Article

Advance Healthcare Directives: Binding or Informational Value?

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Abstract: Advance directives entail a refusal expressed by a still-healthy patient. Three consequences stem from that fact: (a) advance refusal is unspecific, since it is impossible to predict what the patient's conditions and the risk-benefit ratio may be in the foreseeable future; (b) those decisions cannot be as well informed as those formulated while the disease is in progress; (c) while both current consent and refusal can be revoked as the disease unfolds, until the treatment starts out, advance directives become effective when the patient becomes incapable or unconscious; such decisions can therefore not be revoked at any stage of the disease. Therefore, advance directives are binding for doctors only at the stage of advance treatment planning, i.e., only if they refer to an illness already in progress.

Keywords: self-determination; advance directives; advance care planning; binding value; conscientious objection

The Growing Importance of Advance Healthcare Directives

End of life and its correlated issues have proven to be complex and utterly challenging quandaries. Over the past decades, remarkable technological advancements and innovative biomedical techniques have brought about longer average life expectancy, at least in economically advanced countries. Modern intensive care and resuscitation techniques make it possible for patients to survive, who would have otherwise perished. The moment of death, which used to be set by nature and natural laws, has become a 'process' that can be managed by medical science.[1] Nonetheless, 21st Century medicine has taken up a somewhat ill-defined profile: it can lead to a condition that seems to lie halfway between life and death. Modern treatments are, in fact, capable of ensuring an artificially sustained sort of survival, which is hard to characterize from a medical perspective (when does death really occur?), as well as from legal and ethical ones (are patients in a vegetative state, who are wholly dependent upon artificial life-sustaining devices, even to get fed and hydrated, really alive?). In light of the newly available technological opportunities, as well as longer life expectancy rates leading to dramatic increases in the number of elderly people (leading in turn to a higher incidence of age-related degenerative diseases such as dementia and Alzheimer's Disease), anyone could potentially end up in a state of unconsciousness and mental incapacity; yet, all people should be able to keep their right to freedom, dignity and autonomy, and should never be kept artificially alive against their will.[2]

Such an aspiration is tantamount to what is termed in the Anglo-Saxon legal tradition as the 'best interest' of patients, from an ethical-legal standpoint. That same subject, by virtue of its being 'ethically sensitive,' has been the centerpiece of moral, ideological and political discussions and disputes,[3] where two distinct lines of thought are pitted against each other: a radical kind of approach, which dictates the indiscriminate and absolute acknowledgement of an individual right to self-determination (going so far as to approve of euthanasia); and a profoundly different view, grounded in the uncompromising defense of human life.[4] Modern medical

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techniques have become increasingly invasive, and may therefore jeopardize patient dignity by arbitrarily intervening on his or her body. The ever-growing use of highly sophisticated medical devices and new care methods, along with an extension of life's final stages, give rise to novel issues and needs, associated on the one hand with the patients' conditions, particularly terminally ill ones, and on the other hand, with the role of physicians. Advance healthcare directives could thus serve as preventive tools against so-called futile treatments, through the expressed refusal of given procedures on the part of patients. All those factors combined only make increasingly current the issue of end-of-life decisions. In modern societies, in fact, the urge to pass away without pointless suffering and in a dignified fashion is ever more widespread, and it is worth stressing that those who subscribe to advance directives seek to preserve their dignity as human beings, and the values upon which they had based their lives.[5]

The so-called 'right to die with dignity' is starting to assert itself.[6] Such a phrase refers to palliative care, as well as a refusal or a withdrawal of extraordinary treatment measures, which have no longer any therapeutic value whatsoever. In that respect, the refusal of futile care comes into being whenever an ineffective treatment is proposed (liable to exacerbate suffering for patients) or a disproportionate procedure is undertaken, in terms of its risk-benefit ratio.

Living Will

Advance healthcare directives (also referred to as 'advance healthcare statements' or, most commonly, 'living will') are a legal tool that originated in North America[7] and have spread to civil law countries as well.[8]

Living wills constitute a well-founded principle from the ethical, moral, and legal perspectives, through which mentally capable patients determine what treatments they are willing to undergo with their informed consent.[9] Yet, how can mentally incapacitated patients manifest their wishes? They can, by means of advance healthcare directives: such documents are deemed to be a valuable tool for fostering an open discussion between patients and doctors, or medical teams.[10]

An advance directive is an advance statement, in writing, through which mentally capable individuals express their will as to the therapies that they are willing or unwilling to accept, in case they become incapable of making decisions, and are kept alive artificially by means that could make normal interrelationships impossible.[11] Patients may appoint a legal guardian (or 'healthcare proxy holder'). Living wills must be, in order to be viewed as valid, based upon fully functioning decisionmaking power. Living wills, however, by their very nature, make it impossible to accurately determine the wishes of patients who are no longer mentally capable. Such patients might in fact find themselves in circumstances that are very different from those in existence at the time when they signed their directives. In such a scenario, it is essential to figure out whether the wishes laid down in the advance directives, whose contents are merely hypothetical, can be viewed as valid by the time the patient becomes incapable.

In order to properly deal with the issue of whether advance healthcare directives can be considered reliable decisionmaking tools from an ethical and clinical standpoint, it is, above all, necessary to outline their main purposes and lay out the issues that such initiatives are meant to solve. The present article aims

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at fostering a reflection on ethical and moral implications that arise from such approaches, in order to fully comprehend the ethical and clinical significance of such decisionmaking tools.

The Concerns on Advance Directives: Limits and Contents of Living Wills

Advance directives constitute 'decisionmaking acts performed now for the future,' and recognize the patient's prerogative to exercise self-determination, both at a time when he or she is mentally capable and 'now with a view of tomorrow' (in cases in which, for instance, patients may find themselves in a condition of incapacity), with no need to piece together the patient's will through the testimony of others. In our view, there are several doubts and concerns as to the actual validity of such practices. They have to do, above all, with the possible generic nature and the hypothetical contents of the decisions laid out within the directives. In fact, the directives are signed by healthy individuals who seek to make advance decisions about future conditions that are only predictable in abstract terms, e.g., if they become mentally incapable following accidental, abrupt developments such as road accidents, falls, cardiac arrest, or cerebral anoxia due to events of various kinds.[12] Those are decisions, made by a healthy individual, that could occur long before the actual loss of mental capacity takes place, if it ever does. Advance directives therefore reflect the will of patients at a time when they sign them, that is, when the disease has not manifested itself. Due to the way such documents are laid out, living wills cannot determine the choices of patients who are no longer capable. Such patients, once they have become incapable, may well find themselves in a situation that is very different from the one experienced at the time when they signed the directives.[13] In that scenario, it may turn out to be problematic to figure out whether the wishes expressed within the directives are still to be deemed valid when the individual-turned-patient is no longer mentally capable.

Advance healthcare directives should meet the needs of clinical application, thus their contents should be straightforward, unequivocal, and easily interpreted. They do not therefore include any possible disease and establish in detail, for each one, exactly what treatments the patient is willing or unwilling to accept, also in light of the fact that new treatments may become available that were not when the directives were compiled.[14]

Such directives do not therefore appear to be suitable for pointing out to doctors what treatments to carry out or refrain from. In our estimation, advance directives are better suited to single out what treatments patients are determined to refuse, rather than accept: life-sustaining procedures, for instance, which are aimed at ensuring the very survival of patients (namely, artificial nutrition and hydration, mechanical ventilation, cardiopulmonary resuscitation, administration of antibiotics, blood transfusions, and possible emergency surgery). By their very nature, obviously, advance directives introduce an element of disproportion in terms of precision and prediction, between that which can reasonably be determined within the document and the multiple issues the actual event could give rise to. Contents themselves may constitute a problem. However detailed they may be in the abstract, contents are in fact likely to turn out to be generic, inaccurate, and not necessarily significant with respect to the peculiarities of the possible situations that come into being. The conclusion is that the outlining of advance directives does not guarantee actual compliance with the patients' autonomous decisions in

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ultimately determining what treatments they are willing or unwilling to receive, should they become incapable of making their wishes known. Essentially, advance directives necessarily require a time length of time to elapse between when the citizen-patient outlines his or her medical care, and the time when such previously-made decisions become applicable and operative.[15] It is necessary to take into account the fact that the directives may never be applied, if the individual dies of old age. They are only usable if a brain degenerative disease strikes. In such an instance, it can be determined with certainty that the patient will lose his or her decisionmaking power, it is only a matter of when it will happen. In such cases, doctors ought to make sure, as much as possible, that the patient's will is applied to current situations, taking into account medical advancements. From an ethical perspective, advance directives should therefore entail the eventuality of passive euthanasia, in cases when patients had manifested their wish to refuse a life-sustaining treatment that could otherwise be viewed as reasonable and well-suited to the clinical condition (e.g., an antibiotic therapy). Such statements, furthermore, may turn out to be unclear and difficult to interpret for doctors, especially if the patient were unable to thoroughly define the clinical background and setting to which he or she meant to target the directives.

Such possible developments should be particularly accounted for in highly ethnically-diverse countries, where different languages spoken by residents might constitute a considerable barrier, to which heterogeneous conceptual and cultural categories among different agents in the healthcare relationship have to be added.

Living wills may therefore turn out to be valuable tools only in a limited amount of clinical situations, typically those in which impaired decisionmaking occurs as a consequence of a state of unconsciousness that is predictably persistent or permanent, as with patients in permanent vegetative states, or presenting a degeneration of decisionmaking skills brought about by dementia, or neurological and cognitive decadence.

Informed Consent: How is it Applied in Living Wills?

There are many substantial differences between informed consent and advance healthcare directives. They are therefore not ascribed the same degree of effectiveness. Consent or dissent with respect to any given treatment is warranted only if the disease has already manifested itself. The main issue with advance directives has to do with the lack of chronological alignment between consent or dissent to treatment, and the time frame when doctors actually have to act and carry out the necessary treatment. It is arguably undeniable that the requirement of a 'current' expressed decision, in terms of consent or dissent, is impossible to meet. Acceptance or refusal of any treatment is necessarily 'too early' (i.e., expressed at a time of psychological and physical health, far removed from the onset of the disease), or 'overly postponed' (i.e., expressed at a time when the disease has already taken root, which makes it extremely difficult to make a lucid, well thought-out decision, divorced from the sense of anguish, distress, and survival instinct). Thus, living wills cannot ensure current consent, since they are to be applied when patients become incapable, and doctors have to make a decision as whether and how to treat them. The prospective patient's choice is therefore not an informed and considered one, rather it is almost random, grounded on emotions and sensations, rather than sound reasons. Hence, unlike informed consent, advance directives

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are heavily swayed by psychological conditioning rather than free, informed patient volition. Quite often, fear and worry over having to cope with a devastating, life-threatening disease, without a thorough knowledge of it, and the uncertainty of what family and social support to rely on, play a major role in that regard. Decisions by patients before the disease manifests itself cannot be as well-informed as those made while the disease is in progress. In our view, citizens/patients who draw up living wills can never be 'properly'[16] informed as to the actual conditions that they will be under if they eventually become ill, when doctors have to abide by, and apply, their advance directives.[17]

The doubt lingers that patients devoid of proper medical expertise can fully appreciate some notions (e.g., what 'natural' and 'artificial' stand for, when applied to medical procedures), even when they are aided by specialists when outlining their directives. Furthermore, advance consent directives are unspecific, even when they are fully informed, and that makes it all but impossible to establish beforehand what kind of treatments patients will need to undergo in the future. It is moreover necessary to take into account that patients would be required to grant their specific consent to any given treatment. There are undoubtedly ancillary procedures, meant to integrate the main treatment for which consent may be assumed to have been granted implicitly by patients who agreed to the main one, yet the need may arise for invasive procedures as well, which entail significant risks. Such procedures may even be unavailable at the time when the patient draws up his or her will.

It appears nonetheless improper to view any manifestation of a patient's will as invalid, when made prior to the therapy. The hypothetical clinical scenario may in fact be elaborated and expounded upon, making it clear to patients possibly supported by specialists, at the time when patients choose to draw up their advance directives. It is then necessary, in our view, to make assessments and decisions on a case-by-case basis, abiding by the patient's will, as expressed in the advanced directives, whenever possible. In addition to the advance directives, a vital role is played by the healthcare proxy holder, who will have to comply with the patient's expressed wishes and report to the doctors any dissent, provided that it was arrived at through a thorough and proper information process, discussion, and personal reflection, thus making the instructions within the advance directives acceptably reliable.

What Role Should be Ascribed to Advance Directives?

Once it has been acknowledged that advance directives cannot reflect a current type of consent, it is reasonable to try and figure out exactly what kind of role they should play.

Two distinct scenarios may come into being:

> *Case I*: patient X has already expressed, through an advance directive, his or her consent/dissent regarding receiving further treatment. Over the years, the patient falls ill with the disease for which he or she had drawn up the directive, and he or she confirms the choice. The disease progresses, causing the patient to become mentally incapable: is the choice laid out in the directive still to be enforced? We believe that it is, since the patient reasserted it at a time when the disease had already manifested itself, jeopardizing his or

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her life. Hence, although the directive may not be current in terms of when it was drafted, it does hold valid, since there is a stated consent or dissent necessary to proceed.

Case II: patient Y signs an advance healthcare directive. When the disease strikes, the patient remains conscious, yet incapable of speaking and communicating his or her will, which can be manifested by gestures, if the patient chooses so. In that hypothetical case, advance directives would arguably be helpful to doctors, in that patients could confirm their decisions through gesturing. However, that would be unfeasible in cases of generic directives, hence they would not be deemed to be binding.

Outside of such hypothetical scenarios, it appears sensible to acknowledge that the patient was unable to make his or her will known at a time when it was necessary to do so.

The directives' value, therefore rests upon the individual cases in which doctors are called upon to apply them. Useful elements to properly interpret directives and put them into context are mainly: (1) the real clinical conditions of the patients who signed advance directives; (2) the need to trace back all those individual elements related to the choices made by the individual before losing their decision-making capabilities. As far as the former category is concerned, the role played by doctors is pivotal. They, in fact, have to assess the incapable patient's situation with respect to the clinical one, taking into account possible technological advancements and pharmaceutical innovations that became available after the patient signed the living will, or already existing but unknown to him or her. As for the latter profile, it is arguably essential to appoint a healthcare proxy holder, tasked with ensuring that the incapable patient's statements are complied with.

A Further Issue Arises: Incapable Patients Cannot Revoke their Decisions

A somewhat troublesome issue arises from the inability of a mentally incapable patient, who has therefore lost any discretionary power, to back away from previously expressed wishes. There a tangible risk, under such circumstances, that the patient's life could depend on choices made when he or she was still healthy, foreseeing the possibility that a given disease may come into the picture. It ought to be kept in mind that any individual, when drawing up their advance directives while in full possession of their mental faculties, accepts the risk of finding themselves in a situation where they may decide to change their mind but cannot withdraw what they put in writing anymore. That hazard is common to any activity that entails making an early choice.

There can be obviously no certainty that patients who made living wills would confirm the very same decisions while actually confronting the disease. It is in fact possible that someone's will could change once they have fallen catastrophically ill, and it is just as possible that patients may not express the same wishes under conditions that call for medical intervention. Probably (although no one can know for sure) patients who become terminally ill would want to try any possible kind of treatment available, no matter how invasive, in order to stave off or slow down their demise.

Moreover, new developments may arise, in light of which the will previously expressed in the advance directives could be no longer in line with the patient's

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current one. Children or grandchildren may be born, for instance, that might make previous wishes no longer aligned with the patient's current desires; therapeutic and technological advancements may have become available—which could cure previously incurable diseases, or at least improve the patient's quality of life—and of which the patient was unaware. The patient's condition of mental incapacity then becomes an issue, making it impossible to revoke that which was expressed earlier. The lives of advance directive patients may actually depend upon choices made when they were healthy, anticipating a possible illness, which would be different if made when the same illness has already appeared. It is worth mentioning, in that regard, a case brought up by Guido Bertolino in his book "Scelte sulla vita. L'esperienza di cura nei reparti di terapia intensiva" ("Life centered choices. Experiences in intensive care units"): the case of Michael De Bakey, heart surgeon, considered to be a luminary of aortic surgery.[18] When he was 97, he needed aortic and coronary surgery, but he had signed a directive expressing his refusal to be resuscitated if he had ever fallen into a coma. No surgeon was therefore willing to operate on him. The ethics committee was unable to reach any decision, so the patient's wife decided to have her husband undergo surgery. Dr. De Bakey was in intensive care for several days and, when he finally regained consciousness and recovered, thanked the surgeons who had operated on him, voicing his satisfaction over having been treated. It is important to point out that he did not even remember signing any directive with the refusal to be resuscitated.

Recent studies on neurosciences are making breathtaking connections between consciousness and mind, finding that some individuals remain conscious despite major brain damage and the absence of external stimuli. What should be done in such instances? Thanks to the ongoing progress and scientific discoveries in that realm, such issues will most likely turn out to be extremely challenging and thought-provoking. If, on the one hand, a latent state of consciousness further warrants the enforcement of one's right to therapeutic self-determination in any circumstances, on the other hand it might hinder the fulfillment of a patient's decision once the clinical background has become fragile.[19]

Is it Warranted to Ascribe a Binding Value to Advance Directives?

The Oviedo Convention[20] states under article 9 that "previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account."

Nonetheless, taking into account previously expressed wishes is not necessarily tantamount to having to act upon them. The Oviedo Convention, therefore, considers living wills as documents meant to disclose the patient's sentiments, wishes, and aspirations prior to becoming unconscious and yet, at the same time, maintains that doctors may disregard the patient's will if it is deemed to be in conflict with the patient's current best interest. As far as treating mentally incapable patients, doctors are required to "take into account" previously expressed wishes, although they are not bound by those wishes. Doctors, in furtherance of medical science and their conscience, could make a decision to disregard them, yet they have a duty to expound upon their motives for doing so in the patient's records.[21] The Council of Europe has pointed out that freedom of choice is directly tied to the contextual element,[22] and the guide on end-of-life issues argues that there may be good reasons for doctors not to abide by their patients will.[23] Several legislative

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frameworks that do acknowledge the binding nature of advance directives conceive some exceptions, enabling doctors to disregard their patients' wishes. In cases, for instance, where the directives had been laid out long before the patient lost his or her mental capacity or significant medical advancements had occurred, ensuring possible improvement in health conditions and life quality that might have had an impact on the patient's expressed decisions.[24]

It is therefore apparent that an overly strict, deterministic application of advance directives could turn out to be detrimental in terms of patient self-determination.

Binding directives compel doctors to conform to their patient's requests, whatever the contents may be. That brings about a profound change in the way therapeutic relationships and the orientation of medical science are reshaped, being no longer aimed at life and health preservation and relief from disease. At the same time, paradoxically, patients appear to be the masters of their destinies. In actuality, though, the patient can rely on no guarantee as to how others will interpret his or her advance directives, in case he or she should become mentally incapable. Advance directives, in fact, need to be construed by those who are charged with interpreting them.

Doctors are then required to take into account their patient's will, as expressed in the directives, and must view it as legitimate, but can disregard it only if they consider it no longer appropriate within the context of the patient's clinical state and if scientific, pharmaceutical, and technological innovations could be applicable to the patient's condition.

Doctors must autonomously assess the decisions laid out in the directives: if they believe, based on science and their conscience, that such decisions are still timely, they are bound to follow them. We contend, therefore, that the best principle by which to abide is not one of absolute bindingness, for several reasons: first, the advance directive patient's will to be treated or not is untimely, divorced from the current context. There is, in fact, a time lapse, even from a psychological, scientific perspective, between the time when the patient's wishes have been expressed and when they would have to be acted upon. For instance, it appears to be legitimate to disregard the mentally incapable patient's opinions when they were expressed long before becoming ill. Such a lengthy time frame makes it impossible to verify the patient's current will. Second, in light of what has been argued so far, it may be concluded that it is not appropriate to determine in strict and abstract terms whether living wills should be deemed to have a binding or a merely informational value for doctors. We believe, on the contrary, that the issues concerning the effectiveness of advance directives may be solved through constant references to the actual individual instances, on a case-by-case basis, in which the decisions spelled out in the directives should come to be applied.[25] Let us weigh the differences between healthcare directives made by healthy individuals, i.e., in abstract terms with respect to a future contingency when an illness will compromise the patient's mental faculties, and those directives laid out by patients, who may be hospitalized, already diagnosed with some disease whose outcomes, while still uncertain, are easily foreseeable.[26] Last, the dichotomy between a binding nature and an informational function should be overcome, in order to shift the focus onto the role played by doctors: they are the ones who must make a further assessment as to their patients' clinical situations. It is indisputable that if the patient's wishes were not only legitimate, but timely as well, doctors would have an ethical obligation to honor them, as an integral part of the therapeutic alliance made with their patients.[27]

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Treatment Planning and Living Wills: Distinctions

Once it has been verified that living wills are ill-suited for mentally incapable patients, in what ways could incapable patients be enabled to make their wishes known? The answer may be advance treatment planning.[28] Such a process may be successfully applied to chronic diseases. The progression of such illnesses leads to the loss of cognitive functions, and healthcare specialists can certainly predict such a development and make the patient aware of it. Advance planning constitutes an expression of the patient's will that comes into being within the therapeutic alliance that is already established. In that case, both doctors and patients are aware of the disease's progression and how it will likely play out.[29] Take terminal cancer patients, for instance: they are unfortunately bound to lose their lucidity and mental faculties as a result of the opioids that are administered to them for palliative care, or those with brain degenerative diseases such as Alzheimer's disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, cerebrovascular diseases, dementia, and the like.[30] Such conditions inevitably entail the onset of critical developments that can be dealt with in many ways. Patients suffering from similar diseases are likely to develop respiratory dysfunction. In order to keep it under control, a decision should be made as to whether to resort to mechanic ventilation. It is therefore necessary to discuss such a possibility with the patient, long before the dysfunction has taken hold. At that point, in fact, the patient would be incapable of partaking in the decisionmaking process.[31] Thus, the patient has to make a choice, with the support of their doctors and in advance, as to what kinds of treatments they are willing to undergo when the critical conditions manifest themselves.

The advance planning of treatment makes sure that the patient's will is followed within the context of a clinical scenario, with a fairly high degree of accuracy and certainty. This kind of 'advance decisions' is fundamentally different from those made via advance directives, and it seems to be much more akin to informed consent. Resorting to advance treatment planning, in fact, there is a clear diagnosis of which the patient is aware. Moreover, since incurable diseases are involved, the patients will have lived with the condition for a long time already, when the time comes to lay out the treatment planning; thus they will have gained a substantial knowledge of it. Patients have come to know their disease better than anybody else, since they deal with the symptoms on a daily basis, are aware of their degree of tolerability, and the possibility of keeping them in check through medical procedures and drugs. Besides, it is worth noting that with advance treatment planning, patients are called upon to voice their opinions on well-defined medical interventions, related to a clinical background that is just as clear.

When patient directives fit within a path of advance treatment planning, mentally capable patients can directly instruct doctors as to what kinds of treatments they are unwilling to undergo or want to discontinue (e.g., chemotherapy, mechanical ventilation, unbearable dialyses), and agree with doctors on the proper end-of-life compassionate procedures to make their demise as painless as possible. There is clearly a narrower margin of interpretation by third parties (healthcare providers and healthcare proxy holders), who might otherwise be charged with making such decisions.

Although the treatment planning is done in advance, prior to the worsening of the patient's conditions, the decisions stem from timely and well-informed knowledge.[30] Patients can in fact be thoroughly informed about the object of their

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decisions, as well as the actual conditions in which they will be applied, in the near future. In fact, the illness is on-going, and patients are acquainted with the diagnosis and the prognosis as well. Moreover, the patients' relationship with their doctors will go forward until the time comes to make a decision, when the patient has become unconscious. Within that time frame, patients will have a chance to choose whether to confirm or amend the directives that they had previously made. In cases of healthy patients, daily life unfolding usually leads them to give no further thought to the directives they have signed, or even to forget about them. Therefore, advance treatment planning can be thought of as binding on doctors, although patients who have since become mentally incapable are in no condition to confirm their decisions. From that perspective, denying the binding nature of the patient directives expressed during advance treatment planning would be tantamount to scuttling the full development of the incapable patient's personality,[32] running counter to the fundamental principles underpinning the notion of advance healthcare directives themselves.

Conclusion: Advance Treatment Planning is a Far Preferable Option

The arguments made herein are not necessarily meant to discount the importance and usefulness of advance directives. They do have value, in my estimation, and are indeed binding within the context of a shared process of treatment planning, and in the doctor-patient therapeutic alliance, for the time when the patient will no longer be capable of making decisions. When patients make their will known, they are already grappling with the disease, which follows a well-known progression. In that case, advance directives enable doctors to apply less drastic types of therapies, essentially palliative in nature, as required by their patients after being thoroughly informed. That would also shield doctors from possible legal claims. Hence, doctors who have to stick by their patients' wills maintain a degree of discretionary power and responsibility as well. For that reason, it bears repeating that the adoption of advance planning of treatment does not diminish the physicians' scope of responsibility within the decisionmaking process, which is, and will continue to be, the synergy and alignment of scientific knowledge and patient preferences. Advance treatment planning is a far preferable option, since it meets the standard of being an ultimate expression of informed will; besides, it entails the participation in the therapeutic relationship of all the relevant parties (patients, doctors, medical staff members, family members), and it preserves patient self-determination, as well as the autonomy of healthcare providers.

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