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Practitioner accounts of end-of-life communication in Hong Kong, Mainland China and Taiwan: A systematic review

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ABSTRACT

Objective: Communication at the end-of-life (EOL) is complex and multidimensional. Although culture is acknowledged as a key influence, there remains a gap in knowledge about intracultural aspects of EOL communication in the Chinese context. This review presents a synthesis of practitioners' accounts of communication at the EOL in Hong Kong, Mainland China and Taiwan.

Methods: This review was registered prospectively on PROSPERO (CRD42021297052). Five databases were systematically searched using the terms 'communication', 'End-of-Life', 'Hong Kong', 'China' and 'Taiwan'. Empirical research published between 2015 and 2021 was downloaded and appraised. Fifteen articles were included in the review.

Results: Findings highlight the influence of Chinese culture and philosophy, inadequate communication skills training and psychological support for practitioners and legislative and organisational factors.

Conclusion: Education and training for practitioners and public education about the EOL needs strengthening. Enhanced understanding of how culture influences EOL communication will strengthen service delivery and enhance awareness in multicultural communities.

Practice implications: EOL workers need practical and workplace-based support to engage in meaningful communication practices. The influence of culture and the readiness of patients and families to engage in communication are also important considerations.

1. Introduction

The demand for multidimensional care at the end-of-life (EOL) has grown exponentially in recent decades. The intersection of factors such as population ageing, technological advances and the increased prevalence of noncommunicable diseases means that more people are living longer and requiring additional or palliative care during the EOL stage [1,2]. Definitions of this life stage vary and in some jurisdictions such as the UK, "approaching the end of life" is defined as when death is likely to occur within the next 12 months [3] (p. 8). Other regions, in contrast, focus on the EOL as the period during which an individual is terminally ill and death is expected and likely to occur within the foreseeable future [4,5]. Intervention during the EOL period is shaped by supportive rather than curative care as a range of practitioners work to provide patients (also referred to as service users) with medical, physical, spiritual and psychosocial care. Improving EOL care has been a challenging objective for many health systems, and reviews of mature systems in highly developed economies have highlighted the inherent complexity of the macro and micro contexts in which these services operate [6,7]. Factors that support system development include public education campaigns to promote awareness of notions associated with EOL care such as Advance Care Planning (ACP) and Advance Directives (AD). Such campaigns can help to educate people about how to discuss their opinions and preferences and make choices regarding the location and circumstances of their EOL [8]. These campaigns have been found to be particularly salient for population groups who are less likely to engage with EOL care discussions including groups with lower education and income levels [8–10]. Higher levels of community engagement and public awareness of EOL choices have been correlated with high-performing palliative and EOL care systems [11]. Despite the development of this knowledge,

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international EOL care systems remain challenged by under-resourcing, inadequate practitioner education, lack of co-ordination and uneven service coverage [7].

The underlying concepts embedded within aspirations for the delivery of high quality EOL and palliative care rely upon the ongoing, meaningful exchange of information between a range of stakeholders to support the individual needs of service users and their families and friends [12,13]. The importance of communication in EOL care development and delivery has been foregrounded in recent reviews which have focused on perspectives of patients, families and carers [14,15], clinicians [16–18], efficacy of training interventions [16,19,20] and the role of culture in EOL care and communication [21]. Much of the communication research reported in these reviews has been undertaken in Western medical or care settings [22,23] or focused on aspects of intercultural communication between immigrants and local healthcare practitioners in high-income non-Asian countries [24–26]. As highlighted by Pun et al. [27], there is a gap in published communication research that draws on data gathered in East Asian contexts. These authors argued that a greater diversity within communication research will broaden awareness of communication and, importantly, reduce the tendency to transpose Western perspectives onto non-Western settings.

Hong Kong, Mainland China and Taiwan provide unique contexts to examine the complexity of EOL communication and the influence of local cultural, social and political contexts [1,28]. More than 90% of the populations in each of these locations identify as being of Han Chinese ethnicity [29–31] and share cultural and philosophical backgrounds which influence communication practices and attitudes towards death. Despite these similarities, comparative studies have identified significant variation in the quality and continuity of EOL care across these locations [32]. For example, the *2015 Quality of Death Index* [32] identified differences between Hong Kong, Mainland China and Taiwan in indices of human resources, affordability, quality and community engagement.

Issues affecting the quality and coverage of EOL services in these locations reflect variability across healthcare and socioeconomic systems [33], policy, insurance and legislation [34]. For example, although hospice care was introduced in Mainland China in the late 1980s, public awareness remains low [35], ACP and AD are relatively new [36], and aspects of practitioner education are fragmented [37]. Recent actions have been taken to develop hospice and palliative care including the issuing of practice guidelines for palliative care [38] and the expansion of a related pilot program [39]. Hong Kong policies addressing EOL topics such as AD and ‘dying in place’ have developed significantly since 2000 and public consultation was undertaken in 2019 to explore levels of public awareness of EOL options and implementation of policy and related legislative changes [40]. In terms of policy, structure and public awareness, Taiwan’s EOL system has been actively developed through the implementation of the *Hospice Palliative Care Act* [41] and the 2019 *Patient’s Right to Autonomy Act* [42] which was amended in 2021 [43]. These legislative developments have accompanied a drive to promote understanding and acceptance of the obligation of physicians to engage in ‘truth telling’ in relation to diagnosis and likely prognosis [44]. Despite these developments, the signing of ADs in Taiwan remains low at only 4% compared to 10–20% in Western countries [45].

This systematic review contributes to the emerging body of work examining the development of EOL care in Chinese cultural contexts. Research conducted in Hong Kong, Mainland China and Taiwan has examined aspects of service provision [46], multi-disciplinary and multi-agency involvement in ACP [47], AD preferences [48] and needs of patients and caregivers [49]. However, there remains a gap in knowledge about how aspects of intracultural communication influence care delivery. This review specifically aims to address this gap by synthesising empirical research exploring the perceptions and experiences of communication amongst EOL practitioners in these three locations. In this review, the EOL refers to the period leading up to expected or anticipated death during which concepts associated with ACP may be discussed. Findings offer insights into ongoing training and support needs for practitioners as well as informing future research and policy development.

2. Methods

2.1. Search strategy

This review was registered prospectively with PROSPERO (CRD42021297052). Searches of five electronic databases (Embase, PsycINFO, CINAHL (via EBSCO), Medline (via EBSCO), Web of Science) were initially conducted between January and April 2022. Search terms included ‘communication’, ‘End-of-Life’, ‘China’ and ‘Hong Kong’. Searches were rerun in August 2022 and expanded to include the location of Taiwan and the PubMed (including Medline) database. Grey literature was excluded. Final figures of literature retrieved and analysed are reported in Fig. 1.

Database searches yielded a total of 1857 articles, including three articles published in Chinese. These articles were screened by the first two authors (MT and CY) based on the relevance of titles and abstracts. The three articles published in Chinese were screened by the third author (XW) and excluded as they did not meet the inclusion criteria of the review. Forty-nine shortlisted full-text articles (including five identified through manual review of reference lists) were read, assessed and screened by MT and CY for eligibility using a modified version of the JBI QARI tool [50]. Thirty-four articles were excluded after full-text review. A total of 15 articles were included in the qualitative synthesis in this review. All data were reviewed and are reported in accordance with PRISMA guidelines [51].

2.2. Inclusion and exclusion criteria

Articles included in this review reported on original empirical research (quantitative, qualitative, mixed methods) and were published in peer-reviewed journals. Articles were included if they focused on EOL communication issues and practices from practitioners’ perspective in Hong Kong, Mainland China or Taiwan. All included studies explicitly stated that research ethics approval was obtained from a relevant institutional board and that informed, written consent was provided by research participants. Articles were excluded if they: 1) primarily focused on communication of clinical or medical information (e.g., the discussion of specific diagnoses including dementia and Motor Neurone Disease, euthanasia, withdrawal of treatment or specific clinical interventions); 2) only reported the outcomes of training programs or evaluations of specific interventions targeting communication skills; or (3) focused on non-adult (e.g., neonatal or paediatric) patient groups.

2.3. Data extraction

Study information and participant demographics from included articles retrieved during the search process were screened by MT and CY to ensure that they met inclusion criteria. The full texts were then extracted and screened for eligibility (MT and CY). Extracted details included: Study information (author/s and year of publication), geographical location of data collection, number and characteristics of study participants, methods of data collection (focus group discussion, semi-structured interview, questionnaires, etc.), analytical approach and main findings (Table 1).

2.4. Risk of bias (quality) assessment

The 15 articles identified were checked by the first two authors (MT and CY) for methodological validity. Following Scholz et al. [17] a modified JBI QARI Checklist was used. As the checklist does not recommend numerical cut-offs for inclusion, articles were included only if they scored ‘yes’ in all included criteria except the first (i.e., Is there

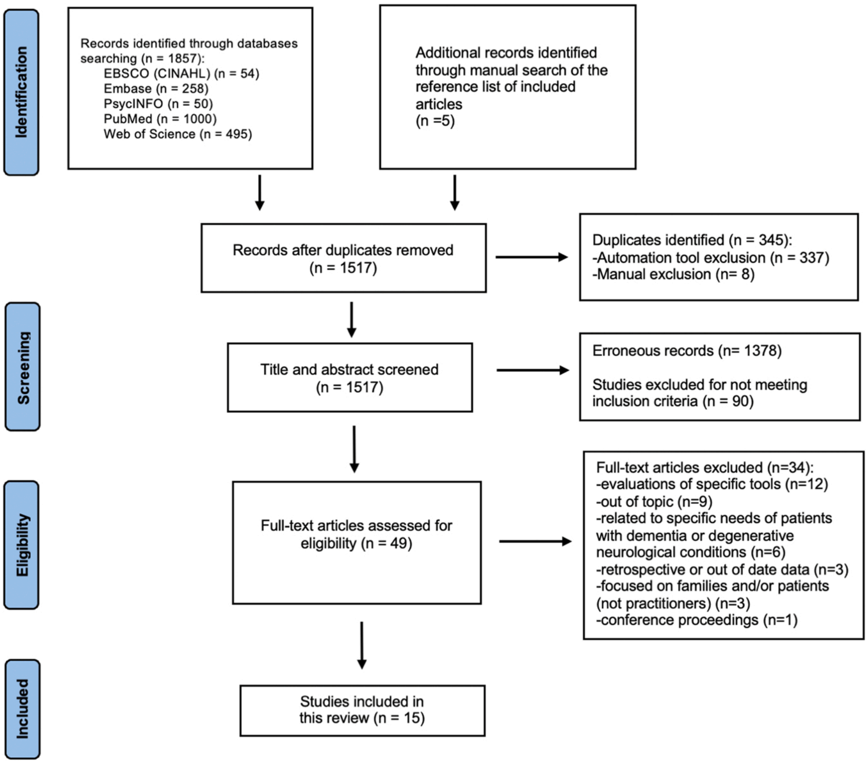

Fig. 1. PRISMA flowchart for systematic review.

congruity between the stated philosophical perspective and the research methodology?) as this may not be explicitly stated in all publications. All 15 articles appraised were classified as high quality and were included in the qualitative synthesis.

2.5. Data synthesis strategy

JBI meta-aggregation three-step process [52] was employed to collate findings in this review: step 1) the findings presented in the articles and as reported by the authors of the original studies were extracted; step 2) findings considered to have similar meanings were combined into categories; and step 3) the synthesized findings were developed into themes from at least two categories.

The included articles were divided among all authors (MT, CY and XW) for independent coding. Each article was read and coded by at least two authors. All authors then discussed, compared, and categorised the findings which were developed into initial themes. Consensus was reached among all authors after theme identification, comparison, reduction, and refinement.

3. Results

Fifteen empirical research articles that specifically focused on perceptions and experiences of communication amongst EOL practitioners in Hong Kong, Mainland China and Taiwan were identified. The synthesis and analysis of the findings of these articles produced three core themes that detail (1) Chinese culture and philosophies; (2) practitioners' communication skills and psychological capacity for EOL communication; and (3) contextual influences. These themes are summarised in Table 2.

3.1. Chinese culture and philosophies

3.1.1. Death as a taboo discussion topic

Although fear of death is a worldwide phenomenon and is not restricted to a particular culture, Chinese culture has developed its own perspectives on death and dying throughout its long history with respect to religious beliefs, philosophies, and cultural practices [53]. Multiple articles reviewed in the current study discussed the notion of death as taboo in Mainland China, Hong Kong and Taiwan and how the conceptualisation of death hindered EOL communication practices in these regions [44,45,54–59]. Discussion about death is considered a harmful act in Chinese culture and is usually avoided by patients, their families and healthcare practitioners as this may have negative impacts on patients' wellbeing, hasten the pace of patients' dying and can incur bad luck [45,56,57,59].

These perceptions lead to the avoidance of discussions about death in Chinese societies. For example, Chan et al. [54] investigated the perceptions of AD by patients with life-limiting diseases, their family members, health professionals and hospital volunteers in a Hong Kong palliative care setting. They found that even though patients regarded AD decisions as ways to reduce their future sufferings and as beneficial to the welfare of their families, hospital volunteers found it difficult to initiate AD discussion as death is a taboo in Chinese culture. This finding is consistent with studies conducted in Mainland China and Taiwan. Taiwanese healthcare professionals found it difficult to initiate ACP discussion as patients associated ACP with giving up on treatments and accepting death [45]. Initiating EOL discussion was also found to increase tension and conflict between healthcare professionals and families [44]. Studies conducted in Mainland China indicated that EOL care was regarded as the most challenging discussion topic even for the most experienced staff and they tended to avoid discussing death with patients [56,59]. Such strong negative attitudes towards death in Chinese culture adversely impact EOL communication and ACP acceptance in Chinese palliative care settings as well as the willingness of practitioners to initiate and engage in EOL communication with patients and their families.

3.1.2. Influence of family-oriented decision-making

Collectivism has been identified as a cultural factor that restricts

Table 1
Data extraction of included studies.

Author (in alphabetical order)	Aim (s)	Setting	Participants	Data Collection Method	Analytical Approach (as stated in included articles)	Main Finding(s)
Chan et al. [54]	To explore the perceptions of advance directive decision making of various stakeholders in the Chinese palliative care setting	Hong Kong	96 participants recruited in the palliative care unit of 2 hospitals • 24 patients with life-timing diseases; • 24 family members; • 24 health professionals; • 24 hospital volunteers	Semi-structured individual interviews	Thematic analysis	• AD decisions were regarded by patients to reduce their future sufferings and beneficial to the welfare of their families. • Family members worried about the psychological burden of AD discussion. • Health professionals underscored the logistic and process of the AD. • The impact of Chinese culture on AD acceptance and the lack of AD promotion in the community were pointed out by hospital volunteers.
Chen et al. [55]	To review the care provided in hospice wards in Shanghai and examine the difficulties in delivering service	Shanghai, Mainland China	14 care providers from 8 community health service centres • 7 physicians; • 7 nurses	Individual interviews	Qualitative content analysis	Identified difficulties in inpatient hospice care in Shanghai: • Lack of patients. • Inadequacies in the service. • Unsatisfactory psychological care. • Lack of multidisciplinary teams. • Lack of staff with various professional backgrounds in local healthcare institutions.
Chen and Lin [45]	To explore the barriers to discussing ACP with patients with chronic kidney disease faced by nephrology nurses	Taiwan	34 nephrology nurses recruited from hospitals in northern, central and southern Taiwan.	8 Focus-group interviews	Qualitative content analysis	• Lack of confidence to discuss ACP. • Difficulty in finding an appropriate opportunity to initiate ACP discussion. • Lack of personal characteristics to discuss ACP. • Conflicting perspectives between doctors and nurses over ACP. • Culture and belief-based barriers to discussing ACP.
Dong et al. [56]	To explore the experiences of Chinese physicians and nurses who care for dying cancer patients in their practical work	Mainland China	15 physicians and 22 nurses	Semi-structured interviews	Thematic analysis Using Colaizzi’s method	• Information disclosure on death and cancer was treated as taboo in Chinese culture which impeded EOL care and communication. • Physicians and nurses strongly wished to deliver high quality care and emphasized the importance to maintain patients’ hopes. • Nurses were more concerned with patients’ physical comfort and wish fulfilment. • Physicians focused on patients’ rights and symptom management. • Specific training in EOL cancer care and communication were required to meet their needs.
Fan and Hsieh [42]	To explore the DNR and EOL care discussion experience among physicians in Taiwan.	Eastern Taiwan	16 physicians recruited from the departments of hospice care, surgery, internal medicine, emergency, and the intensive care unit	Semi-structured interviews	Thematic Analysis	• Family members had multiple roles in the decision process. • Characteristics of the units, including time urgency and relationships with patients and family members, influenced physicians’ work. • Decision-making processes included preparation, exploration of options,

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Table 1 (*continued*)

Author (in alphabetical order)	Aim (s)	Setting	Participants	Data Collection Method	Analytical Approach (as stated in included articles)	Main Finding(s)
						information delivery, barrier solution, and execution. • Physicians shared reflections on their ability and the conflicts between law, medical professionals, and the best interests of patients.
Fu et al. [60]	To explore the lived experience of professionals at an independently operating palliative care hospital department in China's mainland.	Chengdu, Sichuan Province, Mainland China	10 palliative care physicians and 7 nurses at the palliative medicine department in the West China Fourth Hospital of Sichuan University	Semi-structured interviews	Thematic Analysis	Three themes were identified: • Interactions with patients and families. • Factors influencing their work life. • Perceived nature of work.
Lin et al. [44]	To explore the decision-making processes and drivers of receiving palliative care in advance care planning discussions from perspectives of advanced cancer patients, families and healthcare professionals in northern Taiwan.	Taiwan	45 participants • 15 patients; • 15 family carers; • 15 healthcare professionals	Semi-structured interviews	Thematic Analysis	Three main decision-making trajectories were identified: • 'Choose palliative care' was associated with patients' desire to reduce physical suffering from treatments, avoid being a burden to families and society, reduce futile treatments and donate organs to help others. • 'Decline palliative care' was associated with patients weighing up perceived benefits to others as more important than benefits for themselves. • 'No opportunity to choose palliative care' was associated with the lack of opportunities to discuss potential benefits of palliative care, lack of staff skill in end-of-life communication, and cultural factors, notably filial piety.
Shi et al. [57]	To investigate health care providers' knowledge and attitudes toward end-of-life care and analyse its influencing factors. To provide reference for developing effective strategies to promote end-of-life care in China	Changzhi city, Mainland China	132 community health care providers of 10 community health care centres	Cross-sectional survey using Questionnaire of Knowledge and Attitudes toward Caring for the Dying • Bradley Attitude Questionnaire • Chinese version of the Death Attitude Profile-Revised (DAP-R-C)	Statistical analysis using SPSS 22.0	• Community health care providers regarded EOL care positively. • Community health care providers lacked systematic and professional knowledge and skills to care for terminal patients. • Education should be treated as top priority to promote EOL care. • EOL care model should be established with improved policies, systems and laws.
Tse et al. [65]	To understand emergency nurses' perceptions regarding the provision of EOL care in the emergency department	Hong Kong	16 nurses from emergency department (ED) who had experience in providing EOL care	Semi-structured interviews	Qualitative content analysis	• Provision of EOL care in the ED can enhance patients' life, facilitate the bereavement process of families, and enhance the professional development of staff. • EOL service in the ED enriches EOL care in the health care system. • Integration of EOL service in ED is encouraged both locally and globally.
Wang et al. [68]	To examine Chinese clinical nurses' attitudes towards death and caring for dying patients, and to examine the relationships between clinical nurses' attitudes towards death and caring for dying patients	Mainland China	770 clinical nurses from 15 hospitals	Cross-sectional Questionnaire • Chinese version of the Frommelt Attitude Toward Care of the Dying Scale, Form B (FATCOD-B-C) • Chinese version of the Death Attitude Profile-	Statistical analysis using SPSS 19.0	• Nurses' attitudes towards death can impact the quality of care that they provide to dying patients. • Fear or negative view of death negatively correlated with nurses' attitudes towards caring for dying patients.

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Table 1 (*continued*)

Author (in alphabetical order)	Aim (s)	Setting	Participants	Data Collection Method	Analytical Approach (as stated in included articles)	Main Finding(s)
				Revised (DAP-R-C), demographic questionnaire		• Nurses' education level, fear of death, religious beliefs, and previous education/ experience of death can predict their attitudes toward the care of dying patients. • Further education on death and caring for dying patients are needed to improve the quality of care of dying patients.
Wong et al. [58]	To explore the healthcare system enablers and barriers to the provision of quality palliative and end-of-life care from the perspective of healthcare professionals	Hong Kong	72 healthcare providers • 14 practitioners; • 16 nurses; • 42 allied health professionals	15 Focus group semi-structured interviews and 9 individual semi-structured interviews	Grounded theory	• Provision of quality palliative and EOL care is influenced by: 1) Political context, 2) Organization setting, 3) Support to patients, caregivers and family members, 4) Healthcare workers and the public. • Palliative and EOL care are important to improve patients' quality of life. • Improvements to the service frameworks are required (i.e. political framework multidisciplinary approach, and readiness and competence in healthcare workers and community).
Wong et al. [66]	To evaluate the attitudes of emergency doctors in providing palliative and EOL care in Hong Kong, and to investigate the educational needs of emergency doctors in these areas	Hong Kong	145 emergency doctors working in Emergency Department (ED) in 6 hospitals • 60 respondents were from EDs with EOL services; • 85 respondents were from EDs without EOL service	Cross-sectional Questionnaire on emergency doctors' attitudes and perceived educational needs	Statistical analysis using SPSS 20.0	• Participants recognized that the management of the dying process was essential in ED. • Providing palliative and EOL care was regarded as an important competence and responsibility by the participants. • Role and priority of palliative and EOL care in ED are uncertain. • Lack of time and palliative care specialists were regarded as major barriers in providing palliative and EOL care in ED. • Further educational needs on complaints management, communication skills and EOL care ethics were identified.
Xing et al. [61]	To explore the willingness of community health workers to implement advance care planning (ACP) based on the theory of planned behaviour (TPB) and provide a reference for promotion of ACP in Chinese communities	Hangzhou, Mainland China	13 community health workers from 3 community health service centres • 7 nurses; • 6 doctors	Semi-structured interviews	Thematic Analysis Using Colaizzi's method	• Chinese community health workers generally supported ACP implementation. • Hindrance factors included insufficient allocation of community health human resources, imperfect ACP legislation in China and traditional Chinese culture. • Standardized ACP training should be organized. • Community medical environment, organizational norms, and human resources in ACP implementation should also be considered.
Yang et al. [67]	To examine factors that are associated with the apprehension levels of oncology nurses toward hospice care.	Zhejiang Province, Mainland China	201 nurses working from the oncology department from 3 first-tier hospitals	Questionnaires using Professional End-of-life Care Attitude Scale (PEAS). Items in PEAS were translated to Chinese with	Statistical analysis using SPSS 16.0	• Nurses with more education experienced less anxiety when providing care for terminally ill patients.

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Table 1 (*continued*)

Author (in alphabetical order)	Aim (s)	Setting	Participants	Data Collection Method	Analytical Approach (as stated in included articles)	Main Finding(s)
	Factors examined in this study included demographics, nursing experience, education levels, title and post, personal experiences, and attitudes toward end-of-life care			terms adapted to Chinese cultural environment		• Education programs on hospice care could be strengthened to help nurses cope with negative attitudes toward end-of-life care.
Zheng et al. [59]	To elucidate Chinese oncology nurses' experience of caring for dying cancer patients	Tianjin, Mainland China	28 nurses who have been taking care of terminally ill patients in a cancer hospital	Semi-structured interviews	Thematic analysis	• EOL care in China is influenced by traditional Chinese culture which increased difficulty of effective EOL communication between nurses, patients and families. • Nurses encountered emotional distress but also benefited from their EOL care experience. • Participants expressed strong desire to provide quality EOL care to patients and families. • Participants suffered from moral distress due to self-limitation, lack of knowledge and confidence and inexperience in psychological care. • EOL cancer care training is needed by Chinese oncology nurses especially for the younger and less experienced ones.

effective EOL communication and patients' autonomy in decision-making in Chinese healthcare settings. Due to the influences of collectivism, Chinese families were reported to function as a unit and play a more crucial role than individual patients in the medical decision-making process across the three regions [42,44,54,55,58,60,61].

Withholding diagnosis from patients at the request of the patients' families was found to be a common practice among practitioners in Chinese healthcare settings, mainly because they wanted to maintain patients' hopes and avoid conflict with the families [42,44,56,57,59,60]. However, withholding diagnosis from patients together with heavy family intervention in medical decision-making in EOL stages raised concerns for practitioners. Family members may not understand the physical condition, diagnosis and patients' pain when considering how to make the best decisions for the patients [42]. Fu et al. [60] reported that participants in their study felt psychological, moral and ethical burdens due to hiding the diagnosis from the patients and linked these burdens with subsequent feelings of guilt and regret. Similar observations were made in research conducted in Taiwan and suggests that the perceived pressure of social and cultural norms may dominate decision-making even if legislation has been introduced to encourage behavioural change. For example, although the *Patient Right of Autonomy Act* mandates informing and sharing information and diagnosis with patients, Taiwanese practitioners found it challenging to strike a balance between families' wishes, appropriate care for the patients and the local legal system [42,44].

3.1.3. *Filial piety as a hindrance to EOL communication*

Filial piety (*xiao;* 孝) is considered to be the core pillar of Confucian ethics [62] and the most important virtue of all. It specifies the moral norms and responsibilities of the parent-child relationship [63] in which sons and daughters are required to obey and take good care of their parents during their lifetime [53]. The concept of filial piety thus sets an expectation as to how the children should treat their parents [64] while at the same time heavily influencing decision-making in medical contexts [42,44,54,55,60,61,65]. Under the influence of filial piety, sons and daughters tend to favour life-sustaining treatments as they are obliged to do everything to prolong their parents' lives. However, these treatments may not be the best options for the patients and this tension can lead to conflicts between patients, their families and healthcare professionals [42,60,65].

Filial piety was reported by Xing et al. [61] as a hindrance to effective implementation of ACP in Mainland China. Chinese people may be accused of being unfilial if they do not actively seek medical treatments for their dying parents. It is therefore difficult for practitioners to engage family members in certain aspects of EOL discussions. Similarly, Lin et al.'s study [44] discussed the pressure faced by Taiwanese healthcare practitioners when initiating palliative care-related discussions with patients and families. Such decisions were often associated with giving up on medical treatments and were likely to be scrutinised under social pressure and cultural norms. Tse et al. [65] also reported conflicts around feeding issues to be a barrier to quality EOL care in a Hong Kong emergency department. Research participants commented that it was difficult for nurses to decide what to do when the patient's condition did not allow tube feeding but families insisted on it because they would be considered unfilial if the patient (a parent or grandparent) died with an empty stomach. Tse et al. [65] pointed out that practitioners had to balance "patients' best interests against the Chinese cultural belief in unconditional filial piety" (p. 227).

3.2. *Practitioners' communication skills and psychological capacity for EOL communication*

3.2.1. *Ongoing needs for practical communication training and education*

Practitioners from Mainland China, Hong Kong and Taiwan reported

Table 2
Factors influencing EOL communication practices in Hong Kong, Mainland China and Taiwan.

Themes	Subthemes	Papers included
Chinese culture and philosophies	Death as a taboo discussion topic	Chan et al. [54]; Chen et al. [55]; Chen and Lin[45]; Dong et al. [56]; Lin et al. [44]; Shi et al. [57]; Wong et al. [58]; Zheng et al. [59]
	Influence of family-oriented decision-making	Chan et al. [54]; Chen et al. [55]; Fan and Hsieh[42]; Fu et al. [60]; Lin et al. [44]; Wong et al. [58]; Xing et al. [61]
	Filial piety as a hindrance to EOL communication	Chan et al. [54]; Chen et al. [55]; Fan and Hsieh[42]; Fu et al. [60]; Lin et al. [44]; Tse et al. [65]; Xing et al. [61]
Practitioners' communication skills and psychological capacity for EOL communication	Ongoing needs for practical communication training and education	Chan et al. [54]; Chen et al. [55]; Chen and Lin[45]; Dong et al. [56]; Fan and Hsieh [42]; Fu et al. [60]; Lin et al. [44]; Shi et al. [57]; Tse et al. [65]; Wang et al. [68]; Wong et al. [58]; Wong et al. [66]; Xing et al. [61]; Yang et al. [67]
	Inadequate provision of psychological support	Chen et al. [55]; Dong et al. [56]; Fu et al. [60]; Xing et al. [61]; Zheng et al. [59]
Legislative and organisational influences on practitioners' confidence and willingness to communicate		Chan et al. [54]; Chen et al. [55]; Dong et al. [56]; Fan and Hsieh [42]; Fu et al. [60]; Lin et al. [44]; Shi et al. [57]; Wong et al. [58]

few opportunities for practical and comprehensive training and skill development in EOL communication [42,44,45,60,61,65–68]. Practitioners tended to perceive a high demand on their capacity to initiate EOL discussions, especially when service users or families had limited understanding of EOL issues and low health literacy [54,55,61]. One practitioner commented that even when patients seemed to understand their physical conditions, they "just kept their heads in the sand" and refused to communicate about broader issues [55] (p. 186). This reluctance or inability to engage in EOL discussions intensified the need for practitioners to navigate the complexities of social and cultural expectations around discussions of death and decision-making with little engagement from service users. This was further complicated by practitioners' low levels of confidence and their own reluctance to engage in EOL communication [56,68]. Practitioners emphasised the need for training and education that included greater opportunities for practical experience and workplace mentorship to improve confidence in their EOL communication including how to initiate and continue discussions about ACP [65–67]. This was echoed in the study of community healthcare practitioners in Mainland China, in which participants reiterated the need for specific training in ACP communication skills so that they could interact in ways that would minimise patients' discomfort, reduce the risk of disputes and comply with ACP practice guidelines [61]. Low levels of confidence and a reluctance to engage in EOL conversations was exacerbated by a general lack of effective training in death education [57], skills in providing psychological support [45,55,59,60] and palliative care in general [58,60].

3.2.2. Inadequate provision of psychological support

In addition to the perceived lack of specific skills in EOL communication, practitioners also highlighted that their efforts to communicate with service users were hampered by inadequate psychological support for them to cope with the emotional demands of their work [55,56,59–61]. Various studies indicated that although service users were likely to experience high levels of stress and exhaustion, care settings usually provided little or no dedicated support for their psychological adaptation [56,59]. Consequently, practitioners often tried to provide service users with the support required, which then increased the complexity of their own communication. Specific strategies that practitioners found helpful included using indirect communication and active listening [55] or showing their concern and care via physical contact (e.g., hand-holding) [56]. Providing this psychological support to service users was highlighted by practitioners as having a significant impact upon their own emotions, stress, and anxiety [56]. Frequent encounters with dying patients were described as the most challenging aspect for practitioners [60] and patient death was also reported as a source of intense psychological stress for them [55,60]. Practitioners stated that due to inadequate workplace support, they had to cope with the accumulated stress on their own and this could lead to a sense of powerlessness and increased irritability [60]. The practitioners involved in Xing et al.'s [61] study particularly underscored the need for specific training about how to care for their own psychological and emotional wellbeing and linked psychological resilience to both willingness and ability to engage in effective EOL communication.

3.3. Legislative and organisational influences on practitioners' confidence and willingness to communicate

Government bodies across locations were identified in this review as having a key role in creating environments in which practitioners felt safe and empowered to discuss topics related to ACP, AD and EOL more broadly [55,56,58,60]. Understanding and clarification of medico-legal and policy-related issues was important for improving practitioners' confidence in communicating about ACP [44,45,60] and advocating for compliance with AD [42,54]. Unclear or ambiguous government policy and delayed enactment of legislation directly affected how practitioners initiated EOL topics with families and service users across locations [42,44,57,58,60]. In Hong Kong, fragmentation of provision across different types of organisations was reported to be exacerbated by a lack of overarching policy frameworks to facilitate sharing of information, multidisciplinary working and movement of patients across settings [58]. It was also noted that there was limited recording of discussions about AD in medical records which restricted opportunities to continue conversations across visits, sites and multidisciplinary teams [58]. Different approaches across wards in a single hospital in Taiwan were observed to influence the continuity of communication [42]. Shi et al. [57] identified the separation of policy and education related to palliative and EOL care in Mainland China as affecting the cohesiveness of EOL communication. Fu et al. [60] also linked unclear mandatory regulations for palliative care in Mainland China with ethical dilemmas and practice uncertainties reported by practitioners. Practitioners in Hong Kong and Mainland China also reported that internal contextual factors such as the physical environments in which they worked influenced their ability to engage in EOL communication. Inadequate resources in terms of staffing levels as well as limited space [58,65] were key hindrances to initiating and maintaining positive communication relationships with service users [61].

4. Discussion and conclusion

4.1. Discussion

This systematic review of empirical research from Hong Kong, Mainland China and Taiwan offers timely insights into aspects of intracultural EOL communication in Chinese contexts. Cultural factors including attitudes towards death and the significance of the family influence communication and shape how prognosis, life planning and medical decision-making is discussed. Awareness of the nature of intracultural communication highlights the importance of developing training, education and awareness raising approaches that are culturally appropriate from the perspectives of both practitioners and service users. Expressions of some cultural preferences around EOL care and communication can lead to tension if they conflict with bioethical principles that dominate contemporary Western medicine and advocate for the enactment of patient autonomy and self-determination [69]. The influence of collectivist culture on EOL care has been studied in various communities including those of Hispanic [70], Latino [69,71] and Korean [72] backgrounds. Our focus on data gathered in Chinese contexts adds to this body of work. Research across these cultural groups has identified similarities in terms of EOL practices that are "family-centred, and influenced by filial piety, or a duty to respect, care for and protect older adults" [69] (p. 49).

It is of note that preferences shared across cultural groups may be expressed through different practices or rationales. For example, Rising [69] observed that an aversion to direct communication and "truth telling" in relation to a terminal prognosis has been linked to practices of "protective communication" in Latino communities (p. 50). This contrasts with descriptions of how Confucianism has shaped family paternalism and information flows in Chinese contexts [69]. However, awareness of cultural differences and preferences should not lead to overgeneralisations or assumptions in terms of choices made by individual service users. As noted by Rising [69] and Ahalt et al. [71], individual choices may not align with cultural preferences expressed at the group or community level. Cultural competence and sensitivity in EOL communication should aim to facilitate the expression of this variability.

In addition to recognising the pervasive influence of cultural and philosophical beliefs on EOL communication, this review has also highlighted the fundamental influence of external contextual factors on practitioners' willingness and ability to engage in EOL communication. It is of note that legislation in isolation does not determine uptake of actions associated with EOL communication generally and ACP more specifically. Research across geographical locations and settings has consistently identified issues of staffing, time and space along with a lack of emotional support as hindering EOL communication [73,74]. Low levels of public awareness and a lack of common terminology also make EOL communication more challenging for practitioners [54,58,60]. This is particularly important in contexts in which service users have limited understanding of concepts related to EOL care and when practitioners need to navigate complex social and cultural expectations. The design and implementation of awareness-raising campaigns in Chinese contexts need to cater to relevant social and cultural approaches to talking about the end of life. Integration of policy and practice is challenging and has hampered ongoing improvements in already developed EOL care systems [5,7]. The challenges in less developed systems will require creative and culturally appropriate strategies for improvement - this need further supports the case for the development of East Asian perspectives on EOL communication.

A potential limitation of this systematic review is that only published, peer reviewed literature was included. A similar review of grey literature including organisational policies, curriculum documents and training materials published in Chinese may give further insight into everyday communication practices in EOL settings. Additionally, as this review focused on studies from Hong Kong, Mainland China and Taiwan, inclusion of other relevant jurisdictions in the East Asian region will further develop knowledge about diverse communication perspectives.

4.2. Conclusion

Communication at the EOL is complex and multifaceted. This synthesis of empirical research has identified a range of cultural, philosophical, personal and contextual factors that influence EOL communication practices amongst practitioners in Hong Kong, Mainland China and Taiwan and calls for ongoing practical and workplace-based training and education that can build practitioner confidence. This review also suggests the importance practitioners give to aspects of verbal and non-verbal communication that can build relationships and trust with service users and their families. Further research into how these factors influence patient autonomy and involvement in decision-making is required and will facilitate the improvement of service delivery, education and public awareness campaigns. The findings of this review contribute to inter- and intra-cultural understandings of communication at the EOL. The insights are of relevance to EOL service development in a variety of locations as EOL practitioners increasingly need to address the needs of diverse and multicultural communities.

4.3. Practice Implications

Three key practice implications are derived from this review. Firstly, EOL communication practices should be culturally appropriate. For example, using indirect communication strategies such as non-verbal cues, body language, euphemisms and storytelling may support communication with patients and families who are uncomfortable with more direct communication. Considering the central role family plays in Chinese and other family-oriented cultures, family involvement should be acknowledged early in EOL communication and decision-making processes [75]. Practitioners should be supported to develop specific communication skills related to facilitating engagement with families. This may include enhanced awareness of family structures and dynamics [76]. Practitioners can also be supported to learn new ways of communicating with family groups including involving families in aspects of daily care activities like washing or brushing hair or teeth, which can help practitioners to develop trust and build rapport. Sharing memories and family stories can also contribute to positive relationship building and facilitate effective communication between practitioners and service users [77].

Secondly, low levels of public awareness of key EOL concepts related to ACP make it likely that some practitioners as well as service users and families may lack confidence when engaging in EOL discussions. To support service users' participation in EOL communication, organisations can actively develop practitioner communication skills and confidence by involving them in the production of resources for use in their settings such as brochures, or online information aimed at service users and families. This will help to establish a shared vocabulary and way of initiating conversations about EOL.

Finally, this review emphasises the need for practitioners to have access to additional and specific training in EOL communication that includes content related to relevant local legislation. Considering the stress and cultural sensitivity associated with EOL care, practitioners' competence in EOL communication, reflective practice and counselling are recommended for prioritisation. This is particularly important for practitioners in community-based settings who may have less access to formalised training programs. Training that focuses on practical experience and workplace mentorship is likely to be most effective. Related to this is the need for practitioners and organisations across EOL care settings to advocate for governments to issue clear ACP and AD practice and application guidelines to facilitate effective implementation policy and the optimisation of EOL care [61].

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CRediT authorship contribution statement

Margo Turnbull: Conceptualization, Funding acquisition, Methodology, Writing – original draft. **Carol Yu**: Conceptualization, Methodology, Writing – original draft. **Xiaoyan Ivy Wu:** Methodology, Writing – original draft.

Declaration of Competing Interest

The authors have no competing interests to declare.

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