

End of Life Care in a Multicultural Framework: to Treat or Not to Treat

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Canada's growing immigrant population has subsequently led to a rise in cultural, ethnic, and racial diversity. In 2017, 21.9% of the Canadian population was foreign-born and this number is expected to increase to 30% by 2036.¹ The rise in multiculturalism is creating challenges for practitioners in the healthcare system, particularly with regards to conversations surrounding end-of-life care.² These conversations are impacted by many factors including but not limited to: decreased health literacy, family-based decision-making, and insufficient financial and social resources for immigrants.³ Ultimately, this has led to marked differences in quality of care amongst immigrant populations compared to Canadian residents.⁴ Thus, assumptions surrounding end-of-life care from the physician's perspective, as well as the patient's limited knowledge in this matter must both be addressed to prevent discrepancies in care.

In a population study, end-of-life care received by recent immigrants was compared to long-standing residents in Ontario between 2004 and 2015. It was found that immigrants are more likely to die in an ICU, to be admitted to the ICU, and to spend more days on average in the ICU. Furthermore, they are more aggressively treated with mechanical ventilation, dialysis, and surgical feeding tubes.³ These statistics were adjusted for confounders, such as differences in demographics, and it was found that country of origin was strongly associated with risk of dying in an ICU, which may reflect the diversity in healthcare systems and patient expectation on a global scale. Interestingly, the statistical differences were dampened with as patients spent more time in Canada.³

A similar study aimed to evaluate the degree to which end-of-life care values and preferences are associated with advance care planning within racial/ethnic minority groups in the United States from 2002 to 2008.⁵ Non-Latino white patients were significantly more likely to have a do not resuscitate (DNR) order compared to Black and Latino patients. They were also significantly less likely than Black or Latino patients to endorse feeding tubes or antibiotics even if they were to extend their life for one day or up to one month.⁵ It is important to note that treatment preferences often change after discussions surrounding the risks and benefits of life-prolonging treatment.⁶ The development of interventions that educate patients on the relative risks and benefits of spe-

cific life-prolonging treatments is essential to allow patients with terminal conditions to make informed decision.⁵ Ensuring that patients are well educated about treatment options, and making sure their preferences are documented, is integral to maintaining the standards of advance care planning.

In Canada, the growth in demand for home-based care has incited a trend toward palliative care delivered in the home.⁷ Since Canada is an ethno-culturally diverse nation, current studies are investigating end-of-life care preferences among different minority groups. Chinese immigrants make up one of the largest minority groups in Canada, making it imperative to understand their cultural and personal preferences with regards to palliative home care.⁸ A focused ethnographic study examined the palliative home care experience of four Chinese immigrants with terminal cancer, their family caregivers, and health care providers (HCPs). The study unveiled three themes surrounding death and dying: taboos, discursive tensions between patient-centered care and cultural competence, and language barriers.⁹ Anecdotally, there is a perception that Chinese immigrants do not prefer to die at home, which contrasts with growing emphasis on supporting home deaths in Ontario. Although HCPs believed that Chinese immigrants did not want to die at home due to superstition, it may be that recipients were choosing to die in hospitals, palliative units, and hospices to avoid burdening family members.⁹ With the prevalence of home palliative care, families providing care to their terminally-ill or dying kin are subjected to mounting pressure, and access to support services that can mitigate burden is often inadequate. A longitudinal study on Dutch Reformed family caregivers (FCGs) in Ontario found that families play a central role in caring for their loved-ones over the course of an illness and through the dying process. Furthermore, there are likely to be multiple family members involved in caregiving, especially for an aged parent.¹⁰

There are several factors influencing the current disparities observed in end-of-life care. Immigrant populations may change their end-of-life care goals as they become further assimilated into Western culture, which reflects changes in patient preferences over time. However, it is far more likely that clinicians have implicit biases influencing their approaches to end-of-life care discussions with immigrant patients. Research conducted in the United States has supported the notion that physician behavior may be the main contributor to differences in end-of-life care.¹¹ In North America, principles of truth telling and patient autonomy guide the basis of communication with patients whereas in other parts of the

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world family decision making is highly valued.² This can create discordance between the physician and patient due to differences in values, beliefs, and understanding of the illness experience. When it comes to end-of-life care, ethnic minorities are less likely to seek palliative care as observed in end stage renal failure patients in Canada.¹² The preference to die in a hospital may simply be a result of a different or lack of understanding of the value of palliative care. Many HCPs in the study on Chinese patients with terminal cancer noted that working with care recipients who did not speak English added to the level of complexity in discussions surrounding good palliative home care; this was also observed in the Dutch Reformed FCG study.^{9,10} Understanding the risks and benefits of treatment was crucial to Dutch Reformed patients as the predilection to engage in treatments that were considered futile was reduced while those that were understood to improve the quality of life were increased. This knowledge informed treatment decisions, service use, and ultimately, arrangements for care.¹⁰ While reliance on rational decision making regarding end-of-life care may work with some patients, discussing death and dying with others is a cultural transgression.² Furthermore, communication abilities regarding treatment goals are compromised even if patients are fluent in English as the nuances in healthcare communication can remain hidden to those who are recent immigrants.⁴ Additionally, other factors influencing decreased utilization of palliative care in certain groups reflects preferences with regards to more aggressive treatments and familial involvement.² There is a need to recognize the importance of family in the provision of care as well as the need for having a translator on the team, particularly at end-of-life.⁴ The Dutch Reformed FCG study highlights the importance of families working together with HCPs in order to reduce the strain incurred by FCGs, and to implement timely and appropriate interventions to provide better support.¹⁰

Cultural competence is more crucial than ever in a healthcare system that is incorporating an increasing number of immigrants each year into its care. The first step towards a more culturally sensitive practice is for physicians to become aware of their own beliefs, values, and perceptions as well as the ones inherent to the healthcare system itself.² This allows for open communication between physicians and patients and rapport that lends itself to discussions surrounding more sensitive topics in the future, such as end-of-life care. The ABCDEs, which are a list of questions to ask one's patient to ascertain the degree of cultural influence on a patient's attitudes and beliefs can be a helpful tool to integrate into one's practice.¹³ Training on cultural competence should move away from

models that portray cultural beliefs and practices as shared, fixed patterns and take into account individual preferences of care delivery.⁹ Furthermore, to address familial involvement in patient care, which may affect the degree of disclosure of diagnoses, physicians should establish patient preferences regarding decision-making first and abide by patient wishes. Lastly, to overcome linguistic and communication barriers, availability and integration of translators into patient care would greatly enhance the experience.⁴ Awareness of cultural differences that may impact patient health and end-of-life care is the first step towards a more culturally sensitive practice. More research is needed to determine the best course of action on the systemic issue at hand, however in the meantime physicians should exercise cultural sensitivity to ensure all patients are afforded the same standard of care.

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