Barriers in Hospice Use Among African Americans With Cancer

Angela D. Spruill, MSN, ANP-BC, OCN ❍ **Deborah K. Mayer, PhD, RN, AOCN, FAAN** ❍
Jill B. Hamilton, PhD, RN

Forty percent of the deaths that occur in the United States used hospice services, but that number is much smaller for African Americans. African Americans' underutilization of hospice services may not offer them the benefits of this holistic model of end-of-life care. Several factors have been hypothesized for underutilization and include cultural, environmental, religious, and historical perspectives. The purpose of this literature review was to explore the barriers preventing African Americans with cancer from using hospice services. Documentation of underutilization, desire for aggressive care, knowledge of hospice, lack of diversity among hospice staff, religious/hope beliefs, mistrust of the healthcare system, and access to hospice were identified in this review as barriers to use. Interventions should target these barriers to increase utilization. We also need to better understand how African Americans die when not in hospice.

KEY WORDS

African Americans, death and dying, health disparities, hospice

Cancer is the second leading cause of death in the United States, accounting for one in four deaths.[1] African Americans (AAs) are disproportionately affected by cancer when compared with other racial groups.[1] The incidence rate of all cancers in AAs is 504.1 per 100 000 people compared with 470.1 per 100 000 people in the general population.[2] African American men experience a 33% higher cancer death rate than do white men, and AA women have a 16% higher death rate than do white women. While the overall 5-year relative survival rate for all races has improved, AAs continue to have smaller decreases in death rates.[3] Despite these decreases, health disparities continue to persist in both the incidence and rate of death from cancer among the AA community.[1,3] As a result of higher cancer death rates, one may expect a higher use of end-of-life services, yet AAs experience disparities in end-of-life care, specifically in regard to lower hospice use.

The Institute of Medicine's "Approaching Death: Improving Care at the End of Life" defined a "good death" as "one that is free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards."[4] A good death should be an expectation and achievable by all individuals, whereas a "bad death" was described as unnecessary suffering and a disregard for patient's or family's wishes.[4]

Hospice is a holistic model of care for individuals at the end of life that focuses on comfort and palliation of symptoms instead of cure of disease. The goal of hospice is to provide nursing and medical care as well as spiritual and emotional support. Hospice services can be delivered in the home (40.1%), acute-care facility (10.1%), nursing home (18.9%), long-term-care facility (9.6%), or a freestanding hospice center (21.2%).[5] Utilizing compassion and an interdisciplinary approach, hospice use decreases pain, improves patient and family satisfaction, decreases spiritual distress, offers enhanced bereavement services, and may prolong life.[6-8]

In 2009, 41% or 1.56 million people who died in the United States used hospice services.[5] Cancer was the single most common diagnosis comprising 40.1% of the hospice population; the remaining 59.9% was a combination of diagnoses including heart disease, dementia, and diseases of the kidney, liver, and lung.[5] Despite a higher incidence rate of cancer, shorter survival time after diagnosis, and higher cancer death rates, AAs made up only 8.7% of the population who used hospice in 2009,[3] and they were less likely to use hospice services compared with other racial groups.[5]

Having a diagnosis of cancer may also affect the rate and timing of hospice use among all ethnicities. Hill and Hacker[7] suggest that a barrier to hospice use among individuals with cancer may lie with the oncologist and with the number of cancer treatments as there are often several options for therapy before discontinuing curative treatment. As such, oncologists tend to refer patients for hospice care later than

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Angela D. Spruill, MSN, ANP-BC, OCN, is Staff Nurse, University of North Carolina Cancer Hospital, Chapel Hill.

Deborah K. Mayer, PhD, RN, AOCN, FAAN, is Associate Professor, School of Nursing, University of North Carolina at Chapel Hill.

Jill B. Hamilton, PhD, RN, is Assistant Professor, School of Nursing, University of North Carolina at Chapel Hill.

Address correspondence to Deborah K. Mayer, PhD, RN, AOCN, FAAN, School of Nursing, CB #7460, University of North Carolina, Chapel Hill, NC 27599-7460 (Dmayer@unc.edu).

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do other physicians, and patients may feel that more can be done.[7,9]

Of the approximate 1.56 million hospice users, several studies show that AAs use hospice at lower rates than do whites and are summarized here. In their study comparing hospice use and demographics among ethnicities, Colón and Lyke[10] evaluated 1958 AA, Latino, and white hospice patients. They found that AAs use hospice significantly less than do whites ($P < .001$).[10] Using a retrospective analysis of Surveillance, Epidemiology, and End Results (SEER) data of 70 669 cancer patients who died, Haas et al[11] examined whether the racial composition of a community is associated with the use of hospice. As a result of their study, they found that 46% of individuals who died of cancer used hospice during the last year before death. Of those who used hospice, AAs used it significantly less than did whites (42.5% vs 46.5%).[11] Virnig et al[12] conducted a retrospective analysis of SEER data of 651 783 oncology patients to evaluate the variability of hospice use across cancer diagnoses. They discovered that, for all cancers, AAs were significantly less likely to receive hospice services than non-AA patients ($P = .0001$).[12]

These findings are also supported by a study that evaluated hospice use rates in US nursing homes. Using a sample of 288 202 AA and white nursing home residents with access to hospice, AA nursing home residents used hospice less than did white residents (35.4% vs 39.3%) even when controlling for gender, age, education, and diagnosis.[13] Keating and colleagues[14] also evaluated variation in hospice use among cancer patients. They evaluated the influence of patient characteristics, physician characteristics, and local health centers to explain variations in hospice enrollment. After evaluating data from 3805 oncology patients who died of lung, colorectal, breast, or prostate cancer, Keating and colleagues[14] found that there were no significant differences in hospice enrollment among racial groups ($P > .2$).

PURPOSE

African Americans' underutilization of hospice services may not offer them the benefits of this holistic model of end-of-life care. Several factors have been hypothesized for underutilization and include cultural, environmental, religious, and historical perspectives. The purpose of this literature review was to explore the barriers preventing AAs with cancer from using hospice services.

METHODS

Search Strategy

A literature search was performed using PubMed, CINAHL, and PsycINFO using the following MeSH terms: hospice, hospice care, end of life, AAs, black, ethnic minority, cancer, neoplasm, and barriers. Manual reviews of the reference list of articles obtained were also conducted.

Inclusion Criteria/Data Extraction

The articles reviewed were in English language in peer-reviewed journals. Of the 31 articles matching the search criteria, four were excluded because they did not reference hospice. Another three were eliminated because they were review articles, and seven were excluded because they lacked information on barriers to hospice use. The final review consisting of 17 articles matching the search criteria was utilized to identify and analyze potential barriers to hospice use (Table).

RESULTS

Of the 17 articles reviewed, the following barriers were identified: preference for aggressive care, lack of knowledge of hospice, lack of diverse hospice staff, religious/hope factors, mistrust of the healthcare system, and access to hospice.

Aggressive Care

According to Phipps et al,[21] AAs who are near death preferred life-sustaining interventions significantly more than did whites ($P < .004$).[21] These findings were similar to those of Barnato et al,[16] who found that AAs had a more positive attitude toward life prolongation than did whites ($P < .0001$). They also reported that AAs preferred mechanical ventilation for 1 week or 1 month of life extension more than did whites (24% and 36% vs 13% and 21%, respectively).[16] Johnson et al,[20] in their cross-sectional survey of 205 community-dwelling adults 65 years or older, found that AAs were more likely to want more aggressive care than were whites ($P < .001$).

Fishman and colleagues'[18] study on race, treatment preferences, and hospice enrollment echo these findings. In their study, they report that AAs with cancer had a stronger preference for continuing cancer treatment than did whites even when controlling for age, gender, education, and socioeconomic status ($P = .007$).

Knowledge of Hospice

News coverage has been shown to influence cancer treatment options.[17] They completed a comparative study of 660 print and online stories for their coverage adverse outcomes of cancer treatment, treatment failure, death and dying, and hospice or palliative care between mainstream media and AA media that covered cancer news. They found that AA news outlets were significantly less likely to report on adverse effects of cancer treatment ($P = .001$), treatment failure ($P = .006$), and death ($P = .007$). Only seven of the 660 stories mentioned end of life or hospice, and all were found in mainstream media. The authors hypothesized that AA news outlets wanted to portray a more "positive" message and that AAs may opt for more aggressive treatment for fear of being denied treatment.[17]

TABLE Barriers in Hospice Use Among African Americans (AAs) With Cancer

Citation	Sample	Methods	Findings	Weaknesses
Balboni et al[15] (2007)	230 Patients with advanced cancer	Mixed-method questionnaire and interview	AAs reported religion to be very important compared with whites (89% vs 59%) ($P = .001$) Increasing religiousness was associated with a preference for all life-extending measures	Selection bias: less religious individuals may have been less likely to participate in a study examining religion and spirituality
Barnato et al[16] (2009)	2847 community-dwelling Medicare beneficiaries aged ≥65 y	Dual-language, mixed-mode (telephone/mail) survey	AAs preferred mechanical ventilation for 1 wk or 1 mo of life extension more than whites (24%, 36% vs 13%, 21%) AAs had more positive attitudes toward life prolongation interventions than whites ($P < .0001$)	Survey and item nonresponse, which may limit generalizability Reliance on hypothetical scenarios
Colón and Lyke[10] (2003)	1958 patients residing in three southern NJ counties	Retrospective analysis	AAs use hospice significantly less than whites ($P < .001$)	The entire sample resided within three NJ counties, which may limit generalizability Only one in-home hospice was used
Fishman et al[17] (2011)	396 mainstream news stories 264 AA news stories	Comparative study Content analysis of 660 cancer news stories in print and online	News coverage has been shown to influence cancer care treatment options AA news outlets were significantly less likely to report on adverse effects from cancer treatment ($P = .001$), treatment failure ($P = .006$), and death ($P = .007$) 7 of the 660 stories mentioned end of life or hospice, and all were found in mainstream media Reported that there is a positive correlation between knowledge of hospice and the decision to use services	Newspapers and magazines with smaller audiences were not studied Exposure to news media was not measured
Fishman et al[18] (2009)	283 cancer patients	Mixed method: surveys and interviews	AAs had stronger preferences than whites for aggressive cancer treatment ($P = .006$) AAs reported a greater need for hospice services than whites ($P = .005$)	Only five hospices in PA were studied
Haas et al[11] (2007)	SEER data of 70 669 individuals aged ≥66 y who were identified as white, AA, or Hispanic who died of breast, colorectal, lung, or prostate cancer between 1992 and 2000	Retrospective analysis of SEER data from 1992–2001	46% of individuals evaluated used hospice services during a year preceding death AAs and Hispanics used hospice significantly less (42.5% and 44.5%) than whites (46.5%)	Retrospective nature The sample included few AAs living in rural areas; authors were not able to determine differences in use among urban and rural residency

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TABLE Barriers in Hospice Use Among African Americans (AAs) With Cancer, Continued

Citation	Sample	Methods	Findings	Weaknesses
Jackson et al[19] (2000)	30 AAs in 4 focus groups	Qualitative study	Cited lack of knowledge about hospice and its scope as a barrier Lack of diversity of hospice staff was a barrier to use Some members wondered what was wrong with hospice if no AAs wanted to work there Belief that hospice means giving up hope Feeling that a referral to hospice by a healthcare provider was a sign that the provider was giving up on them Suggested this belief was related to existing healthcare disparities and the lack of trust of AAs in the healthcare system	Subjective nature of qualitative study Small sample size Potential for interviewer bias
Johnson et al[20] (2008)	205 community-dwelling adults aged >65 y	Cross-sectional survey	AAs had less favorable beliefs about hospice care compared with whites ($P < .001$) AAs were more likely to express discomfort discussing death ($P < .001$) Spiritual beliefs that conflict with goal of palliative care. If one trusts in God and His will, there is no need to plan for end of life Mistrust of healthcare system ($P < .001$)	Low response rate to survey AAs are more likely to want aggressive care ($P < .001$) Setting was two primary care clinics associated with the same academic medical center, which may affect generalizability of findings
Keating et al[14] (2006)	3805 oncology patients who died of lung, colorectal, breast, or prostate cancer	Retrospective analysis	No significant differences in hospice enrollment among racial groups ($P > .2$)	AAs made up only 10% of the sample Setting was one regional integrated healthcare delivery system, and findings may not be able to be generalized
Lepore et al[13] (2011)	N = 288 202 AA and white nursing home residents who had access to hospice that died in 2006	Descriptive study Combination of 5 data sources using multilevel logistic regression	AA nursing home residents used hospice less than white residents (35.4% vs 39.3%) even when controlling for gender, age, education, and diagnosis	Authors did not offer a significance of their findings

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TABLE Barriers in Hospice Use Among African Americans (AAs) With Cancer, Continued

Citation	Sample	Methods	Findings	Weaknesses
Phipps et al[21] (2003)	68 total patients with advanced lung and colon cancer and their primary caregivers 38 AA patients and 30 white patients	Combination of qualitative and quantitative open-ended questions and follow-up probes	Near death, more AA than white patients wanted life-sustaining interventions ($P < .004$)	Sample was from an urban setting; participants were equal in demographics and may not be able to be generalized to the rest of the US population Small sample size
Rhodes et al[22] (2006)	1578 interviews that included 111 AA decedents	Cross-sectional survey Retrospective study	53.8% of AAs were not informed about hospice Of those who were informed, cancer was the leading cause of death 30.3% received hospice 8.9% aware and still did not enroll Cancer patients were more likely to be informed about hospice $P = .001$	AAs were less likely to participate in the study $P < .001$ Retrospective nature
Torke et al[23] (2005)	23 AAs	Qualitative study Semistructured interviews	Participants reported they felt like entering hospice was ''giving up'' Viewed God as all knowing and that end-of-life issues were God's business; therefore, there was no need to discuss it Cited a desire for hope and miracles as a reason to continue with curative treatment	Subjective nature of a qualitative study Small sample size Potential for interviewer bias
True et al[24] (2005)	68 AA and white cancer patients	Mixed mode Qualitative study: interviews Retrospective analysis of medical records	AAs were more likely to report a belief in divine intervention than white patients ($P = .02$). AAs were more likely to report a belief that a higher power controlled fate than were whites ($P = .04$) Near death, AAs were more likely to prefer life-extending interventions when compared with whites ($P < .001$) Belief in divine intervention was correlated with a preference for cardiopulmonary resuscitation in near-death events ($P = .003$)	Sample was limited to colon and lung cancer only and may not be able to be generalized to the general population
Virnig et al[12] (2002)	SEER data of 651 783 deceased oncology patients	Retrospective analysis of SEER data	AAs were significantly less likely to receive hospice than non-AAs ($P = .0001$)	Retrospective nature

(continues)

TABLE Barriers in Hospice Use Among African Americans (AAs) With Cancer, Continued

Citation	Sample	Methods	Findings	Weaknesses
Waters[25] (2001)	27 AAs in 4 focus groups	Qualitative design	AAs are less likely to plan for end of life Most of the group members believed that ''God is going to intervene'' Participants cited racism and discrimination as a cause of lack of trust of healthcare providers Some felt like ''times are changing'' but still endorsed a belief that AAs do not receive equitable care compared with whites	Subjective nature of a qualitative study Small sample size Potential for interviewer bias
Yancu et al[26] (2010)	314 AA adults at 11 predominantly AA churches	Cross-sectional survey Quantitative design	Most of participants evaluated had a preference for taking care of family at home 79% Participants would use hospice if it were recommended by their physician The majority of those interviewed believed that hospice provides equitable care to all ethnic groups Mistrust in the healthcare system was not found to be a barrier Participants tended to believe that hospice care was equal among racial groups	Surveyed only churchgoers which may not be generalizable to the rest of the population

Abbreviations: NJ, New Jersey; PA, Pennsylvania; SEER, Surveillance, Epidemiology, and End Results.

Fishman et al[17] found that a barrier to hospice use among AA cancer patients is a knowledge deficit of what hospice is and the benefits it provides. They also reported that there is a positive correlation between knowledge of hospice and its mission and the decision making to pursue these services. Jackson et al[19] sought to explore barriers to hospice use among AAs and cited lack of knowledge about hospice and its scope as a barrier.[19] African Americans were interviewed about obstacles from using palliative and hospice care; location of death was an issue and that the majority had a preference for taking care of family at home.[26] According to the National Hospice and Palliative Care Organization, 68.6% of hospice patients die at their home (40.1% in private residences and 28.5% in nursing homes or residential facilities).[5] The authors suggested that a lack of knowledge about hospice and where care is delivered is a barrier to hospice enrollment.[26]

In Rhodes and colleagues'[22] cross-sectional retrospective study, they interviewed 1578 individuals and reported that 53.8% of AAs were not informed about hospice services; of those who were familiar with hospice, 8.9% chose not to enroll. Approximately 30% of AA patients interviewed utilized hospice services, and cancer was the leading cause of death. Oncology patients were more likely to be informed about hospice ($P = .001$).[22]

Lack of Diversity in Hospice Staff

A lack of diverse staff has been cited as a barrier to hospice in AAs. Yancu et al[26] found that 77% of the participants would be more willing to use hospice if hospice teams were more racially diverse. Jackson et al[19] found a barrier to hospice use was lack of diversity of hospice staff, with some AA participants questioning why AAs were not employed by hospice.

Religious/Hope Factors

Torke et al[23] conducted a qualitative study using 23 AA participants that looked at medical care at the end of life. Participants reported they felt like entering hospice was "giving up" and cited this as a barrier to its use. They also viewed God as all knowing and that end-of-life issues were God's business; therefore, there was no need to discuss it. Participants also cited a desire for hope and miracles as a reason to continue with aggressive, curative treatment.[23] Johnson et al[20] found that AAs have a less favorable belief about hospice when compared with whites ($P < .001$) and were more likely to express discomfort talking about death ($P < .001$). Spirituality played a factor in attitudes toward hospice where AAs showed faith and trust in God and felt those beliefs conflicted with the goal of palliative care ($P < .001$).[20] Waters[25] explored AAs' perspectives on end-of-life decisions and described the role that spirituality played in AAs' lives leading to a tendency to be less likely to plan for end of life. Most of the participants believed that "God is going to intervene," echoing other studies in which participants state that God has the final say.[25]

Balboni and colleagues[15] looked at religiousness and spiritual support among cancer patients and associations with end-of-life preferences. They found that AAs (89%) reported that religion was a very important part of their lives compared with 59% of whites ($P = .001$). The authors also found that increasing religiousness was associated with a preference for life-extending medical interventions. They suggest that religious individuals may be more hopeful for a miracle healing than less religious individuals.[15]

In True and colleagues'[24] 2005 study, they examined the role of ethnicity and spiritual coping in the treatment preferences and end-of-life planning of cancer patients. The authors found that AA cancer patients were more likely to believe in divine intervention compared with white patients ($P = .02$) and that AAs were more likely to desire life-supporting interventions including cardiopulmonary resuscitation and mechanical ventilation than whites ($P < .001$).[24]

The theme that hospice means giving up hope was also supported by Yancu et al.[26] In addition, Jackson and colleagues[19] cited the feeling of giving up as a barrier to hospice and perceived a referral to hospice by a healthcare provider as the provider giving up on them. The authors suggested this theme was related to existing healthcare disparities and the lack of trust of some AAs in the healthcare system.[19]

Mistrust of the Healthcare System

A history of discrimination and racism toward AAs help shape their view of the healthcare system. One hypothesis is that mistrust of the healthcare system is one barrier to hospice use by AAs. Yancu et al[26] also found that 79% of participants would use hospice if it were recommended by their physician, and the majority believed that hospice provides equitable care to all ethnic groups. Mistrust in the healthcare system was not found to be a barrier in this study as participants tended to believe that hospice care was equal among racial groups.[26] However, additional studies support mistrust as a barrier to hospice use. Johnson et al[20] they found that AAs had more distrust in the healthcare system than did their white counterparts ($P < .001$). Participants cited racism and discrimination as causes of lack of trust of healthcare providers, and although some felt like "times are changing," they still endorsed a belief that AAs do not receive equitable care compared with whites.[25]

Access to Hospice

Haas et al[11] examined whether the racial composition of a community where a cancer patient lives is associated with the use of hospice. They found that, independent of individual socioeconomic or clinical factors, hospice was used less by AAs living in predominantly minority neighborhoods. The authors point out that supportive services, including pharmacies and home care services, are integral to providing hospice care and state that some minority communities may have less medical infrastructure to support hospice care outside the hospital. They suggested that a lack of community resources and a combination of cultural influences may help explain the discrepancy in hospice usage rates.[11]

DISCUSSION

African Americans have a higher incidence of cancer and higher cancer death rates than do their white counterparts yet comprise only 8.7% of the hospice population.[3,5] The purpose of this review was to identify the barriers preventing AAs from using hospice . A preference for aggressive care, lack of knowledge of hospice, lack of a diverse hospice staff, religious factors, mistrust of the healthcare system, and access were identified as barriers to use contributing to this end-of-life healthcare disparity. It does not appear that any one individual factor is responsible for lower hospice rates as most studies discovered multiple barriers. Instead, barriers are probably multifactorial and include a mixture of cultural preferences, spirituality, and historical perspectives.

Hospice decreases pain, improves patient and family satisfaction, decreases spiritual distress, offers enhanced bereavement services, and may prolong life in those with cancer.[6-8] Most of the articles reviewed document the disparities between AA and other ethnic groups in using hospice and that AAs use hospice services significantly less than do whites.[10-13] In contrast, Keating et al[14] found that there were no significant differences among races in the rate of hospice use. This finding may be a result of sample demographics as AAs made up only 10% of the sample and the study may not have had enough power to detect these differences.[14]

African Americans' preference for more aggressive care at the end of life was supported and seems to have spiritual and historical roots. A strong faith in God and His will appear to guide end-of-life decisions and make AAs less likely to cease curative treatment. However, the idea of aggressive therapy seems in paradox with the concept of God's will by choosing therapies that may only prolong the inevitable. For example, if God's will is for an individual to have a diagnosis of cancer and die of their disease, aggressive interventions seem to interrupt or postpone God's will. Mistreatment and discrimination may also play a part in the choice to pursue more aggressive treatment to avoid what is perceived as a lack of medical treatment when curative therapies are withdrawn with hospice enrollment.[16,20] A preference for aggressive care may also be supported by the fact that AAs with cancer are more likely to die in a hospital than at home ($P = .0002$).[27] Bruera et al[28] found that AA oncology patients are 1.5 times more likely to die in a hospital than white oncology patients ($P < .0001$). Mor and Hiris'[29] study also supports these findings as they also discovered that AAs with cancer were significantly more likely to die in a hospital ($P < .5$).

Multiple articles suggest that lack of knowledge about hospice and the services provided is a barrier to its use. African Americans' exposure to hospice was found to be less than that of other ethnicities and may help explain why it is used less.[17,19,26] Interestingly, Rhodes et al[22] found that oncology patients of all ethnicities were significantly more likely to be informed about hospice services. One could argue that oncologists are informing patients about options but are not timely in making referrals.

Of the studies that addressed diversity of hospice staff, they all agreed that lack of diversity in staff adversely affects hospice use by AAs. In a review of O'Mahony et al,[30] a lack of diversity of hospice staff (different religion) was also discovered as a possible barrier, which supports this review's findings. According to the Hospice and Palliative Nurses Association, only 5% of its members are AAs.[31]

African Americans' trust in the healthcare system has been cited as a barrier to hospice use. However, different sources on this topic are in conflict. Three of the articles reviewed that mentioned trust found that AAs had a lack of trust in healthcare providers, their motives, and willingness to treat them equitably. One article cited that participants saw an improvement in patient-provider relationships, whereas another did not find any trust issues among its participants. O'Mahony et al[30] and Fishman et al[17] also agree that a barrier is mistrust of the healthcare system, causing AAs to opt for more aggressive care because of fear of being denied treatment.

The issue of access to hospice is unresolved. Haas et al[11] found that socioeconomic status was not found to be barrier to hospice and is similar to the findings in Cohen's[32] systematic review, which found that AAs used hospice less even when controlling for socioeconomic factors and educational level. This contradicts some of the findings of O'Mahony et al,[30] which cited lack of access to services (socioeconomic) as a possible barrier.

There are limitations to this review. Only three articles had a primary focus on oncology patients. In addition, four of the articles included cancer as a diagnosis at end of life, but it was not the sole diagnosis evaluated. An additional limitation is the assumption that dying AA oncology patients who do not enroll into hospice are not experiencing good deaths. Perhaps they have family, friends, and community support systems that help achieve the same goals that hospice aims to provide. This warrants further exploration.

More research is needed to address interventions to reduce or eliminate these barriers and measure whether they are successful in decreasing the disparities in hospice use. In addition, more research is needed to assess the satisfaction and quality of end-of-life care of AAs who do not use hospice.

NURSING IMPLICATIONS

This review may aid nursing by bringing to attention the concerns some AAs may have with hospice. Knowledge of AAs' beliefs about hospice use may help nurses raise awareness of hospice use and its benefits. In addition, the cultural components of end-of-life care addressed in this review may also help in providing culturally appropriate care.

CONCLUSION

African Americans are less likely to use hospice services than whites. Barriers to hospice use include lack of trust in the healthcare system, lack of knowledge about services offered, cultural factors including spirituality and the concept of hope, lack of a diverse hospice staff, and access issues. Educating AAs with cancer on the benefits of hospice, fostering a sense of trust and open communication between the AA community and healthcare providers, promoting diversity and cultural competence of healthcare providers, and creating facilities within minority neighborhoods may help decrease some of these barriers. African Americans have a higher incidence rate of cancer, shorter survival time after diagnosis, and higher death rates. Improving hospice use will offer them the benefits of this holistic model of care.

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