Cultivating Cultural Competency at the End of Life

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SAN DIEGO — Counseling patients about end-of-life care is often a difficult task, but it can be more complicated when the patient has an ethnic or cultural background that differs from the physician's background.

Asking open-ended questions about the patient's concerns and fears is often the best way for the physician to elicit such information, experts said at the annual meeting of the American College of Physicians.

Religious beliefs can be a factor in a patient's resistance to palliative care. For example, some patients see their suffering as noble and a test of their faith.

Open-ended questions can be used even if the physician isn't familiar with the culture of the patient. "You don't have to know the details of every culture," said Dr. Bernard Lo, professor of medicine and director of the program in medical ethics at the University of California, San Francisco.

One of the issues that sometimes comes up in treating patients from traditional cultures, such as Asian Americans, is withholding information from the patient. For example, a family member may ask the medical staff to limit the information provided to the patient about the prognosis of their cancer.

Many families believe that explicitly telling the patient bad news will cause unnecessary suffering or cause the patient to lose hope, Dr. Lo said.

Physicians have some options in responding to these types of requests, he said. One approach is to explain to the family why it's desirable to provide the patient with more information. For example, some patients do better when they know their prognosis, because then they can make plans.

Telling patients about their medical condition also provides an opportunity to have a discussion about palliative care. And patients tend to learn about their prognosis anyway, especially in big hospitals, he said.

In addition to talking to family members, Dr. Lo said that finding out what the patient wants is critical. In some cases, what the patient wants and what the family wants may differ. Give the patient a chance to choose how much information he or she wants to hear, he said.

"I think it's good to offer information," Dr. Lo said.

Sometimes cultural issues can also affect how the patient expresses pain. For instance, Dr. Lo recently had a case in which the children of a patient complained that their father's pain was not being adequately addressed. It turned out that the patient, a 56-year-old Chinese American man, was underreporting his pain because he didn't want to bother the nurses.

In that case, patient-controlled analgesia was helpful because he no longer had to ask the nurses for pain relief, Dr. Lo said.

Providing culturally competent care at the end of life also means being aware of racial disparities, said Dr. LaVera Crawley, of the center for biomedical ethics at Stanford (Calif.) University.

A lack of access to aggressive treatments—or even a perceived lack of access—can affect the patient's willingness to receive palliative care later on, Dr. Crawley said.

Documented racial and ethnic disparities in accessing treatment may be one of the reasons there is generally an underutilization of hospice and other palliative care services among African American patients, she said. This group tends to prefer resource-intensive care, such as aggressive interventions. Similar trends are also seen in Hispanic and Asian American families.

For racial and ethnic groups that may have been subject to inequity in their health care, the idea of comfortably dying can be seen as a misplaced priority, Dr. Crawley said.

"Obviously, we have to start thinking about issues of trust," she said. "For large patterns of disparities, you're not going to solve them in your office in that one visit with that one patient."

However, when physicians encounter patients who may be reacting to past discrimination in their treatment, it's important to establish "trustworthiness," she said. To determine if lack of trust is an issue, physicians can ask patients, "Have you ever felt unfairly treated by me or anyone else involved in your care?"

Physicians can also try to identify any behaviors by the medical staff that could be considered impolite or abusive.

Other possible factors in resistance to palliative care include communication issues between physicians and patients, and religious beliefs. For example, some patients see their suffering as noble and a test of their faith, she said.

Physicians can consult experts on the communities they serve to help bridge some of the communication gaps. But when in doubt, ask patients about their personal beliefs, values, and preferences, Dr. Crawley said. ■

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