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FAST FACTS AND CONCEPTS #216

Author(s): Hillary Lum MD, PhD and Robert Arnold MD

Background Patients' cultural backgrounds profoundly influence their preferences and needs regarding discussing bad news, decision-making, and the dying experience. This Fast Fact offers a framework for taking a 'cultural history' to better understand a patient's and family's needs. See also these related *Fast Facts*: #17 (illness experience), #19 (spiritual history), #26 (explanatory model), #183/184 (conflict resolution).

C – Communication. Identify the patient's preferences regarding how and to whom medical information is shared. *Some people want to know everything about their medical condition, and others do not. How much would you like to know?* For those who request that the physician discuss their condition with family members: *Would you like me to speak with them alone, or would you like to be present?* Identify main contacts to give information to about the patient's condition. Carefully explore with families requests to hide information from a patient (see references 4 and 5) – a future Fast Fact will address this topic in more detail.

U – Unique cultural values. Use respectful, curious, and open-ended questions about a patient's cultural heritage to identify their values. *Is there anything that would be helpful for me to know about how you and your family view serious illness? Are there cultural beliefs, practices, or preferences that affect you during times of significant illness?* If the patient is open to discussing death: *What concerns do you have about dying? Are there things that are important to you or your family that I should know about?*

L – Locus of decision-making. For some patients medical decision-making is communally driven rather than individualistic. Multiple family members or a community elder or leader may need to be involved, often without prior official documentation because it is assumed or understood from the patient's perspective. *Do you prefer to make medical decisions about tests and treatments yourself, or would you prefer that others in your family or community make them for you?*

T – Translators. Language barriers are extremely challenging, especially during times of severe illness. Utilize medical interpreters frequently and effectively. Refer to *Fast Fact* #154 for a detailed discussion on using interpreters in palliative care.

U – Understanding the patient and learning as a provider. Reassess what is being heard, understood, and agreed upon frequently, from both the patient's and clinician's standpoint. Specifically confirm the patient's understanding or agreement (beyond nodding or "yes" responses). This is particularly important if a medical translator is involved as miscommunication is common even when using trained medical interpreters – see reference (6). *Can you tell me – in your own words – what you have heard from me and what's most important to you about what I've said?*

R – Ritualized practices and restrictions. Determine if there are specific customs the patient desires to be followed. These must be communicated to other health care providers, especially in the hospital setting. It may be necessary to advocate for the patient and negotiate with healthcare facility administrators to find an agreeable way to honor a patient's wishes. *Are there specific practices that you would like to have in the hospital or at home? Are there aspects of medical care that you wish to forgo or have withheld because of your cultural beliefs? Is anything discouraged or forbidden?* If the patient is approaching death, and willing to discuss it: *Are there specific practices that are important to you at the time of death or afterwards that we should know about?*

E – Environment at home. Given that a majority of hospice care happens in the patient's home environment,

respectfully explore whether there are any needs that can be met by the health care system, and how open the patient, family or community is to receiving care at home. Recognize that patients may be hesitant to voice needs, or resistant to accepting help from outside the community. Even if a trusting, collaborative relationship has developed between a patient/family and clinicians in the hospital, this may not immediately translate into the home setting. With the patient's permission, expectations about cultural-specific aspects of a patient's care should be explicitly communicated to care providers outside the hospital.

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Author Affiliations: University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania.

Fast Facts and Concepts are edited by Drew A. Rosielle MD, Palliative Care Center, Medical College of Wisconsin. For more information write to: drosiell@mcw.edu. More information, as well as the complete set of Fast Facts, are available at EPERC: www.eperc.mcw.edu. Readers can comment on this publication at the Fast Facts and Concepts Discussion Blog (<http://epercfastfacts.blogspot.com>).

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