Introduction

With the overall expansion of an aging population, the number of older adults facing end-of-life decisions is increasing. Many elderly are expected to be incapacitated in late life and expected to loose their ability to take decisions. Several methods exist to help people and their families making such decisions ***(McGuire et al., 2007)***.

Ongoing improvements in medical technology may allow us to prolong death artificially, with the risk of continuing a potentially meaningless and unwanted existence ***(Iserson, 1993)***.

Studies have shown that patients are opposed to aggressive medical treatment unless it will alleviate pain or result in better comfort or safety for the patient ***(Michelson et al., 1991)***.

Modern medicine, then, has made it increasingly important to older adults to retain control of the level of care they receive through the execution of advance directives (ADs) ***(Molloy et al., 2000)***.

It is important to note that dying is not a problem to be solved and rated by a checklist of predetermined preferences, but a human experience that everyone must face ***(The US President's Council on Bioethics, 2005)***.

Advance directives allow people to specify some one who they trust to make crucial decisions on their behalf in case of incapacity ***(McGuire et al., 2007)***.

Attention is needed to understand the outcomes of end-of-life care as they occur when a trustable person is responsible for end-of-life decision making for the incapacitated person ***(McGuire et al., 2007)***.

Incurrent practice in both the United States and Canada, there is a trend to set up Advance directives and to promote their use ***(Blondeau et al., 1998)***.

Complexity of decisions involved in the completion of Advance directives may represent a major challenge for older adults in general and especially for those adults with cognitive decline ***(McGuire et al., 2007)***.

Literature has paid little attention to the influence of cognitive functioning on completion of living wills and other forms of advance directives as Enduring power of attorney ***(McGuire et al., 2007)***.

Cognitive functioning has been shown to influence the process of making medical decisions ***(McGuire, 2000)***.

Simple cognitive abilities such as verbal skills may underlie the capacity to designate a surrogate decision maker or state a treatment preference, whereas higher order cognitive abilities may affect the ability to understand consequences of personal decisions or provide reasons for those choices ***(Allen et al., 2003)***.

As the number of community-dwelling older adults continues to grow, the number of people with mild to severe cognitive impairment is expected to increase proportionately ***(Hanninen, et al, 2002)***.

Mild cognitive impairment is common in community dwelling older adults ***(Ritchie and Touchon, 2000)*** and the prevalence of Alzheimer’s disease reach 10% among adults aged 65 or older and nearly 50% among those aged 85 or older ***(Evans et al., 1989)***.

Aim of the Work

To study the capacity to create an Enduring power of attorney among elderly in nursing homes.

Advance directives

A) Glossary and definitions:

Advance directives (ADs) are documents that allow competent patients to designate the kind of medical procedures that they desire, when they become unable to make such decisions ***(Hopp, 2000)*** and the extent to which measures should be taken to prolong their lives ***(Michelson et al., 1991)***.

Regarding ADs in the USA three types are available:

(a) Durable power of attorney (DPA), which allows an adult to appoint an agent to handle any and all financial matters

(b) Durable power of attorney for health care (DPAHC), in which an adult can designate an agent to make any and all health care decisions

(c) Living will (LW), which specifies the kinds of treatment that the adult does or does not want in the event of terminal illness ***(Rosnick and Reynolds, 2003)***.

A power of attorney (POA) in USA is a legal document that is used to give legal authority to someone else (such as a relative or friend) to make decisions or do certain things on the donor behalf ***(Documatica Legal Forms, 2009)***.

In UK an Enduring Power of Attorney (EPA) is a document appointing a person (an ‘Attorney’) to manage the property and financial affairs of another person (the ‘Donor’), if the donor becomes unable to make financial decisions. The EPA must be registered before it can be used and at least three of their relatives must be notified ***(Office of the Public Guardian, 2008)***.

The Donor of EPA is the person who signs the Power of Attorney (gives up the authority) ***(Office of the Public Guardian, 2008)***. In USA donor is called the Principal ***(Documatica Legal Forms, 2009)***.

In USA **the recipient of power of attorney** is the person who is given the authority is called the Agent or Attorney-in-Fact ***(Documatica Legal Forms, 2009)***.

In UK Agent is called the Attorney**.** An Attorney is someone appointed under either a LPA or an EPA who has the legal right to make decisions within the scope of their authority on behalf of the person (the Donor) who made the Power of Attorney ***(Office of the Public Guardian, 2008)***.

The ‘attorney’ can use the power straight away, or donor can make clear that the EPA is only to be used if donor becomes mentally unable to manage his/her affairs in the future ***(Public Guardianship Office, 2005)***.

Now in UK Lasting Power of Attorney (LPA) was introduced which is a type of Power of Attorney appointing an Attorney to make decisions about the Donor’s personal welfare (including healthcare) or to deal with the Donor’s property and affairs ***(Office of the Public Guardian, 2008)***.

The new LPAs give more protection and extra options than EPAs which only allowed people to make decisions about property and financial matters on their behalf (not personal or health care). LPAs replaced EPAs in 2007 ***(Office of the Public Guardian, 2008)***.

Recently in UK, Advance care planning has been defined as a process of discussion between an individual, their health care providers, and often those close to them, about future care. The discussion may lead to:

- An advance decision to refuse treatment (ADRT)
- The appointment of a personal welfare Lasting Power of Attorney (LPA).

These terms supersede previous phrases such as 'living wills' and 'advance directives' ***(Royal college of Physicians, 2009)***.

An Advance refusal of treatment (ADRT) can only be made by a patient while they still have capacity, but only become active when they lose capacity. It only applies to a refusal of medical treatment ***(Royal college of Physicians, 2009)***.

Personal Welfare Lasting Power of Attorney (LPA) must be made while the patient has capacity, but an LPA can act only when the patient lacks capacity to make the required decision and must act according to the principles of best interests of the donor ***(Royal college of Physicians, 2009)***.

Best interests means that any decisions made or anything done for a person who lacks capacity to make specific decisions must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests ***(Office of the public guardian, 2008)***.

An Alternate agent is the person who replace the first agent should the first Agent be unwilling or unable to perform his or her duties**.** Other names are Successor Agent or Successor Attorney-In-Fact ***(Documatica Legal Forms, 2009)***.

For those who become incapacity-ated and have no EPA or LPA in UK the Court of Protection appoints a deputy for decision taking according to the principles of best interests of the incapacitated; this deputy is called Court Appointed Welfare Deputies ***(Royal college of Physicians, 2009)***.

Springing Power of Attorney is designed to become effective only upon the occurrence of a certain event chosen by the Principal (such as illness or disability) ***(Documatica Legal Forms, 2009)***.

For canceling or enduring the EPA before registering the best way is to sign a ‘Deed of revocation’. If the EPA has been registered, you need to apply to the Court of Protection ***(Public Guardianship Office, 2005)***.

In UK Ordinary power of attorney is not valid once the person is mentally not able to manage his/her affairs. But an EPA can be used in this situation, as long as the attorney applies to the Court of Protection to have the EPA registered ***(Public Guardianship Office, 2005)***.

B) Importance of Advance Directives

End-of-life issues in clinical practice present complex ethical, moral and legal dilemmas that have been heightened by advances in medical technology enabling a dying patient to be kept alive for longer than ever before ***(Samanta and Samanta, 2006)***.

Autonomy, justice and beneficence are three of the main principles of ethical practice ***(Blondeau et al., 1998)***.

Respect for patient autonomy and dignity are fundamental ethical components that engage in end-of-life decision-making ***(Samanta and Samanta, 2006)***.

It has been suggested that an individual is likely to have a positive attitude towards ADs if he/she believes that ADs promote the expression of wishes (autonomy) and equity among human beings (justice), and that they contribute, for example, to helping the family cope with the emotional burden or reduce the fear associated with the risks of relentless therapeutic efforts ***(Blondeau et al., 1998)***.

An individual is likely to have a negative attitude towards ADs if he or she believes that pursuing the best clinical interests of the patient) (beneficence) and considerations of an administrative and legal nature (external norms) should prevail over written wishes ***(Blondeau et al., 1998)***.

A mentally competent individual has the absolute right to refuse medical treatment for any reason and a valid AD for the refusal of treatment is binding if he/she loses capacity ***(Samanta and Samanta. 2006)***.

In the incompetent patient, the withdrawal of life-sustaining treatment is based on the ‘best interests’ test, developed on a model that takes into account the welfare considerations of the person concerned ***(Samanta and Samanta, 2006)***. So the use of ADs is beneficial because they enhance patient autonomy ***(Suri et al., 1999)***.

In addition to the advantages of having one’s wishes known and a surrogate decision maker designated, the execution of ADs may decrease the possibility that guardianship will be necessary when the adult is no longer capable of making or communicating decisions ***(Janofsky and Rovner, 1993)***.

There is little empirical evidence that ADs effectively substitute for or divert from guardianship ***(Wilber, 1995)***. Guardianship should be viewed as an intervention of last resort, as it often results in unnecessary restrictions on personal autonomy ***(Iris, 1988)***. If the execution rate of ADs can be increased, the need for guardianship may also be reduced, and subsequently, the ability of older adults to maintain their autonomy through their final days may be increased ***(Rosnick and Reynolds, 2003).***

Any cost reduction associated with advance care planning is probably related to avoiding "terminal hospitalisation"**,** or because people with an Advance Decision to Refuse Treatment (ADRT) are less likely to receive life sustaining therapy when hospitalized,***(Kish wall as et al., 2001)***.

This can also be applicable by encouraging physicians to avoid unwanted or inappropriate treatment for the terminally ill ***(Tonelli, 1996)*** and so increasing the possibility of receiving desired care ***(Murphy, 1990)***.

ADs may also reduce anxiety for the patient's family members by making the patient's wishes clear ***(Molloy et al., 2000).***

It was found that there was a linear trend between levels of stress and those who did not have ADs ***(Tilden et al., 2001)***.

C) ADs in various cultures

The origin of advance directives can be traced back to USA in 1976, when the Natural Death Act was passed in California, giving living wills official legal status. Most American states have passed legislation that provides a legal framework for living wills, durable powers of attorney, or both at the same time ***(Annas, 1991)***.

USA states have enacted legislation providing legally binding documents for health care decision making in the event of a terminal illness or decisional incapacity ***(High, 1993)***.

In Canada, however until 1998, there was no explicit legislation governing living wills, Durable powers of attorney hold legal status in the provinces of Quebec and Nova Scotia. The passage of legislation governing advance directives does promote their use, which is becoming more and more widespread in the country ***(Blondeau et al., 1998)***.

In the United Kingdom there has been little experience in the use of Advance care Planning (ACP). However, with legislation in the form of the Mental Capacity Act ***(Department for Constitutional Affairs UK, 2005)*** and NHS initiatives aimed at increasing uptake of ACP ***(NHS End of Life Care Program, 2007)*** the use of ACP was increased.

Much of the evidence base for ACP comes from Canada and USA; in interpreting the evidence. There have been differences between the two healthcare systems. In particular, US legislation requires that all individuals admitted to a care home are offered ACP ***(Royal college of Physicians, 2009)***.

In UK, review of the literature demonstrated that most of the general public (60-90%) is supportive of ACP ***(Sahm et al., 2005)*** but only 8% of the public in England and Wales had completed an ACP document of any kind ***(Royal College of Physicians, 2009)*** compared to 10-20% of the public in the US, Canada, Australia, Germany and Japan ***(Thorevska et al., 2005)***.

In USA previous research has demonstrated that African Americans and other racial or ethnic groups have lower completion rates of durable power of attorney documents than Whites do ***(Bullock, 2006)***.

Whites in USA tend to be more knowledgeable of and likely to complete ADs, although this is not consistent across research ***(Gutheil and Heyman, 2005)***.

Additionally, rural community-residing elders may have less access to information about ADs because availability of various health-related services is limited, therefore limiting the contact and potential discussions. So rural individuals may have trouble with health professionals about completion and implementation of ADs ***(Wilson et al., 2006)***.

In USA, All Arab participants (Muslim Arabs and Christian Arabs) indicated that family takes care of an individual at end of life. Arabs try desperately not to go to Nursing homes ***(Duffy et al., 2006)***.

Arab Muslim men feel that having a will is important but not aware of ADs. Arab Muslim women identified cultural barriers related to end of life care. Arab Christian women do not feel they should talk about death in advance ***(Duffy et al., 2006)***.

Resistance to execution of ADs may come from lack of communication between physicians and patients' families ***(Tonelli, 1996)***.

In addition, other sources of resistance may be due to uncertainty about the possible risks and benefits of future medical treatment; uncertainty about how the physician will interpret the document when it goes into effect ***(Tonelli, 1996)***.

The inability of ADs to resolve dynamic decisions that could face the families and providers might cause fear to execution of ADs ***(Zronek et al., 1999)***.

There have been tendencies toward putting off planning for the onset of late life diseases and disabilities until elderly are presented with an immediate crisis ***(Winick, 1998)***.

Some elderly refuse taking action because their present condition is not life threatening and they believe they can rely on others to make decisions for them when the time comes ***(High, 1993)***.

Winland-Brown (1998) suggested issues that might explain reluctance to execute ADs including fear of versus acceptance of death, trust versus mistrust regarding the carrying out of one's wishes, and lack of knowledge regarding the necessity for legalizing one's health care wishes.

This combination of struggles could explain why older adults are not executing ADs in large numbers ***(Rosnick and Reynolds, 2003)***.

Another reason for not completing ADs is the lack of knowledge of the purpose of or process for creating ADs ***(Rodriguez and Young, 2006)***.

More over, according to ***Royal College of Physicians (2009)***. Barriers to increased ADs can be categorized into:

- Client/individual factors (like cognitive ability).
- Family factors (including awareness of ADs need or difficult relationship with the patient).
- Case manager factors (previous experience/lack of knowledge, level of comfort with discussion, lack of training).
- Service factors (lack of funding lack of time).