

A Word of Caution about Advance Directives

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Advance Directives (ADs) are often made without the opportunities for full informed consent. On what basis did the patient make the decision that she would not want to be treated? The decision not to receive treatment should be based on a clear understanding of the situation. It is essential that the patient understands the disorder, the available alternatives, and her chances and risks. This can be rather complicated when the physicians themselves do not have a clear picture about the condition and cannot provide a reliable prognosis.

Furthermore, there are valid concerns about the patient's opportunity to change her mind, the potential for scientific developments, and the clarity of the advance directive. In a patient who is mentally alert and who makes a decision not to receive treatment, there is always the opportunity for the clinician to consider with the patient the reason for the decision in light of the particular clinical features. The clinician also has the opportunity to discuss with the patient why she does not want treatment. Is it fear of pain, loss of dignity, concern for others or any other reason? In these circumstances, the clinician is in a better position to ensure that the patient has thought out the decision carefully. This possibility is removed when faced with an AD and an incompetent patient [1]. As for the potential for scientific progress, competent patients have the advantage of making their decision based on up-to-date knowledge. Advance directives may be made many years prior to the time of their implementation, a period during which new treatment or changes in quality of life opportunities may have occurred. In Israel, patients are required to refresh their signature on Ads every five years.

In addition, ADs are not always clear about the patient's intentions. A leading British physician, Keith Andrews, testifies that he saw an AD stating that if the person developed severe brain damage she would not want to continue living. There was no statement as to whether this decision was to be made on the first day or after a period of several days/weeks/months to give the patient opportunity of recovery. The general statement about severe brain damage gives wide latitude for widely differing views, even among clinicians experienced in the management of brain damage [1].

In Switzerland, there are some fifty different versions of advance directives. In the Netherlands I saw ADs saying: I'd like to die upon the stage when I don't recognize my children [2]. This phrasing is far too vague and too sweeping to serve as guidelines. It provides health care professionals with wide latitude for interpretation that might not always be in tandem with the patient's best interests. Medical conditions are varied and complex. ADs that are usually phrased in general terms might be ill-suited to serve as guidelines to follow. The decision-making process should take into account further factors, most importantly the particular medical condition of the patient and the feasibility of maintaining a reasonable quality of life that is of significance to the patient in concern. The AD together with family testimonials can shed light as to whether the present quality of life is reasonable for the patient and of significance to him or her. We should be wary of the impact that financial considerations may have in deciding the fate of the patient. In the US, there are fears that ADs will be utilized against the patient's best interests to save costly resources. It has been argued that advance directives have not fulfilled their promise of facilitating decisions about end-of-life care for incompetent patients. Furthermore, many legal requirements and restrictions concerning advance directives are counterproductive [3]. The advance directive must be applicable to the present circumstances. The medical care team should consider the length of time that has passed since making the advance directive, changes in the patient's condition, the circumstances that the patient is now in, and the likelihood of successful treatment.

To resolve the conflict between past competent and current incompetent interests, it is suggested that instead of simply enforcing all prior directives, doctors, families, and other people involved in the care of incompetent patients should be able to examine whether the patient's interests would best be served by actions contrary to the AD, in situations in which the incompetent patient appears to have an interest in further treatment and life [4].

References

- 1) Keith Andrews (1996) Euthanasia in Chronic Severe Disability. British Medical Bulletin
- 2) Raphael Cohen-Almagor (2004) Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing Dordrecht: Springer-Kluwer.
- 3) Bernard Lo and Robert Steinbrook (2004) "Resuscitating Advance Directives", Arch Intern Med. 1501-1506.
- 4) John A. Robertson (1991) Second Thoughts on Living Wills. Hastings Center Report, 6-9.

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