POPULATIONS AT RISK

Cultural Beliefs About a Patient's Right Time to Die: An Exploratory Study

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BACKGROUND: Generalist physicians must often counsel patients or their families about the right time to die, but feel ill-prepared to do so. Patient beliefs may help guide the discussions.

OBJECTIVE: Because little prior research addresses such beliefs, we investigated them in this exploratory, hypothesis-generating study.

DESIGN AND SUBJECTS: Anticipating culture as a key influence, we interviewed 26 Mexican Americans (MAs), 18 Euro-Americans (EAs), and 14 African Americans (AAs) and content-analyzed their responses.

MAIN RESULTS: Nearly all subjects regardless of ethnic group or gender said God determines (at least partially) a patient's right time to die, and serious disease signals it. Yet subjects differed by ethnic group over other signals for that time. Patient suffering and dependence on "artificial" life support signaled it for the MAs; patient acceptance of death signaled it for the EAs; and patient suffering and family presence at or before the death signaled it for the AAs. Subjects also differed by gender over other beliefs. In all ethnic groups more men than women said the time of death is unpredictable; but more women than men said the time of death is preset, and family suffering signals it. Furthermore, most MA women—but few others—explicitly declared that family have an important say in determining a patient's right time to die. No confounding occurred by religion.

CONCLUSIONS: Americans may share some beliefs about the right time to die but differ by ethnic group or gender over other beliefs about that time. Quality end-of-life care requires accommodating such differences whenever reasonable.

KEY WORDS: attitude toward death; end-of-life; cross-cultural comparison; terminal care; hospice.
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INTRODUCTION

Every generalist—whether hospitalist, office-based internist, or family physician—attends patients with life-threatening illnesses.[1] Whatever the illness, these patients and their families often look to the generalist for advice about when to use life support. They seek answers to two questions, When is the patient's right time to die?[2] and Who or what determines it? Considerable research describes medicine's typical answers based on patient survival, function, and discomfort. But, since such considerations are often inconclusive, the generalist may want additional guidance based on broader perspectives. Patients' beliefs about the right time to die may provide it.[3–9]

Because little prior research exists, we conducted this exploratory, hypothesis-generating study to begin characterizing such beliefs. We suspected that culture—the values, beliefs, and behaviors a social group uses to interpret shared experiences and transmits to future generations[10–13]—influences those beliefs.[4,14–18] We reasoned that, because death is a universal human experience, every culture must address its meaning.[2,19–23]

Indirect evidence suggests American ethnic cultures have some distinct beliefs about the right time to die. (African Americans, for example, typically want life support far longer than do Euro-Americans.[12,22,24–26]) For that reason we studied the beliefs of three ethnic groups and their gender subgroups. We found some similarities across all groups, some differences by ethnic group, and some differences by gender. The resulting hypotheses, though still requiring definitive confirmation, suggest ways to counsel patients and families facing life-threatening illness.

METHODS

We explored beliefs about dying among Mexican Americans (MAs), Euro-Americans (EAs), and African Americans (AAs)[27–30] as well as their gender subgroups. We considered gender

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subordinate to ethnic group because ethnic culture often defines gender-specific roles.

We recruited older inpatients as subjects, reasoning that age, critical illness, and experiencing the deaths of others had already prompted these patients to think seriously about death.[24] Review of admission logs identified all inpatients at two San Antonio, Texas, hospitals who were aged 50 to 79 and admitted over a 9-month period with any of ten common internal medicine diagnoses—congestive heart failure, angina, acute myocardial infarction, arrhythmia, stroke, chronic obstructive pulmonary disease, gastrointestinal bleeding, pneumonia, septicemia, or cellulitis. All of these diseases except cellulitis (2 subjects only) were potentially life-threatening. From this pool we selected subjects for interview. We used purposive sampling, a technique that ensures adequate subject numbers in predetermined target groups.[31–33] The three ethnic groups, each with two gender subgroups, defined our six target groups. We approached patients for interview only with permission from their primary physicians.

Sixty of 65 subjects who began interviews completed them. Of those 60, 58 subjects could be classified by a validated algorithm into one of the three ethnic groups.[34] We excluded from analysis the five subjects (two MA men, one MA woman, and two AA men) who did not complete interviews and the two other subjects who could not be classified into ethnic groups.

The 58 remaining subjects included 26 MAs (14 men, 12 women), 18 EAs (seven men, 11 women) and 14 AAs (seven men, seven women). Among these 58, the most prevalent admitting diagnoses were congestive heart failure (19 subjects), angina (17 subjects), pneumonia (five subjects), and chronic obstructive pulmonary disease (five subjects). Subjects in the three ethnic groups had similar mean ages but differed in other ways (Table 1). The MAs were typically Catholic, married, and educated through grade 7; the EAs were divided between Catholic and Protestant, mostly unmarried, and educated through grade 12; and the AAs were nearly all Protestant, mostly unmarried, and educated through grade 11. The men and women *within* each ethnic group had similar age, religion, and education distributions (data not shown). AA men and women also had similar marital status distributions, but MAs and EAs had more men than women who were married, and more women than men who were widowed.

Two trained, bilingual women—not necessarily matching subjects' ethnic group or age—served as interviewers. Their interviews typically occurred 3 days after admission, involved 1-on-1 engagement with subjects in their hospital rooms, and lasted roughly 90 minutes. These interviews followed a schedule (available to readers on request), covering multiple topics about death. The schedule used mostly open-ended questions to encourage subjects to respond on their own terms. For example, the open-ended question, "Who or what do you think decides when it is someone's time to die?" introduced the topic for this article. To help subjects describe their beliefs, the interviewer asked each subject early on, "Who is the closest person to you who has died?" The interviewer then cast subsequent questions in terms of that person's death. (We assumed that, given the close relationship, details of the death had remained vivid for the subject even years afterward.) Although most subjects answered referring to that person, some described instead their own "death-like" experiences or their general beliefs about death. The interviewers probed as needed to clarify responses.

Subjects took the interview in Spanish or English as they preferred. Two MAs took the interview entirely in Spanish, ten MAs took it partially in Spanish, and all other subjects took it entirely in English. Bilingual typists transcribed the audiotapes, translating any Spanish into English. Two fully bilingual professionals—the transcription supervisor and one author (J.D.C.)—independently confirmed the accuracy of the Spanish-to-English translations.

The content analysis of transcripts used coders differing by ethnic group, gender, and professional training and occurred in four steps. (Each step involved initial, independent, blinded reviews by two coders; comparison of their interpretations; and consensual resolution of disagreements.) First, judging comments at face value, coders deleted any that were irrelevant to death or dying. For example, they deleted one subject's digression into growing up a sharecropper. "We lived way out in the country," she said. "Going to town was a (special treat)." Second, the same coders sorted the remaining, relevant passages by topic such as the right time to die. Third, one original coder and a senior investigator naïve to the responses identified themes within each topic. Fourth, that original coder and one of two new coders determined for each interview the presence or absence of each theme. Theme presence required agreement between the original coder and one new coder or, when they differed, agreement between one coder and an independent adjudicator.

We report the results for each theme primarily as the percentage frequencies of subjects *within these ethnic or gender samples* who mentioned the theme. Although content analyses are typically reported narratively, percentage frequencies have three advantages here. First, readers can examine directly the responses by ethnic group and gender. Second, readers can judge for themselves the meaningful similarities and differences. And third, researchers can use the quantitative results in selecting priority hypotheses for future, statistical testing. For example, the largest percentage differences might reasonably determine the highest-priority hypotheses. Of additional note, the percentages in any table may add to over 100% whenever some subjects mentioned more than one theme in the table, or to under 100% when some subjects mentioned none of the themes.

Table 1. Characteristics of Subjects

Characteristics	Mexican Americans (26 total: 14 men, 12 women)	Euro-Americans (18 total: 7 men, 11 women)	African Americans (14 total: 7 men, 7 women)
Age (years)			
Mean	63	63	59
Standard deviation	±8.5	±8.4	±5.8
Religion, %			
Roman Catholic	77	39	0
Protestant	15	50	93
Other	8	11	7
Currently married, %	58	33	29
Education (years)			
Median	7	12	11
Interquartile range	3–11	10–12	10–12

The study complied with all institutional review board requirements.

RESULTS

Content themes fell into three categories: general beliefs about the time to die, beliefs about who determines it, and beliefs about which factors signal it. An alphanumeric label designates each theme by the number of the table where the theme appears and its order within the table. 4C, for instance, designates the third theme in Table 4.

General Beliefs about the Time To Die (Table 2). Four themes fell into this category. Sizable minorities of all three ethnic groups and both genders (except AA men) said that every patient has one right or best time to die (theme 2A). As one MA man explained, "I want to enjoy my life ... until God says, 'I'm ready for you. Come over here.' ... (W)e're (all) going to have to go but at the right time."

Yet within each ethnic group the genders differed consistently over two other themes. Some women, but no men, said a patient's time to die is preset (theme 2B). As one MA woman explained, "Whether I sign ... (advance directives) or not, ... (i)f it's my time, ... I'm going to pass away. ... Jesus wants to meet (me) up in heaven." Furthermore, always more men than women said the time to die is unpredictable (theme 2C). One AA man insisted, People are "not God. (They) don't know how long (someone's) going to live," and an MA man said, Even doctors "can't be sure that (a patient's) going to die."

Additionally, most MA men, but few others, explicitly acknowledged death's inevitability (theme 2D). One who did said, "(W)e know that we (will) die. ...There's a limit on human life."

Surprisingly few subjects of any ethnic group or gender mentioned death's finality, that is, the idea that the dead cannot return to this physical life (data not shown; range among gender subgroups, 0–21%). Still, one subject said, "Once you're dead, you can't come back ... and give hell to the doctor."

Who Determines a Patient's Time To Die (Table 3)? Majorities of all ethnic groups and gender subgroups said God helps determine—perhaps decisively—a patient's time to die (theme 3A). One MA man said, "We're here on borrowed time. When God tells you (that) you gotta leave, you do." Similarly, an MA woman explained, "It's God (in control) because ... many times ... people should have been dead but they're not, and people who should have lived have not." Interestingly, every subject who said a patient's time to die is unpredictable (theme 2C) also said God determines or knows that time (theme 3A). "(H)ow do you know when you're dying? (You can't know,)" said an EA man. "God (i)s the only one (who) has the say-so, knowing when you're born and when you're staying."

Table 2. General Beliefs about the Time of Death

Themes	Group	Mexican Americans (26 total: 14 men, 12 women) (%)[a]	Euro-Americans (18 total: 7 men, 11 women) (%)[a]	African Americans (14 total: 7 men, 7 women) (%)[a]
2A. Every patient has one right or best time to die.				
	All subjects	38	33	29
	Men	43	29	14
	Women	33	36	43
2B. Patient's time to die is preset.				
	All subjects	12	11	7
	Men	0	0	0
	Women	25	18	14
2C. Patient's time to die is unpredictable.				
	All subjects	29	17	29
	Men	36	29	43
	Women	17	9	14
2D. Death is inevitable.				
	All subjects	38	17	29
	Men	57	29	14
	Women	17	9	43

[a] *Percentages are within the groups designated in the second column from the left.*

Table 3. Who Determines a Patient's Time to Die?

Themes	Group	Mexican Americans (26 total: 14 men, 12 women) (%)[a]	Euro-Americans (18 total: 7 men, 11 women) (%)[a]	African Americans (14 total: 7 men, 7 women) (%)[a]
3A. God				
	All subjects	77	83	93
	Men	86	71	100
	Women	67	91	86
3B. Patient				
	All subjects	23	17	14
	Men	29	29	14
	Women	17	9	14
3C. Patient's family				
	All subjects	31	11	14
	Men	7	0	14
	Women	58	18	14
3D. Physician				
	All subjects	15	17	29
	Men	14	0	29
	Women	17	27	29

[a] *Percentages are within the groups designated in the second column from the left.*

Table 4. Signals of a Patient's Right Time to Die

Themes	Group	Mexican Americans (26 total: 14 men, 12 women) (%)[a]	Euro-Americans (18 total: 7 men, 11 women) (%)[a]	African Americans (14 total: 7 men, 7 women) (%)[a]
Circumstantial Signals				
4A. When serious disease or poor bodily condition exists				
	All subjects	88	89	86
	Men	93	100	100
	Women	83	82	71
4B. When "unnatural" causes exist (such as accidents, medical errors, or murder), signaling the *wrong* time to die				
	All subjects	27	39	43
	Men	21	29	43
	Women	33	45	43
Patient-related signals				
4C. When patient is suffering				
	All subjects	69	33	64
	Men	71	29	43
	Women	50	36	86
4D. When patient depends on "artificial" life support such as machines				
	All subjects	54	44	36
	Men	64	29	29
	Women	42	55	43
4E. When patient accepts death or at least does not resist it				
	All subjects	50	56	36
	Men	79	57	29
	Women	17	55	43
4F. When patient achieves tranquility in dying				
	All subjects	12	28	7
	Men	14	43	14
	Women	8	18	0
4G. When patient anticipates death positively				
	All subjects	0	22	14
	Men	0	14	14
	Women	0	27	14
Family-related signals				
4H. When family is emotionally prepared for patient to die				
	All subjects	35	44	0
	Men	21	43	0
	Women	50	45	0
4I. When family suffers due to patient's illness				
	All subjects	35	28	14
	Men	29	0	0
	Women	42	45	29
4J. When family has visited before the death				
	All subjects	23	17	43
	Men	36	0	29
	Women	8	27	57
4K. When the family is present for the moment of the death				
	All subjects	31	17	43
	Men	29	0	43
	Women	33	27	43

[a] *Percentages are within the groups designated in the second column from the left.*

Yet *within* MAs and EAs, men and women differed over which people, after God, also influence a patient's time to die. Among MAs the patient (theme 3B) was cited most often by the men; the family (theme 3C), by the women. But among EAs the patient was cited most often by the men; the physician (theme 3D), by the women. And among AAs the physician was cited most often by both the men and the women. Three responses illustrate these findings. An EA man citing patients said, "We have some (control over) when we die by our conduct. ... (Some patients) have willed themselves to die. ... (Also,) if you smoke all your life, ... that influences your (time to die)." An MA woman citing her family at the death of her father recalled, The doctors "wanted to put a pacemaker (in him) ... Me (sic) and my brothers ... were supposed to decide, ... I said, '(He is) too old.'" And an AA man citing the physicians working his father's cardiac arrest said, "(B)y the time the doctors revived his heart ... it was too late. But (they) did it anyway."

Twelve subjects (six MAs, five EAs, and one AA; five men and seven women) also said God works *through* physicians to determine when a patient dies. For example, describing his resuscitations from two cardiac arrests, an EA man said, "(T)he good Lord ... was bringing me back, along with ... the good doctors."

What Signals a Patient's Right Time To Die (Table 4)? In answering this question, subjects suggested three kinds of signals—circumstantial, patient-related, and family-related.

The two circumstantial signals showed similar responses from all ethnic groups and gender subgroups. Specifically, large majorities of each said critical disease or poor bodily condition signals the right time to die (theme 4A). "(T)he body gets so tired of struggling," one MA man explained. "(You) have worked all (your) life … (You've) had enough and (you're) ready to go. … (Y)ou're expiring your soul …" Notable minorities of each group or subgroup also said "unnatural" causes of death (such as vehicular accidents, medical errors, or murder) signal the *wrong* time to die (theme 4B). For example, one EA woman recalled her teenaged son's premature death in an auto accident. Another EA woman, believing medical error had killed her grandmother, said, When the doctors "gave her the platelets, they also gave her bone cancer, and she never came out (of the hospital)." Still other subjects mentioned intentional killing. One MA woman disapproved of physician-assisted suicide, stating, "People should (not help death along) like that doctor (Kevorkian). … Life is precious, and it's God who should decide when you should die." Similarly, an AA woman attributed (possibly erroneously) her mother's premature death to murder, saying, Mama "poured her glass of beer … and, when she drank the first drink, she started foaming from the mouth. … (S)he started hollering … (Then) she was dead. Took her just like that. We don't know how they got (the poison into) the beer …"

Of the five patient-related signals, two concerned suffering, and three concerned attitudes about dying. Unlike the circumstantial signals, the patient-related signals showed different responses by ethnic group or gender.

Majorities of MAs and AAs, but only a minority of EAs, mentioned patient suffering as such a signal (theme 4C). These subjects split nearly evenly between blaming the suffering of particular patients on the disease or on the treatment. An MA man who blamed the disease said, "(My father) had Parkinson's disease … and then he fell down and broke his hip. … It was time for him to leave. … He was suffering." But an AA woman who blamed the treatment said, "(A) real good friend … suffered so … (She was) just laying (sic) there … with that life support on. … (H)er kids just let her suffer right on through it. … (S)he died with that thing on." Like this woman, many other subjects—including most MA men and EA women—singled out "artificial" life support as causing the suffering that signals the right time to die (theme 4D).

The other three patient-related signals concerned the attitudes of acceptance, tranquility, and positive anticipation of death. The ethnic groups as well as the gender subgroups differed over patient acceptance as a signal of the right time to die (theme 4E). Specifically, most MAs and EAs, but only some AAs, cited it. Furthermore, among MAs more men than women cited it, among EAs nearly equal percentages of men and women cited it, and among AAs more women than men cited it. As one MA man explained, "If (the doctor) had done all he could, then I would tell him, 'I'm ready to die because Jesus's already waiting for me.'" One gender subgroup, EA men, mentioned patient tranquility especially often: Nearly half of them cited it as a signal of the right time to die (theme 4F). Nonetheless, an EA woman gave a good, succinct illustration of this theme. When describing her father's death, she said, "(H)e knew he was going, and he was at peace." Lastly, only the ethnic groups differed over positive patient anticipation of death: Some EAs, but no MAs and few AAs, cited it as a signal of the right time to die (theme 4G). For example, one EA man said, "If … spiritual experience is … reality, death leads you to the next classroom. … where we can learn something, … It may be a different dimension, a new type of being … But I look forward to finding out."

Surprisingly few subjects mentioned having lived a long or fulfilled life as signaling the right time to die (data not shown; range among gender subgroups, 0–29%). Nonetheless, one AA woman said, "I don't want to die (yet). I might still have some future. You never know what's up the road for you, something that you can enjoy before you leave this world …"

Of the four family-related signals of the patient's right time to die, one concerned family emotional preparedness, one concerned family suffering, and two concerned family presence at the bedside. *The ethnic groups* differed on family emotional preparedness as such a signal. Many MAs and EAs mentioned it, but no AAs did so (theme 4H). One MA woman, for example, said about her dying father, "I had already accepted that he was going to die. … (So) I didn't have remorse … You've got to be prepared." In contrast, *the gender subgroups* differed on family suffering (theme 4I). Always more women than men mentioned it as a signal. As one EA woman insisted, "I will not be put on machines to live. … I would not put my kids through that. … (W)hy not … make (their) lives easier even if it means ending mine?"

The ethnic groups also differed over family presence at the bedside as signaling the patient's right time to die. Specifically, more AAs than MAs or EAs cited family presence before the death (theme 4J) or family presence at the moment of death (theme 4K) as signals. These subjects considered family presence important before the death for discussing end-of-life care with the patient or the health professionals, or at the moment of death for witnessing the death. Illustrating family presence before the death as a signal, an AA man recalled that his father "was dead (from a cardiac arrest) for 25 minutes before the doctor got his heart going again. That's too long … (At the hospital) I told … the doctors, 'If his heart stops beating, take the machines off, and let him alone.'" This man also urged his sister and brothers "to go to that hospital and talk to your (comatose) daddy for the last time. … (L)ay your hand on him and tell him you love him … They would not go … (but) I did … every day …" Illustrating family presence at the moment of death as a signal, an AA woman said, "I saw (my aunt) … in a coma. … I went back home (to change clothes) … (Then) the doctors (called and) said, 'You'd better get back here.' She died before I got (back to the hospital). … I should have been there for her (when she died) … That's why I get real(ly) depressed." Curiously, although five of the seven EA men had wives and all had children, only three EA men mentioned family emotional preparedness, and none mentioned either family suffering or family presence as signals of the right time to die.

Because religion was a potential confounder in our study, we examined the responses of the sample's two largest religious groups—Roman Catholics and Protestants. We compared responses of MAs and EAs separately. We found no differences by religion.

DISCUSSION

Western values favor accommodating patients' wishes in dying whenever reasonable.[4,35–38] Generalist physicians often bear

the responsibility for achieving this goal but feel ill-prepared to do so. In many cases realizing those wishes requires physicians to know patients' beliefs about who determines the right time to die and what signals it. Yet almost no prior research describes such beliefs. We, therefore, performed this exploratory, hypothesis-generating study to begin the descriptive process.

The results suggest that such beliefs fall into four categories. One is beliefs that characterize most Americans regardless of ethnic group or gender. This category may include beliefs that God influences a patient's time to die, and that serious disease signals it. A second category is beliefs that distinguish American ethnic groups. This category may include beliefs about the definitive signals of the right time to die: patient suffering and dependence on "artificial" life support (for MAs), patient acceptance of death (for EAs), and patient suffering and family presence at the bedside (for AAs). A third category is beliefs that consistently distinguish the genders across ethnic groups. This category may include beliefs that the time of death is unpredictable (more men than women), and that the time of death is preset and that family suffering signals it (more women than men). The last category is beliefs that distinguish the genders only within particular ethnic groups. This category may include beliefs that explicit acknowledgment of death's inevitability is important (MA men), and that family deserve a say about a patient's time to die (MA women).

We emphasize the preliminary nature of the results. Follow-up studies must now definitively test these hypothesized beliefs in larger samples around the country. The studies should also test for potential confounders including religion, education, marital status, and health literacy. Some studies might even examine the impact of discomfort, disability, and stage of dying on these beliefs.[39–40]

Of course, readers must judge our study by its weaknesses and strengths. The weaknesses include the untested assumption that subjects expressed their beliefs fully and accurately, the limited generalizability of purposive sampling, and the possible confounding by religion and education.[7,19,21,38,41–43] The counterbalancing strengths include the conservative, hypothesis-generating approach (ultimately justified by many unanticipated responses); the acutely ill, older subjects who had likely thought seriously about death beforehand; the pretested, bilingual interview schedule; its open-ended questions allowing subjects to speak for themselves; and the rigorous content analysis.

The study's greatest significance (beyond the hypotheses generated) lies in broadening perspectives about the time to die.[39] Many earlier studies have assessed that time according to medicine's traditional priorities—patient longevity, function, and comfort.[9,44–47] Other studies have assessed it according to patients' expressed goals while dying such as maintaining independence, avoiding burdensomeness to others, repairing and strengthening important relationships, and making peace with God.[6,9,40,48–51] A few studies have even explored relevant AA religious beliefs—that God ultimately controls death, doctors are instruments of God's purpose, physical suffering tests one's faith, and faith can both heal and comfort.[13,17,22,37–38] Our study now introduces a broader, cross-cultural perspective based on patients' answers to two questions, Who or what determines the right time to die? and Which factors signal it?

Most dying patients and their families likely ask themselves these questions.[2,5–6,8] Their answers may suggest ways to tailor care to their needs. Yet even if confirmed, our hypotheses provide only a general guide, not a rigid stereotype, for patients' beliefs.[7,12,14–15,20,52] Physicians must still explore each patient's beliefs individually.

Many terminal patients and their families may want to discuss their beliefs about dying with a physician.[2,22–23,33,35–36,53–54] Yet they often hesitate to broach the subject.[55–58] With a broad view of medical care, the generalist physician may be the best person to start the discussion.[18,59] How might the physician do that?[54,60]

Our study suggests one approach. The physician might first review the patient's clinical condition[3,5,14,49,56,61] and explain the importance of patient and family beliefs in planning future care. Then the physician might ask in sequence, "Do you believe a person has one right time to die?" "Who determines that time?" and "What signals it for you?" The physician might try facilitating responses by using examples from our data. About signals, for instance, the physician might say, "For some people the patient's acceptance of death is the most important signal of the right time to die. For other people the family's visits to say good-bye are the most important signal. What for you is the most important signal?" Finally, the physician might explicitly pledge to try to match care to patient or family beliefs. For example, the patient's beliefs about who besides God determines the time to die might suggest key people to consult about decisions to stop life support.[37] The physician must also recognize unrealistic beliefs and warn against them. For example, not every dying patient achieves tranquility, and not all families prepare themselves optimally for a death.[62] Perhaps the hardest case arises when respondents cannot articulate their beliefs clearly. Then the physician might initiate care based on the general beliefs of the patient's ethnic group and gender, monitor patient and family reactions, and readjust as necessary.

In conclusion, the moment a patient dies may live on long afterwards for loved ones and health professionals alike.[18,63–64] It warrants careful planning. We think the cultural beliefs of individual patients about the right time to die can help shape quality terminal care.[9,13,36,65] This study begins to explore such beliefs. We believe pursuing the hypotheses it yields promises great rewards—affirming patients and families and likely increasing the satisfaction of all with terminal care.[4,38–39,66]

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