Cáceres-Titos *et al. BMC Palliative Care* (2025) 24:124
https://doi.org/10.1186/s12904-025-01759-6

BMC Palliative Care

RESEARCH Open Access

Managing cultural diversity in end-of-life care: a qualitative study

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Abstract

Background In an increasingly globalized world, multiculturalism has transformed healthcare settings, making cultural diversity an essential component of care. In end-of-life processes, this context presents unique challenges, where care extends beyond clinical skills to involve complex, sensitive, and compassionate human interactions.

Objective This study aimed to explore the difficulties perceived by nursing professionals in palliative care when caring for culturally diverse patients.

Design The study employed an exploratory qualitative design with a phenomenological approach to examine professional experiences.

Methods Semi-structured interviews were conducted to capture detailed narratives from 11 purposely selected participants, providing a rich understanding of their lived experiences as nursing professionals. The study adhered to the COREQ guidelines (Consolidated Criteria for Reporting Qualitative Studies).

Results The analysis identified five main themes, including linguistic and communicative barriers that hinder trust-building between patients, families, and professionals. Cultural differences in beliefs, rituals, and expectations surrounding death were also noted. Challenges related to support networks, professional profiles, and workplace settings—such as insufficient training in cultural competence and the emotional impact of caring for culturally diverse patients at the end of life—were found to influence the quality of care provided.

Conclusions In an increasingly multicultural world, end-of-life care should reflect the diversity it encompasses. Considering the perspectives of healthcare professionals caring for culturally diverse patients enhances the quality of care for both professionals and patients during their final moments, fostering a more inclusive and humanized care environment.

Keywords End-of-life, Barriers, Cultural care, Transcultural nursing, Qualitative design

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Background

In an increasingly globalized world migratory movements are on the rise. This significantly transforms many countries' demographic and cultural landscapes, leading to a plurality of traditions and beliefs that influence perceptions regarding health, illness, and no less importantly, death [1, 2]. This phenomenon poses considerable challenges to health systems, which are not always equipped to address the needs of culturally diverse populations adequately.

Culture, as a set of knowledge patterns, practices, beliefs, and behaviors shared by community members [3], plays a central role in health care, as it delineates values, decisions, expectations, and practices. Healthcare systems are thus culturally constituted and characterized by deeply rooted values, norms, and practices that may not always align with culturally diverse patients' expectations. In the context of end-of-life care, awareness about how culture affects care, and its professional practices, becomes especially relevant, as it affects personal and professional spheres in both practitioners and patients.

This cultural diversity represents both opportunities and challenges for nursing care. On the one hand, it can lead to enrichment by fostering the adoption of culturally sensitive perspectives on care and suffering [4]. On the other hand, studies conducted in the United States, the United Kingdom, and the Netherlands identify lower quality in care for ethnically minoritized groups, who face barriers that can limit their access to adequate care [5–8]. Such barriers refer for instance insufficient language proficiency, biases against palliative care, lack of cultural competence among healthcare professionals, and services that do not adapt to their needs [9, 10]. In this sense, as highlighted by Cicely Saunders, founder of the modern palliative care movement, it is important to consider how total suffering integrates physical, emotional, social, and spiritual aspects, and therefore care must be adapted to the patient's cultural background diversity [11]. Figures such as intercultural mediators [12] and chaplains [13] take on significant importance in this regard. However, they are still not established in healthcare systems, as is the case in the region where this study is conducted.

As these figures are not available, nurses play an essential role as mediators between patients and clinical practices, affected by health systems lacking cultural competence in their approach, which is delineated by Westernized values, norms, and practices [3].

The barriers stemming from this, together with prevailing ethnocentrism, can lead to the imposition of Westernized views on dying processes, and the disregard of rituals, values, and meanings which are unique to other cultures [14]. This dynamic hinders effective communication between patients, families, and professionals, especially in the realm of palliative care [15, 16].

Communication is an essential tool in nursing care [17], as it both mediates interactions and helps to build meaningful relationships with patients [18, 19]. Research shows that effective communication facilitates trust and collaboration, directly influences the patient's health and well-being, and facilitates the process of facing emotional and cultural challenges that arise at the end of life [20]. This context presents its own specific challenges, such as the conspiracy of silence, in which patients and family tacitly avoid addressing health situations and decisions [21], agreeing to avoid telling the patient about their health situation regarding diagnosis, prognosis and severity [22]. This explains why communication becomes even more important in end-of-life care, where interactions are traversed by intense emotions and marked by the specific challenges of cultural differences. In nurses' professional practice, communication frames daily tasks of care therefore require special understanding and sensitivity towards patients' needs, experiences, and emotional concerns. When patient's and healthcare professional's respective cultures differ, this practice becomes more complex [23].

The need to understand challenges such as the ones described above has led recent studies to explore the influence of culture in the context of palliative care [24]. It is however not yet clear how such influence originates the inequities and barriers affecting minoritized groups in hosting societies. In this context, the awareness about each culture's specificity is particularly relevant, as healthcare professionals in hosting cultures can often be unaware of the cultural specificity of their perceptions and practices regarding health and healthcare ([25]). The study of different healthcare cultures, and their respective ways of leading with cultural diversity, appears as an opportunity to learn both about challenges and good practices in the context of healthcare [26]. This is of the utmost importance in the context of end-of-life care, as it involves an already sensitive area traversed by processes marked by emotions, values, and norms which are deeply rooted in each person's cultural background.

In this context, our contribution addresses the need to further develop the understanding of end-of-life care in culturally diverse populations, focusing on nurses' perceptions. More concretely, the objective of this study is to understand the difficulties perceived by nursing professionals in palliative care when providing care to patients with cultural backgrounds differing from their own. Our study is conducted in southwest of Spain, with a multicultural population of which 10% are migrants, mostly from Latin America, North Africa, and Eastern Europe [27]. Community orientated, and strongly religious, the culture of this area makes it especially interesting to study palliative care in relation to culturally diverse groups [28]. Here, exploring nurses' views on the challenges related to cultural diversity in palliative care will help to identify factors with which to improve culturally diverse care.

Methods

Study design

Our research design followed a descriptive phenomenological approach based on in-depth, semi-structured interviews conducted in person. This methodology allowed us to gather participants' experiences, leading us to dense descriptions directly stemming from the phenomenon studied [29]. As researchers, this granted us access to participants' perspectives and world views, as well as to their accounts regarding the studied processes [30]. Our study followed the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist [31].

Study participants and recruitment

This research was conducted in South-West Spain between December 2023 and March 2024. A purposive sampling method was followed to recruit participants [32]. Eligible participants were: (a) nurses working in palliative care units; (b) those who were willing to participate in the study and sign the informed consent form. We excluded nurses with no experience in this unit. None of the participants left the study. Participants' profiles considered age, sex, professional role, and training in palliative care.

Data collection

Our data was gathered in semi-structured, in-depth, face-to-face interviews (Electronic Supplementary Material). An in-depth interview is a qualitative research technique that is carried out through iterative face-to-face meetings between researchers and informants. In them, researchers seek to access the interviewees' intimacies and individualities, seeking to gain a better understanding of their views, perspectives, experiences and motivations on the topics defined in the study. Seeking to ensure the comfort and neutrality of participants during the fieldwork, we conducted the interviews in the multipurpose room of the provincial palliative care referral hospital. This room offered a quiet and private space, separated from the clinical practice.

After thoroughly reviewing existing literature, the research team designed a guide to conduct the interviews. This guide was pilot tested with two participants to assess the appropriateness and comprehension of the questions, confirming that it addressed the study objectives.

The dates and the times of the interviews were mutually agreed upon. The comfortability and the proximity of the room where the interviews were conducted facilitated the participants' attendance. All the interviews were conducted by researchers trained in qualitative research and semi-structured interviews. Participants meeting the inclusion criteria received a presentation explaining the interview and describing the goals and procedures used in the study. This explanation particularly emphasized the voluntary nature of their participation, referring to the possibility of interrupting it at any moment with no required justification. Participants were granted anonymity, and their personal information was confidentially kept unidentified throughout the research process. Each participant signed the informed consent form before the interview took place.

During the interviews, participants were encouraged to share their personal experiences and to additionally elaborate on the topic. The collection of data continued until it reached data saturation [33]. In total, 11 in-person interviews were conducted, each with a duration that ranged between 30 and 40 min.

All interviews were recorded and transcribed literally to guarantee accuracy and consistency in the data-gathering process. Additionally, field notes were taken during the interviews to record additional information related to non-verbal communication, thus widening the approach of the context of our study. All interviews were made anonymous, assigning pseudonyms to every participant. Additionally, we ensured that the research team was not acquainted with the participants prior to their participation in this study.

Data analysis

Once transcribed, we filed data preserving their anonymity (as P1-P11). We applied discourse analysis based on the model outlined by Taylor & Bogdan [34]. Firstly, two researchers listened to the audio recording to become familiar with the context. The transcribed interview data were thoroughly read, and re-read, conducting a line-by-line codification process. At this point, the identification of relationships and potentially contradictory content within the data led to a further refinement of codes and the emergence of categories, sub-themes, and candidate themes. Researchers met regularly to review and refine these potential themes and sub-themes. These themes were carefully defined and refined to capture the essence of each interview and the specific aspects of the data they represented. Then, to ensure the accuracy of the analysis, each participant was provided with a summary of the themes and sub-themes identified in relation to their experiences, together with the quotes they provided during the interview. This review allowed them to revise the analyzed data to provide feedback on whether the themes accurately reflected their lived experiences and perspectives. After doing so, none of the participants wished to add anything. The analysis was conducted using the qualitative data analysis software (CAQDAS) Atlas.ti version 23.

Scientific rigor

Three criteria were considered to guarantee rigor in this research: credibility, confirmability, and transferability. Credibility was approached by means of the verification process, in which participants could revise and validate identified themes and subthemes, triangulating these data with field notes. To further reinforce credibility, two independent experts in bioethics and palliative care revised and confirmed the identified themes. Periodic meetings were held to debate and reach consensus data analysis, discussing and sorting out punctual discrepancies and ambiguities among researchers. To improve confirmability, researchers actively engaged in a thorough process of self-reflection, maintaining a high degree of honesty and openness. Researchers kept a reflective diary, critically examining their role and reflecting on their previously conceived ideas/possible biases, influences and feelings throughout the study. To facilitate the transferability of our findings to other contexts, we provided a detailed description of the studied context, inclusion criteria and participants' characteristics, data gathering and data analysis processes, and a complete description of our findings. This detailed account permits readers to assess the applicability of our findings in their respective contexts of study, thus enhancing the transferability of the study findings. To ensure a precise and culturally sensitive translation, the process was meticulously designed. The translation from Spanish to English was conducted by professional translators with expertise in the study's specific terminology. Since English is a shared language among all researchers, the translated document underwent an additional review by the entire research team to ensure accuracy, fidelity, and consistency. Moreover, as the researchers share the cultural background of the interviewees, the translation process accounted not only for linguistic accuracy but also for broader communicative elements, including implicit meanings, contextual nuances, and culturally specific expressions. This approach ensured that the translation faithfully captured the participants' experiences and perspectives.

Table 1 Demographic characteristics

Participant	Gender	Age (Range)	Work experience (Range)
P1	Woman	50–60	30–40
P2	Woman	50–60	30–40
P3	Woman	30–40	10–20
P4	Man	60–70	30–40
P5	Woman	30–40	10–20
P6	Woman	40–50	10–20
P7	Woman	50–60	10–20
P8	Woman	40–60	20–30
P9	Woman	50–60	30–40
P10	Woman	30–40	0–10
P11	Woman	50–60	30–40

Source: Own elaboration

Results

Our sample consisted of 11 nurses, with an average age of 48,646 years (SD = ± 9,131 years), ages were between 30 and 61 years old, and the average work experience was 24,727 years (SD = ± 5,868 years). Most participants were female (90,9%). To ensure the anonymity of the participants, age and years of experience were expressed in ranges. Participants' sociodemographic characteristics are described in Table 1.

To obtain our results we followed the discourse analysis. 8 themes and 13 sub-themes were identified, with spirituality and the size of the care network being two emerging categories that emerged from the analysis of participants' discourse. The analysis steps described above, lead us to the results described in Fig. 1.

Linguistic and communication barriers

End-of-life moments are especially sensitive for the person facing this process, but also for those surrounding them. In this sense, communication is essential to understand and care for their needs. In multicultural contexts, however, linguistic and cultural barriers can complicate the interactions involved in these care practices, negatively affecting their quality. Concerning this, participants identified the following challenges as factors threatening their ability to provide appropriate care in their professional practice.

Language barrier

Language barriers emerged as a significant challenge for the nurses participating in the study. They emphasized that the lack of a common language hinders the possibility to create effective therapeutic relationships, notably challenging the development of a patient-centered care approach. This problem is exacerbated in end-of-life care situations, where the need for clear and empathetic communication is essential to address the patient's emotional, physical, and spiritual needs.

> *"Although taking care of a patient from another culture already presents an additional complexity due to not being very used to it, when there is a language barrier, it is much more difficult, because you might not know how they want to be cared for but also, you can't ask them." P5.*

In this sense, the language barrier both affects the quality of care and also generates a feeling of helplessness in

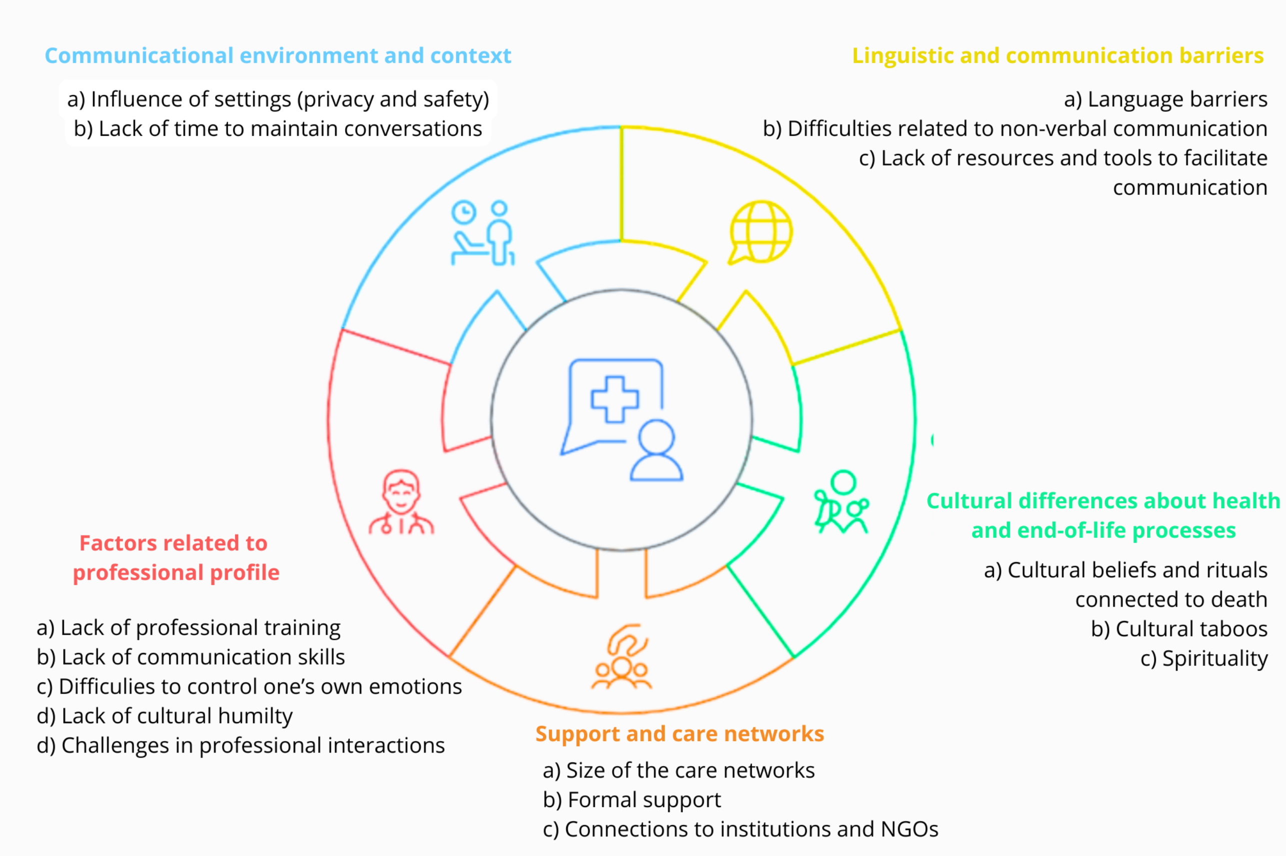

Fig. 1 Themes and subthemes representing perceived difficulties related to caring for culturally deverse patients at the end of life. Source: Own elaboration

nurses, as they cannot ensure that the interventions meet the cultural and personal expectations of the patient.

Difficulties related to non-verbal communication

End-of-life communication processes involve much more than words, as they strongly rely on non-verbal aspects such as gestures, facial expressions, and tone of voice. These elements can vary significantly between cultures and failing to properly identify these differences and solve them, can lead to misunderstandings that affect the nursing-patient relationship.

> *"I don't have the tools to ensure that what I want to say is conveyed. It's not only about verbal concepts, but also about non-verbal communication, tone, body language,… it's not the same thing". P7.*
>
> *"Patients may not feel good if I look them straight in the eye, or maybe they don't want to receive a hug… not sharing the culture makes it difficult to care, and even more so in moments of such vulnerability" P3.*

The lack of familiarity with other cultures' non-verbal codes hinders the possibility of understanding patients' needs, limiting nurses' ability to convey empathy and emotional support, which are essential in palliative care.

Lack of resources and tools to facilitate communication

Another key aspect identified by the informants was the insufficiency of resources and tools to facilitate effective communication. As a challenge, the language barrier is not precisely new, yet nurses consider that the resources that the system provides to overcome it are insufficient, as they do not allow them to correctly interpret the needs of patients at the end of their lives. This explains that, while 24-hour translators are a useful tool, their effectiveness is seen as partial, as literal translation does not always reflect the complexity of the message.

> *"In many cases, a family member or acquanintance assumes the role of mediator. However, since they are not formally recognized within the healthcare system, they often lack the necessary training, which can hinder effective communication. Moreover, patients may feel uncomfortable disclosing certain aspects of their lives in the presence of relatives." P3.*

For informants then, translators are necessary but entails significant limitations. The literal translation of words cannot possibly convey emotional aspects such as the tone of voice, facial expressions, and gestures, which are crucial in making both the patient and their family feel supported and understood.

> *"(We have) a 24-hour translator, but it fails to work. Language requires both literal and cultural translation. Also, communication is verbal but also nonverbal. This is why we need cultural mediators, as families are not always available, but they (cultural mediators) are not in the hospital, they depend on the NGOs." P2.*

This testimony highlights the challenges of language barriers in patient care, stating that while a 24-hour translator service is available, it is not always effective. The participant emphasized that communication involves both literal and cultural translation, as well as verbal and nonverbal elements. Additionally, participants mentioned that cultural mediators are needed to bridge these gaps, particularly when families are unavailable. However, according to the participants, these mediators are not present in hospital and instead depend on NGOs.

Additionally, participants highlighted how intercultural mediators help to alleviate the emotional burden and uncertainties, and feelings of frustration and ineffectiveness, that mark their attempts to overcome cultural and linguistic barriers without proper tools.

Cultural differences regarding health and end-of-life processes

The process of dying is deeply influenced by the beliefs, values and cultural traditions of each person. The different ways in which patients and their families face death can be remarkably challenging for healthcare professionals working in end-of-life care.

Cultural beliefs and rituals related to death

Each culture has unique ways of perceiving death, which directly impacts how people and their families get ready for this moment, and how they face it. Many professionals emphasized that end-of-life care goes beyond alleviating physical pain. Their perception pointed at how caring in this context requires sensitivity to respect the patient's rituals and beliefs, which may involve the acceptance of ceremonies, prayers, the presence of symbolic objects, or the fulfillment of specific traditions.

> *"And when I sat next to her, I realized that woman had a way of experiencing reality very different to someone who did not believe, as she knew: "what is what God wants, that I would always have God's support, that I have tools such as praying, which helps me to relax..." P11.*

Care for patients in the end-of-life context is a complex challenge, as care is affected by cultural differences between patients, families, and healthcare workers. In some cultures, religious faith plays a central role in accepting death, offering a framework that gives meaning to loss and alleviates the fear of the unknown. Yet, in others, death can be taboo, a topic to be avoided at all costs, as openly talking about it can be connected to the possibilities of patients' improvement. In this line, nurses identified the conspiracy of silence as a challenge exacerbated in patients coming from cultures different from their own. Here the conspiracy of silence can lead to behaviors of concealment and evasion from patients' terminal reality, and it can be identified in the avoidance of direct conversations about illness, death, or the patient's condition.

> *"In my view, patients more prone to engage in silence conspiracy are less religious. People who have faith in God, who have religious beliefs, are those who do not engage in silence conspiracy but accept their situation, accept that their family members part to be with God, to reach a better life. They believe that the best is to come, and do not fear it." P6.*

When patients and their families participate in the conspiracy of silence, they often do so, intend to protect their loved ones from the emotional pain that the truth can cause. This behavior, however, can make effective communication difficult, negatively affecting the planning of care, which can lead to misunderstanding patients, failing to properly tend their wishes and needs. For nurses, this represents a remarkable challenge, as the ethics of healthcare demand transparency and respect for patient autonomy.

> *"The conspiracy of silence is always difficult to handle." However, when information is not only hidden out of fear but has a cultural nuance as well, managing this situation becomes even more complicated" P9.*

Cultural taboos

As referred above, while some cultures face death openly and ritualized, others conceive it as a sensitive issue that should not be mentioned directly. In the latter, cultural taboos about death can seriously hinder communication between healthcare professionals and patients.

> *"I have had patients with whom I could not talk directly about death because they felt this would*

> *attract it or bring bad luck. One of the challenges in culturally diverse end-of-life care is to keep the balance between professional honesty with patients, and the respect to their, and their families', beliefs." P8.*

For professional health workers, cultural taboos can bring ethical and emotional dilemmas as they need to find ways of providing information relevant for patients' care, while not failing to respect their cultural beliefs. To professionally adapt to such communication dynamics requires the adoption of a flexible and sensitive approach, as well as being able to rely on the support of intercultural mediators and their help when negotiating cultural differences.

Spirituality

Participants' narratives identified spirituality as an important challenge. It is of note that they underlined how spirituality is not always related to religion but rather refers to the patient's connection with the transcendent and their legacy. Understanding and addressing this dimension requires time, training, and communication skills which are not always available, neither easy to implement, in the clinical setting.

> *"In the end, it is not just the disease that we take care of. It is that need to feel at peace with what they left in this world. And we do not always know how to tackle that." P7.*

Some nurses said that, in many cultures, closing the life cycle involves not only accepting death but also resolving unfinished business, passing on a legacy, and reflecting on the meaning of life.

> *"There are people who feel the need to close cycles: reconcile with family members, share their story, or ensure they leave something positive behind, as if they want to guarantee that their life had meaning. These decisions are deeply personal, but at the same time, they are marked by each person's cultural beliefs." P3.*

This illustrates how spiritual agents or religious mediators, professional roles already recognized in northern Spain, are crucial to facilitate communication and care. When not available, nurses are compelled to assume responsibilities for which they are not always prepared. In addition to this, our results reveal some resistance among certain professionals who do not consider spirituality as a dimension to consider in their care. One of our participants disagrees with this view:

> *"Some colleagues do not see spirituality as part of care, but I believe that for some patients it is as important as their pharmacological treatment." P2.*

Support and care networks

The size of the care network that includes family, compatriots, and formal care (institutions and NGOs), as well as cultural and religious resources available, are essential elements in end-of-life care, especially in multicultural contexts. The diversity in the experiences shared by the participants confirms the need to adapt the provision of care to each patient's specific needs.

Size of the care network

Family accompaniment is essential in care processes, and its role varies significantly depending on culture. In the Spanish context, accompanying the patient throughout the entire process is common. In contrast, in other cultures, accompaniment is marked by a more institutional approach, trusting professionals for nights and resting breaks.

> *"If you have cared for non-Spanish patients, especially those coming from Northern countries, you see that at night they go home, leaving patients under the care of health workers. Here, families accompany the patient 24 hours, but they can feel alone if there is silence conspiracy". P4.*

The lack of company in migrant patients is often explained by the absence of close family networks in the host country, not necessarily being related to restrictive limitations in healthcare centers. In these situations, the lack of a family network compels nurses to adopt a more direct and open communicative approach. They need to strive to provide patients with an accompaniment that seeks to cover as much as possible the support that families would offer.

In addition to the lack of family support in critical moments, nurses refer to the conspiracy of silence as a challenge that, in this context, can affect the quality of care, negatively affecting patients' experience. In these cases, and despite the presence of the families, participants refer to how effective communication processes about patients' health are scarce, if not non-existent. This silence can provoke a deep feeling of emotional isolation in patients, who can feel that their condition and their needs are not being properly understood, neither approached.

> *"Caring for patients who are here alone makes it impossible for you to create silence conspiracy. You need to talk to them clearly so that they can decide*

> *what to do in this situation, whether they go back to their country or face it here, to the end." P9.*

The absence of family members both transforms communication dynamics, as well as brings aside additional challenges related to emotional support and critical processes of decision-making. Informants described how this absence demands an imperative for honesty and clarity, especially in the cases of terminal patients and those in highly vulnerable situations.

> *"Seeing them alone, without their family close by supporting them, when this is something so essential... it is difficult to manage because everyone would want to have their family nearby. Moreover, some face the fact that they may never see their family again because they know they are going to die here, and their family cannot come." P7.*

Connection to formal support networks (institutions and NGOs)

In our data, institutions providing formal care, NGOs and compatriot networks emerged as key elements in care in cases in which patients lacked close family support. Compatriot networks have an essential role here, as they provide both emotional and cultural support, lessening the isolation perceived by patients. On the other side, formal care institutions and NGOs provide resources and services that help them to deal with practical needs in their daily lives.

"*When there are no family members, it is often compatriots who provide company, even when they do not have a direct relationship. This emotional support is essential because it makes patients feel understood, and less alone."* P7.

"Some NGOs do amazing work, and yet sometimes we do not know how to coordinate with them. I feel we make parallel efforts, when we could join forces and do more." P12.

Confirming the important role of formal support, our results highlight the need to develop integrative strategies which are designed to promote collaboration and to join efforts from different sides, facilitating accompaniment considering patients' needs.

Factors related to professional profile

End-of-life care, especially in culturally diverse contexts, requires a set of skills, attitudes, and knowledge that are not always present in professionals' backgrounds. Our narratives reveal the difficulties that nurses face in this regard. Their perceptions point to their lack of training, of communication skills and cultural competence, and the emotional challenges they need to undergo.

Lack of training

One of the most predominant themes in our narratives was nurses' perception of themselves as not being properly equipped to approach patients and families' suffering at the end of life, especially in culturally diverse contexts. Such a lack of training is seen as a factor that affects both the care they provide and their own ability to manage their emotions.

> *"To tackle those aspects that are so related to the patient's suffering..., you need to be prepared to tackle that suffering. And that requires professionals' training in knowledge, skills, and attitudes." P2.*

End-of-life care requires hands-on knowledge, but also interpersonal and emotional skills that help manage suffering effectively. The lack of this fundamental training leads to a disconnection between patients and professionals, affecting the quality of the care they provide.

Lack of communication skills

Our results confirm communication as a fundamental challenge. Professionals reported often feeling forced to share information in abrupt ways, feeling unequipped to perform this task properly, and being aware of the negative impact this can have both in patients and their families. The testimonies collected in our study reveal that the urgency that they feel when fulfilling all their duties, together with this awareness regarding their unpreparedness to communicate effectively, can lead to the development of a personal blockage, in which they avoid feeling empathy and sensitivity.

> *"In the end, to fulfill the legal requirements, the doctors overwhelm the patients with technical information, without a proper explanation. That's because they are not ready to communicate it appropriatrely, but they are legally required to inform." P2.*

Difficulty in managing one's own emotions

Providing care to patients at the end of their lives often makes professionals face their own vulnerabilities. In their narratives, they refer how constant exposure to suffering can lead to emotional overload, affecting both their personal lives and their ability to maintain an appropriate professional relationship with the patient.

> *"Ultimately, when the healthcare professional provides the information and sits in front of a vulnerable person... In that situation, they become very vulnerable as well. Logically, this causes them to suffer both in relation to the suffering of the person facing them and concerning their own suffering, coming from excessively understanding and empathizing*

> *with the other, which leads to suffering in the end." P2.*

This vulnerability is not always recognized, neither is it always adequately managed, which increases the risk of burnout. As a coping mechanism, some testimonies mentioned the need to resort to emotional disconnection:

> *"You are not aware, as you engage in work dynamics in which... Well, yes, ok, even with that capacity to separate, say, as if drawing a curtain and coming home as if nothing would have happened, well, there are times when that works and times when it does not. And when it does not and you cannot get over it, then you turn to diversity of ways, it can be sports or it can be, I do not know, meditation or any other way that helps you a bit, because in the end, it affects you even at a family level, at a family level and also and in your relation to society, and even with yourself." P3.*

Lack of cultural humility

The lack of cultural humility was also identified as another fundamental challenge in the provision of care. Some professionals pointed out that patients from different cultures do not often fully understand their medical situation. If in these cases professionals cannot recognize their own cultural competence shortcomings, they will surely fail to address this patient's need, leaving them to suffer in solitude. Interestingly, participants state that, although it is common for patients to nod during their interactions with healthcare professionals, this does not always indicate that they are truly understanding what is being communicated to them. Importantly, participants perceived that behind patients' superficial responses may lie a lack of critical knowledge about their medical condition, about available treatment options, and even about their possible outcomes. When professionals fail to acknowledge this dynamic, there is a risk that patients will be left with unresolved questions, feeling helpless in their decision-making process.

> *"A nursing intervention I often turn to is the support in decision-making processes because it usually works very well. However, I have encountered patients who I tried to support in making decisions while already in a difficult situation, and throughout their treatment they have been unaware of their situation because it has been explained to them in the quickest way possible, using very technical terms without taking the time to explain what they mean, or because they have built a barrier to avoid understanding." P11.*

Moreover, the lack of cultural humility is exacerbated by the tendency of some professionals to rely on stereotypes or prejudices that can cloud their judgment. These stereotypes, which are often based on generalizations about given cultures, can lead professionals to adopt a condescending or paternalistic attitude. This attitude affects the quality of care and can also erode trust between the patient and the healthcare professional, which is an essential basis in effective care. Some participants reported how some situations can be tricky in this sense, reflecting on how then taking a step back to reset priorities is essential:

> *"There are situations that make you end up prejudging a culture or family, and you have to pause to refocus on that person's needs and rights." P4.*

Challenges in professional relations

Caring for patients from different cultures in the context of end-of-life care presents significant challenges, partly due to differences in opinions and approaches among healthcare professionals themselves. Diverting views can generate tensions among team members, especially when providing care for patients coming from culturally diverse backgrounds.

> *"Your colleagues may think in terms that differ very much from yours and criticize you because of this. Caring for a patient from a different culture, at the end of their life, is very difficult in this sense." P6.*

Addressing these differences is crucial, as establishing a trusting relationship between the nurse and the patient is fundamental to providing effective care. Trust in professionals allows patients to feel safer and more willing to share their fears, doubts, and wishes, which facilitates their engagement in informed decision-making. As one of our participants states, this requires time and effort:

> *"The least you can grant them is the time they need, and of course, this will not happen in just one session or visit, yet it is when that trusting bond is established, that everything becomes much easier." P3.*

The time invested in getting to know the patient is essential to offer personalized care, tailored to individual needs and preferences. However, nursing professionals must also develop skills to actively listen and be open to patients' questions and answers.

> *"You need to start explaining to patients about their conditions. And for that you need, and this is why I believe it is not done, (you need) to know what the patient wants to know, and how far they want to go.*

> *And for that, you need to know the person, and for that you need time; you need skills to remain open to any answer the patient may give you, or any question they may ask you." (P2).*

Communication environment and context

The environment framing the interactions between professionals and patients emerged as a crucial factor due to its influence on the quality of communication. In this regard, professionals expressed concern about lacking physical resources (for instance, adequate rooms to preserve privacy during conversations). Furthermore, it was deemed that they did not have enough time to properly build effective and respectful communication with patients who were already in difficult situations.

Influence of the physical environment

The setting framing end-of-life processes of information is essential to guarantee that conversations take place in effective and sensitive formats. Our Informants highlighted that the lack of private and appropriate spaces for such discussions can create significant barriers, affecting both the quality of communication and the well-being of the patient and family. An environment conducive to end-of-life discussions should be intimate, quiet, and free from interruptions. The possibility of disposing of a room where professionals can talk openly with the patient and their family is hence essential. Without adequate space, there is a risk that conversations will take place in an environment fraught with distractions, which can hinder the expression of emotions and the possibility to address sensitive issues.

> *"If they don't give you the resources, like the time or the training or the possibility of having a space or a room where you have enough privacy, without interruptions or anything, so that you can talk about something so intimate, so unique, for that person and for that family member…then, if you can't work on that because there is another patient next door, because room-consultations are going on,… because obviously you will never be able to work on that conspiracy… (then) it's impossible." (P3).*

Lack of time to interact with patients

The lack of time is a recurring theme in our narratives. It represents an obstacle that significantly impacts the quality of communication between healthcare professionals and patients, especially in sensitive contexts such as end-of-life care. Professionals refer to how they face challenges in carrying out adequate communication processes due to the time constraints imposed by the high demands and volume of patients they must tend to. Such pressure can lead to superficial interactions, limiting professionals' capability to provide the support and information that both patients and families truly need.

When it comes to patients from other cultures, the lack of time becomes an even greater challenge. Cultural differences can profoundly affect perceptions of health, illness, and the dying process. Healthcare professionals must devote additional time to understanding their patients' cultural beliefs and values, as well as to establish effective communication that considers language barriers and cultural expectations. Without this additional time, interactions can be ineffective, failing to meet the patient's needs. Without the necessary time to establish open and empathetic dialogue, professionals may miss the opportunity to identify and respect the patient's preferences regarding their care and end-of-life decisions. One of our participants addresses this difficulty, reporting on their experience:

> *"Many times, I have seen professionals who are information bombardiers. Information can be a bomb, poorly delivered information because I still say that you should not just give information; you need to communicate it, and it involves a process. It is difficult to carry out a communication process when you have 20 patients scheduled for an oncology consultation; I can understand the difficulties." P11.*

This lack of time, even when being understandable, can lead to misunderstandings and feelings of frustration for both professionals and patients. Patients from other cultures may feel misunderstood or ignored if their needs are not adequately addressed. This can erode trust in the nurse-patient relationship, resulting in a less effective and more painful care experience during an already difficult time.

Discussion

Rates of elderly immigrants are increasing in Europe and other developed countries, which emphasizes the need to adapt the health system to diverse populations [35]. In this context, and independently of ethnicity, religion, and culture, the efforts to facilitate access to healthcare should be aligned with the perspective of the Sustainable Development Goals (SDG), concretely with SDG 3 and 10. In the context of end-of-life processes, the adoption of a culturally competent approach to care is essential, as it encompasses processes of care that tend to physical needs, while equally including the emotional, social, and spiritual needs of migrant patients [4, 36]. From this perspective, tackling such needs requires skills that enable healthcare professionals to provide end-of-life care adequately considering patients' perspectives, and gaining their trust. The importance of this is confirmed by studies that show how patients who trust their healthcare professionals report more beneficial behaviors, fewer symptoms, a higher quality of life, and more satisfaction with their treatments [37, 38].

In our study, our results concur with these ideas. Regarding the importance of linguistic and cultural obstacles in terminal patients, our data concur with existing studies [39], referring that the absence of a common language can be a fundamental obstacle hindering effectiveness in communication. Concerning this, they also refer to the importance of non-verbal language. As research shows, non-verbal language (including facial expression and voice intonation, among others) can encompass up to 93% of interpersonal communication [39, 40]. Healthcare professionals therefore need to learn that their gestures, positions, and non-verbal expressions can reveal empathy and trust, or contrariwise, reflect their discomfort or disinterest.

The diversity in attitudes and practices connected to death was another factor that our data revealed as significantly relevant. Differences in this point can lead to misunderstandings and conflicts if they are not dealt with appropriately. Despite some cultural beliefs about how "bad things happen once you talk about them" may lead to avoiding talking about death openly, orthat talking to patients about their death and dying processes abolishes their hopes [41], patients often have their own preferences when talking about death [42]. It is hence essential to carefully examine how they do so, adjusting to their style of communication and to their needs for information at each moment. Concurring with similar studies, our results identified that for nurses, hiding information from patients represented a challenge, as it contradicted assumptions on their autonomy which are characteristic of Western culture [43]. The complexity that these factors encompass in end-of-life communicational processes confirms the urgent need to revise the resources presently available in healthcare settings. In this line, our data also confirms the need to implement interpreting resources that go beyond the mere translation of words, and here the figure of intercultural mediators appears as a viable solution [44, 45].

In addition to the previous factors, our data also highlights the importance of considering the diverse social networks providing support for terminal migrant patients, as many lack families in the hosting country. Our reports referred to the need to include compatriots in the care plan. The role of NGOs and community initiatives in the provision of social and practical support emerged as an essential factor as well. In social networks, or in the absence of them, these two elements cover needs that, among others, can include practical assistance and emotional accompaniment [46, 47].

In agreement with existing research, our data highlighted that healthcare professionals saw the need to be sensitive and respectful regarding patients' spiritual, religious, and cultural needs, even when they differ from one's own [27, 48]. Our findings reinforce the importance of addressing spiritual concerns in holistic nursing care. Nurses need to develop competencies to engage in meaningful conversations about spirituality while respecting diverse beliefs. Collaborating with trained spiritual care providers, such as chaplains, can enhance the quality of end-of-life care by offering tailored spiritual support, alleviating existential distress, and guiding patients through end-of-life decisions. Integrating chaplaincy services into palliative care teams ensures that patients receive culturally and spiritually appropriate support, fostering a sense of peace and dignity in their final moments [49].

Notwithstanding this, our data further concurred with studies that identify sociocultural influences, subtle racism, and prejudices, as factors causing a lack of trust in the interactions between medical care providers and patients in vulnerable populations [50]. The potential threat that such distrust can represent can be connected to another concern identified by the participants: the lack of time and space. Our narratives reveal professionals' daily realities as being traversed by the lack of appropriate spaces and enough time to build adequate processes of communication with terminal patients and their families. Additionally, the spaces available fail to offer terminal patients and their families an intimate environment to engage in such processes safely. This is particularly problematic in culturally diverse contexts, where communication may require more time and sensitivity when building trust-based connections [51].

In addition to all these factors, our data reveals barriers which need to be considered to achieve effective communication. In this area, nurses identify an important lack regarding specific training and skills concerning intercultural communication among nursing professionals. Furthermore, they state that this training needs to include skills regarding their own emotional self-management. In this line, studies confirm the importance of fulfilling this professional weakness, referring that professionals keep on asking for culturally specific tools in their daily practice [52]. Additionally, care providers lack of skills to cope with linguistic and cultural barriers can lead to lower levels of empathy, social conversation, and bonding with migrants and patients coming from ethnic minorities [53, 54]. Despite training in palliative care emerging as a developing area in the academy curriculum, there is a remarkable absence regarding culturally sensitive palliative care, and professors teaching in this field often feel unequipped to train students in this area [55].

In an increasingly muticultural world, end-of-life care should reflect the diversity it encompasses. Considering the perspectives of nurses caring for culturally diverse patients enhances the quality of care for both professionals and patients during their final moments, fostering a more inclusive and humanized care environment. Bearing on this, our results delineate how nurses' perceptions align well with obstacles that hinder an idea of care that is well aligned with patients' real needs. Directly and indirectly, they reflect an awareness about how patients´ experiences and perspectives influence their needs, values and objectives. On this evidence, it can be considered that the golden rule of treating others as one would like to be treated can be called into question. Following Chochinov's [56] *Platinum rule*, we concur with the need to treat patients as they themselves would like to be treated, considering their values and beliefs. In this line, the concept of cultural humility in healthcare appears especially relevant, as it refers to the need to keep a permanent self-evaluation, remain aware of power imbalances, and the development of mutually beneficial connections in the provision of care [57]. In this context, the obstacles identified here would be particularly helpful as a departing point in thinking of possible solutions to improve care in culturally diverse patients in the context of end-of-life care.

Conclusion

Among the difficulties perceived by nurses when providing care to patients from different cultures at the end of life, the need to incorporate cultural competence training into nursing education and continuous professional development stands out. This is crucial for improving intercultural communication and end-of-life care. Additionally, it is suggested to implement intercultural mediation resources that facilitate communication between healthcare professionals and patients from diverse cultures. Recognizing and utilizing social support networks for terminal patients, integrating compatriots and community organizations into the care process, is also essential to address their emotional and practical needs. The study highlights the importance of reviewing the structure of care environments and time management, creating appropriate spaces for private and meaningful communication that cater to the patient's needs. Furthermore, it emphasizes the necessity of addressing the spiritual dimension of care, promoting collaboration with chaplains and spiritual care providers to offer adequate support to patients in their final moments. Finally, we advocate for cultural humility among healthcare professionals, which involves ongoing self-evaluation and the development of mutually respectful relationships with patients. By integrating these findings into clinical practice, potential benefits could be expected for both patients and their families, directly in the care received and indirectly through their ability to trust healthcare providers. On the other hand, nurses would see their daily lives improved, being better equipped to overcome obstacles and to self-manage when dealing with negative emotions.

Limitations

This study has some limitations. Further development of our work could benefit from a wider geographical area that would allow us to examine a wider context and thus consider more dimensions in the study. Despite this limitation, our findings offer an in-depth revision of nurses' perceptions regarding identified difficulties and obstacles in their daily practice. They can be particularly beneficial to improve end-of-life care, in culturally diverse contexts.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12904-025-01759-6.

Supplementary Material 1

Acknowledgements

The research team would like to thank the participants for their selfless collaboration in the study.

Author contributions

Made a substantial contribution to the concept or design of the work: MJCT, JMPS, MRCR and EBGN. Data collection and data analysis were done by: JMCT and JMPS. EBGN, drafted the manuscript. All authors revised the manuscript critically for important intellectual content. All authors approved the final manuscript to be published and have participated sufficiently in the work to take public responsibility for the content.

Funding

The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Data availability

The datasets for this study are not publicly available because of the risk that individual privacy could be compromised; however, the datasets are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

This study followed the international ethical recommendations set out in the Declaration of Helsinki. All participants received an information sheet with relevant details about the study, along with a consent form, which they signed to confirm their voluntary participation. All personal information provided was stored in a way that complied with the legal requirements for the protection of personal data and the guarantee of digital rights (Organic Law 15/1999 of 13 December 1999 and Organic Law 3/2018 of 5 December 2018). This project was approved by the Ethics Committee of the Andalusian Government (PEIBA) with the code Acomp_findevida/23.

Consent for publication

Participants provided informed consent for publication of the quotes.

Competing interests

The authors declare no competing interests.

Received: 30 January 2025 / Accepted: 17 April 2025

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