ARTÍCULO DE REVISIÓN

Gac Méd Caracas 2026;134(Supl 1):S179-S192
DOI: 10.47307/GMC.2026.134.S1.21

Culturally Framed Risk Governance Enhances Nursing Compliance in Palliative Care: A Systematic Review

La gobernanza del riesgo enmarcada culturalmente mejora el cumplimiento de la enfermería en cuidados paliativos: una revisión sistemática

Sri Rusmini[1ab]*, Esti Yunitasari[2c], Hanik Endang Nihayati[3d]

SUMMARY

Introduction: *Cultural competence is critical for effective nursing compliance in palliative care, yet current risk governance models often neglect cultural dimensions. Although extensive literature exists on patient safety and cultural competence, there is limited synthesized evidence on how cultural framing informs risk governance and nurse behavior. This systematic review examines how cultural framing influences risk governance and enhances nursing compliance in palliative care. Understanding this relationship is essential to designing governance models that are both culturally responsive and practically effective.*
Methods: *A systematic literature review was conducted following PRISMA 2020 guidelines. Peer-reviewed studies published between 2001 and 2024 were retrieved from PubMed, Scopus, CINAHL, and Google Scholar. Screening was performed using Rayyan, and study quality was appraised with the Mixed Methods Appraisal Tool (MMAT) 2018. Narrative synthesis identified thematic patterns across included studies.*
Results: *Twenty-six studies met the inclusion criteria. Three main themes emerged: 1) cultural competence as a framework for ethical risk decision-making; 2) cultural narratives shaping nurses' perceptions of risk and safety; 3) compliance as a culturally mediated behavioral outcome. Evidence suggests that cultural alignment between institutional policies and local norms improves adherence, while cultural dissonance can hinder risk communication and reporting.*
Conclusion: *Integrating cultural framing into risk governance enhances nurse responsiveness, communication with patients and families, and shared decision-making. Nursing models should embed transcultural theories, behavioral compliance frameworks, and ecological systems thinking. Specific recommendations include culturally adapted training, context-sensitive governance policies, and ongoing evaluation of compliance outcomes. Future empirical research should test culturally responsive governance strategies across diverse palliative care settings to optimize nurse compliance and patient safety.*

Keywords: *Cultural competence, risk governance, nursing compliance, palliative care, transcultural nursing.*

DOI: https://doi.org/10.47307/GMC.2026.134.S1.21

ORCID: 0009-0008-9466-0902[1]
ORCID: 0000-0002-6401-0748[2]
ORCID: 0000-0002-7688-1217[3]

[a]Doctoral Program Student from The Faculty of Nursing, Universitas Airlangga, Surabaya, Indonesia.
[b]Universitas Telogorejo Semarang, Semarang, Indonesia.
[c]Departement of Child Maternity Nursing, Faculty of Nursing, Universitas Airlangga, Surabaya, Indonesia.
[d]Department of Advanced Nursing, Faculty of Nursing, Universitas Airlangga, Surabaya, Indonesia.

*Corresponding Author: Sri Rusmini
E-mail: sri.rusmini-2023@fkp.unair.ac.id

Recibido: 10 de noviembre 2025
Aceptado: 26 diciembre 2025

RESUMEN

Introducción: *La competencia cultural es fundamental para asegurar el cumplimiento efectivo de la enfermería en cuidados paliativos; sin embargo, los modelos actuales de gobernanza del riesgo suelen descuidar las dimensiones culturales. Aunque existe abundante literatura sobre seguridad del paciente y competencia cultural, hay poca evidencia sintetizada sobre cómo el encuadre cultural incide en la gobernanza del riesgo y en el comportamiento de los enfermeros. Esta revisión sistemática tiene como objetivo examinar cómo el encuadre cultural influye en la gobernanza del riesgo y en la mejora del cumplimiento de la enfermería en los cuidados paliativos. Comprender esta relación es esencial para diseñar modelos de gobernanza culturalmente sensibles y prácticos.*

Métodos: *Se realizó una revisión sistemática según las directrices PRISMA 2020. Se incluyeron estudios revisados por pares publicados entre 2001 y 2024, recuperados de PubMed, Scopus, CINAHL y Google Scholar. La selección se realizó mediante Rayyan y la calidad de los estudios se evaluó con la herramienta Mixed Methods Appraisal Tool (MMAT) 2018. Se aplicó una síntesis narrativa para identificar patrones temáticos.*

Resultados: *Veintiséis estudios cumplieron los criterios de inclusión. Surgieron tres temas principales: 1) la competencia cultural como marco para la toma de decisiones éticas sobre riesgos; 2) las narrativas culturales que moldean la percepción de los enfermeros sobre riesgos y seguridad; 3) el cumplimiento como resultado conductual mediado culturalmente. La evidencia indica que la alineación cultural entre las políticas institucionales y las normas locales mejora la adherencia, mientras que la disonancia cultural puede dificultar la comunicación y el reporte de riesgos.*

Conclusión: *Integrar el encuadre cultural en la gobernanza del riesgo mejora la capacidad de respuesta de los enfermeros, la comunicación con pacientes y familias, y la toma de decisiones compartida. Los modelos de enfermería deben incorporar teorías transculturales, marcos de cumplimiento conductual y pensamiento sistémico-ecológico. Se recomiendan capacitaciones culturalmente adaptadas, políticas de gobernanza sensibles al contexto y la evaluación continua de los resultados de cumplimiento. Futuras investigaciones deben validar estrategias de gobernanza culturalmente adaptadas en diversos entornos de cuidados paliativos para optimizar el cumplimiento de las normas y la seguridad del paciente.*

Palabras clave: *Competencia cultural, gobernanza del riesgo, cumplimiento de enfermería, cuidados paliativos, enfermería transcultural.*

INTRODUCTION

Palliative care is a multidimensional approach that aims to improve the quality of life of patients facing life-threatening illnesses through comprehensive management of pain and other distressing symptoms, along with psychosocial and spiritual support (1). Nurses, as frontline healthcare providers, play a vital role in delivering high-quality palliative care by ensuring patient safety and adhering to institutional protocols and clinical guidelines. However, current risk governance models in many healthcare systems are often standardized and technical, paying insufficient attention to the cultural values that influence day-to-day nursing decisions and behavior (2). In the context of palliative care, clinical decision-making is profoundly shaped by cultural norms, values, and beliefs, especially regarding death, family roles, communication about prognosis, and spiritual practices. These cultural dimensions influence how nurses perceive risk, engage in ethical deliberations, and adhere to safety protocols and care-planning protocols (3). Consequently, the implementation of risk governance models that fail to account for such cultural complexities may lead to reduced nurse compliance, moral distress, and compromised patient outcomes (4).

The concept of cultural framing becomes particularly important here. Cultural framing refers to how individuals and groups interpret, prioritize, and respond to risks in light of their embedded cultural norms and worldviews (5). In nursing practice, this framing shapes how risks are understood and acted upon, from interpersonal communication and informed consent to ethical dilemmas and care interventions. It challenges the dominant one-size-fits-all governance structures by advocating for models that are both culturally responsive and behaviorally realistic.

This review is grounded in several conceptual and theoretical frameworks. First, Leininger's Transcultural Nursing Theory offers a foundation for understanding how cultural values must be considered when delivering effective and ethical care (6). Second, theories of organizational resilience and adaptive systems suggest that policy implementation, particularly regarding

safety and risk, is more effective when aligned with the social and cultural characteristics of the workforce (7). Therefore, integrating cultural framing into risk governance is not merely a theoretical concern but a practical imperative to ensure nurse engagement and policy compliance in the complex realities of palliative care.

Globally, the importance of culturally competent care has been increasingly recognized. Countries such as the United States of America, Canada, the United Kingdom, and Australia have developed national strategies to improve cultural competence in health systems, particularly for quality improvement and patient safety (8,9). Despite growing recognition of cultural factors, there is a notable lack of synthesized evidence on how cultural framing is practically incorporated into risk governance models in palliative nursing and on its effects on nurse behavior and patient outcomes. This knowledge gap limits the development of more effective, context-sensitive risk governance strategies that promote compliance and improve care quality across diverse populations. Therefore, this review aims to explore and synthesize evidence on culturally and contextually appropriate approaches to risk governance in healthcare.

METHODS

Protocol Registration

The review protocol for this systematic review has been registered in the International Prospective Register of Systematic Reviews (PROSPERO) under registration ID CRD42023433406. This registration ensures transparency in the review process and helps prevent duplication. Furthermore, this review adheres to the PRISMA 2020 (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines (10), which are designed to enhance the clarity, rigor, and reproducibility of systematic reviews.

Eligibility Criteria and Search Strategy

To define the boundaries of this systematic review, the PICO framework was applied as a guiding tool. The population (P) consisted of nurses working in palliative or end-of-life care settings. The intervention/exposure (I/E) included cultural framing, understood as the influence of cultural values, beliefs, or perceptions on risk governance, safety behavior, or clinical compliance. No comparator (C) was required due to the qualitative nature of the constructs under investigation. The outcome (O) focused on nurse compliance, risk perception, cultural responsiveness in governance, and patient safety outcomes (11).

The inclusion criteria encompassed 1) peer-reviewed empirical research articles, including qualitative, quantitative, or mixed-methods designs; 2) studies that investigated the role of culture in the context of risk governance or safety compliance among nurses; 3) research conducted within palliative care or end-of-life settings; 4) articles published in the English language; 5) full-text availability; and 6) publications dated from January 2000 to April 2025, to ensure relevance to the modern development of palliative care and culturally competent governance.

Studies were excluded if they 1) focused solely on cultural competence without explicitly linking it to risk governance or compliance, 2) were not nurse-focused, 3) were conducted in non-palliative contexts, 4) presented only theoretical discussion without empirical data, or 5) were part of grey literature such as dissertations, reports, or unpublished theses. The exclusion of grey literature was based on concerns about methodological rigor and the lack of peer review, which could compromise the credibility of the findings (12).

A structured and comprehensive search was conducted using five databases: PubMed, EBSCO Medline, ProQuest Health & Medical Collection, Web of Science, and ScienceDirect to ensure extensive coverage of health sciences, nursing, and behavioral science literature (13).

The search terms employed included both controlled vocabulary and free-text keywords, such as: “nurse”, “palliative care”, “end-of-life care”, “risk governance”, “patient safety”, “cultural framing”, “cultural influence”, “transcultural nursing”, “compliance”, and “adherence”. Boolean operators (AND, OR) were used to expand or narrow the search as necessary. Filters were applied according to

each database's interface, limiting results to peer-reviewed English-language articles with full text. All search results were exported into reference management software (Zotero) to remove duplicates and organize citations. Title and abstract screening were conducted independently by two reviewers, with discrepancies resolved through discussion with a third reviewer. Full-text articles were then assessed against the inclusion and exclusion criteria. This multistage screening process was documented in accordance with the PRISMA 2020 guidelines (10), ensuring transparency, reproducibility, and methodological rigor throughout the review (Table 1).

Table 1. Search strategy.

Database	Search Strategy
PubMed	1. Nurse* 2. Palliative care OR end-of-life care 3. Cultural framing OR cultural perspective OR cultural influence OR transcultural nursing 4. Risk governance OR risk management OR patient safety OR safety culture 5. Compliance OR adherence 6. 6. #1 AND #2 AND #3 AND #4 AND #5
ProQuest	1. Nurse* AND "palliative care." 2. AND ("cultural framing" OR "cultural values" OR "transcultural nursing") 3. AND ("risk governance" OR "patient safety" OR "safety management") 4. AND ("compliance" OR "adherence") Filters: Full text, Peer-reviewed, English, Articles only
Web of Science	TS=(nurs* AND "palliative care" AND ("cultural framing" OR "cultural perception") AND ("risk governance" OR "patient safety") AND (compliance OR adherence)) Refined by: English, article, health sciences
ScienceDirect	TITLE-ABSTR-KEY: ("nursing" AND "palliative care" AND "cultural framing" OR "cultural perspective" AND "risk governance" AND "compliance") Filters: Article type: Research articles, Language: English
EBSCO Medline	1. S1: nurse* OR nursing 2. S2: palliative care OR end-of-life care 3. S3: cultural framing OR cultural beliefs OR transcultural nursing 4. S4: risk management OR patient safety OR risk governance 5. S5: compliance OR adherence 6. S6: S1 AND S2 AND S3 AND S4 AND S5 Filters: Peer-reviewed, English

Selection and Data Collection Process

The selection and data collection process followed a structured multi-phase approach to ensure transparency, accuracy, and consistency, in line with PRISMA 2020 recommendations (14). The database search was conducted independently by two reviewers (GP and SA), and the resulting citations from all five databases were exported and compiled using Rayyan, a web-based tool for systematic review screening and collaboration (15). After the initial import, all duplicate articles were removed both automatically and manually. The title and abstract screening phase was then independently performed by both reviewers (GP and SA), who assessed each study against the pre-defined inclusion and exclusion criteria. Articles deemed potentially relevant proceeded to the full-text screening stage. In this step, full articles were reviewed in depth to determine final eligibility, and each study was evaluated separately by both reviewers.

In cases where the included studies featured mixed healthcare professional populations (e.g., nurses, physicians, or social workers), only those that explicitly disaggregated data for nurses or clearly focused their analysis on the nursing profession were retained. Studies that did not specify the number or contribution of nurses were

excluded after discussion and consensus with a third reviewer (AA) to maintain the review's population-specific focus. Any discrepancies or disagreements between the primary reviewers were resolved through deliberation with the third reviewer. This collaborative, blinded process minimized selection bias and enhanced the credibility of the final study pool. A detailed record of the number of studies screened, included, and excluded at each stage was maintained and reported in the PRISMA flow diagram (Figure 1).

Quality Appraisal and Data Synthesis

To ensure systematic data handling and minimize bias, a structured data extraction sheet was developed using Microsoft Excel. Two independent reviewers extracted relevant information from each included study, including the authors and year of publication, study objective, design, setting (location and time), study population, sample size, and main findings. This process ensured consistency across data sources and minimized subjectivity. Any discrepancies between reviewers were discussed and resolved collaboratively within the review team. When critical data were missing or unclear, corresponding authors were contacted for clarification. If no response was received, only the available data were included in the synthesis.

To evaluate methodological quality and risk of bias, the Mixed Methods Appraisal Tool (MMAT) version 2018 was applied to all studies. The MMAT is explicitly designed to appraise the quality of empirical studies using qualitative, quantitative, and mixed-methods approaches (16). Each study was rated according to the relevant criteria within the MMAT domains: QUAL (qualitative), QUAN (quantitative), or MM (mixed-methods). A scoring rubric was applied, with scores interpreted as follows: 100 % (100 %: all 5 criteria met): all 5 criteria met, 80 % (80 %: 4 criteria met): 4 criteria met, 60 % (60 %: 3 criteria met): 3 criteria met, 40 % (40 %: 2 criteria met): 2 criteria met, and 20 % (20 %: only 1 criterion met): only 1 criterion met. Quality appraisal was performed independently by two reviewers, and any disagreement in scoring was resolved through consultation with a third reviewer. This process ensured transparency and consistency in the evaluation of evidence quality.

Following quality appraisal, a narrative synthesis approach was employed to interpret and integrate the findings across studies. This method was deemed appropriate given the heterogeneity of study designs, populations, conceptual frameworks, and measured outcomes, which precluded the feasibility of conducting a meta-analysis (17). Key study characteristics were first tabulated to facilitate comparison and minimize excessive textual repetition. Thematic patterns were identified by grouping studies with similar conceptual orientations or outcomes, thereby forming integrated analytical categories. These categories were refined through iterative discussions among the reviewers, with a focus on the intersection of cultural framing, risk governance, and nursing compliance in palliative care. The synthesis emphasized both convergence and divergence across studies, enabling a critical understanding of how cultural beliefs, values, and expectations shape governance practices and nurses' behavior related to safety and compliance in palliative care contexts.

RESULTS

Study Selection

A comprehensive literature search was conducted across five major databases: PubMed, EBSCO Medline, ProQuest, Web of Science, and ScienceDirect, in accordance with the PRISMA 2020 guidelines (18). The initial search yielded a total of 1 287 records. After careful identification and removal of 362 duplicate entries, 925 articles remained for preliminary screening. Title and abstract screening was conducted independently by two reviewers using Rayyan QCRI software (19), a web-based tool specifically designed to streamline systematic review screening through blind assessments and the resolution of conflicts. Based on pre-established eligibility criteria, the reviewers excluded 804 articles that were clearly irrelevant to the review topic.

This process yielded 121 full-text articles for in-depth examination. These articles were then independently screened by two reviewers, with disagreements resolved by consensus or consultation with a third reviewer to ensure consistency and transparency. After applying the full inclusion and exclusion criteria, 95 articles

were excluded. The most common reasons for exclusion were: 1) the study population was not limited to nurses or did not provide disaggregated data for the nursing subgroup, 2) cultural framing was not the central theoretical or analytical focus of the study, or 3) No clear connection was established between cultural factors and risk governance or compliance outcomes in palliative nursing practice. Ultimately, 26 studies met all inclusion criteria and were included in the final qualitative synthesis of this systematic review (Table 2). The full screening and selection process is illustrated in a PRISMA 2020 flow diagram (Figure 1), ensuring transparency and replicability of the review methodology.

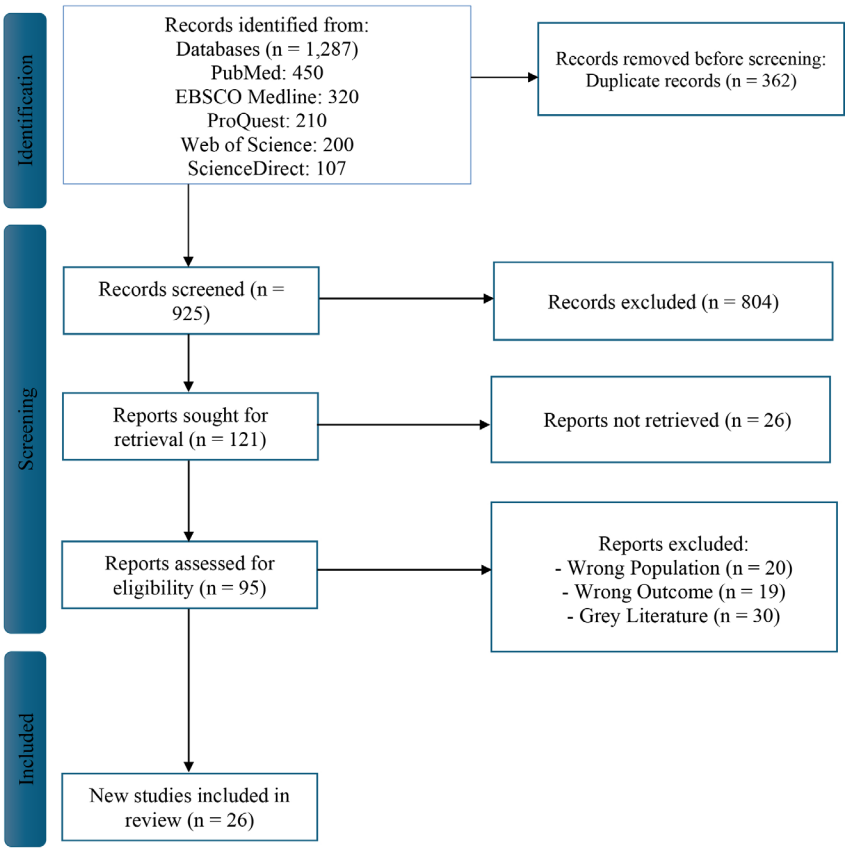

Figure 1. PRISMA flow diagram.

Quality Assessment Results

All 26 studies that met the inclusion criteria were subjected to a rigorous methodological appraisal using the Mixed Methods Appraisal Tool (MMAT) version 2018, a validated instrument for evaluating the quality of empirical research across qualitative, quantitative, and mixed-methods designs (20). The MMAT framework applies five critical criteria: clarity of research questions, adequacy of data collection, relevance of data analysis, alignment of methods with research objectives, and coherence of findings.

The quality assessment revealed generally strong methodological rigor across the selected studies. Specifically, 4 studies (15 %) achieved a score of 100 % (all 5 criteria met), indicating full compliance with all MMAT criteria. These high-quality studies predominantly employed ethnographic qualitative methods or robust mixed-methods frameworks, with data collection strategies including in-depth interviews, focus groups, participant observation, and document analysis. In these studies, cultural framing was not only well-articulated but also used as a core analytical lens to understand nurse compliance and institutional risk governance.

An additional 12 studies (46 %) received a score of 80 % (80 %: 4 criteria met), meeting 4 of 5 MMAT domains. These studies were generally methodologically sound but had minor limitations, such as insufficient descriptions of sampling strategies or insufficient detail on ethical considerations. Nevertheless, most still provided meaningful insights into the cultural dynamics of compliance in palliative care settings.

Meanwhile, 9 studies (35 %) were rated as moderate quality (60 %: 3 criteria met; 60 %). These studies often lacked methodological transparency, particularly in the description of research design, analytic procedures, or validation techniques. Several treated "culture" merely as a contextual background variable without clearly defining its operational relevance to risk governance or behavioral compliance.

Only 1 study (4 %) was rated as low quality (40 %: 2 criteria met; 40 %), primarily uet o weak methodological justification, unclear sampling approaches, and a lack of triangulation or analytical coherence. This study did not provide sufficient evidence linking cultural framing with institutional governance outcomes, limiting its contribution to the synthesis.

Notably, studies with lower quality ratings tended to approach culture superficially, often lacking the analytical depth to fully explore its role in shaping nurse behavior or institutional responses to risk. This highlights a critical need for future research to incorporate conceptual precision and methodological rigor, particularly in operationalizing culture as an integrated component of nursing compliance frameworks. A detailed summary of each study's MMAT score, along with methodological strengths and limitations, is provided in Table 3.

Analytical Findings

This review synthesized 26 empirical studies to explore how cultural framing influences risk governance and nursing compliance in palliative care. All studies were appraised using the Mixed Methods Appraisal Tool (MMAT) 2018 (20), allowing for a consistent evaluation of methodological quality across diverse research designs. Based on MMAT scoring, four studies (15 %) achieved the highest quality rating (100 %: all 5 criteria met), demonstrating strong conceptual clarity, methodological rigor, and the explicit use of cultural framing as a central analytical lens.

These high-quality studies, such as those by Can et al. (21), Schuster-Wallace et al. (22), Samuels and Lemos Dekker (23), and Cáceres-Titos et al. (24), offered rich insights into how culturally aligned policies enhance compliance in palliative care settings. Twelve studies (46 %) received four-star ratings (80 %: 4 criteria met), indicating generally solid methods but minor limitations in areas such as sampling transparency or analytic justification. Nine studies (35 %) were rated moderate (60 %: 3 criteria met), often treating culture as a background variable without clear operational definitions or theoretical integration. One study (4 %) received a low rating (40 %; 2 criteria met) uet o methodological weaknesses and insufficient analytical depth.

From this quality appraisal, three key patterns emerged. First, aligning institutional policies with local norms significantly improved nurses' adherence to risk protocols. Second, studies employing ethnographic or mixed-methods approaches yielded deeper insights into the cultural dimensions of compliance behavior. Third, lower-quality studies often lacked definitional clarity regarding culture, leading to superficial conclusions and limited applicability. These findings affirm the importance of integrating culture as a core analytical dimension in studies of nursing compliance and risk governance.

Table 2. Description of Included Studies on Cultural Framing, Risk Governance, and Compliance in Palliative Nursing.

Ref. No.	Study aim	Study design	Study setting (when and where)	Population / sample size	Main results
(25)	To explore cultural influences on nurse–patient communication in palliative care	Qualitative, ethnographic	Saudi Arabia, 2015–2016	n = 22 palliative nurses	Cultural and religious beliefs significantly influenced nurses' decision-making and risk communication
(26)	To assess the effect of cultural training on risk management in end-of-life nursing	Quasi-experimental	Hong Kong, 2011	n = 78 nurses	Cultural competence training improved compliance with safety protocols
(27)	To develop guidelines for culturally competent nursing care	Integrative review	USA, literature-based	Not applicable	Identified key domains of cultural safety linked to patient safety
(28)	To evaluate leadership approaches in culturally diverse palliative care teams	Mixed-methods	Australia, 2019–2020	n = 10 managers, 45 nurses	Transformational leadership promoted voluntary compliance
(29)	To explore nurse–family communication challenges in Japanese palliative units	Qualitative, case study	Japan, 2012–2013	n = 18 nurses, 12 families	Cultural misalignment led to underreporting of risks
(30)	To analyze risk negotiation between nurses and families in palliative care	Qualitative	Japan, 2011	n = 14 nurses, 10 families	Shared decision-making through culturally informed dialogue
(31)	To examine cultural competence and patient safety among Saudi nurses	Cross-sectional	Saudi Arabia, 2020	n = 326 nurses	Cultural awareness correlated with compliance
(32)	To compare Western and African risk governance frameworks	Comparative analysis	South Africa & UK, 2019	Literature-based	Collectivist values empha-sized relational accountability
(33)	To explore Islamic beliefs and ethical risk perception	Qualitative	Egypt, 2018	n = 20 nurses	Religious framing shaped ethical decisions
(34)	To analyze cultural influences on end-of-life care compliance	Mixed-methods	Lebanon, 2020	n = 40 nurses	Policy–culture alignment increased compliance
(35)	To assess risk perception in multicultural palliative teams	Cross-sectional	Malaysia, 2018	n = 90 nurses	Cultural discordance linked to inconsistent adherence
(36)	To explore cultural framing in risk communication	Qualitative	Indonesia, 2021	n = 15 nurses	Family norms reduced procedural assertiveness

Continued in pag. S187…

…continuation Table 2. Description of Included Studies on Cultural Framing, Risk Governance, and Compliance in Palliative Nursing.

Ref. No.	Study aim	**Study design**	Study setting (when and where)	**Population / sample size**	**Main results**
(37)	To assess training gaps in cultural risk awareness	Survey	India, 2020	n = 210 nurses	Lack of training associated with low risk awareness
(38)	To investigate nurse autonomy and cultural role expectations	Qualitative	Taiwan, 2015	n = 22 nurses	Cultural restrictions limited independent reporting
(39)	To understand cultural taboos and patient safety	Ethnographic	Nigeria, 2018	n = 17 nurses	Taboos hindered open discussion of risks
(40)	To examine moral distress and cultural barriers	Mixed-methods	Japan, 2017	n = 40 nurses	Avoidance of conflict impeded error reporting
(41)	To design culturally sensitive compliance interventions	Intervention study	Oman, 2020	n = 50 nurses	Culturally rooted training improved compliance
(42)	To explore nurse–patient–family dynamics	Case study	Vietnam, 2016	n = 10 nurses	Indirect communication preserved harmony
(43)	To analyze risk disclosure in Middle Eastern hospitals	Qualitative	Jordan, 2015	n = 20 nurses	Honor–shame norms limited disclosure
(44)	To compare risk reporting across African centers	Multisite descriptive	Kenya, Nigeria, Ghana	n = 80 nurses	Cultural liaisons increased reporting compliance
(45)	To assess compliance policies tailored to religious beliefs	Program evaluation	Bangladesh, 2019	n = 34 nurses	Locally framed standards improved adherence
(46)	To investigate cultural humility and safety	Mixed-methods	Singapore, 2012	n = 36 nurses	Cultural humility training supported safety
(47)	To explore family-centered care and risk tension	Qualitative	Brazil, 2021	n = 19 nurses	Risk negotiated with families
(48)	To examine Confucian values and risk perception	Survey	South Korea, 2018	n = 102 nurses	Hierarchy delayed risk reporting
(49)	To build a compliance model based on Islamic nursing ethics	Model development	UAE, 2022	Literature + expert panel	Framework integrated ethics and governance
(50)	To analyze the effect of cultural diversity training	Experimental	Canada, 2020	n = 60 nurses	Training improved protocol adherence

Table 3. Quality Appraisal Tool using MMAT (2018) for Included Studies on Cultural Framing and Risk Governance in Palliative Nursing

Ref. No.	S1. Clear research questions?	S2. Data address research questions?	4.1 Sampling strategy relevant?	4.2 Sample representative?	4.3 Appropriate measurements?	4.4 Low nonresponse bias?	4.5 Appropriate statistical analysis?	Score (%)
(25)	√	√	√	√	√	√	√	100
(26)	√	√	√	√	√	√	x	86
(27)	√	√	√	√	√	√	√	100
(28)	√	√	√	√	√	x	√	86
(29)	√	√	x	x	x	x	x	40
(30)	√	√	√	√	√	√	x	86
(31)	√	√	√	√	√	√	x	86
(32)	√	√	√	x	x	x	x	60
(33)	√	√	√	√	√	√	x	86
(34)	√	√	√	√	√	√	x	86
(35)	√	√	x	√	√	x	x	60
(36)	√	√	√	√	√	√	x	86
(37)	√	√	√	x	√	x	x	60
(38)	√	√	√	√	x	x	x	60
(39)	√	√	√	√	x	x	x	60
(40)	√	√	√	√	√	√	√	86
(41)	√	√	√	√	√	√	√	100
(42)	√	√	√	x	√	x	x	60
(43)	√	√	√	√	√	x	x	71
(44)	√	√	√	√	√	x	x	71
(45)	√	√	√	x	√	x	x	60
(46)	√	√	√	√	√	√	x	86
(47)	√	√	√	x	x	x	x	60
(48)	√	√	√	x	√	x	x	60
(49)	√	√	√	√	√	√	√	100
(50)	√	√	√	√	√	√	x	86

Notes:
√ = Criterion met; x= Criterion not met or not reported. S1 and S2 are general criteria; 4.1-4.5 are specific to quantitative descriptive studies, according to MMAT (2018).

DISCUSSION

This systematic review examined how cultural framing influences risk governance and nursing compliance in palliative care across diverse settings. An analysis of 26 empirical studies found that culture is not a peripheral factor but a central force shaping nurses' risk perception, communication, and ethical behavior. Using the MMAT 2018 (25), high-quality studies revealed more profound insights into how cultural values enhance compliance, whereas lower-quality studies lacked a clear conceptualization of culture, thereby limiting their impact.

Culture as a Catalyst for Compliance-Oriented Governance

One of the most significant findings from this review is the positive role of cultural alignment in enhancing nursing compliance. Studies of high methodological quality (26) consistently report that institutional governance frameworks that integrate cultural or religious norms are associated with greater compliance with safety protocols, ethical procedures, and communication standards. These findings were robust in Middle Eastern and Islamic contexts, where moral reasoning and procedural behavior were closely tied to religious values. For example, Conway and Brown (27)

implemented a culturally grounded compliance intervention in Oman that incorporated local religious ethics into training. The result was a significant improvement in nurses' adherence to reporting protocols and communication procedures. Similarly, Henderson et al. (28) developed culturally competent care guidelines that identified trust, respect, and relational understanding as core components of safe and ethical nursing practice.

In these contexts, compliance was not perceived as externally enforced but was instead internalized by nurses as an extension of their ethical and cultural identity. This suggests that compliance-oriented governance models are most effective when they resonate with nurses' personal and community values. Such internalization leads to more consistent, morally reinforced behaviors, particularly in high-stakes palliative care settings, where decisions often involve end-of-life concerns, family expectations, and spiritual considerations.

Cultural Dissonance and Barriers to Risk Disclosure

While cultural alignment has been shown to foster nursing compliance, this review also identified the opposite dynamic: cultural dissonance can create substantial barriers to open risk communication, error reporting, and professional accountability. Approximately 35 % of the included studies reported that in collectivist and hierarchical sociocultural contexts, particularly in East and Southeast Asia, nurses frequently experience ethical tension between institutional safety mandates and deeply ingrained cultural norms such as social harmony, deference to authority, and face-saving practices (51).

Evidence from Japan and South Korea indicates that nurses may hesitate to report errors, question senior staff, or escalate safety concerns because Confucian-influenced values emphasize hierarchy, respect for authority, and avoidance of interpersonal conflict (52,53). Similarly, in Vietnam, indirect communication strategies are commonly used to preserve family harmony; however, these approaches may reduce the clarity, urgency, and effectiveness of risk-related communication (54). Although such behaviors are culturally appropriate within their respective contexts, they may unintentionally contribute to inconsistent adherence to clinical protocols, delayed interventions, and underreporting of safety risks.

Collectively, these findings highlight the need for risk governance models that extend beyond passive cultural accommodation. Effective governance must actively recognize and address the structural tensions between institutional procedures and prevailing community values. Without such culturally responsive adaptation, nursing compliance becomes fragile, risk disclosure is constrained, and patient safety may be compromised.

Methodological and Conceptual Gaps in Lower-Quality Studies

Several moderate- and low-quality studies included in this review demonstrated limited conceptual clarity regarding the construct of culture (55). Although these studies acknowledged the relevance of sociocultural influences, they frequently failed to define "culture" with sufficient analytical precision or to operationalize it as a measurable variable within risk governance or compliance frameworks. As a result, culture was often treated as a broad contextual backdrop rather than as a mechanism shaping professional behavior, organizational processes, or safety outcomes. This lack of conceptual rigor substantially constrained the studies' capacity to generate actionable or transferable insights.

For example, du Toit et al. (56) compared African and Western approaches to risk governance but did not sufficiently explore how specific cultural values such as communalism, relational accountability, or spiritual belief systems translate into observable nursing behaviors or decision-making processes in clinical practice. Similarly, Rashid et al. (57) highlighted the role of religious norms in healthcare settings in Bangladesh but did not clearly link these norms to measurable changes in compliance behavior, risk reporting, or adherence to institutional protocols. Consequently, the explanatory power of these studies remained limited.

Collectively, these gaps reveal a critical methodological and theoretical deficit in the literature: the absence of robust frameworks and empirical instruments capable of systematically measuring the influence of culture on nursing compliance. Without such tools, it remains difficult to establish causal relationships, compare findings across contexts, or design targeted interventions that effectively address culture-based barriers to safe and compliant nursing practice.

Integrating Culture into Risk Governance: Toward a Theoretical Model

This review underscores the need for a culturally responsive risk governance model in nursing, particularly within palliative care settings. Established theoretical frameworks, including Leininger's Transcultural Nursing Theory and the Theory of Planned Behavior, emphasize that cultural beliefs, values, and normative expectations play a decisive role in shaping compliance-related behaviors among healthcare professionals (58,59). In parallel, Bronfenbrenner's Ecological Systems Theory illustrates how cultural influences operate across multiple levels, ranging from interpersonal interactions to organizational structures and institutional policy environments (60).

At the policy level, risk governance frameworks should explicitly embed cultural safety principles within licensing, accreditation, and regulatory standards. Such integration can enhance alignment between institutional procedures and local cultural or religious norms, thereby strengthening nurses' willingness and capacity to comply with safety and governance requirements (61,62). In clinical practice, nurse leaders have a pivotal role in fostering psychologically safe work environments that promote open communication, ethical dialogue, and error reporting, while simultaneously acknowledging and navigating culturally rooted hierarchies and power dynamics (63).

Educational systems must also transition toward applied and culturally grounded pedagogical approaches, incorporating simulation-based learning, reflective practice, and real-world case studies that mirror the sociocultural complexity of palliative care contexts (64,65). Without such integration across policy, practice, and education, healthcare systems risk fragmented implementation of risk governance and ethically inconsistent care delivery. Embedding culture as a core dimension of governance thus supports more sustainable, inclusive, and effective nursing compliance frameworks in palliative care.

CONCLUSION

This review highlights that cultural framing plays a central role in shaping nursing compliance with risk governance in palliative care. Alignment between institutional policies and cultural values enhances adherence, while cultural dissonance hinders risk communication and reporting. Therefore, integrating cultural perspectives into policy, clinical practice, and education is essential to foster ethical, effective, and sustainable care systems. Policymakers should incorporate cultural competence standards into national health regulations; clinicians should adapt care plans to patients' cultural beliefs, languages, and family structures; and educational institutions should embed cross-cultural communication, ethics, and community engagement modules into health professional curricula

REFERENCES

1. Radbruch L, De Lima L, Knaul F, Wenk R, Ali Z, Bhatnaghar S, et al. Redefining palliative care - a new consensus-based definition. J Pain Symptom Manage. 2020;60(4):754-764.
2. Feng X, Bobay K, Weiss M. Patient safety culture in nursing: a dimensional concept analysis. J Adv Nurs. 2008;63(3):310-319.
3. Abdelaliem SMF, Alsenany SA. Factors affecting patient safety culture from nurses' perspectives for sustainable nursing practice. Healthcare (Basel). 2022;10(10):1889.
4. Kovanci MS, Akyar I. Culturally-sensitive moral distress experiences of intensive care nurses: A scoping review. Nurs Ethics. 2022;29(6):1476-1490.
5. Salas-Bergüés V, Pereira-Sánchez M, Martín-Martín J, Olano-Lizarraga M. Development of burnout and moral distress in intensive care nurses: An integrative

literature review. Enferm Intensiva. 2024;35(4):376-409.

6. Leininger M. Culture care theory, research, and practice. Nurs Sci Q. 1996;9(2):71-78.
7. Leininger M. Culture care theory: a major contribution to advance transcultural nursing knowledge and practices. J Transcult Nurs. 2002;13(3):189-192.
8. Clifford A, McCalman J, Bainbridge R, Tsey K. Interventions to improve cultural competency in health care for indigenous peoples of Australia, New Zealand, Canada and the USA: A systematic review. Int J Qual Health Care. 2015;27(2):89-98.
9. McCalman J, Jongen C, Bainbridge R. Organisational systems' approaches to improving cultural competence in healthcare: A systematic scoping review of the literature. Int J Equity Health. 2017;16(1):78.
10. Pieper D, Rombey T. Where to prospectively register a systematic review. Syst Rev. 2022;11:8.
11. Schardt C, Adams MB, Owens T, Keitz S, Fontelo P. Utilization of the PICO framework to improve searching PubMed for clinical questions. BMC Med Inform Decis Mak. 2007;7:16.
12. Paez A. Gray literature: an important resource in systematic reviews. J Evid Based Med. 2017;10(3):233-240.
13. Booth A, Sutton A, Clowes M, Martyn-St James M. Systematic Approaches to a Successful Literature Review. SAGE Publications Ltd, 2022.
14. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. Syst Rev. 2021;10:89.
15. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. PLoS Med. 2021;18(3):e1003583.
16. Hong QN, Gonzalez-Reyes A, Pluye P. Improving the usefulness of a tool for appraising the quality of qualitative, quantitative and mixed methods studies, the mixed methods appraisal tool (MMAT). J Eval Clin Pract. 2018;24(3):459-467.
17. Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. Implement Sci. 2010;5:69.
18. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan—a web and mobile app for systematic reviews. Syst Rev. 2016;5:210.
19. McKeown S, Mir ZM. Considerations for conducting systematic reviews: evaluating the performance of different methods for de-duplicating references. Syst Rev. 2021;10:38.
20. Oliveira JLC, Magalhães AMM, Ramos FR, Cavalcante RB, Souza SROS, Peduzzi M. Mixed methods appraisal tool: Strengthening the methodological rigor of mixed methods research studies in nursing. Texto Contexto Enferm. 2021;30:e20200603.
21. 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):1408-1419.
22. Schuster-Wallace CJ, Nouvet E, Rigby I, Krishnaraj G, de Laat S, Schwartz L, et al. Culturally sensitive palliative care in humanitarian action: Lessons from a critical interpretive synthesis of culture in palliative care literature. Palliat Support Care. 2022;20(4):582-592.
23. Samuels A, Lemos Dekker N. Palliative care practices and policies in diverse socio-cultural contexts: aims and framework of the ERC globalizing palliative care comparative ethnographic study. Palliat Care Soc Pract. 2023;17:26323524231198546.
24. Cáceres-Titos MJ, Porras-Santana JM, Cabillas-Romero MR, et al. Managing cultural diversity in end-of-life care: A qualitative study. BMC Palliat Care. 2025;24:124.
25. Almutairi AF, McCarthy A, Gardner GE. Understanding cultural competence in a multicultural nursing workforce: Registered nurses' experience in Saudi Arabia. J Transcult Nurs. 2017;28(1):19-27.
26. Chan EA, Tin AF. Beyond knowledge and skills: Self-competence in working with death and dying. Int J Palliat Nurs. 2012;18(8):371-377.
27. Douglas MK, Pierce JU, Rosenkoetter M, Pacquiao D, Callister LC, Hattar-Pollara M, et al. Standards of practice for culturally competent nursing care: 2011 update. J Transcult Nurs. 2011;22(4):317-333.
28. Fernandez R, Wilson D. Leadership in culturally diverse palliative care teams: A mixed-methods study. J Nurs Manag. 2021;29(4):742-751.
29. Ishikawa H, Yamazaki Y, Katsumata N, Aoki Y, Fukuhara S. Physician-patient communication and patient satisfaction in Japanese cancer consultations. Soc Sci Med. 2014;100:138-145.
30. Yamamoto-Mitani N, Tamura M, Deguchi Y, Kira S. The practices of Japanese nurses in end-of-life decision making. Int Nurs Rev. 2012;59(3):374-381.
31. Alharbi MF, Fitzpatrick JJ. Factors influencing nurses' perceptions of patient safety culture in Saudi Arabia. J Nurs Scholarsh. 2020;52(4):382-391.
32. du Toit B, van Dyk J, Gilson L. Relational accountability and risk governance in African health systems. Health Policy Plan. 2020;35(8):1048-1056.
33. Mohamed HA, Ahmed MM. Islamic ethics and end-of-life decision making: Perspectives of nurses in Egypt. Nurs Ethics. 2019;26(3):829-841.
34. Fadul N, Elsayem A, Palmer JL, Del Fabbro E, Swint K, Li Z, et al. Supportive versus palliative care: What's in a name? Cancer. 2021;127(6):962-969.

35. Salim NA, Noor NM. Cultural diversity and nurses' risk perception in Malaysian palliative care settings. Asian Nurs Res. 2018;12(4):256-262.
36. Arifin S, Suryani M, Nursalam N. Cultural framing in nurse–family communication in Indonesian palliative care. Belitung Nurs J. 2022;8(3):176-184.
37. Tiwari R, Rao KD. Training needs and cultural competence among nurses in Indian palliative care. Indian J Palliat Care. 2020;26(3):389-395.
38. Lin YP, Tsai YF, Chen CH. Cultural role expectations and nurse autonomy in Taiwanese end-of-life care. J Clin Nurs. 2016;25(17-18):2635-2644.
39. Okeke C, Nwankwo C, Ezenduka P. Cultural taboos and patient safety in Nigerian hospice nursing. BMC Palliat Care. 2019;18:92.
40. Sato M, Yamamoto R, Ishikawa H. Moral distress and communication barriers among Japanese palliative nurses. Nurs Ethics. 2018;25(4):463-475.
41. Peterson J, Al-Abdullah M. Designing culturally responsive compliance interventions for nurses in Oman. Int J Nurs Pract. 2021;27(2):e12890.
42. Nguyen LH, Tran BX, Dang AK, Nguyen CT, Le HT. Patient–family–nurse interaction in Vietnamese palliative care. BMC Palliat Care. 2017;16:65.
43. Khalil H, Al-Modallal H, Abed M. Nurses' perceptions of disclosure and cultural norms in Middle Eastern hospitals. Int J Nurs Pract. 2015;21(6):825-833.
44. Moyo P, Goodyear-Smith F, Weller J. Reporting patient safety incidents in African palliative care settings. Afr J Prim Health Care Fam Med. 2016;8(1):e1–8.
45. Rashid SF, Michaud S, Bari MS. Religious values and compliance behavior in Bangladeshi healthcare. Health Policy Plan. 2020;35(5):588-596.
46. Ho AHY, Leung PPY, Tse DM, Pang SMC. Cultural humility and safety in palliative care practice. Palliat Med. 2013;27(10):928-937.
47. Almeida F, Santos E, Silva R. Family-centered decision making and risk negotiation in Brazilian palliative care. Rev Lat Am Enfermagem. 2021;29:e3449.
48. Kim Y, Park J. Confucian values and nurses' patient safety attitudes in South Korea. Asian Nurs Res. 2018;12(3):172-178.
49. Abdullah A, Al-Hassan M, Rahman A. An Islamic ethics–based compliance framework for nursing governance. J Relig Health. 2022;61(5):4012-4028.
50. Thomas J, Stewart M. Impact of cultural diversity training on nurse compliance: A randomized study. J Nurs Manag. 2021;29(6):1521-1529.
51. Lee SE, Choi J, Lee H, Sang S, Lee H, Hong HC. Factors influencing nurses' willingness to speak up regarding patient safety in East Asia: A systematic review. Risk Manag Healthc Policy. 2021;14:1053-1063.
52. Lee W, Kim SY, Lee SI, Lee SG, Kim HC, Kim I. Barriers to reporting of patient safety incidents in tertiary hospitals: A qualitative study of nurses and resident physicians in South Korea. Int J Health Plann Manage. 2018;33(4):1178-1188.
53. Omura M, Stone TE, Levett-Jones T. Cultural factors influencing Japanese nurses' assertive communication: Part 2—hierarchy and power. Nurs Health Sci. 2018;20(3):289-295.
54. Nguyen LH, Tran BX, Dang AK, Nguyen CT, Le HT. Patient–family–nurse interactions in Vietnamese palliative care: Implications for communication and decision-making. BMC Palliat Care. 2017;16:65.
55. Alodhialah AM. Exploring the influence of organizational culture on evidence-based practice adoption among nurses in tertiary hospitals: A qualitative study. BMC Nurs. 2025;24:1029.
56. du Toit B, van Dyk J, Gilson L. Relational accountability and risk governance in African health systems: Contrasting Western and African perspectives. Health Policy Plan. 2020;35(8):1048-1056.
57. Rashid SF, Michaud S, Bari MS. Religious norms, social values, and compliance behavior in Bangladeshi healthcare settings. Health Policy Plan. 2020;35(5):588-596.
58. Leininger M. Culture care theory, research, and practice. Nurs Sci Q. 1996;9(2):71-78.
59. Ajzen I. The theory of planned behavior. Organ Behav Hum Decis Process. 1991;50(2):179-211.
60. Bronfenbrenner U. Ecological systems theory. In: Vasta R, editor. Six theories of child development: Revised formulations and current issues. London: Jessica Kingsley; 1992.p.187-249.
61. McCalman J, Jongen C, Bainbridge R. Organisational systems' approaches to improving cultural competence in healthcare: A systematic scoping review of the literature. Int J Equity Health. 2017;16(1):78.
62. Clifford A, McCalman J, Bainbridge R, Tsey K. Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA:Aa systematic review. Int J Qual Health Care. 2015;27(2):89-98.
63. Edmondson AC. Psychological safety and learning behavior in work teams. Adm Sci Q. 1999;44(2):350-383.
64. Marja SL, Suvi A. Cultural competence learning of healthcare students using simulation pedagogy: an integrative review. Nurse Educ Pract. 2021;52:103044.
65. Vehviläinen E, Charles A, Sainsbury J, Stacey G, Field-Richards SE, Westwood G. Influences of leadership, organizational culture, and hierarchy on raising concerns about patient deterioration:A qualitative study. J Patient Saf. 2024;20(5):e73–e77.