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USE OF ADVANCED DIRECTIVES FOR GOOD END-OF-LIFE DECISION MAKING: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Abstract:

Background: - advanced directive care is essential while the patient is staying in the hospital. It's like a legal guardian when the patient is unable to make a decision regarding the tenement and care plan. Advanced directives are not only for older patients but also for young patients who cannot make a decision about their health due to different health and mental conditions. Like stress and depression or while staying alone in an isolation facility. The main purpose of advanced care directives is to ensure patients receive treatment in case of an emergency or crisis and cannot take a decision about their health.

Materials and Methods: To obtain absolute information regarding systematic and meta-analysis and adopt the PICOT technique while developing a research questionnaire. Key words were identified and literature was searched from different websites. Electronic databases used for literature are MEDLINE, Google Scholar, and PubMed databases for the relevant studies.

Result: Three Thousand six hindered Ninthly five studies were extracted from different sources and One Thousand two hundred eighty-three were found duplicated also screened. Finally, Ten studies were included in this systematic and meta-analysis and published between January 1998 and September 2023.

Conclusion: overall advance directives are very useful for patients are any critical condition and end-of-life decision-making or traumatic stress level.

Keywords: Transformational leadership, Nurse Shortage, Resilience, Work-related wellbeing, Creativity and innovation, Technology advancements.

INTRODUCTION

Doctors, nurses, ethicists, and jurists have been dealing with the problem of decision-making for patients who are critically sick while staying in isolation facilities and who have limited cognitive abilities over many years. One legal way that patients can express their wishes before a period of incompetence is through advance directives (ADs), which are written agreements that either designate a surrogate decision-maker (commonly termed durable power of attorney [DPOA]) or provide instructions (often called living wills) [1]. One of the biggest problems in human demographic history is rapidly aging societies. According to scientific estimates, the number of people over 65 who are elderly will triple between 1999 and 2050 [2]. The growing aging population poses an urgent threat to healthcare systems. Increases in life expectancy worldwide, along with the emergence of cancer and other terminal illnesses, have sparked a conversation about dying. The goal of end-of-life care is to provide a patient with an advanced, incurable illness with the best possible quality of life until their death. This raised the significance of the choices made regarding medical treatment [3].

However, new dilemmas regarding ethics are brought about by patients' growing ability to select ADs because of scientific developments in healthcare. It specifically reignites the discussion about how the roles of doctors, nurses, and other health workers are changing, as well as how patient demands are rising, particularly when it comes to making decisions toward the end of life or critical situations while staying in the isolation room for treatment. Comparing various nations reveals that, depending on how autonomy is understood in certain societies, these factors may conflict more or less [4, 5].

As a result, advance directives (AD) have received a lot of attention in recent years as a possible way to safeguard a patient’s autonomy, rights, and dignity in the final stages of their life. Advance directives are generally understood as legal instruments that allow people to specify how they want medical treatment decisions to be made if they are unable to do so for themselves [6]. Therefore, among other things, advance directives can be in the form of lasting powers of attorney, living wills, healthcare proxies, and do-not-resuscitate orders [7, 8].

considering support and hospice care, future research should focus more on advance care planning (ACP), which is designed to provide patients with the best medical interventions possible at the end of their lives while they are alone in the room and considering their preferences and expectations (9–11). An important component of palliative care is ACP. It is a procedure that allows patients who are able to communicate for themselves, who have access to information about the hospice care plan and the prognosis of their illness (12), and who can share and discuss their wishes and preferences with their family and healthcare providers about future end-of-life care based on their values and life experiences (13,14). The Act on Hospice and Palliative Care and Decisions on Life-Sustaining Treatment for Patients at the End of Life (henceforth referred to as the Act on Decisions on Life-Sustaining Treatment) went into effect in 2018 with the intention of upholding terminal patients' right to self-determination while also protecting human dignity and moral principles. [15]

Advanced care planning(ACP) is a vital component of end-of-life decision making in Qatar. To understand and record patients' beliefs, preferences, and future healthcare goals, ACP entails conversations among patients, their families, and healthcare professionals. This procedure ensures that people get the treatment they want, even if they are too sick or unable to express their wishes. ACP plays a critical role in promoting dignified and culturally appropriate end-of-life care in Qatar, where cultural and religious views have a substantial impact on healthcare decisions [16].

Qatar is a nation with strong Islamic customs and culture. Decisions about healthcare, including end-of-life care, are significantly influenced by Islamic beliefs. The idea of ACP is consistent with Islamic teachings, which place a strong emphasis on a patient's autonomy and dignity when receiving medical care. It is also important to understand that different people and families in Qatar may have different interpretations of Islamic beliefs. With an eye toward supporting ACP and end-of-life decision making, Qatar has been actively working to improve its healthcare policies and infrastructure. Palliative care services, which are vital for meeting the physical, emotional, and spiritual needs of people suffering life-limiting illnesses, have advanced significantly in the nation. Furthermore, steps have been taken in Qatar to educate the public and healthcare professionals about ACP. These initiatives seek to uphold people's choices for end-of-life care and encourage informed decision-making [17].

Methodology

This study is a systemic literature review and meta-analysis of programs aimed at assisting decision-making regarding end-of-life care while cannot take decisions about treatment or healthcare.

Search Strategy

A review of the literature was conducted from the databases' establishment to December 2023, using PubMed, Embase, the Cochrane Library, and Web of Science. ACP, advance directives, advance health care planning, elderly, elderly persons, family members, family caregivers, death, end of life, and so forth were used as search items along with keywords.

Inclusion and exclusion criteria

Based on the population, intervention, comparison, outcomes, and study design (PICOS) framework, a literature search was conducted. Participants included all patients receiving end-of-life care, except children. The search includes all advanced care planning interventions programmed to support decision-making as subjects, and survey studies. Comparison groups were created from non-intervention groups of patients who either had standard care or did not participate in these programs.

The completion of advanced care plans and directives, conversations about end-of-life care, and communication quality were the main outcome variables of the interventions.

Decision conflict, the patient's legal representation's confidence in the decision-making process, agreement between the patient and the patient's legal representative over the chosen course of treatment, and congruence between the patient's choices and the care that was provided were secondary outcome variables. Only experimental investigations were included in the study design. Only English-language research published before December 2023 was considered, and the languages were restricted.

The exclusion criteria were as follows: systematic review, repeated publication, case reports, conference summary, and letter.

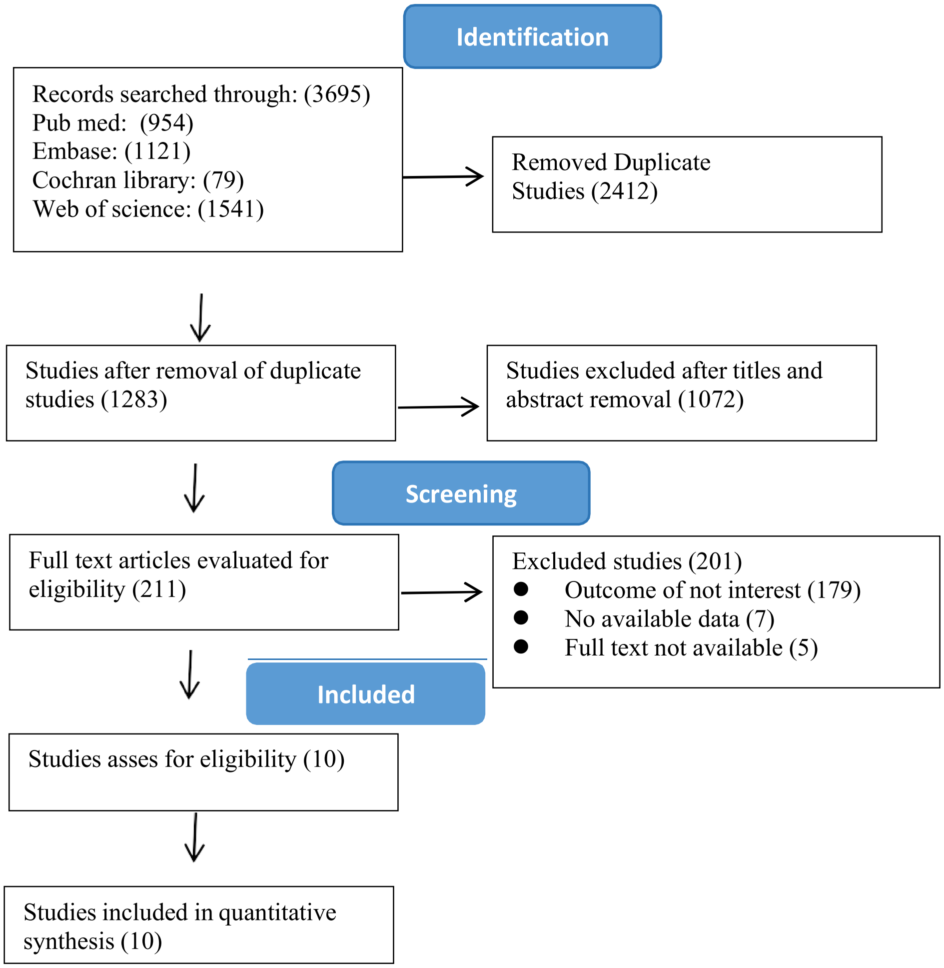
Data extraction

Primary researchers (J Iqbal and Saddiya Alheabil) extracted data from the included papers on their own and performed a cross-check. After debating with a second scholar, disagreements were resolved, and a consensus was eventually achieved. After removing duplicate publications, the remaining research titles and abstracts were examined. After removing any literature that was blatantly unrelated, the complete texts of the remaining publications were screened to identify research that may be included in a meta-analysis.

First author name, publication year, nation, study type, sample size, patient age, and outcome measures were among the details that were taken out of the data.

Quality Assessment

Using the bias risk assessment technique, the primary investigator evaluated the quality of the included studies on an independent basis. The following seven dimensions were used to assess the risk of bias across the included studies: integrity of data results (follow-up bias), selective reporting of results (reporting bias), blinding of personnel and participants (implementation bias), blinding of outcome evaluators (observation bias), randomized sequence generation (selective bias), assignment concealment (selective bias), and other sources of bias. Every study was evaluated on the basis of seven criteria. It was determined to have a low risk of bias, indicating its high quality; if a study met some of these criteria, it was considered to have a moderate risk of bias; if it met none of these criteria, it was considered to have a high risk of bias,, indicating its low quality.



Results

In the current study that was 10 used for data analysis through systematic review. Table 1 illustrates the summary of the study that contains the study with year, country where the study was conducted, its study design, sample size, which instrument is used for data collection and what was the outcome of the study (See table 1).

Table 1: Basic characteristics of the studies

Study	Country	Study design	Sample size	Study Instrument	Outcome
Voltz et al. 1998 [18]	United States, Germany, and Japan	Cross-sectional	159	preliminary questionnaire	• Patients trust family with decisions. • Negative feelings towards future decisions.
Schaden et al 2010 [19]	Austria	Cross-sectional study	139	OEGARI (Austrian Society of Anesthesiology, Resuscitation and Intensive Care) an anonymised questionnaire	• Great interest in end of life decision. • violating autonomy
Ting et al. 2011 [20]	Hong kong	Cross sectional	**219**	Advance directives and life-sustaining Questionnaire	• Majority unaware of advance directives. • Need for increased public education on these issues.
Pérez et al. 2013 [21]	Argentina	Review		Review of literature	• Advanced Directives in Healthcare is useful. • Use influenced by various factors.
Coffey et al. 2016 [22]	Hong Kong, Ireland, Israel, Italy and the USA	Cross sectional	1089	advance directives and perceived confidence in end-of-life care:	• USA nurses have More experience with advance directives. • High confidence and comfort in end-of-life care.
Peicius et al. 2017 [23]	Lithuania	Cross sectional	478	advance directives helpful for good end of life decision	• Advance directives Improves end-of-life decision making and appreciates AD for sharing clinical responsibilities. • Physicians prefer advance directives for end-of-life decisions.
Andreasen et al. 2022 [24]	(Belgium, Finland, the Netherlands, Italy, Poland and United Kingdom)	Cross sectional	1384	questionnaire for Long term care facility of advance directives	• Prevalence of Written Advance Directives in Europe's Long-Term Care Facilities • Significant differences in prevalence among European residents. • Importance of timely, appropriate care planning.
Cipolletta et al. 2021 [25]	Italy	Qualitative	47	Focus group interview	• Legal Regulation of advance directives in End-of-Life Care is insufficient. • Need for improved healthcare service and its Implementation of clearer procedures. • Sharing of procedures with patients and families.
Ye et al. 2023 [26]	China	Cross-sectional study	117	Advance Care Planning directives attitudes	• Early ACP Education for Older Patients should Promotes ACP communications. • Facilitates shared decision-making. • Honors patients' values, preferences, wishes.

Basic risk assessment results of included studies

Among the 10 articles, the quality assessment grade of 3 studies was high, and 7 kinds of literature were medium. (See table 2).

Table 2: Basic risk assessment of the selected studies

Studies	1	2	3	4	5	6	7	8	9	10	11	Points	Grade
Voltz et al. 1998	Y	N	N	Y	Y	Y	N	N	N	Y	Y	7	High
Schaden et al 2010	Y	N	Y	N	N	N	UN	N	Y	Y	Y	5	Medium
Ting et al. 2011	Y	N	N	Y	Y	Y	N	N	Y	Y	Y	7	High
Pérez et al. 2013	Y	N	Y	N	N	Y	N	Y	N	N	Y	5	Medium
Coffey et al. 2016	Y	UN	Y	Y	N	N	Y	N	N	N	UN	4	Medium
Peicius et al. 2017	N	UN	N	Y	N	Y	N	Y	Y	Y	N	5	Medium
Andreasen et al. 2022	Y	Y	N	N	Y	Y	Y	N	N	Y	N	6	Medium
Cipolletta et al. 2021	Y	Y	N	Y	N	N	Y	N	N	Y	UN	5	Medium
Dhakal et al. 2023	Y	Y	Y	N	Y	N	Y	Y	Y	Y	N	7	High
Ye et al. 2023	Y	Y	Y	N	N	Y	Y	N	N	Y	N	6	Medium

1 Source of data is clear, 2 Inclusion and exclusion criteria referred to previous studies, 3 Time period for identify patients, 4 population continuous, 5 subject cover research object, Assessment of quality assurance 7 reason for excluding study participant, 8how to evaluate confounding factors, 9-explanation to deal with loss data. 10 response rate and data collection, 11-followup results

Patients trust their family with decisions, whereas negative feelings toward future decisions

Table 1 reports that the most significant conclusions are that patients receiving palliative care have mixed emotions when making a decision, rely mostly on their doctors' recommendations, and believe that advance directives are helpful in their circumstances. According to the profession’s studies, patients' advanced directives were not as detailed as they would have liked.

Great interest in end-of-life decisions through advanced directives violates patient autonomy.

Table 1 reveals that relatives are integrated into the decision-making process, but from a legal point of view, relatives are denied the right to design for the patient, unless clearly stated in an advance directive. When faced with decisions regarding end-of-life, ICU doctors are particularly concerned about considering their patients' wishes while making decisions. However, the passing of the new law can only be viewed as a significant first step forward as long as patients do not exercise their right to co-determination.

Majority are unaware of advanced directives and the need for increased public education.

In cases where life-sustaining medication is medically unnecessary, the practice of withholding or removing it was approved by older patients with chronic disease. A sizable percentage of them assisted in self-determination if they were mentally capable and corresponded to advanced directives. This might have been connected to the fact that, during the interview, they had received comprehensive information regarding these issues. However, no sizable segment of senior patients had thought through or discussed the matters surrounding advanced directives with others. More work is required to increase public education in this area because the idea of advanced directives and knowledge of life-sustaining care are not generally perceived in Hong Kong. The government may be able to develop measures to promote the idea of advanced directives with the aid of these findings.

Advanced directives are useful but are affected by certain factors

An advanced directive is a legal document founded on the autonomy principle that states a patient's preferences for various medical treatments if the patient is not able to make those decisions for themselves. Three methods are available for expressing advanced directives: Legal Status of Preferences, Living Will, and Appointment of a Healthcare Proxy. Healthcare staff is impacted by the usage of advanced directives in addition to the patients and their families. Although their benefits are widely acknowledged, some common obstacles and elements specific to each research population's peculiarities influence implementation.

Discussion

The great majority of patients in Germany and the USA felt negatively about making decisions for their final days of life. Healthcare professionals should take note of this and be inspired to increase our assistance for these patients. Patients greatly depend on the advice of their healthcare providers, even when making non-treatment-related decisions. This was particularly evident in Germany, where 22% of decisions made by patients involved treatment, yet 32% of patients sought advice from their doctors. These findings suggest that the doctor should start the conversation about advance care planning as soon as possible [27]. Regardless of the patient's specialty, the primary care provider should at the very least start the conversation about advance care planning instead of leaving it to the palliative care specialist [28]. Compared to Germany and the United States, fewer Japanese patients expressed regret about their choice for the future. Rather, their demeanor was more optimistic and philosophical. It is probable that Japanese cultural customs discourage expressing unpleasant emotions [29, 30].

Our study's findings indicate that family members participate in the decision-making process, although legally speaking, relatives in Austria are not allowed to make decisions on behalf of their loved ones unless expressly authorized in an advance directive. Moreover, it is necessary to investigate the appropriateness of the surrogate decision, as demonstrated by the study by Li et al. For family members, participating in decision-making is a significant obstacle [31]. Early identification of opinions and preferences regarding end-of-life care would almost certainly enhance the flow of information and comprehension about this frequently contentious subject between patients and their families [32].

By ensuring a patient-oriented treatment plan that offers the utmost possible understanding and acceptance of the family in an emotionally taxing situation, conflicts between the patient and their relatives as well as between the medical team and the relatives can be resolved early on [33].

After learning about the concept, almost half of the elderly patients in the poll said they would consider adopting advance directives if they were formally enacted in the future. This was the case even though a substantial portion of the respondents had never heard of them before conducting the survey. The acceptability rate was comparable to that of a local study where 49% of senior citizens agreed with the idea of prior directives. This research highlights a significant concern that while determining whether to provide elderly patients with life-sustaining therapy, doctors should take their wishes into consideration. Improved promotion of advanced care planning is necessary. Death and associated topics are rarely mentioned in public in Chinese society, especially among older adults [34–36]. Furthermore, elderly people with chronic illnesses rarely benefit from advance care planning; instead, it has primarily been employed for patients with severe or terminal illnesses (such as metastatic cancer). A life-sustaining choice must frequently be made in an emergency or when an older patient is hospitalized and in critical condition [35].

All US citizens should have an advanced directive, but those over 65 should especially have one, as they account for 70% of the nation's fatalities. Nonetheless, some studies have revealed that many patients still lack advanced directives [36, 37, 38]. There is disagreement in the literature regarding the application of advanced directives. On the one hand, research indicates that only roughly 20% of Americans have advanced directives [39, 40]. However, a survey has indicated that as many as 70% of older individuals who live in the community have already completed their advanced directives.

Advanced directives have become incredibly popular, although there is disagreement over their efficacy [41, 42].

Conclusion

An overview of patients' participation in end-of-life decision-making through advanced directives is provided in this study. Involvement in EOL through AD talks enhanced the understanding of patients' preferences, enhanced the process of dying, and reduced family members' worry, despair, and post-traumatic stress disorder. Despite the established advantages, there are still certain obstacles that prevent patients from participating in their own death through advanced directives. These include, but are not limited to, a lack of knowledge, education, training, or experience; worries about moral and legal ramifications; and the personal preferences of medical professionals. Patients' participation in end-of-life decisions varies widely, as do the viewpoints of patients, family members, and medical professionals. To enhance the patient's experience with EOL care and decision-making, this may direct future studies to offer insights into the patient's preferences.

REFERENCES

1. Teno JM, Stevens M, Spernak S, Lynn J. Role of written advance directives in decision making: insights from qualitative and quantitative data. Journal of General Internal Medicine. 1998 Jul;13(7):439-46.
2. Health data and statics. Available: http://www.who.int/healthinfo/statistics/en/. [Ref list]
3. Department of Health. End of Life Care Strategy: Quality Markers Consultation. 2008. Available: https://www.gov.uk/government/organisations/department-of-health. [Ref list]
4. Horn JR. Advance Directives in English and French Law: Different Concepts, Different Values, Different Societies. *Health Care Anal.* 2014;**22**:59–72. doi: 10.1007/s10728-012-0210-7.
5. Beširevic V. End-of-life care in the 21st century: advance directives in universal rights. *Bioethics.* 2010;**24**(3):105–112. doi: 10.1111/j.1467-8519.2010.01806.x.
6. Evans N, Bausewein C, Menaca A, Erin A, Higginson IJ, Harding R, Pool R, Gysels M. A critical review of advance directives in Germany: Attitudes, use and healthcare professionals' compliance. *Patient Educ Couns.* 2012;**87**(3):277–288. doi: 10.1016/j.pec.2011.10.004.
7. Lorda PS, Velázquez TMI, Cantalejo BIM. Advance Directives in Spain: Perspectives from a Medical Bioethicist Approach. *Bioethics.* 2008;**22**(6):346–354. doi: 10.1111/j.1467-8519.2008.00644.x.
8. The World Medical Association Statement On Advance Directives ("Living Wills") by the WMA General Assembly, Helsinki 2003. https://www.wma.net/policy/.
9. Jaklevic MC. Despite Big Buildup, Few Benefit From Medicare's Advance Care Planning Coverage. JAMA 2021;325:2333-4.
10. Mitchell SL. Controversies About Advance Care Planning. JAMA 2022;327:685-6.
11. Ufere NN, Lai JC. Advance Care Planning in Liver Transplant-Preparing for Both Life and Death. JAMA Intern Med 2021;181:660-1.
12. Combes S, Nicholson CJ, Gillett K, et al. Implementing advance care planning with community-dwelling frail elders requires a system-wide approach: An integrative review applying a behaviour change model. Palliat Med 2019;33:743-56.
13. Fong KC, Chiong W. Understanding Advance Directives as a Component of Advance Care Planning. Am J Bioeth 2020;20:67-9.
14. Fried TR, Paiva AL, Redding CA, et al. Effect of the STAMP (Sharing and Talking About My Preferences) Intervention on Completing Multiple Advance Care Planning Activities in Ambulatory Care : A Cluster Randomized Controlled Trial. Ann Intern Med 2021;174:1519-27.
15. Kim MH. The problems and the improvement plan of the hospice/palliative care and dying patient's decisions on life-sustaining treatmentact. Korean J Hosp Palliat Care 2018;21:1-8
16. Agarwal R, Epstein AS. Advance care planning and end-of-life decision making for patients with cancer. InSeminars in oncology nursing 2018 Aug 1 (Vol. 34, No. 3, pp. 316-326). WB Saunders.

17. Chemali Z, Biffi A, Buch K, Song KW, Osman H. Neuropsychiatry, Palliative Care, and Culture: What Matters Beyond Diagnosis. The Primary Care Companion for CNS Disorders. 2021 Feb 24;23(2):27899.
18. Voltz R, Akabayashi A, Reese C, Ohi G, Sass HM. End-of-life decisions and advance directives in palliative care: a cross-cultural survey of patients and health-care professionals. Journal of pain and symptom management. 1998 Sep 1;16(3):153-62.
19. Schaden E, Herczeg P, Hacker S, Schopper A, Krenn CG. The role of advance directives in end-of-life decisions in Austria: survey of intensive care physicians. BMC Medical Ethics. 2010 Dec;11(1):1-6.
20. Ting FH, Mok E. Advance directives and life-sustaining treatment: attitudes of Hong Kong Chinese elders with chronic disease. Hong Kong medical journal. 2011 Apr 1;17(2):105.
21. Pérez MD, Macchi MJ, Agranatti AF. Advance directives in the context of end-of-life palliative care. Current opinion in supportive and palliative care. 2013 Dec 1;7(4):406-10.
22. Coffey A, McCarthy G, Weathers E, Friedman MI, Gallo K, Ehrenfeld M, Chan S, Li WH, Poletti P, Zanotti R, Molloy DW. Nurses' knowledge of advance directives and perceived confidence in end-of-life care: A cross-sectional study in five countries. International Journal of Nursing Practice. 2016 Jun;22(3):247-57.
23. Peicius E, Blazeviciene A, Kaminskas R. Are advance directives helpful for good end of life decision making: a cross sectional survey of health professionals. BMC medical ethics. 2017 Dec;18(1):1-7.
24. Andreasen P, Finne-Soveri UH, Deliens L, Van den Block L, Payne S, Gambassi G, PACE Consortium. Advance directives in European long-term care facilities: a cross-sectional survey. BMJ Support Palliat Care. 2019.
25. Cipolletta S, Reggiani M. End-of-life care after the legal introduction of advance directives: A qualitative study involving healthcare professionals and family caregivers of patients with amyotrophic lateral sclerosis. Palliative medicine. 2021 Jan;35(1):209-18.
26. Ye L, Jin G, Chen M, Xie X, Shen S, Qiao S. Prevalence and factors of discordance attitudes toward advance care planning between older patients and their family members in the primary medical and healthcare institution. Frontiers in Public Health. 2023 Feb 23;11:1013719.
27. Johnston SC, Pfeifer MP, McNutt R, for the End –hospice care? of Life Study Group. The discussion about advance directives. Patient and physician opinion regarding 3. Who is the patient’s source of support? when and how it should be conducted. Arch Intern for example, family, friends, emergency Med 1995;155:1025–1030.
28. Weitkunat R. Deskriptive Statisitk in SAS. Gustav worker, other professionals, technical help, Fischer Verlag, Stuttgart 1994:121.
29. Markus HR, Kitayama S. Culture and the self: im- 4. How is the patient coping? plications for cognition, emotion, and motivation. Psychol Rev 1991;98:224–253.
30. Ishiwata R, Sakai A. The physician—patient rela- –is spiritual help wanted? tionship and medical ethics in Japan. Cambridge Qu Healthcare Ethics 1994;3:60–66.
31. Li LL, Cheong KY, Yaw LK, Liu EH: The accuracy of surrogate decisions in intensive care scenarios. Anaesth Intensive Care 2007, 35:46-51.
32. Pochard F, Azoulay E, Chevret S, Lemaire F, Hubert P, Canoui P, Grassin M, Zittoun R, Le Gall JR, Dhainaut JF, Schlemmer B: Symptoms of anxiety and depression in family members of intensive care unit patients: ethical hypothesis regarding decision-making capacity. Crit Care Med 2001, 29:1893-1897.
33. Arnuld RM, Kellum J: Moral justifications for surrogate decision making in the intensive care unit: implications and limitations. Crit Care Med 2003, 31:S347-53.
34. Chan TH, Chan FM, Tin AF, Chow AY, Chan CL. Death preparation and anxiety: a survey in Hong Kong. Omega (Westport) 2006-2007;54:67-78.
35. Chu WW, Woo J. Attitudes of Chinese elders towards advance planning on end-of-life issues: a qualitative study in a nursing home in Hong Kong. J Hong Kong Geriatr Soc 2004;12:18-23.

36. Tang CS, Lam LC, Chiu HF. Attitudes to end-of-life decisions: a survey of elderly Chinese with dementia and their carers. Asian J Gerontol Geriatr 2007;2:119-25.
37. Wheatley E, Huntington MK. Advanced directives and code status documentation in an academic practice. Fam Med Sept 2012; 44:574–578.. Investigation of how physicians of the Sioux Falls Family Medicine Program (SFFMRP) were addressing advance directives and code status with geriatric population.
38. Bezzina AJ. Prevalence of advance care directives in aged care facilities of the Northern Illawarra. Emerg Med Australia 2009; 21:379–385.
39. Brown BA. The history of advanced directives: a literature review. J Gerontol Nurs 2003; 29:4–14.
40. Lingler L, Hirschman K, Garand L, et al. Frequency and correlates of advance planning among cognitively impaired older adults. Am J Geriatr Psychiatry 2008; 16:643–649.
41. Silveira MJ, Kim SYH, Langa KM. Advance directives and outcomes of surrogate decision making before death. N Engl J Med 2010; 362:1211– 1218.
42. Teno JM, Gruneira A, Schwartz Z, et al. Association between advance directives and quality of end-life care a National Study. J Am Geriatr Soci 2007; 55:189–194.