WHAT IS THE DIFFERENCE BETWEEN POLST AND A LIVING WILL?

DOES AN INDIVIDUAL NEED BOTH?

Before examining the differences between POLST (Physician’s Orders for Life-Sustaining Treatment) and a Living Will it is useful to examine the similarities. Both honor the individual patient’s right to choose whether or not to receive treatments intended to sustain life. A well written, scenario-specific Living Will should address specific end-of-life treatments, ideally the same as or similar to those addressed in POLST orders: cardiopulmonary resuscitation, medical interventions including life support and ICU treatment, antibiotics, and artificially administered nutrition. In both POLST and Living Wills, individuals may choose to forego treatments intended to sustain life when burdens outweigh benefits (or when there is no benefit in medically futile conditions) in their last chapter of life.

However, the existence of both a Living Will (Advance Directive) and POLST orders in a given individual may seem confusing and potentially conflicting upon initial comparison. There is a tendency to expect them to be “consistent;” that is to state the same restrictions in care. In fact, a well written Living Will may be highly restrictive of treatments, whereas POLST orders may specify the patient’s desire to accept any or all of the very same the treatments that are rejected in the Living Will.

To understand the differences it is critical to recognize that a Living Will (Advance Directive) is a legal expression of choices made by the patient, typically after counseling with a physician or other knowledgeable individual. POLST orders are a set of medical orders written by a physician, after counseling with the patient and/or surrogate(s). Although the treatments under consideration may be the same, the
conditions under which choices are made typically differ. Advance Directives (ADs) make choices of treatments for hypothetical conditions, which may or may not occur in the future and apply to conditions that, by definition, are irreversible, end-stage, and have little or no chance of recovery. POLST orders, since they are active orders intended for the patient’s current state of health, are written as appropriate for the patient’s current situation, whether conditions are end stage or not. In other words, POLST orders are the physician’s best attempt to implement the patient’s wishes for treatment based upon the patient’s current health, should a sudden illness or deterioration in health occur.

However, if new conditions develop which substantially or irreversibly change the individual’s health status, the physician should clearly communicate the implications of the change in status to the patient or surrogate. Based on input from the patient or (if the patient has lost capacity) the patient’s AD and surrogate, the physician may need to revise previous POLST orders. For example, an otherwise healthy person in his late 80’s may wish to avoid CPR because of the low likelihood of survival, or high chance that survival may be in a morbid state and the belief that “when my time comes and my heart stops, it’s OK to go ahead and die a painless death.” However, he or she may still desire other aggressive, life-prolonging medical interventions if there is reasonable hope for recovering functional independence. The individual’s POLST orders may indicate “DNR,” but may also indicate “Full Treatment” under “Medical Interventions.” If that individual’s condition seriously worsens through sustaining a massive stroke and he is unlikely to ever live independently again, he may change his mind about further aggressive medical interventions. The reduced level of intensity of treatment would need to be reflected in an updated POLST.
The same individual’s AD might indicate “Should I become totally dependent on others and lose ability to meaningfully communicate (such as in this example of a massive stroke with paralysis and aphasia), I would not wish to have CPR, life support, tube feeding, or other life-sustaining medical interventions, such as antibiotics or transfusions; I would ask that all my care be directed toward physical, psychological, and emotional comfort.” Thus, the initial POLST orders would request “Full Treatment” including intensive care, while the revised orders would reflect his wishes relevant to his new medical condition, including “Comfort Measures Only,” consistent with his (unchanged) Advance Directive.

When appropriate discussions are held prior to writing POLST orders, conflicts may arise, either between the patient and family, among surrogates, or between the surrogate(s) and the patient’s Advance Directive. In resolving conflict, it is important for all parties to advocate for the patient through arriving at decisions that promote humane and dignified end-of-life care in keeping with the patient’s personal wishes, as may have been expressed in his AD or in conversations with family and physician.

The one circumstance in which there should virtually always be concurrence between treatment choices in POLST and the Advance Directive (AD) is when an irreversible condition specifically addressed in the AD already exists at the time POLST orders are written. In this instance, assuming the individual has lost decisional capacity and the AD is scenario specific (addresses both the specific medical condition which the patient has and the possible treatment choices), the POLST orders should virtually always be written in accordance with the AD, in keeping with the patient’s legal right to Advance Care Planning.
An exception to the above clear distinction between the hypothetical, future application of Living Wills versus the “here and now” application of POLST is the fact that some Living Wills do allow “other” choices which might include “here and now” decisions. For example, an elderly individual, aware of the extremely low probability of survival of cardiopulmonary arrest, might request in his AD that all curative treatments be withheld if he develops an incurable condition. In addition, in keeping with advanced age and the patient’s personal values, the individual might also write “I do not want cardiopulmonary resuscitation under any circumstances” in the AD. The latter is a “here and now” treatment request. To ensure this request is fully honored, however, the individual should still have a physician’s DNR order (POLST or otherwise) written, since healthcare is implemented based upon physicians’ orders and particularly since, in the absence of orders, full, aggressive care is typically initiated.

Similarly, within the POLST orders, the choices of “Additional Orders” under each section allows the possibility for the individual to request that the physician write an order addressing a hypothetical, future situation (as might be requested in a Living Will). For example, if a patient (Mrs. Jones) asks her physician to write in POLST “If Mrs. Jones develops a permanent state of unconsciousness or an imminently fatal condition, she does not want any curative medical interventions at all, just maximum comfort care.”

A reluctance to use an AD or POLST commonly arises when physicians or patients do not clearly understand the limits of AD and POLST documents. Physicians often fear loss of control of the patient and patients fear loss of autonomy. A clear recognition of the limits of both ADs and POLST may serve to reassure patients, family, healthcare providers, and institutions that both POLST and ADs can serve their intended
purposes without causing misdirection of care. POLST and ADs are not irreversible. Decisions made by patients regarding both may be changed with changing circumstances, values, and goals. In fact, POLST orders should be *routinely changed* when significant changes in the patient’s medical condition and related treatment wishes change. Though less frequent, individuals may also wish to change the nature of their AD. Similar to a Last Will and Testament or any other physician’s orders, the most recent legally written AD and POLST supercedes any previous document. Furthermore, one might argue that even in patients who have both POLST orders and an AD, many situations may arise in which specific conditions and/or treatment choices are not addressed by either document. Indeed, this is almost always true. In fact, situations which are *not* addressed by the AD or by POLST likely represent the *majority* of medical decisions encountered by the patient over time. This is to be fully expected, since it is likely that only patients who are very elderly or chronically ill will find POLST orders useful (otherwise, no restrictions in life-sustaining orders will usually be desired) and Living Wills typically apply only to incurable, end-stage conditions. The remaining, great majority of treatment choices involve potentially *reversible* illnesses and must be based upon weighing the burdens versus the benefits of treatment at that time. Such choices cannot be anticipated ahead of time and depend upon numerous individual factors involving the individual patient’s medical condition and personal values and goals. In other words, the patient and physician must continue to make the great majority of day to day treatment decisions. Through POLST, the patient (or surrogate) is simply exerting his or her right to make some decisions to avoid unwanted treatments in the future for circumstances or medical conditions that *already exist*. By enacting a Living Will, the patient is exerting his or her
right to instruct physicians and surrogate(s) to withhold unwanted treatments for hypothetical, *futile* medical conditions that may arise in the future.

No matter how well written and detailed AD and POLST documents are, it is impossible to anticipate all medical conditions and decisions. The remaining great majority of healthcare decisions must be made on an ongoing basis through good communication (informed consent) between physicians and patients and/or families. However, well written and fully communicated *advance* healthcare choices (Advance Directives), and orders relating the patient’s *current* specific desires for life-sustaining treatment (POLST) can serve as a clear roadmap of the *spirit* of the patient’s wishes, which can in turn direct the many other difficult choices that fall on the shoulders of surrogates and physicians. Most importantly, advance care planning (whether through a Living Will or through POLST) should be an ongoing *process* for each individual, centered around development and reflection of his or her beliefs and values, with thoughtful and meaningful conversations about personal choices with healthcare surrogates, family members and physicians. The debate over “who should decide” such issues is best settled by asking “who should decide what?” Physicians should clearly be responsible for obtaining the facts necessary to give sound *medical* advice regarding risks and benefits of treatments being considered, including *abstaining from offering futile treatments*, and taking care not to impose personal values upon the patient. Patients and surrogates, however, should have ultimate authority to make personal *value* judgments, weighing burdens and benefits in choosing non-futile treatment options. These conversations become especially important if a person loses decisional capacity. In addition to increasing the likelihood that the individual’s wishes will be honored, AD and
POLST documents can ease the burden of decisions and avoid potential feelings of guilt that are common in surrogate health care decisions, through ensuring greater consistency with the patient’s personal values.

Numerous articles in the literature point to the failure of Advance Directives to significantly impact end-of-life care, citing the vague language of the documents; the inability or unwillingness of physicians and families to consider the patient “hopelessly ill;” lack of access or availability of ADs and surrogates; unwillingness of surrogates to abide by the patient’s wishes (and physicians’ concerns of liability in overriding surrogates); and general lack of participation of the public in completing ADs (Fagerlin A and Schneider C, “Enough: The Failure of the Living Will,” Hastings Center Report 34, no. 2 (2004): 30-42). When ADs are implemented through specific orders concerning life-sustaining treatments (such as POLST), however, it is highly likely that the patient’s wishes will be honored. Likewise, POLST orders written after a patient has gone through the educational process of writing an AD are much more likely to accurately reflect the patient’s wishes. Thus, Advance Directives and POLST should significantly enhance the effectiveness of each other. To this end, there is a great need to educate a wide variety of professionals who can effectively counsel the majority of adults to empower them to accurately communicate their end-of-life wishes through the completion of scenario-specific Advance Directives. There is an equally great need to educate physicians to understand and recognize the balance between benefits and burdens of medical care, including the timely recognition of medical futility, and to appropriately implement the personal wishes of their patients through Physician’s Orders for Life-Sustaining Treatment when their patients reach advanced age and declining health, both inside and
outside the hospital. Professional and community education about ADs and POLST has the potential to save patients from the burdens of medical interventions which have little or no benefit and can transform the hopeful vision of a “graceful” last chapter of life and a “good” death into reality. The numerous individuals and organizations who support the promotion of POLST orders share this vision, recognizing that healthcare decisions are implemented through specific medical orders that should clearly reflect both the medical judgment of the treating physician and, most importantly, the personal wishes, values, and spiritual beliefs of the patient.

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