

## A Boost for Advance Directives

In the wake of “death panels,” charges in the aftermath of the revision of Directive #58 that Catholic hospitals will no longer abide by patient wishes regarding end-of-life care, and claims of late by some that advance directives are ineffective and virtually useless, a study published in the April 1, 2010 issue of the *New England Journal of Medicine* (Maria J. Silveira, M.D., M.P.H. et al., “Advance Directives and Outcomes of Surrogate Decision Making before Death,” *NEJM* 362, n. 13 [April 1, 2010]: 1211-1218) provides data that suggests that advance directives are, in fact, valuable.

The study examined data from the Health and Retirement Study, specifically looking at adults 60 years of age or older who had died between 2000 and 2006. The research focused on determining the prevalence of the need for decision making at the end of life as well as the loss of decision making capacity. Among those who had lost the ability to make decision for themselves and who had an advance directive, the researchers sought to determine the degree of association between patient preferences as stated in an advance directive and the outcomes of surrogate decision making. Here are some of the salient results:

- Of 3,746 subjects, 42.5% (1,536) required decision making about treatment in the final days of life, of whom 70.3 % lacked decision making

capacity. Hence, 29.8% of patients required decision making at the end of life, but lacked decision making capacity. These findings may suggest that more than a quarter of elderly adults may need surrogate decision making before death.

- Of those individuals who lacked decision making capacity, 67.6% had advance directives. 6.8% only had a living will and 21.3 % only a durable power of attorney for health care (DPAHC), while 39.4 % had both. The authors of the study conclude that “the fact that so many elderly adults complete advance directives suggests that they find these documents familiar, available and acceptable. Moreover, it suggests that elderly patients, their families, and perhaps their health care providers think that advance directives have value” (p. 1217).
- Those patients with living wills generally wanted “limited care” (92.7%) or comfort care (96.2%). Only 1.9% wanted all care possible.
- Living wills were completed a median of 20 months before death and DPAHC’s were completed a median of 19 months before death.
- 83.2% of individuals who requested limited care and 97.1% who requested

comfort care received care consistent with their wishes. The authors note that “although a causal relationship cannot be inferred, our findings suggest that advance directives do influence decisions made at the end of life” (p. 1217).

- Of the ten patients who requested all care possible, five received it. Those with living wills were less likely to receive all care possible than were individuals without living wills.
- Individuals who had a durable power of attorney for health care were less likely to die in a hospital or receive all care possible than those who did not have a DPAHC.

The authors of the study conclude that “advance directives are important tools for providing care in keeping with patients’ wishes. For more patients to avail themselves of these valuable instruments, the health care system should ensure that providers have the time, space, and reimbursement to conduct the time-consuming discussion necessary to plan appropriately for the end of life. Data suggest that most elderly patients would welcome these discussions” (p. 1218).

In another recent study, published in the *British Medical Journal* (KM Deterin et al., “The Impact of Advance Care Planning on End of Life Care in Elderly Patients: Randomized Controlled Trial, *British Medical Journal* 340 (2010): 1345), researchers found that advance planning improves end-of-life care for

elderly patients and helps families cope with the loss.

The research found that hospitalized patients over age 80 who were formally assisted with documenting their end-of-life treatment wishes and with designating a surrogate were almost three times more likely to have their wishes followed, and their family members reported significantly less emotional trauma after the patient’s death. Discussions with patients in the intervention group, generally facilitated by a nurse or allied health worker, averaged 60 minutes over one to three meetings. Treating physicians participated as needed, and patients were encouraged to include their families in the discussions.

Patients in the intervention group (or their family member if they died during the hospitalization) reported significantly more often than those who were not, being “very satisfied” with all aspects of the hospital stay, including involvement in decisions, how well they were listened to, and information provided to them. Family members of patients in the intervention group who died had lower anxiety and depression scores and reported higher satisfaction with the quality of their family member’s death.

As with virtually all studies, these two studies had their limitations. These should be taken account of before conclusions are drawn from them.

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