"Letters: Response to Stump, Klugman, and Thornton, 'Last Hours of Life: Encouraging End-of-Life Conversations'," *The Journal of Clinical Ethics* 19, no. 3 (Fall 2008): 303.

Letters

To the Editor. — The article by Stump and colleagues proposes an interesting approach to end-of-life conversations based on the Last Hours of Life worksheet.[1] Topics covered in this worksheet include the tasks the patient still wants to accomplish in life, the patient's fears about death, the setting where the patient wants to die, the patient's preferred state of mind for the moment of death, and those people the patient wants at the bedside at that moment. The authors report data from piloting the worksheet at seminars and lectures for health professionals from Nevada, California, and Oregon.

As intriguing as this worksheet is, we were surprised that the study design and data analysis did not consider culture. Health professionals in the western U.S. surely constitute a particular culture with specific values, beliefs, and behaviors by which they interpret life experiences. Perhaps some of our prior research can add a helpful, cross-cultural perspective on end-of-life conversations.

We studied seriously ill inpatients' beliefs about important considerations for end-of-life decisions. We recruited subjects by ethnic group and gender. Striking differences in beliefs occurred by both kinds of culture. For ethnic culture, African Americans (AAs) distinguished themselves in three ways from Mexican Americans (MAs) and Euroamericans (EAs).[2] First, unlike the other two ethnic groups, AAs preferred not to talk about end-of-life matters before imminent death. (Of course, the risk of honoring this preference is that imminently dying patients may no longer be able to discuss those matters.) Second, unlike MAs and EAs, AAs virtually never refused life support even when functional outcomes would likely be poor. And third, unlike the other groups, AAs did not spontaneously acknowledge organ donation as an important benefit to others or express a willingness to donate.

Other differences characterized the gender cultures across ethnic groups.[3] For example, men focused almost completely on predicted, acceptable functional capacities. Yet women took into account not only predicted, acceptable functional capacities but also factors such as meaningful times or places to die and the psychological or economic burdens their deaths might place on their families.

Our results highlight certain parts of the Last Hours of Life worksheet for further research. Specifically, it should elaborate the impact on terminal care wishes of subjects' views about specific functional capacities, family dynamics, or beliefs about the body. More importantly, future research with the worksheet should focus more on patients than health professionals, and take explicit account of ethnic and gender cultures. We await with interest the results of this additional research.

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NOTES

1. B.F. Stump, C.M. Klugman, and B. Thornton, "Last Hours of Life: Encouraging End-of-Life Conversations," *The Journal of Clinical Ethics* 19, no. 2 (Summer 2008): 150-9.

2. H.S. Perkins et al., "Cross-Cultural Similarities and Differences in Attitudes about Advance Care Planning," *Journal of General Internal Medicine* 17 (2002): 48-57; H.S. Perkins et al., "Exploring Chronically Ill Seniors' Attitudes about Discussing Death and Postmortem Medical Procedures," *Journal of the American Geriatrics Society* 53 (2005): 895-900.

3. H.S. Perkins, J.D. Cortez, and H.P. Hazuda, "Advance Care Planning: Does Patient Gender Make a Difference?" *American Journal of the Medical Sciences* 327, no. 1 (2004): 25-32.