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Migrant and minority family members in the intensive care unit. A review of the literature

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Abstract

Statistics show that people with migrant and minority background as patients are significant in numbers in the intensive care unit. This also puts family members in the perspective of nursing because family members are an inherent part of the intensive care unit. Family-centered care is perhaps most applicable to vulnerable populations like migrant family in the intensive care unit to meet family member's needs. But very little is known about the situation of migrant and minority family members in the intensive care unit. The aim of the study was to explore the state of the science regarding family-centered care in the intensive care unit of patients with migration background in general and with a possible focus on major migrant populations in Austria—Former Yugoslavian und Turkish origin. A literature review investigated research articles that contained information on migrant and minority family members in the intensive care unit. Key points in the relevant articles were identified and categorized into themes with an explanation of findings at the end. Seventeen articles fulfilled the inclusion criteria. No article was found regarding groups of major migrant population groups in Austria. The included articles uncovered five predominant themes: importance of cultural norms, communication, family dynamics, universal caring, and nursing/provider deficit in culturally competent care. In order to provide adequate nursing care a more cohesive body of information on more specific geographic and cultural populations is

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Conflict of interest

The authors declare that there are no actual or potential conflicts of interest in relation to this article.

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recommended. Because of the complete lack of research regarding migrant families of Former Yugoslavian and Turkish origin into Austria, an exploration of this population is recommended.

Keywords

Family members; Intensive care unit; Migration background; Nursing; Austria

Introduction

Austria's geographical location and the historical sociocultural events have made immigration a key theme in Austria's demographic construction. Data from Statistics Austria confirms trends of increased net immigration of foreigners with migration balances in the negatives for Austrian citizens [41]. In 2010 the net balance of foreign migration was + 31,858 while the net balance of Austrian citizen migration was -4,163. For the last 60 years flow of immigrants into Austria has been consistent and plentiful with no sign of slowing down [41]. Migrant populations are considered more vulnerable due to low socio-economic status and migration situations tend to suffer from poorer health than the rest of the population, and may face inequity in health care services [45].

In Austria, the hospital sector plays a major role in the provision of health care [20]. Statistics show that migrants as hospital patients are significant in numbers. Out of 2,816,240 hospital discharges 8.1 % of patients were non-Austrian citizens. According to Austrian migration data the majority of these non-Austrian patients are of Turkish and Former-Yugoslavian citizenship. This makes up one-fourth of all non-Austrian citizens who were discharged from Austrian hospitals in 2009 [42]. Austrian citizen with migration background from these countries were not included in these numbers. About 5 % of hospital patients in 2008 were treated at an intensive care unit (ICU) [40]. This makes people with migrant background also to a significant number of treated as a critical ill patient in an ICU.

A decade of research shows that family-centered care is beneficial for patients and families and also an important approach to meet family members needs [10, 12, 19, 36, 47]. Because of the acuity of the patient in these settings, the families themselves are extremely emotionally vulnerable and depleted [39]. In migrant populations, the families are at an even higher risk for emotional and psychological depletion because the normal stress of having a loved one in the ICU is potentiated by the stress of cultural isolation [5]. The concept of family-centered care is perhaps most applicable in specific populations where the patient is most vulnerable such as in the ICU where neurological deficit, severity of illness, or levels of sedation impair the patient making family a focal point in decision making [12]. Effective communication and high quality relationships with the healthcare team are of high priority and it is the responsibility of the nurses and doctors to focus on these aspects of care [39]. Increasing growth in diversity of migrants require health systems to take into account differences in needs [32] and require a more proactive role from governments in policy making in consideration of migrant groups in specific areas [25].

Aim

To gain a better understanding of the needs of migrant and minority families in the intensive care unit, the aim of the study was to explore the state of the science regarding family-centered care in the ICU of patients of migrant populations in general and with a specific focus on major migrant populations in Austria (Former Yugoslavia und Turkish origin) The research question was as followed: What is the focus in the existing research on family-centered care in the ICU of patients of migrant background with a possible focus on Former Yugoslavia and/or Turkish migrant background?

Methods

Search strategies and data sources

A literature review was executed based on a search in the databases PubMed, MedLine, and CINAHL. Inclusion criteria were as follows: Migrant population as family members in ICU involving an environment where the patient was at a critical care unit, articles in English or German language with no time limit in the past up to 2012. Keywords for this focus of the search were used in variations and in combination with other keyword categories as follows: Target population (Turkey and all countries of Former Yugoslavia: Bosnia, Herzegovina, Serbia, Croatia, and expanded to (Eastern) Europe. Keywords for family with variations like caregiver, needs, need met, coping, parents, patient-family-centered care. Keywords for ICU were as follows, including variations: intensive care unit, critical care unit. Keyword for migrant populations and its synonyms like ethnicity, culture, minority, language, and diversity and a multitude of different words in this field like cultural, immigrant, migrant, foreign, migrant worker, language barrier, multicultural, minorities.

Search outcome

Eighty-seven articles were chosen for potentially applicable abstracts. Abstracts from the articles retrieved in the initial search were reviewed. After this process 15 articles met inclusion criteria and two articles that met exclusion criteria were included because of their significance to the phenomenon being explored (Fig. 1). These resulting 17 articles were finally included in the article. Quality appraisal of the article reflected the criteria for qualitative and quantitative research [31] and for review articles [11]. All included articles fulfilled the drafted criteria. Following steps were conducted to analyze the relevant articles [14]:

Sorting of the studies and selection of articles based on inclusion and exclusion criteria

- Identification of key points
- Interpretation of results and categorization of findings into themes in relevance to the research question
- Explanation of findings

The following types of research articles were representative of the inclusion articles as follows: seven case studies, six qualitative articles, three quantitative articles, and one literature review (Table 1). All but two of the articles seek to explore or describe the

experience and perceptions of the patients' family members and nurses caring for these patients' family members and over half of the articles are case studies. The conceptualization of "family" in the context of ICU family-centered care predominantly concerns children or infants as patient population. The dependent nature of children on their parents makes it obvious that all studies focusing on nursing care of the child will include parents. The majority of the studies suggest that the existence of literature of family-centered care in this area occurs because of the unavoidable need to incorporate parents into care when the patient is a child.

In the studies, there is a very even distribution of subject of the studies as the following: nurse, parents, mother, and patient. In three studies where the nurse is the subject, the experience of working with the population of migrant families attending the ICU is described. One study explained an educational program for nurses to give culturally competent care to Neonatal ICU (NICU) families. In 2/3 of the studies where the patient is the subject, an anecdotal case study describes raising awareness of the different needs of this population. The existing literature succeeds in exploring multiple perspectives of migrant family-centered care in the ICU. The major findings of these studies indicate that the authors of these articles are from all parts of the world, including representation from North America (Canada and the USA, Israel, and Europe (France, Norway, and the UK). Almost half of the articles (eight) were from the USA.

Eight of the studies described immigrants of first or second generation, five studies implied immigration via description of ethnicity, foreign, or language difficulties. Cultural subgroup populations were as follows: ultraorthodox religious group (one), an Amish family (one), and a Gypsy family (one). For the purpose of this article the population as described above will be referred to as "migrant" unless describing specific studies, which then the word used by the author will be utilized.

The populations explored in each article are very different, again, making findings difficult to generalize for all migrant populations worldwide. Although the representation of geographical, subcultural, ethnic, religious, and immigrant are very diverse and are from all corners of the world, they are very thinly spread with 1–2 articles per group, each with very different approaches, and all with more questions being presented than answers. In terms of world representation, and geographical and cultural population being explored, there exists a starting point for Western countries but there exists little research in Eastern countries.

Findings

The content of the articles will be reviewed in four sections describing predominant themes in the literature in caring for families of "migrant" populations in the ICU: Importance of cultural norms, communication, family dynamics, universal caring, and nursing/provider deficit in culturally competent care.

Cultural norms—Many of the included articles provide recommendations to nurses on how to provide culturally competent care based on observational data collection. Multicultural relatives of patients struggle to preserve the families' cultural belonging within the healthcare system [22]. Incorporation of cultural customs into daily nursing care is

encouraged. For example if it is noted that cultural customs of the family dictate that a woman's hair should remain covered, the nurse should make efforts to do so before visitors enter the room [23]. If a conflict exists between nurses' bedside norms and the cultural needs of the family, it can create friction and stress for both the families and the nurses. In order to create a congruency of care, compromise needs to be achieved between nurse and family. For this to occur, the nurse should set aside ethnocentrism, be culturally sensitive, and be willing to make adjustments for the family [23]. Cultural humility involves developing authentic respect towards patient diversity and developing a broader definition of the concept of culture [37]. By engaging in social nonfocused conversation with the family, the nurse can develop a rapport, gain trust, and indirectly investigate family dynamics [8]. Some cultures have gender preference and are concerned with modesty [22]. One nurse described how she used Leininger's theory of Culture Care Diversity [27] to achieve cultural competence in caring for the family of a critically ill Amish newborn [15]. Through cultural care preservation and management, the nurse acknowledged the difference in cultural norms and made efforts to maintain the presence of woman's culture at the bedside. Through culture care accommodation and negotiation, the nurse made adjustments to care to preserve cultural norms. Through cultural care repatterning and restructuring efforts were made to find a system that would be optimal for patient outcome yet considerate to cultural values. In another study, a nurse used Leininger's theory [28] to provide culturally competent care for a family of Mexican immigrants with a critically ill infant [8]. Høye and Severinsson [23] describe a conflict between nurses and the family over the desire of the family to participate in patient bathing. Difficulty emerged over the "culturally based need of the family to participate vs. nurses' professional perception as total caregiver." Friction occurred as the nurse was accustomed to being the exclusive caregiver in hygiene and bathing, but the family member insisted on participating in the care.

Communication—Communication is an important topic in most of the articles. One study described the emotional experience of the family members of Chinese migrants into America [26]. As their infant was in the NICU, parents described feelings of uselessness that made parents perceive themselves as incompetent, blame themselves for the illness of the child, and feeling as if they had "failed" their family by birthing a premature baby. Family members also blamed each other. Language barriers, inadequate translation, and mistrust precipitated by lack of explanation from the nurse created emotional stress for the parents [26]. Families verbalized in the posthospital experience that if the nurses had informed them of visiting policies early on, they would have been able to function within the rules more appropriately [21]. Parents of NICU patients from this study suggest strategies for improving communication and decreasing stress as follows: answer questions carefully, teach by demonstration, take time to explain in simple English, set up an environment of trust so that families feel "safe" to ask questions [46]. Migrant parents of NICU babies in a North American study verbalized a need for readily available translators and translated educational materials [5]. In a quasiexperimental study, mothers of preterm infants were paired with a buddy (matched based on language, culture, ethnicity, and characteristic of infant) and compared to a control group. Intervention participants reported feeling more confidence, a better understanding of the medical condition of the infant, and an improved quality of listening support [35]. A similar buddy system was used in a Canadian NICU,

where a multicultural committee developed the program to improve cross-cultural care, but outcomes were not measured [5]. “The complex medical issues that arise in the ICU environment require a trained interpreter to communicate effectively” [10]. Interpretation by a family member can be subject to biased translation, withholding of important information, and conflict of interest/confidentiality [22].

They also found that many first and second generation immigrant family members filter information given to the patient in order to reduce concern. One participant said, “We just converse in general terms and did not tell her everything that the healthcare workers told us.” (p. 27). Another participant said, “Our culture does not tell the truth directly. Anyhow, concerning death one does not say: ‘You are going to die.’ Rather: ‘You are going to get well’ and in that way one gives hope” [22]. The Joint Commission on Accreditation of Healthcare Organizations in the USA mandates the use of a trained interpreter not belonging to the family [10]. Despite these mandates for qualified translation, nurses report that they expect relatives to fulfill the interpreter role and exhibit limited awareness of the breach of confidentiality and inappropriateness of this method [9].

In a case study of a NICU treating Mexican immigrant family members, disclosure of many confidential details were disclosed to unrelated families because nurses had no one else to translate [24]. The mother describes the burden of having to be the one to relay health care information; she notes the barriers to understanding, as experienced by the other mothers, because of this lack of appropriate translation: “For most of the mothers who only speak Spanish, they can’t get even the most basic information about their babies. Let alone get to a point where you can have a conversation about who you are and what you would like for care while your baby and you are in the hospital” [24]. A family member may imply understanding and agreement to the health care provider, just to show respect. “I can’t raise any questions, I am also afraid of asking inappropriate questions. I don’t want to upset the doctors or the nurses... To maintain a harmonious relationship; I always say ‘No Question’ when they ask me if I have questions.” [26]. Language barriers or a cultural tendency for minimal speaking may cause a nurse to make an incorrect diagnosis if not diligent [9]. “Many patients with language barriers may not be given interpreters as often as required and poor interpretation can lead to medical errors and adverse outcomes” [7]. Bracht et al. [5] describes a hospital implemented program to increase cross-cultural care in a Toronto hospital where staff and a specific multicultural committee used the following strategies for supporting cultural minorities in the NICU as follows: Hospital cultural interpreters serve as language and cultural interpreters, a parent-buddy program, community resource referrals, and the development of a multicultural perinatal network. This article shared the interventions, but does not analyze the results of implementation.

Family dynamics—The conflict described as “nurses professional obligation to provide information vs. cultural communication” is a multidimensional conflict that creates much stress on the nurse. Most Western cultures have an individualistic approach, where many non-Western cultures attest to collectivism [22]. Many non-Western cultures do not view the patient as an autonomous entity, but rather as part of a family network [10]. Whereas nurses in Western cultures feel a moral obligation to disclose all information to the patient and respect the patients’ autonomous decisions as priority, many cultures function under a very

different hierarchy [8]. Decisions are made by the group. Proxy of choice for some of these families may not be the parents of the child or the spouse, as would be the logical assumption in many Western cultures. “Family members prevented the parents from visiting the child, yet they requested that the godmother see the baby as soon as possible... the neurosurgeon obtained consent from the grandparents, who then had the father sign the document” [44].

Matriarchs or elder males in the group are culturally more likely to be the decision makers [8]. In some cultures, as a part of the focus on the group rather than the individual, the family will decide to keep the “truth” from the patient, withholding important diagnostic data and making stratified decisions without the knowledge of the patient [10]. This becomes difficult for the Western trained nurse, as it conflicts with most Western conceptualizations of morality and ethics. Western concepts of life, death, and brain death cannot be accepted as universal, because many cultures have drastically different perceptions of these processes. In these situations it may become difficult to find a balance where neither staff nor family’s moral principles are violated [24]. A method for evaluating depth of appropriate disclosure includes asking what patients and families prefer, and presenting hypothetical situations. Also watching patient and family for nonverbal cues can be used. If cultural conflicts cause moral conflict within the staff beyond compromise, an ethics consult is recommended [10]. This extended family nucleus is apparent in another situation of conflict described. Families’ need for cultural norms and self determination vs. nurses’ professional responsibility for the clinical environment can create difficulties [23]. This conflict is the most applicable in terms of visiting hours. In many cultures extended family including grandparents, aunts and uncles, and godparents are considered next of kin and want to stand vigil at the bedside at all hours [23, 44]. Nurses suggest that overcrowding of rooms and patient areas by excessive family members generated complaints from other family members and made it difficult to attempt to meet everyone’s, including the patients’, needs [9]. However, the presence of extended family members can greatly improve the patients experience [5].

Universal caring—Four of the studies indicate that there are no differences in the care of culturally diverse families. In these studies, although culturally competent care was appreciated concepts such as quality communication, social and spiritual support, and provider–client relationship were felt to be more important to families [1]. Families, above all, want to feel like the doctors and nurses genuinely care about their relative. Families found this to be more important than communication [46]. African-American mothers reported that the highest source of satisfaction was support from the healthcare team [33]. “Despite (ethnic) differences...family members expectations of professional support from critical care nurses were generally universal-suggesting equitable care, dignity and respect should be universal values.” [43].

Provider deficit—Existing literature shows cultural competence of nursing care is lacking. Cortis [9] explored nurse deficits including racism, limited understanding, and inadequate implementation among nurses for Pakistani immigrants in the UK. Hurst [24] described one American NICU with a lack of resources for their population of Mexican migrants and

described a single case where a mother inadvertently absorbed the burden of meeting the special translation and transportation needs of the migrant mothers. In an article describing a hospital wide implementation of a NICU multicultural committee intended to improve cross-cultural care, parents rated the hospital experience preimplementation with feelings of isolation. They reported that these feelings would have been alleviated had there been someone from their culture to relate to [5]. The committee implemented a teaching program with staff to develop their cultural competence involving an interactive workshop including discussions and multidisciplinary rounds. The staff expressed that the interactive process empowered them with a greater understanding of ways to care for cultural minorities and verbalized feelings of confidence in caring for this population [5].

Discussion

Population and demographic differences caused by migration will be reflected in the patient population in hospitals and ICUs around the world. Different parts of the world have different cultural norms, family roles in illness, perspectives, and belief systems. Independent of their ethno-cultural differences, these people are displaced. They have left their country of origin and are in an unfamiliar environment, their support systems are depleted, and often a language barrier exists [16]. Many factors should be taken into consideration when caring for these migrant populations and their families and care plans must be adjusted to provide culturally competent care. Migrant populations bring to their experience of healthcare a framework based on sociopolitical history and dynamics of culture, ethnicity, immigration, and colonization [46]. Although the international rate of migration is at an all time high and continues to rise, there exists very little research on the needs of migrant and minority families in the ICU. There exists no research on the needs of Eastern European migrant families in the ICUs of Western Europe. In juxtaposition to the historical and statistical presence of migrants in these areas over the past 50 years, this lack of research is alarming.

As migration continues to rise as per predictions from the United Nations the patient populations of migrants and minority families in the ICUs will continue to rise as well. It is important to acknowledge this change in population demographic and tailor healthcare to the special needs of this demographic. In order to do so, evidence-based guidelines for care should be established as outlined in general hospital practice in the USA [10] and in Europe [4]. Intervention studies and programs are recommended for development of information on and guidelines for culturally competent care and positive patient outcomes like in the European initiative of the “Migrant friendly hospital” [38].

The results of this literature review also yields some examples for providing culturally competent care to the families of migrant patients, but since the articles address vastly different cultures around the world, migrating to equally different destinations, and under different circumstances, it is not possible to generalize the accuracy or the applicability of observations to all migrants internationally and to the defined migrant populations in Austria. Current research explores the phenomenon at hand in the loose context of a displaced cultural population. For the purpose of this literature review, the observations made on these groups were analyzed for recurring common themes and reported as such.

In a retrospective analysis of a problem seen in the beginning of the article search process, it can be seen that defining the population is most difficult to consolidate into a major theme. Each article has unique verbiage for the population being explored, and with each word comes subtle differences in definition, describing slightly different populations. This makes results of the studies difficult to generalize toward a specific population and also difficult to generalize toward migrants internationally [33]. A clear definition for “migrants” must be established in order to begin to focus on this population. Although observations and interventions precipitated very common themes and cultural subgroups, ethnic families, and in some cases first and second generation migrants possessed very similar characteristics and needs, the populations compared in this literature search are highly different. It is unclear if inclusion of all populations mentioned in these studies in a comprehensive set of recommendations is appropriate.

In order to discuss transferability of success of interventions and characteristics across cultures, further research has to be done including comparisons of all major cultural migrant populations. Identifying similarities and differences in each major migrant population would make applicability of culturally competent guidelines of care possible. For example, if characteristics of Eastern European immigrants into Western Europe can be generalized, then successful interventions discovered in one migrant group (i.e., Turkish migrants into Austria) can be applied to similar migrant groups from this established regional/cultural group (i.e., Former Yugoslavia migrants into Germany). Subsequent applicability to the critical care setting would also need to be explored.

The Critical Care Family Needs Inventory (CC FNI) is a tool that has been used to measure needs of families in the ICU in general [29, 30]. Although there is light evidence that migration makes a difference in the perception of meeting needs [2, 34] this tool as well as many other instruments are limited and cannot be generalized for Western and non-Western regions alike and would require cultural adjustment for validity and reliability. For example the tool has two questions regarding waiting rooms. In many non-Western hospitals there exists neither a waiting room nor a perception of its role. Also questions regarding “clergy” in a setting where no such service exists, the questions were left blank [3]. Nurses lack proficiency in providing culturally competent care. Many of the articles uncovered nurses falling short at the bedside. Studies should work towards uncovering successful provider education methods to help nurses provide therapeutic care to these families.

In order to provide adequate nursing care to these patients and their families, the international healthcare community must recognize that care that has been historically therapeutic to local populations, or established bedside norms may no longer be appropriate or applicable as the demographic landscape shifts. There must be an identification and exploration of the needs of migrants in the ICU setting, and subsequent tailoring of care plans, objectives, and goals to these unique sociocultural parameters.

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Fig. 1.
Process chart: literature search and utilization

Table 1

Studies with focus on migrant families in the intensive care unit

Reference	Country	Focus/aim	Methodology
Auslander et al. [1]	Israel	Identify which sociodemographic and health-related factors are related to parents' expectations and assessments of care. Emphasis on minority groups	Quantitative
Chambellan-Tison et al. [6]	France	Medical case study of child's course of treatment for severe hypercalcemia secondary to Vitamin D intoxication	Case study
Colon [8]	USA	Description of case study where cultural conflict occurred and where Leininger's culture care theory was employed to provide culturally competent care	Case study
Cortis [9]	UK	Experience of Registered Nurses caring for hospitalized Pakistani patients in the UK	Qualitative
Davidson et al. [10]	USA	Decision making, family coping, staff stress related to family interactions, cultural support, spiritual/religious support, family visitation, family presence on rounds, family presence on resuscitation, family environment of care, and palliative care in the ICU	Literature review
Gibson 2008 [15]	USA	Describe a NICU RN's personal experience in working with a critically ill newborn and his Amish family	Case study
Gonzales 2002 [16]	USA	Anecdotal perspective of non-English speaking patient	Case study
Hammerman et al. [17]	Israel	Response patterns of expectant mothers toward treatment of critically ill and/or malformed infants	Quantitative
Han et al. [18]	Taiwan	Nursing experience of a foreign worker with pneumonia and respiratory failure in an ICU in Taiwan	Case study
Høye and Severinsson [22]	Norway	Experiences of multicultural family members of critically ill patients when they encounter nurses in the ICU	Qualitative
Høye and Severinsson [23]	Norway	Explore ICU nurses' experiences of possible conflicts related to practical situations when encountering culturally diverse families of critically ill patients	Qualitative
Hurst [24]	USA	Examine how the availability resources to ensure family-centered care in an NICU affected one Latina mothers' NICU experience	Case study
Lee [26]	USA	Explore the experiences of first-generation Chinese-American parents while their infants are cared for the ICU	Qualitative
Preyde [35]	Canada	Determine how pairing of patient-caregiver (matching on language, culture, ethnicity, and characteristic of infant) affects mothers	Quantitative
Waters [43]	USA	Impact of different cultural affiliations on expectations of critical care nurses	Quantitative
Wiebe [46]	Canada	Parent perceptions of culturally congruent care within NICU	Qualitative

ICU intensive care unit, *NICU* neonatal intensive care unit