Living Wills: Are They Safe?

by Mark Whitcomb

Advance directives, such as living wills and "Do Not Resuscitate" (DNR) orders, are becoming much more commonplace in the U.S. It is estimated that sixty million Americans now have a living will, (Katsetsos, p.629) A living will is a legal document which is designed to provide guidance to health care providers making decisions on medical and other health care choices should a person become unable to do so. Typically these choices have to do with end-of-life issues such as the termination of life support. DNR orders usually apply only to patients found with no pulse or not breathing.

When catastrophic accident or illness strikes, some patients may wish to forego life-sustaining treatments. This is especially true for the chronically ill elderly who may not be healthy enough to successfully rehab or have good prospects for an acceptable level of recovery, or for patients of any age who are left by illness or accident in a irreversible, vegetative state. In this condition, a patient would be unable to make such a decision himself, and an advance directive would be essential to avoid prolonging an unacceptable situation which might result in nothing but prolonged, useless suffering and the possible depletion of life savings. Without guidance from the patient, it is very hard for loved ones to make such decisions. In studies, bereaved family members have reported significantly less stress, anxiety, and depression during a loved one's end of life situation when an advance directive is present. This suggests that advance planning relieves part of the heavy burden of decision making on family members. (Billings, p.596)

There is little doubt that advance directives, if they are written and used properly, can be beneficial to patients and their loved ones. However, these powerful documents are not always successful in ensuring that the wishes of the patient are carried out. When they are used in real world situations, there can be unanticipated problems. Many of the health care providers who, in emergency situations, are put into the position of interpreting advance directives are hurried and may be insufficiently trained in such matters. This or lack of experience can lead to unintended consequences for the patient.

Different types of advance directives may be misunderstood or even confused with each other. In an article published in the J*ournal of Emergency Medicine*, Drs. Katsetos and Mirarchi illustrate a situation where things went wrong.* They present the case of an 89-year-old male, nursing home resident who had agreed to the terms of a living will which was to be used should he be in a terminal condition or a persistent, vegetative state. This living will was later misinterpreted by the patient's physician and entered onto his nursing home records as a DNR order. Later, when the man became ill with symptoms of slurred speech and hypotension, his records were consulted, and the DNR order was discovered. Because of this, it was deemed appropriate that emergency medical services not be contacted. As a result, the man was transported to the hospital in a private van instead of an ambulance. (Katsetsos, pp.629-30)

Once in the hospital, the patient's situation improved. Because he had a copy of his living will with him, it was examined and found not to preclude treatment. Thus, the man could be treated and stabilized. Because the hospital staff was aware of the erroneous DNR order, they questioned the man closely about his treatment wishes. After he clearly stated, "I know that I am an old man, but if the condition is treatable, I would like the chance to be treated." (Katsetsos, p.630), the patient was found to be suffering from intestinal bleeding and was successfully treated.

As it turned out, the man was lucky. He suffered no lasting harm, and as a result of his ordeal, the false DNR order was discovered. If he had suffered a worse illness in the nursing home, such as a heart attack or a stroke, the false DNR might have prevented him from getting the immediate care he needed. As it was, it was

*Some details of the above case have been altered to protect those involved.

dangerous enough that, in his condition, he was transported to the hospital in a private vehicle.

These events may not be as uncommon as one might imagine. "The Realistic Interpretation of Advance Directives (TRIAD I) study reported that: "the majority of living wills presented to various health care providers were incorrectly interpreted as synonymous to DNR orders — 89% Emergency Medical Services, 79% nurses, 64% physicians." To make matters worse, DNR's can often be mistaken for end of life or comfort care orders. Clearly these are misunderstandings that need to be addressed. (Mirarchi et al., p. 512)

Although advance directives are normally crafted to be used only in specific situations, their content does not always seem to matter. Their existence alone may be sufficient for the patient to receive less care. " A recent study by Silveira et al, indicated that a small but significant proportion of patients with a living will failed to receive the aggressive treatment they requested, and half of the cohort did not receive all the care possible." (Mirarchi et al., p. 511)

Patients themselves can also contribute to the confusion surrounding advance directives. Neither they nor the attorneys who help them write these documents possess the medical knowledge to understand, in advance, all of the medical situations they might face in the future. Even if a physician is able to discuss a variety of options with a patient, the patient may simply not understand what it all means.

Hospitals are busy places, and, as important as end of life issues are, doctors generally do not spend enough time discussing them with their patients. In other research on the subject, Dr. Mirarchi et al., note: "Physicians, when discussing DNR and end-of-life issues with patients, spend 5.6 minutes on the topic and speak for two-thirds of the conversation. Questions could arise as to whether this is enough time for a lay person to be adequately informed and appropriately consented." ((Mirarchi et al., p. 517)

In his article, "The Need for Safeguards in Advance Care Planning," J. Andrew Billings, M.D., also offered the following case history:

"A vigorous, sharp-witted, elderly woman with mild pneumonia, when asked late at night in the emergency department about accepting intubation if her respiratory infection worsened, gave a clear decision that she did not want to be put on a ventilator. The next morning, her primary care physician asked her the question slightly differently, accompanied by realistic prognostication: would she accept a few days of mechanical ventilation in order to get through the worst of the chest infection, understanding that she would very likely recover fully? She said, 'Of course.'" (Billings, p. 595)

This misunderstanding could have been a disaster for this woman if her condition had deteriorated overnight.

Another problem occurs because of the static nature of advanced directives Personal choices may evolve over time or change quickly with changing circumstances. A patient who is looking at an immediate, life threatening situation may change her mind about accepting formerly unpalatable, life-prolonging procedures. In addition, patients who, later in life, have a higher level of baseline disability, may grow to accept lower functional states than they would have as a younger, healthier individual. (Billings, p. 596)

As the length of a patient's stay increases, records and observations from an endless stream of visiting doctors can lead to a very large and unwieldy pile of patient records. In an emergency situation, it can be hard to interpret the relevancy of a living will in the face of confusing and possibly contradictory medical opinions. Add to this the confusion of rotating nursing staff, with different nurses coming on duty every day, and you have an increasingly tough situation where it can be harder for a patient's wishes to be known and understood by all of the caregivers.

The advantages of sitting down and discussing one's wishes with family and physician is clear. This, along with appointing and educating a health care advocate or proxy in the event that you cannot speak for yourself, would make these situations safer. A well-informed advocate should be able to assess the complexity of the immediate medical situation and make decisions based on knowledge of your wishes.

The pro's and con's of living wills are a complex issue which require thought and discussion. This article is meant to serve as an introduction to the issue.

References

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