

A Cross Cultural View on Communication with Family and Cooperation in Palliative Care

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ABSTRACT: Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient's prognosis. There is a form of Cultural competence which includes providing effective health care across diverse cultures by working collaboratively and communicating effectively. Physicians who are aware of their own and their patients' cultural backgrounds, along with the values that are often implicit in current medical models, are better able to achieve mutual understanding within the patient encounter and to focus on culturally appropriate health care interventions. The LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) model is a framework for cross-cultural communication that helps build mutual understanding and enhance patient care. After establishing a baseline understanding of some of the factors that influence and shape family end of life communication, empirical research centered on the communication tendencies of internationally-recognized palliative care clinicians has been studied. Because death is no longer confined to the bedroom and individuals are increasingly turning to hospitals and health care institutes to assist with end of life, the role of palliative care practitioners is vital. To that end, common communication-rooted issues that may transpire among various medical personnel are explored. Focus on a shared underlying tension—care vs. cure—links the findings between family and palliative care clinician communication regarding end of life. Practical communication solutions and suggestions are offered to facilitate productive and mindful end of life communication between and among family members and health care practitioners.

KEYWORDS: palliative, cross, cultural, communication, family, cooperation, family, model, practitioners

I. INTRODUCTION

Handling collusion among patients and family members is one of the biggest challenges that palliative care professionals face across cultures. Communication with patients and relatives can be complex particularly in filial cultures where families play an important role in illness management and treatment decision-making. Collusion comes in different forms and intensity and is often not absolute. Some illness-related issues may be discussed with the patient, whereas others are left unspoken. Particularly in palliative care, the transition from curative to palliative treatment and discussion of death and dying are often topics involving collusion. Communication patterns may also be influenced by age, gender, age, and family role. [1]

Collusion is a non-competitive, secret, and sometimes illegal agreement between rivals which attempts to disrupt the market's equilibrium. The act of collusion involves people or companies which would typically compete against one another, but who conspire to work together to gain an unfair market advantage.

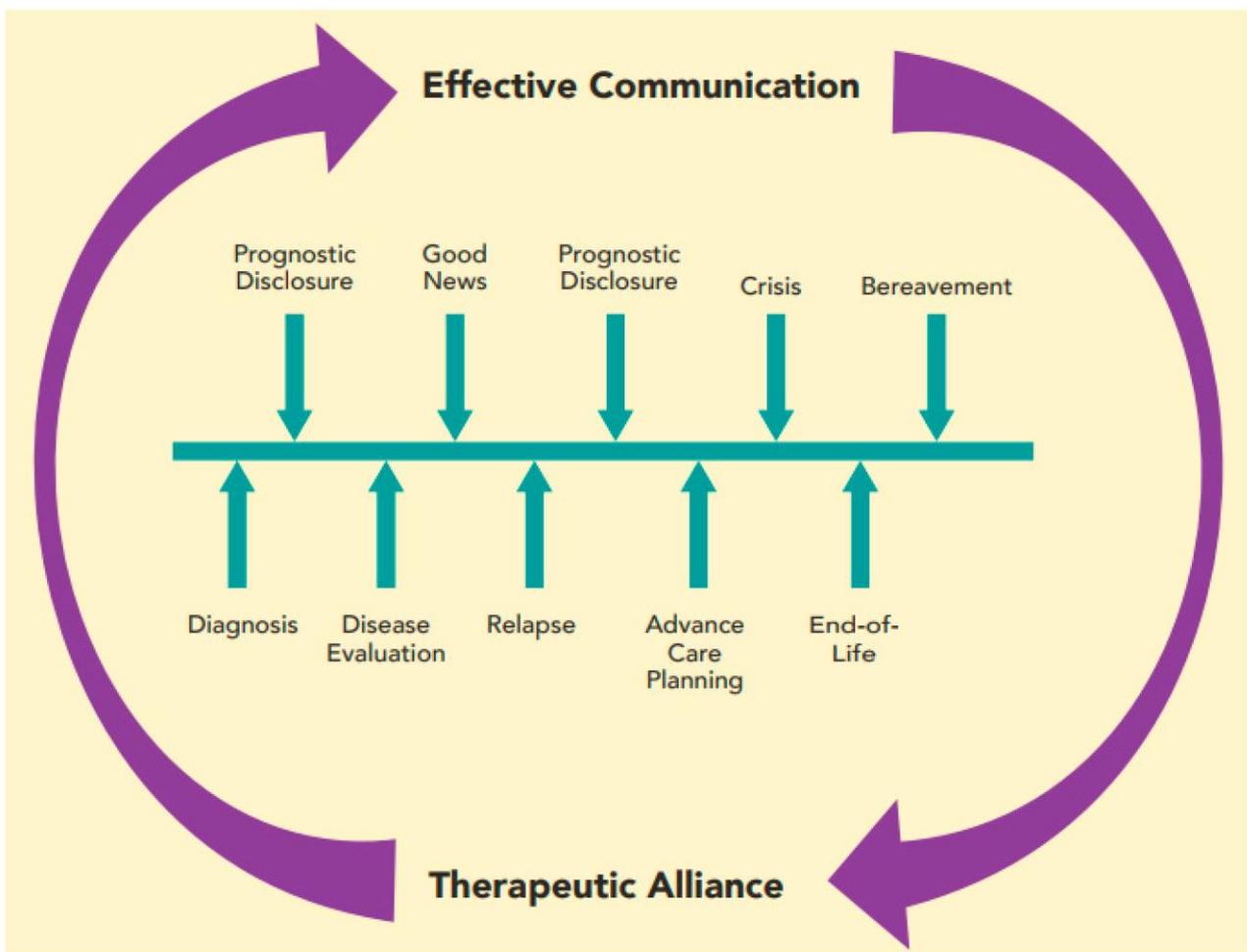


The colluding parties may collectively choose to influence the market supply of a good or agree to a specific pricing level which will help the partners maximize their profits at the detriment of other competitors. It is common among duopolies. Collusion can take many forms across different market types. In each scenario, groups collectively obtain an unfair advantage. One of the most common ways of colluding is price fixing. Price fixing occurs when there are a small number of companies, commonly referred to as an oligopoly, in a particular supply marketplace. This limited number of businesses offer the same product and form an agreement to set the price level. Prices may be forcibly lowered to drive out smaller competitors or may have an inflated level to support the interest of the group at a disadvantage to the buyer. [2] Overall, price fixing can eliminate or reduce competition while also leading to even higher barriers for new entrants.

Based on the research literature, examples of model, borderline and contrary cases of culturally sensitive communication have been developed. Three major uses of culturally sensitive communication are identified, including understanding one's own culture, open and sensitive communication, and strategies to collaborate with the patient and family for optimal patient care. An awareness of one's own cultural beliefs, values, attitudes and practices are identified as an essential first step before learning about other cultures. This awareness includes being sensitive and adaptive to individual cultural differences and relies on clinician self-understanding and reflection. [3] Strategies to collaborate with the patient and family for patient care include respectful and supportive clinician interactions with the family that enable a collaborative approach to care.

II. OBSERVATIONS

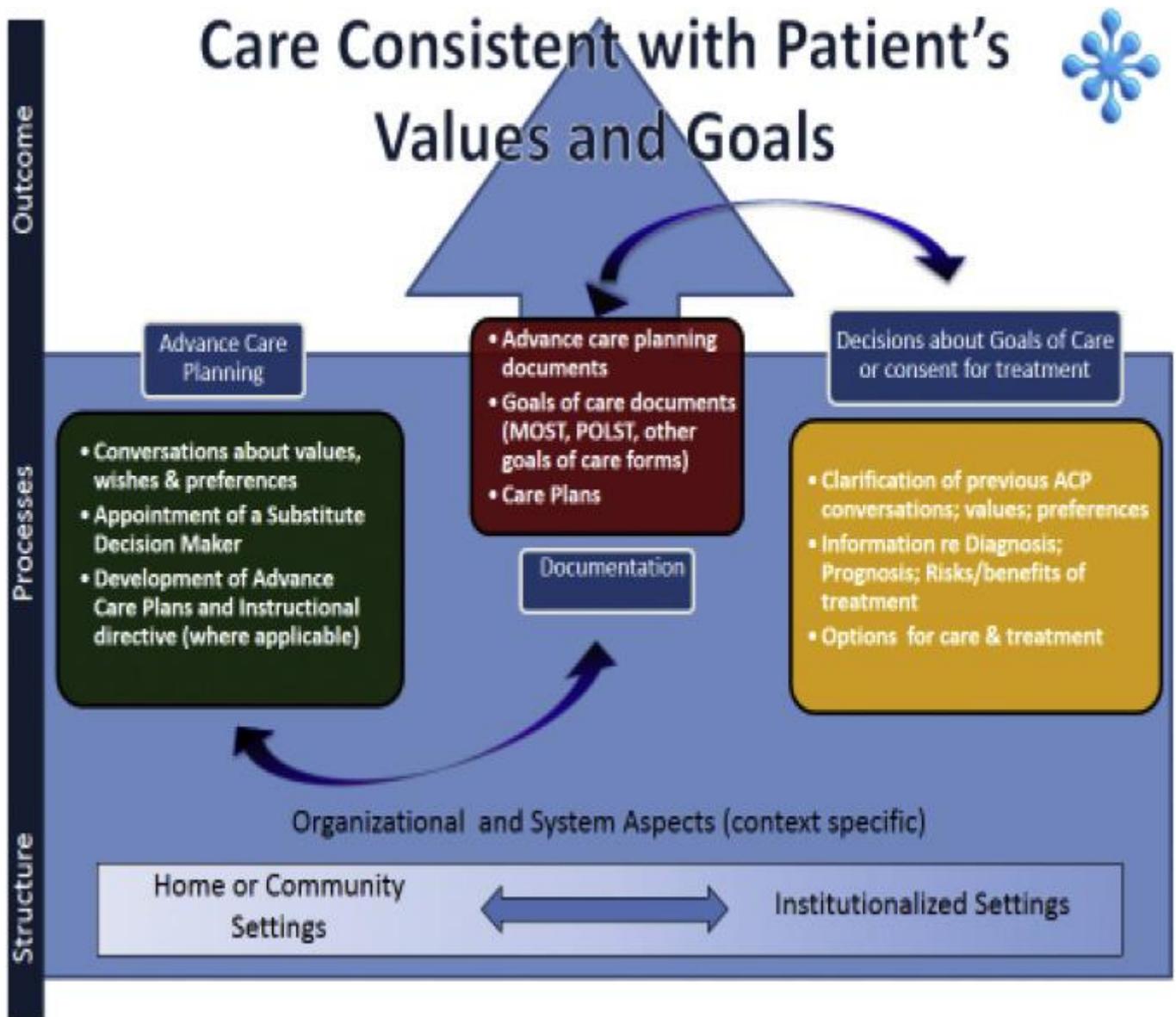
Optimal communication in cancer care requires that the actors involved have adequate levels of knowledge, adequate communication skills, and an open attitude to facilitate the flow of information, emotions, and supportive interpersonal behavior.



In addition, because cancer is often associated with suffering, aggressive treatment, and bodily harm and stigma, the content of communication can be complex. This article also shows key insights into important phenomena that affect the quality of communication in cancer care. These include psychosocial, demographic and cultural factors, highlighting cultural aspects of cancer care in India as a salient example,[4] and technological advances in communication and supportive cancer care. Socio-demographic characteristics of both patients and health care professionals can have profound influences on communication in cancer care. Age, gender, level of education, socio-economic level, and ethnicity are five such characteristics that have been found to influence patterns of communication. For instance, age, gender, and education have been shown to be significantly associated with patient preferences for communication of prognostic information, with younger, female, and more highly educated patients preferring more detailed information and emotional support.

III. DISCUSSION

Culture basically describes the characteristics of individual and group identity. An organized group of learned responses, a system of ready-made solutions to the problems people face that is learned through interactions with others in society. Common components of culture "include a groups shared values, customs, and beliefs that are manifested in behavior. Culture "provides the foundation for schemata used to process memories, form personality expression, and determine appropriate reactions to environmental stimuli" and "cultural belief systems interact with all aspects of information processing.[5]



Cultural sensitivity is the integration of cultural knowledge and awareness into individual and institutional behavior. This sensitivity affects how a clinician interacts with each patient, and impacts communication choices, specific behaviors during treatment, and recommendations and options offered to patients. A practitioner who identifies cultural differences, understands how those differences can affect health habits and healthcare practices, and then integrates that understanding into his or her own day-to-day interactions with patients can be described as culturally sensitive. Provision of healthcare in a culturally sensitive manner involves responsiveness to the attitudes, feelings, and circumstances of people that share common identifying

characteristics (e.g., race, religion, language, and socioeconomic status). Cultural competence requires deeper integration of this sensitivity into practices and protocols to ensure that the care provided will "accommodate cultural differences in health-related values and beliefs.[6]

IV. RESULTS

Cultural sensitivity in palliative care can be illustrated in four areas; preferences for care, communication patterns, meanings of suffering, and decision-making processes. Death is the last characteristic of all living organisms. Regardless of how or where we are born, what unites people of all cultures is the fact everyone eventually dies. However, cultures vary in how they conceptualize death and what happens when a person dies. In some cultures, death is conceived to involve different conditions, including sleep, illness, and reaching a certain age. In other cultures, death is said to occur only when there is a total cessation of life. Similarly, certain cultural traditions view death as a transition to other forms of existence; others propose a continuous interaction between the dead and the living; some cultures conceive a circular pattern of multiple deaths and rebirths; and yet others view death as the final end, with nothing occurring after death.[7]

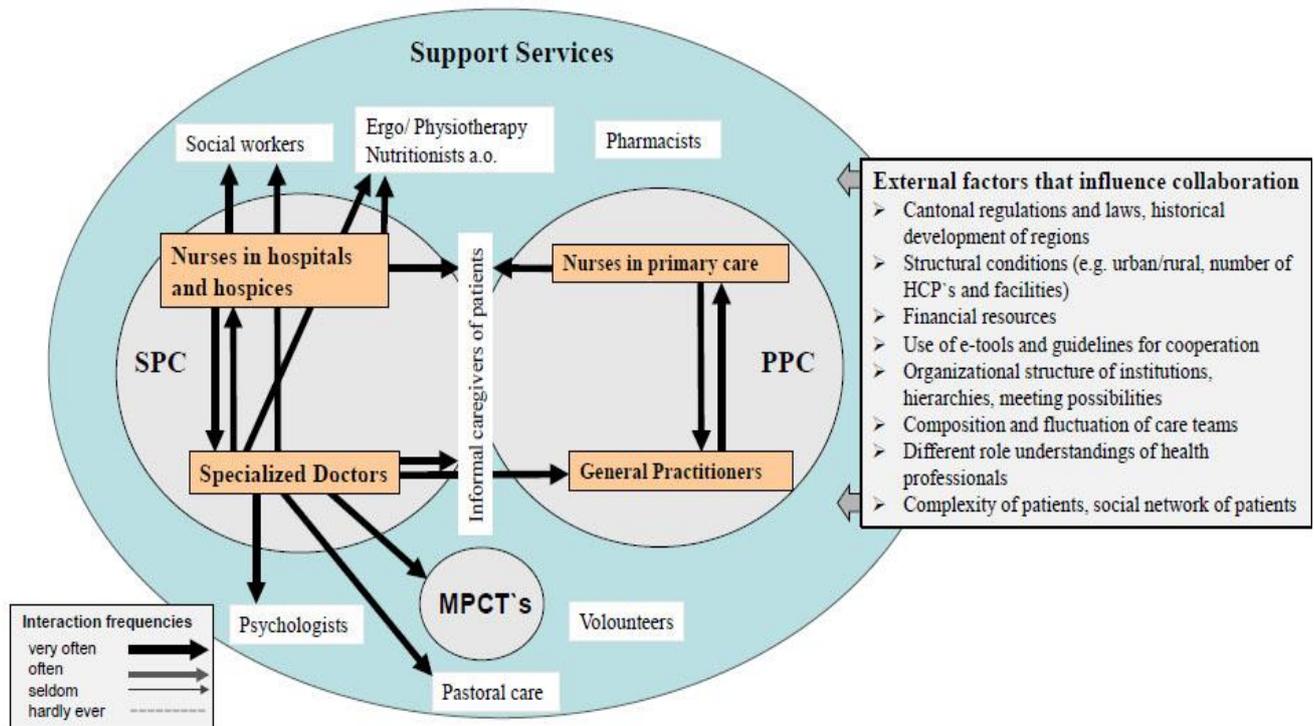


Communication as a mediating variable in achieving the goal of palliative care

These different conceptions have a noticeable influence on their lifestyles, their readiness to die for a cause, the degree to which they fear death, their expressions of grief and mourning, and the nature of funeral rituals. Any reasonably broad conceptualization of death issues would necessarily have to incorporate these various cultural variations. The difficulty of having a unitary view of death or the death experience can be better appreciated when we realize that it is problematic to even define what we mean by death. For more than a hundred years, the clinical definition, referring to the absence of heartbeat and respiration, was the basis on which a person was deemed to be dead. However, advances in medical technology that made it possible for vital signs to be sustained by machines, led to the modifications in this definition to whole brain death, which refers to death as either the "irreversible cessation of circulatory and respiratory functions, or irreversible cessation of all functions of the entire brain, including the brain stem". Thus, the controversy surrounding the definition of death is therefore not surprising that beliefs and conceptions about death and dying vary widely across cultures.

Some cultures believe that life, as is generally construed, departs the body of a person in different situations, such as when one is ill or asleep. Thus conceptualized, people can be said to "die" several times before the final

death. This also means that a person can be defined as dead without meeting many of the criteria listed in the above definition or definitions found in the social and medical literature.[8]

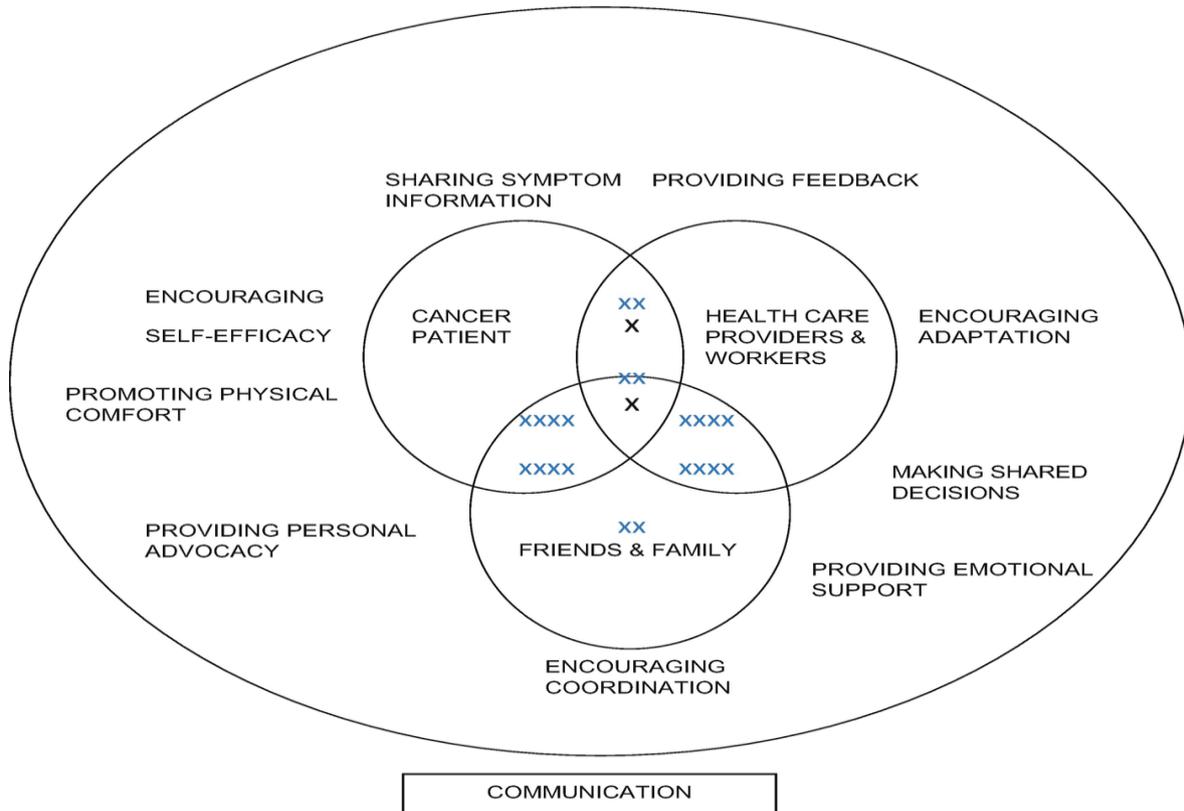


The differences in conceptions about death extend to what exactly happens when one is dead, however defined. Some religious and cultural traditions, envision a circular pattern of life and death where a person is thought to die and is reborn with a new identity. This exit and reentry into life can occur multiple times. This contrasts with the Christian view where death is believed to occur only once. However, Christians do not believe that everything ceases at death. The person sheds his or her bodily form but continues on in spirit where there are consequences: the faithful – believers who kept the faith – are rewarded with eternal joy in heaven, and sinners proceed to hell where there is endless pain and suffering. Among some segments of Buddhism, the dead and the living coexist, and the dead can influence the well-being of the living. If the dead (ancestral spirits) are properly propitiated, the likely outcome is a benevolent spirit that protects the interests of the living. If not accorded the appropriate treatment, the result is an unhappy spirit that may ignore the wellbeing of the living, leading to misery. There are, of course, some cultures in which death signals an abrupt and permanent disengagement. In some instances, people are prohibited from even mentioning the names of the deceased in the fear that doing so may actually endanger the lives of the living or prevent the ghost from leaving this earth and attaining peace. [9]

V. CONCLUSION

Culture is ‘a learned, patterned behavioural response acquired over time that includes implicit and explicit beliefs, attitudes, values, rituals, customs, norms, taboos, arts/ artefacts and lifeways accepted by a community of individuals’ .

COMMUNICATION AND SYMPTOM MANAGEMENT MODEL



India is a multicultural nation recognising the people as the first coming together with years of immigration. The many different cultures mean that cross-cultural communication is extremely important. When people are open to cultural diversity without judgement of right or wrong or good or bad, and when people use both verbal and non-verbal communication in a way that is respectful and acceptable for people from other cultures, people demonstrate cultural sensitivity. It is about being open and accepting of difference. Cultural competence in health care is a set of attitudes, behaviours, knowledge, skills, approaches and actions aiming for effective cross-cultural care, cultural safety, cultural awareness, cultural sensitivity and cross-cultural communication that emphasises inclusion and tolerance rather than exclusion and intolerance. Cultural competence is about accepting, being nonjudgmental, curious and sensitive to others' cultures. Cultural humility is an important attribute of cultural competence and it is defined as developing a reciprocal and equal partnership for mutual benefit and is based on self-awareness of the power imbalance in cross-cultural interactions. Staff who are culturally humble usually encourage the residents to express their care needs as well as meet their other needs.

The major barrier to effective cross-cultural communication between persons is driven by cultural differences aimed at a person's ethnicity, culture or religion. This can present as stereotyping, discrimination, prejudice, abuse, exclusion, intolerance and/ or marginalisation. It can be obvious or hidden and can sometimes occur without the person knowing they are involved in such behaviours. It is important that people are made aware of what constitutes undesirable behaviour so that it can be addressed when and if it arises.[10]

REFERENCES

1. World Health Organization (WHO). Palliative Care. 2015. Web site. <http://www.who.int/mediacentre/factsheets/fs402/en/>. Accessed March 31, 2017.
2. Wikipedia. Culture of the United Arab Emirates. Web site. https://en.wikipedia.org/wiki/Culture_of_the_United_Arab_Emirates. Accessed March 31, 2017.



3. Jones J. Negotiating change: The new politics of the middle East. 2007; 184-186. Web site. <https://www.foreignaffairs.com/reviews/capsule-review/2008-03-02/negotiating-change-newpolitics-middle-east>. Accessed March 31, 2017.
4. Loney T, Cooling RF, Tar-Ching AW. Lost in translation? Challenges and opportunities for raising health and Safety Awareness among a Multinational Workforce in the United Arab Emirates. *Saf Health Work*. 2012; 3(4): 298-304. doi: 10.5491/SHAW.2012.3.4.298
5. El-Amouri S, O'Neill S. Supporting cross-cultural communication and culturally competent care in the linguistically and culturally diverse hospital settings of UAE. *Contemp Nurse*. 2011 Oct;39(2):240-55. doi: 10.5172/conu.2011.240
6. World Health Organization (WHO). Country Cooperation Strategy at a glance. Web site. http://apps.who.int/iris/bitstream/10665/136976/1/ccsbrief_are_en.pdf. Accessed March 31, 2017.
7. Emiratisation NOW assure knowledge retention. Web site. <http://www.emiratisationnow.com/2014/03/emiratisation-goalsrely-on-expatriates.html>. Accessed March 31, 2017.
8. El-Haddad M. Nursing in the United Arab Emirates: An historical background. *Int Nurs Rev*. 2006; 53(4): 284-289. doi: 10.1111/j.1466-7657.2006.00497.x
9. Al-Yateem N, AlYateem S, Rossiter S. Cultural and Religious Educational Needs of Overseas Nurses Working in the Kingdom of Saudi Arabia and the United Arab Emirates. *Holist Nurs Pract*. 2015; 29(4): 205-215. doi: 10.1097/HNP.000000000000095
10. Halligan P. Caring for patients of Islamic denomination: Critical Care Nurses' experiences in Saudi Arabia. *J Clin Nurs*. 2006; 15(12): 1565-1573. doi: 10.1111/j.1365-2702.2005.01525.x