

Strategies for Culturally Effective End-of-Life Care

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As a result of profound worldwide demographic change, physicians will increasingly care for patients from cultural backgrounds other than their own. Differences in beliefs, values, and traditional health care practices are of particular relevance at the end of life. Health care providers and patients and families may not have shared understandings of the meaning of illness or death and may not agree on the best strategies to plan for the end of life or to alleviate pain and suffering. Good end-of-life care may be complicated by disagreements between physicians and patients, difficult interactions, or decisions the physician does not understand. Challenges may result from cultural differences between the patient's background and traditional medical practice. Values so ingrained in physicians as to be unquestioned may be alien to patients from different backgrounds. Physicians need to be sensitive to cultural differences and to develop the skills necessary to

work with patients from diverse backgrounds.

Community and cultural ties provide a source of great comfort as patients and families prepare for death. This paper describes two cases that raise issues about cross-cultural end-of-life practice and suggests strategies for negotiating common problems. Physicians should assess the cultural background of each patient and inquire about values that may affect care at the end of life. They should become aware of the specific beliefs and practices of the populations they serve, always remembering to inquire whether an individual patient adheres to these cultural beliefs. Attention to cultural difference enables the physician to provide comprehensive and compassionate palliative care at the end of life.

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developed liver metastases and did not respond to two cycles of chemotherapy. At his last visit, the patient declined to discuss hospice when his physician raised this option. He has a living will indicating his desire for aggressive treatment if artificial means are required to sustain his life. The physician suspects that the patient's insistence on aggressive care may stem from his failure to understand the limits of available interventions.

The physicians in these cases were perplexed by their patients' seemingly inconsistent or unreasonable actions and decisions. In typical cases, physicians have little information about the patient's cultural and social background even though these characteristics shape end-of-life preferences. In this discussion, we argue that quality end-of-life care requires attention to cultural differences. Only through knowing the cultural background can clinicians make sense of a patient's explanatory models about illness, expectations about care, hopes for the future, and views regarding death (1). Building on many useful general articles on cross-cultural care and the culture of medicine (1–9), we focus on end-of-life care. Attention to cultural differences is particularly important because demographic changes in-

ing nonverbal cues. Rather than indicating agreement, Mrs. Martinez's nod might be merely a social custom, showing politeness and respect for a person in authority (15). Recognizing this possibility, s pny

icisms of the medical system. When specific incidents that engender mistrust are reported, follow-up through appropriate quality assurance committees may be necessary to correct systemic problems (30).

After addressing the fundamental issues of mistrust and misunderstanding, Mr. Byrd's physician dealt with the specific problem (inadequate pain control) troubling his patient. African Americans in the U.S. health care system continue to experience serious inequalities in treatment across a broad spectrum of clinical conditions, from cardiac disease to cancer, diabetes, renal disease, asthma, HIV and AIDS, and pneumonia; pain relief is an additional area of inequality (31–36). Minorities are less likely than other patients to receive adequate pain relief (37–39). Pharmacies in minority neighborhoods are less likely to stock and fill prescriptions for narcotics (40). Aware of these disparities, the physician expressed his commitment to pain relief and ensured that he understood how Mr. Byrd was reporting pain levels by asking him to indicate the level of relief he wanted.

Like Mr. Byrd, patients who have experienced poor access to care may be concerned that palliative medicine represents “giving up,” or second-rate care (41, 42). Belief in the sanctity of life may make it difficult for patients to accept the philosophy of care offered through hospice and palliative medicine (43). In response to this concern, Mr. Byrd's physician assured him that he, the patient, was in control. The doctor might also consider exploring other symptoms and functional limitations experienced by Mr. Byrd and how his family was coping with his illness, thus opening discussion to further clarify the philosophy and services of hospice care. Once Mr. Byrd understood that his physician's disrespectful behavior had been unintentional, he was able to hear offers of palliative care more openly.

judgmental attitude toward unfamiliar beliefs and practices and be willing to negotiate and compromise when world views conflict. In case 1, the physician recognized

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These cases suggest how physicians can better provide culturally effective care in societies characterized by diversity. To do so, physicians need the appropriate attitudes and skills, which have been termed *cultural sensitivity* and *cultural competence* (7, 9).

Cultural sensitivity requires that physicians be aware of how culture shapes patients' values, beliefs, and world views; acknowledge that differences exist; and respect these differences (6). Physicians need to maintain a non-

It is unrealistic to suggest that health care providers should learn the common beliefs about illness and the practices of the many cultural groups in the United States. Nonetheless, it is reasonable for physicians to become informed about the needs of populations they see regularly in their practices. Guidebooks and Web-based resources that compile information about cultural differences can introduce physicians to beliefs and practices relevant to end-of-life care (48–50). Specific cultural issues include the appropriateness of openly naming a disease or discussing death, the expression of pain, attitudes toward suffering, and the role of family members (and professional caregivers) in serious illness.

A tendency to lump together large population groups under broad categories can obscure important differences. For example, the designation “black” could refer to West Indians, Africans, and American-born blacks, among others. “Hispanics” or “Latinos” may include Puerto Ricans, Mexican or Central Americans, Dominicans, Cubans, and others. “Asians” may include persons with ancestry from the Indian subcontinent, China, Korea, Japan, or other Pacific Rim countries. Furthermore, there is great diversity within ethnic and cultural groups. Patients are individuals, and all members of any group do not necessarily share the same cultural traits. For example, although survey and focus group data suggested that African Americans and members of certain Hispanic groups completed advance directives less frequently than European Americans, individual representatives of these groups did not necessarily hold these beliefs (51–55).

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