and as a stimulus for research." There is a clear need for outcome research to be done in the primary care sector itself, on primary care patients as they present in customary (nonacademic) settings for a wide variety of diagnostic conditions. Suggestive findings from research such as that done by Broadhead et al and other studies of actual clinical practice can guide outcome research in clinically useful directions.

References

1. Kamerow D, Pincus H, Macdonald D. Alcohol abuse, other drug abuse, and mental disorders in medical practice. JAMA 1986; 255:2054–7.
2. Wilkinson G. Overview of mental health practices in primary care settings, with recommendations for further research. Series DN, No. 7. Rockville, Md: Alcohol, Drug Abuse, and Mental Health Administration. US Department of Health and Human Services publication No. (ADM) 86-1467, 1986.
3. Schulberg H, Burns B. Mental disorders in primary care: epidemiologic, diagnostic, and treatment research directions. Gen Hosp Psychiatry 1988; 10:79–87.
4. Regier D, Hirschfeld R, Goodwin F, et al. The NIMH Depression Awareness, Recognition, and Treatment Program: structure, aims, and scientific basis. Am J Psychiatry 1988; 45:1351–7.
5. Schulberg HC. Medical treatment effectiveness in primary care mental health. In: Mayfield J, Grady ML. Primary care research: an agenda for the 90's. US Department of Health and Human Services publication No. (PHS)90-3460, Government Printing Office, 1990.
6. Broadhead WE, Larsen DB, Yarnell KSH, et al. Tricyclic antidepressant prescribing for nonpsychiatric disorders: an analysis based on data from the 1985 National Ambulatory Medical Care Survey. J Fam Pract 1991; 33:24–32.
7. Jencks SF. Recognition of mental distress and diagnosis of mental disorder in primary care. JAMA 1985; 253:1903–7.
8. Barrett JE, Barrett JA, Oxman TE, Gerber PD. The prevalence of psychiatric disorders in a primary care practice. Arch Gen Psychiatry 1988; 45:1100–6.
9. Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington DC: American Psychiatric Association, 1980.
10. Goldberg SC, Tilley DH, Friedel RO, et al. Who benefits from tricyclic antidepressants: a survey. J Clin Psychiatry 1988; 49: 224–8.

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Doctor-Patient Communication About Resuscitation: 'Have You Signed an Advance Directive?'

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In their recent debate in *The Journal of Family Practice* about routine discussion of advance health care directives, Drs Saultz and Rodriguez agree on one significant point: physicians need to improve their communication with patients regarding this important issue.[1,2] Unfortunately, little literature exists that reviews specifically how physicians can best discuss these sensitive issues with their patients.

There are two underlying reasons for improving the communicative competence of physicians in discussing resuscitation and life-support measures. First, it is commonly agreed that competent patients have the right to make their own choices about life-sustaining medical treatment. The 1990 US Supreme Court decision *Cruzan v Director, Missouri Department of Health* implied that people can exert this right early through clearly written advance directives. Congress recently mandated that patients who are members of health maintenance organizations or who are in hospitals or nursing homes should receive information discussing advance directives.[4] Second, the responsibility for initiating discussions about advance directives and in-hospital resuscitation traditionally has been delegated to physicians, by both ethicists[5] and patients.[6]

Bioethicists and physicians have concentrated their attention to date on normative ethical principles that they believe should underlie the decision-making process concerning both advance directives and do-not-resuscitate (DNR) orders. These normative guidelines neglect interactional factors present in physician-patient communication, however. Factors such as cultural perceptions of

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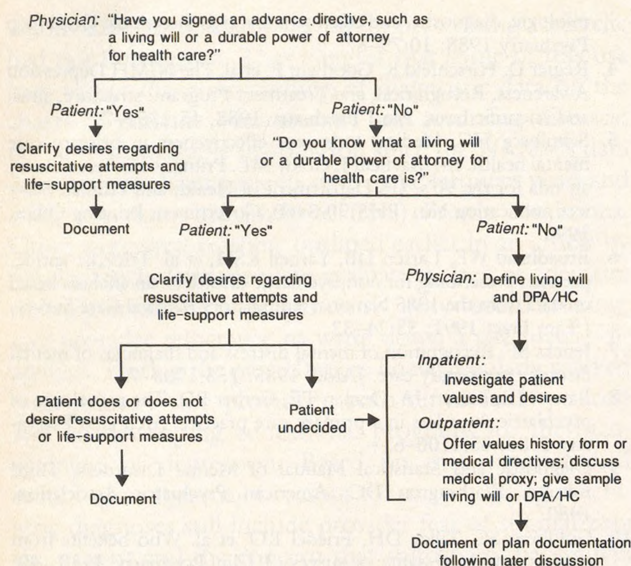

Figure 1. Discussion tree outlining the use of the question "Have you signed an advance directive?" when broaching the topic of resuscitative intent with patients. (DPA/HC denotes durable power of attorney for health care.)

attempted resuscitation and uncertainty regarding outcomes of attempted resuscitation form barriers to both the initiation of discussion and the sharing of information within discussions.[7] Others have suggested that patient values be extensively explored, either through written clarification using a "values history"[8,9] or through presentation of sample medical scenarios.[10] Unfortunately, no mention is made as to how physicians can introduce these explorations of values in the context of the physician-patient relationship.

In response to these concerns, we offer the following suggestion: the question "Have you signed an advance directive, such as a living will or a durable power of attorney for health care?" should be added to the adult review of systems when taking a comprehensive patient history. Figure 1 describes how physicians can use this question to broach the topic of resuscitative intent with patients.

On hearing the question, patients will either respond yes, indicating that they have signed an advance directive, or no. If they have signed a living will or a durable power of attorney for health care (DPA/HC), physicians can clarify their patients' intents and explore the informed consent that culminated in the signing of the advance directive. When time and circumstances permit, as in the outpatient setting, patients should be asked to provide a copy of their living will or DPA/HC for inclusion in the medical record. Further discussion or clarification can then take place at a subsequent visit with the document in hand.

If patients answer that they have not signed an advance directive, physicians can ask, "Do you know what a living will or a durable power of attorney for health care is?" If patients know what these are but do not have one, several explanations are possible: they may want resuscitative attempts and other life support measures; they may be undecided; or they may not have made the effort to consider the issue or need assistance in doing so.

Those who do not know what a living will or DPA/HC is may need brief explanations: "A living will is a written statement of your wishes for your health care and how you want things to be done should you become incapable of communicating with your physicians and telling them your desires when such decisions need to be made. A durable power of attorney for health care is a document used to authorize and provide guidance to someone you trust to make health care decisions on your behalf, should you become incapable of making such decisions."[11] In this case, or if the patient is undecided, physicians can offer values history forms, medical scenarios, or sample living wills and durable powers of attorney to clarify patient intent and facilitate informed consent in later discussions. Physicians can obtain copies of sample advance directives through their state medical associations or Concern for Dying/Society for the Right to Die (250 West 57th Street, New York, NY 10107; Telephone: 212-246-6973). In the hospital, when DNR orders are at issue, physicians can more directly investigate patients' values and desires, recognizing that on the brink of death patients may replace rational decision making with expressions of poorly formulated wishes.[7] Documentation is important because it can facilitate future discussions and decisions about resuscitation or long-term life support.

There are several reasons that support the introduction of the question "Have you signed an advance directive?" into the review of systems for adult patients:

1. The lay public is becoming increasingly aware of living wills and durable powers of attorney for health care. Forty-two states have statutes recognizing living wills; most recognize some form of durable powers of attorney for health care or proxy designation (personal communication, Concern for Dying/Society for the Right to Die, April 1991).

2. The review of systems is learned by students in their first 2 years of medical school, usually well before they are placed in the position of discussing these issues with patients. It is in the preclinical years, before they are faced with real-life situations, that students have time to address the ethical rationales underlying resuscitative decision making as well as the process of coming to a decision with patients or their families.

3. The question is short and easily remembered. Medical students and physicians in training can easily incorporate it into their routine questioning of patients.

4. This question can be used in various clinical settings. Physicians in outpatient settings can use it to introduce a patient-centered review of values and concerns. In the more acute setting of the hospital, it represents a nonthreatening way of bringing up a topic that provokes anxiety in both patients and physicians. "Have you signed an advance directive?" can be asked late in the admission, yet its close-ended format allows physicians to inquire early so that they can gather information and avoid last-minute confusion.

5. Currently there is no standard of care for how physicians initiate and frame discussions regarding resuscitation. Some patients who have well-defined intentions are never given a chance to express these because physicians simply fail to ask about them.[12] The question "Have you signed an advance directive?" standardizes the approach to introducing a discussion about death. At a very minimum, the use of this question allows those patients who have previously thought about how they want to approach their death the opportunity to express their values.

Physicians in training have for years been told to talk to patients about resuscitation but have been given no instructions as to how to do it. In the absence of strategies that address how to discuss resuscitation (not simply how to think about it), physicians will remain confused and anxious, and patients themselves will be denied an opportunity to express their desires. The routine use of this trigger question can promote patient autonomy, facilitate treatment decisions, and open needed physician-patient communication about resuscitative issues and life-support measures.

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References

1. Saultz J. Routine discussion of advance health care directives: are we ready? An affirmative view. J Fam Pract 1990; 31:653–6.
2. Rodriguez GS. Routine discussion of advance health care directives: are we ready? An opposing view. J Fam Pract 1990; 31: 656–9.
3. Orentlicher D. The right to die after Cruzan. JAMA 1990; 264: 2444–6.
4. Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, Section 4751.
5. Annas GJ. Nancy Cruzan and the right to die. N Engl J Med 1990; 323:670–3.
6. Lo B, McLeod GA, Saika G. Patient attitudes to discussing life-sustaining treatment. Arch Intern Med 1986; 146:1613–5.
7. Ventres WB. Resuscitative decision making: ethnographic perspectives. Tucson: The University of Arizona; 1991. Thesis.
8. Doukas DJ, McCullough LB. The values history: the evaluation of the patient's values and advance directives. J Fam Pract 1991; 32:145–53.
9. Gibson JM. Continuity of care and ethics. Cont Care 1990; 9(4):11–4.
10. Emanuel LL, Emanuel EJ. The medical directive: a new comprehensive advance care document. JAMA 1989; 261:3288–93.
11. Baker M. Your health care choices: a guide to preparing advance directives for health care decisions in Arizona. Phoenix, Ariz: Dorothy Garsky Center, 1991.
12. Hare J, Nelson C. Will outpatients complete living wills?: a comparison of two interventions. J Gen Intern Med 1991; 6(1):41–6.