Abstract
This literature review explores a series of palliative and hospice care related studies which highlight effective practices and potential barriers within cross-cultural communication among patients, families, and medical staff. Translating from “medical world” to “real world” is often a major barrier in successful caregiving; however, this complexity is substantially increased due to insufficient cultural competencies. The specialized analysis will be conducted in regard to the context of cancer or oncology patient care. Theoretical frameworks, evidence-based training, and thematic insights will be the foundation of proposed future research initiatives.

Keywords: cross-cultural communication, palliative care, hospice care, cultural competencies
Across the globe, humanity seems to be distributed between two poles of diversity and bonds of the human condition. Arguably, within our global society, there are many divisive demographic identifications such as age, race, nationality, and ideology. Controversy, this global society is bonded through the undeniable components of the human condition. Within this dualism emerges the issue of ensuring health, the central tenet of maintaining life, while still navigating dissenting barriers of multicultural dynamism. This literature review will explore the depth of current contextual issues within the medical engagement as testified by palliative and hospice care providers as well as propose future research initiatives and training development which will serve to eradicate barriers of cross-cultural communication.

**Multiculturalism and Health**

As technology and transportation have developed, the opportunity for global connectivity has grown exponentially. With this global connectivity levels of intercultural interaction and multicultural demographics dualistically increase. For instance, the United Nations reported that “the number of international migrants – persons living in a country other than where they were born – reached 244 million in 2015 for the world as a whole” which is “a 41 percent increase compared to 2000” (Number of international migrants, 2016). However, with large population demographics and varying class division, a massive health disparity epidemic has been simultaneously breed with the growth into the 21st century. disparities are breed intermitted within technological advancements and global shifts. According to the World Health Organization, “there is a 36-year gap in life expectancy between countries” and there are current reports that, “low-income countries have ten times fewer physicians than high-income countries”
Although there is a multitude of global initiatives and programs such as the Centers for Disease Control and Prevention, UNICEF, and the United Nations to bridge discrepancies of health equity, there is a surmountable amount of need which still exists. However, health equity does not stop with just providing accessibility to territories lacking physicians, it also means ensuring that individuals living in areas with “accessibility” are truly able to move beyond the barriers of diverging cultural communication to ensure effective and holistic end-of-life care.

**Literature Review: Current Contextual Issues**

Within this section, journal articles related to current contextual issues within the medical encounter will be analyzed to provide specific background into factors impeding effective intercultural patient-physician interaction. Although primary emphasis will focus on the contextual issues within the medical encounter, additional notes will be taken to underscore the validity, research frameworks, and conclusions of the researchers. Specifically, this section will analyze, *High context illness and dying in a low context medical world* by J. Hallenbeck, *Challenges of mediated communication, disclosure and patient autonomy in cross-cultural cancer care* by Kai, Beavan, and Faull, and *Accommodating the diverse cultural needs of cancer patients and their families in palliative care* by Huang, Yates, and Prior.

**Hallenbeck**

In *High context illness and dying in a low context medical world*, Hallenbeck explores issues which arise from miscommunication between patients, families, and clinicians during mediation of illness. Hallenbeck asserts that through the adherence to low context communication training, clinicians are not equipped or trained to respond accordingly to the needs of patients. Furthermore, patients more notably resort to high context communication
practices due to tension, stress, pain, uncertainty, and perceived threat. This miscommunication can be even more dangerous for cultural barriers heighten in response to stress since each of the individuals involved have situationally increased tendencies to return “back on learned patterns of behavior and language” (Hallenbeck, 2006, p. 114). However, this scenario is not without hope, Hallenbeck suggests by leveraging the contextual aspects of space and time offer to “help clinicians avoid or resolve misunderstandings” (2006, p. 114).

Within the medical context, space is understood as “how we position ourselves relative to others”, however, the premise proxemics is much more intricate than that (Hallenbeck, 2006, p. 114). This spatial alignment is dense in communication properties and can relay many different messages to those among different cultures. Unfortunately, Hallenbeck also notes “most curricula have not addressed the possibility that participants of different backgrounds may have very different understandings of what is being communicated through spacing and nonverbal communication” (2006, p. 114). Future development in clinician training has great potential to alleviate miscommunication within the medical interaction. Furthermore, Hallenbeck notes the aspect of time as being a major contributor to patient satisfaction and receptiveness. Similarly, to the curriculum on space, Hallenbeck acknowledges that there is no existing educational outline to “explicitly address the problem that individuals may actually experience time differently in terms of speed or how best to deal with temporal dys-synchrony as a communication skill” (2006, p. 116).

**Kai, Beavan, and Faull**

One common context of high stress and uncertainty lies within chronic illnesses. In their article *Challenges of mediated communication, disclosure and patient autonomy in cross-cultural cancer care*, researchers Kai, Beavan, and Faull investigated healthcare providers’
perspectives and experiences in administering clinical cancer care among ethnically diverse scenarios. Similarly, to Hallenbeck’s research, this issue was explored due to the high mortality rate of the disease and the emphasis on creating effective and proactive interactions between patients and clinicians. Furthermore, authors note the urgency in assisting marginalized communities for they have higher risk of health disparities.

Kai et al. begin this study by creating clinician-based focus groups “of differing disciplines and cancer care settings, with varying experience of working with ethnically diverse patients, serving populations with varying minority ethnic composition” (2011, p. 919). Among the 106 participants, the care settings of primary care, community health services, hospice and general hospitals were represented. Results were filtered through coding conducted by each researcher to identify group themes.

Researchers found that,

>Caring for patients of differing ethnicity to their own provided positive experiences and opportunities for respondents. Health professionals perceived patients’ needs to be generally similar across ethnic groups, whatever their background. However, they encountered a range of challenges, particularly in encounters with a third party interpreting. Professionals found families’ mediation of communication with patients, and approach to ownership of information about their relatives, could make achieving appropriate assessment, informed consent and discussion of care with patients more difficult.” (Kia et al., 2011, p. 919).

More specifically, the issues with “third party interpreting” arose in many situations concerning patient-provider rapport and deliberation of illness status or treatment. Since the “experience of
family members interpreting for patients was much more common” than having a professional translator, all issues would have to be revealed to familial relations despite the patient’s potential desire for confidentiality or autonomy (Kia et al., 2011, p. 920). From this, researchers offer increased bilingual translator assistance as a potential solution; however, they also note that for this to be most effective (particularly in the circumstance of breaking bad news) clinicians need to brief translators on the patient’s case within an acceptable timeframe prior to the consultation.

**Huang, Yates, and Prior**

Huang, Yates, and Prior further explore the needs of cancer care, except they approach this through the perspective and needs of patients and their families within the context of palliative care. Palliative care is “comprehensive treatment of the discomfort, symptoms and stress of serious illness”, in a general sense the “goal is to prevent and ease suffering and improve your quality of life” (Palliative care, 2011, p.1). Researchers detail their study on “the social construction of cultural issues in palliative care among oncology nurses” through the framework of the grounded theory approach (Haung, Yates, and Prior, 2009, E12).

Researchers conducted in-depth interviews with seven study participants who had been selected through “purposeful sampling” (Haung, Yates, and Prior, 2009, E13). Despite that “only 3 participants had undertaken a formal course of study in palliative care”, six of the participants “had more than 10 years of experience working in various settings related to oncology and palliative care practice” (Haung, Yates, and Prior, 2009, E13).

Throughout the study, participant responses (both nonverbal and verbal) regarding “meanings feelings, perceptions, and interpretations regarding a particular phenomenon, event, or process” was coded to identify recurring themes and concepts. The most prevalent reoccurring themes were “accommodating cultural needs in palliative care” and “the utilization of cross-
cultural communication strategies” (2009, E14). To tactfully accommodate for cultural needs in palliative care, participants noted the additional dimensions of “cultural-religious practices” and “daily living practices” as being essential knowledge when engaging with patients. Likewise, capabilities and competencies such as “the use of nonverbal communication techniques” and “the use of staff from other cultural backgrounds” were also reported as vital in the utilization of cross-cultural communication strategies.

The successes of the participants in responding to patient need was accredited to three elements. First, the participants had their own “views and understating of culture and cultural mores” as well as knowledge of “philosophy of cultural care” (Haung, Yates, and Prior, 2009, E15). Through understanding divisions between human need and dignity, caregivers could navigate treatment which would provide the necessary care while not crossing cultural norms (for instance assigning gender specific caregivers who patients that adhere/belong to cultures with rigid gender-norms). Second, the participants had prior experience “with people from other cultures” (Haung, Yates, and Prior, 2009, E15). By building rapport and larger frame of reference through greater interaction, caregivers could more quickly and more appropriately respond to the needs of their patients. Finally, within their divisions, there were present “organizational approaches to culture and cultural cues” (Haung, Yates, and Prior, 2009, E15). This was essential in scenarios where additional support services or resources were needed to resolve barriers impeding patients from receiving proper care (ex. having trained interpreters on call).

**Future Research**

**Proposal 1: What do interpreters say?**
As indicated by the research of Haung, Yates, and Prior as well as Kai, Beavan, and Faull, the implication of introducing professional translators and interpreters into the medical encounter can yield great levels of patient-physician satisfaction and effective communication. More specifically, this implication has great potential to yield in disclosure and adherence. However, within this discovery the scope of potential research equally expands to include the narrative and viewpoints of professional interpreters. The following section will review Schenker, Fernandez, Kerr, O’Riordan, and Pantilat’s research within the context of a national survey of health care interpreters.

The study methodology included an anonymous electronic survey sent to “respondents who indicated that they work as health care interpreters, either as a primary job or in addition to other duties” through a series of listservs (Schenker et al., 2012, p. 1020). Furthermore, respondents were asked about recent experiences in communicating about issues related to end-of-life or palliative care with regard to frequency and feelings associated. Overall, 142 responses were gathered and many reported cases of end-of-life discussions (85%). With regard to feelings related to professional interaction, many respondents reported feeling “included as a part of the health care team” (Schenker et al., 2012, p. 1022). Controversially to Kai et al., participants also noted existing involvement in discussions regarding the patient prior and after the medical encounter. However, issues regarding feelings and attitudes became increasingly negative when discussing end-of-life with patients. Respondent’s indicated that discussing end-of-life is less satisfying, more stressful, and more uncomfortable. Future suggestions to lessen negative feelings about end-of-life communication include more physician education on “how to conduct end-of-life discussions through an interpreter”, additional interpreter training (personal), and
“avoiding the use of vague language metaphors, or complex medical language that does not translate well” (Schenker et al., 2012, p. 1023-1024).

**Proposal 2: Working with the family**

Although Kai, Beavan, and Faull do note the dangers of familial involvement in multicultural caregiving (specifically to patient autonomy), Sharma and Dy explore the feasibility and advantages of partnering with family stakeholders in attempts to overcome communication barriers among terminally-ill patients. Although documents articulating “best practices” and strategies general topical areas such cross-cultural communication and patient-provider or family-provider engagement, there is not a great amount of literature that “specifically address the influence of cultural beliefs on end-of-life communication nor do they provide an evidence-based approach to conducting family meetings” (Sharma & Dy, 2011, p. 438). The article goes on to detail an array of other literature regarding conclusions of medical encounters within divergent circumstance and contexts however, the issue of preexisting research regarding the intersection of end-of-life communication, cultural beliefs, familial strategies is left unanswered.

**Proposal 3: Web-based Education**

Finally, one of the fastest growing opportunities and landscape for research lies within the platform of web-based education. Similarly, to other themes of globalization, web-based accessibility is dynamically altering the way by which contemporary society gains information. Pew Research reports that in 2015 “two thirds” of adults across the globe use the Internet, however, it is also noted that this rate drops within developing nation-states (Poushter, 2016). By virtue of accessibility, information presentation, and translation programs, web-based educational solutions is an extremely feasible area to develop research on cross-cultural
communication. Moreover, web-based content could be a significant improvement towards the reduction of health disparities when considering the number of areas addressed. Researchers Doorenbos, Lindhorst, Schim, Van Schaik, Demiris, Wechkin, and Curtis led initial efforts in this field as detailed in Development of Web-Based Educational Intervention to Improve Cross-Cultural Communication Among Hospice Providers.

Within creating the pilot web-based education program, researchers focused on being able to “provide realistic case studies that are relevant to hospice social workers and that EOL providers would recognize as situations they are likely to encounter” as well as “maximize active learning through self-reflection, critical thinking, and application of new knowledge” (Doorenbos et al, 2010, p. 241). A total of 21 participants with backgrounds in a hospice facility were divided into three focus groups to cultivate feedback on the varying program scenarios. All feedback was coded by software as well as “independently coded by two investigators” to find emergent themes.

Primary themes related to overall program content were notably positive however, participants did articulate desire for more expansive training. For instance, respondents stated that “more emphasis should be placed on how to communicate core information about hospice services” and that there should be additional “training to include examples of providers who make communication errors, and then demonstrate how these errors could be addressed” (Doorenbos, 2010, p. 247-248). Furthermore, in the scenarios using interpreter’s participants were generally concerned about “using interpreters from the family or community, because of attendant confidentiality and communication issues” and that the program could lessen this issue by providing more explanatory content regarding involvement of “extended family when discussing decisions” (Doorenbos, 2010, p. 248-249).
Conclusion

Overwhelmingly, the studies point to education and access to resources as the primary solutions to overcoming culture-related barriers. On the side of education, caregivers attribute the existence of or lack of formal medical training in cultural competencies as well as experiential engagement to their personal success and failures in communicating with patients outside of their own culture, especially in the case of bad news and end-of-life issues. The other contingency of access to resources deals heavily with insuring on an organizational level there is an opportunity to consult individuals with better professional training with working intermitted with a particular patient demographic. Additionally, making clear channels of involvement between healthcare teams furthers the effectiveness and satisfaction of palliative and hospice care. Although these studies did not create a framework for understanding the patient’s review of the medical encounter, it does begin a foundational cornerstone of exploration and policy adaptation towards bridging the gap of health disparity and diverging cultural associations.
Reference


