Default Options in Advance Directives

How Patients Make Choices for End-of-Life Care

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Advance Directives

- **Advance Directives (ADs)** are a way for patients to state their wishes for care
  - Appoint a Healthcare Representative
  - Specify preferences for care in end of life scenarios

AD v. POLST

AD	POLST
Advance Directive	Physician Order for Life-Sustaining Treatment
Appropriate for all adults	Only appropriate for adults who are seriously or terminally ill
Appoint healthcare representative	No representative appointment
State preferences in certain situations (ex. if permanently unconscious, I want vs. do not want tube feeding)	Medical order signed by provider to either provide or hold certain services/procedures in all cases
Each state has its own form	Each state has its own form (names vary, ex. MOLST)

End-of-life care in US

- The default is often to sustain life
- Most patients wish to die at home, but many end up with hospital visits at the end of life[1,2,3]
- What influences the ways in which patients make choices for care?
- Could default options in AD forms play a role?

Methods

- Systematic review
- Searched for randomized control trials in the past 10 yrs with participants >50 yrs old
- Analyzed studies for quality using the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) tool[4]

Results

- 3 RCTs[5,6,7] were found, along with 1 protocol for a trial currently underway[7]
- 1 study[7] was excluded due to the age of participants
- 2 studies were ultimately included in analysis
  - Halpern et al., 2013[5]
    - High quality RCT per GRADE tool
  - Kressel et al., 2007[6]
    - Low quality RCT per GRADE tool

Halpern et al., 2013[5]

- Randomly assigned 3 types of real ADs to patients >50 years old with incurable diseases of the chest
  - Default comfort-only care
  - Default life-sustaining care
  - No default (standard AD)
- Found that most patients preferred comfort-only care, but that defaults significantly affected their choices ($p<0.01$)

Halpern et al.[5] Findings

	Comfort-only default (n=26)	Standard AD control (n=33)	Life-extension default (n=35)	p-value
Forgo feeding tube	54%	45%	26%	0.01*
Forgo dialysis	--	--	--	0.08
Forgo mechanical ventilation	--	--	--	0.07
Forgo ICU admission	--	--	--	0.06
Forgo CPR	42%	32%	20%	0.03*
Overall comfort-care choices	**77%**	**61%**	**43%**	**<0.01***

Kressel et al., 2007[6]

- Randomly assigned 3 types of mailed *surveys* about ADs to patients >65 years old
  - Default to provide life-sustaining care
  - Default to withhold life-sustaining care
  - No default
- Default options significantly affected the way participants responded
  - 38% in life-sustaining default favored life-sustaining treatment
  - 28% in control condition
  - 20% in the withhold-treatment default

Discussion

- Defaults affect the way people make end-of-life care decisions
- Patients may be influenced by what is normative than their own beliefs on end-of-life care
- Providers, states, healthcare systems need to be aware of this psychology when formulating ADs and conversations with patients

Current & Future Research

- The 2 studies analyzed are limited in that they do not discuss patient-important outcomes
- Current research[8] is underway to see if comfort-only care defaults for seriously ill patients could affect healthcare costs, patient satisfaction, etc.

Final Thoughts

- Could default options increase patient satisfaction, reduce costs, and lower admission rates?
- Can this psychology be used ethically?
- These conversations are billable. Have them!

THANK YOU!

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