

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-19)

Introduced by: Medical Student Section

Subject: Support for the Use of Psychiatric Advance Directives

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(_____, Chair)

Whereas, Nearly 10 million US adults live with serious mental illness, defined as a mental illness that “result[s] in serious functional impairment” and “interferes with one or more major life activities”¹⁻²; and

Whereas, A survey of 213 patients who previously received coercive psychiatric treatment found that they would like to engage in advance planning to determine their preferences for future care during psychiatric crises³; and

Whereas, A psychiatric advance directive is a legal document written by a competent individual with a mental illness, specifying their treatment preferences and/or granting their medical power of attorney to a surrogate during a future psychiatric crisis that impairs the individual’s capacity⁴⁻⁶; and

Whereas, A psychiatric advance directive differs from generic advance directives due to the unique nature of psychiatric illness and treatment⁵⁻⁷; and

Whereas, While most states enable psychiatric advance directive creation under broader advance directive statutes, only 25 states have legislation pertaining specifically to the use of psychiatric advance directives⁴⁻⁶; and

Whereas, In Nevada and New Hampshire, while a patient may designate an agent to make healthcare decisions for them should they become incompetent, they may only specify in writing advance instructions on non-psychiatric life-sustaining care⁴⁻⁶; and

Whereas, The Patient Self-Determination Act of 1990 states that Medicare and Medicaid patients should be advised on opportunities to specify treatment preferences prior to the loss of decision-making capacity when possible⁸; and

Whereas, The Centers for Medicare & Medicaid Services Inpatient Psychiatric Facility Quality Reporting Program Manual specifies that a “patient should be allowed the opportunity to appoint a surrogate decision maker or complete non-psychiatric and psychiatric advance directives”⁹; and

Whereas, The use of psychiatric advance directives can help improve patient autonomy, treatment adherence, and the physician-patient relationship and reduce the need for coercive interventions such as involuntary commitment, seclusion, restraints, police transport, and involuntary medications¹⁰⁻¹²; and

1 Whereas, In the first 6 months following psychiatric advance directive completion, 6.5 percent of
2 patients experienced a coherence crisis intervention compared to 19.7 percent of non-
3 completers¹⁰; and
4

5 Whereas, Patients with serious mental illness who participated in a facilitated psychiatric
6 advance directive completion session were 1.57 times more likely to experience an increase in
7 working alliance between themselves and clinicians after 1 month compared to patients who did
8 not experience the session¹¹; and
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10 Whereas, Psychiatric advance directive completers were 7.8 times more likely to be adherent to
11 their psychiatric medication after 1 year compared to non-completers¹²; and
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13 Whereas, In the largest study of psychiatric advance directive usage to date, in over 1,000
14 patients with mental illness, only 7 percent of respondents had completed a psychiatric AD or
15 designated a surrogate for future psychiatric crises, while 68 percent of respondents expressed
16 interest in completing one¹³; and
17

18 Whereas, A survey of over 400 psychiatrists and psychologists showed that only 37 percent of
19 respondents demonstrated sufficient legal knowledge regarding psychiatric advance
20 directives¹⁴; and
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22 Whereas, The use of facilitated psychiatric advance directive, an intervention in which a
23 psychiatric advance directive is completed by a patient with the assistance of a trained
24 individual, can reduce most barriers to psychiatric advance directive completion^{10,15}; and
25

26 Whereas, Low usage of psychiatric advance directive has led several states and organizations
27 to take steps to increase awareness and utilization of psychiatric advance directives, such as
28 establishing psychiatric advance directive completion clinics¹⁶⁻¹⁹; and
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30 Whereas, Existing AMA policy “encourage[es] the use of advance directives and health care
31 powers of attorney” (H-140.845, Encouraging the Use of Advance Directives and Health Care
32 Powers of Attorney), “educating physicians about advance care planning” (H-85.956, Educating
33 Physicians About Advance Care Planning), and “promotes awareness and understanding of”
34 advance care planning in the unique situation of pregnancy (H-85.952, Advance Directives
35 During Pregnancy); and
36

37 Whereas, Similar to pregnant women, individuals with serious mental illness constitute a special
38 population with unique considerations that warrants additional attention in the area of advance
39 directive usage³⁻⁶; therefore be it
40

41 RESOLVED, That our American Medical Association support efforts to increase awareness and
42 appropriate utilization of psychiatric advance directives. (New HOD Policy)

Fiscal note:

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RELEVANT AMA POLICY**Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845**

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to

encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17

Educating Physicians About Advance Care Planning H-85.956

Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions; (2) supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act; (3) encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment; (4) will work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians; and (5) encourages development of a model educational module for the teaching of advance directives and advance care planning.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 307, A-14; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17

Advance Directives During Pregnancy H-85.952

1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship.
2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics.
3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.
4. The Council on Ethical and Judicial Affairs will consider examining the issue of advance directives in pregnancy through an informational report.

Citation: (BOT Rep. 9, I-15)

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: (Res. 116, A-12; Reaffirmation A-15)

E-5.1 Advance Care Planning

The process of advance care planning is widely recognized as a way to support patient self-determination, facilitate decision making, and promote better care at the end of life. Although often

thought of primarily for terminally ill patients or those with chronic medical conditions, advance care planning is valuable for everyone, regardless of age or current health status. Planning in advance for decisions about care in the event of a life-threatening illness or injury gives individuals the opportunity to reflect on and express the values they want to have govern their care, to articulate the factors that are important to them for quality of life, and to make clear any preferences they have with respect to specific interventions. Importantly, these discussions also give individuals the opportunity to identify who they would want to make decisions for them should they not have decision-making capacity.

Proactively discussing with patients what they would or would not want if recovery from illness or injury is improbable also gives physicians opportunity to address patients' concerns and expectations and clarify misunderstandings individuals may have about specific medical conditions or interventions. Encouraging patients to share their views with their families or other intimates and record them in advance directives, and to name a surrogate decision maker, helps to ensure that patients' own values, goals, and preferences will inform care decisions even when they cannot speak for themselves.

Physicians must recognize, however that patients and families approach decision making in many different ways, informed by culture, faith traditions, and life experience, and should be sensitive to each patient's individual situations and preferences when broaching discussion of planning for care at the end of life.

Physicians should routinely engage their patients in advance care planning in keeping with the following guidelines:

(a) Regularly encourage all patients, regardless of age or health status, to:

(i) think about their values and perspectives on quality of life and articulate what goals they would have for care if they faced a life-threatening illness or injury, including any preferences they may have about specific medical interventions (such as pain management, medically administered nutrition and hydration, mechanical ventilation, use of antibiotics, dialysis, or cardiopulmonary resuscitation);

(ii) identify someone they would want to have make decisions on their behalf if they did not have decision-making capacity;

(iii) make their views known to their designated surrogate and to (other) family members or intimates.

(b) Be prepared to answer questions about advance care planning, to help patients formulate their views, and to help them articulate their preferences for care (including their wishes regarding time-limited trials of interventions and surrogate decision maker). Physicians should also be prepared to refer patients to additional resources for further information and guidance if appropriate.

(c) Explain how advance directives, as written articulations of patients' preferences, are used as tools to help guide treatment decisions in collaboration with patients themselves when they have decision-making capacity, or with surrogates when they do not, and explain the surrogate's responsibilities in decision making. Involve the patient's surrogate in this conversation whenever possible.

(d) Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express his or her own decisions. If the patient has an advance directive document or written designation of proxy, include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to his or her surrogate and others to help ensure it will be available when needed.

(e) Periodically review with the patient his or her goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patient's medical records accordingly when preferences have changed to ensure that these continue to reflect the individual's current wishes. If applicable, assist the patient with updating his or her advance directive or designation of proxy forms. Involve the patient's surrogate in these reviews whenever possible.

Issued: 2016

E-5.2 Advance Directives

Respect for autonomy and fidelity to the patient are widely acknowledged as core values in the professional ethics of medicine. For patients who lack decision-making capacity, these values are fulfilled through third-party decision making and the use of advance directives. Advance directives also support continuity of care for patients when they transition across care settings, physicians, or health care teams.

Advance directives, whether oral or written, advisory or a formal statutory document, are tools that give patients of all ages and health status the opportunity to express their values, goals for care, and treatment preferences to guide future decisions about health care. Advance directives also allow patients to identify whom they want to make decisions on their behalf when they cannot do so themselves. They enable physicians and surrogates to make good-faith efforts to respect the patient's goals and implement the patient's preferences when the patient does not have decision-making capacity.

An advance directive never takes precedence over the contemporaneous wishes of a patient who has decision-making capacity.

In emergency situations when a patient is not able to participate in treatment decisions and there is no surrogate or advance directive available to guide decisions, physicians should provide medically appropriate interventions when urgently needed to meet the patient's immediate clinical needs. Interventions may be withdrawn at a later time in keeping with the patient's preferences when they become known and in accordance with ethics guidance for withdrawing treatment.

Before initiating or continuing treatment, including, but not limited to, life-sustaining interventions, the physician should:

- (a) Assess the patient's decision-making capacity in the current clinical circumstances.
- (b) Ascertain whether the patient has an advance directive and if so, whether it accurately reflects his/her current values and preferences. Determine whether the patient's current clinical circumstances meet relevant thresholds set out in the directive.
- (c) Ascertain whether the patient has named a health care proxy (e.g., orally or through a formal legal document). If the patient has not, ask who the patient would want to have make decisions should he or she become unable to do so.
- (d) Document the conversation, including the patient's goals for care, and specific preferences regarding interventions and surrogate decision maker, in the medical record; incorporate any written directives (as available) into the medical record to ensure they are accessible to the health care team.
- (e) When treatment decisions must be made by the patient's surrogate, help the surrogate understand how to carry out the patient's wishes in keeping with the advance directive (when available), including whether the directive applies in the patient's current clinical circumstances and what medically appropriate interventions are available to achieve the patient's goals for care. When conflicts arise between the advance directive and the wishes of the patient's surrogate, the attending physician should seek assistance from an ethics committee or other appropriate institutional resource.
- (f) When a patient who lacks decision-making capacity has no advance directive and there is no surrogate available and willing to make treatment decisions on the patient's behalf, or no surrogate can be identified, the attending physician should seek assistance from an ethics committee or other appropriate resource in ascertaining the patient's best interest.
- (g) Document physician orders to implement treatment decisions in the medical record, including both orders for specific, ongoing interventions (e.g., palliative interventions) and orders to forgo specific interventions (e.g., orders not to attempt resuscitation, not to intubate, not to provide antibiotics or dialysis).

Issued: 2016