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Constructing belonging of cancer patients with migrant background

cultural competences in end-of-life care

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Constructing belonging of cancer patients with migrant background - cultural competence in end-of-life care

Research Questions:

- How do health professionals experience the influence of migration histories in the palliative care context regarding seriously ill patients with migrant background?
- How is the influence of having a migration history experienced by seriously ill and dying people with migrant background?

Introduction:

- Dying is a cultural and social as well as biological event. Where and how we die is influenced by cultural and social factors (1, 2).
- Low use of specialized palliative care services has been evident in ethnic minority groups across western countries since the 1980s (3). Development of professional cultural competence has been initiated (4,5).
- Initiatives are few and sporadic in the Danish palliative Care context. A need for research to explore the need is pending (6,7).

Methods:

- 15 narrative interviews with palliative care professionals
- 8 biographical interviews with two men and six women with diverse (western and non-western) migrant background and cancer experience
- 2 narrative interviews with bereaved relatives with migrant background.
- Content analysis

Theory:

- Cultural competence: cultural sensitivity + interpersonal caring + Cultural knowledge + Ability to assess and apply knowledge reflexively in the care context (8,9)
- Belonging: Social location, Identification and emotional attachment, Politics of belonging (10)
- Transnational migrants often hold double or multiple belonging via the combination of old and new attachments (11).



Results

"Generally it is about communication...One becomes acquainted better with Ethnic Danish patients; they tell you stories from work life or family life and you get an impression how the family function and communicate, and of what resources they have in humor and such. You don't get that [with migrant patients]" (palliative Doctor A).

I am not sure if it is because we do not invite them to talk or if it is actually because it does take some effort and time to get around those things. It is not like we don't talk to them about it ever – but there might be a slight fear of contact, because: 'what did you escape from? - what is behind?'" (palliative Doctor B)

My experience is that they will take care of that [religious and cultural needs] on their own. They don't need that from me, as a doctor they need me for something professional, just like they need the home care team for assistive technologies and care. The religious and existential matters they will sort out for themselves. I don't think we should worry so much about that. I don't. (GP)

A wedding was pending. A family was to be reunited after displacement. An elderly woman was dying. Prolonging life or not? :

"There was a cultural or religious barrier - or perhaps it was language. I had no idea but I learned (...) If I had known [the family history] it had been no problem to me. I could prolong her life for a few days but not keep her alive" (GP).

"I feel that they take up too much space compared to the other patients and relatives" (Hospice nurse B).

"So we also have a kitchen by the guest room so that 'they' can cook there too because it takes up a lot of space if 'they' are cooking Arabic foods and the entire hospice smells like garlic (hospice Nurse A)"

The reason [for creating a fact-file] is that we began receiving some patients of other ethnic decent and we thought: 'We have to do something', because they carry on in a different way than we do with their rituals. We chose initially to focus on Muslims, because there are so many cultures and we most likely thought that this was the largest group and therefore chose [Muslims] (Hospice Nurse B).

I really look forward to that seminar because I think there is a lot of rituals around their [ethnic minority patients] death – some needs a sheet to cover their head and such and who is that? And things like that - I really don't know (Home care Nurse).

I have learned a lot just by asking. 'What is happening now?', 'What are we waiting for now?'. I Learned this from the first Afghan Family (Hospice Nurse A).



"Our mum": Chinese Woman 86, terminal cancer

"A few years ago our mum was nervous about what would happen to her when she died. She had that wish of being buried in a certain manner. Today she has come to terms with this is not how it is done here [in DK] (...) My sister offered to take her home to New York, because it is possible to buy a plot and never having to move the body. But mum does not want to be apart from dad; therefore she will stay here [in DK] (...) She has given me some money to arrange for her funeral here. She trust that I know how to - I know most about the Chinese traditions and mindset – compared to my sister [in DK] who is too Danish. So I have the fine task to try and grant her wishes"

"She takes an Asian supplement but is very conscious not to mix it with empirical medicine. She makes sure to drink certain soups and types of tea...she really wants rice-soups when she is ill and foods that she likes. But they [home care team] find it difficult to accommodate that. It has to be pre made, but the problem is, they don't have time to heat it – they use the micro wave, but mum does not feel safe with that."

"Our sister lives in a Chinese community [in America] and is up to date with what is supposedly good or bad foods. My mum has faith that she can get her to eat . She eats more when she is cooking her favorite foods".



Belonging?



Culture?



Roots?

Conclusion and implications for practice:

- Biographical information is often lost in the care context
- Professionals' and patients' different constructions of belonging of the patients result in different constructions of motives and needs in the end-of-life care context.
- Despite awareness of common human implications of illness and reactions to illness PCPs respond to diversity by means of cultural knowledge, thus constructing belonging as a single social location (ethnicity) rather than according to the identification and emotional attachment of the patient.
- *cultural knowledge* rather than *caring* tend to gain primacy in the development of cultural competence. This create a risk of undermining patient centeredness in care for patients with migrant background.
- The patient's construction of belonging toward end-of-life is essential in realizing the patient's motives and needs as well as access to informal care resources.