Psychiatric advance directives: May you disregard them?

Nicole S. Luddington, MD, and Douglas Mossman, MD

Douglas Mossman, MD
Series Editor

DO YOU HAVE A QUESTION ABOUT POSSIBLE LIABILITY

▶ Submit your malpractice-related questions to Dr. Mossman at douglas.mossman@qhc.com.

▶ Include your name, address, and practice location. If your question is chosen for publication, your name can be withheld by request.

Dear Dr. Mossman:

My patient stopped antipsychotic medication, experienced a recurrence of paranoid schizophrenia, and now is involuntarily hospitalized. During her admission assessment, she said she had a "psychiatric advance directive." I obtained the document, which says she refuses psychopharmacologic treatment under any circumstances. Without medication, she might take years to recover. How should I proceed?

Submitted by "Dr. Y"

Most psychiatrists who regularly practice hospital-based care know their state's legal procedures for forcing psychotic, civilly committed patients to take medication to relieve their acute symptoms. In most jurisdictions, courts will order medication over a patient's objection after finding that the patient lacks competence to refuse antipsychotic therapy and that the proposed treatment is in the patient's best interest.[1]

But if a patient has a psychiatric advance directive (PAD) that opposes psychotropic medication, things may become complicated. To decide what to do if a patient's PAD precludes administering a treatment you think is necessary, you should understand:

- what PADs do
- what courts have said about PADs
- what your state's laws say about PADs
- where and when to seek legal advice.

What are advance directives?

An advance directive (or "declaration") for health care (ADHC) is a legal document executed by a competent individual that states preferences regarding medical treatment should that individual become incapable of making or expressing decisions.[2-4] An ADHC may be a "living will" that lays out instructions for specific health care situations or a "durable power of attorney" (DPOA) that designates a proxy decision maker, or it may include elements of both. In 1990, the U.S. Congress passed the Patient Self-Determination Act,[5] which required health care institutions that receive Medicare or Medicaid to ask patients whether they have ADHCs and to give patients information about state laws governing ADHCs.

Modeled after medical advance directives, PADs let competent individuals declare their wishes should they need psychiatric treatment during a period of decision-making incapacity.[3,4] At least 25 states have advance directive statutes specific to psychiatry.[6] Depending on the state, PADs may allow individuals to assert their preferences regarding psychotropic medication, electroconvulsive therapy (ECT), alternatives to hospitalization, location and length of voluntary hospitalization, the treating psychiatrist, seclusion and restraint, emergency medications, and visitors.

Dr. Luddington is a former fellow in the University of Cincinnati Forensic Psychiatry Program and Staff Psychiatrist, Robley Rex Veterans Affairs Medical Center, Louisville, KY. Dr. Mossman is Professor and Program Director, University of Cincinnati Forensic Psychiatry Fellowship, Cincinnati, OH.

Table 1

Examples of state laws on compliance with psychiatric advance directives

State	Provider compliance
Kentucky[14]	Providers must provide mental health treatment that complies with the instructions in an advance directive to the fullest extent possible when the instructions are within standards for mental and physical health care and permitted by state and federal law. Providers may override expressed refusals of treatment only if a court order contradicts the advance directive or an emergency endangers a patient's life or poses a serious risk to physical health
Ohio[15]	A provider who does not wish to comply with a patient's declaration must notify the patient and any proxy and document the notification. The provider may not interfere with the patient's transfer to another provider who is willing to follow the patient's declaration. Providers may subject a patient to treatment contrary to a declaration only if: 1) the patient is committed and the committing court acknowledges the declaration and specifically orders treatment contrary to the declaration, or 2) an emergency situation endangers the life or health of the declarant or others
Oklahoma[16]	Physicians and psychologists must follow as closely as possible the terms of a patient's declaration. A provider who cannot comply with the terms of the patient's declaration must make arrangements to transfer the patient and the appropriate medical records without delay to another physician or psychologist
Pennsylvania[17]	If a provider cannot in good conscience comply with a patient's declaration because the instructions are contrary to accepted clinical practice and medical standards, the provider must make every reasonable effort to help transfer care to another provider who will comply with the declaration. While the transfer is pending, the provider must provide treatment in a way that is consistent with the declaration. If reasonable efforts to transfer fail, the patient may be discharged
Utah[18]	A physician must comply with a declaration to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. A physician may subject a patient to treatment contrary to wishes expressed in a declaration if: 1) the declarant has been committed to the custody of a local mental health authority, or 2) an emergency endangers life or health

Prevalence and praise

The prevalence of PADs is unknown. A 2006 survey of 1,011 psychiatric outpatients in California, Florida, Illinois, Massachusetts, and North Carolina by Swanson et al[7] found only 4% to 13% of patients previously executed a PAD. However, most participants said that if given the opportunity and assistance, they would create a PAD.[7]

Psychiatric advocacy groups have lauded the development of PADs. For example, the National Alliance on Mental Illness' position is that "PADs should be considered as a way to empower consumers to take a more active role in their treatment, and as a way to avoid conflicts over treatment and medication issues."[8] Proponents suggest that PADs:

- promote autonomy
- foster communication between patients and treatment providers
- increase compliance with medication
- reduce involuntary treatment and judicial involvement.[4,8]

Mental Health America launched *My Plan, My Life: My Psychiatric Advance Directive* in September 2011 to increase public awareness of the availability of PADs.[9] Therefore, it is safe to assume that most psychiatrists will encounter patients with PADs.

continued

Clinical Point

PADs let competent individuals declare their wishes should they need psychiatric treatment during a period of decision-making incapacity

Discuss this article at www.facebook.com/CurrentPsychiatry

Table 2

Excerpts from state laws on PAD-related liability

State	Liability or immunity
Oklahoma[16]	A provider who transfers the patient without unreasonable delay to another provider or who makes a good faith attempt to do so may not be subject to criminal prosecution or civil liability. The provider may not be found to have committed an act of unprofessional conduct for refusal to comply with the terms of the declaration, and transfer under such circumstances shall not constitute abandonment. However, the failure of a provider to transfer in accordance with this subsection shall constitute professional misconduct
Pennsylvania[17]	A provider who acts in good faith and consistent with the statute may not be subject to criminal or civil liability, discipline for unprofessional conduct, or administrative sanctions. A provider may not be found to have committed an act of unprofessional conduct by the relevant state professional board because the provider refused to comply with: 1) the direction or decision of an individual due to conflicts with a provider's contractual, network, or payment policy restrictions, or 2) a declaration that violates accepted clinical standards or medical standards of care

PAD: psychiatric advance directive

Clinical Point

PADs may allow individuals to assert their preferences regarding ECT, medication, and alternatives to hospitalization

What if a PAD blocks treatment?

What happens when an adult such as Dr. Y's patient has a PAD that precludes effective treatment? A similar situation led to *Hargrave v Vermont*.[10]

Nancy Hargrave, a Vermont woman with schizophrenia and a history of psychiatric hospitalizations, executed a DPOA—Vermont does not have a separate statute for PADs—in which she explicitly refused "any and all anti-psychotic, neuroleptic, psychotropic, or psychoactive medications," and ECT.[10]

In anticipation of situations like this, Vermont's legislature passed Act 114, a 1998 state law that required caregivers to abide by the DPOAs of civilly committed individuals and mentally ill prisoners for 45 days.[10] After this time, a court may override the advance directive and allow involuntary medication administration if a patient "ha[d] not experienced a significant clinical improvement in his or her mental state, and remain[ed] incompetent."[10]

In 1999, Hargrave sued the state of Vermont and other parties in federal court, alleging that Act 114 constituted discrimination under Title II of the Americans with Disabilities Act[11] because Act 114 excluded her from participating in the "services, programs, or activities of a public entity," namely, the use of her DPOA under Vermont state law.[10] The federal district court sided with Hargrave, concluding that "Act 114 was facially discriminatory against mentally disabled individuals." One year later, the U.S. Court of Appeals for the Second Circuit affirmed the district court's ruling.

Surprisingly, no other court has adjudicated this issue. However, in Second Circuit states—Vermont, New York, and Connecticut—DPOAs of mentally ill patients cannot be abrogated. This is an unsettling notion for many psychiatrists, because, as Paul Appelbaum, MD, explains, "Advance directives may now constitute an ironclad bulwark against future involuntary treatment with medication—except in emergencies—even for incompetent, committed patients and even when the alternative is long-term institutional care."[12] Other scholars have pointed out that giving physicians an avenue to override or disregard patients' directives would negate their intended purpose, which is to have one's competently expressed wishes followed when one's decision-making capacity is compromised.[6,13]

Doctors' duties

How you should respond to an involuntary patient's PAD depends on which state you practice in. A physician's obligation to comply with a patient's PAD depends on state law, and most states with PAD laws provide some latitude or options if physicians believe they should not comply with a patient's wishes.[6,13] ***Table 1***[14-18] (***page 31***) cites examples of statutory language regarding a physician's duty to comply with a PAD.

A survey of 164 psychiatrists in North Carolina provides some insight into psychiatrists' perceptions of PADs.[19] After reading a hypothetical scenario about a mentally ill individual whose PAD expressed refusal of hospitalization or treatment with antipsychotics, 47% of the psychiatrists chose to override the PAD. The authors found that "PAD override was more likely among psychiatrists who worked in hospital emergency departments; those who were concerned about patients' violence risk and lack of insight; and those who were legally defensive."

In addition to addressing conflicts between patients' PADs and doctors' views about proper treatment, some state laws also contain clauses that spell out the limits of physician liability in cases of physician compliance or noncompliance with PADs. Excerpts from 2 such laws appear in ***Table 2***.[16-17]

Related Resources

- National Resource Center on Psychiatric Advance Directives. www.nrc-pad.org.
- Duke University Program on Psychiatric Advance Directives. http://pad.duhs.duke.edu.
- Hung EK, McNiel DE, Binder RL. Covert medication in psychiatric emergencies: is it ever ethically permissible? J Am Acad Psychiatry Law. 2012;40(2):239-245.

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Clinical Point

PAD compliance laws vary by state; most states provide options if physicians believe they should not comply with a PAD

References

1. Eclavea RP, Martin LD. State-created right to refuse medication. 53 Am. Jur. 2d Mentally Impaired Persons § 111 (West, 2012).
2. Aitken PV Jr. Incorporating advance care planning into family practice. Am Fam Physician. 1999;59(3):605-614, 617-620.
3. Gallagher EM. Advance directives for psychiatric care: a theoretical and practical overview for legal professionals. Psychol Public Policy Law. 1998;4(3):746-787.
4. DeWolf Bosek MS, Ring ME, Cady RF. Do psychiatric advance directives protect autonomy? JONAS Healthc Law Ethics Regul. 2008;10(1):17-24.
5. Patient Self Determination Act 42 USC § 1395cc, 1396a (1994).
6. Swanson JW, McCrary SV, Swartz MS, et al. Superseding psychiatric advance directives: ethical and legal considerations. J Am Acad Psychiatry Law. 2006;34(3):385-394.
7. Swanson J, Swartz M, Ferron J, et al. Psychiatric advance directives among public mental health consumers in five U.S. cities: prevalence, demand, and correlates. J Am Acad Psychiatry Law. 2006;34(1):43-57.
8. National Alliance on Mental Illness. Psychiatric advance directives. http://www.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=5&ContentID=8217. Accessed July 11, 2012.
9. Mental Health America. My plan, my life: my psychiatric advance directive. http://www.myplanmylife.com. Accessed July 23, 2012.
10. Hargrave v Vermont, 340 F3d 27 (2d Cir Vt 2003).
11. Americans with Disabilities Act, 42 USCA § 12132.
12. Appelbaum PS. Law & psychiatry: psychiatric advance directives and the treatment of committed patients. Psychiatr Serv. 2004;55(7):751-752, 763.
13. Appelbaum PS. Commentary: psychiatric advance directives at a crossroads--when can PADs be overridden? J Am Acad Psychiatry Law. 2006;34(3):395-397.
14. Ky Rev State § 202A.426 (Michie, 2012).
15. Ohio Rev Code § 2135.07 (Page, 2012).
16. 43A Okla. St. § 11-110 (Lexis, 2012).
17. 20 Pa. Cons. Stat. §5804.
18. Utah Code Ann. § 62A-15-1003 (Lexis, 2012).
19. Swanson JW, Van McCrary S, Swartz MS, et al. Overriding psychiatric advance directives: factors associated with psychiatrists' decisions to preempt patients' advance refusal of hospitalization and medication. Law Hum Behav. 2007;31(1):77-90.

Bottom Line

Psychiatric advance directives (PADs) are legal instruments for declaring preferences about mental health treatment. Your obligations regarding the instructions in a patient's PAD differ from state to state. If your patient has a PAD that you believe you should not comply with, check your state's laws on PADs and speak with your attorney or your hospital's legal department.