



A Cry of Exile that Must be Heard: The Need to Consider Cultural Differences in Palliative Care for Immigrant Populations

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Dear Editor,

Immigrants from culturally and linguistically diverse (CaLD) backgrounds in high-income countries often underutilize palliative and end-of-life (EOL) care services, with family members frequently assuming caregiving roles. This underutilization limits access to specialized services designed to alleviate suffering and enhance quality of life. Ensuring person-centered care for CaLD immigrants requires a nuanced understanding of their cultural, linguistic, and social needs, supported by targeted interventions and systemic changes (1).

Accessing palliative and EOL care in high-income Organization for Economic Co-operation and Development (OECD) countries presents challenges for CaLD immigrants, shaped by cultural beliefs, communication barriers, collective decision-making, spirituality, and preferences for family caregiving. These factors contribute to limited access and disparities in care quality. Cultural beliefs profoundly influence how CaLD immigrants perceive illness and make EOL care decisions. For instance, South Asian immigrant communities in Canada often view death as a communal process, prioritizing family involvement over professional services.

Language barriers exacerbate these challenges, with many immigrants, such as Spanish-speaking Latin American immigrants in the U.S., reporting difficulty accessing palliative care information in their native languages. This can lead to low health literacy and reliance on family members as interpreters, reducing patient autonomy. Additionally, perceptions of cultural insensitivity or discrimination by healthcare providers,

as reported by Somali immigrants in the UK, can foster mistrust and result in suboptimal care (2).

In collectivist cultures, such as those prevalent among Chinese and Vietnamese immigrant communities, decisions about EOL care are often made collectively by family or community members. For example, a study of Chinese-American families found that relatives may withhold a terminal diagnosis from the patient to protect their emotional well-being, a practice that can conflict with the western emphasis on individual autonomy. This cultural mismatch can create tension with healthcare providers, who may struggle to align family-driven decisions with patient-centered care models.

Spirituality, whether religious or non-religious, plays a significant role in EOL care for many CaLD immigrants. For Muslim immigrants in Australia, Islamic teachings often guide decisions, with religious leaders providing spiritual support during terminal illness. However, spiritual beliefs can complicate care when, for instance, family members prioritize prayer for recovery over symptom management, as seen in some Nigerian Christian immigrant communities. Balancing spiritual needs with medical recommendations requires culturally sensitive approaches (3).

Many CaLD immigrants, such as Italian and Greek communities in Australia, view family caregiving as a cultural duty and honor. This preference may stem from distrust of healthcare systems, as reported by Eastern European immigrants in Germany who perceive palliative care as "giving up" on their loved ones. Misunderstandings about palliative care's role further

discourage engagement with professional services, reinforcing reliance on family care (4).

Cultural competence is essential for delivering effective palliative care to diverse populations. It requires ongoing learning, self-reflection, and adaptation to create a safe and inclusive environment for patients and families, particularly those with negative prior experiences in healthcare settings. Cultural sensitivity in palliative care involves understanding diverse care preferences, communication styles, meanings of suffering, and decision-making processes. For example, healthcare providers working with Korean immigrants must recognize the importance of non-verbal communication, such as respecting silence during discussions of prognosis. Providers should also be aware of their own biases and spiritual beliefs to respectfully navigate patients' diverse spiritual practices (5).

To reduce disparities, healthcare systems must invest in culturally tailored interventions and systemic solutions. For instance, the Netherlands implemented a community-based palliative care program for Turkish and Moroccan immigrants, incorporating bilingual navigators to bridge communication gaps. Training healthcare providers in cultural competence, such as through Canada's Cultural Competence in Palliative Care curriculum, equips them to address sensitive EOL topics with CaLD patients. Interpreter services, like those offered in Australia's multicultural health programs, are critical for ensuring clear communication (1).

Systemic solutions should include policy reforms to integrate cultural competence into healthcare frameworks. For example, the UK's National Health Service has piloted co-design programs involving CaLD communities to develop culturally aligned palliative care policies. Funding models that prioritize interpreter services and community outreach, as seen in Sweden's palliative care initiatives for refugees, can further enhance access. Engaging CaLD communities in these efforts builds trust and ensures care aligns with their unique beliefs and practices (6).

Conclusion

Addressing the palliative and EOL care needs of CaLD immigrants requires a multifaceted approach that respects cultural diversity and addresses systemic barriers. By incorporating specific interventions, such as

bilingual navigators and community co-design, and investing in training and policy reforms, healthcare systems can deliver equitable, person-centered care. Recognizing the unique experiences of diverse immigrant groups – rather than generalizing their needs – ensures that palliative care is both accessible and culturally resonant.

Footnotes

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References

1. Aker N, Griffiths S, Kupeli N, Frost R, Nair P, Walters K, et al. Experiences and access of palliative and end of life care for older people from minority ethnic groups: a scoping review. *BMC Palliat Care.* 2024;23(1):228. [PubMed ID: 39289662]. [PubMed Central ID: PMC1406721]. <https://doi.org/10.1186/s12904-024-01555-8>.
2. Monette EM. Cultural Considerations in Palliative Care Provision: A Scoping Review of Canadian Literature. *Palliat Med Rep.* 2021;2(1):146-56. [PubMed ID: 34223514]. [PubMed Central ID: PMC8241395]. <https://doi.org/10.1089/pmr.2020.0124>.
3. Nielsen LS, Angus JE, Howell D, Husain A, Gastaldo D. Patient-centered care or cultural competence: negotiating palliative care at home for Chinese Canadian immigrants. *Am J Hosp Palliat Care.* 2015;32(4):372-9. [PubMed ID: 24707010]. <https://doi.org/10.1177/1049909114527338>.
4. Smith AK, Sudore RL, Perez-Stable EJ. Palliative care for Latino patients and their families: whenever we prayed, she wept. *JAMA.* 2009;301(10):1047-57. E1. [PubMed ID: 19278947]. [PubMed Central ID: PMC2782583]. <https://doi.org/10.1001/jama.2009.308>.
5. Phiri GG, Muge-Sugutt J, Porock D. Palliative and End-of-Life Care Access for Immigrants Living in High-income Countries: A Scoping Review. *Gerontol Geriatr Med.* 2023;9:23337214231213200. [PubMed ID: 38026093]. [PubMed Central ID: PMC10666706]. <https://doi.org/10.1177/23337214231213172>.
6. Cain CL, Surbone A, Elk R, Kagawa-Singer M. Culture and Palliative Care: Preferences, Communication, Meaning, and Mutual Decision Making. *J Pain Symptom Manage.* 2018;55(5):1408-19. [PubMed ID: 29366913]. <https://doi.org/10.1016/j.jpainsympman.2018.01.007>.