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Advance Care Planning for Older Hospitalized Patients in China: Perspectives of Patients, Caregivers, and Healthcare Professionals

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Research Article

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Abstract

Background: Older hospitalized patients often live with multiple chronic conditions and face an increased risk of mortality. However, advance care planning (ACP) remains underused in China. Understanding the barriers to and facilitators of ACP among older hospitalized patients may inform strategies to support its implementation.

Methods: Between May and December 2025, we conducted semi-structured interviews with patients aged over 80 years, caregivers, and healthcare professionals at a Tertiary hospital in a city in western China. Interviews explored participants' understanding of ACP, discussions about ACP, factors influencing patients' engagement in or avoidance of ACP, and perceived strategies and support needs for promoting ACP. Data were analyzed using thematic analysis.

Results: We conducted 35 interviews with 5 physicians, 10 nurses, 10 patients, and 10 caregivers. Two of the 10 patients (20%) had completed an advance directive（AD）. Twelve of the 15 healthcare professionals (80%) reported receiving regular ACP training. Four themes that affect the implementation of ACP were identified (1)Awareness of ACP and

sources of information; (2) Psychosocial and contextual factors shaping ACP engagement;(3)Patient values and communication in ACP decision-making; and (4) Strategies and support for ACP delivery.limited patient and caregiver awareness, emotional strain, family disagreement, and differing views on the timing of ACP discussions as important implementation challenges. Participants emphasized the need for professional guidance and communication tailored to patients and caregivers. Healthcare professionals also emphasized the importance of enhanced training, adequate staffing, standardized procedures, policy support, and support from artificial intelligence.

Conclusions: ACP engagement was limited among the patients interviewed.patients and healthcare professionals also differed in their views on the timing of ACP discussions. Professional guidance and communication between patients and their families, as well as training and support for medical staff may facilitate the implementation of ACP.

Keywords: advance care planning; older adults; hospitalization; qualitative research; patients; caregivers; healthcare professionals

1. Background

Advance care planning (ACP) is an ongoing communication process that helps individuals understand and share their values, life goals, and

preferences for future medical care with family members, healthcare professionals, or other people involved in their care [1,2]. ACP may involve discussing future treatment preferences, identifying a surrogate decision-maker, and recording or reviewing preferences when appropriate. An advance directive (AD) is one possible document arising from this process [3].

ACP may be particularly relevant for older adults admitted to hospital. Many live with multiple chronic conditions, and an acute illness can bring rapid changes in their health. In one cohort of emergency admissions among adults aged 70 years and older, 22.6% of patients died within a year. Of those deaths, 59.3% occurred within three months of admission [4]. This early concentration of deaths suggests that waiting until a patient's condition has seriously worsened may leave little opportunity to discuss their care preferences.

Studies of older inpatients have also reported gaps in ACP discussions and documentation. When support is provided during hospitalization, patients may have more opportunity to clarify their preferences, while clinicians and families can better understand what matters to them [5–8]. An admission may therefore be a useful time to begin or revisit ACP. The conversation should take account of the patient's health, willingness to

discuss the topic, and preferences; it need not be reduced to completing a form on a single occasion [1,5,7].

Awareness of ADs also appears limited in Chinese populations. A study of older adults with chronic diseases in mainland China reported that 4.5% of participants had heard of ADs [9]. A population-based telephone survey in Hong Kong found that only 14.3% of adults had heard of advance directives (ADs). When asked to consider a hypothetical terminal illness, however, 87.6% said they would prefer comfort-focused palliative care to life-prolonging treatment [10]. This contrast suggests that people may have clear end-of-life care preferences while knowing little about formal planning [3,9,10]..

In some settings, patient-facing ACP programs and structured communication support have increased engagement with ACP, documentation, and the frequency or quality of discussions [11–14]. However, more complete documentation has not consistently led to better patient-centered or end-of-life outcomes.For example, a cluster-randomized trial of a serious-illness communication program did not demonstrate improvement in its coprimary outcomes, while a large pragmatic ACP trial increased documentation of end-of-life preferences and also found increased potentially burdensome care in a subgroup of patients with serious illness [15,16]. These mixed findings support

evaluating ACP in terms of communication quality and patients' needs, as well as document completion [8,15–19].

Previous research has often focused on specific disease groups or examined ACP from a single stakeholder perspective [19–23]. Less is known about how very old hospitalized patients, their caregivers, physicians, and nurses understand ACP and perceive its barriers, facilitators, and appropriate timing within the same clinical context. This qualitative study therefore explored the perspectives and expectations of patients aged over 80 years, caregivers, physicians, and nurses regarding ACP. Specifically, it examined participants' understanding of ACP, perceived barriers to and facilitators of engagement, beliefs about medical decision-making, and recommendations for improving ACP delivery. The findings may inform more patient-centered approaches to ACP for older hospitalized patients and provide a basis for future intervention research.

2. Methods

2.1 Study design, setting, and participants

This study used a qualitative design based on semi-structured individual interviews. Using purposive sampling, we recruited 35 participants from a Tertiary hospital in Chongqing, China: 10 older inpatients, 10 family

caregivers, five physicians, and 10 nurses involved in the care of older inpatients.

Patients were eligible if they were aged over 80 years, had at least three chronic conditions with a disease history of at least 1 year, were conscious and able to participate in the interview, and were willing to take part. Healthcare professionals were eligible if they had at least 3 years of experience in geriatric medical or nursing care. Family caregivers were eligible if they were the primary caregivers of older patients with chronic conditions, had completed at least junior high school, and were willing to participate.

Ward managers identified potential participants from departmental rosters and recruited them in person. Before the individual interviews, researchers explained the study to participants and obtained their written informed consent. The study was approved by the Ethics Committee of the First Affiliated Hospital of Chongqing Medical University on March 20, 2025 (approval No. 025-202-01).

2.2 Interview guide and data collection

The semi-structured interview guide was developed specifically for this study, a social scientist with expertise in qualitative research and palliative care, based on a literature review and clinical experience. The

research team refined the guide through discussion. An English-language version of the interview guide is provided in Additional file 1.

From May to December 2025, trained interviewers (C.Y., B.Y., Z.Y.X., and C.S.J.) conducted semi-structured interviews with healthcare professionals, patients, and family caregivers. A total of 38 interviews were initiated. Three were not completed, leaving 35 completed interviews for analysis (completion rate, 92.1%). Of the completed interviews, 25 were conducted face to face and 10 by videoconference; all 10 videoconference interviews were with healthcare professionals.

The interview guide explored participants' understanding of advance care planning (ACP), their beliefs about medical decision-making, the professional competencies required of healthcare professionals, and their suggestions and support needs for promoting ACP. For this study, ACP was explained to participants as "the types of decisions made to clarify the medical care a patient would wish to receive when facing a life-threatening illness or injury. ACP may include documenting the patient's preferences for use if they later lose the ability to express themselves".

2.3 Data analysis

All interviews were recorded and transcribed verbatim. Interviews continued until thematic saturation was reached. Weekly team meetings were held to assess whether the sample adequately represented variation across the prespecified eligibility criteria.The data were analyzed thematically. G.M. developed an initial codebook based on the interview guide. Four researchers (C.Y., B.Y., Z.Y.X., and C.S.J.) then independently coded the 35 interview transcripts line by line, using an inductive approach to identify new codes. G.M. and L.N.W. revised the codebook and recoded the initial coding results. The qualitative research team discussed coding discrepancies, newly identified codes, and revisions to code descriptions until consensus was reached.In the second stage, NVivo 12.2 (QSR International) was used to organize the codes through a consensus-based process. Pattern coding and focused coding were applied to capture the breadth and variation of subthemes and to characterize both supporting and discrepant accounts. The full research team discussed the preliminary themes. G.M. and L.N.W. iteratively compared and refined the themes; G.M. coordinated the resolution of differences and developed the final set of themes.

4. Results

4.1 Participant Characteristics and Overview of Themes

A total of 35 participants were included: five physicians, 10 nurses, 10 older inpatients, and 10 caregivers（table 1）. All physicians were geriatric medicine specialists; the nurses were palliative care specialists or geriatric specialist nurses. Two patients (20%) had signed an advance directive (AD), and 12 of the 15 healthcare professionals (80%) received ACP training regularly.

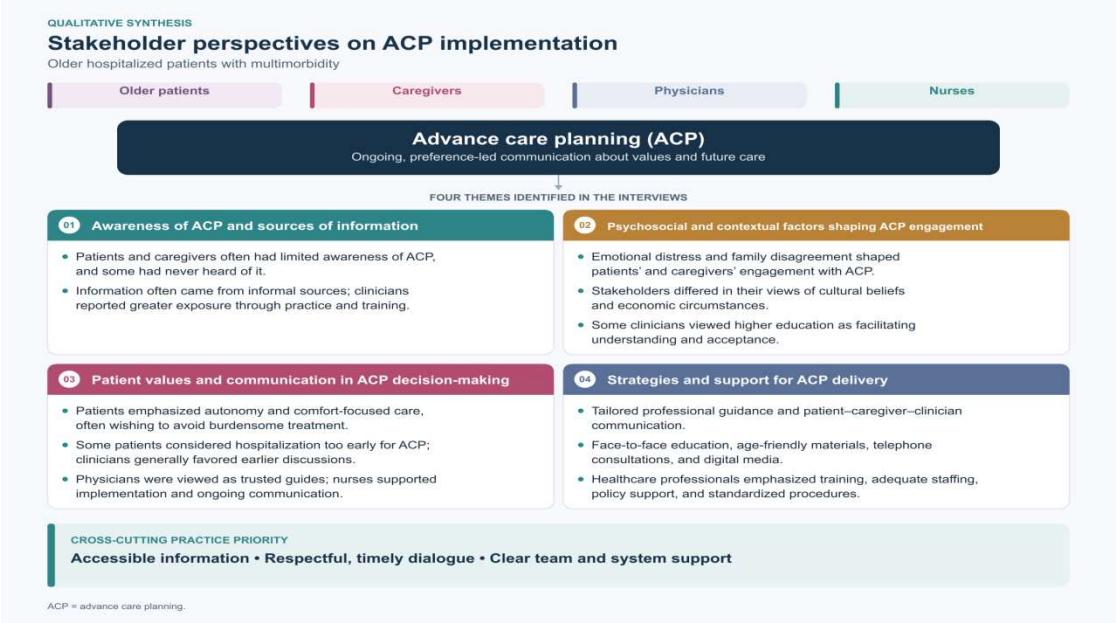
Table 1Participant Characteristics

Characteristic	Physicians (n = 5) n (%)	Nurses (n = 10) n (%)	Patients (n = 10) n (%)	Caregivers (n = 10) n (%)
Sex				
Female	4 (80%)	10 (100%)	6 (60%)	8 (80%)
Male	1 (20%)		4 (40%)	2 (20%)
Age group (years)				
20-39	2 (40%)	7 (70%)		1 (10%)
40-59	3 (60%)	3 (30%)		3 (30%)
60-79				5 (50%)
>80			10 (100%)	1 (10%)
Ethnicity				
Han Chinese	5 (100%)	9 (90%)	10 (100%)	10 (100%)
Ethnic minority		1 (10%)		
Educational attainment				
Primary school			1 (10%)	1 (10%)
Junior high school			2 (20%)	1 (10%)
Senior high school			5 (50%)	3 (30%)
Bachelor's degree		8 (80%)	2 (20%)	5 (50%)
Master's degree	3 (60%)	1 (10%)		
Doctoral degree	2 (40%)	1 (10%)		

Characteristic	Physicians (n = 5) n (%)	Nurses (n = 10) n (%)	Patients (n = 10) n (%)	Caregivers (n = 10) n (%)
Family structure				
Nuclear family	5 (100%)	8 (80%)	4 (40%)	9 (90%)
Extended family		2 (20%)	3 (30%)	1 (10%)
Household income (RMB)				
50,000-100,000		1 (10%)	4 (40%)	7 (70%)
100,000-200,000	1 (20%)	7 (70%)	2 (20%)	3 (30%)
>200,000	4 (80%)	2 (20%)	4 (40%)	
Place of residence				
Rural			1 (10%)	
Town				2 (20%)
City	5 (100%)	10 (100%)	9 (90%)	8 (80%)
Religious belief				
Yes			1 (10%)	1 (10%)
No	5 (100%)	10 (100%)	9 (90%)	9 (90%)

Thematic analysis identified four themes: (1)Awareness of ACP and sources of information; (2) Psychosocial and contextual factors shaping ACP engagement;(3)Patient values and communication in ACP decision-making; and (4) Strategies and support for ACP delivery(Figure 1)

Figure1



4.2 Theme 1: Awareness of ACP and sources of information

Overall, patients and caregivers had limited awareness of ACP. Several participants, including Patients 1 and 2 and Caregivers 1 and 2, reported that they had “never heard of it.” A few caregivers had learned about ACP online or through other people. Caregiver 5 said, “I learned about advance care planning mainly through popular science videos online.” Only a small number of patients had received professional education on ACP; Patient 10 recalled, “A professor from Taiwan came to our ward and talked about related topics.”

Healthcare professionals were generally more familiar with ACP, having encountered it through palliative care practice, academic activities, research, and online sources. Nurse 5 noted, “We started providing

palliative care in 2016, and I have also learned about it through online resources and academic lectures." Nurse 7 first encountered ACP during graduate study in 2018 and later made it a research topic. Physician 2 recalled learning about advance directives through online public accounts, including those associated with Luo Diandian, a Chinese advocate for living wills and a co-founder of the Beijing Living Will Promotion Association (BLPA).

Public education through the media and coverage of high-profile events were also viewed as ways to increase public awareness. Caregiver 5 considered media reports helpful in raising awareness. Physician 4 viewed media coverage of Qiong Yao as an example of how public attention to end-of-life issues might raise awareness of ACP.

Limited public awareness of ACP and difficulties adapting related documents to local practice were perceived as barriers. Nurse 7 noted that ACP remained a relatively new concept in mainland China and that public awareness and acceptance were limited. Physician 5 also expressed concern that promoting ACP documents could be difficult in the current context.

4.3 Theme 2: Psychosocial and contextual factors shaping ACP engagement

4.3.1Educational level

Participants perceived higher educational attainment as a potential facilitator of ACP understanding and acceptance. Physician 3 observed, “People with more education may be more likely to accept palliative care and to understand it more deeply.”

4.3.2 Emotional distress

Emotional distress and disagreements within families were additional barriers. Patient 6 worried about placing a burden on their children: “They are unable to care for me or afford the medical expenses, so I do not want to burden them.” Physician 4 described how families can feel torn when deciding whether to continue treatment: they must weigh the patient’s wishes against their own emotions and concerns about how others may judge them. Nurse 10 noted that some family members did not accept patients’ stated preferences. This resistance could make it harder for patients to take part in ACP.

4.3.3traditional beliefs

Healthcare professionals often viewed traditional beliefs and taboos surrounding death as barriers to ACP discussions. Nurse 10 said, “I think traditional beliefs play a role; people avoid talking about death, and death

remains taboo in society." Physician 2 also noted that awareness of ACP may differ across generations.

Patients and caregivers did not all share this view. Patient 10 said, "No, I accept new ideas. I do not believe in those old, superstitious ideas." Caregiver 4 likewise felt that people of their generation could accept new ideas. Some older patients described death as a natural part of life. Patient 2 said, "I am already in my nineties… This is an inevitable part of life… There is nothing to fear." A Buddhist patient also expressed acceptance, saying, "I have no regrets about when I go; today or tomorrow would both be fine."

4.3.4Economic circumstances

Participants also differed in their views of how economic circumstances influenced treatment decisions. Physician 3 considered family finances an important influence on treatment choices. Caregiver 2 felt that financial resources affected whether families could access tertiary care and participate in ACP. Caregiver 4 offered a personal view: "Families of patients with relatively high pensions do everything they can to keep the patient alive for another day… They pursue treatment because each additional day means more money." This statement reflected Caregiver 4's individual perspective and should not be interpreted as a general finding about families.

4.4 Theme 3: Patient values and communication in ACP decision-making

4.4.1 Patient Autonomy

Most patients emphasized their right to make their own medical decisions. Patient 3 said, “I have lived independently since I started working and do not need others to make decisions for me… My affairs are for me to decide.” Patient 7 had documented a wish to forgo resuscitation and avoid overtreatment.

Caregivers and healthcare professionals also emphasized respecting patients’ preferences. Caregiver 10 said that the children agreed that “the most important thing is to respect the older person’s wishes.” Patient 5 similarly believed that children should ultimately follow the older person’s wishes. Physician 1 stated, “If a patient is reluctant to participate in ACP, we do not insist. We provide options but do not make the decision.” Healthcare professionals nevertheless observed that patients and family members sometimes disagreed.

4.4.2 Preferences for Future Medical Care

Patients generally wished to avoid overtreatment and invasive resuscitation and prioritized relief of suffering and quality of life. Patient 8 expressed a wish to avoid overtreatment. Patient 6 explicitly refused

defibrillation and intubation and had written in an AD, “Only give me pain-relief injections.” Patient 3 said, “I do not seek a long life; I only hope to have a pain-free death when my time comes.”

4.4.3 Timing of ACP Discussions

Healthcare professionals generally favored discussing ACP before a patient became critically ill or received bad news. Physician 5 said, “We should not wait until a patient develops an illness and is being told bad news before introducing this topic.” Nurse 7 also described discussing ACP in advance with patients who were critically ill.

Some patients, however, considered discussions about end-of-life care premature during hospitalization. Patient 1 said, “I have not thought about that; it is still too early.” Patient 2 similarly felt that there was no need to discuss it yet. In contrast, Patient 10 began discussing future arrangements with family after becoming ill: “After I became ill, I started talking with my family about what would happen after my death.”

4.4.4 Leadership and Role Allocation in ACP Communication

Most physicians considered doctors best placed to lead ACP discussions and explain medical decisions. Physician 4 felt that families tended to trust doctors, and Caregiver 8 said the family would be more willing to participate and cooperate if a doctor led the discussion.

Participants also recognized nurses' role in implementing care plans. Physician 1 noted that nurses could take the lead in care quality and the level of nursing support. Physician 2 also recommended involving social workers and other professionals: "Healthcare professionals, together with social workers, should help [patients] make these decisions."

4.5 Theme 4:Strategies and support for ACP delivery

4.5.1 Strategies for Promoting ACP

Patients and caregivers identified individualized professional guidance and accessible health education as key support needs. Caregiver 6 recommended assigning dedicated professionals to provide guidance, while Caregiver 2 felt that discussing ACP in the context of the patient's condition would make it more acceptable. Nurse 3 also recommended face-to-face guidance to help older adults clarify and express their preferences: "Healthcare professionals should provide appropriate guidance to help older adults clarify their wishes and learn how to express them."

Participants saw face-to-face education in hospitals as an important way to introduce ACP. Physician 1 suggested using articles, lectures, case presentations, and brochures for inpatients and outpatients: "Publish health education articles, hold health education lectures … presenting

typical cases … would be more helpful … and distribute brochures to inpatients and outpatients."

Digital and audiovisual media were also suggested. Nurse 9 named WeChat public accounts, social media, and Xiaohongshu as possible channels. Physician 4 pointed to the documentary Sheng Men as a way to help the public understand ACP. Nurse 5 referred to the attention surrounding public figures, saying: "Qiong Yao's death and the attention surrounding public figures like her … let people know that ACP exists."

Some healthcare professionals also called for support from health authorities and the broader public health system. Physician 5 recommended extending ACP promotion beyond hospital wards and establishing dedicated positions to provide telephone consultations or support in clinical departments.

4.5.2 Training Needs of Healthcare Professionals

All participating healthcare professionals considered ACP training necessary. Nurse 7 noted that ACP remains insufficiently disseminated and that healthcare professionals' awareness is limited; training was therefore viewed as important for its integration into clinical practice: "I think it is necessary because ACP is not yet widely disseminated, and healthcare professionals' awareness of it is also limited … Physicians and

nurses need training so that they can actually implement it in their work." Nurse 8 emphasized the humanistic value of palliative care, stating that greater familiarity with palliative care among hospital staff could make care more compassionate: "If everyone in the hospital understood palliative care, the care we provide would be more compassionate."

The training needs identified by participants covered four main areas: knowledge of ACP, communication and palliative care skills, a shift in clinical thinking, and relevant laws and regulations. Nurse 1 emphasized understanding the content, purpose, and significance of ACP: "We need to understand ACP … what it involves and the main purpose and significance of doing it." Nurse 6 highlighted communication skills, including recognizing appropriate opportunities to initiate discussions and communicating ACP concepts to patients and their families in an appropriate manner. Nurse 8 also recommended training in core palliative care skills and communication with patients and families. Nurse 3 called for a shift in clinical thinking: "Healthcare professionals need to change their way of thinking and not view these issues solely from a clinical perspective." Nurse 5 emphasized the need to include current laws and regulations in the training: "The latest relevant laws … also need to be covered in training."

4.5.3 Workload and Time Management

Healthcare professionals differed in their views on how ACP should be integrated into routine work. Nurse 6 supported introducing ACP during everyday discussions about a patient's condition and treatment, with further discussion guided by the responses of the patient and family. Physician 2 said routine clinical duties should come first, with ACP work moving forward when time allowed. Nurse 9 proposed a dedicated team so that ACP tasks could be handled separately from everyday clinical work. Looking ahead, Nurse 8 suggested that artificial intelligence (AI) might reduce routine tasks and free up more time for psychological and emotional support.

5. Discussion

5.1Knowledge, family factors, and sociocultural context

Patients' limited knowledge of ACP in this study is consistent with earlier findings that few older adults with chronic diseases in mainland China had heard of advance directives [8]. A multicenter survey of clinical nurses in southwestern China found that attitudes toward advance directives were generally positive, but nurses' knowledge did not always translate into practice[24]. Most patients in the present study had not received professional guidance and had learned about ACP primarily through the internet, media, or other people. Another interview study involving multiple stakeholder groups also found that some ACP

planning took place outside the healthcare system [25]. Healthcare institutions could help patients access reliable information by offering guidance that is clear, easy to understand, and suited to older adults.

Participants also described emotional distress and disagreements affecting patients and their families. Some patients were concerned about becoming a caregiving or financial burden to their children, while some family members felt conflicted between respecting patients' wishes and continuing treatment.A randomized trial involving older hospitalized patients found that patients receiving an ACP intervention were more likely to have their end-of-life wishes known and respected. Among relatives of patients who died, the study also reported lower levels of stress, anxiety, and depression [26]. A recent systematic review suggests that ACP may improve some caregiver outcomes [27]. ACP interventions involving both patients and caregivers may promote ACP-related actions [28]. Accordingly, ACP discussions can provide patients and families with an opportunity to express concerns and understand one another's wishes. Such discussions should, however, respect patients' preferences and readiness and should not become a process aimed at encouraging document completion.

Healthcare professionals more commonly viewed traditional culture and taboos surrounding death as barriers to ACP discussions. In contrast,

some patients and caregivers in this study indicated that they were open to such discussions, and a few older patients viewed death as a natural part of life. Previous multi-stakeholder interviews and syntheses of healthcare professionals' experiences have also documented concerns about cultural or religious barriers [25,29].These findings may be associated with the relatively high educational attainment of the older inpatients interviewed, the fact that most reported no religious affiliation, and their exposure to media coverage. In particular, one Buddhist participant's equanimity toward death should not be interpreted as evidence that a particular religious belief generally promotes acceptance of ACP.

Participants also expressed differing views on how economic factors influence ACP implementation. Household financial circumstances may affect treatment choices and may also influence families' access to healthcare services and opportunities to participate in ACP. Caregiver 4's comment linking pension income with active treatment reflected a personal view; it cannot establish why other families make treatment decisions. Future studies could examine how financial strain and caregiving resources relate to ACP participation.

At the institutional level, participants reported that the study hospital lacked dedicated ACP forms and standard procedures for these discussions. This finding concerns the study hospital and does not mean that mainland China has no relevant legislation. For example, the Shenzhen Special Economic Zone Medical Regulations include provisions on advance directives for eligible individuals [20]. ACP policies and clinical practices vary across regions. The hospital therefore needs to clarify which documents apply, how discussions should be conducted, and who is responsible.

5.2 Medical decision-making, timing of discussions, and team roles

Patients generally wanted to make their own medical decisions and expressed a wish to avoid overtreatment, reduce suffering, and maintain their quality of life. These preferences can guide ACP discussions, but they do not necessarily mean that patients understand ACP, feel ready to discuss it, or want to complete an advance directive.A systematic review of randomized controlled trials found relatively consistent evidence that ACP improves proximal outcomes, such as communication quality and documentation, whereas findings for some distal patient outcomes were mixed [30]. Clinical discussions should therefore help patients express their goals and preferences, rather than use document completion rates as the sole measure of success.

In this study, healthcare professionals tended to favor initiating ACP discussions early, whereas some patients considered hospitalization too early a time to discuss ACP. A study conducted in a German geriatric palliative care unit found that dementia was more common among non-oncological than oncological patients (38% vs. 8%) and that non-oncological patients had greater functional dependence [31]. Because that study was conducted in a specialized geriatric palliative care unit, its findings may not be directly generalizable to all older hospitalized patients. Nevertheless, they suggest that cognitive and functional status may be relevant when considering the timing of future care discussions. ACP should be regarded as an ongoing and revisable communication process. Healthcare professionals may introduce discussions at an appropriate time based on patients' clinical conditions, values, and readiness, and revisit them when needed, without pressuring patients to participate [32].

Participants considered physicians' professional authority important for building trust, while nurses played an important role in implementing care plans. Some participants also suggested involving social workers and other professionals. Previous multistakeholder interviews and community-based research have reported unclear responsibility for ACP, difficulties in conducting discussions, or delayed initiation [25,33]. In contrast, healthcare professionals in the present study generally regarded

ACP as part of their professional responsibilities, although they differed in their views on specific roles and work arrangements. Team-based ACP should draw on the complementary skills of different professionals while keeping discussions centered on patients' values and wishes.

5.3 Implications for clinical practice and institutional support

Patients and caregivers generally welcomed professional guidance that considered the patient's clinical condition.Healthcare institutions could therefore provide accessible ACP materials and train healthcare professionals to conduct these discussions. Educational approaches could include face-to-face guidance, patient handbooks, telephone consultations, and online platforms. A systematic review of ACP interventions for frail older adults reported improvements in readiness, knowledge, and ACP-related behaviors [34]. Participants also mentioned documentaries and media coverage involving public figures as potential communication channels.

Healthcare professionals identified training needs in ACP knowledge, communication skills, palliative care competencies, clinical reasoning, and relevant laws and regulations. A survey of Chinese nurses and a recent qualitative evidence synthesis of healthcare professionals' experiences both support the need for further training and institutional support; the latter also highlights communication skills [24,29]. Training

should therefore extend beyond didactic instruction and help healthcare professionals recognize appropriate opportunities for discussion, respond to patients' and families' emotions, and discuss future care preferences while respecting patient autonomy. A randomized trial among hospitalized patients found that providing clinicians with patient-specific communication prompts increased documentation of goals-of-care discussions [35]. This provides related evidence for improving hospital communication workflows.

Compared with previous studies of healthcare professionals' responsibilities and barriers to ACP implementation [25,33], healthcare professionals in the present study generally considered ACP part of their professional responsibilities and were willing to participate, with nurses expressing a particularly strong willingness to engage. However, routine workloads and time constraints may affect implementation in practice. Integrating ACP into clinical workflows, establishing dedicated teams or positions, and providing the necessary staffing and procedural support were all identified by participants as feasible approaches.Some participants viewed AI and other technologies as potential tools for reducing routine workloads. The role of these technologies requires further investigation, and they should not replace clinician–patient communication or emotional support.Summary of results

Conclusion

In this single-center qualitative study of hospitalized adults aged over 80 years with multimorbidity, participants described several challenges to ACP: limited awareness among patients and caregivers, emotional strain, family disagreements, and differing views on when discussions should take place. ACP engagement was limited among the patients interviewed. Patients generally valued autonomy and comfort-focused care. Healthcare professionals tended to favor earlier discussions, whereas some patients felt that hospitalization was too soon. This difference highlights the need to consider patients' readiness and preferences when raising ACP.

Participants called for accessible professional guidance and communication involving patients, caregivers, and healthcare professionals. They also identified priorities for implementation, including staff training, adequate staffing, clearer roles, policy support, standardized procedures, and support from AI tools. By bringing together the perspectives of patients, caregivers, physicians, and nurses, this study offers context-specific evidence to inform patient-centered ACP in hospital care and the development of future interventions in similar settings.

Limitations

This study has several limitations. First, it was conducted at an urban tertiary hospital in southwestern China; the findings may not be applicable to other regions or to primary care and rural settings. Second, purposive sampling and participants' educational backgrounds, religious affiliations, and exposure to healthcare services may have influenced their views. Finally, the findings represent participants' experiences and perspectives in a specific clinical setting and should not be generalized to all older patients or families.

Abbreviations

ACP advance care planning

AD advance directive

AI artificial intelligence

Ethics approval and consent to participate The study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of the First Affiliated Hospital of Chongqing Medical University on March 20, 2025 (approval No. 025-202-01).Written informed consent was obtained from all participants before the interviews.

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