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Dedication

I dedicate this project to my family who believed in me and to my partner who has been my biggest supporter throughout my pursuit for education. This research has been inspired by my father, Tony, who left us too soon.

Cultural Perspectives in Pain and Palliative Care

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Abstract

Culturally and linguistically diverse (CALD) patients are constantly challenged by the different levels on which lack of cultural competency or bias occurs in healthcare. This literature review focuses on the healthcare providers' experiences when providing pain and palliative care to CALD populations and explores the challenges that may result in health inequalities. A review of current literature was conducted using PubMed, CINHAL, Sage Journals, Ovid, and Science Direct electronic databases. Sixteen published articles between 2015-2023 were reviewed. Findings from this review identified factors that induce poor quality palliative, pain, and end-of-life (EOL) care among culturally diverse groups. Improving quality of care stresses the importance of overcoming cultural and linguistic challenges in order to become culturally adept in practice. Communication barriers between healthcare providers and patients was the most prominent theme identified across all studies.

Keywords: providers, healthcare professionals, culture, ethnic, pain, palliative care, advance care planning, perspectives, attitudes, and experiences.

Cultural Perspectives in Pain and Palliative Care

Background

Characteristics of patient behavior, including health practices and utilization of health care services, vary among different cultures (Evans et al, 2012). One's perception of health and wellness, pain, and basic necessities in times of infirmity are influenced by culture, all of which may positively or negatively impact health outcomes (Cain et al., 2018; Long, 2011). Worldwide, the United States has more immigrants than any other country, making up an everchanging composition of multicultural backgrounds that necessitate different healthcare provisions (Budiman, 2020; Lowe & Archibald, 2009). According to the United States Census Bureau (2020), the multiracial population has increased considerably since 2010 from about 9 million people to 33.8 million people in 2020, a 276% increase. By 2043, the U.S. is expected to be a majority-minority nation, or plurality nation, where the non-Hispanic white population remains the largest, but no group will make up a majority (U.S. Census Bureau, 2012). This growing, ethnically, racially, and socially diverse patient population requires that healthcare providers understand the intricacies of different cultures in order to adequately meet patient needs (Evans et al., 20120; Peacock & Patel, 2008).

Significance

Culturally and linguistically diverse (CALD) patients are constantly challenged with the task of navigating unfamiliar territories of the English-language dominant U.S. healthcare system (Genoff et al., 2016). Patients who come from different backgrounds with limited English proficiency (LEP) often face obstacles such as language barriers and differences in health beliefs between patient and provider, resulting in poor health outcomes, mistrust of providers, and unmet needs (Genoff et al, 2016; Handtke et al., 2019). CALD patients are vulnerable to various aspects of healthcare, including insufficient pain assessment and management, receive inadequate palliative treatments, and have an increase burden of disease (Amen et al., 2021; Green et al., 2018). Research has indicated that there is less patient compliance and less patient-provider satisfaction in cross-cultural medical interactions (Schouten & Meeuwesen, 2006). Barriers to establishing therapeutic patient-provider relationship arises when health care providers are confronted with the arduous task of providing high-quality care to a wide diversity of cultural backgrounds of which they may not be familiar with (Schouten & Meeuwesen, 2006). Providers have found interactions with CALD patients emotionally demanding and necessitate extra time for ascertaining the reason for seeking care or history of presenting illness (Schouten & Meeuwesen, 2006). In relation to care at the end of life, CALD patients transitioning to palliative care may also need extra support due to the obstacles around language and unique cultural preferences that may limit treatment options (Kirby et al., 2018). Poor intercultural medical communication and failure to provide culturally appropriate care may result in health inequities that further widens the gap in health disparities among societies (Eckersley, 2005; Schouten & Meeuwesen, 2006).

Improving quality of care for marginalized groups stresses the importance of being culturally adept in practice and overcoming linguistic barriers in order to provide patients and families with adequate information for difficult decision-making when approaching the end of life. Research suggests that incorporating patients' cultural values, preferences, and beliefs in care planning and using health language that patients can identify with, helps to build trust, improves pain management, facilitates successful communication, and smooths the transition to palliative care (Dierfeldt et al., 2021; Kirby et al., 2018). Among minority patients, trust in providers has been associated with greater treatment adherence as well as better patient-perceived quality of care and satisfaction (Dierfeldt et al., 2021). Consequently, inadequate communication from healthcare professionals due to language barriers or cultural unfamiliarity may impede understanding of what palliative care entails, which can delay the initiation of hospice or palliative care and result in underutilization of hospice services (Dierfeldt et al., 2021). Palliative care focuses on a holistic approach to reduce distress among individuals with serious illnesses, enabling them to achieve optimal quality-of-life (Cain et al., 2018). Thus, cultural misunderstandings, biases, and inequities have the potential to diminish one's wellbeing during the dying process.

Disparities in healthcare are well-recognized, but the existing research in palliative care has concentrated on inequities among African American and Hispanic populations, and to a lesser extent, other marginalized groups (Johnson, 2013). A review of current literature suggests that research centering on inequalities in pain and palliative care across all racial and ethnic groups is limited. It is crucial to address this knowledge gap in order to better understand cultural nuances that dictate the care we provide to patients with serious illnesses. Recognizing health inequities may serve to improve pain and palliative care management in structurally marginalized populations.

Methods

Study Purpose & Design

This literature review aims to enhance the understanding of cultural barriers in healthcare and explores the attitudes of providers—when faced with difficulties in the management of seriously ill CALD patients—adding valued implications for palliative interventions and support, the delivery of sensitive information to patients, and handling cultural and linguistic challenges proficiently. What are healthcare providers' experiences with providing pain and palliative care to CALD patients during inpatient or outpatient care management?

Search Strategy

A systematic review of empirical studies was conducted using OneSearch, an interface made available through San Jose State University (SJSU). A number of electronic databases were explored, but peer reviewed articles of qualitative or mixed methods research that had a narrative component from PubMed, CINHAL, Sage Journals, Ovid, and Science Direct databases within the last 10 years (2015-2023) were selected. Meeting with SJSU's Health & Human Services librarian was helpful in identifying search terms. Key search terms included "provider," "nurse," "healthcare professional," "pain," "palliative care," "end-of-life," and "advanced care planning." Additional search terms were "culture," "diverse," "ethnic," "experiences," "perspectives," and "attitude."

Inclusion & Exclusion Criteria

Articles selected for this review focused on the perspectives of healthcare professionals while providing inpatient or outpatient care to CALD patients. However, studies that highlighted the patient experience were also included if they addressed healthcare personnel, clinician, or provider experiences as well. Only qualitative studies or mixed methods studies with a qualitative element to the research design were selected. Studies conducted outside of the United States were excluded in this review as the composition of racial and ethnic groups may differ among other countries. Articles not translated or written in languages other than American English were not included as there may be challenges in the feasibility of translating articles. Additionally, some words used in different languages may not have an English equivalent and generalizing language can alter the meaning or context of narratives.

Pertinent characteristics of the study population comprised of adults who provide medical services to CALD patients, including a variety of perspectives from different disciplines as well as different ethnic backgrounds. Inclusion criteria were also American English speakers, all genders, adults ages 18 or older, and healthcare professionals who manage health provisions of CALD patients on a regular basis. Healthcare professionals who play a pivotal role in patient care included physicians, surgeons, nurse practitioners, registered nurses, case managers, chaplains, patient care navigators, medical interpreters, and even those involved in prehospital care such as medical technicians and paramedics.

Data Extraction and Analysis

Details of the included studies were extracted and consisted of study design, participant characteristics, setting, research methodology, methods used to collect data, and results relevant to the review question.

Quality Appraisal

Appraisal of the research studies was performed using the Joanna Briggs Institute (2017) critical appraisal tool, the Checklist for Qualitative Research. The purpose of the checklist is to determine the methodological quality or limitations of each research study (Joanna Briggs Institute, 2017).

Results

The initial literature search yielded 363 articles from various countries. After scanning the abstract of each study, 293 articles were excluded because some did not meet the criteria of publication within 10 years, many studies were conducted outside of the United States, some articles did not have a qualitative design or narrative component, and 33 articles were duplicates. Of the 70 articles remaining, a total of 12 articles were selected after careful analysis of the full abstract. During this phase of screening, studies were further excluded if they did not focus primarily on the provider, nurse, clinician, or healthcare professional perspectives of the palliative care or pain treatment process. Four additional articles were identified from alternative search techniques and from the references of subject-related studies. Subsequently, a total of 16 articles that met the inclusion criteria were selected and analyzed for this literature review.

Population & setting

All 16 research studies were conducted in the U.S. within various healthcare institutions catering to diverse LEP populations as well as multicultural and multiethnic backgrounds. Five studies focused on medical service providers who worked with specific groups, including Native American, Hmong, South Asian, and Islamic populations while other articles focused on culture as a whole. Ten studies focused on multiple stakeholders such as physicians, nurses, and social workers, with a few of these studies also extending to chaplains, administrators, care navigators, interpreters, and other caregivers. Two studies focused primarily on registered nurses, two studies examined the perspectives of both patients and healthcare providers, one study focused on patient care navigators, and only one study was dedicated to emergency medical services (EMS) providers' experiences on prehospital interactions with a range of limited English Proficiency (LEP) populations.

Study design & sample size

The sample sizes among studies ranged from 8 to 1,040 depending on the number of hospitals utilized in each study or whether or not the focus was unit specific. All studies used for this review adopted qualitative or mixed methods designs with phenomenological, narrative, or ethnographic approaches. Qualitative studies carried out semi-structured or in-depth interviews, while mixed methods studies integrated quantitative and qualitative data by conducting in-person interviews or providing open-ended questions on questionnaires.

Language barriers and health literacy

Among the included articles in this review, 13 articles revealed the overarching theme of linguistic barriers in the role of pain management and palliative care discussions, with health literacy being an added challenge to language discordances between patients, families, and clinicians. Understanding that effective communication is an important aspect of culturally competent care, three studies focused primarily on language difficulties experienced by providers during intensive care, hospice, and prehospital care (Barwise et al., 2020; Dressler et al., 2021; Stadeli et al., 2023). In one study, physicians in the intensive care unit (ICU) reported avoiding goals of care (GOC) conversations with LEP patients due to the time-consuming nature of using an interpreter (Barwise et al., 2020). Consequently, conversations about routine updates as well as decision making may occur less frequently or deferred to family members who are proficient English speakers, leading to reduced patient autonomy, lack of understanding, and misconceptions about the care they receive (Barwise et al., 2020). Dressler et al. (2021) focused their study on providers' challenges of using interpreters with LEP patients, noting that inconsistent translational accuracy contributed to the impact of language barriers and thus affects hospice enrollment. During prehospital care of LEP patients, Stadeli et al. (2023) reported that ineffective language interpretation led to disparities and delays in treatment. Telephonic language interpretation increased dispatch times as well as the time to initiation of cardiopulmonary resuscitation (Stadeli et al., 2023). A clear picture and severity of patient conditions require a detailed history prior to decision-making or treatment and is dependent on effectiveness of communication (Stadeli et al., 2023).

Certified interpreters are often used in the healthcare setting and preferred over interpreters by proxy, or family, due to the assurance of accurate translation through healthcare interpreter services (Cicolello et al., 2019) . However, providers found that use of interpreters may interfere with trust and relationship-building as well as misinterpret the meaning of words by discrepancy of word choices (Cicolello et al., 2019). Another concern by providers is that intonation of words, pauses, and body language would not be conveyed with the compassion they hope to communicate in intimate health discussions (Dressler et al., 2021). Ascertaining patient comprehension of critical information through interpretation technologies (i.e., video, phone) was also problematic (Ciocollelo et al., 2019). Less common languages such as HMoob or Arabic have different dialects that may not be readily available both in-person or through language line services due to lack of appropriately trained interpreters (Dressler et al., 2021; Kolmar et al., 2022; Neiman et al., 2019). In Hmong culture, oral communication is the preferred and primary means of communication over written language, therefore, medical and proxy interpreters are heavily relied on (Lor et al., 2021). However, Lor et al. (2021), notes that healthcare interpreters often omit, replace, or add additional words during consultations, and family members often do not provide adequate information. Moreover, interpretation was not feasible in many cases where patients were asked to describe pain. Hmong patients were observed by participants to use few or no descriptors or adjectives to describe discomfort (Lor et al, 2021).

Linguistic barriers in pain management are a significant area of concern addressed by providers due to the challenges of conducting pain assessments in LEP populations (Ayaz et al., 2022; Lor et al., 2021) When a patient endorses pain, nurses are taught to take vital signs, ask about the quality and characteristics of pain, and to evaluate pain intensity. However, nurses in a study of post-operative pain management of LEP patients reported the inability to use common pain scales to determine pain severity, which makes it difficult to regulate the dosage and type of analgesic (e.g., narcotics, NSAIDS, acetaminophen, nerve pain agents) warranted by certain characteristics of pain (Ayaz et al., 2022). Nurses reported that they act quickly when a patient reports severe pain, suggesting that a patient's inability to communicate pain severity may result in untreated pain postoperatively (Ayaz et al., 2022). Lor et al. (2021) revealed that Hmong patients tend to have difficulty conveying their understanding of pain such as spiritual beliefs about the causes of pain that falls outside the realm of Western medicine and cannot be treated with typical analgesics. Furthermore, providers noted that physical indicators such as weight loss, appetite, energy level, and patient's tone of voice are more reliable indicators of pain among Hmong patients and cannot be assessed with a numeric pain scale (Lor et al., 2021).

Providers understanding the details needed to inform patient care is equally as important as patients' understanding of treatment options before making decisions. Multiple studies suggested that LEP patients and families tend to struggle with palliative care or complex medical concepts such as resuscitation preferences or certain medical procedures, which can delay decision-making (Barwise et al., 2020; Neiman et al., 2019; Periyakoli et al., 2015). Nurses working with Hmong patients described how even with adequate translation, there is still incomplete understanding because some medical terms simply do not have HMoob equivalent words (Neiman et al. 2019). Throughout studies, physicians frequently reported knowledge deficits, misconceptions about hospice, and unrealistic expectations about curing a terminal illness a consequence of poor health literacy (Barwise et al., 2020; Cicolello et al., 2019; Periyakoli et al., 2015; Rhodes et al., 2015).

Suboptimal communication in goals of care discussions

Eight studies that focused on advance care planning (ACP), palliative care (PC), and dignity at the end of life (EOL), acknowledged substantial disparities among minority groups in regard to death and dying despite significant efforts to deliver high-quality EOL care (Anderson et al., 2022; Barwise et al., 2020; Cicolello et al., 2019; Espinoza et al., 202; Kolmar et al., 2022; Ladin et al., 2021; Periyakoli et al., 2015; Rhodes et al., 2015). Effectiveness of goals of care (GOC) conversations were reported to be the main barrier in most cases, as certain cultures view talking about death or admitting to illness hastens the process, therefore, decline to engage in EOL discussions (Periyakoli et al., 2015; Rhodes et al., 2015). Physicians described GOC conversations with LEP patients as "emotionally draining" and "hard and stressful" (Espinoza et al., 2021). In one study, Periyakoli et al. 2015 reported that only 0.1% (n=8) of the sample of 1,040 physicians did not experience barriers to facilitating EOL conversations with ethnic minorities as a whole while 99.9% (n=1032) experienced challenges regularly, preventing them from discussing GOC with patients. Asian physicians reported having the most struggles (91.3%), followed by African American physicians (85.3%) (Periyakoli et al., 2015).

Alternatively, one study revealed that some physicians simply did not initiate ACP discussions because they did not feel as though it was their role, with only 25% (n=6) regularly incorporating it in patient encounters (Ladin et al., 2021). In this study of nephrology providers, there were differences in opinions about who should initiate ACP discussions as some felt that primary care providers are better positioned to speak about long term goals and that dealing with kidney failure and dialysis needs were difficult enough. Clinicians noted that communication and cultural challenges further contributed to the difficulty of holding ACP discussions, which created an attitude of avoidance when discussing care options with minority patients. This created role ambiguity and inconsistencies in the care provided to patients (Ladin et al., 2021).

In some cases, providers felt a sense of discomfort with the topic of death, and stereotypes of certain cultures prevented physicians from having GOC conversations (Anderson et al., 2022; Barwise et al., 2020; Khosla et al., 2016; Kolmar et al., 2022; Periyakoli et al., 2015). In a study of palliative care providers working with American Indian patients, Anderson et al. (2022) identified that most participants did not acknowledge the role that stereotypes play in establishing trust in provider-patient relationships and how it might facilitate EOL discussions. In another study of physicians working with Muslim patients, Kolmar et al. (2022) reported clinicians' concerns regarding a big assumption that all Muslim patients want full life-sustaining measures. This impacted the way they approached health discussions and full medical disclosure as they wanted to avoid confrontation (Kolmar et al., 2022). Likewise, Barwise et al. (2020) noted that some physicians admitted to avoiding sensitive EOL discussions with patients and families of unfamiliar languages and cultures due to a fear of offending them. Discussing cultural *faux pas* topics can unintentionally offend patients and their families and ultimately disrupt the provider-patient relationship (Periyakoli et al., 2015).

The complexity of family dynamics also proved to be difficult when discussing diagnoses, prognoses, and palliative care options to patients. Some family members preferred to withhold prognostic and diagnostic information from the patient due to the belief that knowledge of the truth would cause the patient to lose hope (Barwise et al., 2020; Peryakoli et al., 2015). Suboptimal communication with patients may result in unmet patient needs as well as diminish patient autonomy (Espinoza et al., 2021). Findings from another study illustrated that African Americans may view hospice as "giving up" and may resist conversations about EOL care or hospice enrollment. Providers believed that patients were often prepared to choose comfort care but did not do so because family members desired aggressive treatment (Rhodes et al., 2015).

Navigating cultural norms, beliefs, and religion

Family involvement is one aspect of culture that providers may find uncomfortable to navigate. As identified in several studies, some cultures have a strong family presence where each member is involved in decision-making, while other cultures have specific gender roles that answers for the whole household (Barwise et al., 2020; Espinoza et al., 2021; Kolmar et al., 2022; Neiman et al., 2019). Both nurses and doctors caring for Muslim patients reported discomfort working with family hierarchies (Kolmar et al., 2022). Participants spoke about their frustrations regarding the patriarchal, “male-driven” decision maker in the family being incongruent with the primary caregiver who is usually a female. They observed how female family members were often so present in the care of the patient but offered no voice when discussing patient matters (Kolmar et al., 2022).

Alternatively, family-centered decision making may necessitate interactions with several family members simultaneously, requiring more effort expended to EOL discussions (Barwise et al., 2020). Balancing culturally compassionate care with respect for patient autonomy was also challenging for providers in the ICU when families insisted on prolonged, aggressive, or futile care (Espinoza et al., 2021). In a study of providers working with Hmong patients, nurses found that larger family gatherings overcrowded the limited confines of patient rooms. Furthermore, nurses felt that families of Hmong patients did not always accept certain aspects of inpatient therapies, would rather care for their loved one at home, and often declined hospice or palliative services (Neiman et al. 2019).

Patients and families as shared decision-makers tend to embrace similar health patterns and values that can potentially conflict with providers' personal beliefs or clash with the realities of healthcare practices in the U.S. (Khosla et al., 2016; Kolmar et al., 2022; Rhodes et al., 2015). Participants in one study described feelings of distress and anger when choices are made that they cannot identify with; particularly, decisions to provide full treatment to patients with poor prognoses (Kolmar et al. 2022). Another example is truth telling with respect for autonomy, viewed by U.S. healthcare professionals as ethical, but the principles may conflict with some cultures' practice of nondisclosure or withholding of information (Barwise et al., 2020; Cicolello et al., 2019). Espinoza et al., 2021; Khosla et al., 2021; Periyakoli et al., 2015). In another study, a nurse expressed not being able to comprehend a Hmong patient's choice of refusing a major procedure because the patient believed that evil spirits could enter the body during surgery (Neiman et al., 2019).

Among interactions with South Asian patients, providers expressed angst when patients refuse pain medications even when they are clearly displaying severe pain (Khosla et al., 2016). In South Asian culture, medication side effects are concerning for patients due to the potential for drowsiness, confusion, and addiction (Khosla et al., 2016). Interestingly, the belief that morphine is a terminal drug (used to accelerate death) was identified by providers as a theme among both African American and Portuguese patients (Cicolello et al., 2019; Rhodes et al., 2015). Even the mention of morphine, or the "M" word, could shut down any discussion about comfort care before trust could be established (Cicolello et al., 2019). In another study, providers' believed one reason for Pakistani patients declining pain medication is that admitting pain and conceding to medication was perceived as a sign of weakness among their culture (Khosla et al., 2016).

Other identified barriers to patient care are strong spiritual or religious views in the setting of EOL care. Washington et al. (2018) found that spiritual or existential concerns were of particular importance in care for seriously ill U.S. South Asian patients. Faith in God or “Allah’s” hands was acknowledged by many Muslim patients who believed that it is not the family’s choice to cease treatment, but rather, decided by God (Kolmar et al., 2022). Providers experienced situations where families may want to stop life-prolonging therapies but felt incapacitated by their religious beliefs (Kolmar et al., 2022). Similarly, African American patients also conveyed spiritual beliefs that prevented them from “giving up”, which is what they understood hospice or comfort care to mean (Rhodes et al., 2015). Some African American patients wished to “leave it in God’s hands” often desiring more aggressive care than the situation warrants (Rhodes et al., 2015). In terms of pain perspectives, physicians distinguished that a strong religious view among South Asian patients rooted in Hinduism or Buddhist faiths is that pain is the result of *karma*; therefore, it is something to be endured at the end of life as a form of payment for past wrongdoings (Khosla et al., 2016).

Regardless of the patient’s cultural, ethnic, or religious background, participants throughout multiple studies consistently expressed having limited knowledge of different cultures that makes them feel uncertain about the care they provide (Ayaz et al., 2022; Neiman et al., 2019; Periyakoli et al., 2015). Nurses in one study expressed wanting to learn more about how different cultures view pain in an attempt to gain a greater sense of comfort in caring for patients of unique backgrounds (Ayaz et al., 2022). Doctors viewed their “ignorance” of cultural values a major barrier to EOL conversations, and further training could help them better empathize with patients and families (Periyakoli et al., 2015). A large number of studies revealed participants recommending improving palliative care training in the context of culture for all healthcare professionals working with culturally and linguistically diverse patients (Ayaz et al., 2022; Cicolello et al., 2019; Espinoza et al., 2021; Neiman et al., 2019; Periyakoli et al. 2015; Rhodes et al. 2015; Washington et al., 2018)

Institutional barriers

Providers' level of comfort caring for CALD patients may be associated with institutional barriers lending to structural marginalization of certain groups. Institutional barriers were highlighted in five studies as a consequence of lack of appropriate cultural training, scant availability of trained medical interpreters, time constraints for culturally sensitive conversations, and time intensive use of interpreters (Espinoza et al., 2021; Ladin et al., 2021; Periyakoli et al., 2015; Phillips et al., 2018; Stadeli et al., 2023). Participants in one study reported difficulties with interpretation technologies, explaining that certified interpreters were often unavailable, and although less ideal, ad hoc interpreters were utilized instead (Dressler et al., 2021). During prehospital care, providers consistently reported barriers to effective language interpretation with telephonic interpreters, often having to use translation phone apps or a bystander for quicker information gathering during emergencies (Stadeli et al., 2023). In contrast, interpreters in one study asserted that although it is not well-known to healthcare providers in the ICU, interpreters are available at all times and are easy to get a hold of. Particularly, they believed their services should be fully maximized in the ICU setting (Espinoza et al., 2021).

Lack of education and training provided by healthcare institutions were areas of concern among providers. For instance, in one study, Phillips et al. (2018) found that patient navigator programs are not tailored to specific needs of culturally and spiritually diverse patients. Interestingly, navigators working with cancer patients identified 11 interrelated aspects of their role that encompasses patient-centered, culturally appropriate care thus emphasizing the importance of cultural training. Navigators consider themselves to be conduits between patients and providers, helping to resolve misunderstandings, transmitting information in both directions (patient and provider), and clarifying information presented in patient care discussions to promote collective understanding (Philips et al., 2018).

It is important to note that culturally sensitive conversations regarding intimate health concerns typically requires extra time that many providers feel they do not have (Ladin et al., 2021). Periyakoli et al. (2015) asserts in their study that system changes need to occur so all providers can be billed appropriately for their efforts spent on time-intensive complex patient encounters. In one study of older patients in the dialysis setting, some clinicians felt early advance care planning (ACP) discussions would benefit patients facing difficult dialysis decisions, helping them to understand how the process could entail significant quality-of-life implications yet provides only marginal survival benefits in the critical stages of life (Ladin et al., 2021). Contrary to this belief, clinicians stressed that their efforts would be better expended focusing on complex dialysis needs and not difficult ACP discussions, especially if more time is warranted due to language and cultural challenges. Time constraints, minimal training, poor reimbursement, and not understanding how to use ACP billing codes were perceived as main institutional barriers (Ladin et al., 2021). In another study, ICU nurses highlighted the need for standardized protocols that carves in time for making critical health decisions. This institutional change could optimize communication, reduce suffering, and better meet patient needs (Espinoza et al., 2021).

Medical mistrust and provider bias

The concepts of institutional racism and unconscious bias were addressed by one provider as being present in everyday patient interactions affecting the care they provide

(Cicolello et al., 2019). Another provider asserted, patients come into the medical system with trust, but negative experiences skew their views (Rhodes et al., 2015). Trust in the medical system varied among different ethnic minority groups from extreme trust and mild distrust to extreme distrust (Cicolello et al., 2019). Extreme distrust from African American patients were thought to be linked to historical oppression and medical experimentation in the African American population (Cicolello et al., 2019). Similarly, among American Indians, participants also identified mistrust of providers and providers' stereotyping as major themes and likely reasons why palliative care is underutilized (Anderson et al., 2022). Providers in one study believed that underrepresented minorities mistrust the medical system due to perceived ideas in which certain treatments may be withheld or not offered to them while White upper-class patients were offered more aggressive surgeries and interventions (Rhodes et al., 2015).

Discussion

This review focused on provider perspectives while delivering care to minority patients and identified several barriers contributing to inferior palliative care. For instance, language barriers and subsequent impaired understanding extends to abstract elements of health systems as well as patients' understanding of illness severity and treatment options (Barwise et al., 2020). Due to the intricacies of cultural ideals and practices and the role it plays in health care utilization and health beliefs, accurate language interpretation alone cannot completely mitigate the misunderstandings that can take place between patient and provider (Barwise et al., 2020). Language-discordant interactions may involve frequent alterations in interpretation and contain fewer expressions showing support despite efforts of providers to communicate in patient-preferred languages (Espinoza et al., 2021; Schenker et al., 2012; Periyakoli et al., 2015). Physicians are skilled in emotionally challenging conversations near EOL, including disclosing difficult news with sensitivity, attempting to align patient priorities with treatment, and discussing hospice options (Nagpal et al., 2021). When interpreters are used, certain word choices may skew or not fully convey the feeling and meaning of carefully chosen descriptive language used by physicians during intimate GOC conversations (Cicolello et al., 2019). Interpreters help patients and providers exchange spoken or written words, but they may not be able to assist in translating nonverbal communication unique to so many different cultures. In fact, research indicates that only 7% of conversations are verbal, 55% are nonverbal, and 38% is based on paralanguage (Cain et al., 2018).

Communication intermediaries, such as interpreters, may also psychologically create a distance between the provider, patient, and family, increasing the efforts needed to build rapport (Dressler et al., 2021). Building rapport with patients is anchored in the ability to demonstrate empathy through meaningful clinical encounters, which can be challenging to do through an interpreter. Due to difficulties with interpretation technologies, providers may choose to be less formal in assessments by simplifying questions; however, superficial communication with LEP patients creates more room for misunderstandings and inhibits relationship building (Dressler et al., 2021). On the other hand, wait times connecting with an in-person interpreter may cause frustrations in anxious patients and family members, further severing the patient-provider relationship (Barwise et al., 2020; Kolmar et al., 2022; Periyakoli et al., 2015). Even when language translation resources are readily available, clinicians and patients may possess different cultural backgrounds that impede mutual understanding. These findings suggest that it is not sufficient to only focus on linguistic accuracy or communication in patients' primary language. Providers must also possess cultural awareness, be skilled in speaking within the context of one's culture, use appropriate body language, be able to observe nonverbal cues, and understand patient communication patterns.

Along with linguistic challenges, health literacy was highlighted in multiple studies as a major obstacle to appropriate medical management (Neiman et al., 2019; Periyakoli et al., 2015). The rate of inadequate health literacy is predominantly high among LEP populations, resulting in poor health communication, reduced access to healthcare information, and suboptimal health outcomes among minority groups (Mckee & Paasche-Orlow, 2012). Written materials and medical information translated for LEP patients may not consider health literacy and cultural appropriateness, which affects minority groups disproportionately. For example, Hmong patients are a smaller minority group largely impacted by the challenges of health literacy, as the HMoob written language was only recently established in the 1960s, and there are no words to describe certain medical conditions or diagnoses (Neiman et al., 2019). Because of this, older Hmong patients may be completely illiterate in their language, incapable of achieving health literacy, and rely solely on verbal communication (Neiman et al, 2019). In addition, Hmong patients may not always understand underlying causes and have no pain descriptors, making pain management especially challenging at EOL (Lor et al., 2021). Similarly, other ethnic groups such as U.S. South Asians have no concept of pain scales and may not have a correct understanding of medication benefits (Khosla et al., 2016). These are examples of how pain behaviors and the use of nonpharmacological versus pharmacological symptom management varies across cultures. As a whole, LEP patients may be perceived as difficult or noncompliant when there is resistance to treatment due to incomplete understanding and lack what could be viewed as common knowledge.

Factors influencing patients' EOL decision-making is multifaceted and encompasses all aspects of culture such as family involvement, beliefs, spirituality, and religion. Cultural values mediate the experiences of the patient, which then affects how decisions among individuals and families are made (Cain et al., 2018). Several studies in this review acknowledged family-centered approaches a potential barrier to patient care, yet it is well understood that the role of family in EOL care is crucial in helping to shape the experiences of the dying patient (Neto, 2022). Healthcare providers should recognize that promoting family involvement may improve pain management and ease the transition to palliative care. Family members are in the best position to communicate with the patient to help them through the grieving process. They are essential caregivers who devote undivided attention to the terminally ill patient. They are the primary points-of-contact and trusted decision-makers when the individual is unable to verbally express final wishes.

Different cultures highlighted in this review revealed varying attitudes regarding how knowledge of patient prognoses is shared and who should make treatment decisions, sometimes excluding the patient entirely. This practice puts less emphasis on individualism in healthcare and conflicts with the U.S. dominant culture of truth telling and biomedical ethical principle of patient autonomy (Rising et al., 2017). Some families belong to societies that view death as a taboo and may place considerable value on the community to help inform treatment decisions. Thus, talk about death and dying can be considered culturally insensitive and inappropriate (Neto, 2022). Healthcare workers are expected to be accommodating to the beliefs and practices of different cultures, but this could potentially cause moral distress when having to deliver care that is inconsistent with their own personal beliefs (Rising et al., 2017). Withholding information to protect the patient is a common practice among cultures because it instills hope in the seriously ill patient. It is important for healthcare providers to understand that for some cultures, "hope is not based on false optimism or benign reassurance, but it is built instead on the belief that better days or moments can come in spite of the prognosis" (Scanlon, 1989, p. 491). It is also important to recognize that having a full, extensive understanding of different cultural beliefs and practices is not a prerequisite for practicing with respect and cultural humility at all times.

Studies also highlighted societal pressures for families to ensure a proper and holistic transition to EOL care, which might involve caring for the dying patient within their ethnic communities (Andruske & O'Connor, 2020; Neto, 2022). This is partly due to the perceived notion that a "good death" involving specific pre- and post-death practices will not be accommodated in the hospital setting (Neiman et al., 2019). Moreover, families might feel a sense of guilt if they cannot take their loved ones home as promised, often refusing inpatient palliative or hospice care services (Neiman et al., 2019; Neto, 2022). These views are congruent with the ancient Chinese concept of filial piety, a Confucian belief that advocates a set of moral values and norms and instills a sense of moral duty and responsibility to care for their loved ones with respect for their dying wishes (Andruske & O'Connor, 2020). This concept is especially relevant in many Asian cultures (e.g., Chinese, Indian, and Malay) when the patient is a parent or grandparent and where the adult child has an obligation to obey parental wishes and demands despite their own beliefs and judgment (Li et al., 2021). The transition to palliative care is further complicated when the wish of the patient is to manage their illness outside of the hospital setting. Pursuing palliative care apart from the home can be considered abandonment of the ill parent and socially unacceptable (Li et al. 2021). Patients often prefer spending their final days in the comfort of their own home, but issues such as falls, activities of daily living, incontinence, administering medications, and around-the-clock care create a level of complexity that makes dying at home an impractical option (Neto, 2022). Adult children caregivers are often tasked with the described health needs imposed on them by the society in which they belong all while having to juggle modern-day obligations such as jobs, schooling, or their own families.

Among studies, differences in spiritual beliefs were also found to conflict with patient and family perspectives of hospice and palliative medicine. Religious cultural principles may sway people towards life-prolonging treatments that physicians may view as futile (Periyaokli et al., 2015). Throughout the world, religion plays a significant role in shaping one's cultural perspective of life and death (Leong et al., 2016). For example, a popular belief among providers is that families belonging to Muslim culture tend to seek full-treatment and directly attribute those decisions to religious tenets (Kolmar et al., 2022). Contrary to this belief, however, Leong et al. (2016) asserts that most Muslims believe it is acceptable to choose a do not resuscitate status or withdraw life-sustaining treatment in certain conditions where treatments do more harm. This example stresses the important role of religion in healthcare and why it should be integrated in the care provided to patients. Muslim patients have the added complexity of both culture and religion heavily influencing decision-making at EOL, with the majority of U.S. Muslims reporting that religion is "very important" to them (Kolmar et al. 2022; Leong et al., 2016). One unique aspect to Muslim culture is the outside pressures from their embassy on intimate healthcare matters. An anecdote from a physician in one study described an email sent from the Islamic embassy explicating how withdrawing mechanical support or care is against their religion (Kolmar et al., 2022). The issues surrounding EOL care are compounded when spirituality, religion, and governmental concerns are involved in medical decision-making.

Cultural beliefs and practices are prominent in how illness or wellness is perceived among CALD patients, yet the consensus among six studies in this review indicate that culture is poorly understood among providers, especially when there are language and cultural discordances between patient and provider (Ayaz et al., 2022; Espinoza et al., 2021; Ladin et al., 2021; Periyakoli et al., 2015; Phillips et al., 2018; Stadeli et al., 2023; Washington et al., 2018). Providers reportedly felt ill-equipped to participate in faith-based conversations when cultural and religious views were different to their own, suggesting that more culturally competent training is needed in order to facilitate meaningful GOC discussions (Ayaz et al., 2022; Periyakoli et al., 2015). However, due to the growing and increasing diversity of U.S. populations, it is not feasible to learn every aspect of culture. Additionally, researchers have found that cultural competence education tends to focus on the differences of non-dominant groups, which can lead to a do's and don'ts approach to healthcare that increases the risk for cultural generalizations (Silen-Lipponen & Suvi, 2021). While it may be possible to learn certain aspects of various cultures to help inform the care of patients, treating patients based on general cultural perceptions may lead to stereotyping and bias (Ayaz et al., 2022). This leads to mistrust of the healthcare system, feelings of abandonment when certain care options are not offered or withdrawn, and ultimately, unequal health provisions for minority groups (Kolmar et al., 2022; Periyakoli et al., 2015; Rhodes et al. 2015).

Interactions between patients and medical personnel have the potential to provoke stereotype threat, "a disruptive psychological state that people experience when they feel at risk for confirming a negative stereotype associated with their social identity" (Aronson et al., 2013, p. 50). This is an occurrence described by multiple providers who felt that patients feared sharing their cultural identity due to subsequent discrimination, unfair judgement, and prejudices (Kolmar et al., 2022). It is important to recognize that implicit bias, whether or not healthcare providers are aware of their own cultural biases, may still result in unintentional patient feelings of dissatisfaction in the care they receive and feeling devalued in clinical interactions (Aronson et al., 2013). Segregation, mistreatment, and discrimination based on ethnic or racial factors has been well-documented historically in U.S. healthcare with consequences still persisting today (Cain et al., 2018; Elias & Paradies, 2021). Institutional racism in healthcare is a concept that reflects racial injustices affecting minorities' access to healthcare, medications, and services offered to them (Elias & Paradies, 2021). Institutional racism persists because it is often undetectable to those who are privileged by it as well as those who are impacted, because they have no comparison for how other racial and ethnic groups are treated (Elias & Paradies, 2021).

Limitations and Gaps

Despite the volume of knowledge garnered by a review of 16 research articles, results may not be generalizable to all cultures or populations; thus, findings should be interpreted with caution. The inclusion criteria may have been too narrow in scope, which limited use of international research, overlooking various cultures not highly represented in the United States. This body of literature was also limited to pain and palliative care, but health inequities exist among minority groups in all stages of life and all aspects of healthcare. Future research should consider the full spectrum of culturally and linguistically diverse groups to other healthcare settings.

Conclusions and Practice Implications

Primary barriers to pain treatment, palliative care, and EOL care include cultural knowledge deficits, linguistic challenges, cultural differences between healthcare personnel and patients, issues with spiritual and religious beliefs, mistrust in the medical system, lack of culturally tailored training to facilitate GOC discussions, and institutional barriers. A review of research studies highlighted that individuals from minority backgrounds are more likely to experience difficulty communicating their concerns or preferences for pain management or EOL care. A key finding among studies is the attitude of avoidance and feelings of discomfort expressed by providers caring for minority groups, which can be attributed to uncertainty about other spiritual and cultural practices, prejudices, and biases. Presently, attempts to collate information about various cultures has resulted in interventions that treat culture superficially, leading to generalizations and stereotyping (Cain et al., 2018). Cultural competence education should focus more on simulation techniques in an attempt to create real-life scenarios that might be more effective and conducive to learning. More importantly, improving representation of ethnic, cultural, and spiritual diversity among healthcare providers on an institutional level may be a better approach to increasing diversity and improving cultural understanding. A more culturally diverse environment may better meet the needs of multicultural patients as well as expose healthcare professionals to a wider range of perspectives to which they can continue to learn from.

Understanding and respecting cultural diversity in the setting of pain and palliative medicine is essential to ensuring the delivery of high-quality care for patients with serious illnesses, experiencing pain, or nearing the end of life. Improving healthcare to minority groups continues to be a major challenge (Cain et al., 2018). Healthcare professionals must be steadfast in their commitment to better understand the uniqueness of each culture, understand how healthcare systems intersect with people's beliefs and experiences, and view healthcare in multicultural and multilingual lenses.

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Table 1. **Literature Review Matrix**

Author/ Year	**Purpose/ Background**	**Sample & Setting**	**Methodology**	**Analysis & Results**	**Conclusions**	**Strengths & Limitations**	**Implications for future research or practice**
Anderson et al., 2022	Aimed to understand why palliative care is underused by American Indian patients	8 participants, 4 nephrology providers and 4 palliative care providers. Purposive sampling method.	Qualitative. Individual, in- depth interviews were conducted between March and August 2019. Constant comparative analysis of interview transcripts.	Identified five themes: providers' stereo- types, patients' mistrust of providers, patients' end-of-life preferences, available community resources, and patients' family dynamics.	Providers should consider training in trauma-informed care and cultural sensitivity. Stereotypes may impact providers' ability to build trust. Misperceptions related to family dynamics, end-of-life preferences.	Small sample size	Develop and test culturally appropriate approaches to PC. Future research: adopt a community-based approach, traditional approaches, cultural sensitivity.
Ayaz & Sherman, 2022	The purpose of the study was to examine the attitudes, social norms, and behaviors of a cohort of nurses of various ethnic and cultural backgrounds regarding pain assessment and management	RNs (n=6), patients (n=12)	Descriptive qualitative study conducted in a post-operative unit	Issues identified were inadequate pain assessment, lack of understanding of the patient's pain experience, and cultural nuances that affects pain expression and pain medication usage	Nurses should be educated about assessing a person's degree of assimilation in American culture and their individual perspectives regarding pain and pain management	Small sample size, reduced timeframe for data collection due to COVID pandemic, time constraints of the author to meet timeline for funders	Identifies concerns of culturally diverse nurses, challenges regarding pain assessment and management, and highlights issue of culture and cultural competence as it relates to standardization of pain management versus individualized

							patient-centered care
Barwise et al., 2019	The objective of this study was to assess the perceptions of healthcare team members about the factors that influence discussions and decision-making about end-of-life	Physicians (n=16), nurses (n=12), interpreters (n=12) in 3 ICUs in Rochester	Qualitative. An interview guide asking a series of open-ended questions was developed by a multidisciplinary team. One-on-one in-person semi-structured interviews	Identified 6 key barriers to and 5 key facilitators of high-quality end-of-life decision making for patients with LEP.	End-of-life decision making for patients with LEP is significantly different than for English speaking patients.	This study was conducted at a single tertiary care medical center in the United States Midwest, which limits generalizability.	Recognize that it is not required to have an encyclopedic range of knowledge about faith, spiritual and cultural differences but should be more focused on asking, responding to, and accepting differences.
Cicolello, K. & Anandarajah, G., 2019	To gain an in-depth understanding of causes of hospice enrollment disparities in diverse patient populations within one state in the U.S.	Participants, self-identifying from a wide variety of ethnic backgrounds, included physicians (n=5), nurses and nursing assistants (n=6), social workers (n=3), chaplains (n=2), administrators (n=3), and caregivers (n=3). Purposive sampling method.	Qualitative, exploratory. In-depth, individual interviews with multiple stakeholders in hospice care for diverse communities in Rhode Island. Purposeful and snowball sampling strategies. Interviews were audio-recorded, transcribed verbatim, and analyzed.	Five themes emerged regarding patient- and provider-level barriers to hospice enrollment: 1) universal challenges of goals of care (GOC) conversations; 2) cultural norms and beliefs; 3) language barriers; 4) provider-specific challenges; and 5) trust.	Main barrier is effectiveness of GOC conversations. The disparity in hospice enrollment among diverse patient populations is a complex and nuanced problem, involving numerous interrelated barriers. Addressing this disparity will require innovative solutions at multiple levels.	Small sample size, one US city, limited number of interviews based on discipline. Divers sample.	Need for EOL interpreter to serve as proxy between patient and healthcare system. Specifically trained hospice interpreters. Further research needed to determine most effective interventions at multiple levels.
Dressler et al., 2021	To gain an understanding of	Nurses/NAs (n=6), physicians (n=5),	Qualitative, individual	Three primary themes emerged: 1)	Disparities in EOL care and hospice	Findings in the study may not be	Interpretation requires

	how language barriers and interpretation affect hospice enrollment in patients with LEP	administrators (n=3), social workers (n=3), patient caregivers (n=3), chaplains (n=2)	interviews were conducted regarding barriers to quality end-of-life care to diverse patient population. Participants were from Rhode Island. This was a secondary study that addressed language barriers and interpretation. The primary study examined multiple barriers to hospice enrollment	structural barriers inhibit access to adequate interpreter services, 2) variable accuracy in interpreter's translation, 3) interpreter's style influenced efficacy of communication	enrollment in LEP patients persist despite trained medical interpreters. Complex conversations require higher order language interpretation than what is typically available to patients and providers	generalizable to other states	specialized knowledge of cultural associations with death, dying, and hospice. Further program development and study is needed to mitigate impact of language barriers
Espinoza et al., 2021	Purpose was to understand the healthcare team's perceptions of the negative consequences of suboptimal communication	Physicians (n=16), nurses (n=12), interpreters (n=12)	Qualitative study using semi-structured interviews of physicians, nurses, and interpreters from 3 ICUs at Mayo Clinic. One-on-one, in-person, semi-structured interviews were conducted by the multidisciplinary team	They identified 5 consequences of suboptimal communication: 1) Suboptimal assessment and treatment of patient symptoms, 2) Unmet patient and family expectations, 3) Decreased patient autonomy, 4) Unmet end of life wishes and 5) Clinician Moral Distress. timeline for goals of care	Patients with LEP are at risk of experiencing suboptimal communication with the healthcare team in the ICU. There are several educational and quality improvement strategies that ICUs and institutions can take to mitigate these issues.	This study was conducted at a single tertiary care medical center in the United States Midwest, which limits generalizability.	Recommendations to improve communication include1) Education and training for patients, families, clinicians and for interpreters, 2) Greater integration of interpreters into the ICU team 3) Standardized timeline for goals of care conversations with patients and families with LEP.

				conversations with patients and families with LEP.			
Khosla et al., 2016	Investigated the perspectives of health care providers that have cared for seriously ill older South Asians, on the attitudes of US South Asians toward the management of pain experienced at end of life and the factors that influenced these attitudes.	Sample size of 57 comprising of physicians, nurses, social workers, chaplains, administrators, and physician's assistants. Purposive sampling method.	Qualitative descriptive study. In-depth individual interviews and focused-group interviews.	Over-arching theme: most were reluctant to use pain medications. Due to 1) patient-related factors and (2) factors related to the infra-structure and culture of health care in South Asia. Specific themes within these categories are detailed subsequently.	This reluctance was believed to stem from both patient-related and cultural factors, including how medicine is practiced within South Asian health care systems. Patients exhibited stoicism and concerns about side effects.	Diverse sample and larger sample size. Good qualitative approach with two styles of interviews. Geographically restricted area, less generalizable.	Understanding key aspects of the culture of medical practice in South Asia, providers can develop a knowledge base essential to understand the factors that influence attitudes toward pain medicines.
Kolmar & Steinhauser 2022	Explored clinician's experiences with pediatric Muslim patients in EOL	Nurses (n=6), physicians (n=5), and social workers (n=5), convenience sampling	Qualitative study of pediatric clinicians at Duke University Medical Center in pediatric PICU, PCIUC, and pediatric bone marrow unit (PBMU). Semi-structured interviews were conducted.	Major themes included barriers to rapport, barriers to clinician neutrality, and barriers to decision-making	Some themes generalize to other minority groups. Others are unique to Muslim patients sponsored by theocratic governments. Clinicians highlight the impact of religiosity of EOL care	Recruitment bias from volunteer participants. Cultural and religious differences in other parts of the country	More research into barriers to care and effective educational methods is needed
Ladin et al., 2021	Examining barriers and facilitators to ACP might help identify patient-	Clinicians (n=26), patients (n=23), carepartners (n=19)	Qualitative study with semistructured interviews among 4 cities: Boston,	Four themes emerged: 1) role ambiguity, 2) institutional	Discordant views about nephologists' responsibility to discuss ACP with	Underrepresentation of Hispanic patients and lack of data about clinician race	To mitigate disparities, the kidney community must increase

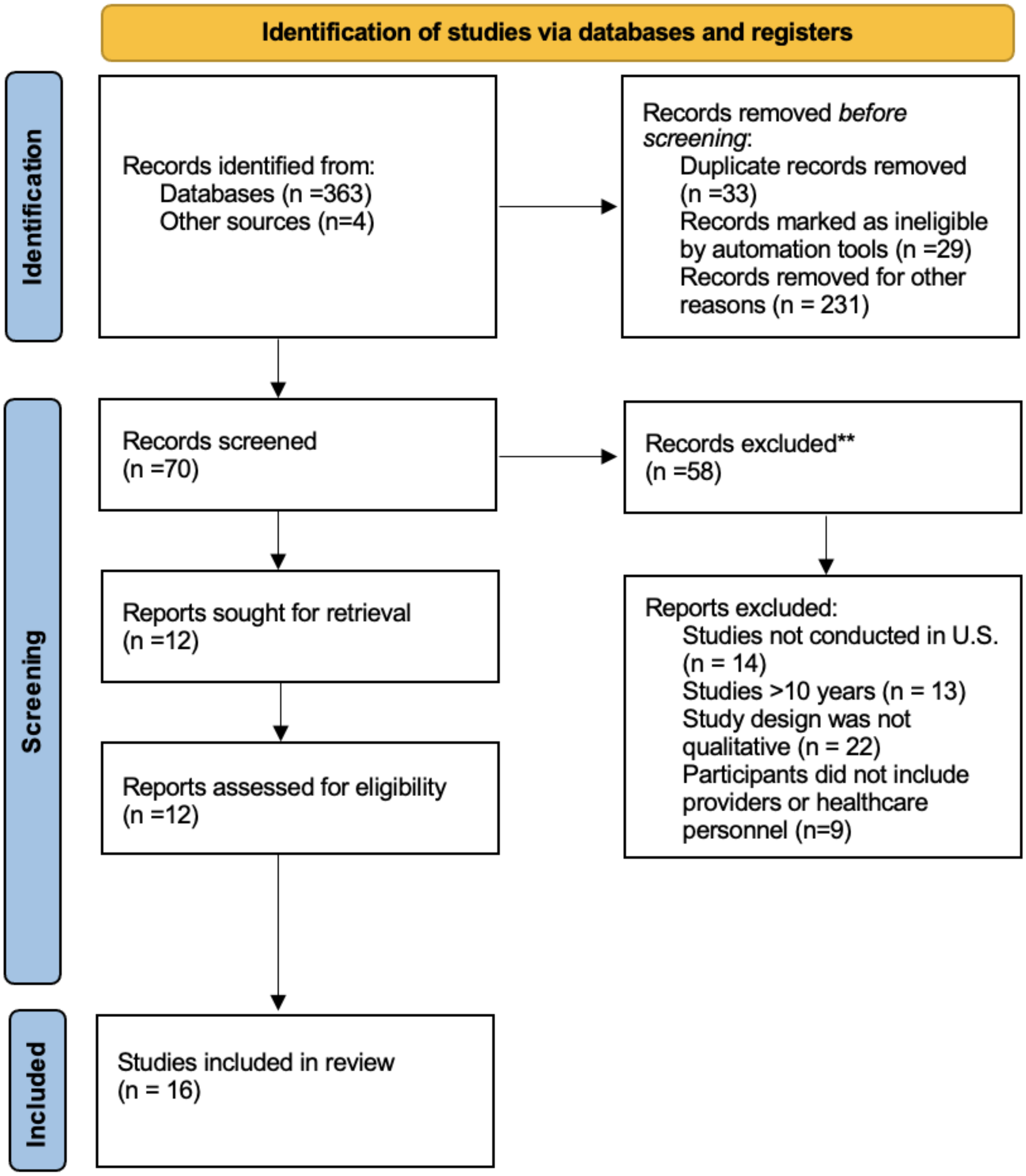
	centered opportunities for improvement		Chicago, San Diego, and Portland	barriers, 3) clinicians questioning the value of ACP, 4) consequences of avoiding ACP	older adults with advanced CKD. Clinicians avoided ACP with minority patients perceiving cultural or religious barriers		clinical efforts to provide culturally sensitive care to underserved groups
Lor et al., 2021	This study examines PCPs' pain communication experience with Hmong patients.	Sample n=15. Physicians (n=8), Nurse practitioners (n=4), PAs (n=3).	A qualitative content analysis was conducted with PCPs. Interviews were audio recorded, transcribed, and analyzed using conventional content analysis. Purposive sampling	Three themes: (a) communication problems related to language, (b) different beliefs about pain, and (c) providers used different strategies to improve communication.	Ineffective pain communication hinders the delivery of culturally congruent health care for Hmong patients. PCPs have greater difficulty communicating with Hmong patients about pain compared to other LEP patient groups.	Conducted in 1 US healthcare facility, limiting generalizability.	Care improves with mutual respect and cultural competence. Understand that cultural beliefs among the Hmong feature spiritual entities and the desire for visual cues to understand pain conditions.
Neiman, T., 2019	The purpose of this study was to describe basic palliative care from the acute care nurses' perspective with consideration for culturally diverse populations.	Registered nurses (n=37)	A qualitative approach was utilized. Thirty-four nurses participated in either focus group or individual interviews.	Assisting tradition, understanding culture, and managing language barriers were identified as themes unique to providing basic palliative care to Hmong patients. Each theme had additional subthemes.	Nurses experienced uncertainty and inadequacy of resources when caring for patients from a Hmong background. Nurses also recognized the strong family ties in this specific population and the importance of supporting tradition while in the hospital.	Lack of diversity in sample group.	It is necessary for nurses to approach patients as individuals within their family context rather than attempting to apply what they know about a group to everyone who might identify with that group. Need for increasing

							diversity in profession.
Periyakoli et al., 2015	Aimed to identify barriers faced by doctors in conducting EOL conversations with diverse patients	N=1040 participants from various specialties—all doctors	Mixed-methods study between two large academic hospitals in California. Qualitative and quantitative data collected	6 themes identified: 1) language and medical interpretation issues, 2) patient/family religious and spiritual beliefs, 3) doctors' ignorance of patients' cultural preferences, 4) cultural differences in truth handling and decision making, 5) limited health literacy, 6) mistrust of doctors and the healthcare system	It is vital to identify strategies to mitigate barriers doctors encounter when discussing EOL concerns with ill patients and their families.	Large sample size. Mixed methods study. Limited by the fact that the study participants only dealt with patients from one geographic area	There is urgent need to train doctors in conducting culturally effective EOL conversations early in the trajectory of any chronic and serious illness in order to facilitate dignity at the EOL for diverse patients
Phillips et al., 2019	Aimed to understand patient navigator roles culturally sensitive cancer care.	Sample size n=297. N=149 responded to the open-ended questions of interest. Respondents were licensed (i.e., nurse or social worker) care navigators. Web-based convenience sample.	Mixed methods. Participants self-administered a 76-item survey. Three questions were open-ended which went through qualitative analysis.	Identified 11 interrelated navigator roles in the provision of culturally competent care.	Patient navigators are uniquely well-positioned to improve cultural competence of cancer care given their role as liaison to patients and providers.	Large sample size. Volunteer participants and only half of survey respondents answered the open-response question	Cancer care settings should use navigators with direct knowledge of patient culture However, communication and cultural competence training is highly recommended.
Rhodes et al., 2015	The goal of this research was to	Physician (n=6), Nurse practitioner (n=1), RN	Qualitative study. Semi-structured	Barriers identified included: lack of	Culturally sensitive interventions	Sample size. Sample population not	Lay health advisor model

	identify barriers to EOL care among AAs and to design a culturally sensitive intervention to inform AAs with advanced illness of their EOL care options in a culturally sensitive manner.	(n=1), Social worker (n=1), Chaplain (n=1), and Health organization representative (n=2).	interviews with hospice and palliative medicine providers and leaders of a national health care organization.	knowledge about prognosis, desires for aggressive treatment, family members resistance to accepting hospice, and lack of insurance.	utilizing both audiovisual materials and the lay health advisor model could be used to increase awareness of options for EOL care among the underrepresented groups.	diverse. Conducted at 1 hospice and 2 palliative care programs.	may be an effective method. Future research of EOL care among members of the AA community, should be designed to better inform AAs and other underrepresented minorities of their options for care at the EOL.
Stadeli et al., 2023	Aimed to identify EMS-perceived barriers and facilitators to providing high-quality prehospital care for patients with LEP	N=39 EMS providers participated in 8 focus groups, firefighters/EMT (n=26), paramedics (n=13)	Qualitative study that explored EMS provider experiences and perspectives on prehospital response for patients with LEP. Focused groups conducted	Barriers included ineffective interpretation, provider bias, distrust of EMS, and unclear acuity of patient conditions, increased illness severity	Improved speed and technology for language interpretation. Focused education on local cultural norms and practices	Experiences may not represent EMS interactions with patients from every language and culture. Not all results are specific to original research question	Focus on targeted interventions to improve modifiable barriers to care
Washington et al., 2018	Aimed to understand the psychosocial factors that affect individuals of South Asian origin currently living in the United States	Sample size of 57 comprising of physicians, nurses, social workers, chaplains, administrators, and physician's assistants. Purposive sampling method.	Qualitative study. Data collected via focus groups and individual interviews of healthcare providers analyzed via directed content analysis	Financial and legal challenges were intertwined, with most provider comments focused on the ways in which immigration status affects patients' eligibility	Recommend improved language interpretation services, support for religious rituals, access to culturally familiar food, caregiver wellbeing, offering spiritual	Not a lot of info on the study, design, or methodology.	Attention to these study findings is likely to benefit palliative care teams committed to enhancing their cultural competence with regard to the

				for health insurance.	(versus religious) connectedness.		provision of psychosocial care.

Figure 1.


Identification of studies via databases and registers
Identification
Records identified from:
Databases (n =363)
Other sources (n=4)
Records removed *before screening*:
Duplicate records removed (n =33)
Records marked as ineligible by automation tools (n =29)
Records removed for other reasons (n = 231)
Screening
Records screened (n =70)
Records excluded** (n =58)
Reports sought for retrieval (n =12)
Reports excluded:
Studies not conducted in U.S. (n = 14)
Studies >10 years (n = 13)
Study design was not qualitative (n = 22)
Participants did not include providers or healthcare personnel (n=9)
Reports assessed for eligibility (n =12)
Included
Studies included in review (n = 16)