Cultural Competence Case Presentation
Death Telling and Cultural Competency

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Case Scenario/History

An 85-year-old African-American male presents to the emergency department in cardiac arrest. The advance care planning document from the nursing home states: "family does not elect to execute an advance care plan at this time".

a. Review of Symptoms
Unobtainable

b. Past Medical History
End staged dementia (unable to communicate needs), h/o urosepsis, coronary artery disease, hypertension and diabetes

c. Family History
Diabetes, hypercholesterolemia

d. Social History
Nursing home resident x 5 years

e. Physical Exam
Temp: cool skin
General: Thin, temporal wasting
ENT: gurgling sounds with bagging
Neck: supple, contracture to the left
Cardiovascular: no pulse, neck veins flat
Lungs: equal breath sounds with bagging
Abdomen: PEG tube in left abdomen, soft, not distended
Extremities: contractures of the arms and legs
Skin: decubitus ulcers on buttocks
Neuro: pupils 5 mm, fixed and dilated

The patient dies in the ED after a 10-minute failed resuscitation. You go to tell the family with the social worker.

There is a large family (son, daughter, four nieces and nephews and a family friend, John) in the waiting room waiting to speak with you. You ask that only the immediate family be in the room for the death disclosure (son and two daughters only). During the death disclosure, you discover that the patient's family has not seen him for the last month. However, they seem very upset during the death disclosure, wailing and crying loudly while calling to God. An hour later, the social worker tells you that, while the family had

no issues regarding the actual disclosure of the death by you, the family was very upset that the rest of the 'family and friends' were asked to leave the family room at the time of disclosure.

1. Why did the family have such a strong reaction when they did not seem to have a close relationship with the patient nor did they have an advance directive for the patient?

Attitudes/Assumptions: The physician

Because of the patient's condition, the patient did not have a caring family.
The patient had a poor quality of life.
Contractures suggest that the patient was suffering and receiving poor care.
The family was not involved so why are they 'acting out' like they are so sad – they probably just feel guilty.
Why was the patient full code, they were 'torturing' their family member and they must be unreasonable or uncaring.

Attitudes/Assumptions: The family

Dad lived a long, good life and fought the good fight.
Dad was the patriarch of the family.
Dad was taken when God was ready.

Provider Knowledge

Knowledge of health beliefs/customs: Cultural differences in the expression of grief. Strength in suffering.

Knowledge of community: Cultural mistrust in End of Life (EOL) decision-making. Documentation of advance care plans in African-Americans.

Knowledge of disparities/discrimination: Tuskegee experiment – helpful treatments withheld. African-Americans receive inferior EOL: care in the US. The material conditions of death and its funerary and mourning rituals figure prominently in African-American history. The confluence of death and loss has been endemic to African-American culture beginning with vast losses of life in slave shipholds during transatlantic slave voyages.

2. Why was the family upset that others were asked to leave since the 'immediate' family was addressed?

Attitudes/Assumptions: The physician

Patient confidentiality is the most important aspect of care to protect and only the immediate family should be told of a death and its circumstances.
Telling a room full of people can be dangerous – someone might become violent.

Attitudes/Assumptions: The family

John, the family friend, went faithfully to see the patient every Tuesday and Thursday to check on him while the children worked but was not allowed to hear that the patient had died.
The doctor was rude and might be hiding something if they can't talk to everyone.

Provider Knowledge

Knowledge of health beliefs/customs: Poor minorities get inferior care. Nursing home as a last resort.

Knowledge of community:

- Important role of extended care providers in the care of the patient
- Caregivers often 'non-family' and can include friends, church members or distant family members
- Nursing homes are a last resort but may be chosen closest to family/caregivers and can be affected by socioeconomic forces

Knowledge of disparities/discrimination: Racial and ethnic disparities and poorer health outcomes do exist in the US often related to socioeconomic factors.

3. Why did the patient not have an advance care plan?

Attitudes/Assumptions: The physician

The family is torturing their family member.
Resuscitation of a patient like this is cruel.
The family is ignorant.
The family is using healthcare resources without thinking about others.

Attitudes/Assumptions: The family

Advance care planning documents are a way of limiting care that you should get.
They want you to sign advance care planning documents so that you will die sooner and not cost 'them' money.
If you are Do Not Resuscitate (DNR), you will get no treatment.
God is the ultimate decision-maker so no documents are needed.

Provider Knowledge

Knowledge of health beliefs/customs:

- Faith-based EOL decision-making
- Poor minorities get inferior care with or without advance care planning documents
- They get 'worse care' if you have an advance care planning document

Knowledge of community:

- There is cultural mistrust of signing documents that might be hard to understand
- Signing away 'rights' is not good (happened with loss of land and sharecropping)

Knowledge of disparities/discrimination

- Racial and ethnic disparities and poorer health outcomes do exist in the US with patients that complete advance care planning document
- Higher rate of satisfaction with advance care planning and end-of-life care when the patient-physician have concordance of race/ethnicity

4. What actions could have been taken by the doctor to avoid/prevent the family's complaint?

Cross-Cultural Tools & Skills

Assume that all family and friends would like to be present for difficult news. Ask the family who they would like to be present for difficult news.

Assume that families can tell you what they want.

5. How would expectations differ if patient was a 20 year old victim of a gunshot wound to the chest (or other violent crime) who died in the ED?

Attitudes/Assumptions: The physician

"Everything" should be done since the patient is so young.

Of course the family will be extremely distraught and react with extreme emotion.

The family will want 'answers'.

A large family response is expected.

The patient was involved in possible "illegal" activity.

The family/friends may be violent and should limit the number in the family room to protect their own safety.

Attitudes/Assumptions: The family

Everything should have been done since the patient was so young.

A timely response to their presence.

An honest disclosure of the events.

Their loved one should not be prejudged.

Cross-Cultural Tools & Skills

Assume that all family and friends would like to be present for difficult news.

Assume that families will not automatically blame the bearer of bad news.

Use non-confrontational death disclosure techniques such as remembering to sit, not stand in every disclosure.

6. What sections of the case incorporate the ACGME 6 areas of core competence?

a. **Patient care** – compassionate and appropriate with mutually beneficial outcome (Green et al, 2002 – Knowledge of caring for patients is linked to four social domains: 1) Social stress and support networks; 2) Change in environment; 3) Life control; and 4) Literary. Expanding the role of the social history will tend to improve patient care)
b. **Knowledge** – demonstrates cross-cultural clinical skills (Betancourt, 2003 – Beware of oversimplification and stereotyping of racial groups. Clinicians should rather assess 'social and historic contexts of certain populations, their socioeconomic status, patterns of immigration, nutritional habits, folk illnesses, healing practices, etc)
c. **Interpersonal & Communication Skills** – generates effective information exchange with patients and their families (Betancourt, 2003 – 'Focused medical interviewing and styles of communication including autonomy vs. family decision-making'). (Singer and Lakha, 2003 – **RISK R**esources of patient and

family, **I**ndividual identity and acculturation, **S**kills available for adaptation to disease, **K**nowledge about ethnic group)

d. **Professionalism** – provides sensitive and ethical care to diverse population (Wright Role NEngl JMed 1998 Role modeling is an important educational method to ingrain professional values, attitudes, behaviors and values in medical training)

Case Outcome

The physician goes back to the family to apologize for excluding any important persons and offers to have everyone in to discuss any concerns the family and friends may have around the patient's death.

References

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4. Betancourt, JR, Green, AR, Carrillo, JE, Ananeh-Firempong, O II. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Reports*, 2003;118(4):293-302.
5. Searight, HR, Gafford, J. Cultural diversity at the end of life: issues and guidelines for family physicians (see comment). *American Family Physician*, Feb 1 2005;71(3):515-522.
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7. Holloway, KFC. Passed on: African American Mourning Stories, Duke University Press, Durham and London, 2002, p152.

Addendum A (attached next page)

This recently-published article - Resident Portfolio: Dr Death – Reflections of Death Telling – serves as an additional resource highlighting the importance of death telling and cultural nuances related to African American family.

Resident Portfolio: Dr Death – Reflections of Death Telling, Chisholm, Carey D., Walthall, Jennifer, Martin, Marcus L., Marco, Catherine A. *Society for Academic Emergency Medicine*, April 2006, Vol 13, No 4.