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Experiences of Advance Care Planning Among Patients, Family Caregivers, and Healthcare Providers: A Qualitative Study

Nora Schneider[1]*, Tobias Frank[2], Julia Kramer[1]

[1]*Department of Nursing Practice and Symptom Care, Faculty of Medicine, University of Cologne, Cologne, Germany.*
[2]*Department of Palliative Clinical Research, Faculty of Health Sciences, University of Bonn, Bonn, Germany.*

Abstract

Advance care planning (ACP) helps ensure that medical care respects patients' personal preferences while enhancing the quality of end-of-life care. However, utilization remains restricted and is routinely prompted by medical emergencies, especially within collectivist cultures where family interconnectedness and emotional resilience influence engagement. There is still limited empirical research exploring how patients, their relatives, and clinicians experience ACP within non-Western medical environments. To investigate how patients, family caregivers, and healthcare practitioners experience and navigate engagement with ACP within a palliative care setting in Thailand. A qualitative investigation employing reflexive thematic analysis. A university-affiliated hospital located in Bangkok, Thailand. Thirty individuals in total: 10 patients living with life-limiting conditions, 10 family caregivers, and 10 healthcare professionals. Semi-structured interviews were conducted at a palliative care facility between January and October 2025. These interviews were transcribed word-for-word, translated utilizing meaning-based equivalence, and analyzed via an inductive, reflexive thematic approach. Four overarching themes (10 subthemes) framed ACP as a relationally negotiated, culturally contextualized practice. (1) Timing and pathways: emotional states, family dynamics, and organizational systems determined when ACP could occur, which was predominantly during acute clinical crises. (2) Values and visions of a good death: priorities were driven by physical comfort, tranquility, and avoiding becoming a burden, though actualization was restricted by caregiving capacity and limited resources. (3) Communication as relational positioning in ACP: patient engagement was encouraged through compassionate truth-telling and gradual information sharing; final choices were mediated within the family unit; medical doctors generally introduced ACP, whereas nursing staff maintained ongoing interpersonal connection. (4) Structural conditions shaping the possibility of ACP: institutional hierarchies, heavy workloads, insufficient training, and a lack of community support networks impede proactive use, thereby perpetuating reactive approaches. ACP within this setting operates as a relationally mediated practice that relies heavily on the alignment of emotional, familial, and structural readiness. Initializing conversations during a crisis points to a breakdown across these integrated areas rather than mere cultural opposition. Enhancing culturally sensitive communication methods, family-inclusive dialogue, clear multidisciplinary responsibilities, and systemic support could encourage timelier and more continuous ACP conversations. In collectivist medical systems, the implementation of ACP depends on the alignment of emotional, familial, and structural readiness. Absent integrated relational and institutional backing, these dialogues remain driven by medical crises despite a shared desire for a dignified death free of unnecessary burdens.

Keywords: Advance care planning, Palliative care, Communication, Decision making, Culture, Readiness

Introduction

Advance Care Planning (ACP) represents an iterative, evolving communication process that empowers individuals to identify and voice their values, expectations, and preferences regarding future medical interventions when facing advanced illness or deteriorating physical health [1-6]. The existing literature demonstrates that ACP

Corresponding author: Nora Schneider
Address: Department of Nursing Practice and Symptom Care, Faculty of Medicine, University of Cologne, Cologne, Germany.
E-mail: ✉ nora.schneider@gmail.com
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fosters greater consistency between a patient's preferences and the medical treatments actually administered, curtails the use of unwanted life-extending measures, and improves family satisfaction with end-of-life management [4-6]. Despite these documented advantages, its global adoption is highly variable and often occurs late in the course of an illness [4, 7-9].

Implementing ACP successfully generally requires evaluating multiple levels of readiness: the patient's psychological and intellectual capacity to participate in the conversation, the family's willingness to engage in collaborative decision-making, and the clinicians' assessment of clinical timing and appropriateness throughout the disease trajectory [3]. In practice, readiness is not merely an isolated psychological trait; it operates relationally and institutionally, shaped by personal relationships, communication norms, and healthcare system environments. Postponements in starting these discussions have been linked to uncertain prognoses, anxieties surrounding the loss of hope, and general discomfort when addressing physical decline [7, 10]. This investigation conceptualizes readiness not as an individual feature, but as a multi-tiered, interconnected state comprising emotional, familial, and structural elements that dictate how participation in ACP unfolds.

Over the last ten years, ACP has transformed from an administrative, document-focused task into a person-centered communication pathway built on trust, sustained relationships, and ongoing dialogue [7, 11-13]. Patients frequently view ACP as both comforting and intimidating, highlighting the internal tension between practical preparation and maintaining hope [7]. Family members often focus on maintaining emotional harmony and protecting their loved one, whereas medical professionals tend to emphasize clinical transparency and vocational accountability [11, 13]. Nurses regularly act as facilitators owing to their close relational proximity and continuous contact with patients [11].

This paradigm shift corresponds with relational autonomy theory, which views decision-making capacities as fundamentally integrated within personal networks and social institutions rather than purely as expressions of isolated individual freedom [14-16]. Autonomy is viewed as an evolving, context-dependent process, particularly during severe illnesses where personal interdependence grows stronger. These viewpoints indicate that engagement in ACP arises from active collaboration among patients, families, and clinicians rather than through solitary choices.

Nonetheless, the bulk of empirical research guiding ACP integration comes from North American, European, and Australian medical models, where individual self-determination and straightforward disclosure are standard practices [4, 7]. On the other hand, research from East and Southeast Asian nations—such as Japan, Taiwan, and Singapore—indicates that ACP dialogues typically occur later in the disease timeline, are mediated by family hierarchies, and are governed by cultural customs that favor indirect communication and emotional filtering [17-20]. Within these communities, decision-making is frequently collective rather than individually asserted, and spiritual frameworks alongside shared moral duties color ideas of what constitutes a good death—specifically highlighting themes of social harmony, avoiding being a burden, and shielding family members [12, 20]. Although this body of literature has mapped out cultural barriers and facilitators to ACP, it has predominantly scrutinized stakeholder viewpoints in isolation, leaving a gap in understanding how choices are collectively negotiated in real-time clinical situations between patients, relatives, and medical staff.

The healthcare climate in Thailand exhibits many of these relational and systemic dynamics. The National Health Act B.E. 2550 provides statutory backing for an individual's right to decline life-prolonging treatments, offering a legal basis for ACP [21]. Later national directives have further supported its integration at the policy level. Even so, actual clinical implementation in daily practice remains inconsistent. Specialized palliative care initiatives are clustered mainly within tertiary referral institutions, where ACP dialogues are usually started by physicians following a referral for advanced disease and are supported by healthcare teams, including nurses who maintain relational dialogue [22]. Outside of these specialized facilities, formal ACP frameworks and records are scarce and poorly integrated into standardized clinical pathways. Systemic barriers—including heavy professional workloads, a lack of hands-on communication training, traditional professional hierarchies, and disjointed community care networks—can further push back timely and proactive utilization [8, 22].

In Thai cultural life, deep-seated family reliance, Buddhist tenets focused on accepting impermanence, and a traditional deference to medical professionals heavily influence communication styles surrounding death [20]. Decision-making is typically a shared family process in which relatives actively manage clinical information and work to protect emotional well-being. These cultural traits do not prevent participation in ACP; instead, they shape how readiness is perceived, determine who is responsible for initiating the conversation, and guide how treatment preferences are balanced within family systems. Consequently, analyzing ACP in this setting requires careful evaluation of relational processes alongside the structural limitations that enable or constrain engagement. While statutory rights to decline life-sustaining care are clearly defined, the routine adoption of ACP during the early phases of illness remains inconsistent and bound to local contexts.

Previous investigations, both within Thailand and across the globe, have mostly analyzed ACP experiences by examining single groups—patients, relatives, or clinicians—in isolation [7, 13, 23]. While this research has highlighted factors such as emotional preparation, communication skills, and institutional resources, it provides limited clarity on how these variables intersect during live clinical interactions. In real-world care settings, ACP conversations unfold through the concurrent negotiation of emotional, familial, and structural readiness across all

involved parties. A unified, triadic research perspective is therefore crucial to understanding how timing, communication strategies, and organizational realities meet to influence participation.

Although ACP has national legal backing, its inclusion in early-stage disease management remains concentrated within specific institutions rather than being adopted across the wider healthcare system. To improve the global implementation of ACP, it is vital to research how emotional, familial, and structural readiness converge in regions where palliative infrastructure is still growing and where collective decision-making is standard practice. This study provides an empirical examination of readiness as an interconnected, multi-level phenomenon that governs ACP participation within a Thai palliative care landscape. Therefore, this study aimed to explore how patients, family caregivers, and healthcare providers experience participation in ACP discussions in a tertiary palliative care setting in Thailand.

Materials and Methods

Research aim

The objective of this inquiry was to investigate how patients, informal family caregivers, and medical practitioners experience and navigate their engagement with ACP within a Thai palliative care environment.

Study design

This investigation utilized reflexive thematic analysis (RTA), drawing on the methodological framework established by Braun and Clarke [24-26]. The inquiry was underpinned by a contextualist critical realist perspective; this viewpoint acknowledges that while ACP experiences are grounded in concrete structural realities (such as organizational hierarchies and logistical constraints), they are concurrently co-constructed through societal norms, interpersonal relationships, and communicative exchanges.

RTA was chosen for its capacity to generate interpretive insights into patterns of meaning across varied participant cohorts, while explicitly treating researcher reflexivity as an essential component of knowledge production. This methodology directly supports the study's goal of understanding how ACP experiences are shaped and negotiated within Thailand's palliative care landscape.

Setting, sample, and participants

The study took place at the Palliative Care Center within a prominent university-affiliated medical center in Bangkok, Thailand—a national tertiary referral institution that regularly provides structured ACP consultations. Although ACP is statutorily authorized nationwide in Thailand, its practical application is largely confined to tertiary medical centers, making this setting a highly informative venue for evaluating ACP dynamics.

Study candidates were selected through a combination of purposive and snowball sampling strategies [27]. Eligible individuals were required to be at least 18 years of age and meet one of the following criteria: (1) patients diagnosed with a life-limiting condition who had completed a formal ACP consultation; (2) family caregivers who participated in those specific dialogues; or (3) healthcare professionals with a minimum of six months of experience guiding ACP within this clinical unit. Family caregivers were operationalized as relatives who participated in therapeutic decision-making or day-to-day care routines.

Patients and their informal caregivers were approached and enrolled independently; consequently, while the sample included several patient-caregiver pairs, participation was not restricted strictly to matched dyads. Healthcare professionals were not required to have personally facilitated the ACP process for the specific patients enrolled in the study; rather, they were selected based on their overarching experience within the department.

To be included, patients had to possess decision-making capacity and a clear understanding of their medical diagnosis, both of which were standardly evaluated by the palliative care staff before study referral. Verification of prior ACP engagement was established via clinical charts and team confirmation. For this research, ACP denoted formalized dialogues within the palliative care unit that targeted goals of care, therapeutic interventions, or advance directives. The clinical experience of healthcare providers was confirmed through their official job descriptions and institutional service logs.

Potential participants were identified by the palliative care unit's clinical staff and initially approached during scheduled outpatient or inpatient visits. Informational materials regarding the study were distributed by the clinical team, and individuals who expressed interest were subsequently contacted by the lead researcher to schedule an interview. Before any study procedures, written informed consent was gathered. Every individual who was formally invited chose to participate.

Reflecting principles of information power [28], a target sample size of 24 individuals (eight per stakeholder cohort) was established, taking into account the specificity of the sample, the research objective, and the expected depth of the dialogue. Data collection continued until the material reached a level of depth and heterogeneity sufficient to support a comprehensive and coherent interpretation.

Data collection

An interview guide for the semi-structured sessions was constructed based on a review of existing literature [11, 23]. This instrument was refined through three successive rounds of expert assessment by two independent qualitative research and ACP specialists, and it was subsequently piloted with one individual from each participant group to ensure clarity and cultural appropriateness.

Following the consent process, confidential face-to-face interviews were held in private rooms on-site. This individual interview format was utilized to lessen potential power imbalances inherent in clinical settings. The primary investigator (a female PhD holder with specialized training in qualitative methodologies and ACP) conducted the sessions in Thai, with logistical support from the palliative care staff.

The interviews yielded rich qualitative data, with sessions being audio-recorded in full (averaging 52 minutes, with a range spanning 38 to 65 minutes). Field notes were utilized to document contextual observations and initial interpretive insights. Verbatim Thai transcriptions were generated within 24 hours of each interview.

The preliminary coding process was executed using the original Thai transcripts, which were subsequently translated thematically into English by bilingual specialists. This process relied on meaning-based equivalence to safeguard specific cultural concepts, such as relational terminology [29]. Cross-linguistic accuracy was maintained via bilingual verification. Member reflections (distinct from member validation) were selectively gathered from the healthcare provider cohort to minimize participant burden and potential distress; vulnerable patients and families were not recontacted [25].

Data analysis

Data analysis was conducted inductively through reflexive thematic analysis situated within a contextualist critical realist framework, adhering to the six-stage methodology outlined by Braun and Clarke [24]. Field notes were incorporated into the dataset after the transcripts had been verified and fully de-identified.

Because the interviews were conducted and transcribed in Thai, both initial coding and early theme formulation were conducted in Thai to preserve semantic and cultural subtleties. The transition to English occurred during the advanced stages of analysis, prioritizing conceptual alignment over literal word-for-word translation [29]. To ensure interpretive consistency, translational choices were critically debated among the bilingual research team. The team explicitly acknowledges translation as an interpretive process that can influence analytical focus.

The analytic pipeline involved continuous immersion in the data, open coding of both explicit (semantic) and underlying (latent) meanings connected to the study's core question, and the synthesis of themes into structured patterns of shared or differing viewpoints across the participant groups. Rather than striving for inter-rater consensus or statistical reliability metrics, analytical dialogues among the research team deepened reflexive analysis and explored alternative ways of reading the data.

Methodological quality and reporting clarity were aligned with Braun and Clarke's Reflexive Thematic Analysis Reporting Guidelines (RTARG) [26] alongside their values-based reporting framework [30], emphasizing structural coherence, reflexive transparency, and explicit accounts of interpretive pathways.

The lead author, a nurse researcher specialized in ACP with no previous clinical ties to the participants, kept a reflexive diary throughout the analytical process. The research group acknowledged that their medical backgrounds and deep familiarity with Thai medical hierarchies naturally shaped their interpretations and that they regularly engaged in internal dialogue to critically appraise their analytical assumptions.

Ethical considerations

Institutional approval was granted by the Mahidol University Multi-Faculty Cooperative Institutional Review Board (MU-MOU-IRB-NS2024/76.2910, Certificate of Approval No. IRB-NS2025/907.1001). Before commencing data collection, written and oral informed consent were obtained from each participant. Enrolment was entirely optional, and privacy was safeguarded through the pseudonymization of qualitative transcripts alongside the use of secure, password-restricted data repositories limited strictly to the research cohort. Audio files were permanently erased immediately following transcript verification. All participants were explicitly briefed on their right to discontinue their involvement at any stage of the process without facing any negative repercussions.

Results and Discussion

Participant characteristics

The final cohort comprised thirty individuals: 10 patients, 10 family caregivers, and 10 healthcare providers. Across the entire sample, 21 out of 30 individuals identified as female (70%). The patient subgroup exhibited an average age of 63 years (ranging from 35 to 78), and all individuals within this group were navigating a cancer diagnosis, with lung cancer (n = 4/10), hepatocellular carcinoma (n = 3/10), and gynecologic malignancies (n = 2/10) being the most prevalent types. Family caregivers had a mean age of 49 years (ranging from 27 to 72) and were predominantly the adult children (n = 4/10) or grandchildren (n = 3/10) of the patients; their caregiving duration fluctuated, though the vast majority reported providing care for ≤ 5 years (n = 9/10).

The healthcare provider subgroup had a mean age of 41 years (range: 25-50) and an average of 14 years of professional experience (range: 2-28). This professional sample consisted of nurses (n = 6/10), family medicine physicians (n = 3/10), and a Traditional Thai medicine allied health practitioner (n = 1/10). These practitioners were drawn from the Palliative Care Center and its affiliated medical services; some held dedicated palliative roles, while others worked in partnership with the palliative team and had direct experience supporting ACP facilitation. A comprehensive breakdown of participant characteristics is detailed in **Table 1**.

Table 1. Characteristics of participants (n = 30). From: Patient, family, and healthcare provider experiences in advance care planning: a qualitative study.

Participant characteristics	Healthcare professionals (n = 10)	Family caregivers (n = 10)	Patients (n = 10)
Gender, n (%)			
Female	9 (90)	8 (80)	4 (40)
Male	1 (10)	2 (20)	6 (60)
Age, years	Mean 41 (25–50)	Mean 49 (27–72)	Mean 63 (35–78)
Primary medical diagnosis of patients, n (%)			
Lung cancer	–	–	4 (40)
Hepatocellular carcinoma (HCC)	–	–	3 (30)
Gynecological cancer	–	–	2 (20)
Bladder cancer	–	–	1 (10)
Relationship to the patient, n (%)			
Spouse	–	2 (20)	–
Son/Daughter	–	4 (40)	–
Grandchild	–	3 (30)	–
Parent	–	1 (10)	–
Professional role, n (%)			
Registered nurse	6 (60)	–	–
Family medicine physician	3 (30)	–	–
Allied health professional (Traditional Thai Medicine)	1 (10)	–	–
Caregiving experience, years, n (%)			
≤ 1 year	–	3 (30)	–
2–3 years	–	3 (30)	–
4–5 years	–	3 (30)	–
≥ 10 years	–	1 (10)	–
Clinical practice experience, years	Mean 14 (2–28)	–	–
Household composition, n (%)			
Nuclear family	–	4 (40)	6 (60)
Extended family	–	6 (60)	4 (40)

Reflexive thematic analysis

The interpretive process generated four primary themes outlining how participants experienced ACP. **Table 2** provides an overview of these themes and their respective subthemes, which are explored below alongside descriptive participant quotes. To facilitate interpretation of these narratives, excerpts are categorized by stakeholder group (P = patient, F = family caregiver, H = healthcare provider). Throughout the analysis, participants' accounts highlighted how intersecting elements of emotional, familial, and institutional readiness collectively determined the precise timing and manner of ACP engagement.

Table 2. Themes and subthemes describing experiences of advance care planning. From: Patient, family, and healthcare provider experiences in advance care planning: a qualitative study.

Main theme	Subtheme
1. Initiation and timing of advance care planning (ACP)	1.1 Preparedness and preferred timing for ACP discussions

	1.2 ACP initiated following health crises or acute events
	1.3 Routine care encounters as opportunities for ACP introduction
2. Personal values and perspectives on a good death	2.1 Comfort, peacefulness, and avoiding burden as family-centered responsibilities
	2.2 Preferences regarding care location, security, and maintaining family cohesion
	2.3 End-of-life preparation, meaningful rituals, and life completion activities
3. Communication processes and relational dynamics in ACP	3.1 Communication style, message framing, and the emotional timing of discussions
	3.2 Roles, accountability, and professional authority in starting ACP conversations
4. Organizational and contextual factors influencing ACP implementation	4.1 Financial constraints and resource availability affecting ACP choices
	4.2 Insufficient preparation and reluctance to initiate ACP discussions
	4.3 Organizational hierarchies and workload pressures promoting reactive rather than proactive ACP

Theme 1: timing and pathways into ACP

This theme describes how ACP dialogues became viable through the intersection, or misalignment, of varied conditions rather than merely by reaching a specific chronological milestone. Even though participants routinely conceptualized ACP through the lens of premature or delayed conversations, the actual initiation of these dialogues was driven by the interplay among the patient's psychological readiness, the family's comfort with the topic, the clinician's understanding of the disease trajectory, and the surrounding interpersonal environment. Consequently, ACP materialized not simply because a certain illness phase had been reached, but as a relationally negotiated event in which emotional, familial, and operational dynamics converged sufficiently to permit discussion. When this alignment was missing, conversations were consistently deferred until physical deterioration or a medical emergency necessitated their initiation.

Participants generally maintained that ACP should commence while patients still have the cognitive capacity to clarify their preferences. In actual clinical environments, however, these discussions were routinely delayed until the patient's health declined or deep interpersonal trust had been cultivated.

Subtheme 1.1: Readiness and preferred timing of ACP

This subtheme demonstrates how the initiation of ACP was dictated by perceived readiness across several parallel levels. Readiness centered mostly on the patient's emotional preparation and the caregiver's willingness to engage, while medical staff calibrated timing against clinical markers and interpersonal trust. Consequently, preferred timing varied among participants and indicated the specific moment in the illness trajectory when ACP felt emotionally tolerable, manageable, or fitting.

A notable portion of patients voiced a desire for early conversations while they still had the capacity to clearly communicate their intentions. As P9 remarked, "We should talk once we know the diagnosis so that we can prepare our minds." Introducing the topic early was viewed as a mechanism that allowed for internal psychological preparation and proactive planning.

However, emotional readiness was inconsistent. Various participants voiced a distinct hesitancy to confront physical decline. P7 noted, "I don't want to talk about getting worse yet; it makes me stressed." In such instances, ACP was experienced as an emotional burden rather than a source of support. Healthcare practitioners noted the delicate balance required between clinical timelines and internal psychological capacities: ACP needs to happen "not so late that the chance is gone, but not so early that the patient is still in shock" (H7), and "once trust has settled, not before" (H8). These reflections imply that initiating these dialogues required both clinical relevance and relational stability alongside emotional tolerance.

Subtheme 1.2: Crisis-triggered entry

In stark contrast to the benchmark of early and incremental planning, a multitude of participants reported encountering ACP reactively during acute clinical declines. Rather than developing into a reflective, future-focused dialogue, ACP was often introduced under severe clinical pressure, when time-sensitive decisions about life-extending therapies had to be made immediately.

P4 remembered, "I first heard about it in the emergency room when the doctor asked if I wanted CPR," showing how ACP was frequently narrowed down to immediate resuscitation choices rather than broad goals of care. In a similar vein, F2 noted, "We usually begin ACP during a crisis." Healthcare professionals acknowledged this systemic trend; as H5 observed, "We start ACP only when the case is referred as nothing more can be done."

Under these clinical pressures, ACP operated less as a forward-looking planning process and more as an immediate reaction to the imminent loss of autonomous decision-making. Medical crises seemed to compress emotional reluctance and systemic delays, generating an urgency that forced the dialogue even if earlier, calmer windows of opportunity had been missed.

Subtheme 1.3: Everyday care as a relational entry point

Diverging from readiness defined strictly by clinical staging, this subtheme underscores how ACP became achievable through the relational environment of day-to-day healthcare. Participants indicated that ACP felt significantly less daunting when woven incrementally into routine clinical interactions rather than presented as a formal, standalone appointment. In these scenarios, readiness grew organically out of interpersonal familiarity, trust, and the routine nature of care activities.

Certain patients reported feeling most at ease discussing ACP within the natural flow of daily clinical interactions rather than in formal conference rooms or high-intensity medical units. P3 shared, "The nurse's gentle care made it easier to talk about dying." Healthcare professionals similarly noted the value of blending these dialogues into routine tasks: "We talk during wound care or IV time; it flows naturally" (H4).

These perspectives indicate that day-to-day clinical interactions serve as a vital communicative infrastructure. Through recurring, low-stakes touchpoints, sensitive subjects could be introduced progressively, allowing ACP to develop without the sudden shock that typically characterizes crisis-driven or formal consultations.

Theme 2: Values and visions of a good death

This theme illustrates how participants' conceptualizations of what constitutes a "good death" profoundly shaped both their end-of-life care preferences and their willingness to participate in ACP dialogues. Rather than treating ACP as a purely clinical or administrative exercise, participants interpreted the process through their personal relational, ethical, and cultural value systems. These core frameworks determined what was prioritized, how clinical options were perceived, and when conversations felt appropriate. As a result, engagement with ACP was deeply tied to moral obligations, family cohesion, and spiritual beliefs.

Across all participant cohorts, a good death was consistently linked to symptom management, internal tranquility, and reduced burden on family members. These core priorities did not merely dictate explicit treatment choices; they also shaped the emotional atmosphere, boundaries, and the overall pace of ACP dialogues.

Subtheme 2.1: Peace, comfort, and non-burden as relational obligations

Across all interview groups, decisions to forgo aggressive, life-extending therapies were framed not merely as technical clinical choices, but as deep expressions of relational accountability. Refusing the artificial prolongation of dying was viewed as an ethically sound duty within family networks, particularly as a means to prevent emotional and practical strain on loved ones.

Patients frequently described prioritizing comfort as a deliberate act of family protection. P2 asserted, "I don't want to burden my children; let me go peacefully," framing the rejection of life-prolonging interventions as a parental obligation rather than a purely individual desire. Similarly, F7 noted, "I just want my mother not to suffer," indicating a clear moral imperative to mitigate physical suffering rather than to extend life at any cost. Healthcare providers noted that these specific values consistently anchored the dialogues: "Almost everyone says they want comfort, not prolongation" (H8).

Participants defined an ideal death as one rooted in peace, freedom from burden, and the preservation of family harmony. From an analytical perspective, these recurring patterns of meaning align with a culturally specific, relational construction of dignity. In this Thai healthcare environment, dignity did not manifest as an expression of individual self-determination; instead, it meant dying in a manner that maintained personal composure, limited familial disruption, and protected loved ones. Thus, descriptions of a good death within these narratives can be understood as achieving death with relational dignity, anchored in collective moral duty rather than individual autonomy.

Spiritual practices further reinforced this viewpoint. One family caregiver described the way the patient turned to chanting as her physical condition declined: "When my mom's illness got worse, she chanted so her mind would be peaceful" (F5). In this instance, spiritual engagement served as a functional mechanism for fostering emotional composure and psychological acceptance. Healthcare practitioners described consciously incorporating terms such as "letting go" (H2) to facilitate emotional adaptation to decline. Rather than structuring choices as the withdrawal or limitation of medical treatment, this communicative framing positioned non-prolongation as an act of compassionate care that aligned directly with the participants' collective desires for peace and the reduction of family burden.

Subtheme 2.2: Place of care, safety, and family harmony

Decisions regarding the preferred site of death were deeply influenced by collective dynamics centered on physical safety and the overall welfare of the kinship unit. Choosing between a domestic setting and a hospital environment

involved not only practical logistics but also a conscious effort to safeguard family caregivers from emotional distress and to preserve structural stability within the home.

While the domestic environment was often portrayed as ideal, many participants found it unfeasible due to safety concerns or caregiving constraints. As P9 observed, "Home would be best, but I'm afraid no one will be there when it gets bad." Other individuals favored hospital-based care as a means of shielding relatives from distressing memories: "I don't want them to remember the house with fear" (P6). Families highlighted the resulting logistical burdens (F8), and medical staff corroborated the systemic limitations that compromise continuity of care outside the hospital (H9).

The preservation of domestic tranquility also dictated the boundaries of communication. Several participants actively avoided explicit dialogue because "it would make others cry" (P5, F2). Clinicians noted that patients regularly redirected conversations to alleviate immediate emotional discomfort (H9). Furthermore, discussing mortality during culturally significant periods, such as the New Year, was viewed as socially transgressive. These communicative norms dictated the specific windows and manners in which ACP could be introduced without fracturing interpersonal equilibrium.

Subtheme 2.3: Life completion, rituals, and preparation actions

Participants' accounts indicated that regularly participating in ACP stimulated broader reflections that extended beyond immediate clinical choices. Deliberations regarding future medical care naturally drew focus toward existential preparation for death and its interpersonal ramifications, including potential family disputes, financial disarray, and emotional volatility. In this framework, ACP served as an interpretive mechanism for comprehensive life completion rather than functioning merely as an isolated clinical encounter.

Psychological preparation involved the incremental acceptance of mortality and a heightened comfort level when discussing physical decline. Conversely, practical preparation involved organizing material assets, clarifying inheritance structures, coordinating funeral arrangements, and preempting future familial friction. These tasks were frequently addressed concurrently with or immediately following ACP dialogues. P3 noted, "I made my will already so that it won't be chaotic later. I feel less worried when we talk about advance care planning because I have already arranged things." Similarly, F1 detailed the redistribution of land titles before death to avert future kinship conflict. Clinicians noted that when patients had systematically resolved these personal matters, they demonstrated greater openness and reduced anxiety during subsequent ACP encounters (H6). Consequently, external preparatory steps not only resulted from ACP but also actively fostered the confidence required to participate in it.

Spiritual and cultural traditions were likewise deeply integrated into ACP encounters, particularly during phases of clinical deterioration or when navigating highly sensitive choices. Actions such as inviting Buddhist monks to perform chanting rituals (F4) or utilizing traditional herbal treatments for symptom relief (P1) were described as strategies for establishing internal calm during challenging dialogues. Within structured ACP encounters, this occasionally required clinicians to balance the honoring of spiritual values with immediate clinical imperatives. Engaging in ACP thus necessitated balancing spiritual, relational, and medical preparation rather than compartmentalizing them into separate spheres.

Theme 3: Communication as relational positioning in ACP

This theme explores how healthcare professionals' communication strategies shape patients' and family caregivers' participation in ACP. Participants underscored that meaningful engagement was determined not merely by the clinical information delivered, but by the manner in which dialogues were introduced, structured, and paced, as well as how decision-making agency was distributed within family networks.

When clinicians introduced ACP incrementally and explicitly validated accompanying emotional reactions, patients and families reported feeling supported and able to participate. Conversely, abrupt or highly directive communication strategies triggered psychological discomfort, withdrawal, or active avoidance. The communicative approach, therefore, directly dictated whether ACP was experienced as a cooperative partnership or an overwhelming intrusion.

Family-centered decision-making frameworks further governed the nature of participation. Choices were regularly negotiated through collective family processes, and the responsibility to speak or decide was distributed across various family members. This distribution directly influenced which individuals engaged in the dialogue and determined the speed at which conversations advanced.

Subtheme 3.1: Tone, framing, and the emotional pace of disclosure

The communicative demeanor of medical professionals exerted a powerful influence on participants' willingness to sustain engagement in ACP dialogues. The vocal tone, conversational pacing, and conceptual framing collectively determined whether these interactions were experienced as empathetic discourse or as a distressing, adversarial confrontation.

Patients highly valued a transparent yet gentle communicative style. P5 remarked, "The doctor spoke frankly but gently, which made me able to keep talking." On the other hand, unvarnished or insensitive communication

disrupted emotional equilibrium. As P7 reflected, "The doctor said it too bluntly… they should read the timing," implying that keeping an acute sensitivity to the immediate emotional climate was essential.

Participants also identified a distinct pattern of crisis framing, wherein ACP was introduced predominantly through urgent, binary choices during moments of acute instability, such as asking, "Do you want CPR?" (F3). When discussions were confined strictly to immediate life-extending options, they were perceived as abrupt and transactional, leaving little room for deeper reflection or mutual understanding.

In contrast, effective pacing involved introducing sensitive topics incrementally over an extended period rather than compressing them into a single interaction. Empathy was demonstrated by actively addressing underlying fears, existential uncertainty, and familial concerns before reviewing clinical options. Respect was shown by honoring established family structures, such as delaying conversations until key family decision-makers were present or allowing patients to give implicit cues of readiness. When these supportive practices were integrated, participants reported a greater capacity to continue the dialogue. Communication techniques, therefore, determined whether emotional readiness could mature over time or fracture under immediate clinical pressure.

Subtheme 3.2: Responsibility, authority, and interdisciplinary roles in initiating ACP

An analysis of the interviews revealed a clear, recurring pattern: the initiation and continuation of ACP were governed by distinct expressions of professional authority. Communication pathways were structured not only by individual style but also by institutional power dynamics and the relational positioning of different disciplines within the medical team.

Physicians were structurally positioned as the holders of formal medical decision-making authority and were consequently expected to open ACP dialogues, particularly those addressing life-prolonging interventions. Multiple patients noted that they "wouldn't know how to start" such a conversation (P1, P5), thereby framing the initiation of these discussions as an exclusively professional duty. Family members voiced distinct concern when clinicians failed to raise the topic: "The doctor never brings it up" (F10). Participation was therefore partially dependent on the clinician's institutional authority and willingness to open the dialogue.

Conversely, nursing staff were described as the professionals who sustained and deepened these dialogues through relational continuity, careful emotional pacing, and repeated interactions during routine care. As H6 observed, "Doctors give facts; nurses add empathy." The constant clinical presence of nurses fostered deeper interpersonal trust and allowed sensitive topics to unfold over time (H9). Through this sustained contact, nurses served as a crucial bridge connecting formal medical authority with the family unit's emotional readiness. Furthermore, certain nurses were increasingly taking on the role of coordinating ACP processes (H2), highlighting a shift in traditional interdisciplinary responsibilities.

Thus, formal institutional authority dictated which professional could officially initiate an ACP dialogue, whereas relational continuity determined whether those conversations expanded and persisted over time.

Theme 4: Structural conditions shaping the possibility of ACP

This thematic category illustrates how systemic and organizational landscapes dictated whether psychological preparedness and communication techniques could be translated into enduring engagement with ACP. Even when patients and their kindred expressed a willingness to participate, organizational barriers—such as financial constraints, educational deficits, clinical overburden, and institutional stratification—determined the viability and scheduling of these interactions. ACP was consequently tethered to institutional realities that either fostered anticipatory dialogue or perpetuated a pattern of crisis-driven response.

Subtheme 4.1: Economic and resource limits shaping ACP decisions

Throughout the data, financial realities constricted the realistic parameters of what ACP could promise, forcing planning to operate within tightly delimited boundaries. Budgetary and logistical pressures directly shaped the care paths deliberated during ACP interactions. Financial distress impeded the continuation of therapies, compromised caregiving efficacy, and restricted the feasibility of utilizing preferred clinical settings.

Patient reflections highlighted this stark reality; for instance, P8 explained that the prohibitive cost of their oncology medication forced them to cease the treatment, demonstrating how financial limitations directly dictated clinical trajectories. Families experienced recurring hospital transit as a profound strain, with F8 noting the necessity of taking professional leave from work every time they had to accompany their mother to the facility. Healthcare practitioners highlighted a deficiency in community-level services, an absence that undermined care continuity and limited domestic assistance alternatives. These combined obstacles narrowed the range of viable choices and defined the practical parameters within which advance care planning could realistically occur.

Subtheme 4.2: Limited preparation and hesitant initiation

Medical practitioners detailed deficiencies in specialized training and a lack of professional confidence, which directly affected their willingness to engage in ACP dialogues. Multiple providers voiced a distinct sense of unease regarding the introduction of highly sensitive subjects.

As H4 observed, the current training infrastructure lacks experiential depth, underscoring the need for interactive workshops where staff can actively practice navigating these sensitive conversations. Other practitioners, such as H3, expressed an explicit apprehension regarding the risk of verbal missteps, showing deep-seated anxieties about accidentally triggering severe patient distress or fracturing the baseline of clinical trust. Deficiencies in formal education diminished professional confidence and fostered a reluctance to communicate.

In this manner, institutional investment in communication skill development directly dictated whether clinical staff felt adequately equipped to open ACP dialogues or whether these conversations were continuously deferred. This pervasive hesitation pointed to systemic gaps in experiential education rather than an intrinsic individual aversion among the staff.

Subtheme 4.3: Hierarchy and workload reinforcing reactive ACP

Institutional stratification and workload overburden further impeded the anticipatory introduction of ACP. Traditional professional role expectations designated physicians as the primary decision-making authorities, while intensive clinical demands left scant opportunity for proactive communication.

This operational barrier was summarized by H5, who explained that excessive clinical workloads combined with the institutional requirement to wait for medical doctors to initiate discussions heavily restricted early interventions. High patient volumes and deeply ingrained hierarchical conventions reinforced reactive initiation patterns. Even in instances where nursing staff identified clear opportunities for dialogue, certain individuals chose to defer due to rigid institutional frameworks (P6). Collectively, these accounts show that professional hierarchies and workload burdens structured ACP as a reactive rather than an anticipatory process, regularly delaying communication until a clinical emergency occurred.

This study advances an ecologically grounded conceptualization of readiness, framing it as a multidimensional, relationally mediated construct that determines when and how ACP becomes viable. Drawing on triadic insights from patients, family caregivers, and healthcare practitioners in a Thai tertiary palliative care setting, we demonstrate that ACP does not unfold as a linear, document-focused process. Instead, it becomes actionable only when emotional, familial, and structural readiness converge sufficiently to sustain dialogue. Engagement was not determined solely by the stage of the disease, but by the degree of alignment across these interacting spheres.

Across the identified themes, readiness manifested not as a chronological milestone but as an interpersonal and institutional state that rendered the timing acceptable. As demonstrated in Theme 1 (Timing and pathways into ACP), participants recounted delaying dialogues until initial emotional shock had subsided or interpersonal trust had been established; this indicates that readiness was bound to emotional stabilization rather than standalone clinical benchmarks. In Theme 3 (Communication and relational decision-making), participants further underscored conversational pacing, empathy, and gradual disclosure as vital prerequisites for engagement. Taken together, these patterns imply that participation demanded a baseline of emotional tolerance before any sustainable dialogue could occur.

Within this study, readiness was comprised of three interconnected domains:

- Emotional readiness denoted the capacity of patients and families to tolerate explicit discussions regarding physical decline without becoming psychologically overwhelmed. This domain was extracted from recurring descriptions of shock, anxiety, avoidance, and the critical need for gentle pacing before discussions could productively advance. Emotional readiness matured relationally through the cultivation of trust and repeated clinical interactions, rather than manifesting at a predetermined point in the disease timeline.
- Familial readiness reflected the collective willingness of the kinship group to navigate care preferences while preserving internal harmony and shielding one another from acute distress. Across Themes 2 and 3, informal caregivers detailed efforts to avoid becoming a burden, maintain domestic peace, and protect children from emotional upheaval. The decision-making process was consistently articulated through relational language, illustrating the practical application of relational autonomy [14-16]. Within this framework, autonomy was expressed through interconnectedness rather than independence. Consequently, readiness in this setting required a shared emotional tolerance and a negotiated consensus rather than solitary individual acceptance.
- Structural readiness pertained to whether underlying institutional environments actively facilitated proactive and sustained dialogue. As shown in Theme 4, participants identified heavy workloads, rigid hierarchical authority structures, a lack of experiential training, and limited community infrastructure as key elements shaping the execution of ACP. Even when emotional openness was present, conversations were frequently delayed by professional role ambiguity or a lack of dedicated discussion time. Structural readiness, therefore, signified institutional enablement rather than an individual's personal disposition.

Participation in ACP became highly viable when emotional tolerance, familial consensus, and structural opportunities successfully aligned. When these domains were misaligned—such as when emotional hesitation intersected with hierarchical delays or financial constraints—conversations were invariably postponed. In these scenarios, a medical crisis operated as a structural override, forcing an engagement that had previously been

deferred. Crucially, readiness within this model is not synonymous with early intervention; rather, it reflects the alignment of relational and institutional conditions that make such early timing possible in the first place.

We therefore conceptualize readiness as a dynamic alignment model in which emotional tolerance (patient–family), familial consensus (relational negotiation), and structural enablement (institutional capacity) must intersect to sustain ACP dialogue. A breakdown or misalignment in any of these domains results in data deferral, whereas an acute clinical crisis serves as a temporary override when alignment is insufficient. This interpretive synthesis clarifies why ACP processes remained predominantly crisis-triggered in this environment, despite widespread conceptual endorsement of early planning.

Rather than being an individual declaration, alignment was relationally negotiated. The timing of these discussions was mutually calibrated through personal interaction rather than dictated entirely by clinical benchmarks. Even though participants generally supported the early planning conceptually, actual discussions were frequently postponed until immediate emotional distress subsided, interpersonal trust was established, or medical urgency demanded action. This aligns with observations from other Asian settings, where anxieties about diminishing hope and ambivalence about the optimal moment limit early conversations [9, 31].

Alignment was heavily influenced by specific communication strategies: using a gentle framework, recognizing patient fears, and managing the pace of information delivery fostered engagement, whereas sudden or purely administrative approaches hindered it. Similarly, professional responsibilities were navigated within established hierarchical frameworks. Medical doctors were expected to start formal conversations about life-prolonging interventions, which mirrors documented practices in Asian medical settings [9].

On the other hand, nursing staff frequently extended and deepened these dialogues by integrating advanced care planning (ACP) into day-to-day clinical interactions. Their continuous presence at the bedside facilitated careful emotional pacing and the development of relational trust. In highly stratified systems where physicians retain formal medical authority, nurses acted as a vital relational framework that maintained alignment across different dimensions of readiness over extended periods. This divergence between formal medical authority and relationally driven influence underscores the need for distinct interdisciplinary roles when launching ACP initiatives.

Crucially, the ongoing prevalence of crisis-driven ACP cannot be blamed entirely on cultural taboos. Delayed initiation of ACP remains a documented challenge across a wide variety of medical systems worldwide [4, 32]. Instead of viewing collectivism as a barrier, our observations indicate that Thai relational ethics actively guide how readiness is conceptualized and negotiated. A strong focus on avoiding being a burden, maintaining tranquility, and shielding the family reflects deeply ingrained cultural values [20].

Spiritual traditions also aided emotional reconciliation and preparedness, aligning with existing research linking spirituality to end-of-life planning [7, 12]. Consequently, collectivism offered a supportive ethical framework for participating in ACP rather than serving as an obstacle.

Viewing readiness as a multi-layered concept alters organizational priorities. Shifting the timeline earlier is ineffective if emotional, family, and institutional factors remain disconnected. Lasting improvement demands initiatives that build emotional tolerance, facilitate family-wide discussions, clearly define interdisciplinary roles, and address organizational obstacles such as heavy workloads and fragmented care continuity.

The researchers' backgrounds influenced their interpretation of the data. The primary author's professional experience as a nurse researcher accustomed to Thai medical hierarchies likely heightened analytical sensitivity to interpersonal dynamics and the supportive role of nursing staff. In line with the methodology of reflexive thematic analysis [24, 25], themes emerged through continuous team discussions and reflexive writing, treating the insights as interpretive analyses rather than impartial, absolute discoveries. Converting data from Thai to English focused on achieving conceptual equivalence [29], acknowledging that interpersonal subtleties within the native language demanded careful interpretive evaluation.

Strengths and limitations

A major benefit of this research is its triadic methodology, which captures and blends the views of patients, family members, and medical staff working within the same care environment. This setup enabled analytical comparisons across different stakeholder viewpoints, revealing ACP as a socially negotiated practice rather than an isolated choice made by a single person. Applying reflexive thematic analysis under a contextualist critical realist framework provided a cohesive structure for interpretive analysis, while reflexive journaling and collaborative team debates bolstered analytical transparency.

Several constraints should be noted. The study took place at a single tertiary medical center where ACP programs were already operational, which might restrict how well these insights apply to non-specialized, community-based, or countryside environments where structural readiness varies significantly. Furthermore, because a large portion of the interviews took place at advanced stages of illness, the data may overemphasize late-stage and emergency-driven scenarios, potentially overlooking the earlier stages of readiness cultivation. Moreover, participants' statements regarding spiritual acceptance could have been shaped by a desire for social conformity. Finally, while the translation process aimed for conceptual equivalence, certain subtleties of Thai relational expressions might not be completely preserved in the English version.

Recommendations

Optimizing the integration of ACP requires a unified focus on emotional, familial, and structural readiness, rather than an exclusive focus on paperwork or individual mindsets. Practice frameworks should feature structured yet adaptable readiness evaluations built directly into standard clinical checkups, allowing dialogues to develop naturally over time rather than delaying them until emergencies arise.

Communication workshops must move beyond mechanical instructions to encompass culturally sensitive pacing, empathetic framing, and collaborative teamwork across disciplines. Recognizing the essential supportive role nurses play, organizational strategies should officially validate and provide resources for nurse-driven or nurse-maintained ACP discussions within hierarchical medical structures. At an institutional level, dedicated time for these conversations, expanded community palliative care programs, and integration into electronic health records are vital to preserving continuity of care as patients move between care settings.

Programs that target only a single aspect of readiness are unlikely to generate permanent improvements. Balance across all domains must be deliberately fostered.

Conclusion

This research frames ACP as an interpersonally negotiated practice that depends heavily on the alignment of emotional, family, and systemic readiness. Within a collectivist and hierarchical healthcare landscape, ACP continues to be sparked mainly by medical crises—not simply by cultural pushback, but because these separate areas of readiness rarely align before an urgent clinical situation arises. In the absence of early alignment, an emergency acts as a temporary institutional override.

Acknowledging that readiness takes multiple forms shifts the implementation focus from a simple matter of timing to an issue of interpersonal and institutional coordination. Long-term participation in ACP requires a purposeful effort to cultivate emotional pacing, family-wide communication, explicit interdisciplinary duties, and organizational backing. Without establishing this harmony, ACP will likely remain a reactive measure, despite the widespread recognition of its fundamental importance.

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