



Advance directives: a tool for anticipating events and assisting urgent attention

The advance directives document (ADD) is a document addressed to the physician in charge, in which a person of legal age, freely and in accordance with legal requirements, expresses the instructions to be considered when he/she should find him/herself in a position preventing him/her from personally expressing his/her will regarding health care and treatment or, once death has taken place, the destination of the body or organs thereof. An ADD should contain all criteria designed to guide medical decision-making, as well as options according to one's personal value system. This includes the following:

- The place where the patient wishes to receive end-of-life care, organ donation and religious ministrations.
- Specific situations for which certain treatments should be either accepted or rejected.
- The instructions and restrictions regarding medical intervention in given situations. Request non-application - or withdrawal thereof if already applied - of vital support measures (cardiopulmonary resuscitation, dialysis, connection to a respirator, nutrition and artificial hydration etc).
- The appointment of a representative. This person must have knowledge of the will of the person he/she is representing, cannot contravene the contents of the document and must act in accordance with the instructions expressed therein.

An ADD shall be rendered valid if it fulfils the abovementioned requirements and is formalized in writing in accordance with current legislation. It may also be formalized before three witnesses, which renders an ADD more easily accessible among hospitalized patients. Oral ADDs must also be taken into account, especially in previously established doctor-patient relationships, and as such should be duly recorded in the clinical history. An ADD can be modified, renewed or revoked at any time; this requires fulfilment of the same requirements as for the initial execution thereof.

The person who has drafted an ADD must ensure the physician in charge and the treating health care centre have knowledge thereof. The existence of an ADD obliges it to be taken into account in the decision-making process. In the event of failing to follow the preferences expressed in the ADD, the physician in charge must justify the reasons for doing so in the patient's medical record³.

The limits set forth by law regarding the application of ADDs are as follows: 1) That the will expressed therein involves an action which infringes current legal regulations. 2) That it should go against good clinical practice, professional ethics or better available scientific evidence. 3) That the clinical situations were not as anticipated and do not match the possibilities anticipated when signing the document.

In this issue of EMERGENCIAS, two articles analyse the degree of knowledge about ADDs among professionals in an extra-hospital Emergency Department⁴ and among patients with decompensated chronic progressive diseases presenting at an Emergency Department of a University Hospital⁵.

In one article, Mateos et al.⁴ assess the extent of knowledge of ADD among health care professionals (41.7% physicians) by means of self-administered questionnaires: 74% of repliers knew what an ADD was, however, only 18% thereof stated having knowledge of the current legislation on the subject. Among the limitations of this study, as acknowledged by the authors themselves, is the fact that only 25% of persons to whom the questionnaire was given actually replied to it.

In another article contained in this issue, Antolín et al.⁵ assess the extent of knowledge had by patients who present to an Emergency Department with chronic diseases (COPD, chronic heart failure and cirrhosis of the liver) on such diseases, as well as their attitude with regard to drafting an ADD. Only 47% of those interviewed has adequate knowledge of their condition and only 19% acknowledged they knew what an ADD entailed. Remarkably, only 3% had ever been approached by the physician in charge on the subject. As discussed by the authors, the limited knowledge had by the patients on their conditions is a well-known fact. Miró et al.⁶ evaluated the extent of knowledge on the possible progression of their condition among HIV-infected patients, discovering that only 74% really had good knowledge of the possible complications. In a study carried out on COPD patients⁷ the same authors, found that only 49% thereof had good knowledge of their condition, which is a similar percentage to that found by Antolín et al.⁵.

In my opinion, and in general, two types of patients will draft an ADD. The first group is made up of patients in a good general condition, where the drafting of the document will be difficult in light of the possible complexity of the situations which might en-

sue. Such documents must be restricted to general instructions, which are possibly those followed by the attending physician him/herself. Such ADDs should express a patient's will on organ donation or situations of certain conditions (vegetative state, advanced dementia). The second type of patients are those who have chronic and progressive conditions of which knowledge of the possible progression is indeed possible; the drafting of the ADD must therefore concentrate on a known therapeutic scenario. As such, patients with COPD⁷ must realise the possibility of being admitted into an Intensive Care Unit, of needing mechanical ventilation, of requiring a tracheotomy, etc.; the drafting of an ADD enables the health care professionals to work more efficiently.

Nevertheless, health care professionals do not give enough information to patients with chronic conditions, who are the most likely candidates for drafting an ADD. Among the reasons behind this lack of information are society's resistance to discussing death⁸, the incompatibility of certain cultures with such subjects¹⁰, and undoubtedly poor training and motivation on the part of the personnel who should bring about such discussions¹¹.

In fact, as a Professor of Clinical Bioethics at the Autonomous University of Barcelona, an optional subject in 6th year of Medicine, I can vouch for the lack of knowledge on Bioethics among students finishing their training, in areas which will become a constant theme during their professional careers: informed consent, ADDs, distribution of resources and above all the process of informing a patient, about which they do not even have the most basic tools. To this one must add another fundamental aspect: the time factor. In overcrowded departments it is unrealistic to expect that a discussion on death will be brought about by a physician with poor communication skills, and that time will be available to draft a document as complex as an ADD. As such, ADDs are not common in health care provision¹². The results of the two articles appearing in this issue of EMERGENCIAS are therefore not surprising. On the one hand, we have the poor extent of knowledge of patients with chronic diseases on the progression thereof, and the fact that only 3% of physicians had discussed the possibility of drafting an ADD. On the other hand, we have the fact that 75% of health care professionals failed to reply to a questionnaire about such a topical issue as ADDs and that only 18% of those who replied were acquainted with the current legislation on the subject.

As part of the university training, we must therefore encourage respect for a patient's autonomy well beyond loss of consciousness. An ADD enables the patient to determine with the highest

precision possible what he/she does not wish to be done. Its function is, therefore, negative, which accounts for its restriction and even its inadequacy. As Diego Gracia states¹³, it is about the patient stating what he/she wants, not what he/she does not want, approaching the issue from a positive perspective; to have an idea of his/her values and plan with the patient the health care to be provided. For this we need time and training. Target patients should be those with chronic and progressive diseases. The first to benefit from this shall be the emergency professionals who at a critical moment will have information on the patient's preferences, thus enabling them to abstain from futile- and thus harmful - actions which go against a person's dignity.

REFERENCES

- 1- Gomez Rubí JA. Directivas anticipadas: la última oportunidad para ejercer la autonomía. JANO 2001;LX(1377):70-1.
- 2- Broggi MA. El documento de voluntades anticipadas. Med Clin (Barc) 2001;117:114-5.
- 3- Montalvo-Jaakelainen F, Moreno-Alemán J, Santamaría-Pastor M. Incidencia de la ley de autonomía del paciente en la gestión del riesgo sanitario. Nuevas perspectivas legales de la información y de la historia. Rev Calidad Asistencial 2005;20:100-9.
- 4- Mateos Rodríguez AA, Huerta arroyo A, Benito Vellisca MA. Instrucciones previas: actitud de los profesionales de emergencias. Emergencias 2007;19:241-4.
- 5- Antolín A, Ambros A, Mangiron P, Alves A, Sánchez M, Miró O. Conocimientos acerca de su enfermedad y de los documentos de voluntades anticipadas en los pacientes con enfermedades crónicas evolutivas descompensadas que consultan en urgencias. Emergencias 2007;19:245-50.
- 6- Miró G, Pedrol E, Soler A, Serra-Prat M, Yébenes JC, Martínez R, et al. Conocimiento de la enfermedad y documentos de voluntades anticipadas en el paciente seropositivo para VIH. Med Clin (Barc) 2006;126:567-72.
- 7- Miró Andreu G, Felez Flor M, Solsona Durán JF. Toma de decisiones médicas en pacientes con enfermedad pulmonar obstructiva crónica. Med Clin (Barc) 2001;116:536-8.
- 8- Morrison RS, Zayas LH, Mulvihill M, Baskin Sa, Meier DE. Barriers to completion of health care proxy forms: a qualitative analysis of ethnic differences. J Clin Ethics 1998;9:118-26.
- 9- Singer PA, Siegler M. Advancing the cause of advance directives. Arch Intern Med 1992;152:22-4.
- 10- Perkins HS, Geppert CM, Gonzales A, Cortez JD, Hazuda HP. Cross-cultural similarities and differences in attitudes about advance care planning. J Gen Intern Med 2002;17:48-57.
- 11- Lo B, Steinbroock R. Resuscitating advance directives. Arch Intern Med 2004;164:1501-6.
- 12- Solsona JF, Sucarratas A, Maull E, Barbat E, García S, Villares S. Toma de decisiones al final de la vida. Encuesta sobre la actitud ante la muerte en el paciente crítico. Med Clin (Barc) 2003;120:335-6.
- 13- Gracia D. Como arqueros al blanco. (ed) Triacastela 2004 San Sebastián: 395-432.

J. F. Solsona Durán
Intensive Medical Services.
Hospital del Mar. Barcelona