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DEDICATION

To My Beloved Aunt,

Marjorie Bush Jones

Never have I known anyone
so encouraging, so accepting,
so uniquely generous, or so remarkable
as my beloved Aunt Marge.

Everyone who knew her,
knew how very special I was to her.

For I am her namesake
and, indeed, she loved me dearly.

I am grateful that in this life,
our familial roots connected and
formed such a wonderful bond.

Surely, she smileth down on me now
with joy and with pride.

It is to her loving memory
that I dedicate this accomplishment.
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CHAPTER I

INTRODUCTION

Statement of the Problem

Patient autonomy and the individual's right to self
determination are issues that have been the source of great
controversy in the legal and medical professions for years.
The recent (1991) enforcement of the PATIENT SELF
DETERMINATION ACT (PSDA) suggests that finally the medical
and legal communities are in agreement regarding the belief
that medical treatment decisions made by physicians should
be in concert with the desires communicated by their
mentally competent patients (Drugay & Gallagher, 1993).

The primary purpose of the PSDA is to provide a set of
statutes that allow competent adults to communicate their
desires regarding the use or non-use of life sustaining
treatment should the loss of decision making capacity occur
at some future point in time. This is accomplished by the
completion of one or more documents commonly referred to as
ADVANCE DIRECTIVES. An advance directive is a means of
recording or documenting an individual's treatment
preferences regarding future health care decisions while the
individual is fully competent.

Despite increasing interest in advance directives, research indicates that the actual execution of written advance directives is low, even among seriously ill patients (Virmani, Schneiderman & Kaplan, 1994). Researchers (Emanuel & Emanuel, 1989) speculate that the reasons for low usage include lack of information and the lack of encouragement from health care professionals.

Traditionally, ethical issues involving medical technology in health care have been viewed as primarily the concern of physicians (Wright, 1987). However, the implementation of the PSDA has expanded ethical concerns regarding decision making to all health care professionals as well as to each person receiving care at a health care facility.

The statistical abstracts of the United States (1993) report that 1.5 million individuals were admitted to hospital facilities in the State of Ohio during the year 1991. The PSDA, which took effect toward the end of that same year, requires that on admission to a hospital or health care facility, each adult be provided with written information about advance directives. It also requires that individuals being admitted to health care facilities be asked if they have an advance directive, and offered the opportunity to complete the advance directives documents if
they so choose.

While patients are generally first informed about advance directives by an admissions clerk on entry to a health care facility (Mezey & Latimer, 1993), those patients wanting more information are typically referred to the social worker on the ward or unit where they will be receiving care. It is assumed and expected that health care social workers will be knowledgeable and will have current and accurate information about advance directives. It is also assumed that the attitude and behavior of the social worker toward advance directives will be such that hospitalized individuals and their families will feel comfortable openly raising their questions, ventilating their concerns, and expressing their personal views and attitudes regarding the use of life sustaining medical treatment.

Traditionally, social workers have been providers of mental health and health care services to individuals attempting to manage stress in their lives (Saxton, 1989). Making choices regarding the use of life sustaining treatment may cause considerable stress to some individuals, especially to those who have limited knowledge and/or poorly informed attitudes about the uses and advantages of advance directive documents. It is not uncommon, particularly in health care settings, for patients and their families to
rely on social work staff to discuss their feelings and perceptions about the health care they are receiving, fears and concerns about medical issues and treatment, psychosocial concerns, and end-of-life choices. End-of-life planning and related issues may be particularly frustrating for elderly people who are alone and may have no living family or close friends to act as advocates on their behalf (Soskis & Kerson, 1992). Social workers must be aware that their knowledge, their attitude, and their behavior regarding the topic of advance directives can significantly influence the tone of their communication and their interaction with patients.

Researchers on the topic of advance directives (Gamble, McDonald, & Lichstein, 1991) have highlighted the importance of open communication between professionals and patients as the cornerstone for enhancing patient autonomy and participation in end-of-life care. Effective communication about decisions concerning termination or refusal of medical treatment necessitates clarifying the level of knowledge, attitudes, and behaviors of those professionals providing counsel to patients. Informed discussion and open communication with individuals about advance directives affords health care social workers a key opportunity to model historically held social work values. Additionally, it encourages and assists families in exercising control
over their lives (Carlton, 1984). However, the ability of social work to make an effective contribution within the framework of a health care agency's objectives requires clarity of social workers' own knowledge, attitudes and behaviors regarding advance directives.

In addition to examining the level of knowledge, the attitudes and the behaviors of health care social workers in the State of Ohio, it is important to determine the extent to which demographic and other factors influence the identified dependent variables. A number of factors are likely to contribute to the knowledge, attitudes and behaviors of health care social workers. Variables identified for use as independent variables for this research included:

**Primary work setting** - This variable was selected because it is possible that some work locations within a health care facility might provide greater exposure to advance directives and may therefore enhance or increase the knowledge, attitudes, behavior, and experiences of social workers whose primary responsibilities are in those areas. For instance, social workers employed in hospice units, or nursing home areas are likely to be more involved with advance directives than social workers working primarily in acute care settings.
Religiosity - This variable was also selected as an independent variable because adherence to religious dogma is often manifested through active involvement and participation in the life of the church. Religiosity, therefore, for the purposes of this study, refers to the frequency of attendance at church services. It is possible that religiosity may make a difference in the knowledge, attitude, behavior, and/or experiences of health care social workers toward advance directives.

Number of years worked with the elderly - It is possible that the number of years worked with elderly populations may result in increased exposure to advance directives and therefore, may influence the knowledge, attitude, behavior, and experiences of health care social workers.

Number of years employed in the social work profession - Longevity in the profession may have some influence on the knowledge, attitude, behavior and/or experiences of health care social workers because of their familiarity with new procedures and policies, coupled with their experience in the profession as issues related to the eventual passage of the PSDA were evolving.
The usual demographic variables: Age, Gender, Ethnicity, and Education were also included as independent variables in this research.

Justification/Significance of the Study

Rigorous research on the knowledge, attitudes and behaviors of social workers toward advance directives is needed and will broaden the scope of data available to health care professionals in Ohio and throughout the country. This exploratory work is ground breaking and moves beyond the current body of knowledge on the subject of advance directives. It also affords the social work profession an opportunity to be at the forefront of new, well documented, empirical information about a subject that, to date, has not been widely investigated. This research will serve to enlighten those who are not aware of advance directives and to further inform and provide new and useful information to those health care professionals who are directly involved in the implementation of the PSDA.

Given the sophisticated developments in health care technology, decisions regarding advance directives have literally become a matter of life and death. These decisions need very careful and informed discussion, consideration, and attention. The knowledge, attitudes, and behaviors of social workers regarding advance directives are
very important because quite often they are intimately involved in the explanation and clarification of advance directives options with patients as they seek to make the end-of-life decisions that are right for them.

History and Scope of Social Work in Health Care

According to Rosen (1974), a public health physician:

To a large extent the history of social medicine is also the history of social policy (welfare).... The roots of social medicine are to be found in organized social work. It was here that medicine and social science found a common ground for action....

The involvement of social workers in the health care system extends to the late 1800s (Bracht, 1990) when Jane Addams established a medical dispensary at Chicago's Hull house. A few years following, in 1905, Dr. Richard Cabot introduced social work into the hospital dispensary at Massachusetts General Hospital. He recognized social work as a major linkage between medical and environmental resources. He said:

Unless the doctor has already acquired the "social point of view" to the extent of seeing that his treatment of dispensary patients is slovenly, without some knowledge of their homes, their finances, their thoughts and worries -- he will think that the social worker is trying to teach him how to do his work whenever she does what he didn't and couldn't do before (Cabot, 1931, p. 180).
This belief is inherent in the ecological perspective as presented by Germain. Germain's work (1973) paved the way for new and innovative approaches to social work practice that included all aspects of the health care delivery system that may have influence on patients' health. In 1918, the American Association of Medical Social Workers was formed, initiating the beginning of the nationwide expansion of social work into health settings (Davidson & Clarke, 1990). The social worker, while not responsible for making medical recommendations, does share the aura of authority in the health care setting (Bartlett, 1961) along with other health care professionals. Within the health care system, social workers are the only members of the professional health care team, whose primary activity and central focus is on the psychosocial, emotional, and environmental components of the health care problem rather than solely on the disease entity itself.

A diversity of functions characterizes the historical growth of social work in health care. It is the combination of mental health skills, the orientation to the practical needs of people and their concrete necessities that makes the combination of clinical social work in health care unique (Bartlett, 1961).

While social work in hospitals dates back to the end of the last century, social work in the health care field
re-emerged as a clearly recognizable social work specialization in the mid 1970s (Carlton, 1984). In the two and one half decades since that time, society has witnessed phenomenal advances in medical technology, coupled with increasing populations of chronically ill persons, including elderly individuals, persons with AIDS, and other patients with long term illnesses. The need to address an increasing range of health care demands involves the need for advanced social work practice skills as well as an integration of services from a wide spectrum of resources.

Driven by technological advances, the essential acute care nature of traditional health services delivery in hospital settings has changed. And, as health care institutions change and expand their horizons to a biopsychosocial perspective, the services of the professional social worker must echo and reflect the redefinition of health care provision in an environment that is continually progressing and changing (Rosenberg, 1994).

According to Hearn (1958), it is the function of a profession to: "1) continually define and redefine the value assumptions upon which practice is based, 2) extend knowledge so that their members may increase their understanding of what they are doing and how it should be done, and 3) help its members to acquire an acceptable level of skill, and then, progressively, to extend that skill" (p. 1). These
tenets of a profession as described by Hearn many years ago give rise to the question -- How progressively has social work extended their knowledge base and skill? As one traces the history and scope of social work in health care from its beginnings to the present, the response to the question is clear. In an effort to meet the ever evolving service needs of patients, social work has made significant and consistent gains over the years in extending the skills of the profession to a level of advance practice in health care settings. The Social workers have come to be appreciated and recognized as unique providers of essential, professional services in the biopsychosocial treatment of ill patients in health care facilities (Rosenberg, 1994). They are trained to function as educators, communicators, advocates, and facilitators (Sansome & Phillips, 1995), depending on the need and circumstances surrounding the patient. The role and scope of social work has evolved enormously over the past decades, and one might speculate that this trend will continue as the profession remains open to innovation and growth in the coming century.

Characteristics of Social Work in Health Care

Progressive advances in health care technology have resulted in increased opportunities and considerable expansion of the role and function of social workers
practicing in the health care field. Unlike social workers in other fields of practice, those working in health care are concerned about the psychosocial needs and problems related to illness, physical disability, and medical care. They also must work in collaboration with other health care professionals as an integral part of multidisciplinary services in medical settings (Carlton, 1984). Each discipline within the health care profession has characteristics that clarify its position (Bartlett, 1961). Therefore, it is useful to identify characteristics that are unique to the social worker's professional orientation and frame of reference when applied to health care settings.

Bracht (1978) identified five specific premises that provide a framework for viewing the contribution that social workers make in the wide range of health programs in this country. They are as follows:

1. Many factors, including cultural and social factors, as well as economic conditions, influence health status, illness prevention and recovery.

2. The effect of institutionalization, as well as behaviors related to illness, can have an effect on an individual's coping abilities.

3. Family and social support, coupled with counseling services, are essential components of good medical services.

4. The community and the health care delivery system
must work to alleviate problems related to access and utilization of health services.

5. An effective problem solving approach to socio-medical community health problems involves active collaboration among members of the health care team.

Social workers share the basic generalist knowledge, skills and philosophy common to the social work profession. In every social work field of practice, however, there is a focus on some particular cluster of human needs. Basic knowledge and skills must be supplemented by knowledge and skills related to the special needs and requirements of a particular setting. Social workers currently employed in health care settings have become vital agents in the multidisciplinary treatment team process. As a result, many allied health care professionals are increasingly referring to social work staff to communicate with patients and their families regarding clarification of options related to advance directives.

It is critical that social workers in health care settings be prepared with the necessary skills and knowledge to relay accurate information regarding end-of-life decision making options to patients. Knowledge of policy issues and health legislation that directly affects patients is critical. It is also important that social workers develop
an appreciation for the transactional nature of their interaction with patients as end-of-life issues are discussed. Lack of keen awareness regarding one's own knowledge, attitudes and behavior can result in subtle and perhaps unintentional attempts to encourage patients to share those same views and attitudes. Such persuasion would infringe on the patient's right to self-determination.

The PSDA is anchored in the perception and belief that competent individuals have the right to self determination. Deciding which alternative medical treatment methods best promote their own personal values exemplifies the individual's exercise of self determination in the context of health care (Brock, 1993). Biestek (1957) defined self determination as "the practical recognition of the right and need of clients to freedom in making their own choices and decisions" (p. 103). Self determination is a value accorded high priority by social work, as evidenced by the following section from the NASW Code of Ethics, which is subsumed under Major Principle II pertaining to the social worker's ethical responsibility to clients:

G. Rights and prerogatives of clients:

The social worker should make every effort to foster maximum self determination on the part of clients.

1. When the social worker must act on behalf of a client who has been adjudged legally incompetent,
the social worker should safeguard the interest and rights of that client/patient.

2. When another individual has been legally authorized to act in behalf of a client (DPAHC), the social worker should deal with that person always with the client/patient(s) best interest in mind.

3. The social worker should not engage in any action that violates or diminishes the civil or legal rights of clients/patients (NASW Code of Ethics, 1993, p. 6).

Indeed, social workers play a very crucial role in the effective implementation and appropriate utilization of the PSDA in health care settings. For this and the above mentioned reasons, the level of knowledge, the attitudes and the behaviors of professional health care social workers regarding advance care directives are very important and need to be researched, clarified and understood. This research, therefore, examines the following research questions.
Research Questions

1. How **KNOWLEDGEABLE** are health care social workers regarding advance directive statutes in the State of Ohio?

2. What are the **ATTITUDES** of health care social workers regarding advance directives?

3. What **BEHAVIORS** do health care social workers exhibit in practice regarding advance directives?

4. What **PERSONAL EXPERIENCES** do social workers have with advance directives?

5. Does **ETHNICITY** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

6. Does **AGE** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

7. Does **LENGTH OF TIME WORKING WITH THE ELDERLY** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

8. Does the **PRIMARY WORK ENVIRONMENT** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?
9. Does GENDER make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

10. Does EDUCATION make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

11. Does RELIGIOSITY make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

12. Does NUMBER OF YEARS WORKED IN THE SOCIAL WORK PROFESSION make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?
CHAPTER II
LITERATURE REVIEW

Introduction

This chapter consists of four sections. The first section provides an overview of the historical background and evolution of events resulting in the enactment of the PSDA. The second section provides a definition and description of the documents included in Advance Directives in the State of Ohio. This section also provides arguments in favor of and in opposition to the use of advance directives. The third section provides a review of pertinent literature on advance directives including conceptual and empirical research on the subject. The fourth and final section of this chapter provides the conceptual framework which guides this research effort. The ecological perspective and the concepts which are embodied in this framework are described and discussed.
Historical Background of the PSDA

The PSDA is a federal law that went into effect December 1, 1991. It was passed by the United States Congress and signed into law as a part of the Omnibus Budget Reconciliation Act (P. L. 101-508, 1990). Enhancement of the public's knowledge of their options regarding health care choices was the primary purpose of the PSDA (Elpern & Burton, 1992). The law requires that all persons being admitted to health care facilities be given the opportunity to express their preferences about the use of life sustaining treatment. Enforcement of this law marks the first time that a federal statute has had, as its primary focus, the right of the individual to refuse life-sustaining medical treatment (Wolf, 1991).

Passage of the PSDA legitimizes the individual's right to self determination by legally allowing them to have control over the type of treatment rendered to them during the final phase of their lives. This relatively new federal law requires that all hospitals, nursing homes, hospices, health maintenance organizations, and other health care facilities that receive medicare and/or medicaid funds inform all adult patients admitted to those facilities of their right to refuse life sustaining medical treatment should they become terminally ill or decisionally incapacitated. In addition, the law requires that health care staff and individuals
being admitted to inpatient health care facilities be provided with written information about advance directives. It is important to note that neither the statute nor the regulations require the dissemination of information regarding advance directives to outpatients or emergency room patients unless they are actually admitted to the health care facility (Ohio Hospital Association, 1995).

All health care professionals need to be well informed about the contents, purpose and importance of the PSDA. Social workers counsel with patients and their families on a regular basis. Therefore, it is particularly critical for social workers employed in health care settings to be knowledgeable about the profound issues and the details of the documents that must be completed in order for patients to execute advance directives. In addition to possessing accurate and current knowledge of the specific requirements and documents used in the social worker's particular state of residence, the attitudes and behaviors of hospital and health care social workers are also quite important in this regard and can have significant impact and influence on the effective implementation of the PSDA in any given health care setting.

The PSDA is highly congruent with social work values regarding self-determination. The law also supports patient
involvement in decision-making, open and candid disbursement of information to patients and informed choice (P. L. 101-508, 1990; Abramson, 1988; Nicholson & Matross, 1989; Proctor & Morrow-Howell, 1990). For these reasons, the PSDA not only has the support of legislators, policy makers and ethicists, but it has also been highly endorsed by a host of advocacy organizations including the National Association of Social Workers and the American Hospital Association's Society for Hospital Social Work Directors.

The chronology of events and ethical dilemmas leading up to and finally resulting in the passage of the PSDA commenced with the Karen Ann Quinlan case in 1976. The Quinlan case made history as the first case to involve debate surrounding the withdrawal of life sustaining treatment from a permanently incompetent individual (Quinlan v New Jersey Department of Health, 1976). This 1976 landmark case involved the New Jersey Supreme Court approval of Miss Quinlan's parents request to remove a life sustaining treatment (a ventilator), from their daughter who was in a persistent vegetative state. Artificial nutrition and hydration were continued. Unexpectedly, Karen Quinlan continued to live for nine years following the removal of the ventilator.

Although there have been many cases that resulted in debate, concern and confusion regarding right-to-die issues,
the United States Supreme Court heard its first right-to-die case in 1989. This case involved a 25 year old Missouri resident, Nancy Cruzan, who following a 1983 auto accident, was, similar to Miss Quinlan, left in a persistent vegetative state (Cruzan v Director, Missouri Department of Health, 1990). Miss Cruzan remained in an irreversible coma for several years before her parents requested that the court order the nursing home to remove the feeding tube that was keeping her alive. Against the family's wishes, the court ruled that the feeding tube itself was not causing Nancy any pain or discomfort and therefore ordered artificial feeding to continue. The case was later reopened and judicial permission to remove the feeding tube was granted. Nancy Cruzan died eleven days later. These dramatic events resulted in the drafting of the PSDA by Senators John Danforth, from Missouri, Miss Cruzan's state of residence, and Daniel Patrick Moynihan, from New York (Hassmiller, 1991).

Between the year 1976, when the Quinlan case gained attention, and December, 1991 when the PSDA went into effect, the legal system rendered over one hundred judicial decisions regarding whether or not to continue life sustaining treatment on terminally ill or permanently incapacitated individuals. The making of these decisions was costly and time consuming and sparked considerable, ethical
controversy between the medical and legal systems and between opposing interest groups. More importantly, in many instances, the court decisions that were made, were in direct opposition to the family's wishes.
Advance Directives Documents

A series of sophisticated medical advances introduced in the 1950s and 1960s brought to the medical arena a host of developments that made it possible to prolong life or extend the process of dying. These highly developed inventions supported the sentiment of the 1970s which promoted saving lives at all costs. State-of-the-art medical equipment designed to maintain life by providing life support is known as life sustaining treatment (Sam, 1992).

An individual's choices regarding use or non use of life sustaining medical treatments are declared in documents known as advance directives. Ahronheim, Moreno & Zuckerman (1994) define advance directives as "instructions given by a patient while he or she has decisional capacity concerning medical treatment he or she would or would not like to receive in the event that decisional capacity is lost" (p. 16). They are written documents which contain the patient's preferences regarding the use of life sustaining treatment measures. Standardized forms and uniform procedures for end-of-life decision-making reflect and promote an appreciation for incompetent patients' wishes as declared prior to becoming incapacitated. This is the main objective of advance directives documents (Sam, 1992).

The two documents most frequently used to indicate end-of-life choices regarding the use of life sustaining
treatments are the living will and the durable power of attorney for health care.

The Living Will

The living will is the most commonly used advance directive document. It is a binding legal document which declares a competent individual's wishes regarding the use of life sustaining treatment, should the individual become terminally ill or permanently unconscious. Although the living will concept has been written about since the 1960s (Emanuel & Emanuel, 1989), the Natural Death Act, enacted in California in 1976, was the first statute to formally recognize living wills and to establish procedures for withholding or withdrawing life sustaining treatments from terminally ill patients (Hassmiller, 1991).

The basic tenets of the living will as defined by the Ohio Bar Association are as follows -- A LIVING WILL:

1. Becomes effective only when a person is permanently unconscious or terminally ill and unable to communicate;

2. Spells out whether or not the patient wants life supporting technology used to prolong his/her dying;

3. Gives doctors the authority to follow the patients instructions regarding the medical treatment wanted by the patient under these conditions;

4. Cannot be revoked by anyone but the patient, who has
the right to change it at any time;

5. Will be followed for a pregnant woman only if certain conditions apply, and;

6. Specifies under what condition the patient would want internal feeding and fluids to be withheld (Ohio Bar Association, 1989).

The Durable Power of Attorney for Health Care

The PSDA also provides for the specification of a proxy or health care agent to act with full authority in representing the patient's wishes by determining the use or non-use of life sustaining measures in the patient's behalf, in the event the patient is incapacitated or unable to decide these issues for him or herself. The designation of a proxy is accomplished by the individual completing the document referred to as the Durable Power of Attorney for Health Care.

The appointed Durable Power of Attorney for Health Care acts as a surrogate decision maker for health care purposes, and has the responsibility for making decisions that would be in accordance with the patient's wishes. In making medical decisions on a patient's behalf, the proxy must take into consideration the values, as well as the moral and religious beliefs of the patient that he or she represents.

Unlike the Living Will, which states the individual's specific treatment wishes, a major advantage of the Durable
Power of Attorney for Health Care document is that it is not limited to terminal conditions. It also allows the designated health care proxy, acting on the patient's behalf, to make decisions regarding medical procedures at any point, should the patient lose mental competence (Goldstein et al., 1991). A principal problem with this, according to Gillick (1995) is that preferences that can be directly translated into medical care are generally not expressed by most people when they are competent. This makes it difficult to know their wishes should they become incompetent.

Anyone may be appointed by an individual to serve as his/her durable power of attorney for health care, with the exception of the individual's doctor or the administrator of the health care facility where the individual is receiving care. A durable power of attorney for health care document is only considered to be valid if the individual is of sound mind at the time the appointment is made, and if no evidence of force or pressure is present (Drugay & Gallagher, 1993).

McClung (1995) reports that the use of the Durable Power of Attorney for Health Care document has occasionally resulted in conflicting desires between surrogates' request and patients' wishes. Both a statistical and an anecdotal literature has emerged detailing circumstances, in clinical settings, in which designated health care proxies have
disagreed with patients regarding the choice of care desired (Hare, Pratt & Nelson, 1992; Seckler et al., 1991; Suhl, 1994; Van McCrary, Allen & Young, 1993;).

Health care professionals counseling with patients regarding advance directives should therefore caution them to appoint only very trusted individuals: 1) who share similar views regarding what constitutes their best interest, 2) who are intimately familiar with their personal values system, and 3) who are knowledgeable about their wishes regarding the circumstances under which the patient would or would not want life sustaining medical treatment used.

Arguments Supporting and Opposing Advance Directives

According to Sam (1992) there are arguments both supporting and opposing the use of advance directives. The arguments in favor of their use are summarized as follows:

1. They promote autonomy by allowing individuals the right to self determination in making end-of-life decisions regarding the use or non use of life sustaining treatments.

2. They relieve health care professionals from the stress and uncertainty of having to make decisions regarding use of life sustaining medical treatment when patients are incompetent.
3. Their use may encourage more open communication between patients and physicians and patients and their families.

4. They relieve families from formerly held decision-making responsibilities.

Arguments opposing their use include:

1. The benefit of current advances in medical technology may not be reflected in advance directives that are not updated.

2. The patients' best interest may not be accurately represented by the designated durable power of attorney for health care.

3. There is no certainty that the wishes of a competent patient would be the same once the patient becomes incompetent.

On the surface, making an advance directive may seem to be an unproblematic way of ensuring the desired care when one is incompetent or otherwise unable to express treatment wishes. Researchers, Emanuel & Emanuel (1993) point out, however, that there are intrinsic limitations in that: 1) people are often not medically well informed, and 2) patients' previously stated preferences may need to be applied to unanticipated circumstances. Similarly, Drane
and Coulehan (1995) assert that human choices are usually tentative and adaptable to changing circumstances. They offer the conceptual argument that it is not possible for the incompetent patient to adapt his or her thinking to new developments or to the particular dynamics surrounding the case situation in which he or she is involved.

**Current Research on Advance Directives**

A Review of the Literature

In years past, patients routinely relied on physicians to make medical decisions on their behalf. Recent years, however, have witnessed a shift from an antiquated and paternalistic approach, to a more autonomous paradigm, with emphasis on the patients right to self determination (Elpern et al., 1993). Under the new and evolving model, researchers have begun examining the knowledge, attitudes and behaviors of both patients and health care professionals toward end-of-life decision making (Emanuel et al. 1991; Goldstein et al., 1991; Hughes & Singer, 1992; Kelner et al., 1993; Schneiderman et al., 1993; Virmani et al., 1993; Westman et al., 1993).

Prior to the enforcement of the PSDA, research indicated that only 4% of hospitals and nursing homes asked patients, on a routine basis, if they had an advance directive (Risdon, Flack & Dallek, 1993). Presently, according to the
Department of Health and Human Services (1993), in a study they conducted of 72 health care facilities in 6 different states, most hospitals and nursing homes are in compliance with the general minimum legislative requirement to provide patients with written material about advance directives.

Patients, as well as some health care professionals, may have difficulty understanding complex documents and medical jargon. Additionally, it is reasonable to suspect that on admission to health care facilities, people are under a great deal of stress (Hague & Moody, 1993). The level of stress, coupled with limited knowledge, could render it difficult to make an informed decision at the point of admission when first invited to do so. It is conceivable that the hospital or nursing home may not be the most appropriate place, nor admission to a facility the most appropriate time, for a patient to be introduced to the topic of advance directives for the first time (Obade, 1990).

The responsibility for inquiring about advance directives often rest with the admitting clerk in many health care facilities (Mezey & Latimer, 1993). The distribution of materials about advance directives by an admitting clerk at the point of admission to a health care facility, while in compliance with the legislation requirements, fails to address the intent of the PSDA. The
primary intent of the PSDA is to inform, encourage and assist people in completing advance directives (Mezey & Latimer, 1993).

If patients are to exercise their rights, they need to be provided with clear cut, simple and accurate information regarding options related to advance directives. They also need to feel comfortable discussing the sensitive, psychosocial issues related to end-of-life choices.

Over the past decade, there has been mounting evidence that patients indeed have the desire to discuss their preferences for life sustaining treatment in the event of incapacitating illness (Emanuel et al., 1991). However, research also shows that patients are reluctant to initiate conversation around this issue. Additionally, research reveals that many physicians have reservations about advance directives and may be reluctant to initiate discussion with their patients around the topic (Edinger & Smucker, 1992).

In research conducted by Kelner et al. (1993) on the views of health care professionals, face to face interviews were held with 20 physicians and 20 nurses to determine their attitude toward advance directives. Similar to the findings of other researchers (Emanuel et al., 1991; Davidson et al., 1989), Kelner's results indicated that the vast majority favored the use of advance directives and had positive attitudes toward them. Few differences in attitude
were found among these doctor and nurse respondents according to number of years in practice, religion, religiosity or gender. An interesting, but typical finding was that in spite of the fact that 39 out of 40 participants in the Kelner et al. (1993) study expressed approval for advance directives, only 11 participants reported that they routinely discussed future wishes regarding life sustaining treatments with their patients or their families.

A substantial literature (Emanuel et al., 1991; Goldstein et al., 1991; Hughes & Singer, 1992; Kelner et al., 1993; Schneiderman et al., 1993; Virmani et al., 1993; Westman et al., 1993) seeking to examine the knowledge, attitudes and behaviors of both patients and health care professionals regarding end-of-life decisions has recently begun to emerge.

Unfortunately, research involving advance directives that has focused on or included the social work profession is sparse. To date, no research effort has been dedicated exclusively to the examination of the knowledge, attitudes, behaviors, and experiences of health care social workers toward advance directives. Similarly, research that examines the factors influencing the knowledge, attitudes and behaviors of health care social workers is absent in the literature.

In their research, Emanuel et al. (1991) investigated the
attitudes of patients toward end-of-life planning, perceived barriers to such planning, treatment preferences and the feasibility of using a particular document in the outpatient setting to specify advance directives. The results indicated that of the perceived barriers to using advance directives, the lack of physician initiative was among the most frequently mentioned barrier, and the disturbing nature of the topic emerged as the least frequently mentioned barrier. More recent research examining perceived barriers to completing advance directives revealed that the reasons most often offered by respondents were lack of information about the advance directives documents and procrastination (Elpern et al., 1993).

Research which has examined the influences of ethnicity and race on knowledge, attitudes and behaviors of social workers toward advance directives has heretofore been absent in the literature. Indeed, race, culture and/or ethnic affiliation are variables that have received very little attention in the literature pertaining to advance directives.

One study that analyzed the influence of race and ethnicity on the knowledge and attitudes of patients concerning advance directives found that the minority groups studied, (African Americans and Hispanics) tended to want life sustaining treatment to continue regardless of the
state of their illness. The findings of their research indicated that, of the groups studied, African Americans were the most likely to feel they would be cared for to a lesser degree if they had a living will. These findings may imply a low level of trust, by minority individuals, in the health care system (Caralis et al., 1993).

In a survey of 215 physicians, nurses, and social workers at a west coast Veterans Affairs Medical Center, researchers (Goldstein et al., 1993) found that attitudes toward advance directives were generally positive. However, while 100% of the social workers surveyed were familiar with the documents, 36% of the physicians and nurses surveyed had very limited knowledge of the documents and 20% of them had no experience using them (Goldstein et al., 1993).

In reviewing the available literature on advance directives, there are many knowledge gaps regarding the role and influence of the social work profession in relation to the Patient Self Determination Act and its effective implementation.
Conceptual Framework

Historical Milieu and Development of the Ecological Perspective

A conceptual model based on the ecological perspective is used to guide this research. The concept of ecology emerged and became part of the sciences in the nineteenth century. Ernest Haeckel, a zoologist and an early proponent of the theory of evolution, first used and coined the term ecology in 1869. He believed that the individual was a product of cooperation between the environment and heredity and proposed that a science be developed to study organisms in their environment (Bubolz & Sontag, 1993).

Ecology is the science that studies the relations between organisms and their environments. This perspective facilitates taking a holistic view of people and environments as a unit. Using this approach, one cannot be fully understood unless the context of one's relationship with the environment is considered (Germain, 1991). It seeks to understand the nature of the reciprocal relationship between the person and the environment. For instance, the diversity found in environments and the enhancement of environmental life supporting properties is a result of people maintaining themselves by utilizing and shaping the environment to meet their needs (Siporin, 1980).

Scholars from many different disciplines have contributed
to and influenced the development of the ecological perspective. Urie Bronfenbrenner has been a major influence in advocating a contextual emphasis in ecological research in human development (Bubolz & Sontag, 1993). Bronfenbrenner (1979) believes that the phenomenological conception of the environment that lies at the foundation of the theory derives its structure and rationale from the ideas of Kurt Lewin. Lewin, a psychologist, takes the position that reality, as it appears to the individual, is the environment of greatest relevance for the scientific understanding of behavior and development (Bronfenbrenner, 1979). Additionally, the noted works of Carel B. Germain (1973) have contributed much to the ecological frame of reference, as have the early works of Harriet Bartlett (1961) and William E. Gordon (1969). Germain's contribution to the ecological perspective has been particularly influential to the practice of social work.

Many key concepts are associated with the ecological perspective. The term ecosystem has remained a key concept in the ecological sciences since it was first proposed by Alfred George Tansley in 1935. The family in interaction with its environment constitutes an ecosystem. And the well-being of individuals and families cannot be considered apart from the well-being of the ecosystem (Bubolz & Sontag, 1993).

A number of basic similarities exist between systems
theory and the ecological perspective. The emphasis on systems and the focus on the dynamic interaction among levels of systems is common to both. Additionally, each perspective provides social workers with a framework with which to view the world. There are also several differences between systems theory and the ecological perspective. Whereas systems theory addresses boundaries of subsystems and the maintenance of homeostasis or equilibrium within a system, the ecological perspective emphasizes the reciprocal nature of transactions between individuals and the environment (Kirst-Ashman & Hull, 1993).

Key concepts central to the ecological perspective include: 1) person-in-environment, 2) adaptation, 3) transactions, and 4) social environment. The person-in-environment focus views people as constantly interacting with various systems around them. Social work has historically been committed to a conception of practice based on person/environment formulation and involved in improving the interactions between the person and the various systems with which the person is dynamically involved. Adaptation implies change and refers to the capacity to change environmental conditions and adjust to them in a manner that supports a goodness of fit between the person and the environment. Transactional relationships are
reciprocal exchanges between entities in which changes in one, over time, influence or produce changes in the other (Germain, 1991). The social environment includes the conditions, circumstances, and human interactions that encompass human beings. In order to survive and develop effectively, individuals and the social environment must be functionally interdependent. This involves effective person-environment interaction with all systems with which one has contact (Kirst-Ashman & Hull, 1993).

In the last few decades the insights of ecology have exerted a growing influence on all of the helping professions. Ecological thinking is emerging as a theoretical perspective that has broad based utility for social work practice (Siporin, 1980). It represents a synthesis of assumptions, concepts and prepositions from ecology in several disciplines. These are useful in describing and explaining interactions between the patient, his or her family, the social worker, and transactions with the environment, as well as a host of other influential systems which impact the individual’s perception regarding the right to self determination. The ecological perspective holds that the person and the environment are equally significant and that the quality of life of humans and the quality of the environment is interdependent.
The Ecological Framework for Social Work Practice in Health Care

Mary Richmond and other early pioneers in the field of social work realized that the environment was very significant in the social functioning of human beings. The ecological approach to social work practice, with its person-in-environment emphasis, provides a useful framework for examining the role of the social worker in the health care system.

It is understandable that the environmental and structural forces within a health care setting could influence one's perception about advance directives. Some individuals may perceive of the hospital environment/system as a place of refuge where they can be healed and cared for by professionals with specialized ability to meet their specific medical needs. Others may be totally dependent upon the hospital system/environment to manage their medical condition, and yet be skeptical and reluctant to fully trust that this environment and the professionals therein will be supportive of their right to self determination.

The concept of self determination is a value that is basic to social work (Congress, 1992). Ewalt and Mokuau (1995) point out that the concept of self determination is clearly linked with the literature from which the prevailing middle-class American ethic of individualism is drawn:
"The feeling of being in control is especially important to people whose parents and grandparents lived lives so dominated by insecurity that control and self reliance became the prerequisites for everything else. Greater control spells more security, and with sufficient security people can start to loosen unwanted social ties and to make more of their own choices about their lives" (Gans, 1988, p.2)

While the concept of self determination is rooted in individualism in the western world, for many cultures and ethnic groups (e.g. Hawaiians, Samoans, Chinese, etc.) the term self determination places high value on group and collective affiliation rather than singular, individual choice (Ewalt & Mokuau, 1995).

In many health care organizations, neither the individual, nor the environment are fully considered. Instead, the treatment agenda is determined by the biomedical assessment and need for treatment, and similarly, the treatment rendered is directed to the disease entity (Germain, 1984). By contrast, and unlike the medical model, a major contribution of the ecological approach rest with its dual concentration on the person-in-environment aspect of development in both cultural and social
environments (Garbarino, 1992).

Within the ecological framework, the balance of ecological forces is not the sole determinant of outcomes for an individual. The ecological perspective views individuals and their environments as mutually shaping systems, each changing over time and each adapting in response to changes in the other. Different people react differently to the same environment, just as different environments react differently to the same person.

Social workers have many significant tasks within the health care environment. As social workers embrace the task of counseling with patients regarding advance directives and end-of-life issues, the ecological perspective (with its person-in-environment focus and its appreciation for the social environment of the individual) offers a comprehensive, integrative approach that has high utility for social work practitioners in health care settings.

The advent of the PSDA and issues related to advance directives have afforded social workers in health care settings a unique opportunity to educate patients by helping them understand the advantages and limitations of advance directives as well as the implications of life sustaining medical treatment interventions. While the opportunity for social workers to make a difference and have a positive impact on patients and on health care systems exists, the
level of knowledge, the attitudes, the behavior and the experiences that social workers bring to the counseling situation need to be known.

Socioeconomic status, educational level, race, ethnicity, age, gender, religiosity, environmental forces are all factors that may come to bear on the level of knowledge, the attitudes and behaviors of individuals in relation to health, illness and right-to-die issues. Similarly, influences from many different systems, and subsystems are likely to impact the knowledge, attitudes and behaviors of social workers employed in the health care system.

In this research, several measures were examined to determine the extent to which certain factors, namely, age, ethnicity, religiosity, gender, education, primary work setting, number of years worked with elderly populations, and number of years employed as a social worker influence the level of knowledge, the attitudes, the behavior, and the experiences of health care social workers in the State of Ohio.
CHAPTER III

RESEARCH METHODOLOGY

The literature contains many definitions and classifications of research methodology. In a broad sense, a research method may be defined as a plan of action or a strategy designed for the purpose of finding a solution to research questions posed by a researcher (Suchman, 1967). The end result of this important aspect of the research process is the selection of a specific, clearly defined methodology, which is effective for collecting the necessary data pertaining to the research questions (Grinnell, 1981).

Chapter III details the methods employed to find answers to the research questions raised in this study. It provides the research design, a restatement of the research questions, sampling procedures, instrumentation, operationalization and measurement of variables, methods used for data collection and a statement regarding the data analysis procedures used in this research.
Research Design

The purpose of this cross sectional research was to explore and describe the level of knowledge, the attitudes, and the behaviors of health care social workers toward advance directives. This study also examined the degree to which various factors influence the knowledge, attitudes and/or behaviors of social workers practicing in health care settings in the State of Ohio. To achieve this purpose, a survey method with a self administered, mailed questionnaire was used to gather data. Surveys were mailed to social workers throughout the State of Ohio who have membership in the National Association of Social Workers and who are employed in health care settings. The social workers selected to participate in the study were asked to complete and return a questionnaire designed to assess their level of knowledge, their attitudes, their behaviors, and their experiences regarding advance directives.

Restatement of Research Questions

1. How KNOWLEDGEABLE are health care social workers regarding advance directive statutes in the State of Ohio?

2. What are the ATTITUDES of health care social workers regarding advance directives?
3. What **BEHAVIORS** do health care social workers exhibit in practice regarding advance directives?

4. What **PERSONAL EXPERIENCES** do social workers have with advance directives?

5. Does **ETHNICITY** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

6. Does **AGE** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

7. Does **LENGTH OF TIME WORKING WITH THE ELDERLY** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

8. Does the **PRIMARY WORK ENVIRONMENT** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

9. Does **GENDER** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

10. Does **EDUCATION** make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

11. Does **RELIGIOSITY** make a difference in the
Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

12. Does NUMBER OF YEARS WORKED IN THE SOCIAL WORK PROFESSION make a difference in the Knowledge, Attitudes and Behaviors of health care social workers?

Sampling Procedures

The target population for this research is social workers practicing in health care settings throughout the State of Ohio. The Ohio Chapter of the National Association of Social Workers (NASW) was employed as the source from which the sampling frame was obtained.

As of May, 1995, the headquarters of NASW reported a total membership of 154,542 social workers in 55 State chapters throughout the United States. The Ohio Chapter licensing board of NASW reports a total statewide membership of 5349 social workers. Of that number, 1051 social workers are currently employed in health care settings throughout the state. Because the NASW membership and renewal application forms requests information such as primary work setting, ethnicity, and other demographic information needed to conduct this research, the Ohio Chapter of NASW was the most feasible database available to identify social workers
employed in health care settings in the State of Ohio.

From a mailing list of 1051 names obtained from the Ohio Chapter of NASW, 82 names were identified as minorities. An oversampling procedure was utilized to assure that an adequate number of minority social workers were included in the sample. This procedure involved selecting all 82 minority social workers to participate in the study.

A systematic random sampling procedure with a random start was utilized for the 969 names of white social workers remaining on the list. In systematic sampling, every kth element in the total list is chosen for inclusion in the sample. Following a random start, every 4th name on the remaining list of 969 names was selected for inclusion in the study. This systematic sampling procedure resulted in 242 white social workers being selected for the study. The total number of social workers chosen to be a part of the sample equaled 324. This number included 242 white social workers and 82 minority social workers who are currently employed in health care settings throughout Ohio.

To obtain the required sample size necessary to be representative of the size of the population utilized in this research (N=1051), a table for determining sample size from a defined population was used. According to Krejcie and Morgan (1970), for a population of N=1100 the sample
size required is $S=278$. The sample size used in this research ($N=1051$, $S=324$) more than met the standard requirement.

**Limitations of the Research**

The sampling frame for this research included only those social workers who have residence in the State of Ohio, who are employed in health care settings, and who hold membership in the National Association of Social Workers. Many professional social workers, who are employed in health care settings in the State of Ohio, do not hold membership in NASW. Those social workers were therefore not included in the study.

One possible reason for not holding membership in this organization may include, but may not be limited to, the fact that the cost involved in belonging to NASW may be prohibitive to some. Whatever the reason for non-membership, because the sample used in this research included only those who have membership, one must be cautious about generalizing the findings to social workers in health care settings who are not NASW members.
Instrumentation

The instrument used in this study was constructed by the researcher. It contains specific questions and statements designed to measure the respondent's knowledge, attitude and behavior regarding advance directives in the State of Ohio. The social worker's personal experience (individual and family experience) with advance directives was also examined.

The questionnaire was divided into four sections. Section I contained a series of statements developed to measure the respondent's knowledge of advance directives in the State of Ohio; Section II utilized a five point Likert scale to measure social worker's attitude toward advance directives; Section III contained statements designed to measure the behavior of social workers regarding advance directives as well as their experience with advance directives; Section IV collected demographic information from respondents. The instrument used for this research can be found at Appendix A.
Operationalization and Measurement of Variables

This exploratory research sought to identify variables that might influence the knowledge, attitudes and behaviors of social workers employed in health care settings. The specific independent variables that were measured and analyzed to determine the extent to which they contribute to the knowledge, attitudes, behaviors and experience were: ethnicity, age, primary work environment, number of years working with the elderly, gender, education, number of years in the social work profession and religiosity.

Operationalization and Measurement of Dependent Variables

The dependent variables used in the study are: knowledge, attitudes, behaviors and experience.

1) Knowledge may be defined as "a structure of concepts and relationships built by reflective thought out of information received. Any experience of participation, observation, reading, or thinking can become a part of a person's knowledge. It will become a part of his or her knowledge if the individual thinks about it, and understands it" (Ebel, 1986, p. 377).

The social worker's role is not to make decisions for patients or to coerce them into completing advance directives, but it is important to be able to appropriately
assist them in understanding the options available and what those options mean. Without accurate knowledge of advance directives, this is not possible.

Effective clinical social work in any specialized field requires a synthesis of knowledge from three essential sources. Bartlett (1961) conceptualized a configuration of knowledge and its resulting practice in terms of the following three frames of reference: (1) the essential elements of social work practice; (2) characteristics of a particular field; and (3) social work practice within the particular field (in this case social work in health care settings). A synthesis of data from the common knowledge base of the profession and specific knowledge about current concerns (Carlton, 1984), such as advance directives, in the health care field, can be integrated into a general framework of understanding.

An individual's understanding of an institution's policy is also very important and is certain to inform clinical practice as well as benefit and inform patients. The hospital social worker needs to take additional steps to insure a sound knowledge base of information regarding issues of grave concern within health care organizations. Issues related to advance directives and end-of-life decisions are the focus of mounting concern in many of the nation's health care facilities. With a firm knowledge
base, health care social workers can be more effective in helping people exercise their right to control the care they receive at the end of their lives.

Measurement of the Knowledge Variable

Respondent's level of knowledge regarding advance directives was measured by the number of correct or incorrect responses to the 15 items in Section I on the survey. This Section included basic questions regarding the living will and the durable power of attorney for health care. Questions and statements regarding basic policy requirements and routine, mandatory procedures required for the implementation of the Patient Self Determination Act were included.

The Knowledge variable was measured by the following 15 questions:

1. Are individuals asked if they have advance directives during the admission process at your health care facility?
2. Do terminally ill, competent persons have the legal right to refuse life sustaining medical treatment?
3. Is the living will form considered part of advance directives?
4. Is the Durable Power of Attorney for Health Care form considered part of advance directives?
5. Is the Power of Attorney form considered part of advance directives?
6. Is there a treatment preference form included in advance directives?
7. Must the living will form be signed by the patient?
8. Must the living will form be signed by the durable power of attorney for health care?
9. To complete a living will, is it necessary for the patient to consult the next of kin?
10. To complete a living will, is it necessary for the patient to consult the durable power of attorney for health care?
11. To complete a living will, is it necessary for the patient to consult a lawyer?
12. Is it all right for a patient to appoint a friend to be durable power of attorney for health care?
13. Is it all right for a patient to appoint a relative to be durable power of attorney for health care?
14. Is it all right for a patient to appoint his/her doctor to be durable power of attorney for health care?
15. Is there any legislation that protects health care professionals if a patient refuses life sustaining treatment?
The knowledge variable was computed to one scale of 15 questions with scores ranging from 0 to 15. Response options on this scale were: 1) YES, 2) NO, and 3) DON'T KNOW. YES was the correct response to some statements and questions on the knowledge scale (specifically, items: 1, 2, 3, 4, 6, 7, 12, 13, and 15). NO was also a correct response to some of the questions and statements on the knowledge scale (specifically, items: 5, 8, 9, 10, 11, and 14). For example, item number four on the scale asks: Is the DURABLE POWER OF ATTORNEY FOR HEALTH CARE form considered part of advance directives? The correct response to item number four is YES. Item number five on the scale asks: Is the POWER OF ATTORNEY form considered part of advance directives? The correct answer to this question is NO. All correct responses were coded as 1 and all incorrect responses coded as 0. Where NO constituted the correct response, those NO responses were reversed and recoded to equal 1. (All health care facilities receiving medicaid and/or medicare funding are required to ask competent individuals being admitted if they have an advance directive. It should be noted that while the vast majority of health care facilities receive medicaid and/or medicare funding, a NO response to item #1 by a respondent whose employer does not receive medicaid or medicare funds would not necessarily constitute an incorrect response).
Because DON'T KNOW was not a correct response, it was considered incorrect and was recoded as 0. Coding for this scale was computed as (1=1), (2,3=0). The scores on the Knowledge scale range from 0 to 15. A Table showing the number of cases, the mean, standard deviation and the range for items on this variable may be found in Chapter IV.

2. **Attitude** is defined as "a hypothetical construct, intended to explain a person's predisposition to evaluate, and as a consequence, to act toward people and events in a particular way" (Pettyjohn, et al., 1986, p. 22). For this study, the social worker's attitude is defined as positive or negative feelings toward the use of advance directives.

**Measurement of the Attitude Variable**

Section II on the survey was designed to measure the attitude of health care social workers toward the use of advance directives. The scale used for the measurement of attitudes was developed by this researcher. This section included several statements in support of advance directives and the patient's right to self determination as well as a number of statements that opposed patient autonomy and minimized the necessity and importance of advance directives.
The Attitude variable was measured by the following 15 measures:

1. It is a good idea for people to be able to make their wishes about being kept alive on life sustaining machines known in advance by completing advance directives.
2. Advance directives reduce family disagreements over whether or not the terminally ill patient would want life sustaining treatment used.
3. Patients worry less about unwanted treatment after completing an advance directive.
4. The final decision regarding whether or not to use life sustaining treatment should rest with the patient.
5. The final decision regarding whether or not to use life sustaining treatment should rest with the family.
6. The final decision regarding whether or not to use life sustaining treatment should rest with the physician.
7. It is better for people to have their wishes about medical treatment known in advance because otherwise they may get treatment they do not want.
8. A terminally ill patient's desire not to have life sustaining treatment should be honored despite family resistance.
9. Patients frequently change their minds about the use of life sustaining treatment after becoming terminally ill.
10. Advance directives will ultimately lead to acceptance of mercy killing and/or assisted suicide.

11. I feel that I may be held legally responsible for making sure the patients' wishes are carried out if I witness the signing of an advance directives.

12. It is not necessary for people to write down their wishes about medical care because their family will know what to do when the time comes.

13. If life sustaining treatment measures are available, they should be used whenever it is possible to prolong life.

14. Medical personnel can be trusted to honor an individual's wishes if they are made known in an advance directive.

15. It is best to avoid talking about serious illness or death before they occur.

A five-point Likert scale was used in this section, with the following response levels: 1) Strongly Agree, 2) Agree, 3) Undecided, 4) Disagree, and 5) Strongly Disagree. Respondent's choices on this scale reflected either positive or negative attitudes toward the use of advance directives. Positive attitudes were defined as those which support the importance and necessity of advance directives. Specifically, items 1, 2, 3, 4, 7, 8, and 14 on the instrument reflect attitudes that support the use of advance
directives. Respondents with positive attitudes toward advance directives would have circled 1) STRONGLY AGREE or 2) AGREE for those items.

Negative attitudes were defined as those which minimize the importance and necessity of advance directives. Specifically, items 5, 6, 9, 10, 11, 12, 13, 15 were considered to reflect attitudes of non support toward the use of advance directives. Those respondents indicating 1) STRONGLY AGREE or 2) AGREE for statements that minimized the value of having advance directives were considered to reflect negative attitudes. Those responses were reversed and recoded as follows: 1) Strongly Disagree, 2) Disagree, 3) Undecided, 4) Agree, and 5) Strongly Agree.

3) **Behavior** is defined as the manner of conducting oneself; anything that an organism does involving action and response to stimulation; and the response of an individual, group or species to its environment. An individual's personal values and attitude can have far reaching effects on what one actually does in the helping process. Beliefs and attitudes of social workers may have an impact on their feelings and behavior with clients (Hepworth & Larsen, 1986). For that reason, it is critical for social workers to develop an appreciation for the ways in which their
knowledge, their attitude and their behavioral approach to advance directives can have a grave influence on patient's interest or lack of interest in executing advance directives.

Measurement of the Behavior Variable

The respondent's behavior regarding advance directives was measured by their responses to 3 questions in Section III on the survey. The following measures were used for the Behavior variable:

1. How often do you assist patients in completing advance directives?
2. How often are you asked by other professionals to help explain advance directives options to patients?
3. How often do you counsel with patients regarding their feelings about advance directives options?

A six-point Likert scale was used with the following response options: 1-Very Frequently, 2-Frequently, 3-Sometimes, 4-Rarely, 5-Very Rarely, and 6-Never. Items measuring the variable behavior were computed into a scale illustrating the number of cases, the mean, the standard deviation and the range. This Section included questions regarding the frequency with which the social worker assists or counsels patients regarding advance directives.
4) **Personal Experience** is defined as direct observation of, or participation in events as a basis of knowledge. For purposes of this study, experience refers to the social worker's individual and family experience with advance directives.

**Measurement of the Experience Variable**

This variable was also included in Section III of the questionnaire. The following measures were used for the Experience variable:

1. Do you have a living will for yourself?
2. Have you appointed a durable power of attorney for health care to make health care decisions in your behalf should the need arise?
3. Does your spouse have an advance directive?
4. Do your parents have an advance directive?
5. Does your brother(s) or sister(s) have an advance directive?
6. Do your children have advance directives?

The personal experience of the social worker was measured by asking the respondent if they had signed a living will for themselves and if they had appointed a durable power of attorney for health care. This was coded as
YES=1 and NO=2. Additional questions related to the social workers' personal experiences included measures asking the respondent if his/her spouse, parents, siblings or children had advance directives. The response options for these measures were coded: YES=1, NO=2, DON'T KNOW=3, and N/A=4.

Descriptive and inferential statistics were used in the analyses of these data. The sole measure used for the regression analysis on this dependent variable was item #1 on the survey: Do you have a living will? This was the measure that most directly related to the social workers personal experience. Dichotomous response categories, YES and NO were recoded as 1=1 and 2=0 for logistic regression. The results are presented in Chapter IV.

**Operationalization and Measurement of Independent Variables**

The primary intention of this research was to examine the knowledge, attitudes, behaviors and experiences of health care social workers toward advance directives and to examine the factors that may influence those identified dependent variables. The independent variables used in this research were: ethnicity, age, primary work environment, number of years working with the elderly, gender, education, religiosity and number of years worked as a social worker. These independent variables were located in the demographic section on the survey (section IV). The degree of influence
of these personal information variables on the dependent variables was examined in this research.

1) **Ethnicity** - refers to the ethnic/cultural background of the respondent. Whereas, race is a biological concept, based primarily on physical attributes, ethnicity is a cultural concept based on cultural characteristics.

Culture has many different meanings. Basically, it is the sum total of the way of living by a group of people that is transmitted from one generation to another (Babcock & Miller, 1994). Others note that culture is characterized by beliefs, values, moral principles, habits, dress, language, rules of behavior, economics, politics, dietary practices and health care (Germain, 1992). Given the strong influences of race and culture on health, illness and death, it is possible that social workers of different cultural and racial backgrounds might view advance directives and related life/death issues differently.

This variable identified the ethnic identity of the respondent. Originally, the minority groups included were listed as follows: 1) White, 2) African American, 3) American Indian, 4) Asian American, 5) Hispanic, or 6) Other. However, because the focus of this research involved only African Americans and White social workers, the nine
respondents who did not fall into one of those two categories were excluded.

2) **Age** - refers to the respondent's numerical, chronological age. Some individuals may be reluctant to provide information regarding their exact age. Therefore, age categories were used. The six age categories were: 1) 25 and Under, 2) 26-34, 3) 35-44, 4) 45-54, 5) 55-64, and 6) 65 and over.

3) **Primary work environment** - refers to the primary, physical work area, or unit in which the social worker is employed. On the survey and in the original coding, levels of primary work environment included: 1) Hospital, 2) Hospice, 3) Nursing Home, or 4) Other. However, these levels were later collapsed and recoded to 1=1, 2,3,4=0.

4) **Number of years working with elderly persons** - refers to the length of time employed in a health care setting that provides services to people 65 years of age and older. This variable identified the categories that specified a range of years that the respondent has worked with persons 65 and older. There were five categories which included: 1) Not at all, 2) Less than 1 year, 3) 1 - 5 years, 4) 6 - 10 years,
5) More than 10 years.

5) **Gender** - refers to the biological sex/gender of the respondent. Levels of the respondent's gender were the obvious categories: Male=1 and Female=2.

6) **Education** - refers to the level of formal education achieved by the respondent. Levels of the highest educational achievement were categorized: 1) High school, 2) 2 years of college, 3) 4 years of college, 4) Graduate school, 5) Ph.D.

8) **Religiosity** - refers to the degree to which religious principles or practices guide actions. Religiosity was measured by how often respondents attended church services. Levels of this variable examined the frequency of church attendance. Included in the range of responses were: 1) More than once per week, 2) Once a week, 3) Two or three times a month, 4) Once a month, 5) A few times a year of less, and 6) Never.
Reliability and Validity

Validity may be defined as the ability of a tool or instrument to measure what it is intended measure (Kerlinger, 1986). There are several methods for determining validity. One method, content validity, is based on the judgment of experts. Content validity is the degree to which a measure covers the range of meanings included within the concepts being studied by the researcher (Rubin & Babbie, 1993). Content validity was evaluated by a panel of experts and face validity was determined by participants in the pilot study.

The interdisciplinary panel of experts consisted of three professionals who have considerable expertise working with advance directives in health care settings. They included one social work administrator, who is the Director of Social Services at a nursing home facility; one physician, who is the Chief of Surgery at a hospital facility in Ohio and the Chairperson of a Bioethics Committee; and one nurse, who is also a member of a Bioethics Committee and the Coordinator of a hospice program. See cover letter to panel members at Appendix B. Revisions were made to the instrument based on the panel of expert's recommendations.

A pilot study was then conducted using six health care
social workers. Participants in the pilot test were excluded from the sample. Face validity is that quality of an indicator that makes it appear to be a reasonable measure of the variable(s) being studied (Babbie, 1990). Participants were asked to provide feedback regarding the language used, the relevance of questions asked, and the appearance of the survey. They were also asked to note the time needed for completion of the questionnaire. See cover letter to participants in the pilot study at Appendix C.

It was determined that the time required to complete the survey ranged from 8 - 10 minutes. Final revisions were made on the instrument prior to the initial mailing.

One method for determining reliability involves calculating internal consistency of items on a scale. Cronbach's alpha was used to measure internal consistency. This computerized procedure involved the testing of a questionnaire based scale by comparing the variation for any single item with the variation of the entire set of items.

An illustration showing the reliability coefficient (Cronbach's alpha) for the dependent variables: Knowledge, Attitudes and Behavior may be found in Table 1. Because only one measure was used for the logistic regression analysis on the dependent variable, Personal Experience, reliability was not processed for this variable.
Table 1

Reliability Coefficients for the Dependent Variables: Knowledge, Attitudes and Behavior

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th># of Items</th>
<th>N</th>
<th>Cronbach's Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>15</td>
<td>203</td>
<td>.87</td>
</tr>
<tr>
<td>Attitude</td>
<td>15</td>
<td>205</td>
<td>.67</td>
</tr>
<tr>
<td>Behavior</td>
<td>3</td>
<td>209</td>
<td>.95</td>
</tr>
</tbody>
</table>
Data Collection

Mail survey methods were used to collect information from health care social workers throughout the state. The basic method for data collection through the mail is the transmission of a questionnaire accompanied by a letter of explanation and a return envelope (Babbie, 1994).

The initial mailing of the questionnaire took place on 3/23/95. It was accompanied by a cover letter which explained the purpose of the study, requested voluntary participation and assured complete anonymity. A stamped envelope with the researcher's address on it was included to facilitate return of the questionnaire. See cover letter sent to respondents at Appendix D. Ten days following the initial mailing, a follow-up mailing in the form of a post card was sent to all 324 social workers encouraging those who had not completed and returned the questionnaire to do so. See postcard follow-up at Appendix E. The data collection process took six weeks.

Dillman's (1978) total design method for implementing survey research was utilized to facilitate and encourage a good response rate. Of the 324 surveys mailed, 217 respondents (67%) returned the questionnaires. According to Babbie (1990), a response rate of at least 50 percent is generally considered adequate for analysis and reporting. A
response rate of 60 percent is considered good, and a response rate of 70 percent is very good. Six of 217 returned questionnaires were excluded because they were incomplete, or because the respondents indicated that they were retired. The actual number of questionnaires used in the analysis was 211 (65%).

Of the 211 surveys used in the analysis, 174 questionnaires were returned in response to the initial mailing and 37 were returned following the second mailing. Early respondents refer to surveys returned before the second mailing and late respondents refer to surveys returned following the second mailing. According to Miller and Smith (1983), late respondents may serve as surrogates for non-respondents and non-response error can be controlled by comparing early and late respondents. Using a t-test, early respondents were compared to late respondents on Knowledge and Attitudes toward advance directives. The results indicate no significant difference, with the probability (p<.25 and p<.16 respectively) being well above the designated alpha level of .05 (See Table 2).
Table 2

Comparison of Early and Late respondents on the Dependent Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Groups*</th>
<th>n</th>
<th>Mean</th>
<th>Std.Dev.</th>
<th>Range</th>
<th>Prob. (.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>1</td>
<td>166</td>
<td>16.7</td>
<td>3.50</td>
<td>15</td>
<td>.25</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>34</td>
<td>10.9</td>
<td>3.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude</td>
<td>1</td>
<td>167</td>
<td>27.3</td>
<td>5.06</td>
<td>30</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>35</td>
<td>26.0</td>
<td>5.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td>1</td>
<td>170</td>
<td>10.8</td>
<td>4.83</td>
<td>15</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>36</td>
<td>12.1</td>
<td>4.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>1</td>
<td>169</td>
<td>13.1</td>
<td>2.47</td>
<td>14</td>
<td>.28</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>34</td>
<td>12.7</td>
<td>2.19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Groups: 1=Early Respondents  2=Late Respondents
Procedure for Data Analysis

The data were generated using the Statistical Package for the Social Sciences (SPSS/x). Descriptive and inferential statistics were used. Descriptive statistics summarize a set of sample observations, whereas inferential statistics move beyond the description of specific observations to make inferences about the larger population from which the sample observations were drawn (Rubin & Babbie, 1993). In this research the demographic data were analyzed for frequencies and percentages using descriptive statistics. Inferential statistics were used to generalize the findings to the larger population.

Multiple regression analysis (MRA) is a statistical method for studying the relation between a dependent variable and two or more independent variables (Shavelson, 1988). MRA shows the overall correlation between each of a set of independent variables and an interval or ratio level dependent variable (Rubin & Babbie, 1993). Stepwise multiple regression was used in this research for the dependent variables: Knowledge, Attitudes, and Behavior. In this statistical procedure, those variables most significant to the regression equation are identified and included in the equation and non-essential variables are excluded. This procedure is helpful in identifying the combination of
variables that best explains variation in the dependent variables. Due to the dichotomous nature of the dependent variable, Personal Experience, logistic regression analysis with a forward stepwise method was used for the analysis of this variable. The alpha level of .05 was selected.

The results of this research effort and the analyses of all significant findings, including summaries and tables, explaining and illustrating results of the regression analyses are presented in Chapter IV.
CHAPTER IV

PRESENTATION OF FINDINGS

Introduction

The primary purpose of this research was to examine the knowledge, attitudes, behavior and experiences of social workers regarding advance directives and to examine and explain the factors that may influence those variables. To accomplish this, a self administered survey was mailed to 324 social workers employed in health care settings throughout the State of Ohio. Two hundred seventeen surveys (67%) were returned. Six of the 217 surveys returned were discarded because they were incomplete. Two hundred eleven surveys (65%) were used in the analyses.

Chapter IV provides a presentation of the findings obtained from the survey responses of 211 social workers regarding advance directives. In this chapter, the results of the research questions raised in the study are presented in four sections. Section I of Chapter IV provides demographic information describing the personal characteristics of the sample. These characteristics were divided into the following three dimensions: 1) Personal
background characteristics, 2) Educational and employment characteristics and, 3) Religious affiliation and involvement. Section II presents findings that describe and explain the knowledge, the attitudes, the behavior, and experiences of the social workers surveyed, as they relate to advance directives. This section was divided into three subsections, each of which focuses on one of the four dependent variables: Knowledge, Attitudes, Behavior and Experience. Responses to items on each of these scales were analyzed using both descriptive and inferential statistics. Descriptive statistics, a method for presenting quantitative descriptions in a manageable form (Rubin and Babbie (1993), was used to provide descriptive information including frequencies and percentages of correct and incorrect responses for the Knowledge scale. Similarly, the results of the attitude, behavior and experience variables are presented. A scale of each of the dependent variables, including the mean, standard deviations and ranges is also presented and explained in this section of the chapter.

Section III reports the results of multivariate analyses using stepwise multiple regression for the continuous dependent variables: Knowledge, Attitudes, and Behavior, and logistic regression for the dichotomous dependent variable, Experience.
SECTION I
DESCRIPTION OF SAMPLE

Descriptive data on the personal characteristics of the social workers who completed and returned questionnaires was examined. This section includes:

1) Personal background characteristics: Gender, Ethnicity, Age, and Marital status;

2) Education and Employment Characteristics: Educational level, Primary work setting, Years worked with elderly persons, and years employed as a social worker and;

3) Religion variables: Religious affiliation and frequency of attendance at religious services.

Personal Background Characteristics

Table 3 summarizes the demographic personal background characteristics as presented below.

Gender: Of 211 respondents, it was not surprising that the majority, 78% (n=165) were female, and 21% (n=44) were male. Two respondents did not indicate their gender.

Ethnicity: A total of 96% of the social workers sampled were African American and White, with 19% (n=41) being African
American and 76% (n=161) being White.

**Age:** The ages of respondents ranged from 20 to 70 years of age. Fewer than three percent of the social workers surveyed were under 25 or over 65 years of age. The majority of the respondents (n=123 or 58%) ranged in age from 35 - 54 years. Forty-four respondents (21%) fell into the age category 26 - 34 years of age.

**Marital Status:** The majority of the social workers in this study, n=134 (64%), were married (see Table 3).
Table 3

Frequency Distribution of Social Workers' Personal Background Characteristics: Gender, Marital Status, Ethnicity, and Age

<table>
<thead>
<tr>
<th>Personal Background</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>44</td>
<td>20.9</td>
</tr>
<tr>
<td>Female</td>
<td>165</td>
<td>78.2</td>
</tr>
<tr>
<td>No Answer</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>211</td>
<td>100</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>134</td>
<td>63.5</td>
</tr>
<tr>
<td>Divorced</td>
<td>23</td>
<td>10.9</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Widowed</td>
<td>9</td>
<td>4.3</td>
</tr>
<tr>
<td>Never Married</td>
<td>40</td>
<td>19.0</td>
</tr>
<tr>
<td>No Answer</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>211</td>
<td>100</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>161</td>
<td>76.3</td>
</tr>
<tr>
<td>African American</td>
<td>41</td>
<td>19.4</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>3.3</td>
</tr>
<tr>
<td>No Answer</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>211</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 or under</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>26 - 34</td>
<td>44</td>
<td>20.9</td>
</tr>
<tr>
<td>35 - 44</td>
<td>61</td>
<td>28.9</td>
</tr>
<tr>
<td>45 - 54</td>
<td>62</td>
<td>29.4</td>
</tr>
<tr>
<td>55 - 64</td>
<td>30</td>
<td>14.2</td>
</tr>
<tr>
<td>65 or Over</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>No Answer</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>211</td>
<td>100</td>
</tr>
</tbody>
</table>
Education and Employment Characteristics

Educational level: All respondents had educational achievements beyond high school. One respondent had only two years of college and 29 respondents (14%) reported having four years of college. Since most social workers employed in health care settings are required to be masters prepared, the finding that the vast majority, 170 (81%) of the respondents had completed graduate school was expected. Eight respondents reported having earned Ph.D. degrees.

Primary Work Setting: One hundred seventeen (56%) of the respondents reported working directly in a hospital environment, while 92 (44%) worked in other health care settings. Other settings may include hospice units, nursing home care units, or other health care related environments, such as home health organizations. These work environments typically had a very high population of elderly persons.

Years worked with persons sixty-five years and older: The highest frequency for this item was in the 1 - 5 year range, with 58 respondents or (28%) falling into this category. The second highest frequency, 57 (27%) followed closely and reported a long history of more than ten years of working with elderly persons. Forty respondents (19%) reported having no experience at all working with the elderly. Six to
ten years of experience with the aged was reported by 37 respondents (18%), and 16 (8%) reported less than one year of experience working with this age group.

**Years employed in the social work profession:** One hundred thirty-six (65%) of the respondents reported having more than 10 years of experience as a social worker, with only 6 (3%) having worked in the profession less than one year (see Table 4).
Table 4

Frequency Distribution of Social Workers Educational and Employment Characteristics: Educational Level, Primary Work Setting, Years Worked with Elderly, and Years Employed as a Social Worker

<table>
<thead>
<tr>
<th>Employment Characteristics</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Two Years College</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Four Years College</td>
<td>29</td>
<td>13.7</td>
</tr>
<tr>
<td>Graduate School</td>
<td>170</td>
<td>80.6</td>
</tr>
<tr>
<td>Ph.D.</td>
<td>8</td>
<td>3.8</td>
</tr>
<tr>
<td>No Answer</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>211</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

| **Primary Work Setting**   |           |         |
| Hospital                   | 117       | 55.5    |
| Other                      | 92        | 43.6    |
| No Answer                  | 2         | 0.9     |
| **Total**                  | **211**   | **100** |
Table 4 Con't

**Years Worked with Elderly**

<table>
<thead>
<tr>
<th>Years Worked</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not At All</td>
<td>40</td>
<td>19.0</td>
</tr>
<tr>
<td>Less Than 1 Year</td>
<td>16</td>
<td>7.6</td>
</tr>
<tr>
<td>1 - 5 Years</td>
<td>58</td>
<td>27.5</td>
</tr>
<tr>
<td>6 - 10 Years</td>
<td>37</td>
<td>17.5</td>
</tr>
<tr>
<td>More Than 10 Years</td>
<td>57</td>
<td>27.0</td>
</tr>
<tr>
<td>No Answer</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>211</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Years Employed as a Social Worker**

<table>
<thead>
<tr>
<th>Years Worked</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 1 Year</td>
<td>6</td>
<td>2.8</td>
</tr>
<tr>
<td>1 - 5 Years</td>
<td>34</td>
<td>16.1</td>
</tr>
<tr>
<td>6 - 10 Years</td>
<td>32</td>
<td>15.2</td>
</tr>
<tr>
<td>More Than 10 Years</td>
<td>136</td>
<td>64.5</td>
</tr>
<tr>
<td>No Answer</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>211</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Religion Variables

Religion: More than half of the respondents, n=109 (51%), reported affiliation with a Protestant religion, while the lowest frequency, n=11 (5%), reported no religious affiliation.

Religiosity: Eighty four respondents (40%) reported attending church once per week or more (30% once per week, 10% more than once per week). Sixty one (29%) respondents reported attending church services a few times per year. Twenty-five (12%) attended services two to three times per month, while twenty-four (11%) of the respondents indicated that they never attend religious services (see Table 5).
Table 5

Frequency Distribution of Social Workers Religious Affiliation and Attendance at Religious Services

<table>
<thead>
<tr>
<th>Religion Variables</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Religious Affiliation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>109</td>
<td>51.7</td>
</tr>
<tr>
<td>Catholic</td>
<td>46</td>
<td>21.8</td>
</tr>
<tr>
<td>Jewish</td>
<td>16</td>
<td>7.6</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>11.8</td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>5.2</td>
</tr>
<tr>
<td>No Answer</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>211</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Religious Service Attendance</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>More Than Once a Week</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>Once a Week</td>
<td>63</td>
<td>29.9</td>
</tr>
<tr>
<td>2 or 3 Times a Month</td>
<td>25</td>
<td>11.8</td>
</tr>
<tr>
<td>Once a Month</td>
<td>14</td>
<td>6.6</td>
</tr>
<tr>
<td>A Few Times a Year</td>
<td>61</td>
<td>28.9</td>
</tr>
<tr>
<td>Never</td>
<td>24</td>
<td>11.4</td>
</tr>
<tr>
<td>No Answer</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>211</td>
<td>100</td>
</tr>
</tbody>
</table>
SECTION II

DESCRIPTION OF THE KNOWLEDGE, ATTITUDES, BEHAVIOR AND EXPERIENCE OF SOCIAL WORKERS REGARDING ADVANCE DIRECTIVES

Data related to the dependent variables and the independent variables selected for this study were examined and analyzed in this section. The four dependent variables used in the analyses were: knowledge, attitudes, behavior and experience. The independent variables used in the research included: primary work setting, number of years worked with the elderly, gender, ethnicity, age, level of education, religiosity, and years worked in the social work profession.

KNOWLEDGE OF ADVANCE DIRECTIVES

The research question related to the knowledge variable was: How knowledgeable are social workers regarding advance directives?

A number of questions designed to determine the level of knowledge that social workers have regarding advance directives was asked on the first section of the survey questionnaire. The response options for this scale were YES, NO, and DON'T KNOW. Each of the items on the scale was recoded to be computed as either a correct or an incorrect
response. (For more information regarding recoding measurements, refer to Chapter III on Methodology.)

The number of correct and incorrect responses to each item may be found in the frequency distribution of social workers' knowledge regarding advance directives (see Table 6).
Table 6

Frequency Distribution of Social Workers Correct and Incorrect Responses to Measures on the Dependent Variables: Knowledge

<table>
<thead>
<tr>
<th>Knowledge Measures</th>
<th>Correct</th>
<th>%</th>
<th>Incorrect</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are individuals asked if they have advance directives during the admission process at your health care facility?</td>
<td>168</td>
<td>79.6</td>
<td>40</td>
<td>19</td>
<td>208</td>
</tr>
<tr>
<td>2. Do terminally ill, competent persons have the legal right to refuse life sustaining medical treatment?</td>
<td>203</td>
<td>96.2</td>
<td>7</td>
<td>3.3</td>
<td>210</td>
</tr>
<tr>
<td>3. Is the living will form considered part of advance directives?</td>
<td>183</td>
<td>86.7</td>
<td>26</td>
<td>12.3</td>
<td>209</td>
</tr>
<tr>
<td>4. Is the Durable Power of Attorney for Health Care form considered part of advance directives?</td>
<td>180</td>
<td>85.3</td>
<td>29</td>
<td>13.7</td>
<td>209</td>
</tr>
<tr>
<td>5. Is the Power of Attorney form considered part of advance directives?</td>
<td>136</td>
<td>64.5</td>
<td>73</td>
<td>34.6</td>
<td>209</td>
</tr>
<tr>
<td>6. Is there a treatment preference form included in advance directives?</td>
<td>102</td>
<td>48.3</td>
<td>108</td>
<td>51.2</td>
<td>210</td>
</tr>
<tr>
<td>7. Must the living will form be signed by the patient?</td>
<td>185</td>
<td>87.7</td>
<td>26</td>
<td>12.3</td>
<td>211</td>
</tr>
<tr>
<td>8. Must the living will form be signed by the durable power of attorney for health care?</td>
<td>135</td>
<td>64.0</td>
<td>76</td>
<td>36.0</td>
<td>211</td>
</tr>
</tbody>
</table>
Table 6 Con't

9. To complete a living will, is it necessary for the patient to consult the next of kin? 174 82.5 36 17.1 210

10. To complete a living will, is it necessary for the patient to consult the durable power of attorney for health care? 146 69.2 64 30.3 210

11. To complete a living will, is it necessary for the patient to consult a lawyer? 183 86.7 28 13.3 211

12. Is it all right for a patient to appoint a friend to be durable power of attorney for health care? 181 85.8 29 13.7 210

13. Is it all right for a patient to appoint a relative to be durable power of attorney for health care? 195 92.4 16 7.6 211

14. Is it all right for a patient to appoint his/her doctor to be durable power of attorney for health care? 150 71.1 60 28.4 210

15. Is there any legislation that protects health care professionals if a patient refuses life sustaining treatment? 100 47.4 111 52.6 211

Sample size ranges from 208 to 211 on this scale because a few respondents did not answer a few of the questions.
As item #1 on Table 6 indicates, most social workers, 80% are aware that individuals are asked about advance directives on admission. Similarly, item #2 shows that most (96.2%) of the social workers who responded are aware that competent individuals have the legal right to refuse life sustaining treatment. This item received the highest number of correct responses followed by item #13 to which 92.4% of the respondents answered correctly. The high number of correct responses to item #13 was not surprising since social workers in health care settings are often asked to witness the appointing of a family member as durable power of attorney for health care for patients.

Responses to item #6 and item #15 are remarkable since slightly more than half of the respondents scored incorrectly on those measures. Many social workers may not be familiar with the treatment preference forms as such, or may not think of the form as a separate document since it is often included as an addendum to the living will. Responses to item #15 were interesting, particularly in light of the high number of correct responses to item #2 on the scale. A possible explanation for this is that while social workers in health care settings often assist individuals with advance directives and are therefore cognizant of the patients' right to refuse treatment, they are likely to be ill-informed about the law itself, the Patient Self
Determination Act, which is the actual legislation that gives persons the legal right to refuse treatment. It is possible that social workers and other health care personnel associate activity related to advance directives to hospital or health care facility regulations without focus on, or knowledge of, the legislation or policy that made the regulation a requirement.

The total score for the Knowledge scale was obtained by summing the 15 items on the scale. Thus, scores for this scale can range from 0 - 15, with the high score indicating the higher level of knowledge.

The calculation of frequencies and percentages associated with respondents' scores is presented in Table 7.
Table 7

Calculated Summation of Scores on the Knowledge Variable

<table>
<thead>
<tr>
<th>Scores</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>.00</td>
<td>2</td>
<td>.9</td>
</tr>
<tr>
<td>1.00</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>2.00</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>3.00</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>5.00</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>6.00</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>7.00</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>8.00</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>9.00</td>
<td>7</td>
<td>3.3</td>
</tr>
<tr>
<td>10.00</td>
<td>12</td>
<td>5.7</td>
</tr>
<tr>
<td>11.00</td>
<td>17</td>
<td>8.1</td>
</tr>
<tr>
<td>12.00</td>
<td>26</td>
<td>12.3</td>
</tr>
<tr>
<td>13.00</td>
<td>43</td>
<td>20.4</td>
</tr>
<tr>
<td>14.00</td>
<td>45</td>
<td>21.3</td>
</tr>
<tr>
<td>15.00</td>
<td>23</td>
<td>10.9</td>
</tr>
<tr>
<td>Missing</td>
<td>8</td>
<td>3.8</td>
</tr>
<tr>
<td>Total</td>
<td>211.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The overall mean for the knowledge scale was 11.55 and the standard deviation was 3.53. Respondents with scores above the mean, ranging from 12-15 were considered to have a high level of knowledge regarding advance directives. One hundred thirty seven, (65%) of the social workers who responded, scored in the high level of knowledge category on this variable. Of that number, a total of 23 social workers received a perfect score.

Respondents with scores ranging from 9-11 were determined to have a moderate level of knowledge about advance directives. Thirty six social workers (17%) scored in this category. Respondents who scored 8 and below were determined to have a low level of knowledge. This represents 14% (n=30) of the respondents who were found to have a low level of knowledge regarding advance directives.

Table 8 presents an illustration in response to the research question: How knowledgeable are social workers regarding advance directives?
Table 8
Illustration of Social Workers Level of Knowledge

<table>
<thead>
<tr>
<th>Level of Knowledge</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>High level of Knowledge</td>
<td>137</td>
<td>64.9</td>
</tr>
<tr>
<td>Moderate level of Knowledge</td>
<td>36</td>
<td>17.1</td>
</tr>
<tr>
<td>Low level of Knowledge</td>
<td>30</td>
<td>14.2</td>
</tr>
<tr>
<td>Missing data</td>
<td>8</td>
<td>3.8</td>
</tr>
<tr>
<td>Total</td>
<td>211</td>
<td>100</td>
</tr>
</tbody>
</table>
Social Workers Attitudes toward Advance Directives

The research question related to attitude asks: What are the attitudes of health care social workers toward advance directives?

Effective December, 1991, federal law requires that issues related to advance directives be addressed with all persons entering health care facilities that receive medicare and/or medicaid government funding. On the attitude section of the survey, social workers were asked to address statements designed to determine whether their attitude was in a positive or negative direction regarding advance directives use.

Statements that support the necessity and importance of advance directives use were included as well as statements that minimized the necessity of their use. Each of the 15 measures on the questionnaire was responded to using a five-point Likert scale ranging from 1) Strongly Agree to 5) Strongly Disagree. Items 1, 2, 3, 4, 7, 8, and 14 on the scale reflect attitudes in support of advance directives. Items 5, 6, 9, 10, 11, 12, 13, and 15 minimize the importance and necessity of completing advance directives. Respondents who indicated Strongly Agree or Agree to those items were considered to have attitudes that reflect that they are not strong proponents of advance directives use. Those responses were reversed and recoded
with levels ranging from 1) Strongly Disagree to 5) Strongly Agree. A total score for the attitude scale was obtained by summing the responses to individual items. Scores could range from 15 - 75 on the scale. Respondents' actual, individual, summed scores for this variable ranged from 15 - 45, with the overall Mean score of 27.01, a Standard Deviation of 5.18 and a mode of 25. Because Strongly agree was coded as 1, scores closer to 15 represented positive attitudes toward advance directives.

Table 9 presents a scale of items measuring the dependent variable, Attitude. Included are the means, standard deviations and ranges for each item.
Table 9
Means, Standard Deviations, and Range of Social Workers Attitudes Regarding Advance Directives

<table>
<thead>
<tr>
<th>Attitude Scale</th>
<th>Mean</th>
<th>Std.Dev.</th>
<th>Range</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is a good idea for people to be able to make their wishes about being kept alive on life sustaining machines known in advance by completing advance directives.</td>
<td>1.18</td>
<td>.43</td>
<td>1-3</td>
<td>210</td>
</tr>
<tr>
<td>2. Advance directives reduce family disagreements over whether or not the terminally ill patient would want life sustaining treatment used.</td>
<td>1.54</td>
<td>.78</td>
<td>1-5</td>
<td>210</td>
</tr>
<tr>
<td>3. Patients worry less about unwanted treatment after completing an advance directive.</td>
<td>1.68</td>
<td>.69</td>
<td>1-4</td>
<td>209</td>
</tr>
<tr>
<td>4. The final decision regarding whether or not to use life sustaining treatment should rest with the patient.</td>
<td>1.38</td>
<td>.68</td>
<td>1-4</td>
<td>211</td>
</tr>
<tr>
<td>5. The final decision regarding whether or not to use life sustaining treatment should rest with the family.</td>
<td>2.07</td>
<td>.89</td>
<td>1-5</td>
<td>209</td>
</tr>
<tr>
<td>6. The final decision regarding whether or not to use life sustaining treatment should rest with the physician.</td>
<td>1.86</td>
<td>.88</td>
<td>1-5</td>
<td>209</td>
</tr>
<tr>
<td>7. It is better for people to have their wishes about medical treatment known in advance because otherwise they may get treatment they do not want.</td>
<td>1.44</td>
<td>.55</td>
<td>1-3</td>
<td>211</td>
</tr>
</tbody>
</table>
### Table 9 Con't

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. A terminally ill patient's desire not to have life sustaining treatment should be honored despite family resistance.</td>
<td>1.44</td>
<td>.57</td>
<td>1-3</td>
<td>210</td>
</tr>
<tr>
<td>9. Patients frequently change their minds about the use of life sustaining treatment after becoming terminally ill.</td>
<td>2.76</td>
<td>.98</td>
<td>1-5</td>
<td>210</td>
</tr>
<tr>
<td>10. Advance directives will ultimately lead to acceptance of mercy killing and/or assisted suicide.</td>
<td>2.07</td>
<td>.98</td>
<td>1-5</td>
<td>210</td>
</tr>
<tr>
<td>11. I feel that I may be held legally responsible for making sure the patients' wishes are carried out if I witness the signing of an adv. dir.</td>
<td>2.12</td>
<td>.98</td>
<td>1-5</td>
<td>210</td>
</tr>
<tr>
<td>12. It is not necessary for people to write down their wishes about medical care because their family will know what to do when the time comes.</td>
<td>1.37</td>
<td>.55</td>
<td>1-4</td>
<td>211</td>
</tr>
<tr>
<td>13. If life sustaining treatment measures are available, they should be used whenever it is possible to prolong life.</td>
<td>1.85</td>
<td>.93</td>
<td>1-5</td>
<td>211</td>
</tr>
<tr>
<td>14. Medical personnel can be trusted to honor an individual's wishes if they are made known in an advance directive.</td>
<td>2.86</td>
<td>1.12</td>
<td>1-5</td>
<td>211</td>
</tr>
<tr>
<td>15. It is best to avoid talking about serious illness or death before they occur.</td>
<td>1.37</td>
<td>.86</td>
<td>1-5</td>
<td>210</td>
</tr>
</tbody>
</table>

Overall Mean=1.95, Std.Dev.=.30

Attitude was measured using a five point Likert scale ranging from 1) Strongly Agree to 5) Strongly Disagree.

The sample size varies from 209 to 211 because, while the response rate was high on this variable, a few social workers did not respond to all of the questions.
Two hundred six (98%) of the 210 social workers who responded to item #1 on the attitude scale Strongly Agreed or Agreed that it was a good idea for people to be able to make their wishes about being kept alive on life sustaining machines known in advance by completing advance directives. The range of 1 - 3 on this item indicates that none of the respondents Disagreed or Strongly Disagreed on this item.

Social workers generally have positive attitudes toward advance directives and tend to be proponents of the patients' right to self determination. The scale reflected no responses of Strongly Disagree to items that minimized the importance and necessity of advance directives use.

Behavior of Social Workers Regarding Advance Directives

Behavior was measured by three items which determine the degree to which social workers counsel with patients regarding advance directives and assist them in completing advance directives. Table 10 presents an illustration of the means and standard deviations of social workers behavior regarding advance directives. The range of response levels on the scale went from 1) Very Frequently, 2) Frequently, 3) Sometimes, 4) Rarely, 5) Very Rarely, 6) Never.
<table>
<thead>
<tr>
<th>Behavior</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Range</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you assist patients in completing advance directives?</td>
<td>3.78</td>
<td>1.67</td>
<td>1-6</td>
<td>209</td>
</tr>
<tr>
<td>2. How often are you asked by other professionals to help explain advance directives options to patients?</td>
<td>3.71</td>
<td>1.73</td>
<td>1-6</td>
<td>209</td>
</tr>
<tr>
<td>3. How often do you counsel with patients regarding their feelings about advance directives options?</td>
<td>3.57</td>
<td>1.66</td>
<td>1-6</td>
<td>209</td>
</tr>
</tbody>
</table>

Overall Mean=3.67, Std. Dev.=1.61
As the range on Table 10 indicates, the responses varied widely, including all levels for each of the statements. Approximately 32% of the social workers (n=66) who responded to these statements indicated that they assist and counsel with patients very frequently or frequently. By contrast, fifty six respondents (26%) indicated that they never counsel with or assist patients with advance directives. Indications that about one fourth of the social workers surveyed have never addressed patients regarding issues related to advance directives may appear to be a surprising and unexpected finding. However, it is very important to note that while the law requires that patients be asked on admission if they have an advance directive, in many health care facilities, they are not referred to a social worker unless they express an interest in completing an advance directive or request more information on the subject. The law requires that patients be provided with information about advance directives, however, this is usually provided in the form of written material on the topic. Referral for counseling or assistance regarding advance directive matters is not a routine procedure. This often only happens when and if patients request it, and for various reasons, many do not. One may speculate that the reasons why more patients do not make the request for more information, counseling or assistance about advance
directives when entering health care facilities includes:

1) Patients are asked about advance directives at the point of admission to a health care facility. Often they are experiencing suffering or a medical crisis, hence the need for admission. This can be a stressful time for many reasons. The admissions process itself is laborious at most facilities. The process usually includes considerable paperwork, considerable waiting and frustration for patients who may be in the midst of acute pain or illness. Patients may not be open to informative dialogue about living wills and durable powers of attorney for health care forms at the point at which they are being admitted to a health care facility.

2) At most health care facilities, patients are asked about advance directives by a clerk, who may or may not provide any encouragement to the patient regarding seeking more information and may or may not be well informed or trained about advance directives.
Social Workers Experience with Advance Directives

Several measures on the survey question social workers regarding the utility of advance directives in their personal lives. There were two levels of response for the first two questions: 1) Yes and 2) No. These two measures related to the social workers individual experience with advance directives. The first of these two measures (Do you have a living will?) was the measure that most directly related to the social workers own personal experience with advance directives, and was the only measure used to comprise the dependent variable, personal experience, used in the logistic regression analysis.

The remainder of the questions relating to the social workers personal life involved the respondents' family experiences with advance directives. Response levels for these questions were: 1) Yes, 2) No, 3) Don't Know and 4) Not Applicable.

A report of the percentages and ranges for all questions pertaining to individual and family experience with advance directives in the social workers' personal lives may be found in Table 11-A and Table 11-B. See Table 12 for a report of the mean, standard deviation and range for the Personal Experience variable (item #1 on Table 11-A) used in the logistic regression analysis.
<table>
<thead>
<tr>
<th>Individual Experience</th>
<th>YES</th>
<th>NO</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have a living will for yourself?</td>
<td>.37</td>
<td>.66</td>
<td>1-2</td>
</tr>
<tr>
<td>2. Have you appointed a durable power of attorney for health care to make health care decisions in your behalf should the need arise?</td>
<td>.35</td>
<td>.65</td>
<td>1-2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Experience</th>
<th>Yes</th>
<th>NO</th>
<th>DK</th>
<th>N/A</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Does your spouse have advance directive?</td>
<td>.22</td>
<td>.45</td>
<td>.06</td>
<td>.27</td>
<td>1-4</td>
</tr>
<tr>
<td>4. Do your Parents have an advance directive?</td>
<td>.32</td>
<td>.36</td>
<td>.20</td>
<td>.11</td>
<td>1-4</td>
</tr>
<tr>
<td>5. Does your Brother(s) or sister(s) have an advance directive?</td>
<td>.08</td>
<td>.41</td>
<td>.44</td>
<td>.07</td>
<td>1-4</td>
</tr>
<tr>
<td>6. Do your children have an advance directive?</td>
<td>.02</td>
<td>.49</td>
<td>.14</td>
<td>.33</td>
<td>1-4</td>
</tr>
</tbody>
</table>
While social workers' responses on the attitude scale indicate support for the use of advance directives, the results of their responses on the Experience scale show that 66% of the respondents reported not having a living will, and 65% reported not having a durable power of attorney for health care for themselves. Similarly, the majority of the family members of social workers do not have advance directives. Only sixty-eight respondents (32.2%) indicated that their parents have advance directives; only sixteen (7.6%) indicated that their siblings have advance directives; and only five (2.4%) indicated that their children have advance directives. These findings indicate that while the majority of social workers' family members do not have advance directives, parents of social workers were more likely to have them than any other family members. This may suggest that older persons are more likely to have advance directives than younger persons.

Section II of Chapter IV is concluded with a summary list of all the dependent variables indicating their overall mean, standard deviations and ranges. The Statistical Package for the Social Sciences was used to analyze the scale.
Table 12

Overall Means, Standard Deviations and Ranges for All Dependent Variables

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Range</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>11.55</td>
<td>3.53</td>
<td>0-15</td>
<td>203</td>
</tr>
<tr>
<td>Attitude</td>
<td>27.01</td>
<td>5.18</td>
<td>15-45</td>
<td>205</td>
</tr>
<tr>
<td>Behavior</td>
<td>11.06</td>
<td>4.82</td>
<td>3-18</td>
<td>209</td>
</tr>
<tr>
<td>Experience</td>
<td>1.63</td>
<td>.48</td>
<td>1-2</td>
<td>210</td>
</tr>
</tbody>
</table>
SECTION III
MULTIVARIATE ANALYSES

Section I and section II presented the characteristics of the sample and described the Knowledge, Attitudes, Behaviors, and Experiences of social workers employed in health care environments throughout the State of Ohio. Section III presents findings that examine and analyze the factors that may influence the dependent variables described in Chapter II. Eight independent variables were used in the study. They are: Primary work environment, Number of years worked with the elderly, Gender, Ethnicity, Age, Education, Religiosity, and Number of years worked as a social worker. Thus, the research questions which were analyzed and explained in this Chapter are as follows:

Research Questions

1. How KNOWLEDGEABLE are health care social workers regarding advance directive statutes in the State of Ohio?

2. What are the ATTITUDES of health care social workers regarding advance directives?
3. What BEHAVIORS do health care social workers exhibit in practice regarding advance directives?

4. What PERSONAL EXPERIENCES do social workers have with advance directives?

5. Does ETHNICITY make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

6. Does AGE make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

7. Does LENGTH OF TIME WORKING WITH THE ELDERLY make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

8. Does the PRIMARY WORK ENVIRONMENT make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

9. Does GENDER make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

10. Does EDUCATION make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

11. Does the RELIGIOSITY make a difference in the Knowledge, Attitudes and Behaviors of health care social workers toward advance directives?

12. Does NUMBER OF YEARS WORKED AS A SOCIAL WORKER make a difference in the Knowledge, Attitude and Behavior of health care social workers toward advance directives?
Multiple regression analysis is a statistical technique used to examine the relation between a dependent variable and two or more independent variables. It allows the researcher to determine the functional relationship between the dependent variable and each of the independent variables (Shavelson, 1988). It also affords the investigator the opportunity to analyze situations in which there are multiple independent variable effects.

The data in this research were analyzed using stepwise multiple regression analyses and logistic regression. Stepwise multiple regression identifies those variables essential to the regression equation by removing those variables which have no significance to the model. This statistical method of analyses was used for those dependent variables that are continuous: Knowledge, Attitudes and Behavior. Logistic regression, is a type of multiple regression used to analyze dichotomous response variables and continuous independent variables (Morrow-Howell & Proctor, 1992). This statistical method was used to analyze the dependent variable: Personal Experience.

Table 13 displays a list of all the independent and dependent variables used in the regression analyses.
Table 13

List of Independent and Dependent Variables used in Regression Analyses

<table>
<thead>
<tr>
<th>INDEPENDENT VARIABLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY WORK ENVIRONMENT</td>
</tr>
<tr>
<td>NUMBER OF YEARS WORKED WITH THE ELDERLY</td>
</tr>
<tr>
<td>GENDER</td>
</tr>
<tr>
<td>ETHNICITY</td>
</tr>
<tr>
<td>AGE</td>
</tr>
<tr>
<td>EDUCATION</td>
</tr>
<tr>
<td>RELIGIOSITY</td>
</tr>
<tr>
<td>NUMBER OF YEARS WORKED AS SOCIAL WORKER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEPENDENT VARIABLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>KNOWLEDGE</td>
</tr>
<tr>
<td>ATTITUDE</td>
</tr>
<tr>
<td>BEHAVIOR</td>
</tr>
<tr>
<td>PERSONAL EXPERIENCE</td>
</tr>
</tbody>
</table>
The equations were computed in a stepwise manner, and all $R^2$ values are based on equations using significant standardized regression weights ($p<.05$). Summaries for the regression analyses are presented in Table 14 for the dependent variable, Knowledge; Table 15 for the dependent variable, Attitude; Table 16 for the dependent variable, Behavior; and Table 17 for the dependent variable, Personal Experience.

Multiple Regression on Dependent Variable: Knowledge

The dependent variable, Knowledge was regressed on the independent variables identified in Table 13 and were loaded into the equation. Table 14 presents the results of this analysis. Of the eight variables loaded, three were significant ($p<.05$). The three significant variables that entered the equation were: 1. Number of years worked with elderly persons (age 65 and over), 2. Attendance at religious services, and 3. Ethnicity. These three independent variables had significant standardized regression weights and the equation accounted for 21.2% of the variance.

Number of years worked with the elderly entered the equation at step number one. Of the variables entering the equation, this variable had the largest beta weight (beta = .3584) and therefore was the strongest predictor of
knowledge. The direction of the relationship was positive. This means that as the number of years worked with elderly persons increases, the level of knowledge regarding advance directives also increases.

Entering the equation at the second step was Attendance at religious services. The beta weight for this variable went in a negative direction (beta=-.2077). The response options measuring religiosity (attendance at religious services) ranged from: 1. More than once a week to 6. Never, hence lower numbers translated to more frequent attendance. Given the coding range from more to less, this may be interpreted to mean that as the frequency of church attendance increases, the level of knowledge also increases.

The independent variable Ethnicity entered the equation at the third step. The beta weight for this variable was in a negative direction (beta=-.1941) which indicates that African Americans are less knowledgeable about policy requirements related to advance directives than are Whites.
Table 14

Standardized Regression Coefficients and Probability Values for Knowledge

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Beta</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary work environment</td>
<td>-.09</td>
<td>.19</td>
</tr>
<tr>
<td>Years worked with elderly</td>
<td>.36***</td>
<td>.00005</td>
</tr>
<tr>
<td>Gender</td>
<td>.09</td>
<td>.20</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>-.19**</td>
<td>.004</td>
</tr>
<tr>
<td>Age</td>
<td>.04</td>
<td>.60</td>
</tr>
<tr>
<td>Education</td>
<td>.02</td>
<td>.73</td>
</tr>
<tr>
<td>Religiosity</td>
<td>-.21**</td>
<td>.002</td>
</tr>
<tr>
<td>Years worked as social worker</td>
<td>-.07</td>
<td>.37</td>
</tr>
</tbody>
</table>

R^2: .21

N: 185

***p<.001
**p<.01
*p<.05
Regression on Dependent Variable: Attitude

The variable Primary Work Setting was the only one of eight independent variables that yielded a significant standardized regression coefficient (beta=.16) for the dependent variable Attitude. This suggests that Primary Work Setting was the only variable loaded into the regression that predicted Attitude. Measures for this variable were: 1) Hospital, 2) Nursing home, Hospice, Other. This was recoded as 1=1 and 2=0. Measures for the dependent variable, Attitude went from positive to negative with the levels ranging from 1) Strongly agree to 5) Strongly disagree.

The beta for this variable was in a positive direction, which may be interpreted to mean that as the number of respondents employed in nursing home and hospice work settings increased, the attitude toward advance directives became more positive. This one variable accounted for 2% of the variance. It is noteworthy that even though the probability was statistically significant (p<.03), the amount of variance explained by this variable is small (R²=.02). This suggest that other variables not included in the equation are needed to explain the variable Attitude. Table 15 shows the regression coefficients and probability for all independent variables loaded into the equation.
Table 15  
Standardized Regression Coefficients and Probability Values for Attitude

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Beta</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary work environment</td>
<td>.16*</td>
<td>.03</td>
</tr>
<tr>
<td>Years worked with elderly</td>
<td>-.11</td>
<td>.12</td>
</tr>
<tr>
<td>Gender</td>
<td>-.03</td>
<td>.64</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.10</td>
<td>.17</td>
</tr>
<tr>
<td>Age</td>
<td>-.13</td>
<td>.08</td>
</tr>
<tr>
<td>Education</td>
<td>.05</td>
<td>.52</td>
</tr>
<tr>
<td>Religiosity</td>
<td>-.04</td>
<td>.60</td>
</tr>
<tr>
<td>Years worked as social worker</td>
<td>-.06</td>
<td>.44</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>187</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001  
**p<.01  
*p<.05
Multiple Regression Dependent Variable: Behavior

All independent variables were loaded into the stepwise multiple regression equation for the dependent variable Behavior. The Behavior variable was measured by how frequently social workers counseled and provided assistance to patients regarding advance directives. The levels of response for this variable ranged from 1. Very frequently to 6. Never.

Three independent variables had a significant standardized regression coefficient and entered the equation for this variable. The independent variable entering on the first step was Number of years worked with the elderly. This variable had the largest beta weight in the model (beta=-.4240). Because this is going in a negative direction and because the response levels moved from positive to negative, this means that as the number of years worked with elderly persons increases, the behavior of social workers, as measured by the provision of counseling and assistance with advance directives, also increases.

Entering the equation at the second step was Gender (beta=-.1984). This finding suggests that female social workers are more likely to assist and counsel patients on issues related to advance directives than are male social workers.

Religiosity, measured by attendance at church services
entered the equation at the third step (beta=.1524). This beta went in a positive direction and may be interpreted to mean that as church attendance decreases, the frequency with which social workers provide assistance and counsel to patients decreases. This means that the less social workers attend church services, the less likely they are to counsel and assist patients with advance directives.

This model yielded an $R^2=.23$ which indicates that the equation accounted for 23% of the variance for this dependent variable.
Table 16

Standardized Regression Coefficients and Probability Values for Behavior

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Beta</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary work environment</td>
<td>.09</td>
<td>.20</td>
</tr>
<tr>
<td>Years worked with elderly</td>
<td>-.43***</td>
<td>.00005</td>
</tr>
<tr>
<td>Gender</td>
<td>-.20**</td>
<td>.003</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.06</td>
<td>.33</td>
</tr>
<tr>
<td>Age</td>
<td>.08</td>
<td>.23</td>
</tr>
<tr>
<td>Education</td>
<td>.05</td>
<td>.42</td>
</tr>
<tr>
<td>Religiosity</td>
<td>.15*</td>
<td>.02</td>
</tr>
<tr>
<td>Years worked as social worker</td>
<td>.09</td>
<td>.22</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>187</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001
**p<.01
*p<.05
Logistic Regression on Personal Experience

Social work researchers often investigate phenomena that are dichotomous as opposed to phenomena measured on a continuous scale. Logistic regression is a sound and appropriate technique for investigating dichotomous variables being researched by social workers (Morrow-Howell & Proctor, 1992).

In this research, logistic regression was selected as the mode of analysis for the dependent variable, Personal Experience, due to the dichotomous nature of that variable. All of the eight independent variables that were used in the stepwise multiple regression analyses for the other dependent variables were also loaded into the logistic regression model. In the analysis, the only coefficient found to be significant (p<.0016) was the independent variable, Age (see Table 17). Other independent variables including: primary work setting, number of years worked with the elderly, gender, ethnicity, education, religiosity, and number of years worked as a social worker were not found to be statistically significant and therefore did not enter the logistic regression model.
Table 17

Logistic Regression Model for Dependent Variable: Personal Experience

<table>
<thead>
<tr>
<th></th>
<th>Chi-Square</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>-2 Log Likelihood</td>
<td>250.181</td>
<td>195</td>
<td>.0047</td>
</tr>
<tr>
<td>Model Chi-Square</td>
<td>10.602</td>
<td>1</td>
<td>.0011</td>
</tr>
<tr>
<td>Improvement</td>
<td>10.602</td>
<td>1</td>
<td>.0011</td>
</tr>
<tr>
<td>Goodness of Fit</td>
<td>196.187</td>
<td>195</td>
<td>.4627</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig</th>
<th>R</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.44</td>
<td>.14</td>
<td>9.93</td>
<td>1</td>
<td>.0016</td>
<td>.17</td>
<td>1.55</td>
</tr>
<tr>
<td>Constant</td>
<td>-2.04</td>
<td>.52</td>
<td>15.56</td>
<td>1</td>
<td>.0001</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The coefficient for the independent variable, Age, .44, indicates the amount of change in the log odds of having a living will.
ADDITIONAL ANALYSES

Additional analyses on the two ethnic groups, Whites and African Americans, used in the regression analyses, were performed. Results of the Knowledge regression show that White social workers are better informed about advance directives than are African American social workers. On this regression procedure Ethnicity did not enter the equation until the third step. Nevertheless, a t-test was performed to examine the differences in the means of the two groups on Knowledge as well the other dependent variables. In order to provide a broad and more inclusive perspective, for this analysis, items measuring all aspects of social workers' experience, including individual and family experience, with advance directives were used to comprise the social workers Personal Experience.

A t-test for independent samples is a parametric test of significance used to determine whether two means are significantly different at a selected probability level. To examine significant mean differences in the Knowledge, Attitude, Behavior and Experiences between the two groups a t-test was performed (see Table 18).

Table 18 shows the results of the t-test which indicate no significant difference on the Attitude and Behavior variables (p<.26 and p<.63 respectively). For those two
variables, we fail to reject the null hypothesis and agree that there is no significant difference (p<.05) in the means of the two groups. The analysis shows that there was a significant difference in the means of the two groups on the Knowledge and the Experience variables (p<.048 and p<.006 respectively), therefore the null hypothesis was rejected. The mean for the Experience variable was 12.85 for Whites and 14.02 for African Americans. Because response levels for this variable were coded with low numbers indicating more experience (e.g. Yes=1) the lower mean value represents more experience.

The p value suggests that the difference in the knowledge mean between the two groups, while significant, could be interpreted to be minimal. Additionally, this analysis shows that Whites have more overall experience in their individual and family lives with advance directives than do African Americans. White social workers were more likely to have advance directives and Whites were more likely to have family members who had advance directives. One could speculate that increased experience with advance directives contributes to increased knowledge of the subject. More research needs to be done in this area.
Table 18
Comparison of African American and White Social Workers on the Dependent Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Groups*</th>
<th>n</th>
<th>Mean</th>
<th>Std.Dev.</th>
<th>Prob. (0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KNOWLEDGE</td>
<td>1</td>
<td>157</td>
<td>11.85</td>
<td>3.16</td>
<td>0.048</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>38</td>
<td>10.32</td>
<td>4.42</td>
<td></td>
</tr>
<tr>
<td>ATTITUDE</td>
<td>1</td>
<td>157</td>
<td>26.68</td>
<td>5.20</td>
<td>0.259</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>39</td>
<td>27.74</td>
<td>5.38</td>
<td></td>
</tr>
<tr>
<td>BEHAVIOR</td>
<td>1</td>
<td>159</td>
<td>10.98</td>
<td>4.77</td>
<td>0.630</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>41</td>
<td>11.39</td>
<td>5.15</td>
<td></td>
</tr>
<tr>
<td>EXPERIENCE</td>
<td>1</td>
<td>156</td>
<td>12.85</td>
<td>2.38</td>
<td>0.006</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>41</td>
<td>14.02</td>
<td>2.50</td>
<td></td>
</tr>
</tbody>
</table>

*Group 1=Whites
Group 2=African Americans
SUMMARY

Stepwise multiple regression analyses and logistic regression were performed for the purpose of answering research questions pertaining to advance directives. The results of the analyses allow the questions posed and researched to be answered and explained by interpreting the findings of statistical procedures.

Some of the eight variables loaded into the regression did not enter into any of the equation models. Variables with standardized regression coefficients greater than the selected probability level ($p<.05$), which did not enter any of the regression equations were: Education and Years employed as a social worker. The results of regression analyses on the dependent variables suggest that these two variables did not make a significant difference in the Knowledge, Attitude, Behavior and/or Experience of health care social workers toward advance directives.

Overall, the variable that made the greatest contribution was Number of years worked with the elderly. This variable entered two of the four equations and entered each of them at step number one. This indicates that the number of years worked with the elderly makes a difference in the Knowledge and Behavior of health care social workers regarding advance directives.
Ethnicity entered two of the four equations. It entered both the Knowledge and the Experience models at the last step. Although the contribution was small, this indicates that ethnicity may make a difference when examining these two variables.

Religiosity also entered two of the four equations. It entered the Knowledge model at the second step and the Behavior model at the third step. This was an unexpected finding which was informational in highlighting the importance of religiosity on matters related to advance directives. The findings of these analyses inform researchers that religiosity does make a difference in the Knowledge, and Behavior of health care social workers toward advance directives.

Gender entered only one regression equation. It entered the Behavior model at the second step. This finding informed us that gender does make a difference in the behavior of health care social workers regarding advance directives and their interaction with patients on these issues. These results suggest that females social workers are more likely than male social workers to work with families around issues related to end-of-life planning and decision making.

Primary Work Setting was the only independent variable to enter the Attitude equation. While the contribution of
Primary Work Setting to positive attitudes was significant, it was small.

These results serve to inform and provide us with useful information regarding the Knowledge, Attitudes, Behavior, and Experiences of health care social workers toward advance directives. The findings also lead to the speculation that other variables, not yet researched, might influence the dependent variables used in this research.
CHAPTER V

Conclusions and Implications

This exploratory research responded to a number of questions regarding health care social workers' Knowledge, Attitudes, Behavior and Experiences regarding advance directives. The study also examined the contributions of several selected independent variables on the identified dependent variables.

The main purpose of Chapter V is to summarize, interpret and discuss the findings of this research effort. Chapter V is divided into six sections. Section I presents a summary and discussion of the major research findings generated by the descriptive and inferential statistics used in this study. Section II provides a statement of the assumptions and limitations of the research. Section III relates and discusses the findings of the research to the relevance of the conceptual framework. Section IV highlights the implications for social work policy and practice. Section V provides recommendations for future research. And Section VI provides a statement of conclusion.
SUMMARY OF RESEARCH FINDINGS

Summary of Descriptive Statistical Findings

Research results generated by the descriptive statistics provided a profile of the respondents personal characteristics:

- With regard to GENDER - The majority (78%) of the respondents (n=165) were female; 21% (n=44) were male.
- With regard to ETHNICITY - The majority (76%) of the respondents (n=161) were White; 19% (n=41) were African American.
- With regard to AGE - The majority (58%) of the respondents (n=123) ranged in age from 35 - 54 years; 44 respondents, 21%, fell into the age category 26-34 years.
- With regard to MARITAL STATUS - The majority (64%) of the respondents (n=134) were married.
- With regard to EDUCATION LEVEL - The vast majority of the respondents (84%) reported having advanced degrees (80.6% had Masters degrees and 3.8% had Ph.D. degrees).

To summarize, the majority of respondents were White, married and female and ranged in age from 35-54 years. This sample consisted of highly educated health care social workers, 64% of whom reported having 10 or more years of experience in the social work profession.
KNOWLEDGE

One hundred thirty seven respondents (65%) received a knowledge score ranging from 12 - 15. With 15 being the highest possible score, this range of scores constituted a high level of knowledge about advance directives. Thirty six (17%) of the respondents scored between 9 - 11 on the knowledge scale. This constituted a moderate level of knowledge. Thirty social workers (14%) had a knowledge score of 8 or less. This constituted a low level of knowledge regarding advance directives. The group mean on the knowledge scale was 11.55.

ATTITUDE

Findings on the attitude scale indicated that social workers generally have positive attitudes toward advance directives. Items on the scale that minimized the use of advance directives were generally not supported by respondents in the sample. With a range on the attitude scale of 15 - 45, the mean score of the group was 27.01.

BEHAVIOR

This variable was measured by determining the extent to which social workers counsel with patients about advance directives. Only 32% (n=66) of the social workers indicated
that they counsel or assist patients with advance directives on a regular basis (very frequently or frequently). Fifty six (26%) indicated that they never counsel patients on issues related to advance directives. It should be noted that 117 of the respondents reported working directly in hospital settings and 92 reported working in other health care facilities specializing in care of the elderly or terminally ill. Many who work in hospital or acute care settings, depending on the area in the hospital in which they work, may not be involved in discussions with patients regarding advance directives. Those who work in settings that provide specialized treatment to elderly persons are likely to be more involved in routine discussions regarding advance directives.

EXPERIENCE

Less than half (37%) of the social workers in the study reported having a living will and less than half (35%) reported having a durable power of attorney for health care. Similarly, the majority of family members of social workers did not have advance directives. Among family members, fifty eight parents of social workers (32%) reported having signed an advance directives document.

The finding that so few social workers have an advance directive was an interesting finding, because the scale
measuring attitudes indicated that social workers generally have high regard for the importance and necessity of advance directives. It is possible that while social workers recognize the value of having advance directives, they may view the actual execution of these documents as being more important to elderly persons who are more likely to be faced with the decision to use or forego life sustaining medical treatment.

**Summary of Inferential Statistical Findings**

The dependent variables were regressed on each of the independent variables. The following results emerged from the stepwise multiple regression analyses. Three independent variables entered the equation on Knowledge: 1) Number of years worked with the elderly (beta=.358); 2) Religiosity (beta=-.205); and 3) Ethnicity (beta=-.194). These three variables accounted for 21% of the variance ($R^2=.21$).

Findings indicate that the independent variable with the most influence was number of years worked with the elderly. This was not a surprising finding. This suggests that social workers who provide services specifically to persons 65 years of age or older were likely to be more knowledgeable about advance directives than those who did not work directly with the elderly. This variable entered
the equation at the first step in two of the four regression models.

The third of three variables to enter the Knowledge equation was ethnicity. This variable also entered the experience model at the last step. An interpretation that Whites have more knowledge than African Americans may be, in part, explained by additional analysis (t-test) which indicated that White social workers also have more experience with advance directives in their individual and family lives than do African Americans. One may speculate that as experience with advance directives increases, knowledge of the subject may also increase.

Religiosity, which was measured by frequency of attendance at religious services, entered two of four equations. It entered the Knowledge equation at the second step and the behavior equation at the third step. This finding was not expected. Other researchers (Sheridan, Wilmer & Atcheson, 1994) measuring religiosity with a social work sample had similar findings. Similar to questions asked in this study, a recent survey of social work educators, who had been teaching at the university level for 15 years, asked several questions that addressed their personal experiences relative to religiosity. A recent study conducted by Sheridan, Wilmer and Atcheson (1994) also used frequency of attendance at religious services as a measure
of religiosity. The findings of this research, which surveyed health care social workers and the findings of their study, which surveyed social work educators, yielded similar results regarding religiosity.

In this research, 30\% (n=63) reported attending church services once per week. Research conducted by Sheridan et al. (1994) on social work faculty reported that 39\% (n=107) attend weekly services. Eleven percent (n=24) of the respondents in this study reported never attending church services, while 17\% (n=47) in the Sheridan et al. study reported no involvement with religion.

On a whole, respondents in the Sheridan et al. research indicated a relatively positive or accepting attitude toward the role of religion in practice. Many, however, stressed the need to keep one's personal beliefs separate from the client's and cautioned against possible harm that social worker bias regarding religiosity might produce (Sheridan, Wilmer & Atcheson, 1994). In a point/counterpoint debate about the role of religion in social work, Amato-von Hemert (1994) states that "religious discrimination is subtle and complex and that the best way to guard against the biasing effect is to bring religion into the open and to examine its impact on the client's situation" (p. 9). This author believes that addressing religion in an open and direct manner supports the professional development of knowledge.
Another author, by contrast, argued that "if the social work profession is to maintain its political and technological gains, we must not move religion to a position of central importance" (Clark, 1994, p. 15). Clark (1994) critically asserts that from a clinical social work perspective, the profession "does not need an increased emphasis on religion for social workers to do ethical and high quality social work" (p. 15).

LIMITATIONS OF THE RESEARCH

This cross sectional research was conducted at only one point in time. Therefore, the results only reflect the Knowledge, Attitudes, Behavior and Experiences of health care social workers at the time of completion of the survey. It should be noted that, as a result of participation in this research, the potential exists for consciousness raising among social workers regarding the patients' right to self determination as related to the use of life sustaining treatment measures. Because all of the social workers utilized in this study were employed in health care settings, it is possible that the mental exercise involved in completing the survey would prompt respondents to be more cognizant of issues related to advance directives.

The measures used in this research were developed by
the researcher and lack standardization. To date, there are no well established scales to accurately measure the Knowledge, Attitudes, Behavior and/or Experiences of social workers regarding advance directives. Despite the adequate to high level of Cronbach's alpha for all measures on which reliability was performed, this provides no assurance of validity for any of the scales.

The sampling frame for this research consisted of social workers who are employed in health care facilities in the State of Ohio and who have membership in the National Association of Social Workers. Since many social workers employed in health care settings throughout the State do not have membership in NASW, caution should be exercised in generalizing the findings of this study to the general population of health care social workers.

In spite of the above limitations, this research calls attention to important issues that impact service delivery and that are of concern to patients and professionals working in health care facilities. Additionally, it provides a response to a number of important questions related to the Knowledge, Attitudes, Behavior and Experiences of health care social workers throughout the State of Ohio.
RELATION OF RESEARCH TO ECOLOGICAL PERSPECTIVE

Because the ecological perspective encourages a holistic approach and emphasizes complex person-environment interaction, it is a useful framework for addressing a number and variety of problems. As a basic premise, this perspective acknowledges that the interaction between the individual and the ecosystem is reciprocal and is of value in comprehending human behavior (Kirst-Ashman & Hull, 1993).

This perspective is in concert with social works' person-environment focus and provides a useful framework for examining the role that social work can play in health care settings. While the environment itself does not determine human behavior, it does influence the opportunities available to the individual as well as the limitations (Bubolz & Sontag, 1993). In using the ecological perspective, the social worker can make an impact at the micro level through therapeutic intervention, and at the macro level as well by proactively encouraging institutional and community adaptation to the patients needs.

It is vitally important that social workers in health care settings be sensitive to the influences that an institution may have on themselves as well as on the patient population. In this research, an examination of health care social workers in the State of Ohio revealed that social workers employed in environments directly serving elderly
persons (age 65 and over) were more knowledgeable about advance directives, counseled or assisted patients more with advance directives and had more experience with advance directives in their personal lives than did social workers with little or no work history with elderly persons. This research also indicated that as length of time worked with elderly increased, knowledge and behavior with advance directives also increased. This finding lends support to the ecological perspective and specifically to the influence of the environment on issues related to advance directives and end-of-life decision making.

An understanding of the person-in-environment concept supports an understanding of the constant interaction of people with various systems in their environment (Kirst-Ashman & Hull, 1993). These systems are called ecosystems and include the family, friends, work, social and health services and other systems with which the individual is involved. In an ecological perspective, social work practice is charged with improving the interaction between the person and these various systems. This perspective is especially important with regard to advance directives because it fosters social work interaction with a range of different ecosystems as may be needed to fully assist families in making end-of-life decisions regarding use or non-use of life sustaining treatments.
IMPLICATIONS FOR SOCIAL WORK PRACTICE

Passage of the PSDA has significant and profound implications for the profession of social work within health care institutions. First, it is important for social workers employed in health care institutions to have an adequate level of knowledge, and accurate, updated information about advance directives if they are to assist patients in understanding their options regarding this important matter. Social workers are off to an impressive start in this regard as this research shows that they have a good level of knowledge on the topic of advance directives.

Social workers can be both instrumental and influential in helping families with whom they, in many instances, have already established a base of trust, to understand the rationale for advance directives and the benefits they offer. Unlike other health care professionals that may share concern about the psychological issues of patients, social workers bring to the health care setting special skills and training, enabling them to effectively assess the patients needs and provide a broad base of services related to social functioning and environmental adaptation. The primary focus of the social worker is the social functioning of the individual. Therefore, social work is a profession
that has the capability of balancing the significant technological supports with the personal/human needs of the individual (Shelvin, 1983).

Recent research shows that neither physicians nor family members have been able to predict, with accuracy, patients' wishes regarding the use of life sustaining treatment measures (Sansome & Phillips, 1995). This coupled with the findings of many researchers (Danis et al., 1991; Diamond et al., 1989; Emanuel et al., 1991; High, 1988; Lo, McLeod & Saika, 1986, and Seckler et al., 1991) that older people want to discuss health care options and preferences regarding the use of life sustaining treatment measures suggest that there are gaps in communication between patients and their formal and informal caregivers. Regarding health care issues, collaboration and communication around patient needs is essential. It is interesting to note that in a recent study designed to investigate the perception of the role and function of social work within a medical facility, Egan & Kadushin (1995) found that while nursing viewed counseling terminally ill patients and their families as a joint function of both disciplines, social workers were divided on whether or not nursing should lend their skills to this process. Collaborative efforts between social workers and other allied health care professionals is particularly important
in health care settings because psychosocial issues are likely to be highly connected to health concerns.

As the demand for productivity increases the opportunity for staff to collaborate on difficult cases decreases. This sometimes results in the loss of a team approach and the de-emphasizing of collaborative efforts between health care professionals (Motenko et al., 1995). However, in considering the patients needs and best interest, it is important for social workers to acknowledge and to be open to any useful influence from the patients' ecosystem.

Given the rise in the number of chronically ill elderly, individuals with AIDS, and terminally ill patients, it is expected that the need for counseling regarding issues related to end-of-life decision making will increase in the coming years. And while this research did not find that social workers are spending considerable time counseling patients regarding advance directives at this time, counseling activity on these matters is likely to increase as people become more knowledgeable and more aware of the benefits of advance directives.

As the need for counseling in this area increases, expansion of the social worker's role will continue to increase. Promotion of the concept of self determination coupled with sound knowledge and positive attitudes toward
advance directives is in concert with the goals and objectives of the social work profession.

Social workers employed in health care settings must therefore seek to:

1) educate individuals and families about issues related to advance directives, 2) facilitate open dialogue between individuals and their significant others, including family, friends, and other allied health professionals, 3) Actively promote patient autonomy and patient self determination, 4) encourage patients to feel comfortable ventilating any psychosocial concerns related to proxy appointments or end-of-life choices, and 5) incorporate discussion of advance directives into their routine interaction with individuals and families as a means of initiating conversation around end-of-life matters.
One of the major advantages of the PSDA is that it allows for increased clarity about the patients' wishes and ultimately greater assurance that the administration of life sustaining treatments is in accord with patients' actual values and preferences. While the benefits of advance directives are obvious, there are many limitations, biases and criticisms of the PSDA that are not so obvious. Policy makers and long term care providers need to be aware of the following concerns:

1) Thirty-five million Americans have no health care insurance and fifty million more have less than adequate coverage. For many poor and/or underinsured people, an offer to complete an advance directive, without including some control over what provider(s) will administer their health care, or in what setting the care will be provided, may not be viewed as enhancing self determination (Caplan, 1991).

2) The PSDA lacks the flexibility to address the plight, issues and concerns of many aging Americans. A major limitation of the PSDA and one that has not been widely recognized or acknowledged in the literature at this juncture, involves issues related to ethnicity and aging. While there may have been no expressed intention or desire to exclude any particular segment of the population,
clearly, the PSDA is a creation and a representation of the dominant culture. For example, it is based on values which promote individual autonomy, as opposed to family involvement.

3) It is based and grounded on written communication as opposed to oral or visual communication, the latter of which is more culturally relevant when seeking to communicate with African American elderly. The PSDA makes the assumption that everyone can read. Many elderly individuals, and African American elderly, in particular, through no fault of their own, may not have had the opportunity to obtain an education, and may be illiterate. Consequently, they may express disinterest in advance directives as a means of covering their illiteracy.

4) It should also be mentioned that the PSDA assumes a basic trust in the system. Many elderly Americans and African American and/or indigent elderly in particular, may have rational and logical reasons to be suspicious of the system. They may wonder whether an advance directive will guarantee their autonomy, or be used instead as a license to limit treatment prematurely in the interest of cutting costs.

5) In terms of implementation, long term care providers and policy makers need to understand that merely asking an ill person, on entry to a health care facility if
he or she has a living will or a durable power of attorney for health care does not constitute a meaningful opportunity for the individual to execute one. Additionally, routinely providing individuals with a handout about advance directives may be ineffective.

Finally, if the true goal of the PSDA is to be realized, health care professionals must go beyond the bare requirement of the law. And, if people are to be encouraged to execute advance directives, the implementation process should be revisited and redesigned to be more effective.

**RECOMMENDATIONS FOR FUTURE RESEARCH**

This exploratory research was an attempt to develop an initial rough understanding of the knowledge, attitudes, behavior, and experiences of health care social workers toward advance directives. It has yielded new insights into several topics for future research with health care social workers. Some of them are as follows:

1) Do health care social workers believe that patients who complete advance directives are more responsible?

2) What is the attitude of health care social workers toward persons who prefer to have life sustaining treatments continue indefinitely?
3) Does the completion or the refusal to complete an advance directive in any way impact the medical care that a person receives?

4) Do health care social workers who are approaching retirement age display more positive attitudes toward advance directives that those who are not anticipating retirement in the immediate future?

CONCLUSION

The results of this research effort contribute to the social work literature focusing on the practices of social workers in health care facilities throughout the State of Ohio. The findings of this study enable social work researchers, administrators and educators in health care settings to pinpoint training needs and to facilitate the improvement of the implementation process for the PSDA.
LIST OF REFERENCES


Cruzan v Director, Missouri Department of Health (1990), 110 SCt 2841.


In re Quinlan (1976), 70 N.J. 10, 355 A.2d 647.


Public Law 101-508 (November 5, 1990). Section 4206. Medicare provider agreements assuring the implementation of a patient's right to participate in and direct health care decisions affecting the patient.


APPENDIX A

SURVEY INSTRUMENT
Please answer all of the questions in order by circling the number next to the ONE BEST RESPONSE for each question or statement.

SECTION I: KNOWLEDGE OF ADVANCE DIRECTIVES

1. Are individuals asked if they have an advance directive during the admissions process at your health care facility?
   1. YES 2. NO 3. DON'T KNOW

2. Do terminally ill, competent persons have the legal right to refuse life-sustaining medical treatment?
   1. YES 2. NO 3. DON'T KNOW

3. Is the LIVING WILL form considered part of advance directives?
   1. YES 2. NO 3. DON'T KNOW

4. Is the DURABLE POWER OF ATTORNEY FOR HEALTH CARE form considered part of advance directives?
   1. YES 2. NO 3. DON'T KNOW

5. Is the POWER OF ATTORNEY form considered part of advance directives?
   1. YES 2. NO 3. DON'T KNOW

6. Is there a TREATMENT PREFERENCE form included in advance directives?
   1. YES 2. NO 3. DON'T KNOW

7. Must the living will form be signed by the patient?
   1. YES 2. NO 3. DON'T KNOW
8. Must the living will form be signed by the durable power of attorney for health care?

1. YES  
2. NO  
3. DON'T KNOW

9. To complete a living will, is it necessary for the patient to consult the next of kin?

1. YES  
2. NO  
3. DON'T KNOW

10. To complete a living will, is it necessary for the patient to consult the durable power of attorney for health care?

1. YES  
2. NO  
3. DON'T KNOW

11. To complete a living will, is it necessary for the patient to consult a lawyer?

1. YES  
2. NO  
3. DON'T KNOW

12. Is it all right for a patient to appoint a friend to be durable power of attorney for health care?

1. YES  
2. NO  
3. DON'T KNOW

13. Is it all right for a patient to appoint a relative to be durable power of attorney for health care?

1. YES  
2. NO  
3. DON'T KNOW

14. Is it all right for a patient to appoint his/her doctor to be durable power of attorney for health care?

1. YES  
2. NO  
3. DON'T KNOW

15. Is there any legislation that protects health care professionals if a patient refuses life-sustaining treatment?

1. YES  
2. NO  
3. DON'T KNOW
SECTION II: Attitudes Regarding Advance Directives
Please continue to circle the ONE BEST RESPONSE that most accurately describes how you feel.

1. It is a good idea for people to be able to make their wishes about being kept alive on life-sustaining machines known in advance by completing advance directives.
   1. STRONGLY AGREE
   2. AGREE
   3. UNDECIDED
   4. DISAGREE
   5. STRONGLY DISAGREE

2. Advance directives reduce family disagreements over whether or not the terminally ill patient would want life sustaining treatment used.
   1. STRONGLY AGREE
   2. AGREE
   3. UNDECIDED
   4. DISAGREE
   5. STRONGLY DISAGREE

3. Patients would worry less about unwanted treatment after completing an advance directive.
   1. STRONGLY AGREE
   2. AGREE
   3. UNDECIDED
   4. DISAGREE
   5. STRONGLY DISAGREE

4. The final decision regarding whether or not to use life sustaining treatment should rest with the patient.
   1. STRONGLY AGREE
   2. AGREE
   3. UNDECIDED
   4. DISAGREE
   5. STRONGLY DISAGREE
5. The final decision regarding whether or not to use life sustaining treatment should rest with the family.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

6. The final decision regarding whether or not to use life sustaining treatment should rest with the physician.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

7. It is better for people to have their wishes about medical treatment known in advance because otherwise they may get treatment that they do not want.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

8. A terminally ill patient's desire not to have life sustaining treatment should be honored despite family resistance.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

9. Patients frequently change their minds about the use of life sustaining treatment after becoming terminally ill.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
10. Advance directives will ultimately lead to acceptance of mercy killing and/or assisted suicide.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

11. I feel that I may be held legally responsible for making sure the patient's wishes are carried out if I witness the signing of an advance directive?

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

12. It is not necessary for people to write down their wishes about medical care because their family will know what to do when the time comes.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

13. If life sustaining treatment measures are available they should be used whenever it is possible to prolong life.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE
14. Medical personnel can be trusted to honor an individual's wishes if they are made known in an advance directive.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

15. It is best to avoid talking about serious illness or death before they occur.

1. STRONGLY AGREE
2. AGREE
3. UNDECIDED
4. DISAGREE
5. STRONGLY DISAGREE

SECTION III: BEHAVIOR AND EXPERIENCE WITH ADVANCE DIRECTIVES

Please continue to circle only one response. There are no right or wrong answers to this section.

1. Have you received any information and/or training at your place of employment about advance directives?

1. YES 2. NO 3. DON'T KNOW

2. Would you say that the information/training you have received has adequately prepared you to assist patients with advance directives?

1. YES 2. NO 3. DON'T KNOW

3. How frequently do you assist patients in completing advance directives forms?

1. VERY FREQUENTLY
2. FREQUENTLY
3. SOMETIMES
4. RARELY
5. VERY RARELY
6. NEVER
4. How often are you asked by other professionals (e.g. doctors, nurses, etc.) to help explain advance directives options to patients?

   1. VERY FREQUENTLY
   2. FREQUENTLY
   3. SOMETIMES
   4. RARELY
   5. VERY RARELY
   6. NEVER

5. How often do you counsel with patients regarding their feelings about advance directives options?

   1. VERY FREQUENTLY
   2. FREQUENTLY
   3. SOMETIMES
   4. RARELY
   5. VERY RARELY
   6. NEVER

6. Do you have a living will for yourself?

   1. YES
   2. NO

7. Have you appointed a Durable Power of Attorney for Health Care to make health care decisions on your behalf should the need arise?

   1. YES
   2. NO

8. Do any of the following family members in your family have an advance directive?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>DON'T KNOW</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPOUSE</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>PARENT(S)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>BROTHER(S), SISTER(S)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>CHILDREN</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
9. Have you been hospitalized for any reason during the past three (3) years?
   1. YES  2. NO

SECTION IV: Background Information
Below are a list of items which relate to your personal background and your work environment. Please continue by circling the number that corresponds with your answer.

1. Which best describes your primary work setting?
   1. HOSPITAL
   2. HOSPICE AREA
   3. NURSING, ASSISTED LIVING OR RESIDENTIAL CARE HOME
   4. OTHER (specify) __________________

2. How long have you provided social work services to elderly persons (65 or older) in that work setting?
   1. NOT AT ALL
   2. LESS THAN 1 YEAR
   3. 1 - 5 YEARS
   4. 6 - 10 YEARS
   5. MORE THAN 10 YEARS

3. What is your gender?
   1. MALE
   2. FEMALE

4. What is your present marital status?
   1. NEVER MARRIED
   2. MARRIED
   3. DIVORCED
   4. SEPARATED
   5. WIDOWED
5. What is your ethnic background?
   1. WHITE
   2. AFRICAN AMERICAN
   3. AMERICAN INDIAN
   4. ASIAN AMERICAN
   5. HISPANIC
   6. OTHER (Please specify) ______________________

7. What is your age?
   1. UNDER 25
   2. 26 - 34
   3. 35 - 44
   4. 45 - 54
   5. 55 - 64
   6. 65 OR OVER

8. What is the highest level of education that you have completed?
   1. HIGH SCHOOL
   2. 2 YEARS OF COLLEGE
   3. 4 YEARS OF COLLEGE
   4. GRADUATE SCHOOL
   5. Ph.D.

9. What is your religious affiliation?
   1. PROTESTANT
   2. CATHOLIC
   3. JEWISH
   4. OTHER (specify) ______________________
   5. NONE

10. About how often do you usually attend religious services?
    1. MORE THAN ONCE A WEEK
    2. ONCE A WEEK
    3. TWO OR THREE TIMES A MONTH
    4. ONCE A MONTH
    5. A FEW TIMES A YEAR OR LESS
    6. NEVER
11. How long have you worked in the Social Work profession?

1. LESS THAN 1 YEAR
2. 1 - 5 YEARS
3. 6 - 10 YEARS
4. MORE THAN 10 YEARS
APPENDIX B

LETTER TO PANEL OF EXPERTS
Panel of Experts:

Thank you for agreeing to help me assess the content validity of the enclosed questionnaire.

As indicated on the cover of the questionnaire, my dissertation research will involve a statewide survey of the KNOWLEDGE, ATTITUDES AND BEHAVIOR OF HEALTH CARE SOCIAL WORKERS TOWARD ADVANCE DIRECTIVES.

Based on your knowledge of ADVANCE DIRECTIVES, what I am asking you to do is to give me feedback on the content validity of the questionnaire itself. For instance:

1. Are the statements and questions clearly stated?

2. Do you think that the statements and questions asked will be effective in measuring the knowledge, attitudes and behavior of health care social workers?

3. Are there any questions that you think need to be included in order to effectively measure the constructs?

4. Please indicate if there is anything about the survey that you believe needs to be changed, added or deleted. Note any improvements that you would recommend.

Please feel free to critique any question or statement on the questionnaire by writing your remarks or recommendations right by the question or statement.

Your feedback will be greatly appreciated and will be considered during the survey revision process.

I would like for you to have this available for me to pick up on Thursday, 2/16/95 if that is possible. Thank you.

Marjorie E. Baker
Ph.D. Candidate
APPENDIX C

LETTER TO PILOT STUDY PARTICIPANTS
Dear Social Worker:

Thank you for agreeing to participate in this pilot study.

Professional Social Workers, like yourself, are major contributors to quality patient care facilities throughout Ohio. Your knowledge, thoughts, and beliefs about current issues of concern to patients are very important to the provision of psychosocial care to the patients we serve.

Issues related to end-of-life decisions are the focus of mounting concern in many of the nation's health care facilities today. As a part of the final requirement for my Ph.D in Social Work, at The Ohio State University, I am conducting a statewide survey to better understand social workers' views regarding advance directives. As a social worker in the health care system, your input is being requested. We are particularly interested in learning where we as professional health care social workers stand on issues and concerns related to ADVANCE DIRECTIVES.

I am asking you to complete the survey and to provide me with any feedback you can offer about the language used, the questions asked or anything that you believe would improve the survey.

Please write any comments that you have on the back of the survey. Please also note on the back of the survey, the amount of time it took you to complete the survey.

Your feedback will be greatly appreciated, and will be considered when the survey is revised.

Because I am working on a time limited basis, I would like to pick this up on Thursday, 2/23/95, if that is possible. Thank you for your time and assistance.

Marjorie E. Baker
Ph.D. Candidate
Dear Social Worker:

Professional Social Workers, like yourself, are major contributors to quality patient care in health care facilities throughout Ohio. Your knowledge, thoughts and beliefs about current issues of concern to patients are very important to the provision of psychosocial care to the patients we serve.

Issues related to end-of-life decisions are the focus of mounting concern in many of the nation’s health care facilities today. As a part of the final requirement for my Ph.D. in Social Work at The Ohio State University, I am conducting a statewide study to better understand Social Workers views regarding Advance Directives. As a Social Worker in the health care system, your input is being requested. We are particularly interested in learning where we as professional health care Social Workers stand on issues and concerns related to Advance Directives.

We are asking you to kindly complete the questionnaire within the next **THREE (3) DAYS** and return it in the enclosed stamped, self-addressed envelope. Please be assured that all responses are completely anonymous. Your input about this issue is very important and will be immensely helpful to our ultimate goal of improving patient care. Please complete and return the survey as soon as possible.

I would be most happy to answer any questions you might have. My address and telephone number are on the back of the questionnaire. Please feel free to write or call. We would also welcome any comments you might wish to provide about the survey or the topic. Feel free to use the space provided on the back of the questionnaire for this purpose. Thank you.

Sincerely,

Marjorie E. Baker
Ph.D. Candidate, Ohio State University
APPENDIX E

FOLLOW-UP POSTCARD
Your name was drawn in a random sample of NASW health care Social Workers in Ohio and a questionnaire on Advance Directives was mailed to you last week.

If you have already completed and returned it to us, please accept our sincere thanks. If not, please do so today.

Because the survey was only sent to a small, but representative sample, it is extremely important that your responses be included in the study, if the results are to accurately reflect the opinions of health care Social Workers throughout the State of Ohio.

If, by some chance, you did not receive the questionnaire, or it was misplaced, please call me collect and I will get another one in the mail to you today.

Sincerely,

Marjorie E. Baker
Ph.D. Candidate