

Advance Care Planning as a Process: Structuring the Discussions in Practice

Linda L. Emanuel, MD, PhD,* Marion Danis, MD,† Robert A. Pearlman, MD, MPH,‡ and Peter A. Singer, MD, MPH§

Advance directives for health care in anticipation of incompetence have received a major impetus for wide scale implementation.¹⁻⁷ However, advance directives are already understood to have risks as well as benefits.⁸⁻¹³ The great difficulty of anticipating, articulating, and then communicating wishes for care in case of incompetence makes the likelihood that any person can accurately convey their wishes to another person uncertain. The tasks of the proxy decision-maker and health care team members in the event of a patient's incompetence are complex and subtle; for example, it is necessary to be able to apply distinctions between substituted judgment and best interests standards¹⁴ or probabilistic interpretations of prognosis.¹⁵ Thus, it cannot be assumed that a patient's wishes will be applied to their circumstances correctly. In many cases, these difficulties come together under trying emotional circumstances, and managing the task without interpersonal conflict, and even litigation, requires skill. Indeed recent evidence confirms the importance of these "talking" skills.¹⁶⁻¹⁸ Nevertheless, health care providers must help patients with advance directives in these suboptimal circumstances, although there is relatively little empirical research information to guide them.

We convened as a group of practicing clinician ethicists. We offer a practically oriented set of core steps and skills, based on our clinical experience and on research, which is intended primarily to help clinicians and teachers in medicine, but it is also a set of defined interventions that may provide a validatable model for research and a guide for health care administrators and others. We describe advance care planning as a *process* of developing a valid expression of wishes rather than a single consultation event or the signing of a statutory document. The approach is analogous to in-

formed consent when the task is completed as an informative decision-making process that is part of a continuing physician-patient interaction rather than the mere signing of a consent form.¹⁹ Everyday office medical practice provides many opportunities for completing the process over time; patients with chronic disablement make several visits a year, and even healthy adults come for their yearly check-up with stories of illness or death in their family. Part of a good physician-patient relationship, the process may help reduce the risks and augment the benefits of advance planning.^{20,21}

A PROCESS OF ADVANCE PLANNING

We identify five steps in an idealized process of advance care planning: (1) raising the topic and giving information; (2) facilitating a structured discussion; (3) completing a statement and recording it; (4) periodically reviewing and updating the directives; and (5) bringing prior wishes to bear on actual decisions (Table 1). Each of the steps requires skills and entails practical considerations.

1. Raising the Topic and Giving Information

Raising the topic may be half the battle for the physician. A model opening might be as follows:

"Ms/r. X, I want to talk with you about planning for future health care. Many now recommend that people make plans to direct their care in case of future severe illness, and that doctors discuss these issues routinely with patients. There is even a federal law whose purpose is to let people know that advance planning is available to them. We should go through these issues together. It is part of helping to ensure that you are cared for the way you would want to be, even in times of life threatening illness when communication may be impossible. There is nothing bad about your health that we have not already discussed; planning for the future simply is prudent for all people."

It is helpful to be able to add here:

"I myself have done this with my own physician as a routine matter. Is this something you have explored before?"

The salient skill at this first step is introducing a potentially taboo topic in a supportive and sensible fashion and allowing the patient to convey his or her level of knowledge and personal approach to it. In many cases, professionals will be able to reassure the patient that advance planning is part of routine care and not a reflection of the patient's prognosis; the patient's frame of mind should be unaffected. For sick patients, emphasis should be placed on the point that such planning is intended not as an abandonment but as an affir-

From the *Harvard Medical School; †University of North Carolina at Chapel Hill; ‡University of Washington and the Geriatric Research Education and Clinical Center & HSR&D, Seattle Veterans Administration Medical Center and Harvard University; and §University of Toronto.

Linda Emanuel was an American College of Physicians Teaching and Research Scholar at the time of writing and is supported in part by the DeCamp Foundation. Marion Danis is supported by grants from the Agency for Health Care Policy and Research and the Department of Medicine of the University of North Carolina at Chapel Hill. Robert Pearlman was supported in part by the Program in Ethics and the Professions, Harvard University. Peter Singer holds a Medical Scholarship from the Canadian Life and Health Insurance Association and a George Morris Piersol Teaching and Research Scholarship from the American College of Physicians. Views expressed in this paper are those of the authors and do not reflect the views of any of the above institutions.

Address correspondence to Linda L. Emanuel, MD, PhD, Harvard Medical School, Division of Medical Ethics, 641 Huntington Ave., Boston, MA 02115.

Table 1. Components of Advance Care Planning

Step	Ideal Guiding Professional	Skills	Actions
1. Introducing the topic and giving information.	Primary physician or other.	Raising a difficult topic; teaching.	Physician—patient encounter; brochures, videos etc.; community organizations.
2. Facilitating the discussion.	Primary physician indispensable; supplementary role possible for others.	Supportive elicitation of wishes; tailoring the modality of planning to the individual.	Proxy should attend; use a worksheet; pencil a draft directive; allow time for reflection and discussion with others.
3. Completing directives and recording the statement.	Primary physician indispensable; supplementary role possible for others.	Judging patient readiness to make decisions.	Test patient resolution with clinical examples. Have copies of directive given to proxy, and others; record in chart.
4. Reviewing and up-dating directives.	Primary physician or other. Physician must see any changes.	Ascertainment of patient's altered wishes and judging patient readiness.	See change of wishes as indicator of possible need for counsel or information.
5. Applying directives to actual circumstances.	Primary physician acting in concert with proxy.	Interpreting directives to fit circumstances; interpersonal communicating; facilitating team work.	Avoid rigidly applying wishes to unpredicted circumstances; interpret statements; attempt substituted judgement.

mation of an enduring therapeutic alliance. Physicians should be aware of their own fears and emotional responses to the topic and be able to judge when and how such responses should be excluded from the professional relationship. More generally applicable skills in doctor-patient communication are discussed in the literature.²²⁻²⁴

There is a substantial amount of basic information needed by lay persons, ranging from knowledge of what advance care planning means to understanding what kind of questions are relevant, before they can be expected to engage in advance planning in a meaningful way. Much information can be conveyed in brochures or videos.²⁵⁻²⁷ Inpatient facilities may have their administrative personnel provide materials to patients on admission as part of the larger information package patients usually receive. Hospitals may have videos on the topic included in their in-house television channels. While information can be acquired through these media without the help of a professional, there is potential for misunderstanding, and we suggest there should be (and materials should make this clear) a clinician available, along with others such as a pastor or social worker, to assist persons who have questions or concerns. One ideal model is to have the physician raise the topic and refer the patient to the information sources, providing a subsequent conversation after the patient has reviewed the materials. The introduction may conclude:

"Here is an information brochure with examples of standard forms people use. We'll talk about it in more depth next time we meet. If you think of questions, write them down and bring them in. Bring anyone with you who you think should hear the discussion"

2. Facilitating a Structured Discussion

The structured discussion should be aimed at framing the issues, and tentatively identifying wishes. It need not aim to

resolve all issues or come to final determination of all prior wishes. Neither should it aim to be a deep personal revelation seeking perfect knowledge of the patient's core self; this is unrealistic and unnecessary. Nevertheless, this step is the core of all advance planning processes.

The skills required of the professional for this stage are those of communicating pertinent medical understanding and of supportive elicitation of the patient's wishes, as in most ideal informed consent discussions. Specific training sessions may be needed to acquire the information, skills, and judgment involved in this critical part of the process of advance planning because, unlike most medical decisions, in this case patients' preferences are cast forward into future scenarios.²⁷⁻²⁹

Initial Decisions About the Mode of Advance Planning

An early part of the discussion may focus on whether proxy designation, instructional directives, or both are most suitable for the particular patient. Most patients should be advised to combine the two forms of planning so that the proxy may be guided by the patient's stated prior wishes.²⁸ Thus, the conversation might continue as follows:

"Ms/r. X, I suggest we start by considering a few examples as a way of getting to know your thinking. I will use examples that I use for everyone."

If, in the physician's judgment, a particular patient proves not competent to make prior directives, he or she might nevertheless be competent to designate a proxy decision-maker. In such a case the conversation might go rather differently. For example, the physician might proceed as follows:

"These decisions may be hard to think about when they are not even relevant right now. You have had a long and trusting relationship with Ms/r. Y. You might even have had

discussions like this before with her/him. Would you want to give Ms/t. Y, or someone else you trust, the authority to make decisions for you in case of need?"

Understanding the Patient's Goals for Treatment in a Range of Scenarios

When instructional directives are suitable, we believe that the physician should help the patient articulate abstract values, goals of treatment, and concrete examples of treatment preferences in order to provide all the major components of decision-making.²⁹ Discussions can be well structured by going through an illustrative predrafted document together; this approach can prevent long confusing and overwhelming encounters. With such structuring, this portion of advance planning can be informative, accessible to patients with a wide range of educational levels, and still quite brief.³⁰ Many documents that can be used for structuring discussions are available; however, a properly validated document should be chosen to maximize the chance that patients are accurately representing their wishes.^{28,31-35}

Scenarios representative of the range of prognosis and of the range of disability usually encountered in circumstances of incompetence should be presented to the patient. The physician might start like this:

"So, lets try to imagine several circumstances. We will go through four and then perhaps another one or two. First imagine you were in a coma with no awareness. Assume there was a chance that you might wake up and be yourself again, but it wasn't likely. Some people would want us to withdraw treatment and let them die, others would want us to attempt everything possible, and yet others would want us to try to restore health but stop treatment and allow death if it was not working. What do you think you would want?"

After a standard set of scenarios, tailored scenarios can be considered. When a patient has a serious diagnosis with a predictable outcome involving incompetence that is not covered in the standard document, the physician might continue:

"We should also consider the situations that your particular illness can cause; that way you can be sure we will do what you want. For sure, all people are different and you may never face these circumstances. Nevertheless, let's imagine . . ."

While illness scenarios may be difficult for people to imagine,³⁶ we suggest that preferences arrived at without illness scenarios are unlikely to be accurate or realistic wishes; a treatment preference without a specified illness circumstance is meaningless.

A patient considering illness scenarios also may be able to articulate which states, if any, are greatly feared and/or are felt to be *worse than death* for them.³⁷ So, for example, the physician may go on:

"People often think about circumstances they have seen someone in or heard about in the news. Some may seem worse than death. Do you have such concerns?"

When a range of scenarios have been considered it is often possible to go back and identify the scenario(s) in which the patient's goals changed from "treat" to "don't treat." This can provide a useful personal threshold to guide the physician and proxy later. The physician may also use it to check back at the time with the patient that his or her wishes are properly reflected, saying, for example:

"Well, we've gone through several scenarios now. It seems to me that you feel particularly strongly about . . ."

Indeed, you move from wanting intervention to wanting to be allowed to die in peace at the point when . . . Do I speak for you correctly if I say that your personal threshold for deciding to let go is . . . ?"

Raising Specific Examples and Asking About General Values

In any scenario after the patient's response about goals, specific examples may be used:

"So, let us take an example to be sure I understand you, not only in general but also in specific. Say you were in coma with a very small chance of recovery, and you had pneumonia; to cure the pneumonia we would have to put you on a breathing machine. Would you want us to use the breathing machine and try to cure; allow the pneumonia to cause death; or perhaps try the treatment, withdrawing the breathing machine if you did not get better?"

Checking and specifying a patient's views by providing concrete examples may be a useful way to reduce the incidence of clinically unrealistic choices by patients. So, for example, a patient who declines intubation but wants resuscitation may need more information on resuscitation and a suggestion as to how his or her wishes may be translated into a clinically reasonable decision.

The preceding discussion about goals for treatment and specific choices may be usefully combined with an open ended question about the patient's reasons for particular decisions and the *values* that pertain to such decisions.

"I think you have given a good picture of particular decisions you would want. Can you also say something about the values or beliefs that you hold? Understanding your more general views can be an important part of getting specific decisions right."

Patients' statements might refer to their wish to act in accord with the positions of their religious denomination, or to their views on the sanctity of life or dignity of death, or they might articulate their disposition to take a chance or to favor a secure choice.

Including the Proxy

The proxy, if already known at this point, should be encouraged to attend this discussion. Much understanding of the patient's wishes can be gained from hearing this part of the process. The clinician can guide the proxy to adopt a listening role; the proxy may ask clarifying questions but should avoid biasing the patient's expressions. Sometimes the proxy can be following the conversation with a predrafted document in hand, noting down the patient's statements. The ground can be set for future discussions between any of the patient, physician, and proxy. The proxy becomes part of the working team, and future interactions between proxy and physician, if the patient does become incompetent, are likely to go more smoothly than they might without such prior discussions.

At this stage, the advance directive should be, at most, pencilled in. The tentative draft can be taken home by the patient for further reflection and review with other involved parties, such as the proxy, family, friends, or pastor. This step can be a useful mechanism for dealing with difference among the parties ahead of time. The structured discussion should be brief and followed by a subsequent meeting when a directive may be finalized. Physicians will initially take longer in these

interviews, but with training in the requisite skills and with experience, time will be reduced.

3. Completing an Advisory Directive and Recording It

The conversation might be resumed at the next step as follows:

"Ms/r. X, have you and Ms/r. Y had a chance to continue the discussion we started 2 weeks ago? I see you have a completed statement now. Let's review your preferences."

The professional's main required skill here is to ascertain whether the patient has reached resolution and is ready to articulate well considered preferences. Any facet of the first two steps not yet complete should be completed at this step. Even if a patient has reached resolution, there should be a reminder that advance directives can be revised if his/her wishes are changed. If the proxy has not been present at previous stages, the physician should particularly encourage the proxy to enter the process at this point. The proxy should again be encouraged to adopt a listening and clarifying role, avoiding undue influence on the patient. It can be helpful for the physician to co-sign the document at this stage to endorse physician involvement and to document the primary physician for ease of future follow up.³⁸

4. Reviewing and Up-Dating Directives

Along with other regular check-ups and screening tests, patients should be told to expect periodic review of their directives. The clinician may re-introduce the topic.

"Ms/r. X, a year has gone by since we completed your advance care plans, and in that time a lot has happened. People do sometimes change their wishes so lets review the wishes you wrote down a year ago."

Competent people are often known to change their minds about all matters, whether they are of great import or not. Reasonable but imperfect consistency has also been found in advance planning decisions by competent individuals.^{36,39,40} Physicians should be aware of this and should review directives with the patient periodically.⁴⁰ Physicians should check which decisions a patient maintains and which are changed. Changed positions should prompt the physician to pay particular attention to the source of change; some changes will be well reasoned, and others will be markers for misunderstandings that need to be clarified. Some people will be generally changeable; the physician should address this observation to the patient, inquiring after the reason. If supportive guidance and education do not permit the patient to reach reasonable stability in his or her advance directives, more emphasis must be placed on proxy decision-making for the patient. The physician will often be able to come to this decision jointly with the patient and proxy:

"Your choices changed on several decisions both times when we reviewed your statement, even though we have discussed the issues a lot. You have already said that you want Ms/r Y to be your proxy. Would you prefer to give these decisions over to Ms/r Y to decide according to what she/he thinks would be in your best interests?"

Some changed decisions may occur after the onset of incompetence. There is continuing debate on how to deal with such circumstances.⁴¹ The physician should be careful to evaluate the exact nature of the patient's incompetence; some patients will be globally incompetent while others will be competent to make some decisions and incompetent for other

decisions. The role of the proxy and possibly a further adjudicating party may be crucial in such circumstances.

The skills that physicians require for this portion of advance planning are not as yet matched by detailed understanding of how patients might make or can be encouraged to make valid and enduring decisions, or of the type of circumstances that tend to prompt changes. It is reasonable to expect that researchers will continue to study how best to elicit patient's enduring and valid wishes.

5. Application of Prior Directives to Actual Circumstances

Clinicians will require both interpersonal and interpretive skills in this difficult final step. Patients will often end up in need of decisions that are not accurately specified in their advance directive. The physicians and proxy, then, must work from the information they have to make a good guess as to what the patient would have wanted. Knowledge of the patient's values, goals, choices in a range of scenarios, and thresholds for withholding or withdrawing specific intervention can all be helpful. Choices in scenarios can often provide very accurate predictors.⁴²

The spirit as much as the letter of the directive should be the focus of the physician and the proxy.⁴³ Documents that are given as an advisory statement rather than a legal imperative are less likely to lead to blind application of irrelevant decisions. So, for example, if a patient has a poorly drafted document stating only that he or she does not want to be on a respirator, the physicians should try to clarify what circumstances this preference applies to; the patient may have intended the statement to apply to circumstances of hopeless prognosis, but may actually be facing a reversible life threatening illness. The physicians and proxy would need to "override" the simple statement in order to honor the true wishes of the patient in such a case; they would be interpreting simple statements to match presumed true wishes, not trumping the patient's wishes.⁴⁴ The full responsibility of this interpretive process and the risks of misusing it in parentalistic judgments should be clear to the physician and proxy.¹⁹

When the physician writes orders for the incompetent patient's care they should be as detailed as the advance directive permits. Thus a "Do Not Resuscitate" order can usually be supplemented with orders such as "evaluate and treat infection," "do not intubate," "provide full comfort care," and so forth. They can be gathered together in a series of orders altogether intended to translate the directive into doctors orders. Life threatening illness often prompts a change in health care facility or attending physician and will, therefore, entail transfer of advance directives from the physician who has guided the process to a new physician.^{9,45} At a minimum, physicians, patients, proxies, and institutions should all be aware of the need to transfer advance care documents with the patient to the new facility and physician. However, transmittal of accurate portrayals of a patient's wishes will rarely be adequately completed by simply passing on a document; whenever possible, the earlier physician should remain available as a key resource as the patient's prior wishes are brought to bear on specific decisions. It is likely that the physician and proxy who have undertaken the entire process of advance planning with the patient will have a more accurate sense of the patient's actual wishes than those who were simply presented with a document after patient incompetence has already occurred. Those who attempt substituted judgments in the absence of specific patient

guidance are known to have discrepancies in their decisions compared with the wishes of the patient, and it is reasonable to assume that explicit communication on the matter should reduce the gap.⁴⁶

Decision-making, especially when there is a proxy involved, is a collaborative matter. The physician and the proxy have distinct roles that should be understood. The physician's role is to diagnose the condition and convey information, opinions, and judgment, and then to discuss them with the proxy, as would ordinarily occur with the patient. The proxy's role is to attempt substituted judgments and speak for the patient wherever possible, or to make best interest judgments as a second best approach if there is no way of surmising what the patient would have wanted. Unless the patient or the local state statutes say otherwise, the proxy should take on the "voice" of the patient and assume equal levels of authority—not more or less—that would have been the patient's.

FURTHER CONCERNS

Are Advance Directives for Everyone?

Time constraints and other practical considerations may lead physicians to target their sicker and older patients. However, younger and healthier patients are often quite interested in the approach.³⁰ Furthermore, advance planning for those who suffer an accident or sudden illness may be most helpful. Advance planning may be considered as a branch of preventive medicine.

There will be a proportion of patients who should not be advised to undertake advance care planning. For example, there are people with no one they wish to choose as a proxy who also have limited ability to imagine future hypothetical situations. Others might find the notion so dissonant with the type of care relationship they want that they do not wish to consider the process. This latter group of patients should still have sufficient discussion to permit understanding of how decisions get made in the absence of directives. For example, the different powers of proxy and next of kin should be clear, as should the occasional role of a guardian ad litem, and the limited ability of substituted decisions to match the patient's prior wishes in the absence of guidance from the patient. Neither physician nor patient should allow themselves the assumption that this is a topic they need not even raise. If the patient and physician are explicitly content with the hitherto more traditional approaches to decision-making at the end of life, this is acceptable.

A considerable proportion of people have no primary care physician or health professional, and the only educational materials that reach them will be through the public media. Some of these people are able to have a physician; they should seek out a physician for the purposes of advance planning if they wish to undertake it. They should be aware that many directives are highly dependent on medical knowledge and understanding of the individual patient's medical circumstances; decisions made in the absence of medical expertise may be inaccurate reflections of the person's true preferences.

People who face limited access to the health care system should not be discouraged from advance care planning if they are inclined toward it. However, people who complete directives without talking to a physician should be encouraged to discuss their views in as much depth as possible with their

next-of-kin or proxy so that ultimately someone will be able to discuss with a physician how the patient's known prior wishes relate to actual circumstances and treatment decisions. Publicly provided information or work sheets to guide persons and their proxy in such discussions can be helpful.³

When and Where Should Advance Directives Be Discussed?

Advance care planning should ideally be initiated in the outpatient setting, where such discussions are known to be well received.^{30,47-50} Then, when the topic is raised on admission to the hospital, as required by the Patient Self Determination Act, it is likely to be less threatening.^{18,51} Inquiry can be continued to an inpatient discussion in selected cases. For example, it is appropriate with patients who are at risk of needing life-sustaining intervention soon, and discussions in this setting can be well conducted, providing guidance and welcome coordination of goals and expectations for all concerned. Although judgment of need for such intervention is known to be difficult, physicians may be guided in part by published criteria.⁵² For those with a completed directive, review during an admission may also be advisable. Other patients with a good prognosis who want to complete directives should first be advised of the merits of deferring the process to an outpatient setting. While there is little data on the question, we fear that those patients who complete directives for the first time in the hospital setting risk making more unstable decisions because of the emotional turbulence of the moment. For those who do complete a directive for the first time during hospital admission, review of the directives after health has stabilized may be particularly important.

Time Constraints

No step in the process of advance care planning needs to take longer than standard doctor-patient encounters.³⁰ Furthermore, advance care planning probably reduces difficult and time-consuming decisions made in the absence of such planning and should, therefore, be understood as a wise investment of time.⁴⁴ Like any other clinical process, skill and experience will make the planning process more time-efficient.

What is the Role for Nonphysician Healthcare Professionals?

Decision-making for incompetent patients has always been among the central tasks of the physician. We regard the facilitation of a structured discussion as the central step in the process of advance planning and, therefore, as particularly dependent on physician involvement. Nevertheless, time constraints and the different communication styles of physicians will make it inevitable that some, and perhaps many, physicians will not include all the steps of advance planning in the routine activities that are the core of good doctoring. Thus, there is likely to be a need for other healthcare professionals to engage in the process of advance planning. Some facilities may form interdisciplinary resource groups or consult services that will be available to physicians or patients who seek extra help. Other facilities may train nursing staff in advance planning. Social workers may have a role in facilitating communication around these difficult concepts. However, we view it as essential that the physician, who must ultimately take responsibility for life-sustaining treatment decisions, communicate with the patient at some point and at least

check with the patient for possible misunderstandings, unrealistic expectations, or wishes for treatment that the physician would find contrary to standards of medical practice or contrary to his or her conscience. Omission of this step risks discovery of advance directives which have internal inconsistencies or other major problems when it is too late to correct the problem. If the physician cannot participate in this step of advance planning, then another appropriate point may be at the next step of completing a signed advisory statement.

Helping Proxies Understand Their Role

The proxy will need to distinguish his or her emotional and personal motives from concerns appropriate to their role as a proxy. Some will have emotional connections with the patient or personal views of their own that will drive them toward more aggressive intervention; others may have monetary or other concerns which may cause a conflict of interest and motivate them toward less aggressive intervention than the patient would have wanted. The physician should be sensitive to these and related possibilities and be able to help the proxy disentangle and understand the relevant motivations, both during the planning process and when making actual decisions. Complex or destructive cases may require further professional counseling and support. Together, the physician and proxy should deliberate the various therapeutic options available. The goal is to avoid any need for one party to assert authority over the other and to achieve consensus instead.

Risks of Placing the Advance Directive in the Patient's Chart

Concerns have arisen about how to record the statement in such a fashion that it is least likely to result in inappropriate care and most likely to be available when it becomes relevant. Advance directives placed in hospital records may run the same risk as "Do Not Resuscitate" orders, which are known to sometimes result in inappropriate cessation of other therapies.^{45,53,54} Education of health professionals on the matter is clearly necessary. Detailed doctors orders can help too. In addition, sections in the medical records for advance directives may be prominently stamped with a statement to the effect that prior directives are (1) intended as an extension of patient autonomy beyond *wishlessness*, (2) may be for the purposes of requesting as well as declining treatment, and (3) have no relevance to care before incompetence.

Copies of the advisory statement and statutory document are best kept not only by the physician but also the proxy and any other person likely to be in early contact in the event of changed medical circumstances. The physician's copy should be recorded as part of the patient's medical records.

Dealing with Legal Concerns

Advance planning statements with physicians should be considered as advisory statements rather than adversarial challenges. (We use the term "advisory statement" in order to distinguish planning devices from narrower statutory documents, which have different legal purposes.⁵⁵) Physicians should make it clear to patients that the advisory statement is the area where medical counsel is most relevant and that the advisory statement is one of the best means of expressing their wishes. An advisory statement can be considered a portrait of a patient's wishes, a profile that should be inter-

preted to fit with whatever circumstances ultimately pertain. Such a statement can be interpreted with the flexibility needed to meet the complexities of medical decision-making and uncertainties of human decision-making.

Clinicians should be reassured that it has been well argued that such advisory statements will be honored under Common, Statutory, or Constitutional Law, even if they are not part of a statutory document.⁵⁶⁻⁶¹ We nevertheless urge health care professionals to be less concerned with legal issues and more concerned with the medical task of translating a patient's deepest wishes into sound medical decisions. Usually, an advisory statement does not need to raise legal issues because its primary purpose is to provide a valid description of the patient's wishes. However, points of legal concern, such as whether living will and proxy statutes in other states are significantly different, may require legal expertise; in such a case the physician should avoid offering unauthorized legal advice and refer to a lawyer.

Physicians may encourage simultaneous use of statutory documents, i.e., predrafted statements designed for specific state statutes, because this is what gives physicians most legal immunity from prosecution when the physician carries out the patient's or proxy's directions. Some statutory documents may contain an advisory section. If not, the advisory and statutory documents may be combined or filed together.

CONCLUSION

The basic notion of extending patient autonomy beyond decision-making incapacity is easy to endorse. It is, however, a difficult concept to actualize. We have offered a schematic concept of advance planning as a five-step process in the hope of providing a useful model for practitioners, for teachers and medical students, and for researchers and institutional policy-makers on advance directives. It is hoped that physicians and other health care professionals will be able to minimize risks and maximize benefits by implementing such a concept of process in advance care planning.

ACKNOWLEDGMENTS

We are indebted to Susan Wolf, JD, Ezekiel Emanuel, and Lynn Peterson, MD, for useful comments on the manuscript. Michael Barry first raised the idea to Linda Emanuel of patient-specific scenarios in directives. Linda Emanuel is indebted to John Stoeckle for all she has learned from him about dialogue between doctor and patient.

REFERENCES

1. Society for the Right to Die. Refusal of treatment legislation: A state by state compilation of enacted and model statutes. New York: Society for the Right to Die, 1991, with update.
2. Omnibus Budget Reconciliation Act of 1990. Pub. L. No. 101-508 4206 4751 (codified in scattered sections of 42 USC, especially 1395cc 1396a (West Supp 1991)).
3. Knox RA. Poll: Americans favor mercy killing. *Boston Globe*; November 3, 1991, p 22.
4. Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association. Chicago: AMA 1989; Opinions 2.20, 2.21.
5. Orentlicher D. Advance medical directives. *JAMA* 1990;263:2365-2367.
6. American Academy of Neurology. Resolution on legislation regarding durable power of attorney for health care. Minneapolis: American Academy of Neurology, 1989.
7. Joint Commission on Accreditation of Health Care Organizations. Accreditation Manual for Hospitals. Oak Brook Terrace, IL, 1992, p 104 R1.1.1.3.2.1.
8. Uhlmann RF, Pearlman RA, Cain KC. Physicians' and spouses' predictions of elderly patients' resuscitation preferences. *J Gerontol* 1988;43:M115-121.

9. Danis M, Southerland LJ, Garrett JM et al. A prospective study of advance directives for life-sustaining care. *N Engl J Med* 1991;324:882-888.
10. Eisendrath SJ, Jonsen AR. The living will: Help or hindrance? *JAMA* 1983;249:2054-2058.
11. Molloy DW, Clarnette RM, Braun EA et al. Decision making in the incompetent elderly; "The Daughter from California Syndrome." *J Am Geriatr Soc* 1991;39:396-399.
12. Wolf SM et al. Special report: Sources of concern about the patient self-determination act. *N Engl J Med* 1991;325:23:1666-1671.
13. LaPuma J, Orentlicher D, Moss RJ. Advance directives on admission: clinical implications and analysis of the patient self-determination act. *JAMA* 1991;266:402.
14. Deciding to forego life sustaining treatment. Washington DC: President's commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983.
15. Knaus WA, Wagner DP, Lynn J. Short-term mortality predictions for critically ill hospitalized adults: Science and ethics. *Science* 1991;254:389-394.
16. Markson LJ, Fanale J, Steel K et al. Implementing Advance directives in the primary care setting. *Arch Intern Med* 1994;154:2321-2327.
17. Morrison RS, Morrison EW, Glickman DF. Physician reluctance to discuss advance directives: An empiric investigation of potential barriers. *Arch Intern Med* 1994;154:2311-2318.
18. Reilly BM, Magnussen R, Ross J et al. Can we talk? Inpatient discussion about advance directives in a community hospital. *Arch Intern Med* 1994;154:2299-2308.
19. Appelbaum PS, Lidz CW, Meisel A. Informed consent. New York. OUP 1987.
20. Emanuel EJ, Emanuel LL. Four models of the physician patient relationship. *JAMA* 1992;267:2067-2071.
21. Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care* 1989;27:S110-127.
22. Levine MN, Gafni A, Markham B, MacFarlane D. A bedside decision instrument to elicit a patient's preference concerning adjuvant chemotherapy for breast cancer. *Ann Intern Med* 1992;117:53-58.
23. Adler IM, Ware JE Jr, Enelow AJ. Changes in medical interviewing style after instruction with two closed-circuit television techniques. *J Med Educ* 1970;45:21-28.
24. Greenfield S, Kaplan SH, Ware JE Jr. Patient participation in medical care: Effects on blood sugar and quality of life in diabetes. *J Gen Intern Med* 1988;3:448-457.
25. Hare J. Talking to your family doctor about difficult health care decisions. Oregon State University Extension Source. Oct. 1991.
26. Cate FH, Gill BA. The patient self-determination act: Implementation issues and opportunities. The Annenberg Washington Program in Communications Policy Studies of Northwestern University, 1991.
27. The Hastings Center Special Supplement. Practicing the PSDA: Selected resources in patient self-determination. 1991;21:S16.
28. Emanuel LL Emanuel EJ. The Medical Directive: A new comprehensive advance care document. *JAMA* 1989;261:3288-3293.
29. Richardson HS. Specifying norms as a way to resolve concrete ethical problems. *J Philos Public Affairs* 1990;19:279-310.
30. Emanuel LL, Barry MJ, Stoeckle JD, Emanuel EJ. Advance directives for medical care—a case for greater use. *N Engl J Med* 1991;324:889-895.
31. Emanuel L. The health care directive: Learning how to draft advance care documents. *J Am Geriatr Soc* 1991;39:1221-1228.
32. Schneiderman LJ, Kaplan RM, Pearlman RA et al. Relationship of general advance directive instructions to specific life-sustaining treatment preferences in patients with serious illness. *Arch Int Med* 1992;152:2114-2122.
33. Emanuel LL. Advance directives, do they work? *J Am Coll Cardiology* 1995;25:35-38.
34. Alpert HR, Emanuel LL, Hoijtink H. Psychometric Analysis of an Advance Directive. *Gerontologist* 1994;34, Special Issue 1:142.
35. Emanuel LL. Advance directives: Evaluating their moral and empirical validity. *Hastings Cent Rep* 1994;24:S27-29.
36. Everhart MA, Pearlman RA. Stability of patient preferences regarding life-sustaining treatments. *Chest* 1990;97:159-164.
37. Pearlman RA, Uhlmann RF, Patrick DL. States worse than death: A role for quality of life in advance care directives. Abstract. 44th Annual Scientific Meeting of the Gerontological Society of America, San Francisco, 1991.
38. Emanuel EJ, Emanuel LL, Orentlicher D. *JAMA* 1991;266:2563.
39. Silverstein MD, Stocking CB, Antel JP et al. Amyotrophic lateral sclerosis and life-sustaining therapy: Patient's desires for information, participation in decision making, and life-sustaining therapy. *Mayo Clin Proc* 1991;66:906-913.
40. Emanuel LL, Emanuel EJ, Stoeckle JD et al. Advance directives: Stability of patients' treatment choices. *Arch Intern Med* 1994;154:209-217.
41. Dresser RS. Advance directives, self-determination, and personal identity. In: Hackler C, Moseley R, Vawter DE, eds. *Advance Directives in Medicine*. New York: Praeger Publishers, 1989, pp 155-170.
42. Emanuel LL, Barry MJ, Stoeckle JD, Emanuel EJ. Advance directives: Extrapolation of unstated decisions. *Med Care* 1994;32:95-105.
43. Sehgal A, Galbraith A, Chesney M et al. How strictly do dialysis patients want their advance directives followed? *JAMA* 1992;267:59-63.
44. Brock D. Trumping advance directives. In: *Practicing the PSDA*. *Hastings Cent Rep*. 1991;219(suppl):S2-3.
45. Miles SH. Advance directives to limit treatment: The need for portability. *J Am Geriatr Soc* 1987;35:74-76.
46. Emanuel EJ, Emanuel LL. Proxy decision making: An ethical and empirical analysis. *JAMA* 1992;267:2221-2226.
47. Bedell SE, Delbanco TL. Choices about cardiopulmonary resuscitation in the hospital: When do physicians talk with patients? *N Engl J Med* 1984;310:1089-1093.
48. Shmerling RH, Bedell SE, Lilienfeld A, Delbanco TL. Discussing cardiopulmonary resuscitation: A study of elderly outpatients. *J Gen Intern Med* 1988;3:317-321.
49. Lo B, McLeod GA, Saika G. Patient attitudes to discussing life-sustaining treatment. *Arch Intern Med* 1986;146:1613-1615.
50. Molloy DW, Guyatt GH. A comprehensive health care directive in a home for the aged. *Can Med Assoc J* 1991;145:307-311.
51. Emanuel LL. Does the DNR order need life-sustaining intervention? Time for comprehensive advance directives. *Am J Med* 1989;86:87-90.
52. Murphy D, Knaus WA, Lynn J. Study population in SUPPORT: Patients (as defined by disease categories and mortality projections), surrogates, and physicians. *J Clin Epidemiol* 1990;43:11-28S.
53. Advance Directives Seminar Group. Advance directives: Are they an advance? *Can Med Assoc J* 1992;146:127-134.
54. Alemayeh E, Molloy DW, Guyatt GH et al. Variability in physicians' decisions on caring for chronically ill elderly patients: An international study. *Can Med Assoc J* 1991;144:1133-1138.
55. Annas GJ. The health care proxy and the living will. *N Engl J Med* 1991;324:889-895.
56. Wolf S. Honoring broader directives. In: *Practicing the PSDA*. *Hastings Cent Rep* 1991;21:58.
57. Emanuel EJ. A review of the ethical and legal aspects of terminating medical care. *Am J Med* 1988;84:291-301.
58. *In re Peter* 108 NJ 365 (1987).
59. *In re Spring* 399 NE2d 493 (1979).
60. *In re O'Connor*, No312 (NY Court of Appeals, October 14, 1988).
61. *Cruzan v Director, Missouri Department of Health*, 110 S. Ct.2841 (1990).