CASE 10

Priya Krishnamurthy

A 73-year-old South Asian Indian woman with a stroke

Scott Kasner, MD, Roy Hamilton, MD, MS, Steven Messé, MD and Sashank Prasad, MD

University of Pennsylvania School of Medicine, Philadelphia, PA, USA

Educational Objectives

- Appreciate that interpretation from one language to another can impair the assessment of cognitive and language disorders.
- Remember that alternative medical treatments are encountered in nearly all cultures and may conflict with standard (Western) medical care.
- Take into account that cultural values regarding the elderly may affect decisions about long-term care.
- Predict that decisions regarding end-of-life care are influenced by numerous factors, including age, religion, and ethnicity.

TACCT Domains: 2, 4, 5, 6

Case Summary, Questions and Answers

Priya Krishnamurthy is a 73-year-old South Asian Indian woman with a history of hypertension who presents to the Emergency Department (ED) with her family because they notice she has been

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bumping into objects on her right side since awakening in the morning. They claim she was not aware of this problem. An urgent CT scan is performed, which demonstrates an evolving stroke involving the left occipital lobe. Her exam reveals confusion, inattention, and some general slowing of her cognition and speech. The patient does not speak English, so her family speaks for her.

1 What impact might her inability to speak English have on the patient's evaluation?

Many individuals of Indian heritage speak English. However, it is not uncommon for elderly patients who have immigrated to the U.S. to primarily speak their indigenous languages and use their children as interpreters. (She speaks Tamil and minimal English, but mostly relies on her son to interpret for her.) This can be particularly problematic in the assessment of cognitive and aphasic disorders because the family may paraphrase the patient's speech rather than simply translate it, and may also make the patient seem better than she really is. Therefore, requesting a professional medical interpreter can be especially helpful. (On the other hand, family members may be more attuned to deviations from a patient's baseline that an interpreter might not be aware of.)

2 Although her age puts her at risk for neurovascular disease, what other factors may be influencing her confusion?

At least two factors can be cited. First, adoption of new familial roles and adaptation to a new society typically present significant challenges for older immigrants. The more disparate the culture, the greater the likelihood that the adjustment process will be difficult for the newcomer, especially the elderly. The conflicts and demands that arise from this can be particularly challenging for individuals who immigrated late in life, and thus can be a source of great stress with deleterious effects on the senior's physical and mental well-being. In addition, the perception that cognitive deficits are a normal component of aging is a common bias that may delay prompt diagnosis and treatment of emerging patterns of dementia, both on the part of patients and their families, as well as health care providers. As an elderly Asian Indian woman, she is at greater risk of coronary artery disease (CAD) than an elderly white woman.

3 What other factors in her personal and social history would be helpful to know in caring for this patient?

Given the patient's immigrant and non-Western background, it is important to have some understanding of her cultural origin as well as to inquire about her family, current living arrangements, educational background, and language skills. By using nonintrusive and carefully targeted questions, the physician learned the following:

Mrs. Krishnamurthy is originally from Madras (Chennai), India, and her family is Hindu. She has been widowed for 6 years, and in that time has been living with her 47-year-old son Rajan (Raj) and his family in the U.S. Raj is a software engineer for a successful company; his wife Lata is finishing her doctoral dissertation in physical chemistry; and they have two children, Rajeev and Pushpa (ages 9 and 4). Mrs. Krishnamurthy also has a daughter, Vijaya, who lives in a town 20 minutes away and is a pulmonologist at a community hospital. Mrs. Krishnamurthy does not manage her own finances or drive, and does not cook most meals, although she has in the past. Her son had always considered performing these tasks as part of his role as a good child, regardless of his mother's ability to do them. He therefore does not know for certain whether his mother would be capable of performing these activities on her own. When pressed further, he states that he has noticed that her thinking has been "off," but felt that this was normal for persons of her age.

Hinduism

Regarded as the world's oldest religion, many of Hinduism's texts and symbols can be traced to the Indus River Valley of what is now Pakistan. Today, Hinduism has become the main religion of India, Nepal, and much of South and Southeast Asia. This spread has allowed it to become the world's third largest religion, with 13% of the global population identifying themselves as Hindus. In North America, the Hindu population exceeds one million, a number that has increased significantly since 1990.

In contrast to the three major monotheistic faiths (Christianity, Islam, and Judaism) Hinduism involves the worship of multiple deities, does not rely on a centralized structure, and is not based on the teachings of a single founder or prophet. Hinduism may be regarded as a henotheistic religion, meaning that it is based on the worship of a primary god, Brahman, but various other deities exist in the religion as well. Three gods, Brahma, Vishnu, and Shiva, and other deities are considered manifestations of and are worshipped as incarnations of Brahman.

Hindus believe that the purpose of existence is to realize the divine nature of life. Each life, whether it be of a man or an animal, has a soul. These souls are continually passing through stages of birth, life, death, and rebirth in a cycle called reincarnation. The purpose of reincarnation is to liberate oneself from his ego and thus be free from the pervasive suffering that it causes. The concept of karma is intrinsically bound to the principle of reincarnation in that the passage of one life to the next is determined by how the previous life was lived. Thus, performing actions that are deemed moral will allow a person to pass on to a stage that is closer to the ultimate goal of enlightenment: nirvana. During this final stage, commonly called moksha, or unification, the soul of a person is finally rejoined with Brahman.

Mrs. Krishnamurthy is admitted to the hospital for further evaluation and treatment. Her extended family is quite large and very involved. During the patient's hospitalization, numerous relatives are constantly at the bedside. Family members often approach the nurses' station to ask questions or make requests, and it is difficult for family members to restrict their time to the hospital's visitation hours. Furthermore, although the patient's son is the legal surrogate decision-maker, the family prefers to arrive at all decisions by consensus. This is a source of frustration for several of the nurses and physicians who feel that that actions of her family and their approach to decision making are preventing Mrs. Krishnamurthy from being treated appropriately or in a timely manner.

4 What are the cultural dimensions to the actions of the patient's family?

In general, U.S. culture is characterized as being more individualistic, assertive, competitive, achievement-oriented, and focused on mastery over one's environment. In contrast, traditional Asian Indian culture emphasizes strong allegiance to family, restraint of emotional expression, and a deep sense of obligation to older people. Large, extended, closely knit families are often a significant element of the Indian social tradition. Without discounting the role of acculturation, in this context, communal and familial deliberation is more prevalent among Asian Indian families, as distinct from the Western, autonomy-driven framework for decision making.

Medical culture often frames the interaction as one-to-one versus one-to-group, as in family. The majority of patients are group-oriented in terms of families or communities. Learning about decision making within family systems is essential for effective and

efficient communication. Caregivers conditioned to the approach where decisions are ultimately made by a single responsible individual may find it difficult to engage families where decisions reflect familial consensus and agreement. These difficult situations require respect, patience, efforts at understanding families' cultural values, timely discussions focused on the best interest of the patient, and the negotiation of limits and boundaries. In large families, identifying an appropriate individual to be the point of contact between the care team and the family can be very helpful.

In addition, there are other sources of conflict around her care. Mrs. Krishnamurthy is less comfortable with male nurses assisting in the personal aspects of her daily care. Also, she declines to eat the hospital food, despite a normal swallowing evaluation, and her food intake is minimal for several days. Her family begins to bring Indian meals prepared at home, which she eats avidly. This soon becomes a point of conflict with the family as the care team feels that she should be adhering to a low-sodium diet to assist in controlling her blood pressure.

5 In what way might cultural issues related to gender lead to conflict in the clinical setting?

Indian culture and traditions regarding personal space and touching differ from those of Western cultures. Physical interactions across gender lines are more restricted, which may become an issue in a clinical setting. This can be negotiated with patients as much as possible, depending on the clinical setting and the availability of the care they request. The patient can be told that the team will try to accommodate his/her requests as much as possible but cannot always do so, and that the first goal is to provide good care to the patient.

6 How do the dietary preferences of this patient impact her care?

Indian diet and cuisine differ substantially from Western foods, and patients may not find hospital food very palatable. This can impact the hospital experience of inpatients who find it very difficult to adjust to new foods, and therefore, it is more likely that food would be brought in by the patient's family. This may or may not be compatible with medical considerations, depending on the patient's diagnosis. It would be reasonable in the management of this patient to consult a registered dietitian (RD) who could advise the family on culturally appropriate meals that would still be healthy. Patients who have had

a stroke may benefit from a low-salt diet and need culturally appropriate recipes and guidance, which a nutritionist can offer. Blended spices, such as those found in curry, may contain salt, but may not be recognized as a source of salt by the family.

Mrs. Krishnamurthy is seen in the neurology clinic 2 months after her discharge. Her daughter-in-law accompanies her and interprets for her, although she is not as facile with English as her husband. The daughter-in-law wonders if her cognitive function has been worsening since her recent discharge from the hospital. Mrs. Krishnamurthy is now able to do very little for herself independently other than dress and feed herself, and she needs help bathing. She is also more socially withdrawn. When asked if she has tried anything that seems to help her, the patient's daughter-in-law volunteers that, on a relative's recommendation, she is seeing an Ayurvedic medicine practitioner and has undergone a number of detoxifying therapies. Mrs. Krishnamurthy is also taking a combination of herbal remedies and maintains a diet that balances certain flavors, temperatures, and consistencies of food. She does not know to what degree this has been helping her mother-in-law.

7 How do culturally related alternative medical treatments affect her "Western" medical care?

In general, it is important to appreciate that many cultures also have belief systems regarding health, healing, and medical treatment. Although these nonallopathic therapies may seem foreign or without scientific merit, it is important to respectfully, and in a nonjudgmental way, ask about their usage by the patient. In India, for example, Ayurvedic medicine is a very common practice. This therapy constitutes a comprehensive system of medical practice based on fundamentally different principles from that of Western medicine and relies on very different diagnostic and therapeutic approaches. This form of medicine focuses on reestablishing the harmony between mind, body, and nature through yoga, diet, herbs, intestinal cleansing, massage, and aromatherapy. Instruction for treatment is derived from the ancient Hindu text *Atharva Veda*. Ayurveda rests upon the *prana*, a fundamental energy that enlivens body and mind. The *prana* is made up of five elements: ether, fire, water, air, and earth. These elements are subdivided into *doshas*, unique patterns of qualities that make up an individual's *praktiti*, or essence. Illness occurs due to an imbalance in a person's essence or environment. Stress, frustration, environment, and diet all contribute to this imbalance. Each patient

receives a specialized treatment of exercise, eating, sleeping, and procedures based on the imbalances of his/her *doshas*.

Patients should not have to sacrifice all other treatment options in order to receive Western medical therapies. Rather, health care professionals should seek ways to safely complement allopathic treatments with alternative and/or nonconventional approaches.

Since Mrs. Krishnamurthy's discharge from the hospital, other extended family members have been watching her and the grandchildren during the day. Her daughter-in-law suspects that she should not be left alone unsupervised. The daughter-in-law is distressed by the growing demands of her mother-in-law's condition, which is imposing on her time and career goals. Although the family's income was sufficient to support either a nursing facility or a home health aid, the family is reluctant to extend the duty for caring for the patient beyond the bounds of the family. After careful consideration, the daughter-in-law decided to forego a postdoctoral position for the time being in order to care for her children and mother-in-law.

8 What cultural issues impact decisions regarding long-term care for this patient?

Caring for a family member with physical or cognitive impairments can result in both physical and mental stress for the caregivers. Further, family members who provide care for a cognitively impaired elder can experience social isolation and loneliness due to the elder's inability to engage in conversation, return or express affection, and/or participate in social activities. Although social changes have made it more acceptable, the decision to place a loved one in a nursing home can still be difficult. This decision may be especially difficult for families whose cultural values strongly obligate them to personally care for the elderly relative. For many families, including Asian Indian, these obligations can be very compelling and may make them less likely to relinquish their elders to the care of another person or a nursing home, despite the financial ability to support such a transition.

Two years later, Mrs. Krishnamurthy suffers another stroke that leaves her with significant neurological deficits. Now completely unable to care for herself, Mrs. Krishnamurthy requires 24-hour care, which includes

assistance with dressing and eating. At this point, the family decides that they can no longer take care of her alone. They reluctantly hire a caretaker to be with her at home during the day. At this stage, her physicians recognize that questions about end-of-life decision making have become pertinent. Although the son was legally empowered to make these decisions, the issue was discussed at a large family gathering. After much discussion, it is decided that Mrs. Krishnamurthy would not want to prolong her life by extraordinary medical measures. One component of this decision has to do with her spiritual beliefs. She is a firm believer in reincarnation.

9 What cultural and religious issues relate to decisions about end-of-life care for this patient?

Ideally, well before catastrophic or end-of-life events, physicians should inquire about advanced directives. Unquestionably, ethnic and/or religious values may loom large at the end-of-life. They may inform decisions about end-of-life care; guide the process by which decisions are made; influence willingness or reluctance to accept pain management or palliative treatment; and determine the rituals of death. Although respect and support of the family is of great importance, the goal should always be to ensure that decisions and treatments are consistent with the goals and values of the patient. If the clinician is unfamiliar with the values and practices of a patient's culture, it is both appropriate and helpful to ask the family about their understanding of death and the rituals of death that are important to them. This is also a situation in which pastoral care may be helpful. Evaluating the degree of adherence, beliefs, and practices is imperative to respectfully support patients at their time of death.

In terms of end-of-life and death, many Asian Indian Hindu patients may prefer to die at home, and some will want to return to India to one of the sacred cities for their death. The notion that suffering is inevitable and the result of karma may lead to reluctance to accept medications for pain control. Family members are likely to gather in large numbers as death approaches. Chanting, prayer, the burning of incense, and other rituals are very common. Once the patient has died, ideally the family should be the only ones to touch the body, and thus the hospital staff should touch the patient after death as little as possible. Traditionally, observant Hindus have a family member of the same sex clean the body, wrapping it

in a red cloth after it has been cleaned. Preference is typically for cremation.

End-of-Life Decisions

Technological and medical advancements have significantly improved the ability to keep permanently unconscious or terminally ill patients alive through artificial means. As long as the patient is mentally competent, he or she has ultimate authority over such decisions. When the patient loses the ability to communicate or make judgments, the situation becomes more complicated. With such advancement also come the questions of end-of-life decisions.

Such decisions are never clear-cut and are oftentimes debated among family, friends, and health professionals. Some believe that artificial treatments may eventually restore the patient to acceptable qualities of life, whereas others view them as unnecessarily prolonging the dying process. As of now, the best way for a patient to express his or her wishes during this difficult time is to make prior preparations in the form of advance directives. An advance directive can be a living will, a document through which the patient directs the doctor to withdraw or continue lifesaving interventions, and/or a medical directive, which allows the patient to name a trusted individual to make end-of-life decisions.

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