**Advance Directives: Psychiatric Issues**

**William H. Reid, MD, MPH**

**First**, much of this issue is about legality, and it must be understood that a health care attorney is a better resource than I for legal questions. I don’t give legal advice. (There are health care lawyers who will happily give a talk or class to trainees about such topics, perhaps a hospital’s own attorney; they have considerable training and experience with advance directives, though sometimes not with psychiatric ones or mental patients.)

**Second**, advance directives are not limited to terminal decisions or care. Many patients, for example, have advance directives regarding psychiatric treatments such as ECT.

**Third**, an advance directive is not the same as a health care power of attorney or other substitute decision document unless that is the advance directive’s purpose (the two are usually quite separate). In fact, they are kind of opposites: An advance directive expresses the patient’s instructions, while a power of attorney (or similar document) allows someone else to give the instructions.

**Fourth**, the purpose of an advance directive is to allow a competent person to make decisions about what should happen to that person if he/she becomes incapacitated/incompetent relative to that decision. That means that the person must be sufficiently competent relative to the topic when the directive is properly created (“executed”) and must lack capacity/competency relative to the topic when the directive is invoked. In addition, since advance directives are a form of consent (usually a negative form, such as a refusal of care), four issues immediately arise:

     (a) All of the elements of consent must be present (knowledge, competency to use that knowledge, and freedom from coercion—voluntariness) when the directive is executed/signed.

     (b) The threshold for competency to refuse care is usually high, since absence of care may well have permanent and/or life threatening consequences.

     (c) The threshold for competency to accept care (such as lifesaving care or ECT) is often very low, especially if accepting care would delay death or prevent other serious consequences. (See below.)

     (d) The patient (and only the patient, except for a judge) can reverse the advance directive at any time. In theory, the patient should be competent to make a reversal decision, but in practice, when the directive involves terminal or risky care, clinicians and hospitals accept the reversal no matter how the patient requests it (for example, if a patient asks for resuscitation at the last moment even though delirious).

NOTE that neither patients nor clinicians are allowed, in most US jurisdictions, to collude with each other to end the patients’ lives, but patients may, under conditions of a proper advance directive, require a clinician to limit, adjust or stop care/treatment.

NOTE that in cases of (or similar to) advance directive for ECT, the purpose of the directive is to establish a valid consent when some incapacity/incompetency is anticipated. Thus, for example, a competent patient who knows that ECT is likely to be helpful, but who wants to guard against being deprived of ECT when she is psychotic or morbidly depressed, can make a competent, knowing and voluntary consent in advance. If she later attempts to refuse while believed to be incompetent, a decision must be made as to whether or not that later refusal is valid (i.e., has all the components of valid refusal). (In practice, such advance directives are more likely to be intended to protect against denial of ECT in jurisdictions that broadly restrict it.)

**Fifth**, to be legally binding on clinicians and facilities, the directive must be properly executed. The process is fairly simple, but I don’t have the legal details. I don’t believe it requires a lawyer in Texas, but the correct format must be followed. Advance directive forms are easily available online, at all hospitals and from many doctors’ offices. One or more witnesses is necessary (perhaps also a physician). Once created, it’s a good idea to give a copy to one’s doctors, relatives, and perhaps attorney.

**Sixth** and finally, a properly executed advance directive is legally binding on clinicians, caregivers, medical facilities, and others (including relatives) provided they know (or should know) that it exists. They are usually placed on/at the front of the chart, pop up in EMRs, etc. Patients admitted to hospitals (or their relatives) are routinely asked whether or not they have an advance directive of any kind. It is probably a crime (but perhaps a minor one) for a clinician or facility to knowingly act counter to a properly executed advance directive. 

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