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Corresponding author:

Ting Liu

tjuliuting@163.com

Author Affiliation:

Tongji University School of Medicine.

Avoidance and concealment of prognostic information during palliative and hospice care for older adults with advanced cancer: a qualitative systematic review

Liu, T; Li, D; Chen, S; Xia, B; Wang, T; Zhu, R; Lin, M; Shen, Y; Li, L.

ADMINISTRATIVE INFORMATION

Support - No support.**Review Stage at time of this submission** - Preliminary searches.**Conflicts of interest** - None declared.**INPLASY registration number:** INPLASY2026100120**Amendments** - This protocol was registered with the International Platform of Registered Systematic Review and Meta-Analysis Protocols (INPLASY) on 28 October 2026 and was last updated on 28 October 2026.

INTRODUCTION

Review question / Objective Review question: Among older adults with advanced cancer receiving palliative or hospice care, how and why do patients, family caregivers and clinicians avoid, conceal or postpone prognostic information, and under what conditions does disclosure become possible?

Objectives: (1) to describe how prognostic information avoidance and concealment are experienced and enacted by older patients, families and clinicians; (2) to explain the individual, relational, cultural and organisational influences that shape these behaviours; and (3) to generate actionable implications for palliative and hospice nursing practice, education and policy.

This is a qualitative evidence synthesis using the Joanna Briggs Institute meta-aggregation approach. It addresses a communication phenomenon rather than the effectiveness of an intervention.

Rationale An accurate understanding of prognosis underpins goal-concordant care at the end of life, including decisions about disease-directed treatment, comfort-focused care, place of care and preparation for death. Yet prognostic information is frequently withheld, softened or avoided. Avoidance is often interpreted clinically as denial, a framing that locates the problem within the patient and overlooks the relational, cultural and emotional logic that sustains it.

Qualitative studies from Asia, the Middle East, Europe, North America and elsewhere have begun to describe this phenomenon, but the evidence is dispersed, small and differently theorised. Previous reviews have addressed truth-telling broadly, the sustaining of hope, or the effects of communication interventions; none has synthesized qualitative evidence specifically on avoidance and concealment among older adults with advanced cancer in palliative and hospice care.

A synthesis is therefore needed to integrate what is known about the meanings, drivers and consequences of avoidance, to explain cross-

cultural variation, and to identify the conditions under which older patients become ready to engage with prognosis. The findings will inform communication training, family-inclusive practice and service design.

Condition being studied Advanced, incurable or terminal cancer in older adults who are receiving palliative or hospice care. Cancer is predominantly a disease of older age, and a substantial proportion of older adults with advanced cancer receive specialist palliative or hospice care in the final phase of life. The review is concerned less with the tumour itself than with a communication phenomenon that occurs in this population: the avoidance, concealment or postponement of prognostic information by patients, family caregivers and clinicians. Prognostic information includes the likely course of illness, expected survival, the goals and limits of treatment, and the imminence of death. The review also considers related phenomena such as collusion, protective silence and mutual pretence, and distinguishes patient-initiated avoidance from clinician- or family-driven non-disclosure.

METHODS

Search strategy Eight electronic databases will be searched from inception to 30 September 2026: PubMed, Embase, CINAHL, PsycINFO, Web of Science, Scopus, the Cochrane Library and Europe PMC. Reference lists of included studies and of relevant reviews will be hand-searched, and forward citation searching will be performed.

The strategy combines four concept blocks: (i) advanced or terminal cancer and older age ('advanced cancer', 'terminal cancer', 'terminally ill', 'incurable cancer', 'metastatic cancer', 'older adult', 'elderly', 'aged', 'geriatric'); (ii) palliative, hospice or end-of-life care ('hospice', 'palliative care', 'end-of-life', 'terminal care'); (iii) prognosis, disclosure or avoidance ('prognos', 'prognostic disclosure', 'prognostic awareness', 'truth-telling', 'breaking bad news', 'information avoidance', 'nondisclosure', 'non-disclosure', 'collusion', 'disclosure', 'communication'); and (iv) qualitative research ('qualitative', 'phenomenolog', 'grounded theory', 'ethnograph', 'interview', 'focus group', 'thematic analysis', 'narrative').

Controlled vocabulary (MeSH, Emtree, CINAHL headings, APA Thesaurus) will be adapted for each database and combined with free-text terms. No date limit will be applied; searches will be limited to English and Chinese.

Participant or population Adults with advanced, incurable or terminal cancer, with a focus on older

adults (aged 60 years and over) receiving palliative, hospice or end-of-life care. Family caregivers and clinicians (physicians, nurses and other health professionals) caring for these patients are also eligible where their perspectives illuminate the phenomenon. Studies of children, of non-cancer populations, or of nursing students without clinical palliative care experience will be excluded.

Intervention Not applicable. This review does not evaluate an intervention. The phenomenon of interest is the avoidance, concealment or postponement of prognostic information during prognostic communication in palliative and hospice care. Any communication practice, behaviour or strategy described in the primary studies will be treated as part of the phenomenon rather than as an evaluated intervention.

Comparator Not applicable. As a qualitative evidence synthesis, the review does not compare interventions. Where primary studies describe contrasting approaches (for example direct disclosure versus family-mediated or staged disclosure), these will be compared descriptively as part of the synthesis.

Study designs to be included Primary qualitative studies (phenomenology, grounded theory, ethnography, qualitative description, interpretive description, thematic or content analysis) and mixed-methods studies with a clearly separable qualitative component. Quantitative studies, reviews, protocols, editorials and conference abstracts will be excluded.

Eligibility criteria Inclusion: (1) adults with advanced, incurable or terminal cancer, or their family caregivers or clinicians; (2) phenomenon concerning prognostic communication, disclosure, truth-telling, prognostic awareness, collusion or avoidance in palliative, hospice or end-of-life care; (3) primary qualitative design, or mixed-methods with separable qualitative data; (4) rich qualitative data; (5) English or Chinese, peer-reviewed.

Exclusion: purely quantitative designs; conference abstracts, editorials, protocols and reviews; studies of children or non-cancer populations; and reports without sufficient qualitative data for extraction. Studies with mixed-age samples will be included when age is reported and the phenomenon concerns advanced cancer or palliative care; this will be documented in the quality appraisal and limitations.

Information sources PubMed, Embase, CINAHL, PsycINFO, Web of Science, Scopus, the Cochrane Library and Europe PMC (inception to 30

September 2026). Reference-list and forward-citation searching of included studies and relevant reviews. No grey literature or trial registries will be searched, because the review concerns published qualitative evidence.

Main outcome(s) The main outcomes are the synthesized findings of the meta-aggregation: the categories and synthesized statements describing how and why prognostic information is avoided or concealed, and the conditions that enable disclosure. The anticipated synthesized findings concern: (1) family gatekeeping and protective collusion; (2) the paradox of awareness and strategic non-asking; (3) hope as a fragile resource; (4) culture, religion and relational autonomy; and (5) clinician discomfort, uncertainty and the relational conditions for disclosure. Confidence in each synthesized finding will be graded using ConQual.

Quality assessment / Risk of bias analysis

Methodological quality will be appraised independently by two reviewers using the JBI Critical Appraisal Checklist for Qualitative Research. The ten items cover congruity between the philosophical perspective, methodology, research question, data collection, analysis and interpretation, researcher reflexivity, representation of participants' voices, ethical approval and the flow of conclusions from the analysis. Each item will be rated yes, no or unclear. Disagreements will be resolved by discussion, with a third reviewer if necessary. No study will be excluded on quality grounds; ratings will inform the ConQual assessment of confidence in the synthesized findings.

Strategy of data synthesis Findings will be synthesized using the JBI meta-aggregation approach: (1) extracting findings from primary studies; (2) grouping findings into categories on the basis of similarity in meaning; and (3) generating synthesized statements that remain traceable to the categories and findings from which they were derived. Findings rated unequivocal or credible will be eligible for aggregation; unsupported findings will be recorded but not aggregated. Two reviewers will develop categories inductively, with discussion and third-reviewer adjudication until a stable structure is agreed. Each synthesized finding will be illustrated with a verbatim quotation and its source study. Confidence will be graded with ConQual, based on the dependability of the primary studies and the credibility of the aggregated findings. Reporting will follow ENTREQ.

Subgroup analysis Formal subgroup analysis is not applicable to meta-aggregation. Descriptive comparisons will nonetheless be made by cultural context (East and Southeast Asia, the Middle East, Europe and North America, Latin America), by participant type (patients, family caregivers, clinicians) and by age focus (studies restricted to older adults versus mixed-age samples). These comparisons will be presented as part of the synthesis and discussion rather than as statistical subgroup analyses.

Sensitivity analysis Statistical sensitivity analysis is not applicable. To test the robustness of the synthesized findings, the review team will conduct planned sensitivity checks by: (1) re-examining the synthesis after excluding studies rated 'unclear' on three or more JBI items; (2) excluding mixed-methods studies with limited separable qualitative data; and (3) excluding studies with mixed-age samples. Any change in the categories or synthesized statements will be reported transparently.

Country(ies) involved China.

Keywords advanced cancer; older adults; palliative care; hospice; prognostic disclosure; information avoidance; collusion; truth-telling; qualitative systematic review; meta-aggregation.

Contributions of each author

Author 1 - Ting Liu
 Author 2 - Dai Li
 Author 3 - Shengli Chen
 Author 4 - Biyun Xia
 Author 5 - Tingting Wang
 Author 6 - Ruimin Zhu
 Author 7 - Minjia Lin
 Author 8 - Yingping Shen
 Author 9 - Li Li