A study of the relationship between the misconceptions of hospice care and the influence on the utilization of hospice care services

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A STUDY OF THE RELATIONSHIP BETWEEN THE MISCONCEPTIONS OF HOSPICE CARE AND THE INFLUENCE ON THE UTILIZATION OF HOSPICE CARE SERVICES

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY

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This study examines the misconception issues that influence the underutilization of hospice services by African Americans. This descriptive study was based on the premise that there is no relationship between African Americans' knowledge of hospice and their decision to utilize hospice. The results revealed that African Americans who completed the survey indicated they understand what hospice is; however the answers provided in the survey were not congruent. The conclusions drawn from the findings suggest that African Americans have misconceptions about hospice, and not a true understanding of what hospice is or how to use the service.
ACKNOWLEDGEMENTS

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CHAPTER I
INTRODUCTION

According to the National Hospice and Palliative Care Organization (2000) as the US population continues to become more racially and ethnically diverse, African Americans and other minorities are strikingly underrepresented in hospice care. The 2003 demographic information released indicated virtually no change in the underutilization of hospice programs by persons of color for the last decade: of the 885,000 persons served, 82% were white, 8% black, and 3% Hispanic/Latino.

Previous research has not isolated one specific reason for under use of hospice by African Americans. The following key factors that contribute to the under use of hospice services by members of the African American community: personal or cultural values in conflict with hospice philosophy, lack of awareness of hospice services, concern about burdening family, economic factors, mistrust of the healthcare system, and expected lack of ethnic minority employees in hospice agencies (Washington, Bickel-Swenson, Stephens, 2008).

Statement of the Problem

African Americans are less likely than Caucasians to use hospice services. Minorities were more likely to die at home and they were less likely to receive hospice care (Enguidanos & Wilber, 2005; Greiner, Pierera & Ahluwalia, 2003).
Because patients dying at home without hospice care report higher rates of pain than those patients who receive hospice care, physicians must work to ensure that minority patients understand all end-of-life care options, including hospice, and how these care options can be delivered in a culturally competent manner (Enguidanos & Wilber, 2005; Greiner, Pierera & Ahluwalia, 2003).

In 2001, African American physicians represented 4.5% of the nation's doctors and this number has not changed significantly since this report. The need for African Americans and people of color to see images of themselves when they seek help or even their ability to trust the hands that serve them is critical to their survival and recovery. Mistrust of the medical community by African Americans is not being addressed (Nettles, Millet & Wahr, 2004).

When patients are not able to trust their doctors, they are reluctant to seek care and often refuse surgery or other treatments that can help them. The fact that hospice has not fully engaged the African American community and that its outreach programs have not been effective within African American communities speak to the need for change and new outreach endeavors. Until the problem of under-utilization of hospice by African Americans is fully addressed, those variables or factors that prevent African Americans from using these services will continue to exist. (Jacobs, Rolle, Ferrans, Whitaker & Warnecke, 2006).

Although hospice is growing noticeably in the United States, under-utilization of hospice by African Americans continues to occur. Factors such as the lack of hospice education and available information, mistrust of the medical community by African Americans, and bias in the health care system may be contributors to this occurrence.
There is research that suggests that African Americans and other people of color underutilize hospice because of ineffective outreach programs (Crawley, Bolden, Payne, Washington & Williams, 2000).

In the past decade, no changes have been noted in the under-utilization of hospice programs by persons of color. Of the 885,000 persons using hospice from 1990 - 2000, 82% were Caucasians, 8% were African Americans, and 3% were Latino/Hispanic (Taxis, 2006).

A study by Born, Greiner, Sylvia, Butler and Ahluwalia (2004) found that the needs and preferences of African Americans were consistent with hospice philosophy and that home hospice may be appropriate in meeting the needs of terminally ill African Americans. Yet in spite of these findings, African Americans seem to shy away from hospice services.

Hospice providers are aware of the benefits of hospice. Health care providers should inform patients that hospice provides palliative care for individuals faced with terminal illnesses, and extend these services to grieving family members. Hospice stresses patient self-determination and acceptance of death (Reese, Ather, Nair, O'Faire & Warren, 1999).

Hospice is primarily a concept of care, not a specific place of care. The nature of dying is so unique that the goal of the hospice team is to be sensitive and responsive to the special requirements of each individual and family (Santrock, 2002).

Hospice affirms life and regards dying as a normal process. However, hospice neither hastens nor postpones death. It emphasizes the spiritual needs of the individual and the family and the individual’s spiritual care is specific to need.
An emphasis is placed on palliative care that aims to relieve symptoms and to give social, emotional, and spiritual support rather than treatment that is designed to cure, and care designed for quality of life rather than quantity of life. It is the latter two functions that sometimes raise concern for African American families (Reese, et al., 1999).

When hospice care is requested, it is often the first time that individuals or their families acknowledge that their condition is terminal. It also may be the first time that dealing with their impending death becomes a reality to both the patient and the family, emphasizing that death is near. An interdisciplinary health care team of doctors, nurses, social workers, counselors, home health aides, clergy, therapists, and trained volunteers make up the service provider team. Their purpose is to help achieve a level of comfort for the patient through pain and symptom control and to enable the patient to remain alert enough to make important decisions, as appropriate. There are many benefits of hospice care to the family (Reese, et al., 1999).

The hospice nurse or social worker meets regularly with the family to keep them informed of the patient’s condition, what to expect, and end-of-life decision-making. These meetings also provide the opportunity to share feelings, talk about expectations, and learn about death and the process of dying (Reese, et al., 1999).

According to Born, et al., (2004), African Americans value having a counselor to help the family adjust and cope with their impending loss. They find closure in knowing that their families will make it without their presence. Hospice is a viable option for African American patients who often have a need to talk and to bring closure to their families at death.
African Americans often fear being a burden or "financial drain" on their families. Yet, the need for this self-disclosure and freeing of familial responsibility for African Americans is not being met by hospice. Hospice offers in-home palliative care; however, sometimes it may be necessary to provide hospice services in a hospital, extended care facility, or a hospice inpatient facility. Participants who had been caretakers of terminal family members reported in retrospect that they would opt to use care facilities so as not to burden their own families with additional hardship. For family providers, however, hospice offers caregivers a break through respite care, which is provided in 5-day periods (Born, et al., 2004).

Patients are cared for either in the hospice facility, nursing home or hospital during this time. The hospice care team also works with surviving family members to help them through the grieving process, which is a natural occurrence following the death of a loved one. A trained volunteer, clergy member, or professional counselor provides support to survivors through visits, phone calls, letters, as well as through support groups. Bereavement services often are provided for at least a year to 13 months following the death of a loved one. In spite of these benefits, African Americans continue to restrict their use of these services (Barrett & Heller, 2002).

According to Doorenbos, Myers and Schim (2004), hospice outreach programs have failed to boost the enrollment of people of color in the utilization of their services. Most hospice programs are run by nonprofit, independent organizations. Some are affiliated with hospitals, nursing homes or home health care agencies. Knowledge about hospice programs is usually available in schools, senior day centers, hospitals, social services agencies, senior complexes, and in medical offices.
In a study by Means-White and Thornton (1989), the emergency room has become a substitute for the physician, outpatient facility and clinic. Many African Americans and people of color do not frequent these facilities and when they seek medical attention or social services, it is usually for problem-specific needs and their concentration is upon what brought them to the facility rather than available literature for reading.

The emergency room provides the door of access to healthcare and is viewed as the community physician by many African Americans and people of color. Pain and the fear of dying are what force many African Americans into the emergency room; hospital visits are not for preventive care but rather for life-sustaining illnesses or severity of pain (Satin & Duhl, 1972).

Taxis’ (2006) study explained that many African Americans’ perception of hospice does not veer from this belief and includes the presumptions that patients die alone, in pain and that even the cost of hospice is prohibitive for them. Hospice facilities and healthcare providers need to better educate patients about hospice and make their services more accessible to people of color. The emergency room is not an adequate distributor of information for African Americans and other people of color.

Purpose of the Study

The purpose of this study is to describe and explain the perceptions and understanding of hospice by African Americans and their willingness to use hospice as a provision for end-of-life and palliative care. This study will analyze the demographics and test for significant relationships between selected variables of the target population. Specifically, the researcher aimed to describe and explain the relationships between
Research Questions

The research questions of the study were as follows:

Research Question 1: Is there a relationship between misconceptions and the utilization of hospice care by African Americans?

Research Question 2: Is there a relationship between racial group and the misconceptions of hospice care by African Americans?

Research Question 3: Is there a relationship between racial group and the utilization of hospice care by African Americans?

Research Question 4: Is there a relationship between gender and the misconceptions of hospice care by African Americans?

Research Question 5: Is there a relationship between gender and the utilization of hospice care by African Americans?

Research Question 6: Is there a relationship between financial constraints and the misconceptions of hospice care by African Americans?

Research Question 7: Is there a relationship between financial constraints and the utilization of hospice care by African Americans?

Hypotheses

The null hypotheses for the study were as follows:

Hypothesis 1: There is no statistically significant relationship between misconceptions and the utilization of hospice care by African Americans.
Hypothesis 2: There is no statistically significant relationship between racial group and the misconception of hospice care by African Americans.

Hypothesis 3: There is no statistically significant relationship between racial group and the utilization of hospice care by African Americans.

Hypothesis 4: There is no statistically significant relationship between gender and the misconceptions of hospice care by African Americans.

Hypothesis 5: There is no statistically significant relationship between gender and the utilization of hospice care by African Americans.

Hypothesis 6: There is no statistically significant relationship between financial constraints and the misconceptions of hospice care by African Americans.

Hypothesis 7: There is no statistically significant relationship between financial constraints and the utilization of hospice care by African Americans.

Significance of the Study

This study adds to that body of knowledge that examines why African Americans are disproportionately under-represented as consumers of hospice care. Findings from this study will provide insight into the development of more culturally-based outreach programming; prepare healthcare professionals to more effectively work with African American patients and their families; and to expand recruitment efforts within African American communities, and other communities of color. This study also will provide recommendations for culturally-based practices within hospice services. Hospice is a very effective program for end-of-life and palliative care. However it is under-utilized by African Americans and other people of color.
There are reasons for this unevenness. This study examines some of these reasons and offers recommendations for change. Change will include aggressive actions on behalf of the medical community, social workers, and other public education resources. Policy recommendations and changes will also influence commercial, Medicare and Medicaid health insurance policies.
CHAPTER II
REVIEW OF LITERATURE

The purpose of presenting this review of literature was to lay a scholarly foundation in order to establish a need for this study. This chapter is a review of the current literature on recent efforts to research African Americans’ misconceptions of hospice services and reasons for hospice underutilization.

Historical Perspective

Hospice developed in the United States in the 1970s as a grassroots movement to promote more humane care for dying people. Hospice philosophy stresses patient self-determination, acceptance of death, and palliative rather than curative care. In addition, it advocates for dying in the home surrounded by loved ones, rather than in an institution surrounded by technology. Social workers provide hospice care in collaboration with an interdisciplinary team of professionals, who attend to biopsychosocial and spiritual needs of patients and families (Reese, et al., 1999).

Since the inception of the Medicare hospice benefit, hospice services have been available to many patients. Despite these additional sources of funding and the evidence of improved quality of care at the end of life, African Americans and members of other ethnic minority groups consistently underutilize hospice (Rhodes, 2006).

There have been studies on end-of-life decision making among racially different groups. Findings from these studies concluded that “African Americans acknowledge
that family and trusted friends can have an influence on end-of-life care decision-making that impact patient outcomes” (Kwak & Haley, 2005).

Cooper-Patrick and colleagues (1999) found that African American patients rate their visits with their physicians less participatory than whites rate their visits with physicians, but that African American patients seen by physicians of their own race rated their physicians’ decision-making styles more participatory.

African Americans facing death and bereavement issues are more likely to seek help from clergy before seeking other formal structures. Faith and belief in God have historically been strong among African Americans and their outreach to their ministers and spiritual healers often comes first. Clergy are qualified to address these issues of African Americans by integrating religious beliefs and practices about death so that dying persons and their families can find some sense of meaning and acceptance in suffering and death.

Education and advocacy about pain management by African Americans and Latino religious leaders may be an untapped resource for increasing referrals to palliative care by these population groups. Some patients believe that pain should be endured and that pain medications should be avoided because by patiently accepting God’s will, including suffering, they are pleasing God by surrendering to Him or they may believe that they deserve to suffer because of their past behaviors (Francoer, et al., 2007).

African Americans have been associated with higher odds of in-patient facility deaths. The tendency of African Americans to die in in-patient settings may reflect a greater preference for the use of life-sustaining therapies, differential access to healthcare and/or mistrust of the healthcare system. Sixty-two percent of the African Americans
surveyed reported preference to die in a hospital rather than at home (Johnson, Kuchibhatala, Sloane, Tanis, Galanos, & Tulsky, 2005).

Healthcare providers who adjust their own culture to identify with the culture of the individual patient are implementing cultural competence. Healthcare providers are prone to bias and prejudices that exist in society (Johnson, 2004).

In another study by Collins, Decker and Esquible (2006), the definition of health for elderly Hispanics and African Americans noted some differences between the groups; however more similarities were present. The study also reported the importance of avoiding stereotypes when providing care to individuals from ethnic and cultural backgrounds.

Lack of staff knowledge concerning cultural or religious beliefs within other cultures has been recently echoed as a potential reason for under-enrollment by ethinically diverse patients as well. Afrocentric blacks are likely to have a profound spiritual approach to dying. When caring for the dying many medical providers place more emphasis on the physical care of the patient. African Americans believe spirituality is an integral part of the continuum of care (Barrett & Heller, 2002).

Each unique care situation should be treated with cultural competence that specifies the needs of the client as defined by that client. Providing culturally competent healthcare services for ethnically diverse cultures is especially important for occasions of great emotion such as a terminal illness and death, which heighten the cultural dimensions for a person and their family (Doorenbos & Myers, 2004).

Cultural barriers of differences in values regarding medical care and spiritual beliefs exist between African Americans and European Americans. African American
hospice access is limited by institutional barriers, including lack of knowledge of services, economic factors, lack of trust by African Americans in the healthcare system and lack of diversity among healthcare staff (Reese, Ahern, Nair, O’Faire & Warren, 1999).

Jacobs, et al., (2006) found that study participants did not trust foreign doctors because of language and cultural differences. The majority of respondents indicated that the race of the physician did not matter. Many respondents had experiences with black and white doctors and never had a bad experience.

Participants reported that experimentation in the healthcare setting affected their views of the trust worthiness of physicians. Trusting physician relationships were important to decision making about seeking care and following treatment recommendations and the patient’s openness and honesty with physicians (Jacobs, et al., 2006).

Participants indicated that it is both the legacy of Tuskegee and also the reinforcement of the expectations of mistreatment in the present day that contribute to their distrust. Respondents indicated that distrust in physicians often led them to forgo care by refusing surgery or other treatment, withdrawing from care all together, or not seeking it in the first place. It also led some patients to change physicians (Jacobs, et al., 2006).

Physician communication with patients, sources of healthcare and demographics account for most ethnic and racial differences of cultural competence. More importantly the above factors are not explaining differences in perceptions of healthcare system wide bias and cultural competence (Johnson, 2004).
Unequal access to all medical care, including hospice and palliative care, is a major obstacle for African Americans and other minority groups. Financial disincentives also create barriers to access to hospices for disadvantaged patients. The emphasis on home care presumes the availability of a full-time caregiver. Constraints in the Medicare Hospice Benefit program mandating in-home care particularly affect disadvantaged patients, including African Americans and those patients residing in inner urban areas where high proportions of persons may live alone or when family support for in-home care is limited (Reese, et al., 1999; Gordon, 1996; Crawley, 2000).

Patients without adequate insurance may be at a disadvantage with respect to receiving hospice care unless hospice agencies are willing to provide unreimbursed care. A number of factors may influence whether or not a person receives unreimbursed hospice care. Having insurance coverage for hospice services as well as for particular patient the factors that affect how hospices distribute charity care (Lorenz, et al., 2003).

Keeping the faith or hope seemed to involve an obligation on their own part to continue to struggle against the disease using medical interventions, all the while acknowledging God's ultimate control. The belief that the end of life is in God's hands may mean for some that planning for the end of life is unnecessary or irrelevant. Some African Americans want the human interventions of aggressive medical care, yet believe that the end of life is beyond human control (Torke, Garas, Sexson & Branch, 2005).

Quality end-of-life care requires attention to cultural differences. Community and cultural ties may provide a great source of comfort as patients and families prepare for death (Crawley, Marshall, Lo, & Koenig, 2002).
Barriers voiced by participants were primarily related to access to care. Lack of awareness of hospice services emerged as the barrier to most often cited to explain lack of utilization of hospice services. Given the cost of healthcare and the low income level of the study participants, inability to pay for care was sighted as a significant factor to receiving any kind of healthcare. The primary themes that emerged in these focus groups suggests that the needs and preference of African Americans are consistent with the priorities espoused by the hospice movement and that home hospice services may be particularly well suited to meeting these needs (Born, et al., 2004).

Misconception of Hospice Influence by African Americans

The author indicated a prominent barrier to hospice involvement is cultural mistrust. Many African Americans continue to remember the Tuskegee Syphilis Study and its abuses of African American men. African Americans’ involvement in hospice by appearing in videos, brochures and hospice facilities may assist in the recruitment process for African American participation, and may begin to limit some of the mistrust that currently exists. Taxis also investigated the cultural values associated with end-of-life care and how these values interface with the philosophical stance of hospice programs. She found that acknowledging the African American perspective regarding end-of-life issues is important to successful treatment (Taxis, 2006).

Membane (1999) found that physician race is associated with differences in attitudes and preference regarding use of end-of-life care. The study found that many African Americans prefer to be treated by a physician of the same race.

Volker (2005) investigated perceptions of hospice from the recipients’ viewpoint, and not from the healthcare provider’s viewpoint. Participants in Volker’s study had a
healthcare provider (HCP), whereas most studies only evaluated participants with no HCP. Healthcare providers in this study were challenged to assist patients, to recognize their values, and articulate to the patient the preferred method of treatment in a way that was respectful of the patient’s unique cultural background. Volker found that participants in this study evaluated their healthcare provider services as favorable and meaningful in their overall treatment process.

Minorities are less likely to receive adequate pain relief and that the reasons for this occurrence are varied. Many African Americans fear a painful death and using hospice services would incorporate palliative care to help alleviate pain. (Crawley, Marshall, Lo, & Koeing, 2002).

Born (2004) reported that lack of access to care, mistrust of end-of-life care, and strong existing spiritual support systems may contribute to the under-utilization of hospice care. The spiritual support systems are used instead of hospice services although hospice does allow patients to incorporate spirituality into their plan of care.

Much of the mistrust by African Americans of hospice is their misconception that hospice services are mostly staffed by Caucasians. The low visibility of minority professionals and the lack of formal programs to provide care in a culturally sensitive way also contribute to the problem of mistrust by African Americans (Kapo, et al., 2005).

Utilization of Hospice Services by African Americans

In a study by Halbert, Armstrong, Gandy and Lee (2006), low trust was found with patients who received care from physicians of another race regardless of setting, i.e., emergency room, clinic, or mobile clinic. Trust appears to be an issue among African Americans, especially in relation to medical care and services. It is possible that as access
to healthcare improves for African Americans, trusting relationships may begin to evolve.

Haas (2007), in a study of elderly Medicare cancer beneficiaries, found that hospice care was less commonly used by individuals who lived in areas with a high percentage of African Americans and Hispanic residents, but commonly used in areas with a low minority census tract. These findings also suggest that there may be limited understanding of hospice or social acceptance of hospice care in these areas.

Desharnais, Carter, Hennessey, Kurrent and Carter (2007) reported that physician and patient communication regarding the patient’s preference for end-of-life care, pain management and communications regarding financial and spiritual factors that influence use of hospice was very low.

Francoer, Payne, Raveis and Shim (2007) found that race and ethnicity shape how individuals cope with chronic illnesses. They reported that race and ethnicity critically shape the experience of coping with chronic conditions and the experience of dying, with a considerable portion of these processes mediated by low socioeconomic status, which was found to be a powerful predictor of health and well-being.

Barriers to palliative healthcare among ethnic minorities may be closely tied to barriers that restrict access to healthcare. Many minority patients and caregivers, the dense social ties of the extended family and church communities provide alternate sources of support which should be carefully integrated into palliative and end-of-life programs.

Recommendations by the participants in the Crawley, et al., (2002) study for improving trust of African Americans’ utilization of hospice included communicating in
terms that the patient and family can understand, asking questions about the needs of the patient and family, waiting for answers and allowing time for dialogue on all levels between healthcare providers and patients. Crawley further reported that these behaviors also were instrumental in providing culturally sensitive care.

The surfacing of cultural mistrust and lack of hospice education in the study were congruent with previously reported barriers to African Americans’ use of hospice. Bias and cultural competence regarding racial and ethnic differences in patient’s perceptions have been measured (Taxis, 2006).

Afrocentric Perspective

Fatalism is a belief that some health issues are beyond human control on the basis of certain views about luck, fate, predestination, and destiny. “Let go and let God” or “It is the Lord’s will” are beliefs that many African Americans embrace especially during times of suffering which both support the fatalism doctrine (Powe & Finnie, 2004).

The Afrocentric approach seeks a perspective of constructive view of African American behavior and it formulates a conception of life that identifies African people with African cultural origins rather than a European cultural origin assumed by Eurocentric scholars. The relationship between cultural, economic and political oppression and spiritual alienation of African Americans and the resulting social problems like youth violence and substance abuse is embedded in the Afrocentric perspective. Most social problems are seen as being rooted in this oppression and spiritual alienation. The problem in a multiethnic and multicultural society in which cultural oppression prevails is that often times the cultural distinctiveness of the culturally oppressed is hidden or suppressed (Schiele, 1997).
Theoretical Framework

Terror Management Theory (TMT) is a theory based on existentialism, which explains how fear of death underlies much of what we do. It focuses on the psychological mechanisms that we use to buffer the anxiety aroused by death awareness. In order to ward off this anxiety, according to terror management theorists, we create and participate in culture (Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004).

By participating in culture, we are able to provide our lives with order, structure, meaning, and even permanence. The TMT theory supports the African American experience regarding end of life issues. According to the TMT theory people are afraid of dying and will use their cultural values to ease that fear (Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004).

Many members of the African American community incorporate spirituality and communalism through the end of life process. What many African Americans are not aware of is that hospice also incorporates spirituality, communalism and palliative care. Hospice’s goal is for patients to be as comfortable as possible through the end of life process. TMT also holds that religious faith leads to the promise of literal immortality, the continuation of life in some form after bodily death.

Expectations of both symbolic and literal immortality achieved through participation in the cultural worldview are implemented to reduce fear of death (Cicirelli, 2002). In Cultural Values and Secondary Prevention of Breast Cancer in African American Women, Beckjord and Klassen, (2008) found individuals’ values are strongly influenced by the social groups to which the individuals belong; thus, social groups are expected to hold shared cultural values, notwithstanding individual variation in values.
within groups. Understanding a patient’s spiritual core beliefs could greatly facilitate the
doctor’s ability to honor the patient’s wishes for end-of-life care.

Additionally, bearing witness to a patient’s faith is often a therapeutic act,
whether or not the physician shares these beliefs. If comfort is derived through belief, the
doctor can bear witness to this comforting nature of the patient’s spirituality. Speaking to
us about the providence of God and experiencing closeness to God seemed to aid our
patients as they approached the end of life. (Branch, Torke, Brown-Haithco, 2006).
CHAPTER III
METHODOLOGY

Chapter III presents the methods that were used in conducting the research study. The following topics were utilized: research design; description of the site, sample and population; instrumentation; treatment of data, and limitations of the study.

Research Design

A descriptive and explanatory research design was utilized in the study. This research design allowed the researcher to measure the major variables under consideration. The study was designed to collect data in order to describe and explain the misconceptions about hospice care and the influence these misconceptions have on the utilization of hospice care services.

The descriptive and explanatory research design allowed for an analysis of the demographic attributes of the respondents, the computation of the misconceptions and the utilization of hospice care services. The research design also allowed for a descriptive analysis and an explanation of the statistical relationship between the misconceptions about hospice care and the utilization of hospice care services. The design facilitated the analysis of seven research questions and seven null hypotheses that was designed to add to the knowledge about how misconceptions of hospice care and the influence these misconceptions had of hospice care services.
Description of the Site

The research study was conducted in Atlanta, Georgia. Atlanta is the largest urban metropolitan city in the State of Georgia. Surveys were administrated in a major public park near the downtown section of the city. The park was an ideal focal point for data. It is home to various annual celebrations and events and is the gathering place for organized sports, exhibits and an array of other activities open to the general public (Piedmont Park Conservancy, 2007). In addition, the park proved to be an ideal setting for the study because of the random demographic of park attendees and volunteer participants.

Sample and Population

The target sample and population were individual randomly selected at a public park in downtown Atlanta, Georgia. Participants selected were a minimum of 18 years of age who self identified themselves as African Americans, black, or of African descent. All of the participants were volunteers and all participants indicated English as their first language.

Instrumentation

The study utilized a fifty-five item survey questionnaire to solicit information from participants. The researcher utilized two previous research studies as a guide in the development of the questionnaire for the study. The two studies that were used as a guide included a study that focused on attitudes to end-of-life issues by Catt, Blanchard, Addington-Hall, Aiz, Blizard and King (2005), and research conducted on attitudes, knowledge and barriers to increased hospice use by Ogle, Mavis and Wang (2003).
The fifty-five items in the survey focused on the knowledge, understanding and attitudes of African Americans towards hospice use. A Likert scale was utilized to determine measurements. The survey questionnaire was designed to be completed in less than fifteen minutes. A consent form was provided with each questionnaire. All of the responses were considered confidential.

Treatment of Data

Data was collected and stored in the office of the research advisor. Data included descriptive statistics such as measures of central tendency, frequency distribution, and crosstabulations. The test statistics for the study were phi and chi square.

Frequency distribution was used to analyze each of the variables of the study. Frequencies was used to develop a demographic profile and to analyze the specific measurements of variables. Crosstabulations were used to demonstrate the statistical relationships between variables.

Two test statistics were used to test hypotheses. Chi square was used to test whether there was a significant statistically significance at the .05 level of probability among the variables, and Phi (Φ) was used to demonstrate the strength of relationship between two or more variables (Bromstead & Knoke, 1995). The following are the values associated with the phi test statistics:

- .00 to .24  “no relationship”
- .25 to .49  “weak relationship”
- .50 to .74  “moderate relationship”
- .75 to 1.00 “strong relationship”
Limitations of the Study

The study is specific only to those participants who voluntarily participated and cannot be generalized to other population groups. Findings are based upon self-reports and these reports may have been affected by the sequencing of the introduction to the survey and research. Participant response bias to the survey items and an inability to establish a causal relationship between independent and dependent variables also are limitations.
CHAPTER IV

PRESENTATION OF FINDINGS

The purpose of this chapter was to present the findings of the study in order to describe and explain the relationship between the misconceptions and utilization of hospice care by African Americans. The findings are organized into the following sections: demographic data; misconceptions and utilization of hospice care services, research questions and hypotheses.

Demographic Data

This section provides a profile of the study respondents. Descriptive statistics were used to report and analyze the following: gender, racial group, level of education, and understanding of hospice care. The target group for the research was composed of adults and families who are familiar with hospice care services and facilities in the Atlanta metropolitan area.

Fifty individuals were surveyed with a questionnaire that contained fifty-five questions designed to ascertain information about hospice care services, their misconceptions and utilization of hospice services and also how their misconceptions influenced by their utilization of these services. The demographic variables utilized for the purposes of the study were as follows: gender, racial group, age group, level of education and an understanding of hospice care.

25
Table 1

Demographic Profile of Study Respondents (N=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>30</td>
<td>60.0</td>
</tr>
<tr>
<td>Male</td>
<td>20</td>
<td>40.0</td>
</tr>
<tr>
<td>Racial Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>44</td>
<td>88.0</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>12.0</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>16</td>
<td>32.0</td>
</tr>
<tr>
<td>30-39</td>
<td>20</td>
<td>40.0</td>
</tr>
<tr>
<td>40-49</td>
<td>8</td>
<td>16.0</td>
</tr>
<tr>
<td>50 yrs up</td>
<td>6</td>
<td>12.0</td>
</tr>
<tr>
<td>Level of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than High School</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>High School</td>
<td>10</td>
<td>20.0</td>
</tr>
<tr>
<td>2 yrs College</td>
<td>12</td>
<td>24.0</td>
</tr>
<tr>
<td>4 yrs College</td>
<td>21</td>
<td>42.0</td>
</tr>
<tr>
<td>Graduate School</td>
<td>6</td>
<td>12.0</td>
</tr>
<tr>
<td>Understand Hospice Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42</td>
<td>84.0</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>16.0</td>
</tr>
</tbody>
</table>
As shown in Table 1, the typical respondent was an African American female who was between the ages of 30 to 39 years old with four years of college and had a very good understanding of hospice care services.

**Misconceptions and Utilization of Hospice Care Services**

Although participants in this study indicated that they had a clear understanding about hospice care, participated indicated that they had misconceptions which tend to influence their utilization of the hospice care services. Based on this indication there was a need to calculate the indicators of misconceptions and the factors that influence the utilization of hospice care services.

Table 2 is a frequency distribution of eight research statements that were used to explain the misconceptions participants had about hospice care services. Table 2 indicates whether or not the respondents agreed or disagreed with a statement that represented a misconception about hospice care.

**Table 2**

**Misconceptions about hospice care (N=50)**

<table>
<thead>
<tr>
<th>Misconceptions</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>1. Hospice means a patient will die soon</td>
<td>24</td>
<td>48.0</td>
</tr>
<tr>
<td>2. Hospice offers care to families after patient dies</td>
<td>24</td>
<td>48.0</td>
</tr>
<tr>
<td>3. Hospice can be an in-home service</td>
<td>45</td>
<td>90.0</td>
</tr>
<tr>
<td>4. Hospice care is the same as home health service</td>
<td>7</td>
<td>14.0</td>
</tr>
<tr>
<td>5. Hospice care includes service in nursing homes</td>
<td>31</td>
<td>62.0</td>
</tr>
<tr>
<td>6. Hospice care includes respite care</td>
<td>29</td>
<td>58.0</td>
</tr>
<tr>
<td>7. Hospice care uses drugs to speed up death</td>
<td>7</td>
<td>14.3</td>
</tr>
<tr>
<td>8. In hospice care death is a homecoming</td>
<td>44</td>
<td>88.0</td>
</tr>
</tbody>
</table>
As shown in Table 2, participants indicated that they agreed with four of the eight research statements (3, 5, 6, & 8) as indicators of misconceptions about hospice care. The other statements (1, 2, 4, & 7) indicated that they disagreed that the statements were indicators of misconceptions about hospice care. The eight statements were computed as MISCON (Misconceptions) variable in order to calculated test statistics for the study.

Table 3 is a frequency distribution of eight research statements that was used to explain the factors which influence the utilization of hospice care services by the participants of the study. Table 3 indicates whether or not the respondents agreed or disagreed that the statements influenced the utilization of hospice care.

Table 3

Factors which influence utilization of hospice care (N=50)

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>#</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>1. Death does not have to be painful</td>
<td>27</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>55.1</td>
<td>44.9</td>
</tr>
<tr>
<td>2. Motives of provider suggesting hospice care</td>
<td>8</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>16.3</td>
<td>83.7</td>
</tr>
<tr>
<td>3. Trusting a healthcare provider of another race</td>
<td>8</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>16.3</td>
<td>83.7</td>
</tr>
<tr>
<td>4. Healthcare institution the represent black culture</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>40.8</td>
<td>59.2</td>
</tr>
<tr>
<td>5. Healthcare provider incorporates spirituality</td>
<td>15</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>30.6</td>
<td>69.4</td>
</tr>
<tr>
<td>6. Hospice care is expensive</td>
<td>31</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>62.0</td>
<td>38.0</td>
</tr>
<tr>
<td>7. African American owned hospice in Atlanta area</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>40.0</td>
<td>60.0</td>
</tr>
<tr>
<td>8. Hospice care is covered by insurance</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>56.0</td>
<td>44.0</td>
</tr>
</tbody>
</table>

As shown in Table 3, participants indicated that three of the eight research statements (1, 6, & 8) agreed that they were factors that influenced the utilization of hospice care. The other statements (2, 3, 4, 5 & 7) disagreed that they represented factors
that influenced the utilization of hospice care. The eight statements were computed as a
UTILZE (Utilization) variable in order to calculated test statistics for the study.

Research Questions and Hypotheses

There were seven research questions and seven null hypotheses in the study. This
section provides an analysis of the research questions and a testing of the null
hypotheses.

Research Question 1: Is there a relationship between misconceptions and the utilization
of hospice care by African Americans?

Hypothesis 1: There is no statistically significant relationship between misconceptions
and the utilization of hospice care by African Americans.

Table 4 is a crosstabulation of the variables misconceptions by utilization of
hospice care services. It shows the relationship between the misconceptions about
hospice care and the utilization of hospice care services. The table indicates whether or
not there was a significant relationship between the two variables.
As shown in Table 4, a majority or 52.1% of the respondents agreed that they had misconceptions about hospice care services. A minority or 12.5% disagreed that misconceptions influenced their utilization of hospice care services.

Phi (Φ) and chi square (p) were employed as test statistics to measure the strength of the relationship and the statistical significance of the variables to each other. As indicated in Table 4, there was no relationship (Φ = .244) determination between the two variables. When chi square statistical test for significance was applied, the null hypothesis was rejected (p = .091) indicating that there was not a statistically significant relationship between the two variable at the .05 level of probability.

Research Question 2: Is there a relationship between racial group and the misconceptions of hospice care by African Americans?

Hypothesis 2: There is no statistically significant relationship between racial group and the misconception of hospice care by African Americans.
Table 5 is a crosstabulation of the variables racial group by misconceptions of hospice care services. It shows the relationship between racial groups and misconceptions about hospice care services. The table indicates whether or not there was a significant relationship between the two variables.

Table 5

Racial Group by Misconceptions of Hospice Care Services

<table>
<thead>
<tr>
<th>Misconceptions</th>
<th>Agree</th>
<th>Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>African American</td>
<td>34</td>
<td>69.4</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>12.2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>81.6</td>
<td>9</td>
</tr>
</tbody>
</table>

\[ \Phi = .177 \quad df \ 1 \quad p = .215 \]

As shown in Table 5, a majority or 69.4% of African Americans agreed that they had misconceptions about hospice care services. The Other racial group in the study also agreed (12.2%) that had misconceptions about hospice care services.

Phi (\(\Phi\)) and chi square (\(p\)) were employed as test statistics to measure the strength of the relationship and the statistical significance of the variables to each other. As indicated in Table 5, there was a no relationship (\(\Phi = .177\)) determination between the two variables. When the chi square test for statistical significance was applied, the null hypothesis was rejected (\(p = .215\)) indicating that there was not a statistically significant relationship between the two variables at the .05 level of probability.
Research Question 3: Is there a relationship between racial group and the utilization of hospice care by African Americans?

Hypothesis 3: There is no statistically significant relationship between racial group and the utilization of hospice care by African Americans.

Table 6 is a crosstabulation of the variables racial group by utilization of hospice care services. It shows the relationship between racial groups and the utilization of hospice care services. The table indicates whether or not there was a significant relationship between the two variables.

As shown in Table 6, the largest number or 45.8% of African Americans agreed that racial groups influenced their utilization of hospice care services. However, near the same percentage of African Americans or 41.7% disagreed that racial groups influenced their utilization of hospice care.
Table 6

Racial Group by Utilization of Hospice Care Services

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Agree</th>
<th></th>
<th>Disagree</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Racial Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>22</td>
<td>45.8</td>
<td>20</td>
<td>41.7</td>
<td>42</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>12.5</td>
<td>0</td>
<td>0.0</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>58.3</td>
<td>20</td>
<td>41.7</td>
<td>48</td>
</tr>
</tbody>
</table>

\[ \Phi = .177 \quad df \quad 1 \quad p = .215 \]

The Other racial group in the study also agreed (12.5%) that racial groups influenced their utilization of hospice care services.

As indicated in Table 6, phi (\( \Phi \)) and chi square (\( p \)) were employed as test statistics to measure the strength of the relationship and the statistical significance of the variables to each other. As indicated in Table 5, there was no relationship (\( \Phi = .177 \)) determination between the two variables. When the chi square test for statistical significance was applied, the null hypothesis was rejected (\( p = .215 \)) indicating that there was not a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 4: Is there a relationship between gender and the misconceptions of hospice care by African Americans?

Hypothesis 4: There is no statistically significant relationship between gender and the misconceptions of hospice care by African Americans.
Table 7 is a crosstabulation of the variables gender by misconceptions of hospice care services. It shows the relationship between the gender of the participants and their misconceptions about hospice care services. The table indicates whether or not there was a significant relationship between the two variables.

Table 7

Gender by Misconceptions of Hospice Care Services

<table>
<thead>
<tr>
<th>Misconceptions</th>
<th>Agree</th>
<th>Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>42.9</td>
<td>8</td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
<td>38.8</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>81.6</td>
<td>9</td>
</tr>
</tbody>
</table>

Φ = .287       df 1       p = .045

As shown in Table 7, the largest number or 42.9% of the females agreed that they had misconceptions about hospice care services. The males in the study also agreed (38.8%) that they had misconceptions about hospice care services. However, a significant percentage or 16.3% of the females disagreed that they had misconceptions about hospice care services.

Phi (Φ) and chi square (p) were employed as test statistics to measure the strength of the relationship and the statistical significance of the variables to each other. As indicated in Table 7, there was a weak relationship (Φ = .287) between the two variables. When the chi square test for statistical significance was applied, the null hypothesis was
accepted \((p = .045)\) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 5: Is there a relationship between gender and the utilization of hospice care by African Americans?

Hypothesis 5: There is no statistically significant relationship between gender and the utilization of hospice care by African Americans.

Table 8 is a crosstabulation of the variables gender by utilization of hospice care services. It shows the relationship between the gender of the participants and their utilization of hospice care services. The table indicates whether or not there was a significant relationship between the two variables.
Table 8

Gender by Utilization of Hospice Care Services

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Agree</th>
<th>Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>13</td>
<td>29</td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>20</td>
<td>48</td>
</tr>
</tbody>
</table>

Φ = .079 df 1 p = .583

As shown in Table 8, the largest number or 33.3% of the females agreed that their utilization of hospice care was influenced by gender. However, a significant percentage of the females (27.1%) disagreed that they their utilization was influenced by gender. Of the males in the study 38.8% agreed that their utilization of hospice care was influenced by gender. A significant percentage or 27.1% of the female disagreed that their utilization was influence by gender. Also, a significant percentage of males or 25.0% agreed that their utilization was influenced by gender.

Phi (Φ) and chi square (p) were employed as test statistics to measure the strength of the relationship and the statistical significance of the variables to each other. As indicated in Table 7, there was a no relationship (Φ = .079) between the two variables. When the chi square test for statistical significance was applied, the null hypothesis was rejected (p = .583) indicating that there was no statistically significant relationship between the two variables at the .05 level of probability.
Research Question 6: Is there a relationship between financial constraints and the misconceptions of hospice care by African Americans?

Hypothesis 6: There is no statistically significant relationship between financial constraints and the misconceptions of hospice care by African Americans.

Table 9 is a crosstabulation of the variables financial constraints by misconceptions of hospice care services. It shows the relationship between the financial constraints of the participants and their misconceptions of hospice care services. The table indicates whether or not there was a significant relationship between the two variables.

Table 9

Financial Constraints by Misconceptions of Hospice Care Services

<table>
<thead>
<tr>
<th>Misconceptions</th>
<th>Agree</th>
<th>Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Financial Constraints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td>48.9</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>31.9</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>80.9</td>
<td>9</td>
</tr>
</tbody>
</table>

As shown in Table 9, the largest number or 48.9% of the participants who said yes to the question agreed that they had financial constraints related to the misconceptions of hospice care. However, a small percentage or 17.0% of these participants who also said yes disagreed that they had financial constraints because of the
misconceptions they had about hospice care. A significant percentage or 31.9% of participants who answered no to the question also agreed that they had misconceptions about hospice care.

Phi (Φ) and chi square (p) were employed as test statistics to measure the strength of the relationship and the statistical significance of the variables to each other. As indicated in Table 9, there was a weak relationship (Φ = .236) between the two variables. When the chi square test for statistical significance was applied, the null hypothesis was rejected (p = .106) indicating that there was no statistically significant relationship between the two variables at the .05 level of probability.

Research Question 7: Is there a relationship between financial constraints and the utilization of hospice care by African Americans?

Hypothesis 7: There is no statistically significant relationship between financial constraints and the utilization of hospice care by African Americans.

Table 10 is a crosstabulation of the variables financial constraints by utilization of hospice care services. It shows the relationship between the financial constraints of the participants and their utilization of hospice care services. The table indicates whether or not there was a significant relationship between the two variables.
Table 10

Financial Constraints by Utilization of Hospice Care Services

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Agree</th>
<th>Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Financial Constraints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>39.1</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>19.6</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>58.7</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>46</td>
<td>100.0</td>
<td>46</td>
</tr>
</tbody>
</table>

\[ \Phi = 0.236 \quad df = 1 \quad p = 0.106 \]

As shown in Table 10 the largest number or 39.1% of the participants who said yes to the question agreed that they had financial constraints related to the utilization of hospice care. However, a significant percentage or 26.1% of participants who also answered yes to the question disagreed that they had financial constraints issues about hospice care. A small percentage or 19.6% of these participants who said no disagreed that they had financial constraints because of their utilization they of hospice care.

Phi (\( \Phi \)) and chi square (\( p \)) were employed as test statistics to measure the strength of the relationship and the statistical significance of the variables to each other. As indicated in Table 10, there was a weak relationship (\( \Phi = 0.236 \)) between the two variables. When the chi square test for statistical significance was applied, the null hypothesis was rejected (\( p = 0.106 \)) indicating that there was no statistically significant relationship between the two variables at the .05 level of probability.
CHAPTER V

DISCUSSION OF FINDINGS

The intent of this study was to describe and explain the perceptions and understanding of hospice by African Americans and their willingness to use hospice as a provision for end-of-life and palliative care. This study also analyzed the target population and answered seven research questions about African Americans, misconceptions and utilization of hospice care services.

The conclusions and recommendations of the research findings are presented in this chapter. Each question is presented in order to summarize the significant findings of interest.

Research Question 1: Is there a relationship between misconceptions and the utilization of hospice care by African Americans?

In order to determine if there was a relationship between misconceptions and the utilization of hospice by African Americans a cross tabulation of the two variables was tabulated. The analysis indicated that of the 48 respondents 25 or 52.1 percent agreed that there was a relationship between the two variables. Also when the test statistic (chi square) was applied the results indicated there was a no relationship (.244) determination between the two variables.

Research Question 2: Is there a relationship between racial group and the misconceptions of hospice care by African Americans?
In order to determine if there was a relationship between racial group and the misconceptions of hospice care by African Americans in the study a cross tabulation of the two variables was tabulated.

The analysis indicated that of the 49 respondents 34 or 69.4 percent agreed that there was a relationship between the two variables. Also when the test statistic (chi square) as applied the results indicated that there was a no relationship (.177) between the two variables.

Research Question 3: Is there a relationship between racial group and the utilization of hospice care by African Americans?

In order to determine if there was a relationship between racial group and the utilization of hospice care services by African Americans. The analysis indicated that of the 48 respondents 22 or 45.8 percent agreed that there was a relationship between the two variables. Also, when the test statistic (chi square) was applied the results indicated that there was no relationship (.177) between the two variables.

As shown in Table 5, the largest number or 45.8% of African Americans agreed that racial groups influenced their utilization of hospice care services. However, near the same percentage of African Americans or 41.7% disagreed that racial groups influenced there utilization of hospice care.

Research Question 4: Is there a relationship between gender and the misconceptions of hospice care by African Americans?

Hypothesis 4: There is no statistically significant relationship between gender and the misconceptions of hospice care by African Americans.
In order to determine if there was a relationship between gender and the misconceptions of hospice care by African Americans a cross tabulations of the two variables was tabulated. The analysis indicated that of the 49 respondents 42.9 percent or 29 of the females agreed they had misconceptions about hospice care services. The males 38.8 percent or 19 of the males agreed that they had misconceptions about hospice care services. Also, when the test statistic (chi square) was applied the results indicated that there was a weak relationship (.287) between the two variables.

Research Question 5: Is there a relationship between gender and the utilization of hospice care by African Americans?

In order to determine if there was a relationship between gender and the utilization of hospice care by African American a cross tabulation of the two variables was tabulated. The analysis indicated that of the 48 respondents 33.3 percent or 16 females agreed that there utilization of hospice. Of the males in the study 25.0 percent or 12 males agreed that hospice utilization. Also when the test (chi square) was applied to the results there was no statistically significant relationship (.079) between the two variables at the .05 level of probability.

Research Question 6: Is there a relationship between financial constraints and the misconceptions of hospice care by African Americans?

In order to determine if there was a relationship between financial constraints and the misconceptions of hospice care by African Americans a cross tabulation of the two variables was tabulated.

The analysis indicated that of the 47 respondents 23 or 48.9 percent who said yes to the question agreed that they had financial constraints related to the misconceptions of
hospice care. Also when the test statistic (Phi) was applied to the analysis the results indicated that there was a weak (.236) relationship between the two variables.

Research Question 7: Is there a relationship between financial constraints and the utilization of hospice care by African Americans?

In order to determine if there was a relationship between financial constraint and utilization of hospice care a cross tabulation of the two variables was tabulated. The analysis indicated that of the 46 respondents 18 or 39.1 percent of the participants agreed that they had financial constraints related to the utilization of hospice care.

Also when the test statistic (Phi) was applied to the analysis the results indicated that there was a weak relationship (.236) between the two variables.

Implications for Social Work

Social Workers can explain the importance of Advanced Directives and the hospice insurance benefit. Patients need the facts about life sustaining treatments, and lower costs of hospice care. Hospice should be presented as a convergence of the African American perspective and hospice philosophy. Palliative care instead of curative care and acceptance of death support the hospice philosophy. The African American perspective supports the ideas that God is in control; therefore, life-sustaining measures may or may not determine whether or not one lives.

Social workers must continue to work with researchers by seeking input from clients and to use the facts to change policy. However, the benefits of your participation include an increase in the knowledge of hospice services. Results from this study will be used for further research to aid other social workers, researchers, and the medical
community in making hospice services conducive to members of the African American community.

This and similar studies are important to the discipline of social work and healthcare providers because it brings attention to the under utilization of hospice by African Americans and provides insight into why this may be so. It is important for social workers and healthcare providers to understand the dynamics and causes for under-utilization of hospice and palliative care in order to more effectively reach out to and embrace African American communities’ use of hospice. This study addresses understanding, attitudes and perception of hospice by African Americans. Healthcare providers, organizations, social workers and caregivers can use this information to aggressively recruit and distribute information by targeting African American communities.

The strengths perspective places values at the heart of its guidance about how clients and workers develop and integrate a growing sense of self-awareness and virtue in their lives. In the strengths perspective lived experience or wisdom is valued over positivist scientifically derived knowledge. The client becomes the central source of knowledge. Knowing the clients' personal truth is a crucial dynamic driving the empowerment and healing process. Social workers in palliative and end of life care shall demonstrate an attitude of compassion and sensitivity to clients, respecting clients' rights to self-determination and dignity. Social workers shall be aware of their own beliefs, values, and feelings and how their personal self may influence their practice.
Afrocentric human service seeks to describe, explain, solve and prevent the problems that people face. The focus of the Afrocentric human service extends beyond the scope of people of African ancestry to address problems that confront all people.
APPENDICES
APPENDIX A

INFORMED CONSENT

We, Robin Goodwyn and Angie Braxton, two MSW students from the Whitney M. Young Jr. School of Social Work at Clark Atlanta University; under the direction of Aisha Tucker-Brown, Whitney M. Young Jr. School of Social Work, Clark Atlanta, will be conducting a research study to examine knowledge of hospice in the African American community of the Metro Atlanta area. We are seeking to find out why so many African Americans are not utilizing hospice services. The study is titled “AFRICAN AMERICANS AND HOSPICE KNOWLEDGE”. We will be surveying African American individuals ages 18 and over. Identification on surveys will use ID numbers instead of names to ensure confidentiality.

The survey will consist of 55 questions comprised of both yes/no and agree/disagree format and should take approximately 20 minutes to complete. At any time, you can refuse to participate or stop taking part in the study without giving any reason, and without penalty. You will endure no harm during the duration of this study. However, the benefits of your participation include an increase in the knowledge of hospice services. Results from this study will be used for further research to aid other social workers, researchers, and the medical community about making hospice services conducive to members of the African American community. Confidentiality will be
APPENDIX A

(continued)

maintained after the study is concluded. Once the study is completed you may request a copy of the results by contacting the Office of Graduate Studies at Clark Atlanta University.

You may also contact the Institutional Review Board through Dr. Georgianna Bolden, Office of Research and Sponsored Programs at (404) 880-6979 for research-related problems or questions regarding subjects’ rights. We will be available to answer any further questions about the research, now or during the course of the project and can be reached at either of the following telephone numbers, (404) 217-2356 or (916) 548-3752. No identifying information about you will be shared with others without my written permission. All information disclosed on the surveys will be kept confidential.

By signing this consent form, you are agreeing to take part in this research project and understand that you will receive a signed copy for your records. Please sign both copies, keep one and return one to the researcher.

__________________________________________________________
Signature of Participant                                      Date

Robin Goodwyn (Investigator)
(404) 217-2356 or robin.goodwyn@student.cau.edu

__________________________________________________________
Angie Braxton (Investigator)                                  Date
(916) 548-3752 or a_geordai@yahoo.com
APPENDIX B
SURVEY QUESTIONNAIRE

ID#___________

TELL ME ABOUT HOSPICE

PART I

Please answer the following demographic questions to the best of your ability.

1. What is your age?
2. What is your gender?
3. What race do you identify with? (Circle one)
   Black Bi-Racial Other
4. What is your highest level of education completed? (Circle one)
   Less than high school High school College (2 yr)
   College (4yr) Graduate School PhD degree

PART II

For the following questions/statements, circle the response that best represents your level of understanding unless additional instructions are specified.

5. You understand what is meant by hospice care.
   Strongly Agree Agree Neutral Disagree Strongly Disagree
APPENDIX B
(continued)

6. How often do you think about end of life care?
   Never Rarely Sometimes Often Always

7. Where did you first hear about hospice?
   Relative Friend Media Work Other

8. You believe in a spiritual being.
   Strongly Agree Agree Neutral Disagree Strongly Disagree

9. You believe that being has a life plan for you.
   Strongly Agree Agree Neutral Disagree Strongly Disagree

10. You believe in a spiritual approach to dying.
    Strongly Agree Agree Neutral Disagree Strongly Disagree

11. Pain and suffering are a part of living as a spiritual being.
    Strongly Agree Agree Neutral Disagree Strongly Disagree

12. Do you have a family member or close friend that has been faced with a life limiting illness? YES NO

13. If so, did they consider hospice care? YES NO

14. Did they use hospice care? YES NO

15. If so, was it beneficial? YES NO

16. If you were faced with a life limiting illness, on a scale from 0-5 (0 being not at all and 5 being highly likely) what is the likelihood of you considering hospice care?
   0 1 2 3 4 5
APPENDIX B

(continued)

17. Do you depend on someone else to make end of life decisions for you?

YES  NO

18. Do you regularly see a healthcare provider (a physician that you see regularly)?

YES  NO

PART III

For the following questions, please circle the answer that best fits your response.

19. If you regularly see a physician, how many times per year?

1-3  4-6  7-9  10-12

20. Your faith community influences your decision about using hospice care.

Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

21. If so, does it influence you to use hospice or not use hospice?

Use  Not Use

22. Your identification with your ethnic group influences your decision about using hospice care?

Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

23. If so, does it influence you to use hospice or not use hospice?

Use  Not Use

24. Hospice incorporates aspects of culture and spirituality.

Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree
APPENDIX B
(continued)

25. Incorporating culture and spirituality is important in your decision to use hospice?
   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

26. Death is a homecoming or transition.
   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

27. Pastoral Counseling and chaplain services are covered by the Medicare Hospice benefit.
   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

PART IV

For the following questions, please circle the response that best fits your level of understanding.

28. Hospice care is designed for terminally ill patients with less than 6 months to live.
   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

29. Hospice care is covered by insurance.
   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

30. Hospice care is covered by Medicare.
   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

31. Do you think financial constraints will determine what end of life care you will have access to?
   YES    NO

32. There are African American owned hospices in the Metro Atlanta area?
   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree
APPENDIX B
(continued)

33. Hospice care can be an in-home service.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

34. Hospice care includes service in nursing homes.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

35. Hospice care includes respite care.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

36. Hospice care is expensive.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

37. If you enter hospice, you can keep your own doctor.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

38. Hospice offers care to families after the patient dies.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

39. Hospice care is the same as home health service.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

40. State and federal reviewers inspect and evaluate hospices.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

41. Hospice care is only catered towards the patients.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

42. Hospice means a patient will die soon.
   Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree
APPENDIX B

(continued)

43. Hospice uses drugs to speed up death.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

44. Hospice is only available to those who can afford it.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

45. Utilizing hospice means no other end of life options is available.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

PART V

For the following questions, please circle the response that best fits your level of understanding.

46. Healthcare providers incorporate spirituality into their healthcare practice.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

47. Regarding a dying relative, one family member should make decision regarding care.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

48. Regarding a dying family member, how many people should be allowed in the patients room when death is about to happen.

0-2    3-5    6-8    9+ (unlimited number)

49. If you were terminally ill, you would accept medication to relieve your symptoms of pain.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree
50. A healthcare provider explains to you that death does not have to be a painful experience. How likely are you to agree with the truth of this statement?

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

51. You question the motives of a healthcare provider of another race that suggested hospice to you or a family member?

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

52. It is difficult to trust a healthcare provider of another race.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

53. A healthcare provider of another ethnicity will have your best interest in mind.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

54. A healthcare provider of another ethnicity will have your best interest in mind.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

55. There are healthcare institutions that represent black culture including design, art and food menus.

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree
APPENDIX C

Institutional Review Board
Office of Sponsored Programs
223 James P. Brawley Drive, S.W. * ATLANTA, GA 30314-4391 * (404) 880-8000
Formed in 1988 by consolidation of Atlanta University, 1865 and Clark College, 1869
March 29, 2007

Ms. Robin Goodwyn" <Robin.goodwyn@student.cau.edu>
Ms. Angie Braxton" <a_geordai@yahoo.com>
School of Social Works
Clark Atlanta University
Atlanta, GA 30314
RE: African Americans and the Barriers to Hospice Utilization.
Principal Investigators: Robin Goodwyn and Angie Braxton
Human Subjects Code Number: HR2007-3-207-2

Dear Ms. Robin Goodwyn:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your revised protocol and approved of it as exempt from full IRB review in accordance with 45 CFR 46.101b.2. You may begin your study after April 2, 2007.

Protocol Approval Code is HR2007-3-207-2/A
APPENDIX C

(continued)

This approval is valid for one year from the date of this notice. This permit will therefore expire on April 1, 2008. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office. Any reaction or problems resulting from this investigation should be reported immediately to the IRB, the Department Chairperson and any sponsoring agency.

If you have any questions, please contact Dr. Georgianna Bolden at the Office of Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

Paul I. Musey, Ph.D.

Chair

IRB: Human Subjects Committee

cc. “Dr. Sarita Davis”<sdavis@cau.edu>

Office of Sponsored Programs, Dr. Georgianna Bolden <gbolden@cau.edu>
APPENDIX D

SPSS

TITLE 'AFRICAN AMERICAN UTILIZATION OF HOSPICE'.

SUBTITLE 'Robin Goodwyn - CAU MSW PROGRAM'.

DATA LIST FIXED/
ID 1-3
AGEGRP 4
GENDER 5
RACE 6
EDUC 7
MENT 8
THINK 9
HEAR 10
BEING 11
PLAN 12
DYING 13
PAIN 14
MEMBER 15
CONSID 16
CARE 17
BENEF 18
SCALE 19
DEPEND 20
HEALTH 21
REGULAR 22
FAITH 23
INFLUEN 24
GROUP 25
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<td>'Q3 Racial group'</td>
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<td>RACE</td>
<td>'Q4 Highest level of education'</td>
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<td>EDUC</td>
<td>'Q5 You understand what is meant by hospice care'</td>
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<td>MENT</td>
<td>'Q6 How often do you think about end of life care'</td>
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<td>THINK</td>
<td>'Q7 Where did you first hear about hospice'</td>
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<td>HEAR</td>
<td>'Q8 You believe in a spiritual being'</td>
</tr>
<tr>
<td>BEING</td>
<td>'Q9 You believe that being has a life plan for you'</td>
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<tr>
<td>PLAN</td>
<td>'Q10 You believe in a spiritual approach to dying'</td>
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<tr>
<td>DYING</td>
<td>'Q11 Pain and suffering are a part of living as a spiritual being'</td>
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<td>'Q12 I have a family member - close friend faced with a life limiting illness'</td>
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<td>MEMBER</td>
<td>'Q13 If so, did they consider hospice care'</td>
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<td>CONSID</td>
<td>'Q14 Did they use hospice care'</td>
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<td>CARE</td>
<td>'Q15 If so, was it beneficial'</td>
</tr>
<tr>
<td>BENEF</td>
<td>'Q16 If faced with a life limiting illness would you consider hospice care'</td>
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<td>'Q17 Do you depend on someone else to make end of life decisions for you'</td>
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<td>'Q18 Do you regularly see a health care provider - physician'</td>
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<td>HEALTH</td>
<td>'Q19 If you regularly see a physician, how many times per year'</td>
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APPENDIX D
(continued)

FAITH
'Q20 Your faith community influences your decision about using hospice care'

INFLUEN
'Q21 If so, does it influence you to use hospice or not use hospice'

GROUP
'Q22 Your ethnic group influences your decision about using hospice care'

NOTUSE
'Q23 If so, does it influence you to use hospice or not use hospice'

CULTURE
'Q24 Hospice incorporates aspects of culture and spirituality'

DECISON
'Q25 Culture and spiritually is important in my decision to use hospice'

DEATH
'Q26 Death is a homecoming or transition'

PASTOR
'Q27 Pastoral counseling and chaplain services are covered by Medicare'

LIVE
'Q28 Hospice care is designed for terminally ill patients with less than 6 months to live'

INSURN
'Q29 Hospice care is covered by insurance'

MEDCARE
'Q30 Hospice care is covered by Medicare'

ENDLIFE
'Q31 Financial constraints will determine what end of life care you will have access to'

OWNED
'Q32 There are African American owned hospices in the Metro Atlanta Area'

INHOME
'Q33 Hospice care can be an in-home service'

NURSING
'Q34 Hospice care includes service in nursing homes'

RESPITE
'Q35 Hospice care includes respite care'

EXPENSE
'Q36 Hospice care is expensive'
APPENDIX D
(continued)

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<td>'Q43 Hospice uses drugs to speed up death'</td>
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<td>'Q45 Utilizing hospice means no other end of life options is available'</td>
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<td>'Q46 Health care providers incorporates spirituality into their healthcare practices'</td>
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<td>'Q47 Regarding a dying relative, one family member should make decision regarding care'</td>
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<td>'Q48 How many people should be allowed in the patients room when death is about to happen'</td>
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<td>'Q50 Death does not have to be painful, would you agree with this statement'</td>
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<td>'Q51 You would question the motives of a health care provider suggesting hospice care'</td>
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APPENDIX D  
(continued)

TRUST  
'S52 It is difficult to trust a health care provider of another race'

MIND1  
'S53 A health care provider of another ethnicity will have your best interest in mind'

MIND2  
'S54 A health care provider of another ethnicity will have your best interest in mind'

BLACK  
'S55 There are health care institutions that represent black culture - design, art and food menus'.

VALUE LABELS

AGEGRP
1 'Under 20'
2 '20-29'
3 '30-39'
4 '40-49'
5 '50 up' /

GENDER
1 'Female'
2 'Male'/

RACE
1 'African American'
2 'Bi-racial'
3 'Other'/'
APPENDIX D
(continued)

EDUC
1 'Less than High School'
2 'High School'
3 '2 Yrs College'
4 '4 Yrs College'
5 'Graduate School'
6 'Doctoral Degree'

MENT
1 'Strongly Agree'
2 'Yes'
3 'Neutral'
4 'No'
5 'Strongly Disagree'

THINK
1 'Never'
2 'Rarely'
3 'Sometimes'
4 'Often'
5 'Always'

HEAR
1 'Relative'
2 'Friend'
3 'Media'
4 'Work'
5 'Other'
APPENDIX D
(continued)

BEING
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

PLAN
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

DYING
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

PAIN
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

MEMBER
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<td>5 'Very Likely'</td>
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APPENDIX D
(continued)

FAITH
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

INFLUEN
1 'Used'
2 'Not Used'/

GROUP
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

NOTUSE
1 'Used'
2 'Not Used'/

CULTURE
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/
APPENDIX D
(continued)

DECISON
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

DEATH
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

PASTOR
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

LIVE
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/
APPENDIX D
(continued)

INSURN
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

MEDCARE
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

ENDLIFE
1 'Yes'
2 'No'

OWNED
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'
APPENDIX D
(continued)

INHOME
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

NURSING
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

RESPITE
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

EXPENSE
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'
APPENDIX D
(continued)

DOCTOR
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

OFFERS
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

SAMEAS
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

INSPECT
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'
CATERED
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree' /

DIESOON
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree' /

DRUGS
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree' /
AFFORD
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

OPTIONS
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

PRACTIC
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/

RELATIV
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'/
APPENDIX D
(continued)

PEOPLE
1 '0-2'
2 '3-5'
3 '6-8'
4 '9up /

RELIEVE
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

PAINFUL
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

MOTIVE
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'
TRUST
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

MIND1
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

MIND2
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'

BLACK
1 'Strongly Agree'
2 'Agree'
3 'Neutral'
4 'Disagree'
5 'Strongly Disagree'.
APPENDIX D
(continued)

RECODE MENT BEING PLAN DYING PAIN FAITH GROUP (1 THRU 2.99=2) (3 THRU 5.99=4).
RECODE CULTURE DECISON DEATH PASTOR LIVE INSURN MEDCARE (1 THRU 2.99=2)(3 THRU 5.99=4).
RECODE OWNED INHOME NURSING RESPITE EXPENSE DOCTOR (1 THRU 2.99=2) (3 THRU 5.99=4).
RECODE OFFERS SAMEAS INSPECT CATERED DIESOON DRUGS (1 THRU 2.99=2) (3 THRU 5.99=4).
RECODE AFFORD OPTIONS PRACTIC RELATIV RELIEVE PAINFUL (1 THRU 2.99=2) (3 THRU 5.99=4).
RECODE MOTIVE TRUST MIND1 MIND2 BLACK (1 THRU 2.99=2)(3 THRU 5.99=4).
RECODE THINK (1 THRU 2.99=2)(3 THRU 5.99=3).
MISSING VALUES
AGEGRRP GENDER RACE EDUC MENT THINK HEAR BEING PLAN DYING PAIN MEMBER CONSID CARE BENEF SCALE DEPEND HEALTH REGULAR FAITH
INFLUEN GROUP NOTUSE CULTURE DECISON DEATH PASTOR LIVE INSURN MEDCARE ENDLIFE OWNED INHOME NURSING RESPITE EXPENSE DOCTOR OFFERS SAMEAS INSPECT CATERED DIESOON DRUGS AFFORD OPTIONS PRACTIC RELATIV PEOPLE RELIEVE PAINFUL MOTIVE TRUST MIND1 MIND2 BLACK (0).
APPENDIX D
(continued)

BEGIN DATA

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APPENDIX D

(continued)

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END DATA.

FREQUENCIES
/VARIABLES AGEGRP GENDER RACE EDUC MENT THINK HEAR BEING PLAN DYING
PAIN MEMBER CONSID CARE BENEF SCALE DEPEND HEALTH REGULAR FAITH
INFLUEN GROUP NOTUSE CULTURE DECISON DEATH PASTOR LIVE INSURN MEDCARE ENDLIFE OWNED INHOME NURSING RESPITE EXPENSE DOCTOR OFFERS SAMEAS INSPECT CATERED DIESOON DRUGS AFFORD OPTIONS
APPENDIX D
(continued)

PRACTIC RELATIV PEOPLE RELIEVE PAINFUL MOTIVE TRUST
MIND1 MIND2 BLACK
/STATISTICS =.
REFERENCES


Cicirelli, V. (2002). Fear of death in older adults predictions from terror management


