General practitioners' knowledge and use of living wills

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Making medical decisions for people who are mentally incompetent, particularly at or near the end of life, is of international interest. In the United Kingdom there are no legal provisions for advance directives or living wills,¹ but the High Court recently upheld that a patient's wishes expressed in an advanced directive are legally binding.²

Most of the work on the use of directives and making decisions about health care for others has focused on institutions. The promising role that living wills could have in longer term advance planning, particularly as a part of good family medical practice, has remained largely unexplored.

Living wills have been legal and binding in the state of South Australia for a decade in the format promulgated under the Natural Death Act 1983. We previously reported the results of a public opinion survey carried out for a parliamentary select committee in 1991 in which the concept of living wills and a medical power of attorney were widely supported, but there were significant concerns about lack of public awareness.⁴ We report the results of a concurrent survey of general practitioners' attitudes to and knowledge of the Natural Death Act.

Subjects, methods, and results

A response rate of 74% (117/158) was obtained to a postal questionnaire sent to a random sample of general practitioners. The design and survey methods have been described.⁵ Only 74 of the respondents were aware of the provision for living wills, 23 of them reporting that they had the forms available in their surgeries. Forty one of the 74 doctors had discussed making a living will with patients, the subject having been raised by the patient in 26 cases and by the doctor in six. Twenty one doctors reported that the patient had completed a living will; the doctor considered it to have been helpful in decision making in 12 cases and to have not been useful in four and was undecided in five.

The general practitioners surveyed were concerned about the concept of living wills and their implementation, notably because of the difficulty in raising the issue with patients and families and the possibilities of having a negative effect on the doctor-patient relationship and generating differences of opinion between doctors and families (table).

To improve the practical application of the legislation, 37% (43/117) suggested introducing a bracelet indicating that a person had made a living will. Such wills, however, are unlikely to operate effectively in accident and emergency departments when patients are seen by staff who do not know them. Support for a more medically specific directive was low (14% (17/117)),

Possible worries and degree of concern about discussing living wills with terminally ill patients who are mentally competent. Values are numbers (percentages) of general practitioners

	Not at all	Somewhat	Very much
It is a difficult concept to explain to patients (n=110)	71 (65)	33 (30)	6 (6)
It is a difficult concept to explain to relatives (n=112)	65 (58)	40 (36)	7 (6)
Patients might think the doctor-patient relationship too contractual (n=111)	67 (60)	35 (32)	9 (8)
It may make the patient lose hope (n=110)	57 (52)	48 (44)	5 (5)

and opinion was divided (51% (57/112)) on the proposed provision of an agent (enduring power of attorney) to make decisions on a person's behalf when he or she becomes incompetent.

Comment

Clearly, lack of knowledge of the Natural Death Act 1983 has been an obstacle to the effective use of living wills in South Australia, and this implies that a carefully executed awareness programme among the public and general practitioners must accompany any legislative change. Although conflict with families is viewed as a common problem, such conflict might arise less often if the person's views have been stated in an advance directive and been discussed within his or her family at the time of making the directive. Any form of living will, advance directive, or agency is intended to clarify what the patient wants and so should be an ally of good medical practice, not a troublesome intruder. General practitioners must be part of their development.

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2 Dyer C. High Court says advance directives are binding. *BMJ* 1993;307:1023-4.

3 Advance directives [editorial]. *Lancet* 1992;340:1321-2.

4 Ashby M, Wakefield M. Attitudes to some aspects of death and dying, living wills and substituted health care decision-making in South Australia: public opinion survey for a parliamentary select committee. *Palliat Med* 1993;7:273-82.

5 Wakefield MA, Beilby J, Ashby MA. General practitioners and palliative care. *Palliat Med* 1993;7:117-26.

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A PATIENT WHO CHANGED MY PRACTICE

Biopsy before baptism

In 1989 I was in charge of a small, remote hospital on the Uganda and Zaire border. It belonged to the local Anglican church but apart from being a missionary I was also the government's district medical officer. We had running water, solar power electricity, and a basic laboratory—a typical rural African hospital. Histopathology services were available through the help of a London teaching hospital, where our biopsies were sent by airmail and examined.

The patient presented with postmenopausal bleeding. She had a large ulcerating tumour of the cervix, grown into the vagina; in fact the cervix seemed totally destroyed. I diagnosed her as having a stage three carcinoma of the cervix. It seemed a purely academic exercise and a waste of time for my learned friends in London but I did take a biopsy. Meanwhile I told the family the bad news, as I did not see any point in waiting for six weeks for the result. There was no hope; this disease could not be removed by an operation. It was my duty to refer her to the hospital chaplain and while I was defeated his sympathetic approach was successful. Soon the woman expressed the wish to be baptised before she died and her wish was granted.

The histology came back as amoebiasis. I invited the woman back and put her on metronidazole, vaginally as well as orally. Within 10 days she was cured and her cervix looked entirely normal. Her baptism had saved her. To my surprise the story did not damage my reputation; she never dreamt of blaming me for my rash and wrong diagnosis. On the contrary, God had done a miracle through my hands and had blessed my drugs, albeit after some delay.

Of course, I wholeheartedly agree with her view, but I also learnt my lesson. I have never again told a patient any bad news before the biopsy result was available.—

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