



# A Confluence of Cultures: Advance Care Planning in Long-Term Care Settings

RESEARCH

SHIMAE SOHEILIPOUR 

KATRINA JANG 

BRIAN DE VRIES 

HELEN KWAN

GLORIA GUTMAN 

\*Author affiliations can be found in the back matter of this article



## ABSTRACT

**Context:** While policies may promote Advance Care Planning (ACP) discussions in long-term care (LTC) settings, practices often result in outcomes different from residents' wishes. We attribute this to a confluence of cultures: healthcare; LTC settings; mainstream societal; and individuals' ethno-cultures. This research explores these cultures as reflected in focus group discussions conducted with residents and family-of-residents in two LTC homes: one exclusively Chinese (EC); one multicultural (MC).

**Method:** Fourteen residents and 13 family members participated in the four focus groups. Discussions were audio-recorded, transcribed, and themes were extracted and compared.

**Results:** Four themes characterized residents' discussions: 1-Variations in Range/Type of ACP Discussions/Actions; 2-Care of Family; 3-Reliance on Staff; and 4-Quality-of-Life at End-of-Life. Exclusively Chinese residents expressed reluctance to speak about ACP, were more likely to state "family would handle it," less likely to call upon staff, and more acquiescent concerning death. Multicultural residents were more likely to pejoratively mention pull or absence of family and reliance upon staff; also, wanting personal awareness and control at end-of-life. Family themes were 1-Timing/Focus of ACP Discussions, 2-Communication with Family, 3-Care Home and Staff Influences, and 4-Cultural and Religious Issues. Exclusively Chinese families spoke of need to involve family in ACP discussions inclusive of residents and of Chinese cultural influences on ACP. Multicultural families reported being "taken by surprise" and feeling "overwhelmed" by requests to engage in ACP and document completion on behalf of residents.

**Conclusion:** Findings provide evidence of multiple cultural influences on ACP in LTC but existing institutional policies and practices offer little direction and support on how to balance/prioritize them. Our analyses may provide a starting point.

## CORRESPONDING AUTHOR:

**Shimae Soheilipour, D.D.S,  
Ph.D.**

Gerontology Research Centre,  
Simon Fraser University  
Vancouver Campus, #2800-515  
W Hastings Street, Vancouver,  
BC, Canada V6B 5K3, CA  
shimae\_soheilipour@sfu.ca

## KEYWORDS:

Advanced Care Planning;  
Ethnicity; Culture; Long-term  
care

## TO CITE THIS ARTICLE:

Soheilipour, S, Jang, K, de  
Vries, B, Kwan, H and Gutman,  
G. 2023. A Confluence of  
Cultures: Advance Care  
Planning in Long-Term Care  
Settings. *Journal of Long-Term  
Care*, (2023), pp. 120–134. DOI:  
[https://doi.org/10.31389/  
jltc.203](https://doi.org/10.31389/jltc.203)

## INTRODUCTION

Advance Care Planning (ACP) 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 ACP is to help ensure that people receive medical care, during serious and chronic illnesses, that is consistent with their values, goals, and preferences (Sudore et al., 2017). “Values, goals, and preferences” are also hallmarks of culture, which Kagawa Singer et al. (2016, p. 6) define as “an internalized and shared schema or framework used by a group to see and experience the world ... and to provide individual and communal meaning for and in life.” Even as these two constructs—ACP and culture—make explicit reference to many of the same constituent components, their relationship, that is, the role that culture plays in ACP is often noted but rarely explicated.

This lack of explication may be a consequence of the complexity of the domain(s), as the process of ACP involves multiple sociocultural realms. Kagawa Singer et al. (2016) previewed this in their Delphi Process project describing a multidisciplinary effort to describe how cultural processes influence health and health behavioral research. They offer a model of intersecting cultural influences on health research that includes: the individual and group of focus, the culture of science, the culture of the researcher/practitioner, and the larger cultural context.

Despite the need and potential efficacy of ACP in long-term care (LTC) facilities, there is low uptake by residents (Martin et al., 2016; Weathers et al., 2016). Cross-country comparisons have also shown that the majority of residents do not have advanced directives (Mignani et al., 2017). Within LTC facilities themselves, few staff members report engagement in ACP (Gilissen et al., 2017), which Checkland et al. (2007) suggest may reflect the influence of contextual and systemic factors that impact the practical implementation of ACP. Research in western countries also indicates that ACP discussion and document completion is consistently lower among ethnic and racial minorities compared to their White counterparts (Harrison et al., 2016; Kale et al., 2016).

The model shown in Figure 1, inspired by the work of Kagawa Singer et al. (2016) underpins our exploration of ACP in two LTC facilities in Canada, one multicultural and the other exclusively Chinese. We adapted the model to characterize the intersecting cultural influences on ACP in LTC explored herein. The four key components of the cultural influences explored in this research are described below, each with relevant literature, both general and with particular reference to the Chinese cultural context.

### THE CULTURE OF THE INDIVIDUAL AND END OF LIFE (EOL)

There are multiple starting points for an analysis of the overlapping circles in the model, perhaps most central,

considering individuals themselves. Individuals have a personal, and familial cultural identity that informs (either implicitly or explicitly) how they live and how they die. An individual’s personal cultural values such as those due to ethnicity strongly influence attitudes, values, and behaviors (Bülow et al., 2008), perhaps most strongly in later life and at end of life. This personal individual cultural identity necessarily informs decisions about treatments and interventions at EOL—and their discussion and with whom. This may include their loved ones, their families, and the healthcare providers they interact with each of whom has a personal culture—including potential discrepant views on EOL treatment, care, and wishes.

For many Chinese, and particularly older adults, cultural values are based on Confucian principles with a variety of implications for later and end of life (Bowman & Hui, 2000). One such central principle is filial piety, obligating children to respect their parents, elders, and ancestors—which is largely shown through care provision. Placement of a loved one in a nursing home may be seen as an abdication of duty and a source of shame (Smith and Hung, 2012).

Li (2013) notes that allowing a parent to die (e.g., by denying potentially life-saving interventions or by not encouraging every possible intervention to save a parent) may also be seen as violating filial piety. In addition, ACP is challenged by the general Chinese cultural taboo concerning discussions about EOL and death, which may be especially upsetting to older generations of a family (Lee et al., 2017). Even though death is seen as a natural part of life, it is believed that talking about death will upset harmony (Li, 2013). Thus, children and caregivers may be expected to do all they can to preserve life, at any cost. Discussions of death may be seen as wishing death upon the person and/or giving up hope and hastening the death process (Muller & Desmond, 1992; Chan et al., 2019).

Perhaps consequently, Lee et al. (2017) note a lack of understanding about ACP, with Chinese older adults or their families sometimes confusing it with making a will, making funeral arrangements, or even euthanasia. Zivkovic (2018) reported that participants in their research felt that completing ACP “foreclosed their future.” ACP was seen as a closing-off of choice; participants reported that they did not complete ACPs because they could not predict the future and would not know what they wanted until they experienced/lived it.

Furthermore, a lack of Chinese equivalent of terms to describe palliative care and hospice emphasizes a need for culturally sensitive translation that addresses EOL care concepts, rather than direct translation (Con, 2008; Feser & Bon Bernard, 2003).

### THE LARGER MAINSTREAM SOCIETAL CULTURE AND EOL

Discussions, decisions, and behaviors pertaining to EOL are influenced by the larger mainstream societal culture

within which the individual and their family is embedded. In some instances, the larger societal culture overlaps substantially with the individual's cultural identity with congruent values and behaviors; in other instances, the overlap may be modest. Such variations in overlap may be associated with support for, or challenges to, approaches to EOL care. Furthermore, through the process of mainstream acculturation individuals may adopt practices, values, and social connections of the culture they are living in, while still retaining their own culture (Berry, 1997). Consequently, through connection to the new environment people may change their views regarding EOL care after migrating (McDermott & Selman, 2018; Jia et al., 2020).

Historically, Canadians have been strongly influenced by European culture and traditions, especially those of the United Kingdom and France, and those of the neighboring United States (Loue & Sajatovic, 2011). Over time, Canada has become increasingly multicultural; in fact, Canada was the first country in the world to adopt a formal policy of multiculturalism when then Prime Minister Pierre Trudeau (in 1971) proclaimed that “although there are two official languages, there is no official culture” (Jedwab, 2020). More recently, in a *New York Times Magazine* interview, Prime Minister Justin Trudeau described Canada as “the first post-national state” claiming that there “is no core identity, no mainstream in Canada. There are shared values—openness, respect, compassion, willingness to work hard, to be there for each other, to search for equality and justice” (Lawson, 2015, para. 46).

In the context of EOL, and notwithstanding the passing of progressive legislation such as the Medical Assistance in Dying Act (MAiD), the Western and North American ambivalence about death is still present in the Canadian context. The passing of MAiD also demonstrates the importance of Western values of individualism and the promotion of autonomous decision-making in ACP as a means of upholding patient autonomy in EOL care (Johnstone & Kanitsaki, 2009; Bowman, 2004). The adoption of Western values and ethics also depends on the level of acculturation of the individual, which may influence their comfort towards discussing EOL care (Vancouver Coastal Health Research Institute, 2022).

Perhaps accordingly, knowledge concerning ACP is spotty. For example, in a Canadian Hospice and Palliative Care Association (2013) survey, when asked, unaided, if they had heard of the term “Advance Care Planning,” only 21% indicated that they had; after a definition was provided, 47% reported that they knew about it. The survey also found that although most thought EOL planning was important, less than half had engaged in ACP conversations with another person and many reported not thinking about EOL at all. Experience mediated some of these findings. For example, those who had experiences with EOL care and/or had lost a family member in the previous 10 years were more knowledgeable about ACP and had at least partially engaged in the process.

## THE CULTURE OF HEALTHCARE AND EOL

Healthcare, too, has a culture, which it inculcates in its professionals. The origins of many of the elements of healthcare systems, such as exist in Canada today, are grounded in a predominantly Western medico-centric culture (Beavis et al., 2015). This culture which focuses mostly on treatment of objective disease symptoms (Pffifferling, 1981; Loustaunau & Sobo, 1997), informs how healthcare professionals engage with others, particularly “patients” and influences how health and illness are viewed, assessed, and treated. This is perhaps most strongly noted at times of health crises and particularly EOL—shaping how it is seen, interpreted, and contemplated.

The values of compassion and equality are central to the country's health care system which promotes “universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay” (Government of Canada, 2019, para. 1). The healthcare culture assumes the values of beneficence and non-maleficence and adheres to the Hippocratic Oath (Shanafelt et al., 2019). At the center of the Canadian healthcare system is the physician-patient relationship. Lower rates of discussion with physicians about treatment preferences among ethnic minorities have been noted (Sinclair et al. 2014; Yarnell et al. 2020). Also, while involving other healthcare professionals in ACP conversation is encouraged (Bergenholtz et al., 2019; Tan et al., 2019), there is limited research on ACP processes from the perspective of interprofessional team members (Arnett et al., 2016) and concerning differences in the extent to which they engage in ACP with minority compared to mainstream older adults.

## THE CULTURE OF LTC AND EOL (THE INSTITUTION)

The above cultural influences necessarily intersect with the culture of LTC, specifically, LTC facilities. The culture of the LTC sector includes stakeholders such as family and/or care councils, healthcare staff, legislators, and lawmakers, and is shaped through regulations, and healthcare spending.

Despite the increasing diversity of residents' ethno-cultural and linguistic backgrounds, the vast majority of LTC homes in Canada continue to be run in accordance with Euro-Canadian norms and values. Most do not meet the cultural, spiritual, and linguistic needs of many immigrant residents, particularly those from racialized, predominantly non-English speaking populations, including those from one of Canada's largest immigrant source countries: China (Koehn et al., 2016).

## The Present Study

We conducted a qualitative study with four groups, two in each of two facilities. In one facility, the resident population was exclusively Chinese and, in the other, residents had a variety of ethnicities, reflecting the community in which it is located. In each

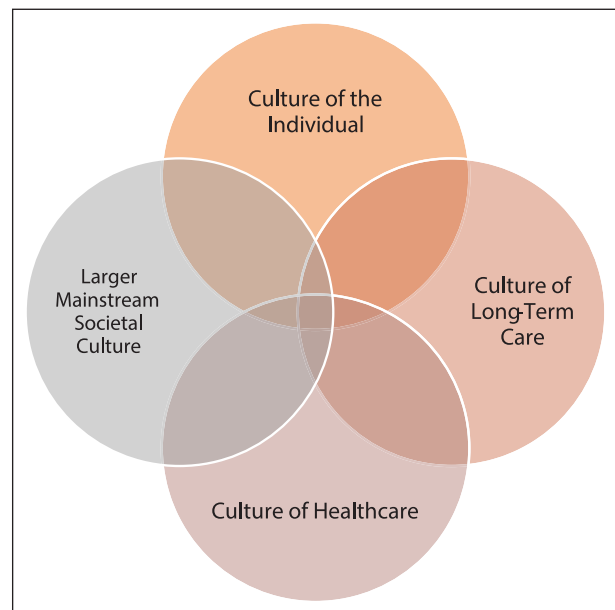
facility, one focus group comprised residents and the other family members, with participants in the two groups not necessarily related to each other. Still, we attempt to highlight in our comparisons some of the intergenerational incongruities encircling EOL.

While policies may promote ACP and EOL discussions in LTC settings, practices often result in outcomes different from residents' wishes. We propose that such outcomes result from a complex confluence of cultures including: healthcare culture, Western culture—with its own unsettled relationship to death, LTC culture with its often conflicting scope of practice perceptions of staff and others (Gutman et al, 2020), and individual cultures of residents, families, and staff (e.g. ethnic culture). The research described here explores the manifestations of these cultures in LTC settings as reflected in focus group discussions about ACP, comparing views and opinions of residents and families-of-residents across the two participating facilities. One objective in doing so was to identify differences that if understood and addressed, might assist LTC facilities to develop policies and programs that would bridge gaps between residents and their families with respect to engagement in ACP. We also expected that there would be differences between the homogeneous milieu of the exclusively Chinese facility and the more westernized multicultural facility that would have implications for the design of ACP-related policies and programs.

## METHOD

A qualitative study consisting of four focus groups was conducted to explore the influence of the intersecting cultures shown in Figure 1 on ACP engagement. Qualitative methods were chosen as the aim was to understand perspectives, motivations, and frames of reference from the lived experience of participants and generate new ways of perceiving or understanding the social phenomenon of interest (Austin et al., 2014). Focus group data are unique in that they offer both what one might expect from more open-ended qualitative interviews as well as cross talk, elaboration (and challenge) of ideas, and natural discussion of principles, values, and ideologies—often with a particular (cultural) group emphasis (Kitzinger, 1994). This is of particular relevance in this research, where the culture of patients or their family members could influence their approach toward ACP and its acceptance at the end of life. Our previous research has effectively incorporated focus group methodology in discussions of ACP (de Vries et al., 2019).

Respondents were recruited from two care homes which were chosen to provide access to different cultural milieus; one exclusively Chinese (EC); the other multicultural (MC) and with a more westernized



**Figure 1** Intersection of Cultures in LTC Settings (Adapted from Kagawa Singer et al., 2016).

orientation. In each home, separate focus groups were conducted with residents and with families of residents. Respondents in the family group were not necessarily related to those who participated in the resident focus group.

The EC care home is operated by a non-partisan, not-for-profit, multi-service, multicultural organization with service locations in Canada and Asia. It offers multiple levels of care to 114 residents (all but one of whom is Chinese) provided by bilingual staff; it is located in a primarily Chinese, downtown section of the city. The ME facility is owned and operated by a large senior living corporation with care homes across North America and England. Currently, the ME home offers long-term care to 108 residents with the cultural distribution of residents, families and staff reflecting the primary cultural groups of the diverse population of the greater Vancouver area: Chinese, South Asian (primarily East Indian), and Caucasian (Statistics Canada, 2017).

The Principal Investigator (PI) shared study materials approved by the Simon Fraser University Research Ethics Board with the Directors of Care in each home. After reviewing the materials and discussing logistics, the PI introduced the study to key staff members and family council representatives. Prospective participants volunteered for the study by contacting the researchers or facility staff. Before starting the focus groups, participants completed short personal profile surveys to gather demographic information and their experiences and knowledge of end-of-life care and advance care planning discussions within the care home.

The focus group discussions were guided by open-ended questions (Table 1) designed to elicit in-depth responses about their understanding, experiences, and perceptions of ACP.

1.	What do you think about the idea of ACP?
2.	What does this facility do to support ACP discussions?
3.	What discussions have you had with staff since you (your family member) moved in about things related to end-of-life and your/their values and wishes?
4.	What discussions have you had with your family member about your (their) end-of-life?
5.	Have you witnessed other deaths at this facility?
6.	What are your fears and worries about discussing your (family member's) advance care plan?
7.	How would you feel about having this type of discussion with your family member?
8.	How would you feel about having this type of discussion with a staff member?
9.	Is there anything else you would like to add?

**Table 1** Focus Group Discussion Guide for Residents/family members.

The focus groups occurred in February 2018 and were held in a designated room provided by the Director of Care/Administrator of each home. The Principal Investigator (PI) conducted all the focus groups. For the resident focus group in the EC home, a social worker was present to provide a translation into Chinese. The same social worker and a Chinese-speaking research assistant assisted with the families' focus group. A bilingual research assistant took notes and transcribed the audio recordings. In the ME home, the focus groups were conducted in English, and a research assistant was present to transcribe the recordings. Each focus group session lasted approximately one hour, resulting in four recordings in total.

### CODING OF FOCUS GROUP TRANSCRIPTS

The focus group transcripts were analyzed using thematic analysis (Braun & Clarke, 2012). Multiple coders reviewed the transcripts to identify consistent topics and codes. The codes were then organized into categories and then further grouped into overarching themes, to reflect the content's meaning.

## RESULTS

Descriptive quantitative data were collected on the participant profiles; the data presented below provide context to the primary qualitative data analysis which follows. The qualitative analysis addresses both the similarities as well as differences in the themes expressed by the Multicultural LTC residents (MCR) and the Exclusively Chinese LTC residents (ECR) followed by the families of residents (MCF and ECF).

### DESCRIPTIVE DATA

Tables 2 and 3 describe the characteristics of the residents and families, respectively.

As shown in Table 2, all residents of the EC care home identified as Chinese. Consistent with the population of greater Vancouver, about half of the ME resident

respondents were Chinese; others identified as South Asian, Black, Latin American, and Japanese. None of the resident respondents in either care home was Canadian-born. A variety of religious traditions were identified, including no religion, across both care homes. The majority of participants in both groups had lived in the care home from one to five years.

As shown in Table 3, the majority of family members in both groups were adult children (and mostly daughters) of residents. Three of the ME family members were Canadian-born; all other participants were from Asia, the majority having arrived in Canada since 1991. All but one of the EC family members were from Hong Kong with a broad range of arrival dates to Canada. All of the EC home family members identified as Chinese; MC family members identified as Chinese, Japanese, and Caucasian. There was a narrower range of religious traditions among the family members than among the resident respondents; among the ME family members, the predominant response was "no religion," though closely followed by Roman Catholic—the most frequently mentioned religious tradition among the EC family members.

Several items were included in the participant profile survey inquiring about knowledge of death in the care home, discussions with staff about EOL care, and with whom resident participants might discuss their EOL plans. Most residents, in both homes, had known someone in the home who had died. When asked if staff had discussed EOL issues with them, MCR respondents were divided in their responses: four replied "no" and three replied "yes." None in the ECR group responded to the question. Similarly, when asked with whom EOL plans might be discussed, the majority of the ECR group did not answer; of those who did answer, the family was identified. Within the MER group, the family was identified by the majority, although residents also noted professional others—and no one.

Only one family member in each of the two groups reported that their loved one was receiving "EOL care." The majority (six) of the MCF members reported that no

<b>VARIABLE</b>		<b>MC HOME (n = 8)</b>	<b>EC HOME (n = 6)</b>
<b>Mean Age (SD)</b>		81.57 (10.8)	77.83 (12.8)
<b>Range</b>		64–93	62–92
<b>Country of Birth</b>	China	4	3
	United State	1	0
	Argentina	1	0
	Fiji	1	0
	Japan	1	0
	Hong Kong	0	2
	Missing	0	1
<b>Year arrived in Canada</b>	1951–1980	2	4
	1981–2000	6	1
	Missing	0	1
<b>Gender Identity</b>	Male	6	2
	Female	2	4
<b>Race/Ethnicity</b>	Chinese	4	6
	South Asian	1	0
	Black	1	0
	Latin American	1	0
	Japanese	1	0
<b>Religion</b>	Roman Catholic	1	0
	Baptist	1	1
	Christian	3	0
	Hindu	1	0
	Shinto	1	0
	Buddhist	0	2
	No religion	1	2
	Missing	0	1
<b>Years lived in this care home</b>	Less than 1 year	1	0
	1–5 years	5	4
	6– or more years	2	2
<b>Lived in other care home</b>	Yes	1	2
	No	6	3
	Missing	1	1
<b>Know residents who have died here</b>	Yes	6	5
	No	2	0
	Missing	0	1
<b>Know residents receiving EOL care here</b>	Yes	1	0
	No	7	1
	Missing	0	5
<b>Any staff talked to you about EOL care?</b>	Yes	3	0
	No	4	0
	Don't know/Missing	1	6
<b>Who might you discuss your plan for EOL care with?</b>	Family member	6	2
	Nurse	1	0
	Physician	1	0
	Power of Attorney	1	0
	Not ready, No one	1	0
	Missing	0	4

**Table 2** Socio-demographic Characteristics of Resident Focus Group Participants.

<b>VARIABLE</b>		<b>MC HOME (n = 8)</b>	<b>EC HOME (n = 5)</b>
<b>Mean Age (SD)</b>		61.71 (9.3)	64.8 (10.4)
<b>Range</b>		47–75	58–83
<b>Country of Birth</b>	Canada	3	0
	China	2	0
	Hong Kong	2	4
	Taiwan	1	0
	British Burma	0	1
<b>Year arrived in Canada</b>	1951–1980	1	3
	1981–2000	4	1
	Missing	0	1
<b>Gender Identity</b>	Male	3	2
	Female	5	3
<b>Race/Ethnic background</b>	White	2	0
	Chinese	5	5
	Japanese	1	0
<b>Religion</b>	Roman Catholic	3	3
	Buddhist	1	0
	Christian	0	1
	No religion	4	1
<b>Relationship with the resident</b>	Spouse	0	1
	Child	5	4
	Sibling	1	0
	Sister-in-Law	1	0
	Son-in-Law	1	0
<b>Years the resident lived in a care home</b>	Less than a year	1	1
	1–5 years	5	3
	6 or more years	1	1
	Missing	1	0
<b>Years the resident lived in this care home</b>	Less than a year	1	1
	1–5 years	4	3
	6 or more years	1	1
	Missing	1	0
<b>Is the resident alive?</b>	Yes	6	5
	No	2	0
<b>Is the resident receiving EOL care now?</b>	Yes	1	1
	No	5	4
<b>Any staff talked to you about the resident's EOL care?</b>	Yes	1	3
	No	6	1
	Missing	1	1
<b>Who might you discuss your plan for the resident's EOL care with?</b>	Other Family members	3	2
	Nurse	5	1
	Care Aide	2	0
	Physician	5	2
	Social Worker	2	1
	Staff (cleaning/kitchen)	2	0
	Alzheimer Society	1	0

**Table 3** Socio-demographic Characteristics of Family Focus Group Participants.

staff members had talked to them about the resident's EOL care; in contrast, among the ECF members, three reported that staff members did speak with them about the resident's wishes. When asked with whom the family member might discuss the plans for the resident's EOL care, responses from the ECF members were fewer in number and clustered around family and physicians, followed by a single mention of nurse and social worker. Responses from the MCF members were more widely distributed with nurses and physicians receiving the most frequent mention, followed by other family members, then care aides. Cleaning and kitchen staff and the Alzheimer's Society received single mentions.

## THEMES OF MULTICULTURAL AND CHINESE CARE HOME RESIDENTS

Four overarching themes characterized the discussions of the two resident groups. These themes, described below, are: The Range and Type of ACP Discussions and Action, Reference to Family, Quality of Life and End of Life, and Reference to Staff. Underlined are the codes assigned to the text, the aggregate of which form the specific overarching themes. These themes speak with varying specificity to the cultural spheres described in Figure 1.

### 1. Range and type of ACP discussions and actions

This theme broadly refers to the personal cultural experiences of the residents—focusing on if, when, and with whom ACP discussions had taken place. In both resident groups, the range spanned from none (e.g., MCR: “no conversation;” ECR: “I don't need to think about it”) through partial discussions with little or no associated actions (e.g., ECR: “management was told about the plans;” MCR: “I don't need to talk about it; let children handle it”) to full discussions and action including having completed the MOST (Medical Orders for Scope of Treatment) form. Both groups made clear connections between ACP and either will (e.g., MCR: “I have a will”) or other post-death plans (e.g., ECR: “We already have our photos taken” [for memorial]). Along such lines, ECR group members spoke of the benefits of planning in advance: “If you prearrange everything, carrying it out will be very easy. It will follow what you prearranged. There won't be much difficult issues.”

An emergent difference is evident between the two groups and is implicit in the examples offered. It foreshadows a subsequent theme, which is the apparent reluctance to speak about ACP (on the part of the ECR group) and the associated reliance on family to “handle it.” This reluctance boiled over when at least one ECR group member expressed significant anger at the issue having been raised at all; he yelled to the group that there was no reason “to think about death when I haven't even died yet.” There were no such emotional reactions in the MCR group.

### 2. Reference to family

This second theme differs evocatively between the two groups; however, in both, the nature and type of family references strongly evoke larger normative societal expectations. The ECR group expressed simply that “family will take care of you.” There was a clear articulation that the family “knows what to do when the time comes.” Family was discussed among the MCR group in a more multidimensional way including a different version of the reliance on family than seen among those in the ECR group. That is, several in the MCR group spoke of the important role of family and the strong pull of family at end of life; they noted that families “don't want to give up on their loved ones” and, as a consequence, exert significant pressure and “do everything to save them.” In contrast, several in the same group offered a sharply divergent perspective and spoke of the absence of family and its impact on ACP: “no conversation; no family here.”

### 3. Quality of life at end of life

Remarkably different approaches were noted in the discussions of this theme evoking healthcare culture through exertions of control at life's end. For the MCR group, the central focus was on the self, both in terms of awareness and control. Residents commented, “When I don't know who I am, I'm ready to go.” They elaborated noting that many are kept alive that “shouldn't be:” “Living is fine, but just being kept alive is not so good.” Relatedly, the MCR group reported that “it's my decision when to go and how—and to say good-bye to everyone.” They wanted to exert control over their life's ending. The ECR group had some brief overlap with this perspective with a resident noting that “someone on breathing machines and chest tubes” compromises personal meaning. Importantly, the ECR group differed with a focus on either letting it be (not caring “about it after you die”)—a kind of acquiescence—or the notion that the path is somewhat predetermined in that advance care plans are already “decided ... by age.” The idea expressed herein appears to be that longevity dictates ACP.

### 4. Reference to staff

Group differences were also noted in the depth and breadth of discussion of this fourth theme, referencing long-term care institutional practices and policies through interactions with staff. The MCR group spoke of contacting “the person in charge” if they were to become ill; they reported that they would be comfortable if the staff raised the issue of ACP with them. In contrast, the ECR group spoke about how the staff “is too busy” to talk and, as such, it was “seldom [that] personal things” are communicated to the staff—including issues of EOL and ACP. Similarly, the ECR group mentioned the absence of



time and opportunity to “express [to staff] what we like or dislike” although, with some caution, they believed that such sentiments could be expressed in the Resident Council. A minority ECR perspective was offered about open communications, particularly with care aides and social workers, about ACP and end of life, though this often defaulted in staff giving “us a form when the time comes.”

## FAMILIES OF CARE HOME RESIDENTS

The discussions of the family groups may also be characterized by four overarching themes: Timing and Focus of ACP Discussions, Communication with Family, Cultural and Religious Issues, and Care Home and Staff Influences. As above, the underlined text refers to the codes from the transcripts that form the basis of the themes, and reference two of the four spheres depicted in Figure 1.

### 1. Timing and focus of ACP discussions

This first theme represented the bulk of the discussions in the family groups indirectly referencing individual and interpersonal cultural experiences with significant mention of the timing of ACP and EOL discussions. For example, a MCF group member spoke of the role of diminishing cognitive abilities and ACP: “I think by the time she is in the facility, I would have found it difficult to speak with her about this because sometimes she’d be with you and then sometimes she wouldn’t be.” Still, members of the MCF group expressed regret that they had not previously discussed such issues in detail: “I wished we had discussed more [with mom].” The ECF members similarly noted that “when we are healthy, we never think about it; but when you are in the situation, it is totally different.” This led members of the group to recommend that people should have such discussions with their loved ones “prior to something really bad actually happening.” Elaborating on this idea, the MCF group commented on the benefit of earlier discussions and preplanning, though comments largely focused on wills and funeral arrangements. An example included: “She did have a will so that was very helpful; We didn’t have the opportunity to talk to her about what she would prefer.” In fact, funeral planning was a predominant focus of discussions for both groups with representative quotes such as “We’ve done all the planning with the funeral home” and noting that “when [parents] die, where you want to send the body to.”

### 2. Communication with (in) the family

Both groups spoke of the challenges and difficulty entering into or engaging the family in such discussions; these comments similarly reference the interpersonal (familial in this case) cultural sphere. Family group members

noted the reticence of individual family members: in the ECF group, one member reported that “any mention or any thinking of death is awful for him. So, we never talked about it;” in the MCF group, one participant said, “it was difficult to talk to her about advanced care and life support and things like that.” There was also some discussion about family dynamics, as they related to such topics (in the ECF group “Getting a family to talk about it openly, it sounds easy, but it’s quite difficult”; in the MCF group “Sometimes we don’t want to talk in front of her. She’s quite moody when talking”).

The ECF group members elaborated on the need for family involvement in such discussions: “Whatever their wishes are, they should articulate right in front of the whole family. Every family member should be there so everyone understands what her wishes are.” Some families in the group reported that they were “quite lucky” in that they have a parent who is “pretty open-minded so that’s why they can talk about these earlier.”

### 3. Cultural and religious issues

This third theme makes explicit reference to the broader cultural milieu of the family member. The ECF members spoke primarily of Chinese cultural influences, though with an explicit appreciation of other cultural backgrounds. As an example of the latter, family members noted that “everybody coming from different background...different religion, different customs” and consequently ACP would “vary with the situation” and the illness. More extensive comments were made in reference to the former, particularly concerning ACP. For example, one group member reported that “So, when we talk about planning, yes, I think most of the Chinese are more conservative. We will talk if they are willing to talk. We don’t talk if they aren’t willing to talk.” Another person added that discussions about EOL are avoided “because they think if you talk about it, it will happen.”

Reference was similarly made to Chinese culture in the MCF group (perhaps not surprising, given the group composition); a representative quote states: “China has legalized that the children generation, that they cannot abandon their parents.” The general discussion, however, revolved around an appreciation of the diversity within diversity. Several group members addressed how culture plays an important role, but “it depends on each family and how open they are towards answering these kinds of questions as well.”

Religion was relatedly addressed in the discussions of culture, though somewhat broadly. For example, in the MEF group, there was some discussion about the role of religious traditions as part of both ACP and funerals. In the ECF group, religions were compared with culture and even “surpass culture” in importance. It was commented that, “religion really helps—no matter what kind of religion.”

#### 4. Care home and staff influences

This fourth theme focused on interactions with staff—both positive and challenging, and the dynamics and interactions within the long-term care setting and culture. The ECF members spoke of the “open dialogue” and “shared values” they have with the staff and that they felt “listened to.” They also referenced culturally sensitive interaction: “the care aides and the nurses even tried to learn his Chinese poems, recite it to him, and his favorite songs.” The discussion among the MEF members also referenced positive interactions about the “accommodating” staff; one individual relayed that when her mother died, “we were told that there was no rush, that ‘Mom had paid for the room...for the month, so there was no rush.’”

Conversely, communication challenges with the staff were expressed by both groups, including (from the MEF group) how long it takes “to get in touch with [the doctor]” and the difficulty in having conversations at the nursing station “it’s so busy.” The size of the care team was also noted as a barrier to communication: “the care team is about a million people” which posed significant challenges “if you want everyone on the team to be in the same loop.” Exclusively Chinese family member focused more attention on EOL issues and activities. Most of the comments were descriptive rather than evaluative; for example, one person described the care home as “usually very quiet about it [death]. Maybe we can see the body being moved, but they’re very quiet about it.” This was contrasted, however, by a comment of some dissatisfaction in the manner in which death was addressed in the care home:

“My aunt passed away; it’s a four-person room. The rest of them, the drapes were drawn. The family was called, and we were there. And two of the residents left the room, and the other one went about her own business as if nothing had happened. That’s not how you do it.”

A substantial portion of the discussions within this theme concerned ACP and document completion in the care home, particularly in the MEF group. Building on the interactions described above, family members spoke of how staff should be raising questions of ACP with them “but not by surprise.” They recommended that ACP discussions be “part of a yearly meeting...so that I have a chance to think about it. I don’t want someone approaching me on the floor on a Tuesday saying, ‘So what’s your plan?’”

Although family members from both groups commented on the challenges in completing ACP, particularly at the time of admission of their loved one (e.g., as noted by an ECF member “we had to complete a package with questionnaire upon arrival”), MEF group

members spoke more forcefully of the stress of this effort. For example, one MEF member reported that she had to complete forms when they assisted their loved one in moving in: “You are really stressed and all of these questions come at you and you just automatically answer them. And then you kind of forget if you’ve actually answered them.” Another MCF group member added: “I think part of it is that the process is all so overwhelming. And you kind of deal with one thing and then it’s ‘now I need to deal with this thing?’ I was so overwhelmed, I don’t remember.” In general, MEF members commented on the need for a structured guide to assist in planning and discussions “before coming to the home would be really useful.” “Any resource that you can put in a family’s hand, that gives them some practical helpful things to look at and a timeline or to do list...once you’ve taken care of this, then here is your next chore....and the next conversation that you need to have...would be very useful.”

## DISCUSSION

In this study we compare residents’ and families’ views of ACP as well as comparing an exclusively Chinese milieu with one that is more westernized. “Culture” in the context of LTC and these two facilities can be understood as systems of ideas, rules, meanings, and ways of living and thinking that are built up, shared, and expressed by a group of people. Our findings suggest that a multiplicity of cultures co-exist in LTC and the way in which they come together or conflict influences engagement/uptake of ACP by LTC residents, and their families and their perceptions of the institution. Evidence of each of the domains shown in [Figure 1](#) and addressed in the introduction to this paper can be found in the analyses presented above—for both the resident and family groups. Perhaps most evident, however, is the intersection of these domains in the experiences related in these focus groups, primarily filtered through the lens of Chinese culture, for both resident groups (though clearly more strongly in the ECR group) and interacting with other cultural spheres, especially for the family groups. We discuss these influences below, beginning with the residents with a focus on the comparison between the two facilities.

### RESIDENT THEMES

Both resident groups evidenced an overall reluctance to speak about ACP—perhaps part of a more general discomfort in discussing death. One resident group member became very angry that ACP and death were being discussed, raising his voice, and threatening to leave the group. Across groups, the different framing of issues at life’s end was noteworthy. However, reasons for this discomfort may be rooted in the specific individual level culture—sensitivities around discussions of death in Chinese culture (Muller & Desmond, 1992; Yap et al., 2018), such as was

observed in our Chinese respondents, are well known. There was additionally a type of acquiescence about death—a sort of dismissal and/or seeing age as a determining factor as in “letting it be” as a result of individual culture among participants from the exclusively Chinese LTC home (Chan & Pang, 2011; Zivkovic, 2018). Participants from the MC home had more Western cultural views (Bowman, 2004; Markus & Kitayama, 1991) of self-control and self-awareness, including quality of life distinctions. This could result from a higher level of acculturation in this group reflected in greater acceptance of the mainstream cultural concepts of autonomy and exercise of liberty.

Deference to family members for the resident’s EOL decision-making was clearly articulated but the role of family was highlighted differently by the two groups. Among the ECR group, the message was that “family will take care of you,” a message often noted in comparable research (Yap et al., 2018; Zivkovic, 2018) and consistent with Chinese collectivist values and the role of children in the care of elderly parents (Chan et al., 2019; Smith & Hung, 2012). However, this may give way to Western cultural decision-making due to higher acculturation and education among children that has been associated with more positive attitudes regarding EOL planning and communication (McDermott & Selman, 2018; Jia et al., 2020). In subtle contrast, among the MCR group, the pull of family wishes, described as exerting pressure to “do everything possible,” appeared to be a pejorative. The difference contrasts explicit and close (ECR) and implicit and more distant (MCR) family influence. Relatedly, families were also noted by their absence exclusively among the MCR group.

Equating ACP with funeral planning is also consistent with previous research (Lee et al., 2017). While there are efforts from federal organizations and local palliative care centers to increase knowledge of ACP there is a gap in understanding both among the greater Canadian culture and among, but larger, within ethnic/racialized cultures.

The conversation about staff in general and their engagement around ACP was also different in the two groups. Among ECR participants, sentiments were expressed about the busyness of the staff, implying an absence of access, and interaction, and the more formal, perhaps ambivalent, relationship that existed. The cultural underpinnings of this would be interesting to explore but was beyond the scope of this study. We note, however, that there is some literature on the discomfort with formal care settings expressed by Chinese older adults (Smith & Hung, 2012). Further, while a culture congruence between EC home staff and residents may suggest improved rapport and comfort for residents in the facility, there still may be barriers to engaging in ACP conversations based on common acceptance of the cultural taboo around talking about death. In contrast, among the MCR participants, there was some agreement that residents could speak to staff about ACP, even as it appeared to happen rarely.

## FAMILY THEMES

Among the family groups, culture was explicitly named at several junctures, ranging in the ECF group from connections to Chinese cultural influences to references to western medical and institutional policies and practices. Both family groups made explicit reference to Chinese culture’s “conservative” nature, lack of openness to discussions of death, and allusions to self-fulfilling prophecies noted, in other studies (Muller & Desmond, 1992; Zivkovic, 2018). Reference was also made to religious traditions and their effect on both ACP and especially funeral planning. Culture was referred to in a more multi-layered manner in the MCF group which expressed awareness of the diversity of cultural, religious, and family perspectives concerning ACP.

On the other hand, the two family groups addressed the dynamics of ACP and EOL discussions juxtaposing Chinese (and other) cultural values with the demands of western residential and medical care. Speaking from their own experiences they highlighted constraints within the LTC and healthcare cultures and the need for more support and resources.

Family members reported a sense of frustration driven in part by the home’s care staff pressuring them, and the policies and procedures associated with, ACP document completion early in the admission process with limited follow-up throughout their loved one’s stay. Staff were seen as part of an LTC culture that defined their scope of practice and role in ACP.

## RESIDENT-FAMILY COMPARISONS

The differences between residents and families, which were most apparent in the range of discussions—from no discussion (more common among the residents) to more active discussion, action, and a recommendation for more supports and resources (more common in families) that may reflect differences between generations in a degree of acculturation, and education.

Comfort and familiarity with both healthcare and LTC cultures, valued differently by Chinese residents and family members who may be more acculturated to Western culture including those who emigrated earlier (Smith & Hung, 2012) may well underlie the finding that family members perceived staff in more favorable terms; they were described as “accommodating” and family members appreciated how they strove to meet residents in their own cultural context. Similarly, the different views expressed by Chinese residents and family members about the timing of initiation of ACP conversation and respecting the individual’s decisions and wishes at EOL may reflect differences in enculturation, acculturation, and time lived in Canada.

To bridge the gap between residents and family members in terms of ACP engagement, it may be necessary to tailor communication and engagement strategies to the specific cultural background of each

group and their degree of acculturation and enculturation to societal norms. This could involve providing different types of information, using different communication styles or methods, and incorporating ethno-cultural references to traditions and beliefs into the ACP process to a different degree. By recognizing and addressing cultural differences between residents and their families, LTC providers can work towards greater engagement in ACP and ensure that residents receive support at the end of life that is congruent with their values and wishes and avoid or minimize intergenerational conflict.

## CONCLUSION

The energies of care home residents are expended in activities of daily living and adapting to changes in physical and/or cognition or mental health and to radical changes to their living environments. Their professional caregivers are focused on providing care. Family members have to navigate not only the demands of the resident but also of the care home and staff, operating within healthcare and LTC cultures. Framing engagement in ACP within an environment of intersecting cultures offers a unique perspective, highlighting areas of congruence and discord. Importantly, existing institutional policies and practices offer little direction and support on how to balance or prioritize these cultures. An appreciation of the many influences, as offered above, may provide a starting point that will lead to increased uptake of ACP in LTC by both minority and mainstream residents and their families.

It is important to recognize that the ethnic composition of a long-term care home can have a significant impact on ACP engagement and outcomes, and policies and programs should take this into account. In a homogenous environment, there may still be diversity within the culture, but it may be less pronounced than in a multi-ethnic environment.

In summary, it is important to design ACP policies and programs that are tailored to the specific needs and cultural backgrounds of the residents and their families in each home. This could involve providing language-specific materials and resources, engaging with cultural and religious leaders in the community, and creating opportunities for cross-cultural education and dialog for healthcare professionals and staff members.

## FUNDING INFORMATION

This research is funded by the Canadian Frailty Network (formerly Technology Evaluation in the Elderly Network) which is supported by the government of Canada through the Networks of Centers of Excellence (NCE) program.

## COMPETING INTERESTS

The authors have no competing interests to declare.

## AUTHOR CONTRIBUTIONS

Shimae Soheilipour: Writing, Investigation, Review and Editing, Project Coordination

Katrina Jang: Writing, Review and Editing

Brian de Vries: Original Draft, Methodology, Formal Analysis, Funding Acquisition

Helen Kwan: Writing

Gloria Gutman: Conceptualization, Review and Editing, Funding Acquisition, Principle Investigator

## AUTHOR AFFILIATIONS

**Shimae Soheilipour, Ph.D.**  [orcid.org/0000-0001-5961-5948](https://orcid.org/0000-0001-5961-5948)

Simon Fraser University Gerontology Research Centre, Canada; Isfahan University of Medical Sciences, Iran

**Katrina Jang, MScOT**  [orcid.org/0000-0001-7492-110X](https://orcid.org/0000-0001-7492-110X)

Simon Fraser University Gerontology Research Centre, Canada

**Brian de Vries, Ph.D.**  [orcid.org/0000-0003-4360-1343](https://orcid.org/0000-0003-4360-1343)

Simon Fraser University Gerontology Research Centre; San Francisco State University, United States

**Helen Kwan, BA**

Simon Fraser University Gerontology Research Centre, Canada

**Gloria Gutman, Ph.D.**  [orcid.org/0000-0001-8810-2287](https://orcid.org/0000-0001-8810-2287)

Simon Fraser University Gerontology Research Centre, Canada

## REFERENCES

- Arnett, K, Sudore, RL, Nowels, D, Feng, CX, Levy, CR and Lum, HD.** 2016. Advance care planning: Understanding clinical routines and experiences of interprofessional team members in diverse health care settings. *American Journal of Hospice and Palliative Medicine*, 34(10): 946–953. DOI: <https://doi.org/10.1177/1049909116666358>
- Austin, Z and Sutton, J.** 2014. Qualitative research: getting started. *Can J Hosp Pharm*, 67(6): 436–40. DOI: <https://doi.org/10.4212/cjhp.v67i6.1406>
- Beavis, AS, Hojjati, A, Kassam, A, Choudhury, D, Fraser, M, Masching, R and Nixon, SA.** 2015. What all students in healthcare training programs should learn to increase health equity: perspectives on postcolonialism and the health of Aboriginal Peoples in Canada. *BMC Medical Education*, 15: 155. DOI: <https://doi.org/10.1186/s12909-015-0442-y>
- Bergenholtz, H, Timm, HU and Missel, M.** 2019. Talking about end of life in general palliative care – what’s going on? A qualitative study on end-of-life conversations in an acute care hospital in Denmark. *BMC Palliative Care*, 18(1). DOI: <https://doi.org/10.1186/s12904-019-0448-z>

- Berry, JW.** 1997. Immigration, acculturation, and adaptation. *Applied Psychology*, 46(1): 5–34. DOI: <https://doi.org/10.1111/j.1464-0597.1997.tb01087.x>
- Bowman, K.** 2004. What are the limits of bioethics in a culturally pluralistic society? *The Journal of law, medicine & ethics: a journal of the American Society of Law, Medicine & Ethics*, 32(4): 664–669. DOI: <https://doi.org/10.1111/j.1748-720X.2004.tb01971.x>
- Bowman, KW and Hui, EC.** 2000. Bioethics for clinicians: 20. Chinese bioethics. *Canadian Medical Association Journal*, 163(11): 1481–1485.
- Braun, V and Clarke, V.** 2012. Thematic analysis. APA handbook of research methods in psychology. *American Psychological Association*, 2: 57–71. DOI: <https://doi.org/10.1037/13620-004>
- Bülöw, HH, Sprung, CL, Reinhart, K, Prayag, S, Du, B, Armaganidis, A, Abroug, F and Levy, MM.** 2008. The world's major religions' points of view on end-of-life decisions in the intensive care unit. *Intensive care medicine*, 34(3): 423–430. DOI: <https://doi.org/10.1007/s00134-007-0973-8>
- Canadian Hospice Palliative Care Association.** 2013. *What Canadians say: The way forward survey report*. <http://www.hpcintegration.ca/media/51032/The%20Way%20Forward%20-%20What%20Canadians%20Say%20-%20Survey%20Report%20Final%20Dec%202013.pdf> [Accessed 10 July 2023].
- Chan, C, Wong, M, Choi, KC, Chan, H, Chow, A, Lo, R and Sham, M.** 2019. What Patients, Families, Health Professionals and Hospital Volunteers Told Us about Advance Directives. *Asia-Pacific journal of oncology nursing*, 6(1): 72–77. DOI: [https://doi.org/10.4103/apjon.apjon\\_38\\_18](https://doi.org/10.4103/apjon.apjon_38_18)
- Chan, HY and Pang, SM.** 2011. Readiness of Chinese frail old age home residents towards end-of-life care decision making. *Journal of Clinical Nursing*, 20(9–10): 1454–1461. DOI: <https://doi.org/10.1111/j.1365-2702.2010.03670.x>
- Checkland, K, Harrison, S and Marshall, M.** 2007. Is the metaphor of 'barriers to change' useful in understanding implementation? Evidence from general medical practice. *Journal of health services research & policy*, 12(2): 95–100. DOI: <https://doi.org/10.1258/135581907780279657>
- Con, A.** 2008. *Cross-cultural considerations in promoting advance care planning in Canada*. Health Canada. [https://www.virtualhospice.ca/Assets/Cross%20Cultural%20Considerations%20in%20Advance%20Care%20Planning%20in%20Canada\\_20141107113807.pdf](https://www.virtualhospice.ca/Assets/Cross%20Cultural%20Considerations%20in%20Advance%20Care%20Planning%20in%20Canada_20141107113807.pdf).
- de Vries, B, Gutman, G, Humble, Á, Gahagan, J, Chamberland, L, Aubert, P, Fast, J and Mock, S.** 2019. End-of-Life Preparations Among LGBT Older Canadian Adults: The Missing Conversations. *International journal of aging & human development*, 88(4): 358–379. DOI: <https://doi.org/10.1177/0091415019836738>
- Feser, L and Bon Bernard, C.** 2003. Enhancing cultural competence in palliative care: perspective of an elderly Chinese community in Calgary. *Journal of palliative care*, 19(2): 133–139. DOI: <https://doi.org/10.1177/082585970301900211>
- Gilissen, J, Pivodic, L, Smets, T, Gastmans, C, Vander Stichele, R, Deliëns, L and Van den Block, L.** 2017. Preconditions for successful advance care planning in nursing homes: A systematic review. *International journal of nursing studies*, 66: 47–59. DOI: <https://doi.org/10.1016/j.ijnurstu.2016.12.003>
- Government of Canada.** 2019. *Canada's Health Care System*. <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html>.
- Harrison, KL, Adrion, ER, Ritchie, CS, Sudore, RL and Smith, AK.** 2016. Low Completion and Disparities in Advance Care Planning Activities Among Older Medicare Beneficiaries. *JAMA internal medicine*, 176(12): 1872–1875. DOI: <https://doi.org/10.1001/jamainternmed.2016.6751>
- Gutman, G, de Vries, B, Kwan, H, Jang, K and Soheilipour, S.** 2020. Institutional and cultural barriers to ACP: Staff perceptions. Gerontological Society of America 75<sup>th</sup> Annual Meeting. *Innovations in Aging*, 4(Issue Supplement 1): 754–755. DOI: <https://doi.org/10.1093/geron/igaa057.2718>
- Jedwab, J.** 2020. Multiculturalism. In *The Canadian Encyclopedia*. Retrieved from <https://www.thecanadianencyclopedia.ca/en/article/multiculturalism>.
- Jia, Z, Leiter, RE, Yeh, IM, Tulskey, JA and Sanders, JJ.** 2020. Toward Culturally Tailored Advance Care Planning for the Chinese Diaspora: An Integrative Systematic Review. *Journal of palliative medicine*, 23(12): 1662–1677. DOI: <https://doi.org/10.1089/jpm.2020.0330>
- Johnstone, MJ and Kanitsaki, O.** 2009. Ethics and advance care planning in a culturally diverse society. *Journal of transcultural nursing: official journal of the Transcultural Nursing Society*, 20(4): 405–416. DOI: <https://doi.org/10.1177/1043659609340803>
- Kagawa Singer, M, Dressler, W, George, S and NIH Expert Panel.** 2016. Culture: The missing link in health research. *Social science & medicine* (1982), 170: 237–246. DOI: <https://doi.org/10.1016/j.socscimed.2016.07.015>
- Kale, MS, Ornstein, KA, Smith, CB and Kelley, AS.** 2016. End-of-Life Discussions with Older Adults. *Journal of the American Geriatrics Society*, 64(10): 1962–1967. DOI: <https://doi.org/10.1111/jgs.14285>
- Kitzinger, J.** 1994. The Methodology of Focus Groups: The Importance of Interaction between Research Participants. *Sociology of Health and Illness*, 16(1): 103–121. DOI: <https://doi.org/10.1111/1467-9566.ep11347023>
- Koehn, SD, Mahmood, AN and Stott-Eveneshen, S.** 2016. Quality of Life for Diverse Older Adults in Assisted Living: The Centrality of Control. *Journal of gerontological social work*, 59(7–8): 512–536. DOI: <https://doi.org/10.1080/01634372.2016.1254699>
- Lawson, G.** 2015. Trudeau's Canada, Again. *New York Times*, 8 December <https://www.nytimes.com/2015/12/13/magazine/trudeaus-canada-again.html>.

- Lee, M, Byon, H, Hinderer, K and Alexander, C.** 2017. Beliefs in advance care planning among Chinese Americans: Similarities and differences between the younger and older generations. *Asian/Pacific Island Nursing Journal*, 2(3): 83–90. DOI: <https://doi.org/10.9741/23736658.1055>
- Li, LB.** 2013. Clinical review: Ethics and end-of-life care for critically ill patients in China. *Critical care*, 17(6): 244. DOI: <https://doi.org/10.1186/cc13140>
- Loue, S and Sajatovic, M.** 2011. Culture. In *Encyclopedia of Immigrant Health* (p. 337). Springer. DOI: <https://doi.org/10.1007/978-1-4419-5659-0>
- Loustaunau, MO and Sobo, EJ.** 1997. *The cultural context of health, illness, and medicine*. Bergin & Garvey.
- Markus, HR and Kitayama, S.** 1991. Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, 98(2): 224–253. DOI: <https://doi.org/10.1037/0033-295X.98.2.224>
- Martin, RS, Hayes, B, Gregorevic, K and Lim, WK.** 2016. The Effects of Advance Care Planning Interventions on Nursing Home Residents: A Systematic Review. *Journal of the American Medical Directors Association*, 17(4): 284–293. DOI: <https://doi.org/10.1016/j.jamda.2015.12.017>
- McDermott, E and Selman, LE.** 2018. Cultural Factors Influencing Advance Care Planning in Progressive, Incurable Disease: A Systematic Review With Narrative Synthesis. *Journal of pain and symptom management*, 56(4): 613–636. DOI: <https://doi.org/10.1016/j.jpainsymman.2018.07.006>
- Mignani, V, Ingravallo, F, Mariani, E and Chattat, R.** 2017. Perspectives of older people living in long-term care facilities and of their family members toward advance care planning discussions: a systematic review and thematic synthesis. *Clinical interventions in aging*, 12: 475–484. DOI: <https://doi.org/10.2147/CIA.S128937>
- Muller, JH and Desmond, B.** 1992. Ethical dilemmas in a cross-cultural context. A Chinese example. *The Western journal of medicine*, 157(3): 323–327.
- Pfifferling, JH.** 1981. A Cultural Prescription for Medicocentrism. In Eisenberg, L and Kleinman, A (eds.), *The Relevance of Social Science for Medicine*. D. Reidel Publishing Company, 197–222. DOI: [https://doi.org/10.1007/978-94-009-8379-3\\_9](https://doi.org/10.1007/978-94-009-8379-3_9)
- Shanafelt, TD, Schein, E, Minor, LB, Trockel, M, Schein, P and Kirch, D.** 2019. Healing the Professional Culture of Medicine. *Mayo Clinic proceedings*, 94(8): 1556–1566. DOI: <https://doi.org/10.1016/j.mayocp.2019.03.026>
- Sinclair, C, Smith, J, Toussaint, Y and Auret, K.** 2014. Discussing dying in the diaspora: attitudes towards advance care planning among first generation Dutch and Italian migrants in rural Australia. *Social science & medicine (1982)*, 101: 86–93. DOI: <https://doi.org/10.1016/j.socscimed.2013.11.032>
- Smith, CS and Hung, LC.** 2012. The influence of eastern philosophy on elder care by Chinese Americans: attitudes toward long-term care. *Journal of transcultural nursing*, 23(1): 100–105. DOI: <https://doi.org/10.1177/1043659611423827>
- Statistics Canada.** 2017. 2016 Vancouver [Census metropolitan area], British Columbia and British Columbia [Province] (table). (Catalogue number 98-316-X2016001). Retrieved June 1, 2020 from Statistics Canada: <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E>.
- Sudore, RL, Lum, HD, You, JJ, Hanson, LC, Meier, DE, Pantilat, SZ, Matlock, DD, Rietjens, JAC, Korfage, IJ, Ritchie, CS, Kutner, JS, Teno, JM, Thomas, J, McMahan, RD and Heyland, DK.** 2017. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. *Journal of pain and symptom management*, 53(5): 821–832.e1. DOI: <https://doi.org/10.1016/j.jpainsymman.2016.12.331>
- Tan, WS, Car, J, Lall, P, Low, CK and Ho, AHY.** 2019. Implementing Advance Care Planning in Acute Hospitals: Leading the Transformation of Norms. *Journal of the American Geriatrics Society*, 67(6): 1278–1285. DOI: <https://doi.org/10.1111/jgs.15857>
- Vancouver Coastal Health Research Institute.** 2022. *End-of-life planning in the South Asian community*. Vancouver Coastal Health Research Institute. <https://www.vchri.ca/stories/2022/07/05/end-life-planning-south-asian-community>.
- Weathers, E, O’Caoimh, R, Cornally, N, Fitzgerald, C, Kearns, T, Coffey, A, Daly, E, O’Sullivan, R, McGlade, C and Molloy, DW.** 2016. Advance care planning: A systematic review of randomised controlled trials conducted with older adults. *Maturitas*, 91: 101–109. DOI: <https://doi.org/10.1016/j.maturitas.2016.06.016>
- Yap, SS, Chen, K, Detering, KM and Fraser, SA.** 2018. Exploring the knowledge, attitudes and needs of advance care planning in older Chinese Australians. *Journal of clinical nursing*, 27(17–18): 3298–3306. DOI: <https://doi.org/10.1111/jocn.13886>
- Yarnell, CJ, Fu, L, Bonares, MJ, Nayfeh, A and Fowler, RA.** 2020. Association between Chinese or South Asian ethnicity and end-of-life care in Ontario, Canada. *Canadian Medical Association journal*, 192(11): E266–E274. DOI: <https://doi.org/10.1503/cmaj.190655>
- Zivkovic, T.** 2018. Forecasting and foreclosing futures: The temporal dissonance of advance care directives. *Social science & medicine (1982)*, 215: pp. 16–22. DOI: <https://doi.org/10.1016/j.socscimed.2018.08.035>

---

**TO CITE THIS ARTICLE:**

Soheilipour, S, Jang, K, de Vries, B, Kwan, H and Gutman, G. 2023. A Confluence of Cultures: Advance Care Planning in Long-Term Care Settings. *Journal of Long-Term Care*, (2023), pp. 120–134. DOI: <https://doi.org/10.31389/jltc.203>

**Submitted:** 17 January 2023    **Accepted:** 04 June 2023    **Published:** 18 July 2023

**COPYRIGHT:**

© 2023 The Author(s). This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs 3.0 Unported International License (CC BY-NC-ND 3.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See <http://creativecommons.org/licenses/by-nc-nd/3.0/>.

*Journal of Long-Term Care* is a peer-reviewed open access journal published by LSE Press.