and in some cases court rulings) in a particular state. (For example, in the few states that provide special protection regarding deprival of nutrition and hydration, the POLST-form must be written in such a way as to implement and not evade such protections.)

1. National POLST Paradigm Task Force, "POLST Program Legislative Comparison as of 1/1/2014", available at www.polst.org/wp-content/uploads/2014/01/POLST-Leg-Chart-Dec-2014-3-column.pdf .

2. National POLST Paradigm Task Force, "Programs in Your State," available at www.polst.org/programs-in-your-state/ .