Advance Directives for Psychiatric Treatment

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Advance directives for psychiatric treatment—long-debated, but little used—are on the verge of having a major impact on psychiatric care. These documents, written while a person is competent, specify how decisions about treatment should be made if the person becomes incompetent. Use of advance directives would seem particularly appropriate in the care of persons with mental illness, which is frequently characterized by alternating periods of competence and incompetence. However, a variety of problems have stymied use of advance directives in such situations. But new statutes, originally designed to apply to general medical treatment, may soon change that.

Two types of advance directives exist: instruction directives and proxy directives (1). Instruction directives, often called living wills, specify actions the person would want caregivers to take should particular situations occur in the future. For example, most states have living-will statutes that allow persons to request termination of life supports should they become terminally ill (2). Living wills are most useful when the circumstances in which they will be invoked can be precisely specified in advance. Their major drawback lies in the difficulty of anticipating future circumstances and providing instructions that take into account all contingencies.

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The use of living wills in psychiatric treatment has been debated for more than a decade (3–5). Thomas Szasz (4), an opponent of involuntary treatment who doubts the reality of mental illness, is the most prominent advocate of the "psychiatric will." He argues that persons who would resist involuntary treatment could make their preferences binding by having a living will made while they are competent. Other proponents favor living wills because they may have the opposite effect: patients who might resist all interventions when they decompensate could grant prospective approval for hospitalization and treatment (3,6).

Szasz' proposal, and other living-will schemes, have been attacked by both sides in the debate about the appropriateness of involuntary treatment. Civil libertarians are afraid that patients will be coerced into signing documents that leave decisions about whether they will be hospitalized and treated to their doctors' discretion (7). Advocates of paternalistic intervention, in contrast, worry that psychiatric wills might prevent treatment of patients who would otherwise suffer needless pain, or might inflict such pain on others (5). Although the discussion of living wills in psychiatry continues (7,8), no state has formally authorized their use.

Proxy directives, the second category of advance directives, are fundamentally different from living wills. Rather than attempting to specify the treatment to be provided, proxy directives designate a third party to act as decision maker in the event that the person writing the directive becomes incompetent. This approach gained popularity in 1983, when it was endorsed by the President's Commission for the Study of Ethical Problems in Medicine. The commission noted that most states already had durable-power-of-attorney statutes, which permit the advance appointment of agents who could make personal and financial decisions (9).

Proxy directives have the obvious advantage of not being constrained by unforeseeable events. Persons desiring to designate a proxy could discuss their values at length with the proxy, with the expectation that the proxy would later apply those principles to whatever circumstances may arise. Appointment of a proxy also makes clear who the ultimate decision maker is, should conflict arise among family members or friends about the patient's interests or desires.

Although the President's commission argued that no new legislation was needed for people in most states to appoint what have come to be called health care proxies, doubts have persisted about the validity of using durable-power-of-attorney statutes for this purpose. Several states, including New York and Massachusetts, recently passed laws that authorize and establish procedures for the appointment of health care proxies (2). Clearly, these statutes were drafted to address situations related to the continuation of life-sustaining treatment when recovery seemed unlikely. But the statutes are broad enough in scope to have considerable impact on psychiatric care as well.

New York's law, for example, which is likely to become a model for other states, allows any competent adult to appoint a health care agent who has the authority to make "any decision to consent or refuse to consent to health care" (10). Competence at the time the directive is written is presumed, unless the person previously has been found incompetent by a judge, but provisions

are available for later challenge of the person's competence in court. The proxy's powers come into effect when the patient's attending physician determines that the patient no longer has the capacity to make health care decisions.

Two additional provisions of the statute are noteworthy. First, the statute allows persons to limit the authority of the proxy in particular situations by absolutely precluding the proxy from consenting to certain forms of treatment. This provision addresses concerns similar to those addressed by living wills. Second, if a patient who has been found to lack capacity by a physician objects to the treatment authorized by the proxy, the treatment cannot be given until judicial determination of the patient's incompetence is made.

Nothing in the New York or Massachusetts statutes limits their applicability in psychiatric care. In fact, in Massachusetts, psychiatric patients' rights groups are already encouraging patients to fill out advance directive forms. Moreover, new federal regulations due to take effect before the end of 1991 will require all facilities that receive Medicare or Medicaid to inform patients, including psychiatric patients, at admission about their rights under state law to sign advance directives (11,12).

What are likely to be the effects of this back-door introduction of advance directives into psychiatric treatment? Their application to treatment with medication (or electroconvulsive treatment) and to hospitalization need to be analyzed separately.

Patients who explicitly instruct their proxy decision makers to reject treatment with antipsychotic medication, for example, or proxies who reject such treatment believing that such a choice reflects the patient's wishes can probably preclude such treatment altogether. Although many states now grant patients some right to refuse medication, refusals that are challenged before courts or other review bodies are almost always overturned (13). However, when it is clear that the decision to refuse treatment reflects a choice made when the patient was competent, the option of judicial review is not likely to be available under a health care proxy law.

The converse, of course, is also true. If an incompetent patient's proxy authorizes treatment, lengthy court proceedings to authorize involuntary treatment should no longer be necessary. If the patient objects to medication, however, a judicial determination of incompetence will still be required before treatment can proceed.

Proxies' decisions about hospitalization constitute a murkier issue. Proxies probably have the power to authorize admission of patients to hospitals for general medical treatment. The prevailing practice has been for hospitals to accept the consent of family members to admit patients who are believed by their physicians to lack capacity to make treatment decisions, even in the absence of advance directives.

However, psychiatric hospitalization has been treated somewhat differently. Incompetent patients who object to hospitalization must usually meet civil commitment criteria before they can be admitted. In many states, even guardians are not permitted to make admission decisions, which must be made by a judge. Incompetent patients who assent to hospitalization have often been allowed to sign themselves into a psychiatric hospital, but this practice now has been called into question (14). The courts are more likely to accept the consent of a proxy as validating the admission of an assenting incompetent patient than to allow proxies to consent to hospitalization over a patient's objections, even after a judicial finding of incompetence.

Of course, the use of advance directives in psychiatric treatment will raise many other practical issues. How easy will it be to determine patients' competence retrospectively when the validity of their directives is in doubt? Will proxy decision makers, in the absence of explicit instructions, truly represent the values and wishes of the people for whom they are making decisions? What will become of patients who effectively block the administration of medication? Unless legislatures choose to exclude psychiatric treatment from the coverage of these statutes, we should know the answers to some of these questions before very long.

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