

AMA Code of Medical Ethics

5.2 Advance Directives

Respect for autonomy and fidelity to the patient are widely acknowledged as core values in the professional ethics of medicine. For patients who lack decision-making capacity, these values are fulfilled through third-party decision making and the use of advance directives. Advance directives also support continuity of care for patients when they transition across care settings, physicians, or health care teams.

Advance directives, whether oral or written, advisory or a formal statutory document, are tools that give patients of all ages and health status the opportunity to express their values, goals for care, and treatment preferences to guide future decisions about health care. Advance directives also allow patients to identify whom they want to make decisions on their behalf when they cannot do so themselves. They enable physicians and surrogates to make good-faith efforts to respect the patient's goals and implement the patient's preferences when the patient does not have decision-making capacity.

An advance directive never takes precedence over the contemporaneous wishes of a patient who has decision-making capacity.

In emergency situations when a patient is not able to participate in treatment decisions and there is no surrogate or advance directive available to guide decisions, physicians should provide medically appropriate interventions when urgently needed to meet the patient's immediate clinical needs. Interventions may be withdrawn at a later time in keeping with the patient's preferences when they become known and in accordance with ethics guidance for withdrawing treatment.

Before initiating or continuing treatment, including, but not limited to, life-sustaining interventions, the physician should:

- (a) Assess the patient's decision-making capacity in the current clinical circumstances.
- (b) Ascertain whether the patient has an advance directive and if so, whether it accurately reflects his/her current values and preferences. Determine whether the patient's current clinical circumstances meet relevant thresholds set out in the directive.
- (c) Ascertain whether the patient has named a health care proxy (e.g., orally or through a formal legal document). If the patient has not, ask who the patient would want to have make decisions should he or she become unable to do so.
- (d) Document the conversation, including the patient's goals for care, and specific preferences regarding interventions and surrogate decision maker, in the medical record; incorporate any written directives (as available) into the medical record to ensure they are accessible to the health care team.
- (e) When treatment decisions must be made by the patient's surrogate, help the surrogate understand how to carry out the patient's wishes in keeping with the advance directive (when available), including whether the directive applies in the patient's current clinical circumstances and what medically appropriate interventions are available to achieve the patient's goals for care. When conflicts arise between the advance directive and the wishes of the patient's surrogate, the attending physician should seek assistance from an ethics committee or other appropriate institutional resource.

- (f) When a patient who lacks decision-making capacity has no advance directive and there is no surrogate available and willing to make treatment decisions on the patient's behalf, or no surrogate can be identified, the attending physician should seek assistance from an ethics committee or other appropriate resource in ascertaining the patient's best interest.
- (g) Document physician orders to implement treatment decisions in the medical record, including both orders for specific, ongoing interventions (e.g., palliative interventions) and orders to forgo specific interventions (e.g., orders not to attempt resuscitation, not to intubate, not to provide antibiotics or dialysis).

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