

**PRECEPTOR'S GUIDE**  
**Cultural Awareness Training and Education in Palliative**  
**and End-of-life Care for medical students**

**Goals:**

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

**Objectives:**

At the end of this module, the students will be able:

1. Identify at least 2 health care disparities for minorities in PC and EOL care in a post-module survey
2. Describe and employ communication skills essential for the healthcare and spiritual needs of minorities in PC and EOL care in case presentations
3. Demonstrate and discuss the spiritual assessment in two patients.

<p><b>* Preceptor:</b> - Use slide presentation - Remember you are trying to stimulate prior learning from their Art and Science of Medicine course.</p>
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**First section:**

1. Didactic presentation:
  - a. What is Palliative Care (PC)? What is End-Of-Life (EOL) care?
  - b. What is culture?
  - c. What are the factors that influence culture?
  - d. What is the role of culture in PC and EOL delivery?
  - e. What healthcare disparities exist in the diagnosis and treatment of minorities? (what has been previously taught in ASM). What is cultural competency?
    - i. Treatment differences in cardiac disease
    - ii. Breast cancer screening
  - f. What is different in this session: healthcare disparities that exist in PC and EOL
    - i. Three core areas: pain assessment and treatment, advance care planning, use of hospice and other PC services
    - ii. Review the data
  - g. With this in mind
    - i. In discussing increased cultural awareness as defined above need to realize culture comes in many shapes and forms. Culture is a part of everything
    - ii. Let's think as an example: spirituality. We will be watching a discussion about a particular case. This case is an example to open our minds to differences that occur in all of our patients.

## TRIGGER TAPE SCENARIO FOR SESSION ONE

### GENERAL CASE DESCRIPTION

Mrs. Schwartz is an 88 year old woman who is a retired teacher. Her husband died of a stroke and her sister died of Alzheimer's disease. She has a daughter, Kristy, who is very close to her and helps with needed activities. Mrs. S began to lose her memory and function ten years ago and Kristy has been helping her cope with gradual impairment, taking over tasks such as paying for bills, depositing and withdrawing money, fixing things around the house, and managing her medications. Mrs. S has been diagnosed of having Alzheimer's disease. In the past year, Kristy had to hire an aide to help the patient with activities of daily living, such as dressing, feeding, ambulating, toileting, and transferring. Six months ago, Mrs. S. was admitted to the hospital for difficulty breathing, and Kristy was told that her mother had "aspiration pneumonia." In the last 3-4 months, Kristy noted that Mrs. S. is not eating well, seems to cough when she eats, and has lost some weight. In terms of mental status, Mrs. S. seems to recognize Kristy but does not speak or answer questions or follow any commands. She is bed- and wheelchair-bound.

### ROLE OF DAUGHTER

Kristy brings Mrs. S. to see Dr. Penn because of her decreased appetite, eating, and weight loss. Kristy is a social worker and has had conversations with Mrs. S. in the past about artificial feeding. Mrs. S. had said that she witnessed her sister and husband die a prolonged death with a feeding tube, and did not feel that was a good quality of life. Mrs. S. also is very religious and told Kristy that she would want to do the right thing when the time came for her, and that her rabbi should be consulted for helping to make important decisions.

### ROLE OF DOCTOR

Dr. Penn interprets Mrs. S.'s wishes as fairly clear that Mrs. S. has had personal experiences about artificial nutrition through her family members, and that since Mrs. S. appears to have advanced Alzheimer's disease, a feeding tube was not going to reverse her symptoms. Dr. Penn therefore feels that inserting a PEG would not be warranted. She counseled Kristy about this and Kristy concurs, but feels she needs to speak with Mrs. S' rabbi.

### ROLE OF RABBI

Kristy contacts Rabbi B... to ask for counsel about Mrs. S and whether or not she should receive a feeding tube, since her eating and intake are not sufficient and she is losing weight. Rabbi B. states that "Of course she should have a feeding tube if she is not eating enough and the feeding tube will help her." Kristy clarified that Mrs. S. had stated she would not want artificial feeding based on her husband and sister's experiences. Rabbi B. laments that Mrs. S. should have consulted him at that point, and he would have "corrected her wrong wishes." Rabbi B. further states that all efforts need to be made to reverse her current condition since people can live Alzheimer's disease for many years.

### GOAL OF INTERACTION

- To demonstrate doctor and rabbi working together and clarifying Mrs. S's situation
- To clarify level of evidence of wishes and decision maker
- To clarify stages of Alzheimer's dementia and that it can be a terminal diagnosis
- Arrive at some sort of resolution about what to do re: feeding tube
- To introduce the concept of palliative care for patients with endstage Alzheimer's disease
- Do you assess a patient's spiritual beliefs?
- What questions would you ask about a patient's spirituality?
- Introduce FICA (see side text box and 2 slides)
- Use FICA twice in your rotation

**Part II:** Case discussions:

- a. Case 1: Wilma Martinez
  - i. As Mrs. Martinez's team of physicians, how would you approach this case?
  - ii. What other questions would you ask?
- b. Case 2: Lawrence Byrd
  - i. As Mr. Byrd's team of physicians, how would you improve communication between Mr. Byrd and yourselves?
  - ii. What are some underlying issues that may contribute to your poor relationship with Mr. Byrd?

**FICA**  
Faith and belief  
Importance and  
influence  
Community  
Address in Care

**Developed as a  
response to AAMC  
task force to improve  
communication in  
medicine in 1998**

Debriefing during the month with teaching fellow and with PC faculty

2. What did you learn from performing the FICA on your patients?
  - a. How can this new information impact your care?
  - b. What are some barriers in obtaining a spiritual history?

**Required:**

1. Krakauer E. et al. Barriers to Optimum End-of-life Care for Minority Patients. JAGS 2002.
2. Payne, R. At the end of life, color still divides. The Washington Post.
3. Perkins HS et al. Cross-cultural similarities and differences in attitudes about ACP. JGIM 2002.
4. Stephen GP et al. Physician and patient spirituality: Professional boundaries and ethics. Annals of Internal Medicine 2000.

**Recommended readings:**

5. Enguidanos S et al. Ethnic variation in site of death of older adults dually eligible for Medicaid and Medicare. JAGS 2005.
6. Welch L. et al. End-of-Life Care in Black and White : Race Matters for Medical Care of Dying Patients and their Families. JAGS 2005; 53: 1145 – 1153.