Transcultural Nursing Principles

An Application to Hospice Care

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❖ Providing end-of-life care that is meaningful to each family, that honors a deep appreciation for the sanctity of human life, requires nurses to develop cultural competence. It is noted that many cultural variations exist in the dying process, in what is considered culturally meaningful, and in what constitutes a good death. Using transcultural nursing concepts as a theoretical base, this article will provide an overview to the hospice practitioner who might be unfamiliar with these concepts. Additionally, a framework is provided to assist with assessments and interventions in multicultural situations. Three specific ethical areas, germane to hospice care, are also discussed: (1) sharing bad news, (2) locus of decision making, and (3) advance directives. Throughout the article, numerous clinical examples are used to underscore the presented concepts.

K E Y   W O R D S

cultural diversity
hospice nursing
palliative nursing
transcultural nursing

It was a brief yet memorable encounter. The patient, a 47-year-old Mexican-American migrant worker, lay dying, surrounded by numerous family members of all ages. The elderly mother clung to her profound Catholic faith, petitioning God on her son's behalf. In an effort to reposition the patient, the staff approached the bedside. The staff had worked diligently to gain the trust of the family, which was nearly crushed with one quick action. Petite and elderly, but clearly the family matriarch, the patient's mother had placed a Catholic rosary with the patient. In a task-oriented mindset, a member of staff had nearly plucked the rosary from the patient's hands and placed it

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uneceremoniously on the bedside table. Immediately, another staff member requested permission to remove the rosary. When the treasured item of hope and faith was placed in the mother's hands, appreciation shone in her eyes. Upon the completion of the nursing task, this mother gently replaced the rosary in her son's hands. A simple act of cultural sensitivity, imperative for the healthcare providers to learn, diverted a violation of the family's heritage and beliefs.

❖ DEFINING TRANSCULTURAL NURSING

Concepts of transcultural nursing were developed by Leininger in the mid-1950s. "Transcultural nursing" has become an accepted phrase, a formal concept, and a field of study extending across cultural lines in search of the "essence of nursing."[1] The implications of these definitions are vast. An increase in migration of people between countries has occurred and gender issues continue to add complex layers to one's world view.[2]

As cited by Andrews and Boyle,[3] numerous authors have identified transcultural nursing as the blending of anthropology and nursing in both theory and practice. Anthropology refers to the study of humans: their origins, behavior, customs, social relationships, and development over time. The use of transcultural nursing principles provides a venue to examine many aspects of the delivery of care.

Cultural factors were not formally integrated into the nursing curricula until the 1960s and 1970s.[4] Many changes were prompted by the seminal work, *Nursing and Anthropology: Two Worlds to Blend* (1970), in which Leininger urged the two professions to share knowledge and experiences. Leininger, the first graduate-prepared nurse to hold a PhD in cultural and social anthropology, continued her work with *Transcultural Nursing: Concepts, Theories, Research, and Practice* (1978). This publication is widely considered the first definitive work on the practice of transcultural nursing.[5]

❖ APPLYING TRANSCULTURAL NURSING PRINCIPLES TO HOSPICE CARE

In a single day, a hospice nurse may care for a foreign-born corporate executive, or a rural family on a country dirt road. Each environment, each person, embodies a different culture. Providing end-of-life care that honors an appreciation for the sanctity of human life requires nurses to develop cultural competence. This article will review the transcultural nursing literature and apply these concepts to hospice practice.

Galanti[2] acknowledges that nurses face "this monumental task on a daily basis; interacting with patients and family members who are ill, scared and generally not at their best" and strives to make various cultural practices seem "interesting rather than annoying." Healthcare providers strive for successful outcomes. Understanding specific factors that shape behaviors is an essential beginning.[1] "Learning about, understanding, and respecting the values and beliefs of others" is a basic definition of cultural competence.[2] It is not a stagnant entity, but a dynamic process.[3]

As cultures interact with each other, inevitable conflicts and clashes ensue, often with impacts on healthcare outcomes. Yet developing cultural competence should be a constant learning process, versus an end point.[3] By first understanding their own culture, nurses should acquire knowledge and understanding of the values and beliefs of other cultures. Then, the knowledge can be incorporated and applied to professional nursing practice.[2]

❖ UNDERSTANDING YOUR OWN CULTURE

Bigby[6] states that understanding one's self is fundamental in understanding how to relate to others; that "personal self-reflection and self-critique are required to explore how different life experiences influence interactions with patients." An equally critical step in developing cultural competence is acknowledging that different expectations may exist between providers and patients. Each will experience similar situations from different perspectives. The beginning of cultural competence, asserts Bigby, is the desire to better one's relations with other groups of people.

Many methods are available for self-discovery. The questions in Table 1 can be used to gain insights into potential sources of bias, as well as to enhance appreciation for one's own cultural beliefs.[3,6] Additionally, awareness of one's personal culture may begin with an examination of one's values, or the things held important. For example, one may wish to examine the typical "American" values such as freedom of choice,

Table 1
Know Thyself: A Self-Discovery Questionnaire for Practitioners[3,6]

1. How would you describe your racial/ethnic identity?
2. What are some characteristics of your racial/ethnic that you view positively? Negatively?
3. When you were growing up, what did you learn to value?
4. At what point in your life did you encounter a person of a different race? Different religious belief? Different sexual orientation?
5. How do you feel when you are alone on an elevator with a person of a different race?
6. What was the role of food in your family of origin?
7. If you had an appointment at 2:00 PM, what time would you arrive?
8. At what point in your life did you encounter someone with a history of incarceration?
9. What is the cultural characteristic with which you have the most difficulty?
10. At what point in your life did you encounter someone with a terminal illness?
11. What is your first thought when you see someone with a physical or mental disability?
12. How do your views change when you discover that a person abuses medication or illegal drugs?

importance of money, or rights to independence and privacy. According to Galanti,[2] a culture's values can be assessed via the way it punishes people. By taking away one's money (such as a fine) or taking away one's freedom (such as incarceration), a typical citizen of America would be deprived of something valued.

Values, or standards that a group of people hold in common, provide a framework to govern one's life, including attitudes and behaviors. Personal decisions and actions are guided by these standards, thus revealing a person's identity. How one perceives and reacts to others is affected by one's values.[7]

Further exploration of one's personal culture may include awareness into one's heritage. The concept of heritage includes cultural, ethnic, and religious backgrounds. Each component contributes to the creation of a culturally unique individual.[8] Culture is a concept that "encompasses beliefs and behaviors that are learned and shared by a group."[2] Luckmann[7] refers to the "common lifestyle, languages, behavior patterns, traditions and beliefs that are learned and passed from one generation to the next." Spector[8] emphasizes culture as a metacommunication system in which the spoken and the nonspoken have significance. Additionally, Tripp-Reimer[4] makes the following point: some habits and behaviors are open to change, but some are acquired early and are much more stable.

Ethnicity is a complex term and may indicate some characteristics that a group shares in common, such as race; a common geographic origin; or a shared set of literature, music, or folk traditions. Shared food prefer-ences, such as eating a kosher diet, might also characterize a certain ethnic group.[8]

Religion is defined by the Office of Minority Health as "a set of beliefs, values and practices based on the teachings of a spiritual leader."[8] Many mysteries—life and death, pain and suffering—are derived from and respond to religious concerns. When framing a health crisis in meaning and purpose, often a religious component is involved.[3]

Acquiring Knowledge and Understanding

An orderly method of acquiring knowledge is the Giger and Davidhizar Transcultural Assessment Model,[1] containing the following six distinct domains: (1) communication, (2) space, (3) biological variations, (4) time, (5) environmental control, and (6) social organizations. Each domain will be individually addressed.

Communication

Communication is the means by which people connect.[3] Culture greatly influences how inner feelings are expressed, and directs the appropriateness of both verbal and nonverbal expressions.[1] Luckmann[7] believes that communication is the cornerstone for nursing practice, and that clear and mutual understanding forms a platform for positive outcomes. Verbal communication involves language. Nurses must appreciate the variety of languages spoken in the United States other than English. Initial introductions to a new patient or unit of care are

critical in establishing a mutually respectful relationship. These exchanges are often difficult, but frequently impossible with the use of idioms and slang. In an example, Galanti[2] reports a verbal misunderstanding between health professionals. A nurse reported that her patient was getting "cold feet" about an upcoming surgical procedure; the Chinese-born physician ordered vascular studies to rule out circulatory problems. Furthermore, the use of silence varies, from signifying respect (Asian cultures), agreement (Spanish, French, and Russian cultures), or the need for privacy (English and Arabic cultures). Nurses should consider the various meanings of silence.

Nonverbal interactions include facial expressions, body posture, eye behaviors, and the use of touch. Eye behaviors can have a multitude of meanings. In many Asian cultures, it is considered disrespectful to look someone in authority directly in the eye, for direct eye contact implies equality. Nigerians may avoid direct eye contact as a show of respect, yet an American job applicant might be viewed as untrustworthy or "shifty-eyed" for lack of direct eye contact. Furthermore, the use of gestures can vary greatly among cultures; imagine the following problematic clinical encounter. An Anglo patient beckoned a Filipino nurse with the "come here" gesture, a motion using the right index finger. Unfortunately, the nurse was extremely offended, as the gesture is used to call an animal in her culture. These classic situations are the very reason why idioms, slang, gestures, and other types of informal communication are best avoided.[2]

As a form of nonverbal communication, touch has historically been a vital part of nursing care. Touch in a professional relationship vastly differs from touch in a personal relationship. When therapeutic communication is the primary goal, appropriate actions might include shaking hands, touching the arm or hand, or stroking the forehead. These gestures may be used to convey warmth, empathy, or reassurance.[9] Touch, a learned behavior, has great cultural significance and meaning. Some cultures, such as the Spanish, Italians, French, Jews, and South Americans, are highly tactile; others are not. Some cultures view touch as healing; Native Americans believe touch can reverse an evil spirit.[1] Recall that touch is not always interpreted in the same fashion by all people. To pat the head of a young person is a sign of friendliness by an American adult, but it is considered a serious insult by Southeast Asians; who believe that the head is the seat of the soul. In many cultures, certain body parts connote a "taboo"

nature. Arab and many Southeast Asians consider the foot the dirtiest body part; showing the sole of the shoe is offensive. Using one's left hand is reserved for toileting functions in Middle Eastern cultures, so handing someone of this culture an item is usually done with the right hand.[10] Furthermore, in rural England, the ring finger was historically considered as healing, never the forefinger or "poison finger."[11]

Religious doctrine has implications for culturally sensitive nurses. In the Orthodox Jewish traditions, touching members of the opposite sex is prohibited. Equal challenges exist with Middle Eastern patients. Strict sexual segregation, in keeping with the laws of the Qur'an, primarily protects the purity of their women. In these instances, same-sex caregivers are ideally matched with such patients.[2] Recall that communication, even touch messages, involves how the communication is interpreted. Observant nurses should constantly be aware of the reactions of patients, taking great care to observe cultural variables.[1]

Space

Viewed as the area surrounding one's body, space is an individual matter. It is dynamic and varies with situation, as well as from culture to culture. Several authors[1,3] describe the early 1960s groundbreaking work of Hall in the area of proxemics, the study of human use and perception of physical space, both personal and social. Three dimensions of space are generally recognized in western culture: the intimate zone (0 to 18 inches, where another's odor, heat, and touch are experienced), the personal zone (18 inches to 3-4 feet, where communication between friends and acquaintances occur), and the social/public zone (3-4 feet to 6-12 feet, where impersonal business is conducted). The business of nursing requires interactions in the intimate or personal distance zones. Additionally, Hall categorized humans into two spatial groups: contact and noncontact. People from a contact orientation tend to view noncontact others as being shy, impersonal, impolite, and boring. Conversely, noncontact people can view contact others as impolite, pushy, obnoxious, and bossy.

Individuals usually do not have a conscious awareness of their personal space requirements and frequently have difficulties understanding the cultural requirements of others.[1] Proximity to another as a form of friendliness, such as in Latino cultures, may be perceived as invasion of personal space by an

American, Canadian, or Briton. Effective and culturally competent nurses respond to patient cues, thus maximizing comfort. Patients who step back, avoid direct eye contact, or pull the chair away from the nurse are sending a message for additional space requirements. In the most basic terms, the use of space is a form of nonverbal communication, a function of how much intrusion by others is considered acceptable.[1] Multiple cultures interact comfortably in small spaces; others do not. The author (MJ) recalls waiting for dinner in a busy London neighborhood eatery. In this setting, her party of two was seriously discouraged from occupying an entire booth, which was a perceived waste of precious space. It would have made a fascinating cross-cultural portrait: two uncomfortable American women, used to having their own "territory," joining two nonchalant British businessmen, very accustomed to shared space in a crowded city.

Biological Variations

Knowledge of growth and development, nutrition, and other biological factors are important, because these factors can affect nursing assessments.[1] For example, body weight and structure can vary widely between races. In addition, susceptibility to disease and interactions with medications can vary widely between races. Nutritional preferences are affected by cultural, social, psychological, economic, geographical, and religious reasons. For example, it might be advantageous for the nurse to be aware of the hot-cold theory, which has been discussed by several authors.[2,3,10] Treatment of disease and the maintenance of health are achieved by correcting and maintaining a balance within the body. Based on their effect, not on actual physical states, foods, medicines, herbs, and beverages are classified as "hot" or "cold." Disease states are also classified; for example, skin rashes are hot. The concept of an upset in the body balance probably originated in China, but these theories can be found in Asian, Latino, Arab, Caribbean, Indian, and Muslim cultures. When the body is balanced, health prevails; when the body is imbalanced, illness results. In Asia, the balancing factors are referred to as *yin*, generally translated as cold, and *yang*, generally translated as hot. Restoring the system's balance is usually achieved through foods, herbs, or other treatments; a "cold" food is used to treat a "hot" illness. Comprehensive lists are difficult to compile, for each culture has its concept of which foods and conditions are "hot" or "cold."

Time

This domain of Giger and Davidhizar is a multifactoral and multicausal phenomenon. The awareness of time is indoctrinated at a young age; even American children in kindergarten experience the consequences of being "tardy" to school. The biological sciences view time as an essential component of many life processes, such as the healing of a physical or emotional wound.[1] Perception of time is complex and value-laden. As noted by 20th century author Dreyfous, "Family values are a little like family vacations—subject to changeable weather and remembered more fondly with the passage of time. Though it rained all week at the beach, it's often the momentary rainbows that we remember."[12]

Clock or calendar time is time that can be measured by pre-established criteria. The concept of social or activity time, not related to clocks or calendars, refers to the patterns and sequences of social life.[1] For instance, "dinnertime" conjures an image understood by many. Health providers must recall, however, that not every culture eats at the same time. Galanti[2] recounts an unfortunate misunderstanding with a Hispanic family, who had a discharge planning appointment at "lunchtime." The family, arriving between 1 PM and 2 PM, thought they were on time. The totally annoyed nurse and pharmacist, having waited for over an hour, communicated their irritation. The session was a complete waste of everyone's time. To avoid communication failures, clock time should always be used to schedule appointments, not a social activity time.

Tempo is an additional aspect of time that should be considered in multicultural interactions.[1] This concept refers to the rate of time: the tempo of life in Miami, FL, a large urban metropolitan area, would be significantly different that the tempo of life in Mulberry, FL, a small, rural, agricultural area. Time orientation, usually framed as past, present, or future, can affect many nursing interactions.[1] Future-oriented individuals are "savers;" planning and preparing are driving forces. Hard work in the present results in future success and time is viewed as a precious commodity that is not to be wasted. These individuals usually take an active role in their healthcare and frequently have well-contemplated advance directives. With regard to illness and death, some future-oriented individuals associate time with a spiritual faith, hoping for a life after death. Present-oriented individuals have difficulty incorporating the future in present-day plans. In some Native American cultures, common themes of the man–nature balance,

or living in harmony with nature, suggest a present-time orientation. Nonadherence to set schedules or appointments, in addition to relaxed and unhurried attitudes, are prevailing themes. The philosophy is living for today, because tomorrow is not promised. Past-oriented individuals display respect for tradition, a reverence for ancestors and strong family ties. Health-care decisions are often influenced by tradition; human relationships are valued over current events. Some cultures view a healthcare crisis as destined (the Filipino term *talaga*) and in the hands of God, unaltered by human intervention.

Environmental Control

Environmental control is defined as an individual's perception of the ability to direct factors in the environment. A variety of health systems affect individuals and their lives. Based on a framework of diagnosis and scientific explanation for illness, the traditional Western medical system focuses on health prevention and curative medicine. Folk medicine systems, however, tend to focus on the relationship between the body and natural phenomena, such as phases of the moon, position of the planets, and changing of the seasons. Information for health-related decisions might originate from the zodiac, the *Old Farmer's Almanac*, or from a variety of healers: a *yerbero* (herbalist) or an *espiritista* (a practitioner who communicates with spirits). Folk medicine networks tend to be multiperson groups of relatives and/or nonrelatives as caregivers.[1]

The locus-of-control theory relates to an individual's perception of the power they have over the situations and events that affect them. An external locus-of-control identifies an individual who believes outcomes are due to fate, chance, or powerful others. If life is viewed in this manner, little connection would be perceived between personal action and health. These individuals tend to be fatalistic about illness, disease, and death. Conversely, an individual with an internal locus-of-control views a relationship between behavior and results, thus acting to influence situations. Cultural attitudes, familial beliefs, socioeconomic conditions, and political factors play a role in an individual's development of personal power and responsibility.[13]

Social Organizations

An array of groups, including family, religious, ethnic, tribal, and other special interest groups, are classified as social organizations. Within these groups, patterns of behavior are learned and passed down through generations. The family, aside from a biological perspective of procreation, serves as the most widely recognized basic social group and provides a platform for personality development. Although the traditional nuclear family, defined as one man and one woman of the same age, race, and religion, who are faithful for life, is the most prominent in the United States, other family structures exist. Nurses might encounter the following families in the course of hospice work, such as an extended family, which consists of multigenerational relatives by birth, marriage, or adoption. Also, alternative families, either adults of a single generation or combinations of adults and children in communal arrangements, might be encountered.[13]

The author (MJ) facilitated a hospital-based hospice admission with an older Hispanic-American man, whose illness prevented him from making his own healthcare decisions. The discharge planning interview actively involved the extended family: a Hispanic former wife, an African-American current wife, all eight adult children, and the *compadrazgo*, the best friend and children's godparent. This clinical example illustrates a nursing approach consistent with the lifestyle and cultural needs of the hospice unit-of-care, where the extended family is emphasized over the individual.

Religious beliefs and affiliations cannot be overlooked, especially during significant life events such as a life-limiting illness, body image alterations, or death. Nurses should be sensitive to the inclusion of recognized religious leaders (such as an Islamic imam or a Catholic priest) to perform rituals that are meaningful both to the patient and to the family.[3] In the case of a chronic or terminal illness, a lack of cure may represent, to some cultures, a punishment or the evidence of sorcery.[10] Additionally, views regarding the meaning of suffering and the afterlife are significant spiritual dimensions that the culturally sensitive nurse might thoughtfully consider.[14]

Ethnic origins are often noteworthy. Many Arab Americans may appear overprotective; it is the family's duty to be supportive in care. In various cultures, families do not plan ahead for future healthcare needs, believing that they might be defying the will of God. In dealings with the Hmong culture, a rugged and rural people from the highlands of Laos, comprehension of any written care plans are often hindered because their culture is primarily oral. Often, traditional healing ceremonies and methods are revered by non-Western

cultures; old ways must be incorporated for the nursing treatment plan to be accepted and effective.[1]

Acquiring knowledge is a continual process. Table 2 provides the reader with additional resources to enhance the development of cultural competence.

Applying Knowledge to Nursing Practice

Without application of knowledge, without effecting positive differences in delivery of care, one's clinical practice could be akin to "a resounding gong or a clanging cymbal."[15] Nothing would change. To understand the relevance of cultural competence to the delivery of care, it is vital to appreciate that each person's unique background and life experience will shape the way a life-limiting illness is viewed. The US Census Bureau predicts that by the year 2030, more than 40% of the US population will self-identify as members of a diverse racial and ethnic group. With these trends, practitioners have a "compelling need for cultural competence" to "increase patient satisfaction and improve patient outcomes."[16]

Conflicts may arise in the arena of ethics. Much of the work in bioethics, which emphasizes informed consent and individual autonomy, are Western constructs. Not all ethnic and cultural communities share these values. Three specific ethical areas are germane to hospice care: (1) sharing bad news, (2) locus of decision making, and (3) advance directives.[14]

In some cultures, sharing news of serious illness and death is disrespectful and impolite. Asians view sharing a cancer diagnosis as unnecessarily cruel; some Europeans view such sharing as inhumane.[14] Chinese practitioners utilize the ethic of *cheng*, which involves protecting patients from harm and bearing the burdens of their illness.[17] Out of respect for aging family members, discussions of serious illness are withheld to avoid unnecessary anxieties. An additional consideration is the reality of the spoken word, as in Native American, Filipino, and Bosnian cultures. Once a negative word is spoken, it is feared that the words will become self-fulfilling.[14] Several authors[2,17] stress giving patients the chance to participate in discussions, rather than imposing Western ways. A

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Additional Resources

Lillian Carter Center for International Nursing seeks to enhance the impact of nursing on a global scale. Named after President Carter's mother, who was a registered nurse, the center's mission is to improve the health of vulnerable people worldwide through nursing education, research, practice, and policy. The Center is housed at Emory University's Nell Hodgson Woodruff School of Nursing. http://prod-www.nursing.emory.edu/lccin/

Transcultural Nursing Society was founded in 1974 by Dr Madeleine Leininger, a nurse anthropologist. The society serves as a worldwide organization for nurses interested in advancing transcultural nursing in education and practice. Members are active in consultation, education, research, direct care, and policy making in both national and transnational arenas. http://www.tcns.org/

Resources for Cross Cultural Health Care is a clearinghouse of information on meeting the language and cultural needs of diverse populations. Their mission includes providing assistance in designing and implementing culturally appropriate healthcare programs and policies. http://www.DiversityRx.org/

Office of Minority Health is a US governmental agency designed to improve and protect the health of racial and ethnic minority populations. Numerous programs, publications, and health links are available. http://www.omhrc.gov/

Oncology Nursing Society has an audio program entitled *Cultural Diversity and Discrimination*, which educates policymakers on issues related to end-of-life care. http://www.ons.org/nursingEd/

Cross Cultural Health Care Program recognizes diverse way to health and serves as a bridge between communities and healthcare institutions. Education materials, training programs, and interpreter information are available. http://www.xculture.org

End-of-Life Nursing Education Consortium (ELNEC) provides nursing educators with training in end-of-life care. Content includes a module devoted to cultural considerations. http://www.aacn.nche.edu/ELNEC

National Center for Cultural Competence, housed at Georgetown University, seeks to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. http://gucchd.georgetown.edu/nccc/

specific intervention might include the following questions: (1) "Some people want to know everything about their medical condition, and others do not. What is your preference?" and (2) "Do you prefer to make medical decisions about tests and treatments for yourself, or would you prefer that someone else make them for you?" Practitioners must recall that many view illness as a family event, not as an individual occurrence.[14,18]

Locus of decision making varies from culture to culture. In traditional Western medicine, patients who make independent healthcare decisions are the norm, but not all adhere to this mindset. Family composition and role responsibilities vary significantly over cultures. In the Gypsy culture, for instance, wisdom is thought to come with age. Decisions are made by the grandparents, because age is viewed as a sign of authority.[2] Other patriarchal societies include Asians, Middle Easterners, and Latinos.[1,2] Roles for women have changed in America but not worldwide. Many cultures do not allow wives of any age to make independent decisions, even regarding their own healthcare. Galanti recounts clinical incidents where Mexican-American women refused to sign informed consents for critical diagnostic and therapeutic procedures, deferring to their husbands. Similarly described is a Middle Eastern family who refused to accept the medical advice of female physician, feeling that matters of chemotherapy were too critical to entrust to a woman. Conversely, weighty decisions might be made by the older women, such as in matriarchal societies of the Navaho and African American.[2]

Illness and dying often involve concepts which are eternally significant to the family involved.[17] Becoming aware of these beliefs, especially with regard to sacred symbols, can avoid misunderstandings. In general, assume that any garment that looks unusual might be worn for spiritual reasons: sacred threads (Hindus), medicine bundles (Native American), red ribbons (Mexican children), rosaries (Catholic), and charms on a chain to ward off the evil eye (Mediterranean).[2] Similarly, illness and dying often involve concepts that have many cultural and symbolic meanings, such as the withdrawal of artificial food and fluids. Aside from the ethics of resource allocation, families of many cultures grapple with dilemma of extending the dying or extending the living.[19]

Advance directives are written instructions that one gives to others to guide healthcare decisions.[2] Survey data show that only 20% of the US population have advanced directives. Usage is significantly lower than 20% in Asian, Hispanic, and African-American populations. Many Asians respectfully care for aging relatives and these duties imply aggressive measures to preserve life. Hispanics frequently have a shared family responsibility and may be reluctant to appoint a single member to be in charge. Such attempts may be seen as offending other relatives. Many African Americans have memories of segregated and often inferior opportunities. Do-not-resuscitate orders may be viewed as an attempt to offer substandard care.[14] Religious themes are often an issue. Muslims, Jews, and Catholics frequently will not allow the removal of life support, which is seen as interfering with God's will. Even suffering is often seen as a chance to demonstrate faith and atone for one's sins. Among Buddhist believers, stopping life support is viewed as interference with one's karma.[2]

Continually Improving Hospice and Palliative Care

It is noted that many cultural variations exist in the dying process, "in what is considered culturally meaningful, and in what constitutes a good death."[20] With this in mind, the following suggestions might guide practitioners.[21] Care should be taken in choosing services for translation. It is generally not advisable to utilize housekeeping staff or a family member, because of age or gender differences, lack of medical knowledge, and possible hidden agenda. Recall that many cultural groups value collectivity and family instead of individualism, so planning of care often actively involves extended family. Finally, the disease processes must not override the "essence of what makes up one's human experience."

As life becomes "increasingly multilingual, multicultural, and multi-faith,"[17] learning the values and history of countless cultural beliefs and practices is challenging. Anthropological studies "support evidence that there is no one universally applicable view of grief."[22] Yet, despite numerous variations in practices, death is still a fundamental human experience.[20] Brody and Hunt[23] adopt a straightforward, seemingly simple approach: applying an "attitude of humility and curiosity…a willingness to learn patient preferences." In making the effort to explore and discover mutually acceptable outcomes, the art of caring and nurturing others is enhanced. Is this not the essence of nursing?

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