

Commentary: The Climate for Physician Adherence to Psychiatric Advance Directives

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Factors that may be significant in rationalizing physician overrides of psychiatric advance directives (PADs) are not only features of individual clinical scenarios, but also are artifacts of the faltering mental health system being navigated by both provider and patient. This system, frequently viewed as hostile to consumer choice and increasingly focused on reacting to recurrent crises, is not predisposed to accepting proactive, person-centered measures such as PADs. In fact, PADs may hold great promise in improving clinical outcomes and even reducing system costs. But to realize the full potentials of PADs requires that providers understand their roles in challenging or perpetuating problems in the larger mental health system.

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In evaluating the susceptibility of psychiatric advance directives (PADs) to override by physicians, Swanson *et al.*¹ discovered the chilling irony that a measure intended to advance personal choice may ultimately sustain or even bolster professional control. Their analysis of various legal and practice considerations reveals a host of justifications that can be invoked during a period of temporary incapacity, to supplant the expressed wishes of individuals with the expert decisions of health care professionals. Certainly, it would be naïve to deny the reality of situations where meaningful and responsible emergency interventions may conflict with an individual's treatment preferences previously expressed through a PAD. In such instances, physician expertise may be crucial to avoid serious harm to self or others. On the other hand, it would be equally naïve to deny the reality that mental health systems charged with serving the people most likely to have executed PADs—those diagnosed with so-called serious mental illnesses and vulnerable to recurrent psychiatric crises—carry a tradition of entrenched practices that dismiss, ignore, or even oppose personal choice when they do not comport with professional recommendations.²

In their study of factors influencing PAD overrides, Swanson *et al.*¹ frequently (and properly) compare PADs to medical advance directives and frame a good deal of their analysis in the context of three criteria formulated by Brock³ in reference to physician overrides of patients' directives in physical health care. These apply to situations: (1) where there are good reasons to question whether an advance directive accurately reflects the individual's preferences; (2) when there is a conflict between the advance directive and the current interests or personal identity of the individual; and (3) when the interests of others may warrant an override.

When translated to the arena of mental health care, these scenarios can have special implications that favor the individual's decision-making. For example, as Swanson *et al.*¹ note, one ironically positive consequence of living with recurrent crises, as do many people who have serious mental illnesses, is that personal preferences expressed in PADs may be based on direct knowledge of how emergency interventions have transpired in the past. In this sense, individuals' instructions for crisis responses contained in PADs may be far less hypothetical than those for medical or end-of-life care. Nevertheless, this is no guarantee that physicians will readily accept the validity of individuals' preferences for psychiatric treatment. The authors find that when applied to mental health care, consideration of these criteria

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may, in one way or another, embolden physicians to apply their own judgments over preferences expressed through a patient's PAD.

The examination by Swanson *et al.*¹ of factors that might rationalize overrides occurs largely on the level of the physician and the individual patient. On their face, these scenarios illustrate how complicated best-practice decision-making may be for a physician treating an individual in crisis who has expressed preferences that diverge from the professional's recommendations for mental health treatment. However, to assume that these predicaments are inevitable aspects of psychiatric care for people with diagnosed serious mental illnesses would ignore the reality that, in some very significant ways, they are artifacts of the larger mental health system being navigated by both the patient and the professional.

The elephant in the room, bluntly described by the President's New Freedom Commission on Mental Health, is that the nation's mental health system is "in shambles."⁴ To a startling degree, public mental health myopically concentrates on immediate crises affecting people with long-term disabilities. Not even doing that with particular success, the system produces remedies that create and tolerate shameful outcomes such as cycles of re-institutionalization, homelessness, and incarceration. Indeed, having carefully examined the delivery of mental health services in this country, in its final recommendations the New Freedom Commission found it necessary to articulate such rudimentary elements as the need for mental health services to be individualized, to reflect the goals and preferences of the person being served, and to convey a sense of hope and recovery.⁵ The commission concluded that the mental health system is so askew that to achieve these fundamentals will require nothing short of a "transformation."

Physicians' consideration of PADs, both conceptually and in direct clinical practice, cannot be disaggregated from these larger realities. Given the state of the nation's mental health care, it seems safe to assert that many individuals who are, or should be, served by these systems go into crises needlessly. Meaningful community-based services and supports would obviate the need for their PADs to be activated in the first place, thus making the dilemmas presented by Swanson *et al.*¹ uncommon.

Taking the world as we now find it, mental health emergencies do occur with great regularity, and physicians may be routinely confronted with the prob-

lematic scenarios discussed by Swanson *et al.*¹ Each of these scenarios carries the imprint of larger systemic failure in mental health care. While the realities of crisis care may oblige physicians to take some immediate action—honoring advance directives, superseding them, or finding some middle ground—failing to attend to the broader factors bringing about these dilemmas simply replicates the short-sightedness that is a hallmark of today's faltering mental health system. In short, the challenge is whether physicians react to PADs in ways that perpetuate the problem or become part of the solution.

Brock's³ first two criteria are closely intertwined, relating to the physician's doubts that instructions expressed through an individual's PAD accurately reflect that individual's wishes, either at the time the PAD was executed or (per Brock's second criterion) in light of major subsequent changes in the individual's personal identity. Despite the reality that these preferences may have been informed by an individual's past experiences in mental health crises, as Swanson *et al.*¹ explain, a physician may feel challenged when an individual with a refractory crisis who has not actually experienced a particular therapy refuses this intervention via a PAD. They envision the physician second-guessing the PAD by asking, "Would this person really have wanted to forego the best—and perhaps only—remaining effective treatment option?" In this scenario, a more central clinical question that acknowledges the mental health system's responsibility to its consumers may be: "Why don't I know whether this individual, who has a history of mental health crises, would want to forego the best, and perhaps only, effective treatment option?"

The short answer is that, notwithstanding reams of treatment notes and other clinical records, the mental health system often knows very little about the individuals it serves, even its long-standing consumers. Clinical relationships in public mental health, both in hospital and community contexts, tend to be quite transient. Even on the diagnostic level, labels commonly flip-flop among various major mental illnesses. What passes for "therapy" in the public system is frequently little more than a discussion of medication compliance and a review of clinical symptoms. While there is a push to adopt more person-centered approaches,^{6,7} for these approaches to take hold meaningfully in practice will require both a culture change and an allocation of resources sufficient to support something more than superfi-

cial contact between consumer and provider. As it stands, unless the individual has designated a spokesperson via the PAD, the physician may have a difficult time turning to professionals who routinely serve the individual to discern what the individual would actually prefer and who that person is. Of course, any determination of a PAD's validity, given significant changes in an individual's identity, presupposes an understanding of who the person is in the first place and what factors guide that individual's decision-making.

The likelihood that PADs may not explicitly address foreseeable emergency situations in many ways speaks to the reactive stance of public mental health services and their inattentiveness to consumers' best interests.⁸ One would expect that between crisis points mental health providers have discussed the benefits of completing advance directives with the individuals they serve and that many consumers with PADs have made them known to providers. Recognizing that the whole intent of an advance directive is to be proactive, these providers should feel some responsibility to review various eventualities with the individual and encourage documentation of personal preferences in ways that will increase the likelihood that PADs will be understood and honored. To the extent that these interactions do not routinely occur, the stage is set for the scenarios presented by Swanson *et al.*¹

The third scenario contemplates that individuals' PADs may be superseded in recognition of "other interests," broadly encompassing everything from physician liability to the well-being of the family and the needs of society. When public safety is the primary "other interest," there is a long-standing, if still contentious, discourse about the interface between mental health and the legal system and individual rights that may inform physicians' thinking. As a practical matter, Swanson *et al.*¹ note that civil commitment may trump instructions contained in an individual's PAD when the dominant presenting issue is physical safety. The authors also note some less discussed "other interests" that may rationalize overrides of individuals' directives, including the expenditure of limited resources and prudent management of taxpayer dollars. Referencing the *Hargrave* decision,⁹ Swanson *et al.*¹ point to the extreme situation of an individual whose PAD refuses all psychiatric medications, thereby protracting hospitalization. They predict limited tolerance for directives that may incur new costs, including the expense of inpatient

care that becomes essentially custodial as a result of individual preferences.

The larger view, of course, is that mental health and related systems are hardly models of efficiency in their encounters with people likely to have PADs. Beyond the human impact of these outcomes, cyclical hospitalizations, incarceration, and even the needless dependency bred by a lack of rehabilitative services for people with serious mental illnesses all entail substantial waste of taxpayer resources across many public systems. In some instances, outmoded state psychiatric hospitals have remained open not out of clinical need, but because they are large employers and political pressure works to avert their closure.¹⁰ Against this backdrop, cost arguments invoked with regard to honoring PADs make a statement about the priority afforded consumer choice as compared with sometimes highly questionable "other interests."

In many respects, the system's record of disregard for individual preferences, sometimes manifest as outright coercion, has helped to perpetuate the dysfunction noted by the New Freedom Commission. Far before PADs appeared on the horizon, perceptions that the system was hostile to personal choice fomented a strong reaction among mental health consumers seeking to assert self-determination.^{11,12} While reflecting diverse viewpoints and aspirations, mental health consumerism has reacted to disempowering tactics in ways that are sometimes blatantly hostile to psychiatry itself.¹³ Given that a sense of control over one's life has long been conceptualized as a core aspect of psychological health, it might be expected that the mental health system would be jarred by such assertions.¹¹ But reverting to its incongruous defaults, the mental health establishment has generally avoided self-critical reflection on its failure to engage the people it is charged with assisting.⁷ Rather, it has been prone to create new pejorative labels for these consumers, such as "hard to serve," "non-compliant," or "lacking in insight."

What is unknown at this point and has potentially significant implications for societal interests, economic and humanitarian, is whether the experience of having one's PAD honored during a mental health crisis may ultimately foster trust and engagement. An *amicus* brief filed in *Hargrave* by 18 former state mental health commissioners and many disability organizations suggested just that, pointing to the ways PADs can promote therapeutic alliances between

consumers and their physicians.¹⁴ Ultimately, positive experiences with PADs may show important clinical and economic benefits that mitigate a broad array of “other interest” concerns.

Yet, the inconvenient truth is that dynamics ubiquitous in the larger mental health system, inadequate or misused resources, short-sightedness, systematized neglect, expedient reliance on coercion, and low expectations of both consumers’ and providers’ capabilities conspire against advance directives’ showing their worth in public mental health. In many ways, the system is predisposed to assume that good, scientifically grounded practice is somehow in conflict with individual rights, including the right to personal decision-making.⁷ From the consumer perspective, past experience with the mental health system may, on the one hand, highlight the critical importance of PADs and, on the other hand, recognizing the system’s inclinations, give reason to view PADs warily. Certainly, a track record of PADs’ being routinely superseded will only reinforce consumers’ attitudes that the very system purporting to help them robs individuals of dignity and a sense of control over their own lives. And that would be very sad.

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