



MINNESOTA CATHOLIC CONFERENCE

# STEWARDS OF THE GIFT OF LIFE

## *A Pastoral Statement on Physician Orders for Life-Sustaining Treatment (POLST) from the Catholic Bishops of Minnesota*

### INTRODUCTION

All human life is sacred. Created in God's image and likeness, each human life possesses immeasurable worth and inviolable dignity. At the moment of conception, a new and unique person comes into being, and the love of God accompanies each moment of life. Death in this world marks the conclusion of our earthly pilgrimage, but not the end of our lives, for we are also called to eternal life.

In our time, advances in medical technology have given us many blessings and the hope of extended lifespan. Surgical procedures, medical devices, drugs, and therapies have improved the quality of life for many. But this progress challenges us to stay informed regarding the many choices and ethical challenges it has created.

Our Catholic faith teaches us that our life and our health are gifts of God. *As stewards of these gifts, we are obligated to take reasonable care of ourselves. We exercise that stewardship when we make thoughtful use of the resources medicine affords to maintain our health and recover from illness.*

Our faith also teaches us, however, that we do not need to use any and all possible means to preserve our lives in this world. Although "a person has a moral obligation to use ordinary or proportionate means to preserve his or her life" (*Ethical and Religious Directives for Catholic Health Care Services*, dir. 56; hereafter "ERD"), we may forgo extraordinary or disproportionate means of preserving life: those which "do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community." (ERD dir. 57.)

Furthermore, in principle, there is an obligation to provide food and water (including medically assisted nutrition and hydration for those who cannot take food orally) to all patients, including those in chronic and presumably irreversible conditions. Medically assisted nutrition and hydration, however, become morally

optional when they cannot reasonably be expected to prolong life, when they would be excessively burdensome for the patient, or when they would cause significant physical discomfort. (ERD dir. 58.)

Determining which life-preserving medical interventions are ordinary and which are extraordinary is often difficult. This is as it should be, given the immeasurable worth of a person's life. It requires careful deliberation, informed by accurate and timely medical information regarding the person's condition, prognosis, and options; the risks and benefits accompanying these options; and the person's own preferences and values. While medicine today is highly scientific, we humbly accept a degree of uncertainty about predictions and expectations for how a person may respond to specific treatments. We strive to make prudential decisions that both respect the value of each life and accept the limitations of our human condition.

Among the most difficult of these decisions are those that must be made when a patient is no longer capable of speaking for himself or herself. Over the years, different forms of "advance directives" have allowed patients to make their wishes regarding medical treatment known ahead of time. The most common are the "living will" and the "Durable Power of Attorney for Health Care Decisions." Of these two the Durable Power of Attorney is far preferable, for experience has shown that the most informed decisions are made by a duly appointed health care agent, a person legally appointed by the patient to speak on his or her behalf, who can speak directly with a patient's health care professionals about the patient's preferences and best interests in light of all the relevant medical information.

Yet even when the agent's guidance is given, it must still be implemented by health care professionals. Disagreements, delays, and confusion about the patient's actual intentions and specific wishes still remain problematic in some cases.

## **POLST (“PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT”)**

As part of recent efforts intended to improve care at the end of life, POLST forms (in Minnesota, “Provider Orders for Life-Sustaining Treatment”) are becoming increasingly discussed in our state and nationwide, particularly for patients in long-term care settings or with terminal illnesses. Like advance directives for health care, the purpose of a POLST form is to help ensure that a patient’s wishes for medical care and treatment in the final stages of life are understood and carried out.

POLST forms, however, differ from advance directives in a significant way. While an advance directive is a patient statement of treatment preferences, POLST forms constitute standing medical orders signed by a physician or other health care professional with legal authority to issue medical orders (in Minnesota, this includes nurse practitioners and physician assistants). As designed, the intention of a POLST form is to assure that the preferences and choices of each patient are honored when decisions are needed.

In Minnesota, POLST forms were developed over the course of several years of consultation and endorsed by the Minnesota Medical Association in December 2009. Many hospitals, long-term care facilities, and health care systems are using POLST, including Catholic health care providers. For this reason, the Bishops of Minnesota believe it important to comment upon POLST.

## **ETHICAL CONCERNS WITH POLST**

While we understand the rationale for POLST, and though the Minnesota form is preferable to that in some other states, we believe that there are sufficient and significant ethical concerns that argue against its use for advance-care planning. Those concerns are both substantive and procedural. That is, the POLST model itself raises important concerns, as does the way in which these forms are constructed and are being used. We summarize these concerns below.

### *THE POLST PARADIGM IS FLAWED*

Though the typical default instruction for any particular intervention on a POLST form is “aggressive treatment,” the form implies that potential medical interventions are in themselves morally neutral. The form does not reflect the patient’s underlying rationale for weighing treatment options that would inform real-time decisions in changing circumstances.

Because we cannot foretell the future, one cannot truly give informed consent for health care treatments when variables such as ability to communicate, the absence or presence of a terminal illness, and actual medical conditions are unknown. From a Catholic perspective, making a morally sound decision regarding end-of-life care calls for informed consent based on information related to the actual circumstances and medical conditions at a particular moment. For both patients and providers, it is difficult to determine in advance whether specific medical treatments will be absolutely necessary or optional. Though we have some ability to determine a person’s course of illness, we do not have absolute certainty. Therefore, any tool created to guide medical management must take these predictive limitations into consideration.

Further, POLST forms tend to oversimplify the medical decision-making process. Decisions depending upon factors such as the benefits, expected outcomes, and the risks or burdens of the treatment are oversimplified by “one-size-fits-all” checkboxes, without the benefit of clinical context. As a result, using POLST bears the risk that an indication may be made to withhold treatment that, under certain unforeseen circumstances, the patient would want to receive. Another grave concern is whether these forms might be used for patients who are not terminally ill, as a form of assisted suicide or euthanasia. Despite the possible benefits of these documents, this risk is too great to be acceptable.

### *PROBLEMS WITH THE POLST FORMS AND PROCEDURES*

In addition to the fact that the POLST paradigm itself cannot be fully reconciled with a Catholic framework for end-of-life decisions, there are a number of specific concerns related to the way in which POLST forms<sup>1</sup> may be utilized:

- 1) Because the form permits but does not require the signature of a patient (or the patient’s legally designated agent), assuring the necessary true informed consent for such important decisions is problematic.
- 2) As standing medical orders that (per the POLST form) are to be followed before consulting with the primary care professional or the health care agent, the use of POLST does not assure that the treatment decisions it orders are appropriate to the current condition, prognosis, and needs of the patient.

3) POLST lacks a conscience clause for the health care professionals who may have ethical concerns with the medical orders they are asked to fulfill.

4) As a relatively new tool, the procedures for a patient to revoke or change preferences on a POLST, once signed, are not clear or reliable.

5) POLST forms may conflict with other advance care directives or durable power of attorney. Because there is no requirement that Advance Health Care Directives (AHCDs) be cross-checked with POLST forms for consistency, a POLST form without a patient's signature could be implemented rather than the patient's wishes expressed in a (non-consulted) AHCD.

6) The signature of a physician (or, in Minnesota, of a nurse practitioner or physician assistant) creates an actionable medical order which is operative upon its signing and which could then legally bind Catholic health care professionals and institutions to follow POLST-form designated treatments that may be contrary to Catholic moral teaching.

7) There is no requirement that the health care professional who signs the POLST form is the one who prepared it with the patient, which, unfortunately, can be the case in a busy practice.

We understand and support the need for advance-care planning, and we thank those who so generously provide care and compassion to those who are sick. However, the problems noted above lead us to discourage the use of POLST by Catholics and Catholic health care providers in light of the better alternatives that are available.

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## **AN ALTERNATIVE**

We call for renewed efforts to educate the Catholic community and other interested persons in the rich tradition of our Catholic teaching on end-of-life care. In particular, we invite those with experience and expertise to work with us in fostering the important conversations about the use of medical interventions that best take place between patients, their designated health care agents, and providers. We repeat our strong support for the appointment of a health care agent who can speak for a patient in the actual circumstances, acting in the patient's best interest consistent with the principles of Catholic teaching, rather than relying on often vague prior written instructions for unforeseeable situations.

At the same time, we recognize that some persons and facilities have already been using POLST. Their evident interest in improving end-of-life care can benefit the development of the education and alternatives noted above. We encourage those with current POLST forms to revisit the directions given and update them, if necessary, to ensure that they are signed by the patients in question to assure that they are consistent with patient wishes and with Catholic teaching. We further encourage that Catholic facilities phase-out the use of POLST forms and provide alternative forms of advance care planning that avoid the ethical concerns we noted above.

The Minnesota Catholic Health Care Directive,<sup>1</sup> and its accompanying Guide, is an excellent alternative that can assist in this transition. The thoughtfully designated health care agent and his or her knowledge concerning the patient's wishes during end-of-life scenarios, along with knowledge of related Catholic moral teaching, are imperative in upholding the dignity of human life and the integrity of the decision-making process.

## **CONCLUSION**

The resources of medicine and technology are our servants, not our masters. Their tremendous potential to prolong life must always be judged in light of the purpose and value of human life itself. As stated in the *Ethical and Religious Directives for Catholic Health Care Services*:

Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining



technology is judged in light of the Christian meaning of life, suffering, and death (Part Five, Introduction).

We believe that this “true moral judgment” requires dialogue that involves the patient, family members and loved ones, and health care professionals, based on the facts of the situation and a realistic appraisal of morally-acceptable options. But above all, it requires a context of prayerful discernment, compassionate support, and our Christian hope for eternal life as revealed in the Risen Christ.

<sup>1</sup> The POLST form can be found on the Minnesota Medical Association’s website:

[www.mnmed.org/Portals/mma/PDFs/POLSTform.pdf](http://www.mnmed.org/Portals/mma/PDFs/POLSTform.pdf)

<sup>2</sup> The Minnesota Catholic Healthcare Directive can be found on the Minnesota Catholic Conference Website:

[www.mncc.org/minnesota-catholic-health-care-directive/](http://www.mncc.org/minnesota-catholic-health-care-directive/)

This document is meant to encourage conversations and faithful decision-making about end of life, while calling to mind Christ’s mystery, that we may be able “to see healing and compassion as a continuation of Christ’s mission; to see suffering as a participation in the redemptive power of Christ’s passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ.” (ERD dir. 59.)



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## ADDITIONAL RESOURCES

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### MINNESOTA CATHOLIC CONFERENCE’S MINNESOTA HEALTH CARE DIRECTIVE

[www.mncc.org/resources/mn-catholic-healthcare-directive](http://www.mncc.org/resources/mn-catholic-healthcare-directive)

### THE USCCB ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (ERD)

[www.usccb.org/about/doctrine/ethical-and-religious-directives/](http://www.usccb.org/about/doctrine/ethical-and-religious-directives/)

### Q&A FROM THE USCCB COMMITTEE ON DOCTRINE AND COMMITTEE ON PRO-LIFE ACTIVITIES REGARDING THE HOLY SEE’S RESPONSES ON NUTRITION AND HYDRATION FOR PATIENTS IN A

“VEGETATIVE STATE” [www.usccb.org/issues-and-action/human-life-and-dignity/end-of-life/euthanasia/upload/q-a-nutrition-and-hydration-patients-vegetative-state.pdf](http://www.usccb.org/issues-and-action/human-life-and-dignity/end-of-life/euthanasia/upload/q-a-nutrition-and-hydration-patients-vegetative-state.pdf)

### EVANGELIUM VITAE: Address by Blessed Pope John Paul II on the Value and Inviolability of Human Life

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