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Negotiated Advance Care Planning in Contexts Without Legal Mandates: A Concept Derivation

Zhihao Han
Zhejiang Chinese Medical University
Xiaoqin Ma
20041028@zcmu.edu.cn

Zhejiang Chinese Medical University

Research Article

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Abstract

Background

Advance care planning is widely defined as an iterative, values-based process that involves communication, documentation, and periodic review. However, in settings without robust statutory enforceability, the authority of plans often depends on relational and organisational governance, and the “negotiated” dimension of ACP remains conceptually unstable. We therefore aimed to derive and operationalise the concept of negotiated ACP for non-statutory or weakly protected contexts.

Methods

We conducted an integrative review to extract definitional statements and attributes relevant to negotiated ACP, searching major English-language databases from inception to 5 January 2026 (Scopus, PubMed, CINAHL, Web of Science) and major Chinese databases (CNKI, WanFang, SinoMed), supplemented by grey literature. Two reviewers independently screened and selected studies using PRISMA procedures, then charted and synthesised conceptual content in a narrative synthesis. To operationalise the “negotiated” dimension, we embedded relational contract theory during attribute mapping and maintained an audit trail linking refinements to theoretical rationale and contextual constraints.

Results

Nineteen studies met inclusion criteria. We extracted nine defining ACP attributes and organised them into an initial layered structure. Applying Macneil’s contract norms indicated that reciprocity was not explicit and that surrogate authority required clearer specification. Accordingly, we retained the nine attributes, revised Personal representative identification to Representative role clarification, and introduced Reciprocal exchange among stakeholders. The final negotiated ACP model comprises a core layer (Values and preferences clarification), an execution layer (Multi-party discussion, Organisational documentation support, and Guidance and information provision), and a safeguard layer (Regular review and updating, Managing uncertainty and conflict, Representative role clarification, Readiness assessment, Legal and policy alignment, and Reciprocal exchange among stakeholders).

Conclusion

Negotiated ACP is a structured, multi-party, explicitly documented, and revisable agreement-process whose practical authority depends primarily on relational and organisational governance rather than statute. The derived attributes and boundary cases provide a practical basis for identification, documentation standards, measurement development, and implementation work in non-statutory settings.

Introduction

Advance care planning (ACP) is increasingly positioned as a core ethical practice in serious-illness and end-of-life care [1]. Contemporary consensus work emphasises ACP as an ongoing process that supports adults to clarify values and goals, communicate preferences with families and clinicians, and review those preferences over time, rather than a one-off completion of documents [2]. This process-oriented view has strengthened the ethical case for ACP by focusing on personhood, dignity, and accountable decision-making under uncertainty [2]. More recently, the ACP as part of a broader continuum of care planning across the life course, highlighting preparation for communication and decisions as health

and circumstances change [3–5]. From a nursing ethics perspective, ACP can reduce avoidable suffering and moral conflict by aligning care with the person's values and clarifying shared decisional responsibility across patients, families, and professionals [6].

In some jurisdictions, ACP is closely linked to legally recognised instruments, which can strengthen the formal authority of previously expressed preferences; however, such legal anchoring is absent or uneven in many settings, including mainland China, where binding advance directives lack explicit nationwide legislative recognition [7–9]. When legal enforceability is uncertain, translating values-based conversations into later clinical actions often depends on relationship-based negotiation, documentation, and shared accountability within clinical teams and families, especially in weakly institutionalised ACP contexts [10]. Contemporary work in socio-legal and health-policy scholarship highlights that agreements in complex institutional settings are commonly governed "in the shadow" of formal rules, relying on relational norms rather than on complete, enforceable instruments alone [11]. Where statutory protections for ACP are limited or absent, it often functions in practice as a relationship-based agreement that must be sustained through ongoing communication, mutual role recognition, and periodic renegotiation among patients, families and clinicians [12].

Relational contract theory has recently been revisited as a useful interpretive frame for understanding such ongoing, revisable commitments, emphasising the wider "contracting process" through which parties maintain alignment over time [13]. Building on empirical observations that formal legal sanctions are often rarely used in practice, Macneil articulated relational contracting as structured by ten "common contract norms" (e.g., reciprocity, flexibility and conflict harmonisation) that guide expectations, constrain power and enable adaptation over time [14]. In mainland China, where empirical studies continue to report legal and procedural uncertainty around advance directives and end-of-life decision-making, a negotiated and revisable approach becomes particularly salient for preserving patient preferences within routine care. Accordingly, we use the term "negotiated ACP" to describe a structured, multi-party, and revisable care-planning process in which patients, families (including potential surrogates), and clinicians reach a shared, values-based agreement that is explicitly documented, routinely reviewable, and modifiable or withdrawable as circumstances change, so that the person's preferences can be carried forward into clinical decisions even in settings without strong legal safeguards [2].

Despite its strong practice relevance in non-statutory contexts, negotiated ACP remains conceptually unstable and is frequently discussed as if interchangeable with generic ACP, shared decision-making, end-of-life communication, the completion of a single clinical record such as a do not attempt cardiopulmonary resuscitation form or a resuscitation status entry in the medical notes [15–17]. This conflation is not simply a matter of terminology: ACP is still widely reduced to a single discussion about resuscitation preferences during an acute episode, which leads to inconsistent practice and obscures the boundaries between ACP and other end-of-life processes [3]. In particular, negotiated ACP is often mistaken for documentation that records preferences about cardiopulmonary resuscitation, or it is treated as though a values-based clinical agreement has the same legal standing as a formally recognised advance directive, even though these documents differ in purpose, legal status, and the extent to which they are meant to be reviewed and updated [18]. Such confusion has substantive ethical consequences: when boundaries are unclear, clinicians may inadvertently intensify power asymmetries, allow family preferences to override patient values, or transform a context-sensitive agreement into a seemingly fixed command [19]. Conversely, reliance on informal arrangements may weaken safeguards for vulnerable patients and compromise the ethical enactment of agreed plans [10].

Negotiated ACP should be understood as an explicitly non-legal yet structured agreement-process that documents a patient-centred plan, remains open to revision, and makes responsibilities and limits transparent precisely because legal enforceability is uncertain [1]. Ethically, negotiated ACP must be underpinned by explicit, operational safeguards: ensuring that participation is voluntary and informed, that conflicts of interest are identified and managed, and that family-involved deliberations include clear procedures to recognise and minimise coercion or undue influence, so that the patient's values are not displaced and accountability is maintained [20]. Accordingly, our concept derivation aims to

stabilise the ethical meaning and boundaries of negotiated ACP for contexts without robust legal protection for ACP, by transferring and adapting key attributes from relevant parent concepts [21–23].

Methods

In this study, we undertook a concept derivation to develop and name negotiated ACP as a context-sensitive concept for settings where ACP is not strongly supported by statute and standardised service infrastructures. Guided by Walker and Avant's concept-derivation procedures, we treated negotiated ACP as a "borrowed-and-adapted" concept: key attributes were transferred from established parent concepts and then deliberately re-specified to fit non-statutory clinical realities [21]. The derivation process combined (a) selecting and justifying parent concepts, (b) extracting and comparing their defining attributes, (c) mapping which attributes were retained, modified, or newly introduced to address contextual constraints, (d) producing an operational definition and preliminary boundaries, (e) constructing model, borderline, and contrary cases to illustrate boundaries [24].

Literature search

The following criteria were used to select sources: (a) documents that defined or described ACP as the pre-specified parent concept and provided extractable defining attributes; (b) documents that described agreement-based or negotiated care planning in settings with limited or uncertain legal enforceability, and contained conceptual content relevant to negotiated ACP; (c) documents reporting information on attributes or conditions needed for negotiated ACP, including multi-party deliberation, documentation and accessibility, review and updating arrangements, role and accountability allocation, and safeguards against coercion or undue influence; and (d) publications in English or Chinese, including empirical studies, theoretical or ethics papers, policy or legal analyses, and guidance documents, only when they contained extractable conceptual information. We excluded sources limited to statutory, legally enforceable advance directives and outcome-only interventions lacking extractable concept.

The search strategy aimed to identify relevant literature from database inception to 5 January 2026 across major health databases (Scopus, PubMed, CINAHL, and Web of Science). To reflect the context of mainland China, we also searched Chinese databases (China National Knowledge Infrastructure, WanFang Data, and SinoMed). Search terms were developed using Medical Subject Headings and relevant Chinese subject terms. The full search strategies for each database are provided in Supplementary File 1. A grey-literature search was also conducted using Google Scholar, accessible thesis repositories, and relevant professional and governmental websites.

To ensure the reliability of the review, two researchers conducted the searches following the same strategies between October 2025 and January 2026 and assessed the eligibility of publications on the basis of their titles and abstracts. The researchers retrieved the full texts of publications that met the eligibility criteria based on the opinion of at least one of the researchers on the basis of their abstracts. However, if the abstract did not provide sufficient information, each researcher read the full article independently. Subsequently, the two reviewers and a third researcher resolved any disagreements and reached a consensus through joint discussions. The PRISMA statement was used to select the final sample of studies and report the results of the integrative review [25].

A narrative synthesis of the results of the selected studies was prepared and an Excel spreadsheet was developed including author(s) and year, country or region of origin, objectives, design, participants or data sources, terminology and definition or description of negotiated ACP, and elements/conditions/attributes, including ethically relevant safeguards and arrangements for documentation, review, and updating. The level of evidence of the studies included in the integrative review was also assessed according to the recommendations of the Johns Hopkins nursing evidence-based practice model [26].

Embedding negotiated-related theoretical perspectives

To operationalise the “negotiated” dimension of negotiated ACP, we embedded relational contract theory within the attribute-mapping stage of concept derivation. Relational norms relevant to making workable commitments in the absence of strong statutory enforceability were extracted from canonical sources of relational contract theory, and were used as an analytic lens to refine our mapping of attributes as retained, modified, or newly introduced.

Results

Parent concept selection and justification

We followed established concept-derivation approaches by selecting a well-defined and widely used parent concept and then mapping and adapting its key attributes to fit a specific contextual problem. This approach is consistent with published concept-derivation studies that begin with a mature base concept and refine it through attribute transposition [27].

We selected ACP as the primary parent concept because contemporary definitions converge on ACP as a process through which individuals clarify values and goals, discuss and document preferences for future care, and revisit these preferences over time. Recent definitional work further emphasises ACP as an evolving, conversation-based practice involving patients and those close to them, rather than a one-off document completion task [28]. These core features: multi-party communication, explicit documentation, and reviewability, provide a stable attribute set that can be mapped and adapted to address the specific challenge motivating this study: how preferences can be carried forward into clinical decisions in settings where ACP lacks strong statutory safeguards and organisational infrastructures are variable.

To capture the “negotiated” dimension, we used recent relational-contract scholarship as a lens to understand ACP commitments as ongoing and revisable, rather than relying only on formally enforceable instruments [13]. This lens supported refining the attribute mapping by justifying where ACP attributes should be strengthened or added in non-statutory settings, particularly clear role and obligation allocation, agreed procedures for revision/withdrawal, and Organisational documentation support specifying what is recorded, by whom, and how records are reviewed and updated. Accordingly, ACP remained the parent concept, while negotiated-related theory provided the rationale for modifications and new attributes that distinguish negotiated ACP from adjacent practices.

Defining attribute extraction

To establish the corpus of conceptual material for concept derivation, we applied the predefined search strategy across the selected databases and screened records through a staged process of de-duplication, title/abstract screening, and full-text eligibility assessment. Following full-text review, 19 studies met the inclusion criteria and were retained for analysis. The study selection process is presented in Fig. 1. The included studies were then charted to support transparent attribute extraction and comparison. For each study, we extracted Author, Objectives, Design, Concept of the ACP, and Elements/Conditions/Attributes. This extraction focused on conceptual content (e.g., definitional statements, key elements, and recommended processes) that could inform the derivation and refinement of negotiated ACP. The characteristics of the included literature and the extracted information are summarised in Table 1.

Across the 19 included studies, we extracted and synthesised conceptual material (definitions, key elements, and recommended processes) to identify nine defining attributes of ACP. To enhance interpretability and support subsequent attribute mapping for negotiated ACP, these attributes were organised into a three-layer structure based on their frequency of appearance and conceptual function: a core layer (the central purpose of ACP), an execution layer (how ACP is enacted in practice), and a safeguard layer (what sustains ACP under uncertainty and variability in real-world contexts). The nine attributes and their layering are summarised in Fig. 2.

Core layer

Values and preferences clarification [1–3, 7, 28–42]. ACP was consistently framed as a values-based process in which individuals clarify what matters most to them and translate these values into preferences for future treatment and care. This attribute anchors subsequent conversations and documentation, ensuring that planning remains person-centred rather than procedure-driven. In the included literature, clarification was not limited to treatment choices, but also encompassed broader goals of care, acceptable trade-offs, and priorities that guide decisions when circumstances change [43].

Execution layer

Multi-party discussion [1, 3, 28–31, 33, 34, 37, 38, 42]; Organisational documentation support [7, 30, 34, 35, 37–42]; Facilitation and information provision [29–32, 35, 36, 41]. The execution layer captures how clarified values are turned into workable care plans. Multi-party discussion reflects the recurrent emphasis on involving patients, families (including potential surrogates), and clinicians in shared deliberation so that preferences are understood, negotiated, and made actionable across stakeholders [44]. Organisational documentation support describes the structures and routines that enable preferences to be recorded, retrievable, and visible within clinical workflows (e.g., standardised forms, electronic health record integration, and clear responsibilities for documenting and communicating decisions) [45]. Facilitation and information provision highlight the need for skilled communication support and accessible, accurate information so individuals can deliberate meaningfully, reconcile misunderstandings, and make informed choices aligned with their values [46].

Safeguard layer

Managing uncertainty and conflict [30, 32–34, 36, 38]; Regular review and updating [1, 29, 31, 37, 38]; Personal representative identification [2, 3, 7]; Legal and policy alignment [7, 35, 41]; Readiness assessment [1, 2]. The safeguard layer reflects attributes that preserve the integrity and usability of ACP over time, particularly where clinical trajectories are uncertain and governance arrangements vary. Managing uncertainty and conflict recognises that preferences may be contested or difficult to apply when prognosis is unclear, priorities compete, or family-clinician disagreements arise; studies therefore underscored the importance of explicit processes for addressing discord and revisiting decisions [47]. Regular review and updating position ACP as iterative, requiring routine reassessment as health status, personal circumstances, or goals evolve [28]. Personal representative identification strengthens continuity when patients lose decision-making capacity by clarifying who should speak for the person and how that role is supported [44]. Legal and policy alignment, while variably reported, concerns the extent to which organisational and policy frameworks legitimise documentation, clarify accountability, and reduce ambiguity in implementation [10]. Finally, readiness assessment denotes timely initiation and tailoring of ACP to the individual's informational needs, emotion, and clinical context, helping to avoid premature, coercive, or ineffective planning [48].

Table 1
Characteristics of studies included in the integrative review.

Author	Objectives	Design	Concept of the ACP	Elements/Conditions/Attributes	Level
Rietjens JAC[1]	Consensus ACP definition; consensus recommendations; proposed outcome constructs.	Delphi consensus	Consensus ACP clarifies values and preferences, discussed with family and clinicians, documented and reviewed.	Readiness assessment; Values and preferences clarification; Multi-party discussion; Regular review and updating.	V-A
Sudore RL[2]	Develop a consensus definition (plus goal statement/strategies) for the adult ACP.	Delphi consensus	ACP supports adults to share values and goals, prepare surrogates, and future decisions.	Readiness assessment; Values and preferences clarification; Personal representative identification.	V-A
Hickman SE[3]	Propose a “care planning umbrella” reframing ACP across immediate and future decisions.	Narrative analysis	ACP is ongoing care planning preparing people and surrogates for in-the-moment and decisions.	Values and preferences clarification; Personal representative identification; Multi-party discussion.	V-B
Chen B[7]	Analyse mainland China’s emerging advance directives framework, legal bases, barriers, and pilot implementation efforts.	Review	Advance directives express persons’ future wishes; without legislation, practice relies on ethics and civil law.	Legal and policy alignment; Values and preferences clarification; Personal representative identification; Organisational documentation support.	V-B
Mori M[28]	Consensus ACP definition and recommendations for Confucian-influenced Asian contexts.	Delphi consensus	Process: clarify values, discuss with family/clinicians, document preferences, review regularly.	Values and preferences clarification; Multi-party discussion.	V-A
Robinson CA[29]	Evaluate a patient-centred ACP intervention and reframe ACP ethics towards relational autonomy in families.	Qualitative study	ACP is a relational conversation negotiating meaning, values and preferences, not surrogate preparation for incapacity.	Values and preferences clarification; Multi-party discussion; Facilitation and information provision; Regular review and updating.	III-A
Lund S[30]	Identify barriers to implementing end-of-life ACP and explain how these barriers operate in practice.	Systematic review	ACP relies on workable conversations and documentation, but implementation is constrained by routine clinical systems.	Facilitation and information provision; Multi-party discussion; Values and preferences clarification; Managing uncertainty and conflict; Organisational documentation support.	III-A
Kishino M[31]	Synthesise evidence on family involvement in ACP	Systematic review	Family-integrated ACP engages patients, families	Multi-party discussion; Values and preferences clarification; Facilitation and information	III-A

Author	Objectives	Design	Concept of the ACP	Elements/Conditions/Attributes	Level
	for advanced cancer and develop a logic model.		and clinicians to align decisions with values.	provision; Regular review and updating.	
Sedig L[32]	Clarify autonomy in patient-family disagreements and guide clinicians to support ethical decision-making.	Narrative analysis	Autonomy includes patients' preferred decision style; clinicians facilitate family-inclusive discussions without coercion.	Values and preferences clarification; Facilitation and information provision; Managing uncertainty and conflict.	V-B
Menon S[33]	Highlight ethical challenges of family involvement in competent patients' decisions and propose relational autonomy.	Narrative analysis	Family involvement should respect patient autonomy while recognising cultural family roles and pressures.	Multi-party discussion; Values and preferences clarification; Managing uncertainty and conflict.	V-B
Craig DP[34]	Explore how bedside patient agents' interests shape clinicians' use of advance care plans.	Qualitative study	Written plans may be displaced by time-pressured best-interests decisions negotiated with bedside agents.	Values and preferences clarification; Multi-party discussion; Managing uncertainty and conflict; Organisational documentation support.	III-A
Huang Y[35]	To explore the value and necessity of ACP practice in China from healthcare professionals' perspectives.	Qualitative study	ACP enables patient-centred end-of-life decisions, but is constrained by family norms and legal gaps.	Facilitation and information provision; Values and preferences clarification; Legal and policy alignment; Organisational documentation support.	III-B
Warner BE[36]	Synthesise clinician and older patient perspectives on TEP shared decision-making.	Systematic review	TEP supports shared emergency planning, but is often clinician-led in acute care.	Facilitation and information provision; Values and preferences clarification; Managing uncertainty and conflict.	III-A
Shermon E[37]	Design and implement a TEP to reduce DNACPR complaints through better communication and documentation.	Mixed-methods study	TEP broadens DNACPR into shared emergency planning, supported by structured discussion and forms.	Multi-party discussion; Values and preferences clarification; Regular review and updating; Organisational documentation support.	III-A
Kesten JM[38]	Explore GP and care home staff experiences using ReSPECT to support emergency planning in care homes.	Qualitative study	ReSPECT translates resident preferences into emergency guidance, but depends on communication and context.	Multi-party discussion; Managing uncertainty and conflict; Regular review and updating; Organisational documentation support.	III-A

Author	Objectives	Design	Concept of the ACP	Elements/Conditions/Attributes	Level
Hawkes CA[39]	Evaluate early ReSPECT implementation in acute hospitals, including use patterns and completion quality.	Retrospective study	ReSPECT embeds CPR recommendations within emergency treatment plans to guide future urgent care.	Values and preferences clarification; Organisational documentation support.	III-B
Huxley CJ[40]	Assess whether completed ReSPECT plans reflect patient preferences and support person-centred care.	Retrospective study	ReSPECT should align documented preferences with actionable recommendations for future emergency decisions.	Values and preferences clarification; Organisational documentation support.	III-B
Cheng M[41]	Identify barriers to making living wills and inform strategies to improve uptake in practice.	Qualitative study	Living will-making needs multi-stakeholder discussion and clearer procedures to support autonomy.	Facilitation and information provision; Values and preferences clarification; Legal and policy alignment; Organisational documentation support.	III-A
Chen Q[42]	Explore patient-surrogate concordance in ACP discussions and factors shaping agreement and disagreement.	Qualitative study	ACP depends on patient-surrogate alignment through discussion shaped by family and context.	Multi-party discussion; Values and preferences clarification; Values and preferences clarification; Organisational documentation support.	III-A

Attribute retained, modified, and introduced

Relational contract theory conceptualises agreements as ongoing relational governance sustained through shared expectations and adaptive coordination, rather than complete, one-off transactions. Within this tradition, Macneil proposed ten common contract norms: role integrity, reciprocity, implementation of planning, effectuation of consent, flexibility, contractual solidarity, the linking norms of restitution-reliance-expectations, creation and restraint of power, propriety of means, and harmonisation with the social matrix [14]. To operationalise the “negotiated” dimension in our attribute-mapping stage, we developed Table 2, which maps these ten norms to the nine defining ACP attributes derived from the included literature.

Table 2
Mapping defining ACP attributes to relational contract norms

Defining ACP attribute	Relational contract norm(s) mapped	Mapping explanation
Values and preferences clarification	Effectuation of consent; Contractual solidarity.	Clarifies shared goals and strengthens agreement guiding future decisions.
Multi-party discussion	Effectuation of consent; Creation and restraint power; Role integrity.	Enables mutual deliberation, balances power, forms shared commitments.
Organisational documentation support	Implementation of planning; Linking norms; Harmonisation with the social matrix.	Embeds agreements in workflows, ensures retrievable records, and stabilises expectations.
Facilitation and information provision	Propriety of means; Effectuation of consent.	Supports ethical communication and information for informed choices.
Managing uncertainty and conflict	Effectuation of consent; Propriety of means; Contractual solidarity.	Provides adaptive procedures for disagreement under uncertainty.
Regular review and updating	Flexibility; Implementation of planning; Linking norms.	Makes ACP iterative through reassessment and revision.
Personal representative identification	Role integrity; Creation and restraint of power; Linking norms.	Defines representative and limits authority when capacity is lost.
Legal and policy alignment	Harmonisation with the social matrix; Creation and restraint of power; Propriety of means.	Legitimises documentation and clarifies accountability within organisational and policy frameworks.
Readiness assessment	Propriety of means; Implementation of planning.	Times initiation to context, reducing coercion, improving feasibility.

As shown in Table 2, applying the ten relational contract norms during attribute mapping indicated that all were represented across the nine extracted ACP attributes except reciprocity, which was not explicit and prompted refinement. On this basis, we retained all nine ACP attributes as the foundational attribute set for negotiated ACP, because they collectively capture the core purpose of negotiated ACP and the key execution and safeguard functions required for workable planning in practice. Accordingly, no attributes were removed at this stage.

During attribute mapping, we found that the relational-contract norm “creation and restraint of power” could not be adequately captured by the attribute Personal representative identification. Although ACP guidance commonly emphasises appointing a trusted surrogate to speak for the person when capacity is lost, surrogate decision-making inherently involves authority that can be exercised inconsistently, contested, or over-extended if its scope and duties are not made explicit [49]. This concern is amplified by persistent clinician-surrogate conflicts in serious-illness contexts, where power asymmetries and competing interpretations of “best interests” may undermine value-concordant decisions [50]. We therefore revised the attribute label to “Representative role clarification” to reflect that negotiated ACP requires not only identifying a representative, but also specifying their responsibilities and the boundaries of authority so that surrogate participation supports, rather than distorts, the agreed plan [51].

Reciprocity in negotiated ACP refers to a patterned “give-and-take” across three stakeholder groups, namely patients, families (including potential surrogates), and clinicians, through which the agreement becomes both ethically legitimate and practically workable. Patients do not merely state preferences; they exchange value-based priorities and acceptable trade-offs for clinicians’ appraisal of feasibility, risks, and alternatives, and for families’ commitment to support enactment across care settings [52]. Families, in turn, exchange contextual knowledge and sustained advocacy for timely clinical clarification, acknowledgement of burdens, and a transparent account of what can (and cannot) be delivered [53].

Clinicians exchange expert interpretation and coordination effort for patients' clarity about goals and for families' cooperation in implementing and revisiting plans [54]. Within this reciprocal exchange, contributions are not left one-sided: questions are met with clarification, expressed values are translated into tailored options, and proposed plans elicit either explicit commitment or further negotiation, allowing the agreement to develop through shared adjustment rather than unilateral decisions. This principle is particularly pivotal where legal enforceability is weak: without statutory compulsion, the credibility and continuity of ACP depend on stakeholders repeatedly reciprocating: confirming, honouring, and revising the agreement as circumstances change. Therefore, we introduce "Reciprocal exchange among stakeholders" as a defining attribute of negotiated ACP to capture this bidirectional exchange that underpins durable, revisable agreements. We positioned Reciprocal exchange among stakeholders within the safeguard layer because, in settings without strong statutory enforceability, the durability of negotiated ACP depends on sustained give-and-take and ongoing cooperation among patients, families/surrogates, and clinicians to maintain adherence and enable revision over time.

Operational definition and conceptual boundaries

Building on the retained, modified, and newly introduced attributes identified through attribute mapping and the relational-contract lens, we propose an operational definition of negotiated ACP and delineate its conceptual boundaries. The definition integrates the three-layer attribute structure (core, execution, and safeguard) and incorporates the additional safeguard attribute "Reciprocal exchange among stakeholders" as well as the revised attribute "Representative role clarification", which together strengthen the "negotiated" dimension in contexts without robust statutory enforceability.

Negotiated ACP is a values-based, multi-party care-planning process developed and maintained in contexts without robust legal protection for ACP, where the authority of plans depends on relational and organisational governance rather than statutory enforcement. Through reciprocal exchange among stakeholders, patients, families (including potential surrogates), and clinicians clarify values and preferences, reach a workable agreement, and create a clinically retrievable, standardised record that is visible within routine workflows. Negotiated ACP is iterative and revisable, with explicit arrangements for readiness-sensitive initiation, review and updating, conflict and uncertainty management, and representative role clarification to define surrogate responsibilities and boundaries of authority.

In contexts without robust legal protection for ACP, negotiated ACP is delimited by a core set of necessary features that distinguish it from adjacent activities. It is present when (a) values and preferences are explicitly clarified; (b) multi-party discussion involves patients, families (including potential surrogates), and clinicians; (c) agreements are supported by organisational documentation support, resulting in a standardised, clinically retrievable record embedded in routine workflows; (d) the plan is iterative, with specified arrangements for regular review and updating; and (e) the agreement is sustained through reciprocal exchange among stakeholders, whereby each party's inputs are actively incorporated to maintain workable commitment over time. Negotiated ACP is further supported by safeguarding features, including guidance and information provision, managing uncertainty and conflict, representative role clarification, readiness assessment, and legal and policy alignment.

Construction of model, borderline, and contrary cases

To illustrate how the defining attributes co-occur in practice and to clarify the conceptual boundaries of negotiated ACP, we constructed a model case, borderline case, and contrary case.

Model case. Mr Li, a 68-year-old man with advanced COPD and recurrent admissions, is hospitalised for worsening breathlessness. The team explains that ACP has no strong statutory enforceability in this setting, but the hospital has a

standardised ACP workflow and documentation pathway. An ACP-trained nurse meets Mr Li privately first, checks readiness ("*Would you like to talk about what matters most if you become sicker?*"), and offers plain-language information about likely trajectories, treatment options, and trade-offs. Mr Li says, "*I want comfort and to avoid being kept alive by machines if there is little chance of recovery*," but adds that he worries about burdening his wife.

A joint meeting follows with Mr Li, his wife, and the respiratory physician. The physician clarifies feasibility and alternatives ("*Non-invasive ventilation may help during flare-ups; intubation is unlikely to restore your baseline*"), while Mr Li and his wife share values and practical constraints. When his adult son insists, "*Do everything*," the nurse facilitates discussion, acknowledges family distress, and sets a conflict-handling plan: if disagreement persists, the team will hold a second meeting and, if needed, request an ethics consult. Mr Li nominates his wife as surrogate, and the team documents representative role clarification, specifying her responsibilities and the boundaries of authority.

The agreed plan is entered into the electronic record using a standard form, flagged for visibility at admissions, and shared with the ward and emergency team. A review date is set for three months, with earlier triggers (acute deterioration or preference change). Before discharge, the nurse confirms mutual commitments: the team will communicate promptly at readmission, the wife will present the ACP record, and Mr Li agrees to revisit decisions as circumstances change. This case exemplifies negotiated ACP by integrating values clarification, multi-party deliberation, reciprocal exchange, workflow-embedded documentation, readiness-sensitive initiation, revisability, and safeguards for power, uncertainty, and conflict.

Borderline case. Mr Wang, a 70-year-old man with advanced heart failure, attends an outpatient review after two recent admissions. When ACP is introduced, he says, "*I don't want to suffer*," and "*If things get worse, I'd rather be at home.*" The clinician provides brief information and writes a short note in the chart. His daughter is present and agrees, but no one clarifies what she should do if he loses capacity, and her authority boundaries are not discussed.

Two months later, Mr Wang is brought to the emergency department in severe respiratory distress. His daughter tells staff, "*Dad said he doesn't want machines*," then adds, "*But I'm not sure what he meant… my relatives are saying we must do everything.*" The prior ACP note is not readily visible in the emergency workflow and there is no standardised, flagged record. Under time pressure and family disagreement, escalation decisions proceed without a clearly retrievable, jointly affirmed plan or agreed procedures for revisiting preferences and managing conflict. This case demonstrates initial values clarification and some family involvement, but it lacks sustained reciprocal exchange across transitions, organisational documentation support, and representative role clarification; therefore, it is a borderline case.

Contrary case. Ms Liu, a 64-year-old woman with advanced kidney disease, is admitted with worsening symptoms. The nurse mentions that, in this setting, ACP documents are not legally binding and may not be honoured consistently across services, but no structured process is initiated to build a shared, revisable agreement. During the ward round, the clinician says, "*We need you to sign this*," and points to a resuscitation section without exploring Ms Liu's values or goals. Ms Liu looks unsure and replies, "*I don't really understand… just do what you think is right.*" Her son is not present, and no attempt is made to involve family, identify a representative, or clarify any role boundaries. No information is provided about likely trajectories, options, or trade-offs, and there is no facilitated discussion to manage uncertainty or disagreement.

Later, a junior doctor completes a resuscitation order based on routine practice. There is no standardised ACP record, no jointly affirmed agreement, and no plan for review or updating. When Ms Liu deteriorates the next day, escalation decisions are made unilaterally under time pressure, and the family is informed afterwards. In a non-statutory context, the absence of reciprocal exchange, workflow-embedded documentation, and safeguards for power and conflict leaves planning entirely dependent on clinician discretion. This case contains none of the defining attributes of negotiated ACP and therefore represents a contrary case.

Discussion

Key findings and contribution

From 19 included studies, we first extracted nine defining attributes of ACP and organised them into an initial three-layer structure. We then embedded relational contract theory to operationalise the “negotiated” dimension for contexts where ACP lacks robust statutory enforceability. Mapping the extracted attributes to Macneil’s common contract norms highlighted two refinement needs: (a) reciprocity was not explicitly represented, and (b) the norm of creation and restraint of power required clearer specification of surrogate authority. Accordingly, we retained the nine ACP attributes, revised Personal representative identification to Representative role clarification, and introduced Reciprocal exchange among stakeholders. The final negotiated ACP model comprises a core layer (Values and preferences clarification), execution layer (Multi-party discussion, Organisational documentation support, and Guidance and information provision), and safeguard layer (Regular review and updating, Managing uncertainty and conflict, Representative role clarification, Readiness assessment, Legal and policy alignment, and Reciprocal exchange among stakeholders).

Our main contribution is to stabilise negotiated ACP as a concept that is both theoretically defensible and operationally usable in non-statutory or weakly protected settings, where ACP is often reduced in practice to one-off form completion, isolated goals-of-care conversations, or single-episode treatment decisions [55]. Contemporary consensus definitions emphasise ACP as an iterative, values-based process that involves family and clinicians and includes documentation and review [4]. Building on this foundation, we specify the additional governance work required when legal authority cannot be assumed: negotiated ACP must be sustained through relational norms that bound power, support feasible agreement-making, and accommodate change over time. By refining surrogate involvement as representative role clarification and introducing reciprocal exchange among stakeholders, we make explicit the “give-and-take” through which patients, families/surrogates, and clinicians generate and maintain workable commitments despite limited legal compulsion. The conceptual clarification provides a clearer platform for measurement, workflow design, and implementation evaluation in settings such as mainland China, where adherence in routine care depends heavily on organisational and relational governance rather than statutory enforcement.

Relational governance in non-statutory contexts

In non-statutory or weakly protected settings, ACP cannot rely on formal legal enforceability to secure consistent recognition and adherence across services and transitions. In mainland China, for example, the absence of dedicated legislation recognising binding advance directives means that the authority of ACP-related documentation may remain contingent and negotiable in practice, increasing the risk that preferences are diluted, disputed, or overridden at points of clinical uncertainty [56]. In such contexts, the viability of negotiated ACP depends on relational governance: agreement is sustained through ongoing collaboration among patients, families (including potential surrogates), and clinicians, supported by organisational routines that make commitments visible and revisable over time. This rationale is consistent with recent literature that frames ACP as an ongoing, values-based process of communication, documentation, and periodic review, rather than a one-time completion of forms [57].

Relational contract theory provides a practical lens for specifying what must be “governed” when statutory safeguards are limited. Macneil’s ten common contract norms describe the informal rules through which cooperation is maintained, authority is bounded, and change is accommodated in ongoing agreements [58]. Using this lens, our mapping showed that the nine extracted ACP attributes could be aligned with nine of the norms, indicating that mainstream ACP already contains much of the governance work required for negotiated practice. This finding supports retaining the nine attributes as the foundation of negotiated ACP, while also helping to explain why definitional and measurement heterogeneity continues to complicate evaluation and implementation: where governance functions are implicit or

unevenly operationalised, ACP may be reduced to isolated conversations or documentation events rather than a sustained, revisable process.

We revised Personal representative identification to Representative role clarification and added Reciprocal exchange among stakeholders. These refinements strengthen negotiated ACP by making explicit the relational governance that substitutes for statutory enforceability in weakly protected settings. First, Reciprocal exchange among stakeholders can act as a self-reinforcing governance mechanism in non-statutory contexts, aligning incentives and creating reciprocal obligations that curb unilateral behaviour, reduce the escalation of disagreement, and sustain workable commitments for patients, families/surrogates, and clinicians [59]. Second, role clarification operationalises “bounded authority” by requiring that surrogate responsibilities and limits are documented, addressing well-described surrogate-clinician conflicts and misunderstandings that can displace the patient’s stated values during crises [50]. Together, the two changes sharpen conceptual boundaries and create more observable indicators, supporting measurement, workflow design, and implementation evaluation, particularly in contexts such as mainland China where legal backing remains incomplete.

Implementation implications for practice

Negotiated ACP can be operationalised by introducing a standardised negotiated-ACP template within the electronic record, explicitly recording the surrogate’s decision scope and responsibilities, and documenting the agreed “give-and-take” commitments. In practice, services can (a) establish a nurse- or multidisciplinary-facilitated pathway that assesses readiness, provides plain-language information, and convenes multi-party discussions; (b) use a standardised electronic record, flagged for visibility at admissions and in emergency workflows, that captures values, agreed trade-offs, representative duties/limits, escalation preferences, review triggers, and an agreed process for managing uncertainty and conflict; and (c) build routines for review and updating at defined intervals and after major clinical transitions. Because legal enforceability is uncertain, clinicians should communicate the non-legal status of plans while using organisational governance, shared documentation, transparency, and escalation routes, to sustain commitment. Digital documentation and sharing systems are central to making plans retrievable across settings [45]. Evidence on ACP interventions remains mixed, underscoring the need to track patient-relevant outcomes alongside documentation rates; therefore, implementation research (evaluating effectiveness, costs, and sustainability) should accompany scale-up [60].

Limitations and future directions

This study is limited by its reliance on published literature and an interpretive synthesis; relevant grey literature, local policy documents, and tacit clinical routines in non-statutory contexts may therefore have been under-represented. The derivation and refinement of defining attributes inevitably involved researcher judgement, and the proposed conceptual boundaries and practical indicators have not yet been empirically tested for clarity, feasibility, or consistency across settings. Future work should use Delphi consensus methods with patients, surrogates, clinicians, ethicists, and administrators to verify the defining attributes and minimum documentation elements, and should also undertake implementation research to test whether a standardised negotiated ACP pathway can be delivered as intended in routine care and whether it improves patient-centred outcomes, reduces decisional conflict, and is acceptable, affordable, and sustainable across settings.

Conclusion

This concept derivation clarifies negotiated advance care planning (ACP) for contexts where statutory protection is limited, providing an operational definition, preliminary boundaries, and practice-facing indicators to distinguish it from adjacent forms of ACP and shared decision-making. The revised attribute set highlights that negotiated ACP is not merely a conversation, but a structured, reviewable agreement process supported by Organisational documentation support, explicit representative role clarification, and reciprocal exchange commitments that make preferences

actionable in routine care. By articulating how these attributes function together to reduce ambiguity, strengthen accountability, and support consistent enactment across transitions, this study offers a coherent conceptual foundation for service design, documentation standards, and evaluation. Future work should validate the attributes and minimum documentation elements with multi-stakeholder consensus and test a standardised negotiated-ACP pathway through implementation research.

Declarations

Authors' contributions

All authors contributed to the study's conception and design. Zhihao Han and Xiaoqin Ma designed the study. Zhihao Han did the analysis of the data and the interpretation of the results. Material preparation and data collection by Zhihao Han and Xiaoqin Ma. The first draft of the manuscript was written by Zhihao Han. All authors read and approved the final manuscript.

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Availability of data and materials

No datasets were generated or analysed during the current study.

Ethical approvals

Ethical approval was not required because this study synthesised publicly available literature and did not involve human participants, identifiable data, or human tissue.

Conflict of interest

The authors declare no conflicts of interest.

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Figures

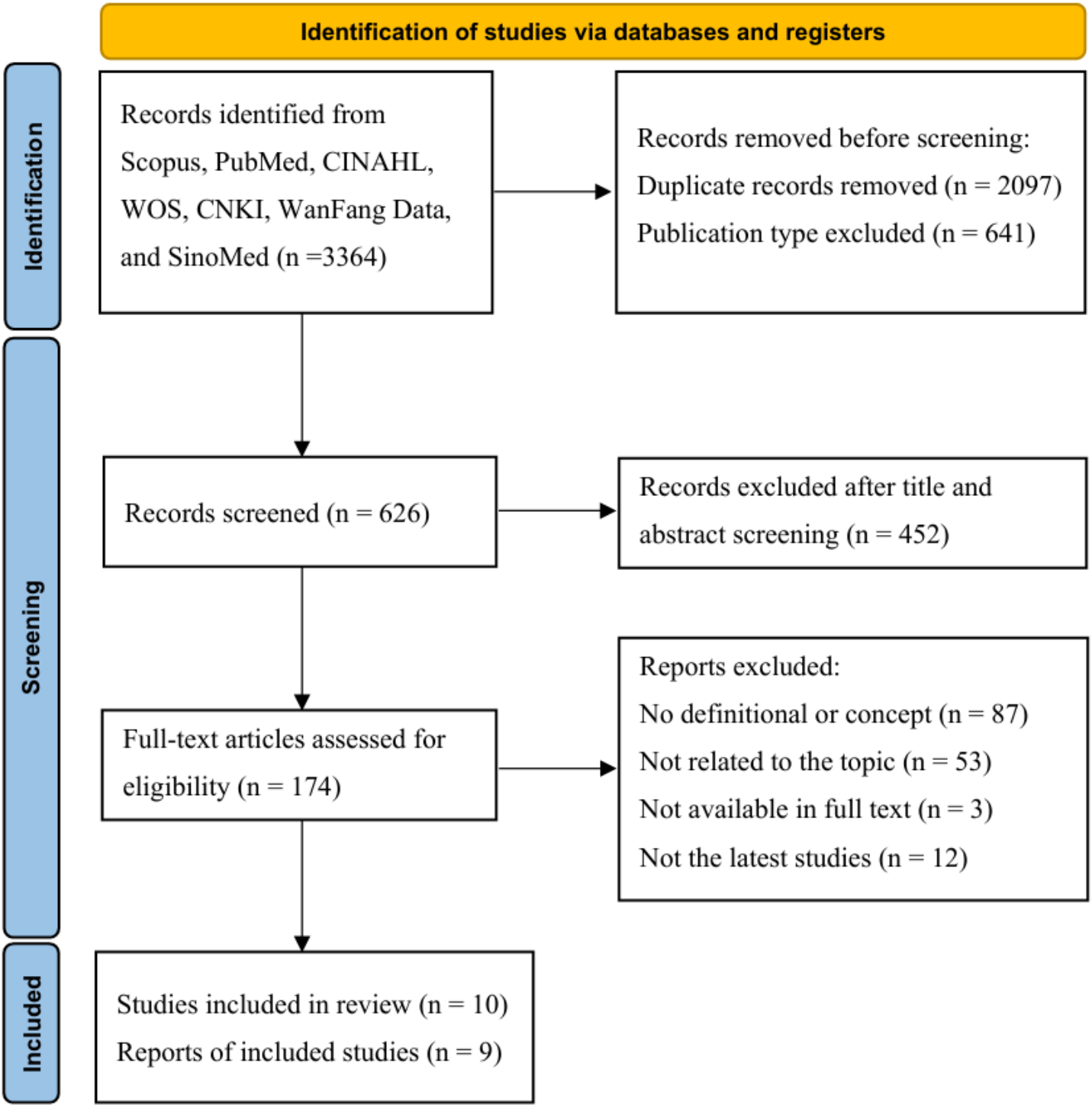


Figure 1

Study flow chart of the sampling process (PRISMA).

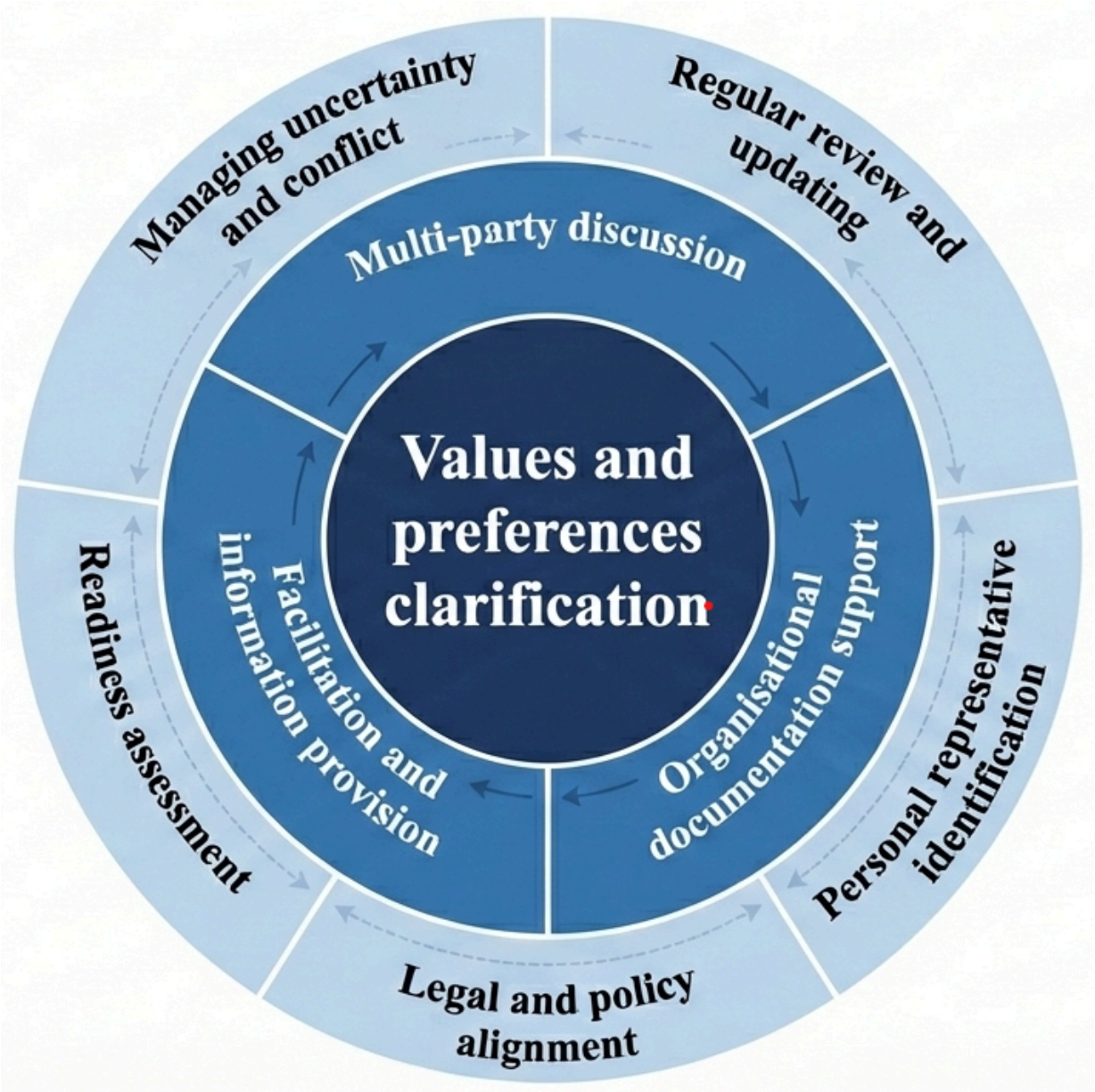


Figure 2

Three-layer model of defining attributes for ACP