

***Completing IPOST***  
***(Iowa Physician Orders for Scope of Treatment)***

***Information and Ethical Guidance***

***2<sup>nd</sup> edition***

**Ethics Committee**

**Stonehill Franciscan Services**

**Dubuque, Iowa**

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## **SECTION I General Information about IPOST**

### **What is the POLST (Physician Orders for Life-Sustaining Treatment) Paradigm?**

It is a comprehensive approach to end-of-life planning that starts with a conversation between health care professionals and patients. This conversation allows the patient to discuss his or her values, beliefs, and goals for care, and the health care professional presents the patient's diagnosis, prognosis, and treatment alternatives. Together they reach a shared decision about the patient's treatment plan that is informed and based on the patient's values, beliefs, and goals for care. The intent is to record a patient's treatment preferences as they near the end of life. The form can be used to clarify whether the patient wants treatments provided to attempt to extend his/her life, wants to receive limited medical interventions or wants to let nature take its course and allow death to occur naturally. (1)

### **How is IPOST related to POLST?**

IPOST was developed based on the national Physician Order for Life-Sustaining Treatment (POLST) Paradigm. This national model is being instituted state by state, but *with some variations among states*. Thus IPOST must be considered on its own.

### **What is the purpose of IPOST?**

It is a tool to help ensure that a patient's end-of-life health care treatment choices are *communicated* and *honored* from one health care setting to another - hospital, nursing home, home care, hospice, EMTs. It is valid ("portable") across health care settings.

### **How is IPOST different from an advance directive (living will, durable power of attorney for health care)?**

An advance directive is a *general expression of an individual's wishes* regarding medical treatments. IPOST is *an actual medical order* for using or forgoing medical treatments. Directives given in a living will and/or durable power of attorney for health care are used in completing the IPOST form. IPOST is a way of turning the wishes

expressed in advance directives into actual orders for patient care. Thus IPOST is a complement to advance directives.

Any adult who is mentally competent can execute an advance directive, including people who are healthy. IPOST is intended for use only by a limited population: persons who are terminally ill, persons with a chronic critical medical condition, and the frail elderly (Code of Iowa Chapter 144D.1, definition of “patient”).

## **Does IPOST negate or supersede advance directives?**

Chapter 144D Physician Orders for Scope of Treatment of the Iowa Code respects the provisions of a living will (Chapter 144A) and the force of a durable power of attorney for health care (Chapter 144B):

*“Physician orders for scope of treatment form” or “POST form” means a document containing medical orders which may be relied upon across medical settings that consolidates and summarizes an individual’s preferences for life-sustaining treatments and interventions and acts as a complement to and does not supersede any valid advance directive. (Chapter 144D.1)*

If an individual is a qualified patient as defined in section 144A.2, the individual’s declaration executed under chapter 144A shall control healthcare decision making for the individual in accordance with chapter 144A. A POST form shall not supersede a declaration executed pursuant to chapter 144A. (Chapter 144D.4)

If an individual has executed a durable power of attorney for health care pursuant to chapter 144B, the individual’s durable power of attorney for health care shall control health care decision making for the individual in accordance with chapter 144B. A POST form shall not supersede a durable power of attorney for health care executed pursuant to chapter 144B. (Chapter 144D.4)

## **Is IPOST part of the federal health care reform law (Patient Protection and Affordable Care Act)?**

No. IPOST is an independent project.

## **Is executing an IPOST form mandatory for eligible patients?**

While using the IPOST form may be recommended, it is not to be mandatory. The IPOST form is an *option* that eligible patients can use. (See Code of Iowa Chapter 144D.4)

## **Is IPOST being promoted as a mechanism for cost containment in health care?**

Cost containment may or may not be a result of the IPOST project; in any case it is not the *intent* of the project. Patients have the right to choose their course of treatment, including those procedures which might increase the cost of their care. There is no requirement or suggestion that the least expensive option be chosen.

## **Is IPOST/POLST a step on the way to allowing euthanasia and/or legalizing “Death with Dignity” (physician assisted suicide)?**

Chapter 144D.4 of the Iowa Code, which establishes IPOST, contains the following stipulation: “This chapter shall not be construed to condone, authorize or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.”

In September 2015 the National POLST Paradigm Task Force issued a statement *Distinguishing POLST from Death with Dignity Statutes*:

Some may have questions about the critical distinction between the Physician Orders for Life-Sustaining Treatment (POLST) movement and Death with Dignity (DWD) legislation. A fundamental difference between POLST and DWD is the intent of the patient: POLST is about how people want to live and be cared for with their serious illness or frailty and DWD is about deliberately ending life...

DWD legislation allows a physician, at the request of a patient diagnosed as terminal, to write a prescription for a lethal amount of medication that the patient self-ingests with the intention of causing death. Patients may choose this practice, called “physician aid-in-dying” (PAD) or “physician assisted suicide” (PAS), only in states where a court decision or DWD legislation makes this option available.

The National Physician Orders for Life-Sustaining Treatment Paradigm recognizes that allowing natural death to occur is not the same as providing a lethal prescription to intentionally cause death. Neither the POLST Paradigm nor any POLST form allows for PAS or PAD, nor does either authorize a health care professional to prescribe medication that would intentionally shorten life.

POLST originated in Oregon in 1991. The Death with Dignity Act passed as a ballot initiative in 1994. The programs developed completely independently of each other by different groups with different goals. (2)

### **How is an IPOST form executed?**

In collaboration with a physician/advanced registered nurse practitioner/physician assistant, a specially trained health care professional assists the patient or his/her proxy decision maker in conversations that build an understanding of a patient's values and goals of care. The IPOST form is then completed, and must be signed by both the patient/proxy decision maker and the physician/advanced registered nurse practitioner/physician assistant.

### **Can an IPOST form be changed?**

Yes. The IPOST form should be reviewed periodically, and a new IPOST completed as needed, when the person is transferred from one care setting or care level to another, or when there is a substantial change in the person's health status, or when the person's treatment preferences change.

## **SECTION II The IPOST Form and Health Care Ethics**

### **What medical treatments are included on the IPOST form?**

IPOST has three sections regarding categories of medical treatment:

A) **CARDIOPULMONARY RESUSCITATION (CPR)** – Person has no pulse and is not breathing

- CPR/Attempt Resuscitation
- DNR/Do Not Attempt Resuscitation

B) **MEDICAL INTERVENTIONS** - Person has a pulse and/or is breathing.

- **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.
- **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, cardiac monitor, oral/IV fluids and medications as indicated. Do not use intubation, or mechanical ventilation. May consider less invasive airway support (BiPAP, CPAP). May use vasopressors. Transfer to hospital if indicated, may include critical care.
- **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes critical care.

Additional Orders: \_\_\_\_\_

C) **ARTIFICIALLY ADMINISTERED NUTRITION** Always offer food by mouth if feasible.

- No artificial nutrition by tube.
- Defined trial period of artificial nutrition by tube.
- Long-term artificial nutrition by tube.

## **From an ethical point of view, when should a medical treatment be used and when is it permissible to forgo (that is, withhold or withdraw) a medical treatment?**

Today the *benefits and burdens principle* is widely used to make such decisions.

According to this principle, a medical treatment ought to be used when it offers a reasonable hope of benefit for the patient and does not entail an excessive burden.

On the other hand, a medical treatment may be forgone (withheld or withdrawn) which does not offer a reasonable hope of benefit to the patient or which the patient considers excessively burdensome. (3)

According to the benefits and burdens principle, there is no treatment that automatically must be used and there is no treatment which can automatically be forgone. Rather, decisions are made on a “case by case” basis. One asks the question: What will be the benefits and burdens of this treatment for this particular patient who is in this particular condition?

## **Is IPOST only about forgoing medical treatment?**

IPOST is not only about forgoing medical treatments; it allows someone to elect to have cardiopulmonary resuscitation, and/or artificially administered nutrition, and/or the full range of additional medical interventions described above.

The goal of IPOST is to determine which medical treatments are *appropriate for the patient given his/her medical condition*. In this regard, health care ethicist John Tuohy and physician Marian Hodges have offered these reflections about the national POLST project: “Key here is that the POLST is a physician’s order *about* life-sustaining interventions, not an order simply to *forgo* them. Especially for patients with complex medical conditions or chronically critical illness, some interventions may offer reasonable hope of benefit, others may not. POLST orders allow for pursuing the interventions that do and avoiding the ones that will pose an excessive burden. POLST is a validated way to help assure clinically appropriate care is delivered at the end of life...”. (4)

## **What should be kept in mind in completing the section of IPOST dealing with resuscitation?**

First, patients or their proxy decision makers completing an IPOST form should have a conversation about their choices which *explicitly considers the respective benefits and burdens of resuscitation for the patient in question*.

For example, successful CPR may keep the patient alive longer but cause injury to the person's body, such as broken ribs, collapsed lung, or punctured spleen. (5) These risks of injury are potential burdens of CPR.

Or again, there are factors which affect the success (and hence potential "benefit") of CPR. While age alone does not determine whether CPR will be successful, illnesses and frailties that go along with age often make CPR less successful. When a patient is seriously ill or terminally ill, CPR may not work or may only partially work, leaving the patient with brain damage and functional impairment. (6)

The benefit (or lack thereof) of CPR and its potential burdens should form the basis of a decision about wanting or forgoing CPR.

Second, *different decisions may be made for different patients about resuscitation because of the different physical conditions of the respective patients.* Consider, for example, a patient with chronic obstructive pulmonary disease (COPD). If "that patient's underlying medical condition means there is no reasonable hope of benefit from pulmonary resuscitation in the event of anticipated respiratory failure," an IPOST order to forgo resuscitation is appropriate, and will mean "the patient won't have to experience the excessive burden of such intervention at the end of life." (7) "At the same time, if a different COPD patient's condition indicates a 'reasonable hope of benefit' from attempted pulmonary resuscitation," an IPOST order for resuscitation is appropriate and "can assure that the intervention will be applied". (8)

Third, *as the condition of a patient changes, decisions about the appropriateness of resuscitation may change.* For this reason, IPOST is not executed "once and for all." It is meant to be reviewed and updated.

## **What should be kept in mind in completing the section of IPOST dealing with various levels of medical interventions?**

The same considerations apply as when dealing with resuscitation.

Patients or their proxy decision makers should have a conversation about their choices which *explicitly considers the respective benefits and burdens* of the various levels of medical intervention *for the patient in question.* Thus different choices will be made for different patients due to differences in their respective physical conditions. And the choices for a particular patient may change over time as the condition of the patient changes.

## **What is meant by *artificially administered nutrition and hydration*?**

Basically, this procedure involves using a tube to deliver nutritional substances and water to a person instead of the person taking in food and water by mouth. It can take various forms:

- *Peripheral intravenous feeding* consists in a needle inserted into a vein in the arm.
- A *nasogastric (NG) tube* is a thin plastic tube inserted through the nose into the stomach or into the first portion of the small intestine.
- A *percutaneous endoscopic gastrostomy tube (PEG) tube* is inserted through the skin into the stomach.
- A *jejunostomy tube* is placed in the small intestine.
- *Central intravenous feeding*, also known as *total parental feeding* or as *hyperalimentation*, is the insertion of a catheter into a central vein near the heart. (9)

## **When might the use of artificially administered nutrition and hydration be considered from a medical point of view?**

Artificially administered nutrition and hydration may be used on a short-term basis following an accident or following surgery when the patient temporarily cannot eat. (10) Artificially administered nutrition and hydration can also be used for longer periods of time in circumstances in which the patient cannot get adequate nutrition and hydration by mouth. For example:

- A patient may be unable to swallow or have difficulty swallowing e.g., because of a head injury, ALS, a stroke, or Parkinson's disease.
- A patient may have a blocked gastrointestinal tract due to cancer.
- A patient may lack enzymes necessary to absorb nutrients in the intestines.
- A patient may have a normal mouth, stomach, and intestinal tract but is averse to or uninterested in eating. (11)

## **What is Stonehill’s policy on artificially administered nutrition and hydration?**

As a Catholic health care facility, Stonehill Franciscan Services acts in accord with the *Ethical and Religious Directives for Catholic Health Care Services* from the United States Conference of Catholic Bishops. (12) This document provides the following directives for making decisions about using or forgoing (withholding or withdrawing) artificially administered nutrition and hydration:

- *In principle, there is an obligation to provide artificially administered nutrition and hydration to patients in need of it.*
- *However, there are cases in which it is morally permissible to forgo medically assisted nutrition and hydration.*
- *The following standard is to be used for determining when it is permissible to forgo artificially administered nutrition and hydration: the procedure cannot reasonably be expected to prolong life or would be excessively burdensome for the patient or would cause significant physical discomfort for the patient.*
- *When a patient is drawing close to inevitable death, the use of artificially administered nutrition and hydration may well not be obligatory. (13)*

## **Why is there considered to be a moral obligation to provide artificially administered nutrition and hydration?**

Providing someone with nutrition and hydration, even by medically assisted means, is considered part of the normal care due to the sick person. (14) This grounds the principle that, in principle, there is an obligation to provide artificially administered nutrition and hydration to patients in need of it.

## **What are examples of cases where it is NOT considered obligatory to provide artificially administered nutrition and hydration?**

There are cases in which artificially administered nutrition and hydration will not be successful in prolonging a patient’s life. A patient may be suffering from such severe heart, kidney, or liver failure that his or her body cannot process, metabolize, or excrete the nutrients or fluids supplied through the feeding tube. (15) Or again, artificially administered nutrition and hydration may not work because the tube itself has

developed complications such as infection or bleeding, or because it has become entangled in the bowels so that the bowel tissue dies and can no longer absorb nutrients. (16) In such cases, artificially administered nutrition and hydration is a futile procedure in a very basic physiological sense. Since it will not work to prolong the patient's life, it is considered permissible to withhold or withdraw it.

Procedures of artificially administered nutrition and hydration do have certain risks. For example, use of a PEG tube can bring about diarrhea, nausea, vomiting, or aspiration pneumonia. (17) Fr. Tad Pacholczyk of the National Catholic Bioethics Center describes a case in which a feeding tube has become "excessively burdensome" for the patient and may be withdrawn:

...if someone is very sick and dying, perhaps with partial bowel obstruction, the feeding tube may cause them to vomit repeatedly, with the attendant risk of inhaling their own vomit, raising the specter of lung infections and respiratory complications. The feeding tube under these conditions may become disproportionate and unduly burdensome, and therefore non-obligatory. (18)

## **Does artificially administered nutrition and hydration have to be provided to patients who are close to death?**

The *Ethical and Religious Directives for Catholic Health Care Services* notes that, "as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort." (19)

In fact, there is evidence that *patients who are allowed to die without artificially administered nutrition and hydration may die more comfortably than patients who receive conventional amounts of hydration.* (20) Dehydration can reduce swelling and increase comfort in a patient suffering from edema (swelling of the body caused by excess body fluids) or ascites (fluid in the abdominal cavity). Cough and congestion may be lessened because secretions in the lungs are diminished. A dehydrated person has less urine output so that problems with incontinence are lessened. Since there is less fluid in the gastrointestinal tract with dehydration, a patient may experience a decrease in nausea, vomiting, bloating, and regurgitation. Indeed, dehydration leads to death in ways that produce a sedative effect on the brain just before death, thus decreasing the need for pain medication. (21)

## **Why does the IPOST form include a choice “Defined trial period of artificial nutrition by tube”?**

In some cases, it may not be clear whether artificially administered nutrition and hydration will prove beneficial or burdensome to the patient. In such cases, time trials are recommended. In other words, artificially administered nutrition and hydration is initiated and, after a defined period of time, the procedure is assessed. If the artificially administered nutrition and hydration has proven successful in prolonging the patient’s life and has not caused severe burdens or significant physical discomfort for the patient, then it should be continued and the IPOST form should be revised to the choice “Long term artificial nutrition by tube.” On the other hand, if the artificially administered nutrition and hydration is not working to prolong the patient’s life or if the procedure has caused excessive burdens or significant physical discomfort for the patient, then it is permissible to stop the procedure and the IPOST form may be revised to the choice “No artificial nutrition by tube.”

## **What if a resident gives a directive in an IPOST form that Stonehill cannot honor?**

Chapter 144D Physician Orders for Scope of Treatment of the Iowa Code contains a “conscience clause” for health care facilities: “A health care provider, hospital or health care facility that is unwilling to comply with an executed POST form based on policy, religious beliefs, or moral convictions shall take all reasonable steps to transfer the patient to another health care provider, hospital, or health care facility” (144D.3). Thus if Stonehill feels it cannot honor a directive given in an IPOST form, the staff will assist the resident in transferring to another facility.

## **What should proxy decision makers keep in mind in completing an IPOST form?**

A proxy decision maker acts in the place of the patient, and should make decisions in accord with the patient’s own intentions and values. (22) Thus a proxy decision maker should ask this question: *How would the patient himself/herself evaluate the benefits and burdens of a medical treatment or procedure?* The patient’s advance directives, oral conversations, and life-long values and behavior patterns can be useful tools in making this determination.

***An IPOST form is completed in consultation with a trained facilitator. Take this booklet with you to your meeting with the facilitator at Stonehill Franciscan Services. The reproduction of the IPOST form accompanying this booklet is for information purposes only and cannot be used to execute an IPOST.***

## Notes

1. National POLST Paradigm Task Force, *Distinguishing POLST from Death with Dignity Statutes* September 18, 2015. <http://www.polst.org/news-events>. Accessed January 2016.
2. *Ibid.*
3. The benefits and burdens principle comes from Catholic health care ethics; see the United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed. (2009), nos. 56 – 57; available at <http://www.usccb.org>. However, the principle is widely used in contemporary health care ethics.
4. Fr. John Tuohy and Marian Hodges, “POLST Reflects Patient Wishes, Clinical Reality” *Health Progress* (March-April 2011): 60-64 at 63-4.
5. Allina Hospitals & Clinics, *What You Should Know about CPR and Advanced Care Planning*. <http://www.allinahealth.org>
6. New York State Department of Health, *Deciding about CPR: Do-Not-Resuscitate (DNR) Orders A Guide for Patients and Families*. <http://wings.buffalo.edu/bioethics/dnr-p.html>
7. Tuohy and Hodges, “POLST Reflects Patient Wishes, Clinical Reality,” p. 63.
8. *Ibid.*
9. David Majors, M.D., “The Medical Procedures for Providing Food and Water: Indications and Effects” in Joanne Lynn (ed.), *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water* (Bloomington, IN: Indiana University Press, 1986); Myles Sheehan, S.J., M.D., “Feeding Tubes: Sorting Out the Issues,” *Health Progress* 82/6 (Nov.-Dec. 2001):22-27.
10. Majors, “The Medical Procedures for Providing Food and Water: Indications and Effects.”
11. *Ibid.*
12. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed. (2009); available at <http://www.usccb.org>.
13. *Ibid.*, no. 58:

In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the “persistent vegetative state”) who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be “excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed.”

For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

14. John Paul II, "Care for Patients in a 'Permanent' Vegetative State." *Origins* 33/43 (April 8, 2004): 737-40.
15. Sheehan, "Feeding Tubes: Sorting Out the Issues."
16. Daniel P. Sulmasy, "Preserving Life? The Vatican and PVS." *Commonweal* 134/21 (Dec. 7, 2007): 16-18.
17. Quality Collaborative, Monroe County Medical Society, Rochester, NY. *Benefits and Burdens of PEG Placement*. <http://www.compassionandsupport.org/pdf/professionals/life-sustaining/BenefitsandBurdens.pdf>. Accessed 2011.
18. Fr. Tad Pacholczyk, "Are feeding tubes required?" *The Catholic Globe* (Dec. 24, 2009):13
19. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed. (2009), no. 58. Available at <http://www.usccb.org>.
20. Joyce C. Zerwekh, "The Dehydration Question," *Nursing* 83 (January 1983): 47-51; Robert L. Fine, "Ethical Issues in Artificial Nutrition and Hydration," *Nutrition in Clinical Practice* 21 (April 2006): 118-25 at 122.
21. Cheryl Arenella, "Artificial Nutrition and Hydration: Beneficial or Harmful?" (2005), [http://www.americanhospice.org/index.php?option=com\\_content&task=view&id=48&Itemid=8](http://www.americanhospice.org/index.php?option=com_content&task=view&id=48&Itemid=8) Accessed January 2009; American Dietetic Association, "Position of the American Dietetic Association: Ethical and Legal Issues in Nutrition, Hydration, and Feeding," *Journal of the American Dietetic Association* 108 (2008): 873-82; American Dietetic Association, "Position of the American Dietetic Association: Issues in Feeding the Terminally Ill Adult," *Journal of the American Dietetic Association* 87 (Jan.-April 1987): 78-85; Zerwekh, "The Dehydration Question." This paragraph is quoted from Janine M. Idziak, *Ethical Dilemmas in Allied Health*, 2<sup>nd</sup> ed. (Dubuque, IA: Kendall Hunt Professional, 2009).
22. Cf. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (2009), no. 25. Available at <http://www.usccb.org>.