Advance Directives, Living Wills, and Futility in Perioperative Care

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KEYWORDS

• Advance directives • Living will • Durable power of attorney for health care • Futility • Do not resuscitate • Perioperative

KEY POINTS

- Living wills and durable power of attorney for health care (DPOA-HC) have different implications for perioperative care.
- Patients can maintain do-not-resuscitate (DNR) orders while in an operating room (OR); however, these orders are fundamentally different from the standard DNR orders and require significant preoperative clarification.
- Futility has many different definitions, mostly because it is difficult to clearly define.
- There are several common cases where futility directly affects surgical care.

Advance directives have been considered essential to any hospital admission for more than 20 years. In the United States, the Patient Self-Determination Act of 1990 made it a requirement that all patients entering a health care institution have an inquiry into patients' advance directives and that information be provided about advance directives if patients have none. The major impetus behind this movement was the increased priority of patient autonomy in medical decision making and decrease in physician paternalism. It was realized that many medical decisions were being made when patients had been incapacitated by illness, and some means of honoring patients' wishes in those situations was required. Incapacitated patients have been subjected to interventions that they did not desire according to previously expressed wishes simply because they did not have written advance directives. In some US states, however, advance directives still only apply if patients are terminally ill; and terminally ill is narrowly defined as a person dying in a relatively short period of time regardless of life-supporting therapy. This strict legal definition can add confusion and complexity

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Surg Clin N Am 95 (2015) 443–451
http://dx.doi.org/10.1016/j.suc.2014.10.005 **surgical.theclinics.com**
0039-6109/15/$ – see front matter Published by Elsevier Inc.

and eliminates the application of advance directives from other situations in which an advance directive would be beneficial.

Initially, few patients had advance directives on admission and then, over the years, as awareness was increased about the necessity of such directives, patients made their advance directives known to their treatment team. Today, however, few patients have printed advance directives placed in the medical record, and discussions regarding a patient's advance directives take place with fewer than 25% of patients.[1,2] Frequently, in surgery, advance directives are implied. In the surgical literature, the concept of "patient buy-in" has been used to describe the implied advance directives that accompany informed consent.[3] After recording more than 50 informed consent discussions, Pencanac and colleagues[4] identified that although surgical risk and the possibility of a difficult recovery requiring invasive postoperative care are discussed, explicit discussion of advance directives is seldom performed. Instead, surgeons seem to rely on assuming that patients understand surgery is high risk and assent that they require difficult postoperative care after a major procedure. This may account for the perception that surgeons are overly aggressive in prolonging life in postoperative care, because a surgeon has had a discussion with a patient and told the patient what to expect intraoperatively and postoperatively, and the patient agreed to pursue the intervention. Some investigators who perform high-risk procedures have identified a greater need for written advance directives in these cases and emphasize the importance of these discussions taking place preoperatively.[2] Barnet and colleagues[5] looked at a series of patients who died within 1 year of their surgery. Only half had an advance directive at the time of their operation.

Studies have looked at surgeons' perspectives on advance directives' impact on end-of-life care. Schwarze and colleagues[6] found that 60% of surgeons who replied to a survey endorse sometimes or always refusing to operate on patients with preferences to limit life support. Interviews with surgeons and nonsurgical intensivists have revealed that advance directive discussions are the framework by which they make end-of-life decisions with patients and families. Written advance directives do not necessarily reflect the reality of what patients want in their end-of-life care.[7]

Even in circumstances in which it seems obvious that advance directives should be used, frequently they are not. Swetz and colleagues[8] looked at the use of advance directives in patients receiving left ventricular assist devices (LVADs). Only approximately 35% of LVAD patients had an advance directive prior to insertion of the LVAD, and only approximately 45% of LVAD patients ever created an advance directive. The advance directives that were present on the patients' charts addressed issues, such as tube feeding, cardiopulmonary resuscitation (CPR), mechanical ventilation, and hemodialysis. Most surprising, however, was that none of the advance directives in the study addressed the LVAD or conditions in which the LVAD should be withdrawn.

ADVANCE DIRECTIVES: LIVING WILLS AND DURABLE POWER OF ATTORNEY

Living wills are legal documents with the purpose of outlining a patient's goals of care and what type and to what extent the patient desires intervention. These documents are created when patients are in a state in which they can make decisions for the future if they would become incapacitated. These documents vary a great deal in content and range from a simple checkbox form that indicates which treatments are permissible to discussing decision making in elaborate hypothetical situations. Initially, living