

Ethical Issues: Advance Planning for Health Care

Our professional obligation to respect patient autonomy gives patients the right to accept or refuse treatment. This right is not lost when the patient can no longer express their preferences. Advance care planning, using written and verbal health care directives, is a method of documenting patient beliefs, values, and preferences about treatment. It allows a patient with decision making capacity to express his or her wishes and/or designate a surrogate decision-maker should circumstances later arise when the patient is no longer able to decide for them self. Advance planning can take the form of written advance directives such as a health care directive (HCD), sometimes called a living will (LW), or durable powers of attorney for health care (DPOA). Evidence of patient preferences can also be legitimately obtained through conversations between the patient and those close to him or her, including family, close friends, and their health care provider. End of life discussions between a patient and their physician should be documented in the medical record whenever they occur.¹

Advance directives only become operative when the patient loses capacity and can no longer make decisions on their own. Done well, advance care planning can enhance relationships, improve communication, and promote team functioning in care of the patient. Most importantly and ideally it can give the patient a voice in future health care decision-making when they become incapacitated and may prevent or ease difficulties when they and the family are struggling with decisions for which there is no clear answer. Unfortunately it doesn't always work that way.

Even with the best efforts at clarifying and specifying the written document health care directives often use vague language that forces the health care team to infer specific treatment choices rather than knowing specifically what the patient would want done. But one cannot infer CPR preferences from the mere presence of a written health care directive because the patient may want reasonable attempts at resuscitation but not other forms of life sustaining treatment such as dialysis, ventilator support, tube feedings, or surgery. Preferences regarding the use of CPR should be addressed specifically and directly with the patient/surrogate before a "Do Not Attempt Resuscitation" (DNAR) order is written.² Only 15-25% of patients have written health care directives, often because they don't think they need one, are confused about what they mean, or find them difficult to talk about. Historically patients, families, and even physicians, have also tended to overestimate the effectiveness of CPR because they have a poor understanding about it and its prognosis for success.³

Many physicians do not raise the topic of advance care planning with their patients and are unaware of patients' preferences regarding cardiopulmonary resuscitation (CPR) and other life sustaining treatments.⁴ However, introducing the topic for further reflection by the patient and informing them about advance care directive options has value. Patients often welcome discussions about advance care planning or the suggestion that they discuss it with family members, but they may be reluctant to raise these topics themselves. Many patients fear a prolonged death involving unwanted technology. Having this discussion with the patient in the presence of their family and/or selected surrogate can also be very helpful in allowing

everyone to know the patient's preferences, beliefs and values.

Utilizing the services of other members of the team to assist in this discussion, such as those trained in social work, pastoral care, nursing, and others who have special skills in counseling about end of life issues can be very helpful. In some circumstances, the physician may determine that he or she is morally prohibited to carry out the patient's wishes. Potential moral conflicts that arise during the planning process should be discussed to avoid problems and consultation with an ethics committee or consultant may be helpful in reconciling such conflict. However, if moral conflict is irreconcilable regarding the patient's directive about treatment, the patient or surrogate should be informed and, the professional relationship may be discontinued if care can be safely and appropriately transferred to another provider. If not, then a moral accommodation will need to be sought in order to meet the needs of the patient and their family, as well as the providers.

Advance directives can be very helpful and they should be encouraged for our patients, however they may presuppose more control over future events than is realistic because medical crises cannot be predicted in detail and we cannot truly predict how patients will die, therefore unexpected problems are likely to arise. Ultimately good communication is the most important thing we can do for our patients. It is important to emphasize with patients and their families/surrogates that written directives may only be partially successful in forcing compliance with their wishes and that emotional preparedness is needed for the unforeseeable events and decisions that lie ahead.⁵

¹ Snyder L. Advance Care Planning. *Physicians Information and Education Resource (PIER)*. 2006. http://acponline.org/physicians/ethical_legal

² Walker RM, Schonwetter DR, Robinson BE. Living Wills and Resuscitation Preferences in An Elderly Population. *Arch Int Med*. 1995;155(2):171-175

³ Fagerlin A and Schneider C. Enough: The Failure of the Living Will. *Hastings Center Report*. 2004;34(2):30-42

⁴ The SUPPORT Principal Investigators. A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients. The Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatments (SUPPORT). *JAMA*.1995;274(20):1591-1598

⁵ Perkins HS. Controlling Death: the False Promise of Advance Directives. *Ann Int Med*. 2007;147(1):51-57