Cross-cultural Medicine
A Decade Later

The Effect of Values and Culture on Life-Support Decisions

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Withdrawing life support is always difficult. When patients and health professionals are from different ethnic backgrounds, value systems that form the basis for such decisions may conflict. Many cultural groups do not place the same emphasis on patient autonomy and self-determination that Western society does and find the idea of terminating life support offensive. Although physicians should never assume patients will respond in a particular way because of their ethnic background, issues of life support should be discussed in a culturally sensitive way. African-American, Chinese, Jewish, Iranian, Filipino, Mexican-American, and Korean patients were surveyed about their views on life support. The findings reported here, although not meant to be definitive, should add to health professionals' understanding about diverse beliefs around life-and-death issues. By becoming aware of this diversity of beliefs, health professionals can avoid the damage to the physician-patient relationship caused by conflicting value systems.

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Many challenges to the physician-patient relationship occur in the period around a patient's death. Even in the best of circumstances, discussing starting and stopping life support is emotionally demanding. Poor communication between the physician and the patient or the patient's family can turn this situation into a nightmare. The psychological damage cannot be undone and may cloud the last memories the family has of the patient. Similarly, the physician will always carry the knowledge that the situation might have been handled better.

Instances of poor communication can occur if the cultural values of the health care professional and the patient are different, and each is unaware of the reasons underlying the other's behavior or viewpoint. This frequently leads to frustration, anger, and stereotyping. The problem is especially important when life-support measures are being discussed, as cultural patterns have great strength and influence in the period around a death.[1] It is unacceptable for a health professional to be ignorant or insensitive to the cultural beliefs of a dying patient.

In this article I address the response patterns of several different cultural groups when issues of life support are discussed and explore some reasons for their reactions. These are preliminary results from a survey of 230 patients at a county facility in Los Angeles, conducted to determine whether important differences existed in the views held by members of various cultural groups toward life support. Patients were given a self-administered questionnaire in either English or their native language and were asked to indicate their age, sex, ethnic self-identity, religion, duration of residence in the United States, and level of education. They were given clinical scenarios with various degrees of illness and asked to record what they would do about life-support issues in those situations. The survey did not address reasons behind the chosen action, but, on occasion, patients volunteered this information. A literature review of pertinent sociologic and anthropologic work expanded understanding of the reasons for various responses.

Table 1 shows the large differences among the various groups with respect to starting or stopping life support. The following discussion examines reasons for these differences, using cases from actual clinical situations.

General Considerations

It is not ethnicity per se but the social experiences of different groups that help shape particular cultural organization and value systems. These systems undergo constant, although sometimes slow, change as the social experiences of groups vary. Furthermore, all cultures are composed of individuals and, thus, intracultural variation can be as great as, or sometimes even greater than, intercultural variation.

I present this discussion to help physicians understand why patients might react in the way described, especially when such behavior is different from the physicians' expectations. I do *not* imply that any single member of an ethnic group will respond in the specific way or for the particular reasons mentioned here. To assume that a patient will react in a particular way can be as detrimental to the physician-patient relationship as ignoring the fact that differences exist among patients. Patients should always be treated as individuals first and members of a cultural group or groups second.

Religion is referred to here for several reasons. Religion is often important in shaping values and the moral fiber of societies and thus can help explain differing views toward

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death. In addition, often even persons who are not active in any religion revert to their religious roots when faced with death.[2]

The patients surveyed here were of low socioeconomic status, a class that frequently retains overt indications of traditional cultural values longer than higher socioeconomic classes.[3] The behaviors surrounding death are among the most resistant to change of any cultural or subcultural pattern.[4] Thus, in times of crisis, patients may return to cultural and religious traditions regardless of their socioeconomic status.

Iranians

Case Example

The patient, a 17-year-old Iranian girl, had a long history of diabetes mellitus with numerous episodes of ketoacidosis. On the day of admission, she was found unconscious. When the paramedics arrived she was asystolic, but a cardiac rhythm was restored en route to the emergency department. She was admitted to the intensive care unit (ICU) on full ventilatory support. On evaluation she was found to be brain dead. The family was informed of the diagnosis and the fact that legally she was dead. They objected to removing the ventilator and insisted on many unnecessary medical procedures. They remained in the ICU most of the time, interfering with the care of other patients. The physicians felt that the family was being unreasonable and inappropriate. On the second day of admission when the family was not present, life support was stopped. When the patient's parents found out what had happened, they became irate and refused to leave the ICU. The attending physician talked to them for a few minutes, became irritated, and left. The resident left in tears when the family told her that she had "murdered" the patient.

Discussion

Iranian patients are usually opposed to stopping life support in any situation. There appears to be little difference in the responses of the Muslims and the Christians in the study group, thus indicating that the trend was based in culture, not religion. Because, however, religious values have a tremendous influence on societal norms, and the predominant moral code of Iran is based on Islamic traditions, those will be discussed.

Life and death are viewed as controlled by God.[5,6] All persons are entrusted with their body, and it is their moral duty to seek medical help when needed. The right to die is not recognized.[7] Because only God can decide when someone

TABLE 1.—*Percentage of Respondents (n=230), by Ethnic Group, Who Agreed to Statements About Starting or Stopping Life Support in Hopeless or Terminal Situations**

Ethnic Group	*Average Age, yr*	*% Male*	*Start Life Support? (%)*	*Stop Life Support? (%)*
African American, n=30	38.6	40	Agree (60)	Disagree (40)
Chinese, n=17	35.1	53	Equivocal (53)	Agree (65)
Filipino, n=28	28.4	32	Strongly agree (80)	Strongly disagree (14)
Iranian, n=25	43.7	48	Strongly agree (84)	Disagree (24)
Jewish, n=27	40.1	70	Strongly disagree (13)	Strongly agree (90)
Korean, n=23	42.3	44	Agree (74)	Disagree (30)
Mexican American, n=37	38.1	35	Equivocal (53)	Equivocal (49)
Reference group, n=43†	36.7	51	Strongly disagree (17)	Agree (71)

*Respondents were given 8 different clinical scenarios and told to pretend they were dealing with the situation described. The respondents were asked to indicate what their decision would be in each case. Four of the situations dealt with starting life support, and the other four raised the issue of stopping life support. The hypothetical patients described in the survey were of both sexes and covered a wide age range. The responses of each ethnic group were divided as follows:

Strongly agree ..... >80% of the responses agreed with the statement
Agree ..... 60% to 80% of the responses were in agreement with the statement
Equivocal ..... 40% to 60% of the responses were in agreement with the statement
Disagree ..... 20% to 40% of the responses were in agreement with the statement
Strongly disagree ..... <20% of the responses were in agreement with the statement

Sample questions

CASE 1. Your 8-year-old daughter, Amy, was healthy until last night, when she was hit by a car. She suffered severe brain damage. The doctors, including a specialist, believe that she will never talk or walk again but she will feel pain. She will always need a breathing machine to keep her alive and will need to be fed by a tube in her stomach. The doctors want to know whether you want to keep Amy on the breathing machine (ventilator) or if you would like it turned off. What would your decision be?

☐ Turn off the machine and let Amy die.
☐ Keep the machine on and keep Amy alive.

CASE 2. Your mother, Guadalupe, has had diabetes and high blood pressure for 15 years. She has had several strokes (blood clots in the brain) but is still functional. Guadalupe has told you several times that she never would want to be kept alive by artificial means. Last night, Guadalupe had a massive stroke and was taken to the hospital. The only thing that is keeping her alive is a breathing machine. Would you turn off the machine?

☐ Yes, I would want the doctors to turn off the machine (Guadalupe would die).
☐ No, leave the machine on.

CASE 3. Your father, Peter, is 64 years old. Over the past year he has lost a lot of weight and has been coughing all the time. Two months ago he was told that he had a cancer in his lung that was not treatable. Since then, he has been in constant pain and has been unable to sleep. Last night, your father developed difficulty breathing and was taken to the hospital. The doctors found that his lungs had filled up with water and that the tumor had spread to his brain. He is no longer able to speak, and this will probably not improve. The doctors state that Peter will die the next day, unless he is put on a breathing machine (ventilator) to keep him alive. Even if the ventilator is used, the doctors say that Peter will die in the next few weeks. The doctor wants to know whether you want your father put on the ventilator. What would you do?

☐ Put Peter on the ventilator.
☐ Not put Peter on the ventilator.

†Reference group was composed of all US-born persons who described themselves as white, Anglo, or Caucasian and whose religion was listed as Catholic, Protestant, or none.

will die and all are mandated to seek medical attention, life support is viewed as an obligation, not an option. Although stopping supportive measures is thought to be "playing God," starting these measures is not; instituting life support is an appropriate use of the "gift" of medical technology that has been given to humanity. Thus, to argue with Iranian patients or their families that to start therapy is also interfering with the will of God carries little moral validity.

The opposition to stopping life support holds true even if a patient is in considerable pain. Long-term suffering presents an opportunity to show courage and faith in God,[8] and taking a life to relieve suffering is forbidden.[6] Individual duress is acceptable if it obviates the societal duress of going against moral standards.[5]

Of note, these rules do not necessarily hold in the case of a defective newborn. Some people believe that evil spirits entered the child, and it is no longer human.[9] In these cases it might be permissible to withhold support, including nutrition.

Initiating a discussion of the issues of life support might anger a patient or family. This is based on the conviction that to tell a patient that there is no hope may hasten the dying process and is thus considered inappropriate and insensitive.[10] Given the necessity of obtaining informed consent in the United States, however, some form of dialogue about the terminal nature of a patient's disease is usually necessary. The manner in which such discussion is initiated is important. In Iranian culture it is rude to go directly to the point.[10] The physician should approach the subject slowly, first engaging in small talk. The family dynamics should also be investigated. If a patient is female, she may be under the guardianship of a male family member.[11] The patient's autonomy may not be honored if her decision is not in agreement with her husband's or father's.

In general, the concept of options and patient autonomy is foreign to traditional Iranian culture.[10] Patients are not used to being asked to make choices and may delay doing so. The health care team may become impatient with the patient or family because they "cannot make up their minds" when, in fact, the patient is expecting the physician to make the decisions regarding care.

Other factors can affect decisions about supportive measures in Iranian patients:

- The family's definition of death needs to be considered. In the case discussed here, the family felt that their daughter was still alive because she had a heartbeat and her skin was warm. Thus, to them, removing the ventilator was tantamount to murder.
- In Iran and in many other Middle Eastern countries, the family is expected to be demanding.[10] This shows concern for their family member. This is why the patient's family in this case stayed in the ICU and was so insistent on a wide range of medical care. Not to have done so would have indicated that they did not care about their daughter. Although physicians often become frustrated with this demanding behavior, to understand the reasons behind it may help alleviate some of the friction it causes.
- If a decision is made to stop life support in a Muslim patient, certain customs should be observed. The family should be allowed to stay in the room and recite the Koran *(Qur'an)* so that these are the last words the patient hears.[2,11] In addition, family members should be allowed to move the bed so that the patient is facing Mecca when he or she dies. Finally, when a Muslim dies, a non-Muslim is not supposed to touch the body, so gloves should be worn.[12,13]

Korean Americans

Case Example

The patient, a 54-year-old Korean man, was admitted to the hospital with idiopathic pulmonary fibrosis. His condition deteriorated rapidly, and it was clear that death would occur within the next week. His physicians wanted to issue a do-not-resuscitate order, but his family disagreed, insisting that everything be done to keep him alive until arrangements could be made to fly him to Korea. The house staff thought that the family was unreasonable about the patient's prognosis and was causing him undue suffering. The family did not understand why the physicians were being so insensitive.

Discussion

There is little in the medical literature about Koreans and their views toward ethical issues in medicine, especially life support. The following factors are important, however: First, most Koreans are religious, with Buddhism and Protestantism exerting the greatest influence.[14-16] Many Koreans interpret stopping life support as interfering with God's will, although starting such measures is not. There is also still a strong Taoist influence in Korea, which places a great value on longevity.[14]

Another, perhaps more important, issue is that of filial piety, or loyalty to one's parents. In Korea as in many Asian countries, elders are to be respected and cared for.[14,15,17,18] Children, especially the oldest son, owe their life to their parents. They are responsible for the parents and must preserve their lives at all cost. To agree to stopping life support, even if this is a parent's desire, may dishonor the family member in the eyes of relatives or the community. How people's actions are viewed by others is important.[19]

In addition to respect for elders, there is also a traditional concept of obedience to the male head of the family. This tradition has been shown to be still present in Korean-American families,[20(p115)] and physicians may find that the father or husband makes life-support decisions about all family members.

Traditional values dictate that a patient die at home.[18] Thus, in this case example, the patient's family was aware of the terminal nature of his illness but wanted to keep him alive long enough to get him back to Korea. The fact that he would die en route was not important to them; the action was more important and preserved their honor.

Chinese Americans

Case Example

The patient, a 69-year-old Chinese-American woman, was admitted with complete right hemiparesis and aphasia due to a stroke. She had a history of several previous infarcts, with a resulting dementia. A feeding tube was placed, but the patient repeatedly pulled it out. The family was asked to consent to a gastrostomy tube for feeding. They refused and, in addition, asked that all intravenous hydration be discontinued. Because of a question the patient's son had asked about the cost of nursing homes, the intern was certain that the family wanted the patient to die so they would not have to spend their potential inheritance on her care. The intern wanted to get a court order for the gastrostomy tube.

Discussion

Literature about traditional Chinese culture provides some explanations for the bipolar trend—both to stop life support and to believe strongly that all measures should be continued.* For centuries the moral outlook of China has been shaped by Confucianism, Taoism, Buddhism, and, more recently, Marxism. This has led to an ethical perspective that is strongly virtue oriented.[21,22] What is valued is not life itself but living in an ideal way. Taoism advocates nonaction and allowing things to be, and Buddhism emphasizes the transitoriness of life.[23] ("Death is only the vanishing of the human body, the true body exists forever."[24(p13)]) These viewpoints, combined with the concept of *Ren* (benevolence, kindheartedness, humaneness),[25] lead many patients or their families to the belief that nature should be allowed to take its course, especially when a patient is suffering. Chinese philosophy has long included the right to choose death,[26] and there is evidence that most Chinese approve of passive euthanasia.[27]

In addition, each person is seen as part of the whole community, and individual actions must always take into consideration the effects on society.[22,28] Thus, economic factors become an issue.[29] If life support is a financial burden on the family, the patient or family is likely to request that it be stopped.[30] An explanation for this view can be found in the teachings of Buddha: The principles of justice and compassion are central.[31] Justice requires an appropriate distribution of health care resources. Compassion encompasses justice. Thus, a patient who decides to forgo life-support measures so the family does not suffer, either emotionally or financially, is performing an act of compassion, which is highly valued.

Opposed to this is a traditional Chinese view that life should be valued and preserved at all costs and that physicians should do their best to save lives.[27,30] This is partially based on the first Buddhist precept that prohibits killing, even when a person is suffering from a painful and incurable disease.[30] There is also the concern that to stop life support is to interfere with a person's *karma*—the idea that suffering is the result of some past deed and if the karma is not "worked out" in this life, the patient will be forced to suffer again in the next life.[31] Yet another factor involved is the concept of filial piety,[25,27,30,32] discussed earlier.

Orthodox and Non-Orthodox Jews

Case Example

The patient, a 34-year-old man with alcoholic liver disease, was admitted with his tenth episode of massive hematemesis over the past six months. During his previous admission 14 days before, the patient received 110 units of fresh frozen plasma and 68 units of red cells. On admission the patient had alcohol on his breath. After 24 hours he was still requiring constant transfusions. The attending physician decided to stop all blood products. On hearing this, the Jewish intern caring for the patient vehemently argued that such action was wrong and then left the ICU extremely upset.

Discussion

When raising the issue of life support with Jewish patients, identifying which sect they are associated with is essential. There is a great dichotomy between the views of Orthodox and non-Orthodox Jews. Both views are discussed here.

Traditional Orthodox teachings are firmly in favor of continuing life support. An Orthodox patient may become upset at a health care team for even bringing up the subject of stopping life-support measures. Reasons for this can be found in Orthodox teachings that take a strong prolife stance. Life is sacred and is to be preserved whenever possible.[33-35] Thus, it is mandatory to maintain one's health[35] and to seek health care when needed.[34] In addition, the traditional interpretation of the Bible says that physicians are mandated to save life when able[34,35] and definitely should not assist a patient's death. (Someone who even closes the eyes of a dying person while the soul is departing is classified as a murderer.[36]) So strong is the requirement to preserve life that the risk of a loss of life supercedes most laws of the Sabbath.[34] Every life is of infinite worth, and even one moment of life is to be valued as if it were a month or a year. The sanctity of life is more important than its quality. Furthermore, physicians cannot make a judgment about another person's quality of life because life may have meaning under all conditions, even when the suffering is immense.[37] Thus, conservative interpretations of Jewish moral standards command that patients seek life-support measures and compel physicians to provide them. Although autonomy is valued, wishes that do not comply with these moral standards are not to be honored.[33]

On discussing his feelings, the intern in this case indicated that he was Orthodox and that he believed that not giving blood to this patient was wrong. This is an important case example because it shows how conflicts due to differences in values do not always come from patients. Physicians, too, carry value systems that relate to their past experiences, upbringing, and ethnic identity. Health care professionals need to be aware of their own biases when dealing with these potentially difficult situations.

The views explored here are not necessarily held by non-Orthodox Jews. Possible reasons for this include that Judaism does not glorify suffering by assigning it the redeeming features that other faiths do. No one is required to withstand intractable pain to preserve life.[38] Judaism is committed to use all available resources to alleviate suffering to every extent possible.[39] Thus, pain should be treated. Prolonging the dying process is also prohibited.[34] Exactly what constitutes this dying process is unclear, but traditionally a person who is dying (a *goses*) is one who will not live more than 72 hours.[35] In this situation, it is permissible to stop life support because it is only prolonging the dying process. Another reason for being against life-prolonging measures is that Jews do not have the same belief in an afterlife or reincarnation that other faiths do. There is the feeling that "when it's over, it's over," and there is no point in prolonging futile care.

African Americans

Case Example

The patient, a 32-year-old African-American man, was admitted after receiving a stab wound to the heart. He had a cardiac arrest in the emergency department, suffering severe brain damage. A month later the patient had no notable return of cognitive function, although he was responsive to pain. He had continuous fevers, though no source of infection was found. The ICU team wished to issue a do-not-resuscitate order, stop antibiotic therapy, and transfer him to the

*See also J. H. Muller and B. Desmond, "Ethical Dilemmas in a Cross-cultural Context—A Chinese Example," on pages 323-327 of this issue.

general medical ward. The patient's wife disagreed and threatened to sue the hospital if these plans were carried out.

Discussion

An exploration of the views that African Americans hold toward do-not-resuscitate orders and life support is especially important because of the higher prevalence in the African-American community (than in the general population) of conditions likely to result in the need for a discussion of such issues. Overall, African Americans have higher incidences of cancer, accidents, the acquired immunodeficiency syndrome, hypertension, diabetes mellitus, and low-birthweight babies[40-47]; they also have less access to needed primary health care.[48]

As is the case with all groups, African Americans cannot be lumped together, as past experiences, religion, and politics are extremely varied. Because of centuries of slavery and racism, their experiences in the United States are dissimilar from all other groups. Patients who recently arrived in the United States from Africa cannot be included in this group, as they have different experiences and medical belief systems.

Although the literature is sparse, there is some support for the finding that African-American patients are more likely to want life-support measures to be continued. Port and co-workers found fewer deaths due to the termination of dialysis in African-American patients than in whites.[49]

Several factors may influence decisions about life-support options. First, African Americans tend to be more religious and more devout than whites.[50] Many patients said that they would continue all measures until the end because it "is wrong" to stop and miracles are always possible. Patients said that they would feel enormous guilt about stopping support. This relates to both strong religious convictions and the observation that, in general, African Americans highly value their elders, long life (regardless of suffering), and the will to survive.[51-54] A physician's statement that the situation is hopeless may not be adequate: only God knows for sure. This may represent a distrust of the medical community rather than strictly religious conviction.

In addition, there are still problems with racism in the medical establishment. It has been shown that African-American patients receive less intense care[55] and are more likely to be negatively stereotyped than other patients.[56] These issues, combined with the perception of some African-American patients that their hospital stay was too short and the care less than satisfactory,[57] may lead to concerns that life support was stopped prematurely because of the patient's race.

Filipino Americans

Case Example

The patient, a 44-year-old Filipino woman with metastatic breast cancer, was admitted with shortness of breath. On admission the house staff discussed the possibility of a do-not-resuscitate order with her. She agreed. Later, while the attending physician was examining the patient with her family in the room, he again brought up the subject of a do-not-resuscitate order. This time she denied that it was what she wanted. On leaving the room, the attending physician expressed displeasure with the resident who had initiated the order "without the patient's consent."

Discussion

The Republic of the Philippines is a diverse nation comprising more than 7,000 islands and with a culture that has been influenced by many countries and religions.[58] Compounding this diversity is the fact that there have been several different waves of immigration to the United States from the Philippines, with each group having unique experiences and backgrounds that would influence their belief systems. Despite this variety, most Filipino patients are apparently opposed to stopping life support.

Many of the Filipinos who have immigrated to the United States are Catholic[59] and believe that patients or physicians should not interfere with God's plan. The Catholic Church abhors "suicide" for any reason,[60] and it is morally wrong to encourage death with any action or omission. Thus, religious conviction is a major reason for continuing life support. Respect for elders is also important, as with Korean and Chinese patients.

The Filipino family greatly influences patients' decisions about health care.[58] Harmony is valued, and personal needs are subjugated to keeping group harmony. Thus, in this case, the patient actually did want the do-not-resuscitate order to be written and did not want life-support measures started. Her family objected, however, and because outright disagreement was to be avoided, she changed her mind.

The perceived cause of a patient's illness can also be a factor in decisions about supportive care. For example, for some Filipinos, illness may be attributed to a punishment from God,[57] and thus it would not be appropriate to interfere. Others believe that people die because they have offended or are possessed by a spirit, a belief that is common throughout Southeast Asia.[61,62] Patients or families may be reluctant to stop life support before the causative agent has been addressed. For example, the brother of a patient thought that she became ill because she swept dirt on a spirit who was walking by, thus offending the spirit. He believed that if the patient apologized enough she would get better, so stopping the ventilator was not appropriate.

Mexican Americans

Case Example

The patient, a 43-year-old Mexican-American woman, was admitted with known metastatic breast cancer. On admission she said she wanted no heroic measures done. Over the next 24 hours her condition rapidly deteriorated, and she became comatose with imminent respiratory arrest. The issue of a do-not-resuscitate order was discussed with the patient's children. They were aware of her wishes but insisted that she be intubated, at least until their father was able to come from Mexico.

Discussion

Mexicans have a rich heritage, with their present culture influenced by indigenous native traditions as well as customs and beliefs imported from Spain and Africa. Mexican Americans have had these traditions modified further by the dominant American culture. This has led to a unique and diversified culture that only partially resembles those of other Spanish-speaking countries. Although Mexican Americans are the largest group of Latino patients,[7] a substantial number of persons come from other Hispanic countries. The following comments should not be assumed to relate to these other groups.

Mexican Americans' beliefs about illness causation are important in determining their views about life support. Health is a gift from God, and ill health, including accidents, may be due to a punishment from God or the saints.* The suffering incurred is part of God's plan and should not be interfered with. Conversely, a patient may believe that the illness is caused by evil spirits or the Devil[67-70] and that a *curandero* (healer) may be able to cure the patient, even when Western medical practices have failed.

Other issues are equally important when discussing life support with Mexican-American patients. First, there is always hope the patient may get better, so to stop life support may cause the Mexican-American family great feelings of guilt. In addition, Mexican Americans believe that enduring sickness is a sign of strength.[70] Some studies suggest that Mexican Americans may have more fear of dying than other ethnic groups.[50] Last, more than 85% of Mexican Americans are Catholic[50] and against anything that hastens death.[71(p282)]

When a patient is terminally ill, the family is involved in all aspects of decision making. The well-being of the family is valued over that of individual members. Traditionally the father or husband is the head of the household,[72,73] and he should make or agree with all decisions. The wife's input is usually influential, however, even when it is not highly visible.

When discussing life support, physicians need to be aware of the concept of courtesy as it pertains to Mexican-American patients. Directly contradicting a physician is considered rude or disrespectful.[67,72] Thus, a physician may think that a patient and the patient's family are in agreement with the plan of action when in fact they are strongly opposed to it. There is also still a strong tendency toward paternalism,[74] and physicians may be expected to make life-support decisions for their patients.

Summary

The frustration that health care professionals experience when treating patients from different ethnic backgrounds can be mitigated by exploring the cultural foundation of the behavior in question. Variants of the factors discussed in this article occur in diverse cultures, although their degree of influence may vary. In addition, people who have identical reactions when confronted with the subject of stopping life support may have entirely different reasons for their behavior. Thus, when discussing do-not-resuscitate orders with patients from any culture, it is best to explore the following issues:

- What do they think about the sanctity of life?
- 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 about matters of importance in the family?

Health care professionals should remember that many patients have immigrated from countries where as much as three fourths of the population does not have access to basic health needs, such as clean drinking water. They have never before faced "high-tech" health care and do not have a clear concept of the implications or consequences of initiating life support. Finally, the concept of patient autonomy that is so highly valued in Western culture, and is the basis of many life-support decisions, is not as important in other cultures.

When faced with life-and-death decisions, all patients draw on a lifetime of experiences for strength and guidance in making decisions. Patients' societal traditions affect their interpretation of past experiences but are not the only factors involved. Each patient must be seen as a person who has a unique belief system, with ethnic background only a part, albeit an important part, of the equation. By discussing life-support issues in a culturally sensitive way, a physician can turn a potentially exasperating experience into an enriching one, with understanding and respect, if not agreement.

*References 63-65 (pp 78-89, 302-313), 66 (pp 213-219), 67-69.

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Contemplating getting back to Barra de Navidad from New York Hospital

In Barra de Navidad they would let me die
like the manta ray who sinks to the sea floor
in a poetic spread-winged design

or that head which dropped to the dust of the village square
with a surprised grimace/grin on its face,
dual mask of tragedy and comedy.

The people of Barra would not understand.
In Barra de Navidad you are either alive or dead
not neither,
bound, probed, cauterized, anaesthetized,
wearing tubes like unpainted Nahuatl arrows.

The white-flecked ceiling turns blue.
I float this steel-rimmed prison-bed
out of sterile air into moisture, breeze and song
4,000 miles southwest to where

death is as simple and unfearsome as the side of that mountain
which invites me to join its red dust,
pain as simple and swift as that hawk who stalks
that fish, that scorpion who stings that leg

each merely another form of that final predator who attacks
when we relax our vigilance.

IRIS LITT©
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