

On having an advance directive

It is first important to understand the difference between the two kinds of advanced directives and then understand which if either is right for you. This section describes the two types of directives and then walks you through the decision of having one or not.

I. What are advanced directives?

Advanced directives are documents that express a patient's choices about medical care or name another person to make decisions regarding medical treatment in the event that the patient is unable to make these decisions themselves. The term 'advanced' is commonly used to connote the idea that decisions made have been discussed before the urgent necessity of medical intervention arises. The term 'directive' intimates the intent of the document is to give guidance to the health care provider regarding the medical treatment desired by the patient.

Advanced directives in the United States are provided in **two** common forms:

1. **Health Care Instructions** known as a "living will"
2. **Appointment of a Health Care Representative** known as a durable power of attorney

Health Care Instructions are documents which explain your preferences regarding cardio-pulmonary resuscitation, life-sustaining treatments, supportive care, symbolic care, and/or euthanasia to your health care provider(s). It is activated if you are determined to be unable to make competent medical treatment decisions.

An **Appointment of a Health Care Representative** is a legal document which permits the 'principle' (the patient) to appoint a representative to make health care decisions should the patient temporarily or permanently lose decision making capacity. The person selected does not have to be an attorney but serves as an 'attorney in fact.'

II. Do I need an advanced directive?

You may ask: "Is it necessary that a person have an advanced directive?" From a legal standpoint you are **not required** to have advanced directives. A health care provider cannot require anyone to have an advanced directive or durable power of attorney that appoints a health care representative for you to receive care. By law the hospital is required to present you with the paper work, however, upon hospital admission. Because of the emotional stress and uncertainty that comes with an hospital admission, we suggest that admission is not a good time to decide if you need an advanced directive.

A. When I don't need a directive

There may in fact be circumstances where an advanced directive may be inappropriate. For instance, a study performed on hospital policy and procedures as well as studies

done in the medical community indicated that three type of life-sustaining decision approaches exist.¹ They include: (1) an emphasis on the physician as the primary agent deciding treatment decisions, (2) an emphasis on participation of agents deemed appropriate to treatment decisions, and (3) an emphasis on the patient as the sole agent rendering treatment decisions.

When your values correspond closely to the values of those of the physician, family, institution, and prevailing social sentiment and communication between these agents are good, 'living wills' may prove to be more cumbersome than a liberating to all involved. You really do not need a directive.

B. When I do need a directive

When value incompatibilities exist between the health care provider and the patient, a properly crafted durable power of attorney for health care decisions may reduce the likelihood of conflicts should dilemmas in treatment decisions arise. Further they encourage physicians, patients, and family members to begin discussions about treatment and future care.

Perhaps the most important factor which affects the probability of realizing your treatment wishes in an advanced directive is your value compatibility with others making treatment decisions, such as the physician, medical center and family. Other factors affect the potential of actualization of the choices expressed in a living will. They include: the urgency of the decision, e.g. catastrophic ct. chronic disease, the presence of physiologic futility, and your mental competence. Furthermore, the type of request made in the directive appeared to affect its observance. It appears that directives refusing intervention were more likely to be observed than those demanding intervention.² Also, a recent study suggests that "prognosis, perceived quality of life, and the wishes of family or friends as more determinative than the advanced directive (your written health care instructions)."³ The point is this: the power to choose exercised by any of the agents seeking primacy in the health care decision-making nexus is dependent upon their power to actualize the decision.⁴ Ten categories of empowerment are worth stating: (1) formal authority, (2) expert authority, (3) referent authority, (4) resource authority, (5) procedural authority, (6) sanction power, (7) nuisance power, (8) power of the status quo, (9) moral power, and (10) personal power.⁵

¹Wernow, Jerome R.: *This Vital Death: Toward a Applying a Postmodern Reconstructed Christian Ethic to the Discussion of Forgoing Treatment in the Critically Ill Hospitalized Adult*. (Dissertation: Leuven, Belgium) v. 2, pp. 396-406.

²IBID. p. 397.

³Hardin, Steven B. and Yasmin A.Yusufaly. "Difficult End-of-Life Treatment Decisions." *Archives of Internal Medicine*. (July 26 2004) v. 164, pp. 1531-1533.

⁴ Koch, Kathryn A.; Meyers, Bruce W.; and Sandroni, Stephen: "Analysis of Power in Medical Decision-Making: An Argument for Physician Autonomy." *Law, Medicine, and Health*. Winter, 1992, v. 20/4, pp. 320-326. The authors describe ten sorts of power and how they effect the realization of patient autonomy. They conclude that only those who exercise power or have it exercised on their behalf are the ones who realize their treatment decisions.

⁵ IBID. p. 323.

To the extent that those making decisions have formal power, resource power, referent power, and/or sanction power is the extent to which treatment decision will be made. There are numerous studies which question the usefulness of advanced directives. The conclusion common to all these studies is that the decision making agent with the most power appears to be the one who ends up making the the patient's treatment decision.⁶ So will an advanced directive be followed? The answer to that question depends largely upon empowerment and many of the conditions summarized below:

1. For the patient:
 - must be competent when making and discussing his/her wishes with other agents
 - the greater the emergency the less likely the honoring of the document
 - the greater the value compatibility with the physician and health care institution the greater the likelihood of honoring of choices
 - the greater certitude of the prognosis for possibility of meaningful outcome, the greater the likelihood of honoring of choices for treatment
 - there is a greater potential to realize requests for omitting treatment than requests demanding treatment

2. For the medical health care representative the likelihood of honoring of choices is associated with:
 - value compatibility with the physician
 - documentation of clearly articulated wishes of the patient
 - absence or presence of medical futility

3. For the physician
 - value compatibility with the executing agent
 - medically reasonable request

4. For the society:
 - decision fits the *staus quo* of the new emerging non-Hippocratic utilitarian society

⁶ The Danis study revealed that 24/96 patient preferences in advanced directives were not followed. They concluded: *The effectiveness of written advanced directives is limited by inattention to them and by decisions to place priority on considerations other than on the patient's autonomy.* cf. Danis, Marion; Southerland, Leslie I.; Garrett, Joanne M.; et. al.: "A Prospective Study of Advanced Directives for Life-Sustaining Care." *The New England Journal of Medicine.* (March 28, 1991) v. 324/13, p. 882.