



# Attitudes toward Death, Perceptions of Hospice Care and Needs for Hospice Care among the LGBT Population

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**Purpose:** This study explored the attitudes of lesbian, gay, bisexual, and transgender (LGBT) individuals toward death and their perceptions of hospice and palliative care, as well as their care needs. It also investigated their preferences for alternative decision-making and advance care planning options at the end of life. **Methods:** A descriptive survey study was conducted with LGBT adults aged 18 and older. Participants were recruited through LGBT organizations and online communities, and data from 207 respondents were analyzed. Questionnaires were utilized to assess attitudes toward death, perceptions of hospice care, and care needs. Statistical analysis was performed using SPSS 20.0, employing the t-test, ANOVA, and Pearson correlation coefficients. **Results:** LGBT individuals generally had low attitudes toward death and negative perceptions of hospice care. Attitudes toward death varied significantly by sex, age, and education, while perceptions of hospice care differed significantly by sexual orientation and education. Care needs in hospice settings also varied significantly by age, gender identity, and education. Most LGBT participants preferred their biological family members (52%) and partners (39%) as surrogate decision-makers. A significant positive correlation was found between perceptions of hospice care and overall care needs. **Conclusion:** The findings highlight the need for healthcare services tailored to LGBT individuals' specific needs. It is necessary to promote social understanding, awareness, and policy support to improve the quality of life for LGBT individuals through more inclusive and responsive healthcare services. It also points to the need for healthcare professionals to increase their awareness and understanding of these issues.

**Key Words:** Sexual and gender minorities, Hospice care, Palliative care, Terminal care, Attitude, Perception, Needs assessment

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## INTRODUCTION

### 1. Background

To maintain consistency in academic terminology, the term “LGBT,” an acronym standing for “lesbian, gay, bisexual, and transgender,” is now commonly used to refer to sexual minor-

ities. The primary concepts defining LGBT are gender identity and sexual orientation [1]. Gender identity is an individual's personal sense of their own gender. Individuals whose gender identity matches their physical sex are described as cisgender, whereas those whose gender identity does not match their physical sex are referred to as transgender [1]. Sexual orientation is defined as the pattern of emotional and sexual attrac-

tion one feels towards others, encompassing heterosexuality, homosexuality, bisexuality, and asexuality [1]. Due to differences in gender identity and sexual orientation, LGBT individuals often encounter significant levels of hatred and prejudice, leading to notable discrimination in healthcare services [1].

Discrimination significantly hinders access to healthcare services for LGBT individuals, often leaving them without adequate care and contributing to social exclusion. In South Korea, national surveys do not specifically capture data on individuals' gender identity and sexual orientation, complicating the assessment of their healthcare needs [2]. This issue extends to health-related research, where 95% of clinical studies focus on transgender and intersex case reports or gender reassignment surgery. Such a narrow scope makes it nearly impossible to understand the broader health status of this population [3], a stark contrast to the more diverse clinical research conducted in other countries [3]. According to the OECD's "Society at a Glance 2019" report, South Korea's acceptance of homosexuality scored 2.8, only half the OECD average of 5.1 [4]. The report highlights that this low level of acceptance may perpetuate social discrimination against sexual minorities and pressure individuals to hide their gender identity and sexual orientation [4]. In this societal context, LGBT individuals in South Korea exhibit lower participation rates in health screenings and face a higher risk of cancer, partly due to sexual behaviors such as anal intercourse. Additionally, they often avoid healthcare institutions and, even when they do seek care, frequently encounter inadequate medical services due to a lack of understanding among healthcare providers. Consequently, LGBT individuals have relatively limited access to palliative and end-of-life care. They also face a greater risk of increased cancer incidence, overall health deterioration, disability, and depression [1]. Therefore, there is an urgent need for research and advancements to ensure competent and equitable palliative and end-of-life care for this population.

The philosophy of hospice and palliative care focuses on reducing the anxiety and fear associated with disease progression and death, while supporting individuals in leading meaningful lives until their final moments. In 2016, South Korea established a legal framework through the enactment of the Hospice, Palliative Care, and Life-Sustaining Treatment Decision-Making Act. Additionally, in 2024, the govern-

ment introduced the Second Comprehensive Plan for Hospice and Life-Sustaining Treatment, which aims to broaden user choice and enhance the system [5]. However, within this framework, there is a notable absence of discussions concerning LGBT individuals. In this context, both LGBT individuals and healthcare providers are fully legally responsible for decisions such as ending life-sustaining treatment or appointing a proxy decision-maker. LGBT individuals often face estranged or severed family relationships. If they do not designate a substitute decision-maker before losing consciousness, they may encounter significant challenges due to the lack of a proxy during critical medical decision-making moments. This absence of a legal representative can prevent essential decisions, such as the discontinuation of life-sustaining treatment, from being made. As a result, this may lead to prolonged, unnecessary life-sustaining treatment or even legal disputes. This situation underscores the need to reassess whether the current legal framework, which permits biological family members to serve as alternative decision-makers, sufficiently protects the self-determination rights of LGBT individuals.

Since the 1980s, research on the health and medical services for LGBT individuals has been actively conducted in the United States. However, studies specifically focusing on hospice care are still relatively scarce [6]. This gap is even more pronounced in South Korea, where a systematic literature review found that by 2013, only 128 domestic studies had addressed health-related variables in LGBT individuals. Among these, research on general health issues, including chronic diseases and hospice care, was extremely rare [3]. Additionally, there is a significant lack of domestic research on how negative experiences—such as discrimination and stigma faced by LGBT individuals when accessing medical services—affect their health [3]. This lack of focus suggests that LGBT individuals continue to be overlooked in research and evaluation efforts. Understanding how LGBT individuals perceive death, their awareness of hospice and palliative care, and their specific needs is crucial for providing holistic care. Therefore, this study aims to provide foundational data to improve access to hospice and palliative care services for LGBT individuals. It also seeks to support the delivery of high-quality, holistic services by hospice and palliative care professionals.

## 2. Purpose of the Study

The purpose of this study was to examine the attitudes of LGBT individuals toward death, their perceptions of hospice care, and their hospice care needs, as well as to identify the relationships among these factors. The specific objectives were as follows:

To identify the general characteristics of the LGBT individuals who participated in the study.

To investigate the attitudes of LGBT individuals toward death, their perceptions of hospice care, and their needs for hospice care.

To analyze the attitudes toward death, perceptions of hospice care, and needs for hospice care according to the general characteristics of LGBT individuals.

To analyze the correlations among attitudes toward death, perceptions of hospice care, and needs for hospice care among LGBT individuals.

To examine LGBT individuals' preferences for alternative decision-makers and whether they have discussed advance care planning.

## METHODS

### 1. Study design

This descriptive survey study explores the attitudes toward death, perceptions of hospice care, and hospice care needs among LGBT individuals.

### 2. Study subjects and data collection

Data collection for this study was conducted after receiving approval from the Institutional Review Board (No. 2024-05-001-001). We employed purposeful sampling to select participants who aligned with the study's topic and objectives. To protect the privacy of LGBT participants regarding their gender identity and sexual orientation, we obtained prior consent from LGBT online communities. We then posted a recruitment notice and survey link on the community's online bulletin board. The inclusion criteria specified LGBT adults aged 18 years or older. This age group was targeted because these individuals are likely to have a relatively clear understanding of

their attitudes toward death, perceptions of hospice care, and hospice care needs, along with well-established gender identities and sexual orientations. Data collection took place from May 27 to June 14, 2024, and personally identifiable information was immediately discarded after the survey concluded. The minimum sample size was calculated using G\*Power version 3.1.9.4, with a significance level of 0.05, an effect size of 0.25, and a power of 0.9, resulting in a required sample size of 207 participants. To account for potential dropouts, the online survey was distributed to 268 participants. After excluding 63 incomplete responses, data from 207 participants were used for analysis.

### 3. Study instruments

#### 1) Attitudes toward death

Attitudes toward death refer to an individual's emotions and beliefs, including both fear of death and acceptance of it as a part of life. These attitudes manifest as either favorable or unfavorable responses [7]. In this study, we used an instrument originally developed by Thorson and Powell [7], which was adapted by Park [8] and further revised and supplemented by Yoo [9]. This instrument comprises 25 items, split into 9 negative and 16 positive statements about death, and utilizes a 4-point Likert scale. On this scale, higher scores indicate more positive attitudes toward death. The reliability of the tool was shown by a Cronbach's  $\alpha$  value of 0.83 in Yoo's study [9], and in this study, Cronbach's  $\alpha$  was 0.94.

#### 2) Perceptions of hospice care

Perceptions of hospice care reflect individuals' understanding of the concept, influenced by personal experiences, knowledge, and cultural factors. This study utilized an instrument initially developed by Kim [10] and Lee [11], which was later revised and enhanced by Gwak [12]. The instrument comprises 20 items categorized into five subcategories: definitions/philosophy (4 items), recipients of care (2 items), care services (8 items), psychology and ethics (4 items), and need for awareness-raising and education (2 items). Responses are measured using a 4-point Likert scale, where higher scores denote a greater awareness of hospice and palliative care. The reliability of the tool was demonstrated by a Cronbach's  $\alpha$  value of 0.85

in Gwak's study [12], whereas Cronbach's  $\alpha$  improved to 0.95 in the current study.

### 3) Needs for hospice care

In this study, we utilized the tool originally developed by Kang et al. [13] and later revised and expanded by Gwak [12]. This instrument comprises 23 items categorized into four sub-categories: physical needs (5 items), spiritual needs (5 items), psychological needs (6 items), and family support needs (7 items). To improve data consistency and minimize neutral responses, Gwak [12] modified the original 5-point Likert scale to a 4-point scale. The validity of the tool was established through factor analysis, with higher scores reflecting greater hospice care needs. The reliability of the tool was shown by a Cronbach's  $\alpha$  of 0.91 in Gwak's study [12] and 0.98 in the current study.

### 4) Preferences for alternative decision-makers and advance care planning

To investigate preferences for alternative decision-makers and discussions on advance care planning, this study used a tool originally developed by Hughes and Cartwright [14], which was adapted, revised, and supplemented to suit the Korean context. The instrument includes four items: preferred alternative decision-maker, whether advance care planning has been discussed with the alternative decision-maker, reasons for not discussing advance care planning with the alternative decision-maker, and level of confidence in the realization of advance care planning.

## 4. Data analysis

Data from 207 LGBT participants were analyzed using SPSS version 20.0. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were employed to present general characteristics, attitudes toward death, perceptions of hospice care, hospice care needs, preferences for an alternative decision-maker, and discussions on advance care planning. Differences in attitudes toward death, perceptions of hospice care, and hospice care needs based on general characteristics were examined using t-tests and one-way analysis of variance, with the Scheffé test employed for post hoc analysis. The correlations among attitudes toward death, perceptions of

hospice care, and needs for hospice care were analyzed using Pearson's correlation.

## RESULTS

### 1. General characteristics

The participants included 117 women (56.5%) and 90 men (43.5%). The largest group was in their 20s, with 86 partici-

**Table 1.** Demographic Characteristics of Respondents (N=207).

Variables	Categories	n(%) or Mean $\pm$ SD
Sex	Male	90 (43.5)
	Female	117 (56.5)
Age (yr)	$\leq 29$	86 (41.5)
	30~39	83 (40.1)
	40~49	32 (15.5)
	$\geq 50$	6 (2.9)
		32.97 $\pm$ 8.03
Gender identity	Cisgender male	41 (19.8)
	Cisgender female	101 (48.8)
	Transgender male	17 (8.2)
	Transgender female	48 (23.2)
Sexual orientation	Heterosexuality	25 (12.1)
	Homosexuality	126 (60.9)
	Bisexuality	56 (27.1)
Coming out experience	Yes	128 (61.8)
	No	79 (38.2)
Partner status	Yes	117 (56.5)
	No	90 (43.5)
Employment status	Yes	186 (89.9)
	No	21 (10.1)
Job (n=186) (if the answer is "yes")	Student	7 (3.8)
	Office worker	147 (79.0)
	Owner-operator	19 (10.2)
	Others	13 (7.0)
Income (KRW/yr)	<15,000,000	27 (13.0)
	15,000,000~20,000,000	5 (2.4)
	25,000,000~30,000,000	79 (38.2)
	$\geq 30,000,000$	96 (46.4)
Education	High school	21 (10.1)
	Bachelor's degree	164 (79.2)
	Master's degree or above	22 (10.6)
Religion	Protestantism	23 (11.1)
	Catholicism	14 (6.8)
	Buddhism	20 (9.7)
	None	150 (72.5)
	Others	-

pants (41.5%), followed closely by those in their 30s, with 83 participants (40.1%). The mean age was  $32.97 \pm 8.03$  years. Regarding gender identity, cisgender females comprised the largest subgroup with 101 participants (48.8%), followed by transgender females with 48 participants (23.2%), cisgender males with 41 participants (19.8%), and transgender males with 17 participants (8.2%). In terms of sexual orientation, homosexuality was the most prevalent (126 participants, 60.9%), followed by bisexuality (56 participants, 27.1%) and heterosexuality (25 participants, 12.1%). Among the participants, 128 individuals (61.8%) had come out, and 117 participants (56.5%) reported having a current partner. Regarding employment, 186 participants (89.9%) were employed, with 147 of these (79.0%) working as office workers. In terms of income level, 96 participants (46.4%) reported an annual income of over 30 million KRW, while 79 participants (38.2%) earned between 25 and 30 million KRW. Educationally, 164 participants (79.2%) had graduated from university, and 150 participants (72.5%) reported having no religious affiliation (Table 1).

## 2. Attitudes toward death, perceptions of hospice care, and needs of hospice care

The mean score for participants' attitudes toward death was  $2.49 \pm 0.49$ , while the mean score for perceptions of hospice care was  $2.96 \pm 0.69$ . Within the five subcategories of perceptions of hospice care, the scores were as follows: definitions/philosophy,  $3.07 \pm 0.85$ ; recipients of care,  $3.06 \pm 0.68$ ; need for awareness-raising and education,  $3.06 \pm 0.93$ ; care ser-

vices,  $2.98 \pm 0.74$ ; and psychology and ethics,  $2.89 \pm 0.76$ . The mean score for needs for hospice care was  $2.97 \pm 0.82$ . Among the four subcategories of needs, the scores were as follows: psychological needs,  $3.06 \pm 0.91$ ; physical needs,  $3.05 \pm 0.92$ ; family support needs,  $3.05 \pm 0.93$ ; and spiritual needs,  $2.81 \pm 0.86$  (Table 2).

## 3. Attitudes toward death, perceptions of hospice care, and needs of hospice care by general characteristics

Significant differences in attitudes toward death were observed based on sex, age, and education. Women ( $2.30 \pm 0.70$ ) exhibited more positive attitudes toward death than men ( $2.53 \pm 0.69$ ) ( $t = -2.32$ ,  $P = 0.02$ ). Regarding age, participants in their 20s ( $2.14 \pm 0.70$ ) had less positive attitudes than those in their 30s ( $2.59 \pm 0.60$ ) and 40s ( $2.78 \pm 0.71$ ) ( $F = 10.29$ ,  $P < 0.001$ ). Additionally, higher educational levels were associated with more positive attitudes toward death ( $F = 11.28$ ,  $P < 0.001$ ) (Table 3).

Significant differences in perceptions of hospice care were observed based on age, gender identity, sexual orientation, and education level. In the analysis by sexual orientation, bisexual participants ( $3.20 \pm 0.62$ ) had higher perceptions of hospice care than homosexual participants ( $2.91 \pm 0.73$ ) ( $F = 3.85$ ,  $P = 0.02$ ). Regarding educational level, participants with a master's degree or higher ( $3.54 \pm 0.23$ ) demonstrated the highest perceptions of hospice care ( $F = 8.53$ ,  $P < 0.001$ ). In contrast, post hoc analyses for age ( $F = 2.84$ ,  $P = 0.04$ ) and gender identity ( $F = 4.03$ ,  $P = 0.01$ ) revealed no significant differences (Table 3).

**Table 2.** Attitudes toward Death, Perceptions of Hospice Care, Needs of Hospice Care (N=207).

Variable	Sub-dimension	Mean $\pm$ SD
Attitudes toward death (out of 4 points)	Total	$2.49 \pm 0.49$
Perceptions of hospice care (out of 4 points)	Total	$2.96 \pm 0.69$
	Definitions/Philosophy	$3.07 \pm 0.85$
	Recipients of care	$3.06 \pm 0.68$
	Care services	$2.98 \pm 0.74$
	Psychology and ethics	$2.89 \pm 0.76$
	Need for awareness-raising and education	$3.06 \pm 0.93$
Needs for hospice care (out of 4 points)	Total	$2.97 \pm 0.82$
	Physical needs	$3.05 \pm 0.92$
	Spiritual needs	$2.81 \pm 0.86$
	Psychological needs	$3.06 \pm 0.91$
	Family support needs	$3.05 \pm 0.93$

Table 3. Attitudes toward Death, Perceptions of Hospice Care, Needs of Hospice Care by Demographic Characteristics of Respondents (N=207).

Variables	Categories	n	Attitudes toward death			Perceptions of hospice care												Needs for hospice care																	
			Total			Definitions/Philosophy			Recipients of care			Care services			Psychology and Ethics			Need for awareness raising and education			Total			Physical needs			Spiritual needs			Psychological needs			Family support needs		
			M±SD	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)	M±SD (p)	t/F (p)			
Sex	Male	90	2.53 ±0.69	-2.32* (0.02)	3.06 ±0.63	1.43 (0.16)	3.19 ±0.69	2.07* (0.04)	2.98 ±0.68	-1.56 (0.12)	3.02 ±0.60	0.74 (0.46)	2.95 ±0.74	1.07 (0.29)	3.18 ±0.92	1.60 (0.11)	3.12 ±0.80	1.78 (0.08)	3.15 ±0.87	1.42 (0.16)	3.00 ±0.83	2.83† (0.01)	3.16 ±0.84	1.37 (0.17)	3.15 ±0.82	1.41 (0.16)									
	Female	117	2.30 ±0.70		2.92 ±0.75		2.97 ±0.85		3.13 ±0.73		2.95 ±0.74		2.84 ±0.76		2.97 ±0.93		2.91 ±0.86		2.97 ±0.92		2.67 ±0.86		2.99 ±0.91		2.97 ±0.93										
Age (yr)	≤29a	86	2.14 ±0.70	10.29† [bc>a]† <0.001)	3.01 ±0.68	2.84* (0.04)	3.09 ±0.77	2.35 (0.07)	2.98 ±0.69	2.43 (0.07)	2.97 ±0.67	2.91* (0.04)	2.94 ±0.74	2.35 (0.07)	3.13 ±0.92	3.69* [c>b]† (0.01)	2.98 ±0.85	3.96† [c>b]† (0.01)	3.02 ±0.90	5.07† [c>ab]† <0.01)	2.80 ±0.84	2.04 (0.11)	3.03 ±0.88	3.99† [c>b]† (0.01)	3.03 ±0.89	3.49* [c>b]† (0.02)									
	30~39b	83	2.59 ±0.60		2.84 ±0.73		2.92 ±0.83		3.04 ±0.74		2.86 ±0.72		2.73 ±0.77		2.83 ±0.98		2.84 ±0.88		2.86 ±0.94		2.69 ±0.90		2.90 ±0.93		2.89 ±0.92										
Gender identity	40~49c	32	2.78 ±0.71		3.24 ±0.62		3.34 ±0.74		3.30 ±0.67		3.25 ±0.56		3.09 ±0.68		3.42 ±0.77		3.40 ±0.60		3.54 ±0.61		3.11 ±0.78		3.46 ±0.65		3.45 ±0.69										
	≥50d	6	2.52 ±0.49		3.22 ±0.48		3.29 ±0.56		3.50 ±0.45		3.23 ±0.54		3.08 ±0.56		3.25 ±0.42		3.38 ±0.60		3.47 ±0.56		3.07 ±0.78		3.56 ±0.65		3.38 ±0.77										
Sexual orientation	Cisgender male <sup>a</sup>	41	2.50 ±0.68	1.67 (0.17)	3.18 ±0.52	4.03† (0.01)	3.32 ±0.63	3.71* (0.01)	3.12 ±0.72	1.48 (0.22)	3.12 ±0.72	3.25* (0.02)	3.04 ±0.67	3.86* [c>d]† (0.01)	3.40 ±0.75	3.65* [a>d]† (0.01)	3.39 ±0.54	8.70† [a>b,c,d]† <0.001)	3.37 ±0.61	6.07† [a>d]† <0.01)	3.20 ±0.68	7.41† [a>c>b,d]† <0.001)	3.47 ±0.58	8.68† [a>c>b,d]† <0.001)	3.46 ±0.56	8.89† [a>c>b,d]† <0.01)									
	Cisgender female <sup>b</sup>	101	2.46 ±0.73		2.94 ±0.77		3.01 ±0.89		3.05 ±0.74		2.95 ±0.74		2.87 ±0.79		2.97 ±0.96		2.94 ±0.90		3.00 ±0.97		2.72 ±0.89		3.00 ±0.95		3.00 ±0.96										
Coming out experience	Transgender male <sup>c</sup>	17	2.08 ±0.79		3.32 ±0.43		3.38 ±0.45		3.35 ±0.55		3.32 ±0.52		3.28 ±0.47		3.35 ±0.70		3.47 ±0.43		3.53 ±0.48		3.27 ±0.58		3.53 ±0.53		3.50 ±0.47										
	Transgender female <sup>d</sup>	48	2.42 ±0.60		2.79 ±0.70		2.86 ±0.72		2.95 ±0.66		2.81 ±0.67		2.65 ±0.73		2.85 ±0.99		2.64 ±0.83		2.72 ±0.93		2.52 ±0.85		2.64 ±0.86		2.64 ±0.86										
Partner	Heterosexuality <sup>e</sup>	25	2.16 ±0.59	2.15 (0.12)	2.84 ±0.62	3.85* [c>b]† (0.02)	3.02 ±0.72	5.01† [c>b]† (0.01)	2.80 ±0.54	2.09 (0.13)	2.78 ±0.52	4.04* [c>a]† (0.02)	2.79 ±0.77	1.33 (0.27)	2.88 ±1.00	4.37* [c>b]† (0.01)	3.05 ±0.95	2.46 (0.09)	2.99 ±1.02	1.84 (0.16)	2.96 ±0.91	1.67 (0.19)	3.07 ±0.98	2.57 (0.08)	3.15 ±0.98	3.12* (0.05)									
	Homosexuality <sup>f</sup>	126	2.47 ±0.66		2.91 ±0.73		2.95 ±0.83		3.09 ±0.76		2.93 ±0.73		2.85 ±0.75		2.96 ±0.95		2.90 ±0.84		2.97 ±0.90		2.73 ±0.85		2.96 ±0.89		2.93 ±0.89										
Employment status	Bisexuality <sup>g</sup>	56	2.45 ±0.82		3.20 ±0.62		3.35 ±0.68		3.13 ±0.65		3.18 ±0.59		3.02 ±0.73		3.37 ±0.79		3.20 ±0.76		3.25 ±0.82		2.94 ±0.86		3.28 ±0.78		3.27 ±0.80										
	Yes	128	2.44 ±0.67	-0.25 (0.80)	3.04 ±0.65	-1.42 (0.16)	3.14 ±0.76	-1.71 (0.09)	3.07 ±0.72	-0.13 (0.90)	3.02 ±0.64	-1.07 (0.29)	2.94 ±0.68	-1.28 (0.20)	3.14 ±0.92	-1.59 (0.11)	3.05 ±0.82	-1.11 (0.27)	3.13 ±0.88	-1.62 (0.11)	2.83 ±0.86	-0.30 (0.77)	3.13 ±0.87	-1.41 (0.16)	3.09 ±0.89	-0.88 (0.38)									
Employment status	No	79	2.41 ±0.76		2.89 ±0.77		2.95 ±0.83		3.06 ±0.70		2.91 ±0.74		2.80 ±0.84		2.93 ±0.94		2.92 ±0.87		2.92 ±0.93		2.79 ±0.86		2.95 ±0.91		2.98 ±0.89										
	Yes	117	2.44 ±0.66	-0.293 (0.77)	2.95 ±0.70	0.741 (0.46)	3.04 ±0.79	0.627 (0.53)	3.03 ±0.74	0.716 (0.48)	2.95 ±0.68	0.766 (0.45)	2.87 ±0.72	0.321 (0.75)	3.00 ±0.95	1.142 (0.26)	2.99 ±0.83	0.223 (0.82)	3.04 ±0.89	0.168 (0.87)	2.82 ±0.85	-0.119 (0.91)	3.06 ±0.88	-0.031 (0.98)	3.01 ±0.88	0.679 (0.50)									
Employment status	No	90	2.41 ±0.76		3.02 ±0.71		3.11 ±0.81		3.11 ±0.67		3.02 ±0.68		2.91 ±0.79		3.14 ±0.89		3.02 ±0.86		3.06 ±0.92		2.80 ±0.88		3.06 ±0.90		3.10 ±0.89										
	Yes	186	2.43 ±0.71	0.12 (0.90)	3.00 ±0.69	-1.22 (0.22)	3.10 ±0.78	-1.66 (0.10)	3.07 ±0.70	-0.28 (0.78)	2.99 ±0.67	-0.57 (0.57)	2.91 ±0.73	-1.42 (0.16)	3.09 ±0.93	-1.31 (0.19)	3.02 ±0.83	-0.77 (0.45)	3.06 ±0.89	-0.63 (0.53)	2.81 ±0.86	-0.02 (0.99)	3.08 ±0.88	-0.89 (0.37)	3.07 ±0.88	-1.16 (0.25)									
Employment status	No	21	2.45 ±0.64		2.80 ±0.79		2.80 ±0.85		3.02 ±0.78		2.90 ±0.76		2.67 ±0.90		2.81 ±0.90		2.87 ±0.93		2.93 ±0.99		2.81 ±0.88		2.90 ±0.96		2.84 ±0.96										

\*P&lt;0.05, †P&lt;0.01, ‡P&lt;0.001, §Scheff.



Table 3. Continued.

Attitudes toward death			Perceptions of hospice care										Needs for hospice care													
Variables	Categories	n	Total		Definitions/ Philosophy		Recipients of care		Care services		Psychology and Ethics		Need for awareness raising and education		Total		Physical needs		Spiritual needs		Psychological needs		Family support needs			
			M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)	M±SD	t/F (P)		
Job (n=186) (if the answer is "yes")	Studenta	7	2.12 ±0.66	4.05 (0.06)	2.87 ±0.80	2.17 (0.09)	2.88 ±0.87	2.40 (0.07)	3.07 ±0.75	1.55 (0.20)	2.91 ±0.67	2.15 (0.10)	2.77 ±0.98	0.92 (0.43)	2.93 ±0.96	2.50 (0.06)	2.91 ±1.00	3.02 (0.06)	2.93 ±1.05	2.84 (0.08)	2.76 ±0.94	3.07 (0.12)	2.98 ±1.04	2.58 (0.06)	2.95 ±1.04	2.67 (0.05)
	Office workerb	147	2.39 ±0.73		2.99 ±0.71		3.07 ±0.81		3.05 ±0.71		2.97 ±0.69		2.91 ±0.74		3.06 ±0.95		2.98 ±0.84		3.03 ±0.88		2.8 ±0.85		3.04 ±0.88		3.04 ±0.88	
	Owner-operatorc	19	2.51 ±0.45		2.73 ±0.70		2.86 ±0.77		2.84 ±0.69		2.75 ±0.65		2.64 ±0.73		2.76 ±0.96		2.66 ±0.89		2.73 ±1.09		2.37 ±0.88		2.75 ±0.91		2.74 ±0.95	
	Othersd	13	2.99 ±0.43		3.35 ±0.36		3.56 ±0.41		3.38 ±0.55		3.36 ±0.48		2.98 ±0.50		3.65 ±0.47		3.56 ±0.43		3.65 ±0.50		3.29 ±0.71		3.62 ±0.58		3.63 ±0.50	
Income (KRW/yr)	≤15,000,000 <sup>a</sup>	27	2.41 ±0.62	0.50 (0.68)	2.99 ±0.70	1.48 (0.22)	2.98 ±0.80	1.02 (0.39)	3.22 ±0.66	3.69* [d>c] <sup>a</sup> (0.01)	3.03 ±0.63	2.32 (0.08)	2.93 ±0.84	1.48 (0.22)	3.04 ±0.83	0.70 (0.55)	3.07 ±0.80	0.90 (0.44)	3.18 ±0.88	1.03 (0.38)	2.79 ±0.84	0.30 (0.82)	3.14 ±0.87	1.25 (0.29)	3.13 ±0.86	1.16 (0.33)
	15,000,000 ~20,000,000 <sup>b</sup>	5	2.54 ±0.66		3.38 ±0.31		3.55 ±0.41		3.20 ±0.76		3.50 ±0.40		3.05 ±0.33		3.40 ±0.22		3.12 ±1.09		3.36 ±1.22		2.96 ±1.01		2.87 ±1.15		3.29 ±1.05	
	25,000,000 ~30,000,000 <sup>c</sup>	79	2.36 ±0.68		2.87 ±0.74		3.01 ±0.82		2.86 ±0.71		2.85 ±0.68		2.75 ±0.84		2.96 ±1.04		2.88 ±0.89		2.92 ±0.95		2.75 ±0.88		2.92 ±0.94		2.91 ±0.93	
	≥30,000,000 <sup>d</sup>	96	2.48 ±0.74		3.05 ±0.68		3.12 ±0.79		3.18 ±0.69		3.04 ±0.69		2.98 ±0.64		3.13 ±0.88		3.08 ±0.80		3.10 ±0.85		2.86 ±0.85		3.16 ±0.82		3.13 ±0.85	
Education	High schoola	21	1.98 ±0.50	11.28* <sup>a</sup> [c>b>a] <sup>a</sup> (<0.001)	3.02 ±0.68	8.53* (<0.001)	3.02 ±0.74	8.48* [c>a,b] <sup>a</sup> (<0.001)	3.00 ±0.65	8.55* [c>a,b] <sup>a</sup> (<0.001)	3.03 ±0.64	10.01* <sup>a</sup> [c>a,b] <sup>a</sup> (<0.001)	2.95 ±0.82	3.85* [c>b] <sup>a</sup> (0.02)	3.17 ±0.81	6.72* [c>b] <sup>a</sup> (<0.001)	3.09 ±0.82	7.32* [c>b] <sup>a</sup> (<0.001)	3.19 ±0.88	8.00* [c>b] <sup>a</sup> (<0.001)	3.03 ±0.80	2.13 (0.12)	3.15 ±0.84	8.56* [c>b] <sup>a</sup> (<0.001)	3.01 ±0.93	9.38* [c>a,b] <sup>a</sup> (<0.001)
	Bachelor's degreeb	164	2.42 ±0.71		2.90 ±0.71		2.99 ±0.81		3.00 ±0.71		2.90 ±0.69		2.82 ±0.76		2.96 ±0.96		2.91 ±0.86		2.94 ±0.92		2.75 ±0.88		2.96 ±0.90		2.95 ±0.89	
	Master's degree or above <sup>c</sup>	22	2.94 ±0.46		3.54 ±0.23		3.70 ±0.34		3.64 ±0.54		3.56 ±0.24		3.28 ±0.43		3.70 ±0.37		3.61 ±0.31		3.72 ±0.34		3.07 ±0.74		3.75 ±0.38		3.79 ±0.31	
Religion	Protestantism <sup>a</sup>	23	2.51 ±0.55	0.66 (0.58)	3.12 ±0.41	1.06 (0.37)	3.25 ±0.55	1.07 (0.37)	2.89 ±0.56	0.67 (0.57)	3.07 ±0.41	0.53 (0.66)	2.98 ±0.50	1.12 (0.34)	3.37 ±0.69	2.12 (0.10)	3.15 ±0.87	1.17 (0.32)	3.22 ±0.89	1.22 (0.30)	3.05 ±0.91	1.59 (0.19)	3.12 ±0.95	0.82 (0.49)	3.20 ±0.85	1.04 (0.38)
	Catholicism <sup>b</sup>	14	2.53 ±0.51		3.18 ±0.44		3.21 ±0.60		3.04 ±0.77		3.13 ±0.57		3.16 ±0.46		3.43 ±0.33		3.19 ±0.49		3.30 ±0.57		2.89 ±0.72		3.25 ±0.56		3.29 ±0.54	
	Buddhism <sup>c</sup>	20	2.57 ±0.66		3.07 ±0.67		3.21 ±0.70		3.00 ±0.90		3.03 ±0.69		2.99 ±0.72		3.13 ±0.99		3.20 ±0.76		3.23 ±0.83		3.06 ±0.71		3.27 ±0.77		3.21 ±0.81	
	None <sup>d</sup>	150	2.39 ±0.74		2.93 ±0.75		3.01 ±0.85		3.10 ±0.70		2.95 ±0.72		2.83 ±0.80		2.97 ±0.98		2.93 ±0.87		2.98 ±0.93		2.74 ±0.87		3.00 ±0.91		2.98 ±0.93	
	Others <sup>e</sup>	-	-		-		-		-		-		-		-		-		-		-		-		-	

\*P<0.05, <sup>†</sup>P<0.01, <sup>‡</sup>P<0.001, <sup>§</sup>Scheff.

In the analysis of subcategories of perceptions of hospice care, significant differences were observed in definitions/philosophy based on sex, gender identity, sexual orientation, and education. Men ( $3.19 \pm 0.69$ ) had higher perceptions than women ( $2.97 \pm 0.85$ ) ( $t=2.07$ ,  $P=0.04$ ), and bisexual participants ( $3.35 \pm 0.68$ ) had higher perceptions than homosexual participants ( $2.95 \pm 0.83$ ) ( $F=5.01$ ,  $P=0.01$ ). Participants with a master's degree or higher ( $3.70 \pm 0.34$ ) showed the highest perceptions ( $F=8.48$ ,  $P<0.001$ ); however, post hoc analysis for gender identity ( $F=3.71$ ,  $P=0.01$ ) showed no significant differences. For recipients of care, significant differences were found in financial status and education. Participants earning over 30 million KRW annually ( $3.18 \pm 0.69$ ) had higher perceptions than those earning between 25 and 30 million KRW ( $2.86 \pm 0.71$ ) ( $F=3.69$ ,  $P=0.01$ ), and those with a master's degree or higher ( $3.64 \pm 0.54$ ) showed the highest perceptions ( $F=8.55$ ,  $P<0.001$ ). For care services, significant differences were observed based on age, gender identity, sexual orientation, and education. Bisexual participants ( $3.18 \pm 0.59$ ) showed higher perceptions than heterosexual participants ( $2.78 \pm 0.52$ ) ( $F=4.04$ ,  $P=0.02$ ), and participants with a master's degree or higher ( $3.56 \pm 0.24$ ) had the highest perceptions ( $F=10.01$ ,  $P<0.001$ ). Post hoc analysis revealed no significant differences for age ( $F=2.91$ ,  $P=0.04$ ) or gender identity ( $F=3.25$ ,  $P=0.02$ ). For psychology and ethics, significant differences were observed based on gender identity and education. Transgender males ( $3.28 \pm 0.47$ ) showed higher perceptions than transgender females ( $2.65 \pm 0.73$ ) ( $F=3.86$ ,  $P=0.01$ ), and participants with a master's degree or higher ( $3.28 \pm 0.43$ ) showed higher perceptions than those with a bachelor's degree ( $2.82 \pm 0.76$ ) ( $F=3.85$ ,  $P=0.02$ ). In need for awareness-raising and education, significant differences were observed based on age, gender identity, sexual orientation, and education. Participants in their 40s ( $3.42 \pm 0.77$ ) showed higher perceptions than those in their 30s ( $2.83 \pm 0.98$ ) ( $F=3.69$ ,  $P=0.01$ ), and cisgender males ( $3.40 \pm 0.75$ ) exhibited higher perceptions than transgender females ( $2.85 \pm 0.99$ ) ( $F=3.65$ ,  $P=0.01$ ). Bisexual participants ( $3.37 \pm 0.79$ ) showed higher perceptions than homosexual participants ( $2.96 \pm 0.95$ ) ( $F=4.37$ ,  $P=0.01$ ), and participants with a master's degree or higher ( $3.70 \pm 0.37$ ) had higher perceptions than those with a bachelor's degree ( $2.96 \pm 0.96$ ) ( $F=6.72$ ,  $P<0.01$ ) (Table 3). The needs for hospice care showed significant dif-

ferences according to age, gender identity, and education. In terms of age, participants in their 40s ( $3.40 \pm 0.60$ ) had higher needs than those in their 30s ( $2.84 \pm 0.88$ ) ( $F=3.96$ ,  $P=0.01$ ). In the analysis based on gender identity, cisgender males ( $3.39 \pm 0.54$ ) showed the highest level of needs ( $F=8.70$ ,  $P<0.001$ ). Regarding educational level, participants with a master's degree or above ( $3.61 \pm 0.31$ ) demonstrated higher needs than those with a bachelor's degree ( $2.91 \pm 0.86$ ) ( $F=7.32$ ,  $P<0.01$ ) (Table 3).

In the analysis of subcategories of needs for hospice care, significant differences were observed in physical needs based on age, gender identity, and education. Participants in their 40s ( $3.54 \pm 0.61$ ) exhibited higher physical needs than those in their 20s ( $3.02 \pm 0.90$ ) and 30s ( $2.86 \pm 0.94$ ) ( $F=5.07$ ,  $P<0.01$ ). Cisgender males ( $3.37 \pm 0.61$ ) and transgender males ( $3.53 \pm 0.48$ ) had higher needs than transgender females ( $2.72 \pm 0.93$ ) ( $F=6.07$ ,  $P<0.01$ ). Participants with a master's degree or higher ( $3.72 \pm 0.34$ ) showed greater physical needs than those with a bachelor's degree ( $2.94 \pm 0.92$ ) ( $F=8.00$ ,  $P<0.001$ ). Significant differences were also observed in spiritual needs based on sex and gender identity. Men ( $3.00 \pm 0.83$ ) demonstrated higher spiritual needs than women ( $2.67 \pm 0.86$ ) ( $t=2.83$ ,  $P=0.01$ ). Cisgender males ( $3.20 \pm 0.68$ ) and transgender males ( $3.27 \pm 0.58$ ) showed higher spiritual needs than cisgender females ( $2.72 \pm 0.89$ ) and transgender females ( $2.52 \pm 0.85$ ) ( $F=7.41$ ,  $P<0.001$ ). In psychological needs, significant differences were observed based on age, gender identity, and education. Participants in their 40s ( $3.46 \pm 0.65$ ) had higher psychological needs than those in their 30s ( $2.90 \pm 0.93$ ) ( $F=3.99$ ,  $P=0.01$ ). Cisgender males ( $3.47 \pm 0.58$ ) and transgender males ( $3.53 \pm 0.53$ ) exhibited higher psychological needs than cisgender females ( $3.00 \pm 0.95$ ) and transgender females ( $2.67 \pm 0.86$ ) ( $F=8.68$ ,  $P<0.001$ ). Participants with a master's degree or higher ( $3.75 \pm 0.38$ ) had higher psychological needs than those with a bachelor's degree ( $2.96 \pm 0.90$ ) ( $F=8.56$ ,  $P<0.001$ ). In the analysis of family support needs, significant differences were observed based on age, gender identity, sexual orientation, and education. Participants in their 40s ( $3.45 \pm 0.69$ ) had higher family support needs than those in their 30s ( $2.89 \pm 0.92$ ) ( $F=3.49$ ,  $P=0.02$ ). Cisgender males ( $3.46 \pm 0.56$ ) and transgender males ( $3.50 \pm 0.47$ ) showed higher needs than cisgender females ( $3.00 \pm 0.96$ ) and transgender females ( $2.64 \pm$



**Table 4.** Correlation for Attitudes toward Death, Perceptions of Hospice Care, Needs of Hospice Care (N=207).

	r(P)	
	Attitudes toward death	Perceptions on hospice care
Perceptions of hospice care	-0.02(0.77)	-
Needs for hospice care	-0.04(0.53)	0.89* (<0.01)

\*P<0.01.

0.86) (F=8.89, P<0.001). Participants with a master's degree or higher ( $3.79 \pm 0.31$ ) showed higher family support needs than high school graduates ( $3.01 \pm 0.93$ ) and those with a bachelor's degree ( $2.95 \pm 0.89$ ) (F=9.38, P<0.001). However, no significant differences were found in the post hoc analysis for sexual orientation (F=3.12, P=0.05) (Table 3).

#### 4. Correlations among attitudes toward death, perceptions of hospice care, and needs for hospice care

A statistically significant positive correlation was observed between perceptions of hospice care and the needs for hospice care ( $r=0.89$ , P<0.01). However, no correlation was found between attitudes toward death and the other variables (Table 4).

#### 5. Preferences for alternative decision-makers and advance care planning

If participants were unable to make medical decisions themselves, 107 participants (51.7%) preferred to have biological family members as their alternative decision-makers, whereas 81 participants (39.1%) chose their partners. Additionally, 60 participants (29.0%) reported having discussed advance care planning with their chosen alternative decision-maker. Conversely, among those who had not discussed advance care planning, 50 participants (34.0%) stated the reason as "Because it hasn't happened yet," and 28 participants (19.0%) expressed, "I don't feel the need to talk about it." Regarding their confidence in their alternative decision-maker's ability to respect their advance care planning, 89 participants (43.0%) felt "confident" or "very confident." In contrast, 94 participants (45.4%) were "not sure" (Table 5).

**Table 5.** Questionnaires related to Alternative Decision-Maker (N=207).

Questionnaires	n(%)
Who should make decisions for you if you are not able to?	
Partner	81 (39.1)
Biological relative	107 (51.7)
General practitioner	8 (3.9)
Other	11 (5.3)
Have you spoken to this person about your wishes if you lose decision-making ability?	
Yes	60 (29)
No	147 (71)
If you haven't spoken about this, why haven't you? (n=147) (If the answer is "no")	
Issue has not arisen	50 (34)
Don't see the need	28 (19)
Too difficult a topic	24 (16.3)
Other	45 (30.6)
How confident are you that your wishes will be respected?	
Very confident	22 (10.6)
Confident	67 (32.4)
Not sure	94 (45.4)
Not very confident	24 (11.6)

## DISCUSSION

This study explored the attitudes toward death, perceptions of hospice care, hospice care needs, preferences for alternative decision-makers, and advance care planning among LGBT individuals. The average score for attitudes toward death among LGBT participants was  $2.49 \pm 0.49$ , lower than that observed in university students ( $2.74 \pm 0.46$ ) [15], volunteers ( $2.83 \pm 0.32$ ) [9], and family members of intensive care unit patients ( $2.54$ ) [16]. This finding is consistent with research on older LGBT adults in North America, which indicates that LGBT individuals often encounter difficulties in receiving care within traditional family structures. Therefore, they tend to have a greater fear of death and a stronger inclination to avoid discussions about it, resulting in more negative attitudes toward death [17]. Negative attitudes toward death can create significant obstacles in end-of-life planning. These attitudes are especially marked in settings where LGBT rights are not sufficiently protected and may be further intensified by concerns about receiving care in medical institutions [17]. To improve the attitudes of LGBT individuals toward death, it is crucial to develop and enhance medical environments that protect their

rights.

Attitudes toward death among LGBT individuals showed significant differences based on sex, age, and education. Notably, higher educational levels correlate with more positive attitudes toward death. This observation aligns with research on middle-aged men, suggesting that enhanced cognitive abilities associated with higher education may lead to more positive perceptions of death [18]. Conversely, participants in their 20s exhibited the most negative attitudes toward death in this study. This finding is consistent with studies indicating that middle-aged individuals generally have more positive attitudes toward death than younger adults. This difference may be due to increased health concerns with age and more frequent encounters with death, such as the passing of elderly parents, which provide greater opportunities for reflection on mortality [18]. Understanding attitudes toward death is crucial as they profoundly influence one's experience of life's finiteness. Thus, it is essential to develop and implement programs specifically aimed at younger demographics to promote more positive attitudes toward death. Such initiatives could significantly improve their sense of life's meaning and overall quality of life.

The perceptions of hospice care among LGBT individuals received an average score of  $2.96 \pm 0.69$ , which is lower than the scores for cancer patients (3.15) and their families (3.13) [12], as well as the families of intensive care unit patients (3.11) [16]. This finding is consistent with research indicating that LGBT individuals often have insufficient access to information or experience with hospice and palliative care. This disparity may be exacerbated for those who have not disclosed their gender identity or sexual orientation [19]. LGBT individuals frequently approach end-of-life care without having established advance care planning, such as appointing an alternative decision-maker, which suggests a lack of proactive preparation or awareness of hospice and palliative care options. Moreover, fears of discrimination or stigma may deter them from seeking necessary palliative care services, further diminishing their awareness and understanding of these care options.

The average score for hospice care needs among LGBT individuals was  $2.97 \pm 0.82$ , which is lower than the scores reported for families of hospitalized terminal cancer patients ( $3.48 \pm 0.81$ ) [20], cancer patients ( $3.67 \pm 0.52$ ) and their families ( $3.89 \pm 0.49$ ) [21], cancer patients (4.24) and their families (4.32)

[12], and families of intensive care unit patients (3.99) [16]. Although no prior studies in South Korea have specifically investigated the hospice care needs of LGBT individuals, making direct comparisons challenging, international research has suggested that LGBT individuals may have higher care needs than non-LGBT populations [22]. However, the findings of this study differ from those international results. Based on previous studies that developed additional survey items to evaluate the unique needs of LGBT populations using validated instruments [22], there is a need for further research in this area. Previous studies have identified key variables influencing care needs, such as the competence of healthcare providers, gender identity, and coming out status [22]. However, this study did not investigate how LGBT individuals perceive healthcare providers' competence, showing significant differences only by gender identity. Thus, further research is needed to examine how these variables affect care needs and to explore differences in needs based on these variables. Additionally, healthcare providers must be cautious of biases and discriminatory attitudes stemming from a lack of understanding of how their hostility can impact the medical choices and experiences of LGBT individuals [23]. By promoting an understanding of the perspectives of individuals from diverse sociocultural backgrounds, providers can offer more practical, consistent, and realistic services. Many LGBT individuals hesitate to disclose their gender identity and sexual orientation due to fears about how healthcare providers may react [24]. When providers fail to recognize these unique needs, it becomes less likely that LGBT individuals' care requirements will be met [22]. Thus, there is a growing need to normalize the collection and documentation of gender identity and sexual orientation in healthcare settings [25]. Incorporating gender identity and sexual orientation into care practices is a vital element in improving the quality of life for LGBT individuals. Sustained efforts to integrate this understanding into clinical practice will better support LGBT individuals, enabling them to lead positive and empowered lives.

In the subcategories of hospice care needs among LGBT individuals, psychological needs had the highest score at  $3.06 \pm 0.91$ . This finding aligns with previous research involving the families of cancer patients [13], families of hospitalized terminal cancer patients [20], home-based cancer patients [26], and families of intensive care unit patients [16]. Furthermore,

LGBT individuals are more likely to face psychosocial issues, struggle with expressing emotional challenges, and are generally less proactive in seeking resources or information to manage these difficulties [1]. Therefore, it is crucial to develop intervention programs that promote effective expression and resolution of psychosocial challenges. Additionally, employing an approach that includes experts or interprofessional teams capable of providing tailored support for these individuals is necessary.

This study identified a positive correlation between higher perceptions of hospice care and increased needs for hospice care. This correlation is consistent with findings from previous research, including studies involving families of intensive care unit patients ( $r=0.49$ ,  $P<0.001$ ) [16] and cancer patients ( $r=0.60$ ,  $P<0.001$ ) along with their families ( $r=0.51$ ,  $P<0.001$ ) [12]. A significant finding from this study is that LGBT individuals demonstrated markedly lower attitudes toward death, perceptions of hospice care, and needs for hospice care compared to previous studies involving other populations [9,12,15,16,20,21]. These results underscore a significant gap in understanding regarding LGBT individuals, highlighting the urgent need for enhanced professional knowledge, educational initiatives to raise awareness, and policy-level support specifically tailored to this group. Holistic care needs can be met when LGBT individuals' requests to include their chosen family in medical decision-making processes are honored [27]. However, healthcare providers often neglect to ask about alternative decision-makers [28], a practice that is largely absent because many LGBT individuals do not disclose their identities. Additionally, some providers may hold biases against LGBT individuals, leading to reluctance in addressing such topics. In this context, it is crucial to encourage discussions about whom LGBT individuals select as alternative decision-makers in the medical decision-making process.

Among LGBT individuals, 52% preferred biological family members as medical decision-making proxies, while 39% chose their partners in that role. In contrast, an international study using the same tool reported that 45% of LGBT participants preferred partners, and only 25% chose biological family members, with partners being the most commonly selected alternative decision-makers [28]. This discrepancy may be attributed to the Confucian values and family-centered cultural

characteristics prevalent in South Korean society. Additionally, previous research found that LGBT individuals who had come out were more likely to designate partners as proxies (51%) and engage in discussions about advance care planning (59%) [14]. However, due to the uneven distribution of responses in this study, these findings could not be replicated. This limitation underscores the need for future studies with more balanced samples, especially considering prior research indicating that younger individuals, those who have not come out, and transgender individuals are more likely to feel uncomfortable discussing advance care planning [29]. LGBT individuals may experience a loss of respect and dignity when healthcare providers fail to recognize their partners—such as cohabitants or de facto spouses—as legitimate decision-makers. This exclusion from the decision-making process can increase the risk of receiving inadequate medical care [25]. However, 24% (53 individuals) of participants in this study who had experienced palliative care reported positive evaluations when their partners were included and respected as part of the decision-making process [27]. These findings suggest that involving partners in the decision-making process can lead to more positive perceptions of hospice and palliative care experiences.

In South Korea, the definition of “family” is limited to spouses and direct lineal ascendants or descendants who are 19 years of age or older. This definition plays a crucial role in decisions regarding the discontinuation of life-sustaining treatment, as it requires the agreement of the patient's family members. This narrow definition excludes de facto partners and same-sex spouses, leading to situations where the rights to self-determination of individuals are compromised. LGBT individuals, in particular, encounter significant obstacles in accessing medical services due to discrimination and a lack of awareness about their legal rights at the end of life [30]. It is essential to thoughtfully assess the specific needs for hospice and palliative care services within this community. The Ministry of Health and Welfare has recognized the need to bridge these decision-making gaps and has announced plans to amend the laws in 2024. The proposed revisions will include provisions for individuals who are unaccompanied and minors without guardians, enabling decisions to discontinue life-sustaining treatment even in the absence of family members [5]. However, the effectiveness of these changes hinges on the establishment of a

proxy system that truly serves the best interests of LGBT individuals. This system must prevent decisions based solely on the subjective judgment of the proxy. To support these changes, additional legal frameworks will need to be developed.

The limitations of this study are as follows: First, this descriptive survey was conducted using an online questionnaire distributed through online communities, resulting in a sample that predominantly consisted of younger participants who are relatively more interested in the subject. This limits the generalizability of the findings to the entire LGBT population. It is recommended that future studies target LGBT individuals across a broader range of age groups. Second, although significant differences were identified based on gender identity and sexual orientation, the study was limited in its ability to explain specific influencing factors. Further research is necessary to conduct in-depth evaluations of the differentiated needs of participants and to explore the causal relationships involved, thereby providing additional validation.

This study explored the health status of LGBT individuals in South Korea by examining their attitudes toward death, perceptions of hospice care, and hospice care needs within a healthcare system experiencing a growing demand for such services among LGBT populations. The findings highlight the importance of incorporating a deeper understanding of the perceptions and needs of LGBT individuals into clinical practice and education. Engaging in comprehensive discussions and considering long-term implications are crucial. These actions can help reduce medical resource wastage, decrease unnecessary exclusion, and build trust between patients and healthcare providers. Furthermore, the study emphasizes the need for a strategic approach to support advance care planning, including the involvement of alternative decision-makers in the medical decision-making process for LGBT individuals. The signifi-

cance of this research lies in its provision of scientific evidence aimed at improving equitable access to hospice and palliative care and facilitating the delivery of holistic services.

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## CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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## AUTHOR'S CONTRIBUTIONS

Conception or design of the work: all authors. Data collection: all authors. Data analysis and interpretation: all authors. Drafting the article: all authors. Critical revision of the article: all authors. Final approval of the version to be published: all authors.

## SUPPLEMENTARY MATERIALS

Supplementary materials can be found via <https://doi.org/10.14475/jhpc.2024.27.4.149>.

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