Two decades ago before the advent of potent antiretroviral therapy, the autonomy and rights of people with AIDS was a common theme of discussion among patient advocacy groups and care managers (Mor et al. 1989). Then, when HIV infection was clearly more life-threatening, it was incumbent upon everyone involved in the care of these patients to insure that they had considered advance care planning and surrogate decision-making as a routine part of care. It was common, early in the epidemic, for HIV-infected patients receiving regular medical care to have a durable power of attorney for healthcare and an advance directive or living will (Steinbrook et al. 1986). Over the past decade this practice has fallen by the wayside to some extent as persons with HIV infection have led healthier, functional lives on effective therapy (Wenger et al. 2001).

For persons with advancing age and long-standing HIV infection, particularly those with even modest cognitive or functional impairment, it seems wise to re-emphasize the importance of establishment of power of attorney and advance directives, since, as it was 20 years ago, many persons with HIV infection may not want their closest blood relative or other default surrogate decision maker (based on state law) to make important medical decisions for them in the event of serious illness. And, over the past 2 decades, the confidence in the effectiveness of established advance directives has grown. Research during the 1990’s led to some discouragement about the effectiveness of advance directives in guiding care decisions (SUPPORT) (Teno et al. 1997). More recent evidence, using agreed-upon directives established between providers and patients or their surrogates, such as the “Physician Orders for Life Sustaining Treatment POLST (2010) form, have indicated that patients and providers may be able to have more confidence that directives will actually be followed as patients move from home to various care settings (Hickman et al. 2010).

References:


References


