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The Attitudes of Critically Ill Filipino Patients and Their Families Toward
Advance Directives

by

Jennifer McAdam

THESIS

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Abstract

Attitudes of Critically Ill Filipino Patients and Their Families Toward Advance

Directives, Jennifer McAdam, RN, MS

Purpose: To understand the attitudes of critically ill Filipino patients and their families toward ADs.

Design and Methods: A descriptive, correlational, cross-sectional study was completed on a convenience sample of 22 Filipino patients and 22 Filipino family members at a West Coast Medical Center. All patients were admitted for either cardiac surgery or cardiac interventions. Participants were interviewed using the Advance Directive Attitude Survey (ADAS) and the Short Acculturation Scale for Filipino Americans (ASASFA).

Findings: The overall attitudes toward advance directives (AD) were positive. Family members scores were significantly more positive than the patients on the ADAS ($p=.014$). Family members were more American acculturated than the patients ($p=.001$). Those with more education had more positive attitudes toward ADs ($p=.018$). Only two patients completed and had prior knowledge of an AD before the study. No family members completed an AD before the study and only 26% had prior knowledge of an AD.

Conclusion: The completion rate and knowledge of ADs in this study was low but the overall attitudes of the Filipino patients and family members toward ADs were positive.

Healthcare professionals need to understand Filipino's cultural perspective regarding

ADs. Further research is warranted to understand how to enhance AD completion rates in the Filipino population.

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Advisor

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Introduction

Advance directives (ADs) are an important tool in critical care. They provide data to the critical care staff about patients' wishes, especially when critical illness itself may decrease decision-making ability. They are legal documents that allow patients to make choices about medical care in the event that they are unable to do so in the future (White, 1997). ADs enhance communication between patients and providers regarding life sustaining technology (Stevens & Hassan, 1994), preserve patient autonomy (Leland, 2001), assist in reducing litigation in healthcare (Castledine, 1994), and have the potential to lower healthcare costs (Emanuel, 1996; Miles, Koeppel, & Weber, 1996).

Despite the many benefits of ADs, only 5-25% of Americans have an AD (Kirmse, 1998). Healthcare professionals may contribute to this problem. Nurses exhibit little interest in educating patients in this area (Johns, 1996) and physicians do not discuss this topic with patients (Hoffman, Zimmerman, & Tompkins, 1997). Time limitations, difficulty bringing up and dealing with the subject matter, as well as possible legal ramifications are identified as the major barriers to physicians discussing ADs (Flarey, 1991; Gordon & Dunn, 1992; Leland, 2001; Morrison, Morrison, & Glickman, 1994).

Research has shown multiple reasons for patients' failure to complete an AD (Kirmse, 1998). Two main reasons are lack of knowledge and lack of physician patient discussion about ADs (Hoffman et al., 1997; Mezey, Leitman, Mitty, Bottrell, & Ramsey,

2000; Morrison, Zayas, Mulville, Baskin, & Meier, 1998; Perkins, Geppert, Gonzales, Cortes, & Hazuda, 2002; Schonwetter, Walker, & Robinson, 1995). Other reasons include procrastination (Elpern, Yellen, & Burton, 1993), dependence on family members to make decisions (Cugliari, Miller, & Sobal, 1995), and fear of not being treated (Murphy et al., 1996).

The AD document was developed from the European-American cultural viewpoint (Ersek, Kagawa-Singa, Barnes, Blackwell, & Koenig, 1998). Studies frequently fail to address how other cultures view ADs (Lim, 1997; Morrison et al., 1998; Murphy et al., 1996). The changing socio-cultural and demographic composition of the United States makes culture a relevant topic. It is estimated that, by the year 2025, 37% of Americans will be members of an ethnic minority (U.S. Bureau of Census, 1999). California data show that approximately half of the population is ethnic minorities, for instance, 10.9% of the population are Asian, 6.7% are African-American and 32.4% are Hispanic (U.S. Bureau of Census, 2000).

Asian-American Pacific Islanders (AAPIs) constitute the fastest growing minority group in the United States (Shi & Singh, 2001). Their numbers increased by 108% from 1980 to 1990 (Yoon & Chien, 1996). In 1997, AAPIs were estimated to make up 3.7% of the total U.S. population. By the year 2050, their numbers will more than double and comprise 10.7% of the U.S. population (U.S. Bureau of Census, 1996). One group that falls within this category is the Filipino population. In California, the Filipino population

comprises 2.7% (U.S. Bureau of Census, 2000). To date there are no studies that address Filipino attitudes toward ADs. Understanding another culture's perspective provides the basis for patient education regarding ADs and exploring whether there is a need for an AD form that is culturally specific.

The overall aim of this study is to understand the attitudes of critically ill Filipinos and their families toward ADs. The specific aims of this study are to 1) Describe the attitudes and compare the differences in attitudes between the critically ill Filipino patients and their families toward ADs; 2) Describe the level of acculturation and compare the differences in acculturation between the critically ill Filipino patients and their families; 3) Compare the relationship between acculturation and attitudes toward ADs of critically ill Filipino patients and their families, and; 4) Determine the relationship between the demographic information and attitudes toward ADs of critically ill Filipino patients and their families.

Review of Literature

Attitudes Toward Advanced Directives

Several studies address the way patients perceive ADs and indicate that attitudes have the potential to influence completion of an AD. A descriptive study by Perry, Molzahn, Nicholas and Dossetor (1995) compared the attitudes of dialysis patients, their families, primary physicians and nurses regarding ADs. They found in their sample of 50 patients that 84% felt it was important to have an AD, yet only 18% actually had one.

About half (52%) of the patients and families felt that treatment should be left up to the physician, but only 12.5% of physicians concurred. The authors did not report racial or ethnic data on the subjects, thus reducing the generalizability to ethnic groups.

Rein et al. (1996) qualitatively explored common themes that impacted the decision to complete an AD. Data of 26 hospitalized patients from multiple units showed that the main themes were the desire to maintain control of treatment decisions; the acuity and chronicity of their illness; relationships with their families; and perceptions of the health care professionals' role in treatment decisions. Their sample was mostly Caucasian (58%) followed by African-Americans (38%) and Hispanics (4%). Unfortunately, they did not specifically discuss the racial or ethnic attitudes of the sample toward ADs.

Nolan and Bruder (1997) assessed medical inpatients' attitudes toward ADs. Their study of 34 patients showed a moderately positive attitude towards ADs. Data on ethnic and racial demographics were not included. Nearly all (96%) thought ADs should be initiated when a patient is healthy and felt they had choices about end of life care. Most (67%) thought an AD would prevent them from obtaining needed treatment, and 82% thought their families would want them to have an AD. The sample in this study was small which raises the issue of generalizability, however, the findings provide valuable insight into attitudes regarding ADs.

Douglas and Brown (2002) also found that their sample of 30 inpatients from an oncology and telemetry unit of a teaching hospital had a moderately positive attitude

toward ADs. They had a racially/ethnically diverse sample that included 19 Caucasians, 10 African-Americans and 1 Hispanic. Those with more positive attitudes were Caucasian, female, elderly and considered themselves in poor health.

Data from a study of 800 ethnically diverse individuals by Murphy and colleagues (1996) showed a strong relationship between having a negative attitude toward ADs and not completing one. In their study, persons with low socio-economic status, little experience with illness or death, and those who had no private health insurance were more likely to have negative attitudes regarding ADs ($p < .05$).

Attitudes of persons of various races and ethnicities toward ADs and how these attitudes may affect perceptions of ADs, have not been studied extensively. A study by Schonwetter et al. (1995) of 137 hospice patients found a significant association between race and completion of ADs ($p < .01$). Using chi-square analysis, non-Caucasians had significantly fewer ADs than Caucasians. Subsequent work by Eleazer and colleagues (1996) assessed the relationship between ethnicity and completion of an AD in the frail elderly population. Using a large cross-cultural sample ($n=1193$), their study consisted of 385 Non-Hispanic Whites, 364 African Americans, 156 Hispanics and 288 Asians (of which 79% were Chinese). They found significant ethnic variations in choice of health care wishes. Asians were more likely than other groups to designate a health care proxy and to have their healthcare wishes documented ($p < .001$). Yet, they were least likely, along with African Americans, to use a written AD when compared to Caucasians

($p < .001$). Non-Hispanic Whites had the highest completion of ADs compared to the other groups ($p < .001$). Filipinos were included with the Asians in this study, but their data were not examined as a subset of the Asians.

Murphy et al. (1996) examined the attitudes toward ADs of elderly multi-ethnic populations from various senior citizen centers in the Los Angeles area using the Ethnicity and Attitudes Toward Advance Care Directives Questionnaire. Included were equal groups of about 200 African-Americans, Korean-Americans, European-Americans and Mexican-Americans. Using chi-square, their findings showed that Korean-Americans and Mexican-American groups had significantly greater negative attitudes toward ADs ($p < .0001$) than European-Americans and African-Americans. In addition, European-Americans had the highest number of individuals that actually completed an AD ($p < .0001$).

Romero, Lindeman, Koehler and Allen (1997) explored the knowledge of elderly Caucasian ($n=469$) and Hispanic ($n=414$) persons toward ADs. Their results revealed that Caucasians were more likely to know, correctly define, and complete an AD than Hispanics. They also noted that, when other demographic variables were controlled, ethnicity remained a significant factor in patient completion of an AD ($p < .001$).

Hoffman and colleagues (1997) studied 110 geriatric outpatients' attitudes toward ADs. Their sample included mostly (61%) African Americans followed by (39%) Caucasians. Using a logistic regression, they found that Caucasians were more likely to

have an AD than African Americans ($R^2 = .03$, $p < .05$). They also discovered that those who had family members living in close proximity were significantly less likely to have an AD ($p < .05$).

Hopp and Duffy (2000) explored racial variations regarding ADs in an elderly population using a family member proxy. Their sample consisted of 86 African American and 454 Caucasians. They found that Caucasians were significantly more likely to have an AD ($p = .001$) and race was a significant factor in whether or not someone had an AD. Internal validity may have been threatened by retrospective data collection and the discrepancy in sample sizes between the African American and Caucasian groups.

Filipino Health Beliefs and Practices

A fatalistic view is a common theme when a Filipino confronts a serious illness. They believe in “bahala na” or what is destined or inevitable. Illness is commonly seen as the will of God. This is the view that may exert the most influence on a Filipino faced with a decision regarding ADs (Cantos & Rivera, 1996; McLaughlin & Bruen, 1998; Vance, 1995). Filipinos also tend to go along with the demands of a more authoritative group to maintain harmony. This means they may agree with a healthcare professional by being respectful in order to avoid disagreement (Vance, 1995).

A Filipino’s view on illness is that it may be caused by an imbalance in spirit or morals. Some view illness as an imbalance that is caused by punishment for bad behavior (Cantos & Rivera, 1996). In rural provinces in poorer regions of the Philippines, health

belief is built on a cluster of concepts: flushing, heating, and protection. Flushing is thought to keep the body free from debris. Flushing is based on the premise that the body is a container and collects impurities. Flushing is a complex, systematic way of removing evil forces from the body. A common home remedy utilized in flushing is vinegar. Heating maintains the balance of temperature and involves the beliefs that hot and cold qualities need to be in balance. Protection guards the body from outside influences. It involves guarding the body against natural, as well as, supernatural forces (Vance, 1995).

There are a limited number of studies that address Filipino decision making regarding healthcare (McLaughlin & Bruen, 1998). The literature does reveal a strong influence of filial piety or the obligation of the family members to care for one another (Nishimoto & Foley, 2001). It is the role of Filipino children to respect elders and to care for them as they age (Cantos & Rivera, 1996). It is also common for the Filipino patient to assume a passive role when he or she is sick and expect family assistance (Cantos & Rivera, 1996).

When healthcare providers need to discuss important decisions regarding a patient's healthcare and end-of-life, the preferred method is for the professional to consult with the head of the family or decision maker. Many times it is birth order that stipulates who the decision maker is. It tends to be the eldest male but may also be a trusted friend or clergy (Cantos & Rivera, 1996). Once the decision maker is consulted, the rest of the family will work together to arrive at the best decision for the ill family member

(Nishimoto & Foley, 2001). Discussions regarding end-of-life and ADs need to be approached carefully. In Filipino culture, discussing these topics brings about fear that the discussion itself may invoke unwanted outcomes (Cantos & Rivera, 1996).

Conceptual Framework

The decision to complete an AD is complex and may depend on a person's attitude toward an AD. The attitudes themselves are influenced by numerous factors: 1) severity of illness; 2) the impact of an AD on the family; 3) the effect of an AD on treatment; 4) patient belief in opportunities for treatment choices; and 5) perceptions of the healthcare professional's role in treatment decisions. The conceptual framework for this study (Figure 1) begins with the work done by Nolan and Bruder (1997) and Rein et al. (1996). They identified and subsequently explored these five interrelated factors and how they had an impact on ADs. This model was developed through qualitative research (1996) and subsequently tested (1997). A sixth factor regarding race, ethnicity and acculturation was added after exploring the literature on ADs.

The literature often uses the terms race, ethnicity, acculturation and culture interchangeably yet, they have distinct definitions. Race is defined as physical traits based on characteristics that are inherited. Ethnicity refers to a subgroup that shares a common history, ancestry or culture. Acculturation is a process by which members of one cultural group assume the traits and behaviors of another cultural group (Seidal, Ball, Dains, & Benedict, 1999). Culture is a complex set of values, beliefs, norms and patterns

that are learned and passed on from generation to generation (Leininger, 1995). For the purposes of this study, the terms race, ethnicity and acculturation are synonymous and refer to culture.

Perception Regarding the Severity of an Illness

Perception of illness is one factor that influences a person's attitude toward ADs. According to Rein et al. (1996), the perception of illness is a person's first consideration before making a decision regarding an AD. For example, someone who perceives himself or herself as sicker, has more positive attitudes toward an AD. They also complete ADs more often than those who view themselves as healthy complete them. Likewise, those who perceive themselves as healthy think they do not have to worry or complete an AD, but their attitude toward them is still positive. Those who are uncertain of their health state tend to be more anxious and therefore more negative toward ADs. If a person has not had any experience with illness, they tend to draw on a family member's experience for decision making. Regardless of the actual illness itself, the perception of illness is an important determinate of whether or not to complete an AD.

Perception of the Impact of AD on the Family

Another factor that may influence a person's attitude toward an AD is a person's perception of the impact that an AD would have on their family. Rein et al. (1996) showed that attitudes were more favorable if a person felt an AD would relieve guilt and financial worries for the family. Conversely, if a person felt an AD would create conflict,

blame and increase stress, this attitude was more negative. Essentially, a person would be more likely to complete an AD if he or she thought the family would agree and support it, and would be less likely to favor an AD if it would upset the family.

Perception of the Effect of an AD on Treatment

The next factor that may affect attitudes toward ADs is a person's perception of the effect an AD would have on their medical treatment. If the person felt that an AD would ensure he or she receives the treatment they want, one would be more likely to have a positive attitude and complete an AD. Whereas if he or she feels that an AD would restrict care or even worse, be ignored, one would have a more negative attitude and be less likely to complete an AD.

Belief in Opportunities Regarding Treatment Choices

Another factor that may affect attitudes toward ADs examines a person's belief in opportunities in treatment choices. This factor depends on whether a person really understands what an AD is and what medical treatment is available. The greater the knowledge in this area, the more likely it is that a person will have completed an AD and have a favorable attitude toward an AD. If a person has little knowledge or experience regarding ADs, the more likely it is that the person will have a negative attitude toward ADs.

Perception of the Healthcare Professionals' Role in Their Treatment Decisions

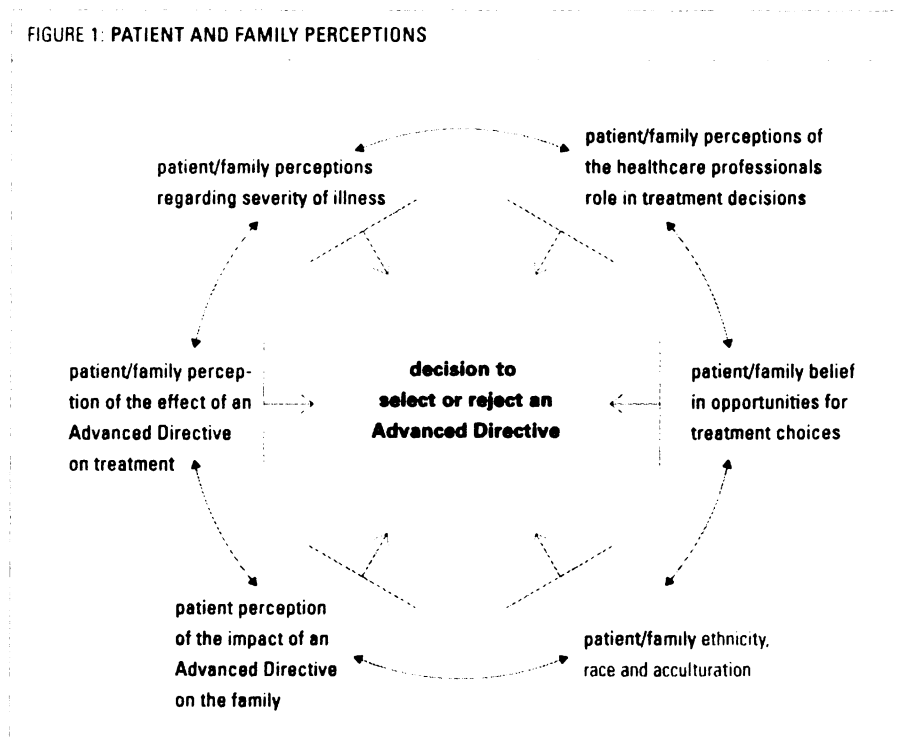
The fifth factor discussed in previous research that may affect attitudes toward ADs includes a person's perception of the healthcare professionals' role in his or her treatment decisions. The decision to select or reject an AD may depend on the patients' or families' feelings regarding how much control the healthcare professional should have over their end-of-life decisions. If a person wanted his or her doctor to make decisions for them, one would be less likely to fill out an AD. Conversely, if the person wanted control over one's own treatment choices, he or she would be more likely to complete an AD and not leave the decisions solely to the healthcare staff.

Race, Ethnicity and Acculturation

The final factor that has the potential to effect completion of ADs is race, ethnicity and acculturation (Perkins et al., 2002). Several previous studies documented attitudes of persons of different racial and ethnic groups toward ADs. Most of these studies focused on African-American, Hispanic, Caucasian, Korean, or Chinese populations (Douglas & Brown, 2002; Eleazer et al., 1996; Murphy et al., 1996; Romero et al., 1997; Schonwetter et al., 1995). In these studies, race and culture did indeed play an important role in the attitudes toward ADs. In all cases, people of Caucasian race and culture tend to be more knowledgeable, positive and complete more ADs than did people from other racial and cultural groups.

There are little data in regards to Filipino attitudes toward ADs. No studies, to date, directly assess Filipino attitudes toward ADs; the data that do exist do not

specifically differentiate Filipinos from other Asians (Eleazer et al., 1996). Yet, Filipino culture itself could affect attitudes toward ADs. Their perception of illness is one of imbalance or punishment. They may feel they have no control over end-of-life decisions. They may even feel that treatment options are not something they could or should write out in an AD. Their culture is family oriented and that characteristic may affect AD decisions. Finally, they view healthcare workers with respect and acknowledge their expertise. They may consider it rude or improper to make decisions instead of letting healthcare professionals, who are considered experts, decide the best course of action (Cantos & Rivera, 1996). All six of these factors in the conceptual framework may affect attitudes toward ADs. This study looks at all the factors, but will focus mainly on the cultural piece and how that may affect attitudes toward ADs.



Methods

This is a descriptive correlational cross-sectional study. It was completed on critically ill Filipino patients and their families to assess their attitudes toward ADs.

Setting/Sample

Data were collected over a six month period in the critical care units of a single 357 bed Northern California hospital. The two units that were used for data collection were the intensive care unit and the coronary care unit, each having 14 beds.

The patient population that surrounds the admitting hospital is 27% Filipino. This is the largest population of Filipino-Americans outside of Manila (U.S. Bureau of Census, 1990). The patients in these units have a variety of diagnoses including respiratory failure, sepsis and neurology problems, but the main focus is on cardiac problems requiring cardiac intervention, including surgery.

Inclusion criteria for the patients were: 1) hospitalized in the critical care unit, 2) self reported ethnicity as Filipino, 3) oriented to person, place and time, 4) able to speak and read English, 5) 18 years or older, and 6) required cardiac surgery or intervention. Patients were excluded if they were comatose, unresponsive and/or intubated. Inclusion criteria for the family were: 1) age of 18 or greater, 2) oriented to person, place and time, 3) able to speak and read English, 4) identified by the patient as the family member most likely to help with medical decisions.

A power analysis was performed prior to the study to determine the number of subjects needed for the study to obtain a power of 0.8 with an alpha of .05. The analysis indicated that 64 patients and 64 family members were needed for a total of 128 subjects for the statistical tests using t-test. A sample of 30 patients and 30 family members were needed for a total of 60 subjects for the correlational statistical tests.

Instruments

The **Revised Version of the Advanced Directive Attitude Survey (ADAS)** by Douglas and Brown (2001) was used to assess critically ill patients' and their families' attitudes toward ADs. It was used with the authors' permission. The original tool, created by Nolan and Bruder (1996), was a 16-item questionnaire that used a Likert scale to determine attitudes toward ADs. Content validity was established using a panel of experts. Internal consistency measured with Cronbach's alpha was .74.

The revised version added concepts not addressed in the original tool. These included: 1) whether ADs impact the amount and quality of care received at the end of life; 2) whether decisions regarding end of life care can be changed once an AD is initiated; and 3) who patients want to have make decisions about their end of life care. Content validity of the revised tool was established by a panel of five experts (nurses working in the area, nursing faculty, and the original author of the tool). Test-retest reliability was established at .796. Internal consistency reliability was established at Cronbach's alpha = .748 (Brown & Douglas, 2001).

This tool is a 24-item questionnaire that uses a 4-point Likert scale designed to determine the extent to which ADs are viewed positively or negatively. The responses are rated from 1 (strongly disagree) to 4 (strongly agree). The range of scores is 24 to 96. Higher scores indicate more positive responses to advance directives. The tool addresses items that include (a) opportunity for treatment choices, (b) effect of advance directives on the family, (c) effect of advanced directives on treatment, (d) perception of illness, (e) whether advance directives affect the amount and quality of care received at the end of life, and (f) who patients want to make decisions about end of life care. Two independent bilingual Filipino American nurses in the critical care units were recruited to translate then back translate the ADAS. A third independent nurse was brought in to resolve any discrepancies. All three were college graduates and had experience translating English into Tagalog. All of them have been raised in the Philippines and now reside in the United States. They are fluent in English and Tagalog and are knowledgeable about both cultures. The tool was translated into Tagalog and then back translated into English. Both English and Tagalog versions were available to the subjects. Two questions were eliminated from the final analysis in this study due to lack of reliability and the recommendation of the author of the ADAS. In this study, the mean Cronbach's alpha coefficient for the ADAS after the removal of the two questions was .78 for the patients and .79 for the family.

A Short Acculturation Scale for Filipino Americans (ASASFA) was used to measure acculturation. This 12-item questionnaire uses a scale from 1-5. Scores can range from 12-60. Lower scores indicate a stronger Filipino acculturation and higher scores indicate a stronger American acculturation. This tool was used with permission from the authors (Dela Cruz, Padilla, & Agustin, 2000). The mean Cronbach's alpha coefficient for internal consistency is .85. Factor analysis confirmed the ASASFA's strong psychometric properties. Content validity was measured by two different sets of Filipino language translators as well as confirmed by a certified bilingual Filipino American court interpreter. This tool was also provided in both English and Tagalog (Dela Cruz et al., 2000). In this study, the mean Cronbach's alpha coefficient for the ASASFA was .85 for the patients and .90 for the family members.

Procedures

The study was approved by the Institutional Review Board (IRB) of the University of California, San Francisco on September 20, 2002. Approval from the IRB of the hospital was also obtained.

Weekly, patients admitted to the two units who underwent either heart surgery or cardiac interventions were identified by the charge nurse. A chart review was completed to determine patient study eligibility. Patients and family members were approached by the researcher who is a nurse in the critical care units. Informed consent was obtained at the time of data collection from the patient and family member. Demographic data were

collected through a chart review. APACHE II scores were calculated using data from the 24 hours preceding the interview.

Data collection was done with the patient alone and the family member alone. Patient data were obtained at the bedside. Family data were obtained at a private alcove located near the two units. After consent, each participant (patient, family member) was given a blank copy of the ADAS and the ASASFA. They were instructed to follow along as the researcher read each question. Participants were asked to verbally respond or point out the response which best-matched how they felt about the item.

Data Analysis

Sample data and all study variables were examined with descriptive statistics using SPSS version 11.0. Findings were described using descriptive and inferential statistics. Analyses for the study hypotheses are as follows.

Specific Aim 1: Describe the attitudes and compare the differences in attitudes between the critically ill Filipino patients and their families toward ADs. Data were analyzed with a matched paired t-test.

Specific Aim 2: Describe the level of acculturation and compare the differences in acculturation between the critically ill Filipino patients and their families. Data were analyzed with a matched paired t-test.

Specific Aim 3: Compare the relationship between acculturation and attitudes toward ADs of critically ill Filipino patients and their families. Data were analyzed with Pearson's Product Moment Correlation.

Specific Aim 4: Determine the relationship between the demographic information and attitudes toward ADs of critically ill Filipino patients and their families. Data for the continuous variables were analyzed with Pearson's Product Moment Correlation and data for the categorical variables were analyzed with a t-test.

Results

Sample Characteristics

A total of 48 participants met the inclusion criteria for the study (25 patients, 23 family members). Three patients declined and one family member declined. Of the three patients, one was not interested, one felt he was too sick, and the other did not want to complete the form. The one family member that declined stated she did so due to her lack of understanding regarding the material even after an explanation.

Patients

Of the 22 patients, all were of Filipino ethnicity (Table 1). The majority (90.9%) were first generation Filipinos. Fifty-nine percent were male. The mean age of the patient sample was 67.9 years (SD 9.06). The highest level of education ranged from grade school to bachelor's degree with over half of the sample having completed high school or less. The majority were Catholic (91.9%) and married (77.3%). Most (90.9%) had a

diagnosis of Coronary Artery Disease. Patients underwent various cardiac procedures including, percutaneous cardiac intervention (45.5%), coronary artery bypass graft (36.4%), and cardiac catheterization (18.2%). Most were receiving no pain or sedating medications at the time of the interview (Table 2). The mean APACHE II score was 12.1 (SD 3.61).

Families

Of the 22 family members, all were Filipino in ethnicity (Table 1). The majority (86.4%) were first generation Filipinos. Most family members that participated (59.1%) were female. The mean age of the family member sample was 51.95 years (SD 17.22). The family members had a higher level of education than the patients with 76.9% being college educated. Eighty-two percent were Catholic and the majority (86.4%) were married. Most family members were children (50%) followed by spouses (40.9%).

Advanced Directives/Knowledge

Of the patient sample, only two patients (9.1%) had an AD (Table 1). Those same two patients (9.1%) were the only ones that had prior knowledge of an AD before the study.

Of the family members, 27.3% had knowledge of an AD prior to the study but none had an AD.

Specific Aims

Specific Aim 1: Describe the attitudes and compare the differences in attitudes between the critically ill Filipino patients and their families toward ADs. The patients' mean score on the ADAS was 62.6 (SD 5.64) and the family members mean score on the ADAS was 66.4 (SD 6.60). Both of these scores indicate a moderately positive attitude toward ADs (Table 3).

The family members scores (Table 3) were significantly higher than the patients scores (mean -3.82 ; $p=.014$, CI -6.79 to -0.85). There was a moderate linear relationship between the patients score on the ADAS and the family members score ($r = 0.41$; $p = .059$) but it was not significant (Table 3).

Specific Aim 2: Describe the level of acculturation and compare the differences in acculturation between the critically ill Filipino patients and their families. Patients mean score on the ASASFA was 28.1 (SD 7.49). This indicates a strong Filipino acculturation. The families mean score was 36.2 (SD 7.33). This indicates a slightly more American acculturation (Table 3). There was a significant difference between the patients and family members ASASFA scores, with the family members scores being significantly higher (mean -8.05 ; $p = .001$, CI -12.20 to -3.89). When the relationship between the patients score was compared to the family members score on the ASASFA, there was a weak linear relationship ($r = 0.2$; $p = .372$), that was not significant (Table 3).

Specific Aim 3: Compare the relationship between acculturation and attitudes toward ADs of critically ill Filipino patients and their families. When the patients scores on the ASASFA were compared to their scores on the ADAS, there was a weak linear relationship ($r = 0.184$; $p = .41$) that was not significant. There was a moderate linear relationship when comparing how the family members scored on the ASASFA to their scores on the ADAS, ($r = 0.431$; $p = .12$) that was not significant.

Specific Aim 4: Determine the relationship between the demographic information and attitudes toward ADs of critically ill Filipino patients and their families. There were no significant relationships when comparing the patients' scores on either the ADAS or ASASFA in regards to their age, gender, education or APACHE II scores. There was a significant relationship between the family members' scores on the ADAS and their level of education ($r = 0.5$; $p = .018$), indicating that the higher their education, the more positive their attitudes were toward ADs. Patients did not have a statistically significant relationship between ADAS and their education ($r = .34$; $p = .157$). There were no significant relationships between age or gender of the family member and their ADAS score. There were no significant differences between the family members' scores on the ASASFA and their education, gender or age.

Due to the small sample size, the study data were analyzed with non-parametric statistical tests with no change in the results. The Mann-Whitney U test was used for the

continuous variables and the Spearman's Rank Order Correlation was used for the categorical variables.

Summary of Findings

In this sample of primarily first generation Filipinos, less than 10% of the patient sample had an AD, and only those two persons who completed an AD had prior knowledge of ADs. No family member had an AD, although more than 25% had prior knowledge of an AD. Data show that both the patients and family members had moderately positive attitudes toward ADs, although family members had significantly more positive attitudes than the patients. When acculturation was explored, patients in this study were more strongly Filipino while the family members were significantly more American. However, there was no relationship between the level of acculturation and having an AD for either the patient or family member. There was no significant relationship between the patients score on the ADAS or ASASFA and their age, gender, education or APACHE II scores. There was, however, a significant relationship between the family members score on the ADAS and their level of education, although this relationship did not influence their actually completing an AD. Age and gender were not correlated with the family member's scores on the ADAS, nor was education, gender or age related to the family member's score on the ASASFA.

Discussion

The results of this study offer some important insights into the attitudes of critically ill Filipino patients and their families toward ADs. The generally positive attitudes that both the patients and the family members had toward an AD are unanticipated for two reasons. First, few participants in this study actually completed an AD, although, this is comparable to other documented findings of 5 to 25% (Kirmse, 1998). Second, the lack of knowledge or understanding of an AD was poor. Only eight out of the 44 study participants actually had previous knowledge and knew what an AD was before the study.

Why the Filipinos in this study had a more positive attitude toward an AD but did not complete one is unclear. One possible explanation reflected in the conceptual framework is that of race, ethnicity and acculturation. These cultural factors may affect the Filipino's attitudes as well as their decision to complete an AD. This is not entirely unexpected because previous studies have found that significantly fewer minorities complete an AD when compared to Caucasians (Eleazer, et. al., 1996; Hoffman et al., 1997; Hopp & Duffy, 2000; Murphy, et. al., 1996; Romero et. al., 1997; and Schonwetter, et. al., 1995). Theoretically, the patients and the family members may agree with the statements on the ADAS such as, "an AD would prevent guilt in the family or prevent costly medical expenses." Yet, when it comes down to completing one, it may be an unfamiliar concept that culturally they understand but do not accept.

In previous studies by Brown and Douglas (2001) and Murphy and colleagues (1996), the participants of other cultures tended to have a more negative attitude toward ADs, not positive as in this study. However, in previous studies, the level of acculturation may have influenced the attitudes toward ADs, but the authors did not specifically address this. In this study, there was a moderate linear correlation between having a more American acculturation and having a more positive attitude toward an AD. In this case, the family members that had higher ASASFA scores had more positive ADAS scores.

Another factor in the conceptual framework, the perception of healthcare professionals role in treatment decisions, may influence attitudes toward ADs. The literature on Filipino's interaction with healthcare providers suggest there is a tendency to be at harmony with a more authoritative group. There is a potential that the participants are simply telling the researcher what they think the researcher wants to hear in order to maintain harmony (Vance, 1995). This may explain in part the more positive attitudes of the Filipinos' toward ADs. The low AD completion rates may be due to the Filipino's waiting for healthcare professionals to tell them it is time to complete an AD.

Perception of an AD on treatment and treatment choices could be another explanation for the low number of participants who had an AD. In this study there was a significant relationship between the level of education and the score on the ADAS which was a similar finding in other studies. In fact, education was a significant factor in completing an AD in several studies (Brown & Douglas, 2001; Hoffman et al., 1997; Hopp & Duffy,

2000; Mezey, et.al., 2000; and Schonwetter et al., 1995). In this study, the higher the level of education that the participants had, the higher the score on the ADAS. The family member tended to have higher education levels than the patients, which could explain their more positive attitudes toward ADs.

On the other hand, other factors besides education could have influenced the family members attitudes toward ADs. In this study, the family members were younger and mostly female. Other studies by Brown and Douglas (2001) and Eleazar et al. (1996) found that gender and age had a significant effect on the attitudes and completion of an AD. They found that older, sicker females were more likely to have a positive attitude as well as complete an AD than other groups. But in this study, gender, age and low APACHE II scores had no impact on the attitudes or completion of an AD. Further work with a larger sample is needed to fully explore these dimensions.

Another explanation for the low completion rate of an AD may be a lack of knowledge concerning ADs. According to Rein et al. (1996), lack of knowledge regarding treatment options and choices was a major factor in whether one completed or rejected an AD. Even though participant attitudes in this study were positive, their lack of knowledge may be the reason for not completing an AD. A lack of knowledge was supported by previous research as a reason for low AD completion rates (Morrison et. al., 1998; Murphy et. al., 1996; and Romero et. al., 1997).

Another factor may be the impact an AD has on the family. Filipinos are a familial culture where the family plays a significant role in all decisions (Cantos & Rivera, 1996). In this study, all the patients had family in close proximity and had close relationships. This could explain the low number of ADs because of an expectation that the family would care for them if they were ill. Therefore, an AD would not be necessary. Prior research by Hoffman and colleagues (1997) also supported these findings. In their study, those who had family members in close proximity were significantly less likely to have an AD.

A final factor that may contribute to the low completion rates of ADs is related to the Filipino's perception of illness. The Filipino's believe that illness is destined or inevitable so they may feel an AD is not necessary. This concept of "bahala na" may prevent them from culturally accepting or completing an AD.

Implications

Data from this study show that Filipinos lack knowledge regarding ADs. The few Filipinos that completed one had previous knowledge of ADs. Future research will need to address culturally sensitive strategies for presenting and conveying information regarding ADs. In this study, however, the family members had more knowledge of ADs, yet no family member actually completed one. The implication for healthcare workers will be to understand why family members are not completing ADs. In this case, the family members' lack of ADs could be affected by the following variables: they were

younger and not experiencing acute illness or maybe they felt that it was not the right time to complete an AD or the “bahala na” attitude. Future research using a larger sample is needed to evaluate whether these variables influence completing ADs.

Attention is also needed to assess the way end-of-life is discussed and approached. For example, the language of ADs can be confusing. In regard to this sample, many participants had trouble understanding the phrase “end-of-life treatment choices”. This may be due to their culture or to the fact that they do not see how one could have choices regarding end-of-life. They may feel that end-of-life just happens and one does not have control over it. In order to have realistic expectations that ADs will be used by other cultures, the language itself may need to become more straightforward and blunt. Future research will be needed to test alternative end-of-life terminology.

A final implication for healthcare workers is related to how family members influence the completion of ADs. It has been noted in previous research that when one has a family member in close proximity, the completion of an AD decreases (Hoffman et al., 1997). Future research will be needed to examine if close family relationships in Filipino population have an effect on completing ADs.

Limitations

There are several limitations to this study. The sample size was small and did not meet the requirements of the power analysis. This was due to the limited number of Filipino patients admitted for cardiac problems during the time of data collection. The



convenience sample was recruited from one-center which limits its representation of the cardiac Filipino population. There is a potential for a Type I error due to the small sample size on the significant findings. Likewise, there may be potential for a Type II error on the non significant findings because of the small sample size or lack of power. A final limitation includes a lack of blinding that may have affected the response to some of the questions. Since the researcher was present for all of the data collection, it may have led to socially acceptable answers because the subjects elected the concept of “harmony” due to the researcher’s social status (Vance, 1995).

Conclusion

In this study, completion rate of ADs was low, yet Filipino patients and family members had positive attitudes toward ADs. Those in this study who were more American acculturated had more positive attitudes than those who were more Filipino acculturated. Those who had more education had more knowledge regarding ADs. Future research needs to focus on interventions to improve AD knowledge, end-of-life discussions and to assess family influence on completing ADs in the Filipino population.

Table 1. Patient and Family Demographics

	Patient (N=22)	Family (N=22)
Ethnicity Filipino	22 (100%)	22 (100%)
Generation Filipino		
First	10 (90.9%)	19 (86.4%)
Second	0 (0%)	1 (4.5%)
Third	2 (9.1%)	1 (4.5%)
Fourth	0 (0%)	1 (4.5%)
Gender		
Male	13 (59.1%)	9 (40.9%)
Female	9 (40.9%)	13 (59.1%)
Age		
22-40	0 (0%)	7 (31.8%)
41-60	3 (13.6%)	8 (36.4%)
61-75	14 (63.7%)	5 (22.7%)
75+	5 (22.7%)	2 (9.1%)
Education		
Grade school	5 (22.7%)	1 (4.5%)
High school	7 (31.8%)	2 (9.1%)
Some College	2 (9.1%)	7 (31.8%)
Associate Degree	1 (4.5%)	3 (13.6%)
Baccalaureate Degree	4 (18.2%)	9 (40.9%)
Religion		
Catholic	20 (90.9%)	18 (81.8%)
Protestant	1 (4.5%)	2 (9.1%)
Other	1 (4.5%)	2 (9.1%)
Marital Status		
Married	17 (77.3%)	19 (86.4%)
Divorced	0 (0%)	2 (9.1%)
Single	2 (9.1%)	1 (4.5%)
Widow	3 (13.6%)	0 (0%)
Completed an AD		
Yes	2 (9.1%)	0 (0%)
No	20 (90.9%)	22 (100%)
Prior Knowledge of AD		
Yes	2 (9.1%)	6 (27.3%)
No	20 (90.9%)	16 (72.7%)
Relationship to Patient		
Spouse		9 (40.9%)
Children		11 (50%)
Sibling		2 (9%)

Table 2. Primary Diagnosis, Procedures, APACHE Scores and Pain/Sedating Medications for the Patient Sample

	Patient Findings
Primary Diagnosis	
CAD	20 (90.9%)
MI	0 (0%)
Chest Pain	2 (9.1%)
Procedures Completed	
PCI	10 (45.5%)
Cardiac catheterization	4 (18.2%)
CABG	8 (36.4%)
APACHE II Scores	
4-12	13 (59.1%)
13-16	7 (31.8%)
17-20	2 (9.1%)
Pain/Sedating Medication	
None	14 (63.9%)
Morphine	7 (31.8%)
Benadryl	1 (4.5%)

Table 3. Mean ADAS Scores and ASASFA Scores of Patients and Family Members

	Total Patient Mean (SD)	Total Family Mean (SD)	Patient and Family Comparison Mean (SD)	95% CI (lower and upper)	t-test, p values
ADAS	62.59 (5.6)	66.4 (6.6)	-3.82 (6.70)	-6.79 to -.85	t= -2.672, p=.014*
ASASFA	28.14 (7.5)	36.18 (7.3)	-8.05 (9.37)	-12.20 to -3.89	t= -4.026, p=.001*

* indicate significant findings

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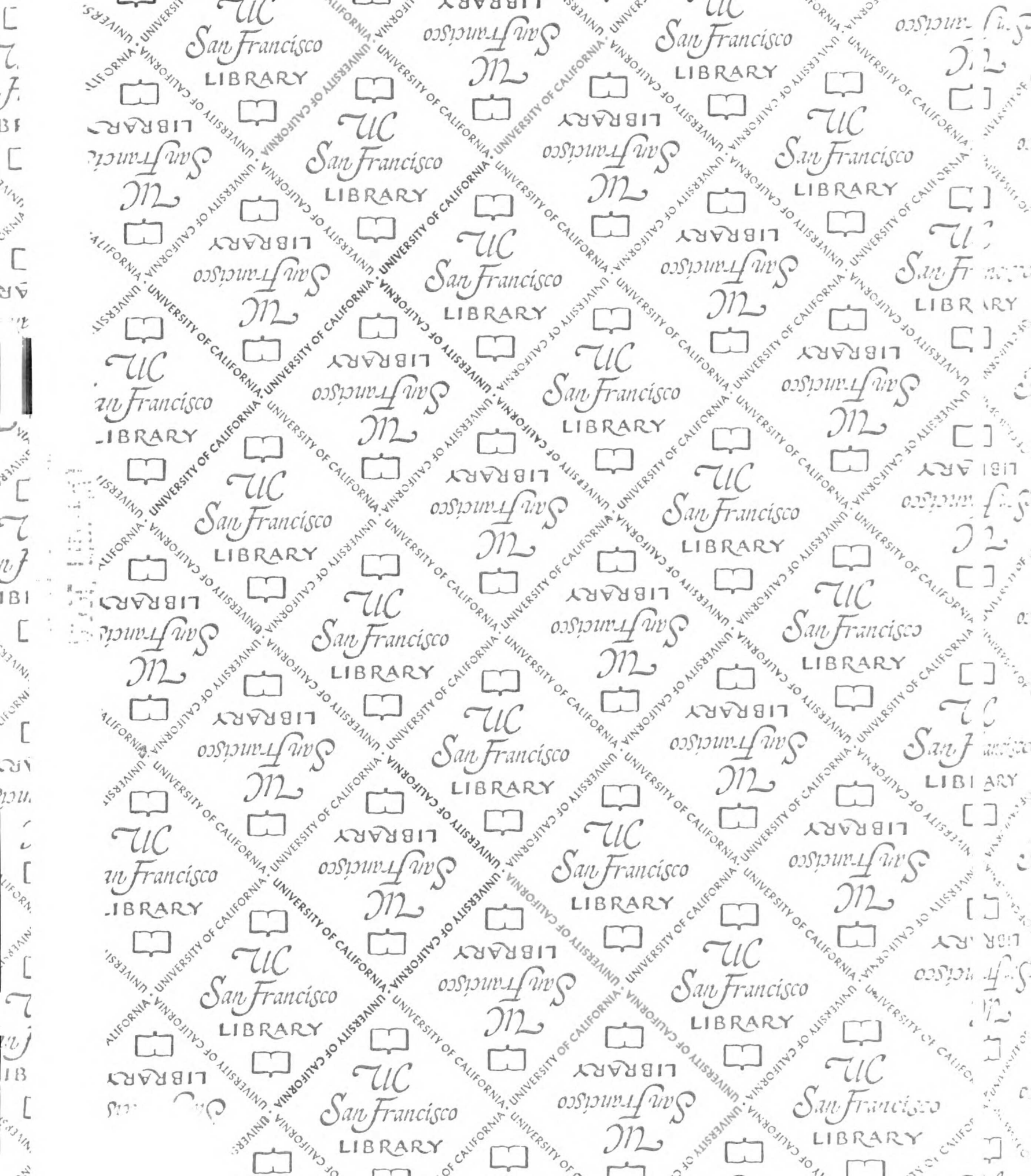
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