Advance directives are an important tool in critical care. An advance directive is a legal document that provides data to the critical care staff about patients’ wishes, especially when critical illness decreases decision-making ability.1 Advance directives enhance communication between patients and providers about life-sustaining technology;2 preserve patients’ autonomy;3 assist in reducing litigation in healthcare;4 and could lower healthcare costs.5,6

Despite the many benefits of advance directives, only 5% to 25% of Americans have an advance directive.7 Healthcare professionals may contribute to this problem. In one study,8 nurses had little interest in educating patients about advance directives, and physicians do not often discuss this topic with patients.9 Time limitations, difficulty bringing up and dealing with the subject matter, and possible legal ramifications are the major reasons physicians do not discuss advance directives.3,10-12
Researchers have found multiple reasons for patients’ failure to complete an advance directive. Two main reasons are lack of knowledge and lack of discussion between physician and patient about advance directives. Other reasons include patients’ procrastination, dependence of patients on their family members to make decisions, and patients’ fears that they will not receive adequate care after an advance directive is in place.

The advance directive document was developed from a European American cultural point of view. Studies often do not address how other cultures view advance directives. The changing sociocultural and demographic composition of the United States makes culture a relevant variable. It is estimated that by 2030, 39% of Americans will be members of an ethnic minority. In California, ethnic minorities account for approximately half of the population.

Asian American Pacific Islanders constitute the fastest growing minority group in the United States. Their numbers in the United States increased by 108% from 1980 to 1990. In 1997, Asian American Pacific Islanders were estimated to make up 3.7% of the total US population. By 2050, their numbers will more than double, and that group will account for 10.7% of the US population. A group that falls within this category is the Filipino American population. In California, Filipino Americans account for 2.7% of the population.

To date, no studies have addressed completion and knowledge of advance directives in the Filipino American population and how the attitudes or acculturation of Filipino Americans affect this group’s completion of advance directives.

The overall aim of this study was to understand the attitudes of critically ill Filipino Americans and their families toward advance directives. The specific aims of this study were as follows:

- Describe the attitudes and compare the differences in attitudes toward advance directives between critically ill Filipino American patients and their families;
- Describe the level of acculturation and compare the differences in acculturation between critically ill Filipino American patients and their families;
- Examine the relationship between acculturation and attitudes toward advance directives of critically ill Filipino American patients and their families; and
- Determine the relationship between certain demographics and attitudes toward advance directives among critically ill Filipino American patients and their families.

Demographic data collected include subjects’ sex, age, education, religion, and marital status.

Review of the Literature

Studies indicate that patients’ attitudes toward and knowledge about advance directives may influence completion of advance directives. In one study, patients who had positive attitudes toward advance directives were more likely than patients with negative attitudes to be of a higher socioeconomic status, to have had experience with illness or death, or to have private health insurance. In a study by Perry et al., most patients (84%) thought that it was important to complete an advance directive. Additional studies suggest reasons for completing an advance directive are related to maintaining control over treatment decisions, level of illness, relationships with healthcare providers, and relationships with families. Upadaya et al. found significant differences in the understanding of patients and the patients’ families about how advance directives should be carried out.

Completion rates and attitudes of elderly patients toward advance directives have also been explored. These studies indicate that elderly whites are more likely to complete and correctly define advance directives than are their counterparts from other ethnic or racial groups. Whites also had significantly more positive attitudes toward advance directives than did elderly members of other ethnic or racial groups.

The attitudes of persons of various races and ethnicities toward advance directives are an important factor in the completion of these documents. Douglas and Brown reported that patients with more positive attitudes were white, female, elderly, and in poor health. In another study, European Americans and African Americans had significantly more positive attitudes toward advance directives than did Korean Americans and Mexican Americans. In most instances, persons of European American culture tended to be more knowledgeable about advance directives, to react more positively, and to complete more advance directives than did people from other ethnic or racial groups. No reported studies focused solely on attitudes and completion of advance directives among Filipino Americans; often, investigators group Filipino Americans with Asian American Pacific Islanders.

A Filipino person may view illness as inevitable, as the will of God, and may follow the advice of an authoritarian person or the head of the family.
Filipino Health Beliefs and Practices

Within Filipino culture, confrontation with a serious illness often results in a fatalistic perception of the problem. Filipinos believe in bahala na, or what is destined or inevitable. Illness is commonly seen as the will of God. This view may most influence a Filipino person faced with a decision about advance directives. Filipinos also tend to go along with the demands of a more authoritative group to maintain harmony. This behavior means that even if they do not concur with a decision, they may agree with a healthcare professional in order to avoid disagreement.

The number of studies in which decision making about healthcare among Filipinos was addressed is limited. Nishimoto and Foley found a strong influence of filial piety, or the obligation of the family members to care for one another. It is also common for Filipino patients to assume a passive role when they are sick and to expect family assistance.

When healthcare providers need to discuss important decisions about a Filipino patient’s serious illness or end-of-life issues, the recommended method is to consult with the head of the family or decision maker, which is usually based on birth order. The decision maker tends to be the eldest male but may also be a trusted friend or clergy member. For a patient with a serious or terminal illness, consulting the head of the family precedes consulting the patient, allowing the patient’s family to disclose the information to the patient. Once the decision maker consults the patient, the rest of the family will work together to carry out the decision for the ill family member. Discussions regarding end-of-life issues and advance directives should be approached carefully. In Filipino culture, discussing these topics brings about fear that the discussion itself may invoke unwanted outcomes.

Conceptual Framework

The conceptual framework for this study (see Figure) is based on the work done by Nolan and Bruder and Rein et al. These investigators identified and subsequently explored 5 interrelated factors and how the factors affected advance directives: (1) severity of illness, (2) the effect of an advance directive on the patient’s family, (3) the effect of an advance directive on treatment, (4) the patient’s belief in opportunities for treatment choices, and (5) perceptions of the healthcare professional’s role in treatment decisions. This model
was developed through qualitative research on hospital inpatients\(^2\) and subsequently tested on hospital inpatients.\(^2\) We added a sixth factor regarding race, ethnicity, and acculturation after exploring the literature on advance directives.

Researchers often use the terms race, ethnicity, and culture interchangeably, yet the terms have distinct definitions. Race is defined as physical traits based on characteristics that are inherited.\(^2\) Ethnicity refers to a group that shares a common history, ancestry, and culture.\(^3\) Culture is composed of a complex set of values, beliefs, norms, and patterns that are learned and passed on from generation to generation.\(^4\) Acculturation is a process by which members of one cultural group assume the traits and behaviors of another cultural group.\(^5\) For the purposes of this study, the terms ethnicity and acculturation refer to Filipino culture.

### Methods

A descriptive, correlational, cross-sectional study design was used to describe the attitudes of critically ill Filipino American patients and their families toward advance directives.

### Setting and Sample

Data were collected over a 6-month period in 2 critical care units (intensive care and coronary care) of a 357-bed community hospital in northern California that serves the population that surrounds the hospital. Twenty-seven percent of the community is Filipino American. This community is the largest concentration of Filipino immigrants in the United States.\(^6\)

Inclusion criteria for patients were that patients had to (1) be hospitalized in the critical care unit, (2) self-report ethnicity as Filipino, (3) be oriented to person, place, and time, (4) be able to speak and read English, (5) be 18 years or older, and (6) require cardiac surgery or cardiac intervention. Patients were excluded if they were comatose, unresponsive, and/or intubated. Inclusion criteria for family members were that they had to be (1) at least 18 years old, (2) oriented to person, place, and time, (3) able to speak and read English, and (4) identified by the patient as the family member most likely to help with medical decisions.

Two power analyses were done before the study to determine the number of subjects needed to obtain an 80% power with an \(\alpha\) of .05. The analyses indicated that 64 patients and 64 family members were needed for a total of 128 subjects for \(t\) test analyses. A sample of 30 patients and 30 family members was needed for a total of 60 subjects for the correlational statistical tests. The study was stopped after 44 subjects because of time constraints of the principal investigator (J.L.M.).

### Instruments

The revised version of the Advanced Directive Attitude Survey (ADAS) by Douglas and Brown\(^3\) was used, with permission of the authors, to assess attitudes of critically ill patients and the patients’ families toward advance directives. The original tool, created by Nolan and Bruder,\(^2\) was a 16-item questionnaire that used a Likert scale (score range of 16-64) to determine attitudes toward advance directives. Content validity was established by using a panel of experts. Internal consistency measured with Cronbach \(\alpha\) was .74.

In revising the ADAS, Douglas and Brown added the concepts of (1) the effect of advance directives on the amount and quality of end-of-life care, (2) changes being made in advance directives after the documents are initiated, and (3) advance directive decisions about end-of-life care being made by patients. Content validity of the revised tool was established by a panel of 5 experts (nurses working in the area, nursing faculty, and the original author of the tool). Test-retest reliability was established at .796. Internal consistency was established at a Cronbach \(\alpha\) of .748.\(^4\)

The ADAS is a 24-item questionnaire that uses a 4-point Likert scale to determine the extent to which advance directives are viewed positively or negatively. The responses are rated from 1 (strongly disagree) to 4 (strongly agree). The range of scores is 24 to 96. Higher scores indicate more positive responses to advance directives.

One bilingual Filipino American nurse in the critical care unit independently translated the ADAS into Tagalog. Another bilingual Filipino American nurse in the critical care unit then translated the ADAS back into English. A third Filipino American nurse resolved any discrepancies. All 3 nurses were college graduates, had experience translating English into Tagalog, had been raised in the Philippines, and now reside in the United States. Although there are many dialects in the Philippines, Tagalog is the official national language and the most widely used.\(^6\) Two questions were eliminated from the final analysis in this study because of the lack of reliability and the recommendation of the author of the ADAS (Rebecca Douglas, RN, MSN, written communication, April 2002). In our study, the Cronbach \(\alpha\) for the ADAS after the removal of the 2 questions was .78 for the patients and .79 for the patients’ families.\(^6\) The participants were offered either the English or Tagalog version of the survey, and they were encouraged to choose the version they were most comfortable answering.

A Short Acculturation Scale for Filipino Americans (ASASFA) was used to measure acculturation. This 12-item questionnaire uses a scale from 1 to 5.
Scores can range from 12 to 60. Lower scores indicate a stronger Filipino acculturation, and higher scores indicate a stronger American acculturation. This tool was used with permission from the authors. The Cronbach α for internal consistency is .85. Content validity was measured by 2 different sets of Filipino language translators and was confirmed by a certified bilingual Filipino American court interpreter. In our study, the Cronbach α for the ASASFA was .85 for the patients and .90 for the patients’ family members.

Procedures

The study was approved by the institutional review board of the university where the principal investigator (J.L.M.) was enrolled and the institutional review board of the hospital where the study was conducted. Patients admitted to the 2 units who met the inclusion criteria were identified weekly by the charge nurse. Chart review was then completed to establish each patient’s eligibility for inclusion in the study. Patients and their family members were approached by the researcher, who was a nurse in the critical care units. Informed consent was obtained from the patient and from the family member before data collection.

Demographic data were collected through a chart review. Scores on the Acute Physiology and Chronic Health Evaluation (APACHE) II were calculated by using data from the 24 hours preceding the interview. Data collection was completed with the patient alone and with the family member alone. Patients’ data were obtained at the bedside. Families’ data were obtained in a private alcove near the 2 units. After consent, each participant (patient, family member) was given a blank copy in English or Tagalog of the ADAS and the ASASFA. Participants were asked to respond verbally or point out the response that best matched how they felt about the item.

Data Analysis

Sample data and all study variables were examined using descriptive statistics and SPSS, version 11.0 (SPSS Inc, Chicago, Ill). Findings were described using descriptive and inferential statistics. Matched paired t tests were used to analyze data for the first 2 aims of the study (assessing knowledge and attitudes related to advance directives and assessing acculturation). Data related to the third and fourth aims (assessing relationships of acculturation and demographics to attitudes toward advance directives) were analyzed with Pearson product moment correlations for continuous variables and matched-paired t tests for categorical variables.

Because of the type of data, a nonparametric analytical approach was also considered. A matched-paired Wilcoxon signed-rank test was substituted for the matched-paired t test, Spearman rank correlation was substituted for Pearson product moment correlation, and the Mann-Whitney U test was substituted for t tests. After reanalysis of the data, there were no changes in the results.

Results

Sample Characteristics

A total of 48 participants met the inclusion criteria for the study (25 patients, 23 family members). A total of 3 patients and 1 family member declined to participate. Of the 3 patients, 1 was not interested, 1 thought that he was too sick, and 1 did not wish to complete the form. The family member who declined stated that she did so because of her lack of understanding of the material, even after an explanation.

Patients

All patients included were Filipino (Table 1); most were first-generation Filipinos and male. The mean age of the patients in the sample was 67.9 (SD 9.06) years. The highest level of education for most patients was high school or less. Most were Catholic and married. Most patients had a diagnosis of coronary artery disease and were receiving no pain or sedating medications at the time of the interview (Table 2). The mean APACHE II score was 12.1 (SD 3.61).

Families

All family members were Filipino (Table 1); most were first-generation Filipinos and female. The mean age of the family members was 51.9 (SD 17.22) years. The family members had a higher level of education than did the patients: 86.3% were college educated. Most were Catholic and married. Most family members were the patients’ children; second-most common were patients’ spouses.

Advance Directives and Knowledge of Advance Directives

Only 2 patients (9.1%) had signed an advance directive (Table 1). Those same 2 patients (9.1%) were the only ones who had prior knowledge of advance directives before the study. More family members (27.3%) had knowledge of advance directives before the study, but none had an advance directive.

Knowledge and Attitudes Related to Advance Directives

The patients’ mean (SD) score on the ADAS was 62.6 (5.6), and the family members’ mean score on the ADAS was 66.4 (6.6). Both of these scores indi-
cate a moderately positive attitude toward advance directives (Table 3).

The patients’ scores on the ADAS (Table 3) were significantly lower than the family members scores ($t = -2.67; P = .01, CI -6.79 to -0.85$). A moderate corre-

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Primary diagnosis, procedures, APACHE II scores, and pain/sedating medications for the patients in the sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td>No. (%) of patients</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>20 (90.9)</td>
</tr>
<tr>
<td>Chest pain</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td>Procedures completed</td>
<td></td>
</tr>
<tr>
<td>Percutaneous cardiac intervention</td>
<td>10 (45.5)</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>8 (36.4)</td>
</tr>
<tr>
<td>Cardiac catheterization</td>
<td>4 (18.2)</td>
</tr>
<tr>
<td>APACHE II scores*</td>
<td></td>
</tr>
<tr>
<td>4-12</td>
<td>13 (59.1)</td>
</tr>
<tr>
<td>13-16</td>
<td>7 (31.8)</td>
</tr>
<tr>
<td>17-20</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td>Pain/sedating medication (at the time of interview)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>14 (63.6)</td>
</tr>
<tr>
<td>Morphine</td>
<td>7 (31.8)</td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td>1 (4.5)</td>
</tr>
</tbody>
</table>

*APACHE II indicates the Acute Physiology and Chronic Health Evaluation II. This score measures the severity of illness. It is based on 12 physiological measurements, age, and previous health status. Scores range from 0 to 71. A higher score correlates with an increased risk of dying in the hospital.*

Acculturation

Patients’ mean (SD) score on the ASASFA was 28.1 (7.5), indicating a less American acculturation. Family members’ mean (SD) score was 36.2 (7.3), indicating a slightly greater American acculturation (Table 3). Patients’ and family members’ ASASFA scores differed significantly; the patients’ scores were significantly lower ($t = -4.03; P = .001, CI -12.20 to -3.89$). Comparison of patients’ and family members’ scores on the ASASFA showed only a weak correlation ($r = 0.2$) that was not significant ($P = .37$).

Relationship Between Acculturation and Attitudes Toward Advance Directives

When the patients’ scores on ASASFA were compared with their scores on the ADAS, the correlation ($r = 0.18$) was weak and not significant (Table 4). A moderate correlation ($r = 0.43$) that was not significant was found between family members’ scores on the ASASFA and on the ADAS.

Relationship Between Demographics and Attitudes Toward Advance Directives

No significant relationships were found between patients’ scores on either the ADAS or the ASASFA.
and their age, sex, education, or APACHE II scores. A significant relationship was found between the family members’ scores on the ADAS and their level of education ($r = 0.50; P = .02$), indicating that the higher their educational level, the more positive their attitudes were toward advance directives. This relationship was in the same direction for the patients but was not significant ($r = 0.34; P = .16$). No significant relationships were found between age or sex of family members and their ADAS or ASASFA scores. When age, sex, and education were controlled for, no significant differences were apparent between the patients and the family members’ scores on the ADAS.

**Discussion**

Our results offer some important insight into the attitudes of critically ill Filipino American patients and their families toward advance directives. The generally positive attitudes that both the patients and their family members had toward advance directives were unexpected for 2 reasons. First, similar to results of prior research, few participants in this study actually had completed an advance directive. Second, only 8 of the 44 study participants had known what an advance directive was before the study, indicating scant knowledge of advance directives. Why the Filipino Americans in this study had a generally positive attitude toward advance directives yet did not complete one is unclear. One possible explanation is that Filipino culture may affect their attitudes as well as their decisions to complete an advance directive. This finding is not unexpected; previous studies indicated that significantly fewer minorities than whites complete an advance directive. Theoretically, patients and their family members may agree with statements on the ADAS such as “an advance directive would prevent guilt in the family or prevent costly medical expenses.” Yet, when it comes to completing an advance directive, agreement does not mean acceptance. In addition, lack of knowledge in this group may have led to lower rates for completion of advance directives.

In previous studies, Korean Americans, Mexican Americans, and African Americans tended to have negative attitudes toward advance directives, not positive as in our study. However, the investigators did not specifically address acculturation. In our study, a moderate, linear correlation was found between having a more American acculturation and having a more positive attitude toward advance directives. In our study, family members who were more American acculturated had more positive attitudes toward advance directives than did family members who were less American acculturated.

The literature on Filipino Americans’ interactions with healthcare providers suggests that Filipino Americans tend to avoid disagreeing with more authoritative groups. The participants could simply have been telling the researcher what they thought the researcher wanted to hear in order to maintain harmony. This possibility may partly explain the positive attitudes of the Filipino Americans toward advance directives. The low completion rates for advance directives, however, may be due to the Filipino Americans’ actually waiting for healthcare professionals to tell them that it is time to complete an advance directive. Low rates of completing advance directives may also be related to Filipino Americans’ belief that illness is destined or inevitable, so they may think an advance directive is not necessary. This concept of bahala na may prevent them from accepting or completing an advance directive.

**Table 3** Differences between scores of patients and family members on the Advance Directive Attitude Survey (ADAS) and A Short Acculturation Scale for Filipino Americans (ASASFA)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Total patient Mean score (SD)</th>
<th>Total family Mean score (SD)</th>
<th>Difference Mean score (SD)</th>
<th>95% CI Mean score (SD)</th>
<th>t Value</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAS</td>
<td>62.6 (5.6)</td>
<td>66.4 (6.6)</td>
<td>-3.82 (6.70)</td>
<td>-6.79 to -0.85</td>
<td>-2.67</td>
<td>.01</td>
</tr>
<tr>
<td>ASASFA</td>
<td>28.1 (7.5)</td>
<td>36.2 (7.3)</td>
<td>8.05 (9.37)</td>
<td>-12.20 to -3.89</td>
<td>-4.03</td>
<td>.001</td>
</tr>
</tbody>
</table>

Although the Filipino American subjects had positive attitudes about advance directives, very few subjects had completed one.

Consistent with other researchers, we found a significant relationship between level of education and positive attitudes toward advance directives. In fact, education had a significant correlation with completion of an advance directive. The family members tended to have higher education levels than the patients had, a finding that could explain the more positive attitudes of family members than patients toward advance directives.
Factors other than education may have influenced the family members’ attitudes toward advance directives, because the family members in this study were young and mostly female. In other studies, older, sicker women were more likely than other groups to have a positive attitude toward advance directives and to complete an advance directive, a finding not confirmed in our study. Further work with a larger sample is needed to explore these dimensions fully.

In the Filipino American culture, family plays a significant role in all decisions. In our study, all the patients had family nearby, had close family relationships, and would probably expect that family would care for them if they were ill. Therefore, the patients in our study may have considered an advance directive unnecessary. Prior research also supports this suggestion.3

### Table 4

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Correlation between ADAS and ASASFA Scores</th>
<th>Correlation between ADAS scores and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>0.18</td>
<td>0.34, P = .16</td>
</tr>
<tr>
<td>Family</td>
<td>0.43</td>
<td>0.50, P = .02</td>
</tr>
</tbody>
</table>

Abbreviations: ADAS, Advance Directive Attitude Score; ASASFA, A Short Acculturation Scale for Filipino Americans.

**Family members had higher education levels than did the Filipino American patients and also had more positive attitudes toward advance directives.**

### Implications

Data from this study show that Filipino Americans lack knowledge about advance directives. The few Filipino Americans who had completed an advance directive had previous knowledge of advance directives. Future research should address culturally sensitive strategies for presenting and conveying information about advance directives. In our study, however, family members had more knowledge of advance directives than the patients had, even though no family member had actually completed an advance directive.

The language of advance directives may be confusing. In our sample, many participants had trouble understanding the phrase “end-of-life treatment choices.” Although we did not address this factor, it may be related to the cultural belief of Filipino Americans that a person does not have choices regarding the end of life. Filipino Americans may think that the end of life just happens and that a person does not have control over it. For advance directives to be used by nonwhites, the language of healthcare workers may need to become more straightforward. Further research is needed to determine alternative terminology about the end of life.

A final implication for healthcare workers is related to how family members influence the completion of advance directives. Previous research indicates that when a patient has a family member nearby, the frequency of completion of an advance directive decreases. Future research is needed to determine whether close family relationships in the Filipino American population have an effect on completing advance directives.

### Limitations

This study has several limitations. The sample size was small and did not meet the requirements of the a priori power analysis. The significant findings could have a type I error, and the nonsignificant findings could have a type II error. All participants were recruited from a single center, which may not be representative of the cardiac Filipino-American population. Because the researcher was present for all data collection, participants may have been responding with socially acceptable answers. Finally, the tool was developed from one culture and applied to another culture, so its validity may have been compromised.

### Conclusion

In this study, few patients had completed an advance directive, yet Filipino American patients and their family members had positive attitudes toward advance directives. Those who were more American acculturated had more positive attitudes than did those who were more Filipino acculturated. Those who had more education knew more about advance directives. Future research should be focused on interventions to improve knowledge about advance directives and end-of-life discussions and to assess the influence of Filipino American families on completion of advance directives.

### ACKNOWLEDGMENTS

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Commentary by Mary Jo Grap (see shaded boxes).

### REFERENCES


