Environmental Scan

Part 1 (Chinese)

Literature review of available published and grey literature related to ACP with South Asian community

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Table of Contents

Objective **3**

Introduction **3**

ACP Definition 3

ACP Outcomes 4

Diversity within Diversity **4**

Western versus Chinese Perspectives **5**

Barriers to accessing ACP resources **5**

Decision Making **6**

Physician's Role 6

Family's Role 6

Pressure to Conform 6

Balancing cultural values with autonomy 7

Knowledge and Understanding of ACP **7**

Wording Matters **8**

Chinese Translation Guide 8

Readiness to Engage in ACP **10**

Readiness Assessment 10

Five Approaches towards end-of-Life Care Decisions amongst Chinese Frail Elderly 11

ACP Initiation **13**

Parents and Children 13

Physicians and Patients 14

ACP Communication **15**

ACP Resources **16**

ACP Led by a healthcare provider 16

Combination of face-to-face interviews and educational materials 16

Storytelling 17

Community Group ACP 17

References **19**

List of Tables

Table 1: Different Chinese philosophies adopt different views of death 4

Table 2: Conflicts between Western Palliative Care values and Chinese values..... 5

Table 3: Chinese Translation Guide..... 9

Table 4: Communication Strategies 11

Objective

The purpose of this literature review is to:

1) provide insight into how members of the Chinese community respond to ACP activities;
2) present opportunities to adapt ACP materials to increase culturally appropriate for members of the Chinese community; and
3) use this information to better inform the development of future ACP activities involving members of the Chinese community.

Introduction

Just over 10 percent of recent immigrants to Canada originated in China,(1) with the highest concentration of Chinese Canadians living in Metro Vancouver, where one in five residents are Chinese. As the Chinese community represents a large proportion of the general population, improving the uptake in Advance Care Planning (ACP), and empowering these communities to advocate for care that is aligned with their values and wishes with this community is a growing priority.

ACP Definition

> *"Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness."*(2)

ACP Outcomes

During the process of conducting ACP a person may:

- choose who will make healthcare decisions for them if they are unable to do so (their substitute decision maker, SDM);
- consider their wishes, values and beliefs
- communicate these with their SDM and/or healthcare providers (HPs)
- document their wishes, values and beliefs in a document such as an advance care plan or Advance Directive (AD).(2)

A person's cultural background and ethnicity can shape their attitudes towards end-of-life conversations as well as their willingness to engage in ACP activities.(3) One's cultural and ethnic identity may also influence the way that people approach ACP conversations, their identification of wishes, values and beliefs, and how they choose to communicate that information with loved ones and healthcare providers.

Diversity within Diversity

Using the term "Chinese people" can be problematic.(4) Although Chinese immigrants may have much in common, it is important to recognize the diversity between and amongst different subgroups of the Chinese community. The Chinese community is a large, heterogenous group of people originating from different regions, belonging to different generations, experiencing different levels of acculturation to Western society, and engaging in different customs and practices. These are all factors that play a role in the attitudes and willingness to engage in ACP. Quite often, research and policy directives tend to combine large groups of people into a single category.(4) Developing research and policies based on broad-based assumptions fails to take into consideration the needs of the individual.

Table 1: Different Chinese philosophies adopt different views of death

Philosophy	View on Death (5)
Confucian	• "Willing to die to preserve virtue" • One should not be afraid of death. If a non-virtuous act is needed to preserve life, one would rather die.
Taoist	• "life and death unified'' • Life and death are natural processes. One becomes part of nature upon death, and one need not grieve when facing death.
Buddhist	• ''belief in new life after death" • Death is part of the process of the wheel of rebirth. Death is a way to Nirvana.
Contemporary	• "Respecting life seriously and accepting death peacefully" • Death is not to be feared

Western versus Chinese Perspectives

Some of the values and beliefs shared between members of the Chinese community present a conflict when confronted with the Western concept of ACP. While none of these factors are absolute barriers to a person completing ACP, they do influence the person's response to the concept and how it could be best presented. These conflicts are described in Table 2.(4,6)

Table 2: Conflicts between Western Palliative Care values and Chinese values

Western Palliative Care Value	Chinese Value
Direct and open disclosure of diagnostic information with the patient	Limited or no disclosure of diagnostic information to the patient
Individual autonomy over decision making	Unwilling to express individual views Shared decision-making responsibility collectively within family members.
Discussion of death and dying	Fear of the topic of death and dying
Direct and assertive communication style	Indirect and passive communication style

More recent research findings suggest that Chinese people living in Western cultures, experience varying degrees of assimilation into western society, which shifts their attitudes and acceptance of ACP and are starting to challenge some of the existing stereotypes. Evidence has suggested that incorporating cultural values and preferences into ACP educational interventions can increase ACP completion among diverse cultural groups.(7) Therefore, understanding the diverse cultural perspectives amongst Chinese community members can ensure that the delivery of ACP practices are respectful, sensitive, and not offensive to the individuals and their families belonging to diverse cultural groups.

Barriers to accessing ACP resources

Members of the Chinese community are confronted with many barriers to accessing palliative care services, despite the potential benefits. *Cultural considerations, social determinants, limited language proficiency, institutional and cultural discrimination, and mistrust of healthcare systems* have been cited as reasons behind uptake of ACP in cultural and linguistically diverse (CALD) populations.(4,8) These barriers can be reduced with the development of government policies, and culturally appropriate ACP programs and resources.

Decision Making

Physician's Role

Chinese culture seldomly acknowledges a patient's autonomy in terms of treatment. Physicians are viewed as experts, holding medical knowledge and experience, and therefore in the best position to make medical decisions on behalf of the patient. When it comes to end-of-life decision making, many Chinese people feel unprepared and uninformed.(9) They may be unaware of their own care preferences if they have not been given the opportunity to think about or review their life values and beliefs. Offering ACP as an opportunity to learn more about end-of-life care, to think about personal values and preferences, and to practice different ways to communicate these wishes with loved ones and healthcare providers is one solution to help bridge this cultural gap.

Family's Role

In Chinese culture, collective decision making within the family has tended to be regarded as the norm. Many Chinese people rely on the family unit to inform health care decisions rather than relying on themselves. There is a tendency for Chinese individuals to consult family members when making important personal life decisions such as marriage, job seeking, or ACP in death.(10) Older generations typically prefer less information, and less involvement with medical decision making than younger generations. A cultural value in Chinese culture is that of filial piety, the respect for one's parents and ancestors. Children are obligated to respect, care, greet, obey, and assure their parents' physical and emotional well-being.(11) Filial piety strongly influences decision-making in China, and therefore, children are expected to do everything to prolong their parents life.(12) Chinese parents trust that their children respect the value of filial piety, and therefore feel comfortable nominating their oldest child to be their substitute decision maker (SDM).(13) In addition, traditionally gender roles are considered as normal as decision making is largely delegated to male members of the family. Dependencies are exacerbated as many older adults experience language barriers and limited understanding of the Western health care systems. Therefore, children are often responsible for providing care, as well as communicating and liaising with healthcare providers on their parents behalf.(14)

Pressure to Conform

In Chinese culture, there is a tendency to avoid family conflict, and adopt a more submissive role when having end-of-life conversations. The opinions of family members and health-care providers take precedence over personal preferences or opinions.(12) For many people, this can present a pressure to conform, to do what is expected of them, and to appease others, even if it does not necessarily reflect what their desires and wishes are.

Balancing cultural values with autonomy

On the other hand, many Chinese people expressed the need to communicate their care preferences with loved ones, and felt that sharing this information would promote their autonomy at the end of life.(15) Encouraging the involvement of family caregivers early in the communication and decision making processes, until the patient objects can be one way to balance collective decision making with autonomy. In addition, patients may exert their autonomy by delegating family members the right to learn about and understand the details of the illness and make treatment decisions on their behalf. Although Chinese people value family shared decision making, they may not favour decisions being made by their relatives alone.(16)

Knowledge and Understanding of ACP

Although ACP is associated with better care at the end of life, better quality of death, and less psychological distress in survivors, ethnic disparities in ACP completion rates have been documented and may be attributable to lack of knowledge about ACP.(17) Furthermore, evidence suggests that the level of knowledge about and familiarity with Advance Directives influence individual's proclivity to engage in ACP.(15) Different research findings suggest that Chinese participants exhibit a wide range of knowledge and experience regarding end-of-life care planning, communication, and Advance Directives.

Misinterpretations of ACP and related concepts, inaccurate knowledge and misunderstandings are other themes that have emerged in the literature.(18) For example, Chinese people indicating previous ACP engagement during a focus group discussion had no ACP experience at all.(15) This suggests that using surveys and tools to collect data, without offering any personal support to clarify any misinterpretations is not effective. This is especially true for cultural groups where the conceptual knowledge of ACP doesn't exist. To answer questions on an abstract concept can be challenging. Healthcare providers are encouraged to make themselves available to spend more time discussing ACP with patients, and answering any questions to make sure that they are familiar with and understand ACP.

An area of concern is that Chinese caregivers have been found to have poor knowledge relating to life sustaining treatments.(19) Common misconceptions include mistaking advance directives for living wills, life trusts, or preferences around asset dispersal or post-mortem organ donations. This can have grave consequences, as these caregivers relied on their own views rather than the patients' wishes to make end-of-life care decisions.(20) This example illustrates the importance of encouraging patients to include written documentation of their values and wishes in the form of an Advance Care Plan while they are still cognitively able to do so. These written documents would help patient's wishes to be respected when they might become terminally ill and mentally incompetent.

Wording Matters

Language barriers interfere with the ability to obtain and comprehend health related information, presenting a challenge for healthcare providers when trying to engage Chinese patients in ACP conversations.(6,15,18,21) Fortunately, in British Columbia, healthcare providers can request Provincial Health Services Authority's spoken language interpreting services for patients who are faced with a language barrier. However, having to conduct sensitive ACP conversations using a third-party can be extremely uncomfortable, making it challenging to establish rapport, and have an honest conversation about values and preferences. Not only is having ACP conversations awkward for the patient, but Canadian Chinese interpreters have expressed being put in difficult situations when Chinese cultural values clash with Western healthcare values. For example, it is difficult for interpreters to know who to take direction from, when there is pressure from families to withhold diagnosis information with the patient, while at the same time being pressured to translate exactly what the physician was saying to the patient.(21) Translators have also expressed the need to help educate patients and their families about palliative care.

It has been shown that in terms of language, there is a lack of a suitable or equivalent term for palliative care or hospice in Mandarin or Cantonese.(22) Interpreters have expressed that Palliative care was often interpreted as "waiting to die".(21) Hearing this, without any clarification can be extremely distressing to patients and their Language interpreters also serve as a cultural liaison, as they also play an important role in clarifying the language and cultural miscommunications. When an interpreter is not available

Patients with low English proficiency may use apps such as "Google Translate" to answer questions that they have on their own, making them more susceptible to misinformation. The Chinese Google translation of "Palliative Care" is 姑息治疗 , meaning "do nothing care".(23) "Similarly, the Chinese Google translation of "Hospice" is 临终关怀, literally meaning, "last minute care".(23) The conceptual equivalent of these words in the Chinese Language does not exist, as palliative care and hospice are still in their infancy phase in mainland China.(5) The lack of suitable and equivalent Chinese words for "palliative care" and "hospice" indicate that translation alone is insufficient, and there needs to be consideration of cultural concepts and meanings in providing health care information.(22)

Chinese Translation Guide

A translation guide that is professional, culturally appropriate, and clearly understood when used in both Cantonese and Mandarin Chinese has been developed by Richmond's Chinese Advisory Committee for English terms commonly used in palliative care. The guide was created with the intent of helping non-Chinese speakers understand the cultural norms and nuances in Chinese translation.

Table 3: Chinese Translation Guide

English Term	Rationale
Palliative Care	Historically, the Chinese translation for palliative care translated to "peaceful ending". The Chinese character that means "end" carries the connotation of death, resulting in the belief that accepting palliative care means giving up on treatments, giving up on life, and passively waiting to die. Recently, areas in Asia including Hong Kong, Taiwan and Mainland China started to move away from the term "peaceful ending" to new terminology that reflects the proactive nature of palliative services and represents an expression of health care services targeted for symptom relief, and not necessarily "treatment" that aims to cure. Use the word "care", not "treatment" to reflect that patients/clients will still receive care for symptom relief when receiving palliative care, rather than being given up on.
Hospice	"Hospice" has been traditionally translated to mean "a facility that people go to for a peaceful death". Instead, use Chinese characters that translates to "a care facility that brings peacefulness, quiet, and ease". Removing death from the translation of Hospice reduces fear and anxieties associated with death. The connotation is that patients/clients will be cared for and spend the rest of their life in peace and at ease, as opposed to being left at a facility to wait for death. Emphasizes hospice as a "care facility" instead of just as a "centre" to remove the negative context previously attached to the traditional translation of hospice which leads to a feeling that Hospice is a place to passively wait for death.
Supportive Palliative Care Unit	In this recommendation the term "supportive" has not been directly included in the translation because the recommended translation of palliative care implies the inclusion of supportive care. Therefore it would be repetitive to include a direct translation of "supportive".
Comfort Care	The recommended translation roughly translates to mean relief, which carries very similar meaning to "comfort" in Chinese and sounds natural in the Chinese language in a health care setting.

English Term	Rationale
Quality of Life	"Quality of life" can be translated directly to roughly mean "good quality of life". However, "good quality of life" in Chinese culture implies high materialistic quality, which is not what it is intended to mean in this context. Therefore, it is recommended that when using this term more content is included to provide clarity of the meaning.
Most Important Goals	"Important goals" can be confusing when directly translated to Chinese. The recommendation is to elaborate on the concept based on the context. For instance, "based on your health condition, how do you define the most meaningful life for you". "What are the most important things to you or what are the things that you want to accomplish in your remaining time".
Living Well until death	There is no direct appropriate translation to this term. Such meaning should be embedded in the sentence depending on the specific scenario. A safe Chinese translation is "maintain the quality of life". The recommended Chinese term implies "good quality of life until the end".

Readiness to Engage in ACP

There have been mixed findings regarding the willingness and readiness of Chinese community members to engage in ACP. Much of the evidence suggests that, ethnic minority groups are less engaged in ACP, representing an ethnic and cultural gap.(24,25) Contradicting these findings are a number of studies that claim that members of the Chinese communities are in fact open and wanting to discuss end-of-life issues.(24)

Readiness Assessment

Assessment is an essential step to gauging one's readiness to engage in end-of-life conversations. Older Chinese people report that they are receptive to end-of-life discussion if this discussion was initiated and provided by a health care provider and incorporated themselves into regular check in appointments. Initiating the end-of-life care discussion should be done in a way that is indirect, impersonal, cultural and age appropriate. This approach be an icebreaker to conversations diminishing the pressure, as direct and personal verbal communication can catch people off guard and turn them away from a discussion completely. Once the conversation is initiated, look to the individual for their response. If a Chinese person says no, their wishes should be honoured, noted,

and re-assessed at a different time if needed. End-of-life conversations are culturally appropriate, if the individual is ready.(26,27)

Table 4: Communication Strategies

Strategy	Example
Use another person's end of life experience	"What do you think about the EOL care experience that you had with ___ (e.g., father, mother, a relative)?"
Frame the discussion as a standard question by policy (standardizing may minimize the taboo)	"If you prefer not to have this discussion, we don't have to talk about it. However, it is our policy that we ask all of our patients."
Acknowledge cultural taboos and ask for permission	"Some of my patients prefer not to discuss EOL care topics. I wonder how you feel about talking about this?"
Provide a Chinese longevity blessing statement as a prompt or describe a longevity scenario	"I wish for you longevity that you live to 100 years old (長命百歲). Do you want to live to 100 years old or older?"
Use provider's own experience as an example	"My mother/father told me what she/he would want at the end of his/her life." "I completed an advance directive as well."

Five Approaches towards end-of-Life Care Decisions amongst Chinese Frail Elderly

A research study revealed five approaches towards end-of-life care decision making among Chinese frail older adults.(28) These approaches provide insight to the different attitudes of Chinese frail older adults towards ACP and their readiness to engage in ACP activities. Having this information available can help inform the development of strategies and programs that promote participation in ACP activities. The strategies are as follows:

1) Holding on to life

- Put a great deal of trust into healthcare providers, medicine and healthcare system
- Are optimistic about the efficacy of modern medicine
- Have faith in the possibility of a miraculous recovery,
- Choose treatments wherever there is a chance for survival

Alleviating suffering is not valued as much as curing disease, and consequently incurable patients tend to feel distanced from the healthcare system, and equate illness as a personal failure.(5) Chinese people are more likely to favour active life-sustaining interventions than other ethnic groups.(4) However, once informed or educated of poor outcomes of the intervention, Chinese people tend to shift their perspectives.

2) Planning Ahead

- Have thought about end-of-life preferences, and are consistent and confident with decisions
- Open and expressive communication, receptive to ACP
- Value autonomy, self-determination, and want to be involved in decision making process

Previous experiences with caring for a loved one, or being confronted with one's own mortality often demonstrated the importance of thinking ahead and make end-of-life decisions. Although these individuals may have participated in ACP activities in the past, it is important to remind them to review their ACP periodically, as end-of-life care preferences can change over time.

3) Weighing benefits

- Acknowledge health deterioration and reversibility
- Understand limitation of medical treatments
- Want to avoid burdens, such as pain and suffering
- Emphasis on quality over quantity of life

The most common desired outcome of ACP was that it lessened the burden of others in making EOL decisions for them.(24) These individuals are receptive to listening to the facts to make an informed decision.

4) Avoiding

- **Pragmatism**

Many Chinese people believe that death is predetermined, and beyond their control, therefore, they did not see the point of planning for their future by engaging in ACP. Instead, these individuals believed that people should live in the present moment and on a day-to-day basis.

- **Topic of death is uncomfortable and upsetting**

Another reason behind the avoidance is fear. Some individuals are afraid to think about death and dying, and find the topic sensitive and uncomfortable. One of the barriers impeding the success of ACP is the general unwillingness of people to discuss the topic of death. ACP facilitators can make death a less threatening topic, by providing people with the opportunity to ask more questions, seek out information and know what options are available when the time comes. Normalizing death and

dying would help people to be more prepared when healthcare provider ask about their wishes for end of life care.

- **Talking about death will bring bad luck**

Some people avoid ACP conversations is because discussing death is considered a sacrilegious and taboo topic that is incompatible with the cultural beliefs of Chinese people.(24) Discussing death and dying is considered to be uncaring, discouraging and disrespectful to others. There is the Chinese belief that open conversations about death and dying will bring bad luck to the individual and hasten death.(13,29–33)

5) Deferring

- Little or no experience in medical treatments
- Anxious about making the "right" decision
- Want to leave decisions to others

Due to their lack of knowledge and experience, these individuals generally feel it is inappropriate to be involved in the end-of-life decision making process. They believed that patients should be submissive to the physician, preferring to leave treatment decisions to the physician's discretion. Some older people may be used to the medical dominant or family-oriented culture, thus their sense of inability to make health care decisions remains regardless of the amount of relevant information given to them during the planning process. They believed that health providers, or sometimes their family had more knowledge and experience with the healthcare system, and they preferred to leave the responsibility of making medical decisions up to them.

ACP Initiation

Parents and Children

Evidence shows that although Chinese individuals express positive attitudes towards ACP Initiating ACP conversations with loved ones and physicians can be extremely difficult. Focus group findings suggest that, most Chinese people place the responsibility on the parents to initiate discussions about end-of-life care preferences with their children, rather than expecting children to broach the subject.(15,18)

Chinese people from younger generations were interested to know their parents end-of-life preferences, however, they were hesitant to initiate the discussion. Because of the traditional Chinese beliefs, they worried that their parents would view the initiation of ACP as acting against filial piety

and hastening death.(24) This was especially sensitive if the children were to inherit assets after their death.

On the other hand, older generations expressed that they wanted to make their end-of-life preferences known to their children so that their children could arrange their end-of-life care without any doubt or guilt.(24) However, they did not initiate the discussion, as they believed their children would be uncomfortable discussing ACP with them, and that the topic might be emotionally upsetting.(34,35) Older generations also typically prefer less information, and less involvement with medical decision making than younger generations. English, Cantonese and Mandarin speaking Chinese people participating in a focus group had expressed a strong desire to avoid discussing end-of-life topics with loved ones until health circumstances made it necessary.

Physicians and Patients

For physicians, it can be extremely challenging to decide when to initiate ACP conversations with Chinese patients. Finding the right time and opportunity was one of the biggest barriers to initiating ACP discussions.(24,30) One study suggests that physicians should broach the subject of EOL treatment preferences well before the resident's conditions deteriorate quickly, so as to allow time to consider their AD preferences.(5) However, the desire to avoid upsetting discussions appears to affect the mode and timing of ACP discussions.(15)

Research evidence suggests that initiating ACP conversations earlier is better (Yonashiro-Cho et al., 2016). However, focus group evidence suggests that many Chinese people feel that direct communication of end-of-life care plans and preferences should be delayed until health declines.(15) They also believe that prematurely discussing the topic is unwarranted and unnecessarily burdensome on loved ones. Many Chinese people expressed that the most appropriate times for ACP conversations were after the diagnosis of a serious illness or when death seemed more or less inevitable. For Chinese Americans, health decline may serve as a significant sociocultural indicator of the last stage of life and the need to engage in ACP and communication.(15)

Disclosure practices of Western physicians are more open, for example they are more likely to communicate diagnosis information, the risks and benefits of treatment and care. However, most Chinese practitioners maintain a more closed approach to patients, withholding diagnostic information from patients, and making decisions on their behalf.(4) Many Chinese families object to sharing information that might cause emotional distress and burden on the patient. Examples of the types of information that are generally withheld from the patient are, telling the patient that they have an incurable or terminal disease or poor prognosis.(12,36) This may hinder the opportunity to engage in ACP, if patients do not have a realistic representation of what their current health situation is. One solution is to involve loved ones early on in the communication and decision-making process, unless the patient objects. Contrary to these previous findings, many Chinese people indicated the

desire for open disclosure and they want to be informed of their diagnosis, prognosis and treatment options at the same time as their family.

ACP Communication

Talking about death and end-of-life care is uncomfortable for many members of the Chinese culture. English, Cantonese, and Mandarin speaking Chinese are averse to directly discussing their wishes with loved ones.(15) One way to make ACP discussions less threatening is through using methods of indirect communication. Messages expressed by using indirect communication are taken more seriously than messages conveyed directly, thus, drawing special attention to the topic's importance.

Examples of indirect communication include:

- Use storytelling to share another person's end-of-life care experience(12,15)
- Asking healthy people to imagine themselves in a declined health condition was discouraged as it may create unnecessary anxiety, and lead to "bad luck".
- Framing the discussion as a standard question by policy(12)
- Use generalized techniques to reduce the sensitivity of the topic.
- Informal contexts, such as during a family dinner rather than formal meeting(15)
- Be sensitive to the language and mindful of specific words used to describe the situation, such as "death", "terminal illness".(12)

Another reason that Chinese people prefer to use indirect modes of communication to discuss ACP is to minimize the emotional burden on their loved ones. One Cantonese woman expressed, *"If we hold a family meeting to talk about it, it might sound so serious that it will make our family very upset, and they won't stop thinking about it, but if we just have a casual conversation about it, they will be less nervous and when the time comes, they'll know what to do"*.(15) Participants may feel that the use of this mode of communication would be less worrisome, more socially acceptable, and understood by loved ones.(18) There is evidence to suggest that members of the Chinese community are more comfortable discussing ACP at community events such as focus groups, or workshops, than with loved ones or their physicians.(15) Chinese community members attending ACP workshops were able to communicate their attitudes and experiences around the topic of ACP directly, there was still a strong desire to avoid discussing EOL topic with loved ones or physicians until it was absolutely necessary.(5) ACP facilitators may consider using small groups or case studies to engage members of the Chinese communities in ACP conversations to make end of life conversations appear less threatening.(24)

ACP Resources

Included in this section are suggestions on how to present or adapt ACP program content in a way that is culturally appropriate.

ACP Led by a healthcare provider

Knowledge AD completion, and ACP discussions increased after a **nurse led, community based culturally sensitive ACP seminar.**(37) The seminar was presented in English and translated into Chinese, using a bilingual Powerpoint presentation as a visual aid. Using a multimodal, one-time educational interventions significantly increased levels of ACP knowledge and engagement. In addition, the researchers had to develop, and translate instruments specific for the study, as researchers were unable to find established instruments that assessed AD and knowledge completion. Chinese culture was integrated by using common Chinese phrases and terms, incorporating Chinese values, and approaching ACP as a family process. Using Five Wishes(38) as a tool, the seminar incorporated a step-by-step, hands on guide of the AD completion process. The seminar ended with a question and answer session to clarify any questions. Using culturally sensitive approaches to health education can help overcome some of the barriers that exist in ACP in individuals from diverse cultural backgrounds.(39) Nurses can partner with community organizations to promote ACP in diverse cultural groups and facilitate the communication among health care providers, and family members.

Combination of face-to-face interviews and educational materials

Knowledge and attitudes towards Palliative Care and Advance Directives, increased self-rated understanding of DNR orders and palliative care, willingness to sign a DNR order after ACP training session(17). Using the concept of four seasons to guide life review, the concerns with health problems, palliative care and ACP issues, and the arrangement of funeral. The handbook included life story, current health status and health habits, life threatening conditions and suffering, medical care decisions related to end-of-life care, and funeral and other items. Information about treatment procedures, benefits and costs of each treatment, and the alternative care available if they did not want invasive treatment such as CPR. ACP handbook contained simple sentences and words in large print with pictures. It was developed specially for older people. Spaces in the pages in the handbook to allow interviewers to write down the residents' wishes and comments during the life review and ACP discussions. Develop rapport through discussion of non-threatening issues through life review and then introduced the critical issues at the end of life (DNR, palliative care, funeral).

Storytelling

The process of story re-telling encouraged Chinese people to reflect on their entire life, linking the past to the present and even to the future.(40) This sharing provided a background for their individual preferences and underpinning values and beliefs and highlighted the individual uniqueness in their preferred care. The differences in personal experiences help to account for the diverse treatment preferences and attitudes towards advance care planning. This substantiates the need to include the component of life review, which allows individuals the possibility to clarify their implicit personal values and beliefs, in the advance care planning process so that treatment preferences can be interpreted in the individual context.(40) Individuals' values and beliefs are fluid and may change over time. Hence, ACP has always been emphasised as an ongoing and dynamic process.(41,42) As long as there are opportunities to introduce the concept, its influences cannot be precluded. Therefore, invitations to advance care planning should not be limited to those who are already well prepared.(28)

Community Group ACP

Focus group discussions had revealed that Chinese people had preferred to use community outreach programs. ACP Outreach program format:(15)

- Seminar or lecture- to open up discussion
- Multiple education series to get comfortable with ACP gradually
- Culturally appropriate guest speakers to share experiences
- Support provision, reassure that person to person assistance is available
- Peer support/Small group discussion- because it is a serious matter
- Use case studies- so that it is not as personal
- video sharing that is not too personal-oriented to introduce the discussion.
- create opportunities for parents and children to get together to discuss this issue.
- making a Mandarin and Cantonese advance directive that is sensitive to their specific cultural needs would increase their acceptance of ACP and the use of advance directive.
- Paperwork, books and flyers are useless and end up in the trashcan.
- The provision of language-specific education, such as the explanation and conversation included in the focus group protocol, may improve community understanding and application of ACP.

- Although patients may be hesitant to engage in ACP, they may be more receptive to the practice if ACP is framed as a tool to help families avoid stress while fulfilling filial duties.
- Broaching the subject through indirect means and use of storytelling to share examples of others who have needed or used ACP may convey information to Chinese adults in an acceptable manner.
- Providers should also be aware that Chinese older adults may express their health and end-of-life care preferences in indirect and informal ways.
- They may attempt to convey their wishes through storytelling or commentary about the experiences of others. Such messages should be considered and, when appropriate, documented in provider records.

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