

fundholding. Fundholders may decide that it is in their interests to form purchasing consortiums—indeed some have already done so. If the consortiums grow in size they will require some form of bureaucratic organisation. The flexibilities of small scale purchasing may then be lost.

It is important to remember that the scheme currently covers only one fifth of the total hospital and community service costs for a practice population: currently all emergency attendances and admissions are excluded, as are medical and psychiatric admissions and community and maternity services. Health authorities have to buy these services for their resident populations, including the patients of fundholders. This entails measuring needs and outcomes, identifying possibilities for health gains, and setting priorities. The skills required to perform these tasks are rarely found in primary care. Fundholding remains an interesting experiment, which should continue as long as there is a commitment to monitor and learn from the experience. But

we have not arrived at the point where general practitioners should take over as the main purchasers of health care.

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Advance directives about medical treatment

Making up one's mind while one still has a mind

Two months ago the Patient Self Determination Act came into force in the United States.^{1,3} It may considerably enhance patients' control over their health care or it may cause unnecessary suffering for thousands of patients and be an intolerable burden to health care institutions. Everyone should be watching this great American experiment with interest.

The act passed through Congress as part of the Omnibus Budget Reconciliation Act. Essentially it requires health care institutions with provider agreements with Medicare and Medicaid (which includes most large hospitals) to advise all patients, on admission, of their rights to accept or refuse medical care and their right to execute advance directives. These institutions must document whether patients have made an advance directive, must implement advance directive policies, and must educate their staff and communities about advance directives. The act does not create any new rights for patients but it places a clear responsibility on the health care institution to initiate such discussion. Many more directives are likely to be drawn up as a result of the act.

An advance directive is a statement made by a person when fully competent about the health care that that person would want to receive (under certain circumstances) if he or she were to become incompetent. A "living will" is usually taken to be a special kind of advance directive concerned with refusing life prolonging treatment.

A British working party on living wills recommended in 1988 that: "Extensive debate should be arranged . . . before any decision is taken to introduce advance directives nationally."⁴ The new American act provides much needed stimulus for such debate.

The debate will need to address three issues: whether advance directives are generally desirable; if they are, what the best setting is for patients' wishes to be sought; and how it can be ensured that patients' wishes are respected at the relevant time. The American experience over the next few years should help to answer the second two questions. But in Britain the answer to the first question is not yet settled.

The central argument in favour of advance directives is that they extend patients' control over their health care.⁵ It is accepted that competent patients have a right to refuse

medical treatment and to choose from among the available treatments; advance directives extend such autonomy to incompetent patients who were previously competent. The main argument against advance directives is that competent people are not well placed to make decisions concerning their future incompetent selves. At its most extreme an argument can be made that the incompetent person is, in many of the situations envisaged, quite literally a different person from the person who completed the directive.^{6,7} The less extreme view is that a fully competent person cannot imaginatively identify with a future incompetent self sufficiently for the advance directive to be relevant.

This doubt is given substance by clinical experience. For example, a woman who many years ago may have made it known that she would not want aggressive life prolonging treatment should she become severely incapacitated may since have suffered several strokes, leaving her aphasic and unable to walk. Yet despite her disabilities and her previous injunction a strong will to live may be obvious.

Other countries have much to learn from the American experiment. It should help to clarify the practical problems in establishing and following advance directives for health care. And it may well generate solutions to these problems. But it is not good enough simply to watch what is happening in the United States. As recommended almost four years ago, Britain needs to begin widespread discussion and debate of the topic—and, in particular, of the fundamental issue: are advance directives the right way to enhance patients' autonomy?

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