

Exploring the Intersection of Cultural Competence and Palliative Care: Challenges and Opportunities

Reena Malik*

Palliative Care Unit, Christian Medical College, Vellore, Tamil Nadu, India

Abstract

When compared to the general population, members of ethnic, racial, and cultural minorities frequently have less access to healthcare and worse health outcomes. Health inequalities have been noted in both the COVID pandemic and other epidemics. Similar gaps have been observed in individuals with severe illness and pain, with minority patients either not having access to or using palliative care as frequently. Cultural competency is one of several ideas that have been put out in the US to solve the problem of unequal access to healthcare. In order to increase access and health outcomes, this project investigates if and how cultural competency might be used to palliative care in India. In the literature, it is stated that cultural competency is a crucial component of the answer for fair healthcare systems in various nations. More financial resources won't always result in a more fair healthcare system, thus solutions to the issues of healthcare inequities must go beyond this. A system that is culturally competent acknowledges and incorporates culture as a key aspect of care, which is especially important at the end of life, at all levels. If successfully implemented, cultural competency will increase patient happiness, improve follow-up and patient compliance, and enhance the palliative care field's reputation with minorities. This could lessen disparities in palliative care access and health outcomes.

Keywords: Palliative care; Decision-making; End of life; Patients; Suffering; Pain; Healthcare

Introduction

The World Health Organization's founding charter was signed in July 1946 by diplomats from 61 nations. The enjoyment of the best achievable quality of health is one of every human being's fundamental rights, without discrimination of race, religion, political belief, economic or social position, according to one of the first sentences of this constitution [1]. Although it may seem clear to most people today to agree in principle with this statement, the truth is that significant discrepancies in health and healthcare exist not just globally but also inside individual nations and communities. In-depth research has been done on the issues surrounding health and healthcare inequalities in the US, and studies demonstrate that there are still differences by ethnicity, race, and culture. When compared to the majority population, those who are members of ethnic, racial, and cultural minorities frequently have less access to healthcare and experience worse health outcomes [2-5]. Healthcare disparities have to do with healthcare quality and accessibility. There is overwhelming evidence of healthcare inequalities in the US, especially among African- or Black-Americans. For instance, in the US, White people are more likely to obtain proper mental health treatment than African-Americans [6]. White and African-American Americans receive diabetes care differently [3]. Compared to Whites, African-Americans need neurology care far less frequently. These are but a few instances. Similar gaps exist among many minorities, including Hispanics, in all facets of healthcare in the US [5,7].

Health outcomes and healthcare disparities are related. Life expectancy is the most visible health difference. In the US, African-Americans' life expectancy is shorter than that of their White neighbours. In 2015, the average life expectancy for African-Americans was 75.5 years, compared to 78.9 for White people [8]. Health inequalities have been noted in many aspects of health, including dental health, and are not only limited to life expectancy [4]. There are health inequalities in the COVID-19 epidemic as well. African Americans were shown to be more likely than White Americans to test positive for the virus in the early stages of the epidemic [9]. There are several factors that contribute

to these health disparities, including lower health literacy, worse living circumstances and environments, an increased possibility of holding employment that put workers at risk for health problems and are less likely to offer them health benefits like health insurance [10-12].

The inclusion of health insurance serves as an example of how discrepancies in healthcare frequently contribute to differences in health. Individuals without health insurance are responsible for covering all medical costs out of pocket. As a result, they will only be able to obtain the healthcare that their budget permits. This medical care might be inadequate or of poor quality. People who get subpar care or have limited access to healthcare are more likely to experience negative health consequences. Even when patients are diagnosed with advanced illness, experience pain and other symptoms, and would benefit from palliative care, healthcare inequities still exist. Palliative care, which takes a comprehensive approach, is a crucial part of plans to deal with pain as a public health problem. Even while pain is frequently thought of as primarily a medical concern, it needs to be researched as a worldwide public health issue. This isn't only due to the widespread incidence of pain; according to estimates, over 20% of individuals experience pain. The burden that pain places on society, the costs to countries, the wider social effect of pain, and, last but not least, the differences in pain and pain management among demographic subgroups make pain a public health concern [13,14].

Sadly, discrepancies in access to palliative care have also been noted. According to studies conducted in the US, minorities are less likely to

*Corresponding author: Reena Malik, Palliative Care Unit, Christian Medical College, Vellore, Tamil Nadu, India, E-mail: reena_234m@gmail.com

Received: 19-Apr-2023, Manuscript No. jpcm-23-98292; **Editor assigned:** 21-Apr-2023, PreQC No. jpcm-23-98292(PQ); **Reviewed:** 05-May-2023, QC No. jpcm-23-98292; **Revised:** 11-May-2023, Manuscript No. jpcm-23-98292(R); **Published:** 18-May-2023, DOI: 10.4172/2165-7386.1000524

Citation: Malik R (2023) Exploring the Intersection of Cultural Competence and Palliative Care: Challenges and Opportunities. J Palliat Care Med 13: 524.

Copyright: © 2023 Malik R. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

have access to palliative care than members of the White population, who makes up the majority of the population, and they also tend to favour aggressive care over palliative care when it comes to the end of life [15-17]. Studies have also indicated that minorities are less likely to be happy with the level of care, communication, and pain control when they do receive palliative care [16]. Numerous variables have been identified as contributing to this gap by a recent scoping review of the literature. Economic instability and a lack of proper insurance, cultural and spiritual views on health and medicine, and geographic location were listed as the key contributing variables in the review. Palliative care is often hampered by communication issues and prejudice on the part of medical professionals [18]. These results highlight the importance of 'cultural and spiritual values' as well as 'difficulties in communicating' since they demonstrate that obstacles to palliative treatment are not just due to economic issues but also have cultural and social roots. Disparities in healthcare and in terms of health still exist in India. People who belong to scheduled castes, scheduled tribes, or other backward castes are more likely to have poorer health outcomes and less access to treatment, and these gaps have also been linked to poverty, rural living, and social class or caste [19,20]. Subgroups of the Indian population might not have equitable access to palliative treatment as a result. Even if more information is required on this subject, such inequalities are a problem for public health. Since the country's first palliative care programmes were founded in the 1980s, palliative care in India has undergone enormous improvement. Sadly, due to a lack of funding, the current schemes cannot offer palliative care to all patients who would benefit from it [21,22]. The problem of fair and equal access to palliative care is especially important given India's low palliative care resources. What can be done to ensure that the population is divided fairly among the little palliative care resources that are available? is the issue that has to be answered. Even though India's healthcare inequalities are mostly caused by poverty, expanding palliative care facilities and offering free palliative care may not be sufficient to eliminate them. Health and healthcare disparities are not merely a financial problem, as has been demonstrated above. Numerous proposals have been put up in the US to solve the problem of unequal access to healthcare. A key component of these strategies is the growth of cultural competency. Palliative care programmes naturally incorporate some attention to cultural concerns into their services since palliative care offers a comprehensive response to pain and suffering brought on by life-threatening disease. According to the WHO, palliative care includes consideration of "psychosocial or spiritual problems" [23]. There are cultural aspects to these issues. For instance, studies conducted in India have revealed that many palliative care patients there encounter spirituality through religion, which has a strong influence on society [24]. Palliative care clinicians in India must be aware of these patterns and communication practises while speaking with patients because communication patterns are also influenced by culture [25-27]. In India, palliative care agencies and scholars have created studies, training courses, and models of palliative care delivery that take into account the local culture. They are conscious of the significance of culture to care. IAPC's Certificate Course in Essentials of Palliative Care, which emphasises spirituality-related topics and communication skill development, is a prime illustration of this. In order for palliative care organisations and professionals to gain pertinent knowledge, abilities, and attitudes, aiming for cultural competency represents a holistic strategy to dealing with patients in multi-cultural situations, as will be discussed below. This strategy may further encourage and strengthen the incorporation of cultural considerations in India's palliative care delivery, training, and research. Systematic evaluations demonstrating the value and effectiveness of cultural competency outside of India provide a solid foundation of

evidence to support its use in palliative care in India. Palliative care programmes naturally incorporate some attention to cultural concerns into their services since palliative care offers a comprehensive response to pain and suffering brought on by life-threatening disease. According to the WHO, palliative care includes consideration of "psychosocial or spiritual problems." There are cultural aspects to these issues. For instance, studies conducted in India have revealed that many palliative care patients there encounter spirituality through religion, which has a strong influence on society. Palliative care clinicians in India must be aware of these patterns and communication practises while speaking with patients because communication patterns are also influenced by culture.

The information that is now available makes it abundantly evident that increasing financial resources alone will not be sufficient to address the issue of healthcare inequalities. The healthcare system will not necessarily become more egalitarian with more financial resources. The US is a good illustration. The healthcare system in the US is the most expensive in the entire globe. However, there is much inequity in the system. When healthcare systems aim for equal healthcare access and health outcomes among the people they serve, they become more egalitarian. In the literature, it is stated that cultural competency is a key component of the answer for fair healthcare systems in ethnically, racially, and culturally diverse countries. One of the best examples of such a diversified society is the US. This ethnic, racial, and cultural variety has deep historical origins, and the US society has continued to diversify through time, much like many other modern civilizations. People continue to leave their places of origin in quest of a better life elsewhere on the world, often motivated by economic or educational possibilities, by a need to escape war or political tyranny, or all of the above. As a result, a growing number of people on the planet now live in cultural settings that are very different from the ones they were born into. This movement has resulted in cultural variety. However, the kind of movement that promotes cultural variety does not just occur across nations. Even inside nations, it occurs. India has always been a crossroads of religions and civilizations. People continue to move within India as a result of work opportunities, with significant movement patterns from rural to urban regions. People from rural areas who are used to more traditional ways of living must adjust to contemporary life in cities where more traditional Indian ways of life coexist with Western ideals and lifestyles. People may also find themselves in locations where they are unable to speak the native tongue. The variety that has always defined India is furthered by this recent exodus. In the environment of which other faiths, most notably Buddhism, Jainism, and Sikhism have emerged, Hinduism is a tremendously varied religion in and of itself. There are sizable minority of Muslims and Christians as well because of migration and conversion [28].

Despite the fact that all Indians share some cultural characteristics, the disparities across Indian regions, faiths, and rural and city life can make people feel alienated. When patients require pain treatment and palliative care, such alienation can have a significant effect. The way members of the surrounding cultural majority experience and express their suffering may differ from the way members of cultural minority do so. Because people attach various meanings to pain based on their cultural background, different people will react differently to pain across cultures. When a person has suffering, their culture will also influence whether or not they choose to discuss it, especially in a hospital setting. For instance, patriarchal dynamics that place a larger priority on males may prevent women from publicly expressing their suffering until it becomes unbearable among more traditional sections in Indian culture. This could cause significant care delays. The type of

pain therapy patients seek may also vary by culture. Ayurveda, Siddha, Unani (or ynn), homoeopathy, and other medicinal traditions coexist in India alongside Western-style biomedicine. Beyond other variables like cost and availability, the type of medical system that consumers select will largely depend on cultural preferences and identity. According to research, using conventional medicine and waiting longer to seek biomedical treatment are related. While culturally influenced attitudes towards healthcare, such as a reluctance to talk about pain or a preference for traditional medicines, can be seen across cultural groups in India, they may be more overt in some groups, such as the rural population, whose traditional attitudes and behaviours have been less influenced by global culture [29]. In fact, research suggests that people from rural and urban regions have different views about health and healthcare. For instance, a 2014 research in Uttar Pradesh found that rural residents were more prone than city dwellers to use analgesics without a prescription and professional medical guidance. When people from rural regions move to the city or even when they seek medical care in metropolitan hospitals, these attitudes and habits could still exist. One element that can help patients get the treatment they require quickly is the deployment of cultural competency at the level of both individual healthcare practitioners and healthcare institutions.

We must first comprehend the meaning of the word "culture" in order to grasp cultural competency. As a result, individuals who were raised in other societies may hold various cultural ideas, practises, and presumptions, and not everyone can be assumed to have a natural knowledge of other cultures. Therefore, cultural competency is necessary for individuals, groups, and systems that interact with people of other cultures. The ability of a person, organisation, or system to (inter)act and appraise situations with knowledge and awareness of diverse cultures is known as cultural competency. Healthcare professionals may deal with people from various cultural backgrounds in an effective way by demonstrating adequate self-awareness, knowledge, and expertise via cultural competency. 'The capacity to work successfully' is what the word 'competence' denotes. Therefore, a culturally competent healthcare system acknowledges and incorporates the importance of culture throughout the system to ensure that it, as well as the organisations and individuals working within it, can operate successfully while responding to the requirements of patients from different cultural backgrounds [30].

At the end of life, all of this becomes very important. Every living thing must eventually deal with the common and constant truth of death. The experience of death and its significance, however, vary from person to person and are greatly influenced by society. Life's latter years can be difficult. Therefore, it is essential to provide healthcare that is culturally competent at this point. Patients' and their family members' expectations of healthcare may be influenced by their culture. There is a chance for conflict, miscommunication, low compliance, and worse health outcomes when these expectations are not realised. Conflict can arise when doctors and patients disagree, or it can arise when patients make decisions that the doctor does not understand or approve of, such as turning down palliative care or failing to follow the prescribed pain management therapy. Here, cultural disparities are frequently the main point of contention. Cultural disparities between the patient's background and the medical profession provide difficulties. Due to the fact that they are frequently pertinent to understanding preferences for treatment when the patient is close to passing away, doctors and the clinical team should investigate beliefs and culturally determined values. Only if a healthcare establishment as a whole recognises the patient's cultural background and incorporates cultural competency can it deliver proper palliative care. Patients and their loved ones will

experience meaning and peace in the dying process more frequently if palliative care providers are aware of and accepting of the cultural background of a patient and incorporate that knowledge into a patient-centered approach. However, failing to take into account the patient's cultural values which may include religious and spiritual values can result in care that is not in line with the patient's objectives. For instance, a research found that patients who had their spiritual needs met by the medical staff near the end of their lives had a higher quality of life and used hospice services more frequently than those who had not.

Fostering cultural competency in Indian palliative care

It is crucial that palliative care programmes in India take into account incorporating cultural competence in their services, training, and research initiatives because it has been demonstrated that doing so will increase patient satisfaction and there are solid grounds for assuming that doing so will improve access to palliative care as well as palliative care outcomes. Research is crucial because it would broaden the body of data supporting cultural competence and demonstrate the effectiveness of cultural competence strategies created especially for Indian palliative care. It is crucial to understand that the concept of cultural competency was originated in the US and that not all of the methods in which it has been used there may be appropriate or practical in developing nations. For instance, cultural competence literature from the US proposes using both multilingual workers and "foreign language interpretation services including distance technologies" to facilitate communication with patients whose native tongue is not English. It's possible that professional translators won't be accessible or inexpensive for India's palliative care schemes. This specifically implies that while the idea of cultural competence in general may be helpful for palliative care in India, programmes for such care need to be conscious that cultural competence models and techniques created in nations like the US may not be immediately applicable to India. In order to determine how much these ideas and techniques may be included into their palliative care initiatives, the programmes will need to conduct research and evaluations. In order to adopt cultural competence, palliative care initiatives will need to concentrate on three key areas: knowledge, attitudes, and skills and apply them to their particular environment while taking the cultural backgrounds of the patient population they are targeting into consideration. The socioeconomic and cultural traits of the groups that the palliative care programme targets are referred to as knowledge. These must be known and understood by physicians, counsellors, and volunteers in palliative care programmes. People who work in initiatives that care for patients in tribal communities, for example, need to understand how these people discuss diagnoses. Clinicians who care for Muslim patients should be familiar with Islamic concepts related to death and dying. Additionally, they must be aware of unique socioeconomic issues that may make it more difficult for Muslim patients to get palliative treatment. In India, Muslims are proportionately more likely than those who belong to the Hindu majority to be less educated and less likely to be employed. Access to healthcare is hampered by this.

The necessity to be attentive to patients' cultural demands and mindful of one's own cultural limits is implied by attitude. Palliative care professionals must be culturally humble. They must be conscious that there may be significant gaps in their understanding of the cultures of the people they are treating. If the palliative care professionals are eager to hear from and learn from their patients, then these gaps do not pose a serious threat on their own. An attitude of respect, empathy, humility, and humility is what is required. It takes expertise to put

these attitudes into practise in patient care. Palliative care professionals cannot learn from patients without cultural competence. Providers of palliative care need to be skilled in determining what patients' illnesses and diseases mean to them, how they interact with the outside world, and how they wish to be treated. Patients will be given more authority to participate completely in the decision-making process about their treatment via the use of cultural humility and expertise. Due to the widely held cultural presumption that people in India must be sheltered from the suffering that bad news might bring, patients are frequently excluded from the decision-making process. In India, medical professionals frequently agree to pleas from the patient's family to withhold the diagnosis and prognosis.

Palliative care professionals will become aware of the limitations of such cultural practises and beliefs and may discover they may not apply to all patients as a result of their cultural humility. Research among cancer patients in India has frequently demonstrated that many of them desire to learn more about their condition and participate in decisions about their care, but are unable to do so. Healthcare professionals that are culturally competent are able to deal ethically with circumstances where the patient's information demands may conflict with the family's desire to shield the patient from damage that they believe would be brought on by the very same knowledge. Patients from various cultural origins will more readily find their way to the palliative care service when cultural competency is included into palliative care programming through cultural knowledge, attitudes, and abilities. Patients will be more compliant with treatment suggestions since they and their loved ones will be happier, return for therapy, and do so. In this approach, cultural competency will aid in enhancing palliative care access and health outcomes in India.

Conclusion

When palliative care services are provided in a country with a diverse population, like India, cultural competency is a crucial instrument for their growth. Cultural competency will likely increase patient satisfaction and, more crucially, lessen inequalities in access and health outcomes in palliative care if it is effectively implemented and tailored to the Indian palliative care setting. The biggest benefit of cultural competency is that it might potentially assist patients greatly while without necessarily significantly raising the expenditures associated with running palliative care initiatives. Although it is necessary to include cultural competency into daily operations and education, doing so does not call for a huge financial outlay. Programmes for palliative care need to begin considering how they might inventively include cultural competency into their operations.

Acknowledgement

Not applicable.

Conflict of Interest

There are no conflicts of interest.

References

- World Health Organization (1946) Constitution of the World Health Organization. Geneva.
- Bailey R, Sharpe D, Kwiatkowski T, Watson S, Dexter Samuels A, et al. (2018) Mental health care disparities now and in the future. *J Racial Ethn Health Disparities* 5:351-356.
- Canedo JR, Miller ST, Schlundt D, Fadden MK, Sanderson M (2018) Racial/ethnic disparities in diabetes quality of care: The role of healthcare access and socioeconomic status. *J Racial Ethn Health Disparities* 5:7-14.
- Como DH, Stein Duker LI, Polido JC, Cermak SA (2019) The persistence of oral health disparities for African American children: A scoping review. *Int J Environ Res Public Health* 16:710.
- Saadi A, Himmelstein DU, Woolhandler S, Mejia NI (2017) Racial disparities in neurologic health care access and utilization in the United States. *Neurology* 88:2268-2275.
- Hankerson SH, Suite D, Bailey RK (2015) Treatment disparities among African American men with depression: Implications for clinical practice. *J Health Care Poor Underserved* 26:21-34.
- Rangachari D, Smith TJ, Kimmel S (2013) Integrating Palliative Care in Oncology: The Oncologist as a Primary Palliative Care Provider. *Cancer J* 19:373.
- Goldsbury DE, O'Connell DL, Girgis A, Wilkinson A, Phillips JL, et al. (2015) Acute hospital-based services used by adults during the last year of life in New South Wales, Australia: A population-based retrospective cohort study. *BMC Health Serv Res* 15: 1-14.
- Ogedegbe G, Ravenell J, Adhikari S, Butler M, Cook T, et al. (2020) Assessment of racial/ethnic disparities in hospitalization and mortality in patients with COVID-19 in New York City. *JAMA Netw Open* 3:881.
- Braveman P, Gottlieb L (2014) The social determinants of health: It's time to consider the causes of the causes. *Public Health Rep* 129:19-31.
- Cockerham WC, Hamby BW, Oates GR (2017) The social determinants of chronic disease. *Am J Prev Med* 52:5-12.
- Phelan JC, Link BG, Tehranifar P (2015) Social conditions as fundamental causes of health inequalities: Theory, evidence, and policy implications. *J Health Soc Behav* 51:28-40.
- Goldberg DS, McGee SJ (2011) Pain as a global public health priority. *BMC Public Health* 11:770.
- Kamal AH, Bausewein C, Casarett DJ, Currow DC, Dudgeon DJ, et al. (2020) Standards, Guidelines, and Quality Measures for Successful Specialty Palliative Care Integration into Oncology: Current Approaches and Future Directions. *J Clin Oncol* 38:987-994.
- Evans BC, Ume E (2012) Psychosocial, cultural, and spiritual health disparities in end-of-life and palliative care: Where we are and where we need to go. *Nurs Outlook* 60:370-375.
- Johnson KS (2013) Racial and ethnic disparities in palliative care. *J Palliat Med* 16:1329-1334.
- Wen Y, Jiang C, Koncicki HM, Horowitz CR, Cooper RS, Saha A, et al. (2019) Trends and racial disparities of palliative care use among hospitalized patients with ESKD on dialysis. *J Am Soc Nephrol* 30:1687-1696.
- Gardner DS, Doherty M, Bates G, Koplou A, Johnson S (2018) Racial and ethnic disparities in palliative care: A systematic scoping review. *Families in Society* 99:301-316.
- Balarajan Y, Selvaraj S, Subramanian SV (2011) Health care and equity in India. *Lancet* 377:505-515.
- Brinda EM, Attermann J, Gerdtham UG, Enemark U (2016) Socio-economic inequalities in health and health service use among older adults in India: Results from the WHO Study on Global Ageing and adult health survey. *Public Health* 141:32-41.
- Kumar S (2013) Models of delivering palliative and end-of-life care in India. *Curr Opin Support Palliat Care* 7:216-22.
- Lynch T, Connor S, Clark D (2013) Mapping levels of palliative care development: A global update. *J Pain Symptom Manage* 45:1094-106.
- World Health Organization (2020) Palliative Care. Geneva.
- Gielen J, Bhatnagar S, Chaturvedi SK (2016) Spirituality as an ethical challenge in Indian palliative care: A systematic review. *Palliat Support Care* 14:561-582.
- Chaturvedi SK (2008) Ethical dilemmas in palliative care in traditional developing societies, with special reference to the Indian setting. *J Med Ethics* 34:611-15.
- Chaturvedi SK, Loiselle CG, Chandra PS (2009) Communication with relatives and collusion in palliative care: A cross-cultural perspective. *Indian J Palliat Care* 15:2-9.

27. Chaturvedi SK, Strohschein FJ, Saraf G, Loiselle CG (2014) Communication in cancer care: Psycho-social, interactional, and cultural issues. A general overview and the example of India. *Front Psychol* 5:1332.
28. Alizadeh S, Chavan M (2017) Cultural competence dimensions and outcomes: A systematic review of the literature. *Health Soc Care Community* 24:117-130.
29. Chae D, Kim J, Kim S, Lee J, Park S (2020) Effectiveness of cultural competence educational interventions on health professionals and patient outcomes: A systematic review. *Jpn J Nurs Sci* 17:326.
30. Govere L, Govere EM (2016) How effective is cultural competence training of healthcare providers on improving patient satisfaction of minority groups? A systematic review of literature. *Worldviews Evid Based Nurs* 13:402-410.