Cultural Considerations in End-of-Life Care

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Objectives

• To raise awareness of and enhance the care for people at end of life

• To honor and appreciate cultural diversity

• To understand how cultural factors influence end of life decision making
What is Culture?

• Factors that influence a person from birth to death
• Wide range of patterns and symbols that express who we are: beliefs, belongings and behavior
• Shared system of values and perspectives with a sub-group or dominant society
• Can be unique where “one size does not fit all”
Cultural Diversity: Demographic Shifts

- Lack of homogeneity between health care providers and patients

- By 2030, older adults will be 19% of total population

- By 2050, one in two Americans will be identified as a racial or ethnic minority.
Components of Diversity

- Race and ethnicity
- Gender and sexual orientation
- Social economic status
- Religion/Spirituality
- Age and educational level
- Previous experiences with death and dying
Cultural Clashes in Health Care Occurs when:

- Patient’s culture is different from a health provider’s culture
- Patient’s culture is different from the institution’s culture
- Mistrust exists from a patient’s previous experience with a health care system
Cultural Diversity issues....

• ...can be problematic in the provision of health care, because diversity issues:
  • Lead to misunderstanding and miscommunication
  • Cause interpersonal tension (e.g. when a cultural violation evokes a strong emotional reaction)
  • Often requires extra time and effort for people to communicate together.
Culture and the Family Role

• Who should be included in the decision-making process?
• Are final decisions left up to the patient?
• How much disclosure of the diagnosis is “culturally” appropriate?
• Is the discussion of risks or prognosis “culturally” appropriate?
• Is the idea of a surrogate as decision-maker acceptable?
Cultural Components includes:

• Previous experience with hospital culture or medical community?
• Decision-making dynamics and role of family
• Spiritual concerns/religious preferences, if any
• Beliefs regarding death, grief, pain and suffering (e.g. pain may serve a spiritual function “redemptive suffering)
• Language and communication style (collaborative or paternalistic)
• Review of 33 studies of racial and end of life decision-making found:

• Non-white racial or ethic groups generally lacked knowledge of advance directives and were less likely than whites to support advance directives. African Americans were found to prefer the use of life support; Asians and Hispanics were more likely to prefer family-centered decision-making than other racial or ethnic groups.

Religion and Death/Dying

• Religion influences death/dying choices in the following way:
  • Blood and organ issues
  • Importance of ritual acts and objects
  • Sense of divine intervention (e.g. “It’s God’s will”)
  • Meaning of pain/suffering
  • Withholding/withdrawing life sustaining treatment
Prevalence of Religion in U.S.

- Religious diversity has risen in last 10 years, more than 70% of Americans are Christian
- 80% of Americans say they “believe in God”
- Over 40% say they attend religious services regularly, usually at least once a week
- Over 80% of African Americans say religion is “very important” when it comes to end of life decisions
- 75-85% say they believe in “miracles” and that God answers prayers for healing someone with an incurable illness

Inquiring About Spirituality

• The most widely used “spiritual assessment” by clinicians is FICA:
  • **F**- The person’s **Faith** or self-identification as a religious or spiritual person
  
  • **I**- The **Importance** of the person’s faith

  • **C**- Is he/she part of a religious/spiritual **Community**?

  • **A**- How does the person want the health care provider to **Address** these spiritual issues
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