

Cross-Cultural Issues in HIV/AIDS Palliative Care Module Contents

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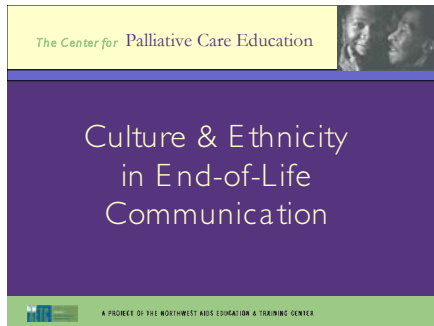
Learning Objectives

At the end of this presentation, participants will be able to:

- Give examples of the influence of culture on end-of-life communication.
- Understand the importance of distinguishing between group differences and individual's values and practices.
- Explain the interaction between trust and cross-cultural communication.
- Describe how to incorporate awareness of cultural issues into clinical care.

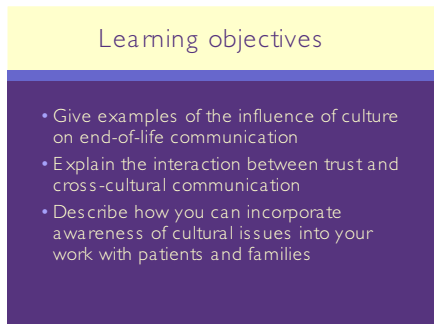
Culture & Ethnicity in End-of-Life Communication

PowerPoint



Trainer Suggestion

Introduce yourself and go over the agenda for the session. If there is time in the session and a small enough group, invite participants to introduce themselves and talk about what they are hoping to learn. Invite questions and comments throughout the presentation.



Slide Note

In this training session we will be discussing specific cultural perspectives which are examples of general concepts in cross-cultural communication about end-of-life care. It is hoped that participants will come away from this training with ideas about how to improve their own cross-cultural communication in their work.

Trainer Suggestion

This may also be a time to elicit from participants specific questions they have or areas they'd like covered in the session.

Consider a case

- 58 year old HIV+ African American man with cirrhosis, variceal bleed, ARDS, sepsis:
 - Team concerned about the value of ICU care
 - Wife feels strongly that life-sustaining care be continued

Slide Note

We'll start with a case: a 58-year-old African American man who was admitted to the hospital with HIV infection and cirrhosis. He was having his 3rd episode of bleeding into his stomach from the varices that the cirrhosis caused in his esophagus. He was also encephalopathic – he wasn't thinking clearly because his liver wasn't functioning enough to clear the toxins, in large part because of the bleeding. His wife reported that even with these problems, he had a good quality of life. Before this episode, he had been able to walk around the house and spend time with his family. In the emergency department, his wife was asked if he would want aggressive life-support and ICU care. She said yes. In the ICU, he was given blood products and fluid, and an esophagogastroduodenoscopy--looking down into his esophagus with a fiber-optic tube to see where the bleeding was. Bands were put around the varicose veins, and the bleeding stopped. He was intubated and on a mechanical ventilator at the time. He started doing a little better, and was taken off the ventilator.

Consider a case

- On hospital day 3 the patient aspirates and then develops ARDS and septic shock:
 - Team feels ICU care is futile
 - Wife is adamant that life-sustaining therapy be continued and seems suspicious of team's motives

Slide Note

On the third day, the patient vomited and aspirated into his lungs, and developed acute respiratory distress syndrome. He was on very high levels of ventilator support. He also developed sepsis syndrome, which meant that his blood pressure was very low, and his condition was worsening. The health care team at that point felt that in continuing to provide aggressive care, they could keep the patient alive for a few days, but that the situation was really futile. His wife remained adamant that life support be continued, and she seemed very suspicious of the health care team's motives as to why they would want to withdraw life support.

Trainer Suggestion

What issues are raised by this case? This is a good place to highlight issues of trust, differences in perspectives about end-of-life care, and decision-making. Elicit comments from participants on these issues that can be discussed during the presentation.

**What Is Culture?
What Is Ethnicity?**

Culture: Totality of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought
- American Heritage Dictionary, 2000

Ethnicity: Large groups of people classed according to common racial, national, tribal, religious, linguistic, or cultural background
- Merriam-Webster Dictionary, 2002

Slide Note

Let's step back from the case for a moment to consider the terms "culture" and "ethnicity". According to the dictionary definition, culture encompasses a broad spectrum of "socially transmitted" factors, including beliefs and behaviors – the kinds of things our grandparents passed on to our parents and on to us. Ethnicity refers to groupings of people by various factors such as race or religion.

Trainer Suggestion

Consider a discussion about the areas in which cultural differences might appear in communication with patients about end-of-life care: perspectives about what is okay to talk about, attitudes about who are prime decision-makers, what is perceived as comforting communication, etc. Participants might be encouraged to share their own experiences of positive and challenging cross-cultural communications.

The role of race & ethnicity in health care in the U.S.

- Differences in health and health care:
 - Often attributable to access to health care and socio-economic status
 - Not often attributable to culture and ethnicity
- Differences in attitudes toward end-of-life care:
 - Often attributable to ethnicity, culture, and religion
 - Not often attributable to socio-economic status

Adler, JAMA, 1993;269:3140
Blackhall, JAMA, 1995; 274:820

Slide Note

In the United States, there are dramatic differences in health status, as well as the in health care that people receive. Studies into the causes of these disparities indicate that most of the differences are not directly related to race, but are attributable to differences in access to health care and to socioeconomic status. However, in our society, race predicts access to health care, access to education and socioeconomic status.

The differences in peoples' attitudes towards end-of-life care, such as preferences for life-sustaining treatments, are also fairly dramatic across different groups. Those differences are not due to socioeconomic status, and they're not primarily due to access to health care. For the most part, they're due to culture and religion. Our attitudes about end-of-life care tend to come more from our grandparents and parents than they do from our education or socioeconomic status.

Why patients from minority cultures may distrust medical establishment

- History of abuse of minorities in research:
 - Legacy of Tuskegee
- Physician behavior toward minority patients may be influenced by negative stereotypes:
 - Perceived higher risk for non-adherence
 - Perceived higher risk for substance abuse
- Ongoing disparities in access and treatment including treatment of pain

Crawley, Ann Int Med, 2002; 136:9

Slide Note

LaVera Crawley and colleagues have published a paper examining issues related to culturally-effective end-of-life care. On the subject of trust, they point out a number of reasons why ethnic minority patients may distrust the medical establishment, including a history of abuse of minorities in medical research.

There is also research that shows that physicians bring negative ethnic stereotypes to their interactions with their patients and may assume that a patient is at higher risk for non-adherence or for substance abuse based on her or his ethnicity. Also, as we mentioned earlier, disparities in access and treatment impact trust.

Trainer Suggestion

Ask the participants by a show of hands how many are familiar with Tuskegee. Then briefly explain the Tuskegee Study: In the 1930s, 399 men signed up with the U.S. Public Health Service in Macon County, Alabama, for free medical care. The service was conducting a study on the effects of syphilis on the human body. The men were never told they had syphilis. They were told they had "bad blood" and were denied access to treatment, even for years after penicillin came into use in 1947. By the time the study was exposed in 1972, 28 men had died of syphilis, 100 others were dead of related complications, at least 40 wives had been infected and 19 children had contracted the disease at birth. It might be useful to point out that while the participants may have learned about Tuskegee in school and thus it seems like academic history to them, many African American patients have learned about it from their community, and its implications and repercussions may be very real to them.

Ethnicity & pain management

- Pain is under treated in some ethnic minorities
- Less access to pain meds in some communities:
 - Drug stores do not stock pain medications

Montson, New Engl J Med, 2000; 324:1023
Cleveland, Ann Intern Med, 1997; 127:813
Todd, JAMA, 1993; 269:1537

Slide Note

That people receive different health care based on their ethnicity is particularly seen with pain management. In some African American communities, for example, some pain medications, particularly opioids, are not stocked in the neighborhood pharmacies. A number of studies have shown that in the hospital and particularly in the emergency room, ethnic minority patients get less adequate pain treatment than do white patients.

Trainer Suggestion

A number of references are available on the subject of health disparities based on culture and ethnicity. If participants are interested, you may wish to direct them to the resource list for this module.

Cultural differences in attitudes about end-of-life care

- Many studies show African Americans prefer more life-support at end-of-life
- African Americans compared to whites:
 - Less likely to discuss EOL care with clinicians
 - Report lower quality of communication
 - More likely to feel discussing death may bring death closer

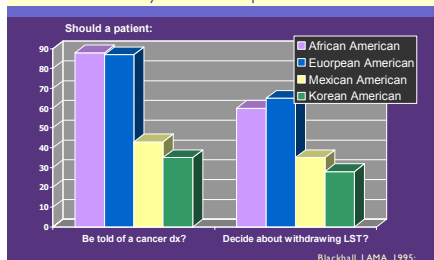
Curtis, Arch Int Med, 2000; 160:1690

Slide Note

As we mentioned, in end-of-life care, culture and ethnicity play a large role in our values and our attitudes.

For example, there have been many studies which show that as a group, African Americans prefer more aggressive care at the end of life than do white Americans. African Americans are also more likely to report that the quality of communication with their clinician is poorer than white patients report. African Americans are more likely to feel that talking about death may actually bring death closer. It's more common among African Americans to believe that what we say can shape our reality.

Cultural differences: Survey of 800 patients



Blackhall, JAMA, 1995.

Slide Note

This is a study looking at 800 patients in the Los Angeles area, 200 in each of four different ethnic groups—African American, European American, Mexican American, and Korean American. It shows dramatic cultural differences in attitudes about end-of-life care. Differences were seen in attitudes around whether a patient should be told that they have a diagnosis of cancer, and whether patients should be the ones to decide about using life support to keep them alive or whether that decision should be made by others. It is important to remember that just because we know someone's race or ethnicity doesn't mean we know their attitudes.

Can discussing death cause harm?

- Studies have shown that people from many different cultures are more likely to believe discussing death can bring death closer:
 - African Americans
 - Some Native Americans
 - Immigrants from China, Korea, Mexico

Curtis, Arch Intern Med, 2000; 60:1690
Carole, J Clin Ethics, 1992; 4:155

Slide Note

People from a variety of cultures, including European American cultures, have the perception that discussing death can cause harm. But this has been particularly seen among African Americans, some Native American tribes and among individuals who come from China, Korea and Mexico.

Decision-making varies by culture of medical system

- Balance of autonomy and beneficence:
 - US: Emphasis on autonomy
 - Europe/Asia: Emphasis on beneficence
- Primary locus of decision-making:
 - US: Patient
 - Asia: Family
 - France: Physician

Slide Note

Even when we're taking care of a patient from the same culture as ourselves, there are cross-cultural communication issues to be considered. We have taken on a new "culture" by virtue of working in the health care professions.

The U.S. had a paternalistic medical system back in the 1960's, the Marcus Welby era. Since then we have moved towards patient autonomy as the primary principle of medical ethics. In Europe, and in many parts of Asia, there has been a stronger emphasis on paternalism, or in a non-sexist language, 'parentalism.' Patients and families across multiple cultures vary as to whether they want a clinician who says, "This is what I think you should do," or whether they want a someone to say, "Here are all the options." There are also cultural differences according to who the decision-maker should be. In the United States health care system, the decision-maker is the patient. In many other cultures, family members make major health care decisions for the patient.

Western bioethics on the Navajo reservation

- Western bioethics expects clinicians to ask patient about advance directives and provide informed consent
- Traditional Navajo values expect clinicians to speak in a positive way
- Advance care planning viewed as harmful and unacceptable

Carrese, JAMA, 1995; 274:826

Slide Note

Here is an example of a way in which a medical culture came into conflict with a traditional culture. This study by Joe Carrese came out of his work as a doctor on the Navajo reservation, where he observed differences between the Western bioethical approach to informed consent and traditional Navajo values.

The Navajo value expects clinicians to speak in a positive way. Advance care planning and informed consent were viewed as harmful and unacceptable because of the Navajo perspective that language can shape reality: If you say to somebody, "You have a 20% chance of dying from this surgery," it's more likely that they'll die because you've said that. So this was a cultural attitude that was in direct contradiction to Western bioethics and the law, the Patient Self Determination Act, which requires clinicians to ask patients about advance directives when they're admitted to the hospital.

Recommendations for bridging cultural differences in clinical practice

- Assessment of patient and families understanding and beliefs
- Preparation:
 - Building trust with patient and family
 - Explicit discussion of misunderstanding
 - Involve community/religious leaders
- Communicate in a caring manner
- Follow through

Carrese, J Gen Intern Med, 2000; 15:92

Slide Note

Dr. Carrese spoke with individuals from the Navajo culture to learn how clinicians could bridge these differences, and he came up with some suggestions. The first is to assess patients' attitudes about discussing their care.

Take time to build trust with the patient and the family, making clear that you care about them as individuals and that you want what's best for them. Involve traditional healers if that would be helpful.

Communicate in a caring way. One suggestion was to refer to a 3rd party in talking about risk. Rather than saying, "If you have this surgery, there's a 20% chance that you will die," say, "Among the people who have this surgery, about 20% of them will die."

Follow-through and foster hope. Even to people with terminal disease, being able to foster hope without being unrealistic is an important part of communication.

These suggestions are very specific to the Navajo culture, but they're also useful for any time when we're in a cross-cultural situation.

Potential solutions

- Exploring cultural beliefs
- Building trust
- Addressing communication barriers
- Addressing religion and spirituality
- Involving the family

Kagawa-Singer, JAMA, 2001; 286:2993

Slide Note

We'll spend the next few minutes talking about some other possible solutions to the challenges of communicating cross-culturally. These include exploring cultural beliefs, building trust, addressing communication barriers, addressing religion and spirituality and involving the family.

Potential solutions:
Exploring cultural beliefs

- What do you think might be going on?
- If we needed to discuss a serious medical issue, how would you and your family want to handle it?
- Would you want to handle the information and decision-making, or should that be done by someone else in the family?

Kagawa-Singer, JAMA, 2001; 286:2993

Slide Note

These are some examples of questions to ask to explore cultural beliefs with patients.

Potential solutions:
Building trust

- Address directly: "Some people find it hard to trust clinicians who are not from their culture. Have you felt that?"
- Make explicit that you will work with patient and family
- Understand and accommodate differences in treatment preferences

Kagawa-Singer, JAMA, 2001; 286:2993

Slide Note

In terms of building trust, one of the suggestions is to talk about the issue of trust directly with patients and their families. Do not let it be the elephant in the room that nobody will talk about. You may find that addressing these issues directly will not always bring about a direct response, so be prepared to continue making efforts to build trust. Remember that working effectively with patients and families includes accommodating treatment preferences which may differ from your own.

Trainer Suggestion

This is an opportunity for a brainstorming session on building trust. An opening question might be, "What experiences have you had in trying to build trust across cultures?" Or, "What other ways could you address the issue with a patient?"

Potential solutions:
Communication barriers

- Obtain trained medical interpreter:
 - AT&T language line if no interpreter available
- Avoid medical or complex jargon
- Avoid use of family as interpreters
- Check understanding:
 - "What is your understanding of your illness and what is happening to you?"

Kagawa-Singer, JAMA, 2001; 286:2993

Slide Note

Here are some examples of ways to address communication barriers, including working with patients who speak limited or no English. When using medical interpreters, it's important to remember that we should not be using family members as interpreters if it can be avoided. Using a family member as an interpreter puts that person in a very difficult position, of being both the family member and a part of the medical team. Even when using an interpreter, it is important to avoid using medical jargon and to check out the patient's understanding of the situation.

Potential solutions: Religion & spirituality

- Address directly:
 - “Spiritual or religious strength sustains many people in times of distress. What is important for us to know about your faith or spiritual needs?”
 - “How can we support your needs and practices?”

Kagawa-Singer, JAMA, 2001; 286:2993

Slide Note

Religion and spirituality are also very important parts of cross-cultural communication in general, and particularly around end-of-life care. It is important to address it directly. Ask these kinds of questions to find out what kind of help they may need and what you can do to give that help.

Potential solutions: Family involvement

- Ascertain key members of the family:
 - Inclusive definition of “family”
- Ensure all family are included as desired by patient
- Assess patient’s desires for who make treatment decisions:
 - Patient alone, patient and family, or family alone

Kagawa-Singer, JAMA, 2001; 286:2993

Slide Note

It’s important to ascertain whether there are key members of the family that should be involved in decision-making. When thinking of family, we mean the family members and friends that are important to the patient. This issue has surfaced particularly in HIV/AIDS care, for example among gay men who may have a spouse or partner who is not recognized by the state as a family member. It is also important to determine who the patient wants as the key decision-maker on the treatment issues.

Agency-level possibilities

- Develop a cultural support team –members of the cultures of patients being served
- Review policies that may interfere with cultural expression:
 - Visiting hours
 - Burning sage
 - Caring for the body after death
- Integrate interpreter services into care delivery

Seibert, J Med Ethics, 2002; 28:143

Slide Note

At an institutional or agency level, solutions may include developing a support team which includes members of the same cultures as the patient populations being served. It may be necessary to address institutionalized policies which are in conflict with certain cultural expressions, such as a smoking ban which would prohibit the burning of sage, an important activity in some cultures. And as was discussed before, integrating interpreter services into the resources of the agency.

Trainer Suggestion

Here is an opportunity to elicit other ideas on dealing with institutional issues, and experiences that participants have had in trying to make agency-level changes.

Special issues about hospice

- Some cultures view hospice care as family being unable to care for patient
 - Emphasize hospice as an adjunct to family, but not a replacement
- Perception of palliative care as no care or withholding care:
 - Focus on building trust

Kagawa-Singer, JAMA, 2001; 286:2993

Slide Note

There are some special issues regarding hospice to consider. Some cultures view acceptance of hospice care as making a statement that the family is unable to care for the patient. This is more commonly the case in Asian cultures. Clinicians can be helpful in those situations by explaining what hospice involves and by emphasizing that hospice isn't taking over the care, or saying anything about a family's ability to provide the care. Hospice is seen an adjunct to the family members to help them provide better care for their loved one, and is not a replacement for that care.

Palliative care may also be seen by patients and families as the withholding of care. To address this perception, it will be important to work on building trust, and we'll be looking at this issue in re-visiting the case we discussed in the beginning of this session.

Reconsider the case

- 58-year-old African American man with cirrhosis, variceal bleed, ARDS, sepsis
- On hospital day 3 the patient aspirates, develops ARDS and septic shock:
 - Team feels ICU care is futile
 - Wife is adamant that supportive care be continued and seems suspicious of team's motives

Slide Note

Let's revisit our case. As you will recall, the patient was in the hospital with bleeding varices from cirrhosis. He was unable to make his own health care decisions due to confusion related to encephalopathy. The team felt that continued ICU support was futile, but the patient's wife wanted to continue with life support and mistrusted the motives of the all-white medical team.

This case raises the issue of building trust across cultures. What the team did in this situation to back off from the decision of whether or not life-support should be withdrawn, and instead the team focused on building trust.

Building trust across cultures

- Focus on building trust:
 - Wife is expert on husband's wishes
 - Team will not withhold any indicated care
- Understand & accommodate differences:
 - Listen to her perspective
 - Allow adequate time
 - Effective cross-cultural communication may take longer
- Involve others:
 - Additional family members
 - Community or religious leader

Slide Note

The team made it clear to the patient's wife that she was the expert on what her husband would want. They emphasized that they were not going to withhold any care that was indicated as long as she thought that he would want it.

Time was spent listening to her perspective, in an attempt to understand and accommodate cultural differences. The wife explained that although the patient had been homebound for quite some time, he was still actively involved in the life of the family and in the raising of their children. His wife felt that if the patient could bounce back enough to spend even two or three more weeks at home with his family, then it would be worthwhile. What she wanted for her husband was not unreasonable, once the team really sat down and listened to her perspective on his quality of life and the kinds of things that he would want. And in this case it was very helpful to involve others. Bringing in people from her community and her church allowed the patient's wife to feel less in a position of having to defend herself and her husband against the medical establishment. As it turned out, the patient died a few days later in the hospital, but his death did not leave a bitter taste for his wife, because she felt that her wishes and the wishes of her husband had been respected.

Trainer Suggestion

Participants may have suggestions for other strategies that the team could have taken to improve communication.

Summary

- Patients' views of end-of-life care may be powerfully affected by culture and ethnicity
- Differences between groups can be a helpful guide, NOT a protocol for care
- Cultural sensitivity requires effort to ask the right questions and listen

Slide Note

In summary, individuals, both patients and family members, and their views on end-of-life care, may be powerfully affected by culture, ethnicity, upbringing, religion and spirituality. We as health care providers need to openly acknowledge and address cultural issues with our patients. Learning about differences between groups can be a helpful guide, but knowing about a particular preference in a community does not mean that every member of the community will feel that way. Cultural competency takes time and requires the effort to ask the right questions, and then listen and learn from what patients tell us.

Incorporating culture into our communication

- Where can we make changes in our current communication practices?
- What next steps can we see ourselves doing to become more informed, more skilled in this area?

Slide Note

This might be a good place to reflect on ways that we can make changes to improve our current skills and practices around cross-cultural communication. A next step might be to think of ways we can become more informed about different specific cultures we're working with, or about the general issues involved. What are some resources that we each can call on to make progress in this area?

Trainer Suggestion

This is a slide which might be used if there is time in the session, to engender conversation or stimulate a brainstorming session on ways participants might make some changes. The format could be in pairs or small groups with reporting back to the large group. The trainer may wish to write up on a board the various actions that participants suggest.

Contributors

Anthony Back, MD	Director
J. Randall Curtis, MD, MPH	Co-Director
Frances Petracca, PhD	Evaluator
Liz Stevens, MSW	Project Manager

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This project is funded by the Health Resources and Services Administration (HRSA) and the Robert Wood Johnson Foundation (RWJF).

Skill building & Interactive Exercises

- ▶ Challenges to Cross-Cultural Communication
- ▶ EPEC Trigger Tape Exercise – *Medical Futility*
- ▶ Discussion Scenarios on Cross-Cultural Communication

Challenges to Cross-Cultural Communication

Type of Activity:	Self-reflection/Discussion
Time:	30-45 minutes
Materials:	Paper Pens or pencils
Purpose:	For participants to identify cross-cultural communication behaviors that are challenging to them and to develop new ways of thinking about these behaviors.

Instructions: Ask the participants to make a list of cross-cultural behaviors they find irritating or that they feel could be open to misinterpretation. Some examples of possible responses include: Nodding or saying “yes” even though not understanding, avoiding eye contact, speaking with a heavy accent or limited English, refusing to deal with you because of your gender, standing very close when talking, laughing when nothing seems funny, speaking loudly or softly. Then have the participants jot down their typical reaction to or interpretation of each behavior. If possible, when presenting this exercise, give an example from your own experience to make it feel safer for participants to speak up about their experiences.

Have participants divide up into pairs or groups of 3-4 to share responses. Give participants permission to share at their own comfort level. Then ask the groups to consider the discussion questions listed below.

Discussion Questions:

1. What are your typical reactions to behaviors you find challenging?
2. What meanings do you assign to these challenging behaviors?
3. How do your reactions and interpretations affect how you deal with a situation?
4. What are other ways of interpreting these challenging behaviors?
5. How have you been able to adapt to or work with a particular behavior that you find challenging?
6. What can you do to help others to work more effectively with challenging cross-cultural communication behaviors?
7. How might you respond the next time you encounter a behavior that you have previously misinterpreted?
8. Give an example or share a story about a time when you misinterpreted a behavior in a cross-cultural communication situation.

Finally, bring the group back together to share insights, new perspectives gained, and ways to apply this knowledge to their work with patients from different cultures.

EPEC Trigger Tape Exercise – *Medical Futility*

Type of Activity:	Observation/Discussion
Time:	20-30 minutes
Materials:	EPEC Trigger Tape #9 – <i>Medical Futility</i> VCR and television
Purpose:	For participants to observe and name good and not-so-good elements of cross-cultural communication in an end-of-life discussion.

This exercise is to be done using the Module #9 Trigger Tape from the EPEC Curriculum. EPEC (Education for Physicians on End-of-life Care) developed a curriculum to provide physicians with the basic knowledge and skills needed to appropriately care for dying patients. In addition to 12 training modules on palliative care topics, EPEC developed accompanying trigger tapes that provide examples of end-of-life communication skills and are used to stimulate discussion. The curriculum and trigger tapes can be ordered from their Website at <http://www.epec.net/content/products.html>.

Emanuel LL, von Gunten CF, Ferris FF, eds. “Module 9: Medical Futility,” *The Education for Physicians on End-of-Life Care (EPEC) Curriculum*: © The EPEC Project, The Robert Wood Johnson Foundation, 1999.

Set-up: Seven days ago, 15-year-old Kevin Robinson was struck by a car while riding his bike and sustained major traumatic injuries. Now, despite maximally intensive therapy, Kevin has developed multi-organ failure. He is currently receiving artificial ventilation and pressor support. The physician meets with Kevin’s mother to discuss Kevin’s care.

Discussion Questions:

1. How does the doctor start the discussion with Kevin’s mother?
2. What things does the physician do well? What things could he do differently?
3. In what ways does the clinician elicit Mrs. Robinson’s values and goals in the care of Kevin?
4. What statements are made by Mrs. Robinson regarding her religious beliefs? How does the clinician address these? Is he effective? Why or why not?
5. What cultural issues might be operating in this situation? How should the physician handle them?
6. How does the clinician handle the differences in values about Kevin’s care? What options are presented to Mrs. Robinson?
7. How does the issue of trust operate in this situation? How is it addressed by the clinician?
8. Do you think the issue is successfully resolved? Why or why not?

Discussion Scenarios on

Cross-Cultural Communication

Type of Activity:	Discussion
Time:	45-60 minutes
Materials:	Case handouts
Purpose:	To give participants an opportunity to evaluate a case and describe solutions utilizing cross-cultural communication skills discussed in the presentation.

Instructions:

Have the participants divide into small groups of 3-4 people each. Give each group a different case to discuss. Allow 15 minutes for the groups to read and discuss their cases. Come back together in the larger group and have each group report briefly on the case and how they handled it.

Case Handouts:

1. Your patient is an African-American man dying of AIDS. You meet with his family to apprise them of his condition. You and the team have decided that further treatment is futile. The patient's parents and siblings insist that everything be done, and become angry when you and the team say it would be futile. What do you need to know? What will you do and say?
2. Your patient is a Chinese man dying of AIDS. He is intubated, and has been unresponsive for the past two days. You have talked to his partner who is his DPOA, and he decided that the patient should be extubated and allowed to die. How do you talk to the patient's parents about this decision?
3. Your Muslim patient has died. You get a call from the nursing staff on the floor asking for you to come and quiet the patient's large extended family who is gathered around his bed wailing in grief. How do you handle this?
4. You meet with your Korean-American patient to talk to her about the futility of further treatment. She is silent and makes little eye contact, but nods and smiles at what you say. How can you be sure the patient has understood you? How can you be sure that you understand the patient's wishes?
5. You are asked to meet with a Latina patient who has a yeast infection. You need to get her sexual history and do a pelvic exam. When the interpreter walks in, the patient is clearly uncomfortable and ready to leave. What might be going on? How do you handle this?
6. You are meeting with a patient for the first time who is a recent Russian immigrant. The patient seems shut down and fearful, reluctant to provide any information. What might be going on? How do you handle this?
7. You are meeting with a Navaho patient and his family to give them a terminal diagnosis and short prognosis. After you have started, the patient and his family get up and leave. What might be going on? What do you do next?
8. You want to refer a dying patient to hospice. You had reluctantly agreed, due to the cultural issues of the patient and her family, to keep her terminal diagnosis from her. But the hospice requires informed consent, which includes the patient acknowledging a less-than six-month prognosis. What do you say to the patient and her family?
9. You meet with a patient's family after his death. The patient's uncle hands you an envelope with money in it and says it is in thanks for your care of the patient. What do you say?

Sample Agendas

We've developed some sample agendas for teaching about cross-cultural issues in HIV/AIDS palliative care. These agendas are adapted from trainings conducted by the Center for Palliative Care Education. The training module components are designed to work flexibly with each other. We encourage your experimentation in combining different components to find a training program that works for you and your audience.

► **If you have one hour...**

Introductions & Pre-Evaluation	<i>5 minutes</i>
<i>Cross-Cultural Issues in HIV/AIDS Palliative Care</i> PowerPoint	<i>30 minutes</i>
EPEC Trigger Tape – <i>Medical Futility</i>	<i>5 minutes showing 15 minutes discussion</i>
Wrap Up & Evaluation	<i>5 minutes</i>

► **If you have two hours...**

Introductions & Pre-Evaluation	<i>10 minutes</i>
Challenges to Cross-Cultural Communication Exercise	<i>25 minutes</i>
<i>Cross-Cultural Issues in HIV/AIDS Palliative Care</i> PowerPoint	<i>30 minutes</i>
Discussion Scenarios on Cross-Cultural Communication	<i>45 minutes</i>
Wrap Up & Evaluation	<i>10 minutes</i>

* Please refer to [Tips for Developing a Training Agenda](#) for more information.

Culture & Palliative Care

Evaluation Forms

We've developed evaluation forms to use with our training modules. They consist of unique identifier information about the participant, and questions aimed at gaining information about participant satisfaction and program effectiveness. You may want to adapt these forms and questions to your own evaluation needs.

Cross-Cultural Issues in HIV/AIDS Palliative Care

- ▶ [Pre-Training Survey](#)
- ▶ [Post-Training Survey](#)
- ▶ [Follow-Up Survey](#)

* Please refer to [Evaluating Your Training Session](#) for more information.

Cross-Cultural Issues in HIV/AIDS Palliative Care

Pre-Training Survey

Thank you for completing this survey. Your input will help us improve our training program and will provide information about its effectiveness to guide future planning. Please answer these questions as best you can – if you're not sure of an answer, just give it your best try.

Date: ___/___/___ ID: Birth month: ___ Day: ___ Last 4 digits of SSN: _____

1. Please rank your current level of skill in cross-cultural communication in palliative care, by checking one of the following numbers from 1 to 5:

Need more skill for basic competency		Adequate skill		Highly skilled
1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Please rank your current level of comfort with cross-cultural communication in palliative care:

Extremely uncomfortable		Somewhat comfortable		Extremely comfortable
1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please answer the following by checking the True or False box:

a. Regardless of a patient's ethnicity, full disclosure of diagnosis and prognosis is the best approach for clinicians in discussing end-of-life care. True False

b. Patient attitudes towards life sustaining treatment are predicted by cultural upbringing more than by socioeconomic status. True False

4. Please give 2 examples of cultural differences in perspectives regarding end-of-life care.

Correct Answers: 3a. False, 3b. True, 4. Correct answers will depend on content discussed in the training session. Examples might include: "Perspectives on amount of life-support" and "decision-making by family members versus patients."

Post-Training Survey

Thank you again for your input to help us improve our training program and guide future planning. As before, please answer these questions as best you can – if you’re not sure of an answer, just give it your best try.

Date: ___/___/___ ID: Birth month: ___ Day: ___ Last 4 digits of SSN: _____

1. Please respond to the following questions using the scale below:

	Not at all		Somewhat		Very much
Did the training hold your interest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you learn things in the training that will be useful for your work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How easy-to-understand was the information presented to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were the educational materials, such as slides or handouts, useful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How responsive was the trainer to the audience’s questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel the trainer’s presentation was culturally sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. What were the strengths of this presentation?

3. How could we improve this presentation?

4. Would you recommend this training to someone else? Yes No

5. Please rank your current level of skill in cross-cultural communication in palliative care, by checking one of the following numbers from 1 to 5:

Need more skill for basic competency		Adequate skill		Highly skilled
1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Please rank your current level of comfort with cross-cultural communication in palliative care:

Extremely uncomfortable		Somewhat comfortable		Extremely comfortable
1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Please answer the following by checking the True or False box:

a. Regardless of a patient's ethnicity, full disclosure of diagnosis and prognosis is the best approach for clinicians in discussing end-of-life care. True False

b. Patient attitudes towards life sustaining treatment are predicted by cultural upbringing more than by socioeconomic status. True False

8. Please give 2 examples of cultural differences in perspectives regarding end-of-life care.

9. What do you anticipate doing differently in your work as a result of this training?

10. How much did this training help prepare you to do the following:

	Not at all		Somewhat		Very much
Provide primary end-of-life care for patients with HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide education and training to other clinicians on end-of-life care issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advocate for better palliative care in your workplace?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other roles or activities related to palliative care: <i>(please list here)</i> ? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Would you be willing to be contacted in one month for a brief follow-up? Yes No

If yes, what is your email address? _____

12. Please write any additional comments, thoughts, or suggestions here. We appreciate your taking the time to complete these surveys. Thank you very much!

Correct Answers: 7a. False, 7b. True, 8. Correct answers will depend on content discussed in the training session. Examples might include: "Perspectives on amount of life-support" and "decision-making by family members versus patients."

Follow-Up Survey

[This is a sample of a letter to send out to your training participants 4-6 weeks after the training.]

Hello!

About a month ago, you attended a presentation on Cross-Cultural Issues in HIV/AIDS Palliative Care, given by [presenter].

Thank you for participating in our evaluation. Your survey responses have been very helpful for planning the next steps in our training program. Thanks also for agreeing to answer some follow up questions for our evaluation. If you have a few minutes to answer the following questions, it would be very helpful.

Now that a month has gone by...

1. What changes, if any, do you feel you have made in your work as a result of this training session?
2. Please rank your current level of skill in cross-cultural communication in palliative care:
(1=Need more skill for basic competency; 3=Adequate skill; 5=Highly skilled)
3. What is your overall rating of the quality of the session?
(1=Poor; 3=Average; 5=Excellent)
4. Please write any additional comments, thoughts, or suggestions here.

Please contact me [your contact information here] if you have any questions about our project or if you'd like us to keep you informed of any upcoming training sessions. Thanks again!

Suggested Handouts

1. Blackhall, L., Frank, G., Murphy, S., Michel, V., Palmer, J. & Azen, S. (1999). Ethnicity and attitudes towards life sustaining technology. *Social Science & Medicine* 48(12): 1779-1789.
2. Carrese, J. A. & Rhodes, L. A. (2000). Bridging cultural differences in medical practice: The case of discussing negative information with Navajo patients. *J Gen Int Med* 15: 92-96.
3. Crawley, L., Marshall, P., Lo, B., & Koenig, B. (2002). Strategies for culturally effective end-of-life care. *Ann Intern Med* 136(9): 673-9.
4. Kagawa-Singer, M. & Blackhall, L. (2001). Negotiating cross-cultural issues at the end-of-life: "You got to go where he lives." *JAMA* 286(23): 2993-3001.
5. The University of Washington Patient & Family Education Committee – depts.washington.edu/pfes/cultureclues.html - has information sheets available regarding communicating effectively with different cultures.
Culture Clues: Communicating with Your African-American Patient
Culture Clues: Communicating with Your Albanian Patient
Culture Clues: Communicating with Your Chinese Patient
Culture Clues: Communicating with Your Korean Patient
Culture Clues: Communicating with Your Latino Patient
Culture Clues: Communicating with Your Russian Patient
Culture Clues: Communicating with Your Vietnamese Patient

Resources

Cross-Cultural Communication

Articles

Beyene, Y. (1992). Medical disclosure and refugees: Telling bad news to Ethiopian patients. *West J Med* 157: 328-332. [PubMed Abstract](#).

Blackhall, L., Frank, G., Murphy, S. & Michel, V. (2001). Bioethics in a different tongue: The case of truth-telling. *J of Urban Health: Bulletin of the NY Academy of Medicine* 78(1): 59-71. [PubMed Abstract](#).

Blackhall, L., Murphy, S., Frank, G., Michel, V. & Azen, S. (1995). Ethnicity and attitudes towards patient autonomy. *JAMA* 274(10): 820-5. [PubMed Abstract](#).

Brotzman, G. & Butler, D. (1991). Cross-cultural issues in the disclosure of a terminal diagnosis: A case report. *J Fam Prac* 32(4): 426-7. [PubMed Abstract](#).

Buchwald, D., Caralis, P., Gany, F., Hardt, E., Muecke, M. & Putsch, R. (1993). The medical interview across cultures. *Patient Care* Apr 15: 141-150, 160-166.

Carrese, J. & Rhodes, L. (2000). Bridging cultural differences in medical practice: The case of discussing negative information with Navajo patients. *J Gen Int Med* 15: 92-96. [PubMed Abstract](#).

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Crawley, L., Marshall, P., Lo, B. & Koenig, B. (2002). Strategies for culturally-effective end-of-life care. *Ann Intern Med* 136: 673-679. [PubMed Abstract](#).

Haffner, L. (1992). Translation is not enough: Interpreting in a medical setting. *West J Med* 157(3): 255-59. [PubMed Abstract](#).

Kagawa-Singer, M. & Blackhall, L. (2001). Negotiating cross-cultural issues at the end of life: "You got to go where he lives". *JAMA* 286(23): 2993-3001. [PubMed Abstract](#).

Kaufert, J. & Putsch, R. (1997). Communication through interpreters in health care: Ethical dilemmas arising from differences in class, culture, language, and power. *J Clin Ethics* 8(1): 71-87. [PubMed Abstract](#).

Kaufert, J., Putsch, R. & Lavalley, M. (1999). End-of-life decision making among aboriginal Canadians: Interpretation, mediation, and discord in communicating “bad news”. *J Pall Care* 15(1): 31-38. [PubMed Abstract](#).

Mull, J. (1993). Cross-cultural communication in the physician’s office. *West J Med* 159: 609-613. [PubMed Abstract](#).

Putsch, R. (1985). Cross-cultural communication: The special case of interpreters in health care. *JAMA* 254(23): 3344-48. [PubMed Abstract](#).

Books

Gardenswartz, L. & Rowe, A. (1999). *Managing diversity in health care manual: Proven tools and activities for leaders and trainers*. San Francisco, CA: Jossey-Bass.

Novinger, T. (2001). *Intercultural communication: A practical guide*. Austin, TX: University of Texas Press.

Samovar, L. & Porter, R. (1994). 7th ed., (Eds.). *Intercultural communication: A reader*. Belmont, CA: Wordsworth Publishing Company.

Videos

Cross-Cultural Health Care Program

www.xculture.org.

Seattle, WA

Available for order on their website at www.xculture.org.

1. *Communicating effectively through an interpreter: an instructional video for health care providers*.

2. *East Africans and mental health: Delivering bad news*.

Culturally-Competent Care

Articles

Adler, N., Boyce, W., Chesney, M., Folkman, S. & Syme, S. (1993). Socioeconomic inequalities in health: No easy solution. *JAMA* 269(24): 3140-45. [PubMed Abstract](#).

Alford, J. & Catlin, G. (1993). The role of culture in grief. *J Soc Psych* 133(2): 173-84. [PubMed Abstract](#).

Barker, J. & Clark, M., (Eds.) (1992). Cross-cultural medicine: A decade later. *West J Med* 157(3): all pages. The entire issue is devoted to cross-cultural medicine. Individual articles are listed under relevant topics.

Barrett, R. & Heller, K. (2001). Death and dying in the black experience: An interview with Ronald K. Barrett. *Innovations in End-of-Life Care* 3(5): Available at. www.edc.org/lastacts.

Beech, L. (1983). Eastern and Western attitudes in the management of death and the Shanti Project as an experimental synthesis. *Diss Abs Int'l* 43(9-b): 3013.

Berger, J. (1998). Culture and ethnicity in clinical care. *Arch Int Med* 158(19): 2085-90. [PubMed Abstract](#).

Berlin, E. & William, C. (1983). A teaching framework for cross-cultural health care. *West J Med* 139(6): 934-38. [PubMed Abstract](#).

Blackhall, L., Murphy, S., Frank, G., Michel, V. & Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. *JAMA* 274(10): 820-25. [PubMed Abstract](#).

Boyce, J., Hodnicki, D. & Ferrell, J. (1999). Patterns of resistance: African American mothers and adult children with HIV illness. *Scholarly Inquiry for Nursing Practice* 13(2): 111-133.

Brownlee, A. (1978). The family and health care: Explorations in cross-cultural settings. *Soc Work Hlth Care* 4(2): 178-9.

Burrs, F. (1995). The African American experience: Breaking the barriers to hospices. *Hospice J* 10(2): 15-18. [PubMed Abstract](#).

Callahan, D. (1995). Frustrated mastery - The cultural context of death in America. *West J Med* 163(3): 226-230. [PubMed Abstract](#).

Candelaria, E. & Adkins, E. (1994). A Mexican-American perspective on death and the grief process. *The Forum* Sept/Oct: 7-19.

Carrese, J. & Rhodes, L. (1995). Western bioethics on the Navajo reservation: Benefit or harm? *JAMA* 274: 826-9. [PubMed Abstract](#).

Cassetta, R. (1994). Cultural competency: Essential to HIV/AIDS care and prevention. *Am Nurse* 26(7): 15. [PubMed Abstract](#).

Chatters, L. (1994). HIV/AIDS within African American communities: Diversity and interdependence. *Health Education Quarterly* 20(3): 321-326.

Chester, B. & Holtan, N. (1992). Working with refugee survivors of torture. *West J Med* 157: 301-304. [PubMed Abstract](#).

Chin, D. & Kroesen-Kendall, W. (1999). Disclosure of HIV infection among Asian/Pacific Islander-American women: Cultural stigma and support. *Cultural Diversity and Ethnic Minority Psychology* 5(3): 222-235.

Cohen, M. & Palos, G. (2001). Culturally-competent care. *Seminars in Oncology Nursing* 17(3): 153-158. [PubMed Abstract](#).

Cowles, K. (1996). Cultural perspectives of grief: An expanded concept analysis. *J Adv Nurs* 23: 287-94. [PubMed Abstract](#).

Crawley, L. (2001). Palliative care in African-American communities. *Innovations in End-of-Life Care* 3(5): Available at. www.edc.org/lastacts.

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Crawley, L., Payne, R., Bolden, J., Payne, T., Washington, P. & Williams, S. (2000). Palliative and end-of-life care in the African American community. *JAMA* 284(19): 2518-21. [PubMed Abstract](#).

Curtis, J. & Patrick, D. (1993). Race and survival from AIDS: A synthesis of the literature. *Am J Pub H* 83: 1425-28. [PubMed Abstract](#).

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Feldman, J. (1992). The French are different: French and American medicine in the context of AIDS. *West J Med* 157(3): 345-9. [PubMed Abstract](#).

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- Hepburn, K. & Reed, R. (1995). Ethical and clinical issues with Native-American elders: End-of-life decision making. *Clin Ger Med* 11(1): 97-111. [PubMed Abstract](#).
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- Kreier, R. (1999). Crossing the cultural divide: A physician's need to be sensitive to a patient's cultural concerns is amplified when the illness is terminal and end-of-life issues are at stake. *Amer Med News* 1/25/99. : Available on the AMA website . www.ama-assn.org/sci/pubs/amnews/pick_99/fadd0125.htm.

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Books

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Boyd-Franklin, N., Aleman, J., Jean-Gilles, M. & Lewis, S. (1995). Cultural sensitivity and competence: African-American, Latino, and Haitian families with HIV/AIDS. In: Boyd-Franklin, N., Steiner, G., et al., (Eds.). *Children, families and HIV/AIDS: Psychosocial and therapeutic issues*. New York, NY: The Guilford Press.

Braun, K., Pietsch, J. & Blanchette, P. (2000). *Cultural issues in end-of-life decision making*. Thousand Oaks, CA: Sage Publications.

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Danis, M. (2001). The roles of ethnicity, race, religion, and socioeconomic status in end-of-life care in the ICU. In: Curtis, J. & Rubenfeld, G., (Eds.). *Managing death in the ICU*. New York, NY: Oxford University Press.

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Irish, D., Lundquist, K. & Nelsen, V. (1993). *Ethnic variations in dying, death, and grief: Diversity in universality*. Philadelphia, PA: Taylor & Francis.

Lipson, J., Dibble, S. & Minarik, P. (1998). *Culture and nursing care: A pocket guide*. San Francisco, CA: UCSF Nursing Press. Includes a set of guidelines for working with a variety of cultures on the topics of health, illness, symptom expression, self-care, birth, death, religion, family participation in care, etc. Groups included are American Indians, Arab Americans, Black/African Americans, Brazilians, Cambodians, Central Americans, Chinese Americans, Colombians, Cuban Americans, Ethiopians, Filipinos, Gypsies, Haitians, Hmong, Iranians, Japanese Americans, Koreans, Mexican Americans, Puerto Ricans, Russians, Samoans, South Asians & Vietnamese..

Michal-Johnson, P. & Perlmutter-Bowen, S. (1992). The place of culture in HIV education. In: Edgar, T., Fitzpatrick, M., et al., (Eds.). *AIDS: A communication perspective*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc..

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Spector, R. (1991). *Cultural diversity in health and illness (3rd ed)*. Norwalk, CT: Appleton & Lange.

Videos

Midwest Bioethics Center

www.midbio.org.

Available on their website:

Nick and Sheila and the world: A case study about patient rights and cultural diversity.

Websites

Access to End of Life Care: A Community Initiative - www.access2eolcare.org. ACCESS is dedicated to improving end-of-life care services for the ethnically diverse populations of the San Francisco Bay Area. The website includes an extensive bibliography, resource links, and information about outreach services available in the San Francisco Bay area.

Asian and Pacific Islander Wellness Center - www.apiwellness.org. This San Francisco organization is primarily focused on education and prevention. They have produced a free, downloadable pamphlet, *Clinician's Guide to Working with Asians and Pacific Islanders Living with HIV*. They also provide links with API organizations throughout the country.

Association of American Indian Physicians - www.aaip.com. AAIP is dedicated to pursuing excellence in Native American healthcare by promoting education in medical disciplines and honoring traditional Native healing methods. The website has links to many resources and

opportunities for Native American patients and healers/physicians, as well as educational resources about HIV/AIDS and other diseases.

BlackAIDS.org - www.kujisource@aaainstitute.org. African American AIDS Policy and Training Institute website.

Cross-Cultural Health Care Program - www.xculture.org. The mission of CCHCP is to "serve as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate." CCHCP provides cultural competency trainings, interpreter trainings, a library, books, videos and articles, and translation services. Voices of the Community profiles are available online. The communities profiled include Arab, Cambodian, Eritrean, Ethiopian, Lao, Mien, Oromo, Samoan, Somali, South Asian, Soviet Jewish, and Ukrainian. Longer booklets can be ordered which include information about Cambodian, Chinese, Filipino, Hmong, Japanese, Lao, and Vietnamese communities.

Cuidados Paliativos, Complejo Hospitalario Xeral-Cies - www.paliativos.com. A Spanish language palliative care hospice site provided by Complejo Hospitalario Xeral-Cies of Vigo, Spain. This site provides a portal to the Spanish language forum which is part of the Inter-Institutional Collaborating Network on End-of-Life Care (IICN). You can search the Growth House database using a Spanish language selection menu from this site.

Diversity Rx - www.diversityrx.org. This site describes its mission as "promoting language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities." The website has information on cultural-competency models and practices, as well as curricula and training programs. A report entitled *Multicultural Health Best Practices* is also available.

Ethnomed - www.ethnomed.org. This site contains information about cultural beliefs, medical issues, and other related issues pertinent to the health care of recent immigrants to Seattle. Culture specific pages include Amharic, Cambodian, Chinese, Eritrean, Ethiopian, Mexican, Oromo, Somali, Tigrean, and Vietnamese. The site also includes clinical topics, journal articles, immigration, and general information about cross-cultural care.

Growth House - www.growthhouse.org/pages.html. This is a comprehensive international clearinghouse of information regarding life-threatening illness and end-of-life care. Topics include palliative medicine, advance directives, grief, and professional resources. Articles, resources lists, a sophisticated search feature and extensive international web links are available. Asian AIDS resources are covered well.

HIV Basics - hiv.hypermart.net. Investigacion Basica y Tratamiento de la Infeccion por HIV.

HRSA HIV/AIDS Bureau - www.hab.hrsa.gov. The site contains publications and resources on HIV/AIDS, including the comprehensive book *A Clinical Guide to Supportive and Palliative Care for HIV/AIDS*.

Initiative to Improve Palliative Care for African Americans - www.iipca.org. The mission of IIPCA is to promote research, education, and policies for the improvement of care for African American patients facing serious illness.

Manager's Electronic Resource Center - erc.msh.org/. Designed to assist health care organizations in providing high quality, culturally-competent services to multi-ethnic populations. Includes *The Provider's Guide to Quality and Culture*. Cultural information is available about African Americans, Asian Americans, Hispanic/Latino Americans, Native Americans, and Pacific Islanders.

Midwest Bioethics Center - www.midbio.org. The community-based Midwest Bioethics Center is dedicated to integrating ethical considerations into health care decision making. It offers workshops and educational programs for professionals and lay people. It also assists health care providers in integrating ethics into clinical work and administrators in integrating ethics into organizations. The Center recently hosted a summit on cultural diversity in health care. Many books and videos are available to assist in communication, advance directives, and palliative care issues.

National Minority AIDS Council (NMAC) - www.nmac.org. This national AIDS organization specifically develops its programs and services for community-based organizations serving people-of-color affected by HIV/AIDS. Their website provides information about NMAC conferences (including the U.S. Conference on AIDS), public policy efforts, research and treatment advocacy programs, technical assistance activities, and publications.

Sociedad Española de Cuidados Paliativos - www.secpal.com. SECPAL is the national professional organization for palliative care in Spain. Website is in Spanish and includes information about regional services as well as international links.

University of California-San Francisco, School of Medicine - medicine.ucsf.edu/resources/guidelines/culture.html. This website has a good cross-cultural medicine resource page.