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Review

Culturally sensitive communication in healthcare: A concept analysis

Laura A. Brooks[a,*], Elizabeth Manias[a,b], Melissa J. Bloomer[a,b]

[a] School of Nursing and Midwifery, Deakin University, VIC, Australia
[b] Centre for Quality and Patient Safety Research, Deakin University, VIC, Australia

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ABSTRACT

Background: Limited guidance exists on culturally sensitive communication related to interactions between clinicians, patients and families.
Objectives: To explore the concept of culturally sensitive communication and identify clinical practice implications and knowledge gaps related to culturally sensitive communication in healthcare.
Methods: A concept analysis was undertaken, using Walker and Avant's (2011) framework which comprises eight consecutive steps to explore the concept and clinical practice implications. A systematic literature search was undertaken to identify papers published between January 1, 1995 and December 20, 2017, leading to the inclusion of 37 relevant research papers in the concept analysis.
Results: Based on the research literature, examples of model, borderline and contrary cases of culturally sensitive communication were developed. Three major uses of culturally sensitive communication were identified, including understanding one's own culture, open and sensitive communication, and strategies to collaborate with the patient and family for optimal patient care. An awareness of one's own cultural beliefs, values, attitudes and practices was identified as an essential first step before learning about other cultures. This awareness includes being sensitive and adaptive to individual cultural differences and relies on clinician self-understanding and reflection. Strategies to collaborate with the patient and family for patient care include respectful and supportive clinician interactions with the family that enable a collaborative approach to care.
Conclusions: This concept analysis aids understanding of culturally sensitive communication, the benefits and challenges associated with its use, and clinical practice implications.

Summary of relevance

What is the problem

- Despite an international focus on improving the quality of care and safety of hospitalised patients, culturally sensitive communication remains poorly understood.

What is already known about the topic

- Understanding the concept of culturally sensitive communication is essential for clinicians to increase their awareness and understanding of best practice when communicating with culturally diverse patients and families.
- When culturally sensitive communication is used, patients are likely to experience a more positive and beneficial relationship with clinicians, and better health outcomes.

What this paper adds

- Ideally, the nature of culturally sensitive communication should be determined by the recipient of care, be individualised and holistic, and incorporate any cultural considerations necessary.
- The defining attributes of culturally sensitive communication explored and explained in this paper, aid in establishing and maintaining a trusting therapeutic relationship.
- This concept analysis enhances understanding of culturally sensitive communication and the benefits and challenges to its use in healthcare.

1. Introduction

Global migration is higher than ever before, with migrants accounting for more than ten per cent of the total population in Europe, Northern America and Oceania (United Nations, 2017). As a result, populations are culturally diverse (World Health Organization, 2016). Cultural diversity not only relates to a per-

* Corresponding author at: 1 Gheringhap Street, Geelong, VIC 3220, Australia.
E-mail address: laura.brooks@deakin.edu.au (L.A. Brooks).

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son's country of birth, but also to their ancestry, the country of birth of their parents, languages spoken, Aboriginal descent, religious affiliation, ideas, belief systems, customs and social behaviour (Australian Bureau of Statistics, 2017). Cultural diversity can create many challenges in the provision of healthcare (State of Victoria, 2016).

Since the 1990s, global population and socioeconomic changes have resulted in an increased number of hospitalised patients from diverse backgrounds (United Nations, 2017). Clinicians must be cognisant of patients' individual healthcare preferences that are influenced by cultural diversity, and the importance of communication to ensuring safety and equity in the provision of healthcare (Bellamy & Gott, 2013).

Cultural sensitivity requires an awareness of cultural diversity, including how culture may influence patients' values, beliefs and attitudes, and involves acknowledging and respecting individual differences (Crawley, Marshall, Lo, & Koenig, 2002). Yet, culturally sensitive communication may be more difficult to define. Research suggests that clinicians may not know how to communicate with persons from culturally diverse backgrounds (Beckstrand, Callister, & Kirchhoff, 2006; Efstathiou & Clifford, 2011), and when communication is not culturally sensitive, there is a potential for it to negatively impact the care provided, and patient and family satisfaction (Williamson & Harrison, 2010). The purpose of this paper is not to prescribe how culturally sensitive communication is to be used in diverse situations. Rather, the purpose is to explore and explain the concept of culturally sensitive communication.

2. Background

It is assumed that clinicians have the knowledge and skills to communicate in a culturally sensitive way (Betancourt, Corbett, & Bondaryk, 2014). Culturally sensitive communication demonstrates understanding and respect for individuals and promotes patient and family satisfaction (Claramita, Tuah, Riskione, Prabandari, & Effendy, 2016; Douglas et al., 2011). Through verbal and nonverbal communication, clinicians attempt to identify individualised patient needs; yet, culturally sensitive communication also relies on clinicians being able to critically reflect on their own values, beliefs, preferences and culture, as well as understandings of traditions, perspectives and practices of culturally diverse individuals, families and communities (Douglas et al., 2011). An assumption is made that clinicians are educationally prepared to use culturally sensitive communication in care provision (Williamson & Harrison, 2010). Yet, evidence suggests that clinicians are ill-prepared to communicate with cultural sensitivity, and opportunities for clinicians to undertake education in this area are often limited to isolated opportunities (Fleckman, Dal Corso, Ramirez, Begalieva, & Johnson, 2015; Maier-Lorentz, 2008; Narayanasamy, 2003).

When communication is not culturally sensitive, patients and families are less likely to be satisfied with their perceptions and experiences of care, there is an increased risk of miscommunication, and cultural disparities may result; leading to poor adherence to treatment, poorer health outcomes and an increased prevalence of adverse events (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Betancourt et al., 2014; Paternotte et al., 2016). Despite an international focus on improving the quality of care and safety of hospitalised patients, culturally sensitive communication remains poorly understood (Esposito, 2013; Flowers, 2004; Friganovic et al., 2016). The aim of this paper is to explore the concept of culturally sensitive communication and identify clinical practice implications and knowledge gaps related to culturally sensitive communication in healthcare, using Walker and Avant's (2011) concept analysis framework (Table 1). It is important to acknowledge that the features that make communication culturally sensitive will vary amongst patients. Hence, culturally sensitive communication should be determined by the patient, as recipient of care, to ensure the approach to communication is individualised and holistic, and incorporates the cultural preferences and considerations identified by the patient (CATSINaM, 2016; CDNM, 2017).

Table 1
Concept analysis approach.

Concept Analysis approach (Walker & Avant, 2011)	1 Select a concept 2 Determine the aims or purposes of analysis 3 Identify all uses of the concept that you can discover 4 Determine the defining attributes 5 Identify a model case 6 Identify borderline, related, contrary, invented and illegitimate cases 7 Identify antecedents and consequences 8 Define empirical referents

3. Method

Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus, EMBASE, Medline and PsycINFO were searched to obtain Australian and international literature published in English between January 1, 1995 and December 20, 2017, related to culturally sensitive communication in healthcare. The year 1995 was chosen as the starting point for searching as this was the time when increased interest was generated about cultural sensitivity and diversity in healthcare, and Leininger, who defined Transcultural Nursing (Leininger, 1995) published seminal work in this area. The search used the following major terms combined with AND or OR 'culturally sensitive', 'communication' and 'healthcare'. Literature obtained included research papers, literature reviews, integrative reviews and editorials. Reference lists of papers already located were manually scanned for additional papers. Government websites and reports were also reviewed for literature relevant to the concept. The initial literature search returned n = 4930 papers, of which n = 258 papers were comprehensively examined for eligibility. After full text review, n = 221 were excluded as they did not specifically examine culturally sensitive communication, and n = 37 papers were included in the concept analysis (Fig. 1).

4. Results

4.1. Defining culturally sensitive communication

As recommended by Walker and Avant (2011), various dictionaries were consulted to complete an initial exploration of how the term culturally sensitive communication is defined and used. A dictionary definition for culturally sensitive communication was not located. Hence, for the purpose of this paper, culturally sensitive communication is defined as effective verbal and nonverbal interactions between individuals or groups, with a mutual understanding and respect of each other's values, beliefs, preferences and culture, to promote equity in healthcare with the goal of providing culturally sensitive care. The words 'culture', 'cultural sensitivity', and 'communication' are individually defined here to facilitate understanding of how these words relate to each other. Culture is defined as "...the sum total of the ideas, beliefs, customs, values, knowledge, and material artefacts that are handed down from one generation to the next in a society" (Colman, 2015, para. 1). Culture is also defined as the "... knowledge, beliefs, arts, morals, laws, customs, and any other capabilities and habits acquired by a human as a member of society" (United Nations Educational, Scientific & Cultural Organisation, UNESCO, 2017, para. 2). Cultural

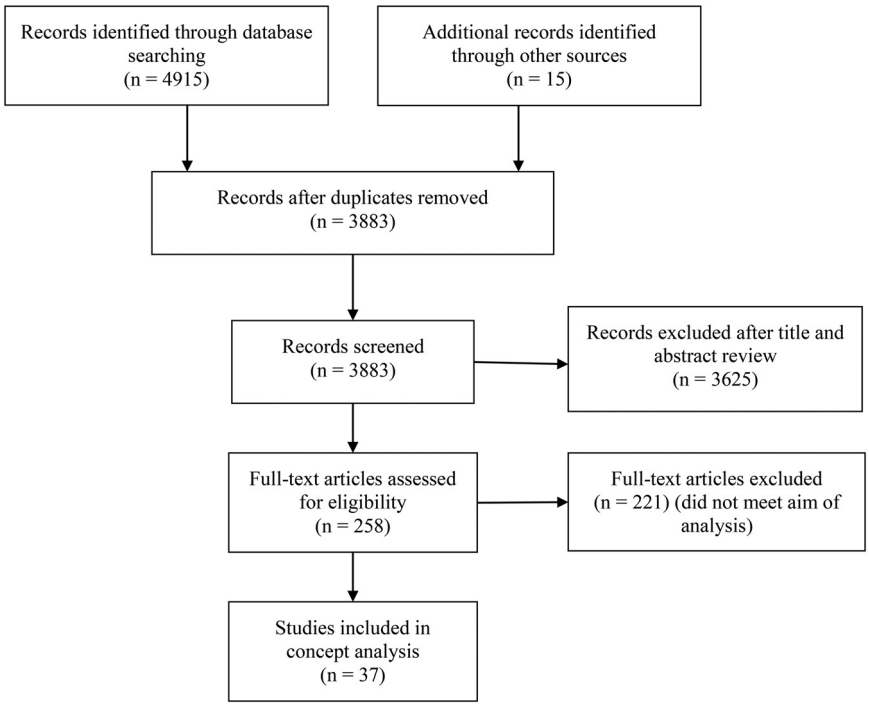

Fig. 1. PRISMA.

sensitivity is defined as "...the ability to recognise, understand, and react appropriately to behaviours of persons who belong to a cultural or ethnic group that differs substantially from one's own" (Porta & Last, 2018, para. 1). The definition of communication in healthcare, more specifically, the clinician-patient relationship, has changed dramatically over time. Historically, clinicians engaged in communication with patients and their family that was paternalistic, authoritarian and hierarchical, however, this has slowly evolved into a style of communication that is more collaborative and patient-centred (McArthur, Lam-McArthur, & Fontaine, 2018, para 1). Communication in healthcare is defined as:

The exchange of information between a patient and their healthcare provider, and includes communications with the family and carer. It involves two-way communication (spoken, written and non-verbal) that engages patients in decision making and care planning. It is tailored, open, honest and respectful and there is an opportunity for clarification and feedback (Australian Commission on Safety & Quality in Healthcare, 2016, p. 1).

4.2. Use of culturally sensitive communication

The literature suggests that the concept of culturally sensitive communication is used in three ways: developing an understanding about one's own cultural beliefs, values, attitudes and practices and those of others; to describe open and sensitive communication; and to describe strategies used to collaborate with the patient and family for optimal care (Claramita et al., 2016; Douglas et al., 2011).

4.2.1. Understanding of one's own culture

The essential first step to learning about other cultures is an awareness of one's own cultural beliefs, values, attitudes and practices (Maier-Lorentz, 2008). This need for awareness is because cultural beliefs, values, attitudes and practices may vary considerably, and clinicians ought to accept and be respectful of these differences (Crawley et al., 2002; Maier-Lorentz, 2008). Being sensitive and adaptive to individual cultural differences rely on clinician self-awareness and reflection (Maier-Lorentz, 2008), and can lead to greater interpersonal cultural awareness and associated patient and family satisfaction (Gallagher & Polanin, 2015). By increasing one's knowledge and understanding of different cultures, cultural beliefs, values and attitudes, clinicians are more likely to provide individualised care for patients that is culturally sensitive (Bellamy & Gott, 2013; Friganovic et al., 2016). Clinicians must also understand that individual patient encounters may require differing approaches (Matteliano & Street, 2012). An evaluation of one's own ability to use culturally sensitive communication is also important for clinicians to gain the trust of the patient and family (Maier-Lorentz, 2008).

4.2.2. Open and sensitive communication

Open and sensitive communication includes active listening and respect of an individual's cultural beliefs and practices (Douglas et al., 2011). Active listening and respect relate to interactions that are transparent, and foster a therapeutic relationship built on trust and respect (Fleckman et al., 2015). Examining ways in which patients and families from diverse cultural backgrounds communicate; including verbal and nonverbal cues, and how this examination may differ within and amongst cultures is necessary for attaining cultural sensitivity (Maier-Lorentz, 2008).

4.2.3. Strategies to collaborate with the patient and family

Culturally sensitive communication is also essential for collaborating with the patient and family in decision-making regarding care. Multiple barriers may impact upon a clinician's ability to collaborate with the patient and family, including language barriers, cultural beliefs and values. Subsequently, family members may experience feelings of helplessness regarding their role in care provision and ability to assist their sick relative (El-Amouri and O'Neill, 2011; Parisa, Reza, Afsaneh, & Sarieh, 2015). Clinicians who use culturally sensitive communication can demonstrate an understanding of patient and family beliefs, goals and values. This approach includes family-centred care, which involves respectful and supportive interactions with the family, fostering partnerships

and promoting continuity of care (King, Desmarais, Lindsay, Pierart, & Sylvie, 2015).

Recommended initiatives to increase family participation in patient care include listening to the family, and encouraging family members to speak first and to contribute to care planning and decision-making, ahead of clinicians (King et al., 2015). Other initiatives include familiarising the family with the hospital environment to assist family members to interpret the clinical environment in a culturally meaningful way, and decrease any fears and insecurities associated with the hospital environment and care provided (Johnstone, Hutchinson, Rawson, & Redley, 2016).

4.3. Defining attributes

From the literature, four defining attributes of culturally sensitive communication have been identified (Table 2). The defining attributes of the actual communication between clinicians, patients and families determine whether and how culturally sensitive communication occurs.

The first attribute involves encouraging patients and families to participate in communication and decision making to the degree where they feel comfortable (Johnstone, Hutchinson, Rawson et al., 2016). Clinicians should also be encouraged to engage in open communication by encouraging patient and family input, and by promoting effective interactions to overcome communication barriers (Flowers, 2004; Johnstone, Hutchinson, Redley, & Rawson, 2016; Maier-Lorentz, 2008). For effective interactions to occur, the views of key individuals in the patients' care should be sought, including the family.

The second attribute involves prioritising cultural considerations in the planning and provision of care. This prioritisation can be achieved by demonstrating respect for the culture of the patient and their family by asking culturally sensitive questions about the patient's and family's values, beliefs and practices; obtaining information about the patient's perceptions and beliefs associated with their presenting illness; and assessing the individual's psychological, physiological and sociocultural needs, secondary languages, non-verbal communication techniques, religion and food preferences (Campinha-Bacote & Munoz, 2001; Maier-Lorentz, 2008). Findings should then be communicated to other clinicians, verbally and in writing in the medical record, and incorporated into a plan to prioritise care (Maier-Lorentz, 2008).

The third attribute involves developing a trusting relationship with the patient and family. This trust can be achieved through using open and non-threatening body language that demonstrates a willingness to help and learn. Establishing rapport and trust are critical to the communication process between clinicians, the patient and family (Cross & Bloomer, 2010; Matteliano & Street, 2012). Clinicians can build rapport and trust by using communication strategies including demonstrating a willingness to learn about different cultural practices and openness in communication exchange (Matteliano & Street, 2012). Trust can be created through active listening, using appropriate body language, using the patient's actual words to communicate, and being flexible and respectful to the needs, beliefs and practices of the patient and their family (Bloomer & Al-Mutair, 2013).

The fourth attribute involves the use of a professional interpreter, a best practice recommendation where language differences exist between clinicians, patients and families (Amouri and O'Neill, 2011; Cioffi, 2003; Douglas et al., 2011). The use of a professional interpreter, in person, is the preferred method for many health services, as it involves a trained professional directly participating in the conversation with the patient, family and clinician, helping to address language and cultural difficulties, and communication challenges (Matteliano & Street, 2012). The use of a professional interpreter is preferred over use of staff or family members, to ensure accurate, unbiased information is being communicated (Campinha-Bacote & Munoz, 2001; McCarthy, Cassidy, Graham, & Tuohy, 2013). Accurate interpretation is crucial to clinician-patient and clinician-family interactions, as it demonstrates respect for the other person's language and input, contributing to the development of a trusting therapeutic relationship (Eckhardt, Mott, & Andrew, 2006; McCarthy et al., 2013).

4.4. Clinical cases

Model, borderline and contrary cases of culturally sensitive communication are presented below. The cases are based on the following clinical scenario:

Mrs. Chen Xie is a 64-year-old woman from northern China, admitted with infective exacerbation of chronic obstructive pulmonary disease. This is her second admission. Mrs. Xie immigrated to Australia with her son and his family ten years ago when her husband died. Mrs. Xie speaks fluent Mandarin, speaks limited English and practices Buddhism. Her son and his family speak fluent English.

4.4.1. Model case

Mrs. Chen Xie is on the respiratory ward, where she is receiving oxygen therapy via nasal prongs. Her family, including her son Bo and his wife are with her. Dr Carlos Pineda the respiratory physician, Jenny Tran the associate nurse unit manager (ANUM), Laurel Bishari the bedside nurse, and a professional interpreter, Andy Zhang are in attendance. Laurel has inquired about Mrs. Xie's cultural and religious beliefs and traditions, and the influence these may have on Mrs. Xie's healthcare needs. Laurel has identified Mrs. Xie would prefer her son, Bo, to be involved in all communication regarding her care. Mrs. Xie and her son Bo, are offered the opportunity to meet with a non-denominational pastoral care worker.

Table 2
Concept of culturally sensitive communication: antecedents, attributes and consequences.

Antecedents	Defining attributes	Consequences
The antecedents of culturally sensitive communication include: • The environment and culture of the ward. • Organisational structures and policies. • Education and communication experience of clinicians. • Sociocultural characteristics of patients, families and clinicians. • Personal characteristics and professional experiences of clinicians.	From the literature, four defining attributes of culturally sensitive communication have been identified: • Encouraging patients and families to participate in communication and decision-making to the degree where they feel comfortable. • Prioritising cultural considerations in the planning and provision of care. • Developing a trusting relationship with the patient and family. • The use of a professional interpreter, a best practice recommendation where language differences exist between clinicians, patients and families.	Outcomes associated with the use of culturally sensitive communication include: • Increased patient and family satisfaction. • Improved adherence to treatment regimens. • Better engagement in patient and family centred care. • Improved health outcomes.

All staff have received undergraduate education and clinical simulation training in culturally sensitive communication.

Dr Pineda: Hello, Mrs. Xie. My name is Dr Pineda. I am the respiratory physician on shift. Here, I have with me Jenny, the nurse in charge of the shift, Laurel your bedside nurse, and a professional interpreter Andy. How would you like me to address you? Would you like to involve one of your family members in this conversation?
Interpreter: Repeats Dr Pineda's introduction in Mandarin.
Mrs. Xie [in Mandarin]: Thank you doctor, please call me Chen. Yes, I would like my son Bo to be involved.
Interpreter: Repeats Mrs. Xie's response in English.
Dr Pineda: Thank you Chen. Bo, I will ask you some questions soon. For now, how are you feeling today Chen?
Interpreter: Repeats Dr Pineda in Mandarin.
Mrs. Xie [in Mandarin]: Thank you doctor, it's really important to me that Bo is involved in my care. I don't feel well at all today, it's very hard to breathe.
Interpreter: Repeats Mrs. Xie's response in English.
Dr Pineda: I'm sorry to hear you are not feeling well Chen. Is there anything we can do to make you more comfortable?
Interpreter: Repeats Dr Pineda's statement in Mandarin.
Mrs. Xie [in Mandarin]: Laurel has been helping me but I'm just so tired and my chest really hurts from all the coughing.
Interpreter: Repeats Mrs. Xie's response in English.
Dr Pineda: Are there any remedies you use at home to assist with your breathing?
Interpreter: Repeats Dr Pineda's statement in Mandarin.
Mrs. Xie [in Mandarin]: I don't usually use anything at home, besides my medication and rest.
Interpreter: Repeats Mrs. Xie's response in English.
Dr Pineda: Do you have any suggestions, Bo, to improve your mothers breathing?
Interpreter: Repeats Dr Pineda's response in Mandarin for Mrs. Xie.
Bo: Mum gets really breathless and tired at home. My wife and I have started caring for her a lot more, but we have noticed lately she has been a lot more breathless, and has needed more assistance.
Laurel, bedside nurse: Chen, how would you rate your pain at the moment? If zero is equivalent to no pain at all, and ten is the worst pain you can imagine?
Interpreter: Repeats Laurel's response in Mandarin.
Mrs. Xie [in Mandarin]: I'm just uncomfortable in my chest, I can't stop coughing. I don't know about the number, it just hurts.
Interpreter: Repeats Mrs. Xie's response in English.
Laurel, beside nurse: Chen and Bo, is there anything that makes the pain worse?
Interpreter: Repeats Laurel's response in Mandarin.
Mrs. Xie [in Mandarin]: When I feel I lack control over my breathing, I feel negative and I worry, which makes the pain worse.
Interpreter: Repeats Mrs. Xie's response in English.
Bo: Mum also gets breathless and her pain increases when she is laying down. Mum has to sit up most of the time to make sure she can breathe. We have some pain medication at home [oxycodone], but mum doesn't like taking it due to the side effects.
Interpreter: Repeats Mrs. Xie's response in English.
Laurel, bedside nurse: Thank you Chen and Bo. Chen, what kind of side effects do you experience with your pain relief?
Interpreter: Repeats Laurel's response in Mandarin.
Mrs. Xie [in Mandarin]: I get dizzy and feel sick in the stomach.
Interpreter: Repeats Mrs. Xie's response in English.
Dr. Pineda: There is medication we can give you to relieve those symptoms as they are common adverse effects of the medication. I will chart you some medicine to reduce the dizziness and nausea.
Interpreter: Repeats Dr. Pineda's response in Mandarin.
Mrs. Xie [in Mandarin]: That would be good if you could thank you, as I don't like taking the medication as I am worried about the serious side effects.
Interpreter: Repeats Mrs. Xie's response in English.
Laurel, bedside nurse: Chen, I will go and get the pain relief and the medication Dr Pineda is charting for you to reduce the side effects. There is also some medication charted that I can give you that should make breathing easier. I think we could also improve your position to assist with your breathing. Would that help?
Interpreter: Repeats Laurel's message in Mandarin.
Mrs. Xie [in Mandarin]: Thank you Laurel, I think it would help. Perhaps a glass of water as well? My mouth is very dry.
Interpreter: Repeats Mrs. Xie's response in English.
Dr Pineda [to bedside nurse]: I think analgesia and repositioning sounds like a good idea Laurel.
Laurel, bedside nurse: Chen, I'll go and get the medications and water, then we will reposition you to get you more comfortable. How does that sound?
Interpreter: Repeats Lauren's communication in Mandarin.
Mrs Xie [in Mandarin]: That sounds good, thank you.
Interpreter: Repeats Mrs. Xie's response in English.
Jenny, ANUM: Chen and Laurel, I'll seek another nurse to come and assist to help you get in a more comfortable position.
Interpreter: Repeats ANUM's response in Mandarin.
Mrs. Xie [in Mandarin]: Thank you, you have all been very kind.
Interpreter: Repeats Mrs. Xie's response in English.
Dr Pineda: Our aim is to keep you as comfortable as we can Chen. Please let us know if there is anything more we can do.
Interpreter: Repeats in Mandarin.
Mrs. Xie [in Mandarin]: I don't think there is anything, not now anyway.
Dr Pineda: Bo, you said you and your wife have been doing more for your mother at home. Have you considered seeking the support of professional care services to assist you?
Bo: No we haven't. According to our culture, it is my responsibility to support mum. I would like to get some support but I don't know where to start.
Dr Pineda: I appreciate this is a difficult time for you, and making decisions like this can be challenging for families, particularly if decisions like this may go against your cultural beliefs. We have a non-denominational pastoral care worker who you might like to talk to. Perhaps they could support you and assist you with thinking this through. Is this something you would be interested in?
Interpreter: Repeats Dr Pineda's response in English.
Bo: Yes, I think we could all benefit from meeting with the pastoral care worker, mum, me, and my wife.
Bo [in Mandarin to his mother]: They have someone we can talk to, not a nurse or a doctor. They can support us as a family.
Dr Pineda: Laurel, would you be able to arrange this meeting at a time that works for everyone?
Interpreter: Repeats Dr Pineda's response in English.
Laurel, bedside nurse: Yes, certainly, I will contact the service after repositioning Chen. Chen, here is your patient call bell, please call it if you need me. I will go and get your water and come straight back.
Interpreter: Repeats bedside nurse in Mandarin.

In this model case, all the defining attributes of culturally sensitive communication are present. The clinicians are working together to ensure the patient and her family are receiving the

best possible, culturally sensitive care. The bedside nurse enquired about the patient's cultural beliefs and values. The patient and her son were given the opportunity to express their needs and any ongoing concerns. They were also given the opportunity to meet with a non-denominational pastoral care worker for further support. All clinicians have received education in providing culturally sensitive communication and are focused on the patient and her needs. A professional interpreter is also used to facilitate effective communication between clinicians, the patient and her family.

4.4.2. Borderline case

Mrs. Chen Xie is currently on the respiratory ward, where she is receiving oxygen therapy via nasal prongs. Her son, Bo Xie is in attendance. The respiratory physician, Dr Carlos Pineda and ANUM, Jenny Tran are conducting the ward round. The bedside nurse, Laurel Bishari is on her break and is not aware the ward round has commenced. Laurel is the only staff member who has completed education and clinical simulation training in culturally sensitive communication. A phone interpreter has been organised.

Dr Pineda: Mrs. Xie. How are you feeling today?
Phone interpreter: Repeats Dr Pineda's question in Mandarin.
Mrs. Xie [in Mandarin]: I don't feel well at all, it's very hard to breathe.
Phone interpreter: Repeats Mrs. Xie's response in English.
Dr Pineda [to Jenny, ANUM]: How has Mrs. Xie been today?
Jenny, ANUM: She has been in a lot of pain, you can see she has an increased work of breathing. We commenced antibiotics earlier for her chest. Is there anything else you recommend?
Mrs. Xie: [Expression of concern on her face].
Dr Pineda [to Jenny, ANUM]: Continue antibiotics and I'll write her up for some more analgesia. She may need a cannula and some intravenous fluids.
Jenny, ANUM: Great, thank you. I'll let Laurel the bedside nurse know. Can you please let Mrs. Xie know that we will get her some more pain relief and her bedside nurse will be back soon [speaking to the phone interpreter]?
Phone interpreter: Repeats ANUM in Mandarin.
Mrs. Xie [in Mandarin]: Thank you, I don't feel well at all.
Jenny, ANUM: We must go now, here is your patient call bell Mrs. Xie, please call it if you need assistance.
Phone interpreter: Repeats ANUM in Mandarin.

In this borderline case, some of the defining attributes of culturally sensitive communication are present. A phone interpreter has been arranged to communicate with Mrs. Xie, however, the interpreter is not used to effectively engage in optimal communication. The clinicians are working together, although they are not communicating with Mrs. Xie about her physical, psychosocial and cultural needs. Mrs. Xie's son is not invited into the conversation, limiting the patient and family involvement in clinical decision-making. Mrs. Xie is given limited opportunity to express her concerns and the clinicians are focused communicating with each other, rather than engaging the patient and her family.

4.4.3. Contrary case

Mrs. Chen Xie is currently on the respiratory ward, where she is receiving oxygen therapy via nasal prongs. Dr. Carlos Pineda, the respiratory physician is busy and needs to commence the ward round with Jenny Tran, the ANUM, however without the bedside nurse and no interpreter service is available. Mrs Xie's son Bo Xie is on his way to the hospital. Staff have not completed any education or training in culturally sensitive communication.

Dr Pineda: Mrs. Xie. You look like you are in pain. How are you feeling?
Jenny, ANUM: Sorry Dr Pineda, Mrs. Xie doesn't speak English. We can't arrange an interpreter service this afternoon.
Mrs. Xie: [Tries to speak in Mandarin].
Dr Pineda [to ANUM]: That's not ideal but we have to move on. How has Mrs. Xie been today?
Jenny, ANUM: I think she has had significant chest pain associated with her chest infection. You can really see she is working hard. She is quite tachypneic. Antibiotics were commenced earlier for her chest. Do you recommend anything else?
Dr Pineda [to ANUM]: Let's continue the antibiotics and I'll chart some more analgesia. She may also need some intravenous fluids.
Jenny, ANUM: Okay, thank you. I'll let Laurel the bedside nurse know.
Mrs. Xie: [Appears distressed].
Jenny, ANUM: We better move on Mrs. Xie, here is your patient call bell, Laurel will be back soon.

In this contrary case, there is little evidence of the defining attributes of culturally sensitive communication. The physician and bedside nurse have sought to assess the patient; however, they have not appropriately considered possible language barriers. The clinicians engage in conversation about Mrs. Xie, without encouraging patient participation and this lack of participation causes Mrs. Xie some distress. There is no evidence of open and sensitive communication, and no staff members have completed education in providing culturally sensitive communication.

4.5. Antecedents

The antecedents are the aspects that precede the circumstance or event, in this case, culturally sensitive communication (Manias, 2010). The antecedents of culturally sensitive communication include: the environment and culture of the ward; organisational structures and policies; education and communication experience of clinicians; sociocultural characteristics of patients, families and clinicians; and the personal characteristics and professional experiences of clinicians.

4.5.1. Environment and culture

The environment and culture of the ward impacts the communication experience for clinicians, patients and families (Claramita et al., 2016). The layout of the clinical area, for example, single or multiple-occupancy patient rooms, the availability of family spaces within patient rooms, and the spaces allocated for private and sensitive conversations, differ within healthcare facilities and may affect clinicians' ability to prioritise cultural considerations and engage in culturally sensitive communication (Douglas et al., 2011). The culture of the clinical environment and whether it fosters interdisciplinary collaboration between healthcare teams and individuals, influences culturally sensitive communication (Almutairi & Rondney, 2013). A strategy to foster interdisciplinary collaboration for effective culturally sensitive communication includes implementation of interdisciplinary simulation-based training (Efstathiou & Walker, 2014). Teams are better equipped than individual practitioners to provide holistic care to patients and families with complex needs, as there is a larger group of individuals with a range of cultural knowledge and skills (Matteliano & Street, 2012). Fostering a culture of interprofessional collaboration is essential to delivering culturally sensitive communication.

4.5.2. Organisational structures and policies

Organisational structures, including hierarchy and significant power differences between physicians and other healthcare professionals, and healthcare policies influence the outcomes and satisfaction of patients and families (Douglas et al., 2011). Organ-

isations need to ensure policies are supportive of and enable culturally sensitive communication (Douglas et al., 2011). An environment that fosters effective communication practices requires organisational support through policy, resources and professional development opportunities to enhance critical skills and knowledge related to culturally sensitive communication (Almutairi & Rondney, 2013).

4.5.3. Education and communication experience of the clinician

The availability of education on culturally sensitive communication directly impacts the quality of culturally sensitive communication (Douglas et al., 2011). Clinicians have expressed their frustration at the lack of education in this area, acknowledging the resultant limitations in caring for culturally diverse patients and families (Maier-Lorentz, 2008). Ideally, education to facilitate culturally sensitive communication would be scaffolded, occurring in undergraduate or professional pre-registration programs followed by communication simulations in clinical practice post-registration (Axtell, Avery, & Westra, 2010; Williamson & Harrison, 2010). Undergraduate programs that have been implemented using guidelines for culturally sensitive communication skills with nursing students, have been associated with increased patient satisfaction (Claramita et al., 2016). The environment for education also impacts culturally sensitive communication (Maier-Lorentz, 2008). For example, for clinicians to gain the knowledge and skills required to practice culturally sensitive communication, the environment should be free of noise and distraction, however, this is not always the case in a busy teaching hospital (Blanchet Garneau & Pepin, 2015).

4.5.4. Sociocultural characteristics of patients, families and clinicians

Culturally sensitive communication may be influenced by the sociocultural characteristics of patients, families and clinicians, if they differ in their beliefs regarding decision making, supportive care and active treatment. Shared decision making is recognised as a prerequisite for optimal patient and family outcomes, however, some individuals see the doctor as the main decision maker, which can lead to a compromise of the clinician-patient relationship (El-Amouri & O'Neill, 2011; Williamson & Harrison, 2010). Sociocultural characteristics that influence culturally sensitive communication include the languages spoken at home, cultural values, religious beliefs and socioeconomic background (Hart & Mareno, 2014).

4.5.5. Personal characteristics and professional experiences of clinicians

The personal characteristics and professional experiences of clinicians may impact their ability to engage in culturally sensitive communication, and can help them develop therapeutic relationships with their patients (Matteliano & Street, 2012). To engage in culturally sensitive communication, clinicians should be able to reflect on their own personal values and beliefs, as well as their professional experiences and related understanding of the perspectives and practices of culturally diverse patients and families (Douglas et al., 2011).

4.6. Consequences

Consequences are those events or incidents that occur as a result of culturally sensitive communication (Walker & Avant, 2011). Outcomes associated with the use of culturally sensitive communication include increased patient and family satisfaction, improved adherence to treatment regimens, better engagement in patient and family centred care and improved health outcomes (Betancourt et al., 2014).

4.7. Empirical referents

Empirical referents, which are categories of phenomena that provide ways of measuring concepts and demonstrate the occurrence of the concept, validate the importance and existence of the concept (Walker & Avant, 2011). Multiple empirical referents are available to measure characteristics related to communication (Schmid & Svarstad, 2002). While these instruments are useful, many aspects remain unexplored, including the impact of different clinical and sociocultural contexts. Despite this focus on communication, culturally sensitive communication does not receive the same attention (Claramita et al., 2016). Methods to increase cultural competency such as the ACCESS (assessment, communication, culture negotiation and compromise, establishing respect and rapport, sensitivity and safety) model, offer nurses a framework to deliver culturally sensitive care (Narayanasamy, 2002). While this model is viewed as a useful framework (Kanchana & Sangamesh, 2016), it does not examine all antecedents that may impact the quality of culturally sensitive communication.

4.8. Implications for nursing

The concept analysed in this paper, including the antecedents, attributes and consequences that are defined and explained, provide clinicians with concrete examples of what should be considered in culturally sensitive communication.

Although this concept analysis provides a level of scope for clinicians, one of the most pressing requirements to improve culturally sensitive communication is education. It is widely recognised that clinicians are ill-prepared to have conversations with patients and their families that reflects cultural sensitivity, however this lack of preparation has only recently been emphasised as an issue in contemporary literature (Meuter, Gallois, Segalowitz, Ryder, & Hocking, 2015). Education programs should be focused on equipping clinicians with the necessary knowledge and skills to enable them to use culturally sensitive communication with patients and families from diverse backgrounds (Betancourt et al., 2014; Esposito, 2013), with the goal of greater cultural awareness and improved patient satisfaction (Gallagher & Polanin, 2015). To implement education programs and evaluate their effectiveness, organisations, educators and policy-makers must ensure clinicians are supported and encouraged to use culturally sensitive communication, in the form of finding ways to communicate, facilitating interpreters and actively involving family members (Johnstone, Hutchinson, Redley et al., 2016). This is because the evidence demonstrates that culturally sensitive communication improves outcomes for patients and families, and they are more satisfied with care (Douglas et al., 2011). Opportunities for education in culturally sensitive communication should therefore be a priority.

The concept of culturally sensitive communication is applicable to all healthcare settings and all countries. Culturally sensitive communication is necessary for all patients in all healthcare environments. Gaps in evidence that require further exploration include the experiences and perspectives of culturally sensitive communication of the clinician, patient and family (Evans et al., 2012), and implementation and evaluation of education programs (Johnstone, Hutchinson, Redley et al., 2016; Maier-Lorentz, 2008). Research to further advance understanding of this concept should be focused on these areas.

5. Limitations

One of the limitations of this concept analysis include the lack of specific research evidence on culturally sensitive communication. Globally, multiple terms are used to define cultural sensitivity, with terms such as 'culturally competent', 'culturally appropriate', 'culturally safe', and 'culturally aware' often used interchangeably (Flowers, 2004). Most of the research in this area focuses on the broader topic of 'culturally competent' or 'culturally sensitive' care, rather than relating these concepts to communication (Almutairi & Rondney, 2013; Garneau and Pepin, 2015). Distinguishing features of culturally sensitive communication highlighted in this concept analysis include communication styles that are open and sensitive, clinician awareness of their own culture and beliefs, and collaborating with the patient and family. Effective communication is essential to providing optimal patient care, therefore there should be a focus on understanding culturally sensitive communication practices (Meuter et al., 2015).

6. Conclusion

This concept analysis was undertaken to refine and explain the concept of culturally sensitive communication, to better understand the concept and how it can be applied to global healthcare and research. This concept analysis enhances understanding of culturally sensitive communication and the benefits and challenges associated with its use in healthcare. Refining and explaining the concept of culturally sensitive communication is important to support clinicians and improve their awareness and understanding of the concept when caring for culturally diverse patients and families. By evaluating and explaining the antecedents of the concept, clinicians can consider the environment or space in which the conversation is carried out. Clinicians can use the defining attributes to prioritise cultural considerations and establish a trusting therapeutic relationship. By using culturally sensitive communication, patients should experience better outcomes; families should be more actively involved in healthcare, and staff should feel less emotional, with less physical and psychological distress. Further research is needed to gain an understanding of current communication and decision-making practices.

Conflict of interest

None.

Ethical statement

I declare that an ethical statement is not applicable as this manuscript does not involve human or animal research.

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References

Almutairi, A. F., & Rondney, P. (2013). Critical cultural competence for culturally diverse workforces: Toward equitable and peaceful healthcare. *Advances in Nursing Science*, *36*(3), 200–212. http://dx.doi.org/10.1097/ANS.0b013e31829edd51

Amouri, S. E., & O'Neill, S. (2011). Supporting cross-cultural communication and culturally competent care in the linguistically and culturally diverse hospital settings of UAE. *Contemporary Nurse*, *39*(2), 240–255. http://dx.doi.org/10.5172/conu.2011.240

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems. A systematic review. *American Journal of Preventive Medicine*, *24*(3 Suppl), 68–79.

Australian Bureau of Statistics. (2017). *Census of population and housing: Reflecting australia - stories from the census, 2016*. http://www.abs.gov.au/ausstats/abs@.nsf

Australian Commission on Quality and Safety in Health Care. (2016). *Patient-clinician communication in hospitals communicating for safety at transitions of care*. https://www.safetyandquality.gov.au/wp-content/uploads/2016/11/Information-sheet-for-executives-and-clinical-leaders-Improving-patient-clinician-communication.pdf

Axtell, S. A., Avery, M., & Westra, B. (2010). Incorporating cultural competence content into graduate nursing curricula through community-university collaboration. *Journal of Transcultural Nursing*, *21*(2), 183–191. http://dx.doi.org/10.1177/1043659609357633

Beckstrand, R. L., Callister, L. C., & Kirchhoff, K. T. (2006). Providing a "good death": critical care nurses' suggestions for improving end-of-life care. *American Journal of Critical Care*, *15*(1), 38–45. http://ajcc.aacnjournals.org/content/15/1/38.short

Bellamy, G., & Gott, M. (2013). What are the priorities for developing culturally appropriate palliative and end-of-life care for older people? The views of healthcare staff working in New Zealand. *Health & Social Care in the Community*, *21*(1), 26–34. http://dx.doi.org/10.1111/j.1365-2524.2012.01083.x

Betancourt, J. R., Corbett, J., & Bondaryk, M. R. (2014). Addressing disparities and achieving equity: Cultural competence, ethics, and health-care transformation. *Chest*, *145*(1), 143–148. http://dx.doi.org/10.1378/chest.13-0634

Blanchet Garneau, A., & Pepin, J. (2015). A constructivist theoretical proposition of cultural competence development in nursing. *Nurse Education Today*, *35*(11), 1062–1068. http://dx.doi.org/10.1016/j.nedt.2015.05.019

Bloomer, M. J., & Al-Mutair, A. (2013). Ensuring cultural sensitivity for Muslim patients in the Australian ICU: Considerations for care. *Australian Critical Care*, *26*(4), 193–196. http://dx.doi.org/10.1016/j.aucc.2013.04.003

Campinha-Bacote, J., & Munoz, C. (2001). A guiding framework for delivering culturally competent services in case management. *The Case Manager*, *12*(2), 48–52. http://dx.doi.org/10.1067/mcm.2001.114902

Congress of Toress Straight Islander Nurses and Midwives (CATSINaM). (2016). *Cultural safety in policy and practice seminar: Summary and implications*. https://www.catsinam.org.au/communications/resources

Council of Deans of Nursing and Midwifery (CDNM). (2017). *Cultural safety in education, practice and research*. http://www.cdnm.edu.au/assets/cultural-safety-final-position-paper.pdf

Cioffi, R. N. (2003). Communicating with culturally and linguistically diverse patients in an acute care setting: Nurses' experiences. *International Journal of Nursing Studies*, *40*(3), 299–306. http://dx.doi.org/10.1016/S0020-7489(02)00089-5

Claramita, M., Tuah, R., Riskione, P., Prabandari, Y. S., & Effendy, C. (2016). Comparison of communication skills between trained and untrained students using a culturally sensitive nurse–client communication guideline in Indonesia. *Nurse Education Today*, *36*, 236–241. http://dx.doi.org/10.1016/j.nedt.2015.10.022

Colman, A. (2015). Culture. In *A dictionary of psychology*. Oxford University Press. Retrieved 25 Jul. 2018, from. http://www.oxfordreference.com.ezproxy-f.deakin.edu.au/view/10.1093/acref/9780199657681.001.0001/acref-9780199657681-e-2018

Crawley, L. M., Marshall, P. A., Lo, B., & Koenig, B. A. (2002). Strategies for culturally effective end-of-life care. *Annals of Internal Medicine*, *136*(9), 673–679. http://annals.org/aim/article/715261/strategies-culturally-effective-end-life-care

Cross, W. M., & Bloomer, M. J. (2010). Extending boundaries: Clinical communication with culturally and linguistically diverse mental health clients and carers. *International Journal of Mental Health Nursing*, *19*(4), 268–277. http://dx.doi.org/10.1111/j.1447-0349.2010.00667.x

Douglas, M. K., Pierce, J. U., Rosenkoetter, M., Pacquiao, D., Callister, L. C., Hattar-Pollara, . . . & Purnell, L. (2011). Standards of practice for culturally competent nursing care. *Journal of Transcultural Nursing*, *22*(4), 317–333. http://dx.doi.org/10.1177/1043659611412965

Eckhardt, R., Mott, S., & Andrew, S. (2006). Culture and communication: Identifying and overcoming the barriers in caring for non-English-speaking German patients. *Diversity in Health & Social Care*, *3*(1), 19–25.

Efstathiou, N., & Clifford, C. (2011). The critical care nurse's role in end-of-life care: Issues and challenges. *Nursing in Critical Care*, *16*(3), 116–123. http://dx.doi.org/10.1111/j.1478-5153.2010.00438.x

Efstathiou, N., & Walker, W. M. (2014). Interprofessional, simulation based training in end of life care communication: A pilot study. *Journal of Interprofessional Care*, *28*(1), 68–70. http://dx.doi.org/10.3109/13561820.2013.827163

El-Amouri, S., & O'Neill, S. (2011). Supporting cross-cultural communication and culturally competent care in the linguistically and culturally diverse hospital settings of UAE. *Contemporary Nurse*, *39*(2), 240–255. http://dx.doi.org/10.5172/conu.2011.39.2.240

Esposito, C. L. (2013). Provision of culturally competent health care: An interim status review and report. *The Journal of the New York State Nurses' Association*, *43*(2), 4–10.

Evans, N., Menaca, A., Koffman, J., Harding, R., Higginson, I. J., Pool, R., . . . & Gysels, M. (2012). Cultural competence in end-of-life care: Terms, definitions, and conceptual models from British literature. *Journal of Palliative Medicine*, *15*(7), 812–820. http://dx.doi.org/10.1089/jpm.2011.0526

Fleckman, J. M., Dal Corso, M., Ramirez, S., Begalieva, M., & Johnson, C. C. (2015). Intercultural competency in public health: A call for action to incorporate training into public health education. *Frontiers in Public Health*, *3*, 210. http://dx.doi.org/10.3389/fpubh.2015.00210

Flowers, D. L. (2004). Culturally competent nursing care a challenge for the 21st century. *Critical Care Nurse*, *24*(4), 48–52. http://ccn.aacnjournals.org/content/24/4/48.long

Friganovic, A., Bloomer, M., Northam, H., Kalauz, S., Sellinger, M., Lopez, V., . . . & Fulbrook, P. (2016). Brisbane declaration culturally sensitive critical care nursing. *World Federation of Critical Care Nurses*, 1–4. http://wfccn.org/

Gallagher, R. W., & Polanin, J. R. (2015). A meta-analysis of educational interventions designed to enhance cultural competence in professional nurses and nursing students. *Nurse Education Today*, *35*(2), 333–340. http://dx.doi.org/10.1016/j.nedt.2014.10.021

Garneau, A. B., & Pepin, J. (2015). Cultural competence: A constructivist definition. *Journal of Transcultural Nursing*, *26*(1), 9–15. http://dx.doi.org/10.1177/1043659614541294

Hart, P. L., & Mareno, N. (2014). Cultural challenges and barriers through the voices of nurses. *Journal of Clinical Nursing*, *23*(15-16), 2223–2233. http://dx.doi.org/10.1111/jocn.12500

Johnstone, M. J., Hutchinson, A. M., Rawson, H., & Redley, B. (2016). Nursing strategies for engaging families of older immigrants hospitalized for end-of-life care: An Australian study. *Journal of Patient Experience*, *3*(3), 57–63. http://dx.doi.org/10.1177/2374373516667004

Johnstone, M. J., Hutchinson, A. M., Redley, B., & Rawson, H. (2016). Nursing roles and strategies in end-of-life decision making concerning elderly immigrants admitted to acute care hospitals: An australian study. *Journal of Transcultural Nursing*, *27*(5), 471–479. http://dx.doi.org/10.1177/1043659615582088

Kanchana, M. N., & Sangamesh, N. (2016). Transcultural nursing: Importance in nursing practice. *International Journal of Nursing Education*, *8*(1), 135–138. http://dx.doi.org/10.5958/0974-9357.2016.00024.6

King, G., Desmarais, C., Lindsay, S., G, Piérart., & Sylvie, T. (2015). The roles of effective communication and client engagement in delivering culturally sensitive care to immigrant parents of children with disabilities. *Disability and Rehabilitation*, *37*(15), 1372–1381. http://dx.doi.org/10.3109/09638288.2014.972580

Leininger, M. (1995). Overview of Leininger's culture care theory. In M. Leininger (Ed.), *Transcultural nursing: Concepts, theories, research, and practices*. New York: McGraw-Hill.

Maier-Lorentz, M. M. (2008). Transcultural nursing: Its importance in nursing practice. *Journal of Cultural Diversity*, *15*(1), 37–43.

Manias, E. (2010). Medication communication: A concept analysis. *Journal of Advanced Nursing*, *66*(4), 933–943. http://dx.doi.org/10.1111/j.1365-2648.2009.05225.x

Matteliano, M. A., & Street, D. (2012). Nurse practitioners' contributions to cultural competence in primary care settings. *Journal of the American Academy of Nurse Practitioners*, *24*(7), 425–435. http://dx.doi.org/10.1111/j.1745-7599.2012.00701.x

McArthur, T., Lam-McArthur, J., & Fontaine, L. (2018). Communication. In *The oxford companion to the english language*. Oxford University Press. Retrieved 25 Jul. 2018, from. http://www.oxfordreference.com.ezproxy-f.deakin.edu.au/view/10.1093/acref/9780199661282.001.0001/acref-9780199661282-e-277

McCarthy, J., Cassidy, I., Graham, M. M., & Tuohy, D. (2013). Conversations through barriers of language and interpretation. *The British Journal of Nursing*, *22*(6), 335–339. http://dx.doi.org/10.12968/bjon.2013.22.6.335

Meuter, R. F. I., Gallois, C., Segalowitz, N. S., Ryder, A. G., & Hocking, J. (2015). Overcoming language barriers in healthcare: A protocol for investigating safe and effective communication when patients or clinicians use a second language. *BMC Health Services Research*, *15* http://dx.doi.org/10.1186/s12913-015-1024-8, 371-371

Narayanasamy, A. (2003). Transcultural care. Transcultural nursing: how do nurses respond to cultural needs? *The British Journal of Nursing*, *12*(3), 185–194.

Narayanasamy, A. (2002). The ACCESS model: A transcultural nursing practice framework. *The British Journal of Nursing*, *11*(9), 643–655. http://dx.doi.org/10.12968/bjon.2002.11.9.10178

Parisa, B., Reza, N., Afsaneh, R., & Sarieh, P. (2015). Cultural safety: An evolutionary concept analysis. *Holistic Nursing Practice*, *30*(1), 33–38. http://dx.doi.org/10.1097/HNP.0000000000000125

Paternotte, E., Scheele, F., Seeleman, C. M., Bank, L., Scherpbier, A. J. J. A., & van Dulmen, S. (2016). Intercultural doctor-patient communication in daily outpatient care: Relevant communication skills. *Perspectives on Medical Education*, *5*(5), 268–275. http://dx.doi.org/10.1007/s40037-016-0288-y

Porta, M., & Last, J. (2015). Cultural sensitivity. In *A dictionary of public health*. Oxford University Press. Retrieved 25 Jul. 2018, from. http://www.oxfordreference.com.ezproxy-f.deakin.edu.au/view/10.1093/acref/9780191844386.001.0001/acref-9780191844386-e-974

Schmid, I. K., & Svarstad, B. L. (2002). Nurse–physician communication and quality of drug use in Swedish nursing homes. *Social Science & Medicine*, *54*(12), 1767–1777. http://dx.doi.org/10.1016/S0277-9536(01)00146-0

State of Victoria. (2016). *Delivery for diversity cultural diversity plan 2016-2019*. https://www2.health.vic.gov.au/about/publications/policiesandguidelines

United Nations Educational, Scientific and Cultural Organisation (UNESCO). (2017). *Cultural diversity* Retrieved from. http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/cultural-diversity/

United Nations. (2017). *World populations prospects*. https://esa.un.org/unpd/wpp/Publications/Files/WPP2017_KeyFindings.pdf

Walker, L. O., & Avant, K. C. (2011). *Strategies for theory construction in nursing* (5th ed). Upper Saddle River: NJ: Pearson Prentice Hall.

Williamson, M., & Harrison, L. (2010). Providing culturally appropriate care: A literature review. *International Journal of Nursing Studies*, *47*(6), 761–769. http://dx.doi.org/10.1016/j.ijnurstu.2009.12.012

World Health Organization. (2016). *World health statistics 2016: Monitoring health for the SDGs*. http://who.int/gho/publications/world_health_statistics/2016/en/