

Awareness and Attitudes toward Advance Care Planning: Do Culture and Generation Matter?

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ABSTRACT Advance care planning (ACP) is a fundamental step for preparing for a ‘good death’ with minimized emotional distress, increased patient autonomy, and improved quality of life. This study examined the awareness and attitudes toward ACP including knowledge of hospice care, cultural and spiritual impacts on the end of life care, and communication difficulties with health care providers among African, Hispanic, and Korean Americans across generations, along with completion of advance directives. This quantitative, cross-cultural study used a convenience sampling method. A total of 342 adults (149 African Americans; 103 Hispanic Americans; and 90 Korean Americans) aged 21 to 85 participated in the study. Results showed there are significant age and ethnic differences in the awareness and attitudes toward ACP. Cultural competency and age specific approaches are suggested.

Keywords: advance care planning, advance directives, generational difference, cultural difference

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INTRODUCTION

Regardless of race or ethnicity, people hope that their core values at the end of life (hereafter EOL) are honored, such as ‘a quick and pain-free death at home,’ ‘time with family or friends,’ ‘desire not to be a burden on family,’ and ‘being able to decide upon medical treatments.’ (Hooyman, Kawamoto, & Kiyak, 2015; Meier, Gallegos, Thomas, Depp, Irwin, & Jeste, 2016; Warraich, 2017). In this context, advance care planning (hereafter ACP) is considered as a fundamental step in preparing for a ‘good death’ with minimized emotional distress, increased patient autonomy, and improved quality of life (Carr & Luth, 2016; Waldrop & Meeker, 2012).

ACP is an ongoing communication process among a patient, family, and health care providers to clarify patients’ preferred treatment they desire and designate families or friends to make healthcare decisions on their behalf at end-of-life (Bravo, Trottier, Arcand et al., 2016; Klinger, In der Schmitt, & Marckmann, 2016). ACP is encouraged to be held when individuals are still physically, cognitively healthy to make their own medical decisions long before a medical health crisis occurs (Carr & Luth, 2017). However, as initial discussion of ACP usually occurs close to the end of life, it is very difficult for patients and their families to deal with end-of-life decisions (Hall, Rowland, & Grande, 2019). Accordingly, ACP is recommended for adults at any age because a medical crisis might occur across the entire lifespan, leading to the loss

of their capacity to participate in medical decision-making (Kavalieratos et al., 2015). Without ACP, families and health service providers may encounter potential conflict in deciding EOL care options since they may not know patients’ preferences about care at EOL (Silveira, Kim, & Langa, 2010). However, despite the advantages, many people fail to engage in ACP because of reluctance to talk about death, insufficient information, lack of patient and family readiness, misconceptions, and difficulty in understanding the contents (Triipken, Elrod, & Bills, 2018).

ACP discussions generally result in the completion of a written advance directives (hereafter ADs), which include legal documents such as a living will and a durable power of attorney for health care (DPAHC). These documents reflect patients’ values, goals, and preferences in the situation that they lose decision making capacity for medical care (Carr & Luth, 2017). In spite of significant efforts to promote ACP and the completion of ADs, only 36.7% of U.S. adults completed any type of ADs. Of those, 29% completed living wills and 33% powers of attorney for health care (Yadav et al., 2017). However, racial and ethnic minorities have been reported to have lower completion rates of ADs than non-Hispanic Whites (Carr & Luth, 2017; Rao et al, 2013). It is critical for health service providers to understand different awareness and attitudes toward ACP and barriers in receiving EOL care among minority adults. Additionally, most studies of ACP have focused on older adults or individuals with terminal illness in institutional settings such as nursing homes and hospitals, which

resulted in the marginalization of the larger aging people with chronic disease living in the community (Kang, Bynum, Zhang, Grodstein, & Stevenson, 2019; Ko, Kwak, & Nelson-Becker, 2014; Petruik, 2018; Shulman et al., 2018), and few have examined awareness and attitudes about ACP among community-dwelling young and middle-aged adults (Kavalieratos et al., 2015). ACP is frequently missed in the treatment steps of young adults with life-limiting illnesses (Smith, 2017). Contrary to popular belief that young adults are unwilling to discuss EOL care, previous studies indicated that they recognize ACP as a relevant health behavior, but have limited information to adopt (Kavalieratos et al., 2015; Tripken & Elrod, 2018). Given those backgrounds, research question examined in the present study includes: “Are there any cultural and generational differences in the awareness and attitudes toward ACP among African, Hispanic, and Korean Americans?” In this study, “awareness” refers to generalized knowledge or understanding about ACP (Trevethan, 2017) and “attitudes” are positive or negative psychological tendencies of an individual about ACP, which is usually formed from underlying values and beliefs (Banaji & Heiphetz, 2010; Eagly & Chaiken, 1993).

LITERATURE REVIEW

Individual’s end-of-life preferences are largely shaped by one’s cultural and spiritual background (Cottrell & Duggleby, 2016; Mehrotra & Wagner, 2019). Among ethnic minority groups, discussions of death and dying tend to meet general societal resistance which manifests as a general unwillingness to discuss end-of-life care including ACP and ‘hospice.’ ACP as an integral part of end-of-life care is closely tied to both effective palliative and hospice care (Weathers et al., 2016). Specifically, ACP is associated with greater use of palliative care and less use of aggressive, life-sustaining treatments (Bischoff et al., 2013). In one retrospective cohort study examining ACP completion of those in hospice care, patients who participated in ACP were more likely to spend time at home in their last year of life (Abel et al., 2013).

In other studies (Carr & Luth, 2017; Koss & Baker, 2016), cultural differences in attitudes toward end-of-life care by racial-ethnic minority groups led to less utilization of hospice services and more life-sustaining therapies for this population compared to non-Hispanic Whites. Additional research on decision-making regarding end-of-life planning found that racial-ethnic minorities have barriers to ACP such as lack of knowledge about ADs, a mistrust of the healthcare system, communication disparities with healthcare providers, and low literacy or language difficulties (Fernandez, 2013; Ko, Nelson-Becker, Park,

& Shin, 2013; Mehrotra & Wagner, 2019). These factors, alone or combined, create barriers that lead to less access to accurate and current information about ACP for racial minorities, decreasing the likelihood of having ADs congruent with their EOL values (Krakauer, Crenner, & Fox, 2002; Mehrotra & Wagner, 2019).

Specific populations of racial and ethnic minorities have been studied to gain insight into cultural and spiritual preferences regarding ACP and hospice care. Specific ethnic and racial minority preferences summarized in this literature review include African American, Hispanic American, and Korean American populations.

African Americans

African Americans are less likely to complete ADs and choose hospice care as an end-of-life care option than non-Hispanic Whites (Johnson, Kuchibhatla, & Tulskey, 2008; Koss & Baker, 2017). Reasons for this include the inherent mistrust of the healthcare system among African Americans. There is also a misconception or lack of knowledge about EOL care, and conflicts of spiritual or religious beliefs in this population (Sanders, Robinson, & Block, 2016). These differences may be explained by multiple factors unique to African American cultural values and beliefs (McDermott & Selman, 2018).

Previous research reported that African Americans tend to exhibit a mistrust of the general health care system and believe that “the system” controls treatment, not considering patient input (Freimuth, Jamison, An, Hancock, & Quinn, 2017). Lack of trust in the healthcare system leads to less utilization of medical services and results in ACP occurring in the later stages of one’s life (Carr, 2011; Hawley & Morris, 2017). African Americans tend to have misconceptions that ADs may impact their medical care (McDermott & Selman, 2018). Despite this prevalent misconception, African Americans and their family representatives frequently choose aggressive, life-sustaining treatments as their an end-of-life care instead of hospice care, even when loved one is in a persistent vegetative state with little chance of benefit from such treatment (LoPresti, Dement, & Gold, 2016; Wicher & Meeker, 2012).

Johnson et al. (2008) indicated that African Americans often sought extensive treatment that may conflict with the goals of hospice care due to their religious/spiritual beliefs. Older African Americans tend to participate more frequently in religious activities than their non-Hispanic White counterparts (Lee. & Zhang, 2018). Accepting hospice care often means hopelessness and death to this patient population. Older African Americans have reported

that hospice care equates to losing faith in God's power to heal and help them get through the crisis (Siminoff, Zhang, & Zyzanski, 2012; Townsend, March, & Kimball, 2017). However, African Americans showed a strong preference to involve family in treatment decisions because of their belief and trust that their family members would understand and follow their EOL preferences for care (Dillion, Roscoe, & Jenkins, 2012; Hawley & Morris, 2017).

Hispanic Americans

Hispanic Americans strong familial interdependence accounts for some of the resistance in this population to participate in ACP and hospice care. The role of family was a prominent factor to affect Hispanic American's decisions regarding hospice and palliative versus curative treatments (Dillion et al., 2012; O'Mara & Zborovskaya, 2016). Family roles were especially important for this population. Above all else, consensus among family members was believed to create opportunities for resolving conflict about medical care options (Cohen, McCannon, Edgman-Levitan, & Kormos, 2010). Hispanic Americans are less compelled to engage in ACP with beliefs that family members will make medical decisions on behalf of the patient (Carr & Luth, 2017). These cultural nuances of Hispanic Americans result in decreased likelihood of this group of people having living wills and healthcare proxies compared to non-Hispanic White Americans (Carr, 2011). In fact, older Hispanic Americans had difficulties obtaining their preferred care because they were less likely to express their preferences to family members or healthcare providers, leading to treatment inconsistencies and low rates of completion of ADs (Kelley, Wenger & Sarkisian, 2010; Orlovic, Smith, & Mossialos, 2018).

Religion was an importantly influential factor on EOL decisions of Hispanic Americans. Hispanic Americans believe that the removal of life-sustaining treatment violates some of the core tenants of their religious beliefs. This population believes strongly that only God can decide to give or take a life (Carr, 2011). EOL decisions in this population often depended upon religious values. However, Hispanic Americans do not always consult a priest or other religious leader to make these decisions. Again, a strong familial interdependence plays a key role in how Hispanic Americans evaluate and decide upon their EOL care (Cohen et al., 2010).

Both Hispanics and African Americans felt that they were uneducated on the matter of EOL care options (Rhodes & Xuan, 2012), but lack of knowledge was a specific barrier for Hispanic Americans in accessing EOL care options (Selsky et al., 2012). According to Colón (2012), over

one-half of the study's sample group had never heard of hospice. Selsky et al. (2012) found that only 29% knew about hospice and only 35% would choose hospice care once they were educated on the topic. Fernandez (2013) emphasized that both the lack of knowledge and the lack of cultural competence among health care providers makes Hispanic Americans less likely to seek EOL care such as hospice care.

Korean Americans

Like African and Hispanic Americans, older Korean Americans were less willing to use end-of-life care options such as hospice or engage in ACP (Ko, Roh, & Higgins, 2013). One study has found that only 12% Asian Americans use ADs (Jang, Park, Chiriboga, Radhakrishnan, & Kim, 2017). Lack of knowledge or misconceptions regarding end-of-life care was a predominant factor in the underutilization of these services. Korean Americans also had a poor of understanding on ADs and more negative attitudes toward ACP than any other minority ethnic group (Jang et al., 2017; Kwak & Salmon, 2007).

For many Korean Americans, conversations about end-of-life care rarely occur with a health care professional. When these conversations did occur, it was almost always when family members faced medical crises (Kwak & Salmon, 2007). The collectivistic culture of Korean Americans is more likely to elevate the family as a group decision-making body when faced with EOL care (Maly, Umezawa, Raliff, & Leake, 2006). Although family members are involved in EOL care decisions for their parents, the final decision is often deferred to the oldest son. Many older Korean Americans who had lived in the Confucian culture placed the responsibility of making the final decisions with their eldest son, so that a clear decision maker is assigned and family conflict is minimized (Kim & Berkman, 2010; Kwak & Salmon, 2007). Confucianism is deeply rooted and still valued as good morality in Korean society. The core tenets of Confucianism, "filial piety" is the moral obligation of adult children to respect one's parents and provide them with care and support in old age, which plays also an important role in shaping the attitudes toward medical treatment of one's parents in Korean society (Park, 2012). Korean society also has a traditional belief that talking about a person's death is taboo and might bring about misfortune or hasten the death. This belief prevents open discussion of end-life-of care as well as death (Hern et al. 1998; Hong et al., 2018). In this cultural context, Korean American adult children are frequently resistant to discuss their parent's EOL care preferences. Furthermore, their parents did not bring up the topic due to fear of a negative reaction from their chil-

dren (Kim & Berkman, 2010; Kim & Foreman, 2011). Resultantly, older Korean Americans tend to avoid discussion about EOL care especially avoiding ACP, hopes that their families will somehow know their EOL wishes without directly talking to them (Park & Hendrix, 2018).

Based on the limited evidences of attitudes and awareness toward ACP among ethnic and age groups, we hypothesized as follows:

Hypothesis 1: Awareness and attitudes regarding ACP will be different by among three ethnic groups (e.g., African, Hispanic, and Korean Americans)

-African and Hispanic Americans are more likely to have higher scores on awareness and attitudes regarding ACP than Korean Americans.

Hypothesis 2: Awareness and attitudes regarding ACP will be different among three age groups (e.g., young adults, middle-aged adults, and older adults)

-Older age groups are more likely to have higher scores on awareness and attitudes regarding ACP than younger age groups.

METHODS

Study Participants

The study was approved by the Institutional Review Board (IRB) at a moderate sized public university in the midwestern United States. Convenience and snowballing sampling methods were used to recruit participants. A total of 342 adults (149 African Americans, 103 Hispanic Americans, and 90 Korean Americans) ages 21 years+ were participated in the study.

Participants consisted of young adults recruited from a moderate sized public university, middle-aged adults recruited from different ethnic-based churches, and older adults recruited from local senior centers in Northwest Ohio. Participants were informed of the study via a recruitment script which explained the purpose, the voluntariness, and ethical aspects such as confidentiality of the study. Trained research assistants were involved in collecting data and helping the participant fill out the questionnaire if needed. Individuals who agreed to participate in the study were asked to sign the informed consent and complete the questionnaire. Some initial discomfort among participants was observed, due to the sensitivity of the topic, but most of all of participants completed the questionnaire once explanations about the purpose of the study and ethical considerations such

as nature of voluntary participation and confidentiality were reviewed.

Measurement

The present study used a questionnaire with 35 questions. The questionnaire was developed based on literature review on the ACP to generate survey items, qualitative interviews to assess the respondents' understanding of the survey statements, and expert groups for content validity verification (Houben, Spruit, Groenen, Wouters, & Janssen, 2014; Kermel-Schiffman & Werner, 2017; Rubio, Berg-Weger, Tebb, Lee, & Rauch, 2003; Sudore, Knight, McMahan, Feuz, Farrell, Miao, & Barnes, 2014). The questionnaire consisted of two parts: (1) demographic information (10 questions), and (2) a list of questions on the awareness and attitudes toward ACP (25 questions). The questionnaire used dichotomous scales, mainly for the measurement of awareness toward ACP which require a yes/no response. Likert-like scales were employed for assessment of attitudes which allow the individual to express the level of agreement or disagreement with a list of statements (Willits, Theodori, Luloff, 2016). Demographics included questions about ethnicity, age, gender, marital status, religion, type of health insurance, self-reported health status, and financial status. Questions on the awareness toward ACP consisted of completion of ADs (a durable power of attorney for health care and/or a living will), level of understanding of ACP and hospice care, and perceptions of healthcare services. Attitudes toward ACP were investigated by asking about their spiritual and cultural beliefs about EOL care, difficulties in communication with health care providers, and past experiences and future intentions to utilize EOL care.

Factor analysis on attitudes toward ACP revealed three domains: "spirituality and culture", "communication disparity", and "utilization on ACP". The Cronbach's alpha value for three domains which indicates the internal consistency (reliability) of the measure was at least .746 for the English version, and .758 for the Korean version of questionnaire. Lots of studies indicated that Cronbach's alpha levels above 0.7 are acceptable (Tavakol & Dennick, 2011). Both African Americans and most of Hispanic participants used the English version of the questionnaire. A few Spanish only speaking Hispanic participants were assisted by bilingual research assistants who translated the questionnaire and helped them complete the questionnaire. The research assistants also clarified meanings of questions when asked. In cross-cultural comparisons, back-translation of the questionnaire is necessary (Maneesriwongul & Dixon, 2004). Since the questionnaire was originally written in English, it was translated into Ko-

rean for Korean participants in this study. To ensure the accuracy of the translation, a bilingual research assistant translated Korean responses into English, and another bilingual research assistant translated them back into Korean. Translating all study materials with an appropriate language from trained bilingual researchers is important to recruit study participants and retain a large sample when studying different groups (Ofstedal & Weir, 2011).

Data Analysis

Using multivariate binomial logistic regression and ANOVA with post hoc tests in IBM SPSS Statistics 26, data were analyzed on the association of age and ethnicity with knowledge about hospice care and completion of ADs, spiritual/cultural values regarding EOL care, willingness to utilize hospice care and barriers in use the service. For purposes of analysis, participants were divided into three age groups consisting of young adults (Aged 21 to 39; N = 145), middle-aged adults (Aged 40 to 64; N = 127), and older adults (Aged 65+; N = 70).

FINDINGS

Demographic Information of Participants

A total of 342 adults participated in the survey. Of this sample, 149 (43.6%) were African Americans, 103 (30.1%) were Hispanic Americans, and 90 (26.3%) were Korean Americans (see

1). Approximately 58% of participants were females and 42% were males. Participants ranged in ages from 21 to 85 (see Figure 2). Over 77 % of participants had attained more than a high school education and 72 % had annual incomes of less than \$50,000. For ADs, majority of participants responded that they have heard of, but not completed, any type of ADs (see Table 1).

Awareness toward Advance Care Planning

Findings indicated that there were significant ethnic ($p < .01$) and age ($p < .001$) related differences in completing ADs, such as living wills and a health care power of attorney. Specifically, Korean Americans were less likely to fill out a power of attorney for health care or a living will, compared to African American and Hispanic American participants. Majority of participants (82.5%) reported that they knew what hospice is, but only 30.9% knew that Medicare covers most of the cost of hospice care services. Moreover, about 78% to 87% participants responded that they had heard about ACP options such as a durable power of attorney for health care and a living will, but had not completed one of these ADs. Middle-aged adults and

older adults were more likely to know that Medicare covers hospice care than young adults ($p < .05$) (see Table 2). For ADs, there were no statistically significant differences across the three ethnic groups in demographic variables such as gender, income, marital status, and educational attainment, so they were not controlled as covariates in statistical analysis.

Regarding past utilization of hospice care, African Americans are 1.22 times and 3.28 times ($p < .001$), respectively, more likely to have family members who had previously received hospice care than Hispanic and Korean Americans (see Table 2). Only 31.4% of the participants were willing to use hospice services if they have a terminal illness, with no significant differences across ethnic groups. There were no significant differences across age groups regarding previous exposure to hospice care. More than 50% of participants reported that they were not sure whether they will use hospice services or not. In addition, as age increased, participants reported that they were more likely to utilize hospice services ($p < .01$). Specifically, older adults reported that they were more likely to use hospice services than young adults, which is expected.

Attitudes toward Advance Care Planning

Culture was found to influence the subjective relationship between health care providers and care recipients. Specifically, Korean Americans are 2.11 times more likely to have difficulties with health care providers with a different race/ethnic background than African Americans, while African Americans have 1.23 times higher than Hispanic Americans, indicating that African Americans have more difficulties with health care providers with a different race/ethnic background than Hispanic Americans. With respect to age differences, middle-aged and older adults are 2.07 and 2.64 times, respectively, more likely to experience difficulties with health care providers than young adults. In addition, Hispanic Americans are 1.50 times more likely to have difficulties speaking to a family member or significant others about their wishes for advance care planning than African Americans, while African Americans have 2.71 times higher than Korean Americans ($p < .001$). On the other hand, the middle-aged and older adult participants are 3.17 ($p < .001$) and 5.92 times ($p < .001$), respectively, more likely to talk about their values and beliefs regarding ACP with family members than the young adult group (see Table 2).

Over 70% of participants replied that religious beliefs were important in EOL care decisions. Specifically, religion was more influential on decision making for both African Americans ($p < .05$) and Korean Americans ($p < .01$)

than Hispanic Americans. African Americans noted that it is much important for health care providers to understand and respect their religious or spiritual beliefs in addition to their cultural values and beliefs compared to the other ethnic groups. Additionally, the importance of religion as an influence on the use of ACP varied by age group with increased salience for older adults ($p < .001$) compared to middle-aged and young adults. This age difference was consistent across the ethnic groups (see Table 3).

The intersection of age and ethnic status created an increased expression of difficulties in communicating with health care providers and an increased necessity for a translator for middle-aged adults in comparison to younger adults ($p < .001$). Furthermore, Korean Americans were the most likely to have difficulties in communicating with health care providers and most likely to need a translator ($p < .001$). Interestingly, the middle-aged group (aged 40 to 64) expressed more difficulties in communicating with health care providers than older (aged 65 to 74) and younger counterparts (21 to 39). There was an interaction effect between age and ethnicity for communication. We found that middle-aged Korean Americans expressed significantly more difficulties in communicating with health care providers and an increased need for a translator compared to their young adult and older adult counterparts ($p < .001$) (see Table 4).

DISCUSSION

For completion of ADs, Korean Americans were the least likely to complete a durable power of attorney for health care and a living will. These findings support previous findings that Korean Americans not only have lower levels of knowledge of ADs but also exhibit negative attitudes toward ACP (Jung & Salmon, 2007). This can be interpreted that a lack of knowledge about combined with negative perceptions of ACP may be led to limited completion of ADs. However, Korean Americans expressed a willingness to learn more about hospice care and to utilize the service when faced with a terminal illness. Expectedly, the older age group was more likely to have completed ADs compared to young and middle-aged groups. These findings are consistent with previous study demonstrating that ADs completion of older adults was higher than young adults (Rao, Anderson, Lin, & Laux, 2013).

While majority of participants responded that they were aware of hospice care, only 30% knew that Medicare reimburses for hospice care. These findings demonstrate that even though people report knowing about hospice care, it is clear that self-reported knowledge, at least for

reimbursement, is overestimated. Previous studies indicated that more exposure to EOL care information was associated with more favorable beliefs about care (Johnson, 2013). However, this study suggests that people should be given detailed and accurate EOL information. Specifically, more educational programs regarding the range of options with ACP, the meaning of palliative and hospice care, and open dialogue regarding hospice and its philosophy should be implemented within the community. Regarding hospice utilization, the Korean American group was the least likely to have family members that had previously experienced hospice care. Commonly, as people get older, they tend to consider using hospice services. This finding is consistent with research that has found that older participants accepted their advanced age as a critical factor in making EOL care decisions (Rosenthal, Wenger, & Kagawa-Singer, 2000).

The results indicated complex patterns between religious beliefs, ethnicity, and attitudes toward EOL decision among three ethnic groups. These may relate to differences between different religious groups (e.g. Protestant vs Catholic), different cohorts (i.e. Millennial, Gen X, Baby Boomers, Silent Generation), and the different ethnic group memberships. However, despite these differences, all three ethnic groups emphasized that health care providers should understand and respect their religious or spiritual beliefs along with their cultural values and beliefs. Previous studies supported racial and ethnic minorities were concerned that healthcare providers would not respect their religious and cultural traditions when offering care services (Volker, 2005). On the other hand, medical mistrust rooted in institutionalized racism is thought to be associated with lower engagement in ACP as well as lower use of EOL services, particularly among African Americans than their White counterparts (Hong, Johnson, & Adamek, 2018; Koss & Baker, 2017).

Regarding language and communication concerns, Korean Americans had difficulty communicating with health care providers with different ethnic backgrounds and exhibited the potential need for a translator. Previous research has indicated that non-English-speaking minorities considered communication as a barrier to care (Thomas, Wilson, Justice, Birch, & Sheps, 2008). In particular, the middle-aged Korean Americans expressed more difficulties in communicating with health care providers and more necessity for a translator than other age groups. In addition, Korean Americans expressed more communication difficulties with health care service providers of a different race when compared to the African Americans and Hispanic American groups. However, it is difficult to interpret whether this issue comes from

cultural difficulties, low English proficiency of Korean Americans, or both factors as these issues are interrelated with each other (Leong & Kalibatseva, 2011).

This study showed that Hispanic Americans have more conversations with their family regarding their wishes for EOL care than the other two groups, which is inconsistent with the previous findings that Hispanic Americans were less likely to communicate their wishes for health care in comparison to other ethnic groups (Selsky et al., 2012). This can be interpreted that some Hispanic Americans may share their wishes for EOL care with their family members rather than their health care providers. In the meantime, Korean Americans were found to be the least likely group to speak about EOL decision making, which is consistent with previous findings (Ko et al., 2013).

Though there were significant findings in this study, several limitations need to be considered when interpreting the results. Firstly, the data were collected using a convenience and snowballing sampling methods from a geographically limited area, limiting the generalizability of the findings. Secondly, the study examined general attitudes about ACP among community-dwelling adults and did not explore participants' current and past health conditions and its effect on their views. This acts as a limitation in that previous health care experiences (e.g. surgery) may act as a variable that is critical to their attitudes toward advanced care plans. Lastly, older adults made up the smallest portion of the overall sample. To address these limitations, further study may be conducted with larger samples in wider geographical area using random sampling methods. Especially, examining theoretical decision-making models of what factors influence the decision to complete advance care plans would be of clear benefit.

CONCLUSIONS AND IMPLICATION FOR PRACTICE

The study examined the awareness and attitudes toward ACP among African, Hispanic, and Korean Americans across age groups, which included completion of ADs, knowledge about and utilization of hospice care, and barriers related to ACP.

Regardless of ethnicity and culture, death related issue is still an uncomfortable topic to share. Therefore, educating the public on death and creating better health care environment delivering accurate knowledge about death and strengths of ACP and ADs is a crucial step in EOL care. In the present study, Korean Americans were the least likely to complete ADs. Considering the knowing-doing gap in ADs in Asian Americans (Jang et al., 2017), more

ethnic and culturally sensitive education about ACP (emphasizing completion of ADs) using appropriate language is essential. For African Americans, the ADs need to be re-designed to reduce the gap in engagement in ACP between African Americans and Whites. Also improving EOL care for this population through ACP may be possible with their faith communities.

Individuals' wishes should be honored in times of need, however, without enough discussion about ACP in advance and written documents, ethical considerations in EOL care are inevitable because maximizing an individual's independence and respecting individual's preference by self-determination often come in conflict between patient's family members and service practitioners (e.g., social workers) in this field of practice (McInnis-Dittrich, 2020). Especially, family members in minority groups may want to pursue every medical intervention for their parents regardless of their wishes because of ethnic and cultural values.

This study showed that EOL care decisions were more dependent on ethnic and cultural factors than other demographic factors, such as level of education and healthcare benefits. In this sense, health service providers like social work practitioners should consider their unique needs based on their cultures, beliefs, and religiosity/spirituality when working with ethnically diverse population (Bullcock, 2011). Social workers also need to raise awareness, educate ethnically diverse groups, connect resources, and advocate them regarding ACP, mainly targeting young and middle-aged adults prior to medical or life crises they may encounter to avoid any family conflicts or ethical issues due to unpreparedness about decision making that can arise at EOL. In this sense, more contents about dying and death across the lifespan perspective should be embraced in social work curriculum, emphasizing a concept of ACP to be able to help clients elude unnecessary ethical conflicts before and after death of family members.

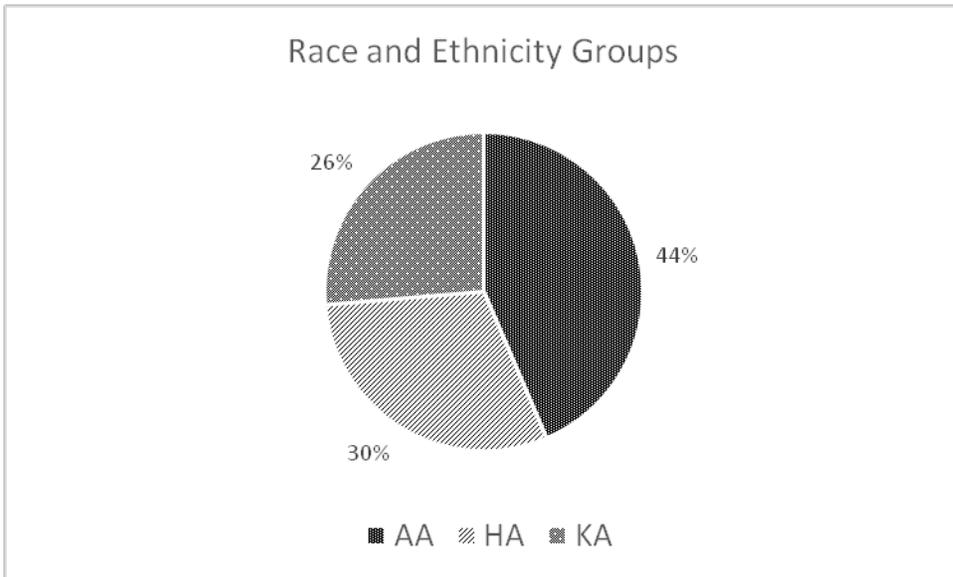


Figure 1. Participants by Race and Ethnicity

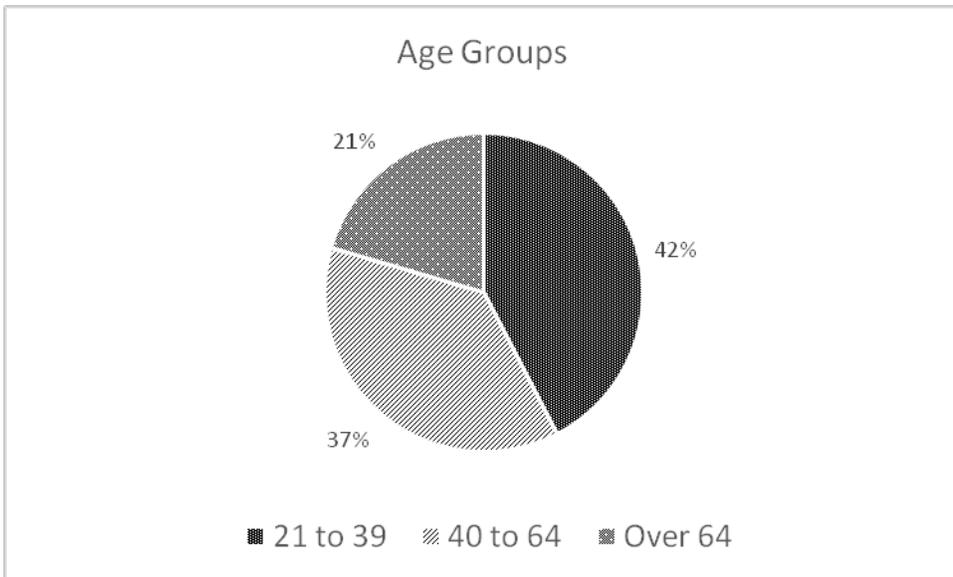


Figure 2. Participants by Age Groups

Table 1. Knowledge and Completion of Advance Directives by Ethnicity (N=342)

	Ethnicity			Total N (%)
	AA (N=149)	HA (N=103)	KA (N=90)	
Power of Attorney				
Never heard of	30	13	28	71 (21)
Have heard, not completed	91	71	50	212 (62.0)
Have heard and completed	28 (18.8%)	19 (18.4%)	12 (13.3%)	59 (17.3)
Living Will				
Never Heard of	5	4	15	24 (7)
Have heard, not completed	110	73	55	238 (69.6)
Have heard and completed	34 (22.8%)	26 (25.2%)	20 (22.2%)	80 (23.4)

Note: AA (African American); HA (Hispanic American); KA (Korean American)

Table 2. Odds of Awareness and Attitudes toward ACP by Ethnicity and Age (N=342)

	Knowledge of Medicare Coverage	Difficulties with health care providers with a different race/ethnic background	Spoken EOL Wishes	Hospice Experiences in Family Members
Ethnicity				
AA (reference group)				
HA	.694	.813	1.503	.820
KA	1.029	2.108*	.369***	.305***
Age				
21 to 39 (reference group)				
40 to 64	2.002*	2.066*	3.166***	.981
+65	2.272*	2.639**	5.919***	.788

Note: Relative odds (exponential betas) are presented.

*p < .05, **p < .01, ***p < .001

AA (African American); HA (Hispanic American); KA (Korean American)

Table 3. Spiritual and Cultural Impacts on ACP by Ethnicity and Age (N=342)

Dependent Variable	(I) Ethnicity	(J) Ethnicity	Mean Difference (I-J)
How important are your religious beliefs in your decision to use end-of-life services (i.e., hospice care)	AA	HA	.21*
	KA		.31**
How important is it for your doctor or other health care providers to understand your cultural values and beliefs	AA	HA	.22*
How important is it for your doctor or other health care providers to respect your religious or spiritual beliefs	AA	HA	.19*
		KA	.33**
Dependent Variable	(I) Age	(J) Age	Mean Difference (I-J)
How important are your religious beliefs in your decision to use end-of-life services (i.e., hospice care)	40 to 64	21 to 39	.21*
	65+		.43***

Note: *p < .05, **p < .01, ***p < .001

AA (African American); HA (Hispanic American); KA (Korean American)

Table 4. Communication Disparity by Ethnicity and Age (N=342)

Dependent Variable	(I) Ethnicity	(J) Ethnicity	Mean Difference (I-J)
I have difficulties in communicating with health care providers due to language	KA	AA	.94***
		HA	.78***
It is important for me to have a translator	KA	AA	.51***
		HA	.46***
Dependent Variable	(I) Age	(J) Age	Mean Difference (I-J)
I have difficulties in communicating with health care providers due to language	40 to 64	21 to 39	.53***
	65+		.45***
It is important for me to have a translator	40 to 64	21 to 39	.36***
	65+		.29**
Interaction Effect (Age * Ethnicity)			
I have difficulties in communicating with health care providers due to language			F=4.886***
It is important for me to have a translator			F=2.887*

Note: *p < .05, **p < .01, ***p < .001

AA (African American); HA (Hispanic American); KA (Korean American)

REFERENCES

- Abel, J., Pring, A., Rich, A., Malik, T., & Verne, J. (2013). The impact of advance care planning of place of death, a hospice retrospective cohort study. *BMJ Supportive & Palliative Care*, 3(2), 168–173.
- Banaji, M. R., & Heiphetz, L. (2010). Attitudes. In D. T. Gilbert & S. T. Fiske (Eds.), *Handbook of social psychology* (pp. 353-393). Hoboken, NJ: John Wiley & Sons.
- Bischoff, K. E., Sudore, R., Miao, Y., Boscardin, W. J., & Smith, A. K. (2013). Advance care planning and the quality of end-of-life care in older adults. *Journal of the American Geriatrics Society*, 61(2), 209-214.
- Bravo, G., Trottier, L., Arcand, M., Boire-Lavigne, A., Blanchette, D., Dubois MF. Guay, M., Lane, J., Hotin, P., & Bellemare, S. (2016). Promoting advance care planning among community-based older adults: a randomized controlled trial. *Patient Education and Counseling*, 99(11), 1785-1795.
- Bullock, K. (2011). The influence of culture on end-of-life decision making. *Journal of Social Work in End-of-Life & Palliative Care*, 7, 83–98. doi:10.1080/15524256.2011.548048
- Carr, D. (2011). Racial differences in end-of-life planning: why don't Blacks and Latinos prepare for the inevitable? *Omega: The Journal of Death and Dying*, 63(1), 1-20.
- Carr, D., & Luth, E. (2016). End of life planning and health care. *Handbook of aging and the social sciences* (pp. 375–394, 8th ed). L. K. George & K. Ferraro (Eds.). New York: Academic Press.
- Carr, D., & Luth, E. (2017). Advance Care Planning: Contemporary Issues and Future Directions. *Innovation in Aging*, 1(1), 1-10.
- Cohen, M.J., McCannon, J.B., Edgman-Levitan, S., & Kormos, W.A. (2010). Exploring attitudes toward advance care directives in two diverse settings. *Journal of Palliative Medicine*, 13(12), 1427-1432. doi:10.1089/jpm.2010.0200
- Colón, M., (2012). Acculturation and attitudes of Latinos toward hospice. *Journal of Social Work In End-Of-Life & Palliative Care*, 8(3), 229-248. doi: 10.1080/15524256.2012.708110.
- Cottrell, L., & Duggleby, W. (2016). The “good death”: An integrative literature review. *Palliative & Supportive Care*. 14(6), 686–712.
- Carr, D., & Luth, E. A. (2017). Advance Care Planning: Contemporary Issues and Future Directions. *Innovation in aging*, 1(1), igx012. <https://doi.org/10.1093/geroni/igx012>
- Dillon, P.J., Roscoe, L.A., & Jenkins, J.J. (2012). African Americans and decisions about hospice care: Implications for health message design. *Howard Journal of Communications*, 23(2), 175-193. doi:10.1080/10646175.2012.667724
- Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes*. Fort Worth, TX: Harcourt, Brace, Jovanovich.
- Fernandez, G. (2013). Why are Latinos not using palliative and hospice care? *New American Media*. Retrieved from <http://newamericamedia.org/2013/10/why-are-latinos-not-using-palliative-and-hospice-care.php>
- Freimuth, V. S., Jamison, A. M., An, J., Hancock, G. R., & Quinn, S. C. (2017). Determinants of trust in the flu vaccine for African Americans and Whites. *Social Science & Medicine*, 193, 70-79.
- Hall, A., Rowland, C., & Grande, G. (2019). How Should End-of-Life Advance Care Planning Discussions Be Implemented According to Patients and Informal Carers? A Qualitative Review of Reviews. *Journal of pain and symptom management*, 58(2), 311–335. <https://doi.org/10.1016/j.jpainsymman.2019.04.013>
- Hawley, S. T., & Morris, A. M. (2017). Cultural challenges to engaging patients in shared decision making. *Patient Education and Counseling*. 100 (1), 18-24
- Hern, H. E., Koenig, B. A., Moore, L. J., & Marshall, P. A. (1998). The difference that culture can make in end-of-life decision making. *Cambridge Quarterly Healthcare Ethics*, 7, 27–40.
- Hooyman, N. R., Kawamoto, K. Y., & Kiyak, H. A. (2015). *Aging Matters: An Introduction to Social Gerontology*. Boston, MA: Pearson.
- Hong, M., Hong, S., Adamek, M., & Kim, M. (2018). Death attitudes among middle-aged Koreans: role of end-of-life care planning and death experiences. *International journal of aging & human development*, 86(1), 51-68
- Hong, M., Yi, E. H., Johnson, K. J., & Adamek, M. E. (2018). Facilitators and Barriers for Advance Care Planning Among Ethnic and Racial Minorities in the U.S.: A Systematic Review of the Current Literature. *Journal of immigrant and minority health*, 20(5), 1277–1287. <https://doi.org/10.1007/s10903-017-0670-9>
- Houben, C., Spruit, M. A., Groenen, M., Wouters, E., & Janssen, D. (2014). Efficacy of advance care planning: a systematic review and meta-analysis. *Journal of the American Medical Directors Association*, 15(7), 477–489. <https://doi.org/10.1016/j.jamda.2014.01.008>

- Jang, Y., Park, N. S., Chiriboga, D. A., Radhakrishnan, K., & Kim, M. T. (2017). The Knowing-doing gap in advance directives in Asian Americans: The role of education and acculturation. *American Journal of Hospice and Palliative Care*, 34(9), 874-879. doi: 10.1177/1049909116668518.
- Johnson, K.S. (2013). Racial and ethnic disparities in palliative care. *Journal of Palliative Medicine*, 16(11), 1329-1334.
- Johnson, K.S, Kuchibhatla, M., & Tulsky, J.A. (2008). What explains racial differences in the use of advance directives and attitudes toward hospice care? *Journal of the American Geriatrics Society*, 56(10), 1953-1958. doi:10.1111/j.1532-5415.2008.01919.x
- Jung, K., & Salmon, J. R. (2007). Attitudes and preferences of Korean American older adults and caregivers on end-of-life care. *Journal of the American Geriatrics Society*, 55(11), 1867-1872. doi:10.1111/j.1532-5415.2007.01394.x
- Kang, J. H., Bynum, J., Zhang, L., Grodstein, F., & Stevenson, D. G. (2019). Predictors of Advance Care Planning in Older Women: The Nurses' Health Study. *Journal of the American Geriatrics Society*, 67(2), 292-301. <https://doi.org/10.1111/jgs.15656>
- Kavalieratos, D., Ernecoff, N. C., Keim-Malpass, J., & Degenholtz, H. B. (2015). Knowledge, attitudes, and preferences of healthy young adults regarding advance care planning: a focus group study of university students in Pittsburgh, USA. *BMC Public Health*, 15, 197. <http://doi.org/10.1186/s12889-015-1575-y>
- Kelley, A., Wenger, N., & Sarkisian, C. (2010). Opinions: end-of-life care preferences and planning of older Latinos. *Journal of the American Geriatrics Society*, 58(6), 1109-1116. doi:10.1111/j.1532-5415.2010.02853.x
- Kermel-Schiffman, I., & Werner, P. (2017). Knowledge regarding advance care planning: A systematic review. *Archives of gerontology and geriatrics*, 73, 133-142. <https://doi.org/10.1016/j.archger.2017.07.012>
- Kim, E. J., & Berkman, C.S. (2010). Role of children in end-of-life treatment planning among Korean American older adults. *Journal of Social Work in End-Of-Life & Palliative Care*, 6(3-4), 164-184. doi:10.1080/15524256.2010.529019
- Kim, M., & Foreman, M.D. (2011). Korean American adult children's beliefs about what their parents want at the end of life. *Clinical Gerontologist: The Journal of Aging and Mental Health*, 34(4), 305-318. doi:10.1080/07317115.2011.572538
- Klinger, C., In der Schmitzen, J., & Marckmann, G. (2016). Does facilitated Advance Care Planning reduces the costs of care near the end of life? Systematic review and ethical considerations. *Palliative Medicine* 2016, 30(5) 423-433
- Ko, E., Kwak, J., & Nelson-Becker, H. (2014). What Constitutes a Good and Bad Death?: Perspectives of Homeless Older Adults. *Death Studies*, 39 (7), 422-432. <https://doi.org/10.1080/07481187.2014.958629>
- Ko, E., Nelson-Becker, H., Park, Y. J., & Shin, M. J. (2013). End-of-Life Decision Making in Older Korean Adults: Concerns, Preferences, and Expectations. *Educational Gerontology*, 39 (2), 71-81, DOI: 10.1080/03601277.2012.682947
- Ko, E., Roh, S., & Higgins, D. (2013). Do older Korean immigrants engage in end-of-life communication? *Educational Gerontology*, 39(8), 613-622.
- Koss, C. S., & Baker, T. A. (2017). Race differences in advance directive completion: The narrowing gap between white and African American older adults. *Journal of Aging and Health*, 29(2), 324-342. doi:10.1177/0898264316635568
- Koss, C. S., & Baker, T. A. (2017). A Question of Trust: Does Mistrust or Perceived Discrimination Account for Race Disparities in Advance Directive Completion? *Innovation in aging*, 1(1), igx017. <https://doi.org/10.1093/geroni/igx017>
- Krakauer, E.L., Crenner, C., & Fox, K. (2002). Barriers to optimum end-of-life care for minority patients. *Journal of American Geriatrics Society*, 50(1), 182-190.
- Kwak, J., & Salmon, J.R. (2007). Attitudes and preferences of Korean American older adults and caregivers on end-of-life care. *Journal of American Geriatrics Society*, 55(11), 1867-1872.
- Lee, E. & Zhang, Y. (2018). Religiosity as a protective factor of psychological well-being among older Black, White and Asian Christians in the United States. *Ageing International*, 43(2), 321-335. <https://doi:10.1007/s12126-017-9319-1>.
- Leong, F.T.L., & Kalibatseva, Z. (2011). "Cross-cultural barriers to mental health services in the United States." *Cerebrum*, 5. Retrieved from www.dana.org/news/cerebrum/detail.aspx?id=31364
- LoPresti, M.A., Dement, F., & Gold, H.T. (2016). End-of-Life Care for People With Cancer From Ethnic Minority Groups. *American Journal of Hospice and Palliative Medicine*, 33, 291-305.
- Maly, R. C., Umezawa, Y., Raliff, C. T., & Leake, B. (2006). Racial/ethnic group differences in treatment decision-making and treatment received among older breast carcinoma patients, *Cancer*, 106 (4), 957-965. <https://doi.org/10.1002/cncr.21680>

- Maneesriwongul, W., & Dixon, J.K. (2004). Methodological issues in nursing research. instrument translation process: A Methods Review. *Journal of Advanced Nursing*, 48(2), 175–186.
- McDermott, E, & Selman, S. (2018). Cultural factors influencing advance care planning in progressive, incurable disease: A systematic review with narrative synthesis. *Journal of Pain and Symptom Management*, 56(4), 613–636. DOI: 10.1016/j.jpainsymman.2018.07.006.
- McInnis-Dittrich, K. (2020). *Social Work with Older Adults: A Biopsychosocial Approach to Assessment and Intervention*, 5th Edition, Boston, MA: Pearson Education, Inc.
- Mehrotra, C.M., & Wagner, L. S. (2019). *Aging and Diversity: An Active Learning Experience* (3rd Ed). New York, NY: Routledge.
- Meier, E. A., Gallegos, J. V., Thomas, L. P., Depp, C. A., Irwin, S. A., & Jeste, D. V. (2016). Defining a good death (successful dying): Literature review and a call for research and public dialogue. *The American Journal of Geriatric Psychiatry*, 24(4), 261–271.
- Ofstedal, M. B., & Weir, D. R. (2011). Recruitment and retention of minority participants in the Health and Retirement Study. *Gerontologist*, 51 (suppl. 1), S8-S20. doi:geront/gnq100
- O'Mara, S. K., & Zborovskaya, Y. (2016). End-of-Life Care in the Hispanic Community, *Journal of Hospice & Palliative Nursing*, 18(1), 53-59 doi: 10.1097/NJH.0000000000000210
- Orlovic, M., Smith, K., & Mossialos, E. (2018). Racial and ethnic differences in end-of-life care in the United States: Evidence from the Health and Retirement Study (HRS). *SSM Population Health*. 7,100331. doi:10.1016/j.ssmph.2018.100331
- Park, H., & Hendrix, C. (2018). A literature review on end-of-life care among Korean Americans. *International Journal of Palliative Nursing*, 24. 452-461. doi:10.12968/ijpn.2018.24.9.452.
- Park, M. (2012). Filial piety and parental responsibility: An interpretive phenomenological study of family caregiving for a person with mental illness among Korean immigrants. *BMC Nursing*, 11(1), 1–28. doi:10.1186/1472-6955-11-28
- Petruik, C. R. (2018). Social Work Practices in Palliative and End-of-Life Care for Persons Experiencing Homelessness: A Scoping Review. *Families In Society-The Journal Of Contemporary Social Services*, 99 (4), 317-328.
- Rao, J. K., Anderson, L. A., Lin, F.C., & Laux, J. P. (2013). Completion of Advance Directives among U.S. Consumers. *American Journal of Preventive Medicine*. 46 (1): 65-70. doi: 10.1016/j.amepre.2013.09.008
- Rhodes, R.L., & Xuan, L. (2012). African American bereaved family members' perceptions of hospice quality: do hospices with high proportions of African American do better? *Journal of Palliative Medicine*, 15(10), 1137-1141.
- Rosenfeld, K.E., Wenger, N.S., & Kagawa-Singer, M. (2000). End-of-life decision making: a qualitative study of elderly individuals. *Journal of General Internal Medicine*, 15(9), 620-625.
- Rubio, D.M., Berg-Weger, M., Tebb, S.S., Lee, E.S., & Rauch, S. (2003). Objectifying content validity: Conducting a content validity study in social work research. *Social Work Research*, 27, 94–104.
- Sanders, J. J., Robinson, M. T., & Block, S. D. (2016). Factors impacting advance care planning among African Americans: Results of a systematic integrated review. *Journal of Palliative Medicine*, 19, 202-227. doi:10.1089/jpm.2015.0325
- Selsky, C., Kreling, B., Luta, G., Makgoeng, S.B., Gomez-Duarte, J., Barbo, A.G.A., & Mandelblatt, J.S. (2012). Hospice knowledge and intentions among Latinos using safety-net clinics. *Journal of Palliative Medicine*, 15(9), 984- 990. doi:10.1089/jpm.2011.0517.
- Shulman, C., Hudson, B. F., Low, J., Hewett, N., Daley, J., Kennedy, P., Daavid, S., Brophy, N., Howard, D., Vivat, B., & Stone, P. (2018). End-of-life care for homeless people: A qualitative analysis exploring the challenges to access and provision of palliative care. *Palliative Medicine*, 32(1), 36–45. <https://doi.org/10.1177/0269216317717101>
- Silveira, M J., Kim, S. Y., & Langa, K. M. (2010). Advance directives and outcomes of surrogate decision making before death. *The New England Journal of Medicine*, 362, 1211-1218.
- Siminoff, L.A., Zhang, A.Y., & Zyzanski, S.J. (2012). Ethnic difference in the caregiver's attitudes and preferences about the treatment and care of advanced lung cancer patients. *Psycho-Oncology*, 12(11), 1250-1253.
- Smith, S.L. (2017) Advance Care Planning Communication for Young Adults: A Role for Simulated Learning, *Journal of Hospice & Palliative Nursing*. 19(5):460-467.
- Souza, A. C., Alexandre, N., & Guirardello, E. B. (2017). Psychometric properties in instruments evaluation of reliability and validity. *Propriedades psicométricas na avaliação de instrumentos:*

- avaliação da confiabilidade e da validade. *Epidemiologia e serviços de saúde : revista do Sistema Unico de Saúde do Brasil*, 26(3), 649–659. <https://doi.org/10.5123/S1679-49742017000300022>
- Sudore, R. L., Knight, S. J., McMahan, R. D., Feuz, M., Farrell, D., Miao, Y., & Barnes, D. E. (2014). A novel website to prepare diverse older adults for decision making and advance care planning: a pilot study. *Journal of pain and symptom management*, 47(4), 674–686. <https://doi.org/10.1016/j.jpainsymman.2013.05.023>
- Thomas, R., Wilson, D. M., Justice, C., Birch, S., & Sheps, S. (2008). A literature review of preferences for end-of-life care in developed countries by individuals with different cultural affiliations and ethnicity. *Journal of Hospice & Palliative Nursing*, 10(3), 142–161.
- Townsend, A., March, A. L., & Kimball, J. (2017). Can faith and hospice coexist: Is the African American church the key to increased hospice utilization for African Americans? *Journal of Transcultural Nursing*, 28(1), 32–39. doi:10.1177/1043659615600764
- Trevethan R. (2017). Deconstructing and Assessing Knowledge and Awareness in Public Health Research. *Frontiers in public health*, 5, 194. <https://doi.org/10.3389/fpubh.2017.00194>
- Tripken, J. L., & Elrod, C. S. (2018). Young adults' perspectives on advance care planning survey. *American Journal of Hospice and Palliative Medicine*, 35(4), 627–634. doi: 10.1177/1049909117727456.
- Tripken, J. L., Elrod, C., & Bills, S. (2018). Factors Influencing Advance Care Planning Among Older Adults in Two Socioeconomically Diverse Living Communities. *American Journal of Hospice & Palliative Care*. 35(1):69-74. doi: 10.1177/1049909116679140.
- Volker, D.L. (2005). Control and end-of-life care: does ethnicity matter? *American Journal of Hospice and Palliative Medicine*, 22, 442-446.
- Waldrop, D.P., & Meeker, M.A. (2012). Hospice decision-making: diagnosis makes a difference. *The Gerontologist*, 52(5), 686-697.
- Warraich, H. (2017). *Modern death: How medicine changed the end of life*, New York, NY: St. Martins Press.
- Weathers, E., O’Caoimh, R., Cornally, N., Fitzgerald, C., Kearns, T., Coffey, A., Daly, E., O’ Sullivan, R., McGlade, C., & Molloy, D.W. (2016). Advance care planning: a systematic review of randomised controlled trials conducted with older adults. *Maturitas*, 91, 101–109. doi: 10.1016/j.maturitas.2016.06.016
- Wicher, C.P., & Meeker, M.A. (2012). What influences African American end-of-life preferences? *Journal of Health Care for the Poor and Underserved*, 23(1), 28-58. doi: 10.1353/hpu.2012.0027.
- Willits, F. K., Theodori, G. L., Luloff, A. E. (2016). Another look at likert scales. *Journal of Rural Social Sciences*, 31(3), 126–139.
- Yadav, K. N., Gabler, N. B., Cooney, E., Kent, J., Kim, J., Herbst, N., & Courtright, K. R. (2017). Approximately one in three US adults completes any type of advance directive for end-of-life care. *Health Affairs (Millwood)*, 36(7): 1244–1251.

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