COMMENTS

Psychiatric advance directives: challenges of implementation

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A psychiatric advance directive (PAD) is a document which outlines the patient's preference in her/his treatment. This is executed when the patient has capacity, so that these directions can guide treatment at a later date when s/he is unwell.

The PAD empowers patients by allowing them to have a say in their treatment and validates the treatment choices. It has been shown to improve motivation to continue with treatment (it improves treatment adherence) and thereby improve the final outcome of the illness (1).

The major concerns about PADs fall in the following areas:

1. Competence to execute PADs,
2. Conflict between PADs and good clinical practice,
3. Access to completed PADs,
4. PADs and resource availability, and
5. Legal issues.

Regarding the issue of competence, this issue may be overblown. We seem to have different sets of standards of competence for executing PADs and medical directives, thus placing our patients at a disadvantage. This also perpetuates the stigma related to mental illness. There is evidence to say that patients who may be unwell are still capable of executing meaningful PADs (2).

The other concern frequently raised by clinicians is of PADs being inconsistent with currently accepted treatment. This raises the larger issue of personal autonomy versus nonconsensual treatment (3). The usual approach would be to follow good clinical practices with adequate documentation by the clinician outlining the reasons for overruling PADs.

Another issue that the clinician has to deal with is regarding whether a patient has executed PADs or not. There are various initiatives which have been suggested to improve the dissemination of PADs (4).

The other area of concern is the resources available to help with the execution of PADs. The involvement of mental health clinicians in this process has its own advantages and disadvantages.

The last is the concern about legal issues. These are multiple and have been well reviewed in the literature (5). These include competence for execution and revocation of PADs, PADs activation, conflict resolution structures and concerns about misuse (including coercion).

The paper by Sarin et al (6) appearing in this journal is a timely review of this important issue and specifically addresses ethical and legal concerns regarding PADs, the feasibility, effectiveness and uptake of PADs. It discusses the rationale of PADs and the international experience with PADs. It then goes on to talk about the challenges posed by PADs internationally and for India. The authors state: "the adaptation of advance directives in the Indian context needs to be researched in detail around the issues of feasibility, acceptability to a range of primary and secondary stakeholders, and effectiveness in implementation".

We have conducted a study on the feasibility of executing PADs at the Schizophrenia Research Foundation (7). 123 patients with a diagnosis of either schizophrenia or schizoaffective psychosis who consented to participate in the study were interviewed by research assistants to assess their capacity. 92 of the 93 patients with capacity completed PADs. The major themes which emerged were in the areas of treatment, facility of treatment, and nominated decision makers. Many of the patients were rated by their clinician as being symptomatic when they completed PADs, and 1/3rd of patients were either from rural areas or not exclusively urban.

Our experience from this study makes us believe that PADs are feasible in India with suitable adaptations for educational qualification of our patients. It will be important to replicate such studies in different populations. However, there will be concerns regarding their enforceability at this juncture and only further informed discourse can guide us forward. With the growing trend in modern medicine towards a more consumer-oriented approach, we think it is imperative to incorporate patients' opinions in their treatment.

References

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