

# End-of-Life Communication Among Chinese Elderly in a Malaysian Nursing Home

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## Abstract

Religion and culture play important roles in influencing end-of-life communication among the elderly. However, little is known about end-of-life communication among elderly nursing home residents. A qualitative study involving a sample of 13 elderly residents of a non-government nursing home in the north of Peninsular Malaysia was conducted to investigate residents' attitudes and ideas about their end-of-life preferences. Thematic analysis was performed to identify major themes emerging from the interviews. This study found that elderly residents actively avoided end-of-life communication, but that their cultural and religious beliefs remained of paramount importance. It is hoped that these findings will provide a platform upon which to improve current nursing home care in Malaysia.

## Keywords

end-of-life communication, culture, religion, nursing home and elderly

## Introduction

In traditional societies like Malaysia, children are often expected to take care of their aging parents. However, rapid economic development, greater life expectancy, and changes in family dynamics and migration have increased the demand for nursing home care (1). Moreover, these societal changes can impinge upon the ability of families to take care of their elderly members, especially when the elderly person presents with mental and physical disability (2). Families may be unable to provide an appropriate level of care due to their working hours. Similarly, the family may be unable to provide care commensurate with the level of disability experienced by elderly person. Consequently, the number of aged care nursing homes has increased to support the needs of the elderly who, for one reason or another, cannot be cared for at home by their family (3). Approximately 1 in 5 Malaysians is expected to be aged 60 or over by 2040, thus making Malaysia home to an aging population (4).

Per the recommendations of the World Assembly on Aging 1982 in Vienna, The Malaysian Ministry of Women, Family and Community Development used the term "aged" that applies to anyone aged 60 years or older, regardless of their ethnicity or religious beliefs (5). Elderly people who reside in nursing homes often have a plethora of age-related health-care problems and require more medical/nursing attention than can be provided in the home (6). As such,

nursing home residents often require a wide range of end-of-life (EOL) care that encompasses symptom control and psychosocial and spiritual support from their health-care providers (7,8). End-of-life communication is a fundamental component of EOL care. End-of-life communication involves the health-care provider working to facilitate the patient's acceptance of death and dying and promoting the well-being of their patients through ongoing conversations that acknowledge the fundamental realities of the patient's health status (9). This includes frank discussions with the patient about the benefit versus burden of prolonging life, to whatever extent that is acceptable to the patient (9). The main goal of EOL communication is to encourage patients and carers to make decisions about their EOL treatment preferences and funeral arrangements (10).

In addition, EOL communication provides an opportunity for elderly nursing home residents to cope with their situation, plan, and make decisions regarding their treatment options in relation to palliative care and funeral arrangements (11). End-of-life communication enables the

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elderly and their family to plan ahead and to prepare for the provision of EOL care consistent with the elderly person's values and beliefs (12). Failure to communicate EOL preferences contributes to greater health-care spending, more unwanted hospital admissions, and reduced patient and family satisfaction (13). These discussions enable physicians and other health-care professionals to assess the elderly resident's preferences regarding their goals of care, to assess and relieve distressing symptoms, and to properly address psychological and existential issues raised by the approach of one's EOL (14).

Notwithstanding, there are situations in which the elderly may be unable to communicate their EOL care preferences. According to the literature, elderly nursing home residents often lack the autonomy to make independent decisions about their EOL care and preferences (15,16). Many elderly, especially those residing in nursing homes, are dependent upon other people, such as health-care providers and family members, for decision-making purposes. In addition, financial constraints can also contribute to the inability for the elderly to plan and make decisions regarding their EOL care, treatment, and funeral arrangements (17). An inability to pay can limit the elderly person's range of EOL care choices.

Other factors impacting the EOL decision-making of elderly people is age-related dementia and cognitive decline. Up to 48% of elderly nursing home residents in Norway were found to be unable to make independent decisions regarding their EOL care preferences in their late stages of life. Moreover, over 80% of elderly nursing home residents suffer from dementia (18). This limits their ability to express their preferences with regard to EOL care. In light of the physical decline and loss of cognitive abilities associated with dementia, the elderly person becomes increasingly dependent upon other people to make EOL care decisions on their behalf.

The timely communication of EOL preferences can facilitate appropriate decision-making about what EOL care and treatment should be provided (10). Timely EOL communication brings together the elderly resident, family members, nursing home staff, and other health-care providers to develop an individualized EOL care plan that acknowledges and is consistent with the elderly person's values and treatment preferences (19). For many individuals, their EOL preferences are influenced by their religious and cultural traditions (20). Notwithstanding, in some cultures, discussions related to death and dying are taboo subjects, thus making it difficult for the elderly to express their EOL care preferences (21).

According to a 2010 population census, Malaysia is home to 26 million people. This figure can be subdivided into various ethnic groups, including Malays and Bumiputera (67.4%), Chinese (24.6%), Indians (7.3%), and others (0.7%). Moreover, the 2010 census indicates that there were approximately 2.2 million Malaysians aged 60 years and above in 2010, with 56.9% being Malays/Bumiputera, 35.6% Chinese, 6.9% Indian, and 0.5% others. Interestingly, although the Chinese elderly is ranked second in the whole

population, the ratio indicates that 1 out of every 8 ethnic Chinese in Malaysia is considered aged. This proportion is significantly higher as compared to other races in Malaysia. The higher rate of aging among Chinese Malaysian is due to their lower rate of fertility, longer life expectancy, and emigration of Chinese younger population (22). In addition, Chinese elders are in the higher proportion to live in nursing homes in Malaysia (23). These demographics underscore the importance of studying elderly Chinese Malaysians, especially in relation to their EOL care preferences.

A review of the related literature found that EOL communication among elderly Chinese was poorly understood (24). Among Chinese families, the preservation of their cultural and religious beliefs is considered of paramount importance to their decision-making process. Discussions related to death and dying are considered taboo subjects for conversation in Chinese culture, potentially inviting bad luck (25). It is commonly believed that an open discussion about dying will hasten one's death (24). In addition, there are also fears that EOL discussions may be perceived of as upsetting, unsympathetic, or disrespectful to others. However, Chinese cultural traditions can also prove to be a rich source of beliefs and rituals with which to open a door to these discussions (26). Most Chinese cultural traditions evolved out of Taoism, Confucianism, and Buddhism. These are the 3 main philosophies that have influenced the thinking and livelihoods of ethnic Chinese for thousands of years (27). As such, traditional death rituals are seen as respectful events in which all members of the family participate.

According to a traditional Confucian interpretation, it is considered as a violation of the principle of filial piety among a child who agrees to a parent's refusal of treatment (28). Based on the Confucian teachings, it is important to avoid from anybody mutilation. Confucian writing describes "our bodies, skin and hair come from our ancestors. No one is permitted to damage them at all" (29). In addition, the Chinese cultural believes in the right to choose death in the face of suffering (30). Among Chinese, passive euthanasia is approved to prevent from suffer. However, these beliefs may be unfavorable in a medical setting. In the medical setting, live-saving and life-sustaining treatment may be options to safe patient's life with a consent from their family. However, in certain circumstances, these treatments will be given without any consent in emergency cases (31). The inequality in end-of-life treatment preferences may lead to greater medical expenses and reduce the patients and family satisfaction (13). Therefore, EOL communication is vital.

However, EOL communication among elderly nursing home residents is scarcely discussed. This is especially true in the Malaysian context. The aim of this study was to investigate the experience and perception of EOL communication among Chinese elderly nursing home residents in Malaysia. This study is necessary to enrich the EOL communication literature, especially in relation to the influence of culture among elderly Chinese Malaysians. In addition,

the findings of this study may be of benefit to the many health-care providers who work with the elderly and who must consider EOL communication a necessary component of their work to improve the provision of services to the elderly. Facilitating EOL communication is essential to encouraging a better quality of life among elderly Malaysian nursing home residents.

## Methods

This exploratory qualitative study involved a sample of 13 elderly residents at a nursing home in Penang, Malaysia. All of the respondents were Chinese. This study was granted ethics approval by the internal board of Social Work from Universiti Sains Malaysia. In addition, approval for this study was sought and provided by the board of directors of the nursing home. Purposive sampling was used to identify potential respondents. The criteria for participation in this study were that respondents had to be aged 60 years or above and be living full time in the selected nursing home. Residents with mental disorders, such as dementia, or with life-threatening physical conditions were excluded from participation. This exclusion criteria were established to ensure the accuracy of data collection and to prevent any complications postinterview, thus ensuring that respondents were protected from any harm that might eventuate via their participation in this study.

The researchers invited nursing home residents to participate by making an announcement at the nursing home canteen during lunch to welcome any of the residents who might be willing to participate in the study. The objectives and rationale of this study were explained in detail. Potential respondents who were interested in participating in the study were asked to meet the researchers in person. Upon meeting potential respondents, the researchers explained that this study relied on voluntarily participation. As such, respondents were reminded that they were free to decline to answer any questions that they found to be irrelevant and were free to withdraw from the study for whatever reason without consequence. Once the respondents had agreed to participate in the interview, they were asked to sign an informed consent form. The informed consent document further clarified the objectives and rationale of the study. The researchers also provided a verbal account of this information and provided respondents with their contact details so that they could discuss any aspect of the study postinterview with the researchers.

The interview schedule utilized open-ended questions to elucidate a deeper understanding of the topic. Questions were related to elderly residents' attitudes toward EOL and their ideas about EOL communication. Cantonese and Mandarin languages were used throughout the interview. The respondents were free to request further explanation at any stage during the interview. Interview sessions were audiotaped. Each interview session took approximately 45 to 60 minutes. The interviews were held in the garden in the

nursing home. This venue was chosen based on the respondents' request. Moreover, the garden provided a simultaneously comfortable yet private venue for the interview sessions. The researchers kept an interview journal and incorporated their personal reflections, impressions, and observations into the analysis.

## Data Analysis

The researchers listened to the tape recordings of the interviews while transcribing the audio verbatim into text. The researchers listened to the recorded interviews several times over to ensure the accuracy of the transcriptions. Thematic analysis was used to analyze the qualitative data. This systematic process helped the researchers to gain a deeper understanding of, and empathy toward, the persons being interviewed; moreover, this process allowed for the identification of themes relevant to the population under investigation (32). These themes were then coded, with both researchers engaged in the same process, after which the researchers compared their themes/codes to ensure the accuracy of their thematic analysis. The themes that emerged throughout the interviews were also validated by the coauthor, who has experience in conducting research related to EOL and bereavement.

To triangulate the data, we applied analytic approach (33). Two additional experts, with expertise in qualitative research and EOL communication, were consulted to provide their perspectives on the data and to provoke critical thinking. These experts were external to the study, thus ensuring that their input was kept free of any unbiased.

## Results

### *Respondent Demographic Characteristics*

Thirteen elderly nursing home residents participated in this study. Table 1 illustrates the sociodemographic characteristics of the respondents. In sum, all respondents in this study were ethnic Chinese. Female respondents dominated the sample, and the majority of respondents were married, ranging in age from 60 to 80 years and above. Almost half the respondents in this study identified as Buddhists and most of the respondents had completed secondary school as their highest level of education. All of the respondents were retired and were financially dependent upon their family. Almost half the sample had a total family monthly income of less than RM2000 (approximately US\$500) per month. Most of the respondents had experienced the loss of a close family member.

Thematic analysis allowed for the identification of a number of themes related to EOL communication. These themes were analyzed according to the respondents' self-report or narratives. The first objective of this study was to investigate the elderly residents' attitudes toward EOL. The second objective was to analyze respondents' perceptions surrounding EOL communication.

**Table 1.** Respondent Demographic Characteristics.

Demographics	n = 13	%
Gender		
Male	6	46.2
Female	7	53.9
Age		
60-70	9	69.2
70-80	3	23.1
>80	1	7.70
Ethnicity		
Chinese	13	100
Religion		
Buddhist	6	46.2
Taoism	1	7.70
Christian	4	30.8
Omnist	1	7.70
Free thinker	1	7.70
Marital status		
Single	5	38.5
Married	6	46.2
Widow	2	15.4
Level of education		
No formal education	1	7.70
Primary school	5	38.5
Secondary school	7	53.9

### End-of-Life Communication Experiences

All respondents reported not having any ideas about or experience discussing their EOL preferences. The 2 salient themes that emerged in relation to this were lack of knowledge about EOL and the idea that death was a taboo subject.

*Never thought about EOL preferences.* Each of the respondents indicate having no knowledge in relation to how to go about communicating their EOL. Five of the respondents believed that decisions regarding their EOL care and funeral should be left to their family because they themselves had no control over their own death. Respondent 1 (R1) shared,

Ideally, these end-of-life decisions should be left with your family, because they know your wishes and can fulfil them in the way you want when your life ends. [Laugh] Die in your own way . . . You see, we can prepare and cope with the cycle of life, from birth, growing old and sickness, but when comes to death-how many of us able to die in our own way? [Frown] No . . . your body might belong to you, but how you die and what happens next is for others, especially your family.

*Taboo to discuss death.* Four of the respondents described having cultural beliefs that prohibited them from discussing their EOL. R7 shared,

Culturally, among us Chinese, death or end-of-life decision making is a taboo subject and it is forbidden to have an early conversation about these matters when the person is still healthy

and alive. We believe that to initiate a conversation about the end-of-life too early will curse the person and is disrespectful. We usually don't want to face this issue until the very last moment. In my case, I started to consider this issue shortly after my husband's death.

Owing to their religious beliefs, 3 of the respondents believed that the EOL was something written by God and thus outside their sphere of control. These respondents indicated that anything that happened to them was somehow related to the law of karma. R9 shared,

We believe in an afterlife and that our present life actions will mirror our next life destination. Before, I didn't believe in any of this superstitious stuff. But attending a Buddhist camp, I began to think about and regret all the sin that I had committed before. Back then, I used to work as a butcher. I killed many animal lives. You see, now I'm unable to move and even lost my grandson.

### Perceptions of EOL Communication

There were 5 themes that emerged in relation to the study's second objective, which revolved around respondents' perceptions of EOL communication with other people. These themes included taboo and religious beliefs, ideal funeral planning, dignity and life after, EOL decisions made by other people, and the need for open discussion.

*Taboo and religious beliefs.* Four respondents reflected upon their concerns that it was bad luck to discuss EOL. These concerns are consistent with the Chinese belief that it is bad luck to discuss issues related to death. R8 shared,

No, [frown] in fact this kind of issue (EOL planning) shouldn't be discussed openly as it is a taboo subject and not something we can discuss openly. I can't tell you why, but like I said just now, you can't simply open-up and discuss this thing. You might not know, something bad might happen after the discussion.

Three of the respondents shared their perspectives on the importance of believing in God rather than discussing EOL. These respondents believed that doing good deeds would help them to achieve a better EOL experience than anything they could plan for. R1 reported,

I am a Buddhist and we believe in karma. No matter how well we plan for a better end-of-life, our past actions affect us. What I have gone through in this present life reflects my actions in the past [pause]. I think I must have done something bad in the past, that's why I lost my husband 20 years ago. But to think about it another way, I might have done some good deeds, that's why I have been placed here, in this nursing home, with free shelter, food and people to take good care of me.

**Ideal funeral planning.** Seven respondents reported that it would be preferable if they could plan their own funeral rather than have to leave it to other people. R3 shared,

Deep inside my heart, I have already made a series of end-of-life decisions. After all, they [healthcare providers] are the outsiders; they aren't in charge of my personal end-of-life decisions. I won't change my mind, regardless of what advice these experts want to offer. A decision is a deal, and I won't change.

Six of the respondents reported having already made some plans about their funeral ceremony. Although Chinese people usually prefer huge funeral ceremonies, some respondents believed that it was better to have a simple funeral ceremony rather than having more complicated funeral rituals. R3 shared,

I hope my funeral will be a simple one. I had a bad experience once attending a complicated funeral ritual. It only portrayed and amplified death as something very scary.

The respondents mocked the idea of having a huge funeral ceremony as a waste, arguing that a lavish funeral would not help to improve their situation or personality. R6 stated,

All these arrangements are a waste. Will a RM40 000 or RM100 000 funeral ceremony boost up your personal character? No way! People will just say, 'Well, all he has is just money; what else can he own or be good at?' It is pointless! It says a lot about your personal character and is what makes a funeral meaningful when all your family and friends come and pay their last respects to you.

Although the respondents in this study planned to have simple funeral ceremonies, they still wanted to follow their religious traditions. According to R1, *It will be a Buddhist funeral ceremony, but not a fancy one.*

**Dignity and life after.** Five respondents described wanting to avoid lifesaving treatments at the end of their lives. Cardiopulmonary resuscitation (CPR) was described as an unacceptable lifesaving treatment. Some respondents described fearing unbearable pain and acknowledged that no one was immortal; as such, respondents argued that it was preferable to let them to die than to keep them alive with aggressive lifesaving treatments. R3 shared,

CPR... that might cause a fracture and I imagine the pain must be unbearable. If my time [death] has come, why should I undergo this kind of treatment? Moreover, lifesaving treatments are very costly. Everyone must face death eventually. No one in this world is immortal.

Three respondents reported wanting to avoid lifesaving treatments because they preferred to die with dignity. Respondents described dignity in terms of having a life or

death without being dependent upon others and not a burden on others. R1 said,

Don't wake me up when I die. Just imagine when you wake up, you might find yourself paralyze. What's the point of living when paralyzed? You're only surviving for your friends and love ones. I don't want that, that's suffering.

Each of the respondents was positive about wanting to donate their organs. Respondents believed that despite being dead, they could still do something good in this world by donating their organs. According to R5,

I would be OK to become an organ donor, because as the Chinese proverb says "Being born brings nothing nor shall death carry anything away." If my organs can help people in need, why not?

**End-of-life decisions made by other people.** Despite respondents having EOL plans of their own, 6 of the respondents reported that a family member should be empowered to make important decisions on their behalf in critical situations. R3 said,

I will include them in the process of making decisions, but I prefer to be the primary decision-maker myself. Their suggestions will serve as reference, but at the end, the final decision will be up to me. But if all of a sudden I should turn terribly sick and lose consciousness, my family member will have to decide on my behalf.

Similarly, R10 shared that EOL discussions could potentially cause disharmony or discomfort in loved ones. However, in a critical situation, R10 believed that her husband probably knew her preferences,

We don't really discuss end-of-life decision making openly. You see, Chinese custom emphasises the need to handle issues in a harmonious way. If you openly discuss this topic, it might cause loved ones to experience uncomfortable thoughts and feelings. I told my husband about some of my thoughts regarding end-of-life planning. He is my life partner, we have gone through so much. He knows what I want. Both of us keep it as a secret from our children; until the day finally comes, only then will my husband help me reveal my wish. It works both ways; same goes for my husband [smile]. I have a habit on keeping diaries of family interactions or family occasions. I hope my family will stay strong and move on with those memories [smile].

In addition, 3 respondents were staying in the nursing home because they had no family at all. These respondents tended to nominate close friends as important people who could be approached to help them with EOL decision-making. According to R8,

I would say “yes” to include my friend [chuckle]. If I am terminally ill, I might be unconscious or be unable to speak. So my friend will be my keeper, making decisions on my behalf. I will accept any decisions he makes on my behalf.

Six respondents reported entrusting decisions-making regarding their EOL care to their health-care providers. The health-care providers could assist the respondents’ families with future planning and decision-making. R10 shared,

The doctor will be the primary person I refer to. His words are kind of a judgement day for me in terms of facilitating end-of-life communication with my family. The nurses might also help me shoulder some of the emotional burden of hospitalization.

Nevertheless, 4 respondents believed that their financial dependency meant that they were obligated to rely on others for EOL decision-making. These respondents were loath to burden other people with their funeral arrangements. R11 said,

Now, I am total dependent upon other people. I’m living on other people’s hard earned money. I don’t like to trouble people. Our deaths shouldn’t burden those around us.

*The need for an open discussion.* Although none of the respondents had ever discussed their EOL plans previously, they believed that the discussion was therapeutic. Nine respondents shared their positive feelings after the interview. R1 stated,

Finally . . . it is a form of relief. At last, I can speak up openly. Thank you for giving me this chance. I suppose it was not that hard to open up about this topic. I want to find some time to discuss this with my family.

Similarly, R8 stated,

Besides my closest friend [smile], this was my first time talking in depth about my end-of-life. It was cool! Not as hard as the topic sounds. In fact, I enjoyed the lively conversation. It was just like a therapy session in dealing with issues about death. Thank you! I may want to know more about the role and importance of the social worker in terms of end-of-life issues [smile].

R5 also wanted to share their thoughts with their other family members with respect to planning for their eventual death. R5 also highlighted the need to discuss EOL preferences regardless of age, gender, or religious differences. R5 said,

This was the first time I have had the opportunity to put it all this into words instead of bottling up in my heart [chuckle]. I hope that more people have a positive experience with end-of-life communication, regardless of their age, gender or religion. We need to practice “near death preparation” before it is too

late . . . we should leave no regrets for those who are still alive, but only good memories for our loved ones.

## Discussion

This study was aimed at investigating elderly Malaysian nursing home residents’ experiences and perceptions of EOL communication. One of the core objectives of a nursing home is to deliver quality palliative (ie, EOL) care (34). This includes the provision of knowledge and practices pertaining to EOL communication to residents. However, this study found that none of the respondents in this nursing home had any experience of EOL communication prior to this study.

Cultural factors might lie at the heart of this reluctance to discuss EOL decision-making with elderly nursing home residents. According to the study by Oka et al (35), Malaysia is very much a collectivist society. As such, most decisions related to elderly nursing home residents are influenced by the residents’ family and friends. This dependence on other people for EOL decision-making limits opportunities for elderly nursing home residents to think about their own EOL. There were also those who believed that EOL circumstances have been divinely ordained; as such, these respondents felt that there was no need for them to plan or make any decisions related to EOL. Malaysian is a highly religious society, home to numerous religions (35). This external locus of control, a product of the belief that EOL matters have been preordained, left some of the respondents in this study feeling that EOL planning and decision-making was a futile endeavor.

In addition, depending on the elderly person’s culture, EOL communication is not likely to be a daily conversation topic. In fact, for many of the respondents in this study, EOL communication was described as a sociocultural taboo, implying that to talk about it was to invoke a source of bad luck (25). As a result, Chinese people often avoided entering into discussions about EOL preferences, such as their funeral arrangements or their preferences in relation to resuscitation orders.

Most Asian cultures value dignity and honor (36). These cultural values were reflected in the respondents’ answers, which repeatedly touched upon the idea of dying with dignity. According to much of the death and dying literature, the elderly typically define “dying with dignity” in terms of adequate symptom control, maintaining bodily integrity, putting one’s affairs in order, the involvement of a palliative care team, and dying in peace (37). This study found the concept of dignity to be associated with a reluctance to accept lifesaving treatments (eg, CPR), believing that lifesaving treatments were simply delaying the inevitable. Moreover, it was feared that unnaturally postponing death could often result in a state of pain and disability, thus robbing the elderly resident of their quality of life and their dignity. On a related note, this study also found that the concept of dignity was related to the following ideas: following the course of nature, embracing one’s own

decisions in the dying process, and not being a burden upon other people.

Elderly Chinese often fear that the process of their dying will come as a burden to their caregivers (38). This issue was reflected in respondents' concern that any efforts on their part to engage their family in EOL communication might upset them. Respondents also expressed concerns about burdening their families with the cost of their EOL treatment and funerals. As a result, some respondents reported being willing to accept decisions made by their family, doctor, or friends in regard to EOL preferences rather than making these decisions themselves. This is consistent with the findings of previous studies reporting a lack of autonomy among nursing home residents in terms of EOL communication (39,40). This study also found that financial constraints contributed to elderly nursing home residents' lack of autonomy in terms of EOL preferences. Respondents with less money were more inclined to simply accept the decisions of others in relation to their EOL care and were less likely to discuss their EOL preferences with anyone.

Notwithstanding, regardless of how limited their economic resources might have been, most respondents in this study expressed a strong desire to see their religious beliefs preserved and respected. Several respondents expressed their wish for a simple but meaningful funeral, in accordance with Buddhist tradition. According to Buddhist culture, a funeral is a final honor, something that the family or other people do on behalf of the deceased. While this sample was comprised entirely of Chinese Malaysians, this attitude reflects the will of Malaysians from all ethnic and religious backgrounds (35). In addition, this study found that the decision of many elderly Chinese to donate their organs was in fact partially mediated by their desire to sacrifice something in order to gain a better afterlife. In line with the law of karma and Chinese culture, which encourages the idea of benefits to other people even though one has died, the elders embrace their thoughts on the importance of organ donation.

Although this study has identified a number of circumstances which might hinder EOL communication among the elderly, the response by the respondents in this study has given some insights that EOL communication can be useful and contains therapeutic effect. End-of-life communication can help to promote individual autonomy, as well as preserve elderly nursing home residents' religious and cultural beliefs (41). One surprising finding of this study was that the respondents reported finding therapeutic value in their EOL communication and that they enjoyed the opportunity to share their opinions about their EOL preferences with the researcher. Therefore, it is important that nursing homes acknowledge the implicit value of EOL communication and that some consideration be afforded to establishing a formal channel for residents to discuss their EOL preferences with their loved ones.

Consequently, health-care providers or nursing home staff who work directly with the elderly should be the target of educational programs aimed at promoting EOL

communication with the elderly. The cultural taboo of believing that EOL communication might bring bad luck can be overcome if the elderly person understands the purpose behind EOL communication. Effective communication around EOL can help elderly nursing home residents and health-care providers or nursing home staffs to better understand and plan for residents' EOL preferences and prevent unwanted lifesaving treatments. The respondents in this study have described these lifesaving treatments as undignified and painful. Nevertheless, it is also suggested that health-care providers and nursing home staff receive cultural competence training in relation to EOL communication to address any erroneous or superstitious beliefs that might provide a barrier against effective EOL communication. This is especially true in the Asian context where traditional cultural values and religious beliefs often dictate the course of life.

## Conclusion

Despite deeply entrenched cultural beliefs forbidding elderly Chinese from talking about their EOL, discussions related to this topic are vital for ensuring that the elderly person's wishes are acknowledged and that they do not feel as though their deaths will be a burden on others. This study concludes that elderly Chinese can overcome this taboo and engage in fruitful and rewarding discussions about their EOL preferences. In addition, although elderly nursing home residents may have difficulty planning their EOL, they still want their cultural and religious belief to be preserved, especially in relation to their funeral arrangements. This study also found that many elderly find EOL communication to be highly therapeutic. However, since there is not much discussion on EOL and the effect of EOL, this study concludes the important to expand the research in either qualitative or quantitative ways and to understand the effect of EOL as well as to include wider population of respondents.

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