

Experience and perspectives on palliative or end-of-life care of Chinese people and their families as immigrants to high-income countries: a systematic review and thematic synthesis

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ABSTRACT

Background A sizeable cohort of Chinese migrants in high-income non-Asian countries is reaching old age and many will develop life-limiting illnesses. They may benefit from palliative care, which is integrated into universal health coverage in many of these countries, but the uptake of this care among migrant communities remains low. Cultural differences between the Chinese and the host community, and poor language skills may be barriers to access, yet understanding the reasons hindering uptake are obscure.

Aims To understand the cultural perspective of how first generation Chinese migrants and their families perceive the provision of palliative care, to identify what exists which may limit their access in high-income non-Asian countries.

Design A systematic review and three-stage thematic synthesis of qualitative studies. Citations and full texts were reviewed against predefined inclusion criteria. All included studies were appraised for quality.

Data source MEDLINE, EMBASE, PsycINFO, CINAHL and PubMed were searched to July 2019.

Results Seven qualitative studies were identified (from USA, UK, Canada and Australia). Across the studies analytical themes that impacted on the use of palliative care services were identified: (1) migrants' intrinsic perceptions of cultural practices, (2) their expectations of and preparation for care at the end of life, (3) perspectives and influences of family and (4) knowledge and communication with palliative care providers in the host country. Key elements found that challenge access to palliative care services in the host countries were: Chinese culture is rooted in the core values of the family as opposed to the individual; migrants' limited experience in their place of origin in accessing healthcare; and practical issues including a lack of language skills of their host country.

Conclusions Palliative care services do not always match the needs of Chinese migrants in non-Asian high-income countries. Engagement and education on multiethnic cultural awareness in both the host non-migrant and the migrant communities is needed.

Key questions

What is already known?

- The use of palliative care services among migrants is less than that of many host populations in high-income countries.
- In traditional Chinese culture death is a taboo which should be avoided when talking with senior family members.

What are the new findings?

- Traditional Chinese medicine may be preferred or taken alongside medical treatments for pain and other symptoms
- The family is central to making key decisions about family members welfare. Death taboo and filial piety can delay direct communication about advanced care planning.
- First generation migrants may lack an understanding of what palliative care is, some may not adequately speak the host countries native language and provision of healthcare translation may be inadequate.

What do the new findings imply?

- The lack of engagement of Chinese migrants in palliative care goes beyond a language barrier. To enhance uptake, the findings suggest the need to further acknowledge the cultural perspectives of migrants including the importance of involvement of the family.

INTRODUCTION

Palliative care, encompassing end-of-life care, is an approach that aims to provide optimal quality of life to people with life-limiting incurable diseases and their families.^{1 2} It achieves this through the early identification of suffering, and the assessment and treatment of physical, social, psychological and spiritual needs. Such care can be provided through hospice care in dedicated facilities or at home. The importance of palliative care is

recognised with its inclusion in the United Nations' International Covenant on Economic, Social and Cultural Rights in 2000 and it has now become integrated into universal health coverage in the health systems in many countries.³ The provision of palliative care services is well established in high-income countries, where advanced hospice-palliative care is often integrated into mainstream healthcare service provision.^{4,5} The global coverage and payment of such services varies by country,⁴ which in turn influences the health-seeking behaviour of people at a palliative stage of a disease. There are also inequalities in access within countries beyond any regional differences, this includes certain population groups.⁶ One such group are ethnic minorities, other groups include those living in more deprived areas or who are socially isolated.

There are policy and organisational initiatives that aim to reduce disparities in accessing palliative care including in the USA,⁷ in Scotland⁸ and across the UK.⁹ Some strategies that aim to be culturally competent for ethnic minority needs have been integrated into countries' health systems. This includes provision of education for healthcare providers on the unique customs of minority populations, and development and application of skills aimed at embedding race-equality strategy. These may involve education on the appropriate codes of behaviour towards ethnic diversity, and ensuring that all organisational procedures and decisions are clear and equitably applied within the context of a diverse patient population.¹⁰ Although findings from the USA have suggested that these strategies have had limited impact in the uptake of palliative care services among migrant communities.¹¹ Other recent initiatives have recommended the need to gather more on the experiences and needs of population groups that access less palliative care.⁹

To better understand the engagement and uptake of palliative care by migrant populations, it is helpful to look at trends in global migration since the Second World War, which saw population shifts from lower-income countries to higher-income ones. The Chinese diaspora community refers to Chinese living outside China, Hong Kong, Taiwan and Macau. They are a good example illustrating these shifts, where major changes to the immigration policies of high-income non-Asian countries, particularly in Anglophone countries such as the USA, Canada, the UK and Australia from the mid-1960s onwards,¹² have seen increases of ethnic Chinese migration. Chinese migrants now make up a sizeable proportion of the population of the USA, Canada and Australia.^{13–15} For example, in the USA since 1980, there has been a sixfold increase Chinese immigrants and who in 2018 totalled over 2.4 million people. Currently, in Australia, this group makes up 8.9% of the foreign-born population.

Many of the Chinese who migrated at working age in the mid to late 20th century will now be reaching older age. This older group of migrants are now at an increasing risk of developing advanced life-limiting illness (malignant and non-malignant), leading to physical,

psychological and social needs, which may benefit from a palliative care approach. Chinese migrants generally like other minority groups have greater difficulty in accessing health services in their host country^{16,17} and are less likely like other minority groups to receive formal palliative care services than host populations, despite the general availability of these services in these high-income Anglophone countries. Several factors are likely to account for the lack of uptake of healthcare services by the Chinese migrant population. One, cultural differences between the Chinese and the host community. The traditional values held by some of the Chinese migrants, such as filial piety and collective well-being of families can be seen to contradict the culture of high-income Anglophone countries, with its greater emphasis on individualism and a de-emphasis on extended kinship relationships.¹⁸ Thereby when approaching death migrants may understandably have a preference for adopting Chinese practices than those of the host country.^{19,20} Another factor is their experiences of healthcare in their country of origin. China's health system, for example, especially before the reform introduced in 2009, was one of the typical healthcare structure in developing countries which required a large proportion of out-of-pocket payment, and lacked social health security or insurance coverage. The unaffordability of healthcare in turn limited its access among both urban and rural residents of China.^{21,22} Another factor limiting Chinese migrants' interaction with host healthcare service may be poor English language skills, as unlike subsequent generations, those now reaching older age are likely to have received a more limited education.²³

There are known qualitative studies that have explored Chinese migrants to high-income countries in relation to end-of-life and palliative care. To identify how to potentially improve access to provision of palliative care and what barriers exist preventing Chinese migrants from accessing this care, this systematic review, through a thematic synthesis of qualitative studies, builds on these studies to seek a more in-depth understanding of the cultural perspective to how Chinese migrants and their families perceive and experience the provision of palliative care.

METHODOLOGY

Review framework including patient and public involvement

In this systematic review, we followed recommended approaches and tools as appropriate to our research question. We did not involve patients and public in the research process.

Identifying studies for review

We included qualitative studies on the perspectives of Chinese migrants who either received palliative care or were family caregivers if they met all the criteria in [box 1](#).

Search strategy and selection criteria

Database searches were conducted from inception to 22nd July 2019 in MEDLINE (OVID), EMBASE (OVID),

Box 1 Study inclusion criteria

Inclusion Criteria

1. Study design

Qualitative study, defined as:

 1. Data collection using in-depth or semistructured interviews and/or focus group discussions.
 2. Data analysis method being qualitative.
2. Study population and aim

Participants were first generation Chinese migrants who either received palliative care or were family caregivers and for which their perspectives were sought.
3. Data
 1. There were extractable data on Chinese migrants' perceptions of receiving palliative care either in general or in specific services, for example, what do they know about the end-of-life care, or how do they perceive the healthcare workers providing them the service. If the study included Chinese migrants and participants from other ethnic groups, only data on Chinese migrants were extracted.
4. Palliative care

The topic for which the participant's views were sought was palliative care. This included pain management, end-of-life discussions or advanced care planning in all settings, for example, hospice or home care, and regardless of patients' age and medical condition.
5. Reporting language

Only papers written in English were included.
6. Report format

Only empirical studies published in peer-reviewed journals were included. Dissertations, thesis and conference abstracts were not included.

PsycINFO (OVID), CINAHL (EBSCO) and PubMed. Full search terms and strategy are detailed in online supplemental appendix A. The reference lists of relevant papers were examined to ensure all relevant studies were included. Screening of titles and abstracts was undertaken by one author (HHYK) with a sample checked by other authors to ensure consistency. All authors agreed those to be included at full text.

Quality assessment

The Hawker quality assessment tool²⁴ was used to examine the methodological rigour of the reviewed articles. Nine items were assessed and scored by a four-point Likert scale, ranging from 1 (equivalent to 'very poor') to 4 (equivalent to 'good'). These items related to the abstract, introduction, methods, sampling, data analysis, ethics, results, transferability and implications. To ensure the comprehensiveness of information, all studies, regardless of their quality, were included in the synthesis. We did explore if the level of quality studies contributed to our themes in a different way. If this was found and appeared to impact on the results, we took this into account in our conclusions.

Thematic synthesis

We followed a three-stage method for thematic synthesis: (1) categorising the text segments based on their meaning (the line-by-line coding of text); (2) developing

descriptive themes by grouping similar codes with meanings and (3) generating analytical themes (overarching themes) by considering the descriptive themes in relation to an operational framework depicting how the participants perceive and receive palliative care.²⁵ First, the direct quotes and their corresponding line-by-line codes were presented in a table in a Microsoft Word document, followed by deriving higher-level free codes from the initial codes (see online supplemental appendix B). Second, all free codes were put in a Microsoft Excel file for grouping according to their meanings. Descriptive themes were generated by the similarities among the free codes. Third, the descriptive themes were rephrased or summarised in clearer terms to generate analytical themes (overarching themes) according to the objectives of this review. One reviewer generated this (HHYK) and the second checked it (BC).

RESULTS

The search strategy identified 369 citations. At screening 35 studies were potentially relevant. At full-text assessment seven studies were included.^{26–32} The reasons for exclusion are shown in figure 1.

Table 1 describes key characteristics of the included studies. Four studies were conducted in the USA^{29–32} with the remaining in the UK,²⁶ Australia²⁷ and Canada.²⁸ Purposive sampling or snowball sampling were mainly used in the studies and data were collected through interviews or focus group discussions. Grounded theory and interpretive thematic analysis were adopted as analytical methods. Apart from one study²⁸ which was a focused ethnography. Perceptions and feelings in receiving palliative care, as well as barriers of deterring people from accessing palliative care were explored in all studies.

Participants

Overall the views of 82 recipients of palliative care (patients), 23 family carers (all adult children), and 21 healthcare providers were presented in the studies (table 1). In Fang *et al*²⁶ and Mondia *et al*,²⁹ these were those of Chinese migrants aged under 55 years. Yonashiro-Cho *et al*³⁰ recruited mainly elder Chinese, while Chi *et al*³¹ and Nielsen *et al*²⁸ recruited adult children and healthcare providers. Heidenreich *et al*²⁷ explored the views of family carers aged between 55 and 65 years. The perspectives of only female migrants, were explored in studies of Fang *et al*,²⁶ Heidenreich *et al*²⁷ and Mondia *et al*²⁹

Quality appraisal

Table 2 presents study quality assessment,²⁴ which showed variable quality across the studies. Of the seven studies, Fang *et al*²⁶ was of highest quality, its findings contributed (because of relevance) the most to the data synthesis in this paper.

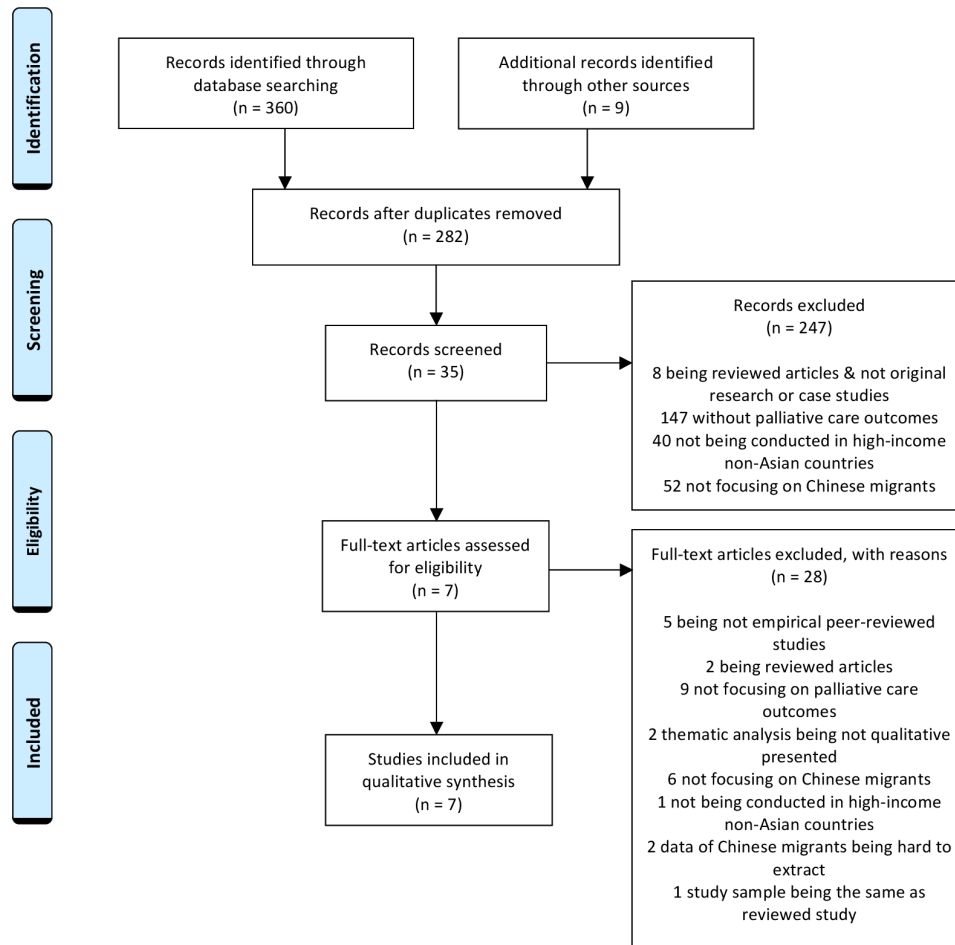


Figure 1 PRISMA flow diagram of primary studies. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

Results of data synthesis

The four overarching themes that emerged from our data synthesis were: (1) intrinsic perceptions of cultural practices, (2) patient expectations on care at the end of life, (3) perspectives and influences on family carers and (4) knowledge and communication in regard to palliative care provision in the host country. We found subthemes within these groups that highlight both differences that Chinese patients and their families may have in general with those in the host country (e.g., the concept of filial piety) but also end-of-life issues that may be similar irrespective of cultural background (e.g., not wanting to burden others).

Table 3 outlines the main themes and their corresponding subthemes. The thematic analysis process is documented in online supplemental appendix B.

Intrinsic perceptions of cultural practices

This theme reflected the participants (mainly the recipients of care) understanding of their traditional cultural beliefs and how it may affect their perceptions on palliative care in their host country. This was found in four studies.^{26–28 32} Recipients described being conflicted by the social norms of the host country that pertain to end-of-life care including the differing roles and expectations

of family and healthcare providers, and in care management.^{26 32} They talked about a sense of obligation to follow host country’s cultural expectations. Moreover, as perceived ‘newcomers’, migrants needed to engage in society outside the Chinese circle,²⁶ as they were geographically and socially detached from their original family and community support systems in their place of origin.²⁷ Some preferred worshipping Chinese gods, but felt pressured to accept new religious images relevant to the host culture.²⁶ A mix of traditional Chinese and current treatments were used by some (Nielsen *et al*²⁸), despite the integration of traditional Chinese medicine alongside current mainstream treatment being discouraged by healthcare providers.^{28 32} Some described these challenges as ‘dampening’ their mental well-being.

Another common thread in these studies was that as Chinese migrants they saw dying as a private matter, and that additional support beyond the family was not important.

Having your family take care of you is better than having the government do it.—Chinese woman living in England²⁶

Participants believed that as death is natural and inevitable,²⁶ treatments were not needed, in particular taking high doses of medications.³² There was reluctance



Table 1 Characteristics of studies included in review

Author	Title	Aim(s)	Setting	N	Participants	Data collection method	Analytical approach
Fang ²⁶	Exploring traditional end-of-life beliefs, values, expectations, and practices among Chinese women living in England: Informing culturally safe care	To explore the end-of-life beliefs, values, practices, and expectations of a select group of hard-to-reach Chinese women living in England	England, UK	11	Marginalised Chinese women aged 25–54	Individual in-depth semistructured interviews	Grounded theory
Heidenreich ²⁷	The experience of Chinese immigrant women in caring for a terminally ill family member in Australia	To explore the influence of Chinese cultural norms and immigration on the experience of immigrant women of Chinese ancestry caring for a terminally ill family member at home in Sydney; To identify factors that may present access barriers to palliative care support services	Sydney, Australia	5	Asian women carers of Chinese ancestry reside in Sydney, aged 55–65	Semi-structured face-to-face in-depth interviews	Interpretive thematic analysis
Nielsen ²⁸	Patient-centred care or cultural competence: Negotiating palliative care at home for Chinese Canadian immigrants	To deepen thinking and understanding of Chinese immigrant experiences of palliative home care	Ontario, Canada	23	11 key informants four first generation Chinese immigrants, aged 50–80 five family care givers three home visiting nurses	Focused ethnographic study; in-depth open-ended individual interviews	Postcolonial theory
Mondia ²⁹	The impact of Asian American value systems on palliative care: Illustrative cases from the family-focused grief therapy trial	To examine the challenges and opportunities that arise in family work and examine the cultural underpinnings that impact on outcomes	USA	5	Chinese American family (care recipient, her brother, older sister, two nieces)	Qualitative analysis of 36 therapy sessions	not stated

Continued

Table 1 Continued

Author	Title	Aim(s)	Setting	N	Participants	Data collection method	Analytical approach
Yonashiro-Cho ³⁰	Knowledge about and perceptions of advance care planning and communication of Chinese-American older adults	To explore the knowledge, attitudes, and preferences of older Chinese Americans toward advance care planning	USA	34	Chinese-American older adults residing in urban areas	Focus groups	Grounded theory
Chi ³¹	Please ask gently: using culturally targeted communication strategies to initiate end-of-life care discussions with older Chinese Americans	To explore communication strategies for Health care providers (HCPs) to initiate end of life care discussions with older Chinese Americans in the San Francisco Bay Area	San Francisco Bay Area, USA	30	14 community-dwelling older Chinese Americans nine adult children 7 HCPs	Qualitative (focused) ethnographic study; Field observations; Individual semistructured interviews	Constant comparative analysis
Duke ³²	Perspectives of Asians living in Texas on pain management in the last days of life	To determine the attitudes about and preferences for pain management in the last days of life for persons born in Japan, China and Vietnam living in	Texas, USA	18	Chinese residing in Texas, aged 29–82	Descriptive qualitative study; a combination of individual and small focus group interviews	Thematic analysis

Table 2 Quality appraisal scores (using tool from Hawker *et al*²⁴)

Source paper (n=7)	Abstract/title	Introduction/aims	Method/data	Sampling	Data analysis	Ethics/bias	Results	Transferability	Implications	Score (out of 36)
Fang <i>et al</i> ²⁶	4—Structured abstract with full information title is clear	4—concise background to discussion, contain up-to-date literature review, highlight gaps in knowledge; statement of aim and objectives may not be clear but can still be found in the paragraphs	4—method is appropriate and described clearly (interview themes mentioned); clear details of the data collection and recording	4—appropriate sampling method; details of who was studied and how they were recruited; explained the reason of being targeted; response rate and justification of sample size are not mentioned in the study	4—clear description of how analysis was done; detailed description of how themes derived	4—ethics: address issues of confidentiality, sensitivity and consent; bias: researcher was reflexive and aware of own bias	4—findings are explicit and easy to understand as the authors divided them into different paragraphs per different themes; tables are explained in text; results directly related to aims	3—only insights of young and marginalised women affected generalisability	4—provided insights from a gender lens, letting us to see whether women being treated unequally; suggest ideas for further research and implications for policy and practice	35
Heidenreich <i>et al</i> ²⁷	4—structured abstract bit better to divide in sections	3—clear statement of aims but no objectives	4—appropriate and described in detail; included interview questions; clear details of the data collection and recording	4—inclusion criteria listed and sampling method appropriate; how study population being recruited described clearly; justified why target this group of participants	4—clear description on how analysis was done; how themes derived are described	3—researchers' own bias not acknowledged	4—findings easy to understand, tables are easily read and explained in text; results relate to aims	3—some context and settings are described but replication of study with larger sample size and different sites are needed	4—contribute to something new; discussed the research question (communication); suggestions of ideas for further research and implications for nursing practice	33
Nielsen <i>et al</i> ²⁸	3—abstract not in good structure	3—full background for explaining the framework used in the study but little mention in the knowledge gap; literature review and background is adequate but aims and research questions not clear	1—no details of data collection	3—inadequate information of sampling strategy	1—no details of data analysis	2—no mention of bias acknowledged	4—findings were easy to follow and understand in a logical progression with subheadings; results directly related to purpose of the study	3—context and setting of the study is described	3—new insights mentioned; suggested ways for policy change	23
Mondia <i>et al</i> ²⁹	3—abstract with most of the information; purpose was not stated	3—inadequate background and literature review; aim and objectives are mentioned; research gap is acknowledged	3—method can be described in details	2—mention of sampling method or settings	2—inadequate details of data analysis	2—only one sentence for de-identification	3—presented logically but more can be added to illustrate results	2—only some context and setting described	3—further research direction and clinical implications are mentioned	23

Continued

Table 2 Continued

Source paper (n=7)	Abstract/title	Introduction/aims	Method/data	Sampling	Data analysis	Ethics/bias	Results	Transferability	Implications	Score (out of 36)
Yonashiro-Cho <i>et al</i> ³⁰	3—abstract with most information but not well-structured	3—some background to discussion, highlighting in knowledge gaps; clear statements of aim and objectives; no research question mentioned	3—method appropriate and data collection is given; recruitment mentioned but can be further elaborated in detail; focus group protocol is included	3—appropriate sampling method; recruitment can be given in detail	3—described grounded theory used and theme derived from coding; more can be given	1—no mention of issues of confidentiality, sensitivity or consent	3—findings in logical progression but can be elaborated more; demographic table was explained in text; data presented relate directly to results	Three context and settings of immigrants in America was described but the interpretation of results may not be generalisable	4—good to suggest informal and indirect ways for communication	26
Chi <i>et al</i> ³¹	4—structured abstract; good literature review	3—concise background to discussion; highlighted the knowledge gap; clear statement of aim but no objectives mentioned	4—appropriate focused ethnographic study with justification; data collection is described with sample interview questions; handling of data is described with information	3—sampling method is appropriate; inclusion criteria recruitment process described; why this group is targeted is missing	4—clear description of how analysis was done; description of how theme derived using open coding and there was triangulation to strengthen the study's rigour	2—only mention informed consent given	4—incldings are explicit and easy to understand; shown clearly in tables; results related directly to aims; direct quotes were presented to support findings	3—context and settings were given and described	4—new insights demonstrated; suggested ideas for further research; suggested implications for practice	31
Duke and Petersen ³²	4—structured abstract with aim, method, results and conclusion; clear title is given	3—no mention of objectives	4—method is described clearly; details of data collection clearly shown	4—inclusion and exclusion criteria of participants described; how they recruited was stated; why this group being targeted mentioned; sample size has justified but response rate is shown yet without explanation	4—clear description of how themes derived: using Krippendorff's thematic data analysis method	3—informed consent was address but confidentiality and sensitivity were not acknowledged; researcher bias was addressed through training for them	4—findings explicit to understand; four themes were discussed point by point; table with themes and subthemes was elaborated in text; results related directly to aims; direct quotes from interviews and focus group discussions used to support the findings	3—most context and setting described, data collected through the study subjects were not generalisable	3—new insights that there should not be cultural stereotype and assumption based on ethnicity or culture group; suggests implications for practice	32

Table 3 Themes, subthemes and included reviewed articles

Themes	Subthemes	Papers included
Intrinsic Perceptions of Cultural Practices	Cultural background and practices Gender role in care	Fang <i>et al</i> ²⁶ Heidenreich <i>et al</i> ²⁷ Nielsen <i>et al</i> ²⁸ Duke and Petersen ³²
Expectations and Comments of Patients on care at the end of life	Personal expectations Healthcare service provision Self-recognition and concerns Appropriate timing	Fang <i>et al</i> ²⁶ Heidenreich <i>et al</i> ²⁷ Nielsen <i>et al</i> ²⁸ Mondia <i>et al</i> ²⁹ Yonashiro-Cho <i>et al</i> ³⁰ Chi <i>et al</i> ³¹ Duke and Petersen ³²
Perspectives and Influences on Family Carers	Considerations of caregivers Caregivers' health Barriers in care engagement	Heidenreich <i>et al</i> ²⁷ Nielsen <i>et al</i> ²⁸ Mondia <i>et al</i> ²⁹ Yonashiro-Cho <i>et al</i> ³⁰ Chi <i>et al</i> ³¹ Duke and Petersen ³²
Knowledge and Communication in regards to palliative care in host country	Knowledge of end of life care Communication and relationship	Fang <i>et al</i> ²⁶ Nielsen <i>et al</i> ²⁸ Yonashiro-Cho <i>et al</i> ³⁰ Chi <i>et al</i> ³¹ Duke and Petersen ³²

to involve healthcare providers for fear of treatment side effects and that they may lose their autonomy,^{26 27} although for some, this reluctance was based on previous negative experiences of using healthcare services in their place of origin.³²

While participants had an expectation of their families providing care for them, this was not straightforward. Some saw problems about by being cared for at home, with one participant stating a superstitious belief that if you die at home, your home cannot be resold, while for others it was a fear of burdening their family.²⁸

Care recipients' expectations of and preparation for care at the end of life

This theme on perceived care at the end of life was seen in all studies.

Participants had strong beliefs about the importance of family values, and that care decisions were often made collectively or deferred to the family.²⁷ Some participants highlighted the loss of these values in their children as second generation citizens of the host country.²⁷

Participants seldom expressed the need to discuss advanced care plans (end-of-life care discussions) and only did if they had managed to accomplish all their wishes with their family^{31 32} or when they felt that they

were in their late stages of life.^{26 30 32} Moreover, they would not actively initiate end-of-life care discussion with their family even when the pain exceeded their tolerance level.^{30 32}

Towards the end of my mum's life, my mum would like to discuss [end of life care preferences] ...—Chinese person living in USA³⁰

Some senior family members expected their children to be the primary caregivers,²⁶ but at the same time, these senior family members would also avoid imposing on their family when they were dying.^{28 32} Likewise, patients did not want to appear troublesome to their healthcare professionals and went out of their way to please them.^{27 29 32}

... please the doctor or nurse ... [and desires] to be easy to deal with, I'm not a trouble maker ...—Chinese person living in USA³²

Some participants anticipated that to provide culturally appropriate care, healthcare providers would need to be sensitive about the 'taboo' surrounding the discussion of death and respect other nuances of Chinese customs such as incense or paper money burning in relation to Taoist belief.^{26 31}

any time you're dealing with an older Chinese, ask them "Are you superstitious about talking about preparing for death?"—Chinese person living in USA³¹

In two studies participants found that the culturally sensitive service was substandard in the availability of interpretation services and ineffective in the self-translation by using electronic dictionary. This contributed to the underutilisation of services.^{26 30}

Perspectives and influences on family carers

This theme looks at the views and concerns of family carers towards palliative care.^{27–32} Carers were found to be reluctant in seeking external assistance and preferred not to disclose the terminal nature of illness to their sick family members.²⁷ If end-of-life discussions with the patient and their family were seen as necessary, some insisted they should be initiated by the healthcare providers.^{30 31} Children initiating end-of-life discussion was perceived as cursing their parents to die, which in other words was unfilial.³⁰

It's better for the parents to bring it up first. Otherwise, the children might worry that ... their parents will feel like the children are trying to curse that they are dying—Chinese woman living in USA³⁰

While adult children may care for parents out of familial bonding and individual feelings of responsibility,^{26 27} some may be unable or unwilling to.

if we are living in our own culture there is always the case for children to be looking after their parents. So normally they would stay home together with their children. But here because of the Western influence they become

independent and they move out and they don't want to live with their parents.—Chinese woman living in Australia²⁷

Knowledge and communication in regard to palliative care in host country

Five studies^{26 28 30–32} explored the ways in which the knowledge of services and treatments such as pain management, and the timing of end-of-life discussion, impacted on the experiences of migrants. In general, both patients and family carers had limited knowledge of palliative care practice in their host country.^{26 28 32} For many, palliative care services did not exist in their place of origin (China, Hong Kong and Taiwan) or at least at the time they left to move to their host country. This in turn limited their understanding of what palliative care may be in the host country, and so had an impact of their demand and uptake for this type of care.²⁸

I don't think they 100% understand what is palliative care for them...In China or in Hong Kong we don't have home care.—a home care nurse from Hong Kong²⁸

Some migrants feared a loss of cognitive functioning out of addiction or overdose to medications which may be offered as part of pain relief. This in turn decreased participants' acceptance of this service.³²

Participants who could not express themselves well in English found it hard to communicate and negotiate with the healthcare professionals.²⁸ Some suspected their doctors discriminated against them due to their limited English language skills.²⁶

If the doctor is impatient, he doesn't want to spend a lot of time listening to us. Because we are limited in the English language ...—Chinese woman living in England²⁶

English-speaking migrants had less misunderstanding and were more familiar with the palliative care service than the non-English-speaking individuals.³⁰ However, even those confident in speaking English were still reluctant to engage with palliative care.³⁰ Many preferred speaking in their dialects when using health services.²⁶ Though healthcare providers attempted to match their patients with staff by ethnicity, they were not aware of the importance of dialect matching.²⁸ In adopting a culturally targeted communication approach to encourage migrant to use palliative care, participants felt that healthcare providers needed to have good understanding of Chinese cultural complexity.^{26 31} They needed to ensure that when discussing end-of-life issues with participants to consider engaging in indirect communication, where these conversations do not directly discuss the participants' own health deterioration, but brooch these topics in general terms.³¹ Participants felt that the use of these strategies would lower the stress levels of Chinese recipients of palliative care.^{30,31}

DISCUSSION

This thematic synthesis of seven qualitative studies captured the experiences and perceptions on palliative

and end-of-life care of Chinese who had migrated to high-income non-Asian Anglophone countries. Most respondents were either recipients of palliative care or family members involved in caring for someone using palliative care services. The synthesis identified four overarching themes which may limit palliative care access to Chinese migrants in their host country: (1) their intrinsic perceptions of traditional cultural practices, (2) participants' own expectations about end-of-life care, (3) the perspectives and influences of family carers and (4) participants' knowledge about palliative care provision in the host country. Each theme was represented in data in more than half of the included studies, thereby demonstrating a commonality of findings across the body of work. Overall the synthesis identified three key elements from these themes. One, Chinese cultural ideology and the stronghold of traditional practices. Two, the limited experience of these migrants in accessing healthcare in their place of origin before migrating overseas. Three, practical issues such as a lack of language skills of their host country, which limited their communication with healthcare professionals. For some Chinese migrants these elements limited their use of host healthcare system including to access palliative care.

We found that some recipients of palliative care had a deep-rooted Chinese cultural ideology which is different from the host culture. Chinese culture is strongly influenced by Confucianism and Taoism, where death is natural and inevitable but associated with fear and mystery. It is not regarded as another phase of life in the way that many Christians believe.³³ The family is the fundamental social unit throughout Chinese history. Thereby the goal of advanced care planning as a means to facilitate patient autonomy is at odds with Chinese traditional culture, where individual autonomy is subordinate to other authorities including family values.^{19 34} A Chinese saying goes, 'Rear sons for help in old age; and store up grains against famine'. This notion encourages people to raise children and provides old people a sense of security. Together with filial piety, traditionally Chinese people are encouraged to be responsible for taking care of their parents when they grow up. In contrast, the dominant culture in many high-income countries, in particular Anglophone, promotes individualism, with children moving away from the family when they grow up. This strong sense of collectivism, unity and togetherness within Chinese families illustrates Chinese migrants' preferences of receiving support and care from their family, and making decisions collectively as opposed to relying on healthcare providers.

Our findings illustrate that the reluctance of Chinese migrants both to seek help from healthcare providers and their sometimes negative feelings for palliative care provision in their host country may also partly stem from their own past experience of healthcare in their place of birth and the differences between this and the care provided in their host country. Access and affordability to mainland China's healthcare system has been poor

especially prior to the 2009 healthcare system reform, in which a large proportion of the population had no financial health protection and were required to make high out-of-pocket payments for healthcare.³⁵ For example, in 2003, 45% and 79% of urban and rural populations, respectively, were not covered by social health insurance schemes.³⁶ In Hong Kong, there are also issues in access and affordability. The public healthcare sector has been overburdened for decades by its high usage rate with low user charges, leading to long waiting lists for many healthcare services.³⁷ This unresolved issue has pushed the Hong Kong government to advocate public-private partnership and encourage citizens to get private health insurance.³⁸ However, the uptake of insurance has been found to be limited.³⁹ Thereby, Chinese migrants have been accustomed to relying on family for support due to inadequate public healthcare financial support. This contrasts with host countries where the local population is used to accessing public health system including free access to palliative care. Although this is not the case everywhere, in the US palliative provision is funded by Medicare and private insurance plans.

For many Chinese migrants, there may be a misunderstanding of what palliative care in their host countries offer, in particularly pain control, which many believe would lead to opioid addiction.³² This may in part have a historic link to the Opium Wars between Britain and China in the 19th century and associated wide-spread addiction, but also because they may feel that their preference for traditional Chinese medicine would be discouraged by healthcare providers in their host countries. Although some second-generation Chinese were less willing to conform to traditional Chinese cultural expectations, others who were family caregivers were reluctant to seek help from the health system. They preferred to do all aspects of care themselves. This may be as they perceive that doctors were not competent in placing their own interests above those of the patients when making decisions,³⁹ in contrast to family members who are better able to make judgements according to the patients' best-interest judgements. However, there may also be pragmatic reasons for family members continuing to care for their relatives such as the loss of family money if the relative went into a nursing home.

Chinese migrants had limited knowledge of palliative care or its potential benefits, though this lack of knowledge may also apply to some members of host populations, in particular those who have not experienced friends or family receiving such care. One difficulty migrants have is poor English language skills which limits the ability of healthcare providers to engage with this patient group about the services that palliative care can offer. In the USA, the UK, Australia and Canada, there are policies and guidelines on translation and interpretation service that aim to help ensure people are able to get access to healthcare service regardless of their languages, despite the different health systems. Although previous studies have shown an underuse of professional interpreters

in the USA and Australia, for example,^{40 41} we are not aware of research showing if the provision of interpreters meet the demands of Chinese migrants. Our review identified that participants preferred to use their own dialects/languages in accessing healthcare, suggesting that it is equally important for healthcare providers not to treat the Chinese migrant community as a homogeneous group. Although, language ability alone is not the only issues to consider as even Chinese migrants with good English language skills were reluctant to use palliative care services, again emphasising the importance of cultural factors.

Chinese migrants can benefit from palliative care service as much as other populations; the key difference lies in their medical help-seeking behaviours. Fogg behaviour model⁴² suggests that people are able to have their behaviour changed only when they are motivated enough and have the capability to perform the desired behaviour. In our review of literature, Chinese migrants at a palliative stage of a disease and their families were not always motivated to seek help from professional healthcare workers because of various hindering factors which we found were mainly rooted in cultural differences. Without recognising the importance of these barriers, the successful promotion of palliative care in the form of professional care will be limited.

Strengths and limitations

We believe this is the first systematic review specifically in this area. It used rigorous and transparent methods in assessing study quality and in analysis of data. Resource limitations, however, prevented us involving patient and public in the research project. Their input would have been particularly informative in the thematic synthesis. However, the themes that emerged were well represented across the studies which were all published relatively recently and represented the voices of over 100 patients and their families. Overall, the methodology used in the papers reviewed were appropriate. All the included studies came from high-income Anglophone countries, mainly the USA and Canada. These two countries represent two forms of healthcare, which may not be generalisable to other countries. Our sample was predominantly female as three of the reviewed articles^{26 27 29} targeted only female Chinese migrants in part perhaps as they are more likely to be their parents' caregivers.⁴³ Nevertheless, we found that their perceptions on palliative care were consistently similar to male participants. Our participant sample comprised participants speaking various dialects, and came from mainland China, Hong Kong and Taiwan. We assumed that this represented the Chinese diaspora community, but acknowledge that we were unable to separate according to the place of origin, a factor which may be important in affecting participants' experience in accessing both health and palliative care. Another consideration is that our findings focused on limitations preventing migrants accessing palliative care. The barriers we found are not relevant to all migrants as

many may not follow traditional culture, they may lack religious beliefs and have a very open attitude towards life and death issues. They may have also enjoyed better medical treatment in their country of origin than is available in their host country and have not migrated for economic reasons.

Implications for practice

Cultural beliefs of Chinese migrants were highlighted as a key barrier to palliative care services in this population. While it is beyond the scope of this review to recommend certain policy or practice initiatives that may increase uptake, we can suggest a few potential strategies in developing more culturally sensitive services.

One is the recruitment of language-competent healthcare professionals, ideally first generation ethnic Chinese migrants, who would be available to match with the migrant population in terms of dialects/languages. Additional staff in the form of qualified translators working in healthcare would be needed and could be used to support palliative care professionals in this context, provided they were given appropriate training in palliative care for this role. It would be important to monitor these language assistance services for uptake and effectiveness. A second strategy is training healthcare providers on how to communicate effectively with the Chinese community when talking about palliative care. Healthcare providers need to be aware that a more nuance and indirect approach may be required when discussing issues related to health deterioration and death to Chinese migrants. It is important to recognise the traditional taboo on talking about death. Some families may be reluctant and uncomfortable to initiate a conversation about end-of-life discussions with a sick relative and would prefer this to be done by health professionals. In communicating with patients and their families, health professionals could consider substituting the term 'palliative' or 'end-of-life care' with other wordings like 'comfort treatment'.⁴¹

Our findings highlight that Chinese participants often rely on family members to provide their care. In turn, family members are reluctant to use palliative care services, although they may prefer healthcare providers to discuss disease progression and end-of-life wishes with the patients. Healthcare providers should aim to establish an early working relationship with family members of patients, to gain their trust and explore ways in which they can discuss sensitive issues of disease progression with the patients. We found Chinese migrants are unclear about the role of palliative care. One way of improving both their knowledge and engaging them in palliative care service, could be through appropriate social support groups for Chinese migrants such as Chinese community centres where community workers could act as mediators or educators.⁴⁴

Further research

Our review focused on the perspectives of Chinese migrants' views of palliative care and those of their adult

children. To develop more appropriate palliative care services for this community, a greater understanding of the perspectives of healthcare providers delivering palliative care to this group is also required. In particular, those professionals with direct experience of working with the target population, suitably qualified and experienced first generation ethnic Chinese health professionals. Our review amalgamated findings from a heterogeneous sample of Chinese migrants from Taiwan, Hong Kong and mainland China. Although all migrants will have similar roots in their belief systems, their place of birth together with their differing cultures, customs and dialects, will influence their perspectives and their expectations to palliative care. Future studies should be conducted on these distinct Chinese populations and/or at least take place of birth into consideration when analysing their data. Studies are needed in other countries of migration beyond high-income Anglophone countries.

CONCLUSION

Chinese migrants, especially first generation, coming to high-income countries may have concerns on receiving palliative care services. This may be due to a preference for their own cultural practices, and their limited knowledge of care systems in host country. Healthcare providers in the host countries need to acknowledge that their services may be insufficiently sensitive to the differing cultural needs of this ethnic group. These include communication issues in terms of recognising differences in linguistics across Chinese populations and in how a family chooses to make healthcare decisions.

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Correction: *Experience and perspectives on palliative or end-of-life care of Chinese people and their families as immigrants to high-income countries: a systematic review and thematic synthesis*

Kwok HHY, Low J, Devakumar D, *et al.* Experience and perspectives on palliative or end-of-life care of Chinese people and their families as immigrants to high-income countries: a systematic review and thematic synthesis. *BMJ Global Health* 2020; 5: e003232. doi:10.1136/bmjgh-2020-003232.

The published version in the discussion section has below two missing references and their respective in-text citations.

1-Haishan H, Hongjuan L, Tieying Z, *et al.* Preference of Chinese general public and healthcare providers for a good death. *Nursing Ethics* 2015;22:217–27.

This reference supports, in addition to the one in the published version, in-text the following statement:

It is not regarded as another phase of life in the way that many Christians believe.

2-Zhou T, Zhang P-t, Mo J-f. The Preference of Palliative Care and Hospice in Patients with Advanced Cancer. *China Cancer* 2011;20:741–5.

This reference supports in-text the following statement:

In communicating with patients and their families, health professionals could consider substituting the term “palliative” or “end-of-life care” with other wordings like “comfort treatment”.

The reference in the published version does not support this statement.

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APPENDIX

Table 1: Search terms and search strings**Table 2: Step one of thematic synthesis: Generation of line-by-line codes from reviewed articles****Table 3: Step two of thematic synthesis: Generation of free codes (higher level) from line-by-line codes****Table 1:** Search Terms (key words and subject heading terms) and search strings of databases used

MEDLINE / EMBASE / PsychINFO (OVID)	CINAHL	PubMed
1 experience.mp.	(palliative care or end of life	((palliative care) OR (hospice
2 perspective.mp.	care or terminal care or	care) OR (end of life care) OR
3 perception.mp.	hospice care) AND	(end-of-life) OR (terminal
4 view.mp.	(perspective or perception or	care) OR (terminally ill) OR
5 expectation.mp.	opinion or experience or	(death and dying) OR (pain
6 opinion.mp.	attitude) AND (migrants or	management) OR (advance
7 attitude.mp.	immigrants)	care planning)) AND
8 1 or 2 or 3 or 4 or 5 or 6		((perspectives) OR
or 7		(perceptions) OR (opinions)
9 palliative care.mp.		OR (experiences) OR
10 exp palliative care/		(attitudes)) AND ((migrants)
11 palliative treatment.mp.		OR (immigrants))
12 terminal care.mp.		
13 end of life.mp.		
14 end of life care.mp.		
15 exp terminally ill/		
16 terminally ill.mp.		
17 (death adj3 dying).mp.		
18 hospice care.mp.		
19 pain management.mp.		
20 advance care		
planning.mp.		
21 9 or 10 or 11 or 12 or 13		
or 14 or 15 or 16 or 17 or		
18 or 19 or 20		
22 exp migration/		
23 exp migrants/		

24	immigrant\$.mp.		
25	migrant\$.mp.		
26	exp immigration/		
27	22 or 23 or 24 or 25 or 26		
28	8 and 21 and 27		

Table 2: Step one of thematic synthesis: Generation of line-by-line codes from reviewed articles

	<u>Text from studies</u>	<u>Line-by-line coding</u>	<u>Line-by-line coding (Refined)</u>
Fang et al. (2015)	Integration would encourage new immigrants to retain the old culture while learning, adapting, and combining aspects of the new culture	Integration of cultures	Combining the old and the new cultures
	One woman described her duty to adopt “english” ways with particular emphasis on being a law-abiding citizen: “It’s like ‘when at Rome, do as the Romans do.’ As a Chinese person, you come to the UK, you follow UK laws and do what English people do.”	Not a personal choice but a duty or responsibility; Obligation to assimilation	An obligation to assimilation
	The elderly parents live separately from their children. Parents have their own lives, and children have their own lives... If you can move about by yourself, then do your best to take care of yourself.	Elderly live independently from their children Do everything by themselves	Living independently from children
	Coming to terms with cultural dissimilarities... Feeling pressured to choose between Western and Eastern religions These varying practices are symbolic of differences between West-ern and Eastern cultures negotiated through processes of acculturation.	Religious practice difference makes chinese feeling pressured	Feeling pressured due to religious practice differences
	others felt pressurized to adopt dominant	Feeling pressured to fit in the norm (want to be included and socially	Feeling pressured of being alien to the local social norm

	religious and spiritual beliefs in England in order to be included and accepted socially.	accepted?)	
	a tension between the differing roles and expectations of family and healthcare professionals in facilitating and supporting a dying individual.	Role of family VS role of HCPs	Tensions appeared between the roles of family and HCPs
	Participants noted that family members, especially children, were expected to be the primary care providers for aging parents.	Chinese thinks that it is obligated for children to take care of their parents	Expectations of children being the primary care providers
	For foreigners [the English], they tend to hire nurses. It seems very unlikely that their children would take care of them and stay with them. In China, the children would take care of aging parents, mostly daughters or daughters-in-law.	EoL care seems to override the role of chinese children	EoL care having the tendency to override the role of children
	It was noted that the social norm in Western society was to hire nurses as primary care providers for ag- ing parents. Conversely, in Chinese society, the norms and beliefs about caregiving are situated with- in the teachings of “filial piety.”	Difference in the primary care providers: Western: nurses Chinese: children (filial piety)	Differences between the west and chinese regarding who to give care mainly due to filial piety
	“Having your family take care of you is better than having the government do it... the nurses take care of you like automatons. Everyone’s the same, and it’s just a process. In China, it’s different. There’s a sense of family.”	Elderly likes having family to take care of them as it feels like being at home (sense of family)	Preference of taken care by family outweighing by government because of strong sense of family
	it was more important to have your family members care for an individual when	They want family members care for them when approaching death rather than HCPs; they don’t want to go to	Disagreement with western caregiving practice Wanting to receive care from family

	approaching death rather than healthcare professionals... disagreed with Western caregiving practices for aging parents, especially the practice of sending seniors to retirement homes	retirement homes (disagree with western caregiving practice)	when approaching death
	Furthermore, the majority of participants emphasized that the child's duty to care for their parents went beyond responsibility, as "the traditional Chinese concept of filial piety" was described as being desired and hoped for by every Chinese parent.	Children's duty to care for parents and goes beyond responsibility	Caring for parents goes beyond responsibility
	Gender differentials were identified in participants' accounts, as caregiving responsibilities were typically placed on daughters or daughters-in-law.	Caregiving role usually on girls (daughters/daughters-in-law); Gender differentials	Female leading the role of caregiving Gender differentials
	It was apparent that the duties of a Chinese woman often resided within the home, which required providing care either for their aging parents and/or for their children.	Women reside at home to provide care for aging parents and children	Women's duty to take care of aging parents and young children
	Issues of gender were apparent during various points of the interviews. It is very common and socially accepted that caregiver duties are not shared between spouses.	Usually caregivers are daughters/daughters-in-law, instead of husbands	Female being usual caregivers
	all participants indicated that mental health supports and services were essential and should be available and accessible when needed to cope with bereavement.	HCPs should also provide mental health support and services for people needed to cope with bereavement	Mental health support and service provision by HCPs
	Chinese migrants in the United Kingdom, however, are described as not dying with the same degree of support and comfort: "Because if someone passes away at home, there will be a lot of people around. But here in the U.K., we've all left our home, and if a family member passed away, we will feel very depressed and	Chinese migrants did not want to die at home, as not wanting to withstand the loneliness and depressed feeling when spouses pass away	Little tolerance of loneliness and depressed feeling when spouses passed away Not wanting to die at home

	will need someone to enlighten us.”		
	“according to traditional Chinese customs, very few people would see a psychologist because people are born, they get old, get sick and they die. This is natural. There shouldn’t be any. There is more in the West.”	Chinese reckons to be born, get old, get sick and die is a natural and normal process; no need to seek psychological advice	Unnecessary to seek psychological advice when approaching death Death being a natural and normal process
	Many of our participants interpreted aging, death, and grieving as a natural process, so that bereavement services and supports were often underutilized... the majority of participants agreed that mental health supports are important and necessary for coping with grief and bereavement, “mental health” and “mental illness” are seen as Western concepts that are overemphasized within the biomedical model	Ageing, death, grieving is a natural process, yet bereavement service was underutilised They think mental health support is important but they don’t use it	Agreeing with the importance of mental health support service Underutilisation of bereavement service
	All participants reported English as either their second or third language and that they would prefer to speak Chinese, either Mandarin or Cantonese.	Their preference to speak Chinese than English	Preference of speaking Chinese when utilising the service
	The barriers limiting clear communication often resulted in frustrations experienced by both the healthcare provider and the health service user	Language barrier not only affects whether the Chinese understand what the HCP said or they describe themselves to HCP, but also frustrates HCP as they can’t effectively deliver services to Chinese	Language barrier interfering the communication and service delivery between the Chinese and HCPs
	If the doctor is impatient, he doesn’t want to spend a lot of time listening to us. Because we are limited in the English language, we have to depend on simple translations to describe the symptoms and other medically related inquiries (. . .) If we encounter good doctors, they will	Chinese thinks that doctors may not have time to listen to their needs as they can only use limited terms or words to describe their symptoms or sickness	Perception of doctors being impatient because of Chinese’s low English oral proficiency
		Chinese has limited knowledge	Limited knowledge regarding EoL

	<p>invest time in trying to understand and communicate with us, and as a result we will feel more comfortable to try and speak.,</p> <p>a general lack of knowledge concerning EoL practices within the United Kingdom:</p> <p>“Like many of us who don’t know English, we don’t know what to do if a person dies. I don’t think we know where cremation should take place, who we should look for, and which places are for burials.”</p>	<p>regarding the EoL practices in foreign places</p>	<p>practices in foreign places</p>
	<p>Explaining health issues and describing symptoms were suggested as presenting a challenge due to language difficulties.</p>	<p>Language barrier leads to obstructed communication</p>	<p>Obstructed communication by language barrier</p>
	<p>Many participants indicated a desire and need for having more culturally appropriate services. It was also emphasized that service provision should come from those who embody the culture and understand the cultural intricacies distinct to Chinese people.</p>	<p>Chinese wants culturally appropriate services, which is given by those who understand cultural complexity distinct to Chinese</p>	<p>Preference of having culturally appropriate services given by those who understand cultural complexity distinct to Chinese</p>
	<p>“it provides great help for us who have trouble communicating.”</p>	<p>Chinese wants someone to act as a bridge for communication & having culturally comfort environment to use the services</p>	<p>Preference of having those who understand Chinese cultural complexity to act as bridges for communication</p> <p>Preference of having those who understand Chinese cultural complexity to provide culturally comfortable medical environment</p>
	<p>interpretation services were available by appointment at the GP office, but the interpreters often failed to show up... “When I take my kid to see the doctor, most of the time [the</p>	<p>Interpretation service is available as written on the menu but not in practice; electronic dictionary device is not accurate enough</p>	<p>Culturally sensitive services existing in name alone</p>

	<p>interpreter] doesn't come. But luckily, that doctor is very nice. While on the phone with me, he translates into Chinese to let me take a look. I type whatever question I have to let him take a look. This is better. But sometimes I still don't feel it's accurate enough."</p>		
	<p>existing health service provision practices are influenced by macro-level political dynamics, where culturally sensitive services are available on a superficial level and not strictly regulated or monitored for uptake and effectiveness.</p>	<p>Solutions for helping Chinese to utilise the services are on a superficial level</p>	<p>Culturally sensitive services being superficial and loosely regulated</p>
	<p>Participants were found to have different attitudes about EoL practices... they were not particularly spiritual, religious, and/or superstitious. However, if forced to choose, they would pray to or worship Buddha or Guanyin. These practices are associated with Taoist beliefs, particularly with traditional EoL customs and beliefs</p>	<p>Chinese's practice of religion closely links to Taoist beliefs</p>	<p>Preference of believing in Chinese gods and traditional EoL customs and beliefs</p>
	<p>In contrast, with respect to British funeral practices, many revealed not having participated in any British funerals since moving to the United Kingdom</p>	<p>Burial practices of Taoist and British are totally different Many participants hadn't engaged in British funerals</p>	<p>Lack of contacts and differences in burial process between cultures</p>
	<p>Their social circle consisted of mainly other members of the Chinese community</p>	<p>Passive engagement beyond Chinese community</p>	<p>Passive engagement outside of Chinese community</p>
	<p>Their older family members resided in China</p>	<p>Not necessary for them to attend any funeral</p>	<p>Unnecessary of attending funeral</p>
	<p>the concept of choice becomes ambiguous when EoL options are available only to those that have</p>	<p>the choices regarding the burial process depends more on the state</p>	<p>Options for burial process depending more on the state than HCPs</p>

	the financial means to exercise these rights.	than the healthcare professionals	
	it is important for healthcare professionals to be aware and responsive to different cultural traditions, practices, and beliefs in order to provide effective EoL care	Cultural difference awareness is anticipated on health care professionals	Cultural difference awareness is anticipated on health care professionals
	Equally important are multilingual informational and/or educational resources for Chinese and other migrants about how such services and arrangements are provided and acquired, in order to help migrants achieve a good health.	Suggest to have multilingual information or education materials for migrants	Multilingual education materials being suggested to migrants
	facing and accepting death, respecting personal wishes and regrets... the importance of paying respect to the ones who have passed on	Chinese thinks death is inevitable; dying is a natural process	Cultural belief that death is natural and inevitable
	Dying was often described as a normal process and death an inevitable outcome: “Everyone who is born dies, right? You don’t know when you’re going to die. That’s fairly normal, I think. Of course, we’ll be sad. It’s family, after all. If your friend or a pet dies, you’ll also be sad. There are emotional attachments. No need to see a doctor. Everyone goes through that process. It’s just a matter of time, sooner or later.”	Sadness is normal as there are emotional attachments No need to see doctor	Emotion attachments being normal Unnecessary to seek medical advice Fear of regrets at the end stage of life
	When participants were asked about their dying wishes, they emphasised the fear of not having completed specific life goals, not having mastered desired skills, and ultimately, not having enjoyed life to the fullest: “If I am going to pass away today, I’m thinking (...) There are so many things I haven’t done yet, and I would feel regretful. Why didn’t I do this	There are many “not having/not yet done” (regrets) in their life (fear of regret)	

	well? Why didn't I learn this and that? Why didn't I enjoy my life? I would feel regretful."		
	Another dying wish frequently mentioned by participants was being honoured and respected by their children.	Although one died, he still wanted to be honoured and respected by children	Anticipation of being honoured and respected when died
	A crucial component of Chinese culture is filial piety, which involves honouring and respecting one's parents when they are alive and after they have died, not as simply a gesture or an act of kindness, but as a part of the children's duty.	Filial piety is a duty, not an act of kindness	Duty of filial piety
	"If my children really want to pay me respects, in England, if you're buried in the ground, if your children are dutiful, they'll visit you, but if not, then they won't in a hundred years! If they are sincere, then they will often think, "I miss my mom." That's enough."	To be dutiful is to respect, visiting the tomb after burying 慎終追遠 (heart > action)	Careful attention to perform the funeral rites to parents
	with respect to an afterlife, the existence of heaven and hell is a significant part of the Chinese religious and spiritual belief system.	Traditional Taoist belief tells that there are heaven and hell and which people enter depends on whether they do good or bad on earth (afterlife concern)	Traditional Taoist belief provokes people's afterlife concern
	"I just try and not do bad stuff in my life, try your best to do good things within your ability, right? This way it'll be good, right? Some people are very bad, and they do bad stuff everyday. When he's in trouble and he goes to the temple and burns the incense, Buddha will not bless him, right?"	The principle of living a righteous life Chinese tends to do right	Living a righteous life brings fortune
	"Here, even if I worshipped God, God will not hear me."	They think that blessings and protection were limited within geographic boundaries; They migrated and became too far from home, so both their ancestors	Blessings and protection from gods were limited within geographic boundaries

		and gods would not bless them	
	in order to regain spiritual “reassurance” and “protection,” the acceptance of a new God or image in the United Kingdom is required.	Necessary acceptance of new religious images	Essence of accepting new religious image
	Several participants indicated significant gender differences that pertain to superstition, religion, and spirituality.	Chinese is very superstitious	Having a superstitious image
Heidenreich, Koo & White (2014)	Ting encapsulated the cultural and social framework influencing her role in caring for her dying father in Australia.	There is no way to complain about taking care of parents as Chinese	Taking care of parents is a duty
	Participants described family being geographically distant in China, Hong Kong and Indonesia and therefore unavailable to help. There was no one to share the burden... “In China maybe much easier because you always have family relative. And because you can take the time to get someone to help her. But here there is no one because the family everyone is working. All the relatives and the good friends living far away.”	Geographical barrier to have burden shared Socially detached from family relatives Living far away from friends or relatives Not able to seek help from others	Geographical barrier deterring people from seeking help from others Living away from country of origin making people socially detached from family relatives
	Maria expressed a strong sense of loss of control in her life and fear in experiencing the new circumstances alone	Fear of confronting death (uncertainty) Leave & vacate	Fear of confronting uncertainties alongside death No readiness to leave and vacate
	“I am having a big depression and loss, because you have to care single handedly... you have to understand that if you are the sole person...	Family member approaching death Feeling helpless, especially having no one alongside	Feeling helpless, having no one by the side when approaching death (carers)

	having to shoulder all these responsibilities the pressure is becoming heavier and heavier...”		
	Participants experienced disruption to the family members’ traditional cultural attitudes and reduction in family and social support in Australia due to migration.	Lack of family and social support Disruption of traditional cultural attitudes	Migration leading to disruption of traditional family and social support
	Lin described “feeling isolated” due to loss of familiar values and family care-related cultural understandings	Loss of family values and cultural understandings Feeling isolated	Feeling socially isolated due to loss of family values and cultural understandings
	Yes [family care is important in our culture], but... I don’t know why my son and my daughter think this way... the [son’s] wife’s from a different culture or something I don’t know. She’s different... my son was married by the pastor in the church and he has lots of things to do... No time for me at all... For one month my son never rings, never come. I get so scared I ring him, I cried.”	Westernised beliefs being educated to the next generation Next generation losing intimacy with family (carers)	Next generation being influenced by westernised beliefs lose rapport with family (carers)
	some of them were reluctant to ask for assistance even though some family members and friends were willing to provide support.	Reluctance of asking for assistance (carers)	Reluctance of asking for assistance (carers)
	I cannot ask my son to give up his job to come back to help... [I have] friends... but they all have to work and they have families and you cannot expect them to be with you all the time.	Always think about others first Not wanting to be burden of children Not wanting to rely on someone who can’t offer or guarantee you limitless help (patients)	Considering others more than himself Not wanting to burden on children Not wanting to rely on someone who can’t offer or guarantee you limitless help

	<p>formal and cultural community services had been offered to assist all the carers, but were declined... Participants were unwilling to accept readily available support, preferring to do it alone.</p>	<p>Unwilling to accept help from services (carers)</p>	<p>Unwilling to accept help from services (carers)</p>
	<p>Participants described their emotional stress in observing and comforting the sick family member suffering distress in facing their incurable illness.</p>	<p>Stress and emotion arisen from taking care of terminally ill family members (carers)</p>	<p>Stress and emotion arisen from taking care of terminally ill family members (carers)</p>
	<p>“My husband upset too. Big depression, he [was] upset too... we had the result of the scan and then he say “why me, why me?”</p> <p>“It’s very hard, [because] my mother-in-law always said “Oh, dying is nothing. Not to worry, not worry”, but she actually she worries... she cries sometimes...”</p>	<p>Carers have to bear ill family members’ sorrow and worries (carers)</p>	<p>Needs to bear ill family members’ sorrow and worries (carers)</p>
	<p>In keeping with the notion and impulse of non-disclosure of the terminal nature of the illness and psychological protection of the sick family member, participants described various ways of avoiding the topic, including evading overt mention of the disease process:</p> <p>“The doctor, he says no more treatment. My husband [does] not know. I not tell him. He loses hope and must have the hope to fight the disease.” (Stella)</p> <p>“No, no [disease prognosis is not discussed]</p>	<p>Carers prefer not disclosing the terminal nature of illness to protect their family members psychologically as they don’t want them to lose hope (carers)</p>	<p>Psychological protection of their family members by not disclosing the terminal nature of illness (carers)</p>

	because I try to make him strong. Because you know in my mind I try to make him happy. If the doctor tell the people there is no hope maybe they're down. . . They feel very poor and very down you know. . .So the children and me feel and give him hope to make him strong.” (Maria)		
	The sick family member's increasing physical dependency and inability to meet personal needs unaided added to participants' emotional distress and left them scarce time for personal respite.	Sick family members' dependence deprives carers' personal time and leads to emotional distress (carers)	Loss of personal time and bringing emotional distress due to dependence of sick family members (carers)
	Now, the current increasing financial responsibilities of the participants caused enormous emotional stress.	Financial burden due to heavy medical cost caused emotional distress to carers (carers)	Emotional distress due to financial burden from medical costs (carers)
	“Umm [I am feeling the financial pressure], so then I start to think if he goes into a nursing home and I will not get the carer's pension and I don't go to work what are we going to do as income and finance? If he goes into a Nursing Home and my care pension stops, then surviving is a problem for us.”	Carers have also thought about hiring others to take care of their family members, but if they live in nursing homes, they cannot receive pensions which not only support the medical cost but also daily lives of family (carers)	Practical financial concerns so keep taking care of sick family members to receive subsidies from the government (carers)
	Participants struggled with the impending loss of the family member and unbearable dread of an isolated and lonely future in being alone.	Anticipation of a lonely future living (carers)	Foreseeing of a lonely future living (carers)
	Sometimes I tell my husband's brothers and sisters, but they don't help me. Sometimes they get cranky to me. They go crook on me. So I keep it inside my heart you know. I can't talk	Not having good relationships with relatives No talking opportunity	Not having talking opportunities because of estranged relationship with relatives

	with someone.		
	The overwhelming daily chores, everything that is outside the normal routine, together with the unexpected stress, threatened their ability to cope.	Stress with which from various aspects made carers hard to cope	Stress derived making people hard to cope with life (carers)
	The strong intensity of the emotional, physical and financial stress required medical intervention for some participants.	Caring for sick family members made carers sick	Mental stress contributing to physical illness (carers)
	“Every night I woke at 1am or 2am and cried and cried and can’t stop... I scared all the time and my neck’s swollen... and I couldn’t breathe (rapid huh huh huh-anxiety attacks)... The doctor gave me Sinequan to make me slow down, make [me] not stressed too much, you know.”	Poor mental health of carers contributed to poor physical health	Poor mental health leading to poor physical health (carers)
Seto-Nielsen et al. (2015)	death was a taboo topic and that dying at home was not the preferred option for Chinese Canadian immigrant care recipients.	HCPs assumed Chinese immigrants preference of not wanting to die at home was a taboo	Cultural taboo of dying hinder people from dying at home (HCP)
	she did not believe that Chinese care recipients wanted to die at home because of a superstition: “If they die at home, their home cannot be re-sell.”	Not wanting to die at home was due to monetary benefit	Monetary benefits contribute most of not wanting to die at home
	Often they felt that Chinese immigrant care recipients wanted to be cared for at home until they were actively dying, at which time, they wanted to be transferred to a palliative unit or hospice where the actual death would take place.	Want to receive care at home but want to die somewhere out of their home	Dying somewhere out of home is preferred

	HCPs implicitly inferred it was a cultural belief that Chinese immigrants did not want to die at home.	Not wanting to die at home was assumed to be cultural belief in Chinese (HCP)	Not wanting to die at home was assumed to be cultural belief in Chinese (HCP)
	<p>“In fact at the very beginning, I don’t want to die at home. I want to go into the hospital to have palliative care. But my son and my daughter-in-law, they were so strong about being at home ... So, I do understand now that if I opt to stay at home, I will have all of this support. But still after I think about it, that is not enough. And I talk to my son and daughter-in-law, just me and dad in this apartment, even with all those support—that is not enough ... So my decision is that I will opt to spend my last days in the palliative care unit.” (CR1)</p>	Adult children want patients to stay at home to receive palliative care, yet they refused to stay at home but rather go to palliative care unit as there are only patients and their spouses at home	The preference of children contradict with that of parents Only old parents staying at home
		Decision of whether to die at home goes beyond cultural beliefs Decision process involves mixing of cultures and negotiations	Involvement of the mix of cultures and negotiation during the decision of place to die Decision of place to die goes beyond cultural beliefs
	Although her discussions with her son and daughter-in-law may indicate an openness to planning for her death, there evidently was something not being discussed	Patients’ opinions cannot be heard Patients’ voices were subjugated (Patients)	People’s opinions and voices being subjugated
	she was concerned that she would not receive the care required in the final stages and that she did not want to rely too heavily on her family.	Worries of not having care Not wanting to rely heavily on family (Patients)	Worries of not having care Not wanting to rely heavily on family
	recipients were silenced in expressing their desire to die at home because they feared burdening their family members.	Fear of burdening family (HCP)	Fear of burdening family (HCP)
	care recipients were choosing to die in hospitals, palliative units, and hospices to avoid imposing	Avoid imposing on family members Refusal to die at home goes beyond superstition	Avoid imposing on family members Refusal to die at home goes beyond superstition

	on family members.		
	there was a difference between the Canadian health care system and that of their country of origin. The understanding that illness and dying were treated differently within the two health care systems (nurse)	Understanding of healthcare system or knowledge about palliative care affects decision of where to die Illness and dying were treated differently within the healthcare systems of local and country of origin (HCP)	Knowledge regarding healthcare system and palliative care matters Differences of palliative care between residing country and country of origin (HCP)
	Chinese immigrants may have a different understanding of palliative home care.	Chinese has a different understanding of palliative home care (HCP)	Understanding of palliative home care is different among Chinese (HCP)
	Chinese immigrants are silenced in expressing their pragmatic, contextual concerns for dying at home.	Refusal of dying at home goes beyond cultural taboo (patients and carers)	Refusal of dying at home goes beyond cultural taboo (patients and carers)
	All HCPs seemed to struggle to reconcile the discourses of patient-centered care and cultural competence.	Contradiction between patient-centered and culturally competent care (HCP)	Contradiction between patient-centered and culturally competent care (HCP)
	she tried to come to know care recipients' and families' preferences and expectations, and how this aligned with her role as a HCP.	Dedication of aligning with patients (HCP)	Dedication of aligning with patients (HCP)
	“I never had a clear vision because I saw so many different variations. You know everything from the extreme example in my mind was a daughter, I actually was yelled at by a daughter on the telephone for talking openly in front of her dad who was the patient, “Don't you know Chinese people don't like to talk about dying?”	Some refuse to talk about dying but some discuss it openly (HCP)	Some refuse to talk about dying but some discuss it openly (HCP)

	<p>To a [Chinese] family sitting around the table and welcoming and being very open with me and doing very active decision-making and planning. ... I am always reluctant to make big statements about any culture because you see so much variation.” (K18)</p>		
	<p>The aim of negotiation was to reconcile the irreconcilable, and HCPs had to rationalize and make sense of their struggles with this task. Her contradictory statements indicated the complexity for HCPs of blending together knowledge, experiences, perceptions, and assumptions to bring reason to their actions and approaches to care.</p>	<p>Difficulties of HCP: To understand the point of view of patients, and to blend together the knowledge, experience, perception and assumption of patients → come up with actions and approaches to care (HCP)</p>	<p>Difficulties in understanding the point of view and then blending together the knowledge, experience, perception and assumption of patients, let alone coming up with actions (HCP)</p>
	<p>“There is no difference. You’re dealing with a dying patient.”</p>	<p>Taking care of Chinese immigrants and other ethnocultural groups has no difference (HCP)</p>	<p>No difference in care for Chinese or other ethnocultural groups (HCP)</p>
	<p>there were prominent end-of-life care needs and concerns for care recipients that took precedence over culture. The shared experience of dying from cancer precluded culture, ethnicity, race, and religion.</p>	<p>Needs & concerns of EoL care go beyond culture, ethnicity, race and religion (HCP)</p>	<p>Needs & concerns of EoL care go beyond culture, ethnicity, race and religion (HCP)</p>
	<p>care recipients and caregivers were able to more seamlessly describe the reconciliation of cultural differences</p>	<p>HCPs are harder to integrate patients’ cultures into their local cultures (Hard acceptance)(HCP) Being compliant to cultural difference and adoption of mixed culture treatment (carers and patients)</p>	<p>Hard to accept and integrate patients’ cultures into local culture (HCP) Being compliant to cultural difference and adoption of mixed culture treatment (carers and patients)</p>

	CR3 felt knowledgeable and comfortable with combining traditional Chinese medicine and his Western medical regimen to suit his symptomatic needs.	Feeling comfortable to integrate traditional chinese medicine to western medicine (patients)	Feeling comfortable to integrate traditional chinese medicine to western medicine
	the discursive tension between traditional Chinese medicine and Western medicine was most discomforting for HCPs.	Only HCPs feeling discomfort for the combined use of different culture medicines (HCP)	Only HCPs feeling discomfort for the combined use of different culture medicines (HCP)
	Most Chinese immigrant care recipients and their family caregivers who did not speak English relied heavily on either professional interpreters or English-speaking family members to help them navigate doctor's appointments.	Reliance on professional interpreters or English-speaking family members in doctor's appointments (patients and carers)	Reliance on professional interpreters or English-speaking family members in doctor's appointments (patients and carers)
	Care recipients and families were resilient in the ways they addressed language barriers.	Resilience in addressing language barriers (patients and carers)	Resilience in addressing language barriers (patients and carers)
	The ways in which care recipients and family caregivers addressed language barriers showed how tacit knowledge surfaced and was blended within the everyday. These hybrid approaches were borne out of necessity.	Solutions of addressing language barriers were blended in everyday No fixed method to deal with language barriers	Creation of lively ways of addressing language barriers in daily lives
	Family caregivers, who spoke English, were depended upon as translators and felt the burden of being available to help interpret for their ill family member.	Feeling burdened out of being interpreters (English-speaking carers)	Feeling burdened out of being interpreters (English-speaking carers)
	the care recipient would not be abandoned due	Carers not wanting their family to be	Not wanting their parents to be

	to lack of communication abilities while at the same time fulfilling caregivers' commitments to employment and their own families as well.	depressed due to language barriers so they devise strategies to help them (carers) Can both fulfill employment commitment and family commitment (carers)	depressed due to language barriers so they devise strategies to help them (carers) Fulfill both employment commitment and family commitment (carers)
	a language barrier is seen as a hindrance to communication in the clinical encounter, but in actuality, it had a cascading effect which required effective negotiation and management in many facets of life.	Language barriers bring a lot of consequences other than communications in clinical settings (patients, carers and HCP)	Language barriers bring a lot of consequences other than communications in clinical settings (patients, carers and HCP)
	The HCPs who did not speak Cantonese or Mandarin explained the difficulties in providing palliative home care to non-English speaking Chinese immigrant care recipients.	Communication is a bilateral process that HCPs would feel hard to deliver care if patients did not understand English. Meanwhile, patients would not know what the HCPs want them to do if they did not know Chinese (HCP)	Bilateral disrupted communication of not understanding a mutual language (HCP)
	"Some agencies will try and make an effort, for instance, if you have a palliative client and family who speak only Cantonese or speak only Mandarin, they will try and match the nurse... But sometimes their language capability doesn't translate into their clinical capabilities so you might have a clinically more capable nurse in palliative care who can't speak Cantonese or Mandarin, or you get a Cantonese-assigned nurse who has no interest or experience in palliative care."	HCP will try matching patients with HCPs speaking the same language, yet clinical capabilities are not guaranteed (HCP) Whether Language capacity or clinical capacity brings the best care	Attempting to match patients with HCPs speaking the same language Clinical capacity may not proportional to language capacity (HCP)
	This home care nurse explained that although she was Chinese and had been matched with a Chinese patient, resolution of the language	Too many dialects in Chinese Not understanding what others are talking about Patients pretend they know how to do	Not understanding what HCPs are talking about but pretend to know it (HCP)

	<p>barrier was mostly assumed. She admitted that communication between her and the care recipient was often difficult:</p> <p>“They think they can speak Mandarin but the way she speaks Mandarin, I thought she was speaking Cantonese. Half the time I don’t understand... it’s really a language barrier because when I explain something to her, she will say, “Yeah, yeah I know” but in the end she would do something that’s different.”</p>	(HCP)	
	home care nurses and care recipients were not necessarily being matched for linguistic similarities	They are culturally and racially matched, but not linguistically matched (matching for language)	Culturally and racially matched but not linguistic matching
	the inability to express their way of knowing in a mutually understood language meant that care recipients’ and caregivers’ knowledge were silenced. Hence, the issues of communication went beyond just a language barrier.	Inability to express their way of knowing in a mutually understood language Not only language barrier, but the issue of communication (understanding of each other)	Inability to express their way of knowing in a mutually understood language Disrupted communication of not understanding each other
Mondia et al. (2012)	She appeared optimistic about her future, yet was irritable and emotionally explosive with her family, causing some withdraw and others to criticise her harshly.	Emotional and sentimental Optimistic about the future but irritable Treat family badly (patients)	Emotional and sentimental Optimistic about the future but irritable Treat family badly
	All of the family wanted to improve communication and harmony	Anticipation of harmonic communication between patients and family members (carers)	Anticipation of harmonic communication between patients and family members
	Sought to diffuse conflict that arose from miscommunication. She encouraged the family to explore their ancestral and cultural bases for	Family members knowing of their roots Diffusal of conflicts arose from	Family members knowing of their roots Diffusal of conflicts arose from miscommunication

	these conflicts, hoping to strengthen familial bonds.	miscommunication (HCP)	(HCP)
	The family's tendency to speak but not listen to each other; this pattern was most evident in Huang's relationship with her elder sister, Yan, for whom she carried long-lasting grudges.	Communication problem: Speak more than listen	Communication problem: Speak more than listen (patients and carers)
	Huang's nieces, Emily and Vicky, felt detached from these battles between their aunts, but curious to understand what caused them.	Next generation loss intimacy from their root's culture bonding Next generation being curious to know more about their family	Next generation lose intimacy from their root's culture bonding Next generation being curious to know more about their family
	The sisters resented their father's negative influence in fostering much distrust of men, on which they blame never marrying. The father was abusive, both physically and emotionally, creating fear that a husband could be like him.	Family affect their perception towards image of opposite sex Fear created during the living with father	Family affecting their perceptions towards the image of opposite sex
	The sisters could not confront failure well. Huang believed that her main priority was to "be perfect for everyone", a duty that had been drummed into her as a child.	Striving for perfection weakened their ability to accept failure	Striving for perfection weakened their ability to accept failure
	The connection between the family's unhealthy communication and the father's influence was a key focus for the therapist. She allowed Huang and her siblings to explore this and openly share the experiences they had with their father, fostering consideration that they could begin to trust more and relate better.	Make use of common experiences or feelings as bridges to bring trust and relation	Make use of common experiences or feelings as bridges to bring trust and relation (HCP)
Yonashiro-Cho, Cote	Those in the English-speaking focus group	People who can speak English having greater knowledge of EoL care	English-speaking people having greater knowledge of EoL care options and

& Enguidano s (2016)	appeared to have greater knowledge of and familiarity with end-of-life care options and practices.	options and practices	practices
	Those in the English-speaking group provided information on how to develop advance directives to a few who were unaware of the process	English-speaking patients are confident to do advance care planning	English-speaking patients are confident to do advance care planning
	Although many English-speaking group participants reported having completed an advance directive on the data collection instrument, it became evident during the discussion that few had actually done so.	Although they know what and how to do advance directives, they have not necessarily done it	Knowing and having done advance directives are different
	There was greater misunderstanding of and lack of familiarity with advance directives in the Mandarin- and Cantonese-speaking groups.	Misunderstanding and lack of familiarity derived from non-English-speaking group	Misunderstanding and lack of familiarity derived from non-English-speaking group regarding advance directives
	Some participants responded by talking about their “life trust” or “will” and discussing their wishes for post-mortem body disposition and asset dispersal.	Non-english speakers not knowing ACP is more than something after death Limited knowledge towards advance care planning	Non-english speakers having limited knowledge towards advance care planning
	Participants also held misconceptions about the process of completing forms.	Unfamiliarise with procedure or consequence of filling out advance directives	Unfamiliarise with procedure or consequence of filling out advance directives
	“I have already written a [living] will, if I really have an incurable disease, I have my attorney write it down in my will already, I don’t want any resuscitation, and I have told my family about it already.”	Some are knowledgeable in advance care planning	Only a few being knowledgeable in advance care planning

	<p>Participants felt being in good health indicated no need for engaging in ACP discussions... “I did not [have a conversation with my doctor] because I am still in good health. So my doctor never say, hi, you have high blood pressure, what do you want to do when you are dead or whatever? So I never talk to her about that.”</p>	<p>Being in good health condition do not want to have ACP discussion Not necessary to talk about something “bad” when in good condition</p>	<p>Not necessary to talk about ACP when situating in good health condition</p>
	<p>Most focus group participants believed that direct communication of end-of-life care plans and preferences should be delayed until health declines and that prematurely discussing the topic was unwarranted and unnecessarily burdensome on loved ones.</p>	<p>Discussion should be delayed until health declines Premature discussions of ACP become burdens for family</p>	<p>Discussion should be delayed until health declines Premature discussions of ACP become burdens for family</p>
	<p>“Not until the doctor tells us that we have an incurable disease should we talk to our family about the arrangements or our wishes.”</p>	<p>Talk only in last minute</p>	<p>Talk ACP only in the last minute</p>
	<p>Participants felt that the appropriate timing for discussing end-of-life care preferences was when death seemed more or less inevitable.</p>	<p>Appropriate timing is when death being at hand</p>	<p>Appropriate timing for ACP: almost dead</p>
	<p>Those who were willing to engage in advance communication expressed their preferences for how these conversations should occur.</p> <p>“[O]ur children need to know what we think. It’s our own business, our decision. Just tell them not to prolong [our life] or procrastinate [our death]”</p>	<p>The way of carrying out conversations matters a lot Patients think that sharing their preferences on how to die can promote their autonomy</p>	<p>Concerns of the way carrying out EoL conversations Promotion of autonomy by sharing patients’ preferences</p>
	<p>Many participants thought it best for older</p>	<p>Carers prefer old parents take</p>	<p>Preference of initiations of EoL</p>

	parents to initiate discussions about end-of-life care preferences with their children rather than expecting children to broach the subject, especially if their children were to inherit assets after their death.	initiations to start EoL discussion instead of children asking parents about it	discussions by old parents instead of children (carers)
	“It’s better for the parents to bring it up first. Otherwise, the children might worry that [by bringing up this topic with their parents] their parents will feel like the children are trying to curse that they are dying”	EoL discussion initiated by children is not respectful in Chinese culture	EoL discussion initiated by children is not respectful in Chinese culture
	Participants also preferred to use informal and indirect methods of communication to discuss their preferences with loved ones.	Informal and indirect communication method is explored	Exploration of informal and indirect communication methods
	“I think a better way is to bring it up casually. Just try to imply [to] them what I want and they’ll know. If we hold a family meeting to talk about it, it might sound so serious that it will make our family very upset, and they won’t stop thinking about it, but if we just have a casual conversation about it, they will be less nervous and when the time comes, they’ll know what to do.”	Casual conversation making both patients and carers less nervous or upset	Casual conversation making both patients and carers less nervous or upset
	They were less forthcoming in having these conversations with family members and physicians.	Even they discussed openly in focus group, they didn’t anticipate to have such conversation with family	Not having EoL discussion with family though engaging in the study (carers)
Chi et al. (2018)	All participants recommended the use of indirect communication approaches, rather than direct questioning, to initiate discussions with older	Indirect communication approach is preferred	Preference of having indirect communication approach

	Chinese Americans to determine their readiness.		
	They recommended that these approaches should be culturally targeted, meaning that they try to take a group or population's lived experiences, values, and beliefs into consideration.	Taking lived experiences, values, and beliefs into consideration of indirect communication of EoL discussion (culturally-targeted)	Adoption of culturally-targeted communication approach for EoL care discussion
	Integrating a question or 2 about advance care planning in check-in paperwork during health-care visits (eg, hospitals, emergency departments) and outpatient settings was strongly recommended by both older Chinese Americans and adult children to increase older Chinese Americans' awareness of advance care planning and help to engage them in EoL care discussions.	Integration of ACP in check-in paperwork during healthcare visit Increase awareness of ACP and help engaging in EoL care discussion among Chinese Americans	Integration of ACP in formal routine medical procedures (policy) Increasing ACP awareness and engaging in EoL care discussion among Chinese Americans
	"... and the doctor will know not to ask or let the patient indicate whether or not they would be willing to discuss it..."	Let patient choose whether to discuss	Let patient choose whether to discuss
	Although completing an advance directive was not mandatory at all healthcare facilities, some require patients with no advance directive to indicate whether they are interested in completing one and/or have an EOL care discussion... The daughter felt the routine inquiry was a nonthreatening and acceptable way to initiate an EOL care discussion with her father who was being checked in to the emergency department.	Integration of EoL care discussion into routine medical procedure is acceptable and nonthreatening (an opportunity)	Acceptable and nonthreatening opportunity of integrating EoL care discussion into official policy

	<p>they were or would be receptive to EOL care discussion assessment provided by HCPs.</p> <p>“you can ask them (older Chinese Americans) first, and then the newer generation that’s like me, they will talk about it. This is okay... You just bring this question up.”</p>	<p>Carers require HCPs to initiate the conversation first</p> <p>Patients are willing to talk about EoL care with HCPs</p>	<p>Having EoL care discussions with parents when initiated by HCPs</p> <p>Parents more willing to talk with HCPs (carers)</p>
	<p>They (HCPs) probably should initiate an EOL care discussion and see whether the patient wants to respond to it or not. If they (older Chinese Americans) say no, then you just honor them and just annotate it if the patient doesn’t want to discuss that.</p>	<p>HCP should only initiate EoL conversation when patients are ready</p>	<p>Initiation of EoL conversation by patients’ readiness (carers)</p>
	<p>HCPs should assess older Chinese Americans’ willingness to engage in EOL care discussions during annual examinations and healthcare visits</p>	<p>Assessment of readiness of EoL care discussion during routine medical appointments</p>	<p>Assessment of readiness of EoL care discussion during routine medical appointments</p>
	<p>but the assessment with their parents must be done in a way that is indirect, impersonal, and culturally and age appropriate.</p>	<p>Adoption of indirect methods to discuss</p>	<p>Adoption of indirect methods to discuss</p>
	<p>All participants consistently recommended the use of indirect, culturally targeted communication approaches.</p> <p>“If you’re too direct, sometimes it’s a turnoff. I think you have to bring it up gently.”</p>	<p>Indirect and culturally-targeted communication approaches are recommended</p>	<p>Recommendation of indirect and culturally-targeted communication approaches</p>
	<p>direct communication was not preferred for EOL care topics... “It [a direct approach] is just like giving them [older Chinese Americans] a</p>	<p>No mental preparation for patients when using direct communication</p>	<p>No mental preparation for patients when using direct communication</p>

	shot without any kind of mental preparation.”		
	HCPs could perform the assessment by initiating a discussion using depersonalized communication strategies.	Introduction of depersonalised communication strategies	Introduction of depersonalised communication strategies
	All participants most frequently recommended the use of another person’s EOL care experience as an example to initiate an EOL discussion.	Making use of others’ experiences for EoL discussion initiation	Making use of others’ experiences for EoL discussion initiation
	asking older Chinese Americans to imagine themselves in a declined health condition was explicitly discouraged because it may provoke unnecessary anxiety and lead to bad luck	Imagine themselves in declined health condition provoke unnecessary anxiety and unease	Imagination of being in declined health condition provoke unnecessary anxiety and unease
	Exploring older Chinese Americans’ perspectives on another person’s EOL care experiences can minimize the sensitivity related to death and dying.	Sensitivity related to death and dying can be minimised by using others’ experience	Sensitivity related to death and dying can be minimised by using others’ experience
	All participants emphasized EOL care discussions should be framed as a standard question to reduce the sensitivity of the topics regardless of whether or not there was an official policy in place.	Making EoL care discussion mandatory (Standard question in official policy)	Making EoL care discussion standard questions in official policy
	Both older Chinese Americans and adult children suggested that HCPs need to be aware of cultural taboos surrounding EOL topics among older Chinese Americans and should query them about this.	Acknowledge cultural taboo and ask for permission	HCPs acknowledge cultural taboo and ask for permission (patients and carers)

	they emphasized the importance of not stereotyping a specific population with certain cultural characteristics.	Not stereotyping someone with certain cultural characteristics (patient-centered or culturally competent?) (HCP)	Not stereotyping someone with certain cultural characteristics (patient-centered or culturally competent?) (HCP)
	Both HCPs and adult children recommended integrating a cultural longevity element into assessment inquiries; however, no older Chinese American mentioned this strategy.	Blessing older Chinese for having longevity when asking for permission (HCP & carers)	Blessing older Chinese for having longevity when asking for permission (HCP & carers)
	they successfully engaged their patients in EOL care discussions using their own experiences as examples.	Using providers' own experience to have EoL care discussion (HCP)	Using providers' own experience to have EoL care discussion (HCP)
	The HCP participants believed that self-disclosure helps diminish sensitivity related to EOL care discussions by modeling and aligning themselves with patients.	Self-disclosure helps reduce sensitivity of patients Modeling and aligning HCPs with patients (HCP)	Self-disclosure helps reduce sensitivity of patients Modeling and aligning HCPs with patients (HCP)
	All participants suggested readiness could be determined by observing older Chinese Americans' attitudes, verbal and non-verbal responses to the initiation prompts, and the HCPs' clinical judgment. "you feel it [the HCP]...you can say a word or two that will lead you, whether you can lead it on or not."	HCPs assessing patients' readiness by observing attitudes, verbal and non-verbal responses, and clinical judgement	HCPs assessing patients' readiness by observing attitudes, verbal and non-verbal responses, and clinical judgement
	healthcare encounters could serve as a good opportunity to discuss EOL care with the approval of the older Chinese Americans... during the check-in process and/or by initiating	Routine medical procedure serves as opportunity for EoL care discussion	Routine medical procedure serves as opportunity for EoL care discussion

	the discussion using the proposed prompts.		
	Based on HCPs' clinical judgment, if HCPs sense that older Chinese Americans are ready and willing to have the discussion, they can then proceed to discuss EOL care planning. If the older Chinese American is not ready for the discussion, HCPs should note this and reassess at a later time.	Assumption of HCPs being able to notice patients' responses and determine the discussion time	Assumption of HCPs being able to notice patients' responses and determine the discussion time
Duke & Petersen (2015)	Most of the participants indicated they would freely acknowledge pain, some out of the 'fear' of pain and others just because they either have a low tolerance for pain, or simply do not want to feel pain... "[no pain] helps to enjoy life more ..."	Expressing their feelings directly Painless condition bringing higher life enjoyment	Direct expression of feelings Painless condition bringing higher life enjoyment
	they would only volunteer presence of pain to their family knowing that their family would seek help to relieve the pain... "... do not want to bother them [the nurses] ..."	Not wanting to become burdens of others Thinking they were bothersome	Not wanting to become burdens of others Perceiving themselves bothersome
	Either parents and/or grandparents would freely acknowledge pain if asked, but might not volunteer it.	Passive in acknowledging pain	Passive in expressing pain
	volunteering presence of pain without being first asked was highly 'individualised' as one participant commented, with about 60% responses for free volunteering.	Whether to present the presence of pain is an individual will, not a collective practice	Whether to present the presence of pain is an individual will, not a collective practice
	the willingness to honour wishes of being pain-	the willingness to honour wishes of being pain-free as oppose to family	Honouring the wishes of being pain-free goes against the views of the

	free despite opposing views of the family member	opinions	family members
	voicing the necessity of advance planning and communication about these issues	Active communication	Active communication regarding advance care planning
	Preference for using a numbered scale to assess pain	Preference for using a numbered scale to assess pain	Preference for using a numbered scale to assess pain
	Pain was often not communicated by the participant or family due to fear of burdening the HCP.	Fear of burdening HCP (patients and carers)	Fear of burdening HCP (patients and carers)
	One participant responded that they would want to 'please the doctor or nurse ... [and desires] to be easy to deal with, I'm not a trouble maker ... most of us.'	Not wanting to bother HCPs Wanting to please HCPs	Not wanting to bother HCPs Wanting to please HCPs
	Some participants reported previous experiences in China where healthcare settings were very busy and hectic, which gave the patient a sense of hesitancy to report any needs.	Previous experience deter patients from seeking help	Previous experience deterring patients from seeking help
	Privacy was important for several of the participants: concern was expressed of possible negative ramifications by a member of the older generation if the family was aware of pain, and if that pain was reported to a HCP.	Concerns that privacy of having pain will be violated when disclosed to family	Concerns that privacy of having pain will be violated when disclosed to family
	Pain was a private matter in that a participant's mother would accept pain medication only if the	Pain is a private matter Acceptance of pain medication only if children not acknowledge they are in	Pain is a private matter Acceptance of pain medication only if children not acknowledge they are in

	children did not know.	pain	pain
	Parents and grandparents of the participants would be more accepting if they had the opportunity to experience the therapeutic effects, and another's parents would if they knew that the side-effects were temporary.	Accepting pain management if they know any side effects being temporary, or can have therapeutic effects	Accepting pain management if knowing any therapeutic effects or side effects
	The fear of side-effects of pain medications, especially the potential loss of the ability to communicate, fear of addiction, and not wanting children to know the parent (participant) were in pain, were also frequently verbalised as a reason for not communicating pain.	Fear of loss of ability to communicate and fear of addiction from pain medications Not wanting their children know they are in pain	Fear of loss of ability to communicate from pain medications Fear of addiction from pain medications Worries of their children knowing they are in pain
	One nurse participant stated she feared receiving pain medications if she were a patient in the US because of the aggressiveness of pain care as opposed to Taiwan where she practised: 'I do not want pain drugs here ... afraid ... stop breathing...very powerful...[we] do not do that there ... even if dying... do other things.'	Aggressiveness of pain care creates fear in people Difference of care provision between residing country and country of birth (HCP)	Fear created through aggressiveness of pain care Differences of pain care provision between residing country and country of birth (HCP)
	Waiting until severe or 'excruciating' pain is experienced was another barrier to communication of pain needs.	Will only communicate pain needs only if it exceeds tolerance level	Will only communicate pain needs only if it exceeds tolerance level
	Lack of knowledge responses dealt primarily with the safe and effective administration of opioids or other similar pain medications. A male participant was also very reticent about accepting pain medications unless he knew the 'exact cause of the pain' and how 'it will help ...	Lack of knowledge regarding the pain medication Patients are willing to accept pain medication if they know the exact cause of pain and the effect of medication Education of pain medication is	Lack of knowledge regarding the pain medication Willing to accept pain medication when the exact cause and effects are known Education of pain medication is necessary

	my pain.' According to several of the participants, their parents would accept medication only if educated about it.	needed	
	Conditions included imminence of death, but some indicated if they were to die soon, they would decline sedation so that they could communicate.	Some said if they are going to die, they may probably accept sedation, but some decline as they want to stay awake to communicate	Acceptance of sedation depending on the ability to communicate with others
	Another would accept sedation closer to death so he can be pain-free to 'enjoy life' more	Acceptance of sedation depends on maintaining quality of life	Acceptance of sedation depends on maintaining quality of life
	how 'brave' the individual feels they are, the more brave, the less likely medication or sedation will be acceptable.	Not receiving medication is a showcase of braveness	Not receiving medication is a showcase of braveness
	One of the focus group participants stated she would accept medication/sedation only if she knew that unfinished business had been addressed.	Any unfinished business not yet addressed would deter patients from accepting medication	Any unfinished business would deter patients from accepting medication
	The two most common reasons participants gave for bearing the pain, and absolute refusal of pain medication under any circumstance were the desire to maintain the ability to communicate, and fear of side-effects, especially loss of cognitive functioning.	People not wanting to accept pain medication is because they have misunderstanding towards these medications would bring undesirable side-effects or consequences Misunderstanding should be addressed by education	Misunderstanding towards pain medication Education of pain medication is necessary
	One participant believed that her mother would decline because pain is natural and a part of the 'life event' and she would rather 'suffer'.	Unnecessarily treating pain as it is a natural process	Unnecessary treatment of pain, being a natural process

	<p>However, if she were making the decision for her mother, she would agree to sedating her mother knowing the effects would be temporary.</p>	<p>Not wanting to see their parents suffering from pain</p>	<p>Not wanting to see their parents suffering from pain (carers)</p>
	<p>would not take medication unless the pain were rated as 10 on a scale of 1–10, and then would accept only very minimal and mild medication. This particular participant was very critical of western tendencies of ‘overmedicating’, and she equated aggressive pain management in hospices in her homeland as ‘elite care’.</p>	<p>Patients would only accept minimal or mild medication even they cannot tolerate the pain Not wanting to be over-medicating</p>	<p>Only acceptance of minimal or mild pain medication even exceeding the tolerable level Not wanting to be over-medicating</p>
	<p>Generational and gender differences of pain tolerance were discussed, and responses showed mothers/grandmothers were more reticent to take pain medication than than fathers/grandfathers.</p>	<p>Mother/grandmother speak less about pain Generational and gender differences of pain tolerance</p>	<p>Mother/grandmother speak less about pain Generational and gender differences of pain tolerance</p>
	<p>Differences in pain management strategies between the East and the West, with the opinion that the West is too aggressive was expressed by five persons.</p>	<p>Pain management in the West is too aggressive</p>	<p>Pain management in the West is too aggressive</p>
	<p>participant feelings of greater satisfaction with pain management in the east with the use of alternative strategies.</p>	<p>Satisfaction of using alternative strategies from the east</p>	<p>Satisfaction of using alternative strategies from the east</p>

Table 3: Step two of thematic synthesis: Generation of free codes (higher level) from line-by-line codes

Free Codes	Acculturation	Family Expectation	Religious belief & Practice	Expectation towards HCPs	Children Responsibilities	Gender Role in Care	Geographical Barriers
Line-by-line Codes	Combining the old and the new cultures	Living independently from children	Feeling pressured due to religious practice differences	Tensions appeared between the roles of family and HCPs	Differences between the west and chinese regarding who to give care mainly due to filial piety	Female leading the role of caregiving	Geographical barrier deterring people from seeking help from others
	An obligation to assimilation	Expectations of children being the primary care providers	Preference of believing in Chinese gods and traditional EoL customs and beliefs	EoL care having the tendency to override the role of children	Caring for parents goes beyond responsibility	Gender differentials	Living away from country of origin making people socially detached from family relatives
	Feeling pressured of being alien to the local social norm	Wanting to receive care from family when approaching death	Lack of contacts and differences in burial process between cultures	Disagreement with western caregiving practice	Taking care of parents is a duty	Women's duty to take care of aging parents and young children	Migration leading to disruption of traditional family and social support
	Feeling socially isolated due to loss of family values and cultural understandings	Preference of taken care by family outweighing by government because of strong sense of family	Traditional Taoist belief provokes people's afterlife concern	Mental health support and service provision by HCPs	Next generation being influenced by westernised beliefs lose rapport with family (carers)	Female being usual caregivers	Not having talking opportunities because of estranged relationship with relatives
	Hard to accept and integrate patients' cultures into local culture (HCP)	Not wanting to burden on children	Living a righteous life brings fortune	Perception of doctors being impatient because of Chinese's low English oral proficiency	Not wanting their parents to be depressed due to language barriers so they devise strategies to help them (carers)	Mother/grandmother speak less about pain Generational and gender differences of pain tolerance	

	Feeling comfortable to integrate traditional chinese medicine to western medicine (HCP)	The preference of children contradict with that of parents	Blessings and protection from gods were limited within geographic boundaries	Preference of having those who understand Chinese cultural complexity to provide culturally comfortable medical environment	Duty of filial piety		
	Only HCPs feeling discomfort for the combined use of different culture medicines (HCP)	Not wanting to rely heavily on family (HCP)	Essence of accepting new religious image	Cultural difference awareness is anticipated on health care professionals			
	Multilingual education materials being suggested to migrants	Fear of burdening family (HCP)	Having a superstitious image	Having EoL care discussions with parents when initiated by HCPs			
		Avoid imposing on family members		Initiation of EoL conversation by patients' readiness (carers)			
		Treat family badly		HCPs acknowledge cultural taboo and ask for permission (patients and carers)			

		Premature discussions of ACP become burdens for family		Blessing older Chinese for having longevity when asking for permission (HCP & carers)			
		Anticipation of being honoured and respected when died		Assumption of HCPs being able to notice patients' responses and determine the discussion time			
		Not wanting to become burdens of others		Fear of burdening HCP (patients and carers)			
		Worries of their children knowing they are in pain		Not wanting to bother HCPs			
				Wanting to please HCPs			
				Active communication regarding advance care planning			

Free Codes	Quality of Care	Contemporary Family Structure	EoL Knowledge	Family Influence	Engagement in Society	Respect to Patients	Quality of Life
Line-by-line Codes	Clinical capacity may not proportional to	Only old parents staying at home	Knowledge regarding healthcare system	Family affecting their perceptions towards the	Passive engagement outside of	Promotion of autonomy by sharing patients'	Painless condition bringing higher

	language capacity (HCP)		and palliative care matters	image of opposite sex	Chinese community	preferences	life enjoyment
	Contradiction between patient-centered and culturally competent care (HCP)	Family members knowing of their roots	Differences of palliative care between residing country and country of origin (HCP)	Striving for perfection weakened their ability to accept failure	Unnecessary of attending funeral	EoL discussion initiated by children is not respectful in Chinese culture	Acceptance of sedation depends on maintaining quality of life
	Not stereotyping someone with certain cultural characteristics (patient-centered or culturally competent?) (HCP)	Next generation lose intimacy from their root's culture bonding	Understanding of palliative home care is different among Chinese (HCP)			Let patient choose whether to discuss	
	Only acceptance of minimal or mild pain medication even exceeding the tolerable level Not wanting to be over-medicated	Next generation being curious to know more about their family	Limited knowledge regarding EoL practices in foreign places			HCPs assessing patients' readiness by observing attitudes, verbal and non-verbal responses, and clinical judgement	
			English-speaking people having greater knowledge of EoL care options and practices			Honouring the wishes of being pain-free goes against the views of the family members	
			Knowing and having done advance directives are different			Concerns that privacy of having pain will be violated when disclosed to	

						family	
			Misunderstanding and lack of familiarity derived from non-English-speaking group regarding advance directives				
			Non-english speakers having limited knowledge towards advance care planning				
			Unfamiliarise with procedure or consequence of filling out advance directives				
			Only a few being knowledgeable in advance care planning				
			Accepting pain management if knowing any therapeutic effects or side effects				
			Fear of loss of ability to communicate from pain medications				
			Fear of addiction from pain medications				

			Lack of knowledge regarding the pain medication				
			Willing to accept pain medication when the exact cause and effects are known				
			Education of pain medication is necessary				
			Acceptance of sedation depending on the ability to communicate with others				
			Misunderstanding towards pain medication Education of pain medication is necessary				

Free Codes	Views towards Dying at Home	Views towards Death	Views of EoL Care Services Provision	Language Preference	Communication between Chinese & HCPs	Self-recognition & concerns	Consideration of family carers
Line-by-line Codes	Not wanting to die at home	Death being a natural and normal process	Unnecessary to seek psychological advice when approaching death	Preference of speaking Chinese when utilising the service	Language barrier interfering the communication and service delivery between the Chinese and HCPs	Considering others more than patient himself	Psychological protection of their family members by not disclosing the terminal nature of illness

							(carers)
Little tolerance of loneliness and depressed feeling when spouses passed away	Fear of confronting uncertainties alongside death	Underutilisation of bereavement service	Attempting to match patients with HCPs speaking the same language	Culturally and racially matched but not linguistic matching	Not wanting to rely on someone who can't offer or guarantee you limitless help		Fulfill both employment commitment and family commitment (carers)
Monetary benefits contribute most of not wanting to die at home	No readiness to leave and vacate	Agreeing with the importance of mental health support service		Disrupted communication of not understanding each other	Emotional and sentimental		Preference of initiations of EoL discussions by old parents instead of children (carers)
Dying somewhere out of home is preferred	Feeling helpless, having no one by the side when approaching death (carers)	Reluctance of asking for assistance (carers)		Inability to express their way of knowing in a mutually understood language	Optimistic about the future but irritable		Not having EoL discussion with family though engaging in the study (carers)
Not wanting to die at home was assumed to be cultural belief in Chinese (HCP)	Cultural taboo of dying hinder people from dying at home (HCP)	Unwilling to accept help from services (carers)		Language barriers bring a lot of consequences other than communications in clinical settings (patients, carers and HCP)	Perception that Emotion attachments being normal		Careful attention to perform the funeral rites to parents
Refusal to die at home goes beyond superstition	Some refuse to talk about dying but some discuss it openly (HCP)	Worries of not having care		Bilateral disrupted communication of not understanding a mutual language (HCP)	English-speaking patients are confident to do advance care planning		Parents more willing to talk with HCPs (carers)

Refusal of dying at home goes beyond cultural taboo (patients and carers)	Cultural belief that death is natural and inevitable	Needs & concerns of EoL care go beyond culture, ethnicity, race and religion (HCP)		Not understanding what HCPs are talking about but pretend to know it (HCP)	Imagination of being in declined health condition provoke unnecessary anxiety and unease	Not wanting to see their parents suffering from pain (carers)
	Fear of regrets at the end stage of life	Being compliant to cultural difference and adoption of mixed culture treatment (carers and patients)		People's opinions and voices being subjugated	Sensitivity related to death and dying can be minimised by using others' experience	Needs to bear ill family members' sorrow and worries (carers)
	Pain management in the West is too aggressive	Preference of having culturally appropriate services given by those who understand cultural complexity distinct to Chinese		Dedication of aligning with patients (HCP)	Direct expression of feelings	Practical financial concerns so keep taking care of sick family members to receive subsidies from the government (carers)
	Unnecessary treatment of pain, being a natural process	Culturally sensitive services existing in name alone		Difficulties in understanding the point of view and then blending together the knowledge, experience, perception and assumption of patients, let alone coming up with actions (HCP)	Perceiving themselves bothersome	Communication problem: Speak more than listen (patients and carers)

			Culturally sensitive services being superficial and loosen regulated		Resilience in addressing language barriers (patients and carers)	Passive in expressing pain	
			Options for burial process depending more on the state than HCPs		Creation of lively ways of addressing language barriers in daily lives	Whether to present the presence of pain is an individual will, not a collective practice	
			Unnecessary to seek medical advice		Diffusal of conflicts arose from miscommunication (HCP)	Will only communicate pain needs only if it exceeds tolerance level	
			Satisfaction of using alternative strategies from the east		Make use of common experiences or feelings as bridges to bring trust and relation (HCP)	Not receiving medication is a showcase of braveness	
			Not necessary to talk about ACP when situating in good health condition		Obstructed communication by language barrier	Any unfinished business would deter patients from accepting medication	
			Concerns of the way carrying out EoL conversations		Preference of having those who understand Chinese cultural complexity to act as bridges for communication		
			Assessment of readiness of EoL care discussion		Exploration of informal and indirect communication		

		during routine medical appointments		methods		
		Preference for using a numbered scale to assess pain		Casual conversation making both patients and carers less nervous or upset		
				Preference of having indirect communication approach		
				Adoption of culturally-targeted communication approach for EoL care discussion		
				Adoption of indirect methods to discuss		
				Recommendation of indirect and culturally-targeted communication approaches		
				No mental preparation for patients when using direct communication		
				Introduction of depersonalised communication strategies		
				Making use of others' experiences for EoL discussion initiation		

					Using providers' own experience to have EoL care discussion (HCP)		
					Modeling and aligning HCPs with patients (HCP)		

Free Codes	Carers' Health	places to die	HCPs point of view	Trust in Authority	Timing for EoL Discussion	Health service as opportunities	Refusal of seeking help	Stress of Carers
Line-by-line Codes	Mental stress contributing to physical illness (carers)	Involvement of the mix of cultures and negotiation during the decision of place to die	No difference in care for Chinese or other ethnocultural groups (HCP)	Reliance on professional interpreters or English-speaking family members in doctor's appointments (patients and carers)	Discussion should be delayed until health declines	Integration of ACP in formal routine medical procedures (policy)	Previous experience deterring patients from seeking help	Stress and emotion arisen from taking care of terminally ill family members (carers)
	Poor mental health leading to poor physical health (carers)	Decision of place to die goes beyond cultural beliefs	Self-disclosure helps reduce sensitivity of patients		Talk ACP only in the last minute	Increasing ACP awareness and engaging in EoL care discussion among Chinese Americans	Pain is a private matter Acceptance of pain medication only if children not acknowledge they are in pain	Loss of personal time and bringing emotional distress due to dependence of sick family members (carers)
			Fear created through aggressiveness		Appropriate timing for ACP: almost dead	Acceptable and nonthreatening opportunity of		Emotional distress due to financial

			of pain care			integrating EoL care discussion into official policy		burden from medical costs (carers)
			Differences of pain care provision between residing country and country of birth (HCP)		Routine medical procedure serves as opportunity for EoL care discussion	Making EoL care discussion standard questions in official policy		Foreseeing of a lonely future living (carers)
								Stress derived making people hard to cope with life (carers)
								Feeling burdened out of being interpreters (English-speaking carers)