Intercultural Problems in the Care of the Dying Patient

GUY DAYNES

SUMMARY

Physicians caring for dying patients in an intercultural situation find themselves up against racial, language, cultural, and religious barriers. These barriers are discussed and means for overcoming them, suggested.

S. Afr. Med. J., **48**, 139 (1974).

The medical care of dying patients is seldom easy, even for a physician of the same racial, language, cultural, and religious group as that of his patients. Such care becomes progressively more difficult to render according to the number of subcultures not shared by the physician and his dying patients. The purpose of this article is to recognise these potential barriers and show that they can be overcome.

THE RACIAL BARRIER

This is a veneer on top of the other 3 barriers. It is only in the absence of what appears to the patient as evidence of a true concern, or in the absence of a sincere desire by those caring for him to overcome the difficulties, that the difference in race becomes a barrier. In such circumstances, race may be used as an excuse to ward off those who appear unconcerned.

THE LANGUAGE BARRIER

Communication with seriously ill patients is often difficult, and as they near the end, so they lose the ability to speak languages other than their mother tongue. If the physician knows a few words and phrases of the patient's mother tongue, this is a great asset. Nurses of the same language group as that of the patient can make up for the physician's deficiency, especially if he can convey through them his involvement in the situation. Even if the physician is unable to speak a word of the patient's language, he should not withdraw himself, for actions can speak louder than words. He can see the patient frequently and feel at least the weakening pulse; he can avoid prescribing distressing last-minute measures, and he can ensure that the standard of nursing care is such as he would like for one of his own people. I have often heard the Black Matron of our hospital say to a nurse who has failed to come up to her own high standards, 'Is *this* the way you would treat your mother?'

St Lucy's Hospital, Tsolo, Transkei
GUY DAYNES, M.R.C.S., L.R.C.P., D.C.H.

Paper presented at the 49th South African Medical Congress (MASA) held in Cape Town on 23 - 27 July 1973.

THE CULTURAL BARRIER

The customary care given to dying people varies widely according to the cultural background of the group, and the physician should be fully acquainted with it. The abandonment of the ailing elderly relative by the family is a custom said to be practised elsewhere in the world, but is unknown in South Africa, unless the transfer to an old people's home be regarded as abandonment. The custom of abandoning appears to arise from man's primeval ancestors.

In the Transkei the opposite appears to be true. The Xhosa people take special care of their elderly folk and wish only the best for them. What constitutes the best varies from time to time and from place to place. Twelve years ago, patients were removed from our mission hospital if it was thought that death was imminent, so that they might die at home. A ceremonial meal with all the family gathered together was eaten in their presence, and the verbal will and last words were heard with close attention. Now that confidence in St Lucy's Hospital has been built up, most families would rather their relatives died in our wards than at home, so that they can have better medical and nursing care at the end. Sometimes the physician faces a dilemma when, for instance, radiotherapy is indicated for the treatment of a malignant tumour: should the patient be transferred to a larger medical centre for treatment, even though he might die there? The cost of returning a corpse may leave the family in dire financial straits; alternatively, to have him buried away from home is against custom, and deep feelings of guilt may arise from such an action, which may perhaps necessitate disinterring and returning the body home at a later date at even greater cost. Thus, a conservative approach to the transfer of potentially dying patients should be adopted.

Allied to the problem of deciding where the best place is to die, is the question: 'with *whom* would the patient rather die?' This is especially important in the care of the dying child, but it should not be neglected in the adult: if possible, the male next of kin, and in the case of a man, his wife, should be present. Children find the greatest comfort in their mothers. This purpose can be best achieve for young Black children by providing accommodation where mother and child can be in one bed. Indeed, such a measure can be life-saving in severe cases

of kwashiorkor, by preventing not only bodily hypothermia, but also mental depression. The presence of the mother appears to generate hope in the child; one can so easily underestimate the importance of keeping hope alive in our mortally ill patients.

In many societies much store is set by knowledge of the last wishes and the last words of a dying patient; attendants at the end should be reminded to make an accurate record of these, in case the relatives ask for them. The giving of the last sip of water is also important, and relatives will be comforted to know that this was done by loving hands.

When the diagnosis of a mortal illness is made, what needs to be said to the patient depends on the culture and religious life and belief of the people. Knowledge of these is required by physicians in such situations. Should the patient ask if he is going to die, I reply, 'Yes' and quickly add, 'this is the one thing that is absolutely certain in this life!' He usually smiles and relaxes a little, thereby enabling me to ask him whether he is afraid of dying soon. I may be able to help him overcome his fears.

Rural Xhosa people appear to appreciate being fully informed about their illness, and they respond accordingly; they are used to mourning, having led hard lives from their youth onwards. The more successful and urbanised people become, the less able are they to live for the day itself, because perhaps they are less practised at facing grief. By continually looking at our successes we render ourselves less fit to face the catastrophes of life. People who have not had to mourn are less equipped to face death.

THE RELIGIOUS BARRIER

It is necessary for the physician to be acquainted with the religious beliefs of his patients if he is to understand their behaviour when they become fearful. Some may fear death but many more are afraid of dying and the suffering that may go with it; whereas others are more afraid of the spirits of those recently dead.

There was once admitted to St Lucy's Hospital a man with multiple abrasions and a broken leg, who had fallen out of the back of a moving truck. Close inquiry into this accident disclosed that a boy had asked the driver for a 'lift' and he had been refused because he was 'always up to mischief'; however, the driver did not see the boy hide in a new coffin in the back of the truck, replacing the lid over himself. A 'lift' was also requested by a man who was told by the trader to jump in the back of his truck, and they set off on their journey. When they were well on their way the boy thought he might emerge from his hiding place, but when the man saw the lid of the coffin slowly rise, he was seized with such terror that he jumped out of the back of the moving truck!

Motivated by a similar fear, our hospital labourers, when detailed to clean the cemetery, ask for extra pay on account of the risks they run; they are paid 'danger money'!

The rural Xhosa people have little fear of death itself, but do have some trepidation at the thought of a journey into the unknown. Preparation is all-important, as for any journey; to them there appears no reason to hang on to the last few weeks of life, provided they are ready for the journey. How different this is from the reaction of the doctor who made a pact with his partner and lifelong friend that, should one of them develop a painful and incurable disease, the other would administer to him an overdose of morphia; when, in fact, such a disease did afflict him, he refused to have any injection whatsoever, in spite of his pain, lest his friend take pity on him and give the agreed overdose!

The Xhosa attitude to time is very different from that of the European: the right time is when you are ready. This philosophy has to be associated with infinite patience, because while one may be ready, the other may not. A similar attitude is applied to death, which is usually awaited with resignation. Sometimes it is predicted with uncanny accuracy, as happened with an elderly woman who lived near St Cuthbert's Mission, and who was a devout Christian. She asked the priest to see her because she felt her time had come to die. All her relatives, Christian and pagan, gathered together on the appointed day and the service was held. The old woman appeared to be radiantly happy, and seemed to pass on her deep faith in God to those around her while all joined in giving thanks for her life; and she died the next night.

It is especially important in a cross-cultural situation for the physician to know who of his seriously ill patients has a religious faith, so that the appropriate minister of religion may be notified. Indeed, if the physician has an active faith himself, he will help his patients by saying a prayer with them; by so doing he will link himself with them in their final hour and will encourage others around to do the same.

Barriers of race, language, culture and religion *can* be broken down if consideration is given to them, with resulting comfort for both physician and patient.