Association Between Training Experience and Attitudes Toward Advance Care Planning Among Healthcare Professionals: A Cross-Sectional Study

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Abstract

**Background:** Training has been found effective in improving healthcare professionals’ knowledge, confidence, and skills in conducting advance care planning (ACP). However, its association with their attitudes toward ACP, which is crucial to its implementation, remained unclear. To fill this gap, this paper examines the association between their attitudes toward ACP and relevant training experiences.

**Methods:** An online survey about attitudes toward ACP of healthcare professionals, including physicians, nurses, social workers, and allied healthcare professionals, currently working in hospital and community care in Hong Kong was conducted.

**Results:** Of 250 respondents, approximately half (51.6%) had received ACP-related training. Those with relevant training reported significantly more positive in the perceived clinical relevance, willingness, and confidence in conducting ACP and levels of agreement with 19 out of the 25 statements in a questionnaire about attitudes toward ACP than those without ($p\leq0.001–0.05$). Respondents who received training only in a didactic format reported a significantly lower level of confidence in conducting ACP than did others who received a blended mode of learning ($p=0.012$). Notwithstanding significant differences between respondents with and without relevant training, respondents generally acknowledged their roles in initiating conversations and appreciated ACP in preventing decisional conflict in surrogate decision-making regardless of their training experience.

**Conclusions:** This paper revealed the association between training and positive attitudes toward ACP among healthcare professionals. The findings showed that training is a predictor of their preparedness for ACP in terms of perceived relevancy, willingness, and confidence. Those who had received training were less likely to consider commonly reported barriers such as time constraints, cultural taboos, and avoidance among patients and family members as hindrances to ACP implementation.

**Background**

Advance care planning (ACP) is a communication process to prepare patients and their families for end-of-life care.(1) Although healthcare professionals generally found ACP important for patient-centered care, many of them were reluctant to conduct ACP due to its sensitive nature and time-consuming process.(2,3) Certain training interventions have been developed to equip healthcare professionals with the skills to facilitate ACP, and the findings showed that training was effective in improving professionals’ knowledge, confidence, and communication skills in conducting ACP.(4–8) However, the effects of training on their attitudes toward ACP, which is crucial to the integration of ACP into routine care practices, has rarely been studied. This paper reports the association between healthcare professionals’ attitudes toward ACP and relevant training experience based on secondary analysis of the findings from an online survey.

**Methods**
Study design

A cross-sectional online survey was conducted between November 2019 and April 2020 in Hong Kong. Around this period, the Hong Kong government had launched a public consultation on legislative issues related to advance directives and dying in place, and the Hospital Authority had just formulated ACP guidelines and templates for clinicians in public hospitals. This survey primarily aimed to investigate the attitudes toward ACP of healthcare professionals, including physicians, nurses, social workers, and allied healthcare professionals currently working in hospital or community care settings in Hong Kong.

Instrument

A questionnaire was developed to investigate healthcare professionals’ attitudes toward ACP based on a literature review and a team of experts in palliative care and ACP. The questionnaire included 25 statements related to recommendations for ACP, as well as benefits and barriers of conducting ACP. The team discussed and revised the items reiteratively until consensus was reached. Respondents were asked to indicate their level of agreement with each statement on a five-point Likert scale, from 1 (strongly disagree) to 5 (strongly agree). Respondents were also asked to indicate their perceived relevance of ACP with their clinical work, willingness, and confidence in conducting ACP on a numeric scale, from 0 (lowest) to 10 (highest). The questionnaire also collected demographic data, including age, gender, disciplines, educational level, clinical experience, and current working setting; the questionnaire also collected experience of receiving training related to ACP and conducting ACP.

Data analysis

Statistical analysis was conducted using SPSS 25.0 (IBM Corp, Armonk, NY). Descriptive statistics was used to summarize the respondents’ characteristics and their responses. The level of agreement with the 25 statements was presented in three levels: strongly disagree/disagree, unsure, and strongly agree/agree, to facilitate analysis. Chi-square test, independent t-test, Mann–Whitney U test, and ANOVA were used to examine the differences in their responses based on training experience. Univariate linear regression was used to identify the association of demographics and training experience with perceived relevancy, willingness, and confidence in conducting ACP. The variables with a p-value < 0.01 were included in multiple linear regression for identifying predictors. Variance inflation factors (VIF) were examined to rule out multicollinearity. All statistical tests were two-sided with the level of significance at 0.05.

Ethical considerations

Ethical approval for the study was obtained from the Survey and Behavioural Research Ethics Committee of the Chinese University of Hong Kong (Ref no.: SBRE-19-112). Participation in the study was on voluntary and anonymous bases to ensure privacy.

Results
Participants’ characteristics

A convenience sample of 250 respondents completed the questionnaire (Table 1). Most of them were female (66.4%) and working in public hospital settings (70.7%). Their mean age was 41.8 years (SD 10.3), ranging from 21 to 69. The respondents mainly included physicians (38.8%), nurses (48.8%), and social workers (11.2%), with an average clinical experience of 17.9 years (SD 10.3, in the range 1–42).
Table 1
Respondents’ characteristics

| Characteristics          | ALL (N=250) | Trained (n=130) | Not trained (n=120) | p^Ψ |
|--------------------------|-------------|-----------------|---------------------|-----|
| Gender                   |             |                 |                     |     |
| Male                     | 83 (33.2%)  | 38 (29.2%)      | 45 (37.5%)          | 0.165 |
| Female                   | 167 (66.8%) | 92 (70.8%)      | 75 (62.5%)          |     |
| Age (years)#             | 41.8 ± 10.3 | 43.9 ± 9.19     | 39.5 ± 11.0         | 0.001 |
| Disciplines              |             |                 |                     |     |
| Medical doctors          | 97 (38.8%)  | 50 (38.5%)      | 47 (39.2%)          | 0.554 |
| Nurses                   | 120 (48.0%) | 60 (46.2%)      | 60 (50.0%)          |     |
| Allied health            |             |                 |                     |     |
| Clinical experience (years)# | 17.9 ± 10.3 | 19.7 ± 9.5     | 15.9 ± 10.8         | 0.004 |
| Educational level        |             |                 |                     |     |
| Bachelor                 | 129 (51.6%) | 61 (46.9%)      | 68 (56.7%)          | 0.274 |
| Master                   | 111 (44.4%) | 64 (49.2%)      | 47 (39.2%)          |     |
| Doctoral                 | 10 (4.0%)   | 5 (3.8%)        | 5 (4.2%)            |     |
| Workplace                |             |                 |                     |     |
| Public hospitals         | 177 (70.8%) | 92 (70.8%)      | 85 (70.8%)          | 0.142 |
| Private hospitals        | 9 (3.6%)    | 3 (2.3%)        | 6 (5.0%)            |     |
| Community centres        | 9 (3.6%)    | 4 (3.1%)        | 5 (4.2%)            |     |
| Care homes               | 7 (2.8%)    | 4 (3.1%)        | 3 (2.5%)            |     |
| Hospices                 | 13 (5.2%)   | 11 (8.5%)       | 2 (1.7%)            |     |
| Private clinics          | 14 (5.6%)   | 6 (4.6%)        | 8 (6.7%)            |     |
| Universities             | 6 (2.4%)    | 1 (0.8%)        | 5 (4.2%)            |     |
| Others                   | 15 (6.0%)   | 9 (6.9%)        | 6 (5.0%)            |     |

Footnote: ^ΨChi Square test, unless specified; #M ± SD, independent t test
Training experience

Approximately half of the respondents (n = 129, 51.6%) had received formal training related to ACP in didactic format only (such as lectures, talks, or seminars) (n = 63, 48.5%); a combination of didactic and web-based (n = 12, 9.2%); a combination of didactic and workshop (n = 29, 22.3%); blended learning with didactic, web-based, and workshop (n = 13, 10.0%); and any format with local or overseas placement (n = 13, 10.0%). Training was associated with older age (p ≤ 0.001), increased years of clinical experience (p = 0.004), and working in internal medicine and palliative care specialties (p ≤ 0.001).

Associations between training and perceived readiness for ACP

Table 2 shows the association of training with the respondents' perceived clinical relevance of, and willingness and confidence in, ACP. Respondents who had received relevant training were more likely to find ACP related to their clinical work than the counterparts (p ≤ 0.001) and they reported significantly higher levels of willingness (p ≤ 0.001) and confidence (p ≤ 0.001) with conducting ACP when compared with those who did not receive such training. Univariate linear regression showed that only specialty and previous ACP training were associated with these three variables, but not age and clinical experience. Multiple linear regression indicated that respondents received relevant training perceived higher relevancy of ACP in relation to their clinical work (β = 0.23, p < 0.001), higher level of willingness to conduct ACP.
with their clients ($\beta = 0.30, p < 0.001$) and higher level of confidence in facilitating the ACP conversation ($\beta = 0.35, p < 0.001$). Specialty is associated with higher level of clinical relevancy ($\beta = 0.22, p < 0.001$) and higher level of confidence ($\beta = 0.15, p < 0.05$), but not for willingness. Respondents who received blended training generally reported the highest levels of relevance, willingness, and confidence when compared with other modes of learning. Those received training only in didactic format reported the lowest ratings and a significant difference was noted in confidence compared with their counterparts ($p = 0.012$).

| Table 2 | Association of training with preparedness for ACP |
|--------|-----------------------------------------------|
|        | Relevancy | Willingness | Confidence |
| ALL (N = 250) | $6.9 \pm 3.0$ | $7.4 \pm 2.6$ | $6.3 \pm 2.5$ |
| Not trained (n = 120) | $6.1 \pm 3.3$ | $6.5 \pm 2.8$ | $5.3 \pm 2.4$ |
| Trained (n = 130) | $7.7 \pm 2.5$ | $8.2 \pm 2.1$ | $7.2 \pm 2.2$ |
| $p^{\psi}$ | $\leq 0.001^#$ | $\leq 0.001^#$ | $\leq 0.001$ |

Variables for multiple linear regression

- Training related to ACP (yes/no) $\beta$ .23 .30 .35
  - t $3.72^{***}$ $4.81^{***}$ $5.95^{***}$
- Specialty $\beta$ .22 .11 .15
  - t $-3.52^{***}$ $-1.81$ $-2.44^*$

Types of training

- Didactic format only (n = 63) $7.1 \pm 2.7$ $7.7 \pm 2.4$ $6.6 \pm 2.3$
- Didactic format and web-based learning (n = 12) $8.3 \pm 2.2$ $8.3 \pm 1.3$ $7.6 \pm 1.5$
- Didactic format and workshop (n = 29) $8.0 \pm 1.7$ $8.7 \pm 1.7$ $8.0 \pm 1.3$
- Blended learning (n = 13) $9.1 \pm 1.4$ $9.2 \pm 1.3$ $8.1 \pm 1.7$
- Any type with local / overseas placement (n = 13) $7.9 \pm 2.9$ $8.5 \pm 2.6$ $7.4 \pm 2.9$

$p^{\phi}$ 0.068 0.076 0.012

Footnote: $^{\psi}$independent t test, unless specified; $^#$Mann-Whitney U test; $^{\phi}$ANOVA; $\beta$, Standardized B coefficient; $^*p \leq 0.05$; $^{**}p \leq 0.01$, $^{***}p \leq 0.001$

Comparisons of attitudes toward ACP between trained and non-trained
As shown in Table 3, significant differences were noted between those with and without relevant training in the levels of agreement with 19 out of the 25 statements concerning ACP. Training was associated with perception of more facilitators and lower barriers for ACP. For example, a higher proportion of respondents who had relevant training indicated that they were comfortable with discussing end-of-life care issues with patients and their family members ($p \leq 0.001$) than their counterparts. They were more likely to disagree that “patients and their family members find end-of-life care discussion difficult or a taboo” ($p$ ranged from $\leq 0.001$–0.006), but they were less likely to be “hesitant to follow ACP documents for fear of legal liability” ($p \leq 0.001$) and considered time a barrier to conducting ACP ($p = 0.010$), compared with those without training.

By contrast, more respondents who did not have relevant training were uncertain whether “the existing ACP policy and guidelines are clear” ($p \leq 0.001$), whether their “seniors/supervisors or co-workers support them to conduct ACP” ($p \leq 0.001$), whether “patients find end-of-life care discussion taboo” ($p \leq 0.001$) and the difficulty “for patients and their family members to reach consensus on end-of-life care” ($p \leq 0.001$).
| Process | Group    | Level of agreement (%) | p   |
|---------|----------|-------------------------|-----|
|         |          | Strongly disagree/ Disagree | Unsure | Strongly agree/ Agree |
| ACP should be integrated into routine care services for patients with chronic illness. | Trained | 5.4% | 11.6% | 82.9% | .831 |
|         | Not trained | 6.7% | 13.3% | 80.0% |       |
| ACP conversation can be initiated by any health professional. | Trained | 13.2% | 13.2% | 73.6% | .063 |
|         | Not trained | 17.5% | 22.5% | 60.0% |       |
| Better not to initiate ACP unless asked by patients or their family members. | Trained | 84.5% | 7.8% | 7.8% | .013* |
|         | Not trained | 69.2% | 18.3% | 12.5% |       |
| ACP should be started early to allow time for contemplation. | Trained | 1.6% | 11.6% | 86.8% | .656 |
|         | Not trained | 3.3% | 11.7% | 85.0% |       |
| ACP should not be started before the patients’ condition worsens because their preferences may change according to the context. | Trained | 61.2% | 14.7% | 24.0% | .050* |
|         | Not trained | 45.8% | 21.7% | 32.5% |       |
| ACP is not necessary because use of life-sustaining | Trained | 88.4% | 7.0% | 4.7% | .072 |

Footnote: Chi-square test
| Group | Level of agreement (%) | \( p \) |
|-------|------------------------|--------|
|       | Strongly disagree/ Disagree | Unsure | Strongly agree/ Agree |
| treatments is a medical decision based on patients’ best interests. | Not trained | 77.5% | 14.2% | 8.3% |
| Documentati | Trained | 7.0% | 9.3% | 83.7% | .052 |
| on of ACP discussion is useful for care management. | Not trained | 5.0% | 20.0% | 75.0% |
| Outcomes | Trained | 1.6% | 1.6% | 96.9% | .193 |
| ACP is helpful to clarify patients’ goals and preferences for end-of-life care. | Not trained | 1.7% | 5.8% | 92.5% |
| ACP destroys patients or their family members’ sense of hope. | Trained | 92.2% | 1.6% | 6.2% | \( \leq .001 \)*** |
| Under no circumstance s should life-sustaining treatments be withheld or withdrawn from patients. | Not trained | 75.0% | 15.8% | 9.2% | .014* |
| It is hard for patients and/or their family members to reach consensus on end-of-life care. | Trained | 43.4% | 31.8% | 24.8% | \( \leq .001 \)*** |
| | Not trained | 21.7% | 37.5% | 40.8% |

Footnote: Chi-square test
| ACP can help to prevent disputes between health care team and family members on medical decisions. | Group | Level of agreement (%) |  |  |  |
|---|---|---|---|---|---|
| Trained | Strongly disagree/ Disagree | 2.3% | Unsure | 7.8% | Strongly agree/ Agree 89.9% |
| Not trained | 3.3% | 18.3% | 78.3% |
| ACP can help to alleviate burden on family decision makers. | Trained | 3.1% | 5.4% | 91.5% |
| Not trained | 4.2% | 21.7% | 74.2% |
| Facilitators | Trained | 6.2% | 10.9% | 82.9% |
| Not trained | 14.2% | 32.5% | 53.3% |
| I am comfortable with discussing end-of-life care issues with patients. | Trained | 6.2% | 11.6% | 82.2% |
| Not trained | 13.3% | 30.8% | 55.8% |
| My seniors/supervisors support me to conduct ACP. | Trained | 10.1% | 24.8% | 65.1% |
| Not trained | 18.3% | 55.8% | 25.8% |
| My co-workers support me to conduct ACP. | Trained | 8.5% | 31.0% | 60.5% |
| Not trained | 18.3% | 52.5% | 29.2% |
| The existing ACP policy | Trained | 23.3% | 28.7% | 48.1% |

Footnote: Chi-square test
| Barriers                                                                 | Group         | Level of agreement (%) | p        |
|----------------------------------------------------------------------|--------------|-------------------------|----------|
|                                                                      | Not trained  | Strongly disagree/      | 34.2%    |
|                                                                      |              | Disagree                | 50.8%    |
|                                                                      |              | Unsure                  | 15.0%    |
|                                                                      | Trained      | Strongly agree/         | 54.3%    |
|                                                                      |              | Agree                   | 21.7%    |
|                                                                      |              |                         | 24.0%    |
| It is difficult to determine if the patient has the mental capacity to make medical decisions. | Not trained  | Strongly disagree/      | 36.7%    |
|                                                                      |              | Disagree                | 28.3%    |
|                                                                      |              | Unsure                  | 35.0%    |
| Patients usually find end-of-life care discussion a taboo.           | Trained      | Strongly agree/         | 46.5%    |
|                                                                      |              | Agree                   | 27.9%    |
|                                                                      |              |                         | 25.6%    |
|                                                                      | Not trained  | Strongly agree/         | 42.6%    |
|                                                                      |              | Agree                   | 18.6%    |
|                                                                      |              |                         | 38.8%    |
| Patients usually find end-of-life care discussion difficult, e.g. difficult to understand the treatments or predict the future. | Not trained  | Strongly agree/         | 24.2%    |
|                                                                      |              | Agree                   | 30.0%    |
|                                                                      |              |                         | 45.8%    |
| Patients’ family members usually find end-of-life care discussion a taboo. | Trained      | Strongly agree/         | 34.9%    |
|                                                                      |              | Agree                   | 27.1%    |
|                                                                      |              |                         | 38.0%    |
|                                                                      | Not trained  | Strongly agree/         | 12.5%    |
|                                                                      |              | Agree                   | 29.2%    |
|                                                                      |              |                         | 58.3%    |
| Patients’ family members usually find end-of-life care               | Trained      | Strongly agree/         | 38.0%    |
|                                                                      |              | Agree                   | 14.7%    |
|                                                                      |              |                         | 47.3%    |
| Footnote: Chi-square test                                             |              |                         |          |
| Group                      | Level of agreement (%) |   | p         |
|----------------------------|-------------------------|---|-----------|
|                            | Strongly disagree/ Disagree | Unsure | Strongly agree/ Agree |
| Not trained                | 15.0%                   | 31.7% | 53.3%     |
| Trained                    | 60.5%                   | 18.6% | 20.9%     | ≤.001***  |
| Not trained                | 32.5%                   | 31.7% | 35.8%     |
| Trained                    | 43.4%                   | 19.4% | 37.2%     | .010*     |
| Not trained                | 26.7%                   | 32.5% | 40.8%     |

Footnote: Chi-square test

## Discussion

A secondary analysis was conducted to examine the association between healthcare professionals’ attitudes toward ACP and relevant training experience. The findings echoed previous studies that healthcare professionals with relevant training felt more comfortable, willing and confident in end-of-life care communication, although training in didactic format only appears less promising.\(^6, 7\) Compared with those without training, the trained healthcare professionals were less likely to consider time constraints, cultural taboos, and avoidance among patients and family members as hindering factors to conducting ACP. These concerns have been widely identified as the major barriers to ACP implementation in the literature.\(^2, 3, 9, 10\) The skills gained from training might enable the respondents to approach the topic and facilitate the process tactfully and effectively. Previous studies on the effects of training interventions on attitudinal changes of healthcare professionals were only concerned about shared decision-making, psychosocial care, and end-of-life care.\(^6, 8\) This study showed that training may also be associated with positive attitudes toward ACP.

Despite the attitudinal differences in relation to training experience, the study findings suggested that healthcare professionals largely have similar views about the merits of ACP and their duties to raise the conversation. They appreciated ACP as instrumental to clarify patients’ preferences and decrease decisional conflicts in surrogate decision-making. High levels of agreement were found on initiating ACP earlier in chronic illness management. The findings were consistent with previous studies that indicate
that ACP is generally agreed by healthcare professionals as necessary to prepare patients and their families for anticipated difficult decisions and that they play key roles as initiators, educators, and facilitators in ACP.\(^{3, 11}\) Given this consensus among healthcare professional regardless of the training experience and clinical background, training using an inclusive approach to enhance their preparedness would be the cornerstone of system-wide ACP implementation.\(^{12}\)

**Study strengths and limitations**

This paper addresses the knowledge gap about the association between training and healthcare professionals’ attitudes toward ACP. Although the survey included respondents with a wide range of clinical backgrounds, we acknowledged several study limitations when interpreting the study findings. First, the sample was recruited by convenience sampling. The findings could not be generalized due to the potential of participation bias. Second, the causal relationship between training and attitudes toward ACP could not be concluded due to the nature of the study and confounding variables. It is hard to determine if enrolment in training was driven by preceding positive attitude toward ACP. Third, the training experience and attitudes were based on self-reports measured by a self-developed questionnaire. Furthermore, the nature of the training varied greatly in the sample. Robust prospective studies should be conducted to examine the effects of training interventions on the attitudes and actual behaviors related to ACP of healthcare professionals.

**Conclusions**

The association between healthcare professionals’ attitudes toward ACP and relevant training experience was examined based on secondary analysis of an online survey regarding attitudes toward ACP among healthcare professionals. The findings showed that the trained healthcare professionals perceived higher level of readiness for ACP in terms of clinical relevancy, willingness and confidence, and they were less likely to consider time constraints, cultural taboos, and avoidance among patients and family members as hindering factors to conducting ACP, compared with those without training.

**Abbreviations**

ACP: Advance care planning; ANOVA: one-way analysis of variance; M: Mean; SD: Standard deviation

**Declarations**

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Authors’ contributions

All authors contributed to the study design, interpretations of results and critical revisions of the manuscript. HC drafted the manuscript. All authors approved the submitted version.

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Availability of data and materials

The dataset is available from the corresponding author on reasonable request.

Ethical approval and consent to participate

Approval for the study was granted by Survey and Behavioural Research Ethics Committee, The Chinese University of Hong Kong (Ref no.: SBRE-19-112) on 23 October 2019. Written consent from respondents was allowed to be waived to ensure anonymity.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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