Instructions for Executing and Using IPOST in Accord With Catholic Moral Teaching

Medical-Moral Commission
Archdiocese of Dubuque

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These instructions are intended for health care professionals and trained facilitators assisting patients or their proxy decision makers in executing an IPOST form or revising and re-executing it.

These instructions are also intended for health care professionals presented with a completed IPOST form as a guide to patient care. The *Ethical and Religious Directives for Catholic Health Care Services* states: "The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, *unless it is contrary to Catholic moral teaching*" (no. 59; italics added). The law establishing IPOST includes a conscience clause for health care professionals: "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." (Code of Iowa 144D.5)

The IPOST form has three sections regarding medical treatment.

The first section deals with *cardiopulmonary resuscitation* (CPR) and offers the choices:

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

The second section presents choices for *level of medical intervention:*

- 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_____

The third section gives options for *artificially administered nutrition,* with an instruction to "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. (1)

The process of executing an IPOST form should start with an extended conversation between a health care professional or a specially trained IPOST facilitator and the patient (or his/her proxy decision maker) which explores the patient's beliefs, values and goals of care in relation to the patient's diagnosis, prognosis and treatment alternatives. Together a decision is reached about the patient's treatment plan that is recorded on the IPOST form. (2) An IPOST form should never simply be handed to a patient or proxy decision maker without explanation.

There is no expectation that all patients (or proxy decision makers) will make the same set of choices in completing an IPOST form. It is not a boiler plate check-off list. The choices will be made differently for different patients based on the current medical condition of the patient and his/her preferences.

An IPOST is not executed once and for all. Its initial execution will be based on the best medical evidence available at the time, but it is a "living" document which is meant to be reviewed periodically and changed if need be so that its directives reflect the current medical condition and wishes of the patient. For example, an IPOST should be reviewed, and a new one executed if necessary, 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. (3)

Resuscitation

Catholic moralists developed a distinction between "ordinary" and "extraordinary" treatments, with the accompanying principle that ordinary treatments should always be provided but that it is permissible to forgo treatments which are extraordinary in character. As stated in the *Ethical and Religious Directives for Catholic Health Care Services,* ordinary and extraordinary treatments were subsequently explained in terms of "proportionate" and "disproportionate" means of preserving life, and then in terms of the benefits and burdens of a medical treatment. (4) Thus the following principles are currently used to make decisions about using or forgoing a medical treatment:

- *A person has a moral obligation to use means of preserving his or her life that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.*

- *A person may forgo means of preserving life that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.* (5)

These standards are often referred to as the "benefits and burdens principle."

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?

Those executing, revising and re-executing, or using an IPOST form to guide patient care should *explicitly consider benefits and burdens of resuscitation for the patient in question.*

FOR EXAMPLE:
CPR works well and can save lives when someone's heart and/or lungs unexpectedly stop due to a heart attack, a severe allergic reaction, or drowning, and the person is quite healthy, and the CPR procedure begins right away. (6) On the other hand, CPR for hospitalized patients does not have particularly good outcomes. The reason is that the cause of the arrest is usually associated with advanced chronic illness. (7) First of all, CPR does not always work. Studies have indicated that, in the hospital setting, immediate survival after CPR is about 44%. (8) Even if the CPR procedure initially succeeds in restoring the patient's heart beat and/or breathing, only about 15% of patients who undergo CPR in the hospital survive to the point of being discharged from the hospital. (9) Moreover, patients surviving through CPR may suffer permanent neurological and functional impairment. (10) Other possible burdensome side effects from CPR include broken ribs, bruised or punctured lungs, and damage to the windpipe. (11) While age alone does not determine whether CPR will be successful, illnesses and frailties that accompany age often make CPR less successful. (12)

Different choices 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."(13) "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". (14)

Finally, *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.

Level of Medical Intervention

Again, **choices should be made based on an *explicit consideration of the respective benefits and burdens of the various levels of medical intervention for the patient in question*** (see above). In making decisions, there must be consultation with the patient's physician about the anticipated benefit (or lack of benefit) and burdens of the various medical interventions in view of the patient's particular health status. 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.

Artificially Administered Nutrition

In Catholic teaching, providing someone with nutrition and hydration, even by medically assisted means, is considered part of the normal care due to the sick person. (15) *Thus, in principle, there is considered to be an obligation to provide medically assisted nutrition and hydration to patients in need of it. However, the procedure becomes optional, from a moral point of view, when it cannot reasonably be expected to prolong the patient's life or if it would be excessively burdensome for the patient or cause significant physical discomfort. The case of a patient drawing close to inevitable death from an underlying progressive and fatal condition is one example of a situation when medically assisted nutrition and hydration is not morally obligatory*. (16)

FOR EXAMPLE:
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. (17) Or again, artificially administered nutrition and hydration may not work because complications have developed with the tube itself such as clogging, infection or bleeding, or because it has become entangled in the bowels so that the bowel tissue dies and can no longer absorb nutrients. (18) 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 morally permissible to withhold or withdraw it.

Procedures of artificially administered nutrition and hydration do have certain risks which create burdens for the patient. For example, use of a PEG tube can bring about diarrhea, nausea, vomiting, or aspiration pneumonia. (19) 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 morally 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. (20)

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." (21) 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. (22) 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. (23)

On an IPOST form, the option of "Long-term artificial nutrition by tube" should be selected unless, in the particular patient's case, <u>one</u> of the following conditions holds:

- **Artificially administered nutrition and hydration cannot reasonably be expected to have the benefit of prolonging the patient's life.**
- **Artificially administered nutrition and hydration would be excessively burdensome for the patient or would cause significant physical discomfort for the patient.**
- **The patient is drawing close to inevitable death.**

In these three cases, it is morally permissible to select the option of "no artificial nutrition by tube" on the IPOST form.

The IPOST form also includes 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 limited 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 excessive**

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."

NOTES

1. IPOST form, sections A, B, C. A copy of the form may be obtained at http://idph.iowa.gov/ipost/form. Accessed April 2020.

2. National Physician Orders for Life-Sustaining Treatment (POLST) Paradigm, *Distinguishing POLST from Death with Dignity Statutes* (September 18, 2015). http://www.polst.org/distinguishing-polst-from-death-with-dignity-statutes. Accessed April 2020.

3. IPOST form, Directions for Health Care Professionals.

4. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* 6th ed. (2018), nos. 56-57. http://www.usccb.org/about/ doctrine/ethical-and-religious-directives. Accessed April 2020.

5. *Ibid.*

6. Palliative Pain & Symptom Management Consultation Program of Southwestern Ontario, *DON'T BE SURPRISED WHEN WE ASK Making an Informed Decision about Cardiopulmonary Resuscitation (CPR).* http://www.palliativecareswo.ca/learning_initiatives/CPR/docs/PlanOfTreatmentCPR_SampleBrochures.pdf Accessed July 2016.

7. David H. Ramenofsky and David E. Weissman, *Fast Facts and Concepts #179 CPR Survival in the Hospital Setting*. http://www.mypcnow.org/wp-content/uploads/2019/02/FF-179-CPR-Suvival-inhospital.-3rd-Ed.pdf Accessed Novmber 2020.

8. *Ibid.*

9. *Ibid.*

10. *Ibid.*

11. Trillium Health Partners, *A Guide to Cardiopulmonary Resuscitation (CPR).* http://trilliumhealthpartners.ca/aboutus/documents/ethics/thp rep cpr brochure.pdf Accessed July 2016.

12. New York State Department of Health, *Deciding about CPR: Do-Not-Resuscitate (DNR) Orders*. http://wings.buffalo.edu/bioethics/dnr-p.html Accessed July 2016.

13. Fr. John Tuohy and Marian Hodges, "POLST Reflects Patient Wishes, Clinical Reality," *Health Progress* (March-April 2011): 60-64 at 63.

14. *Ibid*.

15. John Paul II, "Care for Patients in a 'Permanent' Vegetative State." *Origins* 33/43 (April 8, 2004): 737-49.

16. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, no. 58.

17. Myles Sheehan, S.J., M.D., "Feeding Tubes: Sorting Out the Issues," *Health Progress* 82/6 (Nov.-Dec. 2001): 22-27.

18. Daniel P. Sulmasy, "Preserving Life? The Vatican and PVS." *Commonweal* 134/21 (Dec. 7, 2007): 16-18.

19. Quality Collaborative, Monroe County Medical Society, Rochester, NY. *Benefits and Burdens of PEG Placement*. http://www.compassionandsupport.org/pdfs/professionals/life_sustaining/Benefits_and_Burdens.pdf . Accessed July 2016.

20. Fr. Tad Pacholczyk, "Are feeding tubes required?" *The Catholic Globe* (Dec. 24, 2009): 13.

21. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (2018), no. 58.

22. 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.

23. Cheryl Arenella, "Artificial Nutrition and Hydration at the End of Life: Beneficial or Harmful?" http://www.americanhospice.org/caregiving, accessed July 2016; 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*, 2nd ed. (Dubuque, IA: Kendall Hunt Professional, 2009).