Narrative Review Article

Cultural Variations in End-of-Life Care: Balancing Ethics, Sensitivity, and Decision-Making

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ABSTRACT

End-of-life care presents some of the most ethically complex challenges in modern medicine, particularly when cultural values and religious beliefs conflict with established healthcare standards. As healthcare systems grow increasingly diverse, clinicians are frequently required to navigate tensions between respecting patients' cultural norms and upholding professional ethical obligations. This narrative review examines how cultural conflicts shape ethical decision-making in end-of-life care, focusing on situations in which beliefs about disclosure, autonomy, and treatment refusal diverge from Western medical frameworks. Using a conceptual analysis of case studies, this paper analyzes two cases: a devout woman with advanced pancreatic cancer who repeatedly declined do-not-resuscitate (DNR) orders on spiritual grounds, and a Chinese family that requested nondisclosure of a terminal diagnosis to protect the patient from emotional harm. These cases are evaluated through core bioethical principles of autonomy, beneficence, nonmaleficence, and justice, as well as the alternative frameworks of care ethics and relational autonomy. The analysis demonstrates that a rigid application of Western bioethical standards can unintentionally undermine culturally meaningful forms of care, while uncritical deference to cultural norms can erode patient autonomy and welfare, or compromise professional responsibility. The findings suggest that ethically sound end-of-life care requires flexible, patient-centered communication, institutional support for culturally informed decision-making, and policies that recognize ethical pluralism. This paper concludes by discussing implications for clinicians, healthcare institutions, and policymakers, emphasizing the need for clearer guidelines, enhanced cultural competence training, and greater accessibility of ethics consultation to mediate cross-cultural ethical conflicts at the end of life.

Keywords: End-of-life care; cultural competence; bioethics; autonomy; filial piety; care ethics; principlism; healthcare policy

INTRODUCTION

End-of-life care is one of the most ethically complex areas in modern medicine, where cultural values, religious beliefs, and clinical judgment often collide. When patients' or families' beliefs about death, disclosure, and treatment conflict with clinical recommendations, healthcare providers face profound ethical dilemmas (1). This paper examines how cultural sensitivity and clinical decision-making intersect, using two illustrative cases – a devout woman with pancreatic cancer who repeatedly refused do-not-resuscitate (DNR) orders, and a Chinese family's insistence on nondisclosure of a terminal diagnosis to the patient – to highlight these tensions (1). Drawing on bioethical theory and empirical studies of cultural competence, this review argues that

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neither uncritical regard for cultural norms nor rigid application of Western medical standards will suffice (2). Instead, ethically sound end-of-life care requires patient-centered communication, institutional support for shared decision-making, and a commitment to ethical pluralism that respects diverse worldviews while upholding core principles of beneficence, autonomy, and nonmaleficence (2).

Ethnic minorities compose a substantial share of the United States population (3). The American model of care, which centers autonomy in medical decision-making, is not easily applied to members of some racial and ethnic groups (3). Yet principlism, the dominant framework guiding clinical practice, developed largely within a Western, individualistic tradition and may not adequately reflect the values of patients from collectivist, spiritually oriented, or family-centered cultures (2, 3). This gap is especially acute at the end of life, where decisions carry irreversible consequences and where cultural beliefs about death, dignity, and the afterlife are most deeply felt (4). Empirical work supports this point. In a survey of 800 older adults across four ethnic groups, ethnicity was the strongest predictor of attitudes toward truth telling and decision making, with Korean American and Mexican American respondents far less likely than European American and African American respondents to favor direct disclosure of a terminal diagnosis (5). Cultural background is therefore not a peripheral variable in end-of-life care but a central one (3, 5). Addressing these conflicts requires not only clinical skill but structural reform in training, institutional policy, and law.

CULTURAL SENSITIVITY VS. CLINICAL DECISION MAKING

Traditional Western bioethics relies on the theory of principlism (2, 6). Principlism consists of four general principles – autonomy, beneficence, non-maleficence, and justice – that are used to guide ethical decision-making (2, 6). While principlism allows for consistency and clarity, the principles are rooted in individualistic values and may not be compatible with family-centered cultures or cultures that place a high emphasis on spirituality (2). Other ethical theories, such as care ethics and relational autonomy, move away from a strictly individualistic view of ethics (2, 7, 8). Instead, they emphasize the importance of relationships, the context in which individuals live, and culturally-specific responsibilities. These alternative perspectives provide a basis for decision-making at the end of life, because many decisions made at the end of life are influenced by the social and cultural environment in which an individual lives (4).

When there are conflicts between the values of culture and clinical protocols, it is often because two or more ethical frameworks have assigned different meanings to the same words (2). In end-of-life care, disputes typically occur with regard to whether information should be disclosed, who should be involved in decision-making, and what the goal(s) of treatment should be (1). End-of-life care disputes can be emotionally charged and may include issues related to communication barriers, mistrust, and different expectations regarding the roles of healthcare providers (9). Providers must therefore weigh not only medical options but competing moral frameworks (2).

Two disputes illustrate these tensions. In the first, a woman with pancreatic cancer and a poor prognosis maintained a belief in divine intervention and a strong desire to preserve hope and spiritual meaning throughout her illness (1). She refused to accept DNR orders, declined discussions regarding medical futility, and accepted hospice care only shortly before her death (1). Structural barriers, including limited access to certain medications through Medi-Cal, contributed to her distrust of the healthcare system (1). Her clinicians emphasized her comfort and the reality of her prognosis. Her decisions, however, reflected a different interpretation of "benefit," grounded in her faith and perseverance (1). This difference resulted in unnecessary interventions during the final stages of her illness, caused significant emotional distress to her care team, and created a persistent gap in shared understanding.

The second dispute concerned a Chinese man with nasopharyngeal cancer (1). His family asked that he not be told his disease was terminal, citing a cultural expectation of family responsibility and the belief that disclosure would harm him (1). When the physician concluded that informed consent required disclosure, the family opposed this decision (1). Ultimately, the physician informed him through a third party (1). That decision created tension between the physician's professional obligation to inform the patient and the family's cultural expectations. While the medical team emphasized the importance of respecting the patient's autonomy and telling him the truth regarding his condition, the family emphasized the importance of protecting the patient's emotions and the importance of family decision-making (1).

Both of these disputes illustrate the challenges of

applying the principles of traditional Western bioethics across diverse cultural environments (2). In the second dispute, the principle of autonomy conflicted with the principle of relational autonomy, a model in which decision-making authority is shared rather than located in an individual (2, 8). The family's request for nondisclosure reflected the value of filial piety, which emphasizes respect and protection of elders (1, 10). Requiring the patient to accept individual autonomy in this dispute did not simply enforce the standard ethical principles (2). It would also have overridden a culturally meaningful practice (1).

Similarly, the principle of beneficence was challenged in both disputes (2). In the first dispute, the clinicians believed that a DNR order, together with a shift toward comfort-focused care, best served the patient's comfort and dignity (1). On the other hand, the patient interpreted continued treatment as an expression of her hope and faith (1). These differences in interpretation demonstrate that the concept of "benefit" is not universal. Rather, the meaning of "benefit" is influenced by an individual's cultural and spiritual beliefs (4). Care ethics offers a more contextually sensitive approach to ethics, emphasizing relationships, trust, and responsiveness to the particulars of each situation (2, 7). For example, in the second dispute, a care ethicist would consider the family's request to be a morally relevant consideration and would provide guidance regarding communication to protect the trust of the family while also respecting the cultural values (2). In the first dispute, a care ethicist would guide clinicians in responding to the patient's spiritual beliefs and structural disadvantages, rather than treating the disagreement as a series of discrete procedural decisions, such as code status (1). The care ethics approach could help establish a foundation of trust and increase the likelihood of successful end-of-life care planning. Table 1 summarizes the principal domains of cross-cultural conflict discussed in this review, the contrasting framings each receives, and the implications of each for practice.

INSTITUTIONAL POLICIES VS. CULTURAL EXPECTATIONS

Healthcare ethics committees (HCECs) are most often involved in three situations: disagreement over how to interpret an advance directive, disagreement between family and clinicians about a patient's prior wishes, and cases where a written directive is silent on a patient's culturally specific expectations (13). However,

Table 1. *Domains of cross-cultural conflict in end-of-life care: contrasting ethical framings, illustrative cases, and implications for practice.*

Domain of conflict	Predominant Western bioethical framing	Culturally grounded/ relational framing	Illustrative case	Principal implication for practice
Disclosure of a terminal diagnosis	Full disclosure to the patient; truth-telling as respect for autonomy (2, 11)	Nondisclosure or family-mediated disclosure as protection and filial care (1, 10)	Family requests that a terminal prognosis be withheld (1)	Ask how much the patient wishes to know and whom to involve, rather than assume (5, 12)
Locus of decision-making	The individual patient as primary decision-maker (2, 6)	Shared, family-centered (relational) authority (2, 8)	Family opposes informing the patient (1)	Document the patient's preferred decision-making model in advance (1)
Meaning of "benefit"/goals of care	Comfort, prognostic realism, avoidance of nonbeneficial treatment[1]	Hope, faith, and spiritual meaning; continued treatment as an act of care (1, 4)	Patient declines a DNR order and comfort-focused care (1)	Invite patients to define benefit, harm, and dignity in their own terms (2)
Institutional/ structural response	Standardized policy, informed-consent requirements, ethics committees (19)	Flexible, culturally responsive accommodation (14, 15)	Brain-death and transfusion refusal disputes (1, 16)	Proactive ethics consultation; interpreter access; documented preferences (18, 22)

DNR, do-not-resuscitate. Illustrative cases are drawn from Koenig and Gates-Williams (1). Patterns shown reflect tendencies observed in individual case reports and surveys, not fixed rules for any cultural group.

many HCECs lack formal training in cross-cultural mediation (13). A committee's ability to address the cultural dimension of a conflict is therefore limited when the conflict cannot be resolved as a matter of law or procedure.

Institutional frameworks also affect end-of-life care. One clear example is the Ethical and Religious Directives for Catholic Health Care Services (ERDs) (19). The ERDs are binding governance documents that direct decision-making related to limits on life-sustaining treatments, physician participation in assisted dying, and other end-of-life care practices in hospitals affiliated with the Roman Catholic Church (19). While the ERDs are intended to promote the moral integrity of Catholic health care facilities, they can create ethical challenges for both clinicians and families of patients receiving care in pluralistic health care environments (19). Clinicians may experience constraints on their professional autonomy, and ethics committees may experience difficulties in guiding clinicians regarding the development of care plans that meet the needs of all stakeholders. The availability and quality of end-of-life care may vary across health care systems depending on whether a particular facility adheres to the ERDs (19).

When available, ethics consultation can help resolve value-based conflicts, including those arising from cultural differences, and there is evidence that it does so effectively (13). A multicenter randomized trial found that ethics consultations in intensive care reduced nonbeneficial life-sustaining treatment among patients who did not survive to discharge, without increasing mortality, and were viewed as helpful by 87% of physicians, nurses, and patients or surrogates (18). The use of ethics committees can provide an opportunity for multiple disciplines to come together to discuss the issues related to the conflict; however, this process is generally reactive, meaning consultation typically occurs after a conflict has developed (13, 20). Proactive consultation demands more time and preparation than teams can typically give (13, 20).

Some ethics committees may lack sufficient diversity or expertise to fully represent the perspectives of the patients and communities they serve (13). Because their recommendations are usually advisory, final responsibility for the care plan remains with the treating clinician, who must reconcile that guidance with professional obligations and institutional policies (2, 13).

Institutional limitations associated with the use of ethics committees are exacerbated by inconsistent regulatory requirements. The United States health care system is governed by a complex network of federal, state, and institutional regulations. These regulatory requirements are designed to promote consistency in the delivery of health care services while promoting flexibility in the delivery of culturally sensitive care. At the federal level, the U.S. Department of Health and Human Services' Office of Minority Health has issued the National Standards for Culturally and Linguistically Appropriate Services (CLAS), which call on health care organizations to deliver services that are responsive to patients' cultural and linguistic needs (14). The Joint Commission requires its accredited institutions to respect the rights of patients and to honor the cultural preferences of patients in matters related to care decisions, including decisions related to end-of-life care (15). However, these regulatory requirements establish only general expectations and do not provide specific guidance for resolving cultural conflicts. Each hospital therefore develops its own internal policies for managing the conflicting demands for consistency in the delivery of universal clinical standards and diversity in cultural expectations.

In addition to hospital ethics systems, state medical boards also provide oversight for clinical decision-making (24). However, no single regulatory body defines how cultural conflicts in end-of-life care should be resolved. Clinicians nonetheless remain guided by the core bioethical principles of autonomy, beneficence, nonmaleficence, and justice when navigating end-of-life decisions (22). The decentralized nature of the regulatory framework results in wide variations in how similar patients are treated in similar situations. Two patients with similar cultural backgrounds may receive different care at two hospitals, depending on each institution's policies and the cultural competence of its staff (23). This difference is compounded when federal obligations intersect with varying state laws. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize emergency patients regardless of any cultural or religious objection to such stabilization (24). In contrast, the laws governing advance directives and surrogate decision making vary significantly from state to state (25). These overlapping rules create a regulatory framework that is difficult for clinicians to apply in practice.

Specific examples show how institutional policy can conflict directly with cultural and religious expectations. Koenig and Gates-Williams document one recurring example: requests for indefinite life support for patients who meet the medical and legal definition of brain

death (1). When families reject the medical definition of brain death on religious or cultural grounds, hospitals face both practical and ethical dilemmas (1). Continued physiological support may be emotionally vital for the family, yet sustaining it in the intensive care unit (ICU) conflicts with the medical and legal determination that the patient has died (1). Brain death is a legally and medically recognized determination of death in the United States, and this determination is not altered by disagreement. These cases illustrate, however, that a family's religious or cultural understanding of death may differ from the legal standard (4). Hospitals should therefore respond with culturally sensitive support and education, respecting the family's beliefs while maintaining the validity of the medical determination.

Another example of conflicting policy and cultural expectation is the need for informed consent from the competent adult patient. Informed consent is a cornerstone of Western bioethics, and hospitals generally require it on the basis of autonomy (2, 11). However, in cultures where family-centered decision-making is the norm, direct disclosure may be viewed as inappropriate, harmful, or disrespectful (1). Hospitals must then reconcile their consent requirements with families' cultural expectations. Relational models of autonomy can support involving family members in decision-making, but they do not justify withholding information from a competent patient unless that patient has expressed a preference for limited disclosure or has delegated decision-making to others. Cultural preference alone does not override a competent patient's right to information (3). Since the purpose of informed consent is to protect the voice of the patient, there is inconsistency across the healthcare system in how much flexibility is provided for family or relation-mediated decision making. Therefore, clinicians are often forced to decide, without clear direction, whether the ethical principle of autonomy must take precedence over culturally grounded models of care (2).

Religious objections to standard medical treatments reveal the same gaps. The refusal of blood transfusion by Jehovah's Witnesses is a well-known example (16). While courts have generally ruled in favor of the right of competent adults to decline treatment based upon religious objections, the complexities arise when family members object to this decision, when the patient lacks decision-making capacity, or when minors are involved (16). In pediatric cases, there is greater clarity regarding how to obtain court-ordered consent in states that provide for this option; conversely, other states provide greater discretion to physicians, hospital counsel, or ethics committees (16). The variability of state laws regarding consent for treatment results in inconsistent protection for both patient rights and provider liability. Even where the law is settled, uncertainty persists at the bedside.

Taken together, these examples suggest that existing policy leaves a gap. Federal standards set general expectations without specific guidance for resolving cultural conflict, and state law varies substantially (25), so no single framework reconciles these disputes while preserving the flexibility they require (14, 15). This gap has three consequences. First, it places an undue burden on individual clinicians. Clinicians must make difficult ethical decisions in real time without the benefit of institutional support and clear guidelines regarding procedure. These decisions impact the well-being of the patient, the trust that the family has in the health care team, and the quality of the care that the patient receives. Unless clinicians are adequately trained in cross-cultural ethics, they may inadvertently provide care that is insensitive, biased, or too heavily influenced by their own judgment (17). The preceding case studies illustrate the challenges that clinicians face when trying to reconcile the obligations of their profession, the expectations of their institution, and the cultural values of their patients (1).

Second, inconsistent policy generates disparities. A nondisclosure request accommodated at one hospital may be refused at another, and minority patients more broadly face documented inequities in communication, hospice and palliative care utilization, and symptom management at the end of life (23). Such variability creates inequitable experiences for patients receiving end-of-life care from a cultural perspective.

Finally, the absence of a clear and consistent policy framework limits the ability of hospitals to provide effective training and support to their staff (17). Training in cultural competence is sometimes provided to staff; however, the quality and depth of this training vary widely (17). Without a more robust institutional framework, such training will likely continue to be fragmented and inadequate (17).

ETHICAL CHALLENGES IN CULTURAL CONTEXT

The contrast between Confucian filial piety and Western autonomy represents one of the most important distinctions in end-of-life ethics (1, 10). Filial piety describes the moral obligations owed to

family; within this framework, withholding a grave prognosis and making treatment decisions collectively can be understood as acts of care and respect (1, 10). Western bioethics, by contrast, centers individual self-determination and full disclosure (2, 11). These are not merely different customs but different conceptions of ethical responsibility, which is why conflicts persist even when clinicians, patients, and families all act in good faith (1). They also expose the limits of any single ethical framework applied across cultures and underscore the need for approaches that accommodate ethical pluralism (1, 2).

Both cases described earlier reflect this contrast: the Chinese family's nondisclosure request expressed filial piety and a relational model of autonomy (1, 10), while the first patient's insistence on continued treatment expressed faith and hope that stood apart from her clinicians' emphasis on prognosis and comfort (1). In each, the disagreement was not fundamentally about medical facts but about what constitutes good care, appropriate communication, and moral responsibility at the end of life (1).

These observations should not be overstated. They derive from individual case reports, and cultural groups are internally diverse; treating any practice as uniform within a culture risks dichotomizing cultures into fixed opposites (12). Nie has argued that such dichotomization distorts the realities of both Chinese and Western societies, obscures internal moral diversity, and forecloses cross-cultural dialogue (12). Even where nondisclosure or family-centered decision-making is common, individual patients vary in what they want, and preferences shift over time and with acculturation (5, 12). The clinical implication is not to predict a patient's wishes from ethnicity but to ask. Group-level patterns are recorded: Koenig and Gates-Williams observed that many Hispanic and Korean American patients elected to continue life-prolonging treatment out of faith in the possibility of recovery even when clinicians judged it nonbeneficial (1), but such patterns describe tendencies, not rules, and should inform questions rather than assumptions (3, 5).

Clinicians may perceive the reluctance to discuss death as a form of denial or non-compliance instead of as a culturally acceptable stance (4). Implicit bias among healthcare professionals creates yet another layer of complexity (17). Even when clinicians attempt to provide culturally sensitive care, their own biases and assumptions regarding communication, decision-making, and appropriate treatment may influence the manner in which they interact with patients (17). Shepherd *et al*. reported that a majority of healthcare providers expressed confidence in providing culturally competent care to diverse populations; however, nearly 50% acknowledged that their own cultural background had at times caused discomfort in patients (17). Self-reported confidence is therefore not a reliable proxy for effective care, especially under the pressure of end-of-life decisions (17).

Although cultural competence is often advocated as a solution to these challenges, it is essential to recognize the limitations of this concept (17). As Louw stated, cultural competence is a dynamic process, rather than a static skill (2). This process involves the clinician's continued efforts to develop skills to communicate effectively with patients across cultural boundaries (2). Most cultural competence training programs, however, are inadequate (17). They rely on general characteristics of cultures or oversimplified guidelines, which may create stereotypes rather than promote authentic understanding (17). To truly develop cultural competence, the clinician must engage with the patient's values, recognize individual variability within cultural groups, and be able to navigate ambiguity without relying on assumptions (2). Cultural competency is best achieved when cultural awareness is integrated into the ethical underpinnings of care rather than being treated as an additional consideration (2). This includes allowing patients and families to participate in open and honest dialogue, acknowledging the validity of the moral frameworks of each culture, and establishing organizational policies that support flexible and culturally responsive decision-making. Ethical disagreements during end-of-life care are inevitable; however, a more thoughtful and culturally aware approach can enhance the process and outcome of the care provided.

RECOMMENDATIONS

Clinician/Provider Level

Clinicians should move beyond the surface-level cultural competence model toward a sustained practice of cultural humility (2). This means developing the skills to comprehend and draw out individual patient values through open-ended questioning, without relying on cultural assumptions or stereotypes (17). Questions such as "Who would you like to have with you when you receive important medical news?" or "Is there anything about your beliefs or traditions that you would like me to understand as we make decisions together?" can open space for culturally meaningful conversations

without creating a particular framework. Early and ongoing goals-of-care conversations should be standard practice, initiated before crisis points arise. These conversations should use plain, accessible language and should explicitly invite patients and families to define what "benefit," "harm," and "dignity" mean within their own value systems (2). When language barriers exist, trained medical interpreters (not family members or untrained staff) should be used consistently, both to ensure accuracy and to protect the patient's ability to speak privately if desired (17). Clinicians should also receive structured training in navigating ethically complex conversations, including how to respond to nondisclosure requests in ways that respect cultural values while fulfilling professional obligations (13). Continuing medical education programs should integrate reflective practice and implicit bias awareness not as one-time modules but as ongoing components of professional development (17).

Hospital and Institutional Level

Hospitals should strengthen their ethics consultation services by incorporating interdisciplinary expertise, including professionals with training in cross-cultural mediation, medical anthropology, and religious studies (9). Ethics committees should not function solely in a reactive capacity, convened only after conflict has already escalated, but should engage proactively, supporting advance care planning conversations and offering preventive guidance before disputes arise (9). Institutions should develop standardized protocols for documenting patients' cultural preferences, preferred decision-making models (individual versus family-centered), and disclosure preferences in the medical record, so that this information is visible to the whole care team and does not depend on a single clinician's knowledge (1). Access to language services, chaplaincy, and culturally aligned community support resources should be expanded to ensure equitable care across all patient populations (17). Training programs at the institutional level should be longitudinal, case-based, and grounded in the complexity of real clinical scenarios rather than in simplified cultural generalizations (2, 17). Staff should be equipped not only to recognize cultural differences but to navigate moral ambiguity with confidence and care (17). Institutional policies should also be reviewed to ensure sufficient flexibility, allowing clinicians to adapt care plans in ways that respect both professional obligations and patients' cultural values without experiencing undue legal or professional risk (2).

Policy and Legal Level

Policymakers should work toward developing clearer and more consistent national guidelines that address cultural conflicts in end-of-life care while preserving the flexibility necessary to accommodate genuine diversity. Guidance on specific recurring issues, including nondisclosure requests, family-centered decision-making, and religious objections to treatment, would reduce the burden currently placed on individual clinicians to interpret their ethical obligations independently and in real time (1, 2). Legal standards surrounding informed consent and surrogate decision-making should be refined to better accommodate relational models of autonomy, where appropriate, without undermining fundamental patient rights (2). The current variability in state laws creates inequitable outcomes and exposes both patients and clinicians to unnecessary uncertainty (23, 25); greater alignment between federal, state, and institutional frameworks would promote consistency and fairness. Policies should also support increased and sustained funding for ethics consultation services, interpreter access, and clinician training in cultural humility (17). Finally, policymakers should prioritize investment in research on culturally responsive end-of-life care to ensure that clinical guidelines and legal frameworks evolve in response to the changing demographic realities of the populations they serve (1).

CONCLUSION

Cultural conflicts in end-of-life care reveal limitations in the ability of Western medical frameworks to accommodate culturally diverse healthcare populations (1). The case studies examined in this paper demonstrate how deeply held cultural and religious beliefs (regarding disclosure, autonomy, and life-sustaining treatment) can come into direct tension with Western clinical norms and regulatory expectations (1). While principlism offers a clear structure, the emphasis on individual autonomy and standardized decision-making often fails to capture the increasingly diverse values that shape patients' experiences (2, 6). Other frameworks, such as care ethics and relational autonomy, better reveal these contexts but remain inconsistently integrated into practice (2, 7, 8). At the institutional level, ethics committees and policy frameworks are intended to resolve these conflicts, yet their uneven cultural expertise and largely advisory authority limit their effectiveness (9, 13). As a result, ethical responsibility is frequently shifted onto individual clinicians, contributing to moral distress and

unequal care (23). These challenges are not the result of cultural difference alone – rather, they result from systemic gaps in training, policy understanding, and available support structures (17). Ultimately, ethically sound end-of-life care in multicultural societies requires more than cultural awareness. Clearer institutional policies, strengthened ethics consultation services with genuine cross-cultural expertise, and regulatory frameworks that balance flexibility with accountability are imperative (9). By acknowledging ethical pluralism while committing to core ideals of patient welfare and dignity, healthcare systems can better navigate cultural conflict and provide end-of-life care that is both responsible and responsive (1).

CONFLICT OF INTEREST

The author declares that there are no conflicts of interest related to this work.

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