Literature Review for Advanced Directives and Treatment choices

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Advance care directives not only gives a person self-determination ability it also reduces personal worry, feeling of helplessness and guilt by family members, unwanted intervention that has a harmful effect on a patients quality of life(Lynn, Teno & Phillips, 2007). Studies have shown that the end of life for many people is mostly associated with significant burden of suffering. (Bernabei , Gambassi & Lapane,1998).The suffering with this negative health of a person also have financial consequences both for family members and the society(Covinsky, Goldman & Cook, 1997). Decision making concerning own life and death issues affect a large number of population in the United States. Approximately 2.45 million Americans died in the year of 2005. This statistic reflects an absolute increase in the number of deaths, even though the age related mortality rate is decreasing (Kung, Hoyert , Xu & Murphy 2006).More than 80% of those population in the United States have Medicare. About 5% of those Medicare beneficiaries die every year and more than one quarter of Medicare expenses are reported for the care in the final year of life (Hogan C, Lunney J, Gabel J, Lynn J, 2005). The number of Medicare beneficiaries more than doubled between the years from 1966 and 2004, with the aging and growth of the United States population. This population is also predicted to be double in number again by 2030 to 78 million (Kaiser Family Foundation, 2005) .Evidence shows that the treatment received in end of life if different than what is expected by the patient. The care that individual receives is more militant than what is desired, which sometime prolongs the life but it can cause a lot more suffering (Bernabei , Gambassi & Lapane,1998). Individuals in this category include persons with physical or mental disabilities and others with special needs. Many time preferences of those people are not met because they don’t have their advanced directive done. Advance directives have received increasing advocacy over the past 20 years (Ramsaroop, Reid & Adelman). High profile cases have increased the awareness of an advance care planning and the value that adults can make decisions regarding the types of medical treatment they would like to receive in the future. Regulatory bodies like Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the agencies of the federal government encouraged individuals to complete advance directives. The Patient Self-Determination Act (PSDA) also requires hospitals, home healthcare agencies, skilled nursing facilities and providers of home health care to provide all patients with a written summary of their healthcare decision-making rights and the policies of that facility with respect to advance directives .individuals are to be asked at time of admission if they have an advance directive. Even though legislative and regulatory bodies continue to promote advance directives strongly, the overall prevalence for completion of advance directives in the United States remains low. Estimated rate of completed advance directives based on population ranges from 5% to 15% (Ramsaroop, Reid & Adelman, 2007). There are many reasons for an individual not to fill out an advanced directives such as to avoid mentioning death, improper education and mistrust on heath care workers. Some of these barriers can be minimized by legal, social, or clinical interventions. Studies have shown that patients want their primary care doctor to initiate advance care planning while they are in good health. In addition, most patients felt that it was the physician’s responsibility to initiate the discussion about advance care planning. Different interventions have been tested to promote engagement in advanced care planning and completion of advanced directive. The interventions include having the individual discuss their advanced care planning with their provider; letting the health care proxy participate in the process; describing the proxy’s authority and scope of discretion, the goals for treatment; having the advanced directives available for clinician and proxy; interpreting and applying the preferences of an individual as reflected in the advanced directives; reassessing the advanced directives periodically (Brown, 2003).

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