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Attitudes of the General Public, Cancer Patients, Family Caregivers, and Physicians toward Advance Care Planning: A Nationwide Survey Prior to the Enforcement of the Life-Sustaining Treatment Decision-Making Act

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1 **Original Article**

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3 **Attitudes of the General Public, Cancer Patients, Family Caregivers, and Physicians**
4 **toward Advance Care Planning: A Nationwide Survey Prior to the Enforcement of the**
5 **Life-Sustaining Treatment Decision-Making Act**

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72 **Abstract**

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74 **Context.** To respect a patient's wish for end-of-life care, "the Act on Decisions on Life-
75 Sustaining Treatment for Patients at the End-of-Life" was enacted in South Korea in 2016.
76 Current understanding of people who would be involved in advance care planning (ACP) is
77 crucial to disseminate it systematically.

78 **Objectives.** To investigate awareness and attitudes toward ACP in South Korea.

79 **Methods.** A multicenter, nationwide cross-sectional study was conducted a survey regarding
80 ACP among four groups that would have different positions and experiences: 1,001 cancer
81 patients, 1,006 family caregivers, 928 physicians, and 1,241 members of the general public.

82 **Results.** A total of 15% of the general population, 33% of the patients and caregivers, and 61%
83 of the physicians had knowledge of advance directives. More than 64% of the general
84 population, above 72% of the patients and caregivers, and 97% of the physicians were willing
85 to do so when the disease status was aggravated or terminal. The possibility for changing the
86 plan, uncertainty as to whether directives would actually be followed, and psychological
87 discomfort were common reasons for not wanting to engage in ACP. Routine
88 recommendations for a specific medical condition, heightened accessibility, and health
89 insurance support were common factors that could help facilitate ACP.

90 **Conclusion.** Our findings suggest that strategies for promoting ACP should reflect different
91 perspectives among the general public, patients, family caregivers, and physicians. Public
92 advocacy, resources for approaching and integrating ACP into routine healthcare, as well as
93 systematic support provisions, are needed.

94

95 **Keywords:** Advance care planning, Advance directives, Decision-making, Life support care,

96 Terminal care

97 Running title: Advance directives and POLST awareness

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119 Introduction

120 In South Korea, end-of-life care discussions tend to occur when an individual is rapidly
121 approaching death, and most patients are excluded from these discussions.¹ Although many
122 patients do not wish to undergo aggressive treatment during the terminal phase of an illness²,
123 86.6% of terminal cancer patients were hospitalized during their end-of-life period in 2010.³
124 In contrast, utilization of palliative care is very low: 17.5% among patients with cancer and
125 4.9% of total nationwide deaths in 2016.⁴ A tertiary university hospital survey reported that
126 end-of-life cancer treatment has become more aggressive over a recent 10-year period; 19.9%
127 in 2012 received intensive care during the last month of life compared to only 1.8% in 2002.
128 Furthermore, the time from last chemotherapy treatment to death has shortened from 66 days
129 to 34 days.⁵

130 To enhance a patient's involvement in making decisions, along with respecting a
131 patient's end-of-life wishes, the Act on Decisions on Life-Sustaining Treatment for Patients
132 at the End-of-Life was enacted in South Korea in 2016.⁶ The act permits withdrawing or
133 withholding life-sustaining treatment among patients during the terminal phase of their
134 disease. Furthermore, the act introduced advance directives and physician orders for life-
135 sustaining treatment (POLST) as specific legal forms of advance care planning (ACP).

136 Significant changes have been anticipated in communication about end-of-life care
137 following the act.⁷ It emphasizes patients to play a central role in ACP.⁸ However, having
138 patients directly involved in ACP for end-of-life care is still unusual.⁹ Family members
139 typically write do-not-resuscitate orders (DNR) within several days before death in Korea.^{1,10}
140 Furthermore, discrepancies in attitudes among patients, family caregivers, and physicians
141 towards ACP is a common barrier to communicating appropriate end-of-life care.¹¹⁻¹³

142 The goal of the present study was to investigate awareness and attitudes regarding

143 advance directives and POLST among the general public, cancer patients and their family
144 caregivers, and physicians in order to better advocate for ACP.

145

146 **Methods**

147 *Design and participants*

148 A nationwide, multicenter cross-sectional study was conducted between July and
149 October 2016. Detailed design and selection procedures are described in our prior report.¹⁴
150 Participants comprised four groups that were recruited using the following three distinct
151 procedures: the general population was recruited via a telephone survey, cancer patients and
152 family caregivers were recruited from 12 large hospitals (11 general hospitals and Korea's
153 National Cancer Center, which cover the capital, 5 major provinces, and 3 metropolitan cities)
154 via a face-to-face survey, and physicians from the same hospitals and the Korean Medical
155 Association (KMA) were recruited via an online survey. Our goal was to recruit about 1,000
156 respondents in each group.

157 *General population*

158 Firstly, the survey of the general population who aged 20-70 years old and resided over
159 17 major cities and local districts was conducted by the research staff of World Research, Inc.,
160 in Korea. At each major cities and local districts, participants were recruited using two strata
161 (age and sex) following the 2015 Census of Korea. We used a probability-proportional-to-size
162 technique for sample selection to represent a nationwide sample.¹⁵ Expecting a 10% response
163 rate, we contacted approximately 10,000 individuals from 17 major cities and local districts.
164 Finally, 1,241 of those agreed to respond to the survey on the phone.

165 *Patient and family caregivers*

166 Second, cancer patients and their family were surveyed at their outpatient clinic of 12
167 hospitals. Oncologists, who were coresearchers in this study, were asked to identify patients
168 with cancer. Then, patients and family caregivers were eligible if their age were at least 18
169 years, understood the purpose of the study, could communicate well with research assistants
170 and complete the questionnaire, and consented to participate in this study. 1,001 patients
171 completed the survey of 6,024 who were contacted (16.6% response rate). Of the 5,017
172 caregivers were contacted and 1,006 were included (20.1% response rate).

173 *Physicians*

174 Third, physicians were recruited online, from the 12 participating hospitals and KMA.
175 We sent them an email that included an explanation of the study and the URL for the survey.
176 928 physicians completed the survey and the response rate was 30%.

177 The study was approved by the Institutional Review Board of each hospital (Reference
178 number E-1612-102-815; 22 July 2016). Informed consent was obtained from patients and
179 family caregivers, and the IRB waived the requirement for informed consent from the general
180 population and the physician group. We conducted the study according to the principles of the
181 Declaration of Helsinki.

182

183 *Measurements*

184 A structured questionnaire was developed to investigate participants' awareness and
185 attitudes concerning ACP by researchers based on the literature review and the Act on life-
186 sustaining treatment decision-making in Korea. It contained 1) awareness of ACP, 2)

187 willingness to conduct ACP, 3) a suitable timing to write an advance directive, 4) strategies to
188 facilitate ACP, 5) sociodemographic variables (age, sex, education level, job status, religion,
189 income and the type of health insurance).

190 *Advance directives and POLST awareness*

191 First, the survey provided participants with an explanation about advance directives and
192 POLST, defined as follows by the new act¹⁶: “Advance directives is a statement that an adult
193 could write about determination of life-sustaining treatment and utilization of hospice at a
194 terminal stage. Whoever they are legally adults can write an advance directive without doctor
195 at a designated registration agency. These statements would be used in decision-making
196 regarding life-sustaining treatment and hospice care when they would be at a terminal stage
197 in the future. POLST is a specific treatment plan which a doctor in charge can write regarding
198 life-sustaining treatment and hospice care according to a patient’s opinion at a terminal stage
199 or dying phase. A doctor in charge shall explain a patient the following matters and write a
200 POLST: the disease statue and the methods of treatment, prognosis, the methods of life-
201 sustaining treatment (CPR, mechanical ventilation, hemodialysis, chemotherapy, etc.) and
202 termination of it, selection and use of hospice.” The survey subsequently explored
203 participants’ awareness through the following questions: “Have you heard about an advance
204 directive before this survey?” and “Have you heard about a POLST before this survey?”

205 *Willingness to conduct ACP*

206 The survey asked about willingness to write an advance directive or POLST across
207 different disease stages and types [i.e., healthy condition, upon diagnosis of a serious illness,
208 upon aggravation of the illness, when the terminal stage is unpredictable (e.g., chronic
209 obstructive pulmonary disease, liver cirrhosis), when the terminal stage is predictable (e.g.,

210 cancer), and during the actual terminal stage (e.g., when survival is expected to be no longer
211 than a few months)], with four responses (strongly agree, agree, disagree, strongly disagree).
212 If subjects answered “disagree” to the aforementioned item, they were asked to choose from the
213 following reasons for their unwillingness to begin ACP: 1) I feel psychologically anxious or
214 uncomfortable about preparing for worsening health problems, 2) I think I will change my
215 mind when I face the situation in the future, even if I make a decision now, 3) I am not sure if
216 things will be handled per my wishes, as reflected in the advance directives, 4) I am sure
217 that my family will make a wise decision when I am unable to do so, 5) I don’t know much
218 about advance directives or POLST, 6) It feels like a hassle to prepare for a future occasion in
219 advance, 7) I don’t personally know anybody who is establishing plans, 8) other. These items
220 were constructed based on the literature review^{11,17} and the designated process for ACP by the
221 corresponding act in Korea.

222 *A suitable timing for writing an advance directive*

223 The survey asked about when it would be appropriate for writing an advance directive.
224 The following response options were provided based on the literature review¹⁸⁻¹⁹ and the
225 health care system in Korea: 1) Prior to all operations and treatment bearing a risk of death, 2)
226 Visiting wards and emergency rooms of patients with specific severe diseases, 3) Visiting
227 wards and emergency rooms of every older patient aged 65-70 years and above, 4) Visiting
228 wards and emergency rooms of all patients, 5) Other (health checkup and after all treatments).

229 *Strategies for facilitating ACP*

230 We asked about what would be needed to facilitate ACP. The following response options
231 were provided based on the literature review²⁰⁻²² and the designated process for ACP
232 according to the new act: 1) large scale public outreach and education for ACP, 2) Developing

233 an online program that supports ACP, 3) Establishing administrative organizations
234 responsible for ACP registration, 4) Assigning medical coverage related to ACP, 5)
235 Reviewing and recommending advance directives when patients are admitted to a hospital or
236 an emergency room, 6) Forming a culture that stimulates open conversations about death with
237 families and friends.

238

239 *Statistical analyses*

240 A frequency analysis was conducted to assess distributions of age, gender, education,
241 employment status, area of residence, monthly income, and type of health insurance. The age
242 of the physician group tended to be relatively lower because accessibility of the online survey
243 could be affected by age. To improve the generalizability of the present results, we weighted
244 data from the physician group using the sex and age distribution of the physician population
245 based on KMA statistics.²³ Cross tabulations were conducted to assess awareness of advance
246 directives and POLST, suitable periods for preparing ACP documents, and ranking reasons
247 for not engaging in ACP. Indicator variables were applied for independent categorical
248 variables. A multivariate logistic regression analysis, which corrected for gender, age,
249 education, religion, and income, was conducted to examine which group was more likely to
250 engage in advance directives and POLST activities. Significance level was set to $P < 0.05$,
251 and SAS version 9.1 (SAS Institute, Cary, NC) was used for all analyses.

252

253 **Results**

254 Sociodemographic characteristics for the 4,106 participants analyzed are described in

255 Table 1. Cancer patients were older and were less likely to be employed than participants in
256 other groups. The patient group exhibited the following distribution in terms of cancer stage:
257 Stage I n = 148 (14.8%), Stage II n = 303 (30.3%), Stage III n = 325 (32.5%), and Stage IV n
258 = 157 (15.7%). Physicians were younger, more educated, and had a higher monthly income
259 than the other groups.

260 *Advance directives and POLST awareness*

261 Awareness of advance directives and POLST differed across the four groups. Although
262 only 15.6% of the general population knew about advance directives, one-third of cancer
263 patients and family caregivers were aware (Table 2). The awareness rate was highest among
264 physicians (61.4%, adjusted odds ratio = 9.35, 95% CI, 7.34-11.91). The proportion of those
265 aware of POLST was relatively lower than advance directives across all groups: 9.8% of the
266 general population, 25% of patients and family caregivers, and 50% of physicians.

267 *Willingness to conduct ACP*

268 Willingness to engage in ACP activities differed between the four groups. The rate was
269 lowest within the general population, with physicians reporting the highest (Figure 1).
270 Interestingly, the distribution of willingness rates across all groups was dependent on disease
271 status. Among general population respondents, rates were 46.2% when healthy, 56.9% when
272 diagnosed with a serious disease, 64.2% when the disease state was aggravated, and 68.3%
273 when the status was terminal. In the physician group, rates were 63.6% when healthy but over
274 97% when disease status was aggravated, expected to be terminal, and actually terminal.
275 Willingness among cancer patients and family caregivers were in the middle of the two
276 extreme groups.

277 Reasons for not wanting to write an advance directive or POLST were similar across

278 groups (Table 3). The most common reason was the possibility of the patient changing his/her
279 mind when actually faced with the reality of the situation. The second most common reason
280 was the psychological discomfort produced when thinking about a terminal illness. The third
281 most common reason was uncertainty regarding whether patients' decisions would be
282 respected when the time came.

283 *A suitable timing for writing an advance directive*

284 Participants across all four groups reported that suitable times for writing an advance
285 directive were before all procedures or interventions with a high mortality risk, when the
286 patient was frequently hospitalized, and when the patient was over the age of 65-70 when
287 recently admitted to the hospital (Table 4).

288 *Strategies for facilitating ACP*

289 All groups stated that public promotion efforts and education regarding ACP was the
290 most important means for facilitating ACP. Online programs and setting up offices where an
291 advance directive could be registered were also commonly reported among the general
292 population, patients, and family caregivers. In contrast, providing payment for ACP through
293 national medical insurance was the second most important method (26.4%) among the
294 physician group. Physicians also reported that a change to the culture in which people could
295 feel more comfortable openly discussing death with their family or friends would be helpful
296 (19.1%).

297

298 **Discussion**

299 *Main findings/results of the study*

300 The present study addressed the current understanding and attitudes regarding ACP
301 among different participant samples prior to enforcement of the first Korean legislative act
302 regarding life-sustaining treatment. Although the law was enacted in 2016, the general
303 public's awareness of ACP was below one fifth. Half of the physicians, who are expected to
304 initiate ACP, did not know about the law. When adjusting for gender, education, religion, and
305 income, doctors had the highest level of knowledge, followed by patients and their families.
306 This level of awareness is similar to what has been observed in China and Hong Kong.²⁴⁻²⁵

307 Although willingness to perform ACP differed across the groups sampled, at least more
308 than half of the participants even in non-physician group were willing to do it in most
309 hypothetical scenarios in contrast with their low awareness of ACP. The gap between the
310 awareness and the willingness rate even at a healthy condition were around 30 % in non-
311 physician group. Furthermore, the willingness rates were different in accordance with the
312 disease status or its prognosis. The closer the participants were to making a decision in real
313 situation, the more willing they were to engage in ACP. These findings would be reflective of
314 certain barriers participants reported to engaging ACP procedures. People were concerned
315 about their plans needing to be changed if actually faced with the decision and whether
316 family members and physicians would actually follow through with directives if the patient
317 became incapacitated. These are critical issues, especially when writing an advance
318 directive²⁶. Given that understanding a person's own illness and prognosis will affect his or
319 her decisions, preferences toward LST during a hypothetical situation likely differ
320 significantly from when actually experiencing a serious medical condition. Considering this
321 limitation, we should disclose that ACP is a process rather than a documentation event.²⁷⁻²⁸
322 Thinking ahead to one's own deteriorated health status, a discussion of values and
323 preferences with family members and/or healthcare providers in terms of clarifying care goals

324 is essential to ACP. Even if final documentation is not achieved, the process can be helpful.
325 Furthermore, engaging family caregivers in the discussion should lead to better adherence to
326 a patient's wishes.²⁹⁻³⁰ It is also important to notify the public that written documents can be
327 modified at any time. Also, given that psychological discomfort is a significant barrier to
328 writing an advance directive, cultural shifts may be necessary in order to encourage
329 individuals to more comfortably discuss prospects of health decline and death.²⁸

330 The present results also suggest that strategies for facilitating ACP are possible at
331 different levels, and the priority could differ in accordance with the role that people would
332 play in advance care planning. For instance, at the community level, accessibility can be an
333 essential factor for general people and patients who would write an advance directive.
334 Implementation of online programs and a nationwide designation of registry offices could
335 help increase ACP access.³¹⁻³² At the hospital level, our findings suggest that approaching
336 patients at high risk of deterioration or death (e.g., when considering a risky intervention, or a
337 poor prognosis is expected) could be acceptable. For integrating ACP into routine healthcare
338 procedures at a hospital, we should develop proactive and effective methods for initiating
339 discussions at the appropriate time.³³ Furthermore, a cultural reluctance to discuss death or
340 serious medical conditions is still a big barrier for physicians whom should be tasked with
341 initiating ACP within clinical settings.²⁹ To change this culture, public involvement, including
342 governments, media, and civic institutions, may be critical.²⁸

343 ***Strengths and weaknesses/limitations of the study***

344 A few study limitations should be noted. As the patient sample only included those with
345 cancer, a generalization of our findings to other patient samples should be taken with caution.
346 However, cancer patients would be one of the major groups in ACP discussions, so their

347 attitudes can be meaningful to develop the policy. Also, as our study focused on awareness
348 and attitudes among four groups in response to hypothetical scenarios, attitudes, and
349 behaviors when actually faced with a real situation could be different.³⁰ Investigating the
350 fulfillment of ACP and final decisions regarding end-of-life care after full enforcement of the
351 act is needed. Lastly, the Korean healthcare system and policy regarding ACP could have an
352 effect on our results, indicating a need to follow up these assessments in other cultural
353 contexts.³⁴

354 Despite this limitation, the current situation to try nationwide dissemination of ACP led
355 by the law in Korea could be a useful example of developing policy to promote ACP in other
356 countries. The subsequent years after the enactment of the act on life-sustaining treatment
357 decision-making will be a critical period for implementing and disseminating ACP provisions
358 following the government's policy. This study provides the current understanding and
359 concerns for the major distinct parties most affected by ACP initiatives by a large-scale
360 quantitative survey.

361 **Conclusion**

362 The findings indicated that many of the general public, patients, and their families are
363 willing to start conversations regarding their end-of-life care despite a cultural barrier about
364 talking about death. If ACP discussions are provided by easy methods to access at the
365 acceptable timing, we might initiate it with less burden than expected. Also, the different
366 priorities in facilitating strategies among the groups suggest that supports fitting into each
367 group's role and settings should be needed when promoting ACP. Such strategies could
368 include public education to increase awareness and readiness, available methods for carrying
369 out ACP decisions, implementation of ACP during routine clinical practice, and support from

370 the greater healthcare system. Further studies are required in order to develop these detailed
371 strategies.

372

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Table 1. Descriptive characteristics of the study population

		General population n = 1241	Cancer patients n = 1001	Family caregivers n = 1006	Physicians (unweighted) n = 928	Physicians (weighted) n = 928
		Percentage (%) with number				
Sex	Male	49.3 (612)	39.0 (390)	32.2 (324)	60.9 (565)	76.2 (707)
	Female	50.7 (629)	60.9 (610)	67.8 (682)	39.2 (363)	23.8 (220)
Age, year	<40	37.1 (460)	12.3 (123)	29.1 (292)	66.0 (612)	16.3 (312)
	40-49	20.9 (260)	21.1 (211)	30.2 (304)	23.9 (222)	36.9 (343)
	≥50	41.9 (521)	66.6 (666)	40.7 (409)	10.1 (94)	29.5 (274)
Education	Middle school or less	14.5 (179)	20.6 (205)	7.5 (75)	0 (0)	0 (0)
	High school	45.9 (568)	44.2 (440)	42.0 (423)	0 (0)	0 (0)
	College or higher	39.6 (490)	35.2 (351)	50.5 (508)	100 (928)	100 (928)
Job status	No	38.1 (473)	73.9 (737)	56.6 (569)	0 (0)	0 (0)
	Yes	61.9 (768)	26.1 (260)	43.4 (437)	100 (928)	100 (928)
Religion	No	58.6 (727)	46.3 (462)	49.1 (494)	41.6 (386)	37.7 (350)
	Yes	41.4 (514)	53.7 (536)	50.9 (512)	58.4 (542)	62.3 (578)
Monthly income, in 1,000 Korean won	<2,000	10.8 (133)	26.4 (260)	11.7 (117)	0 (0)	0 (0)
	2,000-2,999	14.9 (183)	19.9 (196)	18.4 (183)	0 (0)	0 (0)
	3,000-3,999	29.0 (357)	22.0 (217)	26.1 (260)	0 (0)	0 (0)
	≥4,000	45.2 (556)	31.7 (313)	43.8 (436)	100 (928)	100 (928)
Health Insurance	National Health Insurance	97.9 (1215)	93.0 (931)	93.54 (941)	100 (928)	100 (928)
	Medicaid	2.1 (26)	5.3 (53)	2.5 (25)	0 (0)	0 (0)
	National Health	0 (0)	1.6 (16)	3.8 (38)	0 (0)	0 (0)

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Table 2. Awareness of advance directives and POLST^{a)}

		General population	Cancer patients	Family caregivers	Physicians
Advance Directives	Yes (%)	194 (15.6)	338 (33.8)	334 (33.2)	570 (61.4)
	OR (95%)	1	2.75 (2.25-3.37)	2.68 (2.18-3.28)	10.44 (8.51-12.81)
	aOR (95%)	1	2.61 (2.11-3.23)	2.50 (2.03-3.07)	9.35 (7.34-11.91)
POLST	Yes (%)	121 (9.8)	262 (26.2)	254 (25.3)	456 (49.1)
	OR (95%)	1	3.28 (2.60-4.15)	3.13 (2.47-3.96)	9.67 (7.70-12.14)
	aOR (95%)	1	3.18 (2.49-4.06)	2.95 (2.32-3.76)	8.61 (6.59-11.26)

POLST, physician's order of life- sustaining treatment. ^{a)}Adjusted for sex, age, education, religion, income.

Table 3. Reasons for lacking the intention to prepare an advance directive or POLST

Reasons	General population		Cancer patients		Family caregivers		Physicians	
	n	%	n	%	n	%	n	%
I feel psychologically anxious or uncomfortable about preparing for worsening health problems.	249	28.7	131	22.2	134	23.1	69	15.6
I think I will change my mind when I face the situation in the future, even if I make a decision now.	181	20.9	132	22.4	139	24.0	158	35.8
I am not sure if things will be handled per my wishes, as reflected in the advance directives.	124	14.3	124	21.0	120	20.7	73	16.6
I am sure that my family will make a wise decision when I am unable to do so.	104	12.0	69	11.7	90	15.5	16	3.6
I don't know much about advance directives or POLST.	101	11.6	79	13.4	47	8.1	34	7.7
It feels like a hassle to prepare for a future occasion in advance.	72	8.3	31	5.3	36	6.2	33	7.5
I don't personally know anybody who is establishing plans.	36	4.2	24	4.1	13	2.2	10	2.3
Other	0	0.0	0	0.0	0	0.0	18	4.1

POLST, physician's order of life- sustaining treatment.

Table 4. The most suitable timing for writing an advance directive

Conditions	General population		Cancer patients		Family caregivers		Physicians	
	n	%	n	%	n	%	n	%
Prior to all operations and treatment bearing a risk of death	687	33.4	498	29.9	442	27.9	489	29.3
Visiting wards and emergency rooms of patients with specific severe diseases	535	26.0	406	24.4	399	25.2	728	43.6
Visiting wards and emergency rooms of every older patient aged 65-70 years and above	425	20.7	333	20.0	326	20.6	240	14.4
Visiting wards and emergency rooms of all patients	283	13.8	213	12.8	203	12.8	100	6.0
Other (health checkup and after all treatments)	126	6.1	213	12.8	213	13.5	113	6.8
Total	2,056	100.0	1,663	100.0	1,583	100.0	1,670	100.0

Tables 5. Strategies for facilitating ACP

Strategies	General population		Cancer patients		Family caregivers		Physicians	
	n	%	n	%	n	%	n	%
Large scale public outreach and education for ACP	455	36.7	398	39.8	390	38.8	344	37.1
Developing an online program that supports ACP	238	19.2	140	14.0	161	16.0	49	5.3
Establishing administrative organizations responsible for ACP registration	221	17.8	177	17.7	172	17.1	66	7.1
Assigning medical coverage related to ACP	172	13.9	135	13.5	147	14.6	245	26.4
Reviewing and recommending advance directives when patients are admitted to a hospital or an emergency room	85	6.8	87	8.7	72	7.2	47	5.1
Forming a culture that stimulates open conversations about death with families and friends	70	5.6	62	6.2	64	6.4	177	19.1
Total	1241	100.0	999	100.0	1006	100.0	928	100.0

ACP, advance care planning.

Figure legend

Fig 1. Willingness to engage in advance care planning. ACP, advance care planning.

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