Advance Directives in Family Practice

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Advance directives have emerged in medicine as an important method by which patients can express future treatment wishes. The major reasons medical professionals have been reluctant to use advance directives are not because of theoretical defects with advance directives, but because of procedural difficulties. Confusion over types of advance directives and their legal status will ease with increased knowledge of advance directives by health professionals. Additionally, that they are often formulated in ambiguous terms and under situations where the patient's competence is in question can be minimized. More widespread and effective use of advance directives will occur if the family physician takes an active role in (1) identifying patients for whom an advance directive would be desirable, (2) effectively communicating information about advance directives, (3) advising their patients about the most effective way to state their directive in medically precise terminology, and (4) explaining when necessary the patient's wishes to other medical specialists and family members.

The hospice movement notwithstanding, current practices in medicine promote the likelihood that large numbers of patients will die in health care facilities in critical care situations. During those last critical days, decisions such as whether to forego life-sustaining treatment or to aggressively pursue a cure or remission must be made even if the patient becomes mentally incompetent or physically unable to do so. In general, the resolution of these issues has focused on methods for determining what the patient might have wished if he or she could competently make the necessary treatment decisions.[1] Advance directives encompass a number of methods that allow patients to participate in future treatment decisions about their own health care should they become incompetent. The scope of advance directives is not confined to withholding or withdrawing therapy, but may include a number of potential treatment options that could affect a patient. Advance directives can be formal or informal depending on the extent of documentation or legal involvement into their development.

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Although the need for advance directives appears obvious, they are nevertheless not widely advocated by physicians. This reluctance appears to be due more to a lack of understanding of their usefulness and legal status than to discomfort with their conceptual design. In this paper various types of advance directives are reviewed, their medical, legal, and ethical usefulness is discussed, and suggestions for their appropriate use in clinical practice are offered.

INFORMAL DIRECTIVES

The traditional method of communicating information regarding treatment wishes occurs on an informal basis between patient and physician.[1] These informal directives often help bind patient-physician trust and may be satisfactory to both physician and patient. Unfortunately, these informal directives do not always resolve the moral, medical, or legal problems posed by treating incompetent patients.

Communication by patients of treatment expectations usually occurs just prior to or during the final critical episode. Only at this point is the reality of the critical situation usually confronted by the patient and physician. As a result of the illness or medication, patients may be in extreme pain or confused. Thus the patient's poor condition can leave in doubt the moral and legal status of the patient's decisions, even when they are clearly expressed. Physicians may feel pres-

sured to make all treatment decisions for the incompetent patient or may be forced to acquiesce to family members who have their own interests, not the patient's, at heart.[2]

Even when physicians recognize the importance of discussing treatment options with patients in critical situations, in practice they often neglect to do so.[3] In one survey, 93 percent of private physicians and 100 percent of house officers surveyed, who had recently participated in cardiopulmonary resuscitation, believed that patients should be involved in the decision to be resuscitated. In practice, however, only 10 percent of these physicians actually discussed the possibility of cardiopulmonary resuscitation with patients who were resuscitated, even though in most instances the cardiopulmonary arrest was predicted. Additionally, physicians' opinions in regard to resuscitation have been found to correlate only weakly with the preference expressed by the patient.[4]

A current practice of many physicians is to document patients' treatment wishes in clinic or hospital progress notes. While such documentation does constitute an advance directive, several drawbacks impair the desirability of this method of recording patient wishes. For example, with this type of documentation, the patients' understanding of the noted treatment wishes could be in legal question, since the notes are not signed by the patient and witnessed. Thus, the major drawbacks with informal directives are that they may not be respected by health professionals and that they are unlikely to be legally binding.

FORMAL ADVANCE DIRECTIVES

Because of the problems associated with the informal methods, more formal and legally binding advance directives have been created in an effort to protect the patient's treatment wishes. These formal directives are of two types, instructional directives and proxy directives. The most common type of instructional directive, the living will, deals primarily with the patient's views about artificial prolongation of life in the face of terminal illness.[1,5] Initially living wills were legally in question; however, after enactment of natural death acts by many states and with strong support by the courts, they have received legal recognition.[6] Properly executed, the living will is a witnessed document that becomes a part of the patient's permanent medical record.

The most widely recognized of the proxy directives involves the appointment of a durable power of attorney for health care.[7] All 50 states currently have provisions authorizing durable powers of attorney. These statutes implicitly allow the proxy to make medical decision should the patient become unable to make his or her own treatment decision. Several states, including California and Pennsylvania, have explicit statutes that recognize the durable power of attorney for health care decisions. For proxies to make good decisions, it is essential that they be knowledgeable about the patient's goals, preferences, and values. In most cases the proxy appointed is a close family or household member. Although in some cases the proxy may lack the education and training to make fully informed treatment decisions, he or she could be involved to the same extent that the patient could have been.

ETHICAL AND LEGAL CONSIDERATIONS

The history of the physician-patient relationship has been identified as being largely paternalistic; thus it is not surprising that communication between physician and patients about the patients' future treatment concerns has been slow to gain acceptance in the medical community.[8] In the last 20 years, however, medicine has come to accept that patients have a legal and moral right to have input into treatment decisions. Indeed, preserving patient autonomy—not just preservation of life—can be argued to be the true goal of medicine.[9] The recognition by courts, physicians, medical ethicists, and the general public of the importance of advance directives is but one overt expression of the concern with the patient's right to control his or her own life.

Many legal objections to honoring an incompetent patient's wishes expressed while competent arise out of a perceived high risk of malpractice litigation or criminal charges. The murder charges aimed at two California physicians who withdrew life support measures from a comatose patient increased apprehension among many in the medical community.[10] Use of formal advance directives can help ameliorate this apprehension, since the physician, family, and courts would then have a clear statement of the patient's desires. If physicians properly respect advance directives, they cannot be guilty of violating the patient's wishes. In fact, most living will legislation formally releases from liability the physician who respects a patient's advance directive. Additionally, misunderstandings among family members, family guilt over not "doing everything," and disagreement among medical staff members, issues that often are at the root of many malpractice cases, would be minimized with an advance directive.[7,11] Some physicians view advance directives as an unnecessary intrusion of the legal system into the practice of medicine. On the contrary, with proper formulation and use of advance directives, overall judicial involvement would undoubtedly diminish.[7]

MEDICAL SUPPORT FOR ADVANCE DIRECTIVES

The use of advance directives should enhance good medical practice. As an expression of patient advo-

cacy and a demonstration of the desire to promote patient autonomy, discussion of advance directives can facilitate the establishment of a therapeutic physician-patient relationship. Occasionally patients who are seriously ill may not seek medical care out of fear that they would "end up living like machines." When the decision has been made to withhold treatment, terminal patients may appropriately feel abandoned or deserted.[12] By assuring these patients in a compassionate way that their welfare is paramount and by ascertaining their treatment expectations through formal advance directives, their anxiety should be allayed. Discussion of advance directives may also serve as a springboard for the consideration of such other issues as social support, finances, and psychological preparation for dying.

The use of advance directives will also facilitate medical practice by preparing the physician for medical crises. While it is generally advisable to err on the side of active treatment when the prognosis is unknown, such action does not negate the value or prevent the activation of an advance directive, should the situation become hopeless. Additionally, many unwanted or unwarranted procedures with their associated expense and adverse effects could be avoided.[13]

In many instances the decision not to resuscitate is not formally announced to members of the health care team or entered into the medical record. Terms such as "slow code" and "chemical resuscitation" describe less than aggressive treatment in patients deemed (sometimes inappropriately) not to be candidates for full resuscitation. Ambiguous terms, verbal orders, and poor communication among hospital staff can lead to misunderstandings and suspicions. Nursing staff in particular are becoming increasingly concerned about the legal liability in discontinuing care when oral rather than written orders are given.[10,14] Advance directives announce formally to the health care team the intentions of the family and the desires of the patient. The air is cleared of the suspicion of illegal, unethical, or negligent practices. Additionally, the task of physicians or ethics committees in determining the medical advisability of major medical decisions in an incompetent patient would be facilitated significantly with clear knowledge of the patient's previously stated wishes.

THE ROLE OF THE FAMILY PHYSICIAN

The family physician, because of his or her unique position as the general coordinator of the patient's health care, should assume a major share of the responsibility for helping patients sort out treatment decisions and state those decisions in the form of formal advance directives. This responsibility occurs on four levels. The family physician should (1) identify patients whose condition makes discussion of advance directives appropriate, (2) pose the issue in a useful and nonthreatening manner, (3) assist, when appropriate, in the formulation of the patient's advance directive, and (4) interpret, when needed, the patient's advance directives to other health professionals and family members.

First, the family physician should identify patients with whom discussions of advance directives would be appropriate. These patients include those who have expressed interest in advance directives or worry about having their treatment wishes ignored. It is also appropriate for physicians to raise the issue of advance directives with patients who are at relatively high risk of being incompetent during the final stages of their life. Patients who have end-stage chronic disease or who have terminal cancer or for whom catastrophic events can be predicted are examples of those for whom discussions of advance directives would be appropriate.

Second, a crucial part of the physician effectively imparting information about advance directives to a patient is the attitude and tone the physician uses in the discussion. As suggested by Angell,[15] one way is to discuss with the patient whether he wants to be informed about all important medical findings, including terminal illness, and whether he wants to be consulted on all important medical decisions, or whether he would like to designate a friend or family member to be informed and to act as his proxy. The physician may do a number of things to help a patient understand information about advance directives. For example, the family physician should clarify long-term prognosis over a series of office visits so that the patient has a clear understanding of the possible need for an advance directive. Additionally, the physician may enhance the patient's understanding of advance directives and reduce the amount of background discussions of advance directives by making available written information on the subject.

Several misconceptions and barriers have interferred with the widespread acceptance and use of advance directives. Probably the most common barrier is the belief among physicians that informing seriously ill patients about their condition would prove harmful. Although this view is prevalent, it has not been substantiated.[16,17] In fact, this view overlooks the benefits that can come from an open and trusting relationship between patient and physician. Another barrier may be the physician's discomfort with discussing death and dying or lack of knowledge regarding types or application of advance directives. One study has also shown that in many cases patients wish to communicate about such issues but that physicians simply do not give their patients the opportunity.[18]

Third, family physicians should be willing to advise their patients about the medical aspects of their advance directives. This advice should not take the form of advice of a legal nature, although it is important that physicians involved with the various types of advance directives be familiar with how or whether they apply

in their own states. Physicians should focus, however, on helping their patients express their wishes clearly, in appropriate language and with appropriate precision. This approach helps minimize the ambiguous terminology that is often a problem with living wills made without the advice of a physician as well as those made with blanket or standard form advance directives. For example, a patient may express fear of respirators and insist that they not be put on one. In fact, with the physician's brief explanation and discussion of respirators, it may become clear that the patient only wishes to avoid being permanently dependent on a respirator. The more specific the advance directive, the clearer its interpretation becomes for physicians and legal authorities.

Fourth, in critical care situations major portions of the patient's care may be transferred to other medical specialists. Thus, decisions about an individual's care may be strongly influenced by medical professionals who have had no personal contact with the patient or family and thus may not understand and appreciate the patient's wishes expressed in an advance directive. It is hoped that a well-written and properly documented advance directive will be adequate to express clearly the patient's wishes. If there appears a reluctance by other medical professionals to respect the directive because of perceived ambiguity or questions of whether the patient was competent when formulating the directive, the family physician should take an active role in reporting the patient's wishes and mental status. In this vein the family physician may also be called upon to act as patient advocate with family members who may not be familiar with the provisions of the patient's advance directives.

CONCLUSION

Sound moral, medical, and legal arguments support the position that the family physician should be directly involved in assisting his or her patients in formalizing and validating advance directives.[19] The role of the family physician in meeting these needs should remain flexible, since different patients have different needs. The primary focus, though, should be to raise the issue and be a compassionate resource concerning the nature of various treatments and the general prognosis of illness (where illness is already present or where the patient is at high risk for such illness). Advance directives are further discussed in the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research report titled, "Deciding to Forego Life Sustaining Treatment."[1] Family physicians are strongly encouraged to familiarize themselves with these concepts to assist patients in the important task of preservation of patient autonomy.

References

1. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: Deciding to Forego Life-Sustaining Treatment. Washington, DC, Government Printing Office, 1983
2. Lo B, Steinbrook R: Deciding whether to resuscitate. Arch Intern Med 1983; 143:1561-1563
3. Jackson D, Youngner S: Patient autonomy and "death with dignity": Some clinical caveats. N Engl J Med 1979; 301:404-408
4. Bedel S, Delbanco T: Choices about cardiopulmonary resuscitation in the hospital: When do physicians talk with patients? N Engl J Med 1984; 301:1089-1092
5. Bok S: Personal directives for care at the end of life. N Engl J Med 1976; 295:367-369
6. California Health and Safety Code. Part I, Division 7, Chapter 3.9, Sections 7185-7195
7. Steinbrook R, Lo B: Decision-making for incompetent patients be designated proxy: California's new law. N Engl J Med 1984; 310:1598-1601
8. Katz J: The Silent World of Doctor and Patient. New York, The Free Press, 1984
9. Cassel EJ: What is the function of medicine? In McMillan E (ed): Death and Decision. Boulder, Colo, Westview Press, 1978, pp 35-44
10. Lo B: The death of Clarence Herbert: Withdrawing care is not murder. Ann Intern Med 1984; 101:248-251
11. Gilfix M, Raffin T: Withholding or withdrawing extraordinary life support. West J Med 1984; 141:387-394
12. Wazner S, Adelstein J, Cranford R, et al: The physician's responsibility toward hopelessly ill patients. N Engl J Med 1984; 310:955-959
13. Bayer R, Callahan D, Fletcher J, et al: The care of the terminally ill: Morality and economics. N Engl J Med 1983; 309:1490-1494
14. Murphy C: Nurses and non-treatment decisions. In Wong C, Swezey J (eds): Dilemmas of Dying. Boston, GK Hall, 1981, pp 47-52
15. Angell M: Respecting the autonomy of competent patients. N Engl J Med 1984; 310:1115-1116
16. Alfidi RJ: Informed consent: A study of patient reaction. JAMA 1971; 216:1325-1329
17. Imbus SH, Zawacki BE: Autonomy for burn patients when survival is unprecedented. N Engl J Med 1977; 297:308-311
18. Beckman HB, Frankel RM: The effect of physician behavior on the collection of data. Ann Intern Med 1984; 101:692-696
19. Schneiderman LJ, Arras JD: Counseling patients to counsel physicians on future care in the event of patient incompetence. Ann Intern Med 1985; 102:693-698