



Advance Directives for Health Care in OB/GYN

FITZMAURICE 5.4.15

Learning Objectives

- ▶ Explain the following legal issues:
 - ▶ Advanced directives for health care
- ▶ Recognize your role as a leader and advocate for women
- ▶ Explain ethical dilemmas in OB/GYN
- ▶ Prerequisites
 - ▶ None
- ▶ See also, for closely related topics:
 - ▶ Communicating with OB/GYN Patients: tips, tricks and common pitfalls
 - ▶ Principles of Ethics in OB/GYN

Definitions

- ▶ Durable Power of Attorney for Health Care
 - ▶ A document that designates an agent or proxy to make health care decisions if the patient is incapable of making them for herself
- ▶ Advance Directive
 - ▶ Formally/legally signed document with instructions outlining a patient's health care wishes, goals and values regarding what will be done in case she becomes incapable of making decisions about her medical care

Definitions (cont'd)

- ▶ “Capable” presumes the patient is able to:
 - ▶ Understand information about her current medical problem
 - ▶ Appreciate the impact of her disease or disability
 - ▶ Appreciate the consequences of various treatment options, including foregoing treatment
 - ▶ Evaluate options, including risks, benefits and alternatives, and to deliberate in accord with her values and beliefs
 - ▶ Effectively communicate her choice

Legal Issues

▶ Declaration of Incapacity

- ▶ Documented by TWO providers in the medical record, OR by court order/formal legal statement
- ▶ Limited to the scope of the particular decision at hand, and must be frequently re-evaluated
 - ▶ Permanent incapacity → conservatorship

▶ Hierarchy of decision making in the absence of a legal document

- ▶ “Substituted judgment” (based on patient’s known values) > “best interests” (based on proxy’s values)
- ▶ Spouse > adult child > parent > adult sibling

Problems with Advance Directives

- ▶ Low completion rate (< 40%)
- ▶ Often too general/non-specific to provide meaningful guidance
- ▶ Sometimes contain conflicting instructions
- ▶ Families often not aware of the document

Why is this so important?

- ▶ Solomon et al. *Am J Public Health*, 1993; 83: 14-23
 - ▶ Surveys distributed to physicians and nurses across 5 hospitals
 - ▶ 47% of respondents reported they had acted against their conscience in the delivery of end of life care
 - ▶ 70% of resident physicians!
 - ▶ The action in question was 4 times more likely to have been one of commission (over-treatment), rather than omission (under-treatment).

Everyone dies, so why is this so hard?

- ▶ Culture values fighting
 - ▶ “Succumbing” to illness → Death = failure
- ▶ Family and patient have never talked about fears and values surrounding death and dying
 - ▶ Disagree often!
- ▶ Providers in critical care situations are often strangers to the patient and family
- ▶ Sense of urgency regarding treatment decisions
- ▶ Choices seem monumental and very final
 - ▶ Easier to defer

How can I help?

- ▶ Encourage everyone to have an Advance Directive that includes naming a DPOA
- ▶ DPOA should be someone with whom the patient has had at least one honest, in-depth conversation about their beliefs, goals, fears and values surrounding death and dying.
- ▶ Writing an Advance Directive is NOT planning to die. It is planning how NOT to die!
 - ▶ Empowers patients to prevent their personal worst-case-scenario, e.g. dying before their son's graduation, dying in pain, short of breath, alone in an ICU, etc.
 - ▶ "Hope for the best, plan for the worst."
 - ▶ Having an Advance Directive does not mean your doctor will "give up" on you

What's in a good Advance Directive?

- ▶ At a minimum, needs to define the patient's personal "minimum acceptable quality of life," or "states worse than death"
 - ▶ E.g. must be able to live independently, or just able to communicate meaningfully with loved ones?
- ▶ Focus on **OUTCOMES**, NOT TREATMENTS
- ▶ May also outline specific actions/treatments in specific scenarios, but overall goal is for document to convey desired (or unacceptable) outcomes such that providers can choose a treatment course that has the best chance of producing (or avoiding) those outcomes

Additional considerations for terminally ill patients

- ▶ “Goals of Care” conversation
 - ▶ Often led by Palliative Care sub-specialist (fellowship trained)
 - ▶ Can be optimistic, but set out REALISTIC survival expectations, e.g. “months not years,” or “weeks to months”
 - ▶ Be explicit in anticipating typical symptoms and health states of concern, i.e the “Trajectory of decline”
 - ▶ Involve family so everyone is on the same page, e.g. family meetings
 - ▶ Conversation can be translated effectively into an Advance Directive
- ▶ Patients over-estimate prognosis, in general
 - ▶ Many change to DNR once the reality of the effectiveness/typical outcome of CPR is explained to them

References

- ▶ Thanks to Ken Rosenfeld, MD at UCLA, my attending physician on my Palliative Care sub-internship, for his amazing teaching, including his Goals of Care talk, which heavily influenced this presentation.
- ▶ General (and minimally acceptable) form available at:
<http://ag.ca.gov/consumers/pdf/AHCDS1.pdf>