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Cultural Barriers in Asian End-of-Life Nursing Care: A Narrative Review

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Abstract: Providing competent end-of-life (EOL) care is highly challenging for nurses due to diverging ethno-cultural values between healthcare providers and patients. While Western biomedical frameworks prioritize individual autonomy and explicit truth-telling, Asian healthcare contexts are deeply rooted in collectivism, family-centered decision-making, and strong religiosity. This narrative review synthesizes current literature to identify the primary cultural barriers, communication challenges, and gaps in delivering culturally responsive EOL nursing care to Asian populations. A comprehensive literature search was conducted across PubMed, CINAHL, ScienceDirect, ProQuest, and Google Scholar for peer-reviewed articles published between January 2010 and October 2025. Employing a researcher-modified PRISMA framework and Boolean search strategies, 679 initial records were screened based on strict inclusion/exclusion criteria. Ultimately, 23 highly relevant articles were retained for qualitative synthesis and thematic evaluation. The synthesis revealed three major thematic barriers: (1) Decision-Making Conflicts (2) Religious and Spiritual Influences; and (3)Communication Gaps. Asian nurses operate as frontline cultural mediators, facing persistent moral distress as they balance rigid Western-centric institutional policies against family-centered cultural expectations. To bridge this gap, healthcare systems must integrate culturally competent communication models into nursing curricula and establish institutional frameworks that support nurses navigating complex ethical and spiritual boundaries at the end of life.

Keywords: *Asian Populations, Cultural Competence, End-of-Life Nursing Care, Palliative Nursing.*

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I. INTRODUCTION

Providing competent care to terminally ill patients with a limited life expectancy and their family is a challenge for nurses. The task becomes even more challenging since nurses bring to the healthcare their culture from their respective ethnic group that may be different from the patient. Indeed, a nurse and a patient may have the same nationality, but can differ in ethnicity, customary practices, and even in cultural and religious beliefs about health and illness. Although nurses reported positive attitudes towards caring for dying patients and their families in most items, they identified negative attitudes towards talking with patients about death, their relationship with patients' families and controlling their emotions (Alshammari, 2023). Hence, the effectiveness of this care is deeply intertwined with ethno-cultural values and beliefs.

Given that nurses are the most numerous among the health providers and are the first point of contact for many patients, it is imperative for them to be culturally competent to maximize the potential for quality nursing care. Studies conducted on cultural competence in health care over the past decade showed a connection between a lack of cultural competence by health care providers and misdiagnoses, mistreatment, loss of trust in the healthcare system, and ultimately higher morbidity and mortality rates, particularly in minority populations. A recent study conducted by Mojini, 2024, highlights the crucial role of cultural awareness in healthcare to enhance nurses' cultural competence and elevate patient care standards. It advocates for the integration of cultural considerations into nursing practice, specifically addressing the needs of indigenous communities.

With increasing globalization and multicultural patient populations, nurses are required to integrate cultural competence into palliative and End-of-Life (EOL) care. Thus, an understanding of culture is necessary in order to provide competent care and treatment. The purpose of this narrative review is to synthesize current literature on culturally responsive EOL nursing care and to identify primary barriers, challenges, and gaps in the existing literature regarding the delivery of culturally competent palliative care to Asian populations. This review will ultimately contribute to current nursing knowledge in end of life nursing care.

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II. METHODOLODY

A. Study Design

A narrative review design was employed to collect, examine, and synthesize existing literature on culturally responsive nursing care among Asian population. This approach provides definitive findings for explicit contextualization, comprehensible, and applicable summary of information (Sarkar & Bhatia, 2021). Hence, it was selected to allow for a comprehensive and interpretive synthesis of diverse empirical evidence, including qualitative, quantitative, and mixed-methods studies, with a particular focus on culturally congruent palliative nursing care among Asian population.

B. Literature Search

The literature search was performed across multiple electronic databases to capture a wide range of peer-reviewed publications. To identify relevant articles or studies, a comprehensive literature search was conducted using databases such as PubMed, CINAHL, ScienceDirect, ProQuest and Google Scholar. However, rather than limiting the search to a 5-year period, the timeframe was extended to include studies published from January 2010 to October 2025, given that the topic remains insufficiently reviewed and is characterized by heterogeneity. Key concepts such as ethno-cultural, religious belief, values, tradition, practices, end-of-life decision-making, and communication of patient, family and nurses, cultural competence, cultural sensitivity end-of-life nursing care and palliative nursing were examined.

Additionally, Boolean search method was utilized in combination with the keywords to refine the search results. Boolean operators “AND” “OR” and “NOT” were applied to exclude irrelevant studies. The operator AND was used to combine keywords or concepts, narrowing the search to studies containing all specified terms. In this study, the research inputted the concept “end-of-life care AND cultural competence” to retrieve articles that discuss both concepts simultaneously. The operator OR, on the other hand, broadened the search by including synonyms or related terms. For instance, “cultural competence OR cultural sensitivity OR transcultural nursing” allows the database to retrieve articles containing any of these terms. Meanwhile, the operator NOT excluded unwanted terms from the search. For example, “nurses NOT doctors” removed studies focusing on medical practitioners.

To minimize the inclusion of irrelevant articles, specific inclusion and exclusion criteria were established.

Table 1 Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Peer-reviewed articles From January 2010 to October 2025	Studies not related to healthcare or EOL care
Articles addressing cultural aspects of EOL or palliative care	Non-English articles
Studies focusing on Asian nursing professionals	Study on non-Asian culture with no bearing to health or EOL

A total of 679 potential articles published between January 2010 and October 2025 were initially identified through searches in PubMed, CINAHL, ScienceDirect, ProQuest and Google Scholar. Articles were initially screened based on their duplicated records, year, and title, followed by abstracts; the full text were examined to determine relevance to the review objectives. After the initial screening, 140 articles remained, of which 36 met the eligibility criteria. Following a full-text review, of the 36 related literature, 23 articles were retained for review and rigorous evaluation.

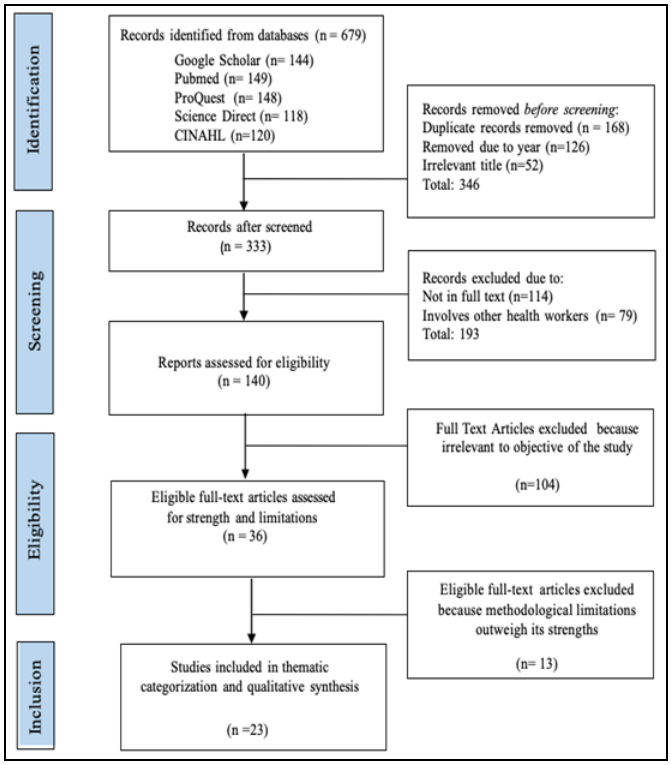

Fig 1 Flow Diagram of Identification and Screening of Studies

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III. RESULTS AND DISCUSSION

- *Studies Related on Asian Culture Truth Disclosure and Decision-Making in EOL Care*

A persistent concern highlighted in recent literature is the ethno-cultural tension surrounding the disclosure of terminal diagnoses. While Western bioethical frameworks emphasize patient autonomy, particularly the individual's right to be informed, Filipino cultural values tend to prioritize beneficence and non-maleficence, often interpreted through a family-centered lens. Norms such as indirect communication, silence, and collective decision-making can impede open discussions about prognosis and end-of-life preferences. In many cases, disclosing a terminal condition is perceived as taboo, as it is believed to diminish hope, which is seen as sustaining the patient's will to live. Consequently, truth-telling may be viewed as an act of harm rather than respect. Nurses frequently encounter ethical dilemmas when families request "protective silence" to shield the patient from distress, a practice that conflicts with institutional policies on informed consent (Corpuz, 2023). This situation, often described as the "conspiracy of silence," can undermine patient autonomy and complicate ethical decision-making in nursing practice (Roman, 2015).

Moreover, within the Asian ethno-cultural context, the family plays a central role in healthcare decisions, which are typically made collectively rather than individually. This approach may contrast with Western biomedical principles that prioritize personal autonomy (Ho et al., 2023). Supporting this, a comparative study by Bullock (2011) found that individuals from culturally collectivist groups emphasized interdependence and shared decision-making, whereas Americans placed greater importance on individualism and autonomy in end-of-life choices. Tensions between professional ethical standards and cultural expectations—particularly when families request withholding information—can lead to moral distress and uncertainty among healthcare providers (Palliative Medicine Reports, 2025).

In examining ethno-cultural influences on end-of-life decision-making, Asian culture strongly favors family-centered approaches over individual autonomy. Decisions regarding treatment options, resuscitation, or withdrawal of care are often made collectively, with significant input from family elders or key decision-makers. While this collectivist orientation can offer emotional support, it may also create ethical conflicts when family preferences diverge from the patient's wishes or clinical recommendations. For healthcare providers, this dynamic can present challenges, especially when the goal is to actively involve the patient in decision-making. Studies indicate that Asian nurses commonly face situations in which families request non-disclosure of diagnoses or advocate for continued aggressive treatment despite poor prognosis (Crawford & Koenig, 2008). Such circumstances complicate the process of informed consent and challenge the nurse's role as a patient advocate.

- *Studies Related on Religious Beliefs and Ethno-Cultural Values as Barriers to EOL Care*

Culturally responsive end-of-life care among Asian nurses is deeply embedded within the country's complex cultural milieu, characterized by rich diversity, strong religiosity, and a predominantly family-centered social structure. Patients and their families commonly interpret illness, suffering, and death through spiritual lenses shaped by the Roman Catholic Church, Islam, and various indigenous belief systems. While these influences can enhance the delivery of compassionate, holistic, and meaning-centered care, they may also introduce significant clinical and ethical challenges. For example, families may place greater trust in faith-based healing, miracles, or divine intervention than in medical prognostication, often resulting in the continuation of life-sustaining treatments despite medical futility. In such contexts, nurses are frequently confronted with the difficult task of balancing cultural respect with their professional responsibility to provide truthful information and advocate for the patient's quality of life.

Furthermore, Asian countries such as Malaysia, Indonesia, Brunei, and other Muslim dominated Asian countries are deeply rooted in Islamic traditions which contribute to the cultural sensitivity surrounding discussions of prognosis and death timelines. Explicitly stating a limited life expectancy is often perceived as presumptuous, as such knowledge is believed to reside solely with a higher power. As a result, conversations about end-of-life care are frequently framed within fatalistic expressions such as the Islamic concept of *Tawakkul* or the complete trust and reliance in Allah's plan after putting in one's best effort. While these beliefs can promote hope, resilience, and spiritual acceptance, they may also impede timely discussions of palliative care and advance care planning, which are sometimes misconstrued as relinquishing hope or abandoning the possibility of divine intervention. Consequently, evidence-based prognostication and planning may be perceived as conflicting with faith. Empirical studies have shown that strong religiosity can delay acceptance of terminal conditions and complicate advance care planning, particularly when discussions about death are interpreted as undermining spiritual beliefs or hope (Abelardo et al., 2021; Balboni et al., 2013). This creates a persistent tension for nurses, who must handle complex issues of spiritual sensitivity and evidence-based practice in end-of-life care.

In addition, core Filipino cultural values such as *pakikisama* (the maintenance of harmonious relationships), *utang na loob* (a deep sense of gratitude or indebtedness), and *hiya* (a sense of shame or social propriety) significantly influence health-related behaviors and communication patterns. These values may act as barriers to open and honest dialogue, as patients may suppress concerns or disagreements to preserve relational harmony, while families may intentionally withhold information to protect the patient from emotional distress. Conversely, values such as *pagkalinga* (nurturing care) and *pagdamay* (shared empathy and collective suffering) reinforce a compassionate, relational approach to caregiving. These cultural constructs play a vital role in shaping ethnoculturally responsive end-of-

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life nursing care, emphasizing interconnectedness, emotional support, and familial solidarity (Ragado & Fernandez, 2022).

Another concern is the predominance of Western-oriented healthcare models, which may not fully correspond with Asian cultural values and practices. Healthcare systems frequently emphasize standardized protocols that tend to overlook indigenous beliefs, spiritual traditions, and customary rituals surrounding death. This disconnect can result in culturally incongruent care, where the needs and preferences of patients and their families are not adequately recognized or respected. Consequently, Asian nurses often assume the role of cultural mediators; however, they may lack sufficient institutional support or formal frameworks to effectively fulfill this role (Cáceres-Titos, 2025).

- *Studies related on Cultural Communication Barriers*

In the context of communication, indirect communication styles remain a notable challenge in ethnoculturally responsive end-of-life (EOL) care. Asian patients and families often depend on non-verbal cues or softened expressions when discussing serious illness, which can lead to ambiguity and misinterpretation. In some instances, the involvement of a religious leader may be necessary to facilitate dialogue among the male head of the family and healthcare providers regarding end-of-life decisions. Nurses may experience difficulty initiating conversations about prognosis, advance directives, or dying due to concerns about causing emotional distress or being perceived as insensitive. Evidence suggests that limited training in communication and cultural competence further intensifies these challenges, resulting in delayed or less effective EOL discussions (Clayton et al., 2007).

Moreover, the use of medical interpreters to bridge communication gaps among ethnolinguistic patients and families has become increasingly common in healthcare settings. Despite its benefits, this practice also presents several concerns. One major issue is the potential for loss, distortion, or oversimplification of meaning during interpretation. End-of-life conversations often involve complex medical, emotional, and cultural nuances that are difficult to translate accurately. A qualitative study on interpreter use in palliative care revealed that certain terms, such as “palliative care,” may lack direct equivalents in some languages, prompting interpreters to approximate meanings or provide subjective explanations (Latif, 2023). This can lead to inconsistencies in how information is conveyed, potentially influencing patients’ understanding of their prognosis, treatment options, and care goals. Additionally, literal translation may fail to capture the emotional tone, cultural context, and implicit meanings embedded in communication, thereby limiting the depth and accuracy of interactions.

IV. CONCLUSION

The narrative review highlights the deeply embedded, complex intersection of ethno-cultural values, religious beliefs, and communication dynamics that define end-of-life (EOL) care within the Asian context. The synthesized literature demonstrates a profound divergence between Western-centric biomedical frameworks, which champion individual autonomy and explicit truth-telling, and the Asian healthcare ethos, which is anchored in collectivism, family-centered decision-making, and spiritual reliance.

The findings reveal that the "conspiracy of silence" and requests for protective non-disclosure are not acts of negligence, but are rooted in core cultural values such as hope, relational harmony, and propriety. Furthermore, deeply ingrained Roman Catholic, Islamic, and indigenous traditions heavily influence how illness and death are conceptualized. Expressions of fatalism and absolute trust in divine intervention provide profound psychological and spiritual comfort to families, yet they simultaneously act as clinical barriers, often delaying evidence-based palliative planning or driving requests for medically futile aggressive treatments.

Communication barriers further compound these ethical dilemmas. The reliance on indirect, non-verbal communication styles, coupled with linguistic nuances that lack direct Western equivalents (such as "palliative care"), creates a high risk for distortion and misalignment during critical EOL dialogues; a vulnerability exacerbated by a lack of institutional training and fragmented interpreter systems.

Ultimately, Asian nurses find themselves operating as frontline cultural mediators. They are caught in a state of persistent moral distress, balancing institutional policies regarding informed consent against their professional desire to provide culturally responsive, and compassionate care To bridge the gap between standardized Western healthcare models and the Asian cultural milieu, healthcare systems must move beyond rigid protocols. There is an urgent need for institutional frameworks that integrate cultural competence into nursing curricula, provide formal support for nurses navigating ethical conflicts, and develop communication models that honor both the patient's dignity and the family’s collective solidarity.

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