

IMPLEMENTATION OF AN ADVANCE DIRECTIVE TEACHING
PROTOCOL WITH NURSES IN A RURAL HOSPITAL

A THESIS
SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF SCIENCE
IN THE GRADUATE SCHOOL OF THE
TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

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DENTON, TEXAS

AUGUST 1998

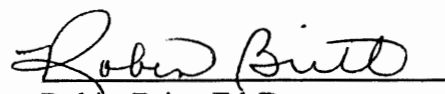
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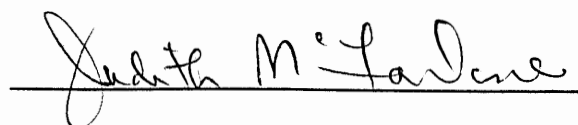
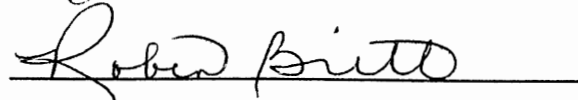
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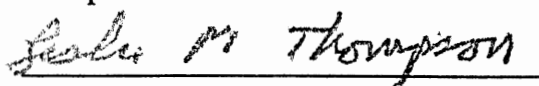
I am submitting herewith a thesis written by Cynthia M. Stoughton entitled
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We have read this dissertation and
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Accepted


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ACKNOWLEDGMENTS

I would like to gratefully acknowledge:

Dr. Robin Britt for her knowledge and encouragement and for lending of hours of her time to read, edit, and guide this project and Dr. Judy McFarlane for the giving of countless hours of reading and editing. For this lending of their time and talents I am forever grateful.

My family and friends--thanks for understanding, trying help, and the hours of encouragement. Without this I could never have completed this program.

My wonderful husband, Brian. Without your unending love and support I would have never have completed this degree.

Wanda Murphy, my friend and partner for the last year. Thanks for all of the hard work, hours of your time, and dedication to this project.

Tammy Stanfield and family; without them, this project would not have been performed. Thank you for the lending of your time and talent.

IMPLEMENTATION OF AN ADVANCE DIRECTIVE TEACHING PROTOCOL WITH NURSES IN A RURAL HOSPITAL

ABSTRACT

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AUGUST 1998

This evaluative research project utilized a quasi-experimental prospective pretest-posttest control group design to test the hypothesis that RNs and LVNs who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to complete an advance directive than RNs and LVNs who do not receive individualized social support. The setting, a rural hospital, yielded the sample of 61 rural nurses (30 control, 31 experimental). The program of the American Association of Critical Care Nurses, "Discovering Your Beliefs about Health Care Choices," provided the intervention. Descriptive and inferential statistics and measures of central tendency were used for data analysis. Chi square, used to test the hypothesis, indicated a significant difference between the two groups ($X^2 = 9.973$, $df = 1$, $p = .002$). RNs and LVNs receiving individualized social support (i.e., educational functionally supportive intervention) were more likely to complete an advance directive than nurses not receiving individualized social support.

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CHAPTER 1

INTRODUCTION

The Patient Self-Determination Act (PSDA) was introduced by Senators John Danforth (R-MO) and Daniel Moynihan (D-NY) and passed as part of the 1990 Omnibus Reconciliation Act (OBRA; US Public Law 101-508, s 4206, 4751, 1990). Effective December 1, 1991, it mandated that an individual's rights to formulate advance directives and make health care decisions be explained to all adult clients on admission to hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations serving Medicare and Medicaid patients (Annas, 1989; Bopp, 1990; Wolf, 1990). The intent of the law is to promote client autonomy, self-determination, and more humane use of life-sustaining treatment. Additionally, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1992) requires institutions to have mechanisms for supporting clients' rights and participation in health care decision making. This commission also requires institutions to have a formalized system for educating staff about the appropriate use of advance directives.

An advance directive, or living will, is a written instruction, that is recognized under state law and relates to the provision of care when the individual is incapacitated. A second type of directive, the durable power of attorney for health

care, is used in situations in which a client is judged mentally incompetent and has authorized a specific person to make proxy on their behalf (Emanuel, Barry, Stoeckle, Ettelson, & Emanuel, 1991).

Increasingly, the manner and timing of death are determined, not by fate but, by decisions made by loved ones, caregivers, and courts (Richter et al., 1995).

Although many people report that end-of-life decision making is important, few have completed written advance directives. Low rates of completion may be due to the lack of information and/or accessibility of forms, discomfort in discussing death and dying, uncertainty regarding the benefits of completing an advance directive, and/or fear and tendency to avoid threatening situations. These suggested reasons for low usage support the concept that completion of an advance directive is a psychological procedure rather than a physiological need. People will approach, explore, and try to cope with situations within their self-perceived capabilities, but they will avoid transactions with stressful or intimidating situations they believe to exceed their coping skills or abilities (Bandura, 1977).

The completion and recognition of advance directives produce tremendous implications for the current health care system and health care providers in relation to cost containment needs, utilization of health care resources, and maximizing quality of life. Current research indicates that health care professionals are concerned about the provision of inappropriate, overly burdensome care to clients near the end of life and about inadequate participation by clients in decision making regarding treatment

alternatives (Solomon et al., 1993). More than other health care professionals, nurses are aware of the negative consequences for clients of decisions to treat or withhold treatment during the terminal phase of illness (Mezey, Evans, Golub, Murphy, & White, 1994). The PSDA legitimizes and reinforces the responsibilities of the nurse in the clients' decision-making process and the nurse's duty to advocate for the decisional rights of clients. The importance of the role of the nurse in the success of the PSDA cannot be overemphasized because, historically, nurses have played a vital role and are the professionals most likely to assist clients and families in the decision-making process and promoting self-care choices (Huch, 1993). A fundamental principle of the nursing profession is respect for persons, which obligates nurses to protect and support the self-determination of clients through their roles as health care provider, client educator, and client advocate (American Nurses Association [ANA], 1992). Therefore, it is imperative that nurses demonstrate autonomy and self-advocacy by completing an advance directive themselves.

In their study, Haisfield et al. (1994) concluded that health care providers supported the use of advance directives for their clients as well as themselves. However, although their subjects (health care providers) thought it was a good idea to have an advance directive, only a low percentage (14%) actually had completed an advance directive. They noted that this finding was consistent with those of La Puma, Oren, Licher, and Moss (1991) who also found that, although people thought having an advance directive was a good idea, only 4% to 17.5% of adults had actually

completed this document themselves. Specifically, Haisfield et al. found that only 1 of 14 health care providers had an advance directive. The researchers concluded from the focus groups' responses that nurses favored advance directives more than physicians and related this to their roles as communicator, educator, patient advocate, collaborator, and researcher.

An informal survey was distributed to 22 graduate nursing students attending a college of nursing in the Southwestern United States in 1996. The results indicated that 68% of the participants had not completed an advance directive. Written comments stated that the failure to complete such a proxy was related to lack of emotional, informational, and/or instrumental support. Of the 32% who had completed a directive, each student indicated that practice in a critical care setting influenced their decision (Barkhouse-McKeen, Murphy, & Stoughton, 1996).

Problem of Study

This study was designed to examine the effectiveness of social support provided by an educational program in relation to the completion of advance directives by licensed registered and vocational nurses (RNs and LVNs). The investigator believed that differences would be found in the rate of completion of advance directives between those nurses in a rural setting who received individualized social support in the form of an educational and functionally supportive intervention

implemented in a rural hospital and those nurses who did not receive individualized social support.

Justification of Problem

Nurses are educated to regard and recognize the personal, medical, and legal issues related to advance directives. A diagnosis describing the problem can be formulated: the avoidance or failure of a nurse to complete an advance directive may be related to a lack of the functional components of social support: emotional, informational, and/or instrumental support. Subjective characteristics of this diagnosis include perceived personal vulnerability, questioning moral/ethical implications, failure to admit fear of death or invalidism, uncertainty about choice or undesired consequences of alternative actions being considered, and recognition of priority of need within self (Carpenito, 1993). Objective characteristics include absence of supportive significant others (family, friends, group), lack of information/instrument, delayed decision making, concern with the meaning of life/death, belief systems, and expressions of values acceptable to subculture but unacceptable to dominant cultural group (Carpenito, 1993).

Utilization of the nursing process and its components, which include assessment, diagnosing, planning, implementation and evaluation (Ziegler, Vaughan-Wrobel, & Erlen, 1986), will assist in the identification of social aggregates and support systems. These systems provide the individual with the psychological

resources to master emotional burdens; opportunity to share tasks; and provision of money, materials, tools, skills, and cognitive guidance to improve their decision-making skills and task completion (Caplan, 1974). Therefore, it may be concluded the nurse also needs an individualized social support system in order to meet the goal of completion of an advance directive.

Theoretical Framework

Different definitions of social support have been formulated; however, Caplan (1974) is considered by many to be the expert in social support theory. Caplan postulated that for social support to occur, there must be an interaction of at least two individuals for the purpose of providing assistance, maintenance, or validation to one or both people. The effect of the supportive activity is to strengthen the individual's ability to function in a stressful environment once a stressor has been encountered. According to Caplan, the purpose of support is to increase vitality as well as promote survival.

Caplan's (1974) social support theory details four aspects of social support: emotional, informational, appraisal, and tangible. Emotional support, provided by an advocate, sustains self-esteem by reinforcing an individual's feeling of self-worth. The desired outcomes of this advocate are to (1) confirm that the individual is understood, (2) validate the individual's feelings, (3) provide comfort, (4) share emotional burdens through sympathy or empathy, (5) provide encouragement, and (6) express concern.

Informational support provides knowledge for decision-making, while tangible support gives individuals the necessary tools, instruments, equipment or goods, finances, and services that promote activity. Caplan further stated that appraisal support is coaching by supportive persons in an active role to assist in maximizing psychological resources and mastering emotional issues. The need or type of support is dependent on the situation or crisis.

Emotional support may be offered in the form of guidance regarding the field of relevant forces involved in expectable problems and methods of coping with them (Caplan, 1974). In regards to end-of-life decisions, guidance may be offered regarding the need for an advance directive and autonomy in the event of a mentally or physically incapacitating illness. Informational support as well as technical and anticipatory guidance may promote a greater factual understanding of the problem condition as opposed to intra psychic understanding (Caplan, 1974). In regards to advance directives, informational support includes education and counseling for the individual. Appraisal support may provide feedback about the individuals' behavior to validate their own identity and to foster improved performance based on adequate self-evaluation (Caplan, 1974). Attendance at an educational program regarding advance directives will assist individuals to assess their opinions and preferences regarding end-of-life decisions and to implement an action plan. The result of tangible or instrumental support is to reinforce the individual's conviction that action must be taken. However, the action must be feasible and the goal attainable (Caplan, 1974). In

regards to advance directives, the goal is autonomy and self-advocacy as determined by the individual's completion of this proxy.

Assumptions

1. Nurses demonstrate autonomy and self-advocacy as professionals and as individuals.
2. Acceptance of perceived personal vulnerability, moral and/or ethical implications, fear of death or invalidism, uncertainty about choice or undesired consequences, and recognition of hierarchy of personal needs increase the reluctance of completion of an advance directive.
3. An individualized, educational, and professional intervention that includes a slide presentation, counselors, informational resources, and an educational format may further increase the completion of an advance directive by a nurse.

Hypothesis

Licensed registered and vocational nurses (RNs and LVNs) who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to complete an advance directive than nurses who do not receive individualized social support.

Definition of Terms

The following terms are defined for this study:

1. Advance directive was conceptually defined as a set of written instructions that describes desired medical interventions that are to be implemented if an individual becomes decisionally incapacitated and designates a person who can make medical decisions, particularly regarding life support (Singleton, Dever, & Donner, 1992).

The term was operationally defined as the completion of a Durable Power of Attorney for Health Care.

2. Autonomy was conceptually defined as self-governance, an individual's right to determine and choose a course of action that reflects personal values without restriction (Fleming & Scanlon, 1994). This term was operationally defined as the completion of an advance directive as Durable Power of Attorney for Health Care.

3. Durable Power of Attorney was conceptually and operationally defined as a document that gives a surrogate decision maker called the attorney-in-fact the authority to make health care and/or property management decisions for the principal who executes the document. This document continues in effect even though the principal becomes incompetent.

4. Durable Power of Attorney for Health Care was conceptually defined as limiting the authority of the attorney-in-fact to medical decision making for the principal.

5. Guardian was conceptually defined as a surrogate decision maker who is authorized by the court to make health care and/or property management decisions for one who has been determined by the court to be incompetent. The term was operationally defined as one who acts in the best interest of the principal or ward, which is not necessarily as the ward would have wished.

6. Licensed nurses, RNs and LVNs are conceptually and operationally defined as all persons granted licensure by the Texas State Board of Nurse Examiners who are the attendees of the educational program.

7. Principal was conceptually and operationally defined as the person who executes a Durable Power of Attorney designating a surrogate decision maker, such as an attorney-in-fact, guardian (Singleton et al., 1992).

8. Social support was conceptually defined as an interaction of at least two individuals for the purpose of providing assistance, maintenance, or validation to one or both people (Caplan, 1974). The presentation of an educational program with a facilitator, counselors, regimented format, and written materials providing social support was the operational definition.

9. An individualized, educational, and professional intervention is a verbal and written program presented by a trained facilitator utilizing a designated educational format to increase awareness regarding the need to discuss, evaluate, and reach end-of-life decisions. This definition formed both the conceptual and operational definitions for administration of social support.

10. Completion of an advance directive was conceptually defined as the individual's self-determined proxy regarding end-of-life decisions that are to be implemented should the individual become decisionally incapacitated. The operational definition was the participant's signature and completion of the requested data on the form provided which designated a self-determined proxy. Failure to complete and sign the form indicated a state of non-determined proxy.

Limitations

No attempts were made to control for possible confounding variables such as age, developmental stage, current health status, social or psychological differences. The knowledge and personal experiences of the participants in regards to prior utilization of advance directives may have biased the findings of this study. The award of a continuing education program (CEU) may have also imposed participant bias. Other limitations include: (1) these findings may not be generalizable to any other population or setting; (2) the data obtained were ordinal-nominal data; and (3) the sample size was small.

Summary

The purpose of this study was to determine if licensed nurses who received an individualized educational program using the components of social support (emotional, appraisal, informational, and tangible or instrumental) had a higher rate of completion of an advance directive than those individuals who did not receive all the components

of social support. The literature review revealed numerous studies and articles regarding advance directives and non-health care professionals. However, little research has been published regarding the completion and self-utilization of advance directives by health care providers. Caplan's (1974) social support theory was used as a theoretical framework and as the basis for the investigator's opinions that individualized social support will assist licensed nurses to practice autonomy in their end-of-life decisions. The investigator assumed: (1) nurses demonstrate autonomy and self-advocacy as professionals and as individuals, (2) acceptance of perceived personal vulnerability, moral and/or ethical implications, fear of death or invalidism, uncertainty about choice or undesired consequences, and recognition of hierarchy of personal needs increase the reluctance of completion of an advance directive, and (3) completion of an advance directive will reduce stress with end-of-life decisions. Thus, the investigator hypothesized that licensed registered and vocational nurses who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to complete an advance directive than nurses who do not receive individualized social support.

CHAPTER 2

REVIEW OF LITERATURE

A discussion of relevant published articles and research is presented in this chapter. The literature review revealed relatively few studies in which researchers have examined the behavior of health care professionals, particularly licensed registered and vocational nurses, with regard to advance directive and autonomous health care decision making. Areas included in the literature review are references to the (1) opinions and attitudes of health care professionals about advance directives; (2) attributes of health care professionals who have an advance directive; (3) advantages and disadvantages of an advance directive; (4) barriers to completion of advance directives; (5) legal and ethical aspects of advance directives; (6) educational interventions and rate of completion of advance directives; (7) the American Association of Critical-Care Nurses (AACN) curriculum and its development; and (8) social support.

Opinions and Attitudes of Health Care Professionals About Advance Directives

Brunetti, Carperos, and Westlund (1991) conducted a study through the use of questionnaires to determine physicians' familiarity with living wills, whether their familiarity was related to an expressed willingness to discuss resuscitation issues with

patients, and whether physicians who had executed living wills for themselves were more likely to discuss cardiopulmonary resuscitation (CPR) with their patients. Their population was chosen from all internists, family practitioners, cardiologists, neurologists, and oncologists registered with the North Carolina Board of Medical Examiners to practice in Mecklenburg County during January 1989. The convenience sample consisting of 1,388 physicians yielded a response rate of 252 subjects. Data analysis included categorization according to sub-specialty of the physician, age, and number of years in practice. For questions 1 through 3, logistic regression analysis was performed and a chi square test for the two independent samples was the test for significance. The remaining questions were analyzed via the Kruskal-Wallis one-way analysis of variance. The Wilcoxon test was utilized to determine pair comparisons, while multiple pair comparisons were adjusted via the Bonferroni correction. The publication did not include reliability and validity information.

Results reported by Brunetti et al. (1991) indicated that 97.2% of the physicians knew of the living will, but only 13.5% had executed one for themselves; older physicians and those with the longest number of years in practice were more likely to have executed a personal living will ($X^2 = 10.9$, $p < .001$); and there were no significant differences among sub-specialties with regard to personal execution of living wills. Of the 252 physicians, 86% indicated personal refusal of CPR if they were terminally ill and 93% indicated they would refuse CPR if terminally ill and mentally incompetent. Additionally, 92% would also refuse artificial nutrition if

comatose, in a persistent vegetative state, with no hope of recovery. The researchers concluded that the reluctance to discuss terminal care or extraordinary medical treatment is part of the natural human tendency to avoid unpleasant thoughts or saddening emotions. Therefore, due to the predisposition of the physician and patient to delay these discussions, an entirely new mechanism to initiate and ensure the individual's choice should be utilized. The Patient Self-Determination Act (PSDA) created such a mechanism in the form of an advance directive.

Medical decisions regarding the prolongation of life, the right to die, euthanasia, and patient rights are among the most extensively discussed decisions within the medical, nursing, and legal professions today. Caralis and Hammond (1992) utilized case vignettes and a questionnaire to survey medical students, house staff, and faculty physicians at the University of Miami School of Medicine. The validity of the instrument was assessed by a pilot test administration followed by a retest of 20 participants. A chi square test determined the differences between proportions and the "categorical data modeling" procedure was utilized to evaluate variables across the four case studies (Caralis & Hammond, 1992).

The responses of 360 participants revealed the following attitudes toward these issues. The majority (76%) of respondents considered withholding and withdrawing life-sustaining therapy consistent with passive euthanasia. Passive euthanasia was more acceptable to 77% of the respondents, and all groups were similarly more disturbed by active euthanasia. Only 51% stated they would accede to the patient's wishes when

lifesaving treatment is refused, and 16% would do so for requested assistance in dying. The majority (68%) of the participants also agreed there is a moral justification for assisting patients to die and feel compassion for a physician who assists in euthanasia. Only 6% were agreeable to deliberately terminate life by medication administration resulting in respiratory arrest, and only 1.1% would administer medication to cause cardiac arrest. Of the respondents, 54% felt age was of moderate importance in decisions to withhold or withdraw therapy and 36% of the house staff considered age very important (Caralis & Hammond, 1992). These results lend support to the emphasis of the various professions to save lives versus the support for the right to die or terminate treatment as decided by the individual.

Gillick, Hesse, and Mazzapica (1993) examined the preference for life-sustaining treatment of physicians and nurses who had significant experience with clients with the diagnosis of persistent vegetative state, terminal illness, severe dementia or coma. Their population consisted of a community teaching hospital's full-time nursing staff and active medical staff. The convenience sample consisted of 248 nurses and 247 physicians. Data analysis included a comparison between refusal rates by health care providers for the various interventions in each of the presented scenarios through two-sample *t* tests. Multiway analysis of the variance was performed to assess the contribution of demographic factors of physicians' and nurses' refusal rates using the S-Plus statistical package.

The respondents were asked to complete a questionnaire regarding future medical decisions for themselves. The questionnaire modeled on the medical directive had 12 interventions and 6 scenarios. The scenarios included coma or persistent vegetative state with no hope of recovery, coma with small chance of recovery, severe brain damage and terminal illness, severe brain damage without terminal illness, and elderly with or without chronic illness prior to an acute medical event. The 12 interventions were: (1) cardiopulmonary resuscitation (CPR), (2) mechanical ventilation, (3) artificial nutrition and hydration, (4) major surgery, (5) minor surgery, (6) chemotherapy, (7) dialysis, (8) invasive tests, (9) blood transfusions, (10) antibiotic therapy, (11) simple diagnostic tests, and (12) pain medications (Gillick et al., 1993).

The nurses' return rate was 115 (46.5%), while the physicians' return rate was 115 (46.5%). Of the subjects, 68.5% were less than 45 years old and (68.7%) of the physicians were between the ages of 35 and 54. The nurses were 67.7% Catholic and the physicians were 23.5% Protestant, 47.8% Jewish, and 16.5% Catholic. The nurses were 91.3% female, and the physicians were 26.9% female (Gillick et al., 1993).

Many nurses and physicians stated that they would refuse a large number of interventions in the scenarios presented. The refusal rate for the interventions pertaining to persistent vegetative state was 89.5%, dementia with terminal illness was 88.4%, dementia without terminal illness was 76.4%, and coma with small chance of

recovery was 60.5%. With a scenario of a healthy elder with acute illness, only 30.9% refused a large number of interventions (Gillick et al., 1993).

Focusing on the goals of therapy and on selection of proxy might compensate for the lack of experiential knowledge that distinguishes health care providers from the general public. People will continue to make choices and exercise their autonomy. Health care providers, with their vast exposure to the intensely ill and frail elderly, can be an invaluable resource in helping the general public to focus on goals and appropriate proxy or perhaps by assuming the role of proxy. Limitations for this study, recognized by Gillick et al. (1993), included the following data. The study was limited to a single institution, may not be generalizable for the public, had a low response rate, and no comparisons were made between medical and nonmedical personnel. No data on reliability and validity were noted.

Mumma (1993) performed a survey of 30 nurses working in an acute neurological-neurosurgical unit in an urban Catholic hospital. The group consisted of 60% registered nurses, 30% licensed practical nurses, and the ages ranged from 20 to 50 years, with the average age being 30 to 40 years.

The questions asked were about refusal of treatment including food and fluids, decision making related to foregoing life-sustaining treatments, and the kind of treatment they would want for themselves or loved one if they were comatose and not expected to recover. The statistical results were: 93% of the respondents agreed with the statement that mentally competent individuals have the right to refuse any

treatment, including fluids and food; 56% believed that an incompetent person should be fed by gastrostomy tube or any means necessary; 73% disagreed with the statement that preservation of life should be valued above all other health care goals; 93% preferred shared decision making by everyone involved in a person's care with regard to withholding life-sustaining treatment; 100% did not want cardiopulmonary resuscitation for self or loved ones if they were comatose and not expected to recover; 82% did not want tube feeding for themselves or loved ones if they were comatose and not expected to recover; and 79% did not want intravenous fluids in the same scenario (Mumma, 1993).

The survey was tabulated, and findings were shared with the staff as a follow-up to the survey. A discussion with the staff revealed thoughtful examination of ethical issues related to withholding life-sustaining treatment, especially nutritional support. Personal and professional perspectives of the issues revealed the fact that the nurses' opinions and beliefs were based on deeply held values. The limitations of this study are the lack of research questions, reliability and validity, size of population, and the use of a nonproven instrument (Mumma, 1993).

Solomon et al. (1993) conducted a survey at five hospitals on professional views of life-sustaining treatments near the end-of-life. The research questions were designed to examine: (1) ways in which health care professionals observe practices within their own hospitals and assess their patients' care near the end-of-life, (2) if the health care professionals are concerned about the misuse of available technologies, and

(3) if the physicians and nurses have an awareness of the national recommendations regarding the patient's right to forego treatment of various kinds and to receive adequate pain control, and if they are aware, do they agree with those recommendations.

The five hospitals were located in Massachusetts, Georgia, Washington DC, and Canada. They included an urban hospital, a Catholic community hospital, and three suburban teaching facilities. The size of the institutions ranged from 180 to 600 beds. Questionnaires were completed by 687 physicians and 759 nurses with a response rate of 61%. The average length of experience of the respondents was 14.3 years in their profession. The physicians' experience averaged 13.6 years in a surgical setting and 12.7 medical years of experience with an average of 8 years at the current institution of practice. An average of 11 clients in each respondent's care had died within the previous 12 months. They also described 26% of the clients that they had cared for within the last year as critically or terminally ill (Solomon et al., 1993).

The self-completed questionnaire of 123 items covered a range of issues: (1) knowledge and attitudes regarding the law, medical ethics, ethical guidelines for clinical practices; (2) knowledge of and adherence to institutional guidelines in the use of life support; (3) practice issues regarding the use of life support and client involvement in decision making; and (4) perceived impediments to good decision making and quality of care (Solomon et al., 1993).

National experts in ethics, medicine, nursing and health law, through a review of the literature on ethical guidelines for treatment near the end-of-life, developed the items included on the questionnaire. This study was pilot tested with 72 subjects for face-to-face validity and test mechanics. Test-retest repeatability over one month on individual items measured on a 5-point Likert scale ranged from 84% to 94%. Questions with ordinal response categories were tabulated by gender, professional, and prior ethics education. Differences in response were answered by Kruskal-Wallis nonparametric one-way analysis of variance. Statistical analysis were performed with a personal computer version of the Statistical Package for the Social Sciences (SPSS) (Solomon et al., 1993).

Of the respondents, 88% reported being aware of institutional policies about obtaining informed consent, 90% were aware of do not resuscitate orders, 70% were aware of the need to document the reason for these orders, 69% were aware of the need to record the patient's wishes in the medical record, and 65% were aware of the need to determine the patient's capacity to make decisions. Attending physicians were satisfied with the patient's involvement 31% to 50% of the time. Only 21% of nurses voiced satisfaction with patient involvement. Almost one-half of the providers reported acting against their consciences in providing care to the terminally ill. Staff were concerned with the provision of overly burdensome treatment four times more often than they were concerned about under treatment. Of the total sample, 87% agreed that all competent clients, terminally ill or not, have the right to refuse life support even if

that refusal may lead to death. Another 42% of the respondents agreed that even if life support such as ventilation and dialysis are stopped, food and water should always be continued. Almost half of the respondents reported having acted against their conscience in providing over treatment. Physicians and nurses recognized the client's right to refuse care, yet, they reported key interventions such as cardiopulmonary resuscitation and mechanical ventilation continue to be offered inappropriately. Communication and inadequate documentation of the client's preference prior to crisis may be the reason for this inconsistency (Solomon et al., 1993).

Most health care providers were unclear regarding the law, ethics, and respective professional standards of practice on the subject of withdrawal of treatment. The respondents to this survey reported being less likely to withdraw treatment, citing reasons such as psychological discomfort with stopping life-sustaining intervention, discomfort with the public nature of the act, fear of a lawsuit from disapproving witnesses even if the act were legally correct, and the fear of sanction by peer review boards (Solomon et al., 1993).

Kelner, Bourgeault, Hebert, and Dunn (1993) corroborated the 1989 survey conducted by Davidson, Hackler, Caradine, and McCord (1989) of the attitudes of Arkansas physicians toward advance directives. Kelner et al. reported that of 1,293 respondents, nearly 80% revealed a positive attitude while fewer than 2% revealed a negative attitude toward advance directives. The researchers conducted personal interviews, following a structured guide, with 20 physicians and 20 nurses selected

from available staff on the basis of convenience and employed in a large teaching hospital in Toronto. The sample chosen included 5 physicians and 5 nurses each from family and community medicine, oncology, intensive care, and geriatrics. Qualitative data, content analysis, and concept saturation were used to group the responses of the participants into key concepts and categories in the mode of grounded theory via a software program.

The benefits of using such directives identified in Kelner et al.'s (1993) study included advantages of improved communication, more confident treatment decisions, less stress and guilt, and promotion of patient autonomy. Additionally, the researchers concluded that physicians and nurses are generally in favor of encouraging patient autonomy through advance directives but do not always feel able to honor the wishes expressed in the directives. It is essential to differentiate between situations in which health care providers are unwilling to comply with an advance directive for clinical reasons and those situations in which a patient's request violates a professional's moral beliefs. Health care providers may be presented with the challenge of relinquishing, at least in part, this central element of their profession in order to honor the patient's treatment preferences. Concerns regarding legal considerations and potential career risks also may influence the willingness of health care professionals to honor an advance directive. No reliability and validity data were noted in this study.

Reilly et al. (1994) conducted 258 scripted interviews with patients admitted consecutively to an acute medical service of a community teaching hospital in

Rochester, New York and contemporaneously surveyed the 68 attending physicians regarding their attitudes about advance directives. Responses were measured on 5-point Likert scales, and dichotomous variables were analyzed by the Pearson χ^2 test. Continuous variables were analyzed through the Student's t test and nonparametric tests, while age was analyzed via the Wilcoxon rank-sum tests.

Reilly et al. (1994) concluded that health care providers generally favor the use of advance directives. However, the providers often are influenced most by clinical exigencies, such as age and severity of illness, when deciding whether to discuss directives with patients. Therefore, physicians tended preferentially to select the elderly and critically ill and ignore the younger, healthier patients ($p < .001$). In addition, physicians admitted that their own assessment of whether the patient should be resuscitated plays a significant role in complying with an advance directive. This study revealed that 90% of physicians favored discussions regarding cardiopulmonary resuscitation (CPR) when the physician's opinion is that the patient should not receive CPR, while 61% favored discussion when the physician supports resuscitation ($p < .001$). Later studies have demonstrated that physicians are poor predictors of their patients' preferences about medical interventions and qualities of life.

Terry and Zweig (1994) conducted interviews with 20 competent residents in a nursing home in Missouri. Additionally, the medical record of each participating resident was reviewed for documentation of advance directives and code status as part of a separate study. Documentation review included the presence or absence of

advance directives, specific terms of the advance directive, code status, and physician documentation of an advance directive and code status. Results of the record reviews were compared with information obtained during the residents' interviews to determine the extent of agreement between the resident and their physician. Eight of the participants had an advance directive documented within their medical record, six others stated they had such a document but none were recorded, and only two of the records contained physician documentation of end-of-life discussions such as code status or advance directives.

Findings from this study further revealed a lack of agreement with resident report and documentation of code status by the physician. Of the 20 records reviewed, 8 demonstrated good agreement between the residents' perceptions and the physicians' documentation. The majority of the residents expressed confidence in their physician and believed their physician would act in their best interest regarding end-of-life issues (Terry & Zweig, 1994).

Wilson et al. (1997) conducted a study to determine if physicians' levels of training or experience relate to their abilities to assess their patients' treatment preferences for end-of-life. These investigators interviewed 230 seriously ill adult patients regarding their desire for CPR, their current quality of life, and their attitudes toward six other common adverse outcomes. Additionally, the medical intern and attending physician caring for these patients were asked to estimate the patient's responses for each of the same items. Comparison of physicians' responses with

patients' responses required all data completion and were only possible when both had non-missing data. The numbers of these pairings available for the individual questions varied and were assessed using the kappa statistic. The differences between the characteristics of the physicians were assessed using paired t tests for continuous variables and a McNemar test for dichotomous variables. Paired t tests of the mean of the raw difference scores determined the ability of the physician to either over or under estimate the patients' scores to determine quality of life estimates and patients' attitudes towards adverse outcomes. T tests for continuous variables, Wilcoxon rank sum tests for ordered variables, and chi-square or likelihood ratio tests for dichotomous and categorical variables were utilized to assess CPR preferences. A multiple logistic regression analysis determined independent correlates of physician-patient disagreement.

Results demonstrated that interns and attending physicians were similarly sensitive and had similar predictive values regarding CPR. However, attending physicians ($p = .04$) more accurately identified those patients not desiring CPR. Scores demonstrated that interns overestimated the patients' quality of life ($p < .004$) as did attending physicians ($p = .68$). Interns overestimated the patient's willingness to accept artificial nutrition ($p < .001$) and life in a nursing home ($p < .01$) as did the attending physician ($p < .001$ and $p < .05$, respectively). There was no univariable or multivariable correlate of intern-patient disagreement about quality of life. Attending physicians who had cared for the patients longer also did not assess

their qualities of life more accurately. Wilson et al. (1997) noted three limitations for this study: patients and physicians did not have instructions that specified how categories should be interpreted; a poor statistical power was used to detect a type II error; and results may not be generalizable to other patients or populations.

Gillick and Mendes (1996) found that among people who are educated as to the realities of being old and sick, there is a strong tendency to favor limitation of treatment for acute illness. A total of 102 full time nurses employed in a 725-bed long-term care institution completed an intervention-specific advance directive for themselves. The directive included scenarios representing terminal illness, dementia plus chronic illness, chronic illness in a nursing home resident, chronic illness in a community-dwelling older person, and a robust, community-dwelling older person. The refusal rate defined as the mean number of refusals for each respondent was the unit of analysis. Refusal rates were analyzed using one-way analysis of variance. Confidence intervals were computed at the 95 % level. The demographic factors that influenced refusal rates were assessed via multivariate analysis using the SPSS statistical package.

Gillick and Mendes (1996) concluded that nurses working in a long-term care institution have strong preferences about limiting a variety of interventions in the elderly. The greater the degree of physical and cognitive impairment, the more limitations were favored. Analysis of the five scenarios revealed refusal rates in each of the 11 cases differed across the five scenarios ($p < .001$ for each of the

interventions). Multivariate analysis revealed the only factor associated with refusal pattern was the type of unit on which the nurse worked. Nurses working on units with the more impaired patients were more likely to express a desire for limitation of treatment for each of the five scenarios presented ($p = .003$). These providers may be biased against vigorous medical treatment for the elderly because the patients they care for have extensive functional limitations. Therefore, it may be necessary for health care providers to expand advance directive planning to include discussions of what constitutes appropriate treatment in a broad range of circumstances. The researchers recognized the following limitations. The study utilized an intervention-specific directive which may fail to identify the goals of treatment and to address possible alternative treatments. The study was confined to nurses working in a chronic care facility and may impose a bias.

Attributes of Health Care Professionals Who Have An Advance Directive

Relatively little research has been done to determine the characteristics of those individuals who assure autonomy and self-determination by completing an advance directive. Stechmiller, Conlon, and Anderson (1991) completed such a study that included five predictor variables. Their population encompassed 500 nurses randomly selected from the membership list of the ANA and 500 physicians randomly selected from the membership list of the American Medical Association (AMA). The study was conducted through the use of an 8-page living will survey questionnaire and the

variables selected included religion, length of experience with the terminally ill, and nature of the relationship (professional or personal) with the terminally ill. Response rates included 185 nurses and 85 physicians. To analyze or select predictor values on the evidence of empirical evidence only, a statistical analysis called classification and regression trees (CART) was used. Limitations recognized for this study were possible personal experience with the subject and concern that a signed living will not be effective. No tests for reliability and validity were noted.

Age was not found to have a significant association with the likelihood of completing a living will and the variables selected included religion, length of experience with the terminally ill, and the nature of the relationship (professional or personal) with the terminally ill. The variables found to be nonsignificant and, therefore, rejected were education/occupation and current region of residence. The strongest predictor for completion was the response of agnostic/atheist for the variable religion. The right to life advocates (one subgroup of the Roman Catholic Church) opposed any form the PSDA legislation. This findings was important since the Vatican issued a position statement in 1981 that supported the right to self-determination in certain situations (Stechmiller et al., 1991).

The second best predictor variable identified was length of experience in providing care to at least one patient, family member, or friend who was terminally ill. Nurses and physicians who have the greatest experience with the terminally ill, greater than 20 years, are more likely to complete an advance directive than those

with less experience. Recognition of the protection provided by legislation may influence these providers (Stechmiller et al., 1991).

The nature of the relationship (professional or personal) with the terminally ill was the next strongest predictor variable for completing an advance directive. Personal experience with family members or personal friends was found to be more predictive than professional experience with artificial life support of the terminally ill. Health care professionals may react to the stress of a terminally ill loved one differently since they may be in the position to be in control of the physical pain, mental anguish, indignity, and the humiliation of a progressive dying state. In a personal situation, the health care professional does not have absolute control over health care decisions of their loved one. Stechmiller et al. (1991) concluded that a personal experience with artificial life support of a terminally ill loved one may have the stronger influence in predicting the likelihood of signing an advance directive. An unexpected result, according to the researchers, was the discovery that the number of nurses and physicians completing an advance directive in the future will most likely increase as a result of the increased credibility of the document.

Storch and Dossetor (1994) identified, in a general public survey performed in Canada, the attribute variables of professional employment status, level of education, annual income, and age as influential on individual attitudes toward advance directives. The study consisted of two relevant three-part questions which were submitted to the Population Research Laboratory at the University of Alberta to be

included in the 1990 Edmonton Area Survey, an annual survey administered by the Department of Sociology. A pretest was conducted, and the necessary modifications were completed. The research questions included attitudes regarding health care treatment decision making, organ donation, advance directives, and quality of life. Participants rated their level of agreement/disagreement using a 7-point Likert scale. The data were analyzed using the SPSS statistical package to demonstrate frequency and cross-tabulation of sociodemographic variables and the participants' responses regarding attitudes towards end-of-life treatment directives.

The total number of participants was 448, 49.6% male and 50.4% female, with a similar age range across six age categories except for a peak of 30.8% (age 30-31) and a low of 9.8% (over 65 years of age). Of the respondents, 57% were employed full time, 28% in blue collar or farm labor employment, 33% in clerical or sales, and 39% in white collar work. Disagreement rates ranged from 57% in white collar populations, 42% in the clerical and sales population, and 41% ($p < .05$) in the blue collar and farm group. In regards to education, 40% had completed high school and further education but did not have a university degree. Three-fourths (75%) of the participants were from North America, 15% of European origin, and 10% of Asian origin ($p < .01$). Approximately 50% were Protestant, 28% were Roman Catholic, 17% professed no religion, and 6% were of other religious persuasions (Catholic or Protestant-- $p < .01$; other religions-- $p < .01$) (Storch & Dossetor, 1994).

The results of Storch and Dossetor's (1994) study indicated that 47% of the participants did not agree that they would leave major decisions to their physician. The younger the participant, the more they disagreed that major decisions should be left to the doctor. Those with lesser education ($p < .05$) tended to agree with allowing the physician to make medical decisions, while those with a greater than high school education tended to prefer more involvement in the actual decision making. Those with "no religion" demonstrated the highest rate of disagreement (65%) to leaving the decisions to the physicians. Participants reporting the highest income had the highest level of disagreement, while those reporting the lowest income were almost equally divided between those who agreed with physician decision making ($p < .01$).

The implications for the health care providers must extend beyond the patient's medical status. The provider must have knowledge regarding the patient's socio-demographic information to stimulate questions regarding medical decisions and the completion of advance directives. Additionally, knowledge of the patient's ethnic origin and religious beliefs are beneficial in end-of-life treatment discussions. Public education in high school on advance directives could prove beneficial in enhancing the preparedness of individuals to communicate their preferences. Health care providers may use a values history to obtain insight regarding the patient's values and their compatibility with the patient's choice of and completion of an advance directive (Storch et al., 1994).

Advantages and Disadvantages of an Advance Directive

The Patient Self-Determination Act (PSDA) was part of the 1990 Omnibus Reconciliation Act (OBRA; US Public Law 101-508, s 4206, 4751, 1990) and became effective on December 1, 1991. Under the mandates of the PSDA, an individual's rights to formulate advance directives and make health care decisions must be explained to all adult clients on admission to institutions and organizations serving Medicare and Medicaid patients (Annas, 1989; Bopp, 1990; Wolf, 1990). This law is intended to promote client autonomy, self-determination, and more humane use of life-sustaining treatment. As a requirement of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1992), institutions must have mechanisms in place for supporting clients' rights and participation in health care decision making. In addition, institutions also are required to have some type of formalized system for staff education regarding the appropriate use of advance directives.

An advance directive, or living will, is a written instruction recognized under State Law that relates to the provision of care regarding life-prolonging treatment when the individual's medical status is considered terminal and/or death is considered eminent (Flarey, 1991). However, a living will may prove ineffectual when actual decisions are needed due to the vagueness of the statements on the living will and the need for a surrogate, legal next of kin, of a nonautonomous patient (Emanuel, 1993; Weir & Gostin, 1990). Additionally, state statutes may vary regarding the actual form accepted and process and procedure for enforcement (Flarey, 1991). The durable

power of attorney for health care (DPA/HC) is a second type of directive used in situations in which a client is judged mentally incompetent or nonautonomous and a specific person, a surrogate, has been authorized to make proxy on their behalf (Emanuel, Barry, Stoeckle, Ettelson, & Emanuel, 1991). This surrogate has the immediate authority to choose between alternative treatments, refuse specific types of treatment, and to refuse any form of life-sustaining treatment or procedure. The surrogate chosen should be the person most familiar with the patient's preferences, committed to ensuring the preferences of the patient, and may be a non-family member (Weir & Gostin, 1990).

The advantages of an advance directive are considerable. An autonomous decision-making process and self-determination rights of the individual are recognized by the medical community and family members (Colvin, Myhre, Welch, & Hammes, 1993). This process and these rights ensure that decision making is determined by the patient or is between the patient or surrogate and the health care provider and should not require the intervention of the legal court system (Ethics Committee of the Society of Critical Care Medicine, 1997). Medical personnel are clearly informed of the wishes of the individual even if previously unknown. Family members are relieved of a potentially difficult situation and even more difficult decisions. The advance directive supports contemporary professional medical ethics and protects health care providers from criminal conviction or civil judgment for withholding or failure to administer specific forms of treatment (Samuels & Barrister, 1996).

Ishihara, Wrenn, Wright, Socha, and Cross (1996) conducted an observational, cross-sectional survey using a convenience sample of 238 patients, selected from high-risk adult patients presenting with acute complaints to an emergency department (ED) in a university hospital during May and August, 1994. This study is of interest since many of the patients reporting to an ED are at high risk for death, unable to communicate because of trauma or altered mental status, and/or suffer from chronic debilitating diseases. The ED staff must provide rapid and aggressive therapy and may not be able to access pertinent patient information before decisions and interventions must be initiated. These facts support the concept that advance directives extend the patient's autonomy in emergency and unforeseen situations.

The survey consisted of a questionnaire conducted by three medical students. The population consisted of those 65 years of age or older or those younger than 65 years of age who had a serious chronic medical disease. The purpose of the study was to determine the number of patients arriving at the ED who had executed an advance directive, how many of the population had brought the directive with them to the ED, whether those who did not have a directive had ever discussed the issue with their primary health care providers, and how many had actually heard of an advance directive (Ishihara et al., 1996).

The study consisted of several outcome measures which included execution of a directive, knowledge of advance directives, method of obtaining the information, whether they brought the advance directive to the ED, and rationales for not

completing a directive. Post-hoc subset analysis for these outcomes in association with race were performed. Data analysis included contingency tables and chi square. A p value of $\leq .05$ determined significance. The Mantel-Haenszel chi square for skewed data was used to report the medians and interquartile ranges (Ishihara et al., 1996).

Ishihara et al.'s (1996) results demonstrated that only 22 % of the population had an advance directive and that of these, only 23 % brought the document to the ED. Of the population who did not have a directive, 95 % reported never discussing the issue with their primary care physician and 42 % did not have any knowledge of a health care directive. The researchers further concluded that blacks were less likely than whites to have these documents ($p < .0002$) or have knowledge regarding the directives ($p < .004$). The researchers attempted to guard against bias in their convenience sample by sampling at different times of the day every day. The sickest patients were excluded from the study. The researchers cited recall bias as a limitation and the recent death of well known figures as a bias.

The disadvantages of advance directives are often related to the inability to predict the future. Refusal of treatment for the future may be based upon misunderstanding, misapprehension, or misdiagnosis. Additionally, with the vast discoveries and new methodologies of treatment, prediction of future health care rewards may be limited at the time of the decision for treatment limitation. The need for individuals to articulate their present values and beliefs to ensure their reflection in future medical decisions has been identified by various authors (Davidson et al., 1989;

Doukas & McCullough, 1991). This presents a challenge to the medical community in assisting patients and families, as well as themselves, to participate in this value identification. Individuals must comprehend their retained right to review, amend, or revoke the directive at any time. Personal views or cultural influences may change fundamentally through the course of a lifetime.

Some health care professionals may view the directive as a lack of trust in the medical team to correctly decide the needs of the patient and may impede or limit the autonomy of the health care professionals. The directive may present an apparent refusal or mislead the health care provider by its generality or specificity. The validity of the directive may be in question in regards to mental competency of the individual and proper witnessing of the actual document (Samuels & Barrister, 1996). Primary health care providers may feel more compelled to honor the directives of clients they have served over periods of time since this relationship complements their knowledge and familiarity with the patients' values and preferences (Palker & Nettles-Carlson, 1995).

Barriers to Completion of Advance Directives

Berrio and Levesque (1996) identified the following barriers to the completion of an advance directive: procrastination, dependence on family for decision making, lack of knowledge about advance directives, difficulty of the topic, waiting for the health care provider to initiate the discussion, the health care provider waiting for the

individual to initiate the discussion, incorrectly assuming that an attorney's assistance is required for completion and legal recognition, fatalism or acceptance of the "will of God," fear of "signing my life away," and fear of nontreatment: The authors identified these barriers from a literature review and personal experiences in patient compliance with advance directive completion.

Cugliari, Miller, and Sobal (1995) studied factors that promoted completion of advance directives within the institutional setting. The research questions were designed to determine: (1) if patients read the information about the health care proxy; (2) the number of patients who sign advance directives before hospital admission and the number who do so after receiving information provided by the institution; (3) the factors which facilitate or impede completion of the health care proxy; (4) ways in which institutional procedures can facilitate completion of the proxy; and (5) if clients are more likely to execute a directive if they receive it prior to admission.

The sample consisted of 419 clients with planned admission to one of two university teaching hospitals in the northeast United States. The instrument included a questionnaire administered via a personal interview by trained experts. Clients were asked if they had completed an advance directive and to identify barriers which prevent people from executing a directive. Self-reported health history and demographic data were collected as well (Cugliari et al., 1995).

A standard statistical package was used by the Cugliari et al. (1995) to produce descriptive and other statistical analysis. Bivariate comparison of the two institutional

groups was done using chi square analysis and t tests with a significance level of $p < .05$. Multi-statistical comparisons were performed for some parts of the analysis. Interpretation of the results considered the possibility of a type I error, using the Bonferroni adjustment to alpha values. Multivariate logistic regression was used to compare demographic data and institutional information which enabled the researchers to predict completion of the proxy form.

The results demonstrated that 73% of the respondents remembered receiving the proxy form. Only 22% remembered submitting the proxy, for inclusion in their medical record, upon admission to the hospital. Of the respondents, 41% remembered receiving the information at a visit prior to admission, and 57% of the respondents who remembered receiving the proxy information reported that they had read the information supplied. Only 16% of the respondents stated they had completed a health care proxy prior to receiving the information from the institutions, while 22% executed a proxy form provided by the institution of admission. These results emphasize the importance of addressing advance directives prior to the crisis or event necessitating admission (Cugliari et al., 1995).

Of the respondents who did not execute the proxy, 12% stated they already had an advance directive, 11% were too busy to execute such a document, 4% took the document home where it remained, and 3% assumed family members would make the appropriate medical decisions. Less than 1% stated that they did not want to burden others with the responsibility of medical and end-of-life decisions. Over three-fourths

(76%) stated that it was very important to plan for future medical decisions. When asked what time frame would be best to discuss advance directives, 60% stated a preference for discussion during office visits, 15% stated a preference for discussion during hospital stays, and 25% stated at other times. Clients were more likely to complete the advance directive if the information had been distributed several days before the actual day of admission to the institution. The completion of the advance directive was not significantly associated with demographic or medical characteristics of either institutional clientele as determined by bivariate analysis, demonstrating the validity of the study. Findings from Cugliari et al.'s (1995) study delineate that people are convinced of the importance of advance directives, yet they have failed to execute the document.

Markson, Fanale, Steel, Kern, and Annas (1994) examined the effect of a combined educational and administrative intervention, targeted at physicians, in reducing the barriers of completion of an advance directive. The institutions included the Home Medical Service of Boston University Medical Center, a physician home care service, and several nursing homes attended by physicians of the Geriatrics Section of the Medical Center of Central Massachusetts. The educational component covered theory and practical application of the law and lasted 5 weeks. The administrative component consisted of administrative consent and support for physicians to allow additional time for conferences with patients regarding advance directives.

Markson et al. (1994) concluded that reluctance by physicians to incorporate advance decision making into primary care can be overcome when providing care to elderly patients. Education regarding the law only is not sufficient to change behavior or attitudes. Identified barriers to completion identified by the physicians included time limitations, lack of administrative support, perceived legal uncertainties, professional culture, the idea of shared decision making, and the preference for protecting patient welfare rather than respecting patient rights. The researchers further concluded from the high patient response that patients will execute an advance directive if physicians initiate the conferences and guide them through the process of completing the document.

Elpern, Yellen, and Burton (1993) administered a questionnaire through personal interviews to a nonrandomized convenience sample of 46 inpatients and 50 outpatients during the fall of 1991. The setting was a 900-bed tertiary care, urban academic medical center providing health care to the Chicago metropolitan area. The questionnaire solicited information regarding demographics, familiarity with advance directives, reasons for not completing an advance directive, and the individuals' preferences for receiving information from the institution. The SYSTAT: System for Statistics was used for data analysis. A chi square and Fisher's exact tests were utilized for comparisons among categorical variables while Mann-Whitney tests were used for comparisons between continuous variables.

Results demonstrated 29% of the total sample had executed an advance directive. Significant differences were found for age ($p = .025$) and self-ratings of current health status ($p = .034$). No significant differences were found regarding sex, race, marital status, religious preferences, education, recent hospitalizations, or recent stay in an ICU. Lack of information and procrastination were the most frequent reasons offered for noncompletion of a directive. Numerous participants stated the belief that the assistance of an attorney was required for execution of the document. The majority (81%) of the sample stated a preference for companionship, such as family member or close friend, during conferences about directives (Elpern et al., 1993).

Colvin et al. (1993) identified the time of completion of the directive as a crucial factor in rate completion. The discussion of the directive at the time of admission to a hospital is often less than ideal since these admissions usually occur under stressful circumstances. Emotional and communication barriers may be experienced and lead to misconceptions and mistrust by the individual. Discussion of advance directives is essential in the primary care setting and discussions in the outpatient setting are well received. The probability that someone who is young and healthy will become incompetent is low, but the advantages of advance directives can be significant in the event incompetence should arise.

Given the above perspective, the discussion of advance directives should be seen as similar to screening and other forms of preventive health care performed

during primary care visits (Emanuel et al., 1991). Emanuel et al. (1991) studied attitudes of patients regarding planning, perceived barriers to planning, treatment preferences in four hypothetical scenarios, and the feasibility of a medical directive. The questionnaire was administered to 405 outpatients and 30 primary care physicians at Massachusetts General Hospital and 102 members of the general public in Boston. Data were analyzed by SAS software. A chi square was utilized to critique comparisons between categorical variables, and the Wilcoxon rank-sum test was utilized for nonparametric distributions.

Data analysis revealed that 93 % of the outpatients and 89% of the general public desired advance directives ($p > .02$). The young and healthy stated at least as much interest as those 65 years of age or greater and in fair-to-poor health. The lack or failure of physician-initiated conferences regarding advance directives was cited among the more frequently mentioned barriers to execution of the document. One of the least cited barriers was the disturbing nature of the topic. Of the outpatient respondents, 71 % stated they would not desire life-sustaining treatments in regards to the four scenarios. There did not appear to be specific treatment preferences in relation to age, self-rated state of health, or other demographic variables (Emanuel et al., 1991).

From the health care professional's perspective, there are a number of factors that are external to the provider-patient relationship that might inhibit discussions of advance directives: limits on the provider's time, lack of administrative support, and

perceived legal uncertainties. The professional culture may be resistant to the concept of shared medical decision making, and the emphasis is on protecting the patient welfare rather than respecting the patient rights. Additionally, the provider may lack the knowledge, expertise, or experience to discuss such matters with the patient (Markson et al., 1994).

Legal and Ethical Aspects of Advance Directives

Flarey (1991) discussed the individual's right regarding decision making, autonomy, and the right to refuse life-sustaining treatment. An individual's right to refuse life-sustaining treatment is supported legally by the common-law right of self-determination and the Constitutionally stated right of privacy. Constitutional rights are not absolute and they must be balanced against a state's interest. The four state interests that must be weighed against a patient's right to refuse treatment include the preservation of life, the protection of innocent third parties, the prevention of suicide, and the protection of the ethical integrity of the medical profession (President's Commission, 1983; Weir & Gostin, 1990). Complexity surrounding the rights of incompetent patients and the conflict between the patient's rights and the state's interest remain an issue today. Physicians are often reluctant to follow advance directives when challenged by family members since America's legal system allows the courts to determine if the state's interest outweighs the patient's rights.

According to Flarey (1991), living wills statutes ensure immunity for individuals who act according to the document or refuse to act. However, a physician who is unable to follow the directive is required to make every reasonable effort to transfer the care of the patient to a physician who can honor the specifics of the document. Additionally, all health care providers possess the right to refuse to participate in any treatment plan that is against their ethical beliefs. Hydration and nutrition are examples of potential ethical conflicts and remain a legal question in several states.

Flarey (1991) defined a durable power of attorney for health care (DPA/HC) as a specifically designed legal instrument for health care decision making by a designated surrogate. The authority becomes effective immediately when the patients become incompetent and unable to express their wishes. However, four requirements must be met before the health care provider allows implementation of the document. First, the health care provider must believe that the surrogate has the authority to make health care decisions. Additionally, the physician must determine, to the degree of medical certainty possible, that the patient no longer possesses the mental or physical capacity to personally make informed health care decisions. The DPA/HC must then be provided with sufficient information to satisfy the standard of informed consent prior to making any health care decisions. The last requirement of the physician is the belief that the surrogate's decision is consistent with the known desires

of the patient (Brunt, 1994). The actual power of the surrogate is defined by the individual state's specifications.

The vagueness of many living wills, the power of the durable power of attorney for health care, and the differentiation between comfort care and life-sustaining treatment contribute to the ethical issues of utilizing advance directives (Brunt, 1994). The ethical dilemma for many health care professionals who support advance directives is accurately estimating the probability of recovery at which an individual patient would wish to terminate treatment. The possibility that some patients may not recover fully or recover with partial impairment of function, which significantly affects quality of life, may change the desired termination point away from very low likelihoods of survival. Many patients or their surrogates support the utilization of life-sustaining measures if there is a possible chance of a meaningful recovery with quality of life (Ewer & Taubert, 1995).

It is imperative for all health care providers to identify as early as possible currently competent patients at high risk of becoming incapable of making their own health care decisions in the future. Patients who become incompetent and have not previously executed a directive for health care lose their ability to inform their physicians or their families of their preferences if or when they are unable to communicate or become incompetent (Janofsky & Rovner, 1993).

Janofsky and Rovner (1993) concluded from their study that a substantial number of nursing home residents had neither a guardian nor an advance directive.

This finding is of concern since this population is at high risk for becoming incompetent as time continues. These investigators utilized a questionnaire, specifically designed at a 6th-grade reading level to ensure maximization of completion rates, which was distributed to the individual designated to be identified in the event of an emergency for the residents. The sample size was 233 and the response rate was 191. Of this number, 81.6% were familiar with the term durable power of attorney, 86.8% were knowledgeable of the term living will, and 94% understood the term guardianship. Of this population, only 15.2% of the nursing home residents were capable of independent decision making regarding health care. A living will had previously been executed by 17.8% of the residents, 48.2% had executed a durable power of attorney for health care, 52.4% had executed neither document, and 23% had a court appointed guardian.

Nurses and social workers often become the patient's advocate when family members challenge advance directives. Health care providers must inform families that legally they must abide by the patient's stated wishes in the event of the presence of an advanced directive. This ensures the protection of the patient's autonomy (Haynor, 1996). Autonomy, a fundamental ethical principle, is the individual's description of medical interventions that are to be implemented or withheld should the individual become incapacitated (Singleton, Dever, & Donner, 1992). In health care, informed consent documents the protection of this principle, since health care providers are required to obtain permission from patients for treatment. The PSDA supports

informed consent in the event of future or unexpected incompetency, whether disease or trauma related, by allowing the individual to state preferences for treatment in advance (Pinch & Parsons, 1992).

The principle of beneficence, which is the desire to promote, to do good, and to avoid harm, provides a guide for health care providers. Benefits from advanced or prolonged medical treatment are not without risk and possible harm. Advanced technologies are regarded as benefits of modern medicine, while technological advances can produce adverse effects on the experience of health care and on the quality of life that one is able to maintain after their use. The application of the principle of beneficence is supported by the PSDA since medical treatment decisions are influenced by the individual's personal history and current contextual factors. Beneficence supports respect of various human values and recognizes the differences among human beings regarding life and death matters (Pinch & Parsons, 1992).

Educational Interventions and Rate of Completion

Although there have been considerable media publications and an increase in public education, the majority of people, healthy and seriously ill, have not completed an advance directive. The lack of directive completion may result from inadequate communication and inadequate health care provider awareness of advance directives. Currently, only one in three directives are documented in the permanent medical record by health care providers.

To influence completion patterns, the focus must be on more than the mere completion of written documents. A process of communication in which patients and health care providers reach an understanding of the patient's intent in the completion of the directive is required. Additionally, plans must be formulated and documented to ensure that these preferences will be achieved (Teno et al., 1997a). There may be an increasing number of ways in which nurses can involve themselves in community education and the development of creative programs to address the mandates of the PSDA. The nurse, as an omnipresent caregiver, educator, and advocate is key to assuring the fulfillment of this mandate for all patients (Fleming & Scanlon, 1994). Through interventions such as the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) the rate has been increased to 90%. Family members have stated that an advance directive assisted in decision making and improved the degree to which directives are viewed as an aid to decision making for the majority of family members (Teno et al., 1997b).

Teno et al. (1997a) conducted a study to assess the effectiveness of written advance directives in the care of seriously ill hospitalized patients. The study, conducted in five teaching institutions within the United States, was an observational cohort study which was conducted 2 years prior (PRE) and 2 years after the PSDA (POST). It consisted of a randomized, controlled trial of an intervention to improve medical decision-making after the PSDA (POST plus SUPPORT). The sample consisted of 4,301 PRE, 2,152 POST, and 2,652 POST plus SUPPORT seriously ill

patients. Interviews were conducted with patients, surrogates, and their attending physicians to determine awareness, completion, and the impact of advance directives. Additionally, the researchers reviewed medical records for documentation of conferences regarding resuscitation, do not resuscitate orders, execution of a directive, and the use or non-use of resuscitation efforts at the time of death. The interventions included the mandated patient education regarding the PSDA and documentation in the medical record. Education regarding communication facilitation by nurses was provided through SUPPORT. Analysis of the population comparisons utilized the chi square test or the Kruskal-Wallis test, as appropriate. The effect of the PSDA was assessed through chi square tests to compare PRE and POST cohorts. The significance of advance directives and their stated four aspects of decision making regarding resuscitation were evaluated by a chi square test. Additionally, a baseline risk score (BRS) and a propensity score were utilized to adjust for imbalances in practices and the likelihood of being assigned to intervention status between the intervention and control groups.

Teno et al.'s (1997a) results revealed that before the PSDA (PRE), 62% of the population were familiar with a living will but only 21% had an executed advance directive. Only 36 (6%) of these directives were found to be documented in the medical records for PRE compared to 35% with documentation for POST. POST plus SUPPORT revealed an average rate of 78% ($p < .001$). PRE and POST patients with and without executed directives had no significant differences in rates of medical

record documentation of conferences regarding resuscitation ($p > .001$). POST plus SUPPORT revealed similar results. Of those individuals with an executed directive, only 12% had discussions with their physicians, 20% had discussions with family members, and 26% had consulted an attorney. Analysis of physician data revealed awareness of one in four directives (25%). Physicians also stated that the directive assisted in decision making in 48% of their cases while hindering decision making in only 4%. The researchers further concluded the future focus for improving the current pattern of practice should be on communication and comprehensive advance care planning.

Rubin, Strull, Flalkow, Weiss, and Lo (1994) demonstrated that a simple educational intervention increased the completion of the durable power of attorney for health care by 18.1%. The design was a randomized, controlled trial. The 1,101 participants consisted of all patients aged 65 years and older who were discharged from Kaiser Permanente Medical Center in San Francisco, California between January 1991 and May 1991. The intervention consisted of an educational pamphlet regarding durable power of attorney for health care. Those in the intervention group (552) also received a durable power of attorney for health care form for completion, telephone assistance, and additional information, while the control group (549) received only conventional care, discussions at the discretion of the physician and patient. Statistical analysis required X^2 tests for proportions and the Fisher's Exact Test for proportions

with small numbers, t tests for means, and 95% confidence intervals for differences between means or proportions of the two groups.

Rubin et al.'s (1994) results revealed no significant baseline differences between the intervention and control groups. However, following their intervention, 18.5% in the intervention group completed a durable power of attorney for health care form while only 0.4% of the control group completed the form ($p < .0001$). These researchers concluded that an educational intervention significantly increased the execution of a durable power of attorney for health care. They further commented on characteristics that might be associated with directive completion. These included the following: (1) women are as likely as males to complete the form; (2) rate of completion is proportional when comparing married and unmarried individuals; (3) African Americans and Hispanics are less likely to execute a directive than non-Hispanic whites and Asians; and (4) there was no significant difference in completion rates by diagnosis.

Educating health care providers about the PSDA is not sufficient to change their reluctance to integrate advance decision making into primary care. To determine the effectiveness of an educational and administrative intervention, a study was conducted by Markson et al. (1994), previously discussed in the section barriers to completion of advance directives. The administrative component consisted of obtaining administrative consent and support for physicians in practice to spend additional time with patients to discuss advance directives. The educational component, a 5-week

course on advance directives, covered theory and practical application of the law as well as consideration of federal and state law and statutes relating to the right to refuse treatment, advance directives, and competence to refuse medical treatment. The course also reviewed the requirements for accurate completion of the documents. The physicians then approached 74 of 356 competent home care patients of whom 48 (65%) completed directives. All 42 competent nursing home patients were approached and 38 (90%) completed directives. The researchers recognized the time, 2 years after the Cruzan decision, as a limitation to the study.

These results suggest that the key to increasing patient use of advance directives in the primary care setting appears to be related to overcoming the reluctance of physicians to raise the subject and to assist in the decision-making process. Advance directives document the outcome of a decision-making process as does informed consent. Unless preceded by the opportunity for careful and informed deliberation, such directives cannot enhance patient autonomy (Markson et al., 1994).

AACN Program Development

The American Association of Critical-Care Nurses (AACN) is a national, nonprofit professional organization that includes members employed in intensive care units and other locations where urgent, high-tech medical treatment or interventions are routine. Members of this organization formed a task force with colleagues at the University of Southern California School of Medicine to create a guide to assist

individuals with the development and communication of advance directives. The program was developed and refined through presentations provided to various focus groups by trained facilitators chosen by the task force members. The final product distributed for publication and education was titled "Discovering Your Beliefs About Health Care Choices." The program was presented, training of additional facilitators, and public distribution of the product was first completed at the National Teaching Institute in Orlando, Florida in May, 1997. AACN has continued to present the program to various groups and are presently amending the program to incorporate improvements to the material.

Social Support

Caplan (1974), considered to be the expert in social support theory, postulated that for social support to occur, there must be an interaction of at least two individuals for the purpose of providing assistance, maintenance, or validation to one or both people. The effect of the supportive activity is to increase the individual's ability to function in a stressful environment once a stressor has been encountered. Additionally, the purpose of support is to increase vitality as well as promote survival. Four aspects of social support--emotional, informational, appraisal, and tangible--are defined by Caplan's theory. Emotional support, provided by an advocate, sustains self-esteem by reinforcing an individual's feeling of self-worth. The desired outcomes of this advocate are to confirm that the individual is understood, validate the individual's

feelings, provide comfort, share emotional burdens through sympathy or empathy, provide encouragement, and express concern. Informational support provides knowledge for decision making. Appraisal support was defined by Caplan as coaching by supportive persons in an active role to assist in maximizing psychological resources and mastering emotional issues. Tangible support gives individuals the necessary tools, instruments, equipment or goods, finances, and services that promote activity. The need or type of support depends on the situation or crisis.

Emotional support may be offered in the form of guidance regarding the field of relevant forces involved in expectant problems and methods of coping with them. Informational support, technical and anticipatory guidance, may promote a greater factual understanding of the problem condition as opposed to intrapsychic understanding. Appraisal support may provide feedback about the individual's behavior to validate the individual's own identity and to foster improved performance based on adequate self-evaluation. Tangible or instrumental support reinforces the individual's conviction that action must be taken. However, the action taken must be feasible and the goal attainable (Caplan, 1974).

Ragsdale, Yarbrough, and Lasher (1993) published an article using Caplan's social support theory as a basis to guide nursing care of stroke clients admitted to a rehabilitation unit of a large teaching hospital in a southern metropolitan center. The authors outlined a plan of care with the inclusion of a significant other. The nursing staff observed the couple for supportive behaviors by both the client and the spouse. A

documentation inservice was provided for the staff and unit management. A case study design was utilized, one male and one female client with English-speaking spouses were included. The selection process was simplistic: the spouses were asked if they would participate. The first two clients who agreed to participate were utilized. Caplan's and Killilea's (1976) theory was used to design the nursing protocol. The eight elements of a social support system were identified: (1) support from a continuous relationship; (2) refuge or sanctuary for stability and comfort; (3) information, guidance and feedback; (4) notion of reciprocal relationship with need satisfaction; (5) help in maximizing psychological resources and mastering emotional issues; (6) provision of material cost and supplies; (7) assistance with the task; and (8) provision of cognitive guidance. Critical elements of social support and supportive behaviors were identified and documented on the nursing care plan to ensure continuity. Both of these clients receiving family support were able to return home with increased confidence and comfort. The spouses expressed feelings of competence and comfort in provision of care. Limitations of the study included lack of research questions or hypothesis, validity and reliability were not addressed, and the small sample size.

Ott and Hardie (1997) conducted a descriptive study regarding the language and readability of advance directive documents. This issue is clearly one of interest since the advance directive document provides informational and instrumental support to assist the individual's understanding and autonomy regarding end-of-life decisions.

Their convenience sample consisted of 10 advance directive documents from various sources. The documents were electronically scanned in 1994 and evaluated via three readability formulas which included Flesch-Kincaid Grade Level, Flesch Reading Score, and Gunning's Fog Index.

The researchers concluded from the means of scores on selected documents that the readability was well above recommended reading levels and some were equivalent to the level required for graduate school. Ineffectual readability prevents the thorough understanding and may adversely influence the choices concerning directives (Ott & Hardie, 1997). Their stated clinical implications included review and evaluation of the readability of the documents by ethical committees and clinicians involved with patient education, utilizing larger print for older adults or those with visual impairments, and awareness of the patient's reading skills by the health care provider.

Health care providers recognize the personal, medical, and legal issues related to advance directives. Acceptance of one's personal vulnerability, fear of death or disability, and hierarchy of personal needs increase the reluctance for completion of the forms. This understanding of significance is demonstrated daily while providing social support to clients and families.

Summary

Most health care providers support patient autonomy and self-determination for their patients but do not always feel able to honor the wishes of their patients. These

conflicts occur because of ethical and moral beliefs of the providers, conflicts among family members, professional desire to manage the care of the patient, and the belief that the patients do not clearly understand the medical implications and finality of their decisions. Research studies conducted to determine the opinions and preferences of the individual health care providers indicate that these providers would not want life-sustaining treatments for themselves in the event of persistent vegetative state, terminal illness, severe dementia or coma, and decreased quality of life functioning. The opinions and attitudes of the health care professionals in regards for advance directives for their patients are influenced by personal age, experience with elderly or critically ill patients, and the desire to save the patient rather than accept the futility of the situation and allow death to occur.

While physicians often are satisfied with the patient's involvement in decision making, nurses voice dissatisfaction with their participation and involvement. This difference may be related to the current differentiated roles of physician and nurse. The physician diagnoses and treats the patient; the nurse administers care, educates, and assumes the role of patient advocate. However, both parties support further education and intervention protocols for the patients and professional staff. Rouse (1991) stated an underlying assumption that if informed of their rights many more people will take advantage of them and that if actively involved in decisions about medical care, more people will get care that is responsive to their needs.

There is a stronger rate of completion of advance directives among agnostics/atheists when compared with those with strong religious beliefs. Personal or professional experience with the terminally ill also results in the formulation and execution of directives for those care providers. Additionally, completion rates appear to be influenced by professional employment status, level of education, annual income, and personal age. Individuals with lesser education are more willing to relinquish decision making to the health care provider than their peers with higher levels of education, such as a university degree. A higher income corresponds with the desire of self-determination, while a lower income does not directly influence this preference.

The execution of an advance directive ensures autonomy and self-determination while alleviating the family of making difficult decisions. Disadvantages are related to the inability to predict the future, potential advances in medical technologies and treatments, and may restrict care administration by its generality or specificity.

Procrastination, dependence on family for decision-making, lack of knowledge about advance directives, difficulty of the topic, and indecision regarding who should initiate the discussion are often the barriers to directive initiation and completion. The time and circumstances regarding the discussion and completion of the directive are also influential in rate of completion. The failure of health care professionals to initiate the discussion and educate their patients may be related to time requirements,

perceived legal uncertainties, and the relationship between the patient and the provider.

Beneficence guides the health care professional to respect and recognize various human values and cultural differences. The provider must acknowledge, accept, and support the patient's autonomy through informed consent. However, the question of informed consent remains a complex and challenging concern for the incompetent patient.

Findings from studies have documented that the majority of people support the idea of advance directives but few have actually executed one. To influence completion, educational programs for professionals and the general public must be supported in theory and financially. However, without commitment from all team members, the patient, and the family, even the most well-conceived educational efforts will fail (Madson, 1983). Health care providers must become more comfortable with initiating the discussion and view the intervention as preventive treatment in the primary care setting.

The AACN program, "Discovering Your Beliefs About Health Care Choices," was developed in conjunction with The University of Southern California School of Medicine to create a guide to assist with the development and appropriate and timely communication of advance directives. AACN continues to review and revise the program contents to ensure that trained facilitators have the most informative and

up-to-date techniques to communicate the knowledge regarding the value of advance directives to ensure autonomy, self-determination, and the rights of all individuals.

The concept of social support and its components--emotional, informational, appraisal, and tangible--provide the mechanism to educate, communicate, and assist any individual with decisions regarding advance directives. Social support provides the individual with the psychological resources to master emotional burdens, opportunity to share tasks, and provision of money, materials, tools, skills and cognitive guidance to improve decision making skills and task completion (Caplan, 1974).

Health care professionals, especially licensed registered and vocational nurses, are the first line of communication regarding advance directives to the public and the individual's need for autonomy and self-determination. The completion or failure to execute an advance directive may be related to the presence or lack of the functional components of social support. Interventions to ensure completion of a directive must be focused on issues such as perceived personal vulnerability, moral/ethical implications, failure to admit fear of death or invalidism, uncertainty about choice or undesired consequences of alternative actions being considered, and recognition of priority of need within self (Carpenito, 1993).

According to the literature review, health care professionals generally favor the use of advance directives. However, the greater the degree of impairment and cognitive impairment, the more limitations of treatment were favored (Gillick & Mendes, 1996). Tenured physicians are more likely to complete a personal health care

directive than new licensed colleagues (Brunetti et al., 1991). Additionally, it seems that while physicians are satisfied with the patient's involvement and autonomy, licensed nurses often voice dissatisfaction regarding the patient's understanding of self-determination (Solomon et al., 1993).

Age, gender, education, occupation, marital status, self-ratings of current health, and current region of residence were not found to have a significant association with the likelihood of directive completion (Elpern et al., 1993; Gillick et al., 1993). The strongest predictors were the responses of agnostic/atheist for the variable of religion; length of experience in providing care, personal or professional to someone who is terminally ill; and the nature of the relationship to the terminally ill individual (Gillick et al., 1993). African Americans and Hispanics are less likely to execute a directive than non-Hispanic whites and Asians (Rubin et al., 1994).

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This chapter contains information on the study design, population and sample, and the protection of human subjects. The research instrument is described as are the procedures for data collection and treatment.

An evaluative research project was designed utilizing a quasi-experimental prospective pretest-posttest control group design to test the hypothesis that licensed registered and vocational nurses (RNs and LVNs) who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to complete an advance directive than nurses who do not receive individualized social support (Polit & Hungler, 1995). Descriptive and inferential statistics were used to describe and summarize the various data. Measures of central tendency were used to describe each group of nurses. Demographic data were analyzed with the frequencies, percentages, and means, if applicable. A chi square test was utilized to identify significant differences between groups regarding the completions of advance directive (Polit & Hungler, 1995).

An extraneous variable that may have affected the outcome of this study was contamination of treatment between the control and experimental groups. Group facilitation by a certified instructor rather than the investigator and the use of a

structured educational intervention limited the threat to internal validity.

Randomization as a selection process was used to assign participants in the control or experimental groups to further limit the threat to internal and external validity by the extraneous variables (Polit & Hungler, 1995).

Demographic data were collected regarding the participants' gender, age, marital status, number of dependents, religion, ethnicity, educational level, and degree of licensure. Personal or professional experience with advance directives, professional years of experience in health care, and personal beliefs concerning advance directive were also explained.

Setting

This study was conducted in a South central rural city in the United States with a population less than 150,000. A private, nonprofit, rural, nonteaching hospital with 204 licensed beds served as the study site. Data collection occurred during the spring of 1998, and the desired sample of 61 total participants was obtained.

Population and Sample

The participants for this study were selected through the institution's mailing lists of 2,000 registered and licensed vocational nurses. Each registered participant, in order of receipt, was randomly assigned to the control (even numbered registrants) or experimental (odd numbered registrants) groups. A coin flip was used to define if the first registrant was to be even or odd. Registration packets included information about

the educational program and opportunity to participate in the experimental studies on advance directives. The planned sample size was estimated with an alpha of 0.05, power of 0.80, and an effect size of 0.50 for the chi square test. A sample size of 61 was recommended in order to avoid a type II error. Balancing the findings of previous research in the area, a large effect size was anticipated (Cohen, 1977). Kok, van den Borne, and Mullen (1997) found in a meta-analysis that patient health education in the science health education tradition has a substantial effect on outcome (the mean effect size of 0.46 for primary prevention and 0.49 for secondary prevention). A strong determinant of effectiveness was a planned and systematic application of social science theory in the intervention development. The principles of reward and feedback have been shown to increase effectiveness and desired behavior.

Eligibility criteria included: (1) ability to read, write, and speak English, (2) current licensure for the state of Texas, (3) professional nursing practice within the last 5 years, and (4) avoidance or failure to have completed an advance directive. Exclusion criteria included an executed durable power of attorney for health care.

Protection of Human Subjects

Approval to conduct the studies was obtained from the institutional review board of Texas Woman's University, and the study institution gave verbal reciprocity (Appendix A). Written informed consent (Appendix B) was obtained from the participants during the registration process for the educational presentation. The

researcher explained the study and the procedure for data collection at that time. Potential risks to the subjects were minimal and included discomfort with sensitive questions or topics, dissatisfaction with the program content and/or presentation, inconvenient times for participation, and dissatisfaction with program environment. To ensure confidentiality of the responses, code numbers were used to represent the participants and report the aggregate data. The responses were kept in a locked cabinet by the researcher until the time of data analysis. For purposes of awarding continuing education units, the data will continue to be secured for a period not to exceed 5 years and will be destroyed at that time.

Educational Intervention Program

The program designed by the American Association of Critical Care Nurses (AACN), "Discovering Your Beliefs About Health Care Choices," was used as the educational presentation to the participants. The program, lasting 3 hours, included a preassessment tool, facilitator's script, participant handouts, participant evaluation, facilitator's evaluation, and facilitator's resource and slides. Permission to use the program was obtained from AACN, who also supplied an abbreviated description of the program (Appendix C). The facilitator was a registered nurse with a baccalaureate degree who received certification to present the educational program regarding advance directives at the National Teaching Institute sponsored by AACN. This program continues to be tested by AACN, having been initially tested with focus

groups. Reliability and validity data are pending. The results of this study were forwarded to the appropriate AACN representative to provide data for reliability and validity.

A demographic data form (Appendix D) was used to record information regarding the participants' gender, age, marital status, number of dependents, religion, ethnicity, educational level, and degree of licenser. Additionally, personal or professional experience with advance directives, professional years of experience in health care, and personal beliefs concerning advance directives were also recorded. The demographic form took approximately 3 to 5 minutes to complete. Information of these variables was collected to aid in explanation of the research findings. Completion or failure to complete the durable power of attorney for health care (DPA/HC) was documented on each participants' form at the end of the educational presentation.

Data Collection

After all necessary approvals were obtained, data collection was begun. The control group of at least 30 RNs and LVNs was provided with educational handouts on advance directives and were offered selected portions of the AACN educational program for advance directives. The educational offering was performed on a Saturday morning. The program was 3 hours in length with a 10-minute break in the middle of the session. The session began at 9:00 in the morning and ended at 12:00

noon. The program included the handouts, slide presentation, and the certified facilitator. The program was AACN's "Discovering Your Beliefs About Health Care Choices." This group did not receive the major components of social support, emotional and appraisal, as defined by Caplan (1974). The participants did receive informational and instrumental support as defined by Caplan (1974). The participants were given a handout of a durable power of attorney for health care to complete at the end of the program if they chose to do so. No notary public was available to notarize the form. The facilitator did offer a question and answer period the last 30 minutes of the program. The participants were offered the opportunity to attend a second presentation of the educational program with all elements of Caplan's (1974) social support at a later date. None of the control group participants chose to accept this offer. The offer was repeated in a letter that was mailed to each participant with the continuing education certificate (Appendix E).

The experimental group of at least 30 participants was provided with educational handouts and all elements of the AACN educational program for advance directives. The program was offered in the same room and facility as the control group. The experimental group's session began at 1:00 in the afternoon and finished at 3:00 in the afternoon of the same day as the program for the control group. The same facilitator presented the program. The handouts and program were the same as the control group. The chaplain and social worker were present and participated in the question and answer session at the end of the program. A notary public was present at

the end of the program to help participants complete their health care proxy. This group received all elements of Caplan's social support theory: emotional, informational, appraisal, and tangible/instrumental. Emotional support in the form of guidance was provided by a social worker and chaplain who reinforced the participants' self-esteem and feelings of self-worth. Informational support providing the knowledge for decision-making was presented by the facilitator's script of the program. Appraisal support in the form of coaching by supportive persons in an active role to assist in maximizing psychological resources and mastering emotional issues was provided by the facilitator, chaplain, social worker, and other group participants. Tangible/instrumental support was provided in the form of actual documents for execution of a durable power of attorney for health care (DPA/HC). Additional tangible support was offered by a notary public, although a notarized signature is not required for the document to be recognized legally.

All participants regardless of the grouping were offered assistance in completing their durable power of attorney for health care if they so desired. Additionally, all participants who chose not to complete a DPA/HC were contacted at the end of 2 weeks to determine if the directive had been executed. The contact was made by telephone or face-to-face interview. Those participants who executed a DPA/HC during or at the closure program had completion of the document verified by the researcher. For those participants who completed the DPA/HC during the

2-week post presentation time frame, the researcher required visual verification of the document.

The procedure for data collection for the study was as follows: (1) the day of the program the investigator examined the facility to assess the room size and temperature; the investigator also evaluated the equipment to ensure proper working order and availability of equipment; (2) each participant was asked to complete a one-page questionnaire of demographic data; (3) participants were informed that termination of the program was allowed at any time without explanation to the investigator; (4) the facilitator presented the planned program to the control and experimental groups according to the chosen script for each groups' participants; (5) participants were given the opportunity to complete a DPA/HC at the end of the program; (6) the investigator visually verified the completed document; and (7) continuing education credits were awarded to all participants who completed the program.

Treatment of Data

Descriptive and inferential statistics were used to describe and analyze the data. The alpha was set at .05 (Polit & Hungler, 1995). Measures of central tendency were used to describe each group of nurses. Information collected on the demographic data form was described with frequencies, percentages, and means, if applicable. To test the hypothesis, differences in completion rates of DPA/HC between groups were

tested with chi square (Polit & Hungler, 1995). Groups were compared for statistical equivalence with chi square analysis. Data analysis on the completion of an advance directive in the experimental group was done to look for significant variables.

Summary

An evaluative research project was designed utilizing a quasi-experimental prospective pretest-posttest control group design to test the hypothesis that registered nurses and licensed vocational nurses who receive individualized social support in the form of an educationally and functionally supportive intervention are more likely to complete an advance directive than nurses who do not receive individualized social support (Polit & Hungler, 1995). The study was conducted in a private, nonprofit, nonteaching, hospital of 204 licensed beds in a rural South central United States city during the spring of 1998.

The subjects for the study were a convenience sample of 61 registered and licensed vocational nurses who were randomly assigned to either the control or experimental group. A coin flip was used to define if the first registrant was to be even or odd. Informed consent for the study was obtained from the participant at the time of registration for the educational program. The investigator used a demographic form, completed at the time of the educational presentation, and the AACN program, "Discovering Your Beliefs About Health Care Choices" provided the required script and format. Descriptive and inferential statistics were used to analyze the demographic

data. The completion of a durable power of attorney for health care was verified by the investigator at the end of the program. For those participants who did not complete a DPA/HC at the program closure, the investigator made contact via a telephone call or face-to-face interview within a 2-week period. Completion of the DPA/HC was verified by visualization of the document by the investigator.

CHAPTER 4

ANALYSIS OF DATA

This chapter describes and reviews the results and interpretations of the data obtained from an evaluative research project utilizing a quasi-experimental prospective pretest-posttest control group design to test the hypothesis that licensed registered and vocational nurses who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to complete an advance directive than nurses who do not receive individualized social support. This chapter includes a description of the sample based on demographic variables, an analysis of the data, and results of the findings.

Description of Sample

The participants for this study were selected through the institution's mailing lists of 2,000 registered and licensed vocational nurses. These nurses had attended prior programs at the institution and/or were employed by the institution or affiliated with the institution at this time or in the past. The private, nonprofit, nonteaching institution with 204 licensed beds is located in a South central rural city in the United States with a population less than 150,000. Each registered participant, in order of receipt, was randomly assigned to the control (even numbered registrants) or

experimental (odd numbered registrants) groups. A coin flip determined the first odd or even number. Eligibility criteria included: (1) ability to read, write, and speak English; (2) current license in the state of Texas; (3) professional nursing practice within the last 5 years; and (4) avoidance or failure to have completed an advance directive. Exclusion criteria included an executed durable power of attorney for health care. Demographic data collected from the participants included gender, age, marital status, number of dependents, religion, ethnicity, educational level, and degree of licensure. Data regarding personal or professional experience with advance directives, professional years of experience in health care, and personal beliefs concerning advance directives were also obtained.

Initially, 64 registered and licensed vocational nurses agreed to participate in the study. However, 3 participants were excluded from analysis due to ineligibility or the exclusion criteria--2 had not practiced professional nursing in more than 5 years, and 1 had completed a durable power of attorney for health care prior to the program, respectively. The remaining 61 nurses comprised the sample; 30 were in the control group and 31 were in the experimental group.

The registered and licensed vocational nurses in this sample varied in age from 26 to greater than 60 years or older. The largest group of the nurses (17, 27.9%) was 60 years of age and older, while the lowest group (5, 9.8%) was 26-34 years old. The mean age category for the total sample was 41-50. Similar to the total sample, the largest number of control group nurses (12, 40%) was 60 years of age and over, but

the smallest group of control nurses (2, 6.7%) were 35-40 years old. The largest number of experimental group nurses (18, 58%) were in the 35-50 year old categories, while the least number of experimental group nurses (3, 9.7%) were 26-34 years old (see Table 1).

All of the nurses in both groups were female; the male gender was not represented in this sample. The majority of the total sample of nurses (46, 75.4%) were married. This marital status was also representative of the majority of the control group (25, 83.3%) and the experimental group (21, 67.7%) nurses. Very few of the remaining nurses in both groups were single, divorced, or widowed (see Table 1).

Most of the total sample of nurses (51, 83.7%) were Caucasian, which was also reflective of the control (26, 86.7%) and experimental (25, 80.6%) groups. The sample also included African American, Hispanic, and Asian (1 [3.5%] experimental group) nurses (see Table 1).

The nurses were of various religious backgrounds with the majority of the total sample (37, 60.7%) as well as the control (19, 63.3%) and experimental (18, 58.2%) groups being Protestant. Other religious affiliations included Catholic, nondenominational, other (when an actual religion was not listed by the subject), and Islamic (see Table 1).

Information regarding the number of dependents per each participant was also obtained. The majority of the total sample of nurses (35, 57.3%) had two to four dependents, which also was exhibited by the control (16, 53.3%) and experimental

Table 1

Frequencies and Percentages of Age, Marital Status, Race and Religion of 61 Registered and Licensed Vocational Nurses by Group

Variables	<u>Control</u>		<u>Experimental</u>		<u>Total</u>	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
<u>Age (Years)</u>						
26-34	3	10.0	3	9.7	6	9.8
35-40	2	6.7	5	16.1	7	11.5
41-50	5	16.7	9	29.0	14	22.9
51-59	8	26.7	9	29.0	17	27.9
60 and over	<u>12</u>	<u>40.0</u>	<u>5</u>	<u>16.1</u>	<u>17</u>	<u>27.9</u>
Total	30	100.0	31	100.0	61	100.0
<u>Marital Status</u>						
Single	1	3.3	3	9.7	4	6.6
Married	25	83.3	21	67.7	46	75.4
Divorced	2	6.7	5	16.1	7	11.4
Widowed	<u>2</u>	<u>6.7</u>	<u>2</u>	<u>6.5</u>	<u>4</u>	<u>6.6</u>
Total	30	100.0	31	100.0	61	100.0
<u>Race</u>						
Caucasian	26	86.7	25	80.6	51	83.7
African American	2	6.7	4	12.9	6	9.8
Hispanic	2	6.7	1	3.2	3	4.8
Asian	<u>0</u>	<u>0.0</u>	<u>1</u>	<u>3.2</u>	<u>1</u>	<u>1.7</u>
Total	30	100.0	31	100.0	61	100.0
<u>Religion</u>						
Catholic	6	20.0	7	22.6	13	21.3
Protestant	19	63.3	18	58.1	37	60.6
Nondenominational	2	6.7	5	16.1	7	11.5
Other ^a	2	6.7	1	3.2	3	4.9
Islamic	<u>1</u>	<u>3.3</u>	<u>0</u>	<u>0.0</u>	<u>1</u>	<u>1.7</u>
Total	30	100.0	31	100.0	61	100.0

^aAn actual religion was not listed.

(19, 61.3%) groups. None of the nurses had 5-7 dependents, but one (3.3%) control group nurse had 8 or more dependents (see Table 2).

The total sample consisted of 40 (65.5%) registered nurses and 21 (34.5%) licensed vocational nurses. Of the 40 RNs, 16 (53.3%) were in the control group and 24 (77.4%) were in the experimental group. Of the LVNs, 14 (46.7%) were in the control group and 7 (22.6%) were in the experimental group (see Table 2).

The basic preparation reported by the total sample included 10 categories. The largest single category for the total sample (20, 32.8%) was LVN basic preparation; this was also the case for the control group (14, 46.7%). However, the largest single category for the experimental group (9, 29%) was BSN (see Table 2).

The majority of the total subjects (41, 67.2%) had 12 or more years of experience, which was reflected in both the control (20, 66.6%) and experimental (21, 67.7%) groups. The least number of total subjects (4, 6.6%) had 1-3 years of experience, which also was reflected in the control (3, 10%) and experimental (1, 3.2%) groups. The mean years of experience for the total sample was 8-11 years (see Table 2).

The subjects reported many different areas of practice within the hospital and outside in the community. The largest areas of practice, reported equally by the total sample, were acute care, critical care, and extended care (8, 13.1%, respectively). The largest number of control subjects (8, 26.7%) indicated the acute care area, while the largest number of the experimental subjects (7, 22.6%) reported the critical care

Table 2

Frequencies and Percentages of Dependents, Degree of Licensor, Basic Preparation, and Years of Experience of 61 Registered and Licensed Vocational Nurses by Group

Variables	<u>Control</u>		<u>Experimental</u>		<u>Total</u>	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
<u>Dependents</u>						
Self	13	43.3	12	38.7	25	41.0
2-4	16	53.3	19	61.3	35	57.3
5-7	0	0.0	0	0.0	0	0.0
8 or more	<u>1</u>	<u>3.3</u>	<u>0</u>	<u>0.0</u>	<u>1</u>	<u>1.7</u>
Total	30	100.0	31	100.0	61	100.0
<u>Degree of Licensor</u>						
RN	16	53.3	24	77.4	40	65.6
LVN	<u>14</u>	<u>46.7</u>	<u>7</u>	<u>22.6</u>	<u>21</u>	<u>34.4</u>
Total	30	100.0	31	100.0	61	100.0
<u>Basic Preparation</u>						
ADN	5	16.7	7	22.6	12	19.7
BSN	2	6.7	9	29.0	11	18.0
BS	0	0.0	2	6.5	2	3.2
MSN	0	0.0	1	3.2	1	1.7
MS	0	0.0	2	6.5	2	3.2
Diploma	7	23.3	2	6.5	9	14.8
LVN	14	46.7	6	19.4	20	32.8
ADN/BS	2	6.7	0	0.0	2	3.2
LVN/BS	0	0.0	1	3.2	1	1.7
ADN/Diploma	<u>0</u>	<u>0.0</u>	<u>1</u>	<u>3.2</u>	<u>1</u>	<u>1.7</u>
Total	30	100.0	31	100.0	61	100.0
<u>Years of Experience</u>						
1-3 years	3	10.0	1	3.2	4	6.6
4-7	2	6.7	6	19.4	8	13.1
8-11	5	16.7	3	9.7	8	13.1
12 or greater	<u>20</u>	<u>66.6</u>	<u>21</u>	<u>67.7</u>	<u>41</u>	<u>67.2</u>
Total	30	100.0	31	100.0	61	100.0

area (see Table 3). Some participants indicated performing more than one role in nursing. The researcher did not discover if this was within one practice setting or if it was at a second practice setting.

Table 3

Frequencies and Percentages of Area of Current Practice of 61 Registered and Licensed Vocational Nurses by Group

Variables	<u>Control</u>		<u>Experimental</u>		<u>Total</u>	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
<u>Area of Current Practice</u>						
Office/Clinic	3	10.0	2	6.5	5	8.1
Acute Care	8	26.7	0	0.0	8	13.1
Critical Care	1	3.3	7	22.6	8	13.1
Education	1	3.3	3	9.7	4	6.6
School Nurse	3	10.0	1	3.2	4	6.6
College health	1	3.3	2	6.5	3	4.8
Home Health	1	3.3	5	16.1	6	9.8
Hospice	0	0.0	2	6.5	2	3.2
Extended Care	3	10.0	5	16.1	8	13.1
Dialysis	1	3.3	0	0.0	1	1.7
Outpatient Day Stay	1	3.3	0	0.0	1	1.7
Retired < 5 years	3	10.0	1	3.2	4	6.6
Home Health Care/Educator	1	3.3	0	0.0	1	1.7
Unspecified	2	6.7	1	3.2	3	4.8
Office/Clinic/Educator	1	3.3	0	0.0	1	1.7
Correctional Health	0	0.0	1	3.2	1	1.7
Occupational Health	<u>0</u>	<u>0.0</u>	<u>1</u>	<u>3.2</u>	<u>1</u>	<u>1.7</u>
Total	30	100.0	31	100.0	61	100.0

The majority of the total sample (37, 60.7%) reported having professional experience, as a registered or licensed vocational nurse, with advance directives, with 11 (18.1%) nurses in the total sample reporting no experience with advance directives. Almost half (14, 46.7%) of the control group nurses had professional experience with advance directives, while less than one-fourth (7, 23.3%) had none. In the experimental group, three-fourths (23, 74.2%) of the nurses had professional experience with advance directives, and 4 (12.9%) nurses had no professional experience. The remainder of the 61 subjects reported various experiences: educational information only and related experience to an immediate family member, a friend's illness, and self-related experience (see Table 4). Many participants indicated more than one answer in this category. The researcher did not clarify with the participants as what the dual answers indicated.

Only 5 (8.2%) of the total sample reported actually having executed a living will, while 56 (91.8%) reported having never executed such a document. In the control group, only 1 (3.3%) nurse had executed a living will, while 29 (96.7%) had not. Of the experimental group subjects, 4 (12.9%) indicated they had executed a living will, while 27 (87.1) had not (see Table 4).

Of the total subjects, 12 (19.7%) indicated having completed a durable power of attorney for health care (DPA/HC) after the educational intervention program, while 49 (80.3%) had not. In the control group, only 1 (3.3%) nurse had completed a DPA/HC, and 29 (96.7%) had not. Over one-third (11, 35.5%) of the experimental

Table 4

Frequencies and Percentages of Experience with Advance Directives, Prior Execution of a Living Will and Completed a DPA/HC after Educational Intervention Program of 61 Registered and Licensed Vocational Nurses by Group

Variables	<u>Control</u>		<u>Experimental</u>		<u>Total</u>	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
<u>Experience with Advance Directive</u>						
None	7	23.3	3	9.7	10	16.4
Professional	11	36.7	12	38.7	23	37.8
Education	1	3.3	2	6.5	3	4.8
Immediate Family	6	20.0	1	3.2	7	11.5
Self	1	3.3	1	3.2	2	3.2
Professional/Immediate Family	2	6.7	7	22.6	9	14.8
Professional/Self	1	3.3	1	3.2	2	3.2
Immediate Family/Self	1	3.3	0	0.0	1	1.7
Professional/Educational	0	0.0	2	6.5	2	3.2
Professional/Friend	0	0.0	1	3.2	1	1.7
None/Self	<u>0</u>	<u>0.0</u>	<u>1</u>	<u>3.2</u>	<u>1</u>	<u>1.7</u>
Total	30	100.0	31	100.0	61	100.0
<u>Prior Execution of a Living Will</u>						
Yes	1	3.3	4	12.9	5	8.2
No	<u>29</u>	<u>96.7</u>	<u>27</u>	<u>87.1</u>	<u>56</u>	<u>91.8</u>
Total	30	100.0	31	100.0	61	100.0
<u>Completed a DPA/HC after Educational Intervention Program</u>						
Yes	1	3.3	11	35.5	12	19.7
No	<u>29</u>	<u>96.7</u>	<u>20</u>	<u>64.5</u>	<u>49</u>	<u>80.3</u>
Total	30	100.0	31	100.0	61	100.0

group subjects reported having completed a DPA/HC after the educational intervention program, while 20 (64.5) had not (see Table 4).

The data from demographic variables were summarized in Tables 1, 2, 3, and 4 for the total sample, the control group, and the experimental group. The mean age group, 41-50 years, was the same for both groups. The mean years of experience, 8-11 years, was the same for both groups. Because the expected frequencies of many cells was less than 5, categories were collapsed and the two groups and were compared for significant differences with chi square analysis for these nominal variables. The data were collapsed into categories of under 40 years of age, over 40 years of age; married, unmarried; Caucasian, non-Caucasian; Protestant, non-Protestant; 7 or less years of experience, 8 or more years of experience; and practiced in the acute care area, practiced in the ambulatory setting. There were no statistically significant differences found between the control and experimental groups for the variables of age, marital status, race, or religion. There was a statistically significant difference between the control and experimental group for degree of licenser, RN or LVN ($X^2 = 3.918$, $df = 1$, $p = .048$). Essentially, the groups were statistically equivalent.

Findings

Data were analyzed to answer the hypothesis: Licensed registered and vocational nurses (RNs and LVNs) who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to

complete an advance directive than nurses who do not receive individualized social support.

The control group received instrumental and informational support during the intervention planned with the theoretical framework of social support. Data analysis revealed that only one (3.33%) participant in the control group completed a DPA/HC at the end of the educational intervention; 29 (96.66%) did not complete a DPA/HC. When contacted 2 weeks after the program, none of this group had completed a directive. Of the individuals who participated in the experimental group, and received all elements of social support with a chaplain, social worker, and notary public, 11 (35.5%) completed a DPA/HC; 20 (64.5%) individuals in the experimental group had not completed the DPA/HC when contacted by the researcher at the end of a 2-week period. Data were analyzed utilizing the chi square statistic, and data analysis indicated a significant difference ($X^2 = 9.973$, $df = 1$, $p = .002$) between groups (see Table 5). The rate of completion for individuals who received social support was significantly higher (35.4%) than individuals who did not receive all elements of social support.

All participants in the control group were offered the opportunity to attend an educational intervention with all elements of social support, yet, all declined. All members of this study were mailed a continuing education certificate with a letter thanking them for participation and the invitation noted above.

Table 5

Chi Square Analysis of Findings

		Control	Experimental	Total
Completion of DPA/HC	Yes	1	11*	12
	No	29	20	49
Total		30	31	61

$$*X^2 = 9.973, df = 1, p = .002$$

All participants of this study were contacted by the researcher at the end of 2 weeks to determine if a DPA/HC had been completed. This contact was made by telephone contact or face-to-face interview. Rationale or comments for not completing the proxy were not solicited at this time.

Data collected between the control and experimental groups revealed the following characteristic. Only one participant in the control group completed a DPA/HC at the end of the educational intervention. The subject was female, married with 2-4 dependents. The subject was over 60 years of age, Caucasian, and Protestant. The participant was a licensed vocational nurse with over 12 year of experience and was employed in home health care. The documented experience with advance directives was professional and immediate family. The participant had not executed a living will or DPA/HC prior to the educational intervention.

Experimental group participants who completed a DPA/HC immediately after the educational intervention had the following characteristics. All participants were female (11, 100%), 10 were RNs (90.9%) and 1 (9.1%) was an LVN, and 6 (54.5%) were married, 2 (18.2%) were single, 2 (18.2%) were divorced, and 1 (9.1%) was widowed. Six (54.5%) participants indicated self only as dependent, while 5 (45.5%) indicated 2-4 dependents. The majority of the group (10, 90.1%) were Caucasian; only one (9.1%) was Hispanic. Almost one-third of the group (3, 27.2%) were in the age group of 51-59 years of age, 2 (18.2%) were 26-34 years of age, 2 (18.2%) were 35-40 years of age, 2 (18.2%) were 41-50 years of age, and 2 (18.2%) were 60 and over. The majority of the group (9, 81.8%) was Protestant, and 2 (18.2%) were Catholic. The data indicated that 4 (36.3%) of the 11 held an ADN, 5 (45.5%) held BSNs, 1 (9.1%) was a diploma graduate, and 1 (9.1%) was an LVN. The majority of the group (8, 72.7%) had 12 or more years of experience in nursing; in the remainder of the group, 1 (9.1%) had 8-11 years of experience and 2 (18.2%) had 4-7 years of experience in nursing. Almost half the group (5, 45.4%) indicated Critical Care as their current area of practice. Current areas of practice for the remainder of the group included 2 (18.2%) were office/clinic, 1 (9.1%) was education, 2 (18.2%) were home health, and 1 (9.1%) was college health. The majority of the group (8, 72.7%) stated they had professional experience with advance directives. Only 4 (36.3%) nurses had a living will prior to the educational intervention and 8 (72.7%) had not completed a living will or DPA/HC prior to the study.

Evaluation of collapsed demographic data from individuals who completed a DPA/HC in the experimental group found area of practice to be statistically significant. Data were collapsed into practice areas of acute care or ambulatory care. Experimental group individuals who worked in the acute setting were statistically more likely to complete an advance directive ($X^2 = 5.103$, $df = 1$, $p = .024$) than those in other settings. One participant completed an advance directive in the control group and when combined with the experimental group, individuals who completed an advance directive revealed no statistical differences found in the demographic data collected. The statistically significant finding that individuals who practice in the acute care setting were more likely to complete an advance directive remained ($X^2 = 4.401$, $df = 1$, $p = 0.036$).

Summary of Findings

This chapter has presented an analysis of the data collected to determine the rate of completion of a durable power of attorney for health care between the control and experimental groups following the presentation of an educational and functionally supportive program for licensed registered and vocational nurses. Descriptive statistics of demographic data and rates of completion were presented. Analysis of the data was performed with a chi square utilizing one degree of freedom and a p value of .002. The results indicated a statistically significant difference between the experimental and control groups on their rates of document completion.

CHAPTER 5

SUMMARY OF THE STUDY

The problem of the study was to examine the effectiveness of an educational and functionally supportive program implemented in a rural hospital in increasing the completion of an advance directive by licensed registered and vocational nurses. Caplan's (1974) social support theory provided the theoretical framework for this study. The components of social support--emotional, appraisal, tangible and informational support--provided the structure for the educational intervention. Social support strengthens the individuals' abilities to function in a stressful situation, increases their stability, and promotes the individuals' survival. The final chapter of this study presents four areas: a summary of the study, a discussion of the findings, conclusions and implications based on the findings, and recommendations for further research.

Summary

The study was an evaluative research project with a quasi-experimental, prospective pretest-posttest control group design to test the hypothesis that licensed registered and vocational nurses who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to complete

an advance directive (a durable power of attorney for health care [DPA/HC]) than nurses who do not receive individualized social support (Polit & Hungler, 1995). The AACN program, "Discovering Your Beliefs about Health Care Choices," was the program utilized in this teaching intervention protocol. Measures of central tendency were used to describe each group of nurses (control and experimental). Demographic data were analyzed with frequencies, percentages, and means, if applicable. A chi square was utilized to identify significant differences between the control and experimental groups regarding the completion rates of a DPA/HC and analysis of statistical equivalence of collapsed demographic variables between the groups. Also, chi square analysis was used to compare demographic variables of the participants who completed a DPA/HC for statistical significance of completion (Polit & Hungler, 1995).

An extraneous variable that may have affected the outcomes of the study was contamination of treatment between the control and experimental groups. Group facilitation by a certified instructor rather than the investigator and the use of a structured educational intervention limited the threats to internal validity. Randomization as a selection process was used to assign participants to the control and experimental groups to further limit the threat to internal and external validity by extraneous variables (Polit & Hungler, 1995).

Demographic data were collected by self-report regarding the participants' age, gender, marital status, race, religion, number of dependents, degree of licenser, level

of education, years of experience, and area of practice. Data regarding experience with advance directives and prior completion of these proxies were also obtained.

The population of study was obtained from the study institution's mailing list. The sample of 61 nurses (30 control, 31 experimental) who met the study inclusion criteria were involved in the study.

Statistical procedures used to analyze the data were performed with the SPSS for Windows computer software program. The data were analyzed using chi square with a p of .05 and one degree of freedom.

Discussion of Findings

The result of this study supported the hypothesis that licensed registered nurses and vocational nurses who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to complete an advance directive than nurses who do not receive individualized social support. The differences in the rate of completion of a DPA/HC following an educational intervention support this finding as documented by the chi square analysis. The experimental group had a statistically significantly higher rate of completion (35.48%; $X^2 = 9.973$, $df = 1$, $p = .002$).

Emanuel, Barry, Stoeckle, Ettelson, and Emanuel's (1991) as well as Markson, Fanale, Steel, Kern, and Annas' (1994) findings demonstrated that more is needed to change behaviors and attitudes than education. Findings from these studies

supported the belief that patients will have a higher rate of completion of advance directives when given emotional and informational support in the form of conferences and assistance from health care providers. Rubin, Strull, Flalkow, Weiss, and Lo (1994) found that a single educational intervention could increase the completion of an DPA/HC by almost 20%. The findings in this study corroborated the earlier research as demonstrated by the difference in completion rate between the control and experimental groups. Cugliari, Miller, and Sobal (1995) found that individuals are more likely to complete an advance directive prior to a physical or emotional crisis such as a hospital admission. The completion of an advance directive was not found to be influenced by medical conditions or demographics. Findings from the present study support this previous finding as exhibited by the educational intervention being performed for individuals who were not hospitalized or in known crisis.

Emanuel et al. (1991) as well as Stechmiller, Conlon, and Anderson (1991) found that age did not play a role in the interest in the completion of an advance directive. The young and healthy were as interested in the completion of an advance directive as those 65 and older. Similarly, in the present study, age did not play a statistically significant role in the completion of an advance directive. However, Brunetti, Carperos, and Westlund (1991) found that physicians with longer years of practice were more likely to have completed an advance directive for themselves. Conversely, in the present study, nurses with longer years of experience were not found to have a higher completion of an advance directive.

Although Stechmiller et al. (1991) found the strongest predictor for completion of a living will to be agnostic/atheist for the religion variable, Elpern, Yellen, and Burton (1993) found no significant differences between individuals who had completed an advance directive for sex, race, marital status, religious preference or education. This study corroborates these findings by reporting no statically significant differences between individuals who completed an advance directive for sex, race, marital status, religious preference or education. In addition, none of the participants in the present study indicated agnostic or atheist for a religious variable. Storch and Dossetor (1994) found that individuals with no religious designation, higher levels of income and higher educational levels were less likely to let physicians make decisions for them. Findings from the present study found indicated that all of individuals who completed an advance directive (100%) had a religious preference (81.82% Protestant). There was no significant difference in the education of individuals who completed an advance directive.

Another strong indicator for completion was the individual's length of experience providing care to at least one patient, family member or friend who was terminally ill. The greater the years of experience with the critically ill the more likely the completion of an advance directive. This study did find, of those individuals who completed an advance directive, 64.29% had professional experience with advance directive, 90.9% were registered nurses, 45.45% practiced in the critical care area, and 72.73% had 12 or greater years of experience. This study found that nurses who

worked in the acute care setting were significantly more likely to complete an advance directive ($X^2 = 4.401$, $df = 1$, $p = .036$) than nurses who worked outside this setting.

Ishihara, Wrenn, Wright, Socha, and Cross (1996) as well as Rubin et al. (1994) found that African Americans were less likely than whites to complete an advance directive. Of the individuals who completed an advance directive, 90.9% were Caucasian in this study. Due to the low number of ethnic groups involved in this study, this finding could not be corroborated.

Conclusion and Implications

The major findings of this research were used to generate the following conclusions:

1. Registered and licensed vocational nurses who receive individualized social support in the form of an educational and functionally supportive intervention are more likely to complete an advance directive than nurses who do not receive individualized social support.
2. Registered nurses with greater years of experience and professional experience with advance directives have a greater percentage of completion of an advance directive if they receive social support.
3. There was a high rate of completion of an advance directive, in this study, of individuals who were Caucasian, Protestant, and married.

4. Age, level of education, and number of dependents did not appear to play a significant role in the completion of an advance directive.

5. Registered and licensed vocational nurses who practiced in an acute care setting were more likely to complete an advance directive after the educational offering than nurses who practiced in other settings.

6. Individuals who did not complete a DPA/HC at the completion of the educational program will not complete a DPA/HC at a later date.

Based on the findings of this study, several implications can be considered concerning the completion of advance directives by registered and licensed vocational nurses. These implications are important to all areas of nursing, research, practice, and education.

Nurses are taught to be strong client advocates and to assist clients to achieve their maximum level of wellness. Nurses assist the client by promoting autonomy and self-determination, which include the areas of physical and emotional caring. This includes educating the clients on health care choices before they enter into a stressful environment and are decisionally incapacitated.

All nurses must become educated on the clients' legal rights, legislation that affects patient care, and end of life decision making. Clients should not just be asked if they have completed an advance directive; social support should be given in the completion of these documents.

Nurses should also be educated on the completion of an advance directive for themselves. Nurses should know when each document becomes effective for themselves and their clients.

Nursing education should include the theory of social support and its components to assist all individuals in obtaining autonomy, self-determination, and maximal independence. Educators must teach students the importance of durable powers of attorney and living wills for the client to achieve these goals.

Implications for nursing research are to find ways to remove barriers to completion of advance directives. By removing barriers to learning and the change process, colleagues are empowered to guide the future of health care and ensure the patients' satisfaction with their quality of life and death.

Recommendations for Further Study

Based on the findings of this study, the following recommendations are offered.

1. Further investigation into which socially supportive actions of advance directives were most influential in the completion of a DPA/HC by health care providers should be undertaken.
2. Further studies should be designed to explore and compare barriers to DPA/HC completion and identify solutions to remove the barriers.
3. A replication of this study should be undertaken using a larger sample size.

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APPENDIX A
AGENCY APPROVAL

TEXAS WOMAN'S UNIVERSITY

DENTON DALLAS HOUSTON

HUMAN SUBJECTS REVIEW COMMITTEE - HOUSTON CENTER

PROSPECTUS FOR THE THESIS APPLICATION TO HUMAN SUBJECTS REVIEW COMMITTEE

(This form, completed and signed, must accompany student's thesis research applications to the HSRC)

This prospectus proposed by: Wanda Murphy and Cynthia Skoushane Existed: Advance Directives For Health Care Professionals: Implementation And Evaluation Of A Teaching Intervention Protocol

Has been read and approved by the members of his/her research committee.

This research (check one):

X Is Exempt from Human Subjects Review Committee review because (see p. 11 of Policies and Procedures manual): Research on individual or group behavior or characteristics of individuals, such as studies of perception, cognition, value theory, or self-development, where the investigator does not manipulate subjects' behavior and the research will not involve stress to subjects.

(If exempt is selected for this research, complete form "Exempt From HSRC Review")

Requires Full Human Subjects Review Committee review because: _____

Requires Expedited Human Subjects Review Committee review because (see p. 12 of the Policies and Procedures manual): _____

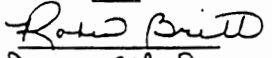
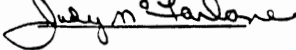
Research Committee:

Type name

Signature

Robin Britt (Chair)

Judy McFarlane

Dean, College of Nursing

Signature

Date

(Submit one copy to the Dean of the Graduate School)
HSRC - Houston Center
Fall, 1999

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

PROSPECTUS FOR THESIS

This prospectus proposed by Cynthia Stoughton and entitled "Advance Directives For Health Care Professionals: Implementation And Evaluation Of A Teaching Intervention Protocol" has been read and approved by the members of her Research Committee.

This research

☒ Is exempt from Human Subjects Review Committee review because: Research on individual or group behavior or characteristics of individuals, such as studies of perception, cognition, game theory, or test development, where the investigator does not manipulate subjects' behavior and the research will not involve stress to subjects.

☐ Requires Human Subjects Review Committee review

Research Committee:

Chairman Robin Britt

Robin Britt

Member Judy McFarlane

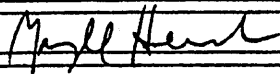
Judy McFarlane

Department Chairman _____
(if appropriate)

Dean of College _____
(if appropriate)

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

HUMAN SUBJECTS REVIEW COMMITTEE - HOUSTON CENTER

Approved by HSRC Chair		Date <u>12-19-97</u>

EXEMPT FROM HSRC REVIEW

If it is the decision of the research committee (for student research) or the department coordinator (for faculty research) that the proposed research is exempt from expedited or full review by the Human Subjects Review Committee (HSRC), please complete the following form. Three copies of this properly signed form and the appropriate prospectus form must be submitted to the chair of the HSRC. In addition, one copy of all research instruments (ie. questionnaires, interview schedules,) must also be included.

Principal Investigator: Wanda Murphy and Cynthia Stoughton

Title of the Research: Advance Directives For Health Care Professionals: Implementation And Evaluation Of A Teaching Intervention Protocol

1. Give a brief description of the study (use continuation pages or attachments, if necessary). Describe the subjects, i.e., are they adults, institutionalized, minors. Describe the procedure that relates to the subjects' participation, i.e., what will the subjects do or what will be done to them.

Nurses are educated to regard and recognize the personal, medical, and legal issues related to advance directives. A diagnosis describing the problem can be formulated: the avoidance or failure of a nurse to complete an advance directive may be related to a lack of the functional components of social support: emotional, informational, and/or instrumental support. These systems provide the individual with the psychological resources to master emotional burdens, opportunity to share tasks, and provision of money, materials, tools, skills and cognitive guidance to improve their decision making skills and task completion. Therefore, it may be concluded the nurse also needs an individualized social support system in order to meet the goal of completion of an advance directive and to ensure its inclusion in their end-of-life decisions.

Participants, sample size of 120, will attend a three hour program on advance directives. The facilitator will be a registered nurse with a baccalaureate degree who completed a three hour training session at the National Teaching Institute sponsored by the American Association of Critical Care Nurses, and is now certified to present the educational

program regarding advance directives. This program is designed to be presented in a workshop style to an audience of 10-50 participants. The program guide is complete with a pre-assessment tool, facilitator's script, participant handouts, participant evaluation, facilitator's evaluation, facilitator's resource and slides.

Demographic data will be collected on the participants' gender, age, marital status, number of dependents, religion, ethnicity, educational level and degree of licensure. Additionally, personal or professional experience with advance directives, professional years of experience in health care, and personal beliefs concerning advance directives will also be explored.

Participants for this study will be selected through the respective institution's mailing list of licensed registered and vocational nurses. Participants will be excluded if they: 1. Have completed an advance directive prior to this study, 2. are not licensed registered or vocational nurses, 3. have not actively practiced in the health care arena within the past five years, and 4. can not read or write English.

This study will be conducted in two South Central cities, metropolitan and rural in the United States. The data will be collected in a private, non-profit, urban, teaching hospital of 1269 licensed beds, 897 operational beds with operations and staff for 853 beds. The data will also be collected in a private, non-profit, non-teaching rural hospital with 204 beds. The data will be collected during the spring of 1998 or until the desired sample of 120 total participants has been obtained.

Each registered participant, in order of receipt, will be randomly assigned to the control (even numbered registrants) or experimental (odd numbered registrants) groups. Registration packets will include information about the educational program and opportunity to participate in the experimental studies on advance directives. Registration for the program will provide informed consent for participants. Participants will be assigned a code number ensuring confidentiality of the responses. The names of the participants and their respective code numbers will only be known by the principal investigators. The identification and corresponding code numbers will be sealed and kept under lock and key, available only to the principal investigators, for a period not to exceed five years. At this time, this information will be destroyed by the principal investigators.

2. What are the potential risks to the human subjects involved in this research or investigation (use continuation pages if necessary) ?

Risk 1: Loss of time

Risk 2: Boredom with the presentation and/or speakers

Risk 3: Fatigue and need for frequent rest periods

Risk 4: Program available at inconvenient times for attendance

Risk 5: Discomfort with sensitive questions or topics

Risk 6: Loss of confidentiality - improper release of data

Risk 7: Dissatisfaction with program environment

Risk 8: Dissatisfaction with the program content and/or presentation

Risk 9: Public embarrassment

3. Is research being conducted for a nonuniversity sponsor? Yes X No

Name of sponsor:

I certify that this research meets the requirements for being exempt from review by the HSRC as specified in the Human Subjects in Research: Institutional Review Board Policies and Procedures (Revised Fall 1994). Three committee members sign for pro-paper or thesis, and all committee members sign for the dissertation research.

Mark Murphy Principal Investigator, Date 12/9/97

Cynthia Stoughton Principal Investigator, Date 12/9/97

Robert Britt Chair, research committee, Date 12/9/97

Julie McFarlane committee member

_____ committee member

_____ committee member

or, in the case of faculty research

_____ Departmental Administrator

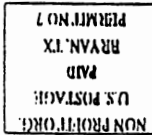
_____ Date

_____ Department

APPENDIX B
INFORMED CONSENT

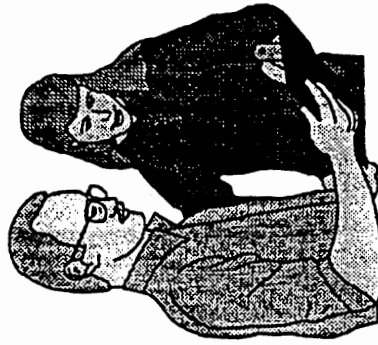
Program Objectives:

1. Define advance directives.
2. State the difference between a living will and a medical power of attorney.
3. Define common healthcare choices and treatments.
4. Explore values and beliefs about healthcare choices.
5. Identify steps necessary to complete advance directives.
6. Identify available resources.



ADVANCE DIRECTIVES

For Healthcare Professionals



St. Joseph Regional Health Center
Education Services
2801 Franciscan Drive
Bryan, Texas 77802

Accreditation:

NURSES: 3.0 Type I contact hours have been applied for. Successful completion requires the participant to attend the entire program and complete an evaluation.

February 21, 1998

About the Program:

The participant is invited to share in an experimental study regarding advance directives. There will be an educational program which will entitle the participant to receive 3.0 free continuing education credits.

To participate in this study, you will need to complete the enclosed application. You will be assigned a time to arrive for this educational offering. Each participant who completes the program will receive the contact hours being awarded. Your participation is anonymous. You may choose to not participate at any time during the program. However, to receive the free CEU's you must complete the entire session. By signing up to participate in this educational offering, you are giving informed consent to participate in this program.

About the Speaker

Ms. Tammy Stanfield, RN, BSN, CCRN will be the program facilitator. Her 15 years of hospital experience encompasses positions as a staff nurse, shift coordinator and currently as a charge nurse in a cardiovascular, neuro med/surg intensive care unit at St. Joseph Regional Health Center in Bryan, Texas. She also continues to serve as a preceptor and staff liaison. Ms. Stanfield received her BSN from Texas Women's University. Ms. Stanfield has been a member of AACN for several years.

Registration:

When: February 21, 1998
The times that will be assigned will be either: 9:00am - 12:00pm or 1:00pm - 5:00pm

Where: St. Joseph Regional Health Center
Education Center
Bryan, Texas

Fee: NO FEE, but please register early as space is limited.

Please bring a sweater for your comfort in the Education Center.

For more information, please call Cynthia Stoughton at (409) 873-2704.

Target Audience:

This program is appropriate for nurses working in all types of health field settings.

ADVANCE DIRECTIVES

for Healthcare Professionals

February 21, 1998

Name _____
Address _____
City, State, Zip _____
Phone (home) _____
(work) _____
Title _____
SSN _____

I agree to participate in this research study and I understand that I may withdraw at any time. I will receive 3.0 continuing education credits for the completion and evaluation of this program.

Signature _____

Please mail the registration form to:

Cynthia Stoughton
Route 1 Box 380
Anderson, Texas 77830

Note: There will be NO ON SITE REGISTRATION for this program.

Confirmation letters with your assigned time will be mailed to you at the address you provide.

If the registration is received too close to the seminar, you will receive a telephone call to indicate the session assigned.

APPENDIX C
AACN PERMISSION TO USE PROGRAM



AMERICAN ASSOCIATION
OF CRITICAL-CARE NURSES

Congratulations on your decision to implement *Discovering Your Beliefs About Healthcare Choices* in your community. This program will help you share important information about healthcare choices in an easy-to-understand format. Most importantly, through this program you will teach people how to make their choices known before the onset of critical illness.

Discovering Your Beliefs About Healthcare Choices is designed to help consumers talk to their loved ones and healthcare providers about their basic life values. The program helps people clarify their values related to healthcare choices and end-of-life decisions. It includes many interactive exercises and practical suggestions to assist consumers in making their wishes known.

Discovering Your Beliefs About Healthcare Choices is not a legal reference on advance directives. The laws that govern advance directives vary widely by state. As the facilitator, you are responsible for being knowledgeable about the laws in your state and securing the appropriate forms.

Please let us know if you have any suggestions for improving the program or if there are particular areas that you think are especially effective. We've included a Facilitator Evaluation form and postage-paid envelope to assist you in sharing your feedback. We are equally interested in participant feedback. Please feel free to share copies of the Participant Evaluation Forms with us.

We hope you enjoy this product. Thank you for your commitment to educating your community about this important topic.

Program Planning

Learning Method

Discovering Your Beliefs About Healthcare Choices is designed to be taught in a workshop style to an audience of 10-50 participants. Because of the program content and the extensive involvement of the participants, the workshop method is particularly appropriate. This learning method also provides the opportunity for effective interaction between facilitator and participant.

Room Set-Up, Time and Space Requirements

According to the Convention Liaison Council Manual, you need at least 10 square feet of space per person for an effective audiovisual presentation. In addition, consider room layout (columns or other obstructions) and space for podiums, audiovisual equipment, screens and flipcharts when you calculate space requirements.

Discovering Your Beliefs About Healthcare Choices requires 2-3 hours to administer in its entirety. This can take place over one or two sessions. Presenting the materials over two sessions allows participants to reflect on the information, discuss the materials with their healthcare partner and make more informed and thoughtful decisions about their healthcare choices.

We suggest a U-shape, horseshoe, hollow square, hollow circle or round table set-up for this program. These styles are effective for interactive sessions.

Audiovisual Needs

To conduct this program, you will need a 35 mm slide projector and screen and a flipchart or whiteboard. You may want to consider a microphone, preferably a lavalier, depending on the size of your group and the room layout.

Pre-Assessment

A pre-assessment tool is provided as part of the *Discovering Your Beliefs About Healthcare Choices* program. If possible, have your participants complete and return this form to you prior to arriving for the program. The information provided will help you structure the program based on the needs of your participants. Feel free to modify the order of the way the materials are presented based on the needs of your participants.

However, if a pre-workshop assessment is not possible, ask participants to respond to the questions listed by a show of hands. Take a moment to write notes on their responses and highlight the areas within the program that will address their needs.

Participant Evaluation

An evaluation form is provided for completion by your participants. Please ask them to complete and return the evaluations to you prior to leaving the program.

Facilitator Evaluation

We are very interested in your feedback regarding the effectiveness and quality of this program. Please complete the Facilitator Evaluation and return it in the postage paid envelope provided in the back pocket of the curriculum binder.

Further program planning and group facilitation information can be obtained by purchasing AACN's *Program Planning Guide*. For a catalog, call 800-899-AACN.

APPENDIX D
DEMOGRAPHIC DATA FORM

Advance Directives For Health Care Professionals
DEMOGRAPHIC DATA

Gender	Marital Status	Number of Dependents	Degree of Licensure
☐ Male	☐ Single	☐ Self Only	☐ Registered Nurse
☐ Female	☐ Married	☐ Two to Four	☐ Licensed Vocational
	☐ Divorced	☐ Five to Seven	
	☐ Widow	☐ Eight or Greater	

Age In Years	Race	Level of Education	Years of Experience
☐ 20-25	☐ Caucasian	☐ ADN	☐ Less than one year
☐ 26-34	☐ African American	☐ BSN	☐ 1 - 3
☐ 35-40	☐ Hispanic	☐ BS	☐ 4 - 7
☐ 41-50	☐ Asian	☐ MSN	☐ 8-11
☐ 51-59	☐ American Indian	☐ MS	☐ 12 or more
☐ > 60	☐ Other (Specify) _____	☐ Other (Specify) _____	

Religion	Area of Current Practice
☐ Catholic	☐ Office/Clinic
☐ Protestant	☐ OR
☐ Jewish	☐ PACU
☐ Hindu	☐ Acute Care
☐ Islam	☐ Critical Care
☐ Buddhist	☐ Educator
☐ Non-denomination	☐ Other (Specify) _____
☐ Other (Specify) _____	

Experience With Advance Directive	I Have A Living Will	I Have A Durable Power Of Attorney For Health Care
☐ None	☐ Yes	☐ Yes
☐ Professional	☐ No	☐ No
☐ Educational Only		
☐ Immediate Family Member		
☐ Friend		
☐ Self Only		

I have completed a Durable Power of Attorney for Health Care following this program:
☐ Yes ☐ No

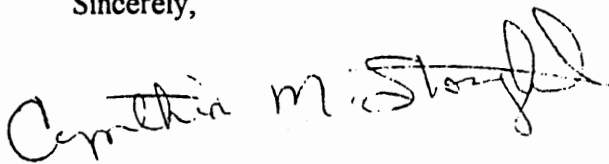
APPENDIX E
LETTER TO PARTICIPANTS

March 12, 1998

Dear Participant:

I would like to take this opportunity to thank you for your involvement in the program "Discovering your beliefs about health care choices" presented at St. Joseph Regional Health Center. Enclosed you will find your continuing education certificate. I am required by AACN to keep a copy of this certificate for five years after the program. I would also like to offer you an opportunity to have the program in its entirety presented with the social support offered the experimental group. This would not give you three more continuing education credits as it is the same essential program you attended before with the addition of support personnel being present (a chaplain, social worker and a notary public). If you are interested in this offering, please contact me at the address below and a program date will be set in the future. I would like to thank you once again for your time and interest in this program. I hope you found the program to be useful as well as educational in your personal and professional life.

Sincerely,

A handwritten signature in cursive script that reads "Cynthia M. Stoughton". The signature is written in dark ink and is positioned above the printed name.

Cynthia M. Stoughton

Route 1 Box 380

Anderson, Texas 77830