ORIGINAL RESEARCH

Awareness, Attitudes and Preferences of Patients 40 to 59 Years of Age on Advance Care Planning in a Private Hospital*

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Background: Decisions during medical crisis are made by the more-abled family member. More often than not, it is the adult son or daughter who makes it. As such, it creates stress and anxiety in the family who will be left behind. With Advance Care Planning (ACP), symptoms of stress, anxiety, and depression are reduced for both the patients and their families.
Objective: To describe and examine the awareness, preferences and attitudes of in- patients aged 40-59 years old in Rivera Medical Center, Inc. towards advance care planning through the Advance Care Planning Questionnaire (ACPQ).
Methods: Descriptive, correlational, cross-sectional study design was used. Necessary permissions were obtained. The modified questionnaire underwent validity prior to the actual application. Coding was done in Microsoft Excel while the statistical analyses were made using SPSS.
Results: The ACPQ Cebuano version has good reliability (Cronbach's $\alpha = 0.71$-0.92). Participants were 49 years old (± 5.5), mostly female (62%), married (74%), Cebuano/Visayan (82%), at high school level (48%), Christian or Catholic (98%), regular employees (42%), earning less than Php 10, 000 a month (36%), living with their spouse and children (66%), having hypertension (44%) or diabetes mellitus (22%), and in "good" health despite the current hospitalization (60%). Majority have limited awareness of ACP (14-22%) but were willing to discuss and learn about ACP (70%). Awareness, attitudes, and preferences towards ACP can be greatly influenced by the doctors.
Conclusion: Limited public understanding and awareness cause the negative reception and slow progress of ACP in the Philippines. The unconscious fear of death accounts for the unease and hesitance whenever the topic on death surfaces, impeding acceptance of ACP. The doctor, being the preferred decision-maker, should therefore be competent enough to help the family understand and cause a positive attitude towards ACP.

Keywords: Advance care planning, adults, palliative and hospice care

Introduction

Advance Care Planning (ACP) is a process whereby patients voluntarily express their preferences – via verbal or written communication – for future care and treatment should they lose capacity to decide for themselves.[1] These preferences are mainly based on the patient's personal values and beliefs, and can be used to make an advance care directive that will guide the family and the healthcare providers in decision-making during a medical crisis. As a result, the patient has the privilege to die with dignity and

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pain-free, especially when further treatment and procedure are pointless attempts in preserving life. It avoids expensive costs for futile treatment and procedures which enable the family to properly allocate scarce resources. Most importantly, the heavy burden of deciding for one's life placed on the family members and even the doctors at such a critical time is also lifted. Overall, the impact of illness is somehow neutralized for both the patient and their loved ones who will be left behind.

For the past two (2) decades, the uptake of Palliative and Hospice Care remained to be low. In 2010, the Advanced Directives Education Act (Senate Bill No. 2573) was filed in congress.[4] This bill directed the secretary of health "to develop and implement a national public education campaign on the importance of advance care planning and of the individual's rights to direct and participate in his or her healthcare decisions". However, this remains to be pending approval since then. To date, no legislation existed in support of ACP in the Philippines.

Another factor that was thought to have impeded the progress of ACP was the knowledge, acceptance, and practices of the doctors in the country. In 2012, Feliciano and Concha conducted a study on the knowledge, acceptance, and practices of resident physicians on advance directives in a tertiary hospital in Davao City.[5] Of the 41 residents (100% response rate), only 58.5% had a passing mark on the knowledge on advance directives, 53.66% were conditionally in favor, and 36.59% were completely in favor. Despite the positive perception on advance directives, the insufficient knowledge and lack of experience caused the difficulty in accepting the concept of advance care. Thus, Palliative and Hospice Care was incorporated into the residency programs in Family and Community Medicine to address this issue in the end of life care.

Still, the Philippines lagged behind, ranking 78th out of 80 countries in the 2015 Quality of Death study index. This was attributed to the severe shortage of palliative and hospice care specialists, lack of government-led strategies and programs, and limited public understanding and awareness.[6] Meanwhile, Taiwan (6th), Singapore (12th), Japan (14th), South Korea (18th), Thailand (44th), India (67th), and China (71st) ranked better in providing end-of-life care. The author hypothesizes that the reason for a poor end-of-life care despite the healthcare professionals' growing awareness of it may be due to the lack of patient's knowledge, preferences, and attitudes on the concept of advance planning. If that is so, then the patient's comprehension and decision-making skills are very important for advance care planning, and eventually will end to an advance care directive. The purpose of planning in advance for one's health care preferences before mental impairment sets in also coincides with the psychosocial development as presented by Erik Erikson. According to his psychoanalytical theory, middle-aged adults (around 40 years old to just about 60) are in the stage where the psychosocial issue revolves around generativity versus stagnation. In this stage, these individuals are now more secure and more capable to extend their resources and capabilities. The actions generated by this are actually expressions of care towards other people other than himself.[9,10] In ACP, the potential psycho-emotional impact on the family brought about by cluelessness on what to do in the middle of a medical crisis is cushioned by the fact that there is an existing written guidance or agreement, provided by the patient himself. It goes to show that the welfare of the family was considered as the patient, the testator himself, made the directives – an act of generativity and care. Thus, it is best to assess the knowledge, preferences, and attitudes of patients 40 to 59 years old on advance care planning, rather than to focus on the elderly population alone.

The general objective of this study was to describe and examine the awareness, preferences and attitudes of older adults aged 40-59 years old admitted in Rivera Medical Center, Inc. towards advance care planning by using the Advance Care Planning Questionnaire (ACPQ).

Materials and Methods

The study employed a descriptive, correlational, cross-sectional study design which underwent two (2) phases.

The first phase involved the validity testing of the Advance Care Planning Questionnaire in Cebuano version (ACPQ-C). Fifteen (15) participants who took part in the study their answers were analyzed using Cronbach's α. The second phase was the actual conduct of the research study on the knowledge, awareness, and preferences of eligible study participants using the said questionnaire (ACPQ-C). Both phases of the study were conducted in Rivera Medical Center, Inc. in Panabo City from October 2017 (1st phase) to November 2017 (2nd phase).

The study included patients aged 40-59 years old, regardless of sex, with or without chronic illness, were mentally –abled, and admitted in the said hospital at the time of study period. Excluded from the study were those who were mentally-challenged or impaired, illiterate, and unwilling to participate. Since the exact population of admitted patients within this age range was not determined, convenience sampling was used to have the sample population. A total of fifty (50) in-patients participated in the research proper. They were screened out for dementia using Clock Drawing Test (CDT).[11] A study by Kirby, et.al. in 2001 showed that the sensitivity of CDT in general elderly community was 76% while the specificities for normal elderly and depressed elderly were 81% and 77% respectively.[12]

The Advance Care Planning Questionnaire (ACPQ) in English version was previously validated by the study done in Malaysia back in 2016.[1] It was found out to be easily comprehensible (Flesch Reading Scale 71), with good construct validity (Keiser- Meir-Oskin Value, Average Variance Extracted, & Composite Reliability of >0.7, 0.5, & 0.5, respectively), and adequate internal consistency (Cronbach's α 0.637-0.915 each domain). The test-retest reliability was 0.738 – 0.947 which indicated good reliability. However, considering its applicability in the local setting, ACPQ was translated into Cebuano by a certified linguist. As some medical jargons did not have Cebuano equivalents, pictures were inserted to increase comprehensibility and reduce researcher bias through question interpretation. Font size was adjusted to 16 points and some instructions were highlighted to reduce interviewer/researcher assistance. Since ACP is a relatively new concept in patient care here in the Philippines, a general overview about it was inserted in the questionnaire. All modifications to the English ACPQ were done with consent from the original authors. Upon the approval of the Ethics Review Committee and the heads of the Department of Family and Community Medicine, both the pilot test for questionnaire validity and reliability and the research proper were conducted.

A total of sixty-five (65) answered ACPQ-C were tallied for both the pilot test (15) and the research proper (50). Data were tabulated and summarized using Microsoft Excel 2016. Statistical analyses were done using the Statistical Package for Social Sciences v.22 (SPSS). The following data processing tools were used:

a. Cronbach's α: This was used to determine how closely related a set of items were as a group in the ACPQ that was translated from English to Cebuano. An α-value of <0.50 pertained to unacceptable internal consistency, 0.50-0.69 pertained to poor internal consistency, 0.70-0.90 pertained to adequate internal consistency, and >0.90 meant redundancy of some items.[13]

b. Frequency Distribution, Percentage, Mean and Standard Deviation: These were used to determine the socio-demographic profile of the eligible study participants admitted in Rivera Medical Center, Inc. according to age, sex, civil status, ethnicity, educational attainment, religion, occupation, monthly income, and persons with whom they live with. These were also used in determining the degree of awareness on ACP, the attitudes towards ACP, and the preferences pertaining to ACP.

c. Correlation Coefficients (Pearson and Point-biserial): These were done to determine the correlation between the patients' awareness, attitudes, and preferences regarding advance care planning and the medical treatments or procedures involved in it.

Ethical Considerations

There were no foreseeable risks, discomforts, inconveniences, including psychological risks/discomforts directed toward the participants. An approval from the Ethics Committee was obtained before the conduct of the study. Informed consents were also obtained from the patients.

Results

The Malaysian-based development and validation study of Advance Care Planning Questionnaire (ACPQ) revealed the final 4 domains with corresponding number of items loaded to them; namely, "feelings regarding ACP" with 5 items, "justifications for ACP" with 4 items, "justifications for not having ACP: fate and religion" with 4 items, and "justifications for not having ACP: avoid thinking about death" with 3 items. Using the data from the pilot test participated in by 15 eligible subjects, the Cebuano version of the ACPQ was proven to be reliable (Table 1).

The mean age of the study participants was 49.0 ($\pm$5.5) years old. Most of the participants were: female (31 or 62%), married (37 or 74%), Cebuano/Visayan (41 or 82%), at high school level (24 or 48%), Christian or Catholic (49 or 98%), with a monthly income less than Php10,000 (18 or 36%), and were living with their spouse and children (33 or 66%). No patient was a retiree or pensioner. Twenty-one (42%) were regularly employed while 19 (38%) were unemployed. Furthermore, 30 patients (60%) rated their health as "good" at least, while the other 20 (40%) as "poor" or "very poor." Twenty-two (44%) had hypertension and 11 (22%) had diabetes mellitus. The patients generally varied in their current illnesses. On the other hand, only 4 (8%) claimed to have no past medical illnesses prior to their current hospitalization.

In terms of their level of awareness on terminologies used in ACP, only 7 (14%) have heard about ACP and 11 (22%) knew what it actually is (Table 3). Of the four ACP-related terms, proxy decision-maker (5 or 10%) and end-of-life decision-making (8 or 16%) were the least heard about. In contrast, most of them reported that they have heard of living will / last will and testament (28 or 56%) and power of attorney (30 or 60%). While 10% to 26% of them heard about the four terms, they were not sure of what these terms meant. There were 23 (64%) patients who heard about the terms from their family and relatives, 20 (40%) from mass media, and 19 (38%) from friends. Only few (7 or 14%) heard about the terms from their doctors. When asked about writing a last will and testament, 30(60%) have never thought of doing it, while there were 4 (8%) who already did.

Table 1. Reliability of the Cebuano version of the Advance Care Planning Questionnaire using Cronbach's α value.

Domain	No. of items	Items	Cronbach alpha Pilot test data
Feelings regarding ACP, with 4 items, and	5	D8, D9, D10, D11, D12	.92
Justifications for ACP	5	D13, D14, D15, D16, D17	.71
Justifications for not having ACP: fate and religion	4	D19, D22, D23, D24	.88*
Justifications for not having ACP: avoid thinking about death	4	D18, D20, D21, D25	.78

Note: * When item D19 was deleted; otherwise, alpha = .22; But the item was retained in actual survey since the domain to which it belongs had already high reliability index.

Table 2. Demographic profile of patients (N=50).

Age, mean + SD, years = 49.0 ± 5.5	n	(%)
Sex		
Male	19	(38)
Female	31	(62)
Civil Status		
Widowed	4	(8)
Married	37	(74)
Divorced/Annulled/Legally separated	5	(10)
Single	4	(8)
Ethnicity		
Others (Muslim, Aklanon, Ilonggo, Mandaya, Boholano)	5	(10)
Educational Attainment		
No formal education	1	(2)
Elementary	7	(14)
High school	24	(48)
College undergraduate/ graduate	18	(36)
Master's/Doctorate	--	--
Religion		
Christianity or Catholic	49	(98)
Islam	1	(2)
Occupation		
Retired/Pensioner	--	--
Has a job at present	8	(16)
Regular employee	21	(42)
Contractual employee	2	(4)
Unemployed	19	(38)
Monthly Income		
Less than Php 10,000	18	(36)
Php 10,001 - Php 20,000	12	(24)
Php Php 20,001 - Php 30,000	1	(2)
More than Php 30,001	--	--
Does not have income or pension	19	(38)
Persons with whom the patients are living		
No one. I live alone	2	(4)
Spouse. Not with children anymore	4	(8)
Child(ren). Not with spouse anymore	6	(12)
Spouse and child(ren)	33	(66)
Siblings and their family	4	(8)
Relatives and their family	1	(2)
Nursing home or home for the aged personnel	--	--
Friends	--	--

Note: "--" = No response

Table 3. Awareness on terminologies used in advance care planning.

Item	Yes n (%)	No n (%)	Yes, but not sure of its meaning n (%)
Have you heard about advance care planning?	7 (14)	43 (86)	n. a.
Do you know what advance care planning is?	11 (22)	39 (78)	n. a.
Have you ever heard about the following terms related to advance care planning?			
Proxy decision-maker	5 (10)	32 (64)	13 (26)
End-of-life decision-making	8 (16)	32 (64)	10 (20)
Living will / Last will and testament	28 (56)	16 (32)	6 (12)
Power of attorney	30 (60)	15 (30)	5 (10)
How did you hear about the terms (above)?			
From doctors	7 (14)	n. a.	n. a.
Mass media (Broadcast /Print)	20 (40)	n. a.	n. a.
Family and relatives	23 (64)	n. a.	n. a.
Friends	19 (38)	n. a.	n. a.
Others (Case hearing, SSS requirements)	2 (4)	n. a.	n. a.
Have you ever thought of writing a last will and testament?	20 (40)	30 (60)	n. a.
Have you written one?	4 (8)	46 (92)	n. a.

Note: "n. a." means not applicable as a response category for the corresponding item in the survey questionnaire

The patient-respondents were also asked about their awareness of and attitude towards ACP (Table 4). Most of them thought that ACP services should be available in the hospital (43 or 86%) and that the discussion on ACP would be necessary (43 or 86%). For the past five years or so, 42 (84%) have had experience of death of family members/ relatives/friends in a hospital; 36 (72%) have taken care of their family members/relatives/friends in a hospital; 35

(70%) had been hospitalized; and equally 35 (70%) have been involved in making decisions on their treatment. On one hand, 31 (62%) patients have not had a family member, relative, or friend who had any experiences with life-sustaining treatment for the past 5 years.

Table 4. Patients' awareness of and attitude towards ACP.

Item	Yes n (%)	No n (%)
Do you think advance care planning services should be available in your hospital?	43 (86)	7 (14)
Do you feel that the discussion on advance care planning would be necessary?	43 (86)	7 (14)
Had you been hospitalized from year 2012 to 2016?	35 (70)	15 (30)
Have you been involved in the decision-making of your treatment for the past 5 years?	35 (70)	15 (30)
Have you had any experience involving the care of your family member / relative / friend(s) in a hospital for the past 5 years?	36 (72)	14 (28)
Have you had any experience of death of a family member, relative, or friend(s) for the past 5 years?	42 (84)	8 (16)
Have you had a family member, relative, or friend who had any experiences with life-sustaining treatment (i.e. CPR, mechanical ventilation) for the past 5 years?	19 (38)	31 (62)

Moreover, 26 (52%) to 35 (70%) patients agreed or strongly agreed that it is better to have expressed their wishes in advance if they had serious medical conditions, especially severe dementia and stroke (Table 5). However, about 11 to 15 (22% to 34%) participants were undecided. Nearly all of those who favored ACP reported that they did agree on advance care planning in order to: i) be able to make their own decision; ii) circumvent possible differences in opinions between their family members; iii) spare their family the indecisions on treatment preferences; iv) become aware of possibly losing their decision-making power due to severe illness or injury; and v) prevent the doctor from doing "anything" unto them when gasping for breath. On the whole, the patients expressed positive feelings towards ACP ($M = 3.6$, $SD = 0.8$). Those who agreed on having ACP, likewise expressed positive reasons for ACP ($M = 4.3$, $SD = 0.4$).

Table 6 shows the results whether or not these participants were encouraged to get involved in their care and if they were willing to discuss ACP in the near future. One of the 50 participants did not complete the rest of the questionnaire. There were 19 patients who disagreed or strongly disagreed on ACP and expressed the following top three reasons for not being in favor of ACP: i) leaving their future or fate to God (15 or 79.0%); ii) "death" discussion being seen as "unlucky" (14 or 73.7%);

Table 5. Patients' feelings regarding ACP.

Item	SA	A	DNK	D	SD	M (SD)
Do you think it is better to have expressed your wishes in advance if. . .						
You had a stroke	7 (14)	25 (50)	15 (30)	1 (2)	2 (4)	3.7 (0.9)
Had a vehicular accident and became comatosed	5 (10)	24 (48)	17 (34)	1 (2)	3 (6)	3.5 (0.9)
Had a heart attack and are on a breathing machine	5 (10)	25 (50)	16 (32)	1 (2)	3 (6)	3.6 (0.9)
If you were to have a cancer	5 (10)	21 (42)	16 (32)	5 (10)	3 (6)	3.4 (1.0)
If you had severe dementia	8 (16)	27 (54)	11 (22)	1 (2)	3 (6)	3.7 (1.0)

Note: SA = Strongly agree; A = Agree; DNK = Do not know; D = Disagree; SD = Strongly disagree; Entries under these four scale points are frequencies (upper numbers) and corresponding % (enclosed numbers) relative to the total patients who responded to the item; M (SD) = Mean (Standard deviation); Overall mean $\pm$ SD = 3.6 $\pm$ 0.8 for feelings regarding ACP.

and iii) family being the ultimate decision-maker for them (14 or 73.7%). However, 4 (21.1%) to 6 (31.6%) of the 19 patients who did not favor ACP were still undecided; that is, they could not indicate the reasons why they disagreed in the first place. However, if taken as a whole, the patients who expressed disagreement on ACP indicated that the eight reasons for not being in favor of ACP were generally true to them (M = 4.0, SD = 0.7). Interestingly, 12 out of 19 (63.0%) patients would rather leave the decision to their doctor when the time is needed. The same number of patients did not favor ACP simply because they had no information at all about ACP.

When asked about whether anyone has encouraged them to get involved in medical decision if ever they became ill, 34 out of 49 patients (69.4%) responded "Yes." Thirty-five out of 49 (71.4%) also expressed that that they would consider to discuss about ACP in the future. The patients were then asked about what medical treatments/ procedures during ACP they would prefer to discuss about (Table 7).

Table 6. Patients' intentions to plan their care in advance.

Item	Yes n (%)	No n (%)
Has anyone encouraged you to get involved in medical decision if ever you became ill?	34 (69.4)	15 (30.6)
Would you consider to discuss on advance care planning in the future?	35 (71.4)	14 (28.6)

Note: N = 49.

Table 7. Patients' preferences over medical treatments/procedures during ACP.

Item	SA	A	DNK	D	SD	M (SD)
Cardio-pulmonary Resuscitation (CPR)	7 (20.6)	21 (61.8)	4 (11.8)	--	2 (5.9)	3.9 (0.9)
Artificial breathing / intubation / ventilators	2 (5.7)	25 (71.4)	3 (8.6)	2 (5.7)	3 (8.6)	3.6 (1.0)
Tube feeding for nutrition support (NGT)	3 (8.6)	23 (65.7)	5 (14.3)	1 (2.9)	3 (8.6)	3.6 (1.0)
Intravenous drip (IVD / "Dextrose")	3 (8.6)	26 (74.3)	3 (8.6)	--	3 (8.6)	3.7 (1.0)
Blood-taking	4 (11.4)	25 (71.4)	5 (14.3)	--	1 (2.9)	3.9 (0.7)
Antibiotics	5 (14.3)	25 (71.4)	3 (8.6)	--	2 (5.7)	3.9 (0.9)
Place of death	1 (2.9)	16 (45.7)	8 (22.9)	6 (17.1)	4 (11.4)	3.1 (1.1)
Dialysis /Hemodialysis	--	23 (65.7)	5 (14.3)	4 (11.4)	3 (8.6)	3.4 (1.0)
Place of care (at home / hospital / nursing home)	2 (5.7)	29 (82.9)	2 (5.7)	--	2 (5.7)	3.8 (0.8)
Chemotherapy	3 (8.6)	24 (68.6)	4 (11.4)	1 (2.9)	3 (8.6)	3.7 (1.0)

Note: SA = Strongly agree; A = Agree; DNK = Do not know; D = Disagree; SD = Strongly disagree;
Entries under these four scale points are frequencies (upper numbers) and corresponding % (enclosed numbers) relative to the total patients who responded to the item; "--" = No response; M (SD) = Mean (Standard deviation); Overall mean $\pm$ SD = 3.7 $\pm$ 0.7 for preferences over medical treatment/procedures during ACP; N = 34 or 35.

Thirty-five patients responded to each of the 10 items, except for the first one with only 34 patients. The four most preferred medical treatment/procedures to be discussed were, as follows: i) place of care (31 or 88.6%); ii) antibiotics (30 or 85.7%); iii) intravenous drip (29 or 83.0%); and iv) blood-taking (29 or 83.0%). Interestingly, 10 (28.5%) patients disagreed or strongly disagreed to discuss about place of death and 7 (20.0%) about dialysis/hemodialysis. A few of them strongly disagreed to talk about each treatment/procedure. There were some patients who were still undecided about the medical treatment/procedures. Taken as a whole however, the patients would prefer to discuss all the medical treatments/procedures during ACP ($M = 3.7$, $SD = 0.7$), except for the place of death, wherein the patients were divided.

As to the recording procedures in ACP, most patients (29 out of 35 or 82.9%) agreed or strongly agreed on written documentation and a copy given to their health care provider and family; while 25 (71.5%) on verbal communication to a family member or acquaintance (Table 8). However, patients were divided in their preference over making an audio or video tape; with 43.0% patients who at least agreed and other 43.0% who at least disagreed.

Finally, the patients were asked about who they would like to appoint as their decision-maker later in the event when they are unable to speak for themselves. Fifteen out of 35 (42.9%) patients reported that they would prefer the doctor more than either their family member or spouse/live-in partner (10 or 28.6% each). No patient chose friend as the decision-maker.

Having been hospitalized and/or involved in medical decision-making over the past 5 years showed positive correlation with the patients' interest to talk about certain medical treatment/procedures during ACP. Specifically, those patients who had been hospitalized in the past 5 years would prefer more likely to discuss about blood-taking during ACP ($rpb = .37$, $p < .05$) while those who experienced caring for a sick family member/relative in a hospital would more likely prefer to discussing tube feeding for nutrition support (NGT) during their ACP ($rpb = .34$, $p < .05$).

Correlations between feelings regarding ACP and preferences over medical treatments/procedures during ACP were examined. The patients' willingness to have expressed their wishes about ACP prior to possibly getting seriously ill were positively correlated with their willingness to talk about several medical treatments/procedures during ACP. On the whole, the more the patients felt positively regarding ACP, the more were they willing to talk about all the 10 medical treatments/procedures, except for the "place of death." (Table 7)

Table 8. Patients' preferences over recording procedures in ACP.

Item	SA	A	DNK	D	SD	M (SD)
Written documentation and give a copy to my healthcare provider and my family	5 (14.3)	24 (68.8)	2 (5.7)	2 (5.7)	2 (5.7)	3.8 (1.0)
Verbally to a family member or acquaintance	1 (2.9)	24 (68.8)	4 (11.4)	3 (8.6)	3 (8.6)	3.5 (1.0)
To make an audio or video tape	3 (8.6)	12 (34.3)	5 (14.3)	9 (25.7)	6 (17.1)	2.9 (1.3)

Note: SA = Strongly agree; A = Agree; DNK = Do not know; D = Disagree; SD = Strongly disagree; Entries under these four scale points are frequencies (upper numbers) and corresponding % (enclosed numbers) relative to the total patients who responded to the item; "--" = No response; M (SD) = Mean (Standard deviation); Overall mean + SD = 3.4 + 0.8 for preferences over recording procedures during ACP; N = 35.

Finally, the patients' awareness and attitudes on ACP were analyzed in relation to their preferences over the 3 recording procedures for ACP. The patients who expressed that ACP services be made available in the hospital would prefer more likely over taking audio or video tape of the ACP, than were those who did not. The patients' willingness to have expressed their wishes about ACP prior to possibly getting seriously ill were positively correlated with their preferences over both written documentation and verbal communication as the recording procedures of ACP (r values ranged from .36 to .64, $p < .05$). Their willingness to have expressed their wishes due to possibly getting stroke and having severe dementia, each equally explained 41.0% of the total variance in the preferred written documentation. Overall, the more positive their feelings were towards ACP, the more they would choose both written documentation and verbal communication as the recording procedures.

Discussion

The slow uptake of Palliative and Hospice Care, low acceptance of advance care, and the low ranking in the quality of death index in the Philippines were attributable to the shortage of specialists, lack of government support, and limited public awareness.[4,5,6] While the shortage of specialists was addressed by the incorporation of Palliative and Hospice Care into the residency training programs such as in Family Medicine and the government's effort in making constitutional amendments to address this type of care to patients, still the limited awareness and understanding of the public seemed to be the most important factor. As reflected in this study, only 14% of the 50 participants have heard about Advance Care Planning (ACP) and only 22% actually knew what it is. When given the general overview of what ACP is all about including its benefits for the family, 86% expressed that it should be available in hospitals or clinics while 84% thought that discussion on it is necessary whenever applicable. Yet, only 62% agreed on the application of advance care planning while 38% disagreed. The main reasons for disagreeing are spiritual faith (79%), emotionally-critical misperception on discussing death in advance (73.7%); and letting the final decision be made by the remaining family (73.7%). In the end, only 70% (35 out of 50) were willing to discuss ACP.

Advance care planning has been shown to have several benefits. Studies showed that ACP reduces symptoms of post-traumatic stress, depression, and anxiety in both the patient and their families.[14,15] The quality of life of the critically ill and dying patients is increased and the experience of the family members towards end-of-life care is improved. ACP also decreases health care costs, considering that medically futile treatments or procedures are no longer used. All in all, advance care planning not only provides dignified death to the patient according to his wishes, but also diminishes the likelihood for the surviving family to have stress, anxiety, and depression. It results to a positive impact on the quality of end-of-life care to both the patient and the family.

However, death and the process of dying are still considered taboo across different races and cultures even to this modern era. This is particularly due to the unconscious fear of death that is hardwired into one's brain and behavior – a theory known as the Terror Management Theory. When confronted by death, or even a reminder of it, fundamental anxiety and discomfort are generated, which individuals try to offset by seeking security, better status, and justifications from their own cultural beliefs and values.[16,17] Such is reflected in this study, in that those participants who were willing to discuss ACP, still find it difficult to discuss place of death. Perhaps the reason why they were more willing to discuss the components of ACP was because they were hoping that these life-sustaining procedures/treatments would still prolong their life despite poor prognostication, rather than understanding whether or not these procedures/treatments are futile.

The role of the physician cannot be overlooked. While most doctors are competent in managing the biomedical aspect of illnesses, majority find addressing the psychosocial aspect very stressful and emotionally draining especially to the inexperienced and untrained.[18] A combination of excellent communication skills and disease-specific

medical knowledge is required to prevent or decrease the negative impact on patients and their families who are in the receiving end.[19] Therefore, it is undeniable that the physician's ability to educate and counsel the patient and their families play a vital role especially in discussing uncomfortable issues such as advance care planning. This skill greatly affects the patient and their families' decision-making, even if the final decision is placed on the family themselves. In this study, 42.9% still rely on their doctor to make the decision for them. As presented, the more positive the participants' feelings were toward ACP, the more willing they were to discuss ACP. Indeed, the physician can greatly influence the decision making of the family.

There seemed to be a discrepancy regarding the recording of ACP outcome. For those patients willing to discuss ACP, there is a positive correlation between agreeing to existence of ACP service in the hospital and audio/video recording. However, when feelings toward ACP and expression of their wishes prior to becoming incapable of deciding for themselves were explored, written documentation and verbal communication were preferred instead.

Conclusions and Recommendations

In this study, most of the patients are female, married, Cebuano/Visayan, at highschool level, Christian or Catholic, regular employees earning a monthly income of less than Php 10, 000, and are living with their spouses and children. Hypertension is the most common morbidity followed by diabetes mellitus. Most of them rated their health as "good" at the time of study, despite the current admission or hospitalization. Majority of the participants are not fully aware of Advance Care Planning (ACP) and the existence of such; but, majority are open to the concept of ACP and willing to discuss its components. However, the unease and anxiety brought about by the unconscious fear of death are evident in the reasons for refusing to discuss death in advance as well as the reluctance in discussing place of death. In advance care planning, the family physician's effective communication skill is necessary to address any emotionally critical misperception because it greatly affects the ability of the patient and the family to decide which step to take next. Advance Directive, which is the outcome of Advance Care Planning, is preferably documented into writing or verbally expressed.

The outcome of this study is only true for one private hospital. Therefore, to strengthen and further the study on advance care, the following are recommended:

1. to conduct the survey/study encompassing a bigger population and if possible, across the different medical institutions here in Panabo City. This may mean extension of study period to more than one (1) month.

2. to conduct the study as interviewer-assisted rather than self-administered. This is because for most lay persons, the topic on death and advance care is still taboo. Thus, they may lose interest and may leave the questionnaire inappropriately and incompletely-answered. Interviewer-assisted survey may ensure that the questionnaires will be filled up completely; however, it entails more effort and time on the part of the interviewer/researcher.

3. Since the outcome of advance care planning may be legally used, further studies on preferences on actual procedures and documentation must be investigated.

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