Australian Critical Care xxx (2018) 1–8

Contents lists available at ScienceDirect

Australian Critical Care

journal homepage: www.elsevier.com/locate/aucc

Review Paper

Culturally sensitive communication at the end-of-life in the intensive care unit: A systematic review

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ARTICLE INFORMATION

Article history:
Received 7 March 2018
Received in revised form
8 June 2018
Accepted 24 July 2018

Keywords:
Communication
Cultural diversity
Cultural sensitivity
End-of-life care
Intensive care unit
Terminal care

ABSTRACT

Objectives: The objectives of this systematic review were the following: (i) to describe whether culturally sensitive communication is used by clinicians (nurses and physicians) when communicating with patients and families at the end-of-life in the intensive care unit and (ii) to evaluate the impact of culturally sensitive communication at the end-of-life. The systematic review question was how is culturally sensitive communication used by clinicians when communicating with patients and families at the end-of-life in the intensive care unit?
Data sources: A search of CINAHL, MEDLINE, Embase, and PsycINFO databases identified all peer-reviewed research evidence published in English between January 1994 and November 2017. Two authors independently assessed articles for inclusion. From the 124 articles resulting from the search, nine were included in this systematic review.
Review methods: Articles were independently assessed for quality by two authors using Caldwell et al.'s framework to critique health research. The data available in this systematic review were heterogeneous, with varied study designs and outcome measures, making the data unsuitable for meta-analysis. The most appropriate method for data synthesis for this systematic review was narrative synthesis.
Results: From the narrative synthesis, two major themes emerged: communication barriers and cultural and personal influences on culturally sensitive communication. Communication barriers were identified in eight studies, influencing the timing and quality of culturally sensitive communication at the end-of-life. Cultural and personal influences on communication at the end-of-life was present in eight studies.
Conclusions: The findings of this systematic review show that clinicians lack the knowledge to enable effective interaction with culturally diverse patients and families at the end-of-life.

1. Introduction

Culturally sensitive communication in the intensive care unit (ICU) has the potential to influence patient and family experiences of end-of-life care.[1] For the purpose of this systematic review, culturally sensitive communication is defined as effective verbal, nonverbal, and written interactions among individuals or groups, with a mutual understanding and respect of other's values, beliefs, preferences, and culture, to promote equity in health care. Culturally sensitive communication is important because populations are becoming increasingly diverse.[2] Cultural diversity relates to a person's country of birth and ancestry, languages spoken, religious affiliation, ideas and belief systems, customs, and social behaviours.[3] With rates of global migration rapidly increasing since the 1990s,[2] the cultural diversity of patients and families can create challenges for healthcare delivery; yet, there is limited guidance for clinicians (nurses and physicians) on how to communicate at the end-of-life.[4,5]

The ICU provides specialised care for patients who have life-threatening injury or illness,[6] with the risk of death for ICU patients as high as 22%.[7,8] For some patients, active treatment may have to be withdrawn and end-of-life care commenced.[9,10] End-of-life care

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https://doi.org/10.1016/j.aucc.2018.07.003

includes the physical, spiritual, and psychosocial assessment, supportive care, and treatment delivered by clinicians.[11] Patients from culturally diverse backgrounds may have particular needs at the end-of-life, and hence ICU clinicians need knowledge and skills in culturally sensitive communication.[12–14]

ICU clinicians are often ill-prepared to provide supportive care to dying patients and their families, especially when families are unable to clearly communicate because of cultural or language barriers.[15] When communication at the end-of-life is not culturally sensitive, there are missed opportunities for understanding patients' and families' needs, leading to patient and family distress.[16,17] Existing evidence demonstrates ICU nurses' perceptions of their encounters with multicultural families;[18] however, this area is underexplored related to end-of-life care. This systematic review aimed to identify, evaluate, and synthesise research evidence, thereby making the available evidence accessible to decision makers.

2. Methods

2.1. Review question

A specific mnemonic for qualitative systematic reviews (PICo) was used to develop the question for this systematic review.[19] PICo includes Population (clinicians), phenomena of Interest (culturally sensitive communication at the end-of-life), and the Context (adult ICU).

The research question is "How is culturally sensitive communication used by clinicians when communicating with patients and families at the end-of-life in the ICU?" The objectives of the systematic review were the following: (i) to describe whether culturally sensitive communication is used by clinicians when communicating with patients and families at the end-of-life in the ICU and (ii) to evaluate the impact of culturally sensitive communication at the end-of-life.

2.2. Systematic search method

A search of CINAHL, MEDLINE, Embase, and PsycINFO databases identified all peer-reviewed research evidence published in English between January 1995 and November 2017, which describes clinician communication with adult patients and/or family members from culturally diverse backgrounds at the end-of-life in the ICU. The review was limited to adult intensive care because of the differences in communication practices between adult, and paediatric and neonatal intensive care cohorts. The focus on patient and family-centred care in paediatric and neonatal intensive care settings, which emphasises the importance of family in the patient's care,[20] means that communication practices in these settings are likely to be inherently different. Therefore, the focus of this systematic review was limited to the adult ICU population. The search time frame was chosen because in 1995, Leininger, who defined Transcultural Nursing,[21] published seminal work in this area. Key journals related to the topic area were also manually searched. Search terms included the major concepts of cultural sensitivity, communication, end-of-life, intensive care, and common Boolean operators (Table 1). Each database was also searched for relevant subject headings. Inclusion and exclusion criteria were developed, reviewed, and agreed on by the team (Table 2). The original search yielded 124 references. From this search, 27 duplicates were removed, leaving 97 references. These references were screened by title and abstract for relevance, resulting in 76 references being discarded, for example, n = 14 articles reported on paediatric or mixed adult/paediatric populations and n = 8 reported literature reviews. In all, 21 articles were retrieved for full review, and from these, 12 were deemed not relevant to the topic and hence discarded. As a result of the search, nine articles were selected for inclusion in this systematic review (Fig. 1). The reference lists for the nine included articles were scanned for other articles relevant to the inclusion criteria; however, no further articles were located. Two authors (LAB and EM) independently assessed articles for inclusion. This systematic review is reported following the guide for Preferred Reporting Items for Systematic Review and Meta-Analyses: The PRISMA Statement for data reporting[22] and the guide for Enhancing Transparency in Reporting the Synthesis of Qualitative research: ENTREQ.[23]

2.3. Quality appraisal

Articles were independently assessed for quality by two authors (LAB and MJB) using Caldwell et al.'s framework to critique health research.[24] This framework was used because it assesses the quality of quantitative, qualitative, and mixed methods research using 11 specific questions.[24] In total, seven of the nine identified articles scored 9/11 or higher against the quality criteria, with two articles scoring 8/11 or below (Table 3).

2.4. Data abstraction

Data abstraction involved extracting data from each article to create an evidence table to ensure a methodical understanding of the study content. This process of extraction enables a systematic analysis and integration of the results from the included studies.[25,26] Data were extracted on study characteristics (study aim/s, country and setting, methods, and relevant key findings; Appendix A).

2.5. Data synthesis

Although meta-analysis is a common method for data synthesis in a systematic review, the data in this systematic review were heterogeneous, meaning they were too diverse, with varied study designs and outcome measures, making the data unsuitable for meta-analysis.[25] Two studies were initially considered appropriate

Table 1
Search strategy.

Culture OR 'cultural* sensitiv*' OR 'cultural* competen*' OR 'cultural* aware*' OR 'cultural* safe*' OR cultural* divers*' OR 'culture* value*' OR CALD OR 'culturally and linguistically diverse' OR 'cultur* group*' OR NESB OR 'non English speaking background' OR 'cross cultur* difference*' OR 'socio cultural factor*'
AND
Communicat* OR 'nonverbal communication' OR 'communication skill*' OR 'communication barrier*' OR 'communication method*' OR 'clinician patient relation*' OR 'clinician family relation*' OR 'physician patient relation*' OR 'physician family relation*' OR 'doctor patient relation*' OR 'doctor family relation*' OR 'nurse patient relation*' OR 'nurse family relation*' OR dialogue OR discourse
AND
'intensive care' OR ICU OR 'crit* care' OR HDU OR 'high dependency unit'
AND
'terminal care' OR 'terminally ill patient*' OR 'end of life' OR EOL OR 'end of life care' OR 'palliative care'

Please cite this article in press as: Brooks LA, et al., Culturally sensitive communication at the end-of-life in the intensive care unit: A systematic review, Australian Critical Care (2018), https://doi.org/10.1016/j.aucc.2018.07.003

Table 2
Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Published in English	Secondary research including literature and narrative reviews, and integrative and systematic reviews
Reports primary research	Abstracts, letters, commentary, editorials, and opinion pieces
Hospitalised patients admitted to adult ICUs	
Subjects/participants were identified as ICU clinicians and/or ICU patients at the end-of-life	

for meta-analyses, however, were deemed unsuitable on further exploration because of their different outcome measures. Narrative synthesis, an approach used to combine the data of qualitative, quantitative, and multiple design studies, is a method commonly used to synthesise data for systematic reviews.[25] Owing to the multiple study designs, narrative synthesis was chosen as the appropriate method for this systematic review.[25]

Narrative synthesis may be performed in different ways, each determined by the review question and characteristics of the included articles.[26] Regardless of the approach to narrative synthesis, the method should aim to eliminate bias, by using a process to the synthesis that is rigorous and transparent, that is followed systematically.[25] The first step of the synthesis involved assessing the robustness of the synthesis by completing the quality appraisal of the included studies. The second step involved developing a preliminary synthesis of the findings of the included articles using thematic analysis by translating the data to identify areas in common between the articles (Table 4). Step three involved exploring relationships within and between articles by systematically exploring the differences between the articles. Steps two and three occurred concurrently and involved identifying differences and similarities between the findings of the included studies and synthesised themes. Finally, step four involved developing a theory related to the research question: "How is culturally sensitive communication used by clinicians when communicating with patients and families at the end-of-life in the ICU?".

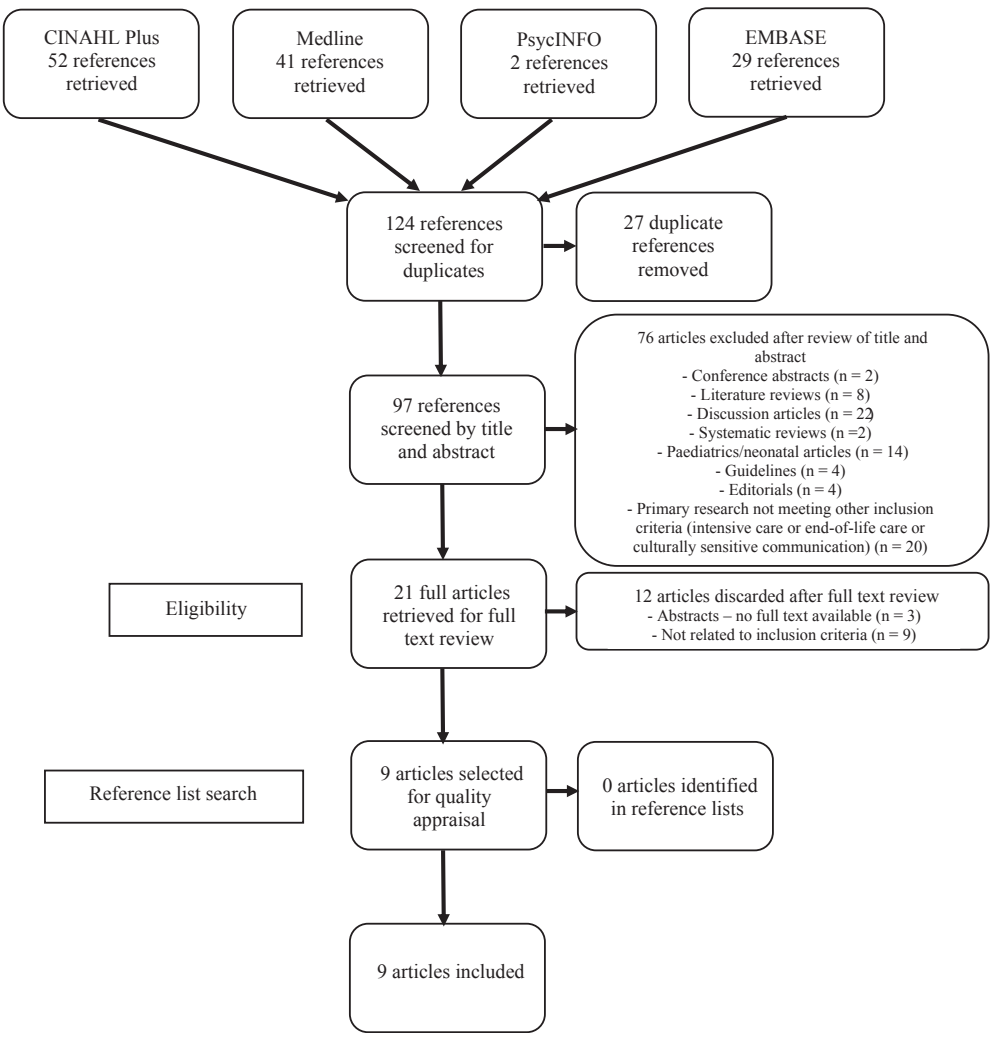

Fig. 1. PRISMA flow diagram.

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Table 3
Quality appraisal using framework by Caldwell et al. (2011).

Author (year)	Quality appraisal		Comments
	Appraisal 1	Appraisal 2	
Aslakson et al. (2012)	7/11	7/11	Qualitative method not justified. Ethical issues such as consent and Human Research Ethics Commitee (HREC) approval not included.
Borhani et al. (2013)	10/11	9/11	Aim is different between abstract and article.
Crump et al. (2010)	9/11	9/11	Abstract does not detail aim or method. Conclusion states what nurses 'must' do but gives no explanation as to how this could be performed.
Gallagher et al. (2015)	11/11	11/11	
Loggers et al. (2009)	9/11	8/11	Literature review is limited. Methodology not detailed.
Muni et al. (2011)	11/11	11/11	
Powazki et al. (2014)	8/11	9/11	Literature review is limited. There is no consideration of potential ethical issues except for voluntariness of participation.
Sprung et al. (2007)	11/11	11/11	
Van Keer et al. (2015)	11/11	11/11	

3. Results

3.1. Study characteristics

The nine included studies were published between 2007 and 2015. Five studies were conducted in the USA, one study in Iran, one study in Belgium, and two studies in multiple countries; one study was conducted in Brazil, England, Germany, and Ireland; and one study in 17 European countries. Four studies were qualitative in nature,[1,27–29] and the remaining five articles were quantitative in design.[30–34] Qualitative methodologies included generic qualitative, grounded theory and ethnography. Sampling strategies were identified as either convenience (n = 6) or purposeful (n = 3). Studies that analysed clinicians' perceptions had sample sizes ranging from 12 to 209 participants. Studies analysing medical records of ICU patients had sample sizes ranging from 302 to 3138 patients. Qualitative data were collected using semistructured interviews and focus groups and analysed using comparative, content, and thematic analysis. Quantitative data were collected using structured interviews, a retrospective medical record audit, and prospective surveys and analysed using descriptive statistics.

3.2. Results of synthesis

Nine articles were included in this systematic review (Fig. 1). From the narrative synthesis, two major themes emerged related to the study objectives: (i) communication barriers and (ii) cultural and personal influences on culturally sensitive communication. Subthemes are presented within each major theme.

3.2.1. Communication barriers

Communication barriers were identified in eight studies, influencing the timing and quality of culturally sensitive communication at the end-of-life. Three subthemes emerged, including clinician roles in communication, communication challenges, and knowledge deficit related to culturally sensitive communication.

3.2.1.1. Clinician roles in communication. There were similarities and differences in the roles of clinicians in communicating with cultural sensitivity at the end-of-life, which were present in five studies.[1,27–29,33] When communicating prognosis and end-of-life care plans with patients and families, nurses perceived their role to be the 'support person', prompting physicians to communicate with the family, being a support person for families during conversations, and fostering and enabling families to participate in decision-making.[1,28,33] Nurses also described how their role involved cultural assessment to assess a family's religious needs, such as the need for prayer or religious texts, including the Holy Quran or Bible when communicating a patient's poor prognosis to family.[1] Physicians were seen to have a central or leading role, including coordinating communication with families including conveying prognosis and seeking consensus on resuscitation decisions; however, multiple contributing factors affected the ability of physicians to communicate with families with cultural sensitivity.[1,27,28]

The level of nurse involvement in end-of-life communication was often dependent on the individual physician leading the communication.[1] Nurses also perceived that physicians did not value nurses' opinions in communication,[33] unless they were considered experienced and skilled in caring for ICU patients at the end-of-life.[1] The potential significance of the nursing role in culturally sensitive communication and decision-making at the end-of-life was highlighted by nurses who wished to have greater involvement in and scope to conduct end-of-life meetings with patients and families.[27] Irrespective of the various roles that nurses and physicians assume in end-of-life communication, the results of

Table 4
Synthesised themes.

Synthesised theme	Subthemes	Aslakson et al. (2012)	Borhani et al. (2013)	Crump et al. (2010)	Gallagher et al. (2015)	Loggers et al. (2009)	Muni et al. (2011)	Powazki et al. (2014)	Sprung et al. (2007)	Van Keer et al. (2015)
Communication barriers	Clinician roles in communication	X	X	X	X					X
	Communication challenges	X		X	X	X	X	X		X
	Knowledge deficit	X	X	X	X			X		
Cultural and personal influences on communication	Cultural influences on communication	X		X		X	X		X	X
	Clinicians' personal and sociocultural characteristics	X	X		X	X	X		X	X
	Patients' and families' ethnic, cultural, and religious backgrounds	X	X	X		X	X		X	X

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these studies suggest there is scope to increase collaboration between nurses and physicians in engaging in culturally sensitive communication at the end-of-life.[28,29]

3.2.1.2. Communication challenges. Communication challenges were identified in seven studies.[1,27,29–31,33,34] Numerous factors can create challenges and impact the quality and quantity of communication among clinicians, patients, and families at the end-of-life in the ICU.[27] Shift changes and the rotation of staff in the ICU were identified as impacting clinicians,[27] limiting their ability to build rapport with patients and families, and leading to ineffective communication among clinicians, patients, and families, such as disagreement regarding the prognosis, treatment plan, and end-of-life care.[33] If the patient's poor prognosis is not explained to the patient and family in a culturally sensitive way using culturally appropriate practices around disclosure of prognosis, for example, consideration of religious needs that aids open communication and facilitates understanding, consensus for end-of-life care may not be reached, potentially prolonging suffering and pain.[34]

3.2.1.3. Knowledge deficit. It was perceived that clinicians were lacking in demonstrating culturally sensitive communication with patients and families. This theme was present in five articles,[1,27,28,33,34] and included clinicians' knowledge deficit and need for education about culturally sensitive communication, particularly as it relates to the end-of-life. One study reported that more than 40% of ICU nurses identified they were underprepared to communicate with patients and families at the end-of-life and that this lack of preparedness resulted in emotional and psychological discomfort and distress.[34] In another study, nurses reported not having access to appropriate resources such as chaplaincy and palliative care personnel and guidance documents to support their communication with patients and families at the end-of-life.[27,28] In an ICU with a diverse cultural, racial, and religious patient population, a lack of knowledge about cultural diversity including culture, race, ethnicity, and religion and limited understanding of cultural differences related to end-of-life care were also identified as impacting on communication.[33] Nurses also suggested that physicians lacked knowledge related to culturally sensitive communication, suggesting this knowledge deficit led to inadequate opportunities for communication with families and misunderstandings.[27] For example, physicians may have a knowledge deficit related to the use of culturally sensitive language, leading to rushed conversations, false hope, and the use of language that families may not understand.[27] The findings of two studies endorse the need for clinician education opportunities that focus on communication and includes peer support.[33,34] Education opportunities should focus on increasing clinicians' knowledge related to cultural awareness and building therapeutic relationships to support culturally diverse patients and families at the end-of-life.[33,34]

3.2.2. Cultural and personal influences on communication

The influence of cultural and personal characteristics of clinicians, patients, and families on communication at the end-of-life was present in eight studies.[1,27–33] Cultural and personal characteristics are categorised into three synthesised subthemes, including cultural influences on communication, clinicians' personal and sociocultural characteristics, and the ethnic, cultural, and religious background of patients and families.

3.2.2.1. Cultural influences on communication. The influence of religion, culture, race, and ethnicity on communication among clinicians, patients, and families was identified in six of the included articles.[27,29–33] Communication differences were documented between clinicians and families of differing race or ethnicity. For example, an American study reported that Caucasian families were more likely to have documentation regarding advance care planning on behalf of their relatives than other families, including African–American and Hispanic families.[31] These findings could be due to differences in patients' cultural and racial preferences in end-of-life care.[31] African–American, Hispanic, and Asian families were also more likely to have documentation of clinician–family conflict at the end-of-life than Caucasian families, which could be related to differences in verbal and nonverbal cultural communication styles, including spoken words and body language.[31] Similarly, another study reported that end-of-life communication and the presence of do-not-resuscitate orders were less likely to occur for African–American and Hispanic patients, a finding thought to be linked to social factors including cultural and religious preferences for end-of-life care.[30]

When cultural and religious preferences were not identified and accommodated in care and communication, conflict sometimes occurred between clinicians, and patients and families.[29] Moreover, families of culturally diverse backgrounds lacked awareness at times of how to communicate their cultural needs with clinicians, further increasing the risk of conflict.[27]

3.2.2.2. Clinicians' personal and sociocultural characteristics. Clinicians' personal and sociocultural characteristics and how these characteristics affect communication at the end-of-life were identified in seven studies.[1,27–32] Nurses identified that nurses and physicians were often uncomfortable and avoided communication about end-of-life care and prognosis.[27] Clinicians avoided communication because of not only their own religious beliefs but also the sociocultural beliefs and practices related to their professions. For example, the 'surgical' culture of a surgeon may be different from the 'medical' culture of an intensivist, with a surgeon viewing the transition to end-of-life care as a failure and hence, less likely to engage in culturally sensitive communication at the end-of-life.[27] Other studies suggest that the frequency of end-of-life decisions and discussions varied depending on a physician's race, ethnicity, and religious affiliation.[31,32] In one study, end-of-life discussions occurred more often if the physician was of Protestant, Catholic, or Jewish religions, or had no religious affiliation, compared with Greek Orthodox or Muslim physicians.[32] These differences may be due to religious beliefs regarding withdrawing or withholding treatment.[32] This finding may also indicate that physicians' approaches to end-of-life communication differ according to their own religious affiliation.[28,32] More specifically, clinicians of a Muslim faith identified an obligation to do everything possible to save a patient's life and to avoid committing a sin, potentially avoiding conversations with families around prognosis and end-of-life care.[28]

3.2.2.3. Patients' and families' ethnic, cultural, and religious backgrounds. The influence of ethnic, cultural, and religious backgrounds of patients and families was identified in seven studies.[27–33] Patients' and families' backgrounds, which include distinctive cultures, religions, or languages, impacted their ability to engage in communication with clinicians at the end-of-life. For example, in the Muslim faith, it is believed that there is a cure for everything and that only God knows where and when a person will die.[35] Individuals and groups from a specific culture or religion may not fully understand the concepts of end-of-life care, leading to potential confusion and conflict when communicating with clinicians. Some physicians avoided conversations with families, assuming that they would not understand the prognosis or that condoning end-of-life care may not be acceptable.[32] The cultural diversity of families may also contribute to unrealistic expectations related to end-of-life care.[28] Families' unrealistic expectations in

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terms of prognosis or treatment due to cultural or religious reasons were at times overly optimistic regarding their relative's prognosis, which resulted in conflict between clinicians and families, and issues related to exchange of medical information.[28,29]

4. Discussion

Is culturally sensitive communication used by clinicians when communicating with patients and families at the end-of-life in the ICU? The findings of this systematic review suggest that it is used in isolated circumstances; however, there are multiple complexities associated with its use. While clinicians appreciate the importance of culturally sensitive communication at the end-of-life, they lacked the knowledge to enable them to communicate effectively with culturally diverse patients and families. What is the impact of culturally sensitive communication at the end-of-life? The findings of this systematic review indicate there are important cultural and personal factors that influence the quality and quantity of communication at the end-of-life in the ICU.

The differences between clinician communication roles at the end-of-life are presented in this systematic review and other studies.[36,37] Nurses assumed the role of the support person in communication at the end-of-life. This role included prompting physicians to have conversations with families regarding prognosis, taking direction from physicians, and supporting the family with cultural and religious rituals,[36,38] such as accessing religious texts or arranging for patients from the Muslim faith to face in the direction of Mecca when they die.[39] Nurses want to be more involved in communication and decision-making at the end-of-life but identified that they require further education and adequate physician support to do so, whereas physicians are central to managing end-of-life communication and delivering prognostic information.[27]

Culturally sensitive communication with patients and families at the end-of-life should be clear and transparent; however, this systematic review has identified that this is not always the case. The complexity of communicating with culturally diverse patients and families increases the risk of communication errors, potentially causing harm to all involved.[29] Language barriers, different communication styles, and a knowledge deficit affect the clinician's ability to demonstrate culturally sensitive communication. Clinicians suggested they are inadequately prepared to communicate with cultural sensitivity at the end-of-life, a finding reflected in other studies.[15,36,40] Some nurses reported feeling frustrated, others fearful, in approaching communication at the end-of-life.[15] Physicians also lack the appropriate knowledge in communicating prognosis, a finding present in another work.[16] Patients and families from diverse cultural backgrounds may express pain and grief related to crises in different ways, such as yelling and overemphasising their feelings,[18] and clinicians are inadequately prepared to communicate with cultural sensitivity in these situations. Ineffective communication can lead to distress not only in patients and families but also in clinicians.[41,42]

Differences in clinician–family communication according to clinicians', and patients' and families' cultures, including religious affiliations and ethnic backgrounds, may have an impact on communication interactions and end-of-life decision-making.[43] Without analysing communication practices, the findings of one study identified that withdrawal of active treatment occurred more often if physicians were of Catholic and Protestant religious affiliations than those of Jewish, Greek Orthodox, or Muslim religions.[44] This systematic review indicates that when clinicians, patients, and families have differing personal, cultural, and religious beliefs regarding end-of-life care practices, communication regarding prognosis and end-of-life care plans may be impaired.

4.1. Implications for practice

There is scope to increase the capability and capacity of nurses to engage in culturally sensitive communication at the end-of-life.[37] For this to occur, education should be a priority; however, to date, opportunities for clinicians to undertake education in culturally sensitive communication are rarely available,[45] such as teaching innovations described in literature on the topic area.[15] Multiple strategies to reduce challenges in communication with culturally diverse patients and families have been identified in this systematic review. These strategies may include implementing appropriate healthcare organisational structures and policies to support culturally sensitive communication education.[46] Using professional interpreters and encouraging patients and families to participate in communication regarding prognosis and end-of-life care are other strategies recommended in research evidence.[47,48] The use of professional interpreters is a best practice guideline for communicating with culturally diverse patients and families[47,49]; however, there is insufficient evidence to demonstrate the use of professional interpreters when communicating about the end-of-life in the ICU.

4.2. Implications for research

There is a growing body of evidence detailing racial and ethnic differences in health care; however, there is a lack of evidence related to the racial and ethnic disparities associated with communication at the end-of-life in the ICU.[31,50] This is an under-researched area in the ICU which requires further exploration to determine how these racial and ethnic differences influence communication and decision-making. The finding that end-of-life discussions occurred more often if the physician was of a particular religion[32] may indicate different outcomes for culturally sensitive communication depending on the religious affiliation of the physician. These cultural and religious differences and the effect they have on end-of-life communication remain poorly understood.[28,29] Further research is required to understand the nature of these differences and the impact they have on patient care.[31,32]

4.3. Limitations

Our study has some limitations. First, only nine studies met our inclusion criteria. This was because there is limited research evidence exploring culturally sensitive communication at the end-of-life in an adult ICU. Research evidence is available from neonatal and paediatric settings; however, there are differences between the approach to intensive and end-of-life care in these settings. Second, the study data available were too diverse and from different study designs, so a meta-analysis was not possible.

5. Conclusion

There is a growing body of evidence demonstrating the need for culturally sensitive communication in health care; however, limited research has been conducted on the use of culturally sensitive communication at the end-of-life in the ICU. This is the first systematic review to comprehensively synthesise research evidence related to the topic area. Culturally sensitive communication is not well defined or translated into clinical practice. It is dependent on the values and beliefs of individual clinicians and has multiple contributing factors. There are challenges related to communication and similarities and differences between how nurses and physicians communicate. The findings also emphasise issues related to the knowledge deficit of clinicians in demonstrating culturally sensitive communication and the need for further

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education. The cultural and personal characteristics of clinicians, patients, and families and how each of these characteristics influences the quality of culturally sensitive communication at the end-of-life are also highlighted in this systematic review. The findings suggest that clinicians lack the knowledge to enable effective interaction with culturally diverse patients and families at the end-of-life.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Authors' contributions

Laura A Brooks, Dr Melissa J Bloomer, and Professor Elizabeth Manias made substantial contributions to all the following: (1) the conception and design of the work, including the analysis and interpretation of research data for the work, (2) drafting the article and revising it critically for important intellectual content, and (3) the final approval of the version to be submitted.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.aucc.2018.07.003.

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Please cite this article in press as: Brooks LA, et al., Culturally sensitive communication at the end-of-life in the intensive care unit: A systematic review, Australian Critical Care (2018), https://doi.org/10.1016/j.aucc.2018.07.003

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Please cite this article in press as: Brooks LA, et al., Culturally sensitive communication at the end-of-life in the intensive care unit: A systematic review, Australian Critical Care (2018), https://doi.org/10.1016/j.aucc.2018.07.003