Knowledge, Attitudes, Experiences, and Confidence of Nurses in Completing Advance Directives: A Systematic Synthesis of Three Studies

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ABSTRACT

Background: Advance directives (ADs) are one of the few means for patients to indicate their end-of-life (EOL) treatment option preference. An effective and consistent solution for increasing the AD completion rate remains elusive. A literature search revealed three studies completed in the United States that employed an identical methodology and focused on registered nurses (RNs). These studies examined a variety of concepts, including nurses’ knowledge, attitudes, experience, and confidence with regard to ADs.

Purpose: This review completed a systematic synthesis of reported results from three survey studies that focused, respectively, on oncology, critical care, and emergency RNs who were members of various professional nursing organizations.

Methods: Our investigation addressed the following research questions: What are the knowledge, attitudes, experience, and confidence of RNs with regard to ADs, and what is the relationship among these study variables? Each study used the Knowledge, Attitudes, and Experiential Survey on Advance Directives Instrument to obtain findings.

Results: Findings indicated that level of knowledge of nurses was about 60% correct and that nurses reported a moderate level of confidence related to ADs. Nurses stated they were experienced in AD discussions and agreed with attitude statements indicating support of ADs. Advocacy was a theme in the findings of these studies, as most nurses agreed with the statement that nurses should uphold patients’ wishes. Time was identified as an impediment to AD completion. Critical care nurses had higher levels of awareness of ADs, as compared with oncology and emergency room nurses, although the cause of this difference is unclear. Although RNs provided AD education and explanations and described the various types of EOL care, these study subjects suggested that discussions of patients’ prognoses may be an intervention more appropriate for nurses or other clinicians with advanced education and training.

Conclusion/Limitations: The low Cronbach’s alpha values in the attitude scales within the survey instrument posed limitations in the original research on the use of attitude scale scores in statistical analysis. The data examined in this study was obtained from published reports, which limited the synthesis and analysis of study findings. Nurses need to refine their role in AD discussions with patients. End-of-life discussions should be an interwoven process between RNs and the multidisciplinary team.

KEY WORDS: advance directives, end of life, nurses, systematic synthesis.

Introduction

The opportunity to state treatment preferences through the execution of an advance directive (AD) is legally mandated in the United States by the Patient Self-Determination Act (PSDA). Despite support from physician groups and the general public (Heiman, Bates, Fairchild, Shaykevich, & Lehmann, 2004), the AD completion rate among adults in the United States is approximately 30% (U.S. Living Will Registry, n.d.; Witte, Menon, Ruskin, Wiley, & Hebel, 2003). Although ADs are widely viewed as an important element of advance care planning (Lingler et al., 2008), an effective and consistent solution for increasing AD completion rates remains elusive (Berger, DeRenzo, & Schwartz, 2008). Although the usefulness of ADs has been questioned, such directives are one of the few means for patients to indicate their end-of-life (EOL) treatment option preferences (SUPPORT Principal Investigators, 1995).

Evidence-based practice requires nurses to assume responsibility for and take part in patients’ EOL decision-making (Browning, 2006). Because nurses are in continuous

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contact with patients, they can perform a key role in distributing information about ADs and encouraging discussions among family members regarding EOL care (Kelley, Lipson, Daly, & Douglas, 2006). Not only do nurses have the opportunity to educate patients and their families on the importance of EOL decisions, they are also in a position to lay the groundwork to facilitate the articulation and documentation of patients’ wishes early in the treatment process.

Nurses’ discussions with patients can include a review of possible treatment options for the patient. This should include how treatment is initiated and what is involved in terminating treatment. Additional information concerning the patient’s specific concerns and desires regarding resuscitative measures, ventilator support, tube feedings, nutrition and hydration, and hemodialysis and pain medications can also be clarified. Because of the many potential scenarios, nurses can coordinate and request assistance from other personnel needed by the patient and his or her family, including physicians, social workers, clergy, and others able to assist patients further delineate their EOL wishes.

Although patients’ knowledge and attitudes have been found to be influential in facilitating AD completion (Campbell, Edwards, Ward, & Weatherby, 2007), patients usually require the assistance and encouragement of caregivers in this process (Ceccarelli, Castner, & Haras, 2008). In one survey, nearly half of patients over the age of 64 years reported never having received any information on ADs from a hospital or other healthcare agency (Campbell et al., 2007). It has been asserted that healthcare providers and professionals need to consider completing and reviewing ADs with patients a priority (Bergman-Evans, Kuhnel, NeNitt, & Myers, 2008). Although there have been criticisms of AD documents in terms of limitations in applicability to future health circumstances, ambiguity of limitations specified by patients, and difficulty in matching stated patients’ wishes to the particular medical circumstance at hand, the AD remains the legal means to allow patients to document their EOL wishes (Levi & Green, 2010). Members of the multidisciplinary team routinely addressing patients’ social, spiritual, physical, and psychological problems can facilitate patients’ AD completion and clarity, thus enhancing the chances for a good death (Haras, 2008). Because attempts to improve AD completion rate through purely focusing on discussions with patients have been unsuccessful, suggestions have been made to further examine the AD completion process within healthcare organizations to further understand nurses’ perspectives on the process (Meehan, 2009).

A literature search identified a variety of qualitative and quantitative studies addressing nurses’ perspectives and experiences with ADs. Three used the same instrument to survey different groups of nurses to measure constructs pertaining to AD-related knowledge, attitudes, experiences, and confidence. Each of these studies had similar research designs and large respective sample sizes (Jezewski, Brown, et al., 2005; Jezewski & Feng, 2007; Scherer, Jezewski, Graves, Wu, & Bu, 2006), which afforded an opportunity to identify common themes and threads and enhance the generalizability of their research findings (Burns & Grove 2009; Fahs, Morgan & Kalman, 2003). Therefore, the purpose of this study was to perform a systematic synthesis of these three investigations. Their focus on the AD-related knowledge, attitudes, experiences, and confidence of registered nurses (RNs) provided the study variables for this investigation. Research questions for this study included the following: What level of knowledge do RNs have related to ADs? What experience do RNs have related to ADs? What attitudes do RNs hold related to ADs? What is the level of confidence that RNs have related to ADs? What relationships exist among study variables?

Methods

This synthesis was performed to identify findings from studies that focused on RNs and their AD-related knowledge, attitudes, experience, and confidence. The authors searched MEDLINE and obtained 3,979 articles with the term “advance directives,” 1,555,691 articles (1992 to present) with the term “study,” and 85,731 articles with the term “nurses.” Combining the search terms yielded a total of 80 studies. A combined search using the singular term “advance directive” did not yield any further findings. The same search protocol in CINAHL yielded 24 articles, and the term “nurse practitioners” yielded an additional two articles. A PsychINFO search yielded 280 articles using the term “advance directives” and found no matches using the above search strategy. A Cochrane database search yielded an additional four randomized controlled clinical trials on ADs that included trials evaluating the efficacy of automated reminders to physicians on AD completion, ADs and mental illness, the impact of ADs on patients’ satisfaction in nursing homes, and patients’ education on ADs by physicians. None of these studies was considered appropriate for this review because they did not incorporate a nursing focus. A Web of Science search using the terms “advance directives” and “study” found 87 articles, none of which were appropriate for inclusion in this review. After a manual search of reference lists for all identified research studies, a total of four research studies, all of which measured knowledge, attitudes, experience, and confidence using the Knowledge, Attitudinal, and Experiential Survey on Advance Directives (KAESAD) Instrument (Jezewski, Brown, et al., 2005; Jezewski & Feng, 2007; Scherer et al., 2006; Waleriuss, Hill, & Anderson, 2009), were selected for inclusion. For comparability, one study was eliminated from this synthesis, because it used only the KAESAD knowledge scale (Waleriuss et al., 2009).

Study Designs

The purpose of each of these three studies was to determine the AD completion knowledge, attitudes, experiences,
and confidence of RNs (Jezewski, Brown, et al., 2005; Jezewski & Feng, 2007; Scherer et al., 2006). All three studies used a descriptive correlational design and survey approach. Each study mailed the same survey tool to a relatively large sample of RNs. The years of data collection were not identified. Study results were published, respectively, in 2005, 2006, and 2007.

Study Subjects


Study Population

Each study used the membership lists of professional organizations including the Emergency Nurses Association, Oncology Nursing Society, and American Association of Critical Care Nurses to recruit participants. Two studies used stratified random samples of ER nurses and oncology nurses by state (Jezewski, Brown, et al., 2005; Jezewski & Feng, 2007). The critical care nurse study randomly selected subjects from the New York State membership list of the American Association of Critical Care Nurses. Response rates ranged from 15% to 23%.

The KAESAD Instrument

All three studies used the KAESAD instrument to collect data. This instrument consists of five sections measuring knowledge of ADs, attitudes regarding EOL issues, experience with ADs, confidence with ADs, and attitudes based on professional experiences with EOL issues, along with demographic questions on personal, professional, and employment status. The instrument has a total of 115 items. The questionnaire format used in all three studies was similar, with the exception of Likert responses for attitudes regarding EOL issues and attitudes based on professional experiences with EOL issues scales. These used a 4-point scale in the oncology nurses’ study and a 5-point scale in the ER and critical care nurse studies. Also, some items were reworded in the KAESAD instrument used in the critical care nurse study.

Instrument validity

A seven-member multidisciplinary panel was consulted to establish content validity. Panel members were experts in EOL care and ADs and represented the fields of nursing, medicine, law, and bioethics. Test–retest reliability and tests to evaluate internal consistency were also calculated in the oncology and ER nurse studies.

Instrument scales

The knowledge scale, the first KAESAD scale, included 30 questions with three subscales related to general knowledge of ADs ($k = 10$), knowledge of the PSDA ($k = 7$), and state laws governing ADs ($k = 13$), with a total possible score of 30. Knowledge items were answered yes, no, or don’t know. Responses in the don’t know category were treated as incorrect. Twenty items for both attitude scales, namely the “attitudes about professional experiences with EOL issues” and “attitudes regarding EOL issues” offered categories of Likert scale responses ranging from agree to disagree. The scale pertaining to experience with ADs required yes or no answers. Another scale measured nurses’ confidence with ADs using a 5-point Likert scale and 11 items, with a total possible scale score of 55, indicating greatest confidence on specified statements. Each survey also included a section with 26 questions on personal, professional, and work-related demographic information.

Instrument psychometrics

Reliability and validity of the KAESAD instrument reported in the oncology and ER nurse studies were similar. The reliability of the oncology nurses’ pilot survey over a 3-week period was reported with a range of .51 to .90 for the various scales of the instrument. The pilot study of ER nurses yielded similar findings of .58–.91. Test–retest agreement for oncology nurses was high on individual items, ranging from .71 to 1.0, and similar to the ER nurse pilot study (.73–1.0). Internal consistency measured using Cronbach’s alpha ranged from .58 to .95 for the oncology nurse study and .52–.94 for the ER nurse study. Because of the low Cronbach’s alpha of .58 for attitudes regarding EOL issues with oncology nurses and .52 for ER nurses, individual item analysis was used in lieu of total scale scores. Attitudes based on professional experiences with EOL issues also had low Cronbach’s alphas in both studies. Individual item analysis was thus also used.

Results

Subject demographic characteristics were summarized, and then knowledge, confidence, experience and attitudes scale and item scores were compared for all three groups. Inferential analysis on the relationships among study variables was also described.

Demographic Information

Over 60% of respondents in all three studies were Caucasian, female, married or living as married, Christian, and held
either a bachelor’s or master’s degree. All studies reported that, although less than 50% of participants had ADs, more than 50% in the oncology and critical care nurse studies reported an AD for an immediate family member. Across all three studies, respondents averaged 45 years of age. Most oncology and ER nurses were employed full time.

Nurses reported receiving education on ADs. Over half of the oncology and critical care nurses had 1–2 hours of formal workplace instruction. The study on ER nurses did not report mean hours of instruction. Most respondents reported that ethics committees were active in their workplace, although only a small percentage of nurses were members of these committees (3.6%–7% as reported in these studies). Table 1 summarizes the sample characteristics of study participants.

Description of Scale Results
The total scale scores for knowledge, experience and confidence were examined. Items from the attitudes regarding EOL decision-making scale and attitudes based on professional experience with EOL issues scale were analyzed separately. Conceptual analysis with inferential statistics was calculated for each group.

Knowledge
Total knowledge scores were remarkably similar in all three studies, with means ranging from 68% to 71% correct. Scores for the three knowledge subscales of general knowledge, knowledge of PSDA, and knowledge of state laws were also similar across studies. The general knowledge subscale produced the highest mean scores of the three subscales. Table 2 summarizes KAESAD knowledge scores.

Attitudes regarding EOL issues
Again, attitude items were examined individually because of the low internal consistencies of the items as a scale. Likert responses for attitude items ranged from strongly disagree to strongly agree. Several attitude items showed similarity in level of agreement among all three groups. Participants in all three groups exhibited high levels of agreement with regard to statements about informing patients of treatment options, giving pain medications even if it hastens a patient’s death, nurses helping patients with ADs, and upholding patients’ treatment wishes (see Table 3).

Lower levels of agreement were noted on the other attitude statements. The percentage of agreement for responses on all attitude items was similar among these studies. All three groups had low levels of agreement with statements reflecting more controversial EOL care issues. These statements included the following: ethically there is no difference between initiating and withdrawing treatment, it is acceptable for healthcare providers not to offer certain treatments to the terminally ill, and ADs lead to euthanasia (see Table 3).

Experience with ADs
In all three studies, this section comprised seven items, five of which were included in the scale. Two items were analyzed separately. The means for oncology, ER, and critical care nurses were similar with mean values (and standard deviations) of 4 (1.11), 3.6 (1.45), and 4.24 (1.05), respectively. Similar mean scores for experience indicated that nurses in all three specialties have a substantial amount of AD experience. All three groups strongly agreed with statements about having cared for a patient with an AD, having counseled patients and families on ADs, and having had discussions about ADs, indicating that all three groups did have experience participating in the AD completion process. Approximately 50% of all three groups had witnessed others providing treatment to a patient when that patient’s AD instructed otherwise. Approximately half of ER and critical care nurses had given care to patients when ADs instructed otherwise, whereas only 17% of oncology nurses had done so.

Confidence with ADs
Mean scale scores for all three studies were similar, ranging from 36 to 40, indicating that nurses felt at least moderately confident in assisting patients and their families with ADs. Oncology and ER nurses were confident that nurses should comply with patients’ ADs and were confident in advocating for patients when patients’ wishes conflicted with that of their families. Oncology and ER nurses expressed little confidence, and critical care nurses showed a slightly higher degree of confidence in their knowledge of state laws. Nurses in all three groups rated themselves as having little confidence in knowing PSDA provisions.

Attitudes based on professional experience with EOL issues
The attitudes based on professional experience items were analyzed individually because of their low Cronbach’s alpha value. Whereas over half of critical care nurses reported that nurses know patients’ wishes, oncology and ER nurses reported that healthcare providers knew the patients’ wishes less frequently (33% and 28%, respectively). Over 50% of nurses in these groups agreed that a living will encourages discussions about the patient’s preferences and nurses can answer patients’ questions about ADs. There was also a high level of agreement (oncology nurses, 60% and ER nurses, 68%) with the statement: Patients are excluded from making decisions because they are inappropriately judged to lack capacity to make decisions.

Approximately half of the respondents agreed with the statements that information is usually sufficient on ADs to guide treatment decisions and that there is not enough time to discuss ADs. The statement indicating that patients had enough knowledge about their medical condition and to prepare ADs had less than 50% agreement among all three groups. See Table 4 for a summary of responses to these items.
Correlation and regression analysis

Although there were many commonalities among descriptive statistics used in these three studies, each used a different approach to analyses that employed inferential statistics. In the critical care nurse study, inferential analysis employed bivariate statistics using correlations and one-way analysis of variance. In the oncology and ER nurse studies, regression analysis employed the various KAESAD scales and demographic and attitude items to determine significant relationships. Because of the difference in inferential analysis and variability of findings across these studies, results of variable relationships will be discussed separately for each study group.

In the critical care nurses’ study, experience was correlated with knowledge and those nurses who had completed
TABLE 2.
Knowledge, Attitudinal, and Experiential Survey on Advance Directives Studies: Mean Knowledge Scores and Percent Correct for Oncology, Emergency, and Critical Care Nurses

<table>
<thead>
<tr>
<th>Knowledge Score</th>
<th>Oncology</th>
<th></th>
<th>Emergency</th>
<th></th>
<th>Critical Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>SD</td>
<td>$M$</td>
<td>SD</td>
<td>$M$</td>
<td>SD</td>
</tr>
<tr>
<td></td>
<td>7.0</td>
<td>1.29</td>
<td>6.8</td>
<td>1.34</td>
<td>7.1</td>
<td>1.22</td>
</tr>
<tr>
<td>General knowledge (0–10)</td>
<td>70</td>
<td></td>
<td>68</td>
<td></td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>PSA (0–7)</td>
<td>3.6</td>
<td>1.46</td>
<td>3.5</td>
<td>1.38</td>
<td>3.7</td>
<td>1.39</td>
</tr>
<tr>
<td>State laws (0–13)</td>
<td>6.8</td>
<td>2.11</td>
<td>7.2</td>
<td>2.08</td>
<td>7.0</td>
<td>2.05</td>
</tr>
<tr>
<td>Total knowledge score (0–30)</td>
<td>17.4</td>
<td>2.45</td>
<td>17.6</td>
<td>3.27</td>
<td>17.8</td>
<td>3.17</td>
</tr>
</tbody>
</table>

Note: PSA = Patient Self-Determination Act.

TABLE 3.
Knowledge, Attitudinal, and Experiential Survey on Advance Directives Studies: A Comparison of Oncology, Critical Care, and Emergency Room Nurse Responses on Select Attitudes Regarding End of Life Issues Items

<table>
<thead>
<tr>
<th>Knowledge, Attitudinal, and Experiential Survey on Advance Directives Study</th>
<th>Oncology</th>
<th></th>
<th>Emergency</th>
<th></th>
<th>Critical Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>SD</td>
<td>$M$</td>
<td>SD</td>
<td>$M$</td>
<td>SD</td>
</tr>
<tr>
<td>Likert scale</td>
<td>4 pt</td>
<td>6 pt</td>
<td>6 pt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inform patient of options</td>
<td>3.8</td>
<td>0.72</td>
<td>5.4</td>
<td>0.98</td>
<td>5.4</td>
<td>1.00</td>
</tr>
<tr>
<td>Give pain medicine though such may hasten patients’ death</td>
<td>3.8</td>
<td>0.50</td>
<td>5.5</td>
<td>0.87</td>
<td>5.6</td>
<td>0.89</td>
</tr>
<tr>
<td>Uphold patients’ wishes even when conflicts with nurses view</td>
<td>3.7</td>
<td>0.64</td>
<td>5.5</td>
<td>0.99</td>
<td>5.5</td>
<td>0.95</td>
</tr>
<tr>
<td>Nurses help patients with ADs</td>
<td>3.2</td>
<td>0.93</td>
<td>4.5</td>
<td>1.44</td>
<td>5.1</td>
<td>1.30</td>
</tr>
<tr>
<td>Assisting patients die should be made legal</td>
<td>2.0</td>
<td>0.99</td>
<td>3.3</td>
<td>1.70</td>
<td>3.2</td>
<td>1.60</td>
</tr>
<tr>
<td>Ethically there is no difference in start/stop treatment</td>
<td>2.0</td>
<td>0.95</td>
<td>2.8</td>
<td>1.57</td>
<td>2.9</td>
<td>1.63</td>
</tr>
<tr>
<td>No treatment of terminally ill because of cost</td>
<td>1.4</td>
<td>0.75</td>
<td>1.8</td>
<td>1.35</td>
<td>2.0</td>
<td>1.40</td>
</tr>
<tr>
<td>ADs will lead to euthanasia</td>
<td>1.3</td>
<td>0.61</td>
<td>2.0</td>
<td>1.20</td>
<td>2.1</td>
<td>1.34</td>
</tr>
</tbody>
</table>

Note. Responses ranged from strongly agree to strongly disagree. % = percentage of agreement; AD = advance directive; pt = number of points or responses in the Likert scale.

TABLE 4.
Knowledge, Attitudinal, and Experiential Survey on Advance Directives Studies: A Comparison of Oncology, Emergency Room, and Critical Care Nurses’ Scores on Attitudes Based on Professional Experiences With End of Life Issues Scale Items

<table>
<thead>
<tr>
<th>Knowledge, Attitudinal, and Experiential Survey on Advance Directives Study</th>
<th>Oncology</th>
<th></th>
<th>Emergency</th>
<th></th>
<th>Critical Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>SD</td>
<td>$M$</td>
<td>SD</td>
<td>$M$</td>
<td>SD</td>
</tr>
<tr>
<td>Likert scale</td>
<td>4 pt</td>
<td>6 pt</td>
<td>6 pt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living will encourages discussion</td>
<td>3.1</td>
<td>0.69</td>
<td>4.4</td>
<td>1.1</td>
<td>4.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Nurses can answer questions about ADs</td>
<td>2.8</td>
<td>0.97</td>
<td>3.7</td>
<td>1.7</td>
<td>4.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Some patients inappropriately excluded from making decisions</td>
<td>2.6</td>
<td>0.88</td>
<td>3.9</td>
<td>1.2</td>
<td>3.7</td>
<td>1.3</td>
</tr>
<tr>
<td>Information on ADs is sufficient to guide treatment</td>
<td>2.6</td>
<td>0.72</td>
<td>3.6</td>
<td>1.1</td>
<td>3.3</td>
<td>1.3</td>
</tr>
<tr>
<td>There is not enough time to discuss ADs with patients</td>
<td>2.5</td>
<td>0.94</td>
<td>3.9</td>
<td>1.4</td>
<td>3.7</td>
<td>1.3</td>
</tr>
<tr>
<td>Most patients have enough knowledge to prepare ADs</td>
<td>2.3</td>
<td>0.80</td>
<td>3.0</td>
<td>1.2</td>
<td>2.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Healthcare providers usually know their patient wishes</td>
<td>2.2</td>
<td>0.78</td>
<td>2.9</td>
<td>1.2</td>
<td>2.7</td>
<td>1.3</td>
</tr>
<tr>
<td>Nurses usually know the wishes of their patients regarding ADs</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>3.6</td>
<td>1.2</td>
</tr>
<tr>
<td>Most patient’s approached early enough in terminal illness</td>
<td>1.9</td>
<td>0.86</td>
<td>2.8</td>
<td>1.1</td>
<td>2.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Patients with Do-Not-Resuscitate orders receive less care</td>
<td>1.6</td>
<td>0.83</td>
<td>2.3</td>
<td>1.38</td>
<td>2.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Nurses spend enough time discussing ADs with patients</td>
<td>1.8</td>
<td>0.64</td>
<td>2.3</td>
<td>1.1</td>
<td>2.4</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Note. Responses ranged from strongly agree to strongly disagree. % = percentage of agreement; AD = advance directive; pt = number of points or responses in the Likert scale.
an AD for themselves (Scherer et al., 2006). Confidence and experience were key predictors for the item asking if nurses should be actively involved in ADs for both oncology and ER nurses, with knowledge being an additional predictor for oncology nurses on this attitude item. Experience and confidence were predictive for additional attitude items in both the oncology and ER nurses’ studies, which stated: The amount of time nurses discuss ADs was sufficient, patients should have a right to refuse life support, healthcare providers should know the wishes of their patients, and information on ADs is usually sufficient to guide treatment. But in general, there were no consistent relationships between attitudes, experience, and confidence among oncology and ER nurses.

**Limitations**

Although two studies selected a random sample of RNs from states and one study focused on RNs from New York State, it is unknown if nurses in other geographic locations may have different experiences with ADs. Although item analysis was employed for the attitude scales because of low Cronbach’s alpha values in the original investigations, this low scale value may reflect bias on particular scale items. In this synthesis, the researcher was not the original investigator in these studies; therefore, compilation of data was dependent on original study reported findings.

**Discussion**

The overall knowledge level among nurses in the KAESAD studies was about 60% correct, a grade typically below the acceptable standard in nursing school. The knowledge level of nurses has been evaluated by many investigators and has been found to range from 30% to 80% correct (Badzek et al., 2006; Ryan et al., 2001), placing the results of the KAESAD studies near the mean of findings of other studies. Lack of sufficient education on this topic may account for low knowledge scores. The importance of knowledge was illustrated by the fact that hours of education and workplace education on ADs were correlated with a higher degree of confidence and more positive experiences with ADs, respectively (Scherer et al., 2006). It was reassuring that nurses did not agree with the statement that terminally ill patients receive less care, reflecting the fact that nurses correctly understand the intent of ADs and how this influences nursing care of patients.

Experience and confidence are other variables to consider in study findings. Nurses agreed with statements about having cared for a patient with an AD, having counseled patients and their families on ADs, and having discussions about ADs, indicating that all three groups do participate in the AD completion process and have had experience with ADs. Nurses admitted lacking confidence with more complex aspects of ADs, including knowing state laws regarding ADs, mediating disagreements between patients and their families about ADs, teaching others about ADs, and knowing PSDA provisions. Those nurses who had limited familiarity with the patient’s AD document completion process may initiate discussions less frequently or only feel at ease or confident when introducing this topic without other nursing demands or interruptions. The end result may be that less experienced nurses have less frequent patient discussions concerning ADs.

Advocacy has been identified as a cornerstone of ADs and advance care planning (Baumrucker, 2006). Findings in these studies concurred with this attitude. Advocacy was reflected in the high agreement of nurses with attitude items including upholding patients’ wishes, helping patients with ADs, and experience with AD completion. There was also high agreement among all groups that a living will encourages discussions with patients. This perspective is consistent with American Nurses’ Association’s position statements that define and support nurses’ discussions on ADs and EOL issues (American Nurses’ Association, 2010a, 2010b, 2010c). Whereas study participants seemed to embrace AD discussions with patients and be involved in this task, some expressed uncertainty about their role with patients with regard to ADs (Jezewski, Meeker, & Robillard, 2005). Others have suggested that several members from the multidisciplinary team should be involved in the process (Jezewski, Meeker, & Schrader, 2003; Shidler, 1998). Although it is apparent that nurses do have a role in the completion of ADs, it appears that nurses’ discussions should be part of a broader and more complex framework of discussions on EOL care preferences (Maxfield, Pohl, & Colling, 2003). How EOL discussions should be delivered and what should judge their effect on EOL care decision making has yet to be determined (George, 2002; Song, 2004). Some maintain that counseling regarding EOL treatment preferences with the end result of AD completion may have multidimensional aspects (Oddi & Cassidy, 1998; Shidler, 1998).

The findings of the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT Principal Investigators, 1995) were unable to demonstrate that discussions concerning EOL planning improved patients’ AD completion. This large randomized trial was designed to demonstrate that improved communication between providers and patients increased AD completion, but in spite of a nurse-administered intervention designed to facilitate patient–provider communication on ADs, patients’ AD completion rates did not improve. These findings were unexpected and not predicted by the investigators (Schroeder, 1999). On the basis of the results of this large investigation, many feel that additional strategies to enhance AD completion with patients need to be explored (Murphy, Price, Stevens, Lynn, & Kathryn, 2001; SUPPORT Principal Investigators, 1995). These results may reflect our limited understanding of the most effective approaches to EOL discussions and treatment planning.

It is possible that discussions concerning AD completion may be more effective as a tiered and interwoven process. Because participants were less comfortable with more
complex situations concerning patients and AD discussions, for example, in the presence of family conflict, nurse interventions could be enhanced by the intervention of nurses and other professionals with advanced degrees. Although education and explanation of ADs, as well as descriptions of various types of EOL care, can be performed by RNs, discussions of patients’ prognosis and specification of an EOL treatment plan may be an intervention more appropriate for nurses or other clinicians with advanced education and training. Surveys of nurse practitioners have indicated that they have a higher degree of comfort than their RN peers in discussing these issues with patients (Schlegel & Shannon, 2000; Tyree, Long, & Greenberg, 2003). Jezewski and Feng (2007) noted having a master’s degree rather than a bachelor’s degree to be a predictor of higher confidence scores for ER nurses. This may imply that EOL discussions should be an interwoven process between RNs and advanced practice nurses and between nurses and the multidisciplinary team.

The nature of the healthcare setting may influence how nurses handle the AD issue. Oncology and ER nurses reported knowing the patient’s wishes less frequently than critical care nurses. Because cancer is the prototype for terminal care due to its often recognizable and predictable terminal phase (Emanuel, Hauser, & Emanuel, 2008), it would seem natural that oncology would be very familiar with patients’ EOL wishes. Postulated reasons that oncology nurses are not aware of patients’ EOL wishes are that patients may feel relatively well when receiving cancer treatment and they may perceive a less imminent need for an EOL treatment plan. Postponement of these discussions may also be a way of giving patients in this situation hope for a good prognosis. Although ADs may be completed while healthy or ill (Baumrucker, 2006), patients may perceive the topic of ADs as confirming a poor prognosis and therefore avoid discussion. Discussions in the context of serious illness can feel threatening to patients (Bergman-Evans et al., 2008). Those who advocate AD discussions, in fact, have suggested that these discussions should occur routinely, not when a patient with multiple comorbidities is seriously ill and most vulnerable (Levi & Green, 2010). It has been postulated that individuals are often uncomfortable talking about EOL issues and procrastinate or avoid such conversations and that healthcare providers often do not initiate these conversations for fear of robbing patients of hope (Green & Levi, 2009). In fact, other oncology advance practice nurses who were included in the survey felt that physicians were a barrier to advance planning because of their reluctance to initiate such discussions with patients (Zhou, Stoltzfus, Houldin, Parks, & Swan, 2010).

The fact that ER nurses do not know patients’ wishes may be a function of their practice area, which focuses on emergent care. Discussions concerning ADs are likely pursued if the patient’s condition deteriorates. In contrast, critical care nurses may have a better understanding of patients’ wishes because of the critical condition of many patients in this setting. In fact, despite low expected clinical benefit, one third of patients with metastatic cancer who die in the hospital are admitted to the intensive care unit (Barnato et al., 2008). The milieu of critical care treatment may provide more opportunity to explore EOL concerns with patients. Furthermore, most patients in critical care are faced with more immediate life and death concerns, thereby making EOL discussions with patients a priority.

The topic of time continued to be another theme in study findings. More than 50% of respondents agreed with the attitude statement that there is not enough time to discuss ADs. Because it has been reported that discussions on ADs may take at least 30 minutes (Perkins, 2007), the perception of lack of adequate time for these discussions discourages clinicians from initiating such with patients. Some practitioners may feel they cannot initiate a discussion on a topic as emotionally laden as EOL care and ADs (Song, 2004) without being available to fully address patients’ concerns. Discussions on ADs may be particularly difficult in settings where emergent and urgent care may be required from nurses and other professionals. Although the office or outpatient setting is more likely to provide routine healthcare than inpatient settings, office encounters are often scheduled at 15- to 20-minute intervals for health evaluations, which also limits the opportunity for AD discussions. In addition, patients may also need time and/or interactions with a variety of healthcare providers to establish an EOL treatment plan with which they feel comfortable.

The content of AD educational sessions that nurses attended was not examined in the KAESAD studies investigated nor have other researchers investigated this topic. Although knowledge is essential for nurses to effectively assist patients with ADs, additional strategies may be necessary to develop skills for effective delivery of information to patients and coordination of EOL patient care and AD completion. It has been suggested that mentoring, role playing, or discussions of ethical issues in practice could be helpful (Furman, Head, Lazor, Casper, & Ritchie, 2006; Torke, Quest, Kinlaw, Eley, & Branch, 2004). Because nurses expressed a low level of confidence in clarifying ADs with other providers, nurses may need coaching on how to coordinate the interventions of the multidisciplinary team more effectively in order to enhance patients’ AD completion.

Controversial attitudes are often evident in discussions on AD completion and EOL care. Over one third of nurses witnessed patients receiving care they specified they did not want or gave care to a patient in contradiction with that patient’s AD (Jezewski & Feng, 2007). Although it has been asserted that there is no ethical difference between withholding and withdrawing life-sustaining treatment and the courts have ruled that no legal distinction exists between the two, others have noted that there may be a psychological distinction between these two interventions.
(Farber et al., 2006). Because nursing care encompasses both curative and palliative aspects and contributes to patients’ quality of life regardless of prognosis, ADs can give direction to nursing care at EOL (Wainwright & Gallagher, 2007). Established ADs can also provide a guideline and benchmark for nursing in patient advocacy issues.

As part of the multidisciplinary team, nurses have a key role in patient discussions and can significantly contribute to the process of EOL planning. Familiarity with the process will enhance communication not only with the patient and his or her family but with the multidisciplinary team. Establishment of a framework for these conversations will enhance the process of advance care planning and increase patients’ AD completion.

References


護理人員對「預立醫療指示」的知識、態度、經驗和信心：
三項研究之系統性綜合文獻回顧

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背景 「預立醫療指示」是病人在臨終前表達想要的治療方式之一；然而，目前在提升預立
醫療指示的完成率方面，尚無有效且一致的解決方法。文獻查證發現，美國有三項研
究以完全相同的研究方法但針對不同護理人員探討此議題，這些研究探討的概念包括
護理人員對預立醫療指示的知識、態度、經驗及信心。

目的 此系統性文獻回顧歸納此三項分別針對腫瘤科、重症單位及急診室護理人員之研究調
查結果。

方法 本文探討兩大研究問題：(1)護理人員在預立醫療指示之知識、態度、經驗和信心為
何？(2)變項間的關係為何？此三項研究皆以預立醫療指示之知識、態度及經驗之問卷
調查來收集資料。

結果 調查結果顯示，護理人員的知識水準有60%正確，對預立醫療指示有中度信心，且對預
立醫療指示的討論都很有經驗並予以支持。「倡護」是這些研究中所呈現的一個重要
概念，且多數護理人員同意認為護理人員應維護病人的意願。時間是完成預立醫療指
示的障礙，重症單位護理人員對預立醫療指示的認識優於腫瘤科或急診室護理人員，
但造成此差異的原因尚不清楚。這些研究建議，討論病人的預後，在護理人員及醫師
的預立醫療指示進階教育和培訓相當重要，以便護理人員對病患提供預立醫療指示的
衛教，並介紹各種臨終照護方式。

結論/限制 態度量表信度偏低，限制了所收集資料之統計分析，且本研究乃根據已發表之研究結
果作二次分析，故亦限制了研究結果之統整與分析。護理人員需加以改善並提高與病
患討論預立醫療指示中所扮演的角色，臨終討論應是護理人員與各醫療團隊相互合作
的過程。

關鍵詞：預立醫療指示、臨終、護理人員、系統性綜合。

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