



Health and Health Care of Pakistani American Older Adults

<http://geriatrics.stanford.edu/ethnomed/pakistani>



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DESCRIPTION

This module presents the small amount of information that is available related to health status and health care of older adults from Pakistani backgrounds in the U.S. It includes some background on the population and traditional health beliefs as well as important clinical considerations.

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MODULE CHARACTERISTICS



Time to Complete: 1 hr, 20 mins



Intended Audience: Doctors, Nurses, Social Workers, Psychologists, Chaplains, Pharmacists, OT, PT, MT, MFT and all other clinicians caring for older adults.



Peer-Reviewed: Yes

LEARNING OBJECTIVES

Upon completion of this module the learner will be able to:



1. Explain major traditional health beliefs among individuals from Pakistani background.
2. List four considerations Western providers should take into account in clinical assessment with Pakistani American older adults.
3. Discuss appropriate approaches in dealing with advance directives and end of life care with Pakistani American older adults and their families.

INTRODUCTION AND OVERVIEW

Demographics

Pakistani Americans are the eighth largest Asian American ethnic group after Chinese American, Filipino American, Asian Indian Americans, Vietnamese Americans, Korean Americans, Japanese Americans and Cambodian American communities. They are also the second largest South Asian American ethnic group, after Asian Indian Americans, and have one of the largest Muslim American ethnic groups in the United States, after the African American community.

Pakistan is ranked as the 12th highest source country for immigration into the United States. Compared to other heritage groups in the United States, Pakistani Americans are well educated with an estimated 60% holding a bachelor's degree or higher professional degrees.

According to the 1990 U.S. Census, there were 81,691 individuals who identified themselves as of Pakistani origin. A U.S. Census Bureau American community survey in conducted in 2005 showed that there has been a tremendous growth of the Pakistani American population with an estimated 210,000 (+/- 18,989) persons reporting a Pakistani descent who are currently living in the United States. (U.S. Census Bureau, 2005)

The Census Bureau, however, excluded the population living in institutions, college dormitories, and other group quarters from all population groups. The Pakistani embassy estimates the number of people of Pakistani origin living in United States to be much higher, closer to 600,000. (Government of Pakistan, 2004, p. 30)

FAST FACTS

According to the United States Census (2001)

- Eighth largest subgroup of Asian Americans
- Second largest south Asian American group
- 60% hold professional degrees
- 4.1% of Pakistani Older Adults live in the United States

TABLE

US Population by Race

<http://www.infoplease.com/us/statistics/us-population-by-race.html>



There are two distinct groups of Pakistani older adults in the United States:

- 1. Older adults who immigrate to the US:** This group consists of the parents or grandparents who immigrated to the US to be reunited with their adult children and to spend their remaining days in the care of their children.
- 2. Adults who immigrate to the US and live here and become older adults:** This group consists of the professionals and their nuclear families who immigrated to this country in the 1950s and 1970s. Their acculturation trajectory is very different from that of the first group as these subjects have often joined the American work force and lived here for many years and may be well acculturated into the American culture.

Given their degree of acculturation, this group's communication skills, decision-making patterns and clinical adherence patterns are likely to differ significantly from those of the older adults who immigrate to the US, to be reunited with their adult children.

(INTRODUCTION & OVERVIEW CONT'D)

Preferred Cultural Terms

The preferred term for Americans with roots in Pakistan is Pakistani American, regardless of their province of origin in Pakistan.

Currently, an estimated 10% of Pakistani Americans are over the age of 55 and the estimated percentage of older adults (>65 years) is about 4.1 percent.

Between the periods of 1989–1992, an estimated 2,433 elders over the age of 60 years emigrated from Pakistan to the United States. In 2005, it was estimated that there were a total of 9342 Pakistani elders with the elderly men (53.3%) slightly outnumbering the women (46.7). About 95.9 % of the Pakistani elders were foreign-born (Young & Gu, 1995; US Census Bureau, 2005).

The immigration of the Pakistani elders since then has continued at a brisk pace and is expected to continue.

Background**The Islamic Republic of Pakistan**

Pakistan displays some of Asia's most magnificent landscapes as it stretches from the Arabian Sea, its southern border, to some of the world's most spectacular mountain ranges in the north. Pakistan is also home to sites that date back to the world's earliest civilizations (the Indus valley civilization of Mohenjo Daro and Harappa) rivaling those of ancient Egypt and Mesopotamia. Pakistan's ethnic and cultural diversity has been formed through the blending of the cultural legacies of advancing Persians, Turks, Arabs, Huns, Greeks, and Mongols, many of whom practiced Islam.

Pakistan emerged on the world map as an independent country on August 14, 1947. When the British colonists vacated the Indian Subcontinent, Lord Mountbatten, the last British Viceroy in India, in response to popular demand, separated the Indian subcontinent into India and the Islamic country of Pakistan. At that time, both West Pakistan (currently known as Pakistan) and East Pakistan (currently known as Bangladesh) were part of the same country (Pakistan).

TABLE

For a language and religion comparison between Older Adults in Pakistan and Pakistani American Older Adults, **see Table 1 on page 6.**


In 1971, East Pakistan seceded from its union with West Pakistan to form a separate country known as Bangladesh, and West Pakistan came to be called the Islamic Republic of Pakistan or in short, Pakistan. With a total area of 803,940 sq. km., it is nearly four times the size of the United Kingdom. Its neighbors include India, Afghanistan, Iran and China.



The first Governor General of Pakistan, Quaid e Azam Muhammad Ali Jinnah delivering his opening address on to the newly-created state of Pakistan. August 11, 1947.

Source: <http://en.wikipedia.org/wiki/Pakistan>. Public domain.

(INTRODUCTION & OVERVIEW CONT'D)

 Table 1	Pakistani Americans: Religion & Language Comparisons with Pakistani Older Adults	
Topic	Older Adults in Pakistan	Pakistani American Older Adults
Religion	<p>An overwhelming 95 percent of the Pakistani population are followers of Islam. There are much smaller Hindu, Christian and Zoroastrian minority communities. Pakistan is not a secular state; the state religion is Islam, and religion influences many aspects of Pakistani political and social life.</p> <p>There are also several distinct ethnic and linguistic groups in Pakistan, including Pathans, Punjabis, Sindhis, and Baluchis.</p>	<p>American older adults are mostly Muslim, followers of the religion of Islam.</p>
Language	<p>Urdu (derived mainly from Arabic and Persian vocabulary and adopting indigenous words and idioms) is the national language of Pakistan. Urdu has a vocabulary similar to Hindi, spoken widely in India. Pakistan has a population of more than 172 million people,</p> <p>The current population growth rate is of 1.99 %*.</p>	<p>American older adults may not speak English (especially the women) and may be able to converse only in Urdu or a dialect (e.g. Punjabi, Pashto). If an Urdu interpreter is not available, an interpreter speaking Hindi is helpful because Urdu and Hindi are similar languages.</p>

*Much of the information in the module is taken from multiple sources in the reference list; individual points are not generally linked to specific references.

PATTERNS OF HEALTH RISK

Life expectancy in Pakistan is 62.4 yrs for men and 64.44 yrs for women. In contrast, life expectancy is higher for Pakistanis living in the United States.

Elderly in Pakistan

According to data from the Pakistan National Statistics Office, the major health problems of Pakistani elders in Pakistan include:

1. Circulatory Disease: hypertension, cerebrovascular accident, coronary heart disease.
2. Cirrhosis: Hepatitis B & C
3. Endocrine Diseases: diabetes mellitus, hypothyroidism, goiter
4. Depression and dementia
5. Cancer: In men oral cavity cancers (sub mucosal fibrosis) related to the prevalence of paan (betel leaf, areca nut and tobacco) chewing, and lung malignancies due to smoking are common; breast and cervical cancers are the most common malignancies in women.
6. Respiratory; pneumonia, chronic obstructive pulmonary disease.
7. Musculoskeletal Disease: osteoporosis, arthritis, fractures
8. Stroke

“...Pakistanis overall are at high risk for coronary heart disease and diabetes mellitus.”

Older Pakistani Americans

Adjustment Problems

New elderly immigrants have adjustment issues in the United States. In Pakistan, they are used to a more active social life and closely knit families. However, in the United States, adjustment to a new country, communication and language difficulties, and problems of identity all heighten the stress leading to depression and adjustment issues.

Hepatitis B Virus

Unlike the American population where only 1-2% is hepatitis B positive, the high carriers rate in the Pakistani population living in the US continues to put them at high risk for liver disease and liver cancer. According to Asian Health Coalition of Illinois the Indian/Pakistani population has a lower infection rate but a higher susceptibility rate (86%).

Cancer

Pakistani and Indian immigrant women in the U.S. are at higher risk for breast cancer compared to their counterparts in India and Pakistan and immigrant men are at higher risk for prostate cancer. The Pakistani immigrant population in the United States also experiences rising rates of lung and colon cancer, mirroring U.S. patterns.

The change in patterns of cancer is believed to be due to immigrants embracing the Western lifestyle of marrying later, having fewer children, getting less exercise and adopting a diet lower in fiber and higher in fat, alcohol and meat.

Also Pakistani Immigrants experience a better survival rate from cancer compared to the non-Hispanic white U.S. population.

(PATTERNS OF HEALTH RISK CONT'D)**Hypertension and Cardiovascular Disease**

Similar to their Indian counterparts, Pakistanis overall are at high risk for coronary heart disease and diabetes mellitus. More specifically, Pakistani immigrant women are at high risk for dyslipidemia and therefore at high risk for cardiovascular disease compared to their American counterparts. Their nutritional habits place them at increased risk for high cholesterol and hypertension.

Tuberculosis

In Pakistan, TB is a public health problem with a high incidence. Proper screening and prophylaxis is indicated for this population.

Arthritis

There is an increased incidence of arthritis in Pakistani women mainly due to environmental factors. Obesity, a high fat diet and less walking also increase the risk.

Genetic Conditions

A study in the United Kingdom (Darr, 1988) showed that about 55% of Pakistani marriages were between first cousins. This may put them at a higher risk for certain diseases, such as the thalassemias.

Health Insurance

Approximately half of the Pakistani older adults living in United States do not have health insurance. Most of them do not work and are dependent on their children who cannot afford their parents' health insurance. If they do work, they are either self-employed or they work in small businesses that don't provide health insurance for them.

Dental Problems

Pakistani immigrants are at high risk for dental problems due to paan chewing and tobacco smoking. In addition, the high cost of dental care can be a financial burden.

“ There is an increased incidence of arthritis in Pakistani women mainly due to environmental factors. ”

Mental Health Problems

Poor social support and economic hardship are important mediators of mental health among immigrants. Feelings of loneliness, insecurity, bitterness and anxiety also increase the incidence of mental problems.

Health Problems for New Pakistani Immigrants

Source: Hawn & Jung 2003, Kemp 2004, In-depth, 2006, WHO 2009

Amebiasis

Mainly seen in immigrants from small towns and rural areas due to unhealthy hygienic and poor sanitary conditions.

Dengue Virus

There is an increase in the number of dengue virus cases in Pakistani immigrants in the last decade. Most cases are seen in immigrants from rural areas.

Hepatitis B

Hepatitis A and E occur, and hepatitis B is endemic. It is more aggressive due to co-infection and super-infection with delta virus. Intra-familial spread of hepatitis B is quite high. Pakistan has a high carrier rate of hepatitis B: between 10 to 14 percent according to ELISA and RIA analyses respectively.

Hookworm

Hookworms are among the most widespread of human parasites and occur all over the tropics and subtropics. They are bloodsucking roundworms that inhabit the duodenum and jejunum. Usually the infection is mild

(PATTERNS OF HEALTH RISK CONT'D)

(hookworm carrier state), but sometimes the infection is heavy and results in anemia and/or hypoproteinemia (hookworm disease). Hookworms are occasionally imported to the United States by immigrants.

Submucosal Fibrosis

This condition is related to chewing paan, a quid of betel leaf, areca nut and tobacco. Submucosal fibrosis results in an increased prevalence of oral cavity cancer.

Thalassemia

Thalassemia is one of the most common inherited hemoglobin disorders in Pakistan. The carrier frequency is estimated to be 5.4%. In Pakistan, 5 out of 100 people are thalassemia patients and around 8 million people are thalassemia carriers. Thalassemia reduces the amount of hemoglobin in the human body leading to anemia.

Malaria

According to the United Nations World Health Organization (WHO), Pakistan has been classified as a country with moderate malaria prevalence and relatively well-established control programs. Despite this, the disease is estimated to cause at least 50,000 deaths out of an estimated 500,000 reported malaria cases every year.

Tuberculosis

Pakistan ranks eighth on the list of 22 high-burden tuberculosis (TB) countries in the world, according to the World Health Organization's (WHO's) Global Tuberculosis Control 2009. In 2007, an estimated 297,108 people in Pakistan (primarily adults in their productive years) developed TB. The emergence of multidrug-resistant (MDR) TB and TB-HIV co-infection is a growing concern in the country.



Display of the items used in a paan chewing session, often the cause of sub mucosal fibrosis. The betel leaves are toward the bottom center and folded. The upper left shows slices of the dry areca nut, while the upper right displays slices of the tender areca nut. A pouch of tobacco is shown on the far right; tobacco is a recent introduction to the chewing of paan.

Source: <http://en.wikipedia.org/wiki/Paan>. Public Domain.

CULTURALLY APPROPRIATE GERIATRIC CARE: FUND OF KNOWLEDGE

Traditional Health Beliefs

Spiritual Peace

Islam does not believe in mind-body dualism. Maintaining spiritual peace is thought to be an essential part of health. Elderly immigrants who are often bound to traditions may believe that disease can be a direct punishment from God for sins committed.


Following religious teachings and not doing evil, therefore, is viewed as an integral part staying healthy. Elders, especially women, may try traditional folk medicine initially when illness strikes and seek allopathic medical help only when the suffering due to the disease becomes intolerable.


Imbalances



Physical and mental illness may be attributed to an imbalance between person and environment. Influences include emotional, spiritual and social state, as well as physical factors like hormonal imbalance.

Cold and Hot Diseases

Humoral changes expressed as too much heat or cold are also important:

 **COLD DISEASES:** Menstrual cramps, pneumonia, and rhinitis. Cold diseases are treated with hot medications or food such as meat, tea and sugar.

 **HOT DISEASES:** Hypertension, pregnancy, skin rashes, tooth aches and acne. Hot diseases are treated with cold medications and food like fresh fruits, rose petals and other herbs.

 **HOT AND COLD:** Stroke or transient ischemic attacks
 are believed due to alternate hot and cold exposure.

Proper treatment of diseases based on heat and cold is believed to bring balance to life.

“ Elderly immigrants who are often bound to traditions may believe that disease can be a direct punishment of God for sins committed. ”

Traditional Health Beliefs among Pakistani Americans

Several traditional health beliefs prevail among many Pakistani Americans. One example is phenomenon of the evil eye (ain-al-hasud), one of several supernatural origins of disease. According to the Koran, it is the belief that one can project harm or misfortune on other by admiring that person's possession with jealousy or envy.

To avert the evil eye blue beads or charms with verses from the Koran are worn. These are called taawiz. The taawiz are symbols of Islamic faith, given by the Maulvies (Moslem priests) and worn by adults to cure and prevent illness caused by the evil eye, ghosts, or spirits.

Consultations with the Pir or Fakir (holy men) and visits to shrines and tombs (Pir's Ziarat gahh) are believed to prevent and cure many physical and mental illnesses, including those caused by ghosts and spirits. Holy water from Pir tombs can be drunk or rubbed on the body of the sick. These practices vary by education, social class, and degree of religiosity; many from professional families lean toward Western medical practices and do not visit shrines.

(FUND OF KNOWLEDGE CONT'D)

Health Systems in Pakistan

There are three types of health systems in Pakistan:

1. Allopathic
2. Homeopathic
3. Unani

The type of health system utilized depends on patients' health beliefs, social status and education levels.

Allopathy

The use of western medication (i.e., antibiotics) is common even in rural areas. These medicines are available at pharmaceutical stores without prescriptions and anyone can have access to them.

**Homeopathy**

Homeopathy is a form of alternative medicine first defined by a German, Samuel Hahnemann, in the 18th century. A central thesis of homeopathy is that an ill person can be treated using a substance that

can produce, in a healthy person, symptoms similar to those of the illness. Practitioners select treatments according to a patient consultation that explores the physical and psychological state of the patient, both of which are considered important in selecting the remedy. The homeopathic path is followed by people in Pakistan who believe that allopathic medicine has a considerable number of side effects.

Unani

Unani is the traditional health system of the Moslems. Unani (literally "Ionian" or Greek) or hikmat, is a form of therapy based on the humoral theory of Hippocrates

According to Unani, there are three states of the body:

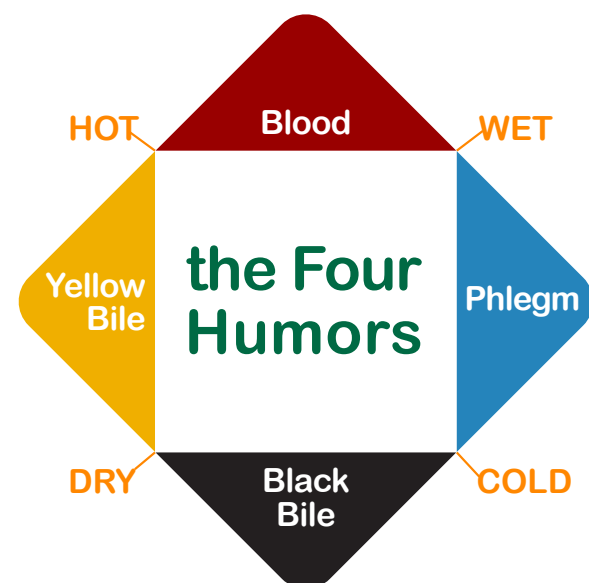
1. Health,
2. Disease, and
3. The neutral state between the two when one is not truly healthy but the signs of disease are not fully manifest.

Unani also propounds the six primary factors in relation to health and disease:

1. The air of one's environment,
2. Food and beverages,
3. Movement and rest,
4. Sleep and wakefulness,
5. Eating and evacuation, and
6. Emotions

These six factors must be properly apportioned in quantity, quality, time, and sequence in order for a person to be healthy. Diseases are caused when the functions associated with the vital, natural, and psychic forces of the body become "obstructed," or unbalanced, owing to a deviation in the humor away from its characteristic temperament.

The Hakim (Unani practitioner) after identifying the imbalance will then often recommend, among other things, appropriate foods that are specifically chosen to correct the imbalance and restore equilibrium. Unani medicine is usually made of herbal plants and contains no animal products.



Adapted from: <http://www.drgrotte.com/Unani.shtml>

(FUND OF KNOWLEDGE CONT'D)

**Cultural Beliefs and Practices:
Other Influences**

According to Al-Jibaly (1998) a sick person should remember that his sickness is a test from God which carries tidings of forgiveness and mercy for him. Thus, he should avoid complaining about his affliction; accept it with patience and satisfaction and asking God to reduce his suffering. Patients may consider an illness as atonement for their sins, and death as part of a journey to meet their God. Illness is thought to be one of the forms of experience by which humans arrive at knowledge of God.

Every year during the month of Ramadan (called “Ramzan” in Pakistan), Pakistani Muslims fast from first day light until sunset. Ramadan is the ninth month of the Muslim lunar calendar, Al-Hijrah. During the Fast of Ramadan, Moslems are not allowed to eat or drink during the daylight hours. Smoking and sexual relations are also forbidden during fasting. At the end of the day the fast is broken with prayer and a meal called the iftar. The fast is resumed the next morning and continues for the whole month of Ramadan.

It is believed that fasting teaches obedience to God and is required only by adults who are physically capable and mentally competent. Elderly people, ill people, travelers, pregnant women, lactating mothers, menstruating women, women with postpartum discharge, and women who have experienced a miscarriage are exempt from fasting. The physiological effects of fasting include lowering of blood sugar levels, lowering of the cholesterol level and lowering of the systolic blood pressure. Also spiritually it draws Moslems closer to their creator.

“ **Religious Moslems eat only Halal (lawful or sanctified meat) and do not eat blood, porcine meat or Haram (non-sanctified) meat.** ”



Men praying at a mosque. Most Pakistani older adults believe diseases can be a punishment from God for committing sins, so they find peace in praying.

Photo courtesy of Mariam Hasan.

Namaz

These are obligatory prayers that are performed five times a day at designated times. Also many traditional Moslems go to the Masjid (Mosque or Islamic Church) on Fridays to offer special prayers. It is important to schedule medical visits appropriately in order to avoid conflicts with namaz. Care givers may need to provide a clean sheet required by women to cover them during prayers.

Wudu

Wudu is the ceremonial washing that is done before prayer and debilitated patients may need help performing wudu. Providers should take care to preserve the cleanliness of the patient's clothes and covers from urine as much as possible, and to help the patient wash or wash him/her for prayer. If there is difficulty or danger in using water then a dry Wudu called Tayamum is acceptable.

Religious Moslems eat only Halal (lawful or sanctified meat) and do not eat blood, porcine meat or Haram (non-sanctified) meat. This means that all forms of pork, such as bacon and ham, are forbidden to Moslems.

CULTURALLY APPROPRIATE GERIATRIC CARE: ASSESSMENT

Important Cultural Issues

Old age is respected in Pakistan. Older adults should be treated with utmost courtesy and respect. During the medical interview with the Pakistani older adult it is important not to forget that formality and respectfulness must be conveyed during the meeting. Appearance is emphasized, and it is also important to sit up straight in meetings and, when standing, to avoid putting one's hands into one's pockets. In conversation, extended direct eye contact can be considered rude.

Same-sex care providers are usually preferred. If a same-sex provider is not available, then examine a female patient in the presence of another female (chaperone) or a female relative (except in medical emergencies).

Care providers should respect elderly female modesty and privacy. Muslim patients, particularly women, may need a special gown to cover the whole body in order to avoid unnecessary exposure during physical examination. Some examinations may be done over the gown.

Allow patients' Imams (religious teachers) to visit them and pray for them. Priests of other faith traditions can pray for or with Muslim patients with patients' permission, using non-denominational words like God.

Nursing homes are not considered a good option because Pakistani cultural values emphasize on caring for elderly parents at home. Also, factors like the level of caregiver's adherence to Asian cultural norms and the older adult patient's marital status play an important role in placing an older adult Pakistani in a nursing home. Older women who have male caregivers at home prefer nursing home care by females.



Most, but not all, older adults from Pakistan are Muslim. Religious preference should be asked rather than assumed and religious beliefs should be respected.

Older adults may not speak English (especially the women) and may be able to converse only in Urdu or Punjabi. Usually they are accompanied by younger relatives who can serve as translators. However, periodically, it would behoove the clinician to use professional interpreters just to make sure that all of the elders concerns are being addressed. This is especially true for elderly women who are brought by their male relatives and out of modesty may not share intimate personal details. Same-sex professional interpreters would be ideal when dealing with elderly women.

Direct eye contact is considered rude and should be avoided, as should unnecessary touch between nonrelated people of the opposite sex.

Older Pakistanis may wear religious paraphernalia e.g.: taawiz (amulet) or topi (religious cap). These should not be removed without the permission of the owner.

The prayer rug and the Koran must not be touched by anyone ritually unclean (e.g., with blood or urine on the hands), and it is preferable that nothing should be placed on top of these sacred objects.

Pakistani food varies from region to region, but most of it is curry-based and spicy. It is similar to North Indian food served in many Indian or Pakistani restaurants in North America. Dietary staples include meat- and vegetable-based curry and basmati rice or chapatti (unleavened whole wheat bread). Pakistani food has a high salt and fat content. Most Pakistani American older adults will find the U.S. hospital food bland and tasteless, and may ask family members to bring food from home.

Hand washing is considered essential before and after eating. Water for washing is needed in the same room as the toilet; Pakistani patients should be provided with bowls or jugs of water in the toilet. If a bedpan has to be used, bowls or jugs of water should also be provided at the bedside.

(ASSESSMENT CONT'D)**Sensitive Issues**

Questions about sexuality are considered to be extremely delicate and personal. Therefore, questions about sexuality should be asked with extreme sensitivity. Asking widowed, unmarried and divorced women about their sex life is a cultural faux pas and can be taken to be an extreme insult. Older women prefer not to change into a gown even with the same-sex provider unless absolutely necessary. It may also be difficult to elicit intimate details such as bodily functions and sexual history when the health care provider interviews the female patient.

Gender Issues

It is commonly believed in Pakistani society that the primary duty of women is to stay home to take care of kids and family. But since economic conditions are getting tougher, women are overburdened both by working outside the home and taking care of household tasks.

Even highly acculturated Pakistani Americans regard it as natural for adult children to be responsible for aging parents and to provide care for them at home. Women customarily are the designated primary caregivers to home-dwelling Pakistani American elders. Such situations in the Pakistani American community result in a high degree of burden when caregivers feel the traditional pressures of providing all elder care personally within the home setting.

Eliciting the Patient's Perspective

The care provider can try to elicit the patient's illness narrative (sometimes called explanatory model of illness) by asking some of the following questions to gain a better understanding of the patient's point of view.

1. What do you call the problem? (e.g. Epilepsy is believed to be Mirgi, caused by evil spirits and instead of seeking medical help, religious specialists called pirs are sought out to exorcise these jinns.)

2. Why do you think this illness or problem has occurred? (e.g., patient may feel that the problem is a punishment given by God for bad deeds committed or due to failure to pray.)

3. What do you think the illness does? (e.g., patient may feel that the illness is washing away her/his sins and would resolve once the sins are washed away or by doing certain religious rituals.)

4. What do you think is the natural course of the illness? What do you fear? (e.g. patients may either have undue fear of the disease or on the other hand may trivialize the disease and feel that it can be resolved by prayer.) It is important to understand the patient's bias so that appropriate education can be provided.

5. How do you think the sickness should be treated? (What alternative therapies are you using currently?) How do you want us to help you? These questions should be addressed sensitively so as not to convey an impression of clinical incompetence to the patient and family. Once the patients' expectations are known, then therapy could be modified to suit their needs, if possible.

6. Who do you turn to for help? Who should be involved in decision-making? Pakistanis have a close knit family structure and the family unit often makes important decisions.

Once the care provider is better able to understand the patient, a trusting relationship can be established, thus leading to better outcomes for both patient and provider.

CULTURALLY APPROPRIATE GERIATRIC CARE: DELIVERY OF CARE

Decision Making and Disclosure

Pakistani culture emphasizes the individual as a part of a family unit, and decisions are made collectively. Pakistani elders will often involve family members in decision making, and an important health decision will commonly involve their conferring with and relying on a son or daughter.

When illness strikes a member of the Pakistani family, it is the family rather than the patient who takes center stage in this process. In the case of a conscious patient, the family and physician will generally protect the patient from the anxiety and distress associated with the knowledge of impending death. This is done by not disclosing the diagnosis or disclosing it in ambiguous terms. When faced with this situation, the clinician should verify that the patient is comfortable with letting the family make his/her health care decisions.

Saying something like: “Mr. Shiekh, I am told that you prefer to let your family make all health care decisions for you and that you would prefer not to know your diagnosis. Is this a correct assumption?” will help confirm the patient’s stance.

If the patient prefers not to know about his/her medical condition, this should be respected. Autonomy is the right to choose, and so patients have the right to choose to remain ignorant about their diagnosis. If the older adult has cancer, treatment options can be discussed with him or her, but it is recommended that the word “cancer” not be used.

It is also believed that the physician is the authority in matters relating to disease and medical interventions. She or he is often symbolically inducted into the family and is expected to direct rather than just facilitate medical management.

Advance Directives/End-of-Life Issues

Asians were more likely than whites to select less aggressive interventions but were unlikely to use written advanced directives. (Eleazer, GP et.al., 1996). Active end of life care planning is an unfamiliar concept to most Pakistani older adults. Care providers who have discussions about advance directives and advance care planning should remember that the older adults might be reluctant to participate in these discussions, as they may believe that talking about death may make it a reality. Worse yet, the older adults may believe that the physician is subtly implying that they (the older adults) have a serious illness and that they are dying. Extreme tact and sensitivity are called for when having these discussions. Ensure that you have adequate time and that patient’s family is present and engage a professional interpreter if possible.

Artificial Support

Maintaining a terminal patient on artificial life support for a prolonged period in a vegetative state is not encouraged in Islam. Also, in Islam, withholding food is forbidden. So providers should be very sensitive to issues regarding withdrawal of tube feedings.

Home Care

Pakistani older adults most commonly may wish to die at home, surrounded by their family and community members. Whenever this is requested, the sensitive clinician may wish to facilitate a patient’s return home, to be cared for there until death.

Gender of Nursing Staff

Pakistani older adults often have a strong preference that care be given by same-sex nursing staff. This is especially true when dealing with the dead body.

(DELIVERY OF CARE CONT'D)**Gathering Family and Friends**

Whether at home or in a hospital, a Pakistani American patient may expect to have family and friends gathered around for a final farewell when death is approaching. This is traditionally an important event in the Pakistani community, allowing a dying person to put right, before death, anything he or she feels is wrong in relationships with family, friends or community. Visiting the sick is a sacred duty according to Islam, as well as a last opportunity to show respect to a fellow Muslim and the family.

Death Rituals

Moslem elders have extensive death rituals, including ceremonial washing of the body with water, directional positioning of the body towards the Holy Land of Mecca, and recitation of the Holy Koran by the relatives. When a patient is dying, the individual should be made to lie facing the direction of the Qiblah (in the direction of the city of Mecca), lying on his/her right side.

If this is not possible, then it is acceptable to allow the individual to lie on his or her back with the face and soles of the feet facing the direction of the Qiblah. In North America the direction of the Qiblah is the Southeast. Loved ones usually recite verses from the Koran.

Caring for the Deceased

Unrelated people should avoid skin contact with the body of the deceased, because it is believed that the body belongs to Allah. The nurse, therefore, should wear gloves at all times after the patient's death. When caring for the deceased, the nurse should close the patient's eyes; wrap the head with gauze dressing to ensure that the lower jaw is closed; flex the elbows, shoulders, knees and hips before final straightening (this is believed to ensure that the body does not stiffen and aids in purification).

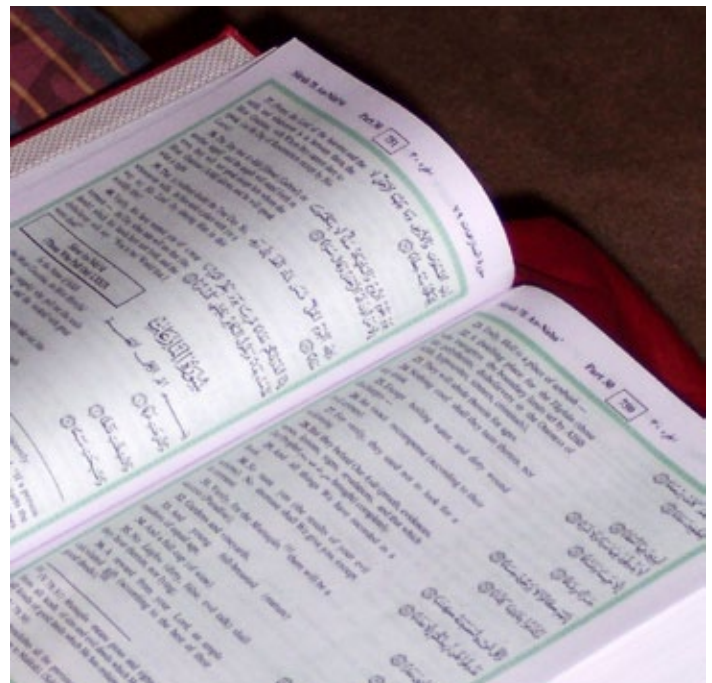
“ Unrelated people should avoid skin contact with the body of the deceased, because it is believed that the body belongs to Allah. The nurse, therefore, should wear gloves at all times after the patient's death. ”

Eliciting Personal Preferences

Eliciting the family's personal preferences for care of the remains of their loved one in a sensitive and gentle manner and facilitating and supporting their rites and rituals as much as possible will go a long way toward alleviating the distress of a Moslem family who may be intensely grieving the loss of their loved ones.

Autopsies

Strict Muslims do not want autopsies performed on family members except for medical or legal reasons, and embalming of the deceased is not permitted unless it is mandated by law.



INSTRUCTIONAL STRATEGIES: CASE STUDIES

In addition to lecture and reading assignments, the following case can be used for discussion or written assignments.

Case of Mrs. P

It's 4:45 PM on a Friday afternoon in August, and the air conditioning is unsuccessfully fighting a valiant battle against the angry San Jose, California sun and clearly failing. The waiting room has been full all day with hot, irritable patients. Sitting in your office, you haven't had time to think about how irritable and hot you are. You look at your watch for the third time in as many minutes. You have committed yourself to leave for vacation with your wife and kids as early as possible this afternoon, and you have one more patient to see before your vacation begins.

You read through the chart of Mrs. P, a 65-year-old Pakistani lady. Mrs. P. moved to California from Islamabad three years ago. You note her medical history is significant for hypertension and occasional insomnia. She has never had a mammogram done. Her hypertension has been moderately well controlled for many years on hydrochlorothiazide 25 mg QD. Recently she was started on doxepin 10 mg qhs for insomnia.

You remember Mrs. Parvez as a shy retiring lady who is usually brought in by her son. Mrs. Parvez is moderately proficient in English and speaks with a thick accent. She also usually lets her son do most of the talking and you remember that you have to persist tenaciously to get her to talk.

Just as you are almost sure that Mrs. Parvez is a 'no-show' today and you switch into your 'vacation mode', your nurse Alicia pops her head in and cheerily announces that "Mrs. P___ has been roomed" and that she is due for her breast exam and Pap smear.

You pick up the chart and walk into the patient's room. Mrs. P is sitting on the exam table and her son Mohammed gets up to greet you. After the initial pleasantries, you say that you want to do a routine

exam and a pap smear. You give Mrs. P an exam gown and tell her to undress and change into the gown, and you leave the room saying that you will be back in a few minutes.

Ten minutes later you walk into Mrs. P's room only to find that it is empty. Astonished, you walk into the waiting area just in time to see Mohammed's car pulling out of the parking lot! Perplexed, you have the clerk reschedule Mrs. P. to be seen in 2 weeks time and request Alicia to call Mrs. P. the next day to follow up. You then hastily leave as your wife is paging you for the third time in 10 minutes. As you pick up your car phone to call your wife you cannot help wonder about Mrs. P. and Mohammed and their sudden departure...

Discussion Topics:



Cultural issues that may be involved in this case—

1. What could account for the sudden departure of Mrs. P. and her son?
2. In a culturally competent practice, what would have been done differently?
3. What might be done by Alicia and the physician to try to repair the relationship?

(INSTRUCTIONAL STRATEGIES: CASE STUDIES CONT'D)

Case of Mr. M

Mr. M, a 76-year-old Pakistani male, is brought to the outpatient clinic for evaluation of gait unsteadiness. He has been diagnosed with renal cell cancer with metastases to the lungs. His wife passed away one year ago, and he had to move to America as all his children have settled here. He is a farmer from Punjab and only speaks Punjabi. A left hemiparesis is found during the examination and the internist wants to get a head CT to rule out brain metastases. His eldest son, who also serves as his translator, accompanies Mr. M and says that he is the primary decision maker for Mr. M. who confirms this statement.

The son takes the doctor aside and requests that she should not tell the patient about suspicion of brain metastases. He agrees with getting the head CT and obtaining a radiation oncology and oncology consult, but requests that all these doctors not mention the word “cancer in the brain.” They can discuss treatment without mentioning the word “cancer.” He thinks if his father knows about the cancer in the brain, he will give up the will to live.

The son still believes that his father will be cured of the cancer. In addition to the allopathic treatment, the family is also consulting with a spiritual healer in New York who has assured them that the cancer will be cured in six months.

The CT scan of the head shows a large brain mass on the right side causing cerebral edema and midline shift. The patient is started on oral corticosteroids and radiation therapy. The spiritual healer in New York has given Mr. M. and his son butter that is blessed by holy words, and they apply it to his head, lungs, and abdomen. Mr. M. develops dermatitis on the scalp, and is told by the radiation oncologist not to use this “hair oil”. The patient stops eating and drinking and becomes very weak and is admitted to the hospital.

Multiple attempts to address advance directives with the son have been unsuccessful. The son wishes his father to be a full code. He believes his father will be cured and

it is in Allah’s hands. He gets angry with the doctors and thinks they just want to get rid of his father because they want to save money. The palliative care team in the hospital is consulted and they obtain a translator who is not related to the patient. The interview is conducted at a time when family is not present. During the interview, the patient starts to cry, and says multiple times that he wishes he were dead. He says he is so ashamed of the fact that he can’t walk and that his daughter-in-law has to help him get in and out of bed.

He is even more ashamed about the fecal and urinary incontinence and that his daughter -in-law has to see him naked and clean him. He says nothing can be worse than this. He does not want to go to New York, but he knows that his son still believes he can be cured and wants to go on. He does not want to share his thoughts with his family, as he does not want them to think of him as a weak person. He still defers all decisions regarding his health care to his oldest son, but wishes that the son would give up and face the reality that he is dying and let him die in peace.

**Discussion Topics:**

1. Communication about the diagnosis
2. Autonomy vs. family decision making
3. Patient’s wishes vs. cultural norms
4. Advance directives

STUDENT EVALUATION

Objective Test (five questions total)

For answer key, see page 20

1. Mrs. Amin, a 76-year-old highly functional lady, is dropped off in clinic by her busy son, who will be back later to pick her up. Mrs. Amin came to see you a few weeks ago is here for follow up of a CT scan of her abdomen. You want to talk to her about end-of-life issues today. You should (*choose one*):
 - ☐ A. Ask her preferences about resuscitation and other end-of-life issues.
 - ☐ B. Make her a 'do-not-resuscitate' as you feel that you know her well and are quite sure that this is what she would want.
 - ☐ C. You would never talk to a Pakistani lady about end-of-life issues, ever.
 - ☐ D. You should ask her to bring her son with her for the next visit.
2. Mr. Ibrahim, a devout Moslem with a history of hypertension, returns to clinic after 3 months and tells you that he has not been taking his medicine. You should (*choose one*):
 - ☐ A. Ask him if he has any reservations/concerns about taking the medicine.
 - ☐ B. Refer him to a Moslem physician who has a better chance of understanding him.
 - ☐ C. Stop the old medicine and add a new and experimental medicine.
 - ☐ D. Pretend to ignore his non-compliance; after all, it is his life and his choice to make.
3. You are a nurse who has been caring for Mr. Asraff an 80-year-old man who just died of prostate cancer in the VA Hospice Care Center. He has no family or friends. Earlier he had requested you to turn him in the direction of the Qiblah as soon as he dies. You should (*choose one*):
 - ☐ A. Do nothing; Islam forbids you to move Mr. Asraff's physical remains.
 - ☐ B. Turn Mr. Asraff's physical remains to face East.
 - ☐ C. Turn Mr. Asraff's physical remains to face Northeast.
 - ☐ D. Turn Mr. Asraff's physical remains to face Southeast.
4. Mrs. Nawaz is a 65-year-old lady with poorly controlled diabetes. You talk to her about starting insulin. Mrs. Nawaz looks uncomfortable, takes the insulin prescription, and does not fill it; nor does she return to see you again. Why do you think Mrs. Nawaz will not take insulin? (*choose one*)
 - ☐ A. She does not trust you anymore and so will not listen to you.
 - ☐ B. She has decided to give up and die and so will never seek medical care again.
 - ☐ C. She is uncomfortable taking insulin, which she knows may be derived from porcine pancreas.
 - ☐ D. She is afraid of pain caused by insulin shots.

(STUDENT EVALUATION CONT'D)

5. You want to start a support group for elderly Pakistani immigrants. Your group meets on Fridays. Though you had a lot of eager elders who were interested in coming to the group initially only 2 of the 40 elders who signed up come to the group. What should you do now? (*choose one*)

- ☐ A. Stop the support group. Support groups are taboo in Moslem culture.
- ☐ B. Serve coke and pepperoni pizza to draw in the elders.
- ☐ C. Just work with the 2 elders who came. After all quality is more important than quantity.
- ☐ D. Move your support group to another day of the week.

**Answer Key**

1. (D) Many older Pakistani women may prefer to defer decision making to their sons or daughters.
2. (A) Mr. Ibrahim may consider an illness as atonement for his sins. Illness is thought to be one of the forms of experience by which Moslems arrive at knowledge of God. Sensitive questioning and gentle persuasion/education is called for when faced with this communication barrier.
3. (D) In North America the direction of the Qiblah is the southeast.
4. (C) All forms of pork, bacon, etc. are forbidden to Moslems. Explaining that you could specifically prescribe non-porcine insulin will make Mrs. Nawaz more willing to take insulin.
5. (D) Many traditional Moslems go to the Masjid (Mosque or Islamic Church) on Fridays to offer special prayers.

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