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Beyond Family-Centered Care: Conceptualizing Family-as-Root in Hospice and Palliative Care

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Abstract

The family is universally acknowledged as a pivotal stakeholder within hospice and palliative care, establishing "family-centered care" as a prominent framework for clinical practice. Nevertheless, the existential and value-based status of families across various cultural landscapes—most notably in East Asian Confucian heritages—extends far beyond the pragmatic responsibilities typically associated with a family-centered approach. The present study delineates and clarifies the concept of "Family-as-Root," an ontologically and axiologically grounded orientation toward kinship that is deeply recognizable within Chinese societies but remains under-theorized within international end-of-life literature. Furthermore, this study differentiates this construct from and explores its relationship to "Family-Centeredness" in palliative care settings. A formal concept analysis was conducted using the eight-stage methodology formulated by Walker and Avant, treating "Family-as-Root" as an analytical framework to capture existential dimensions not fully addressed by current family-centered paradigms. A comprehensive literature search was performed across primary English- and Chinese-language databases (including PubMed, PsycINFO, CINAHL, Web of Science, CNKI, and Wanfang Data) spanning from database inception to August 2025. The analyzed corpus comprised theoretical, empirical, and review literature focusing on family dynamics in hospice or palliative care, end-of-life decision-making processes, and family-oriented cultural ethics. Through a process of progressive reading and thematic coding, we characterized the defining attributes, precursors, and outcomes of both "Family-as-Root" and "Family-Centeredness," while formulating model, borderline, and contrary cases to illustrate how these concepts manifest in clinical scenarios. The conceptual analysis indicated that "Family-as-Root" serves as an ontological-axiological framework grounded in a perspective in which the individual is fundamentally integrated into multi-generational family networks. This construct highlights the family unit as the foundational core of personal identity, generational value transmission, moral responsibility, and existential meaning-making during advanced illness and the dying process. Conversely, "Family-Centeredness" operates as a functional model of care focused on cooperative decision-making, information dissemination, and role negotiation among healthcare providers, patients, and relatives within established medical infrastructures. Within the realm of hospice care, these dual concepts intersect but are not interchangeable: Family-as-Root governs how patients and their kin perceive suffering, a dignified death, and viable choices, whereas Family-Centeredness organizes the mechanisms by which professionals engage with families during care delivery. Recognizing this demarcation underscores expanded nursing competencies, positioning clinicians as cultural translators, mediators of intra-family dialogue, and protectors of the patient and family's existential experience. "Family-as-Root" and "Family-Centeredness" constitute two interconnected yet conceptually separate dimensions of family engagement in palliative care—the former being ontological-axiological and the latter functional-interactional. Distinguishing between these frameworks can facilitate the formulation of culturally congruent hospice care models, improve the evaluation of family needs and strengths, and inform the development of nursing interventions and assessment instruments that more accurately capture diverse familial cultures within China and globally.

Keywords: Family-as-Root, Family-Centeredness, Hospice care, Palliative care, Family nursing, Concept analysis

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Introduction

Within the international landscape of palliative care, "family-centered care" has risen to prominence as a foundational standard [1]. This framework correctly identifies that the trajectory toward death is a collective journey impacting the entire kinship network, rather than an isolated experience confined to the individual patient [2]. Nevertheless, when this paradigm, which evolved primarily out of Western perspectives centered on individualism [3], is introduced into a societal framework like China's—which prioritizes collective responsibility and relational interdependence—its philosophical assumptions and operational frameworks reveal notable limitations [4]. The discordances stemming from this cross-cultural implementation highlight an urgent requirement for a comprehensive cultural critique and philosophical evaluation of the foundational concept of the "family" itself [5].

Within the healthcare landscapes of Chinese communities, the concepts of "Family-as-Root" and "Family-Centeredness" are frequently utilized interchangeably in both clinical settings and academic papers. This conceptual merging, however, serves as the precise origin of multiple ongoing challenges in palliative care [4]. From a theoretical standpoint, "Family-Centeredness" primarily serves as a sociological and nursing practice model that treats the family as the fundamental unit of care [1, 2]. Its main objective is to optimize family utility relative to clinical systems, including facilitating dialogue, supporting healthcare choices, and mobilizing care resources [2, 3]. Conversely, "Family-as-Root" represents an ontological-axiological paradigm grounded in Chinese philosophical heritage, particularly the Confucian principle of filial piety. This view positions the family as the primary origin of individual identity, moral conduct, and existential purpose, driven by an internal logic focused on multi-generational duty, cultural preservation, and relational longevity [4, 5]. In the context of this discussion, "Family-as-Root" functions as an analytical conceptual designation rather than a universally recognized clinical phrase; it identifies a behavioral dynamic that is highly recognizable in Chinese caregiving but insufficiently addressed by contemporary family-centered terminology in end-of-life literature.

In contemporary hospice and palliative care systems, the majority of supportive interventions remain restricted to the functional levels of family-centered care, emphasizing relatives' participation in data sharing, treatment decisions, and caregiving [6]. Although these initiatives are essential, they often fail to address the deeper, meaning-making dimensions of Family-as-Root. Consequently, healthcare professionals may find it difficult to interpret and address behaviors commonly observed among Chinese families at the end of life—such as the practice of "protective truth concealment" regarding a terminal diagnosis or prognosis [7], or the demonstration of mourning and fidelity through intricate ceremonial activities [8]. When these actions are characterized merely as patterns of dysfunctional communication or as obstacles to patient self-determination, the underlying cultural framework that motivates them is easily ignored. This dynamic subsequently limits the cultural sensitivity of clinical practice and restricts the efficacy of interventions designed to optimize the quality of the dying process and bereavement care.

While the concept of Family-as-Root originates from the distinct historical and philosophical milieu of Chinese societies, its conceptual relevance extends significantly to international hospice environments. Cultural dynamics comparable to Family-as-Root—which prioritize profound multi-generational ties, collective identity, and the preservation of family reputation—are similarly observable in Latino familism, African kinship networks, and various Southern European family structures [9, 10]. Multi-generational interactions—such as advocacy by adult offspring, protective information filtering, and family-guided choice processes—are likewise documented in Western environments. However, they are frequently analyzed through alternative ethical and legal frameworks. Even within highly individualistic Western societies, when individuals confront advanced illness and impending mortality, the preservation of "relational integrity" [11] and the search for "meaning in life" [12] routinely become paramount. A more precise conceptual differentiation between deep cultural-ontological perspectives on kinship and functionally directed family-centered care can therefore expand our understanding of how families comprehend suffering, a "good death," and ethically sound choices across diverse settings.

In light of these conditions, a methodical concept analysis examining both "Family-as-Root" and "Family-Centeredness" is warranted. From an academic standpoint, such an evaluation can clarify their historical origins, defining features, precursors, and outcomes, thereby outlining their theoretical boundaries. From a practical standpoint, it can explain why an exclusively functional perspective on the family may prove inadequate in palliative care, particularly within cultural environments where the family serves as the fundamental landscape for moral identity and existential purpose. Consequently, this investigation seeks to (1) delineate the defining attributes, theoretical development, and practical expressions of Family-as-Root and Family-Centeredness in end-of-life care; (2) assess their points of intersection and divergence across distinct logical dimensions; and (3) establish recommendations for patient assessment, intervention formulation, and role advancement within nurse-led palliative care. Through these objectives, we aim to offer a more grounded theoretical infrastructure and progressive strategic viewpoints for culturally sensitive hospice practices within Chinese societies and alternative cultural environments.

Materials and Methods

Concept analysis methodology

This investigation utilized the traditional eight-stage concept analysis framework developed by Walker and Avant. This methodology was selected because it provides a structured approach for clarifying intricate, ambiguously applied concepts that are central to nursing practice [13]. The eight sequential stages consist of:

1. Selecting the concept;
2. Determining the purpose of the analysis;
3. Identifying all uses of the concept that can be discovered;
4. Determining the defining attributes;
5. Constructing model, borderline, related, and contrary cases;
6. Identifying antecedents and consequences;
7. Defining empirical referents; and
8. Considering theoretical connections with broader frameworks.

Within this study, we implemented the Walker and Avant methodology in a manner that explicitly centers both empirical research and the underlying philosophical-cultural landscape. Empirical studies and theoretical papers within hospice and palliative care were utilized to discern the manner in which "Family-as-Root" and "Family-Centeredness" manifest and operate in real-world scenarios. In contrast, classical and contemporary scholarship on Chinese family ethics and related cultural heritages were used as conceptual materials to inform, rather than dictate, the analytical process.

Why these two concepts matter

To understand family dynamics at the end of life, we chose to analyze "Family-as-Root" alongside "Family-Centeredness" for three primary reasons:

Clinical relevance

Many of the most complex dilemmas in palliative care—such as withholding a prognosis from a patient, family-led decisions, and friction between what a patient wants versus what the collective family expects—stem directly from how a family views illness and obligation [14]. Healthcare providers often label these situations as "family-centered care," but they actually run much deeper into cultural and existential territory. Separating these two concepts provides immediate, practical clarity for clinical assessment, communication, and patient support.

Theoretical ambiguity

The current literature across palliative care, family nursing, and medical sociology frequently lumps terms like "family-centered care," "family involvement," "familism," and "relational autonomy" together in confusing and inconsistent ways [15, 16]. Researchers rarely distinguish a family's deep existential role (as the core of a person's identity and moral duty) from the practical, functional care models used by healthcare systems. This lack of clarity makes it incredibly difficult to build reliable, theory-based intervention tools. A systematic concept analysis helps untangle these layers.

Cultural urgency

In Chinese societies, as well as many other collectivist cultures, the family is far more than just a caregiving team—it is the foundational anchor of human existence, lineage, and values [17]. Today, rapid demographic shifts, the medicalization of death, and the spread of Western bioethical concepts are creating new friction points in end-of-life care. We urgently need a theoretical framework that highlights the cultural logic of Family-as-Root while keeping it in open dialogue with international models of family-centered care.

Data sources and search strategy

To build a comprehensive, culturally inclusive evidence base, we searched major English- and Chinese-language databases from their inception through August 2025. This included PubMed, PsycINFO, CINAHL, and Web of Science for international publications, and the China National Knowledge Infrastructure (CNKI) and Wanfang Data for literature from China.

Our search combined controlled medical vocabularies (like MeSH) with free-text keywords covering three main categories:

1. Hospice, palliative, and end-of-life care;
2. Family, family-centered care, family involvement, familism, and kinship; and
3. Serious, advanced, or terminal illness, and the dying process.

We used boolean operators (AND, OR), synonyms, and spelling variations to build sensitive, highly targeted search strings for each specific database [18]. For example, the PubMed string paired family terms (such as"family", "familism", "family-centered care") with specific end-of-life and palliative care terms.
We also reviewed the reference lists of key papers to catch relevant publications missed by the database searches (citation chasing). The screening and reporting process followed PRISMA guidelines, as applicable, for a concept analysis, and the overall flow is shown in **Figure 1**.

Selection criteria and review process
We established clear boundaries to select literature that offered genuine theoretical and empirical value for defining Family-as-Root and Family-Centeredness in palliative care.

Inclusion criteria
- The text explicitly discussed, analyzed, or measured families, family roles, family-centered care, familism, or closely related concepts within hospice, palliative, or serious illness contexts.
- The paper was theoretical, empirical (qualitative, quantitative, or mixed-methods), or a literature review that offered distinct conceptual insights into how families are valued or involved in care.
- The publication date fell on or before August 2025.
- The full text was accessible in either English or Chinese.

Exclusion criteria
- Conference abstracts, dissertations, short commentaries, news briefs, or non-academic articles lack deep conceptual or empirical substance.
- Papers where family dynamics were mentioned only in passing rather than being the core focus of the analysis or intervention.
- Literature is completely unrelated to end-of-life, hospice, or advanced illness settings.
- Duplicate records found across multiple databases.

All citations retrieved from our searches were compiled into reference management software to remove duplicates. Two authors independently reviewed the titles and abstracts against our criteria. Full-text articles of potentially relevant studies were then retrieved and evaluated independently by the same two reviewers. Any disagreements were resolved through team discussions and, when necessary, consultation with a third author to reach a consensus.
Our initial search yielded 3,138 records. Following duplicate removal and a stepwise review of titles, abstracts, and full texts, 31 articles met all criteria and were selected for the final concept analysis. The complete selection breakdown and reasons for exclusion are detailed in **Figure 1**.

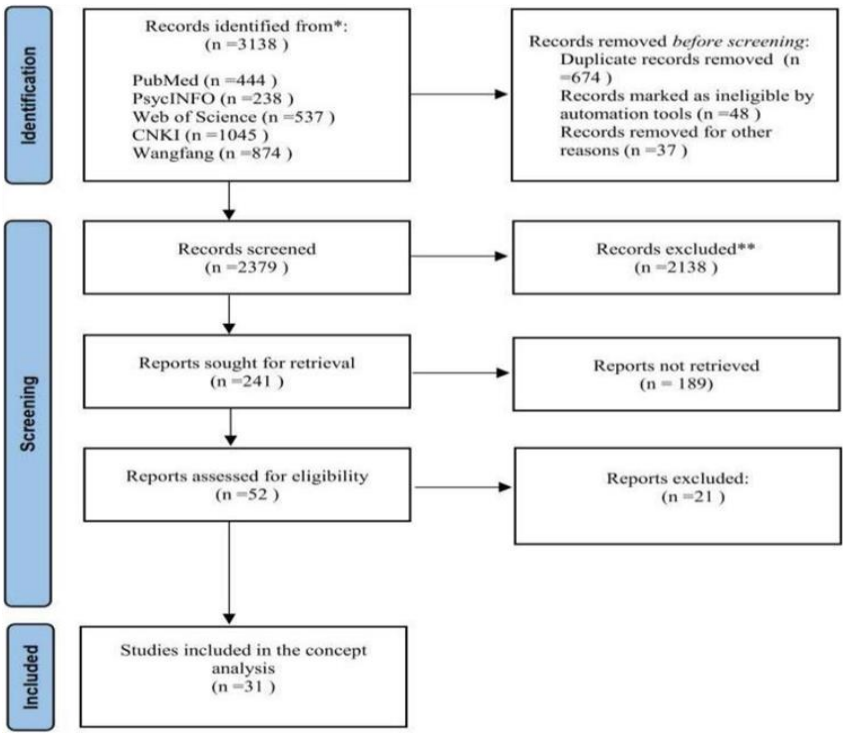

Figure 1. The flowchart for the literature screening.

Data extraction and analytical protocol

A customized data extraction tool was built to gather essential characteristics from each selected publication. The recorded parameters included the publication year, geographic region, research methodology (theoretical, qualitative, quantitative, mixed-methods, or literature review), the specific clinical care environment, patient and family demographic traits, and the conceptual framing, measurement, or discussion of kinship variables. We focused extensively on text segments detailing the overarching significance, value structures, designated duties, ethical responsibilities, and decision-making authority of families operating within hospice and palliative care environments.

The analytical stage of this concept evaluation followed a progressive, recursive process:

1. Every selected paper was reviewed in full by at least 2 investigators, who independently documented prospective attributes, preconditions, and outcomes associated with both Family-as-Root and Family-Centeredness. These baseline codes were cross-compared, debated, and synthesized into higher-order conceptual domains by constantly contrasting findings within and across international and Chinese bodies of literature.
2. We investigated how these thematic domains intersected or separated across the two frameworks, identifying which real-world clinical patterns supported or complicated their conceptual boundary lines.
3. Combining insights from the coded literature with relevant philosophical frameworks, we sharpened the core defining elements of each concept and mapped its distinct precursors and downstream outcomes.

To demonstrate how Family-as-Root and Family-Centeredness display themselves in everyday clinical environments, we developed model, borderline, related, and contrary cases. These clinical scenarios were generated as composite profiles blended from previously published empirical studies and conceptual overviews rather than primary patient data, maintaining total participant anonymity while retaining analytical depth. Finally, we surveyed existing evaluation instruments and clinical nursing strategies that track elements of either Family-as-Root or Family-Centeredness, considering how these refined conceptual boundaries could guide the design of future, culturally adapted clinical assessment models and care delivery frameworks.

Results and Discussion

This concept analysis provides an integrated framework showing how "Family-as-Roo" and "Family-Centeredness" reside within separate academic and philosophical genealogies, how their core attributes and practical manifestations overlap or differ in end-of-life care, and how they produce distinct preconditions, outcomes, and functional mandates for clinical nursing.

Conceptual origins and theoretical positioning

Philosophical foundations of "Family-as-Roo"

The conceptual framework of "Family-as-Roo" is derived directly from the core architecture of Chinese cultural and philosophical heritage, which views the domestic family unit as the foundational arena of human life. Classical Confucian philosophy treats the individual not as an isolated, self-contained agent, but as an interconnected node embedded within an intergenerational kinship network bound by filial obligations, designated relational roles, and ritual propriety [19, 20].

Within the classic moral progression of "cultivating the self, regulating the family, governing the state, and bringing peace to the world," the family serves as the primary crucible where ethical character is forged, societal values are adopted, and existential purpose is passed down through generations.

From this perspective, a person's foundational identity is anchored in relational embeddedness and lineage continuity rather than independent, autonomous choice. Individual trials and triumphs are viewed through the lens of collective family honor or loss of face. Consequently, major life transitions—including advanced disease, active dying, and the bereavement process—are encountered as crucial moments that evaluate the cohesion of the family as a shared moral and spiritual collective. This ontological-axiological paradigm emphasizes value-centered placement, a relational view of being, sacred transcendence (including ties to ancestors and ceremonial commemoration), and historical continuity across time as the defining markers of Family-as-Root.

Theoretical development of "Family-Centeredness"

Conversely, the framework of "Family-Centeredness" is built upon contemporary social science models and healthcare systems. Its development stems from structural-functional sociology, family systems theory, and the implementation of family-focused care delivery models originally established within pediatric medicine and chronic disease tracking [15, 21, 22]. Within these scientific traditions, the family is defined as a bounded social entity whose internal structures, communication loops, and collective coping mechanics directly dictate health trajectories.

Family-centered care is a practice paradigm that treats family networks as active clinical allies, engaging them directly in shared healthcare decisions and supporting their internal balance as they navigate modern medical

bureaucracies. Its principal objective is to maximize the structural and functional efficiency of the kinship unit: how clinical data flows, how caregiving duties are divided, how external resources are deployed, and how internal disputes are mediated during periods of illness and medical management.

Viewed together, Family-as-Root and Family-Centeredness function on separate conceptual tiers. Family-as-Root describes a profound cultural-existential perspective on the person-family bond, prioritizing identity formulation, baseline values, and spiritual meaning. Family-Centeredness represents a functional, institutional design that coordinates how medical professionals engage with family units in everyday practice. The following sections expand upon this core distinction to clarify the defining features and clinical displays of each concept. Crucially, a meta-analysis of Family-Centeredness across the gathered literature highlights an ongoing theoretical omission: structured, process-oriented family engagement frameworks frequently overlook how families build moral significance, manifest filial piety, and maintain multi-generational lineage at the end of life.“Family-as-Roo” is introduced in this study as a bridging concept to make this theoretical omission visibly transparent and clinically actionable.

Analytical dimensions and conceptual models

Core attributes of“Family-as-Roo”

The conceptual review extracted four intertwined dimensions that delineate the Family-as-Root framework:

Value-rootedness

The kinship network functions as the foundational paradigm through which individuals define a meaningful existence, a dignified death, and an honorable confrontation with disease. Personal successes and shortcomings are continuously viewed through the matrix of ancestral reputation or collective shame [23]. In the presence of a terminal prognosis, patients and relatives regularly express obligations such as“avoiding dishonor to the family line,” “reciprocating parental devotion,” or “maintaining solidarity among siblings.” This demonstrates that ethical evaluations stem from collective ancestral values rather than solitary individual desires.

Relational ontology

The individual is conceptualized as fundamentally interdependent, meaning that personal identity and self-worth are inextricably tied to the execution of specific domestic roles, such as being a devoted child, a reliable parent, or a protective spouse [24]. Clinical choice pathways during advanced illness mirror this interdependent reality: patients frequently place the psychological comfort and pragmatic needs of their relatives above their own, while family members often adopt a unified collective agency when navigating clinical options, expressing grief, or coordinating daily care.

Sacred transcendence

The Family-as-Root construct contains an element of spiritual and metaphysical significance. Through ancestral commemoration, spiritual or localized folk ceremonies, and highly symbolic customs surrounding active dying and funerary traditions, kinship groups actively pursue unbroken continuity between living members and deceased predecessors [25]. End-of-life choices—such as the geographic location of death, the handling of the body, or the practice of specific spiritual rituals—are fundamentally driven by an overriding desire to sustain harmony with ancestors and secure spiritual protection for future lineages.

Diachronic continuity

A defining feature of Family-as-Root is its structural alignment with an intergenerational, historical continuum. Individuals perceive their lifespans as brief segments within a broader familial timeline that extends backward to ancestral generations and forward to unborn generations [26]. End-of-life choices, including enduring profound physical suffering, making substantial financial sacrifices, or safeguarding family assets, are routinely vindicated by a desire to protect “future descendants” or “perpetuate the familial lineage.”

Combined, these four features construct a theoretical framework where the family serves as the ultimate anchor for existential being, moral duty, spiritual unity, and historical longevity. Consequently, palliative interventions interacting with a Family-as-Root dynamic must expand beyond immediate symptom relief to support the family unit’s overarching pursuit of ethical integrity, spiritual harmony, and generational continuity.

Core attributes of “Family-Centeredness”

In parallel, the literature yields four distinct defining features characterizing the Family-Centeredness model:

Structural functionality

The family is viewed as an organized social structure tasked with achieving practical objectives, such as providing psychological comfort, overseeing daily care, making healthcare decisions, and managing resources [27]. The

primary analytical focus centers on whether these pragmatic operations run smoothly during a health crisis, and how multidisciplinary healthcare teams can optimize or offset functional weaknesses within the unit.

Problem-solving orientation

Family-centered paradigms emphasize the immediate capacity of the kinship group to identify clinical challenges, deploy internal and external assets, and execute adaptive coping mechanisms when confronting acute health events, such as unexpected symptom spikes, emergency admissions, or the transition into palliative care [28]. Clinical protocols within this framework aim to streamline communication channels, strengthen coping capacities, and facilitate shared decision-making processes.

Actual interactivity

A foundational pillar of Family-Centeredness is the quality and efficiency of real-time communication between the family system and medical professionals. This includes transparent transfer of clinical data, collaborative deliberation on treatment pathways, clear demarcation of caregiving roles, and maintenance of mutual respect within clinical partnerships [29]. The emphasis is squarely placed on visible behavioral interactions rather than on underlying existential or cultural belief systems.

Synchronic coordination

Family-centered care models typically operate within a short-term, localized timeframe, focusing on aligning family members with healthcare providers during specific episodes or milestones of medical management. Multidisciplinary family consultations, care planning sessions, and structured discharge protocols serve as prime examples of this immediate coordination [30].

Together, these attributes outline Family-Centeredness as a pragmatic, process-driven model for regulating how medical institutions and clinicians incorporate family units into active care. While this approach is fully compatible with a Family-as-Root perspective, it does not inherently account for the deep ontological-axiological dimensions of kinship that dominate specific cultural landscapes. To provide an integrated view, **Table 1** delineates the primary differences between Family-as-Root and Family-Centeredness across theoretical, temporal, and clinical dimensions.

Table 1. Conceptual comparison of "Family-as-Root" and "Family-Centeredness" in hospice care. From: "Family-as-Root" and "Family-Centeredness" in hospice care: a concept analysis and implications for nursing practice.

Dimension	Family-as-root (FaR)	Family-centeredness (FC)
Conceptual foundation	An ontological and value-based perspective emphasizing the intrinsic connection between the individual and the family.	A care-oriented framework that views the family as an integral component of healthcare delivery and support.
Primary emphasis	Formation of identity, ethical responsibilities, construction of meaning, and preservation of family lineage.	Effective communication, collaborative relationships, shared problem-solving, and coordinated care management.
Understanding of family	A moral and spiritual collective that serves as the principal source of belonging, values, and cultural continuity.	A social unit that interacts with healthcare systems and functions as a recipient and participant in care.
Understanding of the individual	A relational being whose identity is deeply embedded within intergenerational family connections.	A distinct individual who exists within the family context while maintaining personal autonomy.
Time perspective	Longitudinal and intergenerational, encompassing links among past, present, and future generations, including ancestors and descendants.	Mainly focused on the present, particularly on stages of illness and specific care-related situations.
Defining characteristics	Value orientation, relational understanding of personhood, spiritual transcendence, and continuity across generations.	Functional organization, emphasis on problem-solving, active interaction, and coordination of care activities.
Approach to decision-making	Family reputation, filial obligations, responsibilities toward ancestors, and commitments to future generations shape decisions.	Formal shared decision-making processes, preference clarification, and open information sharing guide decisions.
Interpretation of suffering and a "good death"	Suffering and end-of-life experiences are assessed based on whether family duties have been honored and whether long-term family harmony is maintained.	Suffering and dying are evaluated based on symptom management, alignment with stated goals, and adaptation of both patients and caregivers.
Common family practices in hospice care	Collective family decision-making, withholding distressing information for protection,	Attendance at family conferences, discussion of caregiving responsibilities, active

	preference for dying at home or near ancestral roots, and extensive ritual observances.	information seeking, and cooperation with professional guidance.
Position of healthcare professionals	Professionals are viewed as visitors within the family's moral and cultural sphere, providing support for family meanings, traditions, and rituals.	Professionals act as collaborators and coordinators, facilitating communication, care planning, and ongoing support among family members and the healthcare team.
The major focus of nursing care	Understanding cultural and familial values while promoting discussions about obligations, legacy, and spiritual matters within the family.	Evaluating family functioning and providing support for communication, role adjustment, caregiver strain, and service coordination.

Abbreviations: FaR = Family-as-Root, FC = Family-Centeredness.

Clinical expressions and case illustrations

Practice-based differentiation of conceptual expressions

By mapping these theoretical attributes against empirical data from contemporary hospice and palliative care studies, we find that Family-as-Root and Family-Centeredness produce distinct behavioral trends and clinical expectations.

When dealing with diagnostic and prognostic truth-telling, a Family-as-Root dynamic frequently manifests as protective non-disclosure. This behavior is driven by filial devotion and an ethical imperative to protect the patient from "existential distress" or total despair. While an orthodox Family-Centeredness perspective might interpret this choice as a breakdown in communication or an infringement on patient self-determination, a Family-as-Root lens recognizes it as a coherent moral choice situated within a family-first hierarchy of values.

In terms of medical choice pathways, Family-as-Root manifests through collective decision-making assemblies, reliance on ancestral paradigms, and a focus on collective reputation and historical continuity. Conversely, Family-Centeredness prioritizes highly structured family conferences, the explicit clarification of individual patient preferences, and collaborative decision-making models designed to synchronize treatment strategies with the patient's stated goals of care.

Regarding hands-on care and end-of-life practices, Family-as-Root is marked by absolute family immersion in physical caregiving, the constant presence of extended kinship networks at the clinical bedside, and extensive pre- and post-death rituals that re-establish intergenerational connections. Family-centered frameworks focus instead on mitigating primary caregiver strain, organizing efficient labor divisions, aligning community resources, and offering structured bereavement interventions.

Case manifestations

Model case for "Family-as-Root"

The following model case demonstrates how the logic of Family-as-Root dominates end-of-life care. This narrative is a composite profile derived from peer-reviewed qualitative research on Chinese families navigating terminal oncological trajectories [30].

Mr. Chen, a 78-year-old individual originally from a traditional rural community, had spent his later years residing with his adult children in a major metropolitan center. Following a diagnosis of advanced, terminal lung cancer, his children explicitly requested that the attending medical team withhold the fatal nature of the prognosis from him. They maintained that "an aging father should be protected from such an overwhelming psychological burden" and that "depriving him of hope would cause him to abandon his will to live." A family council was organized without Mr. Chen's presence to chart the next steps in care. The adult children collectively elected to pursue aggressive, invasive chemotherapy regimens despite minimal medical utility, asserting that "if we fail to exhaust every conceivable medical option, we violate our core filial duties and will be unable to hold our heads up before our ancestors and village relatives."

Throughout the entire course of the disease, the kinship unit managed the patient's care through a framework defined by a relational view of being and long-term generational continuity. The siblings systematically distributed duties, with specific individuals managing inpatient accompaniment, financial obligations, and ceremonial arrangements. When Mr. Chen experienced acute delirium and attempted to dismantle his intravenous access lines, his children did not view this strictly as a clinical complication, but rather as an indication that "our father's ancestral spirit is enduring a profound transition." In his final days of life, they firmly arranged his relocation to his ancestral village so he could "pass away on the precise soil where generations of our lineage rest." Taoist ceremonies and ancestral offerings were organized well in advance, and the grandchildren were systematically instructed in the proper methods of bowing and addressing their ancestors during the upcoming funeral rites.

This case highlights how the pillars of value-rootedness (collective reputation, filial obligation), relational ontology (unified family agency), sacred transcendence (metaphysical ancestral bonds), and diachronic continuity (the preservation of lineage) dictate every clinical choice and action. External professional intervention remains strictly limited to symptom control and specialized technical procedures, while the family unit retains absolute control over moral assessment and meaning-making.

Exemplar case for "Family-Centeredness"

The second composite narrative depicts a clinical landscape in which family-centered care serves as the structural foundation for end-of-life management. This scenario is drawn from empirical studies investigating family conferences and family-focused protocols within palliative medicine [31].

Mrs. Li, a 65-year-old individual diagnosed with advanced colorectal malignancy, was admitted to an inpatient hospice department. Upon her arrival, the clinical team conducted an initial family appraisal, identifying her spouse and two adult offspring as her primary care network. A structured conference was coordinated with Mrs. Li directly participating, during which the attending palliative specialist outlined her prognosis and corresponding medical paths. Rooted in family-centered methodologies, the interdisciplinary team invited each relative to articulate their unique concerns, supported Mrs. Li in identifying her personal goals, and streamlined the division of caregiving responsibilities (delineating hands-on domestic care, designating the primary point of contact for the medical staff, and mapping out shared financial liabilities).

Over the subsequent weeks, scheduled family updates were utilized to evaluate symptom management, refine the active clinical plan, and mediate burgeoning interpersonal friction. Nursing staff provided psychoeducational support to the relatives, taught practical interventions for home pain management, and routinely monitored caregiver strain. Social work partners helped link the family unit to local community resources and guided advance care planning dialogues. Following Mrs. Li's passing, bereavement interventions were geared toward assisting the surviving spouse and children as they integrated into altered domestic roles and daily patterns.

This scenario highlights structural functionality (the organized distribution of caregiving tasks), a problem-solving orientation (collaborative management of clinical and domestic issues), actual interactivity (continuous dialogue between the family and the healthcare team), and synchronic coordination (interdisciplinary collaboration at pivotal clinical junctures). While the family's deep-seated cultural values clearly influence their individual inclinations, the overriding therapeutic objective is to maximize workflow and outcomes at the intersection of the domestic unit and the healthcare system. Viewed together, these two clinical exemplars demonstrate that Family-as-Root and Family-Centeredness can operate concurrently within palliative environments, yet they highlight fundamentally distinct layers of family engagement. Identifying which paradigm guides behavior in a specific clinical scenario enables nursing professionals to adapt their communication strategies and supportive actions accordingly [30, 31].

Precursors, downstream outcomes, and clinical mandates

The causal chain of "Family-as-Root"

The baseline precursors of Family-as-Root encompass:

1. Deeply ingrained cultural paradigms that prioritize filial piety, ancestral reverence, and collective family reputation;
2. Social frameworks that support multi-generational living arrangements and robust extended kinship networks; and
3. Cumulative life experiences through which individuals learn to contextualize major existential milestones through the lens of family duty and generational longevity [32-34].

These pre-existing conditions govern expectations regarding how advanced illness and dying should be managed, which individuals hold the right to be informed, and what constitutes a legitimate medical choice.

The real-world outcomes of Family-as-Root within palliative environments are double-edged. On a positive note, it can trigger intense family engagement, comprehensive pragmatic assistance, and deep emotional safety networks for the patient; bolster psychological resilience by reframing personal physical suffering within a grander narrative of family meaning; and compel relatives to consolidate substantial resources for caregiving [35]. Conversely, it can result in the erasure of the patient's self-stated choices, the deliberate hiding of prognostic realities, ethical coercion to accept invasive treatments merely to satisfy family expectations, and complicated mourning trajectories when relatives believe they have fallen short of their perceived moral duties [36].

For professional nursing, this causal path implies that clinicians must learn to identify Family-as-Root as a distinct cultural paradigm, avoiding both its idealization and its pathologization. Clinical assessments must explore how families conceptualize their mutual obligations, vulnerabilities, and aspirations relative to their ancestors and future offspring, and how these internal frameworks dictate choices regarding the geographic site of care, the deployment of life-sustaining measures, and preferred funerary customs.

The causal chain of "Family-Centeredness"

The baseline precursors of Family-Centeredness originate primarily within institutional health policy, organizational systems, and professional education. These encompass:

1. The systemic advocacy for patient- and family-focused care as an institutional metric of quality;
2. The institutional establishment of interdisciplinary palliative teams and standardized family conference workflows; and

3. Professional development curricula that highlight advanced communication techniques, shared medical choice models, and caregiver welfare tracking [20, 37, 38].

When these underlying criteria are met, the downstream outcomes for palliative care manifest across several dimensions: kinship units are systematically integrated into clinical data loops and care coordination; disputes between relatives or between the family and the medical staff are more readily identified and resolved; primary caregiver exhaustion can be detected and managed proactively; and care transitions across distinct medical settings become more seamless [39]. However, if Family-Centeredness is executed in a purely mechanistic manner—confined strictly to checking boxes and holding rigid meetings—its capacity to tap into a family's profound values and inner narratives remains underutilized, and cultural friction can worsen if professional medical guidance runs counter to familial convictions and traditions [40].

Practicing within a family-centered framework demands professional mastery in conducting family appraisals, facilitating inclusive group discussions, guiding role distribution, and providing psychoeducational support. Concurrently, nurses must remain alert to situations where standardized, family-centered protocols run counter to the ethical mandates imposed by Family-as-Root, necessitating highly sophisticated mediation.

Multi-level impact on clinical nursing

Synthesizing these two distinct constructs reveals a multi-tiered influence on contemporary palliative nursing practice.

- Individual nurse level: This synthesis highlights a critical need for advanced cultural humility and self-reflection. Clinicians are encouraged to move past a reductive view of relatives as simple care providers or procedural impediments, choosing instead to explore how the family's underlying ontological and axiological commitments dictate their behavioral responses to terminal illness and death [41].
- Patient and family level: Separating Family-as-Root from Family-Centeredness enables clinicians to identify divergent decision-making structures—specifically, whether clinical priority is given to personal self-determination or to a collective family will—and to accurately decode varied expressions of mourning and appraisals of healthcare quality [42-44].
- Service system level: This analysis reinforces the need to advocate for healthcare delivery systems that enable the fluid integration of extended kinship groups, respect culturally vital rituals, and incorporate local community and spiritual assets. Institutional policies and clinical workflows can be systematically audited to ensure they do not unintentionally invalidate culturally rooted care expressions, while simultaneously shielding vulnerable patients from undue pressure or clinical harm.

Empirical referents

Measurement tools related to "Family-as-Root"

The academic literature reveals a modest though steadily expanding catalog of evaluation instruments that align with dimensions of Family-as-Root, particularly within Sinitic cultural frameworks. Among these, the Contemporary Chinese Familism Scale stands out as a hallmark instrument designed to quantify convictions regarding familial duty, reciprocal intergenerational obligations, and the prioritization of collective domestic welfare over individual preferences [45].

Specific domains within this tool—such as "family obligation", "respect for elders", and "collective orientation"—directly correspond to the core concepts of value-rootedness and diachronic continuity. Other existing assessment metrics, including indices of filial piety, intergenerational solidarity, and domestic duty, provide only partial coverage of the broader Family-as-Root framework. Nevertheless, the majority of current diagnostic tools target cognitive-attitudinal variables and fail to encapsulate the sacred transcendence (such as ancestral bonds and ritual significance) or the lived relational ontology identified here as foundational features. Furthermore, very few of these metrics have been empirically validated in hospice or end-of-life care contexts.

These existing deficits underscore a critical requirement for subsequent psychometric development. Future tools must explicitly embed the four core attributes of Family-as-Root, maintain sensitivity to the unique dynamics of palliative environments, and offer the capacity to gauge the degree to which families align with this structural paradigm when navigating terminal illness and the dying process.

Measurement tools related to "Family-Centeredness"

By contrast, researchers possess a much more robust selection of diagnostic instruments for operationalizing Family-Centeredness and its related paradigms. The Family Adaptability and Cohesion Evaluation Scales (FACES) and the Family Assessment Device (FAD) are widely used metrics for evaluating family cohesion, systemic adaptability, interpersonal communication, and collaborative conflict resolution [46, 47]. These specific instruments mirror the structural functionality and problem-solving orientation identified in this analysis, and their utility has been demonstrated across diverse disease trajectories and varied cultural populations.

Furthermore, dedicated metrics for family-centered care—including the Perceptions of Family-Centered Care Scale and comparable instruments adapted for pediatric and adult medical environments—center primarily on the

family's firsthand experiences regarding dignity, information sharing, collaborative decision-making, and structural partnership with clinical providers [48]. These evaluation metrics correspond directly with the attributes of actual interactivity and synchronic coordination.

Synthesizing these empirical referents demonstrates that while Family-Centeredness has been thoroughly operationalized through validated diagnostic tools, Family-as-Root is only partially measured by current metrics. This disparity reinforces the view that Family-as-Root and Family-Centeredness are theoretically independent constructs, yet unequally represented in contemporary empirical literature, underscoring the need to develop culturally tailored instruments and clinical protocols for end-of-life environments.

This conceptual analysis delineates "Family-as-Root" and "Family-Centeredness" as two interconnected yet distinct dimensions characterizing family engagement within palliative settings. Family-as-Root encapsulates an ontological-axiological paradigm wherein the family unit serves as the primary nexus for identity, ethical duty, and existential meaning-making; conversely, Family-Centeredness constitutes a functional, interactional framework governing how healthcare practitioners collaborate with patient networks. Our conclusions indicate that conflating these two underlying frameworks masks critical catalysts for friction in hospice environments and threatens to reduce culturally competent care to mere procedural modifications. Within this discussion, we emphasize the philosophical value of this conceptual distinction, its real-world utility for restructuring culturally sensitive end-of-life care, its broader applicability beyond Chinese cohorts, and the manner in which it prompts an evolution in professional nursing roles [30, 31].

From function to meaning: Deepening the perspective of nursing philosophy

A primary insight from this investigation is that the operational "ceiling" of many contemporary family-centered methodologies stems from their disproportionate focus on clinical functions and communication workflows. Family-centered frameworks have significantly enhanced clinical nursing by prioritizing partnership, transparent dialogue, and collaborative decision-making. Nonetheless, these models typically rely on a systems-functional conceptualization of the family as an operational unit executing specific tasks, rather than as the existential "root" of human identity and value systems. When the family network is viewed simply as an auxiliary resource or a secondary setting for executing patient-centered protocols, the profound moral and existential framework that kinship groups connect to illness, mortality, and mourning can remain under-theorized.

By defining Family-as-Root as an independent paradigm, our evaluation enriches the philosophical tenets of nursing practice by centering relational ontology and value-rootedness. Under this framework, the individual is seen as fundamentally inseparable from interconnected networks of intergenerational relationships; personal identity is collectively forged through the fulfillment of domestic responsibilities and the preservation of generational continuity. This stance aligns with relational theories in nursing philosophy and clinical bioethics. Yet it provides a clearer explanation of how family-derived values shape what patients and relatives interpret as a "successful" or "failed" end-of-life experience. Crucially, our intention is not to endorse Family-as-Root without critique, but rather to reveal the structural normative framework through which many families make sense of physical suffering and medical choices [30].

Concurrently, distinguishing between Family-as-Root and Family-Centeredness does not imply a strict polarization. Instead, this analysis indicates that functional, interactional engagement with patient relatives is invariably embedded within, and limited by, foundational ontological-axiological orientations. In clinical environments, family-centered strategies that focus solely on communication dynamics and shared decision-making workflows may yield short-term success. Still, they cannot fully resolve tensions arising from deeper concerns about filial obligation, family reputation, or intergenerational legacy. From the standpoint of nursing philosophy, this reality demands clinical models that unify process-oriented, family-centered methodologies with deliberate exploration of the family's broader framework for meaning-making, rather than treating cultural background as a simple "modifier" of domestic utility [31].

Reconstructing culturally sensitive care: From "awareness" to "integration"

Cultural sensitivity in end-of-life care is frequently conceptualized as a challenge of awareness and attitude, in which healthcare providers are urged to respect diverse cultural tenets, avoid stereotyping, and adapt communication strategies. Although this awareness is vital, our conclusions demonstrate that it proves insufficient when cultural frameworks like Family-as-Root fundamentally dictate how kinship groups conceptualize illness, prognostic disclosure, therapeutic alternatives, and the rituals surrounding mortality. Within these clinical landscapes, merely "respecting cultural variance" without a theoretical grasp of the underlying paradigm can result in superficial accommodations or, conversely, unacknowledged friction between professional clinical standards and domestic expectations.

The analytical distinction between Family-as-Root and Family-Centeredness offers a more operational theoretical mechanism for reshaping culturally sensitive interventions. During the initial assessment phase, nursing staff and interdisciplinary teams can systematically evaluate not only the specific individuals driving decision-making and care execution, but also the manner in which relatives outline their mutual duties, how they anchor current choices

to ancestral legacies and upcoming generations, and what they define as an ethically valid dying process. Utilizing investigative questions like "What will allow your family to achieve long-term peace regarding these choices?" or "How do your family's historical traditions guide your perspective in this situation?" prompts the articulation of core Family-as-Root priorities rather than restricting the dialogue to immediate logistical matters. This methodology aligns with relational and family-grounded interpretations of self-determination and medical choice in pluralistic societies [41].

When formulating care pathways, identifying the Family-as-Root paradigm prompts the merging of meaning-centered interventions with functional assistance. For instance, alongside managing pain and physical symptoms, clinical teams can guide structured family dialogues on unresolved obligations, reconciliation, and legacy preservation; assist relatives in organizing rituals vital to maintaining ancestral continuity; and allocate dedicated opportunities for intergenerational life reviews and storytelling. These clinical approaches reframe specific behaviors—such as an unyielding demand to return "home" for the final moments or the orchestration of elaborate post-death ceremonies—not as illogical requests, but as vital manifestations of diachronic continuity and sacred transcendence.

Similarly, the documentation and evaluation of palliative interventions can shift from vague statements of "cultural respect" to highly precise tracking of how Family-as-Root and Family-Centeredness variables were navigated. Did the interdisciplinary team successfully align the clinical strategy with both the patient's individual goals and the family unit's sense of moral obligation? Were points of friction between individual self-determination and family-grounded values explicitly recognized and negotiated, rather than suppressed by institutional regulations or domestic coercion? Addressing these inquiries demands the systemic integration of Family-as-Root principles into the standard language and daily routines of hospice care, rather than treating it as an elective programmatic add-on.

Implications beyond the Chinese context: Insights for global hospice care

Although the concept of Family-as-Root arises from Sinitic philosophical frameworks, this analysis indicates that its underlying rationale is not exclusive to Chinese populations. Across numerous cultural landscapes—including distinct Latin American, African, and Southern European communities—robust intergenerational ties, collective family honor, religious doctrines, and kinship-grounded obligations serve as central drivers in formatting end-of-life choices and mourning customs [9, 10].

Even within highly individualistic Western settings, qualitative inquiries into terminal illness and bereavement consistently show that individuals make sense of their existential trajectories through family histories, collective identities, and persistent relational bonds [11, 12].

The theoretical boundary separating Family-as-Root from Family-Centeredness provides a generalizable conceptual framework for examining these dynamics globally. Family-as-Root offers an analytical lens for characterizing cultural systems wherein the family unit is experienced as the foundational moral universe that gives meaning to individual choices. In contrast, Family-Centeredness delineates the methods by which healthcare organizations formally attempt to engage families in the care process. In certain environments, these two domains may be highly congruent; in others, formalized family-centered procedures may run counter to domestic expectations rooted in religious tenets, customary laws, or tribal structures. Exposing this underlying duality can facilitate more sophisticated comparative investigations into family dynamics within hospice and palliative care research.

For the international palliative care community, this analysis highlights the critical need to transcend simplistic dichotomies such as "individualistic versus collectivistic" cultures. Instead, it directs attention toward the specific patterns through which families are understood as the roots of personal identity and ethical obligation, and how these internal frameworks intersect with organizational models of family-centered care. Future cross-cultural investigations could utilize the distinct attributes of Family-as-Root and Family-Centeredness as analytical concepts when decoding qualitative evidence, organizing comparative case studies, or designing psychometric assessment tools. Such scholarly efforts would serve to refine and validate the cross-cultural generalizability of this framework while pinpointing context-specific trends of alignment and divergence [9].

Innovation in clinical application and evolution of the nurse's role

Lastly, this conceptual analysis highlights tangible innovations for bedside application and the progressive evolution of professional nursing roles in end-of-life settings. At the bedside, nurses frequently serve as the primary clinicians, spending extended periods with patients and their relatives, thereby positioning them to directly witness the complex interpersonal dynamics surrounding truth-telling, medical decision-making, and caregiving duties. The conceptual distinction between Family-as-Root and Family-Centeredness provides nurses with the precise vocabulary to interpret these interpersonal patterns without romanticizing or pathologizing family conduct. Rather than categorizing protective information withholding or an unyielding insistence on specific rituals as mere "non-compliance" or "cultural obstacles," nursing professionals can interpret them as clear reflections of distinct value hierarchies and existential priorities [41, 42].

This analytical framework expands the professional scope of the nurse from a purely functional coordinator to an interpreter of cultural values and a mediator of intra-family communication. Nurses can assist families in articulating their unstated assumptions, bridge the intersection between patient and relative narratives, and identify clinical points where Family-as-Root obligations and institutional family-centered guidelines are in tension. Within interdisciplinary team conferences, nurses can advocate for embedding meaning-focused approaches—such as narrative therapies, life review work, or ritual accommodations—directly into care plans alongside routine symptom control and caregiver support measures [49-51].

At the institutional and organizational tiers, this evaluation charts clear paths for professional education and clinical service enhancement. Educational curricula for palliative care nurses could incorporate structured modules on concepts such as Family-as-Root, relational ontology, and cultural humility, paired with case-based learning to analyze how these theoretical models manifest in complex clinical environments [41-44].

Institutional protocols can be audited to ensure they provide adaptable space for engaging extended kinship networks, performing vital rituals, and balancing a profound respect for family-grounded values with structural safeguards for patient autonomy and safety. In the arena of healthcare policy, separating Family-as-Root from Family-Centeredness provides a clear explanation for why hospice frameworks engineered within individualistic societies cannot be directly transplanted into different cultural spheres without strategic adaptation [39, 40].

While the nature of this investigation remains strictly conceptual, it produces a distinct series of hypotheses and operational propositions that can be tested through future empirical tracking. For example, it would be highly beneficial to investigate whether families that exhibit a pronounced alignment with the Family-as-Root framework demonstrate distinct patterns in decision-making workflows, caregiving burdens, and bereavement trajectories, and to examine how specialized nursing strategies might optimize outcomes for these specific cohorts [29, 30, 45]. These potential trajectories are explored in greater depth in the subsequent sections, which address study limitations and future research avenues.

Ethical and legal considerations

Within the framework of principlism, this specific friction is frequently conceptualized as a delicate balancing act between upholding individual self-determination and fulfilling the duties of beneficence and non-maleficence; conversely, care ethics and models of relational autonomy highlight that personal inclinations are routinely developed and maintained within relational networks and mutual accountability [5, 43]. The purpose of this investigation is not to advocate for replacing patient autonomy with absolute family jurisdiction. Rather, it elucidates how families' internal moral landscapes shape the meaning of the dying process and explains why medical practitioners require explicit methodologies to accommodate family engagement without undermining vital patient protections.

From an ethical standpoint, Family-Centeredness is routinely operationalized via procedural safeguards—such as transparent information disclosure, the identification of care goals, and structured family conferences—geared toward promoting beneficence and mitigating harm while respecting individual autonomy [39, 40]. Conversely, the concept of Family-as-Root clarifies why these standard procedures can be perceived as morally deficient if they neglect filial responsibilities, family reputation, and intergenerational legacy. Concurrently, a strong alignment with Family-as-Root can introduce vulnerabilities regarding undue external pressure or the erasure of a competent patient's explicitly stated choices [43].

From a legal and regulatory standpoint, most statutory frameworks distinguish between:

- Family involvement that has been explicitly authorized by the patient (such as instances where a patient chooses family-mediated communication channels or designates a surrogate decision-maker), and
- Family decision-making dynamics that override the patient's documented or known inclinations.

The former paradigm can be integrated with the requirements of informed consent, provided that clinicians explicitly document the patient's choices and cognitive decision-making capacity. The latter scenario, however, generally demands additional protective measures, including formal ethics consultations, rigorous verification of proxy decision-making boundaries, and recourse to advance directives or alternative legally binding mechanisms [14, 15].

For professional nursing practice, this reality imposes a dual obligation:

1. To streamline culturally resonant family dialogue and respect legitimate domestic roles, and
2. To protect the patient from external coercion while preventing avoidable clinical harm.

Practical interventions include evaluating how the patient wishes clinical data to be managed, allocating dedicated time for internal family deliberation while ensuring the patient's perspective remains central when desired, explicitly documenting designated roles, and escalating unresolved disputes through interdisciplinary team protocols and formal ethics channels when required [41].

Intergenerational dynamics across cultures

Intergenerational dynamics likewise influence end-of-life communication pathways and clinical decision-making within Western societies, even where healthcare infrastructures are deeply rooted in individual informed consent.

Adult offspring and spouses routinely function as care advocates, information intermediaries, and moral witnesses, and individual family units may diverge significantly in how they prioritize protective concealment, prognostic truth-telling, and mutual accountability during the dying process [21, 33, 39].

Consequently, the core cross-cultural challenge centers not on whether family influence is present, but rather on how that influence is ethically validated, legally structured, and clinically managed within each distinct environment. This reality reinforces the utility of separating Family-as-Root (representing an internal meaning and obligation architecture) from Family-Centeredness (representing an operational care-process framework), rather than oversimplifying cultural groups into a restrictive individualistic-versus-collectivistic dichotomy [10].

Study limitations

This conceptual evaluation has several limitations.

- Interpretive nature: As a fundamentally interpretive undertaking, this study does not offer direct quantitative or empirical data on clinical outcomes specifically tied to "Family-as-Root" or "Family-Centeredness". The defining characteristics, precursors, and downstream outcomes outlined here reflect conceptual judgments derived from the reviewed literature, and alternate interpretive perspectives remain viable.
- Methodological constraints: The implementation of Walker and Avant's framework, while providing procedural transparency, is grounded in a traditionally essentialist paradigm and may not adequately capture the historically shifting, context-dependent evolution of family concepts in end-of-life care environments.
- Linguistic scope: The evidence base was restricted to publications in English and Chinese, indexed in the chosen electronic databases. Consequently, relevant scholarship published in other languages, grey literature, and localized, community-grounded knowledge may have been omitted, particularly regarding Family-as-Root-like dynamics operating outside of Sinitic settings.
- Source selection: The philosophical literature utilized was not systematically compiled via a rigid review protocol but was instead purposively selected, and the researchers' own positionality as scholars deeply integrated within Chinese cultural and clinical systems unavoidably influenced the trajectory of the analysis.
- Scope of empirical referents: The summary of diagnostic evaluation metrics and clinical interventions was intended to be illustrative rather than exhaustive and did not include a comprehensive psychometric review or a formal effectiveness evaluation, thereby limiting the definitiveness of conclusions regarding empirical referents.

Conclusion

This conceptual analysis differentiates "Family-as-Root" and "Family-Centeredness" as two intertwined yet theoretically independent dimensions characterizing family engagement within palliative care settings. "Family-as-Root" marks an ontological-axiological framework in which the family system serves as the foundational source of personal identity, ethical duty, spiritual connectivity, and intergenerational legacy. Conversely, "Family-Centeredness" delineates an operational-interactional paradigm that organizes how healthcare providers engage family networks in communication, medical choice, and care management.

Elucidating their distinct core attributes, precursors, and downstream outcomes—and demonstrating their practical expressions via composite clinical scenarios—proves that conflating these independent paradigms masks pivotal points of friction regarding prognostic disclosure, collective choice models, and traditional ritual practices, particularly within Chinese and other family-oriented cultural spheres.

Concurrently, this evaluation indicates that Family-as-Root and Family-Centeredness can be successfully harmonized within multi-tiered palliative care frameworks that pair robust, family-centered clinical workflows with explicit exploration of the family's broader meaning-making systems. For the nursing profession, this reality establishes an expanded responsibility to interpret cultural values, mediate intra-family communication, and formulate clinical interventions that address both immediate pragmatic demands and deeper existential concerns. Subsequent empirical and cross-cultural investigations should refine, operationalize, and evaluate this dual framework, thereby supporting the evolution of end-of-life care that is not merely family-centered in its procedural execution but also deeply responsive to the family unit as an essential anchor of meaning during terminal illness and mortality.

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