

Issues in Hospice Utilization by Mexicans

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The research examines the limited use of hospice programs by Mexicans—the largest Latino population in the United States. Factors in the use of hospice services, the role of hospice staff in the provision of services, and the most effective means of communicating information and promoting hospice use among Mexicans were examined. Focus groups stratified by two age cohorts and length of residence in the United States were held with Mexicans in Arizona and Michigan. Eight groups were held with community residents and two groups with providers of services to the Mexican community. Factors inhibiting use of hospice services by Mexicans include knowledge of hospice programs, fear of discrimination by agencies, possible cost of hospice services, and language issues. Factors encouraging hospice usage were also cited. Hospice staff needs to understand Mexican culture, provide good care, and encourage the patient. A number of approaches to promoting hospice use, dispelling myths about hospices, and providing information about hospices were suggested. Structural factors as well as attitudes are thus crucial in determining hospice usage by this important group.

Keywords: *attitudes; families; roles*

As baby boomers enter their mid-50s, issues concerning caregiving and end of life have begun to receive increased attention in gerontology. Caregiving is an issue faced by all families, but the extent to which it creates objective and subjective burdens may differ between ethnic groups. In this article, we focus on Mexicans—the largest Latino group in the United States. Research on Mexicans has made it clear that this population expects family members to assist them as they grow older (Cuellar, 1990; Delgado, 1982;

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Markides, Boldt, & Ray, 1986). The use of the family and other members of the informal social network may not only be preferred but required by Mexicans because of financial barriers to their use of a variety of long-term care settings (Espino, 1993). Mexican families have thus been found to make less use of formal long-term care and health services than their Anglo counterparts (Greene & Monahan, 1984; Guendelman & Wagner, 2000).

Out of choice or by necessity, Mexican families take on major caregiving responsibilities for family members. A recent, nationwide, American Association of Retired Persons (AARP) survey of individuals aged 45 to 55 found Latinos from a variety of backgrounds to be more "family-focused" (Belden, Russonello, & Steward & Research/Strategy/Management, 2001, p. 8) than Whites, Asians, or African Americans. Among Latino respondents, the researchers found that one third had taken on major caregiving responsibilities for their elders. Despite this high level of responsibility, many of these Latino providers expressed guilt about not doing enough for their elders.

Caregiving responsibilities do not lessen as a person exhibiting physical and cognitive impairments grows older. The caregiving responsibilities faced by families caring for individuals in the last stages of life can be very extensive and involve a variety of health care functions. Palliative care options, including hospice programs, are now available to assist in this caregiving and, hopefully, alleviate some of the burden faced by families. A recent report from the U.S. General Accounting Office (2000) indicated that utilization of hospice services continues to increase dramatically. However, there are no indications that minority usage of hospices is increasing as rapidly as it is among other groups. A 1996 survey (Gordon, 1996) of 832 hospices revealed that hospice staff believed minorities in their service areas were underserved. This finding affirms the statement by the Task Forces on Access to Hospice Care by Minority Groups of the National Hospice Organization that "hospice care was not readily available and/or utilized by People of Color. With notable exceptions, it appeared that hospices had been unsuccessful in serving non-White communities proportionally to their presence in the potential hospice population" (Harper, 1995, p. 3.)

In this article, we examine factors in the use of hospice services by Mexicans, the role of hospice staff in the provision of services, and the most effective means of communicating information and promoting hospice use among Mexicans. Data from the National Hospice Organization indicated that, in 1995, only 4% of hospice clients nationwide were from Latino backgrounds (Connor, personal communication, January 2000). As the Latino population becomes the largest minority population in the United States, the research agenda for palliative care programs must include an understanding of the most effective means of informing the Latino community about hospice

services, approaches to dispelling myths about hospices, and what Latinos regard as desirable behavior on the part of hospice staff.

Knowledge and Use of Hospice Services

As Torrez (1998) reported, there is only limited knowledge about available health and social services in Mexican communities in the United States. In some cases, this lack of knowledge may be related to the limited ability of many Mexicans and Mexican Americans to speak or read English. Mor, Hendershot, and Cryan (1989) reported that knowledge of hospice programs is related to levels of education, and Haber (1999) stressed the importance of education in the knowledge of minority populations about hospice care.

Regardless of the availability of information and bilingual workers, insurance issues have a negative impact on hospice utilization by Latinos. Latinos are the population group in the United States least likely to have health insurance, and, among Latinos, Mexicans are the most uninsured group (Miranda, 1990). Doctors are the traditional gatekeepers to programs such as hospice care (Simard & Volicer, 1998). With a lack of continuity of care including a regular primary-care physician, Latinos are less likely to be screened for terminal illnesses, less likely to receive an early diagnosis of terminal illness, and less likely to be referred by a physician to a hospice program (Gordon, 1995).

Cultural Barriers to Use of Hospice Services

Traditionally, Mexican Americans have relied on *curanderos* or folk healers to meet their health care needs (Applewhite, 1995). The use of modern medicine by Mexicans is often discouraged because health providers do not respect important traditional values. These include an emphasis on personal relationships, respect, and modesty. Concern about violations of these cultural values may discourage Mexican families from hospice utilization, particularly if they believe that hospice staff will try to take over for the family (Noggle, 1995).

Mexicans have also been viewed as fatalistic in their attitudes toward illness with a passive acceptance of terminal illness (Gordon, 1995; Talamantes, Lawler, & Espino, 1995). Passive acceptance of terminal illnesses may also reduce the interest of Mexicans in palliative care programs. Some writers have suggested that Mexicans are reluctant to report pain (Gordon, 1995). The willingness to suffer pain may be viewed by Mexicans as having religious sanctions or because of a belief that services are not available to minority populations (Gordon, 1995). In addition, beginning with

research in the 1970s, there have been strong indications that Mexicans are reluctant to have anyone know that they or a family member are dying (Kalish & Reynolds, 1976). Discussions of the process of dying and quality of life issues for a dying patient are one of the most important elements of hospice services.

These findings clearly point to both structural and cultural attitudes that affect the use of hospices by various groups. As reported elsewhere (Gelfand, Balcazar, Parzuchowski, & Lenox, 2001), the data from the focus groups in this research clearly indicated important cultural attitudes toward care of terminally ill patients, including a preference for family care.

Method

Focus groups were used to explore the issues related to utilization of hospices and staff characteristics. The participants in the research were recruited from Mexican populations in Michigan and Maricopa County, Arizona. In Michigan, the statewide population of Latinos has grown by 61% since 1990. In metropolitan Detroit, Michigan, the 2000 census counted 118,000 Latinos—a jump of 51% since the 1990 census (Arellano & Gray, 2001). In Arizona, the Latino population has grown by 80% since the 1990 census and now accounts for 25% of the statewide population. The census also indicates a growth of 41% in the Latino population living in Maricopa County—the most populous area of the state (Janofsky, 2001). Out of the 3 million people living in Maricopa County, 763,000 are Latino and 624,000 of this group are Mexican (U.S. Bureau of the Census, 2001). In both states, the growth rate of the population among Latinos more than 60 years old is expected to be high until at least 2025.

The focus groups were stratified by age cohort to provide an opportunity to explore the differences in attitudes between two crucial age cohorts: individuals between the ages of 45 and 64 and individuals above the age of 65. Each of the groups is at a different life stage. Whereas individuals between the ages of 45 and 64 are primarily facing issues of caregiving, older individuals are facing not only caregiving issues but possibly the onset of life-threatening or terminal illnesses.

Acculturation was taken into account by stratifying the sample by length of residence in the United States as well as by age. A dividing line of 5 years and above of U.S. residence was utilized to stratify the sample in both age cohorts. For each age and residency category, two focus groups were conducted. There is no guarantee that 5 years of U.S. residency is the dividing point between more and less acculturated individuals. A separate

acculturation scale (Balcazar, Castro, & Krull, 1995) was therefore administered to each participant in the study. In addition to the eight focus groups with Mexican community residents, two focus groups were held with providers of services to Mexicans. Although these individuals worked with the Mexican community, not all of them were from Latino backgrounds.

Participants for the community resident groups were recruited primarily through contacts of the researchers and associates with Latino community organizations. Participants were also recruited through advertisements in Spanish-language newspapers and at a health fair coordinated by the Arizona Latin Health Association. No questions were asked about the immigration status of the participants, but it was evident that the majority of the participants were not legal immigrants. Participants received an honorarium of \$20 each, and refreshments or a meal were also provided. The \$20 may have been the inducement for many of the undocumented individuals to participate in the groups.

The community groups ranged in size from 5 to 12 individuals. The community groups included 66 individuals, 60 of whom were women. There were 31 participants in the groups for individuals between the ages of 45 and 64, and 35 participants in the groups for individuals more than 65 years of age. All of the participants were from Catholic religious backgrounds. The provider groups were composed of 10 individuals each. No participants were recruited from hospice programs, because former hospice clients are knowledgeable and usually positive about the services provided. Although information on income or educational level was not asked, it was evident that all of the respondents were from lower socioeconomic backgrounds. This bias resulted from the reliance on community organizations, advertisement, and a health fair to recruit participants.

The most difficult participants to secure for the research were individuals who were in the United States less than 5 years. Among the group above 65 years of age, this cell could not be completed. Scores on the acculturation scale, however, indicated that members in all of the groups were low in acculturation. Based on a low of 1 and a high of 5, the highest acculturation score of any group was 2.48. The questions for the groups were translated from English into Spanish and then retranslated into English by separate individuals. The questions probed: (a) knowledge of hospice services among the participants, (b) factors they believed affected the use of hospices by the Mexican community, (c) the most effective ways to provide information and dispel myths about hospices in the community, (d) services participants would want or not want hospice staff to provide terminally ill patients, and (e) the best means of incorporating spirituality into hospice services.

The community groups were conducted in Spanish and facilitated by Spanish-speaking facilitators and cofacilitators. The provider groups were held in English. All groups were audiotaped. Subsequent to the groups, a process of transcription and translation was employed. Two experienced, bicultural and bilingual professionals conducted the process of transcription and translation. The bicultural professional whose native language is Spanish transcribed audiotapes from focus groups conducted in Spanish into a word-processing document. Once the Spanish transcription was completed, the translation process followed. The bicultural professional whose native language is English led the translation process with help from the other bilingual professional. Translation of the transcribed material was done simultaneously; one of the transcribers read the material in Spanish while the other wrote the translation in English. Double-checking of the translated material was conducted periodically throughout the translation process to ensure that the English translations and the original Spanish matched as closely as possible. As a result, the translations did not always result in perfect, grammatical English usage.

The English versions of the resident transcripts were coded with the assistance of *Ethnograph* (Qualis Research, 1998), a software program designed for the analysis of qualitative data. The coding was done independently by two of the investigators. After the independent codes were completed, discussions were held about individual segments. Differences in coding were discussed and resolved. Although comments from the provider groups are included for clarification, the results presented below represent the analysis from the community groups.

Results

Factors in Hospice Use

Because no major differences were found between the groups held in Michigan and those conducted in Arizona, the analysis concentrates on differences between the groups of 45- to 64-year-old individuals and those with participants above the age of 65. All interviews were conducted between January and April 2000. The tables present the data by these groups.

Participants in all of the eight groups expressed the view that there was no knowledge about hospice care in the Mexican community (Table 1). In three of the groups, participants believed that the perception in the community that hospice was an in-patient service impeded its use by Mexican families.

Table 1. Factors in Use of Hospice by Group

<i>Hospice Use</i>	<i>Total</i>	<i>Ages 45 to 64</i>	<i>Ages 65+</i>
No knowledge	8	4	4
Doctor	2	1	1
Fears	6	4	2
Inaction	3	2	1
In-patient	3	1	2
Language	4	2	2
Nurses	4	2	2
No cost	3	2	1
Pain	3	2	1
Priest recommends	3	1	2

NOTE: Numbers in individual cells in the table represent the number of groups for which a specific code word developed in the analysis was appropriate. The maximum in each cell is 8 for the Total column, and 4 for each of the age cohort columns.

In addition to a lack of adequate and correct knowledge, there were also a variety of fears negating the use of hospice. One fear was concern about ethnic discrimination by agencies. Most prominent were fears relating to immigration status. This included investigations of whether applicants were legal and requests for documents. As one woman stated,

They shouldn't ask so many questions. If they want to help, help. That's all. Because many times the people get scared. "Hey, do you have legal documents?" "Hey, how long have you been living in the U.S.?" "Hey, where are you from?" "Hey, what did your grandmother die of?" It's because these things really scare people.

These concerns result in an unwillingness of people to provide information. As a participant stated,

Exactly, do you think I am going to give you my information so that you can go right to my boss? For me, I'd better not.

Three of the younger participant groups and two of the senior groups expressed fears about the possible costs of hospice services. Interestingly, in three of the groups, participants saw the lack of hospice utilization as a result of inaction on the part of individuals to seek services. This inaction might have some relationship to past negative discriminatory experiences or fears.

If fears in the community could be allayed and a positive attitude toward service utilization promoted, participants still saw other obstacles to the greater use of hospice services. Not surprisingly, language issues were very prominent. Because of the paucity of bilingual staff in many agencies, the inability of many Mexicans to speak English was viewed as a major obstacle by half of the groups. Developing adequate knowledge about hospices in the Mexican community will not be sufficient if difficulties in language are not overcome.

The already cited factors are negative in their impact on hospice utilization by Mexicans. A number of positive factors were also cited. These primarily relate to the medical services perceived by participants as part of hospice services. Most important was the availability of nurses who could help with medication and other medical needs of the patient. In three of the groups, the ability of nurses to dispense medication to control pain was cited as important. If hospice services could be provided at n

cost, this was seen by three of the groups as a factor that would positively influence the use of hospice services. Finally, participants in three groups cited the recommendation of hospice services by priests as one possible avenue for encouraging hospice use.

Characteristics and Roles for Hospice Staff

Providing effective palliative care is a difficult task, and focus group participants had some clearly defined parameters for the characteristics of hospice staff and feelings about the types of services that hospice staff should provide to patients and families (Table 2).

Participants in seven of the eight groups saw the need for hospice staff to understand Mexican culture as important. This understanding encompassed general traditions of the culture and specific healing traditions. Having knowledge of Mexican food was also mentioned as an aspect of understanding the culture:

It's important because each one of us, for example, here the Americans have their own culture, which no one is going to change. If a Hispanic says to them, it is better this way, it is not going to happen. The same thing is going to happen to the Hispanic. So by respecting their culture, you are going to understand them.

Five of the groups felt that it was possible for staff to gain this understanding through training.

Equally important as an understanding of the culture, and perhaps related to it, was an insistence in all but one of the groups that hospice staff should not

Table 2. Characteristics and Roles of Hospice Staff by Group

<i>Category</i>	<i>Total</i>	<i>Ages 45 to 64</i>	<i>Ages 65+</i>
Understand culture	7	4	3
No hope	7	3	4
Encourage	6	2	4
Qualities	2	1	1
Be Latino	2	1	0
Know ill	2	1	1
No bad care	2	1	1

NOTE: Numbers in individual cells in the table represent the number of groups for which a specific code word developed in the analysis was appropriate. The maximum in each cell is 8 for the Total column, and 4 for each of the age cohort columns.

tell a patient that there is no hope and that they are dying. Indeed, encouragement of the patient was seen as an important role for hospice staff, but older participants stressed this role more:

Don't tell the patient that he is ill. Make the person feel happy so he is not sad, continue ahead, give the person energy, and make him know that we are all alive and that he still has to continue ahead.

Particular qualities of hospice staff were emphasized in two groups. These included compassion and tolerance for the involvement of family and children in patient care. One group that included para-professionals emphasized the need for hospice staff to look presentable when they visited a patient and family.

The question as to whether hospice staff working with Mexicans should be Latino in background received different evaluations from providers and community participants. In one of the provider groups, there was a consensus that the hospice staff should be Latino in background. In the second group, the providers' clients were primarily individuals with developmental disabilities. These providers felt that the ethnic background of the providers was not important to individuals with developmental disabilities. What was important was how they related to and treated the client. For the community participants, only three groups felt that the hospice staff should be from Latino backgrounds. However, in two of the younger groups and three of the senior groups, the ability of hospice staff to speak Spanish was regarded as important.

The final emphasis of at least two of the groups was on the need for hospice staff to provide good, quality care. It is therefore important that hospice staff knows the illness of the patient and does not provide bad care. The

definition of good care by the participants centered around a restricted view of hospice care that stressed medical care by nurses including injections and medications, pain control, and dressings, but no personal care (Gelfand et al., 2001).

Promoting Information and Use of Hospice

Although hospice programs may understand the role that Mexican families believe is appropriate for their services, these programs still need to promote the use of their services. These promotional activities need to be targeted to the community. Four major strategies were recommended by participants to promote hospice use (Table 3).

Brochures and flyers that provide basic information about hospice services are widely available. In many communities, these brochures are now available in Spanish. However, generalized brochures do not necessarily address the beliefs about hospices that may be present in the community—some of which are mistaken. The groups suggested a number of approaches to dispel myths about hospice care. These myths include the beliefs that hospices are always in-patient services, that there is no role for the family in hospice caregiving efforts, or that hospices offer 24-hour services to a patient and family.

Dispelling myths is not an easy task and cannot always be accomplished through flyers or pamphlets. In a culture where trust and personal relationships are valued, one-to-one discussions of programs such as hospice care may be the most viable approach to changing beliefs. Volunteers from the community may also be a mechanism for dispelling myths because of the trust that will be accorded these community residents. Finally, two groups suggested advertisements that discussed the actual role of hospices in service delivery to terminally ill individuals. In addition to these ideas, one group mentioned providing information to doctors so that they clearly disseminate information to patients regarding hospice care.

Providing Hospice Information

Providing information about hospice services can be accomplished through a number of means. Responses from the participants made it clear, however, that information about hospice is very limited in the Mexican community. Participants in all of the eight community groups cited a lack of knowledge about hospices, but they had many ideas about sources that could be utilized to bring information about hospices to the community and promote the use of hospice services. As indicated in Table 4, the most widely

Table 3. Multiple Suggestions for Promotion of Hospice Use by Group

<i>Category</i>	<i>Total</i>	<i>Ages 45 to 64</i>	<i>Ages 65+</i>
Information to dispel myths	5	3	2
One-to-one	4	1	3
Volunteers	4	2	2
Advertise	2	1	1

NOTE: Numbers in individual cells in the table represent the number of groups for which a specific code word developed in the analysis was appropriate. The maximum in each cell is 8 for the Total column, and 4 for each of the age cohort columns.

Table 4. Multiple Citations of Hospice Information by Group

<i>Category</i>	<i>Total</i>	<i>Ages 45 to 64</i>	<i>Ages 65+</i>
Television	5	4	1
Radio	4	3	1
Flyers	4	2	2
Senior centers	3	1	2
Clinic	3	2	1
Schools	2	2	0
Speaker	2	1	1
Newspapers	2	1	1
Church meetings	2	1	1
In-home	2	1	1
Church bulletin	2	2	0

NOTE: Numbers in individual cells in the table represent the number of groups for which a specific code word developed in the analysis was appropriate. The maximum in each cell is 8 for the Total column, and 4 for each of the age cohort columns.

regarded source of information for the community was television. Television was mentioned in all of the groups with participants ages 45 to 64 years but in only one of the groups of seniors. In one of the younger groups, Spanish-language television was emphasized. Radio was also mentioned by four groups with three of these groups in the 45- to 64-years-of-age category. Although audio and visual media were viewed as the most important sources of information, four groups suggested printed flyers and two groups suggested newspapers. Verbal communications were also valued as was indicated by the mention of speakers and church meetings. These speakers could be utilized not only at church meetings but also at in-home sessions, which would include small groups of individuals. Meetings at schools or flyers given to children at schools to bring home to their parents were also mentioned in two groups. The locales in which information could be provided

were also varied. In addition to individual homes and church meetings, some groups viewed senior centers and clinics as places to disseminate information about hospice programs.

In addition to these multiple citations, the groups mentioned a number of places and types of information. These included doctor's offices, supermarkets, prayer groups, and health fairs. Flyers, posters, information through the mail, as well as information in insurance pamphlets were also mentioned. One group suggested priests as a trusted and valuable source of information about programs such as hospice care. In another group, providing information at work sites was seen as potentially valuable. When this suggestion was probed, participants in five groups suggested restaurants as a work site where many Mexicans could be reached.

Discussion

It is clear from this and previous research (Gordon, 1995) that additional information about hospice services is no guarantee of increased utilization. This is true of both of the age cohorts in this research. The differences by age cohort indicate some divergence in the most effective means to communicate information about hospices to the Mexican community. The greater emphasis on the one-to-one relationships among the older participants and the reduced emphasis on television may reflect the lesser role that the media has in their lives. For those older Mexicans active in aging programs, senior centers may be an effective communication channel. Whatever the approach, there is clearly a lack of adequate knowledge in the community about hospice services among Mexicans and Mexican Americans in both age cohorts.

In the Mexican and Mexican American community, there are increasingly diverse sources of information. These include the Spanish-language newspapers, television and radio, and their English-language counterparts. Rodriguez (2001) argued that the Spanish-language media is generally most relied upon by first generation Latino immigrants rather than their children or grandchildren. Whatever sources of information are stressed, the information developed needs to contain not only specifics on benefits and eligibility but information that addresses myths about hospice. For Mexicans, it is crucial that information about hospice care clarifies the role of hospices and the role of family as caregivers for terminally ill individuals so that hospices are not seen as disparate from Mexican cultural values (Gordon, 1995, 1996). The cost of hospices and the availability of hospice care for individuals and families without insurance are also unclear in the Mexican community.

Mexicans with adequate knowledge and an interest in using hospices may not want to take advantage of all of the possible services provided by hospice programs. The restricted view of services may not coincide with the philosophy of many hospice programs but reflects the reality of traditional, Mexican cultural values. Understanding of these values was very important to the participants, but they were also positive about the possibility of training non-Latino staff about these values. Although bilingual staff was seen as very important by participants and providers, participants would accept non-Latino hospice staff if they had an understanding and respect for Mexican values and traditions.

Conclusion

Hospice services are valuable for all ethnic/racial groups. When the range and nature of hospice services were explained to participants in this research, they were very willing to recommend hospice use:

Well, it is something special. Why not? Nobody gives what hospice gives. As we all said, we all are afraid to get close to a hospital. Well, we don't have money. We don't have documents. How are we going to go there? And now as we are getting to know what hospice is, it is something very nice and much help to the family.

Immigration issues can create problems for all service providers concerned about the welfare of the Latino community, and these problems will not abate without changes in immigration policies. There is also, however, a strong need for a culturally sensitive approach to providing hospice services to the Mexican community. The translation of general hospice materials into Spanish is not an adequate response to the concerns and value orientations raised by the participants. In 1996, Gordon stressed the need for education of minority physicians about hospice. What is also needed is education of hospice staff and volunteers about minority communities including the cultural beliefs, traditions, and factors that may make them hesitant about using hospice services.

The research reported here has a number of limitations. The number of communities from which the participants were drawn is too small to examine community influences that may be specific to various Mexican communities. Although Arizona has a large Mexican population and Michigan has a much smaller but growing population, the attitudes of residents in these two states may not be representative of Mexicans living in other areas.

The sources utilized to assist in recruitment of participants ensured that most of the participants were from lower socioeconomic backgrounds. Concerns about the fears many of the participants had of providing information resulted in this information not being requested. Differences in socioeconomic characteristics and insurance coverage among Mexicans throughout the United States may be reflected in results that differ from those obtained in this research. The groups were also predominantly composed of women. Future research needs to examine gender differences in attitudes toward these issues.

Researchers in aging have also paid only limited attention to Mexican American families whose residence in the United States extends back many generations. These families may differ greatly on measures of acculturation as well as socioeconomic status from the individuals who participated in this research. Their attitudes toward caregiving and formal service utilization may also differ greatly.

Efforts to assist Mexican families in the United States with caregiving through increased use of palliative care must therefore take into account structural factors in the community, the socioeconomic status of the community residents, and cultural factors. In addition to literacy levels in both English and Spanish, structural factors include the impact of immigration on family cohesion and resources. The impact of differences in eligibility of documented and undocumented individuals for a variety of services including health and social services also needs further exploration. Cultural attitudes and traditions interact with these structural factors. These cultural traditions may be altered through acculturation resulting in altered attitudes of future cohorts of Mexicans and Mexican Americans. These changes are already evident in ongoing research among long-term Mexican residents of Western Michigan. An understanding of current cultural attitudes of the majority of Mexicans toward caregiving, terminal illness, and the structural factors that impinge on this group's effort to obtain services will help to maximize their access to and use of important palliative care programs.

To provide effective information about end-of-life services and referral to provider organizations, it will also be necessary for palliative care organizations to be more closely linked to the aging network and other community service providers. The new National Family Caregivers Support Program of the Older Americans Act is now beginning to fund programs. The initiative provides opportunities in all states for palliative care organizations and Area Agencies on Aging to link together to provide information and services about palliative care to their Mexican constituents. Churches are also a potential source of information about end-of-life care issues and services for Mexicans in many communities. Finally, community organizations that provide

services to Mexicans who are below the age of 60 or 65 may be important sources of information and referral of palliative care services to younger individuals facing the problems of providing care for older individuals in the last stages of their life. For palliative care organizations, this research indicates a need to review the cultural competency of the staff and the way palliative care services are explained and offered to Mexican families.

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