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Letter to the Editor

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Awareness and use of Advance Directives in the Spinal Cord Injured Population (Spinal Cord 2002; 40: 581–594)

The article by Drs-Blackmer and Ross on 'Awareness and use of Advance Directives in the Spinal Cord Injured Population' (*Spinal Cord* 2002; 40: 581–594) highlights the importance of health-care advance directives and their tailoring for specific groups. It is unfortunate that the authors, although recognizing that the contents of an advance directive for HIV patients may not all be applicable to the spinal cord-injured population, did not logically carry that recognition through to their suggested advance directive at the end of their article.

Those with spinal cord injuries may be at a greater risk in certain health areas, but otherwise may well be healthy with a reasonable life expectancy. They, like most persons not suffering from a terminal illness, are not interested in procedures. They are concerned about outcomes. If intervention, such as tube feeding, surgery, or any of the others listed in the advance directive have a reasonable chance of restoring them to health, then they want those interventions. Healthy persons are primarily concerned with the end result and not the means by which that result is achieved.[1]

Also, it is unfortunate that the authors in the preamble to their example on advance directives refer to the advance directive as a 'legal document'. It may or may not be that, depending on the laws of the jurisdiction in which it is signed (or in which it is to be enforced). In Canada, the law with respect to advance directives varies from province to province. For example, in British Columbia, what the authors propose would not be a 'legal document'. Under that jurisdiction's legislation, an advance directive that does not meet the legal requirements may be evidence of the maker's wishes but is not necessarily enforceable, and the person named as proxy has no decision-making authority under that directive (but may have, depending on his or her relationship to the maker, decision-making authority as a 'temporary substitute decision-maker' under British Columbia legislation).

The authors state the proxy is to follow the maker's wishes but go on to say if no wish is specified that the proxy 'would make the decision based on the person's best interests taking into consideration the person's values and beliefs'. They have omitted the generally recognized test in North America that takes precedence over 'best interests' and that is 'substituted judgment'. If a proxy can determine what the maker would want, then that is what should happen. Applying the best interests test qualified by 'taking into consideration the person's values and beliefs' is not enough. 'Best interests' is the basis on which physicians used to make decisions for patients, ignoring what the patients may in fact have wanted. What the patient may want may not be what others think is best and 'substituted judgment' and 'best interests' should never be confused.

It is important that those using the advance directive example in the article understand that it may not be legally binding on the proxy or legally enforceable in the jurisdiction in which it is made or used. It is, although unfortunate, vital that legal advice with respect to these matters be obtained on making the advance directive to ensure that the wishes of the maker will be carried out.

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References

1 Browne A, Sullivan W. Advance directives: a third option. *Annals Roy Coll Physicians Surg Canada* 1999; **32:** 352–354.