DEVELOPMENT AND SOCIETY
Volume 45 | Number 2 | September 2016, 255-274
10.21588/dns/2016.45.2.004

Social Work Perspective: Comparing Korean Social Workers' Education and Knowledge of Advance Directives*

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This study aimed to analyze the differences in the status of social workers' education and knowledge level of advance directives between geriatric hospitals and long-term care facilities in South Korea. The study employed a quantitative research model of collecting data from 401 social workers with a structured questionnaire. Data were analyzed by descriptive statistics and an independent T-test, using the SPSS 21.0 program. It showed significant differences in medical knowledge of advance directives between those who work at geriatric hospitals and at long-term care facilities (2.20±0.87, 2.26±0.91, respectively; $p<0.05$). Knowledge level about artificial feeding tubes and hemodialysis was significantly lower among those at geriatric hospitals than those at long-term care facilities. The level of knowledge about medical and general areas of advance directives significantly differed based on their educational level in both geriatric hospitals and long-term care facilities. This study proposes the importance of the social workers' knowledge level in assisting elderly patients and their family members in long-term care settings, suggesting the importance of developing educational programs and licensing regulations prior to enforcing of the Act on Decision over Hospice and Palliative care and Life-prolonging Care for Dying Patients.

Keywords: *social worker, advance directives, knowledge, education, long-term care*

*This work was supported by the National Research Foundation of Korea Grant funded by the Korean Government (NRF-2016S1A3A2925399). Funding for this paper was provided by Namseoul University 2015.

Korean Elderly Patients and their Family Caregivers in Long Term Care Settings

The proportion of older persons in South Korea is gradually growing. In 2000, the elderly population rate was 7.22% of the total Korean population, and it is gradually increasing, up 12.22% in 2014 (Organization Economic Cooperation Development: OECD 2014). Also, the life expectancy of the Korean population is reaching 79 years for men, and 85.5 years for women in 2014 (Korean Statistical Information Service: KOSIS 2015). According to the World Health Organization (WHO 2014a), the highest life expectancy at age 60 in 2013 was recorded in the North American region by 23 years and the lowest record was in South-East Asia region by 17 years. To compare with Europe and West Pacific regions, the life expectancy age at 60 of South Korea was recorded by 24 years. Among three East Asian countries—China, Japan and Korea—China was recorded with the lowest life expectancy at age 60 by 19 years and Japan was the highest record by 26 years.

Korean elderly are enjoying extended longevity and living longer than ever before. However, they have remained about 13 to 19 years with 2-3 functional needs for activities of daily living (ADL), depending on long-term care services as well as multiple medical cares (Korean Statistics 2015). 89.2% of Korean elderly patients were diagnosed with non-communicable diseases (NCDs) with cancer accounting for most of the total deaths from NCDs (WHO 2014b). These indications for elderly patients are leading them to have more "personal care" components that are frequently provided in combination with care and basic medical services such as nursing care (wound dressing, pain management, medication, health monitoring), as well as prevention, rehabilitation, and hospice and palliative care (OECD 2013).

They have also benefitted from full national health care insurance coverage, financed by universal health care insurance established in 1988. Also they have benefitted from a newly-extended national long-term care (LTC) insurance that is financing a full coverage of LTC services with only a less-than-20-percent co-payment regardless of income and properties (National Health Insurance Service: NHIS 2014). LTC benefits include a range of services which were requested by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic ADL. The Act on LTC Insurance for Senior Citizens was passed unanimously in the Assembly's plenary session on Apr. 2, 2007 and enacted on Apr. 27; it was

enforced as of Jul. 1, 2008. This is a type of social insurance is based on the principle of social solidarity. The nation and society agreed to share the responsibility for LTC and nursing care for senior citizens with Alzheimer's disease or stroke instead of leaving the entire burden on their families. The LTC benefit covers health expenses for LTC institutional facilities over six months. On the contrary, the Medicare plan only covers a very short period of LTC services for skilled nursing facility and home care services in the U.S. It offers very limited coverage for LTC institutional services based upon insurers' income and properties (Center for Medicare & Medicaid Service: CMS 2015).

The geriatric hospital is a health institution intended to provide long-term acute care services, financed by NHIS to provide medical and nursing care in case of diseases, injuries, rehabilitation, and nursing etc., for elderly patients who do not have acute conditions. The duration of their hospitalization is longer than in an acute hospital, and their discharge is often delayed for several reasons. In 2014, the ratio of geriatric hospital expenses increased almost 18.8% compared with the 2013 expenses, including doctor's visits and other medical expenses (NHIS 2014). Table 1 shows the increasing ratio of health expenses for the geriatric hospital from 2008 to 2014. In fact, the elderly patients in both geriatric hospitals and LTC facilities required the same level of nursing care and functional assistances in an instance (Kim and Jung 2012). However, the standard of care and staff per service are regulated separately by two different health insurance systems in South Korea.

According to the national survey on the status of elderly life in 2014, which is conducted every three years, 88.9% of subjects desired to withhold life-sustaining treatments for non-treatable conditions at the end stages of life (Ministry of Health & Welfare 2014). Most subjects preferred to have less

TABLE 1
Physician and Medical Expenses of Geriatric Hospitals, 2000 to 2014

Classification		2008	2009	2010	2011	2012	2013	First Half of 2013	First Half of 2014	Rate of Change
Geriatric Hospital	Visiting Days	1,835	2,243	2,652	3,103	3,658	4,328	2,043	2,373	16.2
	Medical Fee	9,998	13,219	17,364	21,312	25,986	31,749	14,926	17,725	18.8
	Wages	7,351	9,790	13,102	16,108	19,695	24,110	11,336	13,446	18.8

aggressive treatments, to be treated with respect and dignity, and they wished for comfortable end-of-life care. Eight out of 10 elderly responded that what they valued most in their last moments, was to be surrounded by their family members at home and to arrange their end-of-life care with a painless death (Korea Institute for Health & Social Affairs 2015). About 85% of Korean patients and their family members preferred to regulate the pre-consulting for end of life care decision (EOLCD) with medical staff in advance, from the national survey for the perception of hospice-palliative service (Ministry of Health & Welfare 2011).

Unfortunately, a less-open culture on death and dying and regulated health care infra-systems for hospice and palliative care have caused many of them to stay more days in an acute care unit and end their life in intensive care unit with unnecessary life-prolonging treatments. Finally, in 2014, 73.1% of elderly patients ended their life not in their home but in a medical institutional setting (Korea Statistics 2014).

In this study, the EOLCD is defined by the process of decision making for less aggressive and prolonged life-sustaining treatments in the end stages of life in advance, including services and programs for hospice and palliative care.

Vulnerable Elderly Patients and Family Caregiver under the Act on Decision over Hospice · Palliative Care and Life-Prolonging Care for Dying Patients in South Korea

The right for the elderly patient to make decisions regarding the type and extent of treatments during the final life stages is drawn from guidelines prepared by the Council of Europe that stated, "Older persons should receive medical care only upon their free and informed consent and may also freely withdraw consent at any time" (Council of Europe, Recommendation CM/Rec 2014). From a human rights perspective, therefore, the elderly patients' autonomy regarding EOLCD is an essential part of human well-being. They must be informed about the clarification for diagnosis and treatment options, and respected for the consideration of their values, goals, and wishes in their end-of-life care.[1] However, the process of EOLCD in a culturally diverse

[1] The UN (WHA 67.19) defined comfortable care as designed for psychosocial and cultural support in the end stages of life. available from http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R19-en.pdf

society may be confused when elderly patients who are severely impaired lack mental capacity or ability in a critical moment. In addition, physicians' lack of communication skills and less competence with cultural perspectives may result in elderly patients and their family caregivers' decision without fully-discussed decisions for prolonged life-sustaining treatments during this end-stage of life (Billings 2012; Johnstone and Kanitsake 2009; Valente and Haley 2012).

In South Korea, since 2014, several bills related to the process of EOLCD had been evaluated by the Bill Commission of the National Assembly throughout the process of modification and unification into one alternative bill. It was finally enacted in the Act on Decision over Hospice Care, Palliative Care and Life-prolonging Care for Dying Patients on Jan. 8, 2016. [2] Under the law, there are distinct, positive benefits for every citizen over 19 years old in South Korea. The purpose of the law is to legislate the right to make health care decisions in the very last end stages of life and regulate health care expenses for hospice and palliative care in both hospital-based facilities as well as home-based care services, financed by NHIS.

Currently, Korean elderly patients who are placed in a community or LTC facility tend to have limited knowledge of advance directives (Hong and Kim 2013; Park and Song 2013). Also, their family caregivers prefer to make the decisions on behalf of elderly parents at their end stages of life (Hwang et al. 2016). Many physicians are willing to forgo the communication regarding EOLCD and protect themselves from any legal complicity with family members (Kim and Huh 2013; Moon et al. 2012; Suh and Park 2014). Therefore, all of them obviously fall through the cracks during the process of EOLCD in LTC settings. As a result, only 5.5% of elderly patients who suffered advanced dementia end their life in LTC facilities with comfortable care, compared to 62.6% of American elderly patients with same condition in nursing homes (Rhee 2016).

Social Worker's Education and their Knowledge Level of Advance Directives

In LTC settings, communication about EOLCD among the elderly patients, their family caregivers, and health care professional occurred often, and

[2] Act on Decision over Hospice Care, Palliative Care and Life-Prolonging Care for Dying Patients on Jan. 8, 2016 No. 14013,

played a critical role. Clearly processing EOLCD is not a one-size-fits-all process. Sabatino (2010) insists that the decision-making process regarding end-of-life care should be viewed as a communicational model rather than as a legal transactional model that focuses more on the completion of legal forms. If such a model was to reflect the contextual aspects of this process and accommodate the various communication skills and psychosocial support specific to the culture of the elderly and their families, the process could lead to a fully developed and informed decision. The family caregivers of elderly relatives with advanced dementia in LTC settings may experience greater difficulties in initiating the discussions on behalf of their elderly relatives for multiple reasons, such as the stigma of certain diseases, a lack of knowledge, a less open culture of dying and death (Csikai and Martin 2010; Kennett and Payne 2010; Reinhardt et al. 2013; Teno et al. 2012).

Social workers in various health care organizations play an integral role in the process of EOLCD to collaborate with their interdisciplinary colleagues and facilitate conversation between physicians and elderly patients and their family caregivers (Black 2006; McInnis-Dittrich 2004; Molly, Stiller, and Russo 2000). Their knowledge level of advance directives and professionally acquired skills can help their practices in the process of assisting elderly patients' EOLCD-making to reduce their anxiety and help understanding the pros and cons of the process (Bern-Klug 2012; Bomba, Morrissey, and Leven 2011; Herman 2013).

In South Korea, there are a few studies that were conducted for social workers in health care organizations, relating their knowledge, attitude, and perception of EOLCD. Han (2015a) found social workers' knowledge did not meet the level to educate and discuss EOLCD with elderly patients and their family caregivers in LTC facilities. Choi (2014) found social workers in hospice and palliative services did not engage to complete advance directives in the process of EOLCD.[3] Social workers' education can also affect their intentions for engaging in end-of-life care (Kwon, Park, and Song 2015) and their understanding of the social workers' role and the rights of EOLCD (Han 2015b).

Therefore, this study aimed to analyze the differences in the status of social workers' education and knowledge level of advance directives between

[3] In the Cancer Control Act, enforced March 23, 2013, No. 11690, Ch. 23 (the responsibility of providing information by medical professional), and Ch. 24 (the process of decision making for palliative care), the patient and the family must be given information to make a decision about hospice and palliative care. However, the discipline of the responsibility and the procedure were not confirmed in detail.

geriatric hospitals and LTC facilities in South Korea, suggesting the importance of developing educational programs and licensing regulations prior to enforcing of the Act on Decision over Hospice and Palliative Care and Life-prolonging Care for Dying Patients.

Method

Sampling and Procedure

In this study, total 401 subjects participated in the survey, including 104 social workers from geriatric hospitals and 297 from LTC facilities to analyze differences in the status of their education and knowledge levels of advance directives (AD) between the two types of facilities. In order to keep equality, objectivity in sampling, and assure autonomy, we went through the following sampling acquisition procedure. There are three steps to collect the questionnaires from geriatric hospitals. First, the researcher and research assistant called to explain the purpose of the study and requested to have member organizations' information for the "Korean association of geriatric hospitals." Second, the research team randomly contacted every member organization by region to get permission and mailed out questionnaires to the 200 organizations that agreed to participate. Third, the team collected questionnaires by return mail from the organizations. The rate of participants in the survey was 55.5%, receiving 111 questionnaires from 200 organizations. In the final data, 104 social workers' questionnaires were analyzed, excluding 7 of them with mostly missing data.

The main survey was carried out between the beginning of August 2015 and end of December 2015. The research process was reviewed and approved by the Institutional Research Board of, Namseoul University, and followed the bio-ethical standard of Namseoul University. All procedures were conducted to protect as much personal information of the subject as possible, and subjects signed a written consent of their voluntary agreement (IRB No.1041479-201503-HR-028).

The data from social workers in LTC facilities was taken by Han's sampling in her study (2015a). In the first step, the researcher visited the "Korea association of LTC centers for senior citizens" to obtain permission for their reference, explain the purpose of the study and ask for their cooperation. Second, the survey was conducted with the reference in a local program for the "high level of continuing education for social worker and

administrator."

The study's procedure had two steps. The preparation meeting was held with 15 members, including graduate students and social workers who work in LTC facility. In the meeting, the reference group collected opinions about accuracy of composition, terminology of the questionnaire and executed composition process. In South Korea, the terms of advance directives (AD) vary, such as advance medical directives, advance medical written decisions, etc. In this study, the team decided to use the term of AD as an official term.

Measures and Data Analysis

From the main survey, in order to measure the level of knowledge about AD, the study referred to the regulation for AD in New Jersey.[4] The level of knowledge of AD was measured by two areas including medical knowledge and general knowledge, composed of 10 questions on a 5-point Likert scale. 'A' means a geriatric hospital, and 'B' means a long-term care facility.

Table 2 shows numbers, score ranges, mean (standard deviation), and the reliability of scales for both groups. The mean (standard deviation) of

TABLE 2
Numbers, Score Range, Mean and Standard Deviation, and the Reliability of Scales

Variables	Number of Items		Score Range		M (SD)		Cronbach's α	
	A	B	A	B	A	B	A	B
AD Medical knowledge	4	4	4-20	4-20	2.02 (0.75)	2.26 (0.93)	0.880	0.919
AD General Knowledge	6	6	6-30	6-30	2.26 (0.85)	2.34 (0.99)	0.897	0.884
AD Overall knowledge	10	10	10-50	10-50	2.16 (0.71)	2.31 (0.80)	0.900	0.887

Advanced Directive: AD, M: Mean, SD: Standard Deviation, A: Geriatric Hospital, B: Long Term Care Facility

[4] NJ is the first state to combine the living will and the designation for medical health care proxy in one document and enforce laws related to Advance Directives (N.J. Stat. Ann. 26:2H-53-2011. "Advance Directive for Health Care Act", originally 1991, and revised 2011) and Advance Directive for Mental Health Care (N.J. Stat. N.P.L. Chapter 233 "Advance Directive for Mental Health Care Act", 2005).

medical knowledge is 2.02 (0.75) in a geriatric hospital, and 2.26 (0.93) for LTC facilities. For general knowledge, A is 2.26 (0.85), and B is 2.34 (0.99).

General demographic and descriptive data for personal variables which were selected by sex, religion, license, work experience, education, the helping experience for elderly patients and their family caregivers about AD and giving information for life sustaining treatments, and service regulation were reviewed. Service regulation was measured by whether they were assigned to participate and offer aid in the process of EOLCD as a duty of social worker in their work.

All collected data are analyzed with SPSS 21. We used descriptive statistics to measure mean (M), standard deviation (SD), frequencies, and an independent T-test to compare mean values between two groups.

Result

The status for personal characteristics

Finally, the subjects of this study are 104 social workers who work in geriatric hospitals, and 297 social workers from LTC facilities. Table 3 shows personal variables of social workers, followed by frequency, mean, and stand deviation, using descriptive statistical analysis. 'A' means a geriatric hospital, and 'B' means a long-term care facility.

As for geriatric hospitals, 81.7% of social workers are women. 65.9% respond they have religion and 34.1% do not have religion. Concretely we classified religion into Protestantism, Buddhism, Catholicism, no response and no religion. 23.3% claim Protestantism. Only 15.5% answered that they have experienced education and/or training for AD and EOLCD. 28.4% have experience offering information on AD, and only 18.3% have experience giving information on life-prolonging treatment. In addition, just 12.5% responded that participating and giving help on EOLCD are obligations of their work. Regarding their licenses, 48.1% possess the first grade of license and 10.6% have a medical social worker license. Currently, a medical social worker license is regulated by the Korean Association of Social Workers (2016).[5]

[5] The Korean Association of Social Workers was founded in1973 to regulate the licensing and continuing education for the members who have passed the test with at least one year of taking a special supervision course for a first grade license.

TABLE 3
Personal Characteristics of Social Workers in Geriatric Hospitals and Long-Term Care Facilities

Variables	Classification	Frequency (N)		Percentage (%)	
		A	B	A	B
Sex	Woman	85	208	81.7	70.3
	Man	19	88	18.3	29.7
Religion	Believe	60	221	65.9	84.7
	No religion	31	40	34.1	15.3
	Catholicism	14	43	23.3	19.5
	Buddhism	13	71	21.7	32.1
	Protestantism	33	107	55.0	48.4
License	First grade	50	30	48.1	10.2
	Second grade	54	263	51.9	89.8
	Medical social worker	11	0	10.6	0
Work experience	Scope of years of experience (A/B), 0.17 year-20years/1-4years, Average 3.46years/3.31years				
Education (Training)	Have	16	63	15.5	21.5
	None	87	230	84.5	78.5
Experience giving information on AD	Have	29	163	28.4	55.3
	None	73	132	71.6	44.7
Experience providing information/ consulting on life-prolonging treatment	Have	19	214	18.3	72.5
	None	85	81	81.7	27.5
Number of beds	Range of numbers of beds (A/B), 35-600 beds/1-120 beds, Average 217.38 beds/26.68 beds				
Service regulations about EOLCD	Yes	13	182	12.5	63.6
	No	87	104	83.7	36.4

Advanced Directive: AD, A: Geriatric Hospital, B: Long-Term Care Facility

In case of subjects in LTC facilities, approximately 70.3% of subjects are women, and 84.7% respond they believe in a religion. 48.4% say that they are Protestant. With reference to EOLCD, 55.3% of subjects have experience giving information about AD to elderly patients and their family. 63.6% said that in their workplace, participating and offering help in the process of EOLCD are assigned as a duty of social workers.

The status for education and social workers' preferences in the context of education

Table 4 shows the status of education and social workers' preferences in the context of education. In the Table 4, 'A' means geriatric hospital, 'B' means a LTC facility. As a result of analyzing experiences of professional education and training about EOLCD, in group A, 84.5% responded that they had never received any education or training. Also 61.8% said that they knew the importance of education and training, but there was no information or opportunity to receive the education. In group B, 78.5% had no experience of education, and 89.8% answered that there were scanty opportunities for education.

Regarding where they receive education, in the A group, workers most received continuing education (27.6%), followed by college (24.1%), religious organization (20.7%), and institutions (17.2%) and course for a license (10.3%). In contrast, most of the B group received education in courses for a license (34.7%), followed by institution (22.7%), continuing education (22.7%), college (10.7%) and religious organization (9.3%). When asked what the type of education they want, 71.1% from the A group and 73.6% from the B group preferred continuing education. The following answers in A group were course for a license (14.4%), workplace (12.2%), and school curriculum (2.2%). Similarly, the second highest answer of B group was workplace (15.9%), followed by course for a license (7.6%) and school curriculum (2.9%). It seems that both subjects prefer 1-day continuing education. Regarding the education schedule, most of the A group wants one day (48.3%) or online education (22.5%). In contrast, the B group prefers one day (39.6%) and 2-4 lecture hours (23.0%).

As for what contents of education they preferred, with multiple responses available, the A group responded, in descending order, skills of counseling-psychotherapy (71.3%), general/medical knowledge of AD and case management practice in each (54.0%), legal knowledge (32.2%), plan for intervention and evaluation skill (28.5%), and cooperation with

TABLE 4
The Status for Education and their Preferences in the Context of Education

Variable	Classification	Frequency (N) A / B	Percentage (%) A / B
Experience of receiving education	Have	16/63	15.5/21.5
	None	87/230	84.5/78.5
Reasons for lack of training/education	Know the importance of education and training but no chance of information or opportunity	42/185	61.8/89.8
	No need for education and training	15/6	22.1/2.9
	Postponing because of others' education and training	2/13	2.9/6.3
	Absence of educational institution	9/2	13.2/1.0
Where they received education and discipline	School	7/8	24.1/10.7
	Institution	5/17	17.2/22.7
	Continuing education	8/17	27.6/22.7
	Course for a license	3/26	10.3/34.7
	Religious organization	6/7	20.7/9.3
Preferable education form	School curriculum	2/8	2.2/2.9
	Continuing education	64/204	71.1/73.6
	Workplace	11/44	12.2/15.9
	Course for a license	13/21	14.4/7.6
Preferable education schedule	2-4 hours special lecture	11/62	12.4/23.0
	1 day education	43/134	48.3/39.6
	2-3 days continuous education	15/43	16.9/15.9
	Online lecture and test	20/31	22.5/11.5
Preferable education contents	General/medical knowledge	47/214	54.0/27.9
	Legal knowledge	28/128	32.2/16.7
	Cooperation with multidisciplinary professional medical team	16/71	18.4/9.3
	Case management skill	47/118	54.0/15.4
	Plan for intervention and evaluation skill	30/77	28.8/10.0
	Skills of counseling-psychotherapy	62/159	71.3/20.7

A: Geriatric Hospital, B: Long-Term Care Facility

multidisciplinary professional medical team (18.4%). On the other hand, the B group responded with the highest percentage at general/medical knowledge (27.9%), succeeded by skills of counseling-psychotherapy (20.7%), legal knowledge (16.7%), case management (15.4%), plan for intervention and evaluation skill (10.0%), and cooperation with multidisciplinary professional medical teams (9.3%).

Social Worker's Personal Characteristics and Knowledge Level of AD

Table 5 shows the level of the knowledge about AD significantly differed based on social workers' personal characteristics in both groups. The medical and general knowledge levels of AD of social workers in both groups are different in significant ways in this study. For the case of geriatric hospitals, the medical knowledge level of AD is significantly differed by personal characteristics of religion ($p<0.05$), education ($p<0.05$), experience helping with life-sustaining treatment (LST) ($p<0.001$), experience giving information on AD ($p<0.01$) and presence of service regulation ($p<0.05$). The general knowledge level of AD is also significantly differed by education ($p<0.05$), experience helping with LST ($p<0.01$), and experience giving information on AD ($p<0.05$).

In addition, in the case of LTC facilities, the medical knowledge of AD significantly showed the differences in social workers' education ($p<0.001$), experience with helping LST ($p<0.05$), and experience giving information on AD ($p<0.01$). As for general knowledge, the mean scores between the two groups show significant differences in education experience ($p<0.001$) and service regulation ($p<0.05$).

Conclusion and Discussion

The National Association of Social Work (NASW 2015) recommended creation of a new subsection on the proposed rule for "Medicare and Medicaid Program; Reform of Requirements for LTC Facilities," addressing advance care planning within 483.21(b). By recommendation, a social worker who has trained professionally in LTC settings has to engage in the discussion and education of the residents and their representatives in interdisciplinary care plan team meetings. Since 2010, NASW has set the standard and norm for the task performance concerning social work practices in the process of EOLCD. NASW has updated the requirements for professional education

TABLE 5

The Knowledge Level of AD and the Mean Differences between Two Groups by Social Workers' Personal Variables

Variables		Geriatric Hospital					Long -Term Care Facility				
		N	Medical knowledge M(SD)	t(P)	General knowledge M(SD)	t(P)	N	Medical knowledge M(SD)	t(P)	General knowledge M(SD)	t(P)
Religion	Have	60	2.14 (0.77)	2.365*	2.39 (0.84)	1.401	218	2.25 (0.91)	-0.597	2.33 (0.95)	-1.835
	None	31	1.75 (0.64)		2.12 (0.90)		40	2.35 (1.00)		2.63 (0.90)	
Education	Have	16	2.70 (0.91)	3.337*	2.75 (0.70)	2.579*	63	3.08 (1.02)	7.680***	2.84 (0.90)	4.296***
	None	87	1.90 (0.65)		2.16 (0.85)		227	2.03 (0.73)		2.26 (0.95)	
Experience of helping LST	Have	19	2.60 (0.86)	3.974***	2.78 (0.65)	3.651**	211	2.33 (0.95)	2.369*	2.43 (0.96)	1.517
	None	85	1.89 (0.66)		2.14 (0.85)		81	2.07 (0.79)		2.25 (0.98)	
Experience of helping AD	Have	29	2.34 (0.77)	2.711**	2.57 (0.75)	2.303*	162	2.38 (1.00)	2.737**	2.44 (0.98)	1.121
	None	73	1.90 (0.71)		2.14 (0.87)		130	2.10 (0.75)		2.31 (0.94)	
Service Regulation	Yes	13	2.53 (0.87)	2.572*	2.69 (0.78)	1.866	181	2.32 (0.97)	1.208	2.51 (1.04)	2.453*
	No	87	1.97 (0.71)		2.22 (0.84)		102	2.19 (0.79)		2.24 (0.78)	

AD: Advanced Directive, M: Mean, SD: Statistical Deviation, LST: Life-Sustaining Treatments, * p<0.05, **p<0.01, ***p<0.001

and training, which have been developed for social work skills in the process of EOLCD and in contents of education for a social worker license (NASW, 2010).[6] Social workers in hospice or LTC facilities who participate in the process of EOLCD must be especially professionally disciplined and educated to provide secure service for their patients and family members (Bomba et al. 2011).

The result of the study found there were significant differences in social workers' medical knowledge of AD between those who work at geriatric hospitals and at long-term care facilities (2.20±0.87, 2.26±0.91, respectively; $p<0.05$). Their knowledge level of AD significantly differed based on their education in both groups. However, social workers in both groups agreed that their medical and general knowledge level of AD could not meet the level to give information and education to elderly patients and their family caregivers in both LTC settings. It is a critical time to attend to the importance of developing educational programs and licensing regulations prior to enforcement of the Act on Decision over Hospice and Palliative care and Life-prolonging Care for Dying Patients. Therefore, the study would suggest some conclusions as follows for the patients' safety and elderly patients' rights to make end-of-life care decisions.

First, according to the results, social workers in both geriatric hospitals and LTC facilities participate and help elderly patients and their family caregivers without confident knowledge in the process of EOLCD. Only 15.5 % of social workers who are working at geriatric hospitals and 21.6% from LTC facilities responded that they took some kind of education or training for the practice regarding EOLCD. It turned out that they engage in the process of EOLCD-making without sufficient medical and general knowledge of AD. This might result in harm to the elderly patient and the family's ability to complete AD and/or EOLCD-making in advance.

Under present laws, their licenses require only a certain level to do their work in both fields.[7] Therefore, efforts must be made for safe and secure services for the elderly patient and the family in the process of EOLCD. In

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[6] National Consensus Project of Quality Palliative Care. "Clinical Practice Guideline for Quality Palliative Care" https://www.hpna.org /multimedia/NCP_Clinical_Practice_Guidelines_3rd_Edition.pdf, 2013.

[7] Enforcement Decree of the Medical Service Act, No.22075, March 19, 2010, Retrieved (01/05/2016) from http://www.law.go.kr/eng/engLsSc.do?menuId=1&query=%EC%9D%98%EB%A3%8C%EB%B2%95&x=0&y=0

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the discussion of developing detail regulations prior to enforcement of the new law, it ought to include set standards and norms for the social workers' task performance in the process of EOLCD-making.

Second, the study found that social workers mostly want to update their skills of counseling-psychotherapy and the knowledge level for medical/general and legal areas of AD, included preferentially in contents of education for EOLCD. In detail, the subjects from geriatric hospitals responded in descending order to skills of counseling-psychotherapy (71.3%), general/medical knowledge of AD and case management practice in each (54.0%) and legal knowledge (32.2%). On the other hand, the social workers from LTC facilities responded in order to general/medical knowledge (27.9%), succeeded by skills of counseling-psychotherapy (20.7%), legal knowledge (16.7%), and case management (15.4%).

The concrete knowledge of social workers who are engaged in completing AD and EOLCD- making is also an essential part of medical social services. In developing the contents of education and/or training programs, the study would suggest inputting their preferences and requests for the curriculum, including the skills for providing emotional and psychosocial support as well as care management skills.

Third, the study found that social workers in both groups who have taken some education relating to the AD and/or EOLCD show significantly higher mean scores of medical and general knowledge levels than those who have not. Therefore, in further discussion, we suggest the necessity for both development and execution of education and training for the purpose of progress in medical social service. Also, some pre-requisite courses and/or continuing education on hospice and palliative care should be integrated for knowledge as a basic element of all undergraduate education for social workers who intend to work in health care settings. In addition, on the basis of the ethical principles established by the Korean Association of Social Workers, the context of the autonomy of the elderly patients and their families should be included in the programs.

Lastly, we would like to discuss some limitations of this study. First, prior to enforcement of the new law, the study composed the areas of knowledge for AD, referring to New Jersey legislation. Therefore, in a future study, the study would suggest referring to the new law. Second, the subjects, which are a limitation of this research, are also small-scale geriatric hospitals compared with the size of LTC facilities. And third, a single individual often plays the roles of social worker and administrator in an LTC facility, which could have led to potential conflicts of interest in their responses. Finally,

future studies should also broaden the sampling to include and comparatively analyze acute hospitals as well as special units for intensive care and emergency care.

(*Submitted*: August 5, 2016; *Accepted*: September 2, 2016)

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