Advance Directives, Historical Review, Legislation and Perspectives on the Clinical Relationship

Voluntades anticipadas, revisión histórica, legislación y perspectivas en la relación clínica

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Abstract

This narrative review addresses the historical and legal evolution of advance directives globally and locally since their emergence. It starts

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from the principle of autonomy in modern bioethics and its relationship with the patient's vulnerability, as well as the consideration of death by health professionals. It highlights the essential role of the advance directives document as a valuable tool in the physician-patient-family relationship, being fundamental to understanding the patient's perspective. The document is defined considering the medical literature and its application is discussed, stressing the importance of not waiting until advanced clinical deterioration for its implementation. The review also examines national and international legislation, as well as current medical knowledge, with the aim of facilitating consensual decisions among all parties involved in patient care.

Keywords: autonomy, bioethics, knowledge, decision making.

1. Introduction

1.1. Historical background

Bioethics has a well-known etymological origin: life *(bios)* human behavior *(ethos)*, commonly translated as ethics of life; Potter in 1970 defined it as a new form of knowledge that bridges the empirical and human sciences, and called it "bioethics", a bridge between life and human behavior, life and ecology, and life and the environment. Decision-making (ToD) in modern medicine has its foundation in bioethics (2).

Based firmly on the bioethical principle of autonomy, the emphasis on a patient-centered approach has been increasing since the early twentieth century, at which time courts began to try physicians of the age of aggression for performing operations without the consent of their patients (2). Serious illness and imminent death can often condition patients' wills to the point of becoming incapable of exercising autonomy with respect to medical decisions (3). A useful approach to these difficult situations is to make decisions in the "best interests" of patients; however, because such decisions require value judgments, about which thoughtful people almost never

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agree, ethicists, lawyers, and legislators have sought a more reliable solution (3).

Advance directives (VA) are written to anticipate treatment options and choices should a patient become incapacitated by advanced illness (3). Possible treatments often addressed include mechanical ventilation, cardiopulmonary resuscitation, artificial nutrition, dialysis, antibiotics, or transfusion of blood products (3). Decisions about life-prolonging treatments for patients in settings such as intensive care and oncology generate a high emotional burden because they experience the very real possibility of dying (4). In this interactive process, the healthcare professional brings his knowledge, as well as information about the options, risks and benefits in reference to a diagnostic or therapeutic intervention, while the patient brings his preferences and concerns, regarding his experience with the health problem, his beliefs and values (5).

In the last decade, and because of the regulations in Colombia regarding euthanasia, VA and medically assisted suicide given by Law 1733 of 2014 under Resolution 2665 of 2018 (6,7), and Resolution 971 of 2021 (8); what concerns the VA document (DVA), in addition to referring to the concept of bioethics just delimited, highlights the importance of keeping in mind the wills of people at any stage of the disease. In Colombia, the right to subscribe the DVA appears for the first time in Law 1733 of 2014, "which regulates palliative care services for the comprehensive management of patients with advanced, chronic, degenerative and irreversible diseases"; then comes Resolution 1216 of April 20, 2015, referring to the guidelines for the organization and operation of committees to give effect to the right to die with dignity (9). The Ministry of Health in Colombia, repeals Resolution 1051 of 2016 on the DVA, expanding its provisions and partially regulating Law 1733 of 2014; the latter, known as the Consuelo Devis Saavedra Law (Name given in honor of a woman who remained 14 years in a coma, a case that led to raise the possibility of regulating palliative care), which regulates palliative care services for advanced, degenerative, chronic and irreversible

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diseases (10). Giving compliance to the regulation of these services, the Ministry of Health and Social Protection of Colombia, issues Resolution 2665 of 2018 where the requirements of the DVA are defined (11).

1.2. Global historical/legislative analysis of advance directives

The Euthanasia Society of America (ESA) (12) was a pioneer in generating the idea of a document that concluded in the work of the lawyer Luis Kutner, published in 1969 under the name *Due process of euthanasia: the living will, a proposal* (13), in which the author considers: "legitimate, as an integral part of the right to privacy, the refusal of treatment that would extend the patient's life in the face of an incurable and irreversible condition".

A case that made world news was that of Karen Ann Quinlan, a 22-year-old woman diagnosed with an irreversible coma on life support for many years. Her parents requested that she be withdrawn from life support treatments, arguing that this had been Karen's will, a situation that generated great debate in courts and medical committees, since the decision to withdraw the devices was taken in the context of an irreversible disease (14,15).

A few years after this case, in August 1976, the *Natural Death Act* (16), was passed in California, which promoted guarantees to the subject of the right to suspend or not to accept medical treatment and the protection of the health professional against any legislative act to respect the expressed will of the patient; this resource was the first to regulate natural death as a right to die of the dying person. This law gave way to the elaboration of guidelines and orientations, established how to write the document with recommendations including the need to register it in the clinical history and giving it a legislative character by characterizing it as a free process with a validity of 5 years (16). It was established that the document drafted in the hospital should be drawn up by personnel from outside the institution, with no kinship between the patient and witnesses to be

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valid; it should provide absolute benefit in the event of the death of the sick person and the formers cannot be minors or pregnant women. In 1977, the document was legally validated in 7 American states (17).

By 1983, the right of a person with a durable power of attorney to appoint an attorney to make decisions in his or her place, if he or she does not have the capacity to do so, due to limitations in his or her health condition, was recognized in the *California's Durable Power of Attorney for Health Care Act* (18,19).

In the United States of America in 1990, due to the requirements of regulation in cases of persons with reduced capacity or inability to make decisions and to guarantee self-determination, the first *Patient self-determination act* (PSDA) 20) was created, was created for the purpose of informing the public about advance directives (AD) and to promote their use by publicizing rights regarding decisions about one's own medical care, to resolve ethical conflicts arising from withholding or failing treatment in irreversible (21) situations, and to ensure that the health care provider communicates these rights (22,23). Since the PSDA went into effect, hospitals, health homes and nursing homes have made a commitment to write AD guidelines, and health professionals must have the capacity to guide the ToD and the writing of the DVA from the moment the clinical relationship begins (24). However, this aspect is not complied with in most institutions in Colombia.

In Germany since 2009 there is a VA Act (25,26); compared to that law is a complete and detailed statute which is the English Mental Capacity Act of 2005 (27). In France, in 2016; an updated law of patient's rights focused on the attention to the FdV and the concept of VA (28). In South Korea since 2018 DVA are legal according to the Act on Palliative Care, and Palliative Care and Life Support Treatment Decisions for Patients to the FdV (TSV Decision Act) (29). In Canada, was passed by the Canadian Parliament in 2016, the Medical Aid in Dying Act, following an amendment to the law that criminalized medical aid in dying (30).

Since the Declaration of Alma-Ata in the year 1978 and the Ottawa Charter for Health Promotion, the World Health Organization urges patients to both individual and collective participation in health. VA promotes patient autonomy and empowerment based on personal values and perceptions, as well as cultural background and goals and expectations of care (31,32).

1.3. Perspective of the physician-patient or clinical relationship

In recent decades, there has been a change of perspective in the physician-patient relationship, evolving from a paternalistic model to one centered on patient autonomy and the right to information and participation in clinical ToD (33,34). Since its conception, VA has been widely promoted and supported worldwide as a fundamental part of Advance Care Planning (ACP) (35). There is good evidence of positive impact on patient care, including increased satisfaction with physicians and clinic visits (36), decreased cost and utilization of medical care (37), decreased chance of death in the hospital, and use of life-sustaining treatments (38). However, there is little evidence against the use of VA, this contrast has led many studies to explore possible barriers to completing VA, including low awareness and lack of knowledge of patients about them (39,40), in addition to the lack of time spent by physicians to know about them and even to execute or promote their application (41). Several intervention studies have demonstrated success arguing that patient education and communication can be effective in promoting VA completion (42-45). A systematic review by Brinkman-Stoppelenburg, Rietjens, and Van der Heide found that comprehensive discussion of advance care policies may be more effective than VA alone in improving compliance with patient end-of-life wishes and satisfaction with care (38). The King's Fund in the UK gives us some key findings to contemplate (46):

- A holistic approach to help patients and caregivers become more functional, independent and resilient.

- Developing community awareness and confidence in care coordination programs promotes legitimacy and engagement.
- Effective communication based on good working relationships among multidisciplinary team members is essential.
- Shared electronic health records can support the process, but a "high-touch, low-tech" approach can also be very effective.
- Care coordination programs should be localized so that they address the priorities of specific communities.
- Leadership and commitment (from both communities and health care providers) is vital to establishing a shared vision.

The inherently ethical and value-laden nature of decisions about FoV can be very demanding and emotionally charged for the health professionals involved (47,48). Physicians' individual views, beliefs, experiences, and the longevity of their relationships with colleagues and families obfuscate the ToD process for them (49,50). Harmful emotions experienced by health care professionals during this process include discomfort, stress, fear, and frustration, and appear to be related to communication difficulties, poor collaboration, lack of consistency, and inappropriate choice in establishing conversations about POV (50-52). In mental health, the use of Advance Directives even increases trust in the doctor-patient relationship (53).

1.4. Advance directives and their relationship with health professionals.

Studies carried out in Spain in relation to the attitudes and knowledge of professionals about Advance Directives indicate that, while attitudes are favorable, knowledge about what they are and how they are implemented is generally scarce (34,54-58). In a review by Coleman, this synthesis of the literature shows that, in general, physicians express positive attitudes towards VA (59). Respect for patient autonomy emerges as the main determinant of these attitudes. In the field of research, the study "Proyecto al final tú decides", led by Pablo Simón, shows in its results the favorable attitude of medical and nursing professionals towards the usefulness of VA (60,61).

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Although physicians may be in favor of VA in theory (62), they prefer them less in comparison with their patients and use them infrequently (63).

In a study with medical students, it was found that, without a positive attitude toward death, physicians are more likely to find it difficult to effectively help dying patients and their families based on individual education, religion, faith, ethnicity, and other characteristics, and are more likely to exhibit anxiety and fear of death (64).

Recent contributions from international literature, agree that comprehensive and complex VA programs involving health professionals bring better outcomes, especially qualified or trained professionals, such as facilitators and social workers in Canada (65), Family Physicians in Australia (66), Registered Nurses (RN) in the Netherlands (67) and Australia (68).

In Colombia in 2021, Alvarez Acuña *et al.* showed that, over the course of 2020, 24% of physicians received one or more DVA from their patients (69). Only 53% of professionals inform and educate their patients about the DVA, because they believe they must sign the document, but do not have it available, 77.1 % of respondents perceived the same frequency of patients who completed a DVA, after the approval of the Resolution in 2018 (69). 86.6% of healthcare professionals say they comply with a DVA, even if the patient may benefit in another way (69). A study conducted in Colombia in patients to the FdV (70), found that 14% had signed their own VA; in addition, a higher number was reported because 24% of practitioners said they had received one or more DVA during the last year (69). Despite the progress made in the country by studying the knowledge and attitudes of health professionals regarding this document (69), there are still gaps in relation to the knowledge that health personnel have about Advance Directives in our country.

1.5. Advance directives and their relationship with patients

It has been reported, moreover, that primary care patients show a great willingness to have VA; both young and healthy subgroups

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expressed at least as much interest in planning VA as those over 65 years of age, as well as those with a regular to poor health situation (71). An important question about VA is, if the wishes recorded in the documents remain stable over time, the issue of maintaining preferences is linked to the currency of VA (71). Numerous studies have been conducted on this topic, summarized in a systematic review by Auriemma *et al.* (72) in which they found that preferences in general remain stable, with greater firmness among patients with a serious illness (72,73) and people who had completed a VA (74-78).

Malawi is one of the few countries with a national palliative (79) care policy, thus limited human and material resources in the health system often result in patients being admitted to palliative care to the FdV (80), usually at home. In Spain, Llordés *et al.* have reported that only 2% of the population has formalized the use of VA, although 38% say they have heard of them (81). The frequencies of VA described in the literature vary widely showing large regional and interdisciplinary differences; it is evident that the percentage of people who have an effective DVA remains very low in the general population (82,83). In studies of non-oncology patients in the United States of America, 7% of patients admitted for acute cerebral hemorrhage had an adequate document (84). In Japan, 44% of patients with various types of cancer reported having a VA (85). In a study in Germany from 2009 to 2019, among patients who died in the ICU in 2019 compared with a complementary 2009 cohort, a significant increase in VA before death was observed (86); the increase in ICU patients who died after VA is concordant with a trend recognized in many other ICUs in Europe (87).

Zheng *et al.* investigated factors influencing VA preparation in cancer patients, including 23.2% with head and neck cancer, increased age, female gender, higher educational level, religious affiliation and higher Eastern Cooperative Oncology Group (ECOG) (88) status were found to be significant variables in univariate analysis (89-92). The association between increasing age and the presence of VA was also demonstrated in a study of veterans without underlying malignancy from a rural area of Alabama and another study of

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patients with hemato-oncologic disease (93-94). Mahaney-Price *et al.* found religiosity to be a relevant influencing factor, in addition to the influence of age (94). VAs is used more in chronic diseases, e.g., COPD patients or HIV-infected population (96).

1.6. Human vulnerability principle

The principle of human vulnerability is a condition that must be recognized in all people as an essential component of respect for the values, beliefs and autonomy that govern the essence of people, and that is framed in the understanding of being owners in some way of the control of our life (97).

Currently, after having lived the experience of a pandemic such as COVID-19, it has been possible to understand the importance of being more prepared to recognize the convenience of treating, assessing and identifying in an adequate and timely manner the prognosis that anticipates the process of end of life until death in different pathologies and degrees of severity that afflict patients (98-103). The pandemic caused situations of uncertainty leading in a discouraging way to the fact that palliative care was not one of the strategies considered early in Colombia, especially in those patients with a condition of high risk of death; possibly the lack of knowledge of palliative medicine by physicians, families and patients, and on the other hand, the difficulty or limitation of human, technical and technological resources together with the overflow in health care and ignorance of the VA of patients, led to redistribute priorities in care by directing efforts towards other measures of higher priority (99-106).

It is important to understand how, from the point of view of health care, it becomes a little easier to care for those patients who are undergoing a process of POV when working in a multidisciplinary manner (66,107-111). Institutions should support the creation of hospital bioethics committees to advise physicians on their care and promote the discussion of ethical dilemmas faced by physicians who must somehow undertake the care of patients with different degrees of complexity to offer treatments adjusted to the process of FdV until their own death (71,77,110,112-114).

1.7. Advance directives and death as the end of life

When speaking of death, one must necessarily include the decision-making process or VA as an opportunity for patients to have their wishes respected at any moment of their existence. Training on the care of the FdV is very limited in different medical scenarios (28,62,91,112), the lack of knowledge and national availability of palliative medicine makes questions are generated according to the vital condition of people to carry out much more justified treatments according to each patient's situation (28,47,62,69,115,116). The physician would be of great help in defining the course to be followed with the patient, and would also be responsible for giving complete, honest and clear information, and would assume the role of guiding the decisions to be made according to the information obtained from the patient when this is possible, or from the family (5,29,71,92,112,113,115).

In order to address these issues it is necessary to understand that an honest, empathic and open communication should allow informed decisions to have a greater forcefulness, understanding and comprehensiveness; it is necessary to involve in the context all the information regarding the methods of diagnosis and possible treatments that have been exhausted to provide not only the final care of the patient but a responsible care for the time of his death (44,47,59,63,71,117,118).

It is necessary to have accurate clinical information, to know the level of guilt and adherence to define the benefits of a certain decision; to know if the patient has previously refused studies or treatments that could ethically or clinically compromise him/her (70,89-91,106,107,114,119,120).

Integrating health care attention with mercy, compassion and empathy to intervene in the serious condition of the patient and his quality of life, taking into account the dimension of the human being from physical, spiritual and psychological aspects, his values and beliefs, from a deeply ethical basis (115,120-122), allows to offer a support system that helps patients to live until the last moment of his life in the best possible way and provide efficient accompaniment promoting adaptation and awareness of the disease, which can contribute to the management of grief to his family (117,123,124).

2. Medical knowledge of the advance directives document

The creation of Advance Directives and their corresponding registries arose so that physicians and patients could communicate on a permanent basis, having a general rule or standard on which to rely (125). However, if healthcare professionals do not have the necessary knowledge and attitude to work with this tool, there is a danger that the VA and the PAA will not be used correctly (54). Studies have shown that there is little training in the process of dying (126,127) and minimal research on the recognition of patients' interests at the POF stage (126,128). It is known that primary care physicians begin to talk and share with their patients the decisions to be made at the FdV (129) and physicians, in general, agree that, if patients make a DVA, it favors the dialogue on the ToD at the FdV and is an aid to know the wishes of the patient (130-132).

Although knowledge among these health professionals generally reaches a higher level than among the general public, most doctors and nurses do not have detailed knowledge about VA (as a concept), the laws currently in force (including their binding character in ToD processes) and, above all, how VA can be put into practice; this ranges from administrative aspects (they are often unaware of how to consult the corresponding VA Register) to how they are supposed to proceed in a specific clinical case (57,133).

The study conducted in physicians by Bachiller *et al.* (134) indicated that 29.7% of the respondents did not know that there is legislation regulating VA. Furthermore, only 10.8% of the physicians surveyed were aware of such legislation, while 98.2% thought it was important to inform patients of the possibility of granting advance directives and 51.9% agreed to apply the patient's preferences in advance directives if they are carried out legally (134). The study by Santos Unamuno *et al.* (135) carried out among family physicians, concluded that 82.5% of the physicians considered that they had little or no knowledge of advance directives; only 11.8% had read the current legislation and 97% agreed that the existence of a living will would facilitate advance directives. In the same sense, Simón Lorda *et al.* (54) in their study with physicians reported a mean knowledge of 5.3 (SD: 2.4) on a scale of 0 to 10 in primary care and 5.2 (SD: 2.7) in specialized care. In a similar study by Ameneiros *et al.* (136) the knowledge about advance directives of primary and specialized care physicians reached a mean of 3.8 (SD: 2.3; range 0 to 10). In Colombia there are few studies that evaluate this knowledge; however, Álvarez and Gómez in 2022 conducted a study in which 533 health professionals participated. Most of the participants were chief nurses (49.34 %), followed by physicians (44.09 %), specialists (31.14 %) and subspecialists (12.95 %). Fifty-four percent (n = 286) stated that they were unaware of the existence of the law regulating the VAD in Colombia; 34.33% (n = 183) stated that they were aware of the requirements to be met by this document (69).

2.1. Application of Advance Directives in Different Clinical Scenarios

The severity suffered during the COVID-19 pandemic and the higher mortality among people with comorbidities shows that physicians and surrogate POAs, such as next of kin, often engage in discussions about goals of care to interpret patients' known values (103). Consideration is given to patient preferences in acute, often stressful conditions, and to deciding what intensive care or palliative care would be in accordance with their wishes (103).

A VA may come into effect if the patient enters a permanent vegetative state after an event such as cardiac arrest or severe brain trauma, or if the patient is diagnosed with a terminal illness such as metastatic cancer and lacks the capacity for ToD. Transferring what has been studied by Alvarez *et al.* regarding the knowledge of VAD in 2022 (69), there are multiple scenarios for the application of VAD in critical care, general and intermediate care, and emergency departments, among others.

For practical purposes, we can classify the people who decide to implement their VA into two types (137). The first is made up of those who, using the DVA format set out in Resolution 2665 of 2018 87), have gone directly to the registry of these, or to the places administratively stipulated for this purpose, and have carried out the procedure in compliance with the requirements established by law (137). Healthy people often make the decision according to their own experiences, comments from other patients, or non-medical information. In principle, by the *clinical circuit* when the time comes, when they are affected by a pathology and do not have the capacity to make decisions, the clinician must take this will into account to respect it and make it effective (137). The second type of people who consider implementing the VA is made up of those who are current patients, i.e., who, because of their pathology, have reached the clinical relationship (137).

2.2. Clinical relationship

The care and monitoring of the pathological process should promote assertive communication about the goals of care of a person that is very important in the entire trajectory of a serious illness and influences the quality of life of patients and their families (138,139). Acute anxiety and existential distress associated with mortality salience, fear of pain, and other distressing symptoms often overwhelm standard coping strategies (140). To improve medical ToD, it is important to recognize that people may not make decisions rationally and that emotions impact decisions (141).

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2.3. Decision making

Decisions about life-prolonging treatments in many clinical settings, such as intensive care and oncology, are fraught with emotion precisely because they evince the very real possibility of dying (4). The premise that delegates are rational decision makers underlies most (failed) efforts to improve these decisions, ranging from VA (142) documentation to address arithmetic: the ability to understand and work with numbers with pictographs in providing prognostic estimates. These efforts have failed because, even when perfectly informed, people do not always behave rationally by dispassionately weighing costs and benefits and choosing the best option (4). If they did, many decisions could be improved simply by providing decision makers with the right information (4). For example, researchers studying VA use have repeatedly observed that delegates sometimes accept treatments that the patient's VA suggests they might not have wanted (142). Even when surrogates receive more information about their loved one's preferences by allowing the proxy and patient to discuss the living will, proxies do not end up choosing treatments that are aligned with the patient's preferences (143).

2.4. Chronic illnesses

A common misconception is that chronic diseases with critical intercurrent episodes, in which there are no clear prognostic indicators, cannot benefit from VA (137). Chronic obstructive pulmonary disease (COPD) is an example of this type of pathology (137). Despite the unpredictable course of the disease and the high mortality rate in patients with COPD, the use of VAD is uncommon (144,145). Patients with COPD tend to experience significant morbidity for longer than patients with lung cancer (146). However, previous research has shown that when physicians discussed VA issues with their patients, the quality of care was rated as high (147). This suggests that the problem is not so much the quality of communication

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of care to the POV, but of assertiveness in communication from the onset of care (145). Furthermore, the current literature recommends a multidisciplinary approach to VA that includes multidisciplinary training to ensure high quality palliative care for patients with COPD (146,148).

Integrating early discussions about VA for patients with heart failure (HF) into routine care can facilitate informed and shared ToD regarding complex therapeutic options and palliative care that are aligned with personal values and preferences (149,150). HF patients and their families have also strongly supported early integration of VA or palliative care discussions (151). The utilization of VA has been shown to be efficient in reducing the burden of HF care and improving clinical outcomes for patients/families, including reduced utilization of medical care (152-154), reduced use of aggressive treatments to POV (155), efficient symptom improvement (152,153), improved quality of life (152,153), and in turn timely palliative consultation/hospice enrollment (156).

When inquiring about VA, most patients, including those on chronic dialysis, want to be involved in decisions about life-sustaining therapies (71,157,158). Health states and severity of intervening illnesses rather than descriptions of treatments influence dialysis patients' preferences (159). Hospital staff may also influence the feelings of these patients (160). However, dialysis patients give a significant degree of freedom to their families (delegates) in decisions regarding life-sustaining therapies, independent of their emotional affect (161).

Dementia is the paradigm of complex and severe disease, in which the DVA is presented as a basic element to improve their care (162). Although ideally it would be done in early stages that allow the active participation of the person in the ToD, in most cases it is proposed in advanced stages (162). More than 60% of people living in nursing homes have some type of cognitive impairment (20-30% in advanced stages) (163). Advanced dementia presents a high difficulty in determining the vital prognosis in terms of survival time, and

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in this context the affected persons may be forced to receive intensive and inappropriate treatments (162). The review of critical decisions in people with advanced dementia is performed in only 50% (164), when families participate reduce costly interventions without benefits, prioritizing welfare (165). There are observational studies showing that difficulties with swallowing and infections act as poor prognostic indicators. Recognition of these provides an opportunity to refocus disease progression and care and the application of VAD may be a good starting point (162).

Evidence shows that preferences for life-sustaining treatments depend on the clinical context, which supports the implementation of VA when the patient is clinically stable.

2.5. End-of-life and death phases

Death has generally been a topic that is considered negative and excluded from everyday conversations (70). However, when one is of advanced age or has a serious illness, one often thinks about it and the conditions under which it will occur (168-170). Death can occur suddenly, but in most cases, it results from an illness or chronic condition that usually requires medical attention and, therefore, takes place in the medical context (171). Serious illness can limit cognitive abilities, while increasing anxiety among the patient and family, undermining the ability to think critically and make decisions at difficult times (172,173). The dying process often makes what was once important to them less so, while problems that were once ignored may become increasingly significant (174). Difficult decisions often fall to family members who may be distressed or disagree about an appropriate course of care, despite the presence of an advanced directive (175-177). The perception that a patient received care commensurate with his or her wishes has been found to decrease anxiety, depression, trauma, regret, improved trust, reassurance, and family satisfaction with care (178,179). However, when care is perceived as discordant, the opposite may occur (139).

In relation to terminal illness, the Spanish Society of Palliative Care (SECPAL) defines it as an advanced and progressive condition that cannot be cured (180). This disease has no apparent or reasonable chance of response to specific treatment. It is characterized by the presence of numerous problems or intense symptoms, which are multiple, multifactorial and changing (180). These symptoms generate a strong emotional impact on the patient, his family and the health care team (180). This impact is closely related to the presence, explicit or implicit, of death (180). In addition, it is associated with a life prognosis of less than 6 months (180). Elderly patients with a "terminal illness" such as advanced dementia or end-stage COPD may live a long time and die of an unrelated cause (110).

Issues to the POV, such as PAA, palliative care, place of death, and family roles, are valuable for cancer patients (181-184). FdV decisions include determining how aggressively a patient will be treated and upper limits on treatment (limiting treatment) (51). A patient's resuscitation status is another POV decision because patients may continue active treatment; however, due to the patient's condition, it may not be appropriate to resuscitate in the event of cardiac arrest (51). In addition, it may be decided that active treatment is no longer effective, in which case treatment changes from active to comfort measures, and the patient is palliated (185). It is argued that no two patients are alike and that the decision to continue or withhold life support measures must consider many individual patient factors and therefore can only be made on an individual basis (186).

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