

Nursing Roles and Strategies in End-of-Life Decision Making Concerning Elderly Immigrants Admitted to Acute Care Hospitals: An Australian Study

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Megan-Jane Johnstone, PhD, RN, FACN¹,
Alison M. Hutchinson, PhD, MBioethics, RN¹,
Bernice Redley, PhD, RN¹, and Helen Rawson, PhD, RN¹

Abstract

Purpose: There is a lack of clarity regarding nursing roles and strategies in providing culturally meaningful end-of-life care to elderly immigrants admitted to Australian hospitals. This article redresses this ambiguity. **Method:** A qualitative exploratory descriptive approach was used. Data were obtained by conducting in-depth interviews with a purposeful sample of 22 registered nurses, recruited from four health services. Interview transcripts were analyzed using content and thematic analysis strategies. **Results:** Despite feeling underprepared for their role, participants fostered culturally meaningful care by “doing the ground work,” “facilitating families,” “fostering trust,” and “allaying fear.” **Discussion and Conclusion:** The Australian nursing profession has a significant role to play in leading policy, education, practice, and consumer engagement initiatives aimed at ensuring a culturally responsive approach to end-of-life care for Australia’s aging immigrant population. **Implications for Practice:** Enabling elderly immigrants to experience a “good death” at the end of their lives requires highly nuanced and culturally informed nursing care.

Keywords

end-of-life care, nursing practice, transcultural health, gerontology

According to the 2011 Australian census data, 14% of the Australian population was aged 65 years and older. Over the next 40 years, the proportion of the Australian population older than 65 years is projected to almost double to around 25%. Of this population, overseas-born older Australians (19.4% of whom are of non-English-speaking backgrounds) will be disproportionately represented, with this demographic projected to increase to 66%, compared with just 23% for the older Australian-born population (Australian Institute of Health and Welfare, 2004). In keeping with these projections, it has been suggested that between the years of 2011 and 2025, the number of people aged 65 years and older from culturally and linguistically diverse backgrounds will increase from approximately 650,000 to around 950,000 (National Seniors Australia Productive Ageing Centre, 2011).

Older immigrants in Australia are most likely to have been born in European countries other than the United Kingdom and Ireland (Australian Bureau of Statistics [ABS], 2013a, 2013b). The vast majority of these older people migrated to Australia following the devastation of Europe during World War II and, in the cultural context of Australia,

are commonly referred to as “post–World War II migrants” (circa 1950s–1960s). The main countries of origin of post–World War II immigrants include Italy, Greece, Poland, The Netherlands, Germany, the former Yugoslavia, the former USSR, and Hungary. The countries of birth of other older immigrants (circa 1970s, 1980s, and after the 1990s) include Vietnam (following the Vietnam War), Philippines, Middle Eastern countries, Chile, and China.

Adding to the complexity of Australia’s aging immigrant population, according to 2006 Census data, more than 200 different languages are spoken at home by older immigrants. Of these languages the top 10 spoken are Italian, Greek, Cantonese, Arabic, German, Mandarin, Vietnamese, Spanish, Croatian, and Polish (National Seniors Australia Productive Ageing Centre, 2011). Significantly, according to the ABS,

¹Deakin University, Melbourne, Victoria, Australia

Corresponding Author:

Megan-Jane Johnstone, School of Nursing and Midwifery, Faculty of Health, Deakin University, 221 Burwood Highway, Melbourne, Victoria 3125, Australia.

Email: megan-jane.johnstone@deakin.edu.au

the proportion of older immigrants not proficient in English is estimated to be 34% (ABS, 2013a). This means that at least one in every three older immigrants of non-English-speaking background presenting to an acute care hospital for treatment may require a qualified health interpreter to assist them to navigate the health care system (Johnstone & Kanitsaki, 2008a).

The ABS (2011) has estimated that of the 143,500 Australians who die each year, approximately 54% (77,490) will die in acute care hospitals (Forero et al., 2012). Meanwhile it has been estimated that of the 140,290 immigrants who died in Australia during 2011, 80% were aged 65 years and older (ABS, 2013b). The implications of these estimates for Australia's aging immigrant population and their carers are far reaching. There are at least two reasons for this: First, there is a recognized mismatch between the focus of an acute health care system and "the needs of people approaching the end of life" (Bloomer, Moss, & Cross, 2011, p. 2). As well there is a recognized policy and practice gap between the cultural competency of health care providers and the culture care needs of older people from diverse cultural backgrounds whose cultural lifeways are not always understood or respected in the planning and delivery of end-of-life (EOL) care (Johnstone, 2012; Johnstone & Kanitsaki, 2008b, 2008c, 2009).

The Australian State of Victoria, the location in which this study was conducted, has the second largest multicultural population in Australia, with 26.2% of its population born overseas in more than 200 countries and more than 22% of its population speaking a language other than English at home (Victorian Multicultural Commission, 2013). Evidence suggests that elderly immigrants of non-English-speaking backgrounds in Australia have higher rates of admissions and hospital bed utilization in the last year of life compared with the Australian-born population (Rao, Warburton, & Bartlett, 2006). It is anticipated that as Australia's population ages, older people with chronic illnesses will increasingly be admitted to hospital when their symptoms and EOL care become unmanageable at home. Despite these estimates, there is a paucity of Australian research systematically investigating issues concerning EOL hospital care for elderly immigrants and its overall impact on attendant families.

A "good death" has been defined as a death that is "free of avoidable distress and suffering for patients, families, and caregivers," generally accords with the patients' and families' wishes, and is "reasonably consistent with clinical, cultural, and ethical standards" (Field & Cassel, 1997, p. 4). In Australia, there are significant ethnic aged disparities in accessing and receiving what might be regarded as "good" EOL care (Clark & Phillips, 2010; Ethnic Communities Council Victoria, 2012; Krouskos, 2009). Moreover, anecdotal evidence suggests that when admitted to the hospital for care during the final stages of life, elderly immigrants do not always experience a good death. This has left families feeling resentful of the care that was (not) given to their

Table 1. Research Questions Guiding the Study.

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- What do nurses know and understand about culturally responsive end-of-life (EOL) care?
 - What do nurses perceive and understand their roles to be in EOL decision making concerning elderly immigrants admitted to hospital at the end of their lives?
 - What strategies do nurses use to engage in EOL decision making concerning elderly immigrants admitted to hospital and needing EOL care?
 - What do nurses perceive and understand to be the relationship between their EOL decision making and the "quality of death" outcomes for elderly immigrants and their families in hospital contexts?
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loved ones and distrustful of a system that they themselves may have to access in the future when facing the end of their own lives. Compounding this problem is the different understandings that practitioners have generally about the scope, definitions, goals, and approaches to EOL care. In contexts involving people from culturally and linguistically diverse communities, differences are often greater, adding a further layer of complexity to the issue (Economist Intelligence Unit, 2010; Evans et al., 2012; Gysels et al., 2012; LoPresti, Dement, & Gold, 2014).

Nurses can make a profound difference to how patients and their families experience the dying process and the ultimate moment of death that will inevitably follow (Cioffi, 2006; Hov, Hedelin, & Athlin, 2007; Høye & Severinsson, 2010; Rolland & Kalman, 2007; Silèn, Svantesson, & Ahlström, 2008). There is, however, a lack of evidence and clarity regarding the roles and strategies used by nurses in EOL care (Adams, Bailey, Anderson, & Docherty, 2011; Ranse, Yates, & Coyer, 2012). To redress this problem researchers have posited that a systematic understanding of "what roles nurses enact and what strategies they use in EOL decision making and care is necessary to ensure that decisions made are consistent with the patient's and family's goals of care" (Adams et al., 2011, p. 2). To this end, this study aimed to answer and was guided by four research questions listed in Table 1.

The purpose of this qualitative study was to explore and describe nursing roles and strategies in EOL decision making and their possible link to enabling a good death for elderly immigrants admitted to hospitals in the Australian State of Victoria. Accordingly, this study sought to explore and describe nurses' knowledge and understanding of what constitutes culturally responsive EOL care, their perceptions and experiences of engaging in EOL decision making when caring for elderly immigrants in hospital contexts (created and mediated by the multidimensional interactions of professional and institutional governance, and the multidimensional power relationships that mediated the nurses' practice), and the strategies they used in trying to enable a good death for their patients.

Table 2. Participants' Cultural Diversity Education.

Category	No education	Work-based education ^a	Work-based experience ^b	Personal experiences ^c	Non-work-based education ^d
Acute care nursing staff	3	2	3	—	2
Aged care nursing staff	1	—	2	1	—
Palliative care nursing staff	1	5	1	1	3
Total	5	7	6	2	5

Note. One participant from each of the Acute and Palliative Care groups did not provide data. Where a participant has made comments that fall into multiple categories (e.g., AC.09, P.05, P.08), all statements were included. Therefore, total number of responses will exceed the actual number of participants in the study.

^aWorkshops, seminars, conferences, journal club meetings. ^bMaking informal observations, seeking advice from more experienced peers, asking patients and families. ^cDrawing on own formative life experiences (e.g., death of a loved one; growing up with people of diverse cultural backgrounds), immigration experiences of either self and/or family, being of a non-English-speaking background. ^dPrivate reading; viewing television documentaries and film on themes concerning cultural diversity, racism, death and dying; Internet searches out-of-work hours.

Method

This study was undertaken using the qualitative exploratory descriptive methods described by Lincoln and Guba (1985) and Patton (2002). A qualitative exploratory descriptive research approach was chosen since it is eminently suitable to facilitate the rich description, comparison, classification, and conceptualization of new knowledge from previously disorganized and/or nonrelated data (Patton, 2002). It is also a highly pragmatic approach that enables “quite concrete and practical questions” to be addressed by people who are “wondering if what they are doing is working” (Patton, 2002, pp. 135-136).

Participants

A criterion-based purposeful sample of 22 registered nurses was recruited from four different health services in metropolitan Melbourne and regional Victoria. Participants were selected on the basis of the following criteria: holds current registration as a nurse; practicing in a hospital in the State of Victoria; and has been and/or is involved in the care of non-English-speaking background immigrant patients aged 65 years and older admitted to hospital during the past 5 years for care at the end of life. Of the 22 nurses recruited to the project, 11 worked in medical-surgical wards and critical care (coded as AC), 8 worked in “acute” palliative care (coded as PC), and 3 worked in the aged care sector (coded as AGC). The final number of participants interviewed was determined by the point at which informational redundancy (data saturation) was achieved.

The majority (91%) of participants were female, and of those who completed the demographic questionnaire, most (82%) had been in their current position more than 5 years (range 1-20 years). Eleven participants indicated they had undertaken postgraduate studies (postgraduate certificates [$n = 3$], postgraduate diplomas [$n = 1$], master degrees [$n = 7$]), with four (20%) indicating that they had completed their highest professional qualification in the past 5 years. None of

the participants had undertaken any *formal* education on cross-cultural considerations in EOL care (Table 2).

Data Collection

Data were collected via a demographic data sheet and via in-depth, semistructured individual interviews conducted either face-to-face or via telephone. Interviews were guided by 14 broad open-ended interview questions keyed to the research questions (Table 3) and conducted in a conversational style. Each interview lasted between 35 and 90 minutes (average length of time 60 minutes). All interviews were audio-recorded and transcribed verbatim by a professional transcriber. Of the interviews conducted, 19 were conducted by the researchers and 3 were conducted by a research assistant trained in qualitative research methods.

All participants were provided with information about the project and its purpose via a plain language information sheet and direct communication either face-to-face or by telephone. Further information was also provided at the time of interview.

Data Analysis and Rigor

Data were analyzed by the investigators using the following steps: verbatim transcription of the audio-recorded interviews; active reading of the data (asking questions while the transcripts were being read); annotating data; creating and assigning categories, which on account of interpretations being related to the research questions, became the categories. In using these steps, data were searched for patterns, linkages, and plausible explanations (Patton, 2002). Initial data configurations were reconfigured in an attempt to find other ways in which the data could be interpreted or organized and which might have led to different findings. Rival configurations and organization of themes or competing explanations that were not supported by the data were either dropped or modified. Conversely, configurations, themes, and explanations that were supported by the data were judged

Table 3. Broad Interview Questions.

1. Tell me about your nursing career and when you first became involved in providing end-of-life (EOL) care for elderly immigrants in the acute care setting.
2. What, if anything, particularly stands out about your experience in providing EOL care for this population?
3. How well prepared do you think you are for providing EOL care to elderly immigrants in the acute care setting?
4. Describe for me what you know and understand by the notion of “culturally responsive EOL care.”
5. What would you consider to be a “good death” or a “quality death?”
6. Tell me what you *think* is the role of nurses in EOL decision making involving elderly immigrants and their families.
7. Describe for me what decision-making strategies:
 - (a) You personally have used when planning and providing EOL care for elderly immigrants in the acute care setting.
 - (b) You have observed other nurses use when planning and providing EOL care for elderly immigrants in the acute care setting.
8. How do you *feel* when providing EOL care for elderly immigrants in the acute care setting? What satisfies/dissatisfies you?
9. Describe the kind of relationships you have developed with elderly immigrants and their families when providing EOL care in the acute care setting?
10. Tell me how you *know* whether a patient is experiencing a “good death?” (e.g., describe the indicators/criteria you would use to inform your judgment that the patient/family is in fact experiencing a “good death”).
11. What do you believe is the relationship (if any) between nurses *EOL Decision making* and “quality of death” (*good death*) outcomes for elderly immigrants and their families in the acute care setting?
12. What culture-specific EOL care practices do you find acceptable/unacceptable? Which of these practices would you encourage/discourage?
13. What processes do you believe are best suited to promoting a “good death” for elderly immigrants and their families when admitted to hospital for EOL care?
14. What do you think are the greatest challenges in approaching elderly immigrants and their families to discuss EOL issues?

to have the best “fit,” namely, between data and analysis, and were retained (Lincoln & Guba, 1985; Patton, 2002).

In order to ensure the rigor of the study, due attention was given to upholding the principles of credibility, fittingness, auditability, confirmability, and triangulation (Patton, 2002). In the case of triangulation, two forms were used: *source triangulation* and *analyst triangulation*. In the case of source triangulation, this was achieved by recruiting participants from across several geographic sites and areas of practice (acute care, acute palliative care, aged care) and examining the consistency of different data sources within the same method. Further validation was achieved by comparing information gained by a review of relevant literature with data obtained from the interviews. In the case of *analyst triangulation*, this was achieved by the four named coauthors of this report analyzing the data and comparing their respective individual findings.

Ethical Considerations

The study was approved by the Human Research and Ethics Committee at Deakin University (HEAG-H 19_2013) and four metropolitan health services at which participant recruitment and interviewing occurred: BH (13-71_BH), EH (LR97/1213), MH (13195X), and NH (LR 18/13). Informed consent was obtained from each participant prior to the collection of data, and all identifying information such as names and institutional affiliations was deleted from all transcripts and replaced with numerical codes. Participants were advised that they were free to withdraw from the study at any time. No participants withdrew their consents.

Findings

Analysis of the data revealed that a lack of formal learning opportunities in both their undergraduate and postgraduate nursing courses had left participants feeling underprepared for EOL decision making when caring for elderly immigrants admitted to hospital. In order to remedy their knowledge deficit, most of the participants had resorted to self-directed learning. Through this learning, the nurses had developed their capacity to provide highly nuanced culture care to elderly immigrant patients and their families. The examples given by participants in this study were interpreted as indicating that the nurses were highly sensitive, aware, compassionate, attentive, curious, flexible, and open to inquiring about and exploring the “real” needs, feelings, thinking, and wants of elderly immigrant patients and their families.

Knowledge and Understanding of Culturally Responsive EOL Care

Data analysis revealed that, initially, most participants had little knowledge or understanding of what constituted culturally responsive EOL care and felt overwhelmed and underprepared when first encountering patients and families from diverse cultural backgrounds. As one participant bluntly stated, “I was ignorant” (PO1, p. 27). Another participant recounted that, when she first encountered the challenge of caring for patients who spoke different languages and the need for her to understand people’s different cultural beliefs and practices, it was “quite a shock” (AC.07, p. 32).

Recognizing the need to remedy their lack of culture care knowledge, the majority of participants actively set about to

improve their capacity to provide culturally responsive EOL care. Significantly, their main source of learning was not from formal professional education courses, as might be assumed. Rather, as the data revealed, the most influential site of learning was “on the job”—achieved through asking questions, talking with and observing others (especially asking family members, “What would you normally do at home?”), and engagement with other more experienced nursing peers.

Several participants, who were themselves immigrants or the children of immigrants, also drew on their own personal background and cultural knowledge to inform their practice, particularly when caring for elderly immigrants who shared the same cultural heritage as themselves. Despite having a shared cultural background with their patients, these nurses were nonetheless aware that challenges remained, especially when making assumptions about what is “culturally appropriate.” As one participant reflected,

We think we know—being from that culture. I think I know enough about that culture to be able to provide [responsive care]. But sometimes the patients and family surprise me and things happen and I think “Oh hang on, I didn’t really think of that” [. . .]. Until the issues come up, we just take for granted what we do. When things do go wrong, then we have to pick up the pieces. (PC.04, p. 2)

Participants were also especially conscious of ensuring they “did the right thing” and did not do the wrong thing through ignorance. As one participant explained,

I didn’t want to be responsible for this person going to hell, for want of a better word, or whatever it is that they believe in. Or their spirit not being pure because of something that I’d done through ignorance. (AC.04, pp. 9-10)

Not all participants understood or accepted the idea of culturally responsive EOL care, however, or that *culture* per se had a significant bearing on how patients and their loved ones experienced EOL care and the dying processes. Some participants strongly believed “the culture doesn’t come into it” (AC.09, pp. 4-5). There was also a strong co-relation between this “culture blind” belief and the stance that effective EOL care for patients from culturally different backgrounds was the same as for *any* patient and simply involved “good symptom management.” While accepting that cultural considerations were important, one participant strongly believed that these only came into play *after* the patient had died, asserting, “I don’t really decide based on culture. I just act on symptoms [. . .]. It’s only after the patient passes away that you take this culture into consideration” (PC.06, p. 7).

Role of Nurses in EOL Decision Making

The responses of most participants strongly suggested that they did not perceive themselves as having a role per se in EOL decision making. Rather, participants perceived and

experienced their role as being at the forefront of assisting the elderly immigrants and their families to understand the dying process and to face death. This included helping patients to reflect on the meaning of their lives and to generally support them and their families in coming to terms with the death that was pending. It was acknowledged, however, that this was often very difficult when the patient and nurse did not speak the same language. As one participant reflected,

They’re facing death and probably can’t communicate that to many people in their language. I think if I had to communicate fear in Italian or Greek, having learnt it from the age of 30 or something, it would be horrendous, because I’ve got to use the words that would come from my heart. Your mother’s language is your emotional language. So if you can’t use that language, you can’t express yourself. (AC.01, p. 9)

Participants gave several reasons for why they did not perceive themselves as having a role in EOL decision making as such. Some indicated that they had simply been excluded from EOL decision-making processes in their practice domains even though they were adept at determining when a patient was about to die. Others had simply equated EOL decision making with *medical* decision making—notably about when to stop, start, not start or withdraw “futile” life-prolonging treatment—something which, in their view, fell outside of the purview of nurses. They believed that nurses were more concerned with decision making about *care* at the EOL and the need for EOL care to encompass *compassion and comfort*.

Despite not perceiving themselves as being at the forefront of EOL decision making, participants nonetheless strongly believed that they had a primary role to play as patient advocates aimed at ensuring that the needs both of patients and families were being met. This role was described as encompassing the following: *doing the ground work*, *allaying fear*, *facilitating families*, and *overcoming language barriers*. The specific strategies used in this role are described in Table 4.

Cases were recounted that underscored the extreme fear and terror of death that some elderly immigrants and their families felt and which nurses would work diligently to assuage. One example involved the case of a Greek-born man who did not speak English. Remembering this man, the participant reflected, “You could see the anxiety around ‘I’m dying, I’m dying, I’m scared’—he had a fearful component to that [. . .]. He was making the sign of the cross on multiple occasions and saying ‘I’m terrified’” (PC.03, p. 5).

Strategies Used to Engage in EOL Decision Making

When involved in the planning and implementation of EOL care for elderly immigrants, participants did not perceive themselves as being strategic per se in their decision making. Ironically, they nonetheless revealed a number of strategies

Table 4. Advocacy Role of Nurses in End-of-Life Decision Making.

- *Doing the ground work:* “gathering information,” “finding out what the patient wants,” “being in tune and picking up cues,” “ascertaining whether the patient “really understands,” and “asking the right questions”
- *Allaying fear:* by “being readily available,” “having a discernible presence at the bedside,” and “constantly checking yet at the same time ‘giving space’ both to the patient and the family”
- *Facilitating families:* by “actively involving family members,” which included “listening to family,” “encouraging them to speak first,” “finding out who the contact person is for the family,” and “dealing with angst”
- *Overcoming language barriers:* “finding ways to communicate,” “facilitating interpreters,” “finding out who’s the best person for that person to communicate with regarding what they would like”

they used and which they believed helped them “get it right” when planning and delivering EOL nursing care. The strategies identified were closely aligned with what they had described previously as part of their perceived patient advocacy role. Notable among the strategies described were “working with the family,” “building rapport and fostering a trusting relationship,” and “undertaking their own assessments of patient and family needs.”

Participants identified that fundamental to working effectively with immigrant families was “taking extra time,” “asking the family,” “listening well,” “finding out what’s important to them,” “determining the patient–family decision making model,” “engaging a spokesperson,” “providing explanations and overcoming fear,” “being there and not letting them do it on their own,” “stepping back and reaching compromises,” and actively involving them in the patient’s care. Building rapport and fostering a trusting relationship, in turn, required nurses to “get to know the patient and family first,” “give a bit of ourselves,” “take the time necessary to build relationships and not rushing conversations about the patient dying,” “glean information from the patient,” “read people well,” “learn from each other,” “be on the same page,” “overcome suspicious talk,” “respect the patient’s life wishes,” “keep the patient clean,” “place meaning into their experience,” and generally work in a focused way to foster trust in the nurse–patient relationship. Trust was perceived as being particularly important. As one participant explained, it can be very easy to lose the trust of patients and their families:

You can lose trust by just not being able to answer a buzzer or something [. . .] Trust—I guess you’ve got to feed it to let it grow and the more that that grows the better it will make it easier for us and them as well to be able to do things better. (PC.04, p. 29)

With regard to undertaking their own assessments of patient and family needs, this was described by participants as encompassing the use of qualified health interpreters, “making good use of the multicultural nursing workforce”

and aiming to “getting it right.” Underpinning all three of these dimensions was communication and having a continuous open dialogue with patients, families, and the health care team.

Perceived Relationship Between EOL Decision Making and Quality of Death Outcomes

In contemplating the possible relationship between nurses’ EOL decision making and quality of death outcomes, participants sought first to clarify what they considered to be a good death. Although views varied, most considered a quality or good death as a process during which the patient was able to maintain meaningful relationships with his or her loved ones and be enabled to come to terms with his or her own existential anxiety about dying—to be “at peace.” Not all agreed with this stance, however. Several participants suggested that ultimately there is no direct causal relationship between nurses’ EOL decision making and quality of death outcomes since it can never really be known that a good death has, in fact, been achieved. Moreover, if a good death has been achieved, this is likely to be due more to the involvement of the patient’s *family* rather than to the nurses—notwithstanding the substantive role that the nurses played in facilitating families to be fully involved in the EOL care of their loved ones. Some participants questioned whether it was even possible to achieve a good death in a meaningful way, given the existential agony many people feel (patient and loved ones alike) when death approaches and occurs.

Despite these considerations, three fundamental nursing care processes were identified as having a significant bearing on whether elderly immigrants and their families experienced a “quality death”: “bridging the gaps,” “maintaining hygiene,” and “providing highly attuned symptom management.”

With regard to bridging the gaps, participants considered that nurses had a vital role to play in bridging what they saw as gaps in communication and continuities of care that might otherwise leave a patient and family vulnerable to a poor quality death. As one participant explained, “Basically nurses play a very vital role between the patient, family and the doctors [. . .] she is the one who completes the whole circle and won’t leave any gaps” (AC.06, p. 8).

Maintaining hygiene (e.g., “paying attention to the little things” and “keeping the patient clean”) was identified as being an understated yet vitally important role of nurses in EOL care. As one participant emphasized:

It’s a mundane thing—but it’s the little things that get noticed when the family first walk into the room—if it’s clean. If the patient is clean and the room is tidy, the family feels that their loved one is being cared for. (AC.12, p. 1)

Finally, in keeping with their earlier views, participants identified *symptom management* as critical to achieving quality death outcomes:

... pain or other symptoms, that those symptoms would be met as best as possible with the limitations that we have with all of those things. I don't think we can always get it perfect. But we can try not to prolong death and we can make sure we do our absolute best to get on top of symptoms. (AC.01, p. 8)

Discussion

There are strict professional course accreditation standards for nursing programs in Australia concerned with ensuring the quality of nursing services and the protection of the public interest and public safety (Australian Nursing & Midwifery Accreditation Council, 2012). These standards prescribe that education providers have a responsibility to enable graduates to develop an appreciation of social and cultural diversity, with Standard 4: Program Content of the *Registered Nurses Accreditation Standards 2012* explicitly requiring the inclusion of subject matter that “gives students an appreciation of the diversity of Australian culture, develops knowledge of cultural respect and safety, and engenders the appropriate skills and attitudes” expected of a registered nurse (Australian Nursing & Midwifery Accreditation Council, 2012, p. 14). In light of these requirements, it is concerning that participants in this study felt that their professional education did not prepare them adequately (or, in some cases, at all) to be able to provide culturally competent EOL care to elderly immigrants and their families following admission to a Victorian hospital.

The participants' sense of being ill-prepared for providing EOL care is not unique to the cultural context of Australia. Similar observations have been made elsewhere. For example, a *Nursing Times* survey of more than 900 nurses found that 69% of those surveyed indicated “they did not have sufficient skills or time to talk to patients about dying” even though caring for dying patients was “very much part of the nurses role” (Middleton, 2010). A U.S. study investigating nurses' communication of prognosis and implications for hospice referrals similarly found that it was not common for nurses to discuss EOL issues with either patients or their families in hospital contexts (Schulman-Green, McCorkle, Cherlin, Johnson-Hurzeler, & Bradley, 2005). This study has shown that these concerns can be exacerbated in contexts involving patients from diverse cultural backgrounds.

Despite their reported lack of formal education, most of the participants in this study nonetheless adopted strategies that enabled them to develop the knowledge and skills necessary to make appropriate decisions and to provide culturally respectful and meaningful EOL care. The nurses in this study quickly recognized that when working with elderly immigrants and their families, they required what Tervalon and Murray-García (1998) have termed “cultural humility”—specifically, they needed to “engage continually in self-reflection and self-critique as lifelong learners and reflective practitioners” and, via these processes, to redress the power

imbalance that otherwise exists in the professional–patient relationship. Data revealed that the lessons the nurses learned from this reflection enabled them to become

flexible and humble enough *to say that they do not know when they truly do not know* and to search for and access resources that might enhance immeasurably the care of the patient as well as their future clinical practice. (Tervalon & Murray-García, 1998, p. 119)

Arguably one of the most striking findings of this study is that the participants did not perceive themselves as being engaged in *EOL decision making* per se. This perception is, however, at odds with the nurses' own practice descriptions captured in the course of this study. As the examples given have shown, the participants' daily practice was wholly imbued with incremental decision making about *what* care they would give to their dying patients as well as when, how, and with whom (e.g., family). This finding requires further investigation and explanation.

The findings of this study underscore the need for greater emphasis to be placed on the *cultural* dimensions of EOL care and the role and capacity of nurses to participate in EOL decision making when caring for elderly immigrants in hospital contexts. It is significant that neither of these processes have been adequately addressed in the Australian Commission on Safety and Quality in Health Care consultation draft of the proposed *National consensus statement: Essential elements for safe and high-quality end-of-life care in acute hospitals* (Australian Commission on Safety and Quality in Health Care, 2014). An especially noteworthy omission in the consultation draft can be found in Section 9 of the document. Here an appropriate recommendation is made that health professional education and training “should include specific cultural competencies for providing end-of-life care to Aboriginal and Torres Strait islander peoples.” Significantly, there is no comparable recommendation for also having specific cultural competencies for providing EOL care to immigrants in Australia.

Limitations

A significant limitation of this study was, despite concerted attempts, the failure to recruit emergency department nurses. A second limitation relates to the absence of a strong cohort of nurses working in areas such as critical care units and intensive care units. Accordingly, the findings of this study may reflect more strongly the views and practices of “acute” palliative care nurses than those of acute care nurses per se. Nonetheless, feedback from various nursing audiences where the preliminary findings of this study have been shared has suggested there is a high degree of transferability to and strong fit with the experiences of nurses practicing in other locations and clinical contexts.

Conclusion

Nursing practice would benefit from the formalization of the nursing-specific EOL care strategies identified by nurses in this study and which stand to enhance EOL care not just for elderly immigrants but also for all people across the life span facing the end of their lives. To this end, it is suggested that the Australian nursing profession has a significant role to play in policy, education, practice, and consumer engagement initiatives aimed at ensuring a culturally responsive approach to EOL care for Australia's aging immigrant population. Meanwhile, further research is required on nursing pedagogy and praxis apropos culture care at the end of life.

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