

'Default' options influence patient choices in advance care directives, study shows

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Advance care directives allow patients to provide instructions about their preferences for the care they would like to receive if they develop an illness or a life-threatening injury and lose the capacity to make decisions for themselves. While many people may assume that patients have strong preferences for the type and aggressiveness of care they wish to receive near life's end, a new study by researchers at the Perelman School of Medicine at the University of Pennsylvania suggests that for many patients, preferences for end-of-life care are constructed on the spot and heavily influenced by the ways in which the options are presented. Specifically, the investigators found that even when it comes to such seemingly personal decisions as end-of-life care, people tend to accept options that are presented as the default, much as they accept the default in choosing automobile insurance or whether to contribute to 401(k) programs.

The research is published in the February 2013 issue of [Health Affairs](#).

"We found that default options have large influences on the [care](#) patients choose near the ends of their lives," said Scott D. Halpern, MD, PhD, MBE, assistant professor of Medicine, Epidemiology, and [Medical Ethics](#) and Health Policy, and director of the Fostering Improvement in End-of-Life Decision Science (FIELDS) Program at Penn. "Although this result will be surprising to many, it makes a lot of sense on closer inspection – how could we expect patients to have deep-seated preferences about choices that are rarely encountered, difficult to contemplate, and about which we do not get feedback as to whether

previous, similar, choices did or did not promote our broader goals?"

Halpern said that despite national policies and laws promoting the use of advance care directives, there has never before been a study comparing different types of advance directives. As a result, clinicians have no way of knowing what type of directives to recommend for patients to help them make and document these difficult decisions. To explore how patients make these decisions, the researchers randomly assigned 132 seriously ill patients with life expectancies of two years or fewer to complete one of three types of advance directives. Two types had end-of-life care options already checked on the form—resulting in a "default" choice—but one of these prioritized care focused on comfort, and the other, care focused on extending life by all means possible. The third type was a standard advance directive with no options pre-selected. On each form, patients could easily choose from among all possible options.

The research team found that overall, most of these seriously ill patients preferred comfort-oriented care, but the default options influenced those choices dramatically. For example, 77 percent of patients in the comfort-oriented default group chose an overall plan of care that prioritized comfort, while 43 percent of those in the life-extending default group rejected that default and selected comfort-oriented care instead. Among the standard advance directive group with no option already selected, 61 percent of patients selected comfort-oriented care. The authors found similarly large influences of default options on patients' desires to receive feeding tubes, mechanical ventilation, dialysis, or admission to an intensive care unit.

The researchers note that what makes the findings eye-opening is that these large differences were not due to patients just failing to recognize the default. Instead, after patients completed their directives and had them signed by a witness, the team called patients, helped them focus on the default option used (or not used) in their assigned directive, and

asked them if they would like to change any of their choices. Only after patients had the opportunity to change their stated preferences did the directives become parts of the patients' medical records. The researchers found that none of these patients changed their original selections about their preferred care plans. Furthermore, patients in all groups expressed equally high satisfaction with their [advance care](#) planning, suggesting that patients were content to be guided in making such decisions.

"This study strongly suggests that many patients do not hold deep-seated preferences regarding their end-of-life care," said Halpern. "However, the study does not yet tell us whether we should use advance directives with default options in clinical practice. Instead, this work provides motivation for future research examining whether using default options in [advance directives](#) may improve important outcomes, including [patients'](#) receipt of wanted and unwanted services, resource use, survival, and quality of life."

Provided by University of Pennsylvania School of Medicine

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