

The Relationship Between Ethnicity and Advance Directives in a Frail Older Population

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OBJECTIVE: To assess the relationship between ethnicity and Health Care wishes, including Advance Directives, in a group of frail older persons in PACE (Program For All Inclusive Care Of The Elderly).

DESIGN: Retrospective chart review of 1193 participants in the PACE program.

SETTING: Program of All Inclusive Care Of The Elderly (PACE), a comprehensive managed care demonstration program serving frail older participants at 10 sites across the nation.

PARTICIPANTS: A total of 1193 older adults, all of whom met state criteria for nursing home level of care. There were 385 non-Hispanic whites, 364 blacks, 156 Hispanics, and 288 Asians.

MEASUREMENTS: Presence or absence of advance directives, type of health care wishes selected including living will, durable power of attorney, and health care proxy.

RESULTS: Frail older white, black, Hispanic and Asian Americans differ significantly in their health care wishes and how they choose to express them. Blacks were significantly more likely to select aggressive interventions and less likely than non-Hispanic whites and Hispanics to utilize a written instrument for expressing health care wishes. Whites were significantly more likely to utilize written documents for advance directives, whereas Asians were more likely to select less aggressive interventions but were unlikely to use written advance directives.

CONCLUSIONS: In this population, we found significant ethnic variations in choice of health care wishes. Although health care wishes are an individual decision, an awareness of cross cultural patterns can assist practitioners in addressing the concerns of their patients, as well as assisting Health Care Policy Development. *J Am Geriatr Soc* 44:938-943, 1996.

Health care providers are frequently faced with the necessity of addressing issues of withholding and withdrawing life-prolonging therapy. Since the Nancy Cruzan case,¹ more and more attention has been drawn to the issue of advance directives. It is increasingly apparent that when presented with a choice, individuals may not want aggressive measures such as cardiopulmonary resuscitation (CPR) or ventilator support. However, unless addressed in advance, these measures may be implemented because the specifics of health care wishes were not explicitly discussed or documented. With life-sustaining and life-prolonging therapies ranging from the simple (tube feeding) to the complex (surgical intervention) widely available, the expressed wishes of the patient are invaluable guides in planning treatment.

Many factors influence a person's responses to questions about health care wishes in the event lose their capacity for decision-making. These factors may include religion,^{3,4} education,⁵ knowledge about advance directives,^{6,7} presence of dementia,^{8,9} as well as others.¹⁰ Cowley et al.³ have traced the historical conflict between secular, medical, and religious beliefs about the relative values of sanctity of life, medical beneficence, and quality of life. A look at the influence of current health status on end of life decisions has shown that relative youth, greater independence (based on activities of daily living), and fewer medical diagnoses all correlate positively with the desire for Cardiopulmonary Resuscitation (CPR) and other life support measures.¹⁰

Cultural and ethnic values are also factors that may have an impact on health care wishes. It is important to understand the cultural, ethnic, religious, and individual factors that influence end of life treatment preferences. Such understanding may assist providers in understanding their own biases as well as the likely biases of their patients. Eliciting health care wishes is often "more art than science," and recognizing both patient and provider attitudes and prejudices may be important to assess the patient's true wishes. For example, it is possible that cultural, ethnic, or religious factors may lead a patient to make a choice that he or she would not have made independent of these biases. Patients may make choices that please the cultural, ethnic, or religious community rather than follow their own wishes. Further, it is possible that these factors may have an impact on health care costs since choosing more aggressive care is likely to be more costly.

These studies found differences in attitudes toward end of life decisions among various ethnic groups, but they looked primarily at younger age groups. In contrast, the

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current study was undertaken to characterize differences in attitudes in a group of frail older adults representing four different ethnic groups. In this paper, we review the recorded wishes of competent adult patients, as well as incompetent patients through the wishes of surrogate decision makers obtained before a medical crisis. How racial differences might play a role was addressed in a prospective study in the University of Miami general medicine continuity clinics.¹¹ This study compared the end of life medical treatment decisions of blacks, Hispanics, and non-Hispanic whites. More blacks (37%) and Hispanics (42%), compared with non-Hispanic Whites (14%), wanted their doctors to keep them alive regardless of how ill they were. More non-Hispanic whites (89%) agreed to stop life prolonging treatment under some circumstances compared with blacks (63%) and Hispanics (59%). Klessig's study¹² also reviewed cross cultural issues in end of life decisions.

METHODS

All patients included in the study were enrolled in one of the PACE (Program of All-Inclusive Care for the Elderly) projects. PACE is a national demonstration project replicating a model of comprehensive geriatric care initially developed at OnLok Senior Health Services in San Francisco, California.

Details of the services provided by the PACE program have been published elsewhere.¹³⁻¹⁵ The basic focus of the program is to provide community-based services to frail older participants, allowing them to remain in the community as long as it is medically, socially, and economically feasible. The close relationship which develops among the participants, caregivers, and interdisciplinary team members makes the program especially well suited to addressing sensitive issues, including end of life treatment options. Obtaining health care wishes is emphasized in the PACE model but not standardized. The term "health care wishes" is used broadly to include Living Wills and Durable Power of Attorney for Health Care, as well as verbally expressed wishes about end of life decisions, including cardiopulmonary resuscitation (CPR), advanced cardiac life support (ACLS), feeding tubes, etc. In general, most sites try to obtain health care wishes within 3 months of enrollment. Most sites allow any level of provider to obtain the patient's wishes, though the physician or nurse practitioner in charge of the patient's primary care usually leads the discussion. For incompetent patients, a surrogate decision-maker discusses end of life decisions with the provider. Because sites are found in various geographic locations, the details of recording health care wishes also vary with legal and community standards. For example, some sites record advance directives regarding tube feeding and hydration, while others do not. All sites record information on "code status" i.e., the use of basic life support (BLS) and/or advanced cardiac life support (ACLS). However, some sites allow for basic life support without ACLS while other sites only initiate BLS (CPR) if ACLS is also approved by the patient. "Conditional Life" support is also allowed by some sites and would include limited interventions such as doing everything short of placing a patient on a ventilator. Most sites record wishes in narrative form in the progress notes and flag the chart for the patient's wishes, although some sites use a specific form.

The authors, practitioners, and researchers in the field of geriatrics, generated a set of questions whose answers would

characterize the recorded health care wishes of the PACE Program participants. If health care wishes were documented in the patient's medical record, then information about whether there was a living will, durable power of attorney for health care, or other health care proxy, and the identity of the decision-maker, was recorded. If there was no documentation of the patient's health care wishes, the reason for no documentation was recorded (e.g., the patient was a new enrollee in the program, decision pending, the patient/surrogate refuses to decide, etc.).

Because legislation regarding advance directives differs from state to state and the PACE program spans multiple jurisdictions, a generic set of descriptors for types of advance directives was utilized in this study. These included a formal living will, a durable power of attorney for health care, or another written designation of a surrogate decision-maker for health care (other health care proxy).

The case review form was pilot-tested at Palmetto Senior Care in Columbia, South Carolina. The records of 30 patients were each reviewed by two trained abstractors and compared for agreement. This pilot test of the record review form and data collection procedures yielded a reliability in excess of .95.

The research question was incorporated into an ongoing quality improvement activity, which encouraged participation and helped ensure consistency of data collection across PACE sites. A contact person was identified at each site to answer any questions about interpretation of the record review form and to assure uniform data collection. Ten of the 12 PACE sites were able to participate in the data collection (see Appendix for participating sites). Data were collected on all patient records at participating sites over a 6-week period, and completed record review forms were forwarded to the investigators at the University of South Carolina School of Medicine, Division of Geriatrics, for processing and analysis. There the forms were edited and entered into a data file that was merged with DataPace, a continuously updated master file containing demographic, medical history, and treatment data on all active PACE patients.

The data were analyzed on the University of South Carolina mainframe system using both SAS and SPSSX statistical programs. Quantitative variables were assessed using Student *t* test or ANOVA. Crude comparisons of the proportion of patients with expressed health care wishes in each ethnic group were made using chi-square. Because of the potential impact of the patient's age, gender, mental status, education, marital status, and the presence of living children on the decision to express health care wishes, these variables were included in multiple logistic regression analysis as potential confounders. Statistical significance was set at $\alpha < .05$.

RESULTS

Chart review forms for 1193 patients were completed and the data merged with DataPace. Table 1 shows demographic and background characteristics. Whites and blacks each made up about one-third of the sample, Asians were about one-quarter, and Hispanics were 13.1%. One hundred sixty-eight cases were missing information on the Short Portable Mental Status Questionnaire (SPMSQ).¹⁶ These cases, consisting of 76 whites (45.2%), 41 blacks (24.4%), 49 Hispanics (29.2%), and two Asians (0.6%), were deleted

Table 1. Demographic Profile of PACE Patients

	White n = 385	Black n = 364	Hispanic n = 156	Asian n = 288	Total n = 1193
All patients (%)	32.3	30.5	13.1	24.1	100.0
Mean age	79.8	76.9	77.2	80.6	78.8
Mean years education	10.1	8.4	7.1	7.3	8.5
# MSQ _{Adj} errors	3.3	4.6	4.0	3.9	3.9
# MSQ _{Unadj} errors	3.5	5.1	4.8	4.7	4.5
Married (%)	20.8	18.4	23.1	19.1	20.0
With children (%)	60.8	67.9	76.9	87.2	71.4
Male (%)	27.8	26.9	28.2	26.0	27.2
Mean age	77.1	76.5	76.7	78.6	77.2
Mean years education	10.3	8.3	6.5	8.2	8.7
# MSQ _{Adj} errors*	3.5	4.2	3.9	2.6	3.5
# MSQ _{Unadj} errors	3.7	4.8	4.8	3.2	4.0
Married (%)	48.6	48.0	47.7	41.3	46.6
With children	54.2	68.4	80.0	74.7	66.7
Female (%)	72.2	73.1	71.8	74.0	72.8
Mean age	80.8	77.2	77.4	81.3	79.4
Mean years education	10.0	8.4	7.3	6.9	8.4
# MSQ _{Adj} errors*	3.2	4.7	4.1	4.4	4.1
# MSQ _{Unadj} errors	3.5	5.2	4.9	5.2	4.7
Married (%)	10.0	7.5	13.4	11.3	10.0
With children (%)	63.3	67.7	75.9	91.6	73.9

* MSQ adjusted for years of education completed.

from the analysis. Nearly all of these cases were served by a single PACE site.

There were significant differences in the ethnic mix at the PACE sites. For example, more than 90% of all Asians in the study were at the OnLok site, whereas the El Paso site had a majority of the Hispanics. About 95% of the participants at the South Carolina site were black. The average age of study subjects was 79 years, range 48 to 102. Seventy-three percent of patients were female, and there is no difference in the gender distribution by ethnicity. However, there were significant ethnic differences in age, years of education completed, mean number of errors on the SPMSQ, and the percent with living children. Whites and Asians were, on average, about 3 years older than blacks and Hispanics ($P < .001$). Whites had completed 2 years of education more than blacks and about 5 more years than Hispanics and Asians ($P < .001$). Whites had fewer errors on the SPMSQ, whereas blacks, Hispanics, and Asians differed by an average of less than 1 point ($P < .001$). Although 20% of all patients were married, almost 90% of the Asians had living children compared with 77% of the Hispanics, 68% of the blacks, but only 61% of the whites ($P < .001$).

Females were significantly older than males (79.4 years compared with 77.2, $P < .001$), were more likely to be married ($P < .001$), and were more likely to have living children ($P < .001$). Although there were no gender differences in years of education completed, women had more errors on the SPMSQ ($P < .01$).

Table 2 presents the percentage of patients who had any form of health care wishes recorded in their charts and the percentage with a durable power of attorney (DPA), health care proxy (HCP), and living will (LW) according to demographic characteristics. More than three out of four patients

Table 2. Percentage of Patients with Recorded Health Care Wishes (HCW), Durable Power of Attorney (DPA), Health Care Proxy, and Living Will (LW) by Ethnic Background

	White n = 385	Black n = 364	Hispanic n = 156	Asian n = 285	P
HCW	76.4	80.0	39.1	95.5	<.001
DPA	28.1	5.0	7.1	2.1	<.001
HC proxy	20.5	7.1	17.3	36.1	<.001
LW	2.3	0.3	0.6	2.4	.047

(77.2) had recorded health care wishes as defined in the Methods section; 12% were expressed as DPA, 20% had a designated HCP, but only 1.5% had executed a living will. There were significant differences in the recording of health care wishes and the legal instrument used according to demographic characteristics.

Nearly all of the Asians, but fewer than 40% of the Hispanics, had health care wishes recorded in their medical charts, whereas about 80% of whites and blacks had their wishes recorded ($P < .001$). Legal instruments including a DPA, HCP, or LW were rarely executed by blacks. A DPA was most common among white patients ($P < .001$) and a HCP was most common among Asians ($P < .001$). About 2% of whites and Asians, compared with less than 1% of blacks and Hispanics, had a LW ($P = .047$).

There were no significant differences between males and females, between married and unmarried, or those with living children and those who were without children in the proportion of patients with recorded health care wishes nor in the

type of instrument used. However, patients older than age 80 were significantly more likely to have recorded health care wishes ($P = .034$) and to have a HCP ($P = .022$). Similarly, patients with more than four errors on the SPMSQ, adjusted for years of education, were significantly more likely to have a DPA ($P = .010$) than those with fewer SPMSQ errors.

Multivariate logistic regression analysis was performed to estimate the effects of ethnic background on the presence of health care wishes and the type of instrument used while controlling for the potential confounding effects of gender, age, educational attainment, marital status, presence of living children, and mental status. The results are shown in Table 3.

There were significant ethnic effects in the recording of health care wishes and in the use of a durable power of attorney and health care proxy, but no statistically significant ethnic differences in the execution of a living will net of the potential confounders. Asians were 6.48 times more likely than whites and blacks and nearly 50 times more likely than Hispanics to have recorded their health care wishes. Whites were nearly 10 times more likely than blacks, nearly 5 times more likely than Hispanics, and nearly 28 times more likely than Asians to have executed a durable power of attorney. The use of a health care proxy was significantly more likely among Asians, who were 5.28 times more likely than whites, nearly 100 times more likely than blacks, and approximately 30 times more likely than Hispanics to have a health care proxy indicated in their medical record.

Two other significant effects were noted. Patients with living children were almost twice as likely to have a durable power of attorney than those without children. Similarly, patients with more than four errors on the SPMSQ, adjusted for years of education completed, were 1.54 times more likely

to have a health care proxy than those with fewer SPMSQ errors.

Health care wishes with regard to code status were recorded by 80% of the patients. More than 95% of Asians, but only 41% of Hispanics, specified a code status in their health care wishes. These included 'No code' (49%), 'Full Code' (12%), 'Basic or Conditional Life Support' (14.2%), or some other specific instruction or explanation of code status (5.4%). Table 4 shows the percent requesting "No Code," 'Basic or Conditional Code,' and 'Full Code' according to ethnic background.

There were significant differences by ethnic background in the percentages requesting each code status. More than 80% of the Asian but only 16% of the Hispanic patients requested 'No Code' ($P < .001$); 19% of blacks, 10% of whites and Asians, but only 3.9% of Hispanics requested 'Full Code' ($P < .001$). Basic or conditional code status was authorized by 25% of blacks, 14% of whites and Hispanics, and fewer than 1% of Asians ($P < .01$).

Older patients were more likely to have 'No Code' ($P < .001$), whereas patients less than age 80 were more likely to have requested 'Basic Life Support' (16.4% vs 11.9%; $P = .025$) or 'Full Code' (15.9% vs 7.9%; $P < .001$). Educational attainment and number of errors on the SPMSQ were not significantly related to requests for a specific code status, but females (10.5%) and married patients (10.9% were significantly less likely than men (16.1%; $P = .008$) and those without spouses (16.4%; $P = .020$) to have a full code status. Patients with living children were significantly more likely to be 'No Code' (51.9% vs 41.6%; $P = .001$) and significantly less likely to have requested basic life support (11.3% vs

Table 3. Odds Ratios and 95% Confidence Intervals for Health Care Wishes Associated with Ethnicity, Gender, Age, Education, MSQ Errors, Marital Status, and Living Children (Logistic Regression Model)

	HCW	DPA	HCP	LW
Ethnicity				
White	1.00	1.00	1.00	1.00
Black	1.08	0.10	0.56	0.14
Hispanic	0.71-1.62	0.06-0.18	0.00-0.24	0.02-1.14
Asian	6.48	0.04	5.28	1.08
Hispanic	0.13	0.21	0.17	0.43
Asian	0.80-0.21	0.10-0.41	0.04-0.74	0.05-3.60
Asian	3.30-7.67	0.01-0.19	3.26-8.57	0.36-3.27
Male Gender	1.19	0.87	1.22	2.85
>80 years	0.77-1.84	0.53-1.45	0.73-2.04	1.00-8.14
>80 years	1.16	1.11	1.15	0.83
>12 years education	0.81-1.65	0.73-1.69	0.74-1.78	0.29-2.34
>12 years education	0.73	0.90	0.77	2.49
≥4 MSQ _{Adj} errors	0.42-1.28	0.48-1.70	0.35-1.69	0.74-8.31
≥4 MSQ _{Adj} errors	1.03	0.71	1.54	0.59
Married	0.72-1.47	0.46-1.10	1.01-2.34	0.18-1.91
Married	1.29	1.33	0.76	0.30
Living children	0.79-2.12	0.77-2.28	0.42-1.37	0.06-1.44
Living children	0.74	1.71	0.82	1.13
Living children	0.50-1.10	1.09-2.68	0.48-1.39	0.37-3.46

HCW = Recorded Health Care Wish in Patient Record
 DPA = Durable Power of Attorney
 HC = Proxy = Health Care Proxy
 LW = Living Will

Table 4. Percentage of Patients with Code Status by Ethnicity and Demographic Characteristics

	White n = 385	Black n = 364	Hispanic n = 156	Asian n = 288	P
No code	49.6	37.6	16.0	80.2	<.001
Basic	14.3	25.0	14.1	0.4	<.001
Full code	10.0	19.0	3.9	10.1	<.001

21.4%; $P < .001$). The existence of living children did not affect a patient's choice to be 'Full Code' ($P = .980$).

Table 5 shows the estimated odds of having each code status recorded according to demographic characteristics. Controlling for the effects of other demographic characteristics by multiple logistic regression, white patients are more than twice as likely as black patients, and five times more likely than Hispanics, but only about one-third as likely as Asians, to be 'No Code.' At the same time, black patients are 2.65 times more likely than white patients, 3.11 times more likely than Hispanics, and 75 times more likely than Asians to request basic or conditional life support. Similarly, 'Full Code' status was twice as likely in blacks compared with Asians and almost 5 times more likely compared with Hispanics.

Few demographic characteristics were related to choice of code status net of the effect of ethnic background. Patients 80 years of age and older were more likely to be 'No Code' ($P < .001$) and less likely to be 'Full Code' ($P < .001$) than younger patients, and those with more than 12 years of education were less likely to request a 'Full Code' ($P = .048$).

Table 5. Odds Ratios and 95% Confidence Intervals for Code Status Associated with Ethnicity, Gender, Age, MSQ Errors, Education, Marital Status, and Presence of Living Children (Logistic Regression Model)

	No Code	Basic	Full Code
Ethnicity			
White	1.00	1.00	1.00
Black	0.49	2.65	1.60
Hispanic	0.35-0.68	1.70-4.15	0.96-2.52
Asian	0.19	0.85	0.35
Male gender	0.11-0.32	0.40-1.81	0.09-0.55
>12 years education	2.74	0.03*	0.80
>80 years old	1.86-4.03	<.01-0.25	0.47-1.37
≥4 MSQ _{Adj} errors	0.88	0.96	1.45
Married	0.63-1.24	0.59-1.57	0.94-2.25
With living children	1.05	1.29	0.46
	0.66-1.67	0.70-2.38	0.21-0.99
	1.74	0.76	0.48
	1.31-2.31	0.50-1.14	0.32-0.72
	1.09	0.86	1.08
	0.82-1.45	0.57-1.30	0.73-1.59
	1.03	1.01	1.33
	0.70-1.50	0.58-1.74	0.82-2.14
	1.31	0.48	1.08
	0.96-1.79	0.32-0.71	0.70-1.65

compared with those with less than a high school education. Patients with living children were about half as likely as those without children to request 'Basic Life Support' or a 'Conditional Code.'

DISCUSSION

Our data indicate substantial differences between whites, blacks, Hispanics, and Asians in elicited preferences for health care wishes including choice of instrument and code status net of the effects of age, gender, educational attainment, number of error on the SPMSQ, and whether there are living children. These differences may reflect differences in attitudes between whites, blacks, Hispanics, and Asians about end of life decisions and/or differences in knowledge about the purpose and function of advanced directives.

Blacks

We found that blacks were particularly unlikely to select written health care instruments such as living wills and durable powers of attorney compared with whites and Asians. This may represent a reluctance on the part of many blacks to "sign anything" out of fear of exploitation. Many black PACE program participants grew up in the Deep South under conditions of open segregation and oppression and are likely to be aware of a history of negligent treatment by the medical and research communities. In addition, poor education may contribute to an unwillingness to sign a living will or a durable power of attorney as a result of unfamiliarity with such documents.

We also found that blacks were more likely to select aggressive intervention (i.e., full code) than whites, Hispanics, or Asians. This is consistent with another study that found blacks to be more likely to seek medical intervention and life-sustaining measures, regardless of the likely futility of effort or the expected quality of life, than the general population.¹¹ It has been suggested that the high level of religiosity in this population may underlie this desire for more aggressive end of life intervention.¹²

Hispanics

The results of the study in Hispanic groups also yielded some interesting findings. Hispanics were more likely to refuse to give any form of advance directives (of the 91 participants without health care wishes recorded, 35% were attributable to refusal). A low percentage of Hispanics selected living wills and durable powers of attorney. Hispanics were least likely of all the ethnic groups to select "no code" (i.e., no life prolonging measures). Other studies have indicated the importance of religiosity as well as the importance of the daughter as primary caregiver^{11,16} in this ethnic group. These studies also have indicated a low utilization rate of health services thought to be predominately the result of inadequate access and language barriers.

Whites

Previous studies^{11,12} have also found differences between non-Hispanic whites and other ethnic groups with respect to the selection of advance directives. This is confirmed in this study. White participants were more likely to have written advance directives, including a living will or durable power of attorney, than blacks, Hispanics, or Asians. They were also less likely to have selected a surrogate to express their health

care wishes. Whites selected "no code" more often than Hispanics and blacks, but less often than Asians.

Asians

The majority of Asians (79%) in this study were Chinese Americans. Older Chinese, especially the first generation US immigrants, are reluctant to talk about death. Many believe that just talking about death can bring bad omens. Despite the reluctance to talk about death, many hold traditional cultural beliefs, rooted in the Eastern religions of Buddhism and Taoism and in Confucianism, that there is a natural time for death. Additionally, the Chinese hold great reverence for those who have died, particularly one's own ancestors.

Several factors result in the finding that few Asians were able or willing to sign legal documents such as Living Wills and Durable Powers of Attorney for Health Care. Many of the first generation older Chinese immigrants in PACE are monolingual and illiterate in English, and the accepted legal instruments are in English. Secondly, the reluctance to sign legal documents may reflect the cultural importance the Chinese place on the honor of the spoken word and verbal agreements.

Study Limitations

This study is limited by its retrospective nature and the fact that because of the non-uniform distribution of ethnic groups, location and site staff may have been co-variables and account for the differences seen (rather than ethnicity per se). This could be of particular importance in the case of Asian subjects, almost all of whom are participants in the OnLok site, which developed the model over 2 decades and is, therefore, more experienced in its application. In addition, there is no "standard method" of obtaining health care wishes across the PACE sites. Although the importance of obtaining advance directives is emphasized at OnLok and has been emphasized at all in-service training of the replication sites, there is naturally some institutional variation between sites. The differences between the PACE practitioners in obtaining health care wishes may be another variable that cannot be adequately accounted for in the current study. Thus, there may be institutional, provider, or site biases that are not accounted for in this study. In addition, the race of the person eliciting health care wishes may impact on choice of advance directives and was not addressed in this study, and differences may reflect differences in cross-cultural communication.

Further, this retrospective chart review is limited in that it reflects only what health providers recorded in the patient's record. There may be differences, based on the provider's and the patient's ethnicity, in the way that health care providers document or do not document in a patient's record. Thus, the behavior studied may reflect the health providers' behavior in recording health care wishes rather than the actual wishes of the patients themselves. The differences could, therefore, reflect differences in recording between ethnic groups rather than different choices, per se, between ethnic groups.

Other secular effects may also have influenced our results. For example, most of the Asians in our study are located in San Francisco, an area with high public discourse

on advance directives and health care proxies because of the HIV epidemic. Such publicity may have had an impact on Asians at OnLok, thus acting as a confounding variable.

CONCLUSION

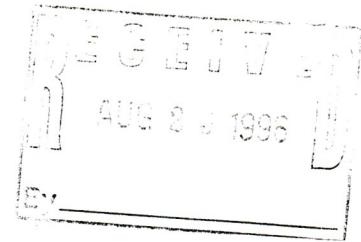
This retrospective study of health care wishes, including advance directives, among a group of frail older people enrolled in the PACE project, suggests that ethnicity has a significant impact on patient's choices and may be more important than other sociodemographic factors including gender, age, educational attainment, marital status, and the presence of children. This finding has important implications for medical personnel and highlights the need for cultural sensitivity when presenting individuals of different ethnic background with the options available to them for expressing their health care wishes.

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APPENDIX

Participating sites included Comprehensive Care Management, Bronx, NY; Elder Service Plan, East Boston, MA; Palmetto SeniorCare, Columbia, SC; Community Care For The Elderly, Milwaukee, WI; Bienvivir Senior Health Services, EL Paso, TX; Total Longterm Care, Denver, CO; OnLok/PACE, San Francisco, CA; Independent Living For Seniors, Rochester, NY; Center For Elders' Independence, Oakland, CA; and Sutter SeniorCare, Sacramento, CA.



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DEPARTMENT OF MEDICINE
DIVISION OF GERIATRICS

TO: Doctors Carlton Hornung, John Egbert, Cathy Eng, Jenny Hedgepeth, Robert McCann, Harry Strothers, Marc Sapir, Ming Wei, Malissa Wilson, Charles Bryan, James Raymond, Tom Brown, Ms. Judy Baskins, Ms. Carolyn Egbert, and Mr. Brian Jowers

FROM: G. Paul Eleazer, MD, Acting Director

Please find attached a copy of the article which appeared in the *Journal of the American Geriatrics Society*. Years in the making! In any event, it's finally out! Thanks for all of your hard work!

GPE/jw

Enclosure

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