

# Medicine

## Geriatrics and aged care

When carrying out assessments, remember that people come from diverse backgrounds, and different medical and health care systems. Many people may be unfamiliar with the concepts of palliation, geriatric assessment and/or rehabilitation.

For many, the idea of nursing homes can be very upsetting and can be considered insulting. Most older people expect to stay with their family until they die. The elderly are the children's responsibility, are looked after mainly by their daughters, and are rarely put in nursing homes. This is true in Australia, and the daughters of ageing people play a substantial role in home care (Legge and Westbrook, 1994). However, in some new Australian families, this tradition is changing.

For those who need nursing home/hostel accommodation, a list of ethno-specific and multicultural nursing homes is given in the **Resources** section.

There is a need for special sensitivity to the traumas of the

aged, who can be totally isolated. Elderly people often do not vocalise their fears and discomfort, and may try to pretend they are well, as they do not want to upset their family or prevent them from going to work. They may avoid calling their children at work to take them to the doctor or hospital. There may be language barriers with children and grandchildren.

Aged people need to receive adequate information about appropriate community services before discharge.

Aged people may not receive the community services they need after discharge, such as domiciliary care, Meals on Wheels, and so on, because often there are not culturally appropriate services. It may be important to have people from the same background and religion to assist them at home (if the family is unable to), to inform family carers of additional community support, and to recognise the isolation of home carers of the aged. Very elderly patients, and younger patients with certain conditions, may experience considerable

confusion complicated by their migration, and may lose language facility.

## Oncology/Palliative care

Masi (1989: 229) argues that "as palliative care acknowledges and values the uniqueness of the individual, it must allow for great variability on the part of patients and families in the degree of autonomy and control they wish to maintain in terminal care. The sensitive professional who listens carefully, seeks to understand the needs, offers help and allows choices, will be deeply appreciated by persons of all cultures at this highly stressful time in their lives".

According to Masi (1989), one's cultural heritage can impact on terminal illness in various ways including:

- ⊙ Values and ethics of good pain control.
- ⊙ Acceptability of and comfort from various analgesics.
- ⊙ Decision-making around treatment issues e.g. cessation of treatment, use of intravenous fluids, artificial feeding etc.

- ⊙ Degree to which truth (e.g. diagnosis, future outcome) is valued and spoken openly.
- ⊙ Degree to which one is a member of one's culture, or is modified by other influences.
- ⊙ Management of dying care - care at home or in hospital - which model is most acceptable.
- ⊙ Specific practices that surround death, funerals, burial etc.
- ⊙ Manner of grieving and types of community supports available.

In some cases, families may expect that patients are not to be told directly their diagnosis or prognosis, particularly in the event of disease such as cancer or terminal illness. This is common in the Mediterranean, South America, Asia, the Middle East, and former USSR. It is usual in these cultures for the physician to advise close family members, and they choose whether to tell the patient, based on their perceptions of how such knowledge will affect the person's mental state, if they are told news which takes all their hope away. This needs to be balanced with the legal requirement in Australia that the



person needs to know their situation in order to give informed consent to their procedures. Also they may want to change their will.

However, even within the same community, individuals have different preferences about this. A person may not want their relatives to know.

There is a need for clinical judgement on this difficult issue of balancing the different perspectives. One compromise is to ask the family how and when to tell the person, and work with the family to tell them.

People generally appreciate being told an unpleasant diagnosis subtly and gently, and in a diplomatic way based on culturally appropriate protocol.

Using a gentle way of presenting information, e.g. "the growth" as opposed to "cancer", is often easier to hear initially, as cancer may be seen as a death sentence due to lack of information on early diagnosis/prevention and the different cultural beliefs about cancer. Cancer prevention programs are very difficult because there may be the perception that talking about cancer exacerbates or may cause the condition.

Issues of quality of life, amputations and fluid loss have different meanings to different cultures, and these topics also need to be explored in individual cases.

