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Improving cultural competence in end-of-life pain management

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MANAGING PAIN is a central component of end-of-life care, and nurses are in a prime position to relieve pain and suffering throughout the dying process. But as the United States continues to become more ethnically and culturally diverse, healthcare providers face increasing challenges as they care for patients with different cultural values.

Cultural competence is especially important in end-of-life care because cultural beliefs, values, and experiences shape each patient's definition of a "good death." This article will discuss cultural factors that may influence end-of-life pain management, describe methods for incorporating cultural sensitivity into pain assessment, and offer suggestions for improving nurses' ability to care for

culturally diverse populations at the end of life.

What is pain?

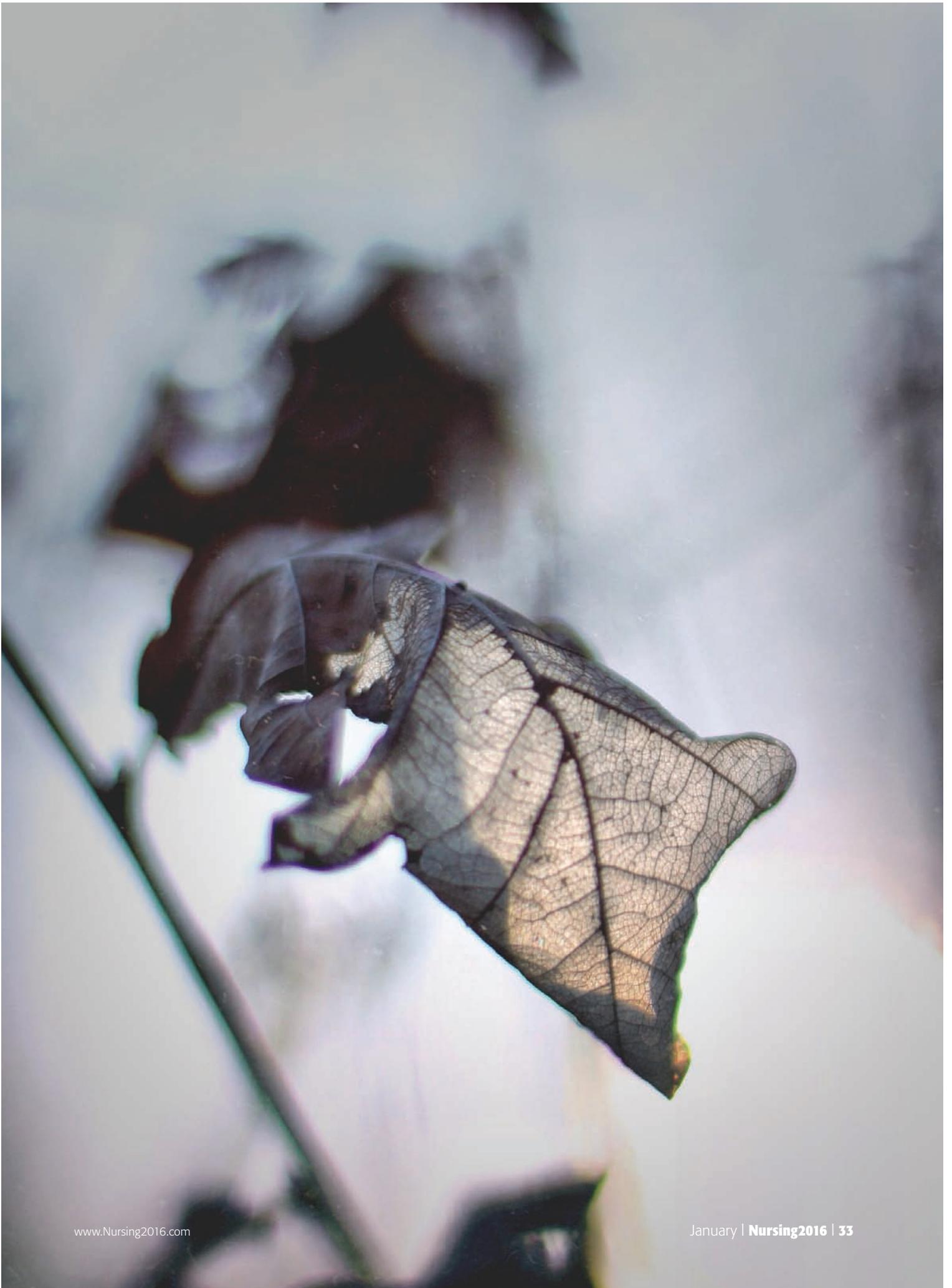
Pain is a subjective, physical, and emotional experience shaped by cultural values and beliefs.¹ It's been described as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" by the International Association for the Study of Pain.² But McCaffrey's landmark definition, "pain is what the experiencing person says it is, existing whenever he says it does," is particularly helpful when discussing pain in culturally diverse populations.³

Pain is among the most common symptoms experienced at the end of

life. Smith et al. found that in a nationally representative sample of older adults, the prevalence of moderate-to-severe pain during the last month of life was 46%.⁴ This statistic illustrates the importance of pain management, including frequent assessment and adjustment of pain interventions at the end of life.

Palliative, hospice, and end-of-life care

The World Health Organization describes palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering."⁵ Palliative care is appropriate for patients at any point in the course of



illness. For example, a patient newly diagnosed with chronic obstructive pulmonary disease may seek palliative care services to relieve symptoms of activity intolerance or breathlessness.

End-of-life and hospice care are synonymous terms that describe specific forms of palliative care provided to patients throughout the dying process, particularly during the last 6 months of life. Additionally, end-of-life care focuses on comfort measures as opposed to curative measures.⁶ Research has shown that all these services are underutilized by patients in certain cultural groups. (See *Disparities in end-of-life care*.)

How patients view pain and death

Cultural beliefs surrounding pain and death affect patients' attitudes and preferences in end-of-life care. In some cultures, openly discussing death is inappropriate. For example, Cheng et al. conducted a survey of East Asian palliative care physicians.⁷ Seventy percent of participants from Taiwan reported that patient family

members were reluctant to discuss end of life. Fifty-six percent identified the cultural belief "bad things happen after you say them out loud" as a reason family members avoid end-of-life discussion. Consequently, families may avoid discussing death to avoid bad luck or tempting fate.

Certain cultural groups may request that healthcare providers withhold disclosure of a terminal diagnosis to protect the patient. In some Asian cultures, these requests stem from a desire to preserve hope or to prevent emotional suffering in the dying patient.⁸ Healthcare providers must consider such beliefs before approaching patients with news of a poor prognosis.

These beliefs can be a significant barrier to the initiation of pain management at the end of life. Researchers have found that oncologists often cite family reluctance to discuss end-of-life issues with patients as a major barrier to initiating pain management in dying patients.⁹ Providers may misinterpret a reluctance to discuss impending death as a refusal of pain treatment.

Similarly, cultural beliefs about the origin, role, and meaning of pain can affect how a patient perceives pain. Many beliefs regarding pain stem from religion and spirituality; for example, some religious groups believe pain is a part of God's plan, a penance for sins, or a test of faith. In contrast, other cultures ascribe positive meanings to pain; for example, some patients may believe in the mantra "No pain, no gain." These patients may view pain as a sign of progress toward recovery. Chinese patients may believe pain results from an imbalance between yin and yang, which has its roots in Taoism, Buddhism, and Confucianism.¹⁰

Similarly, cultural beliefs affect how patients express pain. Many cultures have negative attitudes toward expressing pain outwardly; for example, Black American, Hispanic American, Asian American, and

American Indian patients may be reluctant to complain of pain due to strong cultural beliefs in stoicism.^{11,12} As a result, these patients may prefer to keep a neutral face and avoid grimacing, crying, or moaning, even if their pain is severe. Stoic pain behavior can lead to inaccurate pain assessments if nurses interpret the lack of observable cues such as facial expression, body posture, crying, or moaning as the absence of pain.

In a systematic review of the literature, Cintron and Morrison found that providers were more likely to underestimate the severity of pain in Black American and Hispanic American patients compared with White American patients.¹¹ This underestimation could be associated with Black American and Hispanic American patients' preferences for stoicism.

In addition, cultural beliefs may affect self-report of pain. A study of cancer pain experience found that Asian Americans reported significantly lower pain scores than Black Americans, Hispanic Americans, and non-Hispanic White Americans. Interestingly, there were no differences in severity of symptoms associated with cancer pain, such as lack of energy, shortness of breath, or difficulty sleeping.¹² Asian Americans may believe that they should endure pain bravely to serve as a role model for others or to improve their standing in life after death.^{10,13} In these cultural groups, decreased pain expression may lead providers to assume the absence of pain, causing under- or nontreatment of symptoms.

Decision-making preferences

Cultural values influence how patients make healthcare decisions. Western cultures, for example, strongly value independence and autonomy.^{8,14} However, many non-Western cultures place more impor-

Disparities in end-of-life care

Healthcare disparities in culturally diverse populations have been well documented in the literature, which demonstrates that end-of-life care services are underutilized by culturally diverse populations. For instance, the National Hospice and Palliative Care Organization found that non-White patients accounted for less than one-fifth of hospice patients in the United States in 2012.⁶ The Agency for Healthcare Research and Quality found that Black Americans, Asian Americans, Pacific Islanders, American Indians, Alaskan Natives, and non-White Hispanic Americans were all less likely than White Americans to receive end-of-life care consistent with their wishes.⁵⁶

tance on collectivism and community.¹⁴ Members of such cultures may prefer to make healthcare decisions as a family. Xue, Wheeler, and Abernethy found that many Chinese patients preferred to have their families discuss serious illness with providers.¹⁵

Furthermore, many Asian cultures have strong beliefs in filial piety, a duty to care for parents or older family members. For instance, Korean families may want to make treatment decisions for older adult patients because such decisions are emotionally burdensome.¹⁶

In a literature review, researchers found that Mexican Americans and Black Americans preferred to make healthcare decisions as a family, viewing autonomy as isolating and burdensome.¹⁷

Research has demonstrated that religion and spirituality can strongly influence healthcare decision making.^{8,18} Silvestri, Knittig, Zoller, and Nietert found that patients with advanced lung cancer ranked faith in God as the second most important factor in treatment decision making, whereas physicians ranked this factor last.¹⁹ Nurses need to consider the role of religion and collectivism when discussing the decision to move toward end-of-life care with patients and their families.

Lost in translation

The concepts of hospice and end-of-life care may have different meanings when translated into different languages.²⁰ Misconceptions about what constitutes hospice care can be a barrier to hospice enrollment among patients with limited English proficiency. For instance, in Mexico, the Spanish word *hospicio* refers to an orphanage for poor homeless children. In Chile and Ecuador, *hospicio* describes an asylum.²¹ Because of these definitions, Spanish-speaking patients and fam-

Tips to improve cultural competence in end-of-life pain management

- Be aware of different cultural beliefs surrounding end-of-life care. Ask the patient about his or her preferences for decision making. Should you talk with the patient directly, together with his or her family, or with the patient's family alone? Use a professional medical interpreter to ensure understanding.
- Discuss pain management at the end of life. What does pain mean to your patient? Does the patient want relief from pain, and if so, how should it be treated? Provide both pharmacologic and nonpharmacologic options for pain management. Address any knowledge deficits surrounding the use of opioids at the end of life. Discuss any desired folk remedies or complementary therapies, verify their safety, and incorporate them into the plan of care whenever possible.
- Use validated pain assessment tools to evaluate the effectiveness of pain interventions. Ensure that the patient understands how to use them correctly. Remember to interpret pain scores in light of the patient's cultural beliefs.
- Don't neglect to assess for spiritual pain. Collaborate with spiritual advisors and healthcare chaplaincy to help patients and families make peace with their death, if the patient desires. Accommodate patient and family requests for time and space for praying, meditation, and other rituals.
- Pursue further education in providing end-of-life care. Support initiatives to increase public awareness of the benefits of hospice.

ilies may believe hospice is for abandoned patients.

Besides problems with translation, end-of-life care may have negative cultural connotations. Black American patients may have negative attitudes toward end-of-life care due to distrust in the healthcare system and a preference for life-sustaining treatment.^{22,23} Armstrong et al. proposed that a higher level of distrust with the healthcare system among Black Americans is due to more frequent experiences of racial discrimination compared with Whites.²⁴ Examples include the notorious and unethical Tuskegee study, in which hundreds of Black men with syphilis were studied for decades without their consent and denied treatment as part of a U.S. Public Health Service study of the "natural course" of untreated syphilis.²⁵ The historical denial of aggressive, disease-oriented treatment for Black American patients has helped to shape cultural attitudes.^{23,25} Thus, when healthcare providers recommend end-of-life care, some Black American patients may per-

ceive this as withholding curative treatment.²⁶ Hospice bridge programs allow patients to begin palliative care while continuing life-sustaining treatments; these programs may be more acceptable to Black American patients than traditional end-of-life care, which focuses on comfort measures alone.²²

Similarly, some cultural groups may believe that end-of-life care is incongruent with certain cultural values. Many Asian cultures stress the importance of filial piety and a respect for parents and ancestors. Because of these values, Asian American families may believe it's solely their responsibility to care for aging parents. Such families may consider professional end-of-life care, particularly institutionalized care, a failure to fulfill this responsibility.²¹

To increase the acceptability of end-of-life care, patients and families from cultural groups with strong collectivist values should be encouraged to participate in care to whatever degree they desire. Wong and Chan found that Chinese fam-

ily members expressed a strong desire to be involved in daily patient-care activities.²⁷ Nurses can easily accommodate this request by assuming an educator role versus providing daily patient care directly. Nurses can teach family members how to provide oral care, reposition, bathe, and perform passive range-of-motion exercises. Some families may even request that family members provide all forms of patient care and that nurses be involved only in medication administration. Encouraging family involvement can increase the acceptability of professional end-of-life care for these families.

This collectivist style of interaction with patients and families may differ dramatically from the style of more individualistic cultural groups. For example, White Americans may enroll in professional end-of-life care because they prefer to have nonfamily members provide hygiene care.²⁷ This arrangement may allow patients to preserve their dignity and independence by not

relying on family members for such personal care.

How, when, and why to treat pain

Cultural beliefs influence how, when, and even if patients treat pain. In Western culture, medications are a first-line treatment for pain. The use of opioid medications can be especially problematic, as many patients have a fear of opioids.²⁸⁻³⁰ This is a major barrier because opioids are frequently the mainstay of pharmacologic end-of-life pain management.³¹

A common myth held by patients and even some healthcare professionals is that opioids hasten death.^{32,33} According to Zerwekh et al., hospice nurses have observed that many patients equate morphine with dying.³⁰ Furthermore, Hispanic Americans and Black Americans may equate the use of pain medication at the end of life with euthanasia.²¹

However, several studies have found that increasing opioid dosages at the end of life didn't shorten survival and in some cases may even

prolong survival.³¹⁻³³ Azoulay and colleagues found that increasing overall opioid dosage was associated with improved survival when compared with making no change or decreasing overall dosage.³² Similarly, Bengoechea et al. found that the median survival from day of maximum opioid dose to death was longer for patients who received higher doses of opioids than those who received lower doses.³¹

Many patients refuse to use opioid medications because of fear of addiction. In one study, Black American and Hispanic American patients expressed fear of addiction to pain medication more frequently than White American patients.¹⁰ An earlier study found that even with moderate-to-severe pain, terminally ill patients from racial or ethnic minority groups were more likely to refuse more potent pain medications than White Americans due to fear of addiction.³⁴

Family members may also resist opioid treatment for terminally ill patients because they correlate strength of medication with severity of illness.³⁰ Patients and families may believe that transitioning to opioids means accepting that death is imminent. In Asian, Hispanic, and Muslim cultures where discussions surrounding death are taboo, patients may avoid opioids to prevent bad luck or tempting fate.⁸

Some families believe that early administration of opioids can lead to having less pain medication options if the patient's pain worsens in the future; consequently, some families try to postpone opioid treatment until the last hours of life.²⁹ Nurses should reassure patients and families that opioids have no maximum dosage and can be increased or rotated as needed to provide pain relief.

Some non-Western cultures believe in folk remedies to relieve pain. For example, many Asian

Education to improve cultural competence

Healthcare providers need specialized training to provide end-of-life care to culturally diverse populations. Traditionally, the curricula for end-of-life care training include cultural proficiency as a separate module. However, Doorenbos, Briller, and Chapleski recommend an approach that integrates culture as a major factor in end-of-life communication and decision-making.⁵⁷ Stein, Sherman, and Bullock developed an educational program to train practitioners to provide end-of-life care for patients and families that responds to cultural concerns.⁵⁸ The researchers found that healthcare providers felt better prepared to provide culturally sensitive end-of-life care after attending an educational program that integrated cultural issues throughout a standard end-of-life curriculum. These results suggest that generalized cultural competency training is insufficient to prepare providers for delivering end-of-life care in culturally diverse populations.

Similarly, healthcare providers require specific training for communicating with patients about end-of-life decisions. Granek et al. found that oncologists were dissatisfied with the lack of formal training on how to discuss end-of-life issues with patients.⁹ In particular, the researchers found that oncologists had difficulty talking to terminally ill patients about the need to transition from curative treatment to end-of-life care when death was imminent. These opinions have significant implications for patients from cultural groups that frown on questioning a provider's clinical judgment. Patients from these cultural groups may rely on providers to decide when end-of-life care is appropriate and avoid discussions of death to be "good patients."

cultures rely on acupuncture, coining, cupping, moxibustion, and herbal remedies to treat pain.^{8,13} Coining involves rubbing heated oil on the skin, usually the back or shoulders, and then strongly rubbing a coin over the area in a linear fashion. In cupping, heated glass cups are applied to the skin, creating suction as a way of stimulating the flow of energy. Moxibustion is a technique in which herbs are burned near the skin to facilitate healing. Special instruments called moxa sticks are often used to hold the burning herbs a few inches above the skin.

Chinese American and Mexican American patients may eat certain hot or cold foods to restore balance in the body.¹³ Patients may also enlist the care of spiritual healers to treat pain. Filipino American patients and families may use medicinal herbs, *halaman*, from a *herbolaryo*, or witch doctor to prevent evil spirits from entering the patient's body.⁸

Nurses should try to incorporate traditional remedies into end-of-life care as long as they're not harmful to the patient. For the patient's safety, however, nurses must first conduct a thorough assessment of any alternative medicines or herbal therapies that a patient is using to avoid dangerous interactions with other prescribed drugs. For example, herbal preparations containing garlic can affect coagulation, which can be dangerous for patients taking anticoagulants.³⁵ Nurses should collaborate with pharmacists to ensure the safety of complementary and alternative therapies, especially when combined with prescribed medications.

Asking for help

Whether or not patients consider it appropriate to ask for pain treatment can be influenced by their cultural beliefs. Cultures that hold healthcare professionals in high regard may rely on the nurse or provider to ask



Nurses should collaborate with pharmacists to ensure the safety of complementary and alternative therapies.

about pain and offer treatment.¹⁰ Patients from such cultural groups may refrain from requesting pain treatment to be a "good patient" and avoid the appearance of questioning or challenging the provider's expertise.¹³ Asking for pain medication may also be considered a sign of weakness, particularly in cultures where people believe that pain must be endured.⁸

Besides physical pain, many patients experience spiritual pain at the end of life. Nurses must be sensitive to the spiritual needs of patients in different cultural groups. For instance, Filipino American families may rely on prayer to ease pain at the time of death. Some families hold a daily evening rosary prayer with extended family members throughout the dying process.^{8,36} Black Americans may also rely on prayer to treat pain.³⁷ Nurses can address these

practices by extending visiting hours and offering private rooms so that families may pray together with the dying patient.

Nurses should be aware of preferred cultural and religious rituals at the time of death. For example, Muslim patients may prefer to be positioned so that they face Mecca as they approach death.³⁸ In Buddhist cultures, families may request that no one touch the body of the patient after death until the proper prayers are recited to ensure that the patient's spirit has a peaceful transition to the afterlife.³⁹ Families from Western cultures may request time to lie with the patient after death.⁴⁰ Nurses should make every effort to accommodate spiritual practices at the end of life.

Patients and families can benefit from spiritual care offered by healthcare teams. Balboni et al. found that spiritual care led by medical teams was "associated with better patient quality of life, greater hospice utilization, and less aggressive medical interventions at the end of life."⁴¹ The researchers proposed that medical teams may be better at addressing spiritual needs such as finding acceptance and spiritual peace in dying because they have more knowledge regarding the disease processes of terminal illnesses. This contrasts with community spiritual support systems, which may focus on belief in miracles or perseverance through suffering.

Communication is key

Many ethnic and cultural minority groups speak languages other than English and have limited English proficiency. Healthcare providers identify a language barrier as a significant impediment to effective communication about end-of-life care.⁹ Research indicates that healthcare providers may be less likely to explain options for palliative care to patients whose cultural, ethnic, or

religious backgrounds are different from their own.⁴²

Language barriers can also lead to inadequate pain assessment. For instance, a patient may tell her family that she has an “annoying soreness” in her native language. A family translator may interpret the complaint as a mild nuisance, when the patient is actually experiencing significant pain, leading to undertreatment of the patient’s pain.

Coolen described the misunderstanding she had while treating a Cambodian hospice patient. When asked about the location of his pain, the patient pointed to his heart, which the clinician interpreted as cardiac pain. After further discussion with the patient’s family, the clinician discovered that the patient’s “heart pain” was actually a reference to the pain of burdening his family with his illness.⁸

Nurses can overcome language barriers by thoroughly assessing their patients’ preferences for communication. Ask patients to indicate which language they prefer for communication and if they’d like interpretive services. Federal law and policy requires the provision of language services to patients with limited English proficiency. These services should be provided by a qualified professional medical in-

terpreter, not friends or family.⁴³ Karliner, Jacobs, Chen, and Mutha noted that the use of professional interpreters decreased communication errors, increased patient comprehension, improved clinical outcomes, and increased satisfaction with communication and clinical services compared with the use of family members or clinical staff.⁴⁴

Different cultural groups may have preferences for communication such as individual, group, or family discussion, or written materials. The National Standards for Culturally and Linguistically Appropriate Services in Health Care dictate that healthcare organizations must provide easily understood printed materials, including consent forms and medical or treatment instructions, for patients in their native language.⁴³ Because of the wide cultural variations surrounding the concepts of death and pain, appropriate interpreters and translated materials are necessary for discussing end-of-life care.

Assessing individual variations

While nurses need to recognize and respect different cultural beliefs and values, they must also be careful to avoid stereotyping and not to assume that all members of a certain cultural

group share the same values. Level of acculturation and time living in the United States can influence healthcare practices, particularly among later generations.⁸

Kleinman’s Explanatory Model of Illness is useful for assessing cultural generalizations in individual patients.⁴⁵ This model consists of eight simple questions to illicit what illness means to the patient (see *Eight questions to explore the meaning of illness*). It can also be adapted to assess a patient’s beliefs about pain and death. For instance, the first question asks the patient to identify his or her problem. As discussed previously, cultural beliefs surrounding pain and death vary widely. One patient may identify his or her problem as “not being able to see my grandchildren grow up”; another may say, “the pain is so bad that I can’t do things for myself.” This identification helps nurses to discern the patient’s values and goals for end-of-life care; for instance, whether the patient’s priority is more time with family or better pain control to maintain independence.

Choosing a pain assessment tool

Comprehensive, culturally sensitive pain assessment is an integral part of end-of-life pain management. Numerous scales have been developed and validated to quantify levels of pain in culturally diverse populations.

- The **Numeric Pain Rating Scale** consists of a vertical line with evenly spaced marks numbered from zero to 10. The patient circles the number that corresponds to his or her pain intensity. In a variation of the scale, the patient can also verbally indicate his or her pain score. This scale has been validated for use with older Black Americans and older Koreans.¹⁰ As with all tools, nurses need to ensure patients understand how to use the

Eight questions to explore the meaning of illness

Guided by Kleinman’s Explanatory Model of Illness, nurses can ask these simple questions to understand how cultural values and beliefs influence the patient’s experience of illness.

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take?
- How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?

Adapted from Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLOS Med.* 2006;3(10):e294. Reprinted under the Creative Commons Attribution License.

Numeric Pain Rating Scale. Burhansstipanov and Hollow found that some American Indian patients chose good luck or sacred numbers rather than the number that correctly identified their pain level.⁴⁶

- The **Visual Analog Scale (VAS)** is a 10-cm horizontal line with “No pain” at the left end and “Worst possible pain” on the right end. The patient makes a mark along the line to indicate his or her pain intensity. The nurse then measures from the “No pain” end to the patient’s mark to obtain a pain score from 0 to 100 in millimeters. The patient must have the fine motor skills necessary to utilize a pen or pencil, which may be difficult for a patient at the end of life. Also, the extra step of measuring the patient’s mark adds a potential source of error in the nurse’s assessment. Herr and Garand found that the VAS may be inappropriate for patients with impaired cognition.⁴⁷ However, this scale has been validated for use with older Black Americans, older Koreans, non-Hispanic Whites, and Asians with cancer pain.¹⁰

Again, nurses must exercise caution when adapting scales for use with patients from different cultural backgrounds. For instance, Chinese or Japanese patients may misinterpret the VAS because the scale presents horizontally as opposed to vertically, which is how Chinese and Japanese languages are read.¹³

- The **Faces Pain Scale-Revised** is composed of a series of faces that progress from a neutral facial expression indicating the absence of pain to a grimacing expression indicating the worst possible pain.⁴⁸

The patient selects the face that corresponds to his or her pain intensity. The scale was originally developed for pediatric patients, but psychometric evaluations indicate that the tool is valid and reliable for assessing pain in older adults with



A patient who believes that pain should be endured may report a low pain score.

normal to moderately impaired cognition.⁴⁷ Kim and Buschmann also found the scale to be useful among older Korean Americans.⁴⁹ The scale has been translated into more than 30 languages.²

Interpreting findings correctly

Regardless of the pain assessment tool used, nurses must be mindful of incorporating cultural values regarding pain perception and expression when interpreting pain scores. For example, a nurse may observe that a patient with cancer is grimacing, hypertensive, and tachycardic. However, if the patient has a cultural belief that pain should be endured, he or she may report a low pain score using a standard pain intensity rating scale. The nurse should assess the patient’s cultural beliefs surrounding pain and pain treatment and use

this information to assess whether additional assessment is necessary.

As an example, Narayan described the case of a Vietnamese patient with gastric cancer who refused pain medication due to a cultural belief in stoicism and enduring pain without complaining. By performing a comprehensive pain assessment rather than relying on a pain intensity rating scale alone, the nurse discovered that the patient attributed his pain to an imbalance of energy in his body and that he preferred medicinal herbal tea and meditation to manage pain. She incorporated his preferred pain management techniques by asking a pharmacist if morphine elixir could be safely added to his herbal tea. Reassured that this would be safe, the nurse demonstrated to the patient how to add the morphine elixir and explained that he could use it to treat his pain if it becomes overwhelming.¹³

Reaching out to patients and families

Research has demonstrated that educational interventions can increase hospice use among culturally diverse populations.⁵⁰ Planning for end-of-life care outreach programs should incorporate cultural beliefs and values. Cultural groups that value family or community may respond more positively to community-based outreach methods. For instance, because many Korean Americans prefer family involvement in end-of-life decision making, outreach programs should target not only older adults, but other family members as well.⁵⁰

Location can also influence the effectiveness of end-of-life outreach programs. Lyke and Colón recommended the use of locations that are central to minority community interaction.⁵¹ For example, in Hispanic American communities, grocery stores and beauty salons are ideal for reaching underserved populations.

Among Black Americans, churches have played a key role in health outreach initiatives.³⁷ Such community points of access are particularly effective because they're familiar, non-threatening environments compared with traditional health agencies or social services.

Nurses can use patient education to dispel myths and fears about opioid medications; for example, by explaining that appropriate use of opioids at the end of life doesn't shorten survival and highlighting the benefits of opioid therapy: increased energy, decreased shortness of breath or air hunger, and reduced physical and psychological distress.⁵²

Fear of addiction is another significant factor. Providers must differentiate physical dependence from addiction when discussing the use of opioid medications with patients and families.

Patient-focused pain education programs have been shown to improve patient satisfaction with pain management. In a randomized controlled trial, Chou and Lin provided cancer patients with an educational booklet that addressed patient concerns about reporting pain and using analgesics.⁵³ The researchers found that patients in the experimental group that received the booklet reported higher satisfaction with the pain management provided by both nurses and physicians. More important, the researchers found that greater patient satisfaction with pain management improved patient adherence to pain treatment regimens.

Cultural competence is caring

The heart of nursing is caring for people. It's both a privilege and a duty to care for patients with competence and compassion, especially during the last moments of their lives.^{54,55} Improving cultural competence ensures that nurses can provide optimal end-of-life care to people from all cultural backgrounds. ■

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