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Educating Gerontologists for Cultural Proficiency in End-of-life Care Practice

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EDUCATING GERONTOLOGISTS FOR CULTURAL PROFICIENCY IN END-OF-LIFE CARE PRACTICE

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An educational program was developed to train practitioners to provide care for patients and families that are responsive to cultural concerns. The aim was to increase knowledge and improve attitudes toward providing culturally proficient and culturally sensitive care for patients and families facing life-threatening illnesses. The program consisted of six half-day sessions on key areas in end-of-life care practice. The modules integrated and infused content related to ethnically and culturally diverse populations in a comprehensive training format. Evaluation

This project was developed with the support of the Healthcare Foundation of New Jersey, the Aetna Foundation, and the Roche Foundation.

Gary L. Stein was Executive Director, New Jersey Health Decisions, Verona, NJ during the implementation of this project. This project was conducted under the auspices of New Jersey Health Decisions.

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results suggested that the program was successful in increasing participant knowledge and attitudes towards cross-cultural interdisciplinary practice of end-of-life care.

Training end-of-life care professionals in cultural proficiency has been considered in social work (Del Rio, 2004; Congress & Lyons, 1992); medicine (Crandall, George, Marion, & Davis, 2003; Wear, 2003); nursing (Hadwiger, 1999; Braithwaite, 2005); and psychology (Carter, 2001; Chin, 2007). The necessity for this training becomes clear when disparities in health care among older adults are examined. Hospice and palliative care are considered the gold standards of care to ensure that patients experience a good death (Emanuel & Emanuel, 1998; Steinhauer, Clipp, McNeilly, Christakis, McIntyre, & Tulsy, 2000). A good death is one which is free of pain and suffering and is consistent with individual wishes and preferences (Bradley, Fried, Kasl, & Idler, 2001; Tong, McGraw, Dobihal Baggish, Cherlin, & Bradley, 2003). However, according to data from the National Hospice and Palliative Care Organization (2008), Black and Latino individuals are far less likely than White individuals to receive this gold standard of care.

There have been a number of studies that reported race and ethnic differences in preferences and receipt of end-of-life care across groups (Carlis, Davis, Wright, & Marcial, 1993; Garrett, Harris, Norburn, Patrick, & Danis, 1993; Karim, Bailey, & Tunna, 2000; McKinley, Garrett, Evans, & Danis, 1996; Tulsy, Cassileth, & Bennett, 1997). In a study to examine racial and ethnic variation in use of hospice and high-intensity care in patients with terminal illness, Smith, Earle, and McCarthy (2008) conducted a retrospective study using surveillance, epidemiology, and End Results-Medicare data for 40,960 non-Hispanic White, non-Hispanic Black, Asian, and Hispanic fee-for-service Medicare beneficiaries aged 65 and older with advanced-stage lung, colorectal, breast, and prostate cancer. They found 42.0% of elderly White patients with advanced cancer enrolled in hospice, while enrollment was lower for Black (36.9%), Asian (32.2%), and Hispanic (37.7%) patients. Interestingly, differences between White and Latino patients disappeared after adjustments for clinical and sociodemographic factors were performed. The data also showed higher proportions of Black and Asian patients than of White patients were hospitalized two or more times (11.7%, 15.0%, 13.7%, respectively); spent more than 14 days hospitalized (11.4%, 17.4%, 15.6%, respectively); and were admitted to the intensive care unit (ICU) (12.0%, 17.0%, 16.2%, respectively) in the last month of

life; and died in the hospital (26.5%, 31.3%, 33.7%, respectively). These unadjusted differences in receipt of high-intensity care according to race or ethnicity remained even after adjustments were made.

Given the reports of previous studies, which suggest that disparities in access and utilization of optimal care at end of life exist, it behooves us as gerontologists to close the gap in services to these underserved populations. Because racial and ethnic minority older adults have higher morbidity and mortality rates than White individuals (Center for Disease Control and Prevention, 2008), figuring out how to target and improve care for these populations is imperative. Increasing practitioners' knowledge and attitudes towards cross-cultural practice is a must.

Disparities in help-seeking and service utilization across racial/ethnic groups may arise from lack of knowledge and skills in cultural competence on the part of the practitioner. Not recognizing the myriad ways that patients present with both physical and mental disorders can lead to inaccurate diagnoses and under-treatment (Fadiman, 1998; Snowden, 2003). Research has shown that the inability to converse with patients in their own language can greatly impair the ability of health care professionals to provide adequate treatment to patients (Brach, Fraser, & Paez, 2005). Betancourt (2003) suggests that "poorer health outcomes may result when sociocultural differences between patients and providers are not reconciled in the clinical encounter" (Betancourt, 2003, p. 500). Adding to the complexity of the situation is the difficulty many health care professionals have in talking with patients about end-of-life issues, even when cultural differences do not exist (Meir, Morrison & Cassell, 1997).

Gerontologists must respond to the increasing diversity among older adults in the U.S. population. Disparities in health care among cultural and demographic communities are widespread across the U.S. health care system generally and, particularly, in the provision of end-of-life care and pain management. The National Healthcare Disparities Report states that "disparities related to race, ethnicity, and socioeconomic status pervade the American health care system" (Agency for Healthcare Research and Quality [AHRQ], 2004, p. 1). These differences encompass the use of services, access to health care, and quality of care for a range of serious health conditions—including cancer, diabetes, end-stage renal disease, heart disease, HIV/AIDS, mental health, and respiratory disease—at hospitals and long-term care facilities and in the community (AHRQ, 2004; Institute of Medicine, 2003).

Bullock (2006) reviews the substantial literature documenting the barriers African Americans experience in accessing palliative and

end-of-life care. For example, African Americans do not utilize hospice service at the same rate as non-African Americans. Crawley, et al. (2000) report that only 8% of patients utilizing hospice care are African American compared to 83% who are White. Reese, Ahern, Nair, O'Faire, and Warren (1999) suggest that this underrepresentation may be due to a combination of factors, some of which are "cultural barriers of differences in values regarding medical care and differences in spiritual beliefs, . . . institutional barriers, including lack of knowledge of services, economic factors, lack of trust . . . in the health care system, and lack of diversity among health care staff" (Reese, et al., 1999, p. 549). Older Asian Americans are also less likely than White patients to utilize hospice care (Ngo-Metzger, et al., 2003).

Research by Green, et al. (2003) supports the findings of the Institute of Medicine's (2003) report on health care disparities that "racial and ethnic minorities tend to be under-treated for pain when compared with non-Hispanic Whites" (Green, et al., 2003, p. 277). Furthermore, a panel convened by the Robert Wood Johnson Foundation (RWJF) in 2004 reported that 30% of cancer patients who were not on morphine failed to receive World Health Organization (WHO)-recommended analgesics for pain; in contrast, 65% of minority cancer patients failed to receive WHO recommended pain care (RWJF, 2004). Many minority patients are reluctant to let their needs be known. This is particularly true for those who have been discriminated against within the medical or health care system in the past. Finally, in a comprehensive review of studies of racial difference in hospice use, Cohen (2008) found that African American patients use hospice care at disproportionately lower rates than White patients, even after controlling for sociodemographic and clinical characteristics. Mistrust was alluded to as a factor of influence.

Mistrust of the U.S. medical system among minority groups should not be underestimated, "it is inherent with almost any interaction with the health care system" (RWJF, 2004, p. 1). A recent report from the Center for Minority Health at the University of Pittsburgh Graduate School of Public Health argues that the mistrust that African Americans feel towards the profession of medicine is not irrational. Moreover, it is reflective of the legitimate discontent of individuals and families who experience racial discrimination imposed by institutions of medicine (Rajakumar, et al., 2009).

Satisfaction with medical care among dying patients and their families differs between African Americans and Whites (Welch, Teno, & Mor, 2005). African American family members were less likely to rate the quality of care received in the last days of life as excellent or very good. They were also dissatisfied with physician communication,

especially regarding information about treatment options, and they were concerned that the decedent's treatment wishes were not honored. Furthermore, they were "more than twice as likely as Whites to have used all or most of their savings to pay for their care" (Welch, Teno, & Mor, 2005, p. 1150).

Many cultures have had painful experiences with the health care community (Stein & Bonuck, 2001; Duffy, Jackson, Schim, Ronis, & Fowler, 2005) and have developed a deep mistrust of the motivation of many providers. For example, Bullock (2006) convened 12 focus groups in North Carolina between 1999 and 2001 consisting of 102 African Americans aged 55 years or older. One focus group participant received unanimous support in observing the following:

We have seen too many people be mistreated by doctors and nurses and just don't believe all this stuff they are telling us about a good death. If they don't treat you good when you are getting around well, why would they honor and respect you when you are on your last leg and dying. It just don't make sense to us old black people. (Bullock, 2006, p. 191)

Recognizing this mistrust can help providers understand some of the reactions from patients. The greater the level of cultural proficiency on the part of staff, the greater the possibilities for bridging the gaps between disenfranchised patients and health care providers. As stated by one researcher: "Good intentions cannot abolish a history of inequities and mistrust between groups" (Duffy et al., 2005, p. 156).

Some cultures look at illness and death in way very different from that of the dominant American culture. Among her African American focus group participants, Bullock (2006) found that 86% favored dying in a hospital to dying at home or in a hospice setting; 65% of participants "viewed the withdrawal or withholding of life support as a premature act on the part of medical providers" (Bullock, 2006, p. 191). Similarly, Duffy et al. (2006) and her colleagues report on the great diversity of end-of-life preferences among Arab, Hispanic, Black, White, and female focus group participants. For example, Hispanic and Black women "want everything possible to be done to maintain life," whereas men in these groups "prefer to die with dignity and good care . . . with little medical intervention;" for Whites, the focus was on "choices" and making one's own decisions (Duffy et al., p. 152). While contemporary health practice generally emphasizes truth telling and autonomy, some cultures value decision making by the whole family and not talking specifically

about death. Understanding and honoring these differences will help health care staff provide much more culturally proficient care.

Koenig and Gates-Williams (1995) frame the challenge of respecting diversity—"how can we respect differences while avoiding stereotyping of patients" (Koenig & Gates-Williams, 1995, p. 247)? To best respond to the needs of patients requires knowledge of the various responses to illness and death as well as the skills of individualized client and family assessment (Koenig & Gates-Williams, 1995, p. 246).

The researchers in this article used a multistaged approach to increasing cultural knowledge and attitudes. Rather than assuming the ultimate goal of cultural competence, this research began with a more primitive phase of cultural proficiency in which the practitioners gained a level of knowledge that would enable them to feel more prepared to work across cultural groups. Proficiency was viewed as an earlier phase in the process of achieving cultural competence. The development of the educational curriculum for this end-of-life care program was premised upon the notion that cultural competence is an ongoing course of action which requires continuous learning. Proficiency can be observed more immediately and reported more readily in postprogram evaluation. These components of curriculum development were integral to the work undertaken to prepare practitioners.

METHODOLOGY

Analysis of Educational Deficiencies and Needs

The principal investigators analyzed the state-of-the-art in professional education in end-of-life and palliative care. We consulted the existing curricula for physicians (Education for Physicians in End-of-Life Care, known as EPEC Project, developed by the American Medical Association, 1999); nurses (End-of-Life Nursing Education Consortium, known as ELNEC, developed by the American Association of Colleges of Nursing, 2000); and social workers (Project on Death in America-sponsored Social Work Leadership Development Award professional education projects; Project on Death in America, 2004; and Project on Death in America, 2001). In addition, we considered the curriculum and implementation of a continuing education certificate program that the authors conducted at the Kean University Department of Social Work in 2001 to train experienced social workers for end-of-life care practice. What almost all educational programs in cultural proficiency have in common is approaching it through presenting culture in discrete modules.

For example, the ELNEC program has nine modules, one of which comprehensively addresses “Cultural Considerations in End of Life Care” (American Association of Colleges of Nursing, 2000). The EPEC training consists of 17 modules, none of which deal directly with cultural issues; however, cultural concerns are occasionally noted and a module on “Negotiating Goals of Care” calls for understanding patient culture as a skill area (American Medical Association, 1999). Doorenbos, Briller, & Chapleski (2003) argue that “a more effective educational strategy involves treating culture as a major thread permeating many aspects of [end-of-life] communication and decision-making.” (Doorenbos, Briller, & Chapleski, 2003, p. 406). This approach, which the current project employed, allows for the infusion of cultural issues throughout the whole curriculum.

Advisory Committee

We convened an advisory committee of 17 leaders in end-of-life and palliative care and cultural competency education to obtain input on all aspects of this project. Committee members included faculty and administration from New Jersey social work, medical, and nursing schools; medical, nursing, and pastoral care staff from urban medical centers and hospices; medical ethicists; and the State Ombudsman for the Institutionalized Elderly. Nine committee members were noted for their educational programs and research on cultural perspectives; eight members were African American, Latina, or Asian-American. The committee met once for 3.5 hours in January 2006 to review and provide guidance on all aspects of the project including the following:

- The scope of the project, including target audiences and cultural communities that should be addressed;
- Course content;
- Recruitment of participants;
- A draft curriculum to be implemented in six half-day sessions over approximately 20 hours;
- Program logistics, including faculty recruitment, location of training, dates and timing of the program, and continuing education credits;
- Program evaluation.

In addition, in-depth individual meetings were held by six members who could not attend the committee meeting. Member guidance on each of these areas was integrated into the implementation phase.

Participant Recruitment

Participants were recruited from northern and central New Jersey, as well as through intensive outreach to Newark-area hospitals, community-based organizations, nursing homes, HIV care organizations, community action groups, universities, and other institutions. For broader outreach, program announcements were sent to hospitals, hospices, nursing homes, the State Office of the Ombudsman for the Institutionalized Elderly's long-term care regional ethics networks, the New Jersey Hospital Association, the National Association of Social Workers—New Jersey Chapter, the New Jersey State Nurses Association, developmental centers, New Jersey Health Decisions' Disability Ethics Network, and the New Jersey Hospice and Palliative Care Organization. In addition, Newark-area outreach was expanded by sending announcements to managerial and direct service staff from approximately 30 organizations and hospitals. Announcements were followed by direct telephone contact with each staff member. Program applications were required to provide contact information, educational and professional background, demographic and cultural background, course expectations, and information on cultural communities served. Because one of our funders had a special commitment to the diverse communities in the Newark area, staff who worked in this metropolitan area received a full scholarship to attend the program. Participants outside Newark paid a modest registration fee.

Outreach efforts resulted in a class of 56 health care providers, including social workers, nurses, clergy/chaplains, administrators, and a small number of professional students. Of these participants, 29 were employed by organizations and institutions in Newark and surrounding Essex County communities.

Our participants comprised a highly diverse group of health care and social service professionals. Just over half (52%) of our participants were European-American/Caucasian, and slightly less than half (48%) were people of color (Black/African American, 25%; Latino/Latina/Hispanic-American, 14%; Asian-American/Pacific Islander, 7%; and Native American or Alaska Native, 2%). The majority were female (89%); the mean cohort age was 47 years ($SD = 11.63$). Most were either Catholic (41%) or Protestant (39%), with a small number of participants from other religions, including Jews and Hindus, as well as agnostic or "spiritual" individuals. Participants had a mean of 13 years experience providing end-of-life and palliative care ($SD = 9.29$). They represented social work (52%), nursing (32%), and ministry or pastoral care (13%).

Delivery of the Educational Program

The course was divided into six three-hour modules around major topical and interdisciplinary themes in end-of-life care practice. Cultural proficiency was integrated and infused into each of these modules. Faculty for the course included leaders in end-of-life and palliative care, as well as cultural proficiency and health disparities. Educational approaches included faculty presentations, interactive discussions, role-plays, and participant exercises. The following were the key themes, topical areas, and objectives of each session:

Module 1: Culture and Cultural Proficiency

- 1. Understanding the meaning, roles, and implications of culture in society—including health disparities, minority status, demographic/individual characteristics (for example, gender, sexual orientation, age, religion, disability status, and national origin) that influence culture, and the values to client care of understanding culture and being culturally proficient.**
- 2. Understanding the impact of cultural identity and practices on end-of-life care, including the diversity of beliefs and practices among different communities, as well as among individuals within communities.**
- 3. Acquiring assessment skills, through discussion and role-play, on the meaning of culture for individual clients, exploring beliefs regarding health and illness, pain and suffering, and rituals, and practices.**
- 4. Developing a model of cultural proficiency and appreciating its underlying values and assumptions.**

Module 2: Principles of Palliative Care

- 1. Understanding the overall principles and goals of hospice and palliative care.**
- 2. Understanding the physical and psychosocial assessment and treatment of pain and distressing symptoms.**
- 3. Gaining insight into the contributions of culture, religion, and spirituality on the delivery of palliative care. Special attention was given to the relationship between cultural perspectives and pain management, societal stigma of opioid medication, and managing pain among substance users.**
- 4. Observing how these principles were applied to a culturally informed palliative care practice among families affected by HIV/AIDS in Africa, as presented by a leading HIV physician who developed a model program there.**

Module 3: Death and Bereavement

1. Understanding the meaning and impact of grief and loss among newly bereaved individuals, including grief symptoms and reactions and complicated grief reactions.
2. Understanding the cultural aspects of mourning, rituals, and family support.
3. Acquiring knowledge of the death and mourning rituals and beliefs among diverse religious traditions and ethnic communities, including Hispanic, Chinese, Hindu, Islamic, and Jewish. These cultures were selected as they were representative of those most often encountered by the training participants.

Module 4: Ethics, Law, and Policy; Organ Donation

1. Acquiring knowledge on the principles of informed consent and the health care decision-making capacity, including surrogate decision-making for those lacking capacity.
2. Understanding the use of advance directives (health care proxy documents and living wills) and do-not-resuscitate (DNR) orders, and the role of culture (race, ethnicity, religion, and language) on advance care planning.
3. Understanding key concepts for assessing cultural preferences regarding health care decision-making (for example, how illness and disease are discussed within the family; how decision-making is shared or delegated by the patient and family; the relevance of religious beliefs; rituals around caring for the body; the cultural importance of age and gender; and histories of poverty, discrimination, and lack of access to care).
4. Encouraging the use of community resources, such as religious leaders, family members, and language interpreters.
5. Understanding the process of procuring organs for donation and the importance of organ donation, especially among communities of color. Approaches to discussing organ donation with families were considered.

Module 5: Family Perspectives on Giving and Receiving Care

1. Understanding the definitions and structure of families, including familial structures across diverse ethnic and racial communities.
2. Gaining insight on family and cultural styles for handling emotions, conflict, and rituals across diverse communities.
3. Developing skills regarding tools to assess family functioning, resources, and reactions to loss, including psychosocial assessment, ecomaps, and genograms.

Module 6: Professional Issues of Leadership/Institutional Issues

1. Understanding the contribution of team approaches and leadership styles to organizational functioning.
2. Gaining skills through discussion and role play in conflict resolution, especially around cultural issues.
3. Understanding the Continuum of Organizational Cultural Competence (cultural destructiveness, cultural incapacity, cultural blindness, cultural precompetence, cultural competence, and cultural proficiency), as well as institutional strengths and weaknesses in serving diverse cultures.
4. Understanding the influence of cultural diversity among staff and of the institutional culture on client services.
5. Developing skills in assessing institutional cultural proficiency.

To further clarify the course content, details of two of the modules are provided. In the module on Culture and Bereavement, the presenters discussed how culture might affect an individual's response to grief. Mourning rituals were presented and there was a discussion of factors that might complicate mourning in the U.S.. Participants were asked to share the culturally prescribed rituals of their own faith and ethnic communities. The presenters then provided information on some of the beliefs and rituals that might be important to various communities, including Hindu, Sikh, Hispanic/Latino, Chinese American, Chinese Buddhist, Islamic, Jewish, and Native American. Participants then had an opportunity to talk about patient situations and how health care professionals could incorporate a culturally sensitive perspective into their treatment.

The module on Family Perspectives on Giving and Taking Care discussed the various types of families and family structures encountered in health care settings. Family cultural, spiritual, and religious beliefs and practices related to life, death, and family were discussed. Various salient elements regarding different cultures were presented. Those cultures included Native American, African/African American, Haitian/Haitian American, Cuban/Cuban American, Mexican/Mexican American, Chinese/Chinese American, Korean/Korean American, Arab/Arab American, Anglo/Anglo American, Italian/Italian American, and Irish/Irish American. The impact of the immigration experience and levels of acculturation were also discussed. Participants had the opportunity to practice with various family assessment tools, such as the ecomap and genogram. The module included information on different types of family structures, such as open, closed, and random. It also addressed various elements

of family functioning that should be assessed, including flexibility, styles and effectiveness of communication, leadership, and decision-making. How emotions are handled within the family, as well as how to assess family resources, were discussed. The module ended with a dialogue about how to help families prepare for coping with the loss of a loved one, taking into account all that the health care professional can learn about the family's culture.

The delivery of the course was completed in July 2006. Participants were provided certificates and continuing education credits (CEUs) for social workers, nurses, and chaplains/clergy.

Evaluation

An independent research consultant prepared a quantitative survey that was completed anonymously by each participant at the end of the final session ($n = 47$). The survey requested input about the quality and effectiveness of the course as a whole, by topical area/module, and faculty member; it also asked about the impact of the program on the participants' work with diverse cultural communities. Respondents were also offered opportunities to provide comments on additional training that would be helpful and to offer ideas for using the knowledge gained from the course. As this was not a research project, complex statistical tests were not performed. While a pretest/posttest procedure could have been helpful, the authors regarded data collected after the training was completed as valuable for assessing program efficacy. Respondents are capable of remembering their level of knowledge prior to participating in the course.

RESULTS

Eighty-two percent of the class ($n = 47$) completed the evaluation questionnaire. Table 1 provides overall ratings for the course. On

Table 1. Overall rating for the course on cultural proficiency

	Cultural proficiency course overall rating (On a scale of 1–5)						
	1	2	3	4	5	<i>M</i>	<i>SD</i>
Usefulness of course	0	0	4	12	31	4.57	.65
Will use knowledge	0	0	3	9	35	4.68	.59

Table 2. Rating of knowledge of course content and difference between pre- and postcourse scores

Mean scores of knowledge of course content before and after course (on a scale of 1–5)			
	Mean: pre- (self-report)	Mean: post	Difference
Module 1 (understanding culture)	3.31	4.38	+1.07
Module 2 (death and bereavement)	3.51	4.49	+0.98
Module 3 (ethics, law, policy; organ donation)	3.13	4.36	+1.13
Module 4 (family perspectives)	3.59	4.57	+0.98
Module 5 (leadership)	3.33	4.29	+0.96
Module 6 (principles of palliative care)	3.37	4.63	+1.26
Entire course	3.37	4.45	+1.06

a Likert scale (1 to 5, with 5 “to a great extent useful”), most participants rated the course as extremely useful ($M=4.57$, $SD=.65$) and most stated it was likely they would use knowledge gained in their practices ($M=4.68$, $SD=.59$).

Each module was evaluated separately to measure specific knowledge acquired, as well as the degree to which participants believed knowledge was gained after course participation. Table 2 provides ratings for the primary knowledge objective for each module, with a comparison of reported knowledge before and after the course. Increases in knowledge were found for each module. The primary objective for each module was selected. Finally, Table 3 provides participant ratings of increases in knowledge and skills in six critical areas.

Table 3. Number and percentage of participants rating primary knowledge objective for modules as helpful to a great extent (rated 4 or 5 on a 5-point scale)

Course content questions	<i>N</i>	%
Improve ability to assess the meaning of culture for clients ($n=45$)	39	87
Understand cultural aspects of mourning ($n=47$)	39	83
Understand use of advance directives and role of cultural attitudes on advanced care planning ($n=47$)	39	83
Gain insight on family and cultural styles for handling rituals ($n=45$)	40	89
Understand role of cultural diversity among staff and the institutional culture ($n=44$)	37	84
Gain insight into contributions of culture, religion, and spirituality on delivery of palliative care and pain management ($n=46$)	43	83

DISCUSSION

Can educators in end-of-life care better promote provider awareness of, and sensitivity to, the cultural perspectives of their patients/clients? All too frequently, continuing education programs neglect to seriously consider cultural issues due to the broad range of interdisciplinary issues that comprise end-of-life care. When cultural issues are addressed, they are frequently presented as a separate panel on traditions and rituals by professionals representing diverse cultural communities. This project offered an alternative approach for promoting culturally proficient care in end-of-life situations: integration of cultural issues throughout the various end-of-life care disciplines, with greater attention to assessing the cultural aspects of care from the perspectives of each individual client and family.

Based on the findings from our evaluation, integration appears to be an effective approach for promoting cultural proficiency among providers of end-of-life care. On all measures, whether considered by thematic module or the course as a whole, participants reported increases in knowledge and skill level on the cultural aspects of end-of-life care. This was demonstrated in the critical areas of assessing the meaning of culture among clients, the cultural aspects of bereavement, the impact of cultural attitudes on advance care planning, and the contributions of religion and spirituality in end-of-life care. Participants expressed great interest in bringing the knowledge gained back to their practice settings by better attending to their patients' cultural concerns and by developing opportunities for in-service training. Moreover, participants remained enthusiastic about the course throughout. This was evidenced by very positive comments in the evaluation, as well as by consistently high attendance rates averaging 90% for each of the modules. Participants indicated that they would like further training on bereavement among children and teenagers, cultural story-telling, and, most tellingly, how to teach others about health care issues. They appreciated the content of the course and wanted even more in-depth material on differences among specific cultures regarding end-of-life care, as well as a greater exploration of cultural traditions during the dying process and after death. Following the program, one participant reported as follows:

I was able to apply the knowledge gained from your course to tailor each interaction I have with my clients. I ask more in-depth questions that may help me in determining if there are any cultural gaps. I often try to observe interactions with my colleagues and their Hispanic clients.

By doing this, I am available to try to help my co-workers better understand the cultural differences that may exist.

The authors anticipate that enhancements in knowledge and awareness regarding culturally proficient care, as a result of participating in this and similar programs, will translate into more respectful and, therefore, improved care for patients and families. Koehn & Swick (2006), in describing their cultural educational program known as Transnational Competence, state that the goal of enhancing the cultural proficiency of health care practitioners is two-fold: “improved health outcomes for patients in social, cultural, and geographical transition, and reduced health inequities for dislocated and otherwise disadvantaged populations” (Koehn & Swick, 2006, p. 551).

LIMITATIONS AND FUTURE IMPLICATIONS

There are several limitations of this project. Pre- and posttests were not carried out. The only evaluation occurred at the end of the training and involved participants’ assessing their level of knowledge and understanding prior to the course. No objective measures of knowledge, understanding, or skills were undertaken. There was also minimal follow-up after the course to assess the degree of change in palliative and end-of-life care practice as a result of taking the course. Future educational interventions should study relationships among provider cultural proficiency, patient and family satisfaction, and the quality of patient care; long-term outcomes of cultural proficiency training on end-of-life care practice; and comparisons of outcomes on end-of-life care practice between training programs that infuse cultural issues throughout the training program and those that separate cultural concerns into specific modules.

CONCLUSION

Despite the limitations of this study, the educational model presented in this report adds a new dimension to the understanding that gerontologists have about how to provide end-of-life care that is responsive to cultural concerns. Much can be gleaned from the development and delivery of the Certificate Program in Cultural Proficiency for End-of-Life Care Practice. The integration and infusion of cultural issues into the educational materials and training steps that guide practitioners to becoming cultural proficient in end-of-life care made this

a comprehensive program. The focus on key areas in end-of-life care practice provided a knowledge base for gerontologists to improve their skills. Evaluation results suggest that the program was successful in increasing participant capacity to engage in cross-cultural end-of-life care in interdisciplinary practice.

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