

TESTIMONY REGARDING SCR 43 (Senator W. J. McPherson, Jr.)

“Creates the LaPOST Study Committee to make recommendations ... whether to establish such a program in this state”

House Health & Welfare Committee, June 2, 2009

Good Morning, Madam Chairman, and Ladies & Gentlemen of the Committee!

My name is Dr. W. A. Krotoski; I am a physician, currently retired, with M.D., Ph.D. and M.P.H. degrees. I have lived in Louisiana since 1974, and in Baton Rouge since 1982. I am President of, and represent *The Hippocratic Resource*, a Louisiana-wide organization of physicians, dentists, nurses, scientists and other health professionals who have committed to promoting the life-respecting principles of the Hippocratic Oath, the foundation of medical ethics. I have taught both at Tulane and LSU Schools of Medicine and Public Health, as well as their Graduate Schools. Currently, I continue to serve on Baton Rouge General Medical Center’s Institutional Review Board, helping to evaluate the ethics of research protocols, and have recently published in *The Linacre Quarterly*, a journal devoted to the philosophy and ethics of medical practice.

I am testifying to express caution regarding the issue of LaPOST, or Louisiana Physicians Orders on Scope of Treatment, for the following reasons:

Based on the traditional premise that a person’s life, from its earliest beginnings at fertilization until its natural end, is in the hands of our Creator, as well as on the expectation that advances in medical knowledge and technology to alleviate suffering and prolong life will continue to occur, the traditional Judeo-Christian focus of good medicine has been to use whatever is available to those two ends. It has also been generally accepted that the competent physician in a good doctor-patient relationship will know and be able and willing to use all that is available for the good of his patient. On that basis he/she has been accorded special privileges in matters of life and death – such privileges, however, being subject to the applicable tenets of the Hippocratic Oath, to peer review, and to community professional standards. It is also the general rule that the competent physician, most often having greater professional education and experience, knows more than the patient regarding what is good and necessary for the latter in terms of treating and/or curing disease, particularly when the patient is not capable of making decisions for him/herself. None of the above over-rides patient autonomy, or, if formally delegated, defined family decision rights and responsibilities.

Recognizing that our Maker can intervene at will to shorten or lengthen life, the role of the physician, as commonly understood, therefore, has been to use all means necessary to prolong life until He exercises His will. Nevertheless, it is recognized that our lives do have endings, and that natural, endogenous disease conditions may have a natural history or expectation of incurability resulting in death – sometimes to the relief of the patient, who thus experiences the ultimate alleviation of physical suffering. Suspension of extraordinary means, however, does *not* include stopping hydration and/or alimentation, which ethically must continue unless they, themselves, become unduly burdensome. Barring such eventuality, however, the responsibility of the physician remains understood to be to strive to cure the illness, to sustain life, and to alleviate suffering consistent with the former two, and this must be the ultimate basis for any “advance directive.”

In 1995, a new type of advance directive was promulgated in Oregon. Called a “Physicians Order for Life Sustaining Treatments” form, or POLST, it initiated a “sea change” in regard to responsibility for terminal care. Instead of the (more knowledgeable) physician having the traditional primary responsibility for doing what was necessary to keep a patient alive – with the patient having been given the opportunity to “opt out” of certain extraordinary life-sustaining treatments – POLST placed the primary burden of determining what treatments to use to help sustain life on the (less knowledgeable) patient. *Shortly thereafter, Oregon became the first state to legalize assisted suicide, despite the latter’s absolute conflict with the Hippocratic Oath.*

In 2000-2001, the state of Washington implemented a POLST preference, replacing advance directive / DNR (do not resuscitate) forms with POLST forms at its nursing homes, statewide. As in Oregon, and *with POLST as background, Washington State legalized assisted suicide, in 2008.*

In Louisiana, measures to reduce active physicians’ input to a pre-determining bracelet have been periodically introduced, but have repeatedly failed. The LaPOST, or “Louisiana Physicians Orders for Scope of Treatment” forms, although not eliminating an advance directive *per se*, reduce active decision-making to a series of pre-determined instructions (orders) – which could prevail, even if the timing is not appropriate.

LaPOST is presumably well-meaning, yet fundamentally flawed, as it removes the physician’s responsibility for keeping a patient alive to the best of his ability under a given set of circumstances, and places that responsibility back onto the patient – who is the one generally least able to understand his or her illness, and to help him or herself. It reduces life-and-death decisions to a mere “standardized form,” and even allows

non-physicians to make survival decisions; if promulgated in Louisiana, it will quickly become the “gold standard” excuse for not providing quality life-saving care, and could pave the way for an assisted suicide law. Unless extraordinarily carefully crafted, it could put the onus on emergency, non-physician personnel to determine whether a form is in existence, rather than conduct case-appropriate emergency procedures first; eliminate sanctions against emergency medical technicians who choose to withhold life-sustaining procedures; de-criminalize, in effect, so-called mercy-killing or euthanasia and *de facto* suicide; invalidate insurer’s rights; allow virtual falsification of death certificates; and, as suggested by the Florida Catholic Conference, allow forms to be signed by someone like Jack Kevorkian, among additional concerns. As an aside, I find it problematic that there is no real representation on the proposed Study Committee from among the pro-life community.

One of the reasons given for promoting POLST (Physicians Orders for Life Sustaining Treatment) in Washington State was “the discouraging results with advance directives.” However, if such results were, indeed “discouraging” (term not defined), I would suggest that there would be little difference between advance directives currently in use and LaPOST forms identifying Physicians Orders for Scope of Treatment, other than the latter’s necessary complication. Death is not a comfortable subject for many, yet hemming patients in with a poorly understood, very complex LaPOST list would not be effective; ultimately, it could be cruel. Patients frequently do not hear what they do not want to hear!

In summary, I feel that there is reason for great caution regarding any set of advance directives, but, most especially, any that are so complicated that they exceed the patient’s ability to comprehend the reasons for any standardized instructions, or relegate often-complicated decision-making to a standard form that cannot cover all possible eventualities.

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