

## Advance care planning for Māori, Pacific and Asian people: the views of New Zealand healthcare professionals

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### What is known about this topic

- Facilitating knowledge about advance care planning (ACP) with patients and families can increase the likelihood that preferences for end-of-life care are known and respected.
- In pluralistic and multicultural societies such as New Zealand, significant differences exist in the uptake of ACP between European-based populations and other cultural groups.
- ACP is more complicated in a culture where decision-making by whānau (extended family) is important.

### What this paper adds

- Increasing knowledge about ACP may involve techniques to improve information access and the utilisation of shared norms and values to assist with discussions between Māori, Pacific and Asian health professionals and their patients and families/whānau.
- The findings also demonstrate the importance of engagement with Māori, Pacific and Asian health professionals in the development of ACP education resources for patients, families/whānau as well as for other healthcare providers.
- Findings indicate a need for more family-/whānau-centred models of care (including ACP), addressed much earlier in the healthcare process and within the community setting.

### Abstract

Despite the benefits of advance care planning (ACP), international research has suggested that in pluralistic and multicultural societies such as New Zealand, significant differences exist in the uptake of ACP between European-based populations and other cultural groups [Crawley (2005)]. The purpose of this study was to therefore explore the views of generalist palliative care providers in both the community and hospital settings regarding the barriers to ACP adoption as well as methods to increase knowledge about ACP among Māori, Pacific and Asian cultural groups within New Zealand society. Eleven individual interviews, two joint interviews and three focus groups were conducted with health and social care professionals with a wide range of knowledge and experience in palliative care. Challenges were related to a number of issues based on culture, including family decision-making style, a need to 'do everything' and a reluctance to discuss issues surrounding dying and death. Suggestions to increase the knowledge of ACP included techniques to improve information access and the utilisation of shared norms and values to assist with discussions between Māori, Pacific and Asian health professionals and their patients and families/whānau. Findings indicate a need for more family/whānau-centred models of ACP, addressed much earlier in the healthcare process and within the community setting.

**Keywords:** advance care planning, culture, end-of-life, generalist, palliative care

### Introduction

In New Zealand, as with other developed countries, concerns have been voiced by health professionals and the general public that patients at the end of their lives, and in particular older patients, can be subject to inappropriately invasive interventions. Studies of dying in hospitals conducted internationally, most notably the SUPPORT study in the US (Freeborne *et al.* 2000) and the later APROPRICUS study in nine European countries and Israel (Piers *et al.* 2011), identified that the use of invasive medical technology was 'prolonging dying' for many patients at the expense of optimising quality of remaining life.

There is evidence to suggest that facilitating advance care planning (ACP) with patients and their families can increase the likelihood that preferences for end-of-life care are known and respected (Detering *et al.* 2010). ACP has been defined as:

A voluntary process of discussion about future care between an individuals and their [sic] care providers, irrespective of discipline.

This might include a discussion of:

The individual's concerns and wishes, their important values or personal goals for care; their understanding of their illness and prognosis, and their preferences and wishes for the type of care or treatment that may be beneficial in the future and the availability of these. (Henry & Seymour 2008, p. 5)

Furthermore, research by Ratner *et al.* (2001) concluded that facilitating ACP among seriously ill community patients and their families was associated with end-of-life care at home.

Culture can be defined as:

A historically transmitted pattern of meanings embodied in symbols. (Geertz 1973, p. 89)

Culture depends on 'shared meanings' and provides a perceptual screen through which patients and families give meaning to the experiences of health, illness, dying, death and grief (Parkes *et al.* 1997). Thus, the beliefs, values and customs adopted within a culture can influence patients' and families' communication with healthcare providers as well as their treatment choices (McLaughlin & Braun 1998). These influences come into sharp focus in end-of-life decision-making (Crawley *et al.* 2002). Despite the benefits of ACP, international research has suggested that in pluralistic and multicultural societies such as New Zealand, significant differences exist in the uptake of ACP between European-based populations and other cultural groups (Krakauer & Truog 1997, Crawley *et al.* 2002, Degenholtz *et al.* 2002, Krakauer *et al.* 2002, Perkins *et al.* 2002, Crawley 2005, Kwak & Haley 2005). Moreover, in spite of the increased attention to cross-cultural considerations in healthcare, including end-of-life care, these considerations have rarely been incorporated into the formulation of ACP plans and policies (Johnstone & Kanitsaki 1997).

New Zealand is required to deliver healthcare, including end-of-life care to an increasingly culturally diverse society. Although NZ Europeans constitute 67.6% of the population, many other cultural groups are represented, including the indigenous Māori population (14.6%), Asian peoples (9.2%) (Chinese, Indian, Korean, Filipino, Japanese, Sri Lankan, Cambodian, Thai, Vietnamese, Indonesian and other Asian) and Pacific peoples (6.9%) (Samoan, Cook Island Māori, Tongan, Niuean, Fijian, Tokelaun and other Pacific) (Statistics New Zealand 2006). Māori in particular, as the indigenous people of New Zealand, have specific rights to equitable access to appropriate healthcare provision under the Treaty of Waitangi. According to Durie (2001), Māori health perspectives emphasise:

The nature of relationships, especially those that nurture a secure cultural identity and offer a sense of stability in a fast-changing world. (p. 27)

However, the notion of individual autonomy regarding medical treatment enshrined in western medical tradition and in ACP in particular is not necessarily consistent with traditional Māori views. According to Durie (1994), interdependence, rather than independence from whānau, is integral to Māori. Personal and family identities are not distinct entities (Durie 1994). Whānau involvement at times of illness is therefore expected (Durie 1977). The whole issue of ACP is more complicated in a culture where decision-making by whānau (extended family) is important (Wareham *et al.* 2005). In addition, although distinct in language, culture and history, evidence indicates that Māori, Pacific and Asian groups are both more collectivist than individualist in their worldviews (McLaughlin & Braun 1998). International studies have identified the involvement of family in decision-making (Bowman & Singer 2001, McGrath *et al.* 2001) and a tendency to withhold prognostic information on the basis that it might cause a loss of hope (Bowman & Singer 2001, McGrath *et al.* 2001, Chan & Kayser-Jones 2005, Hathaway 2009), as key factors influencing end-of-life planning and care among Māori, Pacific and Asian groups (McLaughlin & Braun 1998). Furthermore, among Māori, Pacific and Asian groups, the power of words to transform thoughts into reality prevents discussion of death (i.e. speaking about death will bring about death). All of these factors combine to create challenges to the implementation of ACP as presently formulated within the New Zealand context.

While a number of international studies have been conducted on ACP in relation to indigenous and minority groups (e.g. United States, Canada and Australia), there is a paucity of information within the New Zealand context. More generally, few studies have examined the palliative and end-of-life care needs of Māori, Pacific Island and Asian populations within the society with the available literature focusing predominantly on barriers to specialist palliative care (Bellamy & Gott 2013). Efforts have been made by a number of district health boards across the country to introduce ACP programmes. The purpose of this study was to therefore explore the views of generalist palliative care providers regarding the challenges to ACP adoption as the methods to increase knowledge about ACP among the diverse cultural groups represented within New Zealand society.

## Method

### Sampling

Health and social care professionals with a wide range of knowledge and experience in palliative care were recruited. 'Generalist' palliative care providers were chosen to participate because they deliver the majority of care to patients with palliative care needs. Leaders of Māori community support services and Pacific and Asian hospital support services were recruited to provide cultural expertise. General Practitioners (GPs) were also included due to their key role in palliative care management in the community.

### Research ethics

The study received ethical approval from the Auckland Regional Health and Disability Ethics Committee.

### Procedure

A member of the research team invited participants in person or by email and provided them with a participant information sheet prior to their consenting to participate. As snowball sampling was used, response rates are not available.

Interviews and focus groups for hospital-based health professionals were conducted in private meeting rooms or offices. The other interviews and focus groups were held in the workplaces of the community-based participants or in a meeting room at the University. The researcher who conducted the interviews and focus groups (R.F., a researcher of European ethnicity) has extensive experience in qualitative data collection with diverse cultural groups; she was unknown to all participants except one.

### Data collection

The focus group and interview guide was developed following a review of the literature (Gardiner *et al.* 2011). A number of key areas were included in the guide: understanding and experience of palliative and end-of-life care; nature and extent of potentially inappropriate hospitalisations; and understandings of and attitudes towards the implementation of ACP. The guide was used to enable a 'guided conversation' that allowed the participant to also raise issues and concepts that may not have been considered by the researchers (Curry *et al.* 2009). The first two interviews were considered pilot interviews; how-

ever, as no problems were found in the design of the focus/interview guide, they were used in the final analysis. The interviews and focus groups lasted between 30 and 45 minutes and were audio-recorded with the informed consent of the participants.

### Analysis

Thematic analysis (Boyatzis 1998) was used to analyse the data. This form of analysis:

Provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data. (Braun & Clarke 2006, p. 78)

Interviews were transcribed and read over a number of times. Thereafter, data were analysed and codes were assigned to selected excerpts. These excerpts were further analysed to look for patterns and then grouped into themes.

## Findings

### Demographic characteristics

Eleven individual interviews, two joint interviews and three focus groups were conducted. Participants reported NZ European (19), Māori ethnicity (3) or membership in a Pacific (3) Asian (5), Southeast Asian (7) or other European (3) groups. The focus groups and joint interviews were all uni-professional and comprised people who worked together and knew one another well. The exception was the Māori joint interview, which, for logistic reasons, included both a physician and a hospice cultural liaison officer (see Table 1 for the demographic characteristics of the participants).

In brief, the influences of culture on ACP utilisation topics, which emerged in the interviews, were organised in terms of predominant themes. These themes involved both perceived challenges based on cultural beliefs and traditions as well as techniques to increase knowledge about ACP. The views reported are based on professional as well as shared cultural experiences. Themes related to cultural challenges to ACP included 'do everything', 'collective decision-making', 'harmony' and 'difficult discussions'.

#### *Do everything*

Difficulties with ACP were perceived to be shaped in part by cultural obligations. Implementing an ACP would signify a lack of caring on the part of the family as they would feel like they were not doing all

**Table 1** Demographic characteristics of participants

Interview	Role	Ethnicity	Age
1	Consultant	NZ European	50–59
2	Renal physician	NZ European	40–49
3	Medical oncologist	NZ European/Māori	40–49
4	Emergency medicine	NZ European	40–49
5	Intensivist	NZ European	50–59
6	Colorectal surgeon	NZ European	60–69
7	Nurse leader-hospice	NZ European	50–59
8	House officer	European	20–29
9	Anaesthetist	British	30–39
10	Anaesthetist	NZ European	40–49
11	Inpatient unit nurse	Chinese	30–39
Focus group			
Oncology	Staff nurse	NZ European	50–59
	Staff nurse	British	30–39
	Staff nurse	NZ European	30–39
	Charge nurse	NZ European	40–49
	Staff nurse	NZ European	20–29
	Staff nurse	Scottish	30–39
	Nurse specialist	NZ European	30–39
Pacific	Pacific health manager	Samoan	50–59
	Pacific family support worker	Tongan	Not specified
Older people	Staff nurse	Indian	30–39
	Staff nurse	Tongan	40–49
	Staff nurse	Indian	30–39
	Staff nurse	NZ European	40–49
	Staff nurse	NZ European	50–59
	Staff nurse	European	30–39
GP	GP	NZ European	50–59
	GP	Chinese	Not specified
	GP	Chinese	Not specified
	GP	NZ European	30–39
Māori	Kaitakawaenga (Māori liaison co-ordinator)	Māori/European	40–49
	Respiratory registrar	Māori	Not specified
Renal	Staff nurse	Chinese	20–29
	Staff nurse	Filipino	Not specified
	Staff nurse	Filipino	20–29
	Staff nurse	Indian	20–29
	Staff nurse	Indian	20–29
	Staff nurse	NZ European	Not specified
	Staff nurse	Korean	20–29
	Staff nurse	Filipino	30–39
	Renal nurse educator	NZ European	50–59

GP, General Practitioner; NZ, New Zealand.

they could for their family member. This was highlighted particularly for Pacific and Asian families:

The other thing is [you] never have advance care planning with a Polynesian family ... because they want everything. There's grandma, totally stroked out, can hardly do anything and you say now we've got this resuscitation form which asks if we want to jump on her chest, give her CPR if she has a cardiac arrest, 'oh no, we want everything'. If [medical intervention is] available they'll take it, every opportunity ... because to withdraw it is something that culturally is very difficult. It shows that they don't love

their relative if they're willing to withdraw treatment. (GP focus group – Asian physician)

A renal nurse reiterated the point, speaking about the sense of obligation to care for older family members:

Oh, Polynesian patients probably ... I think in their culture it's difficult for them. You know they're very much orientated towards caring for their older family members and doing everything for them. And it's difficult for them to accept that perhaps that family member's come to the point where they decide they don't want to prolong their

life... (Renal nurse focus group – European renal nurse educator)

#### *Collective decision-making*

Some participants spoke about the decision-making process, and how cultural differences may affect how patients made decisions about healthcare. Immediate and wider family may need to be consulted before the patient will make plans. This may, at times, prove difficult, given that relatives may not always reside locally.

I guess another issue with Māori because the whānau are so involved, is actually getting them together so that everyone's involved in that decision ... And I guess that's a kind of a logistic issue, trying to get everyone together to actually make that decision, or to make those plans. (Māori focus group)

The decision-making process in relation to an end-of-life care was seen as particularly difficult when a family was multicultural, highlighting the cultural differences surrounding the dying process:

The father was very ill ... and he had had two wives. So he had children to the first wife and children to the second wife. He was Māori, the first wife was not Māori, and the second wife was Māori. So his second family was very strong in their Māori, you know their tikanga, their knowledge of things Māori ... so the eldest members of the family, the eldest sisters who by rights have more of a say, the youngest sisters didn't listen to the older sisters because they wanted to do things the Māori way ... he'd been very active in the Māori world, he was very well known and well respected. (Māori focus group)

The collective nature also means that the patient may not have the ultimate say in what happens. It may be pointless therefore to have written instructions when decisions are not made by individuals, but by the extended family or by their appointed representative.

Because Chinese do still have that connectivity idea, so I could make my decision now, I could tell you I'm going to want to be cremated when I die, I want to have my organ donation, I want to not have CPR when I have car accident. But I talk to my husband a lot of time. He said to me I can't make the decision, it's not up to me when I become unconscious. (Asian nurse)

#### *Harmony*

Based on the desire to preserve harmony, patients may withhold their wishes from family members, especially if those wishes contradict those of the larger family. When speaking of Pacific families, a member of the renal nurse focus group stated:

So it's not just like the nuclear family that you're dealing with. You're dealing with aunts, uncles, okay ... sometimes, the family members influence the patient more, that finally the patient has to say yes or no to the family members. (Renal focus group – Indian nurse)

Preservation of harmony was also implicated in the tendency of participants from collectivist cultures to defer to the judgement of healthcare professionals, rather than their personal wishes. A GP speaking of Pacific patients and families stated:

Interviewer: So there are cultural barriers to implementing advanced care planning?

Most definitely, but by the same token, it's easier for you because they are also willing to defer to the doctor's judgement. (GP focus group – European physician)

#### *Difficult discussions*

Some participants commented on the cultural differences when it comes to discussing death. Participants from the Māori focus group in particular saw not only Māori as having difficulty discussing death, but other cultures also:

You know I've seen it many times with Māori. Because we can't sort of have that discussion around, it's not just Māori, it's a lot of different cultures as well, and certainly with Polynesian cultures it's very similar as well. My in-laws, both of them are quite elderly and not well, and neither of them will talk about what they want to happen for them in their last days. Or, you know even trying to get them to write a will, those sorts of things, they just don't wanna go there ... Because to them it's like hastening that possibility of their death. (Māori focus group)

Related to this issue is the belief that speaking and planning for end of life are concomitant to giving up on life. Families feel that such discussions will dishearten the patient. However, without discussion how can planning for future care occur? A member of the Pacific focus group stated:

We don't want to prepare for death because that actually shows that we don't have faith that this person's going to live. You know, so we leave it until the last minute, until the last minute, until they've passed on and that's it. Now we can prepare for the funeral because he's already passed on. But while they're still alive, there's still room there for miracle. (Pacific focus group)

#### **Crossing the information gulf**

As well as outlining cultural factors that may create challenges to ACP, participants provided a number of recommendations that may assist patients and their families/whānau in increasing their awareness

of planning options including ACP. Themes related to this topic included 'information access', 'lost in translation' (overcoming language challenges) and techniques to draw on 'previous experience'. Each theme is described as follows.

#### *Information access*

Improving understanding of ACP involved increased access to information about and referral to hospice services. A member of the Māori focus group stated:

I think an important way to improve ACP is early referral to the hospice community palliative care service ... if they can make connections now ... then they can kind of use them [hospice] as an advice service. (Māori focus group)

A personal approach to members of the community was also suggested as a method to provide information. In cultures where trust and personal relationships are key, face-to-face conversations via community organisations may be the most effective option for increasing awareness.

Often I'll sit there and just weave flowers, you know, out of harekeke [New Zealand flax], and you know often the young people, young girls will come up ... And I'll say oh give this brochure to mum you know I work at the hospice, that sort of thing. (Māori focus group)

The use of technology was advocated to increase knowledge and debate about ACP. In a time when consumers have become accustomed to having answers to healthcare questions, only a click away, it was recommended that information about ACP be made more easily accessible.

Advance care planning in Hong Kong, they actually were making into legal document and they have a public consultation on the Internet ... and it's through the Hong Kong government. (Asian nurse)

Other forms of technology (cell phones, iPods, etc.) were recommended as a method to increase knowledge of both palliative care and ACP.

We have to get smart as well about technology and start using the technology that is available to us. Young people in particular ... young Māori in particular are really techno-savvy, you know ... cell phones and iPods, and iPhones and computers ... so we need to figure out a way of ... getting information through in some of those formats. (Māori focus group)

#### *Lost in translation*

Language was also implicated as creating a challenge to ACP information access. A member of the Pacific focus group suggested the following:

So it's actually my hope that if we're actually able to have, like, a compact of files or a compact of information that you want to give to these families and you translate it in the mother tongue... . (Pacific focus group)

#### *Previous experience*

In addition to finding new methods to increase information access, there was a suggestion to tie increased understanding of ACP to previously held knowledge. In particular, members of the Pacific focus group suggested a link to knowledge about life insurance:

A lot of people are actually employed by the insurance company to sell their life insurance, so, and they sell it to their own relatives and their own families ... And when they talked about the life insurance, then they talked about the plan for death ... So when they're actually admitted here, there is a sense of familiarity ... So that's how the whole thing works and the whole educational process. (Pacific focus group)

## **Discussion**

The present study explored the views of healthcare professionals regarding cultural barriers to ACP as well as ideas to increase knowledge of ACP among Māori, Pacific and Asian patients and families. The study supports the findings of prior research concerning the impact of cultural values on end-of-life care decisions (McLaughlin & Braun 1998, Bowman & Singer 2001, Kagawa-Singer & Blackhall 2001, Searith & Gafford 2005, Bellamy & Gott 2013).

One potential explanation for the lack of support for ACP among Māori, Pacific and Asian groups may relate to the 'universal' moral principles (e.g. autonomy, beneficence, non-maleficence and justice), which shape western cultural beliefs (Beauchamp & Childress 2009). According to Johnstone and Kanitsaki (1997, p. 407), autonomy is:

*The preeminent principle in western bioethical thought and ... the principal guide to ethical decision-making in healthcare.*

This 'curative model' (Fox 1997) stands in sharp contrast to the cultural beliefs of Māori, Pacific and Asian patients and families, which place a greater emphasis on the role of family/whānau in decision-making. Within New Zealand, the concept of cultural safety was developed in nursing to redress issues of power, vulnerability and control within the health services, initially bi-culturally with Māori and more recently expanded to all health professionals and all patient groups to address the needs of a multicultural society (Wepa 2005). This inclusive approach requir-

ing self-reflection by healthcare professionals on their own cultural attitudes may be easier said than done within the constraints of healthcare institutions. Difficulties may arise when western healthcare professionals attempt to merge deeply embedded notions of 'universal' moral principles (e.g. autonomy and justice), which are independent of context, with the largely relativistic beliefs and values of diverse patients (Wood 2010).

While western medicine emphasises the importance of ACP with the goal of enhancing the quality of life, other cultures, particularly Māori, Asian (such as Chinese) and Pacific (such as Samoan and Tongan) peoples, are less receptive to this concept. Filial piety, which reflects the children's role to protect parents from negative circumstances, is common in Māori, Pacific and Asian cultures, which might make the initiation of advance care communication more difficult (Ko & Lee 2010, Kim & Foreman 2011, Ko *et al.* 2012). Furthermore, 'family' for Māori, Pacific and Asian cultural groups was recognised by participants (as noted in previous research) to go beyond the nuclear family to include cousins, aunts, uncles, friends or even church groups (Ryder-Lewis 2005). This has implications as highlighted by the Māori focus group in terms of bringing whānau together to make decisions.

The results also reflect the power of words. It is well documented that in Māori as well as many Pacific and Asian cultures, discussions surrounding death are to be avoided. Such discussions are viewed as both disrespectful to elders and 'polluting' capable of causing bad luck (McLaughlin & Braun 1998, Frey *et al.* 2013).

In the light of these considerations, how then can ACP adoption take place and more importantly is ACP appropriate? In a context in which family decision-making is integral, ACP as presently formulated may be seen at best as unhelpful and at worst as harmful to the caring relationship between family and patient (Candib 2002, Bito *et al.* 2007). Evidence suggests that for diverse cultural group members to be truly engaged in end-of-life care planning, there must be recognition of family members as integral players in the therapeutic relationship rather than as a barrier to be overcome (Johnstone & Kanitsaki 1997). Further exploration of family/whānau-centred rather than patient-centred approaches to healthcare planning incorporating a more holistic (inclusive of spiritual and psycho-social well-being) rather than the biomedical (illness-centred) view of care must be pursued (Frey *et al.* 2013). This is particularly important in former colonial societies where issues of distrust of the health system and programmes persist (Toafa *et al.* 1999, Harris *et al.* 2005).

Caution must be taken, however, by healthcare professionals and policy makers in making blanket judgements about an individual's level of interest in ACP based on the cultural background. Research has demonstrated a lack of willingness among healthcare professionals to discuss end-of-life care plans (including ACP) based on cultural assumptions (Chen & Hawks 1995, Frey *et al.* 2013), thereby limiting awareness of available options. Thus, culturally accessible educational information surrounding ACP should be provided to allow patients and families enough information to make informed decisions about healthcare in general and ACP in particular.

The development of culturally accessible information about ACP should begin with recognition of cultural differences in understanding. Māori, Pacific and Asian peoples each imbue a unique cultural significance to death and dying (Schwaas 2005, Stallworthy & Glavish 2013). For example, in Samoan culture, failure to fulfil a person's dying wish (mavaega) can result in a curse for the living (Bathgate & Pulotu-Endemann 1997, Tamasese *et al.* 1997). The Māori focus group also spoke of cultural differences in the dying process. Thus, ACP must accommodate both:

Today's diverse [Māori] individuals and traditional understandings of whānau who observe customs associated with dying and death inherent to a timeless communal past, evidenced by stories of aroha (love, care and concern) and manaakitanga (caring for the mana and esteem of the dying and their whānau). (Moeke-Maxwell 2013, p. 200)

The findings also demonstrate the importance of engagement with Māori, Pacific and Asian health professionals. As recommended by the Pacific support group, the distribution of ACP educational information tailored to each cultural group (translated as well as culturally appropriate in language) could help in increased awareness. Prior research has indicated that many Chinese and Korean older adults in New Zealand are immigrants who lack English language skills and rely on their families to access health services (Garrett *et al.* 2008). Easily accessible information in their primary language could assist with understanding of ACP.

Technology-supported information concerning ACP was also recommended to facilitate shared decision-making. In a world of 24-hour news, search engines and high-speed Internet access, patients have grown accustomed to accessing information (e.g. Jeannot *et al.* 2004, Schwartz *et al.* 2006). Improved information access has also changed the dynamics between patients and clinicians, promoting more active engagement in the decision-making process (Weiner & Bondich 2006). Following from this recom-

mentation, decision aids, utilised extensively to assist in deliberating treatment options (Stacey *et al.* 2011), are one possibility in facilitating conversations between patients, their families/whānau and healthcare professionals concerning ACP.

The reluctance of Māori, Pacific and Asian families/whānau to engage in needed conversations was also addressed. Drawing on shared norms and values, discussions between Māori, Pacific and Asian health professionals and patients and families/whānau would not only increase awareness of ACP but also timely hospice referrals, decreasing delays in future care plan discussions. Finally, prior knowledge and experience (e.g. insurance) can also act as a bridge to the understanding of new information (e.g. ACP). Education research drawing on constructivist learning theory has supported the view that new learning occurs best when a person makes a connection between pre-existing knowledge and new knowledge (Bruner 1996).

While this paper adds insights into cultural perspectives in ACP, the opinions reflect the experiences of healthcare professionals, who, although themselves members of diverse cultural groups, may support a western view of the benefits of ACP. These views may differ from those offered by patients and their families/whānau. In addition, while similarities and differences across and between cultural groups were noted based on participant responses, a thorough examination of common and unique beliefs and values will require further exploration with patient and family/whānau. Nevertheless, the findings, although exploratory, are reflective of those reported in the international research literature.

## Conclusion

In the light of the growing cultural diversity of older New Zealanders, it is increasingly important for researchers, healthcare professionals and policy makers to both recognise and understand the unique role culture plays in shaping attitudes, preferences and important decisions surrounding end-of-life care. As other researchers have reported (e.g. Kagawa-Singer & Blackhall 2001), ACP, as presently designed, appeals more to European-based populations than to more collectivist cultures. In the end, it must be recognised that not all cultural groups will want to participate in ACP because it is deemed incompatible with their beliefs about death and dying. The goal is to be able to offer culturally accessible information about ACP to everyone so that ultimately they can have a say in their end-of-life care. Future research should explore more family/whānau-centred models

of ACP, addressed much earlier in the healthcare process and within the community setting (McLaughlin & Braun 1998). One Asian participant summed it up best:

No, even though we live in quite a western way here, we may eat fish and chips, but we're still doing things our way. (Asian nurse)

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