How acculturation influences attitudes about advance care planning and end-of-life care among Chinese living in Taiwan, Hong Kong, Singapore, and Australia

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Background:

Understanding attitudes towards life and death issues in different cultures
is critical in end-of-life care and the uptake of advance care planning (ACP) in different countries. However, existing research suffers from a lack of cross-cultural comparisons among countries. By conducting this comparative study, we hope to achieve a clear understanding of the linkages and differences among healthcare cultures in different Chinese societies, which may serve as a reference for promoting ACP by considering cultural differences.

Methods:

Our researchers recruited Chinese adults who could communicate in Mandarin and lived in metropolitan areas in Taiwan, Hong Kong, Singapore, and Australia. Focus group interviews were conducted, and the interview contents were recorded and subjected to thematic analysis.

Results:

Between June and July 2017, 14 focus groups with 111 participants were conducted in four regions. With traditional Chinese attitudes towards death as a taboo, many participants felt it would be challenging to discuss ACP with elderly family members. Most participants also desire to avoid suffering for the self and family members. Although the four regions' participants shared a similar Chinese cultural context, significant regional
differences were found in the occasions at which participants would engage in end-of-life discussions and select settings for end-of-life care. By contrast, participants from Singapore and Australia exhibited more open attitudes. Most participants from Taiwan and Hong Kong showed a preference for end-of-life care at a hospital.

Conclusions:

The developmental experiences of ACP in Western countries, which place a strong emphasis on individual autonomy, cannot be directly applied to family-centric Asian ones. Healthcare professionals in Asian societies should make continuous efforts to communicate patient status to patients and their family members to ensure family involvement in decision-making processes.

Key words: Advance care planning, Culture, Cross Culture Research

Background The concepts of end-of-life care and advance care planning (ACP) were developed in Europe and the United States, and most related research has been conducted in Western countries. As vast differences exist between family-centric Asian cultures and Western cultures, which place strong emphasis on individual autonomy, the developmental experiences of Western countries cannot be directly applied to Asian ones [1]. In fact, family decisions usually take precedence over individual decisions in...
the medical decision-making processes of Asian patients [1]. The ACP process involves several steps, including medical decision-making and end-of-life discussions, which are in line with the traditional disease and healthcare beliefs of European Americans. However, this process conflicts with the tradition of family involvement in medical decision-making among Asians, leading to difficulties in the uptake of ACP [2, 3].

In traditional Chinese culture, the discussion of death is considered a cultural taboo [4]. Even among the geographically proximate countries of South Korea, Japan, and Taiwan, where traditional Eastern cultures are dominant, significant differences exist in attitudes towards end-of-life care due to differences in traditional cultures, values, the proportions of religious groups, and governmental interventions [5]. People with the same cultural background may change their views regarding end-of-life care after migrating to other countries due to the influence of factors such as social values and language barriers. Bito et al. conducted focus groups with English-speaking Japanese Americans, Japanese-speaking Japanese Americans, and Japanese living in Japan and compared end-of-life care and palliative care services [6]. In terms of presenting bad news, the Japanese participants had faced fewer situations of bad news disclosure. The preferred decision-making models of all three groups involved family members as participants or main decision-makers, but English-speaking Japanese Americans regarded individual participation and opinion expression as a critical component.
Similarly, Matsumura et al. reported that English-speaking Japanese Americans had more positive attitudes towards forgoing care, ACP, and autonomous decision-making [7].

The understanding of attitudes towards life and death issues in different cultures is a key concept in end-of-life care. Lin analysed the pursuit of the meaning of end of life among Chinese immigrants in the U.S. and concluded that the understanding of patients’ values towards life and death is greatly beneficial to the provision of appropriate cross-cultural nursing care [8]. This is consistent with the findings of a study by Sinclair et al. [9], who reported that respect for and understanding of cultural backgrounds and the provision of appropriate information for decision-making constitute the first steps in discussing end-of-life issues among migrant groups. An effective ACP program includes repeated interactive discussion sessions, decision aids, and interventions targeting multiple stakeholders, which are closely associated with the local socio-cultural environment and health system [10].

Many studies have shown that cultural barriers pose the greatest challenge to the uptake of ACP in Asian countries [11-13]. However, the existing research suffers from a lack of cross-cultural comparisons among countries. This leads to difficulties in understanding cultural contexts and their subtle influences on the popularisation of ACP [14, 15]. By conducting this comparative study, we hope to achieve a clear
understanding of the linkages and differences among healthcare cultures in different Chinese societies, which may serve as a reference for the promotion of ACP in other countries.

Methods

The study participants were Chinese adults who could communicate in Mandarin and lived in metropolitan areas in Taiwan, Hong Kong, Singapore, and Australia. Participant recruitment and focus group interviews in the four regions were conducted by three researchers. Each focus group, which involved 8–10 participants and lasted for 1.5–2 hours, was led by researchers using a semi-structured interview guide.

Analytical methods

The interview contents were recorded, transcribed, and subjected to thematic analysis. All participant data were delinked to ensure anonymity. The transcripts were read multiple times, and meaningful content was marked for inductive analysis and identification of key themes by two researchers.

Results

Between June and July 2017, 14 focus groups with a total of 111 participants were
conducted in Taiwan, Singapore, Hong Kong, and Australia (Table 1). The findings from the focus groups are summarised in Table 2.

Table 1. Description of the Four Focus Group Samples

|                          | Taiwan | Hong Kong | Singapore | Australia |
|--------------------------|--------|-----------|-----------|-----------|
| Proportion of Chinese in population (%) | 99     | 92*       | 76.2**    | 5.6       |
| Number of focus groups   | 8      | 2         | 2         | 2         |
| Number of participants   | 59     | 18        | 17        | 17        |
| Gender of focus groups (female, %) | 42(71.1) | 10(55.5) | 11(64.7) | 12(70.5) |

* 2016 Population By-census – Summary Results (Report). Census and Statistics Department. February 2016. p. 37.
** “2014 Population in Brief” Archived from the original on 13 May 2015.

People with whom the participants wished to discuss ACP for themselves

In general, the participants from the various regions wished to discuss issues regarding their acceptance of end-of-life care with their family members. The majority of participants would engage in discussions with their children; a small number indicated that they would discuss it with their spouses, but almost none of the participants mentioned their intention to discuss it with their elderly family members. In particular, participants from Taiwan frequently mentioned the need to obtain the opinions of
doctors or healthcare professionals before discussing it with their family members, which demonstrates the difference in the degree of respect towards and reliance on healthcare professionals between Taiwan and other regions.

'I often tell my daughter that I do not wish to receive interventions at the end of life. I have already told my daughter about my desired arrangements after death, as my daughter is also an open person.' (Participant HK5 from Hong Kong)

'Nowadays, I tell them [my children] about my healthcare wishes for the future, I think that radiotherapy and chemotherapy are a waste of resources and will impose a mental burden on them. I hope they will respect my wishes.' (Participant S4 from Singapore)

'The doctor is professional, so he knows how severe your condition is and what kinds of treatment you will need. I will discuss with the doctor; I think I need to consult a professional before compromising with my children.' (Participant TC2 from Taiwan)

People with whom the participants wished to discuss ACP for elderly family members

With traditional Chinese attitudes towards death such as ‘death is a taboo subject’ and ‘death is ominous’, many participants felt that it would be difficult to discuss ACP with elderly family members. The participants tended to rely on the traditional Chinese concept of ‘men are superior to women’. Therefore, certain participants expressed the view that they would
ask a male relative, which is usually the eldest son, to assume the responsibility.

'I said, “You should tell our elder brother and not just tell me, because this should be known to everyone, not just me.’ Before my father passed away, I was the one taking care of him, and he had already told me everything regarding his end-of-life matters. My mum and elder brother are still around, I have an elder sister too...and a younger brother. You know, men are considered superior in Chinese culture, I said that I have no right to express my opinion.’ (Participant S1 from Singapore)

Occasions at which participants would discuss end-of-life care with their family members

Although the participants from the four regions shared a similar Chinese cultural context, significant regional differences were found in the occasions at which participants would engage in end-of-life discussions. Participants in Taiwan were inclined towards specific occasions to initiate such discussions. These occasions included the following: becoming aware that someone they know had a serious health condition, coming across a discussion of a related topic on a television program, or after seeing a cemetery advertisement during a trip. Participants in Hong Kong expressed similar views about the necessity of specific occasions. It was mentioned that people usually made use of family gatherings to initiate discussions with their children through indirect methods such as reflection or hinting when the care situations of other relatives were being discussed.
‘When I saw that on TV, I said, “Don’t do that in the future.” I told him that because I happened to see it on TV.

Such issues cannot be directly discussed as it will make everyone uncomfortable.’ (Participant TC8 from Taiwan)

‘In Hong Kong, it is inevitable that multiple generations live together, so it is more appropriate [to discuss] at family gatherings or when everybody comes back for a meal. There are not many occasions to talk about such matters out of the blue. Most of the time, the conversation is about having a patient at home, or someone saw a great-uncle in a bad condition [referring to the end-of-life care situation] ...these are occasions to initiate discussion.’ (Participant HK2 from Hong Kong)

By contrast, participants from Singapore and Australia exhibited significantly more open attitudes. They were willing to engage in end-of-life discussions at any occasion, e.g. during hospitalisation or everyday life at home.

‘I think it is more appropriate to discuss with your family during everyday life, because you won’t know when you will encounter such a situation. Sometimes when you sit down and chat with your family members, you can discuss such issues. Nowadays, people have fewer children, so it will not be troublesome. With direct communication, all family members will have the same understanding.’ (Participant S2 from Singapore)

‘Of course, we have already discussed it at home, this is something that must be done. It can be discussed during mealtime or at any time.’ (Participant A1 from Australia)
In fact, once the discussion about ACP had been initiated, the reactions of the participants’ family members did not differ among the various regions. Additionally, the majority of elderly or junior family members involved in the discussion did not view the topic as taboo, which was contrary to expectations.

‘No, children nowadays don’t view it as taboo, we have to tell them that this is our own affair; it should not be difficult to discuss our own affair.’ (Participant TC12 from Taiwan)

‘On one occasion, I was having tea with my mum and aunt, and I started to talk about it. Actually, the mood during the discussion was great and I realised that all three elderly family members had their own wishes. However, the mood should not be too sombre during the discussion.’ (Participant HK3 from Hong Kong)

**Desired medical treatments towards the end of life**

The participants from the various regions were inclined towards receiving palliative and supportive care for the reduction of pain and increase of physical comfort towards the end of life. They were not receptive to life-sustaining treatments that prolonged the near-death process, including intubation, defibrillation, and cardiac massage, as they felt that such treatments not only increase the pain of the patient but also cause distress for their relatives.

‘If I have terminal cancer, I will be concerned about the dying process. I will make it clear that I will not accept invasive treatments even when I become unconscious. I will let my husband and children know my desired arrangements before dying as those treatments are meaningless.’ (Participant T6 from Taiwan)
‘I told my husband that I do not wish to be resuscitated when life reaches the stage where I become unaware and unconscious, as it is meaningless and prolongs suffering; it puts a burden on my family and makes them suffer too.’ (Participant HK5 from Hong Kong)

Selection of setting for end-of-life care

Differences in opinion regarding the setting for end-of-life care existed among the participants from different regions. Participants from Singapore had divided opinions, with some showing a preference for end-of-life care at home due to the visitor restrictions at hospitals and the inconvenience of travelling back and forth from the hospital for their family members. Other participants preferred to pass away in a hospital or hospice care unit in view of the lack of healthcare professionals and medical equipment at home, the complicated process of filing out a death certificate for a home death, and negative emotions such as fear and a sense of loss that may arise in young children.

‘Only four visitors are allowed in the hospital ward, so if the patient has visitors, she [the nurse] will tell you that there are visitors waiting downstairs. Those visitors will have to wait for their turn to visit, which is very inconvenient. There are no visitor restrictions if the patient is at home, and the visitors can be at ease when they visit.’ (Participant S5 from Singapore)

‘There’s a sense of belonging at home, but you may have to consider the sense of emptiness that your family members will experience after you pass on, the need to call a doctor to examine the body, post-death
arrangements…there are many complicated matters, so I don’t want to pass away at home.' (Participant S8 from Singapore)

Most participants from Taiwan and Hong Kong showed a preference for end-of-life care at a hospital, with the reasons differing between the regions. Participants from Hong Kong stated that although public hospitals offered the advantage of lower cost compared to private hospitals, the length of the hospital stay was also restricted. In addition, family members would have to bear the additional cost of bed reservation at a nursing home during the hospitalisation period. Some participants preferred at-home care by a domestic helper if circumstances permitted; however, they would opt to seek medical treatment and pass away in a hospital setting in case of an emergency, as the process for filing out a death certificate for a home death is relatively complicated. Participants from Taiwan preferred end-of-life care by a palliative care team at a hospital as they trusted hospice care personnel and did not wish to increase the burden on their children.

‘Hospitals will provide the evidence of death so that you can obtain the certificate of death. If someone passes away at home, there are more troublesome matters to deal with. When my uncle died, the certificate of death was only issued one month later; his family members had to go to court and seek a lawyer; it’s very troublesome…’ (Participant HK3 from Hong Kong)
Discussion

Chinese societies place great emphasis on group and family decision-making. In situations where decision-making is required for end-of-life care, personal autonomy and self-determination do not take precedence; instead, there is a strong reliance on doctors and family members, and authoritative healthcare experts are usually entrusted with the final say. In this study, participants from Taiwan expressed the belief that the professional opinions of doctors had to be sought before discussing ACP with their family members. Participants from other regions also indicated the need to discuss it with their children and spouses before making a decision, which is consistent with the results of previous studies that investigated the differences in end-of-life care decision-making processes between U.S. and Asian populations [16, 17]. In a study by Chu et al. [18] on 2,878 hospitalised patients eligible for ACP, it was found that the participation of healthcare professionals in ACP discussions was a key factor for the completion of advance directives in the subject, and the participation of family members was a key factor for end-of-life care decision-making. These findings are highly consistent with the results of the present study.

The concepts of high-context cultures (HCs) and low-context cultures (LCs), which were introduced by the anthropologist Edward T. Hall in 1959, can be used for the systematic classification of cultures [19]. Within HCs, the interpretation of messages
relies on cues arising from cause-effect relationships. Members rely heavily on non-verbal cues (body language, silence, facial expressions, etc.) when communicating with others, utilise indirect and roundabout methods in their thinking processes and conveyance of information, and interact with each other under the influence of their relationships. By contrast, members of LCs utilise clear, direct spoken and written words for communicating and conveying messages, and tend to emphasise logic and argumentation [19]. The cultural contexts of countries are not absolutely high or low but relative to those of other nations. For instance, countries in the East generally have HCs compared with Western countries. In the present study, participants from Hong Kong and Taiwan were inclined towards the utilisation of specific occasions and scenarios for the initiation of end-of-life care discussions, whereas participants from Singapore and Australia did not exhibit such an inclination. This is consistent with the findings of Chen and Wang (2013) [20], who found that compared with countries with a Western culture, countries with an Eastern culture or a blend of Eastern and Western cultures were inclined towards the communication styles of HCs, which involve the utilisation of contexts, cause-effect relationships, and other metaphorical methods to interpret conveyed messages. By contrast, countries with a Western culture were inclined towards the communication styles of LCs, which involve the direct communication of arguments. Among the four regions investigated in this study,
Taiwan and Hong Kong have predominantly Chinese societies. Participants from these two regions indicated that they would initiate ACP discussions by utilising similar situations faced by others or appropriate opportunities (such as changes in circumstances) to subtly express their wishes regarding end-of-life care, which is consistent with the indirect communication methods of the HCs in Eastern countries.

In Singapore and Australia, which have been influenced by Western cultures to a greater extent, the participants indicated that they would utilise direct conversations to discuss their wishes regarding end-of-life care with their family members, which is in line with the direct communication styles of the LCs in Western countries. Therefore, our findings provide a clear explanation of the differences in communication contexts among different regions [21].

In recent years, high-quality end-of-life care has received increasing attention due to the issue of global aging. Participants from various regions had different considerations when selecting the desired setting for end-of-life care, which included family financial status, social benefits and public health insurance, the need for professional healthcare, the feelings of family members, and the convenience of family visitation. Gomes and Higginson (2006) [22] reported that medium or high social class and living with relatives were key influencing factors of the selection of home care in terminally ill patients with cancer. In addition, communication and coordination among family
members [23] and the degree of complexity of the caregiving [24] also influenced the choice of setting for end-of-life care.

Conclusion

On the whole, the message conveyed by individuals in a Chinese cultural context regarding end-of-life decision-making is the desire to avoid suffering for the self and family members. In Chinese societies, parents usually provide unconditional support for their children and hope to ease their financial and emotional burdens. Therefore, they are less concerned about their own well-being and would rather prioritise the enhancement of their family members’ well-being. When selecting end-of-life care programs or care settings, such individuals will wittingly or unwittingly convey the following message: ‘I can receive care in any setting as long as it is convenient for my family.’ In other words, the desire to avoid inconveniencing their family members takes precedence over their own wishes. Healthcare professionals in family-centric societies should make continuous efforts to communicate patient status to patients and their family members to ensure family involvement in decision-making processes, so as to alleviate patient distress [25].

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Abbreviations

ACP  Advance Care Planning
LCs  low-context cultures
HCs  high-context cultures

Authors’ contributions

All authors contributed to the study conception and design. Material preparation, data collection, and analysis were performed by Ying-wei Wang, Jyh-Gang Hsieh. The first draft of the manuscript was written by Fu-Ming Chiang, and all authors commented on previous versions of the manuscript. All authors have read and approved the final manuscript.

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Availability of data and materials

Not available due to ethical regulations.
Ethics approval and consent to participate

The study was reviewed and approved by the Research Ethics Committee of the Hualien Tzu Chi Hospital, Buddhist Tzu Chi Medical Foundation (#IRB105-32-B). Each participant received written information about the research project in advance and provided informed consent before the focus groups were conducted.

Consent for publication

Not applicable

Competing interests

The authors declare that they have no conflicts of interest.

Footnotes

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| People with whom participants wished to discuss ACP ("who") | Taiwan | Hong Kong | Australia | Singapore |
|----------------------------------------------------------|--------|-----------|-----------|-----------|
| Participants were inclined to rely on healthcare professionals. The opinions of a doctor had to be sought before discussion with family members. | Participants wished to express their wishes to their family members and spouses during everyday life. At the end of life, prolongation of life was no longer important as the high costs of nursing care and medical treatment, limited hospital bed availability, and the wish to lighten the economic and mental burden of family members would take precedence. | Participants mainly wished to discuss ACP with their children, close family members and spouses. To avoid bringing trouble to their children, most participants had already completed their legal paperwork or were planning to do so with a lawyer or insurance company. The open attitudes of participants, which included a clear emphasis on the self and respecting each family member as an independent person, were significantly different from the attitudes of people from predominantly Chinese societies. | Governmental policies support the active promotion of will-making and implementation of ACP. Participants wished to discuss it with their relatives (spouses, children) as they had experiences with sudden deaths and did not wish to cause trouble for the younger generation. |

| Setting for ACP discussion ("where") | Medical institutions, outpatient clinics | The discussion could be held anywhere with no restrictions on the type of setting | The discussion could be held anywhere with no restrictions on the type of setting | The discussion could be held anywhere with no restrictions on the type of setting |
|------------------------------------|----------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|

| Occasion for initiating ACP discussion ("when") | Occasions such as chancing upon related scenes in television programs, passing by places of religious worship, broadcasting of related news reports on audio-visual media, and experiencing certain physical symptoms may be utilised for the initiation of ACP discussion | Participant was still in good health; certain occasions are utilised for initiating ACP discussion, such as family gatherings (with avoidance of festivals and birthday celebrations) or when other family members fall sick | Participant was still in good health; the topic of ACP can be brought up naturally during everyday conversations or when participant is admitted to a long-term care facility or diagnosed with a terminal illness | The attitudes of participants were significantly more open. ACP discussion may be held at any occasion, e.g. during hospitalisation or during everyday life at home |

| Content of ACP discussion ("what") | *End-of-life medical treatments -Participants were inclined towards receiving palliative and supportive care for the reduction of pain and increase of physical comfort | *End-of-life medical treatments -Participants were inclined towards receiving palliative and supportive care for the reduction of pain and increase of physical comfort | *End-of-life medical treatments -Participants were inclined towards receiving palliative and supportive care for the reduction of pain and increase of physical comfort | *End-of-life medical treatments -Participants were inclined towards receiving palliative and supportive care for the reduction of pain and increase of physical comfort |
|-----------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|

*Setting for end-of-life care
Table 2. Discussion Areas for Different Perceptions of Advance Care Planning among Chinese Living in Four Regions

| Method of ACP discussion (‘how’) | Similar situations faced by others could be used to initiate the subtle expression of wishes regarding end-of-life care | Participants were inclined to seek appropriate opportunities (e.g. changes in circumstances) to initiate discussion with family members during family gatherings | Participants would be able to receive insurance pay-outs regardless of care at a hospital or at home due to long-term care benefits and robustness of healthcare schemes | - At home: visitor restrictions at hospitals, increased convenience for relatives, related childhood experiences - In a hospital/hospice facility: availability of medical equipment, ease of filing death certificate, family members will not experience fear at home |

| of physical comfort | *Setting for end-of-life care Participants preferred end-of-life care by a palliative care team at a hospital as they trusted the professionalism of hospice care personnel and did not wish to increase the burden on their children. | *Setting for end-of-life care Participants preferred end-of-care life at home but would opt to pass away in a hospital as the process for filing a death certificate when death occurs at home is complicated. | At home: visitor restrictions at hospitals, increased convenience for relatives, related childhood experiences - In a hospital/hospice facility: availability of medical equipment, ease of filing death certificate, family members will not experience fear at home |