CHEST

Navigating Ethical Conflicts Between Advance Directives and Surrogate Decision-Makers' Interpretations of Patient Wishes

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PODCAST

There is little guidance on what clinicians should do when advance directives (or living wills, specifically) are challenged, particularly when surrogate decision-makers' interpretations of patients' wishes conflict with the living will. In our commentary, we make a controversial argument suggesting that overriding living wills can be ethically preferable to the alternative of strictly adhering to them. We propose four ethical considerations for determining whether it is ethically supportable to override living wills. CHEST 2016; 149(2):562-567

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The September 2014 Institute of Medicine report called for systemic changes regarding how and when advance care planning (ACP) conversations occur. In July 2015, the Centers for Medicare and Medicaid Services issued a proposed rule establishing separate payment for ACP discussions with Medicare beneficiaries, which would include reimbursement for time spent discussing and completing advance directives (ADs).[1]

Owing to these professional and legislative efforts, ADs are projected to take on a greater role in decision-making.[2] Ethical theory and clinical practice presuppose that ADs, and living wills (LWs) specifically, extend patients' voices when they lack decision-making capacity and should be interpreted literally.[3] However, LWs may not reflect patients' preferences because wishes may change, ADs lack nuance in language, and patients may misunderstand the purpose or function of ADs.[4]

Although these ethical problems have been acknowledged,[5] there is little guidance regarding what clinicians should do when LWs are challenged, particularly when surrogate decision-makers' interpretations of patients' wishes conflict with the LW. One exception is the research of Smith and colleagues,[6] who provide guidance in cases where the AD fits poorly with the situation. We build on their work by focusing on cases where the AD is applicable but contextual features suggest that a literal interpretation may not achieve either the intended

ABBREVIATIONS: ACP = advance care planning; AD = advance directive; LW = living will; MPOA = medical power of attorney; POLST = California Physician Orders for Life-Sustaining Treatment

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autonomy-enhancing goals or account for beneficence-based, best-interest considerations.

Consider a recent case representing about 5% of our ethics consultation case volume. Mr C was a 64-year-old candidate for double-lung transplant who had pulmonary fibrosis. Before transplantation, he appointed his wife as medical power of attorney and completed an LW requesting ongoing aggressive measures for terminal or irreversible conditions. His wife, Mrs C, was present for AD completion. While completing the LW, he said to Mrs C, "I trust you will do the right thing for me, if the time comes." Two years after transplant, Mr C experienced progressive decompensation, including a stroke with irreversible loss of decision-making capacity, and he was not a candidate for retransplantation. Mr C's clinicians believed comfort-oriented therapies were most medically appropriate, although they would also have supported aggressive therapies including tracheostomy and long-term acute care placement. Mrs C contended that the LW did not represent her husband's wishes because he: (1) signed it under the belief that completion was a condition to transplantation; (2) never envisioned needing a long-term facility and artificial support; and (3) believed Mrs C could "override" the LW if "the time comes." Three family members supported her interpretation. The care team enlisted our ethics consultation service to determine whether proceeding with the wife's interpretation and treatment choice was ethically supportable.

Legal consensus regarding how to manage LW-surrogate conflicts is lacking. Specifically, some states' statutory laws permit "variances" from the LW, although in our review of state laws allowable variances are rare, and where they exist the statute does not provide guidance on when, why, and how it might be acceptable to override an AD.[7] For example, the California Physician Orders for Life-Sustaining Treatment (POLST) indicates that a legally recognized decision-maker may request modifying the orders in collaboration with the physician, based on the known desires of the patient.[8,9] Nevertheless, the POLST is still used in only a minority of states, and even in those states where it is used, such as California, there is little guidance on the types of criteria or considerations that physicians and surrogates should discuss in their "collaboration." Thus, the legal landscape is muddled at best. Ethically, the default position is strict adherence to the LW, using an ethical presumption that strict adherence would be most representative of patients' wishes.[10]

Here, we make a controversial argument: that strict adherence may not be in keeping with patients' wishes and that as such, under limited circumstances, it would be ethically acceptable for clinicians to disregard the LW under substituted judgment (ie, using a surrogate's interpretation of patient wishes). Doing so would require strong support showing that substituted judgment is the most accurate representation of a patient's wishes. Although it may be controversial to consider overriding LWs, it can be ethically preferable to the alternative of strict adherence to the LW because overriding can achieve autonomy-enhancing goals.

We propose four ethical considerations for determining whether it is ethically supportable to override LWs (Table 1). We believe these criteria provide clinicians guidance in states that allow ADs to be overridden, in a way that is ethically (and legally) sound. These criteria can also be used as a framework for clinicians in states that allow physician-surrogate modification of a POLST and states that are silent on the matter. In short, our principal goal is to promote dialogue and encourage principled reasoning about this problem. Our secondary goal is to provide an ethical framework that is versatile and may be used to guide physicians practicing in any state.

In terms of implementing these criteria, the first two considerations described subsequently (medical appropriateness and corroboration) are necessary to override LWs to ensure a beneficence-based, autonomy-enhancing outcome, one that is in keeping with what is medically sound and with what the patient likely intended. Of the final two considerations (discretion or purpose), at least one must be met to further substantiate surrogates' interpretations of patients' wishes. We identify several important factors to illustrate how each criterion might or might not be satisfied.

Ethical Considerations

Medical Appropriateness

In keeping with the ethical principle of beneficence, the surrogate's interpretation and treatment selection must be medically appropriate, meaning that the expected benefits are sufficiently greater than the expected harms or negative consequences.[11]

Patients and surrogates cannot insist on therapies that are medically inappropriate but they can select from a range of options, even if the option selected is not optimal or concordant with physicians' recommendations.[12] Here, Mrs C requested a comfort-oriented option that