

# The Patient Self-Determination Act and Psychiatric Care

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**The Patient Self-Determination Act (PSDA) has been in effect since December 1, 1991. The primary purpose of the PSDA is to promote patient awareness of advance directives. Many psychiatrists are unaware of the PSDA and its requirements or believe that the PSDA does not apply to psychiatric facilities and patients. In this article the requirements of the PSDA are reviewed. Potential applications of advance directives in psychiatric care are discussed and problem areas are identified. It is suggested that psychiatrists take an active role in the implementation of the PSDA.**

The Patient Self-Determination Act (PSDA)<sup>1</sup> was passed by the U.S. Congress in the wake of the U.S. Supreme Court's decision in *Cruzan v. Director, Missouri Dept. of Health*<sup>2</sup> and became effective December 1, 1991. In *Cruzan* the Supreme Court implicitly endorsed the right of individuals to make decisions regarding the termination of life-sustaining treatment while also upholding the states' authority to impose reasonable procedures to ensure the reliability of these decisions. The PSDA arose from Congress' interest in promoting the use of advance directives as a means of facilitating reliable patient involvement in decisions regarding the withdrawal of life-sustaining care.

Although the PSDA has been in effect

since 1991, a recent survey of hospitals suggests that some may not be in compliance with the law.<sup>3</sup> Anecdotally, it seems that psychiatrists and administrators of psychiatric hospitals may be particularly uninformed about the existence of the PSDA and its provisions. It is not surprising that psychiatrists have paid little attention to the PSDA, given the focus by Congress, the press, and the majority of academic authorities on "death and dying" issues. However Congress has framed the PSDA broadly, and state legislatures have followed suit, enacting statutes that permit advance directives concerning medical decisions in general. It seems that advance directives will play an increasing role in all future medical care, including psychiatric care.

The use of advance directives in facilitating the withdrawal or withholding of life-sustaining care has been discussed exhaustively, but there has been little discussion of issues relevant to psychiatric care. There are two main areas of

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particular concern to psychiatrists. First, certain treatment decisions in psychiatric care will fall outside the scope of advance directives; for example, involuntary hospitalization cannot be averted through an advance directive. Second, the potential use of advance directives to facilitate suicide has not been appreciated among medical practitioners.

The purpose of this article is to review terminology relevant to advance directives and to summarize the requirements of the PSDA. In addition potential implementation problems related to psychiatric treatment will be discussed.

### Terminology

There are two categories of advance directives: living wills and durable powers of attorney.<sup>4</sup> Living wills contain instructions from patients about how to proceed in particular medical situations if patients become incompetent (for example, decisions to enter "do not resuscitate" orders, to withdraw life-sustaining treatment, or to forgo certain types of interventions). Durable powers of attorney allow individuals to specify who should make medical decisions in their stead if they were to become incompetent. In effect if the patient becomes incompetent, advance directives avoid the delay of guardianship proceedings and allow patients to choose who will make their health-care decisions. Hybrid forms of advance directives, combining elements of living wills and durable powers of attorney, also exist in some jurisdictions.

### The Requirements of the PSDA

The PSDA requires covered health-care entities (1) to provide summaries to

patients of existing state law concerning advance directives, (2) to develop and to provide to patients institutional policies regarding advance directives, (3) to facilitate the use of advance directives, and (4) to educate the public about advance directives.<sup>1</sup>

All institutions that participate in the Medicare and Medicaid programs must comply with the PSDA. The PSDA and the interim final rules specify hospitals, nursing homes, home health agencies, and hospice programs.<sup>5\*</sup> Various health-care entities constituted under Federal guidelines—HMOs, competitive medical plans, and other prepaid plans—which receive Medicare and Medicaid monies, also must comply with the PSDA. Individual psychiatrists are affected only through their affiliation with covered facilities.<sup>1,5</sup>

Agreement to comply with the PSDA is now a component of Medicare and Medicaid provider contracts. Enforcement of the PSDA is via existing Medicare and Medicaid mechanisms that vary depending on the type of facility. The Health Care Financing Administration may refuse to pay for services, terminate current contracts, or refuse to enter into provider contracts with facilities that do not conform to the requirements of the PSDA.<sup>5</sup> Thus institutions should be highly motivated to comply with the PSDA.

Some psychiatrists and administrators have taken little notice of the PSDA, apparently because they believe that its

\* At the time of publication, the final rules had not yet been issued.

## Patient Self-Determination Act

provisions do not apply to psychiatric facilities or to psychiatric patients. However neither psychiatric patients nor psychiatric facilities are excluded categorically from the provisions of the PSDA.<sup>1,5</sup>

**Summaries of State Law** The PSDA does not require states to enact any laws with respect to advance directives. The PSDA merely requires that information about existing state law be promulgated to patients and the public. Specified providers must give patients written information concerning their rights under state law to make decisions concerning medical care, including the right to accept or refuse treatment and the right to formulate an advance directive, if any.<sup>1,5</sup>

Facilities will not be left on their own to craft these statements. Under the provisions of the PSDA, each state is required to develop a written description of state law concerning advance directives, which is to be distributed to Medicaid providers and HMOs. The current regulations do not specify whether it is mandatory for individual providers to use state-drafted descriptions or whether providers are free to adapt the description or draft their own. It is the prerogative of each state Medicaid bureaucracy to decide the status of the state-drafted description.<sup>1,5</sup>

**Institutional Policies** The specified providers must develop and maintain policies on advance directives and provide each patient with the written policy regarding the implementation of advance directives. When state law provides for physicians or facilities to refuse

to honor advance directives on grounds of conscience, "a clear and precise explanation" must be given to the patient.<sup>5</sup>

Rather than give each patient a full version of its policy, providers may opt to furnish patients with a short version of its policy (as well as state law), noting that a longer document is available. Prepaid plans, which may be an umbrella for multiple individual provider organizations, may choose to supply patients with a copy of each organization's policy; alternatively, they may simply inform the patient that each component organization has its own policies for implementing advance directives.<sup>5</sup>

**Facilitation of Advance Directives** The PSDA includes several provisions intended to promote and facilitate the use of advance directives. First, each institution, as specified above, must document in the medical chart whether a particular patient has formulated an advance directive. Second, the PSDA requires these institutions to ensure that they are in compliance with state law regarding the handling of advance directives. Finally, the PSDA prohibits facilities from discriminating on the basis of advance directives. (The drafters of the PSDA were concerned that facilities might discriminate *against* patients who had not formulated advance directives. Presumably the drafters believed that patients with advance directives would be desirable to hospitals—lengthy and costly disagreements about the withdrawal of life-support devices would be avoided—and might be admitted preferentially.)<sup>1,5</sup>

**Public Education** The PSDA re-

quires institutions to educate staff and the community about the use of advance directives. To fulfill this provision, hospitals may distribute information to the public via pamphlets, public lectures, or other media.<sup>1, 5</sup>

***Incapacitated Patients*** The specified summaries of state law and institutional policies must be provided to individual patients at the time of admission to the hospital or skilled nursing home, before initiation of home health care, at the time of initial care by a hospice, or at the time of enrollment with an eligible health care organization.

The commentary accompanying the regulations implementing the PSDA provides for an exception:

If a patient is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the facility should give advance directive information to the patient's family or surrogate. . .<sup>5</sup>

As the quoted excerpt indicates, the PSDA provides for excluding from the provision of information those "incapacitated" due to mental disorder. A reasonable interpretation of "unable to receive information" due to mental disorder would include those patients who are unable to benefit from the information and might include those whose clinical status may be harmed in some way. It is imperative therefore that hospitals and other facilities take this into account in formulating policies to implement PSDA. For example a hospital may decide to defer conveying information in questionable cases until a physician has

the opportunity to assess the patients' capacity to receive the information.

In the event of incapacity, information as required by the PSDA must be given to the patient when he or she has regained capacity. Family and surrogates are to receive information in the interim.

Because the PSDA language is vague and has not been clarified by the Health Care Financing Administration, various interpretations are possible and litigation may result. In these circumstances, the need for hospitals to implement clear policies is especially important.

### **Problems of Implementation of the PSDA**

***State Summaries*** In many states it will not be readily apparent how state law should be characterized or summarized. Many states have recently-enacted statutes. Whereas much has been written about the potential utility of advance directives, little case law is available to provide guidance to those drafting summaries and policies. Indeed a recent study of state law descriptions mandated by the PSDA found considerable variation in the content across jurisdictions. Half of the states' disclosures did not note the importance of discussion of the advance directive with family or the designated surrogate, and one quarter did not discuss the importance of discussion with a physician. Two thirds of the disclosures failed to discuss areas of legal uncertainty. Not a single state discussed standards for determination of competence.<sup>6</sup>

Therefore it is important that knowledgeable physicians be involved in draft-

## Patient Self-Determination Act

ing state summaries. This is particularly so if the state mandates a single description. It is likely that these disclosures will be drafted with the information needs of the terminal patient in mind. Inevitably any fixed disclosure will fail to discuss information of importance to individual patients. It is possible that these scripted disclosures may contain elements that could be found offensive, if not harmful, to certain patients. In general it seems advisable for physicians to seek flexibility in disclosure information. Psychiatrists as well as other physicians will then be able to tailor the discussion to the circumstances of specific patients.

The state-generated descriptions are significant regardless of whether they are mandatory, because they will be presumed to be an accurate and authoritative summary of the law. Furthermore these statements will be important in educating staff and patients about the appropriate use of advance directives. The content of the statements is even more significant when one considers that the dissemination of information envisioned by the PSDA does not require the involvement of physicians. Indeed, in order to provide information to individuals at the time of enrollment in a prepaid plan, it is difficult to see how physicians could be involved. It is likely that most physicians will discuss advance directives with elderly and terminally-ill patients as a routine matter. However it is less likely that psychiatrists routinely will discuss advance directives with their patients.

In view of the undeveloped nature of

the law in this area, caution is warranted lest patients be misled. Prudently crafted summaries should contain considerable information on what is *not* established by state law since this may include the most important areas of concern. If states mandate inaccurate or misleading descriptions, hospitals may choose to offer greater explanations and more balanced discussion of the law to their staff and patients. Patients should be encouraged to discuss health-care decision making with their physicians and loved ones. Patients should also be informed about the applicable standards for adjudicating competence, so that they will have some understanding of when their advance directive may be triggered.

***Institutional Policy Development*** Psychiatrists should take the initiative to involve themselves in the development of policies in their home institutions. Because of the focus on death and dying issues, hospitals may appoint committees to develop these policies that are heavily weighted with geriatricians, oncologists, and other physicians involved with the care of the terminally ill. These physicians will not be able to anticipate problems that may arise in psychiatric care. Furthermore psychiatrists have much to contribute to other physicians' understanding of the complexity of issues that may arise from the use of advance directives. Questions about the validity of advance directives and the competence of patients at the time of execution of directives will eventually arise in the general medical fields.

The reasoning found in a recent court decision indicates the potential prob-

lems that advance directives may pose. In upholding an involuntarily hospitalized woman's refusal of electroconvulsive therapy (ECT) via advance directive, the court noted that the treating psychiatrist had accepted her written consent to receive ECT shortly before she executed an advance directive refusing the same treatment. Rather than being puzzled at the inconsistency and questioning the rationality of the woman's actions, the court inferred that if she had been competent to consent, she must have been competent to formulate the directive refusing the treatment.<sup>7</sup> Whether other courts are likely to reason along similar lines—ignoring physicians' practice of accepting patients' consent to treatment at a lower level of capacity than that required for refusal of treatment—is not clear. However physicians may want to consider adopting hospital policies and consent forms that make this distinction clear.

**Interpretation** Advance directives will present problems of interpretation. In part the difficulties posed by any given advance directive will depend on how broadly or narrowly it has been written. Precisely written directives covering a narrow range of circumstances may leave little open to interpretation. The difficulties of anticipating situations, understanding the alternatives, and conveying instructions suggest that such directives will be uncommon. On the other end of the spectrum, the patient may simply indicate a number of principles or general goals, such as "Do not keep me alive if there is no hope." Such a directive may be open to differing

interpretations. Physicians will need to anticipate methods for resolving uncertainties. There is a growing body of literature discussing problems related to ensuring that written directives accurately convey patients' wishes.<sup>8-10</sup> There appears to be no substitute for frank discussions between doctors and patients regarding medical decision making.

### **The PSDA, Advance Directives, and Psychiatric Care**

**Treatment Decisions** The course of action specified in an advance directive must be a legitimate one. Generally this means that the directive must be a health-care decision the patient could make when competent. For example the directive could not legitimately direct the physician to act illegally. This could happen if the individual who drafts the advance directive is unfamiliar with state law governing medical practice. States vary considerably for example in defining the clinical circumstances in which life-sustaining care may be withheld or withdrawn.<sup>11</sup>

**Treatment Refusal** As with the example of withdrawing life-sustaining care, the legitimacy of an advance directive will depend on the law of the jurisdiction and the clinical context.

For example advance directives will have no impact on the right to refuse treatment in those states that do not recognize a postcommitment right to refuse treatment. Nor will advance directives be relevant in those jurisdictions that have recognized such a right, but

## Patient Self-Determination Act

base override of refusal on treatment-related factors, not incompetence.<sup>12, 13</sup>

Advance directives may play a role in those jurisdictions which base override of refusal on incompetence. Indeed some jurisdictions have specified a substituted judgment standard of decision making. Under this method of judicial decision making, courts attempt to determine what the patient would want if competent, often looking to past statements of the patient for guidance.<sup>12-13</sup> To date only one case involving the use of an advance directive in psychiatric treatment has been reported. *In re Rosa M.* the court upheld a New York woman's refusal of ECT via the use of a living will.<sup>7</sup>

**Facilitation of Treatment** Many patients seek treatment and comply with prescribed care when well and competent. Patients may want to use advance directives to extend their competent decision making in favor of treatment to cover episodes of refusal which may arise when ill, thereby eliminating costly delays associated with judicial review.<sup>14</sup> However advance directives can be revoked at any time, regardless of competence, and therefore patients may readily refuse the treatment they had previously chosen to accept.

This illustrates yet another way in which the use of advance directives for psychiatric care poses problems. Advance directives are triggered by the development of a patient's incompetence, which is readily determined when an individual is comatose or in a persistent vegetative state. Gross competence determinations of this sort are likely to be

left in the hands of physicians. However the determination of incompetence in conscious, objecting, psychiatric patients is more problematic and states are more likely to require formal adjudication.

**Psychiatric Hospitalization** Involuntary and voluntary hospitalization must be considered separately.

In nearly all jurisdictions involuntary hospitalization is not contingent on a patient's incapacity to make an informed decision; rather, the state's interests in averting suicide and violence justify civil commitment.<sup>12</sup> Patients' consent is not required, nor is civil commitment based on overturning an incompetent decision. Therefore, in the majority of jurisdictions, advance directives will have no bearing on involuntary hospitalization. *An advance directive cannot be used to avert civil commitment.*

The APA's Model Civil Commitment Statute requires a finding of decision-making incompetence as a predicate for civil commitment.<sup>15</sup> Texas restricts the application of its "grave disability" commitment standard to those who are incompetent.<sup>16</sup> It is not known how courts would respond to advance directives if the APA statute were adopted. Nor is it clear how Texas courts would respond if faced with incompetent, gravely disabled patients who had formulated advance directives stipulating no hospitalization. It seems unlikely however that courts would allow such patients to be released untreated. It is more plausible that the court would find some grounds for involuntary hospitalization.

However, advance directives may play a role in enabling patients who desire hospitalization to be more rapidly treated. The importance of advance directives in this context may increase as a result of a recent U.S. Supreme Court decision in the case of *Zinermon v. Burch*,<sup>17</sup> which permitted a Florida man to sue the state because he had been allowed to voluntarily sign into the hospital when he was allegedly incompetent to do so. In the wake of this decision, patients of questionable competence who wish to be hospitalized—as well as nonprotesting patients—are likely to face increased difficulties gaining admission to psychiatric facilities.<sup>18, 19</sup> Advance directives may play a valuable role in allowing the patient, while competent, to prescribe the circumstances under which he or she will be admitted. Hospitals' concerns about the adequacy of consent to hospitalization would be allayed by the presence of such a directive.

As with specific psychiatric treatments, the usefulness of advance directives will be more limited in those jurisdictions that do not permit hospitalization to be provided over the objections of the patient without judicial authorization.

It should also be noted that at least one state has placed voluntary hospitalization off-limits to advance directives.<sup>20</sup>

**Suicide** Many physicians and lay people may find it difficult to distinguish the legitimate withdrawal or termination of life-sustaining care from suicide. Whether one distinguishes suicide by invoking the intentionality of the act, or by the fact that it involves the initiation

of self-destructiveness as opposed to allowing a disease process to run its natural and inevitable course, it is acknowledged that suicide differs from the termination or withdrawal of life-saving treatment.<sup>4</sup> Thus even competent patients may not be permitted to commit suicide and suicide can not be facilitated through the use of an advance directive. The distinction may be difficult to articulate to other physicians or to hospital administrators, but it is imperative that psychiatrists do so.

Psychiatrists must ensure that hospital committees, in their efforts to facilitate the use of advance directives, do not implement policies that interfere with suicide prevention procedures. Problems are likely to arise in emergency rooms or other settings where the responsible physicians are not likely to have had previous relationships with their patients.

Consider the example of a patient who presents to the emergency room with an accompanying advance directive. The treating physician may know only that the patient is *in extremis* and needs to be treated aggressively; for example the clinical situation may call for intubation and respiratory support. The accompanying advance directive may state the patient's instruction *not* to receive such treatment. The treating physician will not know if the patient has taken an overdose of tricyclic antidepressants in a suicide attempt, has an incurable, terminal illness, or whether the patient was competent at the time of formulating the directive. The physician also may



## Patient Self-Determination Act

not be certain that the patient authored the directive.

Hospitals should enact policies that minimize the likelihood that advance directives could be used to interfere with suicide prevention while respecting the legitimate decisions of patients. This could be achieved by implementing procedures requiring that there be some test of the directive's legitimacy (i.e., that the patient was competent and wrote the document, the decision reflects the desire of the patient, and suicide is not a motive) before honoring an advance directive likely to result in death. Ideally the treating physicians who have discussed these matters with their patients would be able to validate the legitimacy of advance directives; patients' families and friends may also serve this function.

More subtle difficulties related to suicide may arise in the context of terminal care. Empirical evidence indicates that depression is a frequent and undiagnosed condition in the elderly medical population.<sup>21</sup> It has been suggested that alleviation of suffering following the treatment of depression among this population often leads to a renewed interest in living. Similar observations have been made about cancer-related pain, which is undertreated by some physicians.<sup>22</sup> Reversible causes of physical and mental pain and suffering, which lead to death-seeking, should be sought. Advance directives that facilitate dying should not become substitutes for appropriate treatment and care of the suffering.

### Conclusion

The PSDA was passed with the intention of popularizing advance directives.

The underlying motive was to avoid the prolonged litigation associated with termination of life-sustaining care, which has intruded into the privacy and prolonged the suffering of some patients and their families. It should also be noted that traditional legal approaches to patients' incompetence, primarily through judicial proceedings leading to guardianship, have not met the needs of the mentally ill. Thus the goal of the PSDA, the promotion of legitimate patient autonomy in making health-care decisions, is one that psychiatrists should share.

If the PSDA is successful in achieving its primary goal—the popularization of advance directives—it augurs a new era of revolution in medical decision making. Like the last revolution, the formation of the doctrine of informed consent, the battle cry is increased patient authority over medical decisions. With the use of advance directives patients extend their decision-making rights to include periods of future incompetence. Physicians should join with patients in this new battle when legitimate patient authority is concerned.

Advance directives however do present problems unlike those associated with previous legal developments. Because patients can draft these documents in isolation from their treating physicians, advance directives threaten to uproot such decision making from its natural context: the doctor-patient relationship. Policies for implementing and honoring advance directives are still being developed and should be designed to facilitate doctor-patient collabora-

tion. Patients should be encouraged to develop their directives after discussion with their treating physicians, who can help them to anticipate future medical problems, provide information about the nature of medical interventions, and clarify any misunderstandings patients may have. In addition physicians and hospitals would be prudent to implement policies that recognize the role of the treating physicians in validating that the course of action demanded by advance directives accurately reflects the legitimate choices of their patients.

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