

Editorials

Advance Directives 1991: Is The Cart Before The Horse?

The United States Supreme Court decision in the case of Cruzan versus the Director of the Missouri Department of Health¹ has stimulated an intense national debate. Announced in June 1990, this decision affirmed the primacy of state law in right-to-die cases but left many issues unresolved. Intensified state and federal legislative activity has resulted in many new laws. The most important for all health professionals is the federal Patient Self-Determination Act of 1990 (part of the Omnibus Budget Reconciliation Act of 1990²). Scheduled to take effect on 1 December 1991, this act requires hospitals, nursing homes, and hospices to advise patients of their rights to accept or refuse medical care and to execute an advance directive. Compliance with this act is a condition for Medicare and Medicaid reimbursement.

Advocates for the Patient Self-Determination Act have a wide range of reasons for supporting this law. Clinicians foresee greater opportunities to understand their patients' values and provide better care. Ethicists believe such statutes can increase patient participation in medical decision making and increase patient autonomy. Third-party payers, especially the Health Care Financing Administration, hope to decrease health care costs by eliminating unwanted care.

Ideally, advance directive discussions routinely should occur before times of crisis. Critics emphasize physician inaction in implementing advance directives as the reason legislative action was required. All acknowledge, however, that a purely procedural response to this act by hospitals will neither facilitate physician-patient communication nor promote patient autonomy.

Submitted 6 August 1991.

From the Department of Family Medicine, Oregon Health Sciences University School of Medicine, Portland. Address reprint requests to Glenn Rodriguez, M.D., Department of Family Medicine, Oregon Health Sciences University School of Medicine, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201.

In this issue of *JABFP*, Daly and Sobal³ have contributed to our growing understanding of how advance directives are now used. In the physician house call program at the University of Maryland, family physicians with special interest in geriatrics demonstrated that systematic discussion of advance directives can increase the frequency with which patients prepare these documents. The results of the study (55 percent completed a durable power of attorney for health care and 5 percent had a living will) compare favorably with previously published data on the rate of advance directives in other populations.⁴ This probably reflects the values and preferences of the physicians who advised these patients. Nevertheless, information on the frequency of use does not yet answer the more important question: Do advance directives facilitate better patient care?

Shifting legal precedent and several recent studies indicate we have much to learn about how best to use these documents. In a provocative study, Danis and colleagues⁵ showed that advance directives concerning treatment preferences were not followed 25 percent of the time. Unforeseen circumstances arose that caused health care providers or family proxy decision makers to reinterpret or overrule a previously documented advance directive. Seckler, et al.⁶ found poor agreement between the wishes of competent, chronically ill elderly patients and surrogate decision makers using a hypothetical cardiopulmonary resuscitation scenario. In their ruling in the Cruzan case, the Missouri Supreme Court rejected the concept of advance directives saying, "It is definitionally impossible for a person to make an informed decision — either to consent or to refuse — under hypothetical circumstances."⁷ A recent report documents incomplete evaluation of competency prior to appointment of a durable power of attorney for health care as patients were admitted to a secured dementia ward.⁸ Limitations, both theoretical and practical, of advance directives as

they are now used, are only beginning to be recognized.

How have we come to a crossroads where federal legislation is enacted to protect citizens from their physicians? Will physicians resent the Patient Self-Determination Act for this reason? How are other fundamental principles of medical ethics—beneficence, nonmaleficence, and justice—factored into this new legal equation for medical decision making? Difficult decisions at the margins of life remain the most sensitive issues we face as physicians, individuals, and a society. There are no clearly correct answers. The ideal advance directive does not exist. As noted by Seckler, et al. we need a new “standard which promotes trust between patients and their caregivers (both family and professional) and would return to a recognition that not all of life’s events can or should be anticipated.”⁶ This new standard must recognize the limits of medical knowledge and human foresight. It must combine best-interest considerations, surrogate decision making, and written advance directives. Research into patterns of communication and decision making will bring clarity to the debate. Family physicians must begin to act now within the new requirements of the Patient Self-Determination Act to find techniques that are effective for them and their patients. This act is an important, though imperfect beginning. We must not allow it to become a “medical Miranda warning”⁴ distorting our best traditions of helping and healing.

Glenn Rodriguez, M.D.
John Saultz, M.D.
Portland, OR

References

1. Cruzan v Director, Missouri Department of Health, 110 S Ct 2841 (1990).
2. Omnibus Reconciliation Act of 1990, 42 USC 1395 cc (A1).
3. Day MP, Sobal J. Advance directives among patients in a house call program. *J Am Board Fam Pract* 1992; 5:11-5.
4. La Puma JA, Orentlicher D, Moss RJ. Advance directives on admission. Clinical implications and analysis of the Patient Self-Determination Act of 1990. *JAMA* 1991; 266:402-5.
5. Danis M, Southerland LI, Garrett JM, Smith JL, Hielema F, Pickard CG, et al. A prospective study of advance directives for life-sustaining care. *N Engl J Med* 1991; 324:882-8.
6. Seckler AB, Meier DE, Mulvihill M, Paris BE. Substituted judgment: how accurate are proxy predictions? *Ann Intern Med* 1991; 115:92-8.
7. Cruzan v Harmon, 760 SW 2nd 408 (Missouri 1988).
8. Goldstein MK, Shadlen MF. Misuse of durable power of attorney for health care. *J Am Geriatr Soc* 1991; 39:730.

Any Truth In Psychological Explanations?

... most of the public does not believe in the existence of mental illness.

— I.D. Glick, et al.

How’s this for irony? The only patient I saw, during a 2-week locum tenens, who mentioned the word “nerves” as a complaint seemed not to provoke in me any need for a psychological explanation. She met criteria for *DSM-III-R* code 296.3 (recurrent major depression), and I prescribed an antidepressant as easily, and with the same confidence, as I would have prescribed an antihypertensive had her problem been essential hypertension. I felt no special need to do what Balint called the “long interview.”

On the other hand, the patient who stirred most my interest in a psychological explanation was being treated, without benefit, for Lyme disease. There was disagreement about the diagnosis among her consultants in neurology, rheumatology, and infectious diseases; and her regular physician was at wit’s end. Her extensive medical record was full of test results, mostly negative or normal, but contained not a shred of personal information about her life and relationships. I itched to do the long interview.

Each of these vignettes illustrates, in its own ironical way, the ambiguity I have about psychological medicine nowadays. The first, a straightforward mental disorder (which in former times I would have felt obligated to explore psychologically), seemed best treated as an organic disease. The second, a straightforward organic disease, raised psychological questions that expert

Submitted 2 July 1991.
From Birmingham, AL.