

Original Article

Cite this article: Hamama-Raz Y, Cohen Y, Ben-Ezra M (2022). Preferences for end-of-life care settings among the healthy population in Israel—Related socio-demographic variables. *Palliative and Supportive Care* 20, 383–388. <https://doi.org/10.1017/S1478951521000742>

Received: 21 September 2020

Revised: 10 May 2021

Accepted: 30 May 2021


Key words:

Care settings; End of life; Healthy population; Preferences; Socio-demographic variables

Author for correspondence:

Yaira Hamama-Raz, Ariel University, Ariel, Israel. E-mail: yairahr@ariel.ac.il

Preferences for end-of-life care settings among the healthy population in Israel—Related socio-demographic variables

Yaira Hamama-Raz, PH.D. , Yael Cohen, M.S.W. and Menachem Ben-Ezra, PH.D.

Ariel University, Ariel, Israel

Abstract

Objective. Preferences for end-of-life (EoL) care settings is of considerable interest for developing public health policy and EoL care strategies. Culture, the cause of illness, and background characteristics may impact preferences. The present study aimed to explore preferences for EoL care settings: homes, hospitals, and inpatient hospice units among the general healthy population in Israel. Possible associations between the setting preferences and socio-demographic characteristics were also examined.

Method. A cross-sectional survey was conducted among 311 healthy adults who were recruited through a representative internet panel of the Israeli population using the Israeli census sampling method. The sex ratio was almost 1:1 with 158 women (50.8%) and 153 men (49.2%). All participants completed self-report measures using an online survey system. The questionnaires assessed sociodemographics and preferences for EoL care settings.

Results. This survey revealed that 52.1% of the participants expressed preference for being cared for at home rather than in an inpatient hospice unit, 40.8% expressed being cared for at home rather than in a hospital, while 36.7% had no preference regarding being cared for in hospital or in a hospice unit. Among the socio-demographic variables, only age and gender were found to be significantly associated with preferences for EoL care settings.

Significance of results. The present study highlights the need to be cautious when regarding home as the preferred EoL care setting, as some individuals declared that they would prefer EoL hospice/hospital care. Age and gender should be considered when discussing and tailoring strategies regarding EoL preferences.

Introduction

Preferences for end-of-life (EoL) care settings (i.e., home, hospital, or inpatient hospice unit) are one of the most influential factors for determining the actual place of death (Gomes et al., 2015). Previous studies have shown that culture shapes preferences regarding decision making associated with EoL care (e.g., Cain et al., 2018; Huang et al., 2019). Bentur et al. (2012) stated that “for many Jews in Israel the concept of ‘sanctity of life’ (*kedushat hakhayim*) is a central value; this contributes to a tendency for patients to request and for physicians to provide ‘aggressive’ modes of care even as patients approach the end of life” (p. 3). Thus, we sought to explore preferences for EoL care settings among the healthy population in Israel.

In a systematic review conducted by Gomes et al. (2013), 24 studies showed that the majority of the general public (52–92%) preferred dying at home. The preference for this setting stems from the notion that the home, where the patient is generally surrounded by family, seems to enable greater peace for patients at the EoL (Calanzani et al., 2013; Gomes et al., 2015). However, several researchers noted that the preference for dying at home, from the relatives’ perspectives, is inconsistent, considering pain control and levels of grief (Wright et al., 2010; Gomes et al., 2015), suggesting that decisions regarding EoL care settings are not easy choices.

Hospices or palliative care units were the second most frequently chosen settings for EoL care (Gomes et al., 2012). According to the World Health Organization (2002), palliative care is designed to improve the quality of life of patients with a serious illness and their families. Indeed, several researchers showed that hospice care units improve quality of care and satisfaction among patients and caregivers (e.g., Seaman et al., 2016). Nevertheless, other studies noted that the term “palliative care” or “hospice” carries a stigma for physicians, patients, and their caregivers, who regard it as synonymous with death and dying, diminished possibilities of hope for cure, loss of control, hopelessness, and abandonment (Collins et al., 2017; Dai et al., 2017). Likewise, Shen and Wellman (2019) found that palliative care stigma was associated with less prospective usage of palliative care for one’s self and for one’s family members as

it was associated with negative stereotypes such as quitters, lazy, hopeless, and weak-willed. These inconsistent findings highlight the complexity regarding EoL care decisions.

The setting least chosen for EoL care noted by Gomes et al.'s (2012) research was hospitals. Some researchers and clinicians who explored cancer patients, caregivers, and clinicians found that unexpected health changes such as family caregivers becoming overwhelmed with the responsibility of caring and controlling severe symptoms, caused respondents to feel unsafe at home and to favor institutional care (Rainsford et al., 2018). However, hospital wards are often characterized with multi-occupancy rooms and noise that negatively impact on patient's experiences at EoL (Brereton et al., 2012). Moreover, Donnelly et al. (2018) revealed in a quantitative descriptive post-bereavement postal survey that bereaved relatives felt that patients' psychological, emotional, and spiritual care needs were not always fully considered and responded to appropriately or in a timely manner.

Possible associations with EoL care settings were proposed in relation to socio-demographic variables; Gomes et al. (2012) found in a cross-national comparison among the general public in Germany, the Netherlands, Portugal, and Spain that the preference for home death decreased with age up to 60 years old and increased in the age groups 60–69 and 70+. In addition, previous experiences of caring for a close relative or friend with cancer had no influence on the preference for home care. In a systematic review of the United Kingdom literature, Calanzani et al. (2013) found that choosing hospice or a palliative care unit as the preferred place of death was reported by those with younger age, and among those who had cared for or experienced the death of a relative or friend. With regard to gender differences, Sharma et al. (2015) found among men with metastatic cancers that they were three times more likely than women to receive EoL care in an intensive care unit. Likewise, in a German survey concerning preferences of place of death in a theoretical scenario, women stated that they preferred not to die in a hospital (Fegg et al., 2015). Concerning marital status, preference for dying at home was more common than preference for dying in a hospice or hospital among people who had never married or were never in a relationship (Foreman et al., 2006). Individuals with poor self-rated health were found to be less likely to prefer being cared for at home (Chung et al., 2017). Regarding education level, results revealed inconsistency; Hamano et al. (2020) did not find a correlation between the level of education and preferences for EoL care among the general public, while Chung et al. (2017) found that post-secondary education or above was associated with an increased preference to be cared for and to die at home (Chung et al., 2017). Likewise, the results involving religiosity revealed inconsistency; Wilson et al. (2013) found no correlation between religion and preference for a specific EoL care setting. However, Pradilla et al. (2011) revealed that among those who practiced a religion, 74.6% preferred EoL home care, 22.4% preferred a hospital palliative care unit, and 3.0% an acute care hospital.

Given the above, the current study sought to explore preferences for EoL care settings, namely home, hospital, or inpatient hospice units, among the general healthy population in Israel and possible associations with socio-demographic variables. The current hypotheses were examined: (1) Most of the participants would prefer EoL home care rather than hospital or hospice units; (2) Older age, single family status, male gender, lower self-rated health, lower level of education, and previous exposure to cancer of close relatives or friends would indicate preference

for EoL institutional care such hospitals or hospice units. In addition, religiously oriented individuals would prefer EoL hospital care.

Methods

Participants and procedure

The study used an internet panel of about 130,000 Israelis that adheres to the Israel Bureau of Statistics in key demographic factors, including age, gender, and marital status, that represent the general population (Bodas et al., 2017). From this panel, potential participants were invited to participate in the study via e-mail. Eligibility to participate in the study included age 18 or older, no history of cancer illness, and fluency in Hebrew. The study was approved by the authors' affiliated University IRB committee.

A sample of 311 Israelis was selected using stratified and random sampling methods based on age, gender, and marital status, in order to obtain a sample that is a close approximation to the general population. Each participant signed an electronic informed consent form before accessing the questionnaire. The mean age of the sample was 40.2 years (SD = 14.8; range 18–70). The sex ratio was almost 1:1 with 158 women (50.8%) and 153 men (49.2%). The majority of the sample was in a committed relationship ($n = 212$; 68.2%). Education was divided into four categories: elementary school 2 (0.6%), partial high school 12 (3.9%), graduated high school 138 (44.4%), and academic 159 (51.1%). Self-rated health was distributed as follows: poor 3 (1.0%), mediocre 29 (9.3%), good 160 (51.4%), and excellent 119 (38.3%). Regarding religiosity, 156 were secular (50.2%), 102 traditional (32.8%), 34 religious (10.9%), and 19 ultra-orthodox (6.1%). All participants were Jewish and born in Israel. Previous exposure to cancer was noted by 54.0% ($n = 168$) of the participants.

Instruments

The following battery of self-report questionnaires was administered: *Socio-demographic* — relating to age, gender, marital status, religiosity, education, and self-rated health that was assessed on a 4-point Likert scale (1 = bad to 4 = excellent) (Benyamini et al., 2003). In addition, previous exposure to cancer of close relatives or friends was reported (1 = being exposed to cancer; 2 = not being exposed to cancer).

Preferences of EoL care setting were measured using three separate items taken from the Attitudes of Older People to End-of-Life Issues Questionnaire (AEOLI; Catt et al., 2005). First: "If I were severely ill with no hope of recovery, I would rather be cared for in an inpatients hospice unit than at home." Second: "If I were severely ill with no hope of recovery, I would rather be cared for in a hospital than in an inpatients hospice unit." Third: "If I were severely ill with no hope of recovery, I would rather be cared for in a hospital than at home." Each question was rated on a 5-point Likert scale ranging from "1" strongly disagree to "5" strongly agree. Higher values meaning more agreement with the designated preference.

Statistical analysis

In order to test the first hypothesis, we present an extensive description of the dependent variables. For the second hypothesis, we conducted a simple correlation matrix in order to learn about associations between the study variables and the dependent

variables. Finally, we conducted regression analyses in order to learn of the associations separately for preferences of each of the three-care settings (namely home, hospice unit, and hospital) with socio-demographic variables and previous exposure to cancer.

A preliminary analysis was conducted for potential Multicollinearity. Applying the rules used in the literature stating that tolerance of less than 0.20 and/or variance inflation factor (VIF) of 5 and above indicate a multicollinearity problem (O'Brien, 2007). The preliminary analysis of the hierarchical regressions yielded tolerance ranging from 0.629 to 0.966 and VIF of 1.036–1.589. These results indicated that there was no multicollinearity problem. The regression was re-estimated using 5,000 bootstrapped draws.

Results

The distribution of preferences of EoL care settings can be seen in Table 1. Regarding the question: “If I were severely ill with no hope of recovery, I would rather be cared for in an inpatient hospice unit than at home,” 52.1% of the participants stated “disagree” and “strongly disagree” to be cared for in inpatient hospice unit rather than at home. In referring to the question, “If I were severely ill with no hope of recovery, I would rather be cared for in a hospital than in an inpatient hospice unit,” 35.7% of the participants stated “disagree” and “strongly agree” to be cared for in hospital rather than in an inpatient hospice unit.” Finally, concerning the question, “If I were severely ill with no hope of recovery, I would rather be cared for in a hospital than at home,” 40.8% stated “disagree” and “strongly disagree” to be cared for in a hospital rather than at home.

Regarding gender differences, men scored higher on the preference “Cared for in an inpatient hospice unit rather than at home” in comparison to women (men = 2.65 [SD = 1.30] vs. women = 2.36 [SD = 1.17]; $t = 2.082$; $p = 0.038$). The same was true for the other two preferences: “Cared for in a hospital rather than an inpatient hospice unit” (men = 3.32 [SD = 1.12] vs. women = 2.87 [SD = 1.06]; $t = 3.626$; $p < 0.001$) and “Cared for in hospital rather than at home” (men = 2.95 [SD = 1.17] vs. women = 2.56 [SD = 1.02]; $t = 3.087$; $p = 0.002$).

Examining the second study hypotheses, Pearson correlations were calculated between socio-demographic variables and previous exposure to cancer (the independent variables) with preference for EoL care setting which was the dependent variable (see Table 2). As can be seen, among the socio-demographic variables (i.e., age, gender, marital status, religiosity, education, and self-rated health) and previous exposure to cancer, only age and gender were found to be associated with EoL setting preferences. Specifically, both older age and male gender were significantly, but weakly associated with preferences for EoL hospice or hospital care rather than EoL home care, and EoL hospital rather than EoL hospice care.

In addition, the results of the regressions analyses regarding the dependent variable — EoL care settings (see Table 3) revealed that no demographic variable or exposure to previous cancer (the independent variables) were found to be associated with preference to be cared for in an inpatient hospice unit rather than at home. However, male gender was associated with preferences for be cared for in hospital rather than in an inpatient hospice unit ($B = -0.381$; Std. $\beta = 0.106$; $t = -2.985$; $p < 0.01$). Moreover, older age ($B = 0.015$; Std. $\beta = 0.203$; $t = 2.927$; $p < 0.01$) and male gender ($B = -0.253$; Std. $\beta = -0.114$; $t = -1.991$; $p < 0.05$) were positively associated with preference for cared for in a hospital rather than at home.

Discussion

The present study aimed to explore preferences for EoL settings (i.e., home, hospice unit, and hospital) among the healthy population in Israel by focusing on socio-demographic variables. Our findings revealed a complex picture regarding preferences of EoL settings. Home was preferred by some individuals, while others preferred to be cared for in inpatient hospice units or hospitals. In addition, when participants were asked if they preferred to be cared for in hospital rather than in a hospice unit, 36.7% had no preference, followed by 35.7% who preferred EoL hospital care.

Previous studies found that home was the preferred setting for EoL care (Gomes et al., 2012; Wilson et al., 2013). Similarly, some of our study participants declared that they also would prefer EoL

Table 1. Descriptive statistics of the dependent variables regarding preference for end-of-life care ($n = 311$)

	Prefer hospice over home		Prefer hospital over hospice		Prefer hospital over home	
Mean	2.50		3.09		2.75	
Std. Deviation	1.247		1.108		1.113	
Std. Error of Mean	0.071		0.063		0.063	
Median	2.00		3.00		3.00	
Mode	1		3		3	
Confidence Interval of Mean	2.5 ± 0.139 [2.361–2.639]		3.09 ± 0.123 [2.967–3.213]		2.75 ± 0.124 [2.626–2.874]	
Answer distribution	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Strongly disagree	84	27.0	29	9.3	47	15.1
Disagree	78	25.1	57	18.3	80	25.7
Neutral	83	26.7	114	36.7	106	34.1
Agree	40	12.9	78	25.1	59	19.0
Strongly agree	26	8.4	33	10.6	19	6.1

Table 2. Correlations between demographic variables and exposure to cancer with variables regarding preference for end-of-life care ($n = 311$)

	Prefer hospice over home	Prefer hospital over hospice	Prefer hospital over home
Age	0.178**	0.152**	0.231***
Sex	-0.118*	-0.202***	-0.173**
Marital status	0.100	0.080	0.130*
Religiosity	-0.013	0.013	-0.048
Education	-0.027	-0.098	-0.056
Self-rated health	-0.103	-0.047	0.008
Exposure to cancer	0.030	0.027	0.097

* $p < 0.05$.
 ** $p < 0.01$.
 *** $p < 0.001$.

home care. This may be explained through the terror management theory (TMT) perceptive, which is based on the assumption that to achieve psychological equanimity humans are continuously propelled to drive thoughts of death out of conscious awareness (e.g., Pyszczynski et al., 1999), suggesting that the home is the least likely setting to arouse mortality salience due to its characteristic peaceful atmosphere (Rainsford et al., 2018). In line with this notion, it seems that hospice units and hospital wards represent care settings that are identified with dying patients (Gomes et al., 2012). In addition, the familiarity of the home allows people to be surrounded by their personal belongings and loved ones (Calanzani et al., 2013), and thus might suppress death-related thoughts that can emerge in institutional care settings. Nevertheless, some of our participants revealed positive attitudes toward institutional locations by indicating no preferences regarding hospital vs. hospice (36.7%). These results might suggest caution in assuming home as the ultimate preferred location for EoL care. Moreover, 35.7% of the participants in our study preferred to be cared for in a hospital rather than in a hospice unit. This might be explained through Schultz et al. (2012) reflections on palliative care in the Jewish tradition. The authors claim that in Judaism, “even if the goal is not a cure, one common approach is to do whatever is possible to extend life, since one moment of life in this world is more valuable than all the world to come” (p. 4). Moreover, according to Torah-mandated Jewish law (*Halakha*), life is a gift of God and as such, the individual is entrusted with maintaining health and seeking preventative and curative medical care as required (Gabbay et al., 2017). Thus, it is possible that the participants perceived the hospital as the place where medical interventions are more acceptable and where their course of illness will be actively addressed in contrast to palliative units which focus on the provision of comfort and alleviation of pain and suffering (Sholjakova et al., 2018).

Findings with socio-demographic variables that were explored in relation to the explained variance of preferences toward EoL care settings, indicate that older age was associated with positive attitudes toward being cared for in a hospice unit or hospital in comparison to home. A possible explanation can be that at the EoL, home care involves dependency on significant others or family members that need to address the patient’s nursing needs, which might produce feelings of being a burden. Indeed, in Judaism, the duty of filial responsibility is expressed in the fifth commandment “Honor thy father and thy mother.” As the

Table 3. Regressions analyses of the association between each of the attitudes toward end-of-life care and demographics variables ($n = 311$)

Variable	Prefer hospice over home Model $R = 0.214$; Model $R^2 = 0.046$			Prefer hospital over hospice Model $R = 0.257$; Model $R^2 = 0.066$			Prefer hospital over home Model $R = 0.268$; Model $R^2 = 0.072$		
	B	Std. β	t statistic	B	Std. β	t statistic	B	Std. β	t statistic
Age	0.011	0.006	1.884	0.008	0.005	1.520	0.015	0.005	2.9273
Gender	-0.205	0.145	-1.410	-0.381	0.128	-2.9853	-0.253	0.127	-1.9912
Marital status	0.054	0.143	0.378	0.054	0.126	0.433	0.068	0.125	0.542
Religiosity	0.011	0.080	0.136	0.040	0.071	0.572	-0.052	0.070	-0.739
Education	-0.089	0.119	-0.748	-0.201	0.105	-1.927	-0.144	0.104	-1.388
Self-rated health	-0.141	0.110	-1.284	-0.045	0.096	-0.467	0.087	0.096	0.907
Previous exposure to cancer	0.071	0.131	0.540	0.024	0.115	0.210	0.171	0.114	1.495

Note: Gender was coded as (1 = Male; 2 = Female); Marital status was coded as (1 = not being in a committed relationship; 2 = being in a committed relationship); Religiosity was coded as (1 = secular; 2 = traditional; 3 = religious; 4 = ultra-orthodox); Education was coded as (1 = elementary school; 2 = partial high school; 3 = graduated high school; 4 = academic); Previous exposure to cancer was coded as (1 = being exposed to cancer; 2 = not being exposed to cancer).
 $2p < 0.05$.
 $3p < 0.01$.

great majority of elderly people in Israel live in close proximity to at least one of their children, elderly people are commonly cared for by their children (Lavee and Katz, 2003). In line with this notion, research conducted among the general public in South Dakota (Hughes, 2015) revealed that older respondents (age 60–95) were more likely to say it was “very important” not to be a burden on family at the EoL. Moreover, Israel’s four health plans operate home medical care units that provide palliative care for patients with metastatic cancer and neurological and degenerative diseases; however, the staff are typically available only during normal working hours while during the evening and at night they are not generally available to provide these services (Rosen et al., 2015). Hence, it might be that older people prefer to be cared for in a setting which is recognized as having 24/7 services, that might address their needs without any additional burden on significant others or family members. In line with this notion, Waller et al. (2018) revealed among oncology outpatients that the top five perceived benefits concerning hospital were in the descending order: “pain being managed well, not being a burden to family and friends, having medical staff on call, family being able to have a more ‘normal life,’ and having access to lots of medical care” (p. 38).

Regarding gender, our findings show that the explained variance of preference for hospital care in comparison with home care was mainly related to male gender. A possible explanation can be that men may feel safer in institutional settings, particularly if care at home may be perceived with less pain management and with greater burden on family members (e.g., Calanzani et al., 2013). Indeed, previous studies showed that fear of becoming dependent on the family, perceiving oneself as a financial burden to others and lacking social support were related to acceptance of a hastened death (Rietjens et al., 2006; Yun et al., 2018). Moreover, Broom and Cavenagh (2010) suggested through a qualitative research among home care patients that the sense of eroded masculine identity owing to home care increased the feeling of being a burden, the need to accept help from family members and lack of independence. Likewise, Ullrich et al. (2019) found that among male patients with incurable, progressive diseases, receiving home palliative care, and dependence on others correlated with a sense of diminished social value and a stronger need for maintaining one’s masculine identity. Another explanation may be related to cultural aspects. According to Schultz et al. (2012), in Judaism, some patients or their families might refuse home palliative care because they see it as a prohibited form of “giving up” on healing. Thus, in line with the masculine identity that also highlights the need to fight and not to give up (Ullrich et al., 2019), preference for hospital-based care among men is understandable.

Implications

The current findings raise possible implications. First, exploring preferences for EoL care settings among healthy populations will allow health policy makers to develop suitable interventions regarding EoL decision making, palliative care knowledge and effective ways of communication regarding EoL care settings. This is highly recommended as in the present study participants rated neutral attitudes concerning EoL care in a hospice unit vs. a hospital, although each setting has a different purpose. Thus, public health campaigns may be recommended to “change the narrow understandings of palliative care, reframing underlying narratives from those of disempowered dying to messages of choice,

accomplishment and possibility” (Collins et al., 2017, p. 7). Moreover, this campaign should be tailored with sensitivity to age and gender as these background characteristics were found to have a role in preferences for EoL care settings. Second, caution is needed in assuming that home care should be the default location for future care of terminal patients. Thereby, clinicians should offer opportunities for discussion of EoL care settings throughout the trajectory of a life-threatening illness, and not only near death, in order to enable informed decision making by their patients regarding EoL care preferences. Given the key role of informal caregivers and the influence that perceived family burden may have on patient choices, it would be preferable to ensure that the patient’s choice can be supported by their family members (Waller et al., 2018). For example, they can apply a multidisciplinary family meeting approach that can convey information, discuss goals of care, and plan care strategies with patients and family caregivers regarding EoL care and decisions (Hudson et al., 2008).

Limitations

Several important limitations need to be acknowledged. First, our data are cross-sectional in nature and do not allow for causal hypotheses. As such, longitudinal studies would be recommended to examine if and why preferences change over time, especially since the present study was conducted among a healthy and young population, and preferences may change with the advance of age and illness. Second, the study was limited to Israel and possibly influenced by its health system and the culture-specific characteristics of its citizens; thus, generalizability to EoL care preferences for individuals in other countries is limited.

Conclusions

The current research highlights the importance of exploring preferences of end-of-life care settings among healthy populations in a variety of countries in order to develop appropriate culturally sensitive EoL healthcare policies. Our findings reinforce the role of age and gender in reference to attitudes toward EoL care settings and highlight the variety of EoL setting preferences, suggesting caution in assuming home as the ultimate choice at the EoL.

Ethics approval and consent to participate

The study was approved by the Institutional Review Boards for Non-Medical Human Research of the authors’ university. The participants were included after giving their informed consent.

Funding. The study was not supported by any external funding. There was no assistance in this research or writing of this article other than the authors.

Conflict of interest. All authors confirm that there are no known conflicts of interest associated with this publication and that there was no financial support for this work that could influence its outcome.

References

- Bentur N, Emanuel LL and Cherney N (2012) Progress in palliative care in Israel: Comparative mapping and next steps. *Israel Journal of Health Policy Research* 1(1), 9. doi:10.1186/2045-4015-1-9.
- Benyamini Y, Blumstein T, Lusky A, et al. (2003) Gender differences in the self-rated health–mortality association: Is it poor self-rated health that

- predicts mortality or excellent self-rated health that predicts survival? *Gerontologist* 43, 396–405.
- Bodas M, Siman-Tov M, Kreitler S, et al.** (2017) Psychological correlates of civilian preparedness for conflicts. *Disaster Medicine and Public Health Preparedness* 11(4), 451–459.
- Brereton L, Gardiner C, Gott M, et al.** (2012) The hospital environment for end of life care of older adults and their families: An integrative review. *Journal of Advanced Nursing* 68(5), 981–993.
- Broom A and Cavenagh J** (2010) Masculinity, moralities and being cared for: An exploration of experiences of living and dying in a hospice. *Social Science & Medicine* 71(5), 869–876.
- Cain CL, Surbone A, Elk R, et al.** (2018) Culture and palliative care: Preferences, communication, meaning, and mutual decision making. *Journal of Pain and Symptom Management* 55(5), 1408–1419.
- Calanzani N, Higginson IJ and Gomes B** (2013) *Current and Future Needs for Hospice Care: An Evidence-Based Report*. Commission into the Future of Hospice Care. <https://pdfs.semanticscholar.org/1ff9/a586fa92fe0c1-ce20528da07a9e8c3284acc.pdf>.
- Catt S, Blanchard M, Addington-Hall J, et al.** (2005) The development of a questionnaire to assess the attitudes of older people to end-of-life issues (AEOLI). *Palliative Medicine* 19(5), 397–401.
- Chung RYN, Wong ELY, Kiang N, et al.** (2017) Knowledge, attitudes, and preferences of advance decisions, end-of-life care, and place of care and death in Hong Kong. A population-based telephone survey of 1067 adults. *Journal of the American Medical Directors Association* 18(4), 367.e19.
- Collins A, McLachlan SA and Philip J** (2017) Initial perceptions of palliative care: An exploratory qualitative study of patients with advanced cancer and their family caregivers. *Palliative Medicine* 31(9), 825–832.
- Dai YX, Chen TJ and Lin MH** (2017) Branding palliative care units by avoiding the terms “palliative” and “hospice” - A nationwide study in Taiwan. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 54, 1–6.
- Donnelly S, Prizeman G, Coimín DÓ, et al.** (2018) Voices that matter: End-of-life care in two acute hospitals from the perspective of bereaved relatives. *BMC Palliative Care* 17(1), 117.
- Fegg M, Lehner M, Simon ST, et al.** (2015) Was beeinflusst Entscheidungen am Lebensende? Ergebnisse einer repräsentativen Umfrage in Deutschland [What influences end-of-life decisions? Results of a representative German survey]. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz* 58(10), 1118–1123.
- Foreman LM, Hunt RW, Luke CG, et al.** (2006) Factors predictive of preferred place of death in the general population of South Australia. *Palliative Medicine* 20(4), 447–453.
- Gabbay E, McCarthy ME and Fins JJ** (2017) The care of the ultra-orthodox Jewish patient. *Journal of Religion & Health* 56(2), 545–560.
- Gomes B, Higginson IJ, Calanzani N, et al.** (2012) Preferences for place of death if faced with advanced cancer: A population survey in England, Flanders, Germany, Italy, The Netherlands, Portugal and Spain. *Annals of Oncology* 23(8), 2006–2015.
- Gomes B, Calanzani N, Gysels M, et al.** (2013) Heterogeneity and changes in preferences for dying at home: A systematic review. *BMC Palliative Care* 12(1), 1–13.
- Gomes B, Calanzani N, Koffman J, et al.** (2015) Is dying in hospital better than home in incurable cancer and what factors influence this? A population-based study. *BMC Medicine* 13(1), 235.
- Hamano J, Hanari K and Tamiya N** (2020) End-of-life care preferences of the general public and recommendations of healthcare providers: A nationwide survey in Japan. *BMC Palliative Care* 19, 38. doi:10.1186/s12904-020-00546-9.
- Huang YL, Yates P, Thorberg FA, et al.** (2019) Adults’ perspectives on cultural, social and professional support on end-of-life preferences. *Collegian* 26(6), 621–628.
- Hudson P, Quinn K, O’Hanlon B, et al.** (2008) Family meetings in palliative care: Multidisciplinary clinical practice guidelines. *BMC Palliative Care* 7(1), 12.
- Hughes J** (2015) UK: The best place in the world to die. *BMJ* 351, 5440.
- Lavee Y and Katz R** (2003) The family in Israel. *Marriage & Family Review* 35(1–2), 193–217.
- O’Brien RM** (2007) A caution regarding rules of thumb for variance inflation factors. *Quality & Quantity* 41(5), 673–690.
- Pradilla HC, Ospina OLC and Alonso-Babarro A** (2011) Preference for place of death and related factors of the elderly in the Mediterranean Isle of Ibiza. *Colombian Journal of Anesthesiology* 39(2), 174–188.
- Pyszczynski T, Greenberg J and Solomon S** (1999) A dual-process model of defense against conscious and unconscious death-related thoughts: An extension of terror management theory. *Psychological Review* 106(4), 835–845. doi:10.1037/0033-295X.106.4.835.
- Rainsford S, Phillips CB, Glasgow NJ, et al.** (2018) The ‘safe death’: An ethnographic study exploring the perspectives of rural palliative care patients and family caregivers. *Palliative Medicine* 32(10), 1575–1583.
- Rietjens JA, van der Heide A, Onwuteaka-Philipsen BD, et al.** (2006) Preferences of the Dutch general public for a good death and associations with attitudes towards end-of-life decision-making. *Palliative Medicine* 20(7), 685–692.
- Rosen B, Waitzberg R and Merkur S** (2015) Israel: Health system review. *Health Systems in Transition* 17(6), 1–212.
- Schultz M, Baddarni K and Bar-Sela G** (2012) Reflections on palliative care from the Jewish and Islamic tradition. *Evidence-Based Complementary and Alternative Medicine* 2012, 1–8.
- Seaman JB, Bear TM, Documet PI, et al.** (2016) Hospice and family involvement with end-of-life care: Results from a population-based survey. *American Journal of Hospice and Palliative Medicine* 33(2), 130–135.
- Sharma RK, Prigerson HG, Penedo FJ, et al.** (2015) Male-female patient differences in the association between end-of-life discussions and receipt of intensive care near death. *Cancer* 121(16), 2814–2820.
- Shen MJ and Wellman JD** (2019) Evidence of palliative care stigma: The role of negative stereotypes in preventing willingness to use palliative care. *Palliative & Supportive Care* 17(4), 374–380.
- Sholjakova M, Durnev V, Kartalov A, et al.** (2018) Pain relief as an integral part of the palliative care. *Open Access Macedonian Journal of Medical Sciences* 6(4), 739–741.
- Ullrich A, Grube K, Hlawatsch C, et al.** (2019) Exploring the gender dimension of problems and needs of patients receiving specialist palliative care in a German palliative care unit—the perspective of patients and healthcare professionals. *BMC Palliative Care* 18(1), 59.
- Waller A, Sanson-Fisher R, Zdenkowski N, et al.** (2018) The right place at the right time: Medical oncology outpatients’ perceptions of location of end-of-life care. *Journal of the National Comprehensive Cancer Network* 16(1), 35–41.
- Wilson DM, Cohen J, Deliens L, et al.** (2013) The preferred place of last days: Results of a representative population-based public survey. *Journal of Palliative Medicine* 16(5), 502–508.
- World Health Organization** (2002) *Palliative Care*. Geneva: World Health Organization. <https://www.who.int/cancer/palliative/definition/en/>.
- Wright AA, Keating NL, Balboni TA, et al.** (2010) Place of death: Correlations with quality of life of patients with cancer and predictors of bereaved caregivers’ mental health. *Journal of Clinical Oncology* 28(29), 4457–4464.
- Yun YH, Kim KN, Sim JA, et al.** (2018) Comparison of attitudes towards five end-of-life care interventions (active pain control, withdrawal of futile life-sustaining treatment, passive euthanasia, active euthanasia and physician-assisted suicide): A multicenter cross-sectional survey of Korean patients with cancer, their family caregivers, physicians and the general Korean population. *BMJ Open* 8(9), e020519.