EDITORIAL

Controlling Personal Health Decisions for the Oldest Old

Public health practitioners help the oldest old (persons aged 75 years and older) prevent falls, protect against communicable disease threats, cope with arthritis and many other chronic ailments, and deal with the loss of loved ones and lifelong friends. Collectively, assisting the oldest old as they manage their health is a core objective of public health practice.

When M.R.G suggested this theme issue at a *Journal* editors meeting, he had another set of health-related controls in mind—specifically, the legal documents that allow us to direct the course of our life when we cannot. When thinking about these controls, most people usually consider only the prospect of documents that address one's final affairs after death, such as a last will and testament, a living trust, or an organ donor card. A will allows a person to control the distribution of his or her wealth and personal property in accordance with his or her wishes and minimizes the tax impact of those transfers. A living trust is an approach to distributing wealth after death, which is set up and funded during life to avoid the burden of probate. An organ donor card authorizes the gift of a decedent's organs for the benefit of transplant recipients.

Perhaps more important, though, are the legal documents that structure the control of one's medical and financial affairs during a period of incapacity, whether preliminary to the end of life or as a consequence of a traumatic injury or disease. The most significant of these documents are the general durable power of attorney, which appoints someone to act as an agent for legal, financial, and sometimes health matters when the principal is unable to do so, and the advance medical directive, which is also known as a "health proxy." A health proxy—which is often accompanied by a health care power of attorney—is a set of directions that advises family members and medical professionals about wishes for medical life-support and other intervention. Also applicable to periods of incapacity is a contract

Warren DeWitt (right), aged 76 years, moved into the Peters household in Gladesville, West Virginia, to help look after Maxine and Arden, both aged 90 years. At the time this photograph was taken (2000), Warren had lived with the couple for over a year, cooking, cleaning, and maintaining the grounds. His chores also included trimming Arden's hair. Photograph by Ed Kashi. Printed with permission of Ed Kashi Photography. Available at http://www.EdKashi.com.

for long-term health care insurance, which provides coverage for long-term conditions not covered by or limited by more traditional health care insurance.

Preparation of these documents has traditionally fallen to attorneys; accordingly, addressing the issues covered by these documents has not been a core objective of public health practitioners. Ironically—and often, tragically—the implications of not having these legal protections in place falls most heavily on health practitioners and family members. Without a general durable power of attorney or a health proxy for an incapacitated person, health providers may be placed in the uncomfortable position of choosing the type and duration of treatment, which are all too often life-and-death choices. Moreover, the court system—impersonal, bureaucratic, and expensive as it is—is often invoked to make decisions that can have unalterable impacts on the mental health of family members. We cannot understate the anguish felt by family members who argue with other members about treatment and financial matters, sometimes to the point of lawsuits and family disintegrations. Conversely, many of us have witnessed a sense of relief for the oldest old who have prepared these documents. Without question, possessing up-to-date legal documents advances the dignity and autonomy of the incapacitated and dying and enhances public health and clinical public health practice.

HOW MANY ARE PREPARED?

The AARP, a few other organizations, and scholars have studied which people have end-of-life or post-death legal directives and some of the reasons people do or do not.[1–3] In our own recent national survey, we found that more than 40% of Americans 75 years or older did not have a health proxy, 32% did not have a power of attorney, 52% did not have a living trust, 67% did not an organ donor card, and 20% did not have a will. Of the 80% with a will, almost half had not updated it during the last 10 years, raising concerns about the efficacy and scope of those documents. Overall, 10% of the oldest old had all 5 documents, 46% had at least 4, and 61% had at least 3. The good news is that these proportions were more than double the proportions of the US population aged 25 to 74 years who had these documents, with the exception of organ donor card (the younger population was more likely to have an organ donor card). In other words, the oldest of the elderly appear to have taken more control over their affairs than have their younger counterparts.

REASONS FOR HAVING THE DOCUMENTS

Some of the reasons people have legal end-of-life and post-death documents are predictable, such as simply becoming older, achieving more education, acquiring wealth, getting married, and having children and grandchildren—in other words, factors that relate directly to self-interest. A second set of factors, although weaker predictors than that of self-interest, depend on an individual's personal history. These secondary factors include having parents who had these documents and discussed them with their children; being prompted to prepare the documents by parents, relatives, friends, or acquaintances; having good experiences with attorneys and health care practitioners; and personally experiencing a serious health problem or living with someone who had these documents. By contrast, measures of personal efficacy, such as having a flu shot, getting one's blood pressure checked, engaging in civic activities such as voting and attending local government meetings, are less predictive of possessing any of these documents in the younger US population.

The self-interest factors do not entirely disappear in the oldest of the elderly group. For example, with regard to having a health proxy, we observed that owning a home, having children, having siblings, and becoming older ranked third through sixth as predictors of having a health proxy for that group. However, the highest ranking predictors were having received good advice and counsel from attorneys and having one's eyes checked, with receiving good care from dentists and being a member of AARP also as strong predictors. In addition, not having enough money to pay for the documents is a much weaker predictor in the oldest of the elderly population than in the younger age groups. In other words, while some people believe that the elderly do not change their views or behaviors, this study suggests that their views and behaviors can be modified, at least with respect to these particular legal documents.

ENCOURAGING THE RELUCTANT

In light of the inevitable transformation of the Baby Boomer generation into the largest oldest cohort, the marketplace is likely to address some of the public health community's concerns regarding individuals acquiring and updating these legal tools. After all, members of the Baby Boomer generation have, on the whole, accumulated more wealth and are living longer than previous generations and therefore have more reasons to protect their health and financial resources with these legal documents.[4–8] But the Baby Boomer generation is large and varied, and many of its members are less fortunate than their counterparts. Although having a will, an organ donor card, and long-term health insurance may be more a matter of individual circumstances and choice, we believe that all of the oldest old need at least a health proxy and a durable power of attorney. Our analyses and those of others suggest that some of the oldest of the elderly can be persuaded that they need these key documents, that working with legal aids is prudent and not hazardous,[9] and that being proactive rather than fatalistic does not diminish but rather enhances their control.

We believe that public health practitioners, social workers, attorneys, religious advisers, and others can play a major role in persuading the oldest old to secure these documents and take more control of their health and resources, and we urge them to do so. In particular, we encourage the exploration of partnerships between the elder and disability law sections of federal, state, and local bar associations with their counterparts in the public health arena. These partnerships could encourage the oldest old who do not already have their "affairs in order" to do so by backing these encouragements with the credibility of these organizations. Therefore, much of the anxiety that the elderly feel about addressing these issues could be alleviated, and greater protections against undue influence—often a concern when dealing with the oldest

old—could be more effectively built into the process. With these encouragements, rather than viewing the drafting of such documents with the anxiety of death and taxes, the issue could be reframed to one of preserving personal autonomy and dignity. ■

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Contributors

M.R. Greenberg developed the idea for the research, wrote the survey, and the editorial. M.D. Weiner added questions to the survey, refined the instrument, and added text to the editorial. G.B. Greenberg provoked the idea for the survey, suggested questions, and added to the text.

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