

OBJECTIVES:

To review the common issues at the end of life across cultures and the measures that can be taken to address these issues.

DATA SOURCES:

Published articles and textbook chapters.

CONCLUSION:

Culture plays a critical role in how patients, families, and health care providers view the end of life. Cultural competence in end-of-life care includes knowledge and experience and working in cross-cultural situations.

IMPLICATIONS FOR NURSING**PRACTICE:**

Increased culture-specific knowledge will provide nurses with a basis for beginning exploration of individual or family beliefs.

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0749-2081/05/2101-830.00/0
doi:10.1053/j.soncn.2004.10.007

CULTURAL ISSUES IN PALLIATIVE CARE

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ETHNIC, racial, or cultural disparities exist at all levels of health care, including hospice and palliative care.¹⁻³ The result of these disparities is underutilization of services and under-treatment of patients and populations, which translate to unnecessary suffering and poorer outcomes for minorities, especially those foreign-born and non-English speaking.⁴⁻⁶

This article discusses common issues at the end of life and across cultures and the measures that can be taken to address these issues. Concepts central to this article include demographic changes, culture, and cultural competence.

The late 20th century has seen profound demographic changes. In the United States there are 329 languages known to be in use and 32 million people who speak a language other than English. The situation is similar throughout the developed world.⁴

Culture may be defined as “the learned and shared beliefs, values, and lifeways of a designated or particular group that are generally transmitted intergenerationally and influence one’s thinking and action modes.”⁷ Often, there are difficulties in separating culture and religion or other aspects of life. In some cases, a strong, fundamentalist religion exerts more influence over life and death than the culture in which the religious person lives; in other cases, the religion is the primary influence on the culture.⁵

Cultural competence is the ability to “perform and obtain positive clinical outcomes in cross-cultural encounters.”⁸ Within this broad definition are two related sets of competencies:^{5,8,9}

- Generic cultural competence is the knowledge and skills applicable to any patient or community cross-cultural encounter. This competency is gained through being involved in cross-cultural encounters on a regular basis; observing and evaluating patient, community, and provider (one’s own) responses to cross-cultural encounters; gaining general knowledge and skills related to cross-cultural health care; and maintaining an attitude of respect for and openness to other cultures.
- Specific cultural competence is the knowledge and skills applicable to patients and communities from specific cultural backgrounds. This

competency is gained through learning about other cultures and one's own culture from "participant-observer" patient and community encounters, from other sources such as the literature, and from personal or other professional endeavors to expand the knowledge base regarding specific cultures. The problem of culture-specific knowledge is the tendency to generalize such knowledge to all patients from a particular culture, which, of course is stereotyping and thus counter-productive. However, despite virtually every author for the past 20 years warning against stereotyping, the reality is that much culture-specific information in the literature does apply to many individuals and families from the culture under consideration. Culture-specific knowledge is a framework for beginning to understand individuals and families. Galanti¹⁰ points out that generalizations open the door to understanding cultures, while applying generalizations to all people from a culture is stereotyping and closes the door. The capacity to communicate on a deep level with persons who speak languages other than the native language of the host country is part, but far from all, of this competence. The use of interpreters is necessary, but their interactions must also be observed and understood to insure that relationships are truly therapeutic.

There is increasing awareness that cultural competence applies both to individual practitioners and to institutions.¹¹

LEARNING ABOUT CULTURES

A first step in providing quality care across cultures is to identify and learn about the main cultures with which one has contact. If, for example, there are patients from Vietnam and Guatemala in a facility, one would find culture-specific information on both populations. Sources include the literature, contacts in the community, and the patient and family.

The Literature

The literature has an enormous and rapidly growing body of knowledge on cultures and health care. As noted above, these tend to focus on generalities that seldom apply in total to a particular person or situation, but do provide a framework or basis of understanding.

Contacts in the Community

Contacts in the community can provide valuable insight into a culture, and geographic or other

particulars. The tendency for immigrants and refugees to live in enclaves extends also to a tendency for people from a particular area of a country or population to cluster. Time spent in what is seen as a Nigerian area may reveal that most people in that area are Hausa-Chadic or another subgroup from Nigeria. Information from such people would thus be more specific to their group and to patients served within the health care facility. Making community contacts is extraordinarily easy in most cases. This author prefers contacts in restaurants, laundries, and the like over community centers, churches, and so on. People in the former often have an agenda of promoting their particular organization or perspective, while less formal contacts will be open and receptive to talk about their culture or beliefs.

The Patient and Family

The patient and family provide information on their culture and on their own personal health beliefs and practices. What more could we ask? Numerous assessment tools exist, and more are being developed on a regular basis. This author has seen none that feature the brevity and utility of the classic guide developed by Tripp-Reimer et al¹² to identify issues related to illness and its impact on the family. The following is an example of this assessment tool modified by the authors¹²:

1. What do you think caused this to happen?
2. Do you have an explanation for why it started when it did?
3. What does this sickness do to you; how does it work?
4. How severe is this sickness? How long do you expect to live?
5. What problems has this sickness caused you or your family?
6. What do you fear about this sickness?
7. What kind of treatment do you think you should receive at this point?
8. What are the most important results you hope to receive from this treatment?
9. Do you have other hopes or fears?

COMMON ISSUES AT THE END OF LIFE

The following is extracted from 30 years of experience in working with immigrants and refugees in the United States and overseas. These issues are strongly influenced by culture, are com-

mon, and apply to most patient care situations, regardless of culture, religion, or other individual factors. Each issue is briefly discussed, examples are given, and initial interventions proposed. In many cases the initial interventions are given as assessment questions. Subsequent interventions would emerge as the questions are explored.

Unique Differences

There are differences and conflicts in understanding among groups, within groups, between individuals, and even within individuals. Examples of intercultural differences are too numerous to cite in a meaningful way, but several may illustrate differences at the end of life. Among Laotians, for example, funerary chanting in *Pali* (the liturgical language of Theravada Buddhism) is viewed by some as helping guide the spirit onward, by some as focusing the chanters on the inevitability of suffering and the transient nature of life, while others may embrace both views.^{5,13} Hindus from India may believe in one God, many gods, or no gods.¹⁴ Some Muslims accept organ donations or autopsies, while others accept neither.¹⁵ There are innumerable examples of people from the same culture or religion having different core beliefs. This generalization is a basis for assessment, not the answer to the question.

Interventions. Based on the nurse's on-line research (eg, Laotian beliefs on death) the nurse might ask about a specific saying or belief, eg, "I was reading about Laos yesterday, (with such a statement the nurse has probably gone far beyond the interest shown by any other provider) and read a Laotian proverb that says: 'nobody can control when a woman delivers a baby. Nobody can control when a monk disrobes (leaves the priesthood). And nobody can control when a person dies'¹⁶ What does that mean to you?" Or, "I read that among people from India there may be a belief in one God (*Brahma*, right?) or many gods such as *Brahma*, *Shiva*, *Krishna*. "What is your belief?" "What is your belief about organ transplantation?"

Experiential Issues

Almost every immigrant and refugee in the world is a stranger in a strange land and thus faces a myriad of challenges. These challenges include language, the impact of cultural disconnection in everyday life, generational/cultural conflicts

among the different generations (or worse, an absence of different generations), and a host of other issues. People from some locales, such as El Salvador, Cambodia, Bosnia, Sudan, and others also commonly live with the long-term effects of war, trauma, and torture (expressed as post-traumatic stress disorder, depression, spiritual distress, chemical dependency, and the like, and often multiple expressions or "dual diagnoses"). In every case, the effects of disconnection and trauma are exacerbated at the end of life. They are further exacerbated by the experiential loneliness inherent in living and dying in a society that has forgotten (if they ever knew) that bad things have happened in Nigeria/Biafra and other places.

Interventions. "You are from El Salvador, yes?" "What was it like living there?" "Why did you leave?" "Were there problems with different religious groups?" A follow-up action is an online search for the country in question (eg, El Salvador history). In less than 2 minutes this search produced information on death squads, unemployment, and the exodus of 20% of that country's population. This information provides further opportunities for assessment and connection with the patient.

Language/Cultural Barriers

Language barriers are a well-known factor in the difficulty accessing and utilizing health care.³ Language barriers also make difficult the meaningful and deep communications that are foundational to hospice and palliative care. Patients experience frustration as they attempt to, and then give up on, communicating needs beyond their basic needs, or in some cases, even the most basic needs.

The use of translators or interpreters is fraught with pitfalls. (Translators communicate the patient's words, while interpreters communicate the meaning of the patient's words.) In either case, complete accuracy is almost impossible in (1) understanding what another person is saying, (2) communicating that information to a third person, who must then (3) process and understand the information and (4) respond to the information through the third party! Institutional translators offer advantages in that they have an understanding of policies and procedures. However, in every culture there are communication-confounding socio-cultural issues not readily apparent to

others (eg, differences in social class, gender issues, age issues, and inter-cultural conflicts). Although these may inhibit communication, it is a rare institutional translator who will admit to this. The more traditional the culture, the more ingrained these barriers tend to be. Telephone translations are sometimes necessary, but are far from ideal.

Family members may be the only option for communicating. The liabilities in using family members as interpreters include the possibility of interpersonal issues distorting communications and difficulties in communicating sensitive or "bad news" to a loved one. Moreover, there are federal guidelines that proscribe using family members in this role unless requested by the patient.¹⁷

Written materials are helpful for people who read and comprehend at the level at which the materials are written. Translating such materials into second languages with complete accuracy is difficult, especially to less-common languages. In all cases, written materials require review and confirmation by content and language experts.

Resolving Relationships

Problems and pain in life are universal among humans. Often, they concern relationships with others. In Western cultures, the focus on the individual and relationships promotes the resolution of relationships, while in more traditional cultures, such as Southeast Asian, the focus on the family and maintenance of personal and familial equanimity is less conducive to the resolution of relationships.

Interventions. Palliative care interventions include the nurse acting as a go-between with people in conflicted relationships. This effort is helped by a drive (more pronounced in the West) toward reconciliation in relationships and hindered by the interpersonal vulnerability inherent in attempting reconciliation, family or gender roles, or cultural imperatives such as stoicism. As noted above, not all cultures share this drive or ethos with the West, hence attempts to promote reconciliation may be unsuccessful with persons from more traditional cultures.

Decision-Making

Truth-telling and (informed) decision-making are key components of hospice and palliative care,

especially decisions about resuscitation, extraordinary measures, and related issues. Among the most powerful culture-related determinants in sharing information and decision-making is the relative importance of the individual versus the family. In Western cultures and religions, the individual is the first consideration (eg, it is always the patient who gives informed consent [if competent]); while in many traditional and some modern cultures, the well-being of the family is the first priority. It is very common, for example, for Korean or Japanese families to expect to be informed of the patient's status and to make treatment decisions for the patient with the family's best interests paramount. Often, the oldest male will make decisions for a family member or the husband will make decisions for the wife.^{5,18}

Note that beliefs when talking about end-of-life issues often include not only the patient, but also the family. While there may be greater discomfort with the idea of truth-telling with the patient, that discomfort may also include the family.

Interventions. Regardless of culture-related beliefs and practices it is incumbent on Western health care providers to insure patient autonomy. One means of fulfilling obligations to patient, culture, and ethical standards is to ask the patient to whom information should be given and who should make decisions (family members should not translate in such a discussion).¹⁹

Family Involvement in Care

Hospice evolved, in part, because of the disenfranchisement of the family in end-of-life care in technological society.²⁰ In many cultures, it is expected that the family will be responsible for the care. Despite the positive value ascribed by many to such involvement, extensive family involvement often arises from very negative situations. For example, in much of the world there simply is no one else available to provide care, so family involvement may be more about survival than following valued tradition. A tradition of family involvement in care may or may not be carried over to end-of-life care in the West.

It must also be noted that family involvement in care usually means women's involvement in care. This occurs across most cultures, especially the more traditional ones. One exception is that pregnant women are sometimes prohibited from con-

tact with what are perceived to be negative or dangerous (to the fetus) situations.⁵

Interventions. The basic assumption here is that it is usually good to have the family involved in end-of-life care, especially in technologically oriented settings. Basic nursing care is the means to the end, and includes teaching family members how to provide care, teaching the family how to plan the care, involving others, and otherwise providing supportive care to the family. When working with families from other cultures, it is often necessary to explain how the health care system works and the value of family involvement.

Religion and Faith

All major religions address at great length the questions of death and what happens when and after a person dies. The scripture of the major world religions contains passages specific to dying and death. In Buddhism, for example, life (and thus, death) is characterized as follows:

“Thus shall ye think of all this fleeting world: A star at dawn, a bubble in a stream; A flash of lightning in a summer cloud; A flickering lamp, a phantom, and a dream.” From the Diamond Sutra (of the Buddha).²¹

The Gospel of Peter in Christianity’s New Testament is not dissimilar:

“All mortals are like grass; all their glory like the flower of the field; the grass withers, the flower falls . . .” 1 Peter, 24²²

While some patients and families reject spiritual care, religion and faith are integral aspects of end-of-life care for many people.

Providing spiritual care can be challenging under many circumstances, and is especially difficult when the patient and family are refugees or immigrants and culture/religion-congruent spiritual care resources are difficult to find.

Interventions. Spiritual care at the end of life is beyond the scope of this article. What we will look at, though, are some means of reaching across cultures to see how spiritual care or growth is possible in a cross-cultural setting. As with other areas of cross-cultural care, interventions here include exploring the patient’s and family’s beliefs and desires. Specifically, one might explore the patient’s or family’s faith history. While patient charts always reflect a religious preference, it is worthwhile to ask the patient and family what

faith they follow or have followed in the past. The question of faith in the past is important because many people cease to practice or believe at some point during their life. The onset of a spiritual crisis will most likely bring one back to their spirituality. Other areas for intervention include:

- What spiritual resources or actions were meaningful or helpful in the past? Of course, some resources are not accessible, but some approximation of some can be found.
- For many people at the end of life, a “ministry of presence” is comforting. That is to say, any care provided by a person of faith is generally comforting.
- Spiritual interventions from one faith are sometimes appropriate for a person of another faith. The author has seen several instances where Christian prayers were offered for Cambodian Buddhists, and in every case, the care was deeply appreciated. Obviously there is potential for problems if the patient is not spiritually syncretic with respect to other faiths.
- Reading from the patient’s religious books is possible, if both parties speak the same language and the book is in the same language. The Old and New Testaments are examples of such scriptural possibilities. Some editions of the *Qur’an* are in Arabic and English, and reading this book may be helpful. (Note: washing one’s hands is required before touching the *Qur’an*.)
- Assisting with finding congruent outside sources of spiritual support is usually the role of the chaplain’s office.

Involvement of Clergy

Among many people in the Western world and among Judeo-Christian faiths, clergy are viewed as supportive providers of religious and spiritual care, comfort, knowledge, wisdom, and so on. Clergy regularly visit hospitals, hospices, and patient homes to provide care and comfort to patient and family. This is not the case with every religion and culture. Clergy from most Buddhist denominations, for example, do not visit hospitals or homes before the patient dies and the relationship between Buddhist clergy and the laity is entirely different than between Christian clergy and laity. In the former case, the relationship is neither interpersonal nor particularly comforting, except that the provision of familiar ritual may be enormously comforting. In many cultures influenced by Buddhism, the primary source of spiritual care

is the family, including, for some, family members who are deceased.

Interventions. “What do (people of your faith) expect from clergy when a person is terminally ill (or sick)?” “When you think about your religion and your beliefs in religion, what is most helpful to you?” “To whom do you turn for spiritual help?”

Life Support and Advance Directives

Paradoxically, the more technology-oriented and sophisticated the patient, the more likely she or he will be willing to forgo life support if it is perceived to be futile (We’ve drunk from *that* cup!). The challenge of life support in end-of-life care, especially when different cultures and levels of understanding are involved, is for patient and family to fully understand the disease prognosis and the purpose of life support. Universal use of advance directives has cleared some misunderstandings, but language and cultural barriers inevitably result in situations in which misunderstandings occur. Indeed, attempting to communicate such issues may be deeply offensive to some patients (eg, conservative Muslims):

“No man grows old or has his life cut short but in accordance with His (God’s) decree.” The Creator 35:11 (from the *Qur’an*).²³

It should be noted that submission to the will of God is the central belief of Islam. The word “Islam,” in Arabic, means surrender (to God) and a Muslim is one who surrenders to God. The idea, then, of discussing these matters is simply not appropriate for humans.¹⁴

Interventions. Life support and advance directives must be discussed with the patient (if competent) in modern Western health care settings. To accomplish informed consent in these and other matters it is necessary first to spend time explaining the prognosis in a culturally appropriate way. For example, if the patient is a conservative Muslim, the interaction is enabled by same-gender providers, respectful and formal behavior, and acknowledgment of the Muslim belief that life and death are according to the will of God. Explaining the concept of the advance directive as a cultural and legal requirement in the West is helpful.

Explaining the prognosis and concept of the advance directive to persons with little education

or technologic sophistication is a challenge. Underlying this difficulty is the faith of the unsophisticated in technology to solve all problems. It is necessary to point out that this is not the case.

Suffering

Suffering is a universal human experience. In Buddhism, for example, the First Noble Truth (from which all other Buddhist teachings flow) is that all sentient beings suffer. Hospice and palliative care are focused on reducing suffering. With the apparent conflict between the inevitability of suffering and the dedication to reducing suffering, it is well, to explore why some people are so accepting of suffering and its common cause at the end of life, including physical pain or other symptoms.

Reasons for accepting suffering include the idea that suffering is inevitable, a deserved punishment for sin, a means of purification, a means of showing strength, or part of the experience of life and thus to be embraced rather than resisted. Others may see the effects of treating the suffering as worse than the suffering itself. The latter is relatively common among Southeast Asian Buddhists, who place a high priority on being alert and mindful, as opposed to having a clouded sensorium from the effects of pain medications.

Interventions. Each of the reasons noted above provide avenues of exploration. In some cases, exploration yields quick intervention (eg, patients who believe that suffering is inevitable can be taught about and treated for pain). The treatment of patients whose suffering is related to other issues, such as deserved punishment for sin, would be focused on forgiveness or acceptance (spiritual care). In some cases, suffering is resistant to intervention; the intervention then, might be directed to the nurse and others involved in the care. The issue in this case is how to remain graceful in the presence of unrelieved suffering.

Expression of Pain

Differences in the experience and expression of pain among different cultures have long been a subject of research. Differences in the experience of pain in infants as young as 2 months have been identified and there is evidence that people from some cultures are more or less stoic than others (eg, Hispanic males tend to not complain of pain). How-

ever, there is enough variation within cultures to make generalizations subject to error.^{5,24-26}

Interventions. In cross-cultural and any other health care, the use of standard tools (eg, brief pain inventory) is essential. Readers should be aware that “faces scales” are mystifying to enough patients that they should be used only with great attention to whether the patient really does understand the different expressions on the scale. Asking patients to rate their pain “on a scale of 1 to 10 . . .” is also difficult for some to understand. Learning about frequently encountered cultures and any research on the particular culture is important. Nurses should be aware of the potential for the family or others from the patient’s culture to inhibit complaints of pain and if this occurs, develop alternative plans for assessing and treating pain. Most important is careful attention to detail in assessing pain and the patient’s communication style and their values and beliefs.

The Meaning of Dying and Death

Every culture and every religion invests significant energy in the issue of death because, of course, we are all enormously concerned about our own deaths and the deaths of those we love. In Shintoism (indigenous Japanese religion), death is seen as impure and not to be dwelt upon. Many Mexicans, on the other hand, embrace death as evidenced by ritual and celebration, including giving children skeleton-themed candy on *El Dia de los Muertos* (The Day of the Dead). Cultures and individuals may fear death, deny death, embrace death, joke about death . . . but few ignore it. The one constant is that virtually all people want to die with dignity.²⁷ Individual variations on achieving dignity and ideals of dying are infinite.

Ideas about the best place to die may be culture-based, related to the sophistication of the persons involved, the circumstances of the illness, family circumstances, or other issues. Some Native-American cultures believe the spirit of the person who died remains at the place of death and is harmful to the living; hence, home is a bad place to die. More knowledgeable or sophisticated people tend to want control over the situation and understand that with sufficient support home may be a better place to die than the hospital. Less knowledgeable or sophisticated people sometimes think that modern medicine can cure all ills, and thus resist leaving the hospital.

Interventions. The family or patient might be asked about their cultural (or religious) beliefs about how a person who is sick or dying should be treated. Questions about the best place to die may reveal opportunities to educate patients and families about options or to clear up misconceptions.

Immediate After-Care

What happens after death is strongly culture-related. In technological cultures such as the United States, the common practice is to move the body quickly from the place of death to somewhere else. The family usually has minimal involvement except in “making arrangements” for someone else to “prepare” or “restore” the body. Deviation from this quick and sanitary practice may be viewed with some degree of suspicion (eg, why would a family want to keep the body at home for a day or more and why would they want to wash it themselves?). In such cultures there are few proscriptions on who can and cannot touch the body. Anyone with an assigned role in the process may handle the body, which is still somewhere else. Note that roles are assigned by law and institution rather than culture and family.

In other cultures there are clear, cultural-defined expectations and roles for what happens after death. Among Laotians, for example, the body is washed by family members and kept at home for up to 24 hours (3 days is the ideal). While the family is responsible for caring for the deceased, there are no prohibitions against other people touching the body. After-care includes the family washing the body, dressing it in white with some articles of clothing torn and put on backward to confuse malevolent spirits intent on stealing the spirit, and placing a coin or engraving in the deceased person’s mouth with answers to riddles expected to be asked in the spirit world.²⁸

Traditionally minded Indians, on the other hand, believe that only same-sex family members should touch the body. After being cleaned, a cloth is tied around the deceased’s head to keep the mouth closed, the thumbs tied together, the great toes tied together, the body wrapped in a red cloth, and placed so the head is to the south.¹⁴

Interventions. Beliefs about discussing death-related issues influence the approach to the question of what beliefs the family and patient may

have (see Sharing Information and Decision-Making above). As with other aspects of working toward cultural competence, the question of after-care may be approached first by determining common cultural practices and second by asking the most appropriate person in the family what is expected or desired in terms of after-care. While there may be some discomfort with the issue, there usually is greater discomfort in the family or patient not knowing what is likely to happen after death and what can be accommodated and what cannot. Discussing these issues from the perspectives of the patient/family and the institution usually results in relief of at least some anxiety because invariably there is (usually unspoken) concern.

Autopsy and Organ Donation

Autopsy and organ donation are significant culture-related issues and have been mentioned several times previously in this article. In general, the more sophisticated and technologically oriented the individual, family, or culture, the more accepting of autopsy and organ donation. Persons from countries with cultures influenced primarily by Islam have traditionally resisted autopsy and organ donation because of the importance of going to the grave with the body intact. In recent years, however, many religious scholars have reinterpreted religious law and there is growing acceptance of donation.^{27,29,30}

Interventions. Autopsy and organ donation are often emotion-laden issues; hence, discussion is promoted by careful explanation of the purpose(s) for the procedure(s) and reassurance that the body is treated respectfully. Involvement of a respected imam (Muslim clergyman) may be necessary.³¹

Disposal of the Body

Beliefs about proper disposal of the body are influenced by culture and religion, with some (eg, Indian Hindus) wanting only cremation and others (eg, Iranian and other Muslims) wanting only burial. There are also cultural and religious beliefs about the orientation of the body (eg, head toward Mecca among Muslims and to the south among Indians), when the body is buried or cremated (within a day among Arabs and according to astrological signs among Thais), color of the body's clothing (white in Southeast Asia and red in In-

dia), use of makeup (common among Americans and uncommon in the developing world).^{5,27}

Many immigrants and refugees are enormously concerned about the final resting place being in their home country. Among poor immigrants and refugees, it is common for families and friends to collect donations for the purpose of shipping the body or ashes to the homeland.⁵

Interventions. Except to understand that variation exists and to respect the variation, there are no interventions necessary on the part of the health professional.

Grief and Bereavement

Participant observation of grieving practices on the part of health professionals is a means of understanding cultural variations and universals in life and death. Among the culture-influenced variations in grief and bereavement⁵ are:

- Expression of emotion, ranging from restricted such as seen among many Anglo North Americans, unrestrained such as seen among black North Americans, and ritual expression such as the ululations of Arab women.
- Function of the funerary ritual, which may include a "celebration of the life (of the deceased)" as seen among many North American Protestants, an opportunity to experience and express individual and collective grief and comfort such as seen among many Jews, and a ritual to help the spirit progress through the spirit world such as seen in Southeast Asia.
- Length of funerary and related ritual, ranging from a few days in North America and Europe to a series of events at specified intervals (often days 1 to 3, 7, 30, 100, and then yearly) among disparate cultures such as Kurds, Mexicans, and Jews.
- Length of bereavement, ranging from a few days in technological cultures to a lifetime (for women) in some traditional cultures such as in India.

A critical issue in grief and bereavement is the extent to which the culture supports the bereaved. Such support may be gotten through ritual or the support of family or other people. In some cultures there may be initial support, but later, support (including socioeconomic) may be withdrawn. In many cultures widowhood can be an economic disaster. In most Arab (Muslim) cultures, women inherit less than men and in some cultures (eg, in parts of Nigeria), women have no inheritance. A

childless woman has one option: becoming a secondary wife of her husband's brother.⁵

CONCLUSION

Culture plays a critical role in how patients, families, and health care providers view the end of life. Cultural competence includes (1)

knowledge and experience and working in cross-cultural situations and (2) possessing and using culture-specific knowledge and experience. Culture-specific knowledge is a basis for beginning exploration of individual or family beliefs. In all cases and all issues, the central question is what the beliefs of the individual and family are.³¹

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