

Original Article

Advance Care Planning: Preliminary Report of Differences and Similarities between Korean and Korean American

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Purpose: This study was conducted to do preliminary report of differences and similarities between Koreans residing in Korea and Korean Americans residing in America regarding their awareness of end-of-life care, attitudes toward advance care planning, truth telling, and preferred decision-making model. **Methods:** Two participating groups were selected: a) Koreans residing in Korea, and b) Koreans Americans who had resided in the United States for at least 20 years. 25 Koreans and 23 Korean Americans who were older than 65 years old participated in this study. They were asked via a self-administered questionnaire that contained demographic questions and questions about end-of-life decision making regarding awareness of end-of-life care, attitudes toward advance care planning, truth telling, and preferred decision-making model. A Chi-square was used to measure differences between Koreans' and Korean Americans planning. A P value of less than 0.5 was considered significant. Data analysis was performed using SPSS 18.0. **Results:** In some aspects of awareness of end of life care, attitudes toward advance care planning, and truth telling, both groups had similar opinions. However, there were significant differences between groups in the necessity of end of life documentation, preferential informing the truth, and preferred decision making model. **Conclusion:** There were similarities and differences regarding some end of life issues between the Koreans and the Korean Americans.

Key Words: Advance care planning, Terminal care, Hospice care, Republic of Korea, Asian Americans

INTRODUCTION

Discussions about death and dying and making decisions about end-of-life care are not easy tasks for anyone, especially when making a choice between quality of life and quantity of life. In the United States, the health care system is based on the concept of respect for autonomy and the patient's right to self-determination (1). Since many patients lose decision-making ability when they become seriously ill, advance care planning has been widely used in the United States to preserve autonomy in end-of-life decisions (2). In addition, advance care planning is promoted to ease medical care

toward the end of life (3).

The Patient Self-Determination Act (PSDA) was implemented in 1991. One of this Act's major goal was to clarify and protect person's medical care decisions through using of formal advance directives which are documents made by competent adults that indicate their health care if and when they are incompetent. This legislation is letting U.S. society think over urgency of the way to deal with end-of-life care and decision making (4). Although the law emphasizes protection of dignity and independence at the end-of-life, some studies have identified barriers to end-of-life decision making that stem from cultural differences in values, beliefs, and attitudes regarding end-of-life care (5). From the study of

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Murphy et al. (6), it was found that minority elderly people were less likely than non-Hispanic White elderly people to use an advance directive and more likely to have negative attitudes toward having conversations about end-of-life care planning and advance directives. Thus, clinicians in culturally diverse settings have cross-cultural difficulties with end-of-life care decisions and the approaches that patients. The United States is a nation increasingly composed of people with diverse racial or ethnic and cultural backgrounds. Decision making for end-of-life care in a cross-cultural context can be difficult because these decisions must be understood within cultural beliefs and values (2). With increasing diversity in the United States, conflicts between patients and physicians who have different backgrounds are becoming common. Therefore, the risk of misunderstanding on two different cultures at the end-of-life is also increasing (4). In addition, the rapid increase in the number of minority elders demonstrates the importance of recognizing the role of race or ethnicity and culture on end-of-life care and decision making. This interest is reflected in the enactment of the Patient Self-Determination Act, which aims to encourage patients to ensure that their values are respected at the end-of-life (7).

In 2002 Asians made up 4.2% of the U.S. population, including Chinese as the largest group, followed by immigrants from the Philippines, India, Vietnam, and Korea (8). Over half of the Asian population in the United States lives in California, New York, or Hawaii, led by California. Half of the Korean immigrants in California live in Los Angeles. In 1990, the Korean population in America was 798,849 and by 2007, the number of Korean Americans reached about 1.5 million, making them the fifth largest group of Asians in the United States, after those from the Philippines, China, India, and Vietnam (9). The rapid increase in the number and proportion of Korean immigrants suggests the importance of recognizing and understanding the Korean ethnicity and culture regarding advance care planning in the United States.

Although it is important to understand the connection between diversity and end-of-life decisions, there is very limited evidence to guide culturally sensitive approaches. While the Korean population in the United States has increased, there is little known about end-of-life decision making by Korean American elderly people and there has been limited research regarding decision-making models of Korean immigrant

groups and within-group variations (3). The concept of advance care planning is unfamiliar to Koreans. Yet, 100 years of history regarding Korean immigration to the United States have made Koreans adopt the American culture. Therefore, the object of this study was to investigate differences in advance care plan between Koreans who live in Korea (herein Koreans) and Koreans who have lived in America for a long time (herein Korean Americans) regarding (a) awareness about end-of-life care, (b) attitudes toward advance care planning, (c) disclosing bad news and truth telling, and (d) preferred decision-making model.

METHODS

1. Participants

Two participating groups were selected: (a) Koreans residing in Korea, and (b) Korean Americans who had resided in the United States for at least 20 years. Those respondents were sent via a self-administered questionnaire that contained demographic questions, questions about end-of-life decision making. Participants in the study were Korean men and women, 65 years of age or older, living either in Korea or California, U.S.A. Respondents who were younger than 65 years or who did not self-identify as Korean or Korean American were excluded from participation. The first group consisted of respondents to the questionnaire that was sent to adult day care centers in Korea (after obtaining permission from the persons in authority at the facilities). The second group consisted of self-identified Korean adults age 65 and older residing in California. Fifty-six older adults participated in the study: 30 Koreans and 26 Korean Americans. Responses from five participants from Korea who failed to answer one or two questions on the survey were excluded from the study. The responses from three Korean American participants were excluded because the participants had immigrated to America less than 1 year previous to the study. As a result, 25 Korean and 23 Korean American elderly participants' responses were collected as a data.

2. Study instruments

A self-administered questionnaire containing demographic questions and questions about end-of-life decision making was distributed to Koreans in Korea and Korean Americans. The

demographic survey was used to obtain information on age, gender, and annual house income, year of education, marital status, residential status, religion, and health insurance status. End-of-life decision making survey was modified from the Ethnicity and Attitudes Toward Advance Care Directives Questionnaire by Murphy et al. (6). Murphy et al. (6) developed the instrument to investigate differences in attitudes of elderly participants from several ethnic groups toward disclosure of the diagnosis and prognosis of a terminal illness and end-of-life decision making. End-of-life decision making survey included a self-administered questionnaire designed to measure the participants' awareness (question No. 1, answered to hospitalization for the last 5 years of yourself, family member or death of a family member, relative or friend), attitudes toward end-of-life (question No. 2~7, yes or no, or agree strongly or agree somewhat, disagree somewhat, disagree strongly), preference for truth telling (question No. 8~12, yes or no, agree strongly or agree somewhat, disagree somewhat, or disagree strongly), and designated surrogate for end-of-life decisions (question No. 13, who make end-of-life decision whether the physician, family members or patients themselves).

Content and format were developed after review of relevant medical literatures. The questionnaire includes scales designed to measure issues that were relevant to this study, as well as previously validated scales. Once modified and finalized, the questionnaire was translated into Korean and then back into English by an independent agency with experience in translating to ensure sameness of medical and technical terms. The comprehensibility and reliability of the survey instruments were pretested with five Korean Americans in the Los Angeles area and five Koreans in Seoul, South Korea (via international mail). All participants were at least 65 years old but varied in gender, age, and education level. None reported any problems in completing the questionnaire.

3. Statistical analysis

A Chi-square test was used to measure differences between Koreans' and Korean Americans' demographic characteristics and their end-of-life decision making and advance care planning. A P value of less than 0.05 was considered significant. Groups were tested for comparability on age, gender, household income, education, marital status, residential status,

religion, and health insurance status. Data analysis was performed using SPSS 18.0.

4. Data collection process

With permission from an adult health center in California, the researcher introduced herself to the clients of the center after they had completed the morning program and were waiting for lunch. The researcher described the study and invited them to participate by completing the surveys: the demographic and the advance care planning survey and they were expected to take 15 to 20 minutes to complete the five pages. Those who were not interested in participating in the study were free to leave the room. The participants placed signed consent forms and completed surveys in two separate designated boxes. 26 people were responded out of 50 members (52%). In addition, the researcher also obtained permission by e-mail from elderly health center in Seoul, South Korea to send the survey and informed consent forms to the center by international mail. The director of the center distributed and collected consent forms and surveys during their class, placed them in separate envelopes, and returned them to the researcher by international mail. According to the designated person who collected data, there were 60 members in the class but 30 people were responded (50%).

5. Protection of human subjects

Permission to conduct this research was granted by the Institutional Review Board at California State University, Long Beach. The center in Korea was approached after obtaining consent from the head of the selected facility. All participants signed a consent form explaining risks and benefits of participating in the study. Participants were told that participation was strictly voluntary and that they could withdraw from the study at any time without repercussions. All completed surveys were kept secure by the researcher, who was the only person to have access to the data.

RESULTS

1. General and clinical characteristics of the participants

The sample included Korean men and women over 65 years old who either lived in Korea (herein Koreans) or had resided in the United States for more than 20 years (herein

Table 1. Demographic Characteristics of Participants (N=48).

Characteristic	Koreans (n=25)	Korean Americans (n=23)	Total	χ^2	df	P
Gender				10.435	1	0.001
Male	0	8	8			
Female	25	15	40			
Education				40.580	3	<0.001
Junior high school	25	2	27			
High school	0	11	11			
University	0	9	9			
Graduate school	0	1	1			
Marital status				11.961	2	0.003
Divorced	1	3	4			
Married	4	13	17			
Widowed	20	7	27			
Residential status				19.016	2	<0.001
Lump sum lease	3	0	3			
Rented	1	14	15			
Owned	21	9	30			
Religious affiliation				21.547	3	<0.001
Buddhist	14	0	14			
Catholic	3	1	4			
Christian	7	20	27			
None	1	2	3			
Health insurance				8.908	1	0.003
Yes	25	16	41			
No	0	7	7			

Korean Americans). The Koreans (mean=80.80 years, SD=4.933 years) were significantly older than the Korean Americans (mean=75.57 years, SD=6.051 years). In addition, all Koreans participants were female whereas 8 males (34.8%) and 15 females (65.2%) of Korean Americans were participated. While all Korean participants reported having a junior high school education for their latest education, 21 Korean American participants (91.3%) were reported high school and college education as their latest education. Twenty one of Koreans (84%) owned their home, whereas nine of Korean Americans (39.1%) owned their homes. While fourteen of Koreans (56%) were Buddhist, twenty of Korean Americans (87%) were Christians. All Korean American participants had health insurance, whereas sixteen (69.6%) of Korean Americans had health insurance and seven (30.4%) of them did not have health insurance. These demographic characteristics of these 48 Korean and Korean American participants are summarized in Table 1.

2. End-of-life care decision making

Regarding end-of-life decision questions, this study showed

similarities and differences in attitudes between Koreans and Korean Americans. For instance, for the question of awareness of end-of-life care, both groups had experienced with being hospitalized of themselves. Yet, while more Koreans were experienced with death of a relative or friend or spouse, more Korean Americans had experienced with their family members' hospitalization (Table 2).

For the question of attitudes toward advance care planning, both groups were aware about end-of-life care and heard of it, yet very a few of both groups were actually written of it. While both of groups liked to express will of end-of-life care, twenty one of Koreans (84.0%) strongly agree that such end-of-life documentation were not necessary due to trust in the family to make decisions (Table 3).

For the question of truth telling, both groups did not think that to know the truth was not harm to the patient. However, twenty two Koreans (88.0%) wanted their family to know about the truth first, whereas seventeen Korean Americans (73.9%) wanted themselves to know about the truth first (Table 4).

For the question of preferred decision making model,

Table 2. Participant Responses Concerning End-of-Life Care (N=48).

Topic	Koreans (n=25)	Korean Americans (n=23)	Total	χ^2	df	P
Hospitalization of self				0.720	1	0.396
No	7	8	15			
Yes	18	12	30			
Hospitalization of family members				6.817	1	0.009
No	20	10	30			
Yes	5	13	18			
Death of a family member				16.293	1	0.000
No	5	18	23			
Yes	20	5	25			
Death of a relative or friend				5.648	1	0.017
No	4	11	15			
Yes	21	12	33			
Would want life-sustaining treatment				13.349	3	0.004
Agree	16	8	24			
Moderately agree	6	1	7			
Moderately disagree	2	8	10			
Disagree	1	6	7			

Table 3. Participant Responses Concerning Advance Planning (N=48).

Topic	Koreans (n=25)	Korean Americans (n=23)	Total	χ^2	df	P
Heard of "living will" or "death with dignity" declaration				12.267	2	0.002
Yes	19	14	33			
Yes, unsure of the meaning	6	1	7			
No	0	8	8			
Had written a living will				1.283	1	0.257
Yes	1	3	4			
No	24	20	44			
Better to express personal wishes in advance				3.122	2	0.210
Strongly agree	5	10	15			
Moderately agree	18	12	30			
Moderately disagree	2	1	3			
Better to wait until the situation arises to make decisions				7.549	3	0.056
Agree strongly	1	2	3			
Agreed moderately	9	12	21			
Disagree moderately	15	6	21			
Disagree strongly	0	3	3			
Family will know what to do about medical wishes				13.148	3	0.004
Agree strongly	15	3	18			
Agreed moderately	6	8	14			
Disagree moderately	4	9	13			
Disagree strongly	0	3	3			

sixteen Koreans (64.0%) named the physician to make end-of-life decision for the patient, whereas fourteen Korean Americans (60.9%) named themselves as the person to make this decision (Table 5).

DISCUSSION

This study was designed to compare differences between

Koreans and Korean Americans regarding their awareness of end-of-life care, attitudes toward advance care planning, attitudes regarding truth telling, and preferred decision-making model. Demographic survey of this study had showed that there were significant age differences and gender. The study finding had showed that the Korean respondents were significantly older than the Korean American respondents. Therefore, this age difference may be attributed to the finding that

Table 4. Participant Responses Concerning Truth Telling (N=48).

Topic	Koreans (n=25)	Korean Americans (n=23)	Total	χ^2	df	P
Harmful to the patient				6.805	3	0.078
Agree strongly	0	5	5			
Agree moderately	5	5	10			
Disagree moderately	7	6	13			
Disagree strongly	13	7	20			
First tell the patient about the cancer				3.181	1	0.074
Yes	11	16	27			
No	14	7	21			
First tell patient's family about the cancer				8.999	1	0.003
Yes	22	11	33			
No	3	12	15			
First tell patient that he/she will probably die				10.101	1	0.001
Yes	7	17	24			
No	18	6	24			
First tell family that patient will probably die				6.011	1	0.014
Yes	22	13	35			
No	3	10	13			

Table 5. Participant Responses Concerning Who Should Make Decisions about Using Life-Prolonging Machines (N=48).

Decision maker	Koreans (n=25)	Korean Americans (n=23)	Total
Physician	16	4	20
Family	2	5	7
Patient	7	14	21

Korean respondents had more experience with family death and death of friend and relative than Korean American respondents. Furthermore, all Koreans participants were female whereas 8 males (34.8%) and 15 females (65.2%) of Korean American were participated. It could be from the place that the study had happened in Korea was female prevalent area. This study took the elderly health center in Seoul and class members were all females. In Korean culture, male elderly are not tending to go the places which have a lot of female elderly present. There was a study done regarding sex-differences in end-of-life decision making in Flanders, Belgium by Smets et al. (10). From the study of Smets et al. despite of the factor that sex is not a definite factor in the predominant of end-of-life decision making, gender gives different effect to the decision-making process, possibly there are a difference in the way that male and female join in end-of-life decision making process (10). Smets et al. found that between different genders are mainly related to the patient's cause and place of death not a definite factor to give

different attitudes toward end-of-life decision making (10).

From this study, 22 Koreans (88.0%) and 9 Korean Americans (39.1%) agreed or moderately agreed with to using life-sustain treatment. From the study of Blackhall et al. (11), it studied attitudes of people age 65 and older from four ethnic groups (European American, African American, Korean American, and Mexican American) regarding abstention from life support. While European Americans were the least likely to want life support, Korean Americans were very positive regarding life support. Korean Americans were most likely to believe that life support should be continued in all circumstances.

This study showed that all Korean respondents were heard the word of "living will" or "death with dignity" but only 4% of them had actually written up a living will or a similar document while 65.2% of Korean Americans heard words of "living will" or "death with dignity" yet, 13% of them actually written a living will or a similar documents concerning end-of-life medical decisions. According to Sun et al. (12), Sun et al. studied recognition of advance directives by patients and physicians in a hospice care ward in Korea. While there were 134 cancer patients and 97 medical doctors in one university hospital, the majority of them was unfamiliar with or did not know about advance directives and they did not know about the actual meaning. Nevertheless, majority of them had showed positive attitudes toward advance directives (12). From this study, these study findings showed that since

the Korean respondents were significantly older than the Korean American respondents, the Korean respondents should be heard more about advance care planning terms than Korean American respondents. In fact, they still did not know about the actual meaning of advance care planning and none of them actually written about advance care planning while only a few of them written about living will or similar documents. Also from the study of Heo (13), although Koreans have positive attitudes about use of advance directives, they do not have proper knowledge of advance care planning and family members and medical staff members make decisions for the patient in most cases. Advance care planning should be made by the patient while they are still competent to make decision for themselves; however, no case of advance care planning could be found in Korea. After the Patient Self-Determination Act (PSDA) was passed in 1991, there were efforts to increase use of advance directives in the United States (4). Although the Patient Self-Determination Act declares the goals of legally clarifying for patients, families, and health care providers the patient's preferences for end-of-life care and to make document as legally, acceptance of advance care planning by non-Whites is lower than among Whites (4). However, those Korean Americans from this study lived in America more than 20 years therefore they must have more knowledge regarding the Patient Self-Determination Act than Koreans who live in Korea.

Both groups in the current study (92.0% of Koreans and 95.7% of Korean Americans) strongly or moderately agreed that they would prefer to express their wishes regarding medical treatment in advance because a sudden illness (e.g., stroke) or accident (e.g., traffic accident) might make them incapable of communicating and thus making decisions. Furthermore, 60.0% of the Korean respondents and 39.1% of the Korean American respondents moderately or strongly disagreed with the statement that it is better to wait until the situation arises to make decisions about treating serious illness, rather than writing documents in advance. Korean respondents (84%) strongly or moderately agree that the patient's family member would know what to do regarding their end-of-life medical care, while Korean American respondents (47.8%) strongly or moderately agreed with the statement. Although Korean respondents and Korean American respondents had positive attitudes toward advance care planning, Korean re-

spondents had lack of autonomy to make end-of-life decisions than Korean American respondents. This finding could be supported from the study of Frank et al. (14). Frank et al. investigated relationships between patient autonomy and end-of-life decision making among elderly Korean Americans. Frank et al. (14) interviewed 20 Korean Americans in depth and then chose one participant as a typical case. This study was based on a long period time with the case study participant regarding one Korean Americans' attitudes toward end-of-life decisions. This person's story illustrated that a family-centered approach to medical decision making was significant part of the Korean cultural pattern. Yet, Korean Americans from this study lived in America for a long period of time therefore they were more adopted the western culture than people in Korea while Koreans are holding on the traditional family centered care. Although both of groups, Koreans and Korean Americans had same nationality, each of groups has showed different responses regarding patient autonomy depend on their length of staying in two different countries. In addition, there was the study done regarding preserving end-of-life autonomy by Galambos (15). Galambos (15) extensively reviewed the literatures and examined two legal effects to enhance the act of end-of-life autonomy. After the PSDA became a legal act, advance directives were tend to be made from a white, female, middle to upper socioeconomic background people. Although education is the major component to enhance of this act, education only would not increase to the completion of advance directives. According to Galambos (15), there were several studies have done and shown elderly people prefer to have informal discussions with family members than the completion of a formalized written advance directives. Furthermore, there were several studies shown that older adults have tendency to delay the completion of advance directives to a later time and to delegate to others to make health care decisions in times of need (16,17). Therefore, for this current study, since Korean respondents were significantly older than Korean American respondents, there were possibilities that Korean participants had shown lesser autonomy than Korean American participants.

Both groups (80.0% of Koreans and 56.5% of Korean Americans) strongly or moderately disagreed that doctors should not discuss death and dying with the patient because

doing so could be harmful to the patient. The groups clearly differed on items of truth telling. For example, they gave different response to the item that, when a physician diagnoses a person as having cancer that has spread to several parts of the body and the physician believes that the cancer cannot be cured, the physician should first tell the patient about the cancer or the physician should first tell the patient's family about the cancer. Most of the Korean respondents (88.0%) agreed that the patient's family should be told first. A similar question asked whether, in the case that the physician believes that the patient's death is impending, the physician should tell the patient first or the patient's family first. In response to this item, 88.0% of the Koreans chose family first but 73.9% of the Korean Americans chose patient first. While the most of Korean respondents chose the family first for truth telling, the most of Korean American chose the patient first. Blackhall et al. (18) researched differences in attitudes of elderly participants from four ethnic groups (Korean Americans, Mexican Americans, European Americans, and African Americans) and reported that Korean Americans were significantly less likely than other ethnic groups to believe that a patient should be told of a terminal prognosis and less likely to believe that the patient should make decisions about the use of life support. Instead, Korean Americans tended to believe that the family should make decisions about end-of-life care. As the researcher mentioned above, since time passed and Korean Americans adopt the American culture, Korean Americans have more autonomy to make end-of-life decision than Koreans.

A patient may become very ill and a decision must be made about whether to put the patient on machines or administer treatment that will prolong the patient's life for a while but will not cure the illness and may be uncomfortable or painful. Respondents were asked to indicate who should make the decision about whether to administer this life-prolonging treatment. From this study, the most Koreans (64.0%) chose the physician to make the decision but 60.9% of Korean American respondents chose patient to make the decision. There was study performed by Kwon et al. (19) which investigated patient autonomy in end-of-life decision making in Korea. In a survey of 1,019 Korean participants about various end-of-life issues, respondents were asked to indicate who should be favored to make end-of-life decisions;

44.2% responded that the physician should make end-of-life decisions in the absence of perceptions of socioeconomic burden. Koreans commonly give a high level of respect to and trust in medical doctors. Korean respondents chose the physician as the decision maker because they believed that physicians have special knowledge and experience that would qualify them to be the decision maker (19).

From current study, although Korean Americans also have strong family centered cultural background, most of Korean American respondents chose the patient, itself first to make end-of-life decision. It may be due to that Korean American respondents of this study were much younger than Korean respondents. Furthermore, they were more adapted to westernized independence thought and had more autonomy toward end-of-life decision making than Korean respondents.

CONCLUSIONS

This study has limitations such as, the participants in this study were too small convenience samples, and they might not be representative value of all Koreans or Korean Americans. In addition, due to too small groups, study findings may not be reliable and validated. Also, all Korean respondents were female while Korean American respondents had male participants, this gender difference may lead to different attitudes toward end-of-life care decision. In addition, this study finding had showed some of Korean American participants in this study were holding on to the Westernized thinking while some of them still hold on to Korean cultures. As a result, these study findings were not clearly manifested to two different attitudes toward end-of-life care in Koreans and Korean Americans.

Yet, although those findings were from small groups, they were matched and supported by previous studies. Besides, research on these topics could provide valuable information to enhance end-of-life care practices in health care setting whether in Korea and America. Furthermore, many Korean American older adults in America do not speak or understand English well and they rely on their families to gain access to social and health services, these data can support and bring the attention the needs to understand minority Korean elders in America.

Despite all efforts to translate and back to translate the

questionnaire, there may have been language differences that affected responses. This study was originally designed to assess Korean American's acculturation and their attitudes toward advance care planning. Hence, during the survey, Korean Americans were asked to answer the demographic survey, the self-identity acculturation scale, and the advance care planning survey while Korean were asked to answer the demographic survey and the advance care planning survey. From the survey questions of acculturation scales, English Communication skills were also asked. In fact, Korean American participants had low grades on the acculturation scale and they had too low on English communication skills, the acculturation scale was not addressed in the study from the results and the discussion. It could be that sample of Korean Americans were too small and were not able to address full grade on the acculturation scale.

Chi square was used to measure whether paired variables were independent or not. A significant Chi square result indicates that the variables were not independent, that the proportions of cases in the cells, overall, were not as expected. Remarkable cell frequencies were reported to show the differences between the two groups, but Chi square does not specifically demonstrate that the differences are statistically significant. Tests of significance of specific cell proportions were not made.

There is currently insufficient research literature available on end-of-life care among Korean and Korean American elderly people. In addition, there was none of study done to compare between Korean and Korean American groups. Hence, the need for more in-depth research considering the interaction of multiple variables is indicated. Future research should examine a large representative sample of Korean and Korean American older adults, including those with serious illnesses. In addition, this study finding had showed some of Korean American participants in this study were holding on to the Westernized thinking while some of them still hold on to Korean cultures. As a result, these study findings were not clearly manifested to two different attitudes toward end-of-life care in two groups. So that, for future research, it is supposed to assess about acculturation on Korean Americans. From the study of Kagawa-Singer and Blackhall (20), through careful examination of within group variations, such as acculturation differences, people can understand better about differences between

groups and within groups due to education, age, gender, geographic location and individual acculturation.

Future research should assess whether Korean and Korean American elderly people understand the issues and mechanics of end-of-life care, such as advance directive and life-prolonging treatment. As it was mentioned before, education is the key factor to enhance the knowledge of end-of-life care decision. In addition, this study was not plan to compare distinction between Korean and Korean Americans rather, this study was plan to look for differences and similarities of attitudes of both Koreans (whether reside in Korea or America) regarding end-of-life care. In fact, sample was too small to address reliable values of Koreans and Korean Americans so that this subject needs to be investigate further with more numbers of respondents.

Therefore, this study is considered preliminary report for future research.

요 약

목적: 한국에 있는 한국 사람들과 미국에서 사는 재미 교포들간의 삶의 마지막 치료에 대한 인식, 삶의 마지막 전 계획에 대한 태도, 진실을 직면하는 태도 그리고 마지막 치료에 대한 결정을 누가 내리기를 원하는 지에 대한 다른 관점들에 대해 밝히고자 한 예비 연구 논문이다.

방법: 65세 이상의 한국에 사는 한국인들 25명, 미국에서 20년 이상 사신 한국인들 23명이 선택되었고 이들은 자신 개인신상에 대해 묻는 질문지와 임종에 가까워질 때 원하는 치료, 임종 전에 사전 계획을 세우는 것에 대한 것, 고칠 수 없는 자신의 병에 대한 진실을 대한 태도, 그리고 누가 마지막 치료에 대한 결정을 내리기를 원하는 지에 대한 질문지에 답하게 되었다. χ^2 test로 한국인들 대상자들과 재미 교포 대상자들의 다른 점을 측정하는데 사용하였고, P value가 0.05보다 작은 것을 유용한 자료로 사용하였다. 자료 분석을 위해서는 SPSS 18.0을 사용하였다.

결과: 삶의 마지막 돌봄의 인식, 돌봄계획에 대한 태도, 그리고 진실 알리기 등의 항목에서는 한국인과 재미 교포간에 비슷한 의견을 보였다. 하지만, 삶의 마지막 돌봄에 대한 문서화, 진실을 누구에게 먼저 알릴 것인지, 그리고 선호하는 의사결정모델에서는 유의한 차이를 보였다.

결론: 한국인과 재미교포 사이에는 몇 가지 삶의 마지막 이슈에 대해 공통점과 차이점이 있었다.

중심단어: 사전 치료에 대한 계획, 말기 치료, 호스피스 치료, 한국, 아시아계 미국인

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