

Surgery/Critical Care

Operations, especially when urgent, are very frightening for both the patient and relatives because of the perception of a high risk of death.

Doctors should clearly explain the procedure and post-operative care to the patient and close family members, using an interpreter, and diagrams or models, where appropriate.

People need to be given the opportunity to express their fears. For example, one mother refused to let her child have surgery for a cleft palate because of fear of brain damage, but did not have the opportunity to discuss these fears with the doctor.

It may be necessary to have a professional interpreter in theatre for procedures that do not require a general anaesthetic.

Informed consent is a major issue. It is very difficult to be sure that even patients who speak English as their first language fully appreciate the nature of a condition, the procedures that might be

involved and the risks entailed, and are therefore in a position to give true informed consent. For those who do not speak English as their first language, the difficulties are magnified, and fear may also inhibit language facility at this time. Patients or guardians (e.g. parents) may create the impression of understanding when they do not have full comprehension of the procedure. This includes operations and ECT.

If the person is not competent in English, make sure you get an interpreter who can explain the procedure, the risks and the benefits, in the person's own language.

It may be helpful to ask if patients would like you to talk to someone in their family to help with the decision about the procedure.

People may not ask questions and may say they have understood, even if they have no or only partial understanding. If it becomes a legal issue in a court of law, it is important to have checked comprehension. How would you prove that they have understood?



Most people entertain fears of dying if they have an operation. Signing the consent may create the impression that the operation is very risky, and the doctor is evading responsibility by getting them to sign. So explain that it is standard for all patients to sign, and explain why they need to sign the consent form.

In some countries, procedures such as endoscopies are done without sedation. Make sure the patient understands that in Australian hospitals, some form of sedation is usually used, otherwise they may be needlessly anxious.

On the other hand, various procedures are now done in Australia as day surgery and often with local anaesthesia only, whereas patients may be familiar with such operations occurring for inpatients with a general anaesthetic.

Again, a comprehensive description of the procedures with sufficient time for the patient to ask questions and clarify their own worries and uncertainties is essential.

Organ transplantation

Each culture has a unique view of organ donation, often based on religious beliefs and sometimes reinforced by state law. For

example, some Japanese come to Australia for transplantation because it is not allowable in Japan. This topic is dealt with comprehensively in *A Hospital Handbook on Multiculturalism and Religion* (see Resources section).

It is helpful to be aware of cultural/religious attitudes, but of course individual preference is all important.

Muslims or Buddhists for instance, may be offended at being asked about organ transplantation. For some Muslims, the attitude may be that if Allah has ordained them to die, they have to die, and no-one has the right to interfere with the will of Allah by receiving a transplant. Also, some believe that by even talking about dying, one is doing wrong, because this is a negative attitude. Discussions about removing organs after death may be offensive. Some may be distressed if it is suggested that they donate body parts for transplantation procedures, because their body belongs to Allah/God, not to them. On the other hand, some have the attitude that if the donation of their organs can save another person's life or sight, that is of great religious merit.



Intensive care/Coronary care

It is important to explain the purpose of critical care units to reassure patients and family, who may assume the patient will die.

Monitoring systems can be threatening, especially to people who are not familiar with medical technology, and it should be remembered that patients/families may not have a clear understanding of the implications or consequences of initiating life support.

Taking patients off life support also raises cultural as well as personal issues.

People hold very different attitudes to patient autonomy and self-determination, and some may find the idea of terminating life support offensive (Klessig, 1992:316). Different value systems relating to the role of medical practitioners in life decisions may lead to conflict. As a result, it is important that issues of life support be discussed fully and sensitively.

Treat patients as individuals first and members of cultural groups second.

People making life-and-death decisions draw on a lifetime of experiences, and their cultural traditions are not the only factors involved. Each person has a unique belief system, with cultural background forming only part of the picture.

Before discussing do-not-resuscitate orders, the concept may need to be explained, as it may be unfamiliar to some patients. When discussing these orders with patients from any culture, explore the following:

- ⊙ What is the patient's/family's attitude to resuscitation?
- ⊙ What is their understanding/perception of life support?
- ⊙ What is their definition of death?
- ⊙ What is their religious background, and how active are they currently?
- ⊙ What do they believe are the causal agents in illness, and how do these relate to the dying process?
- ⊙ What is the patient's social support system?
- ⊙ Who makes decisions in the family?

Adapted from Masi 1989

