

From Documented Preferences to Decisions That Honor Them: An Integrative Review of Advance Care Planning, Family Obligations, and Institutional Accountability in Culturally Diverse Asian Healthcare Settings

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Abstract

Advance care planning can document treatment preferences before decisional capacity deteriorates, yet documentation alone does not ensure that subsequent decisions reflect those preferences. Across Asian healthcare settings, preference enactment may depend on family participation, clinicians' interpretation, organizational processes, and legal or policy arrangements. To examine how advance care planning preferences are documented, interpreted, mediated by family obligations, and translated into healthcare decisions across culturally diverse Asian settings, with particular attention to conditions associated with concordance or non-concordance between prior preferences and later care. Integrative review using design-sensitive appraisal and transparent review-selection reporting. Six reproducible PubMed-indexed search routes covering 2018–2026 returned 65 records. After removal of 11 within-route duplicate or variant returns and 11 cross-route duplicate publications, 43 unique records entered screening. Ten were excluded at title/abstract screening, 33 reports were assessed, and six were excluded after report-level assessment, leaving 27 included evidence units. Empirical, review, consensus, programme-theory, and legal or policy evidence was integrated while preserving differences in design and context. The literature distinguished preference elicitation and documentation from later enactment. Family involvement could support understanding, communication, and preparation, but could also alter how previously expressed preferences were interpreted or operationalized. Evidence from Taiwan demonstrated that documented preferences could remain non-concordant with subsequent end-of-life care. Across settings, implementation was additionally shaped by communication practices, professional readiness, organizational resources, documentation accessibility, role clarity, and legal or institutional procedures. Advance care planning in Asian settings is best understood as a translation process rather than a documentation event. Honoring preferences depends on how patient-authored wishes are carried through family, professional, organizational, and legal decision processes while preserving distinctions between participation, interpretation, delegated authority, and substitution.

Keywords: Advance care planning, Advance directives, Family decision-making, Goal-concordant care, Cultural context, Institutional accountability

Introduction

Advance care planning (ACP) is intended to help people clarify values, discuss future treatment, identify relevant

decision partners, and record preferences that can guide care when direct participation later becomes difficult. A five-sector Asian Delphi process defined ACP in explicitly relational terms, incorporating patient preferences, discussion with significant others and healthcare professionals, and processes for recording and reviewing decisions [1]. Yet implementation across the Asia-Pacific region remains uneven. Comparative evidence indicates substantial variation in access, organizational support, professional infrastructure, family-led processes, and the extent to which ACP has

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become embedded in routine care [2]. The practical problem is therefore broader than whether a preference has been expressed: the question is whether that preference remains recognizable and influential when an actual decision must be made.

Family involvement is central to this problem. An integrative review of Asian family participation found considerable willingness for relatives to engage in ACP but lower levels of actual participation, with cultural expectations, legislation, communication and knowledge affecting how families became involved [3]. Public evidence across the Asia-Pacific region similarly suggests that favorable attitudes toward ACP can coexist with limited discussion or documentation [4]. These gaps matter because willingness, discussion, written documentation and eventual treatment concordance are different outcomes. Treating them as interchangeable obscures the points at which previously expressed preferences can be reframed, delayed, overridden, rendered inaccessible, or displaced by later relational and institutional processes.

Healthcare professionals and patients also approach ACP with heterogeneous expectations. Asian evidence concerning healthcare professionals identifies knowledge limitations, uncertainty about timing, family dynamics, legal ambiguity and organizational constraints as recurrent influences on ACP practice [5]. Patient-focused synthesis likewise shows variation in willingness to participate, preferred decisional roles, beliefs about illness and death, and the extent to which patients wish relatives or clinicians to participate in future decisions [6]. These findings caution against representing Asian healthcare as a single collectivist alternative to individual autonomy. The analytically important issue is how particular patients distribute decisional involvement, how others interpret that distribution, and whether institutions preserve the distinction between a patient's preferences and the preferences of those assisting with decision-making.

A qualitative study in multicultural Singapore illustrated how ACP is often experienced through family networks rather than solely as an individual-clinician transaction, while also revealing uneven understanding of legal and procedural aspects of planning [7]. Wider East Asian communication research further demonstrates that patient, family and professional roles are shaped by institutional routines, linguistic practices and culturally situated expectations that differ within as well as between jurisdictions [8]. Family-centred practice therefore

cannot be assumed to have a single effect. It may support deliberation and continuity, but it may also create ambiguity about whose interpretation becomes decisive. Japanese work has attempted to address this tension directly. A systematic review of Japanese ACP recommendations emphasized culturally responsive preference elicitation and attention to family relationships [9]. Subsequent consensus work produced a culturally adapted action guideline that retains family-centred engagement while explicitly supporting people who hesitate to express preferences [10]. This combination is important because it separates relational participation from the surrender of patient authorship. Family involvement may be consistent with autonomy when it helps a person formulate, communicate, or enact preferences; it becomes analytically different when family wishes replace those preferences without an authorized basis.

Communication conditions further influence this distinction. A systematic review of end-of-life communication in Hong Kong, mainland China and Taiwan identified cultural expectations alongside training, psychological, legislative and organizational factors affecting professional practice [11]. In Hong Kong, a nurse-led post-discharge ACP programme involving patients and family members improved selected proximal outcomes, including dyadic congruence, decisional conflict and documentation [12]. Such findings demonstrate that structured relational processes can be modified, but proximal improvements do not establish that subsequent treatment will necessarily remain concordant with prior preferences.

The same caution applies to decision-support interventions. A Korean randomized trial found that an ACP video decision aid could improve knowledge and intention to document preferences [13]. A Taiwanese quasi-experimental study similarly reported improved consistency between older adults and surrogates after use of a decision aid [14]. These outcomes are relevant to preparation, communication and interpretation, but they remain upstream from the later clinical moment in which a preference must be retrieved, understood, weighed against current circumstances and translated into action. This review therefore examines the evidence as a sequence of connected but non-equivalent processes: documenting preferences, interpreting them within family relationships, carrying them through changing clinical conditions, and allocating responsibility when institutional processes fail to support their enactment.

Materials and Methods

This integrative review was designed to accommodate heterogeneous evidence concerning ACP in Asian healthcare settings, including quantitative, qualitative and mixed-method empirical studies; systematic and integrative reviews; consensus and guideline-development research; programme-theory work; and substantive legal or policy analysis. The unit of inclusion was a distinct evidence report addressing at least one component of the review question: preference elicitation or documentation, family or surrogate participation, interpretation of prior wishes, implementation or enactment of ACP, concordance between preferences and subsequent care, or institutional and legal accountability for decision processes.

Searches covered evidence published from 2018 through 2026. Six reproducible PubMed-indexed search routes combined terms for “advance care planning,” “advance directive,” or “living will” with Asian regional or jurisdictional terms and concepts relating to family, caregivers, surrogates, concordance, preferences, consent, implementation, institutions, policy, and goal-concordant care. The routes separately emphasized the Asia-Pacific region; China, Taiwan and Hong Kong; Japan and South Korea; Southeast Asian settings including Singapore and Thailand; goal-concordant care; and implementation or policy. Search execution returned 65 records. Eleven within-route duplicate or variant returns were removed, leaving 54 records, followed by removal of 11 duplicate publications appearing across routes. Forty-three unique records therefore entered title and abstract screening.

Eligibility decisions were based on substantive relevance rather than journal prestige. Records were retained when they provided empirical, synthetic, methodological, programmatic, legal, or policy evidence capable of informing the relationship among ACP preferences, family participation, enactment, concordance, or institutional processes in an Asian setting or a directly relevant comparative design. Records were excluded when the Asian setting criterion was not met, ACP was incidental to the reported work, or the publication did not constitute an extractable evidence unit. Ten records were excluded at title and abstract screening. Thirty-three reports were assessed at report level; all were sufficiently retrievable for eligibility assessment. Six were excluded: three lacked a qualifying Asian setting or directly relevant comparative component, two did not provide

extractable evidence on the review's core processes, and one was commentary without a distinct empirical, synthesis, policy, or legal evidence unit. Twenty-seven evidence units remained in the integrative synthesis.

Because the evidence base contained substantially different study designs, appraisal was design-sensitive. Empirical qualitative, survey and mixed-method evidence was assessed with reference to the Mixed Methods Appraisal Tool 2018 criteria, which were developed to permit appraisal across distinct qualitative, quantitative and mixed-method categories without collapsing methodological differences into a single undifferentiated quality construct [15]. Review-level evidence was evaluated for clarity of search and eligibility procedures, appropriateness of appraisal and synthesis, and correspondence between evidence and conclusions. Consensus, programme-theory, quality-improvement and legal or policy sources were interpreted according to their stated design and were not treated as equivalent to controlled empirical evidence.

Reporting of identification, screening and inclusion followed the transparency principles of PRISMA 2020 while retaining the integrative review as the substantive review design [16]. Search and selection numbers were reconciled arithmetically at each stage rather than inferred from the final bibliography. The resulting selection process is shown in **Figure 1**.

Data extraction preserved evidence type and context. For each included unit, information was recorded on country or region, healthcare setting, participants or actors, decision context, focal constructs, definitions or operationalizations, intervention or policy exposure where applicable, measurement or data source, mechanisms or processes, analytical method, temporal design, main findings, contradictory or null findings, stated limitations, and applicability boundaries. Missing information was not inferred.

Synthesis proceeded iteratively. Evidence was first examined within its native design category and then compared across four analytically distinct functions: how preferences were elicited or documented; how family members and other actors interpreted or mediated those preferences; whether and how preferences influenced later decisions or care; and which organizational, professional, legal, or policy conditions shaped enactment. Convergent findings were retained alongside contradictory and context-dependent evidence. Associations were not converted into causal mechanisms, and programme-theory or legal propositions were treated

as explanatory or operational propositions unless independently supported by empirical evidence.

The review also distinguished evidence used directly in the included synthesis from contextual or methodological sources used to clarify measurement, appraisal, intervention logic, or institutional comparison. This prevented broader international findings from being presented as if they were direct evidence about Asian

populations while allowing them to inform interpretation where appropriate.

The resulting evidence architecture differentiates several ways in which a preference can exist before a later treatment decision. **Table 1** summarizes these forms without assuming that recording, interpretation and enactment are interchangeable.

Table 1. Forms through which advance care planning preferences entered later decision processes in the reviewed evidence

Preference representation	What was made explicit	Principal interpretive actor(s)	What the representation could establish	What remained unresolved at the point of later care
Formal directive, DNR order, living will, or equivalent recorded instruction	Specific treatment refusal, limitation, or stated care preference	Patient initially; clinicians and authorized decision partners later	A documented prior expression that can be retrieved and compared with subsequent care	Whether the record is current, available, applicable to the clinical situation, and given appropriate authority
Structured ACP conversation recorded in clinical documentation	Values, goals, treatment priorities, or anticipated decisions	Patient, clinician, and often family	A richer interpretive account than a stand-alone order	Whether later decision-makers preserve the patient's intended meaning
Family- or surrogate-supported preference articulation	Patient preferences discussed or clarified through relational deliberation	Patient and family or potential surrogate	Shared understanding and possible improvement in decisional preparedness	Whether support remains interpretation or becomes substitution
Decision-aid or readiness-based expression	Knowledge, intention, values, readiness, or provisional treatment preference	Patient, sometimes with surrogate participation	Proximal preparation for ACP discussion and documentation	Whether intention or readiness becomes a stable, accessible, clinically actionable preference
Family-integrated ACP encounter	Preferences discussed in the presence of relatives who may later participate in decisions	Patient, family, clinician	Opportunity for anticipatory clarification and mutual understanding	Whether later stress, disagreement, changing circumstances, or institutional routines alter the agreed interpretation
Clinician- or system-mediated ACP record	Preferences entered into a workflow, template, electronic record, or organizational process	Clinicians and healthcare organization	Potential continuity across encounters and teams	Whether the information travels across settings, is reviewed, and governs action when competing pressures arise

The selection arithmetic supporting this review is displayed below.

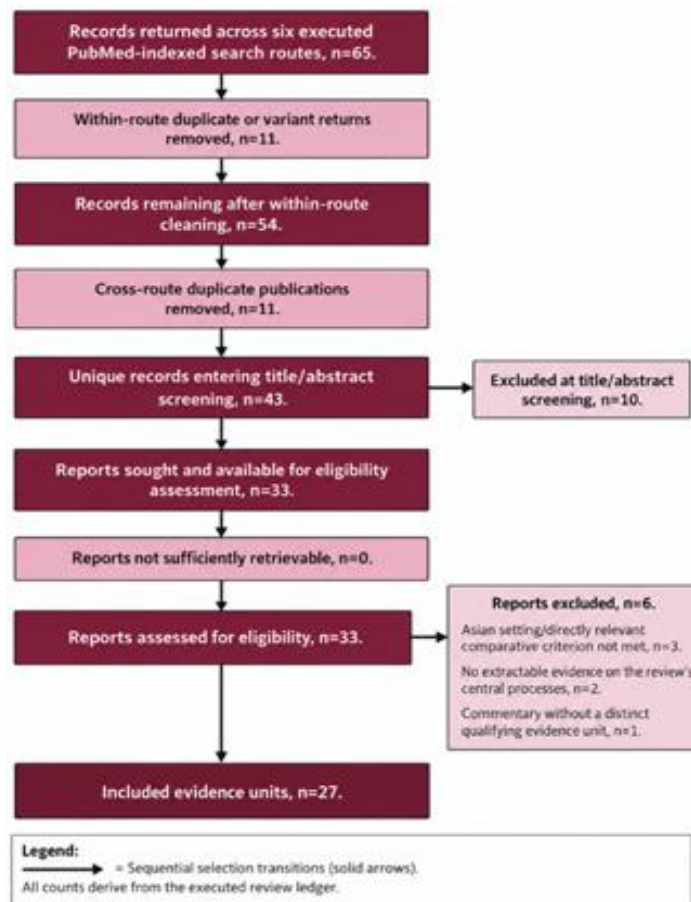


Figure 1. Study-selection flow diagram

Results and Discussion

The included evidence demonstrated that ACP was represented through several distinct forms rather than a single endpoint. Some studies focused on formal documentation, others on readiness, discussion, surrogate understanding, family participation or organizational implementation. This variation was analytically important because evidence concerning intention to complete ACP or agreement during a planning conversation could not be treated as equivalent to evidence showing that later treatment matched a previously documented preference.

Direct evidence of this distinction came from Taiwan. In a longitudinal retrospective cohort of patients receiving palliative shared care, Lee and colleagues identified a subgroup whose end-of-life treatment was non-concordant with previously documented DNR or comfort-care preferences [17]. The study linked non-concordance to relational and interpretive circumstances recorded in the clinical record, including family distress,

incomplete understanding and limitations in patient participation. Because the design was observational, these factors cannot be assumed to have caused non-concordance; nonetheless, the study demonstrates empirically that a documented preference can exist without determining subsequent care.

Dyadic ACP evidence provides a complementary perspective. A systematic review and meta-analysis of dyadic interventions found improvements in outcomes such as advance-directive documentation and communication with clinicians, with possible benefits for patient-caregiver congruence and confidence [18]. These findings support the value of involving potential surrogates before decisional crises arise, but the outcomes remained predominantly preparatory or communicative. They do not establish that dyadic preparation removes later disagreement or institutional barriers.

Culturally adapted interventions similarly showed both potential and limitation. A Japanese feasibility randomized trial of a nurse-physician collaborative ACP

intervention adapted from the Serious Illness Care Program demonstrated that family involvement, trust and culturally responsive communication can be incorporated into a structured intervention [19]. The trial, however, did not meet every feasibility target and was not designed to establish definitive clinical effectiveness. A broader scoping review of ACP decision aids found that such tools commonly support information exchange and value clarification, while feasibility and downstream effects vary [20]. Taken together, these studies indicate that decision support can strengthen preference formation and discussion without eliminating later translation problems.

Readiness evidence reinforces that distinction. A systematic review and meta-analysis found that individuals occupy different stages of readiness depending on the ACP behavior being considered, meaning that readiness to discuss preferences, identify a surrogate or complete documentation should not be collapsed into one construct [21]. A related intervention review reported only modest overall improvement in readiness and judged the included trials to be of low quality [22]. Readiness is therefore useful for understanding where ACP engagement may stall, but it is not a proxy for whether later care honors a patient's wishes.

Preparedness for decision-making also extends beyond the patient. Measures developed for patients and surrogates treat preparedness as a distinct construct involving knowledge, confidence and readiness for future decisions [23]. Although those measurement data were not derived from an Asian population and therefore serve only a contextual role here, Asian professional evidence points to related implementation problems. In a Chinese oncology mixed-method study, nurses described limited ACP communication alongside uncertainty about timing, passive patient or family engagement, professional reluctance and inadequate institutional or policy support [24]. These findings shift attention from preferences themselves to the conditions under which professionals are able and willing to help patients and families interpret and act upon them.

Family involvement produced particularly heterogeneous findings. Chinese oncology nurses described filial norms, family-mediated decision-making, ethical tension, and information or power asymmetries as recurrent challenges in ACP communication [25]. By contrast, a comparative study involving adults in Taiwan and the United States found

that Taiwanese respondents could simultaneously express acceptance of family delegation and concern that family members might not accurately represent their preferences [26]. These findings are not contradictory once delegation and concordance are treated as different concepts: a person may accept a substantial family role while remaining uncertain that relatives will choose as the person would choose.

Stakeholder evidence from Shenzhen further illustrated the distinction between formal authorization and practical enactment. Participants described a gap between the autonomy-supporting intent of living wills and the institutional realities through which such documents are created and later interpreted, including situations in which clinicians or family members may exercise substantial practical influence [27]. Because the study was qualitative and local, it cannot establish the prevalence of these problems across China. It does, however, identify concrete points at which legally recognized preferences can become dependent on organizational procedure and interpersonal interpretation.

Family-integrated ACP may reduce some of these interpretive uncertainties when conducted prospectively. In Japan, a mixed-method feasibility study of family-integrated ACP found that structured conversations could support mutual understanding among patients, relatives and clinicians [28]. At the same time, some participants experienced distress, and the usefulness of family involvement depended on existing relationships and clinician engagement. Family participation therefore functioned as a potentially valuable process rather than an intrinsically protective mechanism.

Temporal stability posed another challenge. In China, a randomized trial of a culturally sensitive ACP game showed immediate improvement in selected engagement-related outcomes, but gains were not maintained at one month [29]. The qualitative component suggested that repeated discussion and family support may be necessary to sustain engagement. This finding is important because it shows that preference-related preparation is not necessarily durable. A plan created or discussed at one point may require reinforcement, review or reinterpretation as health status and family circumstances change.

Organizational variation was also visible in South Korea. A cross-sectional study of nurses across different care settings found differences in ACP awareness and participation, with time constraints, competency, staffing

and role or policy conditions emerging as implementation concerns [30]. These data are associative and should not be read as proving that any single organizational feature causes poor ACP implementation. They nevertheless indicate that professional willingness alone is unlikely to determine whether planning becomes routinized.

Across the Results evidence, three recurring distinctions emerged. First, preference expression, documentation and later enactment were empirically separable. Second,

family participation varied in function, ranging from support for communication and mutual understanding to situations in which relatives became powerful interpreters of what prior preferences meant. Third, organizational conditions influenced whether ACP remained usable over time, including documentation systems, role clarity, professional preparedness, opportunities for review and institutional support. These distinctions informed the comparison of family and institutional processes summarized in **Table 2**.

Table 2. How family obligations and institutional processes could alter the path from documented preference to later decision

Decision-process situation	Family function observed or implicated	Institutional function observed or implicated	What could preserve patient-authored meaning	Principal risk to enactment
Preference discussed before serious deterioration	Participation, clarification, emotional preparation	Time, trained facilitation, documentation support	Repeated patient-led explanation and explicit clarification of the desired family role	Discussion remains informal or is not retrievable later
Preference documented in an advance directive, DNR order, or equivalent record	Awareness of and interpretation of prior wishes	Accessibility, applicability review, clinician recognition	Clear record plus opportunity to confirm that family members understand its intended meaning	Record exists but is inaccessible, considered outdated, or displaced in practice
Surrogate expected to participate in later decisions	Representation, interpretation, delegated decision support	Identification of legitimate decision role and escalation procedures	Prior discussion about values and the scope of surrogate authority	High family involvement is mistaken for accurate representation
Family distress or disagreement arises during deterioration	Emotional support, advocacy, reinterpretation, or contestation	Clinician mediation, ethics support, conflict-management pathways	Explicit distinction between patient preference, family concern, and authorized substitution	Family distress changes the practical decision without clear justification
ACP requires transfer across teams or settings	Family may supply continuity where records do not travel	Information systems, handover practices, role accountability	Accessible and reviewable documentation across transitions	Fragmentation separates the preference from the later decision
Preference becomes clinically ambiguous because circumstances changed	Relational knowledge of values and prior reasoning	Structured reassessment and documentation update	Re-evaluation anchored in the patient's values rather than simple literalism	Either rigid adherence to an outdated instruction or unsupported replacement by others' preferences

The reviewed evidence also varied in where disagreement or non-concordance appeared. Some studies located difficulty early, in awareness, readiness or willingness to discuss ACP. Others identified problems during documentation or interpretation, while the Taiwan cohort demonstrated divergence at the later treatment stage. Still others located the problem in

institutional conditions such as staffing, policy, record accessibility or role definition. **Table 3** therefore organizes the evidence according to the point in the ACP-to-decision process at which enactment could become vulnerable, while preserving the distinction between observed findings and later interpretive synthesis.

Table 3. Points of convergence and divergence across culturally diverse Asian evidence

Point in the ACP-to-decision process	Convergent pattern across evidence	Important divergence	Practice or policy problem exposed
Awareness and readiness	Positive attitudes toward planning did not consistently translate into completed discussions or documentation	Readiness varied by behavior, population and intervention exposure	ACP systems cannot assume that favorable attitudes equal preparedness for specific actions

Preference elicitation	Structured conversation and culturally adapted support could improve knowledge, expression or dyadic understanding	Some patients preferred active involvement; others accepted substantial family or professional participation	Elicitation must identify both treatment preferences and the patient's preferred distribution of decisional roles
Documentation	Formal records and structured documentation created a retrievable statement of prior wishes	Documentation quality, accessibility and perceived applicability varied	Recording systems require mechanisms for retrieval, review and updating
Family participation	Family involvement frequently supported communication, understanding and anticipatory preparation	Family mediation could also introduce uncertainty about alignment or create ethical tension	Institutions need to distinguish supportive participation, authorized delegation and unsupported substitution
Professional implementation	Clinicians and nurses generally recognized ACP as important	Timing uncertainty, reluctance, workload, competency and policy gaps affected practice	Responsibility cannot be allocated solely to individual clinician motivation
Later enactment	Prior discussion and documentation provided a basis for subsequent decisions	Documented preferences did not invariably produce concordant end-of-life care	Accountability must extend to the processes that carry a preference into an actual decision
Maintenance over time	Repeated engagement and family or professional support could reinforce ACP	Intervention gains and expressed readiness could diminish, while health circumstances changed	ACP requires review and continuity rather than treatment as a one-time completed task

Integrative synthesis of advance care planning, family obligations, and institutional accountability

Across the reviewed evidence, the central challenge was not simply whether advance care planning occurred, but whether a preference retained its meaning and practical authority as it moved from an earlier planning encounter into a later clinical decision. A mixed-method systematic review of experiences across patients, families, and healthcare professionals identified family involvement, empowerment, and integration into routine care as recurrent features of successful ACP processes [31]. Evidence from Chinese long-term-care facilities extended this observation by identifying organizational leadership, staff preparation, resources, resident readiness, and culturally responsive communication as interdependent preconditions for implementation [32]. These findings locate ACP within a cross-level process in which interpersonal understanding and organizational capacity operate together.

This distinction becomes clearer when documentation systems are considered. Health-system improvement programmes outside Asia have combined technical solutions—such as structured documentation, electronic record tools, and workflow prompts—with adaptive changes involving clinician behavior, role expectations, and organizational coordination [33]. A separate health-system initiative likewise showed that ACP documentation can be increased through institution-wide infrastructure rather than relying only on individual clinicians [34]. These studies cannot establish that identical interventions would produce the same results in Asian systems. Their relevance is narrower: they

demonstrate that whether a preference remains visible and actionable depends partly on organizational arrangements that extend beyond the original patient-clinician conversation.

The reviewed Asian evidence also shows that family influence is embedded in wider social relationships rather than reducible to a simple individual-versus-family contrast. In Japan, religious and community motivations were associated with ACP discussion and were interpreted through participants' experiences of reflection and shared meaning [35]. In China, caregivers could be highly involved in ongoing cancer care while still reporting limited ACP awareness, confidence, or support for acting as future surrogates [36]. Family presence therefore does not necessarily imply preparedness to interpret a patient's prior values accurately. Relational closeness, practical caregiving, and decisional readiness are related but analytically distinct.

Kin structure may further affect how preferences are operationalized. A Singaporean mixed-method study found that childlessness and available social networks shaped formal and informal approaches to future care planning [37]. This does not mean that people without children are intrinsically disadvantaged; rather, it shows that the availability and composition of potential decision partners can change the practical route through which an ACP preference is carried forward. Legal and procedural arrangements become especially important when those routes are contested. A recent China–Korea analysis of conflicts between advance directives and family consent proposed explicit procedures for identifying applicable directives, clarifying surrogate roles, and managing

disagreement [38]. Because this work is normative and doctrinal rather than an outcome evaluation, its proposed workflow should not be interpreted as clinically validated. It nevertheless highlights a question that empirical ACP research often leaves implicit: who is responsible for resolving conflict when prior documentation, family wishes, and current clinical judgment diverge?

The integrative synthesis generated from these findings distinguishes four linked functions. First, preference authorship concerns what the patient actually expressed, including values, treatment wishes, desired family involvement, and any delegation of future authority. Second, relational interpretation concerns how family members, surrogates, and clinicians understand and communicate those preferences. Third, clinical translation concerns whether an earlier preference remains applicable to the patient's present condition and is incorporated into the actual decision. Fourth, institutional stewardship concerns whether organizations provide the records, handovers, role definitions, review procedures, conflict-management processes, and professional support needed for the first three functions to operate reliably.

These functions should not be treated as sequential guarantees. A well-documented preference may still be unavailable at the point of care; an informed family may still disagree; a surrogate may understand the patient's

values but be uncertain how to apply them to an unforeseen clinical situation; and a clinician may recognize a prior preference but work within an organization lacking a clear process for escalation. The Taiwan non-concordance evidence illustrates the downstream consequence of such discontinuities [17]. The Chinese oncology evidence shows how communication and organizational uncertainty can arise earlier in the process [24]. The Chinese long-term-care programme theory suggests that implementation depends on organizational readiness as well as interpersonal engagement [32].

The synthesis therefore supports a proposed distinction between participation and decision displacement. Family participation can include listening, clarification, emotional support, interpretation of values, or patient-authorized delegation. Decision displacement occurs when another actor's preference becomes practically decisive without a clear basis in patient authorization, current incapacity rules, clinical applicability, or legitimate surrogate responsibility. The reviewed studies do not permit estimation of how frequently displacement occurs across Asian healthcare systems. They do, however, show that participation and influence vary sufficiently that the two concepts should not be conflated.

Table 4 integrates these functions while retaining their different evidentiary status.

Table 4. Conditions that connect documented preferences with later decisions

Translation function	Patient-authored content that must remain identifiable	Family or surrogate role	Clinical or organizational requirement	Failure pattern exposed by the evidence	Evidence status
Preference authorship	Values, treatment wishes, acceptable outcomes, desired degree of family involvement	Support expression or receive authorized delegation	Record preferences clearly and review them when circumstances change	ACP is discussed but remains vague, provisional, inaccessible, or outdated	Directly supported across consensus, intervention, and observational evidence
Relational interpretation	Intended meaning of the patient's prior expression	Clarify values, provide contextual knowledge, or represent previously authorized wishes	Distinguish support, interpretation, delegation, and independent family preference	High family involvement is assumed to equal accurate representation	Directly supported, with substantial contextual variation
Clinical translation	Applicability of prior wishes to the current decision	Contribute relevant knowledge without automatically replacing the patient's preference	Retrieve documentation, assess applicability, communicate uncertainty, and reconcile changing circumstances	Prior wishes are known but do not govern the treatment actually delivered	Directly supported by non-concordance and implementation evidence
Institutional stewardship	Continuity of the patient's previously expressed values across settings and time	Participate within a clearly defined decision structure	Provide accessible records, role clarity, trained staff, review processes, handovers, and escalation routes	Responsibility becomes fragmented among individual clinicians, families,	Supported by implementation evidence; some cross-level relationships remain proposed

				services, and legal processes	
Conflict resolution	Patient-authored preference plus any valid delegation of authority	Express concern, interpretation, or authorized surrogate judgment	Separate disagreement from legitimate substitution and provide formal escalation where needed	Family preference, clinical judgment, and prior documentation remain unresolved	Empirical evidence identifies conflict conditions; specific accountability pathways are partly proposed

The cross-level relationships generated by this synthesis are represented in **Figure 2**.

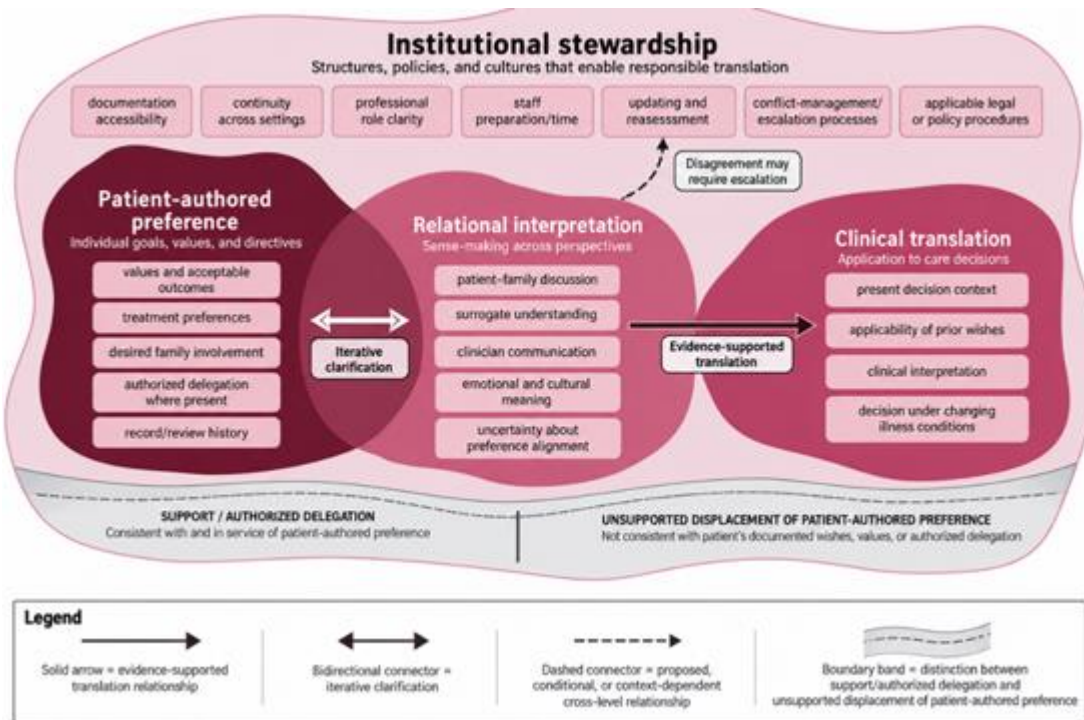


Figure 2. Integrated conceptual synthesis

This review indicates that ACP in culturally diverse Asian healthcare settings cannot be evaluated solely by whether discussions occurred or documents were completed. The stronger question is whether patient-authored preferences retain sufficient clarity, accessibility, and authority to influence later decisions. Evidence from Taiwan directly demonstrates that prior preferences and actual end-of-life care can diverge [17]. Other studies identify upstream conditions that may contribute to such divergence, including uncertain timing, limited professional preparedness, family-mediated communication, inaccessible or incomplete implementation processes, and changing clinical circumstances [24].

Family involvement is therefore best understood as functionally variable. The Asian family-participation

review shows that relatives commonly occupy important ACP roles [3]. The Hong Kong trial indicates that structured dyadic participation can improve selected communication and concordance-related outcomes [12]. Japanese family-integrated ACP evidence suggests that such participation can promote mutual understanding while also producing distress for some participants [28]. Chinese caregiver evidence further shows that practical caregiving involvement does not necessarily imply preparedness to act as a surrogate in ACP [36]. These findings argue against classifying family involvement itself as either a facilitator or barrier. Its implications depend on the role authorized by the patient, the family's understanding of the patient's values, the decision context, and the institutional processes governing disagreement.

Institutional accountability becomes especially important when ACP documentation exists but cannot reliably shape care. Comparative implementation evidence shows substantial variation in organizational and national support [2]. Korean nursing evidence identifies time, competence, staffing, and role conditions associated with ACP practice [30]. Chinese programme-theory work places leadership, resources, professional preparation, and culturally appropriate communication among the preconditions for sustained implementation [32]. Legal and procedural analysis from China and Korea further illustrates that conflict between an advance directive and family wishes can require explicit rules for determining applicability, authority, and escalation [38]. Taken together, these sources suggest that responsibility for honoring preferences cannot reasonably be assigned only to the clinician at the bedside.

Several limitations constrain the synthesis. The Asian evidence base is geographically uneven, with substantial contributions from China, Taiwan, Japan, South Korea, Hong Kong, and Singapore and less evidence from many other Asian jurisdictions. Reviews and primary studies also use different definitions of ACP, readiness, engagement, family participation, documentation, concordance, and implementation. Healthcare systems and legal arrangements differ sufficiently that jurisdiction-specific findings should not be generalized across the region. Intervention evidence is heterogeneous, and some readiness evidence is of limited methodological quality [22]. Programme theories and legal frameworks illuminate possible mechanisms and accountability arrangements but do not establish that those mechanisms causally produce more preference-concordant care [32].

The principal contribution of the integrative synthesis is therefore conceptual but evidence-bounded: ACP effectiveness should not be inferred from documentation alone. The clinically meaningful outcome is produced through a chain of interpretive and institutional work extending from preference authorship to relational understanding, clinical applicability, and organizational stewardship. Each link can support continuity, but each can also introduce a different form of uncertainty.

Implications for practice and policy

Clinical practice should document more than a treatment preference. ACP records should, where feasible, identify the patient's underlying values, the intended role of family members or surrogates, and whether decision

authority has been delegated for particular circumstances [1]. Documentation should also be reviewable as illness trajectories and relationships change. The Taiwan evidence on non-concordant care shows why a prior order cannot be treated as self-executing [17].

Family participation should be supported deliberately rather than assumed. Relatives may need opportunities to hear the patient's reasoning, clarify uncertainty, and understand the limits of their future role [3]. Where patients explicitly authorize substantial family involvement, practice should preserve that choice. Where family concerns differ from a documented patient preference, clinicians should distinguish emotional or interpretive disagreement from legitimate surrogate authority.

Healthcare organizations need mechanisms that preserve ACP across transitions. These include accessible documentation, clear professional responsibilities, routine review, staff preparation, handover processes, and escalation routes when disagreements cannot be resolved at the bedside [30]. Such infrastructure should be adapted to local legal and cultural conditions rather than imported as a uniform model. Programme-theory evidence from Chinese long-term-care facilities suggests that organizational commitment and resources are integral to implementation rather than peripheral supports [32].

Policy should similarly avoid framing ACP as the completion of a form. Where legal recognition of advance directives exists, operational guidance is still needed for locating records, determining applicability, clarifying surrogate roles, documenting departures from prior preferences, and resolving conflicts [38]. Accountability is strongest when institutions can explain how a patient-authored preference was interpreted and why the eventual decision was considered consistent—or necessarily inconsistent—with it.

Conclusion

Advance care planning can preserve patient preferences only when those preferences remain interpretable, accessible, and actionable at the point of later decision-making. Across culturally diverse Asian healthcare settings, family participation may strengthen understanding and continuity, but it may also alter how preferences are interpreted when roles, authority, or alignment are unclear. Documentation therefore represents the beginning of an implementation problem

rather than its completion. The evidence supports a conditional conclusion: decisions are most likely to honor prior preferences when patient authorship is preserved, family roles are explicitly understood, clinical circumstances are reassessed, and healthcare institutions accept responsibility for carrying preferences reliably across time, settings, and conflict.

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