

Providing Palliative Care Across the Cultures

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Goals

- To identify health care disparities as they appear in palliative care delivery
- Develop communication skills necessary to address the health care needs and spiritual beliefs of patients and families from diverse backgrounds in palliative care
- Demonstrate an increased awareness of the impact of culture and one's own value system on the provider /patient relationship

Palliative Care

“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

(World Health Organization)

Palliative Care...

- Focuses on relieving suffering, improving quality of life
 - affirms life, sees death as a personal and natural process
 - many diagnoses
 - appropriate early in course of illness and diseases where cure is a real possibility
 - patient and family preferences respected
 - may be combined with curative therapies or may be the focus of care

...Palliative Care

- Interdisciplinary care of the patient and family
- Pain and symptom management
- May include disease-modifying or “curative” treatments
- Psychological, social, spiritual support
- Bereavement support

Culture

- **A system of shared symbols**
- **Provides security, integrity, belonging**
- **Constantly evolving**

Components of Culture

- Ethnic identity
- Gender
- Age
- Differing abilities
- Sexual orientation
- Religion and spirituality
- Financial status
- Place of residency
- Employment experience
- Education level

Role of Culture in Palliative Care Planning

- Pain avoidance: universal but...
- Socioeconomic influence
- Family decision making
- Preferred location of death
- Quality of life vs. quantify life
- Voice of the elderly person

Palliative care planning issues

- Key participants
- Language taboos
- Disclosure/Truth telling
- Withdrawal vs. withholding
- Suffering and pain
- The meaning of illness/suffering
- The meaning of the dying process and death

Cultural Competence

"The ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients' social, cultural and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background or English Proficiency."

LCME Standard for Cultural Competency, 2000.

Healthcare Disparities

Are the differences in the incidence, prevalence, mortality and burden of diseases and other health conditions that exist among specific population groups in the US.

The Office OF Minority Health Report "Eliminating Ethnic Healthcare Disparities", HRSA, NOVEMBER, 2000

Healthcare Disparities in PC

- Performed a systematic review of healthcare disparities for minorities in PC.
- Dr. Cintron identified race and ethnicity implicated as major factors in :
 - pain assessment and management
 - advance care planning and end-of-life communication and decision-making
 - use of hospice and other palliative care services

Permission obtained from Dr. Cintron.
Funded by Patient-oriented Research in Geriatric Palliative Care (K24) - National Institute on Aging
Research Supplement to Promote Diversity in Health-Related Research - National Institute on Aging

Pain Studies

- Dr. Cintron performed a systematic review on the affect of race and ethnicity on pain assessment and management
- He searched English-language articles from 1990-2005
- Only 35 studies met criteria

By permission from Alexie Cintron, MD, MPH presented at the AAHPM 2006 Annual Meeting

Prescription Patterns

- 11 revealed disparities by patient race/ethnicity
 - African Americans and Hispanics more likely to
 - Receive no analgesia
 - Receive less opioid

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Pain Assessment

- 3 Studies
- Majority of African Americans and Hispanics have pain underestimated by providers
 - Non-whites less likely to have pain recorded
 - Race/ethnicity not predictive of pain assessment for lone bone fx patients

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Barriers

- 12 studies

Patient-related	
Whites	Fewer barriers, MDs accessible, no financial diff
African Americans	Wait longer, use ER, racial discrimination
Hispanics	Financial barriers, least likely to seek care or Rx
Provider-related	No difference by pt race in opioid Rx decisions
Pharmacy-related	Inadequate opioid stocks at minority locations

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Advance Care Planning Studies

- Dr. Cintron performed a systematic review on the affect of race and ethnicity on advance care planning and end-of-life communication and decision-making
- He searched English-language articles from 1990-2005
- Only 33 studies met criteria

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AD Prevalence

- 15 Studies
- 13 revealed whites more likely to use ADs (LW, DPAHC, HCP, DNR, DNH)
- 1 revealed no difference
- 1 revealed hospitalized non-whites more likely to have DNR order written

African Americans	Less likely to have any AD among NH residents, hospitalized pts, elderly, pts w/ CA
Hispanics	Less likely to have AD
Asian Americans	More likely to have DNR order

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Goals of Care Discussions

- Health care wishes discussed
 - Whites more likely to do so
 - African Americans more likely to want but do not
 - Hispanics and Asian Americans mixed
- Adjusting for other factors
 - SES variables => differences persist
 - Other variables (eg. Knowledge of AD, prior experience w/ vent or WH/WD tx, available agent, have PCP) => differences disappear

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LST Preferences and Decisions

- 14 Studies Identified
- African Americans more likely to choose LST compared to whites
 - Consistent over time and across care settings
 - Even in advanced illness and after prolonged hospitalization
 - Switch from DNR to CPR
- Survey of physicians: African Americans more likely to choose LST (CPR, vent, tube feeds) for themselves in setting of advanced illness or vegetative state

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Hospice and other services

- Dr. Cintron performed a systematic review on the affect of race and ethnicity on use of hospice and other palliative care services
- He searched English-language articles from 1990-2005
- Only 12 studies met criteria

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Hospice Service Utilization

- 8 studies
- All revealed minority groups less likely to use hospice
- African Americans and Asian Americans less likely even after adjusting for clinical and socioeconomic (SE) factors
- Hispanics less likely, but difference tends to disappear after adjusting for SE factors

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Barriers to Hospice Use

- Surveys of hospices
 - African Americans affected by admissions criteria, particularly caregiver requirement
 - Hispanics affected by language and financial barriers (many depend on free care)
- Surveys of African Americans and Hispanics
 - Lack of knowledge of hospice services
 - Cost of health care services
 - Language barriers
 - Distrust health care system motivation

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Palliative Care Services

- Search for PC units, PC consultation services, and PC ambulatory care produced no studies examining the effect of race/ethnicity on access
- One study of access to palliative treatments identified in hospice search
 - VA patients with advanced prostate CA
 - African Americans as likely as whites to receive palliative XRT, rehab, hospice care, medications for symptom management

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Patients and their views of their physicians

94%: spiritual health is as important as physical health.

77%: physicians should consider a patient's spiritual needs.

48%: wanted their physicians to pray with them.

42%: physicians should ask about their patients' faith healing experiences.

70%: physicians had never discussed religious beliefs with them before

(King et al, 1994)

Adapted from Gergen-Barnett L et al. JGIM 2006; 21: 481 – 485

More Views

- USA Weekend Poll
 - 65% wanted MD to routinely ask about spirituality
 - 10% of MDs had asked

USA Weekend Feb 12-20, 1998

Adapted from Gergen-Barnett L et al. JGIM 2006; 21: 481 – 485

Recommendations for Clinical Practice:

- Incorporate spiritual assessment as part of clinical assessment
 - Respect patients' beliefs
 - Not impose own belief system on patients
 - Consider religious/spiritual interventions e.g., meditation, pastoral consultation, to complement traditional psychotherapeutic practices or ritual
- Modified from David Larson, NIHR

Adapted from Gergen-Barnett L et al. JGIM 2006; 21: 481 – 485

How to Assess Your Patients' Spirituality: FICA

- F : Faith or Beliefs
- I: Importance and influence
- C: Community
- A: Action/Address

Modified from Puchalski C and Romer A. J Palliat Med.2000;3:129.

FICA

F: Faith and belief:

“Do you consider yourself to be a spiritual or religious person?”

“What is your faith or belief?”

“What gives your life meaning?”

FICA

I: Importance and Influence:

“What importance does faith have in your life?”

“Have your beliefs influenced that way you take care of yourself and your illness?”

“What role do your beliefs play in regaining your health or dealing with debility?”

FICA

C: Community:

“Are you a part of a spiritual or religious community?”

“Is this of support to you and how?”

“Is there a group of people you really love or who are important to you?”

FICA

A: Action/Address in care:

“Would you like to speak to a chaplain?”

“Would you like me to address these issues in your health care?”