# THE ETHICS OF ADVANCE DIRECTIVES

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# FINANCIAL DISCLOSURE

- I have nothing to disclose

# ADVANCE DIRECTIVE DEFINITION

- A directive made in advance of losing decisional capacity
- Advance = Before
- Directive = Wishes

Seems so simple….

# TYPES OF ADVANCE DIRECTIVES

- Living Will
- POLST- Physician orders Life Sustaining Therapy
- DPOAHC- Durable Power of Attorney for Healthcare

# ETHICAL PRINCIPLE BEHIND ADVANCE DIRECTIVES

- Autonomy- the right of an individual to determine their own path

Also:

Beneficence- to do good

Non-maleficence- to avoid harm

# ETHICAL THEORY SUPPORTED BY AD

- Utilitarianism- the right thing to do is the thing that produces the most good for the most number of people

# TROUBLESOME WATERS

- AD only applies when the patient lacks decisional capacity
- Decisional capacity can wax and wane- how do we know what the patient really wants?
- For example an advance directive says ‘no ventilator’ and the patient seems confused but is experiencing dyspnea and asking for help breathing. Which is the authentic wish?
- Is it ethical to ask a short of breath person if they want to be rescued at the moment of crisis?
- AD generally only covers CPR, ventilation, antibiotics and tube feedings. What about dialysis?

# DECISIONAL CAPACITY ISN'T THE ONLY PROBLEM

- AD applies in a terminal state or in a state of permanent unconsciousness

Ask 2 doctors to define each of these terms and you will have 2 different definitions

# TERMINAL STATE

- Hospice eligible if '6 months to live', what if we predict they have 7 months if they are on the vent, getting dialysis and tube feeds? Do we continue aggressive interventions?

# PERMANENT UNCONSCIOUSNESS

- A permanent vegetative state is defined as a state of unconsciousness that lasts at least 6 months
- Does that mean I have to stay on the vent for 6 months if I said I didn't want it?

# IF A PERSON CAN'T MAKE DECISIONS FOR THEMSELVES

There are 2 ways to make decisions for another

Substituted judgement- if a preference was ever stated (can be written or verbal)

Best interest- typically errs on the side of preserving life

We have to educate families about this- what THEY want is not how decisions should be made.

# SURROGATE DECISION MAKERS

- In Washington we have a hierarchy

  Guardian

  Spouse

  Adult Children

  Parents

  Siblings

No aunts, uncles, grandparents or cousins are LNOK in Wa unless made DPOA

# HARD TO FOLLOW AN AD IF YOU ARE NOT THE ONE WHO COMPLETED IT WITH THE PATIENT

- Life and death decision- how informed was the patient when they completed the AD?
- Was the POLST completed during a 15 minute visit about something else?
- What are the patients values and goals? How can we help meet them?
- Documentation of the details of the conversation goes a LONG way in helping to understand the true wishes of the patient

# SO FAR ASSUMPTION HAS BEEN AD LIMITS TREATMENT; WHAT IF THEY WANT AGGRESSIVE TX?

- Chose yes to CPR, Vent, tube feedings but has a terminal condition or may be actively dying
    - What role does justice play?
    - Are we obligated to continue treatment when it seems as if it is only prolonging the dying process?
    - What about a refractory GI bleed? How many units of blood can they have?

# ETHICAL ADVANCE DIRECTIVES

- Discuss all possibilities that are able to be predicted ie- SOB for COPD pt
- Explain how ACLS components work together- TV CPR is better than real life
- Document discussion- think of it as a process, not a one time task, talk about goals, values
- Revisit document from time to time
- Discuss DPOA, encourage pt to discuss wishes with them, should not be a secret document
- Make sure it's in the chart and not in a lawyer's office

# ETHICAL ADVANCE DIRECTIVES

- Assess decision-making capacity at different times of day, get a referral for assessing DMC
- Treat delirium aggressively to try to re-establish DMC

- Conclusions