



How do cultural factors influence the provision of end-of-life care? A narrative review

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ABSTRACT

Background: Culture influences the way in which patients, families and professionals provide care and undergo decision-making at the end of life.

Objective: Therefore, our research questions were: How do cultural aspects influence the needs, perceptions, and experiences of patients and their families in end-of-life care? What implications does cultural diversity have for professionals who care for individuals at the end of life?

Methods: A narrative review was conducted between June and July 2022. Articles published between 2017 and 2022 in peer-reviewed journals were included.

Results: A total of 43 studies were included. Our findings were grouped into four themes: 1) places to die and preferences about healthcare interventions (e.g. parts of the immigrant population tend to receive more aggressive and invasive interventions); 2) advance care planning and verbalization of death (e.g. less use of ACP in some minority groups); 3) rituals and family involvement during healthcare; 4) professionals addressing multiculturalism in care at the end of life (e.g. lack of training in addressing the context of multiculturalism).

Conclusions: These findings could contribute to making professionals more aware of cultural aspects that influence the process of death and highlight the need for further training in the handling of such situations.

1. Introduction

End-of-life care can be defined as the planning and supportive care that an individual receives at the end of his/her life (Huffman & Harmer, 2022). This care is traditionally multidimensional, embracing many aspects of well-being such as physical and psychological aspects, but also social, spiritual, environmental, and cultural factors (Fukuzawa & Kondo, 2017).

In general, individuals closer to the end-of-life tend to experience a complex and changing combination of emotions and thoughts, embracing different perspectives toward their death, and undergoing a series of subprocesses (i.e., psychological death, social death), which may coincide with the moment of biological death, or may precede it by days, weeks, or even months (Espinhar Cid, 2012). During these transitions, each person draws on resources, both internal and external, to cope with fear, anguish, and sadness. (Ahmadi et al., 2019).

At the end of life, some of the greatest concerns of patients are to

control pain symptoms, to reduce physical and emotional suffering, to avoid unnecessary prolongation of life, to feel fulfilled and reduce family burden, and to receive dignified and respectful treatment by the health professionals (Donnelly et al., 2018; Steinhäuser et al., 2000). Although health professionals, especially nurses, strive to understand the preferences and priorities of their patients at the end of life, they consider communication and educational gaps as some of the most important barriers to provide such care (Price et al., 2017), especially for culturally diverse societies, such as Europe and North America (Hebert et al., 2011; International Organization for Migration, IOM, 2019). In this context, considering the cultural aspects of these individuals is an important objective of care.

Based on the previous literature, culture may have an important influence in end-of-life care. Focusing on patients' and families' perspectives, one systematic review evidenced that the conservation of cultural identity of origin, the value given to the family over the individual, the limited experience of migrants when accessing the health

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system of the host country, as well as language differences, constituted barriers among the Chinese immigrant community to receiving end-of-life care in high-income countries (Kwok et al., 2020). Following that same direction, Wicher and Meeker (2012) compared end-of-life preferences between African Americans and non-Hispanic White individuals, finding that African Americans used more aggressive life support therapies and less Advance Care Planning (ACP) documents, or hospice services. Religious beliefs also impact the visions and perspectives of end-of-life care as noted by Choudry et al. (2018) who observed different concepts of life, life after death, and the different rituals involved, among five religious' traditions in the UK.

Switching the focus to healthcare professionals, another review, carried out by Pentaris and Thomsen (2020), found that palliative care staff in Denmark and the UK felt the need to adapt their styles of care when working in multicultural contexts. Similarly, a review that studied culturally sensitive communication, found that communication barriers and cultural and personal factors were the two major influences found in 8 of the 9 studies included (Brooks et al., 2019).

Although there are studies assessing cultural elements in end-of-life care, they tend to focus on very specific aspects of this field, such as including a specific geographical region (Kwok et al., 2020; Pentaris & Thomsen, 2020; Wicher & Meeker, 2012), a single cultural element (Choudry et al., 2018), a certain disease (e.g., cancer) (Balante et al., 2021), a particular setting (e.g., intensive care units) (Wong et al., 2018), or embracing only a single aspect of care (Brooks et al., 2019).

Therefore, a broader review is needed in the current scientific literature, expanding the scope of interest, including different settings, samples, and cultural perspectives studied all over the world. This could help healthcare professionals to understand how important cultural aspects are to their patients, allowing them to provide integrated, humanized, and holistic care at the end of life.

Therefore, our research questions were: *How do cultural aspects influence the needs, perceptions, and experiences of patients and their families in end-of-life care? What implications does cultural diversity have for professionals who care for individuals at the end of life?* Therefore, the present study aims to investigate how cultural factors influence the provision of end-of-life care.

2. Material & methods

2.1. Design

This is a narrative review of the updated scientific literature. The protocol was registered "a priori" in PROSPERO (Glyn-Blanco & Badanta, 2022). This review followed the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guidelines (Page et al., 2021) (see Supplementary material).

2.2. Search strategy

The search was carried out independently by two researchers between June and July 2022 in PubMed, Scopus, CINAHL, PsycINFO and, Web of Science databases, using the following search strategy: ("end of life" OR "end of life care" OR "end of life decisions" OR "end of life practices" OR "palliative care") AND ("cultural diversity" OR "cultural beliefs" OR "cultural practice").

The research question was elaborated following the PICOTS structure (Table 1).

2.3. Inclusion and exclusion criteria

Original articles published in the last five years (between 2017 and 2022) in peer-reviewed journals were included, with no restrictions of language, or geographical setting. This date limit was set in order to provide the most updated information and considering the vast number of articles available concerning this topic. Articles of quantitative,

Table 1

PICOTS (population, intervention/exposure, comparator, outcome, time and study design) criteria.

PICOTS criteria	
Population	Individuals at the end of life, family members and professionals caring for these individuals
Intervention/ exposure	End-of-life care in a cultural context
Comparator	Standard practice in dominant cultural setting or no comparator
Outcome	Needs, perceptions, experiences with care at the end of life
Time	Not applicable
Study design	Original studies including quantitative, qualitative and mixed designs

qualitative, or mixed methodology that addressed the influence of cultural aspects on the care provided to patients at the end-of-life (i.e., in the final months or days of their lives) were included. Opinion articles, editorials, comments, non-peer reviewed materials, and other synthesis of literature were excluded. Furthermore, publications related to people under palliative care, but without an imminent terminal prognosis, were also excluded.

2.4. Study selection and data extraction

After searching the literature, all references were included in the Mendeley Software 1.19.18. The initial screening was carried out by two reviewers independently reading titles and abstracts. Duplicate publications were also excluded in this phase. Subsequently, the selected articles were read in full text.

Finally, the main characteristics of the selected articles were extracted, considering the geographic area of the study, the purpose, methods, and the main findings, as well as the methodological quality of each study.

2.5. Assessment of methodological bias

The studies that met the inclusion criteria were assessed by two reviewers independently for methodological validity prior to inclusion in the review. Any disagreements between the reviewers were resolved by a third reviewer. Methodological bias was assessed using tools that ensure high-quality presentation of observational studies (i.e., STROBE) (Von Elm et al., 2008), and of qualitative studies (i.e., SRQR guidelines) (O'Brien et al., 2014). Studies scoring low on these appraisals were excluded.

2.6. Development of themes

To answer the research questions for this review, the reviewers used the thematic manual analysis (Braun et al., 2019), which is a method for identifying, analyzing, and reporting patterns (themes) within data. This analysis followed the following phases: 1) familiarizing with the data, 2) generating initial code, 3,4) searching and reviewing for potential themes, 5,6) defining and naming themes and producing the final report. A theme was developed based on codes and associated ideas that answered each of the research questions. Any disagreements about the codes and categories were resolved between the authors, and all of them had to agree to create a specific theme.

3. Results

The search process identified 356 publications (PubMed $n = 77$, Scopus $n = 101$, CINAHL $n = 96$, Web of Science $n = 60$ and PsycInfo $n = 22$) that matched the search criteria (Fig. 1). After removing duplicates, 179 articles remained, of which another 122 articles were excluded after screening the titles and abstracts. A total of 57 articles

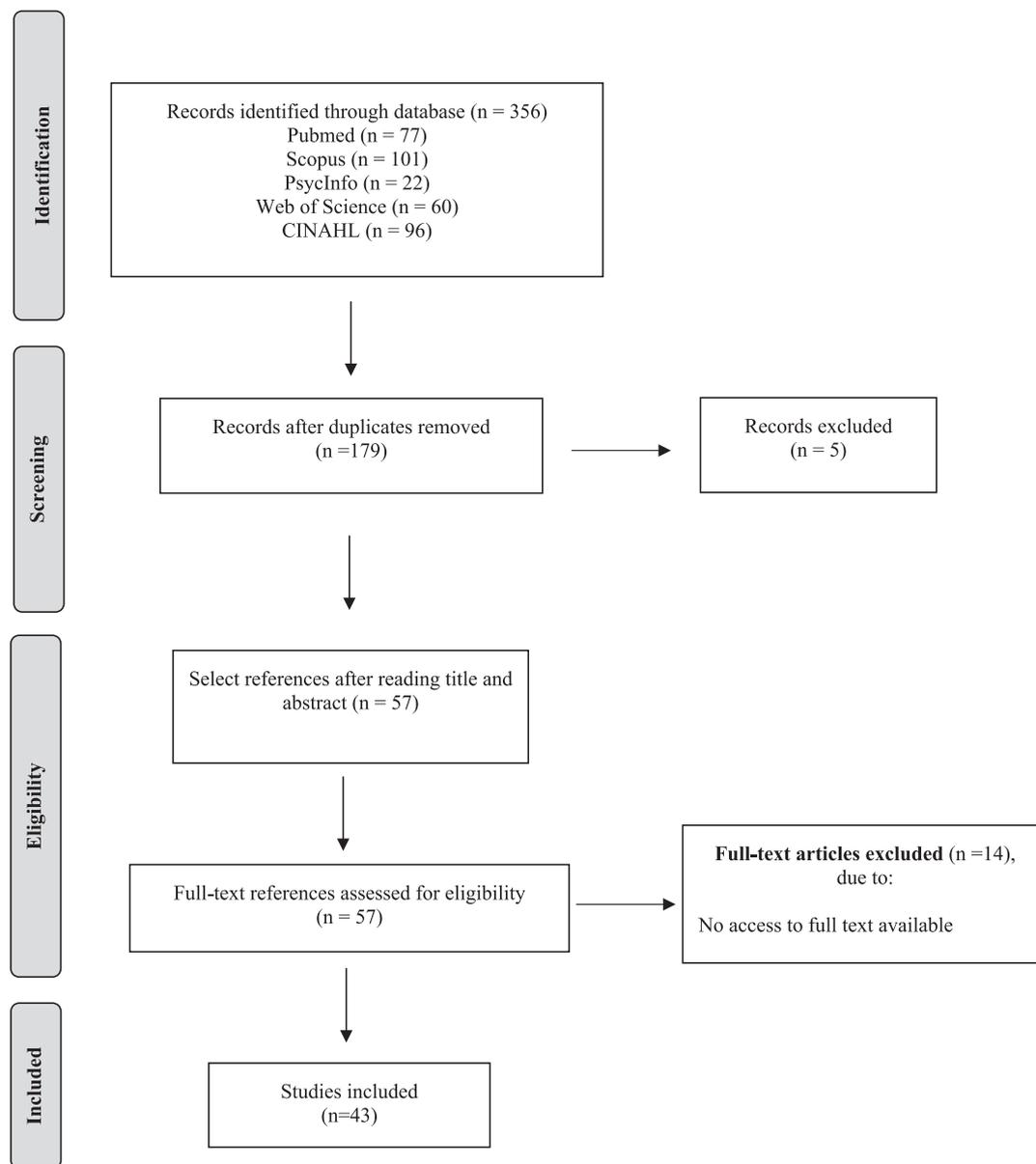


Fig. 1. Flowchart for the selection of articles for the review.

underwent full-text analysis, and the final sample included 43 studies.

3.1. Characteristics of the included studies

A total of 43 articles were included in the systematic review, 39.5 % of them were published in the last three years ($n = 17$), and they were predominantly qualitative studies ($n = 26$; 60.5 %). Over a third of the studies were developed on the American continent ($n = 17$; 39.5 %), followed by Europe ($n = 8$; 18.6 %), and Oceania ($n = 7$; 16.3 %).

To explore how cultural aspects modulate the needs, experiences and attitudes toward end-of-life care, most studies included professionals from the health, social or spiritual fields ($n = 24$; 55.8 %) mostly nurses (75 %), as well as citizens, end-of-life patients, or their relatives ($n = 22$; 51 %). Among the participants, the percentage of women was higher in 69.2 % of the publications, but only 14 articles (32.6 %) included participants aged 60 years old and over.

Quality assessment revealed that most studies presented appropriate research questions, clearly defined populations, good response rates, appropriate exposure and outcome variables, and control for confounders. In the assessment of adherence to the reporting guidelines, all

articles included in this review were considered of high or medium quality for observational studies (STROBE). After the assessment using the Standards for Reporting Qualitative Research guideline (SRQR), no article was rejected, and studies fulfilled most of the items. However, the most frequently missed item was related to the characteristics of the researchers and the techniques to enhance trustworthiness.

Our analysis of the findings of the articles was grouped into the following four themes based on the perspectives of the patients and families; and professionals: 1) places to die and preferences about healthcare interventions; 2) advance care planning and verbalization of death; 3) rituals and family involvement during healthcare; 4) professionals addressing multiculturalism in care at the end of life (Table 2).

3.2. Theme 1. Places to die and preferences about healthcare interventions

The studies in this review reveal that there is a preference, at the end of life, for being cared for by people who share elements of the patients' culture (McCleskey & Cain, 2019), and that a greater level of religiosity, or belonging to a minority ethnic group is related to a greater demand

Table 2
Results description for the review.

Reference	Objective	Methods	Sample	Main findings
Agbawodikeizu et al. (2019) Nigeria	To examine the attitudes, perceptions and suggestions of adults toward end-of-life (EOL) planning in one of Nigeria's Igbo areas.	Mixed methods	<i>N</i> = 587 adults (577 in quantitative phase and 10 in qualitative phase). Gender: 53.9 % males Age: 18–44 years old (70.9 %) and ≥45 years old (29.1 %).	Half of the participants (51.1 %) had negative attitudes toward end-of-life planning, as well as toward delegating or accepting end-of-life planning for their loved ones. These negative attitudes were most influenced by greater religiosity, fear of death or young age. The belief in healing miracles was prominent, so thinking about death and planning end-of-life care was considered to underestimate the powers that they believed could save lives.
Al Mutair et al. (2019) Saudi Arabia	To explore the perceived impact and influence of cultural diversity on how neonatal and paediatric intensive care unit (NICU and PICU) nurses care for Muslim families before and after the death of infants/children.	Qualitative (semi-structured interviews)	<i>N</i> = 13 registered nurses from the NICU (<i>n</i> = 6) and the PICU (<i>n</i> = 7).	Nurses reported that language differences made it difficult for them to empathise well, so they relied on body language, or translation from other nurses or professional interpreters. They also highlighted the importance of understanding and anticipating the cultural and religious needs of families, giving them resources to pray (e.g., prayer mat, boxes to put religious objects in, or time to pray with their children). Some of the cultural care provided to the baby/child before and after death included bathing them using 'Zamzam' water (holy water from the Zamzam well in Mecca brought by relatives), having a recording of the Qur'an near the baby, and preparing the body after death by joining his/her hands and directing the body toward Mecca. Finally, nurses also used their faith or prayer to maintain their motivation and resilience, which was needed due to the emotional and personal impact of their work.
Barwise et al. (2018) USA	To determine whether code status, Advance Directives (ADs), life support preferences, use of comfort measures before death, and timing of decision making were different for patients with limited English proficiency (LEP) in the ICU as compared with patients who spoke English.	Quantitative (retrospective cohort study)	<i>N</i> = 27,523 patients admitted to the ICU.	Patients with LEP presented less ADs during ICU admissions (11.0 %) compared to patients without LEP (36.8 %). They were less likely to implement 'do not resuscitate' (DNR) orders at the time of their discharge from the ICU (7.3 % vs 10.3 %), and on ICU admission (0.5 % vs 1.5 %), and less likely to change their code status from full to DNR during their ICU admissions. Orders for comfort measures before death were put in place in 41 % of LEP patients and in 64.7 % of English-speaking patients. Restraints were used more often on LEP patients (16 % vs. 12 %). However, there were no differences found in the rates of mechanical ventilation between the two groups (37.5 % vs. 36.1 %) or in rates of dialysis, vasopressors, CPR, continuous intravenous analgesia, or sedation.
Bazargan et al. (2021) USA	To test the effects of race, socioeconomic status, health status, spirituality, perceived discrimination, and medical mistrust on the EOL desires of non-Hispanic White and non-Hispanic Black older California adults.	Quantitative (Survey of California Adults on Serious Illness and End-of-Life 2019).	<i>N</i> = 773 (190 non-Hispanic black people and 583 non-Hispanic white people). Gender: 51.7 % females Mean age: 67.14 years old	From an ethnic point of view, more black participants wished to have a higher level of respect for cultural beliefs and values (83 %) than the white participants (62 %) (<i>p</i> < 0.001) to be comfortable and pain-free at the end of life. More black participants also desired a closer

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Table 2 (continued)

Reference	Objective	Methods	Sample	Main findings
Benbenishty et al. (2020) Different countries of Europe and Middle East	To explore the European and Middle Eastern intensive care nursing ceremonies and rituals surrounding care provided to patients after death.	Qualitative (interviews)	N = 23 critical care nurses from 16 countries in Europe and Middle East	relationship with their caregivers (73.7 %) compared to the white participants (58.9 %) ($p < 0.001$). The nurses mentioned rituals such as blessing the body, touching the forehead or chest, or crossing the deceased patient, showing respect by not eating or drinking until the body was transported to the funeral home, or opening the windows to allow the deceased's soul to escape from this world. Some practices to ensure dignity included washing the body, shaving men and providing a clean pillow, removing all lines and tubes connected to the patient, or lighting a candle. One nurse created a "palliative care cart" which contained a Bible, the Koran, amulet beads, a bottle of holy water, a book of hymns and prayers, CD music, and a head covering for the deceased. The nurses considered personalizing cultural practices and customs as necessary, including providing family time to be with the loved one, accurate information, and guidance and comfort. However, sometimes there were restrictions on the number of family members that could be present at one time.
Bloomer et al. (2019) Australia	To explore the impact of cultural factors on the provision of EOL care in a geriatric inpatient rehabilitation setting.	Mixed method	Phase 1: $n = 54$ geriatric inpatients who died; Phase 2: $n = 19$ clinicians (nursing, medical and allied health). Gender of inpatients: 55.6 % males. Mean age of inpatients: 83 years old.	Nurses detected difficulties in end-of-life care related to language barriers and limited use of interpreters. They also reported the need to culturally attend to the religious and nutritional needs of their patients to provide comfort, however, the use of pastoral care and the adequacy of diets was questionable. Although professionals recorded religious demands in medical histories, some such as lighting candles and the presence of religious figures (e.g., Rabbi) before and after death were not always satisfied or allowed by the institution. Participants reported a perceived lack of training in cultural care in end-of-life care.
Broom et al. (2019) Australia	To explore how health professionals experience their encounters with migrant cancer patients.	Qualitative: 8 Focus Group Discussions (FGDs)	N = 57 (26 allied health, 13 medical practitioners, 10 nurses, 8 community workers). Gender: 82.5 % females Age: 80.7 % between 30 and 59 years old.	Health professionals expressed that generalising cultural aspects generated stereotypes and prejudices about families. Balancing institutional, professional, and personal values was also considered important. This meant that when facing Western values, such as patient autonomy and communicating individual information to the patient, cultural sensitivity must be shown so as not to correct family values in order to satisfy those of the professionals. Lack of time was a barrier to learning about different cultures and providing quality care.
Cable-Williams and Wilson (2017) Canada	To identify the influence of the culture in Canadian long-term care facilities on the awareness of impending death and initiation of a palliative approach to care for residents aged 85 years and older.	Qualitative: interviews, observation, and a FGD.	N = 50 key informants (nurses, pastoral care worker, nutritionist, social worker, managers), and focus group with family members.	The professionals report that there is an institutional culture of maintaining the scarcity of human resources, despite the increase in demands for care due to the health situation of the elderly. The participants work with the approach of the institution as a

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Reference	Objective	Methods	Sample	Main findings
De Voogd et al. (2021) The Netherlands	To determine registered nurses' and care assistants' difficulties and strategies for preserving dignity of migrant patients in the last phase of life and their families.	Qualitative (5 FGDs)	N = 29 (assistants, nurses, social workers and team leaders). Gender: 96.5 % females.	place where people live, not where they will die. Although staff routinely voiced the significance of being present with dying residents, they were aware that it can be difficult for family members to fulfil this duty when the dying process takes more than a few days. Finally, facilitating comfort was understood to be a compelling duty to avoid patients to die in pain. Specific factors, such as language barriers or the increased involvement of family members in decision-making, were considered, by some nurses, as barriers to preserving the dignity of patients. Some nurses ignored the decisions or preferences of the relatives and only asked and considered those of the patient, others tried to convince relatives of the professionals' ideas by providing intentional information. Some key figures suggested talking to family members and patients together, accompanied by a professional interpreter to ease the decision-making process and safeguard the patients' and families' dignity. They also recommended the use of a cultural mediator or spiritual counsellor to help in difficult situations. Some nurses asked about the wishes and cultural practices of patients and relatives to meet these needs, accepting decisions such as the rejection of morphine, even though these decisions were thought to decrease quality of life and dignity of the patient. Other preferences expressed by the patients were related to how to wash intimate body parts and gender-matched care staff. These were not always grasped by the staff due to language barriers.
Fearon et al. (2019) Mauritania	To understand the principles of EOL care and the perspectives of health professionals, families and communities in rural areas of the Islamic Republic of Mauritania (West Africa).	Qualitative (31 semi-structured interviews and 8 FGDs)	N = 76 (33 health care professionals, 12 recently bereaved family members and 31 community leaders). Gender: 77.6 % males.	The participants believed that God is the only one who can know and decide when a person will die. From the point of view of Islam, it might be arrogant to try to make and report a prediction about the time of death. The belief that God has the power to heal all illnesses encouraged decisions to prolong life in search of curative options. The professionals avoided communicating bad news because they believed that the patients could die from the stress of the news and the community would lose confidence in the professional. However, relatives preferred clear and direct communication in order to prepare for the patient's death. The family was considered responsible for providing a dignified death, called a "good death". This was understood as a death in which the patient was practicing their faith, without pain or debt, was clean and surrounded by his relatives at the time of death. After death, relatives used to direct the

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Reference	Objective	Methods	Sample	Main findings
García-Espinel et al. (2017) Spain	To identify the values and perceptions of Roma people during the dying process of a member of their community in hospital.	Qualitative: communicative case study (communicative observations and communicative daily life stories)	N = 9 (extended family members, other Roma people, and civil servants working with the Roma)	body to Mecca, wrap it in a clean cloth and, generally, have the burial in <24 h after death. When a member of the Roma community falls ill and enters his/her last days, a network of support and communication is developed throughout the process, where decision-making is strongly linked to the older leaders of this community. Care is usually done at home and all members of the family and community are involved. If dying at home is not an option, relatives accompany the patient at the hospital. Regarding the health system, Roma people express barriers to good care, such as the lack of space, perceived discrimination or not being able to take the body immediately after death.
García-Navarro & da Costa (2017) Spain	To identify the perceptions of health professionals about palliative care for culturally diverse patients, and about the incorporation of intercultural mediators.	Qualitative (in-depth interviews)	N = 9 (Registered nurses (n = 7) and intercultural mediators (n = 2) from sub-Saharan Africa, Maghreb, and Eastern Europe.)	The professionals asked about cultural aspects during the initial interview with patients and family members, recognising the importance of the culture and beliefs, migration history, family roles, coping strategies, or rituals that patients wish to carry out in their end-of-life process. Thus, they identified different concepts of death (e.g., punishment in Western societies), rejection of opioids due to the belief that they would create addiction, demands of certain body positions to die, and intimacy preferences. Cultural mediators were able to offer more in-depth details about how culture influences the meaning and expression of physical pain and suffering. They also shed light on cultural values related to communication and the differences between languages. Therefore, they are an important resource in the understanding of culture and conflicting situations.
Green et al. (2018) Australia	To elicit the experiences of palliative care health professionals when providing care for patients from culturally and linguistically diverse (CALD).	Qualitative (4 FGDs)	N = 28 (doctors, nurses, social workers, pastoral care workers, occupational therapists and physiotherapists.)	The professionals underlined the importance of focusing care on individuals' needs rather than cultural generalisations. However, the language differences made communicating and understanding between patients and professionals more difficult, so the participants looked for relatives, or workers who knew the language to mediate the conversations. They also found conflicts related to the principle of autonomy (keeping the patient well informed), whereby there was a common preference of relatives not to disclose certain information to their loved ones about the exact details of their illness or situation. This created a dilemma, especially when there were relatives living abroad who would not arrive in time to see the patient alive if they were not informed properly or in a timely manner. Although professionals considered it important to incorporate the

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Reference	Objective	Methods	Sample	Main findings
Hayes et al. (2020) Australia	To know how people from CALD communities might respond to Advance Care Planning (ACP) and EOL discussions.	Qualitative (semi-structured interviews)	<i>N</i> = 39 interpreters	<p>cultural beliefs of patients and families, they acted looking for a middle ground between certain family beliefs (e.g., about medication and food) and professional opinions.</p> <p>The interpreters identified cultural differences in the way of discussing death (moral difference), such as avoiding talking about death or serious illness directly, or using certain words in conversations, as well as preferences not to plan death because it is a matter of destiny or God.</p> <p>Difficulties in communication and having to use interpreters to communicate affected knowledge of health and death. The patients adopted the customs of the health system of their country of origin (e.g., not making their own decisions). In addition, the lack of knowledge about the process of dying was also influenced by the migration process, since it did not allow people to experience the death of older relatives who remained in the country of origin.</p>
Hinderer and Lee (2019) USA	To estimate the impact of a culturally tailored nurse-driven educational intervention on the relationship between attitudes toward ADs and ACP.	Quantitative (Pre-posttest workshop): advance directives questionnaire (ADQ), Advance Directives Attitudes Scale (ADAS)	<i>N</i> = 72 Chinese Americans. Gender: 63.9 % females. Mean age: 61 years old.	<p>One month following the workshop, of those who did not have an AD or no previous ACP discussion, an additional 10 participants reported having an AD and an additional 16 individuals engaged in a discussion with friends and/or family about their ACP wishes. The attitudes toward ADs were significantly higher immediately after the intervention than before ($p = 0.014$). There was no significant difference between ADAS scores from immediately after the intervention to one month later ($p = 0.975$), indicating that attitudes remained stable for this period. Of those individuals who did not have an AD prior to the workshop, a significant relationship was found between ADAS scores and AD completion ($p = 0.019$).</p>
Iida et al. (2022) Japan	To explore the cultural views and beliefs regarding palliative and end-of-life care among the staff in Japanese long-term care facilities.	Qualitative (FGDs and semi-structured interviews)	<i>N</i> = 71 staff and 10 facility managers (care workers and nurses). Gender: 59.5 % females. Age: 20–69 years old.	<p>Given that people are currently more accepting of the natural course of death in facilities, rather than expecting a medicalized death, the staff do not consider end-of-life care as special, but a continuity of the usual care patients receive at home.</p> <p>As part of end-of-life care, people over 80 preferred more active interventions until death and were against talking about death. The professionals supported the use of technologies and considered remaining both physically and psychologically intact (kirei) as very important, without suffering wounds, sores, and oedema.</p> <p>Regarding relatives, they have a duty to be with the dying person, and if this is not possible, they demand the presence of professionals.</p> <p>Professionals sharing experience with other young or new staff,</p>

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Reference	Objective	Methods	Sample	Main findings
Inglehart et al. (2021) Several countries	To investigate how attitudes toward euthanasia differ among countries, and economic, religious, and health-related factors.	Quantitative (World Values Survey)	N = 389,243 participants from 62 countries.	understanding death as something frequent and inevitable, and creating family-like relationships with residents were strategies used to deal with the death of patients. Among high-income countries, 23 of 24 countries tended to informally justify and accept euthanasia, while 12 of 38 low-income countries showed a decline in acceptance over time. The Netherlands was the country that was most in favor of euthanasia (7.47/10) and Jordan was the country that was most against it (1.5/10). In addition, it was noted that a greater importance of religion within the country generated a lower acceptance of euthanasia.
Johnstone et al. (2018) Australia	To describe the processes that nurses use to foster cultural trust when caring for older immigrants of non-English speaking backgrounds hospitalised for EOL care.	Qualitative (in-depth and semi-structured interviews)	N = 22 Registered Nurses. Gender: 91 % females.	The nurses described the importance of building trust with the patient and their families by first giving 'a little bit of themselves', knowing them on a personal level before focusing on their illness, speaking to patients and families in their language, if possible, and understanding the family functioning and respecting their preferences. For example, showing quality care, by maintaining patient hygiene, strengthened this trust and calmed family members.
Karadag et al. (2019) Turkey	To determine the attitudes of nurses toward care of dying individual as well as religious and cultural factors that influence their attitudes.	Quantitative (questionnaire and Frommelt Attitudes Toward Care of the Dying Scale)	N = 189 nurses (101 nurses working in a hospital in Western Turkey, and 88 working in a hospital in Eastern Turkey) Gender: 88.9 % females. Mean age: 32.9 years old	Among the nurses who worked at the Eastern Hospital, 72.7 % stated that the patient's cultural and religious beliefs positively affected their attitude toward death and caregiving, whereas only 46.5 % of the nurses working at the Western hospital shared this opinion and 48.5 % of the nurses working in the west believed that they had no effect. In general, some nurses (16.4 %), encountered difficulties in providing care due to their own cultural and religious aspects, and 58 % of these nurses felt uncomfortable or restricted when providing care to patients of the opposite sex.
Kelley et al. (2018) Canada	To conduct Participatory Action Research (PAR) in partnership with four First Nations communities to create local palliative care programs.	Mixed methods with PAR, surveys, interviews and FGDs.	N = 279 community members and external health care providers.	The participants identified the involvement of the family, in the caring of the patient, as a necessity. Although 87 % of indigenous people would prefer to die at home, the participants expressed a lack of formal palliative care available in the community to feel safe providing this care at home, and a social and cultural barrier to accessing care. Death was perceived by members of the community as part of life, so it should not be feared. Also, culture plays an important role at the end of life as it is a time to pass on traditions, share experiences and participate in traditional ceremonies. Health professionals expressed great satisfaction in working in collaboration with members of the indigenous community, as they

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Reference	Objective	Methods	Sample	Main findings
Kirby et al. (2018) Australia	To explore the experiences of people from CALD backgrounds, and their caregivers, in a palliative care setting.	Qualitative (semi-structured interviews)	N = 30 (14 caregivers and 16 patients) Gender: 70 % females. Age: 20–89 years old.	were able to create more intimate relationships. Communication barriers with health professionals, poor explanation of the meaning of palliative care, or the lack of a direct translation of the term in different languages made it difficult to understand the concept. Effective communication between professionals and patients about symptoms, such as pain, was also difficult since tolerance varied with culture and accessibility of analgesics in the country of origin. Many participants believed that talking about death would speed up the process and was associated with giving up. Religion played a central role in facing and defying the prognosis of death, helping to maintain hope, since there was the belief that God knew more and could heal better than the health team.
Mahilall and Swartz (2021a) South Africa	To analyze the views and dilemmas of cultural and racial issues as experienced by spiritual carers in a hospice in Cape Town, South Africa.	Qualitative (interviews and FGDs)	N = 9 spiritual care workers. Gender: 55.5 % males.	The spiritual care workers considered the importance of knowing how patients and family members want to talk about the situation, the acceptable words for conversations, and the taboos that must be avoided. They stated that indigenous people in South Africa respect the role of the ancestors and follow their wishes when trying to reverse the terminal diagnosis or prepare a proper burial process. The workers felt that it was necessary to distinguish between ‘good’ superstitions (they help to understand cultural beliefs and practices) and ‘bad’ superstitions (they evoke fear). Participants also felt that the organizational culture was difficult to practice, based on a Western model that did not fit with the cultures of the patients, and that there was insufficient funding for end-of-life spiritual care.
Mahilall and Swartz (2021b) South Africa	To understand the experiences and views of representatives of hospices in the Western Cape province of South Africa on the provision of appropriate spiritual care against the backdrop of multifaceted diversities.	Qualitative (2 FGDs)	N = 23 employees of hospices (nurses, social workers, managers, spiritual care workers, psychologist).	Some participants reported that hospice workers needed to have a basic understanding of major religions and cultures in order to provide quality spiritual care. However, others felt that religion should not be mixed with spirituality, and that the most important thing was to know oneself and not be prejudiced, since some patients preferred to be cared for by someone with whom they had a personal connection rather than a cultural similarity.
McCarthy et al. (2020) Senegal	To understand everyday experiences and responses to death, care, and family relations related to family deaths in urban Senegal.	Qualitative (FGDs, interviews, and 8 workshops).	Family members (n = 59), NGO, and religious leaders (n = 17), and FGDs with 24 individuals.	The participants expressed the importance of the moral and economic support of the family in situations of death. Death is expressed as a community event, so members of the community help plan the burial, donate money, advise, and accompany. In addition, death was understood as a wish from God, so its acceptance was promoted, and religious beliefs and practices served as frameworks for consolation.

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Reference	Objective	Methods	Sample	Main findings
McCleskey and Cain (2019) USA	To investigate similarities and differences in end-of-life care preferences, across racial and ethnic groups.	Qualitative (6 FGDs)	N = 39 (African American, Hispanic, and White people). Gender: 64 % females. Age: 19–92 years old.	Under the regulations of the Muslim religion, the material belongings of the deceased were distributed, generating a difficult process due to the emotional bonds associated with material objects. The participants had a general preference for health personnel's honesty when talking about serious illnesses, through an understanding and culturally coherent communication. The nature and amount of medical information desired by participants varied among individuals, regardless of race/ethnicity. The African American and Latino groups considered it necessary to have providers with whom they shared similar characteristics (ethnicity/sex/religion). This issue was not mentioned in the white population groups. African Americans were less satisfied with the quality of health facilities in their communities, highlighting a lack of professionals, dilapidated infrastructures, and a lack of coordination.
Nayfeh et al. (2021) Canada	To evaluate satisfaction with the quality of end-of-life care for patients from diverse ethnocultural backgrounds.	Quantitative (End-of-life Satisfaction Survey)	N = 1,543 family members of death patients: Caucasian (68.2 %), Christian (66.6 %) and English-speaking (81.9 %).	The mean satisfaction score with the quality of end-of-life care was 8.3/10. However, the satisfaction score was lower among people with language barriers, and in Muslim family members. The areas they prioritised for quality improvement included being kept well, and honestly, informed, the existence of clear roles among the health-care team, and having a religious leader to listen to concerns.
Neiman (2019) USA	To explore the experiences of acute care nurses in providing basic palliative care to culturally diverse patients.	Qualitative (7 FGDs and 8 structured interviews).	N = 34 Registered Nurses. Gender: 94.1 % females. Age: 21–64 years old.	The nurses promoted the practice of rituals (e.g., dressing the patient in a death suit, burning incense) and the expression of preferences (e.g., acceptance or not of analgesics, refusal of hospital care to care at home). Although nurses attempted to limit language barriers by using interpreters or mobiles, many patients subsequently showed incomplete understanding of the information. Nurses generally felt insecure when they did not know their patients' culture well. Some chose to ask patients or family members directly for information. Some nurses valued the involvement of the family while others thought that it could reduce the availability of palliative care spaces for patients.
Okamoto et al. (2020) Hawaii	To explore traditional and contemporary Marshallese palliative care practices.	Qualitative (3 FGDs)	N = 19 Marshallese people living in O'ahu island in Hawaii. Gender: 52.6 % males. Mean age: 47.6 years old.	The older people living on their native island preferred to die at home, but they preferred to die in institutions if living outside their island, just like the younger participants. Both young and old participants prioritised dying without pain, using natural or allopathic medicines. However, the elderly people were opposed to the use of life-sustaining interventions with artificial life extension, while the young accepted more invasive interventions.

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Reference	Objective	Methods	Sample	Main findings
Orlovic et al. (2019) USA	To examine racial and ethnic differences in EOL care utilisation and end-of-life planning in the United States.	Quantitative: Health and Retirement Study (HRS)	N = 9228 participants of the HRS, pooled across 6 survey waves, from 2002 to 2014.	The participants defined a “bad death” as any death of unexpected nature and cause, related to witchcraft, or in which the ceremonies are not subsequently performed properly. Some cultural practices were keeping the body with the family for up to 7 days so that friends and community members could bring gifts of condolence. While the older people were against cremation, the younger ones agreed to perform rituals without the body present. A higher proportion of non-Hispanic Black (43.5 %) and Hispanic White (43.4 %) people died in the hospital compared to non-Hispanic Whites, who were more likely to die in a nursing home (26.6 %). African American participants were 23.2 % less likely to die at home than White Americans, and Hispanics were 50.2 % less likely to die in a nursing home compared to White Americans. African American and Hispanic participants were more exposed to intensive care (life support and renal dialysis) during their last months of life, had shorter hospital stays, and were significantly less likely to have a living will and to carry out any advance end-of-life planning, compared to White Americans.
Rahemi and Parker (2019) USA	To investigate preferences, attitudes, and behaviours regarding EOL care planning among young and middle-aged Iranian American adults.	Quantitative: Attitude Toward Advance Decision Making (ATADM) scale, Spiritual Perspective Scale (SPS), Acculturation Scale (AS), Health Care System Distrust Scale (HCSDS), and Lubben Support Network Scale-6 (LSNS-6)	N = 251 Iranian Americans living in USA. Gender: 52.3 % females. Mean age: 34.23 years old.	In conditions of disease without cure, 56.8 % of the Iranian Americans would prefer hospitalisation and intensive treatments; 40.6 % would prefer comfort care instead of treatments, and among them, almost 30 % and 11 % would choose to stay at home and institutions respectively. Only 13.2 % had heard of ADs, and 12 % had heard of ACP. Positive attitudes toward ADs were associated with a higher level of acculturation and more years living in the USA.
Rahemi et al. (2019) USA	To explore older Iranian American adults' preferences for home or hospital care when they face EOL conditions; and to identify how participants prefer to communicate these preferences.	Quantitative: ATADM, SPS, AS, HCSDS, and LSNS-6.	N = 125 Iranian Americans (either as first or second generation) living in USA. Gender: 58.4 % females Mean age: 60.74 years old.	Most of the participants would prefer to receive end-of-life care in a hospital (84.8 %) rather than at home (15.2 %), and 54.1 % of them had communicated their preferences, through written documents or verbal conversations. A higher proportion (52.7 %) of people who have experienced the death of a family member communicated or filled out the documents about their end-of-life wishes, compared to 28.1 % of individuals who had not experienced the death of a family member.
Ramalingam and Ganesan (2019) India	To identify the social and cultural determinants of EOL care practices in a rural area of Tamilnadu.	Qualitative (2 FGDs and 4 in-depth interviews)	N = 22 residents with experience in taking care of elderly or terminally ill individuals in their household. Age: >40 years old.	The high costs of keeping a terminal patient hospitalised prompted participants to expedite death to reduce costs. Cultural customs were aimed at ensuring a peaceful death for their loved ones, so all family members had to participate in rituals, such as feeding the sick with holy water and sand, oil baths and cold water, or practices to

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Reference	Objective	Methods	Sample	Main findings
Rhee and Jang (2020) USA	To examine the prevalence and cultural factors associated with the designation of a substitute decision-maker (SDM) among older Asian Americans.	Quantitative (Asian American Quality of Life survey)	N = 499 older Asian Americans (Chinese, Vietnamese, Korean, Asian Indian, and other Asian). Gender: 54.7 % females. Mean age: 69.4 years old.	peacefully end life and alleviate suffering (based on hypothermia, renal failure, or aspiration pneumonia). Although care was a moral and spiritual duty (to bring the patient closer to God), family members expressed the negative effect that patient care had on their social life, since they could not separate themselves from the patient. The SDM assignment document was completed by 22 % of the sample. Ethnicity, time living in the US, English proficiency, and level of acculturation significantly affected the proportion of SDM designation. Participants of Indian origin had the highest percentage of SDM allocation (31.2 %), and those of Korean origin the lowest (8.2 %). Immigrants who were living in the US for ≥10 years were more likely (26.4 %) to designate SDM than those who were living in the US for <10 years (4.3 %). SDM assignment levels were particularly high among participants with good English proficiency (50 %) and those with a high level of acculturation (30.8 %). Finally, being less likely to assign an SDM was also associated with greater refusal to talk about death.
Roeder-Schur et al. (2019) Austria	To gain insights into relevant aspects of palliative care in the clinical encounter with terminally ill cancer patients with migrant backgrounds and their relatives.	Qualitative (semi-structured interviews)	N = 21 staff members from different disciplines in oncology and palliative care (physicians, nurses, psychologists, spiritual care provider and social worker, and volunteer). Gender: 71 % females. Mean age: 42 years old.	The professionals considered that a good professional/patient ratio, few patients per room, and the possibility of extending visits during hospitalisation, were measures to facilitate the involvement of extended families and avoid inconvenience for other patients. They also identified the importance of the interdisciplinary nature of the team and improve the nurse's ability to make decisions for the management of patients' pain expression. Conversations about the end of life were complicated by linguistic limitations and the insecurity of professionals when dealing with patients with diverse cultures and other models of health care. However, they tried to respect their practices and rituals, allowing the family to give homemade food to their loved ones, or light candles.
Rosenberg et al. (2019) USA	To identify suggestions and conflicts in providing cultural, sensitive, and respectful paediatric palliative care.	Qualitative using one-day conference (four workshops focused on race/ethnicity, economic disparity, religion/spirituality, or family values).	N = 142 individuals representing medicine, nursing, social work, research, chaplaincy, and patient navigation.	Conflicts in clinical care could be favoured by cultural differences between staff and patients (the mentality of the biomedical culture), the prejudices of professionals, low accessibility to care services, lack of interpreters, and the tensions created by the family as a microculture that could create tensions between the needs of the patient and family members (e. g., families sometimes stood in the way of providing information). The professionals mentioned the need to have compassion, remembering that the family is experiencing a tragedy, and managing their own emotions. They also considered that they had to understand the meaning of some

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Reference	Objective	Methods	Sample	Main findings
Schweda et al. (2017) USA, Germany, and Israel	To explore moral perceptions on EOL decision making.	Qualitative (12 FGDs)	N = 82 religious (Jewish/Christian) and secular persons. Gender: 64.6 % females Age: 20–90 years old.	medical terms and processes from the family members' point of view and avoid negative judgments. Among the participants in Germany and the USA, the autonomy and dignity of people are emphasised, respecting decisions in ADs. In addition, there is a moral duty of professionals to manage individual ADs to reduce this burden on family members. On the contrary, religious participants in Israel used to respect the 'divine creation' or 'law of nature', so the circumstances of death should not be interfered with. This implies rejection of euthanasia and limitation of therapeutic effort. The experts highlighted the need to learn and use specific communication tools and techniques to support patient-centred care, to know the culture and prejudices of the health personnel themselves, to avoid mechanised techniques and the stereotyping of patients. The preferred teaching methods were face-to-face teaching, workshops with case-study discussions, role plays and immersive experiences, as well as coaching, supervisions, and mentoring.
Semlali et al. (2020) Switzerland	To provide educators and decision makers with ideas for how to implement cross-cultural training in palliative care at the EOL.	Qualitative (4 FGDs)	N = 26 experts in palliative care and in cross-cultural training (physicians, nurses, psychologist, experts in social science and migration, chaplains).	Participants stated that respecting beliefs (e.g., using language consistent with beliefs about God and higher powers, or employing neutral phrases to encompass many religions) provided a space to initiate spiritual conversations with patients and family caregivers. In general, physicians were less comfortable discussing spiritual or religious issues with their patients, while social workers, nurses, and case managers tended to perform more interventions related to faith and spirituality.
Siler et al. (2019) USA	To describe palliative care and oncology clinicians' perspectives on the challenges and facilitating factors in meeting the spiritual needs of patients with lung cancer and their family caregivers.	Qualitative (3 FGDs and 5 interviews to key informants)	N = 19 experienced palliative care and oncology clinicians representing nursing, medicine, social work, and chaplaincy. Gender: 63.2 % females. Mean age: 50 years old.	ACPs were less common among people born outside Australia (21.9 %) than native Australians (28.9 %). Immigrants who required an interpreter were less likely to complete their own ACP documentation and more likely to complete them through a health professional or another person (46.4 %). This trend was most prevalent among immigrants from southern Europe where 13 % completed their own ACP documents, and 56.8 % were completed by health professionals. The group born in Africa were the group who, in general, had the least completion of ACP documentation (58.5 %). The group which had the highest percentage of ACP document completion were born in western Europe (72.2 %).
Sinclair et al. (2021) Australia	To explore the influence of birth country and sociodemographic and cultural variables on ACP uptake.	Quantitative (national multicentre audit of ACP documentation).	N = 4187 health records from 100 sites across 8 Australian jurisdictions. Gender: 60.3 % females. Age: ≥65 years old	Although most physicians expressed an adequate level of skills and knowledge about basic palliative care, 24 % of them stated that they did not have access to palliative care for their patients (for example, 49 %
Tadipatri et al. (2021) South Africa	To analyze Sub-Saharan African physicians' skills and type of palliative care provided to brain tumor patients, the role of cultural beliefs, availability of resources, and challenges faced.	Quantitative (survey)	N = 109 physicians. Gender: 68 % males.	

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Reference	Objective	Methods	Sample	Main findings
Tarabeih et al. (2020) Israel and USA	To examine the impact of the level of religious observance on the attitudes toward end-of EOL decisions and euthanasia of Jews.	Quantitative: Revised-Profile Attitude Death questionnaire.	N = 271 Jews from Israel and the USA (Secular, Traditional, Religious and Orthodox participants). Gender: 72 % females. Age: 18–61 and above years old.	of the participants did not have access to liquid opioid agents). Nigerian physicians (90 %) were more knowledgeable about palliative care compared to Cameroon (35 %) and felt more comfortable not delaying initiation of palliative care and prescribing medication and discussing patient and family concerns. Among physicians, 50 % stated that the beliefs of patients or their families did not allow them to accept palliative care, and 23 % indicated that their own beliefs affected the delivery of palliative care. More than half of the sample (52 %) stated that initiating palliative care is only appropriate when irreversible deterioration is evident, and 47 % stated that open end-of-life discussions should not be held before ruling out all curative treatment options. Orthodox Jews, compared to secular Jews, were more supportive of the health professional being responsible for making end-of-life decisions (3.39 and 1.88, respectively from a Likert scale of 1–5 points). Secular Jews supported more than Orthodox a supportive environment for the patient at the end of life (3.66 vs. 4.23), the idea of a dignified death (3.83 vs. 2.89), the acceptance of autonomy of the patient to make end-of-life decisions (4.26 vs. 3.07), as well as greater attention to the opinion of family members (4.06 vs. 3.36). However, religiousness had no influence on knowledge about euthanasia, nor were the differences between groups in Israel and the USA significant.
Van Keer et al. (2019) Belgium	To investigate the delivery of bad news to patients and relatives in a multi-ethnic critical care context.	Qualitative: interactive observation, in-depth interviews, and patients' medical records.	Interactive observation resulted in 880 informal conversations, bad-news conversations for 11 patients (from Morocco, Turkey, Greece, Congo and Tunisia), and interviews to 27 nurses and 8 physicians. Gender (patients): 72.7 % males. Mean age (patients): 62 years old.	Professionals often did not consider patients to be suitable interlocutors to talk to about death due to their medical condition, language differences, emotional intensity, low educational level, and ethnocultural contexts. Therefore, health professionals preferred to talk to family members, using interpreters or co-workers. The lack of time and private spaces led to brief conversations with family members in front of patients, even though family members often did not want to speak in front of their loved ones to prevent patients from losing hope. The relatives believed that Western hospitals had infinite curative options, which, together with their cultural and religious beliefs, favoured the denial of the prognosis of death.
Yarnell et al. (2017) Canada	To examine EOL care provided to immigrants to Canada in the last 6 months of their life.	Quantitative (cohort study)	N = 967,013 decedent migrant patients. Gender: 50.5 % males. Median age at death: 79 years old	Recent immigrants died more often in intensive care (15 %) compared to long-term residents (10 %). During the last 6 months of life (comparing both groups), recent immigrants received more intensive care admissions (24.9 % vs. 19.2 %), hospital admissions (72.1 % vs.

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Reference	Objective	Methods	Sample	Main findings
				68.2 %), mechanical ventilation (21.5 % vs. 13.6 %), dialysis (5.5 % vs. 3.4 %), percutaneous feeding (5.5 % vs 3 %) and tracheostomy (2.3 % vs 1.1 %). Coming from Asia (38 %) and Africa (18 %) was a factor related to being more likely to die in intensive care compared to being from North America (11 %) or Europe (19 %).

for respect toward wishes, beliefs and values before death (Bazargan et al., 2021).

An important consideration, at the end of life, is the choice of place of death. A study carried out in Canada (Yarnell et al., 2017) confirmed that, among immigrants, Asian and African people were more likely to die in intensive care units (38 % and 20 % respectively), compared to Europeans (19 %) and North Americans (11 %), and probability increased with time of residence in the destination country. According to Okamoto et al. (2020), being away from one's country of origin and far from family is what leads Marshallese migrant patients to hospitalisation at the end of their life, since this provides them with a sense of some form of accompaniment, when receiving care without the support of their family.

Another dilemma is related to the acceptance or rejection of medical interventions as part of end-of-life care. Several studies have shown that migrant and minority patients tended to accept more invasive therapy options (e.g., invasive mechanical ventilation, tracheostomy, renal dialysis) in hospital settings (Orlovic et al., 2019; Rahemi et al., 2019; Yarnell et al., 2017). This is possibly explained by a paternalistic framework of the health system in their countries of origin, where informed consent is frequently not implemented, and decisions usually fall into the hands of health professionals (Barwise et al., 2018; Hayes et al., 2020). In addition to the medical culture of the country of origin, there is a strong belief among some migrants, that hospitals in high-income countries have numerous curative possibilities, thus maintaining the hope of finding an effective treatment that will prevent death; that was the case of migrants from the large ethnic minority groups in Belgium (Van Keer et al., 2019).

The religiosity of patients is another factor that influences decisions to use invasive measures (Fearon et al., 2019). This qualitative study carried out in Mauritania showed that Muslim people felt the obligation to try treatments of any kind, considering that there is no disease for which God has not created a cure, and prioritizing the prolongation of life, relying on their faith in God to find that cure. In the same way, a greater religious adherence is directly related to more negative attitudes toward euthanasia and limitation of therapeutic effort (LTE), considering God as the highest authority in the decision of how and when life should end (Hayes et al., 2020; Inglehart et al., 2021). This not only implies the acceptance of death as God's plan, but also modulates the expression of sorrow or emotions of sadness, as it was observed in a qualitative study with family members and religious leaders in Senegal (McCarthy et al., 2020). However, Schweda et al. (2017) showed how this influence could sometimes be reduced when individuals had personally experienced the suffering of their relatives at the end of their lives.

Finally, within the same culture, intergenerational differences have also been found. Marshallese older adults in Hawaii were against the use of life-extending interventions, as opposed to the younger individuals who tended to have a greater acceptance of them (Okamoto et al., 2020).

3.3. Theme 2. Advance care planning and verbalization of death

The tendency to plan and talk about aspects of death, is related to the

migratory process, the length of residence in the host country, and the process of acculturation. First, from the point of view of interpreters interviewed in Australia, the migration process directly influences the view that migrants have of death itself, since they have often not been present for the death of relatives who remained in their country of origin (Hayes et al., 2020). Regarding the meaning of death, this differs between cultures (for example, there is the perception of death as a punishment for some Western societies), resulting in difficulty in discussions between professionals and patients (García-Navarro & da Costa, 2017).

Secondly, other studies showed that the process of acculturation, and longer time residing in the host country, increased advance planning - including the likelihood of appointing a substitute medical decision maker (SDM) - and more positive attitudes toward euthanasia (Rahemi & Parker, 2022; Sinclair et al., 2021). An example is that of immigrants who were living in the USA for ≥ 10 years; they were more likely (26.4 %) to designate SDM than those who were living in the US for < 10 years (4.3 %). In addition, SDM assignment levels were particularly high among participants with good English proficiency (50 %) and those with a high level of acculturation (30.8 %) (Rhee & Jang, 2020).

Generally, the use of end-of-life planning documents is less among ethnic minorities, people with limited host language proficiency, religious people (Hayes et al., 2020; Orlovic et al., 2019; Rhee & Jang, 2020), and immigrants. This is observed in the results of Sinclair et al. (2021), where residents born outside Australia completed fewer advanced planning documents (21.9 % vs. 28.9 %) than native Australians.

In some cultures, and religious contexts, there is a belief that planning the end of life is synonymous with defeat, can advance the arrival of death, and constitutes a blasphemous act by competing with the divine powers of God, aspects in which the results of studies conducted in different parts of the world (e.g., Nigeria, Australia) coincide (Agba-wodikezu et al., 2019; Kirby et al., 2018). In other cases, some multicultural families in Belgium limited the use of terms related to death, and asked professionals to be discreet in conversations in front of their loved ones, since they considered that these conversations were a great stressor that could make the patient lose hope (Van Keer et al., 2019). On the contrary, in the case of the indigenous population in Canada, the arrival of death was accepted as part of the natural process of life and this moment was an opportunity to transmit cultural traditions and perform communal ceremonies (Kelley et al., 2018).

3.4. Theme 3. Rituals and family involvement during healthcare

According to the results of this review, rituals are frequently used and are a symbol of respect toward terminal patients, fulfilling both their needs and those of their families. Some examples are: the use of Holy water and baths with oil and cold water (Ramalingam & Ganesan, 2019), orienting the patient's body toward Mecca after death and wrapping it in a clean cloth (Al Mutair et al., 2019; Fearon et al., 2019; García-Navarro & da Costa, 2017), leaving the body with the family for several days so that community members can bring condolence gifts (Okamoto et al., 2020), dressing the patient with specific clothes after death (Neiman, 2019), and washing intimate body parts (de Voogd

et al., 2021).

According to the results of two qualitative studies carried out in Europe (Spain and Austria), for these rituals, family and community members adopt a special role as the representatives of their traditions in the provision of care and support (García-Espinel et al., 2017; Roider-Schur et al., 2019). The failure to carry out family cultural ceremonies properly, is considered, by some, a cause of “bad death” (Fearon et al., 2019). However, intergenerational cultural clashes and different demands for care are also observed. For example, a qualitative study conducted in Japan showed that the idea of not doing anything and simply allowing death, is something that older adults, in Japanese culture, cannot accept. However, younger individuals tend to accept the natural course of death, prioritizing comfort at the end of life (Iida et al., 2022). Another study showed that older groups were against cremation, while younger generations agreed to carrying out rituals without the presence of the body (Okamoto et al., 2020).

Finally, some cultural rules generate discomfort among family members. For example, feeling emotional distress when distributing the material belongings of the deceased (McCarthy et al., 2020), or alterations in social life due to not being able to separate themselves from their loved ones while caring for them (Ramalingam & Ganesan, 2019).

3.5. Theme 4. Professionals addressing multiculturalism in end-of-life care

Although migrant and native populations often share the same needs and problems at the end of life, cultural clashes, and prejudices held by professionals (e.g., attribution of lower intellectual capacity), increase the complexity and hinder appropriate care for culturally diverse groups (de Voogd et al., 2021; Tadipatri et al., 2021; Van Keer et al., 2019). Furthermore, the care provided at the end of life by professionals is linked to the organizational culture where they work (Broom et al., 2019). For many health professionals and social workers in western contexts, this implies a concept of palliative care based on pharmacological interventions, intensification of techniques, and closer liaison with family members (Cable-Williams & Wilson, 2017), which does not always coincide with the demands of patients and families.

While some family members give little importance to the patient's decision-making, and locate more authority in God (Schweda et al., 2017; Tarabeih et al., 2020) or take responsibility themselves, professionals who work with a Western biomedical framework try to keep the patient fully informed, so that they can actively participate in decision-making (García-Navarro & da Costa, 2017; Rosenberg et al., 2019). Such culture shocks can lead professionals to avoid conversations with patients, which creates moral conflicts, and a lower perceived satisfaction by immigrant communities with the services provided, as occurs among African American and Latino groups in the USA (McCleeskey & Cain, 2019).

Sometimes, religious beliefs and the presence of the family with their loved ones are perceived by health professionals as intrusive, with too many family members involved in the decision-making process, or as contrary to the medical standards (de Voogd et al., 2021; Green et al., 2018; Mathew et al., 2021). This includes health professionals who feel that it may not be possible to accommodate such large families, in hospital facilities which have not been created under this paradigm (García-Espinel et al., 2017; Neiman, 2019), something that is ultimately reflected in a perception of nuisance for other native patients and their relatives (Roider-Schur et al., 2019).

Another important factor that influences the provision of multicultural care at the end of life is the language barrier between professionals and patients and their relatives (Roider-Schur et al., 2019; Semlali et al., 2020; Van Keer et al., 2019). End-of-life care requires the development of professional-patient relationships within a difficult context: conducting meaningful conversations; providing psychological support (Johnstone et al., 2018); reporting on the progress of the disease; discussing treatment alternatives; and making decisions about medical

interventions. In this context, Al Mutair et al. (2019) conducted a qualitative study in Saudi Arabia with registered nurses from the NICU and the PICU and showed that language differences can be an obstacle for professionals to manage their patients' care and adequately express empathy. Furthermore, this can result in misunderstanding concepts in clinical practice (Barwise et al., 2018; Kirby et al., 2018; Rahemi & Parker, 2022; Roider-Schur et al., 2019), and lower satisfaction with the care provided at the end of life (Nayfeh et al., 2021).

Language barriers between professionals, patients and family members, may be overcome by relying more on non-verbal communication, as well as using interpreters, co-workers, or family members of patients to translate. However, there are ethical concerns in using non-professional interpreters and intermediaries, who may not convey all details due to a lack of knowledge of specific medical terms, or a desire not to give all the information to their loved ones (Al Mutair et al., 2019; de Voogd et al., 2021; Van Keer et al., 2019). In addition, these interactions require more time, more resources, and several parallel conversations, making them uncomfortable for staff. For this reason, professionals tend to avoid such conversations, reducing the depth of discussions (Barwise et al., 2018; Bloomer et al., 2019; Kirby et al., 2018), or to seek instant alternative methods with less human interaction such as translations using mobile devices (Neiman, 2019).

Although some professionals also choose to learn key words in the language of their patients, not only to promote communication but also to create a sense of trust in the patient (Green et al., 2018; Mahilall & Swartz, 2021a), there is a need to respect the fact that, in some cultures, talking about death directly, or using certain taboo words, is not accepted (Broom et al., 2019; Fearon et al., 2019; Hayes et al., 2020; Kirby et al., 2018).

Despite the challenges, many professionals strive to respect the wishes and cultural practices of their patients. This includes such things as: allowing families to provide home-cooked meals or to light candles (Roider-Schur et al., 2019); using language consistent with religious and spiritual beliefs (Siler et al., 2019); giving families resources for prayer (e.g., prayer mats, boxes to put religious objects or opportunities to pray with their children) (Al Mutair et al., 2019); and respecting the burning of incense, in recognition of the families' belief that otherwise the spirits would not rest. Additionally, they help them express their preferences (e.g., acceptance or not of analgesics, refusal of hospital care) (Neiman, 2019). However, Mahilall and Swartz (2021b) found that some professionals prioritised creating a relationship with their patients on a personal level, leaving aside specific cultural or religious aspects, suggesting that certain patients preferred to be cared for by people with whom they had a personal connection rather than a cultural similarity.

In order to improve the quality of cultural end-of-life care, professionals emphasize the importance of working in multidisciplinary teams, which increases their ability to assist decision-making in managing patients' pain (Roider-Schur et al., 2019), avoids imposing their own religious/spiritual beliefs (Karadag et al., 2019), and highlights the importance of not stereotyping certain groups (e.g., different generations within the same culture) (Benbenishty et al., 2020; Gravier et al., 2020; Hayes et al., 2020; Kirby et al., 2018; Mahilall & Swartz, 2021a; Okamoto et al., 2020; Semlali et al., 2020). In short, a deeper understanding of the culture of the patients improves the therapeutic relationship and reduces insecurity (Neiman, 2019).

It is interesting to note that there are some interventions intended to promote a greater culturally tailored care among health professionals, which could change clinical practice. For instance, Hinderer and Lee (2019) carried out a quasi-experimental study among nurses and offered a workshop on Advance Directives. They found that those who received culturally tailored interventions were more likely to favor offering Advance Directives to their patients. According to Rosenberg et al. (2019), it is important to provide continuing cultural education for health professionals that includes development of communication skills and emotional intelligence, as well as understanding of the functioning of social services, and the complexity of culture.

4. Discussion

Our first finding was that cultural aspects ultimately affect the place of death and preferences about healthcare interventions. It was found that immigrants are more likely to die in hospitals and tend to receive more aggressive interventions, probably due to the lack of family and social support available (Barwise et al., 2018; Okamoto et al., 2020; Orlovic et al., 2019; Rahemi et al., 2019) and the belief that high-income countries have more advanced medical technology. In this sense, it is important that the government make stronger connections with the immigrant community, in order to provide the appropriate social support. This could be achieved using community centers, immigrants' festivals, and physical and leisure activities. It is beneficial to make immigrants aware of the limits of Western healthcare, in order to help patients to better understand their disease and limited prognosis. Similarly, it was found that religious faith was associated with pursuing more invasive treatments (Fearon et al., 2019; Hayes et al., 2020). In such cases, it is important to understand what the religious and spiritual reasons are for prolonging life, and therefore working with chaplains and religious leaders could help minimize possible misunderstandings.

Advance Care Planning seems also to be affected by language barriers; unfamiliarity with Advance Care Planning and its individualistic nature in which personal control is particularly important within a Western perspective (Stein & Stein, 2019), and believing that advance planning could accelerate death or be a sign of defeat (Rhee & Jang, 2020; Sinclair et al., 2021). However, in recent decades, policy and regulatory changes have worsened health-care quality and access for immigrants (e.g., restrictions on access to public health insurance programmes, intimidation within health-care settings) (Khullar & Chokshi, 2019). Therefore, health professionals must be careful when assuming the rejection of end-of-life care is culturally determined, since this could underestimate other material problems such as economic barriers to access resources, and lack of infrastructure of the health system, mainly in rural areas (Jervis & Cox, 2019). Furthermore, from the outset of palliative care, professionals should explain what advance care planning is, asking for help from certified health translators and reassure that this planning is neither irreversible nor does it cause any shortening of life (Menon et al., 2018).

Another important factor that has appeared in our review is the use of rituals when patients are approaching death. Rituals have always been widely used by different cultures throughout history. Prayer can offer cultural comfort to people who are grieving and help maintain a sense of control and identity during crises, offering them meaning and structure. Despite varying outward appearances, prayer rituals from different cultures follow similar structures, understanding this allows nurses to appreciate their meaning and use this to deepen the quality of care provided (Anderson & De Souza, 2021). However, the diverse resources that are required for these rituals could be demanding for medical and healthcare staff to provide. It is important to value and respect such beliefs and rituals in order to provide holistic and integrative care. As a symbol of "good death", health professionals should pay attention to the end-of-life desires of their patients and family wishes, post-death decision-making and rituals, including communication and remembrance of the death, and integrate these in clinical practice (Balmer et al., 2022).

Finally, it was observed that health professionals have a pivotal role in the cultural needs of their patients. Many general practitioners feel a responsibility to initiate end-of-life conversations, since these facilitate patient decision-making, avoid futile treatment, save time in the long term, prepare families for patients' deaths, and enhance the therapeutic relationship. However, they also describe the need for caution in raising sensitive topics, and recognize there are several barriers, such as different religious beliefs, preconceptions, cultural shock, and language barriers (Asamoah, 2019; Thomas et al., 2020). The latter are considered one of the most important problems during end-of-life care and it is essential that health managers provide all the support needed to

minimize them by providing resources, such as appropriate interpreters.

5. Limitations and strengths

This narrative review has some limitations that should be considered while examining our results. First, although five databases were searched, it is possible that some studies were not indexed in these databases and, therefore, some information could have been lost. Second, our search revealed that some studies include the immigrant population without considering the culture of care and customs at the end of life of these groups. In other words, since some articles are published by Western authors, results may have some biases related to the Western point of view. Third, the generalizability of the conclusions is limited due to the heterogeneity within different existing cultures. Based on the general themes obtained in our results, future studies could be more precise in addressing decisions about advance planning, preferences for care and interventions, therapeutic relationship with health professionals, and cultural practices at the end of life in a specific culture or group.

Finally, these results are useful for designing humanization strategies for care, such as establishing personal connection, anticipating needs, honoring the family by honoring the patient, improving sensitivity and cultural competence, and making space for religious and spiritual practices. All of this helps to rethink strict hospital regulations and policies, which could otherwise make it difficult to support family members' grief and the expression of their cultural identity as part of the end-of-life care process.

6. Conclusion

The present review has shown that cultural factors influence several end-of-life issues in clinical practice, such as patients' treatment preferences, planning of death, rituals and family involvement and provision of care by health professionals. These findings show the importance of making professionals aware of cultural aspects when patients are close to death and highlights the need for continuing education to handle such situations.

CRedit authorship contribution statement

Bárbara Badanta: Conceptualization, Methodology, Formal analysis and interpretation, Software, Writing- Reviewing and Editing, Supervision, Project administration, **Marta Beatrice Glyn-Blanco:** Investigation, Formal analysis and interpretation, Data curation, **Giancarlo Lucchetti:** Formal analysis and interpretation, Writing- Original draft preparation, Validation, Visualization.

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Declaration of competing interest

No conflict of interest has been declared by the author(s).

Data availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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