

# The Influence of Cultural Factors on Advance Healthcare Directives

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Received: 19 Jun 2025 Revised: 28 September 2025 Accepted: 29 September 2025 Published: 15 October 2025  
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## Abstract

**Background:** Advance directives play a crucial role in end-of-life healthcare decisions, and their effectiveness is widely acknowledged. However, adoption rates of advance directives vary significantly across different cultural contexts. This underscores the need to understand how cultural factors influence perceptions and practices regarding advance directives to improve end-of-life care and ensure patient autonomy.

**Objective:** This scoping review aimed to identify and examine the cultural factors affecting the acceptance, understanding, and utilization of advance directives in diverse cultural settings.

**Methods:** We conducted a systematic literature search from 1998 to 2024 across multiple databases, including PubMed, Scopus, APA PsycINFO, CINAHL, Cochrane Library, and Web of Science, using the Arksey and O'Malley framework. Manual searches were also conducted to supplement our findings. Sixteen studies focusing on the cultural impact of advance directives in various healthcare settings were selected and analyzed.

**Results and Conclusion:** Out of 2606 articles identified, 16 met the criteria, spanning over different populations. Our findings revealed that cultural beliefs, family dynamics, societal norms, and religious values strongly influence attitudes toward advance directives. A significant theme across many cultures was the importance of family involvement in end-of-life planning. These findings underscore the diversity of cultural approaches to end-of-life care and the necessity for healthcare providers to adopt culturally sensitive approaches.

**Keywords** Advance Directives, Healthcare Decision-Making, Cultural Factors, Patient Autonomy, Cross-Cultural Comparison

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## Introduction

Advance directives are legal documents that allow individuals to outline their preferences for medical care in the event that they become unable to make decisions for themselves, often due to terminal illness or incapacitation (Nedjat-Haiem et al., 2023). These documents serve as a guide for healthcare providers and family members, ensuring that a patient's medical treatment aligns with their wishes, especially concerning life-sustaining measures and end-of-life care. Despite their critical role in patient autonomy and end-of-life planning, advance directive completion rates remain suboptimal worldwide (Butler et al., 2015; Yadav et al., 2017). In the United States, only 36.7% of adults have an advance directive (Yadav et al., 2017). Cultural elements play a significant role in the limited engagement with advance care planning, as societal beliefs, values, norms, and communication styles substantially influence individuals' attitudes and behaviors towards such planning (Bassett, Paulson and McClure, 2022; Torres Blasco, Rosario and Shen, 2023). For instance, imagine a health carer in a bustling city hospital who faces a dilemma when a patient's family insists on a care approach that starkly contrasts with what the patient desired in their advance directive. This clash between the individualist viewpoints prevalent in Western cultures, which emphasize patient autonomy, often stands in stark contrast to the collectivist perspectives of Eastern cultures, where value is placed more on family and community involvement (Hamano, 1997). Cultural beliefs about truth-telling, quality of life judgements, and death and dying further influence openness to advance directives (Searight and Gafford, 2005). These cultural considerations are pivotal in understanding the varying attitudes towards end-of-life planning across different societies.

Despite this interest and the clear influence of cultural factors, advance directive uptake remains suboptimal due to diverse patient-level and system-level barriers (Yadav et al., 2017; Bailey, 2018). Moreover, patient factors reflect individual experiences, attitudes, beliefs, and communication preferences. These individual determinants are profoundly shaped by cultural frameworks, including concepts of autonomy, truth telling, family involvement in decisions, religiosity, death perceptions, and values influencing treatment preferences (Searight and Gafford, 2005). Cultural beliefs related to fate, spiritual healing, collectivism versus individualism, quality of life judgments, and tradition further impact advance directive openness (Sherman and Free, 2018). Diverse cultural schemas surrounding death and dying particularly influence the

willingness to discuss and document end-of-life wishes in a healthcare context across ethnic groups (Zivkovic, 2021). These varying schemas play a critical role in how different communities perceive and approach end-of-life planning.

Building on this understanding, it becomes evident that a cultural worldview acts as an interpretive lens through which individuals perceive illness, suffering, medical decisions, and quality of life preferences. Besides, Dominant Western bioethics emphasizes patient autonomy, truth telling by health care workers, and individualized end-of-life choices documented in advance directives (Chattopadhyay and Simon, 2008; Negri, 2012). Nevertheless, within many ethnic minority groups, decision-making patterns that favor collective or family-oriented approaches over individual preferences, or that rely on spiritual healers, continue to be prevalent (Cura, 2015). This prevalence of communal decision-making and the involvement of spiritual aspects in healthcare choices underscore the complexity of integrating diverse cultural practices into a standardized healthcare framework.

Additionally, direct communication styles favored in Western medicine can prevent some cultures from openly discussing death. In Japanese culture, euphemisms and indirect phrases allow "beating around the bush" regarding prognosis (Davies and Ikeno, 2011). Chinese culture traditionally avoids direct acknowledgment of terminal diagnoses, preferring family-based disclosure (Hamano, 1997). Such norms influence receptiveness and readiness to complete advance directives. Cultural preferences for physician-directed paternalism versus patient autonomy similarly impact end-of-life planning engagement (Marsac et al., 2018).

Strong religious and spiritual orientations shape reactions to advanced directives across cultures. Faith in divine control over life and death may conflict with individualized decisions in advance directives (Cahn and Zietlow, 2016; Determeyer, 2016). Belief in miracles and hope for supernatural healing can discourage acceptance of terminal prognoses and end-of-life planning (Bibler, 2014). Understanding unique factors rooted in cultural and religious perspectives is critical for policy makers who ultimately seek to contribute to improved advance directives and consequently health outcomes.

Cultural beliefs and values clearly mediate how patients and families perceive illness, make medical decisions, communicate with providers, and plan for end-of-life care. However, additional research synthesis is needed to systematically map the global evidence regarding sociocultural impacts on advance directive completion across diverse groups. While prior reviews have examined

aspects of culture and end-of-life care, no scoping review has broadly captured international literature explicating how cultural constructs influence advance directive decision-making specifically.

Therefore, the present scoping review aims to: (a) Assess the extent and depth of research exploring how various cultural backgrounds and norms shape perceptions and practices related to advance directives, (b) Identify and map out the cultural variables that impact the acceptance, understanding, and utilization of advance directives across different cultural settings, and (c) Provide insights and recommendations for healthcare professionals and policymakers to better accommodate cultural diversity in the context of advance directives.

**Methods**

**Study design and research question**

This scoping review was conducted using the Arksey and O'Malley framework (Arksey and O'Malley, 2005). The results are presented in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco AC et al., 2018). Our methodology encompassed five key steps: (1) identifying the research questions, (2) identifying relevant studies, (3) Selecting the studies, (4) charting the data, and (5) collating, summarizing, and reporting the findings (Arksey and O'Malley, 2005). The primary research question guiding this review is: 'How do various cultural

backgrounds and norms shape perceptions and practices related to advance directives in healthcare decision-making?

**2.2. Search Strategy**

A meticulous literature search was conducted to explore the influence of cultural factors on advance directives in healthcare decision-making for this scoping review. PubMed, Scopus, APA PsycINFO, CINAHL, Cochrane Library, and Web of Science, utilizing a combination of Medical Subject Headings (MeSH) and keywords were used. These were linked using the Boolean operators “OR” and “AND” to cover aspects related to cultural factors, advance directives, and healthcare decision-making. The search terms included: (“Culture” OR “Cultural Factors” OR “Cultural Diversity”) AND (“Advance Directives” OR “Healthcare Decision-Making” OR “End-of-Life Care”) AND (“Healthcare” OR “Patient Preference” OR “Medical Ethics”). Customized search equations were developed for each database to capture both published and unpublished English literature from January 1, 1998, to February 25, 2024. Additionally, manual searches of reference lists from relevant articles and gray literature were performed. The detailed search strategy equations formulated for the considered databases are presented in Table 1. This comprehensive approach was designed to collate all relevant studies concerning the impact of cultural factors on the use and understanding of advance directives in diverse healthcare contexts, thereby informing the synthesis for the scoping review.

**Table 1:** Search strategy

Search Strategy		
	(((((“Advance Directives” [MeSH]) OR “Living Wills” [MeSH]) OR “Healthcare Power of Attorney” [MeSH]) AND (“Cultural Characteristics” [MeSH] OR “Cultural Diversity” [MeSH])) AND (“Decision Making, Shared” [MeSH] OR “Patient Preference” [MeSH]))	PubMed
	(TITLE-ABS-KEY ( "Advance Directives" ) OR TITLE-ABS-KEY ( "Living Wills" ) OR TITLE-ABS-KEY ( "Healthcare Power of Attorney" )) AND ( TITLE-ABS-KEY ( "Cultural Factors" ) OR TITLE-ABS-KEY ( "Cultural Diversity" )) AND ( TITLE-ABS-KEY ( "Shared Decision Making" ) OR TITLE-ABS-KEY ( "Patient Preference" ))	Scopus
	("Advance Directives" OR "Living Wills" OR "Healthcare Power of Attorney") AND ("Cultural Characteristics" OR "Cultural Diversity") AND ("Decision Making, Shared" OR "Patient Preferences")	APA PsycINFO
	(MH "Advance Directives" OR MH "Living Wills" OR MH "Health Care Power of Attorney") AND (MH "Cultural Characteristics" OR MH "Cultural Diversity") AND (MH "Shared Decision Making" OR MH "Patient Preferences")	CINAHL

("Advance Directives" OR "Living Wills" OR "Healthcare Power of Attorney") AND ("Cultural Factors" OR "Cultural Diversity") AND ("Shared Decision Making" OR "Patient Preference")	Cochrane Library
(TS=("Advance Directives" OR "Living Wills" OR "Healthcare Power of Attorney") AND TS=("Cultural Factors" OR "Cultural Diversity") AND TS=("Shared Decision Making" OR "Patient Preference"))	Web of Science

## Eligibility Criteria

The literature selected for this review encompassed English-language abstracts and papers published from January 1, 1998, to February 25, 2024, with a focus on the influence of cultural factors on advance directives within the realm of healthcare decision-making. The core inclusion criteria were centered around studies that explore how different cultural backgrounds and norms affect the understanding, acceptance, and implementation of advance directives. Eligible studies included those that addressed advance directives in various healthcare settings, emphasizing how cultural factors influence these directives. These studies encompassed various forms of advance directives, including living wills, durable power of attorney for healthcare, and do-not-resuscitate orders, among others.

In our selection process, we did not restrict the inclusion by study type, aiming to encompass the full range of existing literature relevant to the topic. However, we made a specific decision to exclude commentaries, review articles, brief reports, and letters to ensure a focus on more comprehensive and detailed studies. The eligible population for this review included individuals from diverse cultural backgrounds interacting with the healthcare system, irrespective of their specific health conditions. Both qualitative and quantitative assessments of the influence of cultural factors on the understanding and use of advance directives were considered. This approach allowed for a comprehensive understanding of how cultural norms and values shape healthcare decision-making processes involving advance directives.

Studies were included if they assessed the impacts of cultural factors on the perception, acceptance, and application of advance directives, focusing on outcomes that directly relate to these aspects. Exclusion criteria were applied to studies that did not evaluate the impact of cultural variables on the use or understanding of advance directives, especially those lacking detailed exploration of cultural influences or contextual considerations in healthcare settings. This methodology ensured a focused and relevant collection of literature, providing valuable insights into how

cultural diversity is accommodated in the context of advance directives in healthcare.

## Data extraction and selection process

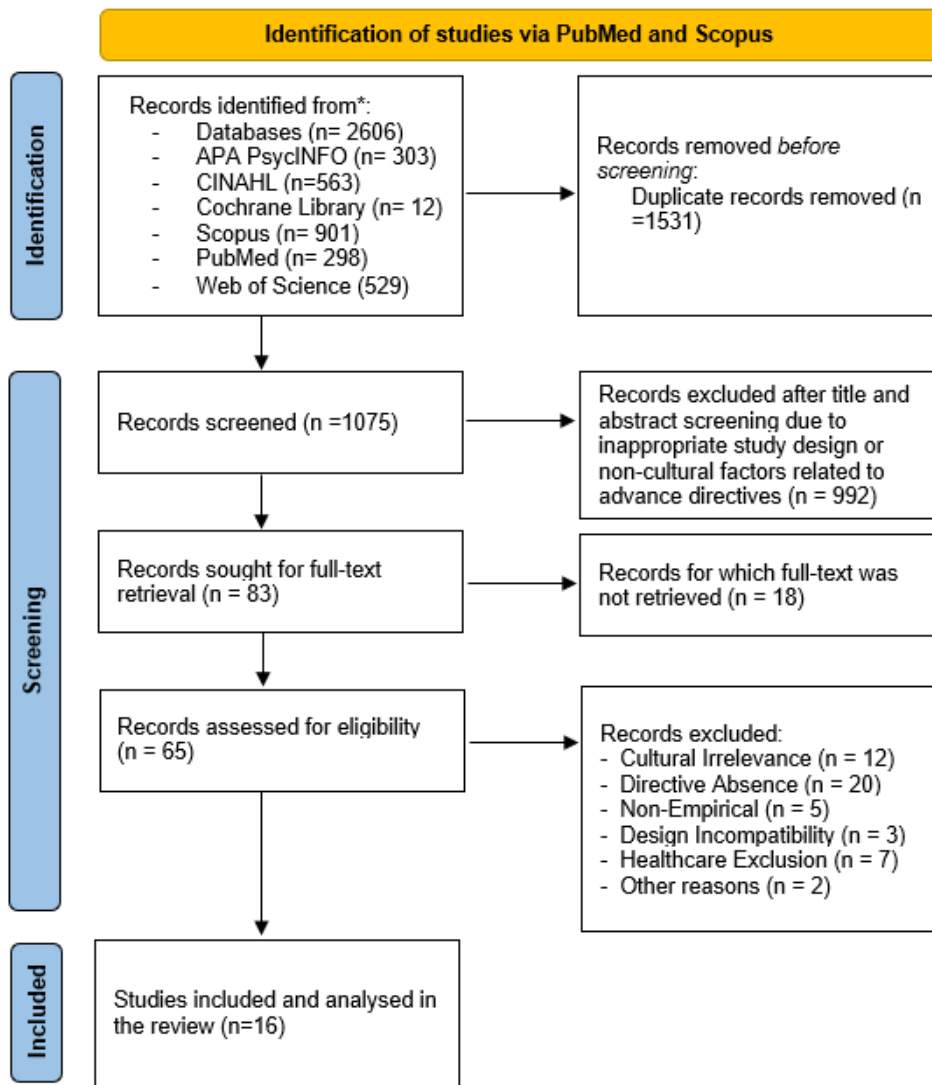
For the studies included in our scoping review, key parameters were charted by three independent authors (AS, SH, and SA), with confirmation by a fourth author (AM). This charting was focused on mapping out the impact of cultural factors on advance directives in healthcare decision-making. The data extracted included the Study Design, Country of Study, Population Studied, Sample Size, Mean Age, Cultural Context, Type of Advance Directive and Key Findings. This comprehensive charting process was critical for synthesizing findings across various studies, particularly examining the interplay between cultural contexts and the use and understanding of advance directives.

## Data Extraction from the Literature

After the relevant literature was selected, the data were systematically extracted and tabulated using Microsoft Word, version 2019 (Microsoft).

## Results

Our extensive literature search across various databases including PubMed, Scopus, APA PsycINFO, CINAHL, Cochrane Library, and Web of Science initially yielded a total of 2606 records. The removal of 1531 duplicate records left us with 1075 studies for title and abstract screening. This process resulted in the exclusion of 992 records due to inappropriate study designs or their irrelevance to cultural factors related to advance directives, narrowing the field to 83 records for full-text retrieval. However, full-texts for 18 records could not be retrieved. After further evaluation, 65 records were assessed for eligibility, leading to the exclusion of 49 studies for various reasons such as cultural irrelevance (12), absence of directives (20), non-empirical nature (5), design incompatibility (3), healthcare exclusion (7), and other reasons (2). Ultimately, 16 studies met our criteria and were thoroughly analyzed and included in our review. The detailed process of study selection is displayed in Figure 1 of our PRISMA flow chart.



**Figure 1:** Study selection flowchart.

**Characteristics of included studies**

A total of 16 studies, spanning from 1998 to 2024, were included in this scoping review, showcasing a diverse range of research approaches. The array of study designs comprised: 1 Cross-Cultural Study (Voltz et al., 1998), 1 Case-Control Study (del Pozo Puente et al., 2014), 1 Survey Study (Alano et al., 2010), and 6 Cross-Sectional Studies (Duke, Thompson and Hastie, 2007; Lee and Park, 2015; Huang et al., 2018; C. W. H. Chan et al., 2019; Martins and Nunes, 2023; Oshow, Shah and Ali, 2024). Additionally, the

review included 1 Qualitative Interviews Study (C. W. Chan et al., 2019), 1 Analysis of Consultation Records Study (Wu et al., 2023), 1 Qualitative Phenomenological Study (Poveda-Moral et al., 2021), 1 Secondary Analysis of Cross-Sectional Data Study (Choi and Ko, 2024), 1 Comparative Survey Study (Periyakoil et al., 2014), 1 Pre-Posttest Repeated Measures Non-Experimental Design Study (Hinderer and Lee, 2019), and 1 Mixed-Methods Study (Trarieux-Signol et al., 2014). (Details mentioned in Table 2).

**Table 2:** General Design, Demographics, and Cultural Context of Included Studies

Study	Country	Study design	Population Studied	Sample Size	Mean age	Cultural Context	Type of Advance Directive
Voltz RJ et al., 1998	USA, Germany, Japan	Cross-cultural study	Patients in palliative care institutions (mostly cancer patients)	USA: 90, Germany: 34, Japan: 34	USA: 68.0 years, Germany: 62.6 years, Japan: 58.6 years	Comparison of perspectives in the USA, Germany, and Japan	Formal written AD, informal AD, entrusting decisions to family
del Pozo Puente K. et al., 2014	Spain	Case-control study	General population attending health centers in Albacete Health District, Spain	123 subjects with AD compared to 123 without AD	53.3 ± 14.5 years	Spain	Formal written AD
Alano GJ et al., 2010	United States	Survey Study	Hospitalized and community-dwelling cognitively intact patients over 65 years of age	200 subjects	N/A	United States (New York)	Living will, healthcare proxy, durable power of attorney for health care, MOLST, DNR, DNI
Oshow et al., 2024	Kenya	Cross-sectional study	Adult patients admitted to a tertiary care center	286 participants	Median age of 44.0 years	Kenyan, with a focus on various religions and ethnicities	Living wills and healthcare surrogates
Chan CW et al., 2019	Hong Kong	Qualitative interviews	Patients, families, health professionals, and hospital volunteers in Hong Kong	96 participants: 24 patients with life-limiting diseases, 24 family members, 24 health professionals, and 24 hospital volunteers from two regional hospitals	N/A	Chinese culture in Hong Kong	General ADs
Wu YL et al., 2023	Taiwan	Analysis of consultation records	Urban residents in Taiwan participating in ACP consultations	2337 participants	60.45 ± 14.09 years	Taiwanese urban residents	Standardized AD Forms
Poveda-Moral S. et al., 2021	Spain	Qualitative phenomenological study	Professionals in Hospital Emergency Department and Emergency Medical Services	24 participants	N/A	Emergency care services in Catalonia, Spain	General ADs
Chan CWH et al., 2019	Hong Kong	Cross-sectional study	General population of Hong Kong	2002 participants	N/A	Hong Kong Chinese population	General ADs
Choi S and Ko H, 2024	South Korea	Secondary analysis of cross-sectional data	Community-dwelling older adults in South Korea	9920 older adults	73.80 ± 6.33	Older adults in South Korea	General AD Factors
Periyakoil VS et al., 2014	United States	Comparative survey of attitudes towards ADs across time (1989 vs. 2013)	Doctors of various specialties at academic medical centers	1081 doctors participated in 2013	N/A	Medical professionals in academic centers	Focus on doctors' attitudes towards Advance Directives and their personal end-of-life preferences
Lee MH, Park YH, 2015	South Korea	Cross-sectional study	Older cancer patients	130 patients	70.8	South Korean older cancer patients	A self-structured AD Form
Huang HL et al., 2018	Taiwan	Cross-sectional study	Nursing home residents with dementia	143	82.45 ± 7.28	Taiwanese nursing home	Various End-of-Life AD Types

						residents with dementia	
Hinderer KA et al., 2019	United States	Pre-posttest repeated measures non-experimental design	Chinese Americans	72	61.1 ± 12.2	Chinese Americans	General form of Advance Directives (ADs)
Trarieux-Signol S. et al., 2014	France	Mixed-methods study with retrospective analysis and qualitative analysis	Patients with hematological malignancies	197 patients	64.4 ± 15.8	Patients with hematological malignancies in France	General ADs
Duke G. et al., 2007	United States	Cross-sectional study	Hospitalized patients	47 patients	N/A	Hospitalized patients in East Texas	General ADs
Martins CS, Nunes R, 2023	Portugal	Cross-sectional study	Palliative patients and their caregivers	120 participants (60 patients, 60 caregivers)	Patients: 70.6 ± 13.2, Caregivers: 58.6 ± 13.5	Portuguese palliative patients and caregivers	Portuguese Advance Directive (PAD)

**Abbreviations:** AD - Advance Directive; MOLST - Medical Orders for Life-Sustaining Treatment; DNR - Do Not Resuscitate; DNI - Do Not Intubate; USA - United States of America; SF-36 - Short Form-36 Health Survey; SAPS - Scales for the Assessment of Positive Symptoms; ACP - Advance Care Planning; PAD - Portuguese Advance Directive.

In the realm of advance directives, the studies in our review highlighted a variety of types across different cultural contexts. Voltz RJ et al. (1998) and del Pozo Puente K. et al. (2014) focused on Formal Written ADs, Informal Ads (Voltz et al., 1998), and entrusting decisions to family (del Pozo Puente et al., 2014). Alano GJ et al. (2010) and Oshow et al. (2024) examined Living Wills, Healthcare Proxies, Durable Power of Attorney for Health Care, MOLST, DNR, and DNI (Alano et al., 2010; Oshow, Shah and Ali, 2024). A similar theme was explored by Chan CW et al. (2019) and Poveda-Moral S. et al. (2021), who also studied General Ads (C. W. H. Chan et al., 2019; Poveda-Moral et al., 2021), along with Chan CWH et al. (2019) and Choi S and Ko H (2024), who looked into General AD Factors (C. W. H. Chan et al., 2019; Choi and Ko, 2024). Hinderer KA et al. (2019), Trarieux-Signol S. et al. (2014), and Duke G. et al. (2007) contributed further to our understanding of General Ads (Duke, Thompson and Hastie, 2007; Trarieux-Signol et al., 2014; Hinderer and Lee, 2019). The remaining studies, including Wu YL et al. (2023), Lee MH, Park YH (2015), Huang HL et al. (2017), and Martins CS, Nunes R (2023), each added unique perspectives to the study by focusing on different aspects of advance directives (Lee and Park, 2015; Huang et al., 2018; Hinderer and Lee, 2019; Martins and Nunes, 2023) such as Standardized AD Forms, Various End-of-Life AD Types, and Portuguese Advance Directives (PAD), respectively. The participant demographics in the studies were diverse, reflecting a broad spectrum of cultural backgrounds. The sample sizes varied significantly, ranging from smaller focused studies with 24 participants in qualitative interviews to larger-scale analyses involving up to 9,920 participants in the secondary analysis of cross-sectional data. While specific age details were not always

provided, the studies that did report age showed a range of participant ages, indicating a wide demographic representation across different cultures and healthcare contexts.

### Personal Influences

#### Cultural and Religious Beliefs

Personal cultural and religious beliefs shape global advance directive awareness, attitudes, and decision-making. In Kenya, Oshow et al. (2024) found that religious connections affected advance directive awareness. Hindus were more knowledgeable than Muslims and Christians (Oshow, Shah and Ali, 2024). This shows how spiritual beliefs affect healthcare choices. Chan et al. (2019) found that religious beliefs and afterlife conceptions influenced advance directive acceptance among Chinese in Hong Kong (C. W. H. Chan et al., 2019). Various nations also have various views on death and terminal illness decision-making. Voltz et al. (1998) showed significant differences in US, German, and Japanese opinions. Germans and Americans avoided and reacted badly to end-of-life conversations, whereas Japanese participants were more accepting and receptive. This difference highlights how cultural norms and social narratives about dying may severely affect persons' emotional attitudes towards advanced directives (Voltz et al., 1998). In certain religious organizations, spiritual beliefs are associated with greater advance directive fulfillment rates. According to Findings in France (Trarieux-Signol et al., 2014) and Muslim communities (Huang, Neuhaus and Chiong, 2016), including religious leaders in healthcare decisions increases the possibility of formalizing advance directives. Details in Table 3.

**Table 3:** Cultural Determinants in Advance Directive Choices

Study	Type of Advance Directive	Key Findings
Voltz RJ et al., 1998	Formal written AD, informal AD, entrusting decisions to family	The results showed that cultural context significantly influences patients' attitudes towards advance directives in palliative care. In the United States and Germany, most patients had negative feelings towards end-of-life decisions, whereas in Japan, patients exhibited a more positive or philosophical attitude, possibly reflecting cultural differences in expressing and handling such decisions.
del Pozo Puente K. et al., 2014	Formal written AD	The study found that preparing advance directives was associated with several socio-demographic and health factors. Women, individuals with secondary or higher education, those living without a partner or children, and chronic medication users were more likely to prepare ADs. Additionally, a long-term relationship with a family physician, a family history of AD, and lower levels of social interaction were also influential factors.
Alano GJ et al., 2010	Living will, healthcare proxy, durable power of attorney for health care, MOLST, DNR, DNI	Factors predicting AD completion among older adults included personal beliefs about ADs aiding in end-of-life suffering relief, being asked to complete ADs or receiving explanations about them, major surgery experiences, and demographic factors like gender and age.
Oshow et al., 2024	Living wills and healthcare surrogates	The study found significant differences in AD knowledge and attitudes based on religious affiliation, with Hindus showing the highest awareness and Muslims the least. It also noted a gender disparity in AD knowledge, with males having higher awareness than females. Cultural and religious influences significantly affected AD awareness and preferences in the Kenyan context
Chan CW et al., 2019	General ADs	The results showed that family members play a crucial role in the decision-making process, often concerned about the psychological burden of discussing ADs. Health professionals focused on logistics and the process of ADs, while hospital volunteers emphasized the need for more promotion of ADs in the community, taking into account the cultural importance of family opinions in such discussions.
Wu YL et al., 2023	Standardized AD Forms	The results showed that 94.1% of the participants completed ADs and 87.8% appointed HCAs. Factors significantly associated with AD completion included welfare entitlement, the setting of ACP,

		participation of second-degree relatives, and the intention of not being a family burden.
Poveda-Moral S. et al., 2021	General ADs	The study identified barriers to managing advance directives in emergency care, including personal and professional barriers, family member influences, organizational and structural issues, and health system barriers.
Chan CWH et al., 2019	General ADs	The study revealed a low prevalence of AD completion (0.5%) but high acceptance among those aware of ADs (80.2%). Significant predictors for AD acceptance included religion, optimism, and respecting patients' wishes. Cultural factors like family involvement in AD discussion and good communication with healthcare professionals were emphasized for the Chinese population.
Choi S and Ko H, 2024	General AD Factors	The study identified several factors influencing the completion of advance directives. These included gender, higher education level, physical and mental health status, attitude towards death, and other socio-demographic factors.
Periyakoil VS et al., 2014	Focus on doctors' attitudes towards Advance Directives and their personal end-of-life preferences	The results showed that doctors' attitudes towards ADs have not significantly changed over time. Gender, ethnicity, and specialty influence attitudes.
Lee MH, Park YH, 2015	A self-structured AD Form	The study found that a high percentage (93.1%) of older cancer patients in South Korea intended to complete ADs. However, only 30.0% were aware of ADs, and 9.0% had been informed by healthcare providers. Significant factors influencing attitudes towards ADs included family function, perceived health status, period of education, and age.
Huang HL et al., 2018	Various End-of-Life AD Types	The study found that less than half of the nursing home residents with dementia had advance directives (39.2%), and the majority (96.4%) of these directives were completed by family surrogates. Predictors of having an advance directive included surrogates' previous experience in signing a do-not-resuscitate as a proxy, being informed about advance directives by healthcare providers, and the nursing homes having policies for advance directives and a religious affiliation.
Hinderer KA et al., 2019	General form of Advance Directives (ADs)	The study found improved attitudes toward advance directives among Chinese Americans after participating in a culturally tailored nurse-led educational intervention.
Trarieux-Signol S. et al., 2014	N/A	The study examined factors associated with the designation of health care proxies and writing advance directives among patients with hematological malignancies in France. Findings indicated that patients who wrote advance directives were statistically older and more likely to have expressed a

Duke G. et al., 2007	General ADs	<p>desire to meet a religious representative or a volunteer. Marital status was significant in appointing a health care proxy.</p> <p>The study explored factors influencing the completion of advance directives among hospitalized patients in East Texas. Influential factors included spouses, family members, and sense of spirituality. Most patients learned about advance directives from family, friends, and personal attorneys rather than healthcare providers. The primary reason for completing an advance directive was not wanting to be a burden on their family.</p>
Martins CS, Nunes R, 2023	Portuguese Advance Directive (PAD)	<p>The study found that knowledge of advance directives among Portuguese palliative patients and their caregivers was influenced by sociodemographic factors. Only a small percentage were aware of Portuguese Advance Directives (PAD), and even fewer had completed one. The study suggests the need for better dissemination of information about PAD and the role of healthcare proxies, especially among certain sociodemographic groups to improve end-of-life care planning.</p>

**Abbreviations:** AD - Advance Directive; USA - United States of America; MOLST - Medical Orders for Life-Sustaining Treatment; DNR - Do Not Resuscitate; DNI - Do Not Intubate; ACP - Advance Care Planning; PAD - Portuguese Advance Directive; HCA - Healthcare Agent.

### Awareness and Attitudes to Death

Death knowledge and attitudes are profoundly affected by culture. These characteristics affect how individuals interpret advance directives and arrange end-of-life care. Emotional and psychological attitudes about death and terminal illness decision-making vary widely among cultures. In a fundamental cross-cultural study by Voltz et al. (1998), US, German, and Japanese participants had quite different views on end-of-life decisions (Voltz et al., 1998). Japanese respondents were more accepting and receptive to end-of-life decisions than German and American respondents (Voltz et al., 1998).

In Eastern cultures like Japan, life and death are embraced. This makes addressing end-of-life issues more acceptable. In contrast, Western nations like the US and Germany consider death taboo, making discussion uncomfortable. The results also show that cultural death beliefs and behaviors may strongly impact advance directives. Chan et al. (2019) found that religious beliefs and afterlife conceptions strongly influence advance directive acceptance among Hong Kong Chinese (C. W. H. Chan et al., 2019).

### Individual Characteristics

Gender, education, health condition, and past healthcare

experiences have been found to influence attitudes towards advance directives and decision-making in various global contexts, alongside cultural and religious perspectives. Numerous studies indicate that women are more likely than men to utilize advance directives. For instance, del Pozo Puente et al. (2014) (del Pozo Puente et al., 2014) found that Spanish women were more inclined to complete advance directives, aligning with cultural norms where women assume caregiving responsibilities and prioritize their own health. Moreover, individuals with higher levels of education tend to exhibit greater awareness and acceptance of advance directives. Similar findings have been reported by del Pozo Puente et al. (2014) (del Pozo Puente et al., 2014), as well as studies conducted in the United States (Alano et al., 2010) and South Korea (Lee and Park, 2015), suggesting that people with higher education are more inclined to formalize their end-of-life care preferences through advance directives.

The studies also found that personal health state and healthcare experiences can strongly impact attitudes and decisions. Chronic diseases, long-term drug need, and past healthcare experiences such as surgery are related with greater advance directive fulfilment rates (del Pozo Puente et al., 2014). These experiences typically lead people to consider and prepare for future healthcare situations, leading to advance care planning. Wu et al. (2023) noted that welfare

access, venues for advance care planning meetings, and the desire not to burden family members also influence Taiwanese advance directive choices (Wu et al., 2023). These results highlight the intricate interaction of personal, social, and family influences that influence decision-making.

## Family Dynamics

### Family Opinions and Involvement

Family input and engagement are crucial to improve directed decision-making across cultures. Multiple studies have shown that family relations generally pass individual decisions, particularly in Asian and Hispanic cultures. Chan et al. (2019) discovered that family-centric beliefs strongly influence advance directives among Hong Kong's Chinese people (C. W. H. Chan et al., 2019). The study found that families were worried about the psychological difficulties of addressing end-of-life problems, which prevented open talk and advance directives. Moreover, studies in Taiwan and other Asian countries emphasize family perspectives in forward directive decisions (Wu et al., 2023). Wu et al. (2023) found that people prepare ahead to avoid emotional or financial stress on family. Many Asian countries embrace collectivism, which emphasizes family duties. Extended family and community relationships can impact advance directive views and decisions. Wu et al. (2023) found that extended relatives' engagement and the location of advance care planning conversations affect Taiwanese advance directive fulfilment (Wu et al., 2023).

### Influence of Spouses and Friends

In addition to family bonds, the attitudes and decisions regarding advance directives are influenced by spouses and close friends in various cultures. In Western countries, where individual liberty holds great value, spouses and close friends typically play a prominent role in discussions regarding advance directives. Duke et al. (2007) conducted a study that revealed the significant influence of spouses and friends on the advance directive views of participants from the United States (Duke, Thompson and Hastie, 2007). The establishment of trust and emotional connections in intimate relationships shapes end-of-life decisions. According to Martins and Nunes (2023) (Martins and Nunes, 2023), spouses hold a crucial role in Western advance directive decisions. The complexity of marital bonds and the shared experiences within them give the viewpoints of spouses more weight compared to other family members. Spouses and friends exert a greater influence in Western society, but their impact is somewhat diminished in non-Western cultures. In Asian and Hispanic societies, where decision-making is more family-centric, spouses and friends are considered secondary to the viewpoints of the larger family unit, but their opinions still hold significance.

## Community and Societal Factors

### Community Norms and Values

The results also highlighted how community-wide norms and values exert a profound influence on decisions surrounding advance directives, with notable differences observed between Eastern and Western societal contexts. In Asian cultural settings like Hong Kong, Chan et al. (2019) found that families emphasized the psychological burdens associated with having open dialogues about end-of-life matters (C. W. H. Chan et al., 2019). This reluctance to engage in frank discussions stems from deeply fixed community norms that prioritize emotional harmony and avoidance of distressing topics within family units. In contrast, Western societies, such as the United States, tend to place greater emphasis on individual autonomy and self-determination in healthcare decision-making processes.

### Healthcare System and Policy

Systemic issues in healthcare systems and regulations affect advance directive acceptance and integration across cultures. The literature analysis identified institutional and policy issues and obstacles. Provider knowledge gaps, lack of simplified processes, and infrastructural restrictions hamper advance directive adoption in healthcare systems. Poveda-Moral et al. (2021) recognized these systemic hurdles as major challenges to advanced directives across cultures (Poveda-Moral et al., 2021). Healthcare professionals are also skeptical and resistant to advance directives due to policy uncertainty and legal differences. In a longitudinal US research by Periyakoil et al. (2014), clinicians still expressed questions regarding the practical administration of advance directive rules, despite patient lobbying and regulatory reforms (Periyakoil et al., 2014). Healthcare systems function in varied cultural settings, compounding these systemic issues. Institutional policies and procedures that ignore community cultural requirements, attitudes, and norms might unintentionally hinder advance directive implementation.

### Religious and Institutional Influences

Religious belief and faith-based healthcare institution regulations affect advance directive acceptance and integration across cultures. Spiritual beliefs, institutional belief systems, and end-of-life care decision-making are interconnected, as the research study shows. Religious convictions and the willingness to include religious leaders in healthcare choices have been linked to greater advance directive completion rates among various religion groups. Research with French (Trarieux-Signol et al., 2014) and Muslim (Huang, Neuhaus and Chiong, 2016) people indicated that those who supported religious authority in medical decision-making were more motivated to write

advance directives. These results demonstrate the deep impact of spiritual beliefs on healthcare decisions and the perceived significance of advance care planning tools within particular religious systems. Engaging with religious leaders or following religious teachings may provide legitimacy and meaning to end-of-life aspirations. Faith-based healthcare facilities' attitudes and practices may also affect community acceptance and execution of advance directives. Wu et al. (2023) found that Taiwanese nursing institutions' religious affiliations affected advance care planning acceptability and integration (C. W. H. Chan et al., 2019).

## Discussion

This scoping review synthesized evidence from 16 studies spanning 1998 to 2024, highlighting the profound influence of cultural contexts on advance directive awareness, attitudes, and decision-making processes across diverse global healthcare settings. The included studies used underscore how various socio-cultural factors shape perspectives and behaviors surrounding end-of-life care planning.

Ethnic and religious identities construct powerful culturally embedded meaning systems that greatly shape perspectives on death and end-of-life decisions. Different cultural groups have unique value systems, leading to varying emotional responses and norms that shape experiences of terminal illness (Voltz et al., 1998). Imagine a healthcare provider in a multicultural urban hospital who encounters a family from a collectivist culture, resistant to discussing their elderly patriarch's terminal diagnosis. This scenario highlights the complex interplay of cultural norms that can challenge healthcare professionals. Eastern philosophical traditions, which emphasize the acceptance of impermanence, often lead Japanese patients to be more open to discussions of mortality. This stands in contrast to Western tendencies, where there is generally a greater focus on avoiding such discussions (Sachs, Shega and Cox-Hayley, 2004). Religious cosmologies shape how different faiths view death. For example, the Hindu belief in rebirth often correlates with a higher awareness and acceptance of advance directives among its adherents. In contrast, certain Christian denominations may view the discontinuation of life support as conflicting with divine intentions, influencing their perspectives on end-of-life decisions (Engelhardt and Iltis, 2005; Cahn and Zietlow, 2016; Oshow, Shah and Ali, 2024). Moreover, in collectivist societies where social harmony is often prioritized, there can be a clash with the Western values of individualistic self-determination, especially in the context of healthcare decisions (Kato and Sleebom-Faulkner, 2011; C. W. Chan et al., 2019). However, familial obligations contrast with biomedical ethical norms on truth disclosure. Ultimately, recognizing

this cross-cultural diversity in attitudes towards the existential reality of death itself is vital for negotiating different views and providing patient-centered, culturally-competent end-of-life care (Nayfeh, 2014).

Healthcare providers should reflect on their cultural biases and engage in cultural competence training to navigate these complex interactions effectively. In line with these cultural complexities, there was a predominance of family decision-making over individual autonomy in end-of-life care choices, particularly in Asian and Hispanic/Latin cultures (C. W. H. Chan et al., 2019). Families frequently avoid open discussions about terminal illness due to concerns about the emotional impact on loved ones. This focus on family preferences over individual choices in collectivist cultures sharply differs from Western bioethical standards that prioritize personal autonomy in healthcare decisions (Sass, 2004). These varying cultural scripts regarding who should make decisions highlight the conflict between the values of family duty and individual freedom. For healthcare providers, acknowledging and navigating these cultural differences is essential for delivering culturally sensitive, patient-focused care, especially in end-of-life planning (Nayfeh, 2014).

Interpersonal family dynamics and relationships critically influence perceptions and utilization of advance directives in line with cultural value systems. Across both Eastern and Western contexts, consultations with spouses, relatives, and community advisors like attorneys emerged as pivotal in shaping end-of-life care preferences within family units (Duke, Thompson and Hastie, 2007; C. W. Chan et al., 2019). The importance of family involvement in healthcare decisions often originates from cultural traditions that either highlight duties towards relatives, like filial piety, or aim to avoid placing burdens on family members. In collectivist cultures, using advance directives can sometimes conflict with established moral codes related to family decision-making structures and responsibilities towards elders (Ha, Lee and Yoo, 2023). In contrast, individualistic cultures often see advance planning as a way to uphold self-determination. However, even in these contexts, input from spouses and attorneys is essential, not only for legal formalities but also for distributing responsibilities in end-of-life care (Chung et al., 2020).

These interpersonal family dynamics interlink with broader community-level influences like religious dogmas and institutional belief systems in shaping advance directive perceptions (Litalien, Atari and Obasi, 2022). Spiritual convictions correlate with increased advance planning (Trarieux-Signal et al., 2014), while faith-based healthcare facilities can promote or discourage utilization based on beliefs, as seen in Taiwanese nursing homes (Huang et al., 2018). Collectively, ethnic and cultural identities, rich in

customs, folklore, and heritage, shape the societal interpretations and meanings attributed to death and dying processes (Graham and Howard, 2016). People might be hesitant to adopt advance directives, influenced by cultural values that prioritize family unity over individual preferences (Wiener et al., 2013). For these reasons, healthcare providers should sensitively navigate this complex interplay of individual, familial, community, and societal factors rooted in diverse cultural value systems when facilitating advance care planning discussions and decisions (Wiener et al., 2013).

While individual factors like gender, education, and health status show some consistency in predicting advance directive adoption across contexts (Alano et al., 2010; del Pozo Puente et al., 2014), all-encompassing sociocultural barriers hinder universal integration. System constraints, including provider knowledge gaps, ambiguous protocols, and infrastructural deficits pose problems (Poveda-Moral et al., 2021). Personal discomforts and familial apprehensions rooted in collectivistic cultural ideals over individual autonomy also hinder adoption (Wiener et al., 2013). Strikingly, even in individualistic cultures, skepticism persists, for example, American doctors continue to harbor reservations about advance directive policies over decades despite growing patient advocacy movements (Periyakoil et al., 2014). Negotiating this complex interplay of individual, interpersonal, community, institutional and societal barriers demand nuanced cultural competence.

The findings also underscored how cultural lenses shape decisional roles and behaviors surrounding advance directives across multiple socio-ecological levels. At an individual level, personal beliefs rooted in ethnic or spiritual value systems exert a profound influence on emotional orientations and advance directive completion rates, as evidenced by the significant variations observed across different religious affiliations (Johnstone and Kanitsaki, 2009; Trarieux-Signol et al., 2014; Oshow, Shah and Ali, 2024). For instance, studies have shown that individuals from certain cultural backgrounds may be more hesitant to engage in advance directives due to beliefs around preserving life at all costs (Wiener et al., 2013) or deference to family decision-making (Mitty, 2012). The interplay between deeply held cultural and spiritual beliefs and individual attitudes towards end-of-life planning manifests in the disparities witnessed in advance directive adoption rates among diverse demographic groups (Hong et al., 2018). This dynamic reflects how personal beliefs are intertwined with broader cultural values.

However, these individual values often intersect with powerful familial and community forces that exert considerable influence. Relationship dynamics, like spousal roles and connections with relatives or peers, frequently

override individual preferences, especially in collectivistic Asian and Hispanic contexts that emphasize family-centric decision models (Duke, Thompson and Hastie, 2007; C. W. H. Chan et al., 2019). Consultations with advisors like attorneys further integrate long-standing communal value systems into the advance directive process. These interpersonal spheres of influence interlink with broader ethnic-cultural identities, folk beliefs, and institutional dogmas that construct social meanings around death and dying. As evident of faith-based Taiwanese healthcare facilities, community philosophical outlooks directly impact organizational policies and practices surrounding advance directives (Huang et al., 2018). Collectively, these multifaceted cultural underpinnings intersect with systemic determinants like provider biases, protocol uncertainties, and infrastructural barriers (Periyakoil et al., 2014; Poveda-Moral et al., 2021) to facilitate or hinder universal adoption and implementation of advance directive initiatives across diverse settings. This complex interplay highlights the need for a nuanced approach.

In line with this, top-down advance directive initiatives that lack sociocultural understanding tend to fuel skepticism, even among physicians (Periyakoil et al., 2014). A paradigm shift engaging diverse communities in culturally-grounded policy design is imperative (Wiener et al., 2013). Adopting a collaborative approach accounting for the interplay between individual values, relationships, community beliefs, and institutions is crucial for developing culturally competent frameworks (Huang et al., 2018; C. W. Chan et al., 2019). Only through an emic understanding of cultural nuances shaping end-of-life attitudes can initiatives gain meaningful uptake across populations (Duke, Thompson and Hastie, 2007).

Given the insights derived from this study, its significance lies in the exploration of how diverse cultural backgrounds shape advance directive decisions in healthcare, a critical area in patient-centered care research. This research, focusing on the influence of cultural factors on advance directive decision-making, underscores the imperative for further exploration through large-scale, multi-cultural studies. Future research should aim to establish a more comprehensive understanding of how cultural nuances specifically affect healthcare decisions at the end of life. To understand the long-term effects of cultural influences, future studies should follow participants for longer periods. Additionally, employing a mix of both qualitative and quantitative methods will be crucial. This approach will allow for a deeper understanding of the cultural dynamics at play in end-of-life decision-making from both subjective and objective standpoints.

In the context of advance directive planning, which is often sensitive and complex due to varying cultural beliefs

and practices, it is essential to incorporate structured assessments of how cultural factors influence these decisions. Our study advocates a systematic evaluation of cultural attitudes and beliefs aimed at increasing advance directive uptake. Such an approach is vital to assess the specific efficacy of interventions tailored to diverse cultural settings and to better understand how cultural nuances shape healthcare decisions at the end of life.

## Conclusion

This review not only sheds light on the significant role that culture plays in shaping end-of-life care decisions but also challenges healthcare providers and policymakers to rethink and reshape end-of-life care practices. To truly make a difference, it is imperative that those on the front lines of healthcare engage with these findings not as abstract concepts but as actionable insights. Every healthcare professional has a role to play in ensuring that their practice is culturally sensitive and responsive. By embracing a more nuanced understanding of cultural diversity, healthcare providers can better meet the needs of their patients, ensuring that care strategies are not only effective but also respectful of diverse values and beliefs. This proactive approach towards cultural competence can transform patient care at its most critical stages and foster a more inclusive healthcare environment.

## Statements and Declarations

**Data availability statement** The data that support the findings of this study are available from the corresponding author upon reasonable request.

**Funding Statements** The authors declare that no funds, grants, or other support were received during the preparation of this manuscript.

**Conflict of interest** The authors have no relevant financial or non-financial interests to disclose. Although some authors (Abdulmalik Fareeq Saber as Editor-in-Chief, and Safin Hussein and Arpi Manookian as members of the editorial board of Health Innovation Reports) hold editorial positions within the journal, they were not involved in the editorial decision-making or peer review process for this manuscript. The review and publication process was handled independently by other editors to ensure objectivity and transparency.

**Acknowledgements** is extended to the dedication and effort invested in this scoping review focused on cultural factors influencing advance directives in healthcare decision-making. Appreciation is also extended to those who indirectly supported this endeavor, contributing significantly to the successful completion of this comprehensive

exploration in the field of healthcare ethics and cross-cultural studies.

**Author contributions** Abdulmalik Fareeq Saber conceptualized and designed the study, led the development of the research objectives and methodology, supervised the literature search, data extraction, and synthesis processes, contributed substantially to data interpretation, drafted the original manuscript, and critically revised all sections for important intellectual content. Safin Hussein conducted the systematic literature search, participated in study screening and eligibility assessment, contributed to data extraction and charting, assisted in drafting the Methods and Results sections, and reviewed the manuscript for accuracy. Sirwan Khalid Ahmed contributed to the study design and methodological framework, participated in data interpretation and thematic synthesis, assisted in drafting and revising the Results and Discussion sections, and provided critical intellectual input. Doaa K. Al-seleet participated in literature screening and data extraction, contributed to organizing study characteristics and cultural determinants, assisted in drafting the Results section and tables, and reviewed the manuscript for clarity. Hana Kamil Zainalddin assisted in data organization and synthesis, contributed to the interpretation of cultural and religious influences on advance directives, and reviewed and edited relevant sections of the manuscript. Farzand F. Hamid contributed to the critical analysis of healthcare system, policy, and institutional factors, assisted in refining the Discussion section, and provided expert input on ethical and system-level implications. Arpi Manookian provided senior academic oversight and supervision, contributed to conceptual refinement and theoretical framing, critically reviewed the manuscript for scholarly quality and coherence, and approved the final version for publication. All authors read and approved the final manuscript and agree to be accountable for all aspects of the work.

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