ABSTRACT

Objective: To discuss the policy issues of palliative care for improving the quality of care of the dying, to limit unnecessary therapeutic medical interventions, to provide access to trained palliative care providers, to ensure the availability of essential medications for pain and symptom control, and to improve awareness of advance directives issues through educational initiatives. Also, to formulate and develop advance directive guidelines for the health professions and other professions, including the agencies involved in dealing with advance directives.

Methods: Various databases and internet engines were searched to find all related information about the concept. English language literature reports published between 2010 and 2017 were reviewed.

Results: The ethical principles relevant to health professionals, patients, and their family members when they encounter difficult decisions with regard to end-of-life treatments focus on four important moral commitments: respect for autonomy, beneficence, nonmaleficence, and justice. Discussions regarding advance directives could be viewed as opportunities for lawyers, health professionals, and theorists to work together to protect the interests of patients. Advance directives must be recognized that decreased social disparity and bias about killing that performs the conveyance of administrations in society, including health care services. Policy for the end of life reflects respect and protection existing in the wishes of patients with the end stage to die naturally or to die with human dignity and certification of patients' rights to self-determination to die naturally and peacefully without being held by any equipment or technologies. Regarding the research, knowledge, perspectives, and practices of nursing personnel concerning advance directives, it was found that nursing staff reflected lack of technology, lack of opportunity, and lack of knowledge concerning federal and state laws and general information about advance directives, showing a need for clarification concerning the most practical setting for advance directive formulation.

Conclusion: This paper includes a comparative analysis of the literature, comprising reviews of advance directives at the end of life and the development of the advance directives process for health professions and other professions, including the agencies involved in dealing with advance directives. This may provide a basis for developing guidelines in order to avoid misunderstanding in the implementation of advance directives.

Keywords: Advance directives, end of life, policy, non-maleficence, dilemma
Advance directives (ADs) are a patient's statement serving their own judgement and human rights while they no longer have time from their severe disease. Advance directives provide physicians and family members with a clear indication of the subjectivities of the patients. Advance directives thus may provide the individuals' family members with an obvious indication of the patient's hopes. It also helps physicians complete their professional responsibilities to patients, especially when confronting the difficult choice when life-sustaining treatments should be withheld or withdrawn for the best attention of the patients.

The ethical principle of advanced decisions is guaranteed and protected by the Constitution of the Kingdom of Thailand according to article 12 of the National Health Act 2007, which states that "everyone has the right to self-determination when they are at the end of their life or to end stage of illness."

There are various views about active euthanasia and passive euthanasia. For the health professions, the ethical principle of nonmaleficence is the dilemma of doing something or doing nothing. In other words, the question of treatment withdrawing or withholding is still a dilemma for the health professions. However, doctors, nurses, and health professionals still lack knowledge, awareness, experience, and the proper attitude towards patients at the end of life.

Palliative care requires advanced care planning, and palliative care at the end of life is neither beneficial nor needs of patients does it address the

A further step in confirming these views and values with physicians would be by making advance directives. Advance directives issues, especially in serious periods of illness between physicians and patients, reduce intensive treatment and expenditures, yet do not increase mortality.

Finally, there are no existing laws or practice guidelines regarding the physician's responsibility. Death and terminal illness experiences in the past played an important role in illness perception and decision-making, and today many are confused when the issue of advance directives is raised.

PURPOSE
The purposes of this paper are:

1) To discuss the policy issues of palliative care
2) To improve the quality of care of the dying, to limit unnecessary therapeutic medical interventions, to provide access to trained palliative care providers, to ensure the availability of essential medications for pain and symptom control, and to improve awareness of advance directives issues through educational initiatives
3) To formulate and develop advance directive guidelines for the health professions and other professions, including the agencies involved in dealing with advance directives

METHODS
A comparative analysis of the literature, comprising reviews of advance directives at the end of life and overviews of previous research studies, was used in the present study to generate a synthesis of the existing knowledge of advance directives at the end of life. Therefore, the methods used in this review article were as follows: 1) collecting data from articles, texts, and related studies, and from the institutions involved, including the determinants discussed in epidemiological studies and data related to advance directives at the end of life; and 2) the analysis and synthesis of advance directives at the end of life.

ADVANTAGES OF ADVANCE DIRECTIVES FOR END OF LIFE
Ethical principles:
The ethical principles relevant to health professionals, patients, and their family members when they encounter difficult decisions with regard to end-of-life treatments focus on four important moral commitments: respect for autonomy, beneficence, nonmaleficence, and justice. First, autonomy is the respect for the individual making the decisions. Thus, the free and fully-informed consent of the patient is provided regarding termination of life with respect to the autonomy to follow the advance directives. Secondly, beneficence is defined as comparing the cost-benefit analysis and treatment against the risks. Thirdly, nonmaleficence means to do no harm, and this has predominated and been upheld regarding both legal and ethical concerns for patient care. Health professionals must not provide treatment that might be deleterious to the patient. The benefit of therapy balances the harm, and the physician can provide appropriate care to avoid harm to the patient under advance directives. The relevant ethical issue is whether the advantages outweigh the responsibility. Health professionals cannot prescribe ineffective treatments to patients that offer risks and possible harm with no likelihood of an advantage. This principle is most expedient when it is balanced against beneficence. Health professionals act with nonmaleficence by stopping a procedure or medication that appears to be harmful or refusing to continue a treatment shown to be ineffective.

**Standpoints of patients and their families vs. health professionals and other care providers**

The primary advantage of advance directives is to allow patients to voice their desires regarding the treatments administered at the end of their lives. The patient can then determine at what point treatment should stop and how pain management can be administered to relieve suffering until his/her death. Patients should address end-of-life decisions in their advance directives in terms of refusing treatment. Unnecessary medical interventions, including treatment and delayed natural death, can increase the suffering of patients through pain, stress, fatigue, and added cost. By using advance directives, patients can specify the treatments that they wish to be prescribed. However, whether healthcare professionals are required to comply with the patients’ wishes within advance directives requires further clarification. Health professionals should ensure that instructions follow according to the advance directives, and they should notify the patient of any difficulties or ethical issues that prevent them from carrying out the instructions. The importance of having advance directives in place should be clarified with health professionals, patients, and their loved ones or families so that all concerned are aware of which procedures, aggressive interventions or treatments the patients do or do not want if they lose the ability to communicate. Advance directives can prevent arguments, as family members or loved ones may have different ideas regarding artificial resuscitation or the best treatment. When patients have advance directives in place, this eliminates any arguments that could occur among their families. Nurses with knowledge of the relevant cultural, legal, and ethical issues, and also of advance directives, could improve decision-making at the end of life. Nurses perform an important role in advising patients regarding the importance of advance directives and how to set them in place, and well-informed nurses are comfortable discussing these issues with their patients.

**Decision-making for advance directives**

Discussions regarding advance directives could be viewed as opportunities for lawyers, health professionals, and theorists to work together to protect the interests of patients. Health professionals need a clear understanding of the factors that affect on a patient’s behavior, attitudes, beliefs, preferences, and decisions during end-of-life care. Some people prefer euthanasia and compassion, while others believe that the truly merciful way to manage suffering in end of life patterns is to request euthanasia in an application. Advance directives are extremely flexible, allowing patients to change their mind at any time. Patients can usually cancel advance directives simply by destroying the document or writing a new one.
Ethical principles
Advance directives must be recognized that decreased social disparity and bias about killing that performs the conveyance of administrations in society, including health care services. The individual's determinations identity most powerless against inappropriate or indifference is poor people, minorities, and the disadvantaged individuals. In numerous countries, medicinally helped sustenance and treatments are viewed as restorative treatment, continually symptomatic treatment. These might be utilized to legalize the deprivation of life-supporting medications for patients that are disabled however but not be cured. Additionally, the perception of all social and religious and to be sure identity contrasts among individuals is past the extent of the informing. Ordinarily, attempt to foresee patient's inclinations infrequently complex restorative circumstances that they can't drive by offering a hopeless of alternatives that might be utilized to inhibit treatment health care providers would need in individual conditions. The patient respects and trusts that the physicians will apply their expert capability to the patient's treatment plan and advantage. Considerably more vitally, the patient trusts that their doctors will do nothing to damage them.

Standpoints of patients and their families vs. health professionals
Because it is the duty and moral dimension of medical intervention to support the diminishing patient defend patients' disease and respect as a one of a kind individual regardless of any condition. The advance directives put tremendous drive under the duty for specialists, who empower pick if likewise when that living produces results, the moment that medical intervention if make pulled back then again withheld. Specialists as often as possible consider the shot of survival while considering the fitting treatment alternative, the load of treatment, expected span of treatment in their contemplations. Making a living will have its related impediments. Some of the time living wills is composed of equivalent terms. It in some cases has strange implying that numerous specialists do not agree with advance directives. Decision-making for advance directives

Advance directives are not particular adequate about what treatments a patient want or does not want and when the patient does/does not want them. The decision regarding the medical intervention to be withheld is the physician's authority and this power is not restricted to special care, such as ventilators to assist with breathing, but to any medical intervention—from not treating a curable infection to withdrawing food and fluids so that the patient starves and dehydrates to death. For the physician, at least, human life in living bodies commands respect and respect -by its very nature. As its respectability does not rely on upon the individual assertion or patient assent, repudiation of one's agrees to live do not deny one's living collection of trustworthiness. The most profound moral rule limiting the physician's power is not the self-sufficiency or opportunity of the patient; nor is it his empathy nor genuine expectation.

In addition, the hospice/palliative care setting are not implicitly ideas, and there are not many hospice offices, petite in the method for sorted out hospice action, and a couple of pros in palliative care, albeit a few endeavors, are presently under the approach to attempt and kick off the hospice development in every setting or in each nation.

ALTERNATIVE SOLUTIONS FOR THE END OF LIFE POLICY
Policy for the end of life reflects respect and protection existing in the wishes of patients with the end stage to die naturally or to die with human dignity and certification of patients' rights to self-determination to die naturally and peacefully without being held by any equipment or technologies. This is one way to help patients to be taken care of with human dignity. Up to now, in society, there are debatable issues about arranging for the advance decision regarding the rights to refuse medical treatment and a medical code of ethics, including related law having to follow consequences later on, which affects from patients, their family, and health professionals.
**Patients**

The stress of patients and their families involving dispute about decision-making at the end of life with health professional, such as the decision whether to use or stop the use of life-sustaining medical procedures. Patients should be talked with family members about treatment and care desires. It is important for patients to understand that it might come a time that they will not be able to make these decisions by themselves. The advanced decision may be a part of a wider discussion where a patient expresses their thoughts about care and treatment in a more formal way and can be seen as part of more general willingness to debate about the death more openly and to deal with anxieties concerning to what might happen to them that patients have in case they become mentally incapacitated. For patients, they can say what treatment they want to refuse and cancel their decision – or part of it – at any time. Moreover, patients must be respected for their decision making not to complete advance directives and reassured that they would not be abandoned or receive standard care if they do not elect to formulate advance directives.

**Families**

Much of research shows that the decision making at the end of life is related to families. In the US, patients with cardiac disease wanted to make their end-of-life decisions by considering the views of family members instead of allowing their decisions to be handled by health professionals. The research in South Korea shows that 92.9% approved the need for the implementation of advance directives by family caregivers. So alternative solutions for the family include asking about the views of family members regarding the decisions of the patient, the need to comply with the wishes of loved ones not to withdraw treatment or life support, or their reasons for not wanting to withdraw treatment or life support from the patient. Moreover, the health professional must explain the procedure of advance directives clearly to the family as well.

**Health professionals**

In Germany, there is some research about the desire of patients undergoing treatment of cancer during the end of their lives. According to research in the United Kingdom studying the perceived barriers to the completion of advance directives with cancer patients and family members, the results indicated that physician do not suggest the topic or discuss end-of-life care. Regarding the research, knowledge, perspectives, and practices of nursing personnel concerning advance directives, it was found that nursing staff reflected lack of technology, lack of opportunity, and lack of knowledge concerning federal and state laws and general information about advance directives, showing a need for clarification concerning the most practical setting for advance directive formulation. In a study by Jezewski et al., the mean score on knowledge of advance directives, in general, was 70% but only 53% on state laws. The study of Westley and Briggs concluded that nurses who feel uncomfortable with a discussion of advance directives due to a lack of the skills needed to facilitate effective end-of-life planning need tools and training to help them feel more confident that the patient’s health-care wishes are expressed. Moreover, patients, their family, and health professionals should discuss finding joint solutions in a so-called “family meeting.” Physicians have to give the correct information to patients and their relatives to accompany decision-making.

Making society and health professionals have positive attitudes toward a living will arrangement and palliative care is important because they can create understanding and allow for patient-centered care, which will allow patients to receive optimal benefits.

**CONCLUSION**

The advance directives cited in this paper have been explained as a statement, usually in writing, in which a person indicates while being mentally competent the designation of healthcare he/she would like to obtain in
the future when he/she is no longer competent so as to prevent and resolve conflicts between patients, their families, and health professionals. This may become a basis for further developing any necessary guidelines and avoiding any misunderstanding in the implementation of advance directives. This paper makes the following recommendations for consideration about policy implications for the end of life as the following:

1. Future research should focus on interventions to facilitate advance directives regarding the end-of-life care by enhancing the knowledge, skills and other resources of nurses, and by clarifying the roles of the nurse and other health personnel to formulate advance directive practice guidelines.

2. Healthcare professionals should allow the parties and their families become involved in making any carefully together each option should be considered decision, while the advantages and disadvantages of with healthcare professionals, patients, and family members.

3. If there are disagreements about the existence or validity of advance directives between health professionals themselves or between health professionals and the patient or family, all of the staff members involved in the patient's care should have the opportunity to express their viewpoints. All discussions should aim to resolve the issues surrounding the validity of advance directives and confirm their applicability to the current circumstances, not attempting to overrule the patient's advance directives.

4. Establish policies that will encourage hospice care into the health system of the country that provides comfort and quality of life, rather than cure for end-of-life patients.

5. Advance directives should be reviewed and updated at regular periods in order to ensure that they remain valid and applicable.

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CONFLICT OF INTERESTS
The authors declare no conflicts of interest in this research

REFERENCES


