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Advance Directive – A Surgical Viewpoint

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The advance medical directive (AMD) is basically designed to provide autonomy to patients to determine in advance their wish to die naturally and with dignity when death is imminent and when they lose their capacity to decide or communicate. It legally registers the views and wishes of the patient. It also removes the family from making an emotional decision during a time of grief and provides the physician to implement instructions expressed by the patient without worry of legal repercussions.

The number of terminally ill patients who are kept alive on life sustaining measures in Singapore and the impact the directive would have on them are presently unknown. However, the recognition for the need for such a directive is a sign of a broader willingness on the part of the government and the community to discuss death openly and to deal with the anxieties patients might have in the event that they become mentally incompetent. This is especially important in a society like ours where an increasingly greater proportion of the population will be in the aged group.

There is concern in the medical community that AMD legislation is a stepping stone to the legislation of euthanasia. There is significant ethical and legal differences between the two. The AMD registers the fundamental and legitimate right of terminally ill patients to die when death is being postponed by artificial means. This is in contrast with euthanasia where the primary purpose is to actively cause or hasten death by artificial means.

What would be the total impact of the AMD on the local community? In America where living wills have been legislated since 1991 only 15% have opted for some form of advance directive. For a start the AMD's impact on the local community would be small. Firstly, it is a opt in scheme. As with most opt in schemes, most healthy people would not take the time or effort to draft an AMD. Secondly, given our cultural and religious backgrounds, opting for an AMD may be seen as ominous especially among the superstitious elderly. Therefore should physicians encourage patients to give advance directives? Should physicians invite elderly patients and those with severe illness to discuss life sustaining treatment? Though the opting of the AMD is totally voluntary, the physician should as part of the routine evaluation, discuss and aid in the decision making especially when there is a likelihood of the patient's mental capacity becoming impaired in the future as in senile dementia. Reluctance to discuss such issues should be respected. Experience overseas has shown that most patients welcome such discussions and usually want the physician to initiate such directives. HIV patients may also have a particular interest in completing an advance directive.

Education of the public and the medical community on the AMD is absolutely necessary. Guidelines need to be drawn to assist the lay public and the physician on terms like terminal illness, imminent death and life sustaining measures which are difficult to define. The public should be educated to respect the wishes of the family members. Presently physicians and medical students receive little training in these matters and this should be rectified. Both physicians and patients should be educated that the AMD need to be continually reviewed at regular intervals as an ongoing patient-doctor dialogue. This is in the event that the patient changes his/her mind or the prognosis of the medical condition has changed or new treatment options are available.

The impact of the AMD on hospital practice will for a start basically be confined to accident victims and intensive care patients. Another area would be in the withdrawal of treatment in a patient who had life-prolonging treatment instituted in the emergency department and subsequently found to have an advance directive. However in most cases physicians would continue to institute resuscitative efforts and treatment before considering an illness terminal and initating an AMD search. This would reassure both family and physician that everything medically has been done before an illness is deemed terminal.

Doctors should not take an impersonal and legalistic approach when implementing the AMD especially when there is objection from the family. In such situations every attempt should be made to obtain the support of the family before implementing the AMD. Implementation of the AMD does not preclude palliative care. Control of pain and comfort should continue to be instituted.

In conclusion, the impact of the AMD on the local community awaits to be seen. Though opting for an advance directive is the patient's responsibility, it should be done with proper medical advice and counselling. This can only be brought about by adequate education and open dialogue between physicians, patients and their families.

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