

# **HEALTH AND HEALTH CARE FOR PAKISTANI AMERICAN ELDERS**

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## **DESCRIPTION**

This module presents the small amount of information that is available related to health status and health care of elders from Pakistani backgrounds in the U.S. It includes some background on the population and traditional health beliefs as well as important clinical considerations. It is designed to be used in conjunction with the Core Curriculum in Ethnogeriatrics.

## **LEARNING OBJECTIVES**

After completing this module, learners should 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 elders.
- 3) Discuss appropriate approaches in dealing with advance directives and end of life care with Pakistani American elders and their families.

# CONTENT<sup>1</sup>

## I. Introduction and Overview

### A. Demographics

According to the 1990 U.S. Census, there were 81,691 individuals who identified themselves as Pakistani in the U.S. About 5% of the total were over the age of 55 and the estimated percentage of the elderly (>65 years) was about 1.7 percent. Between the period of 1989-1992, a total of 2,433 elders over the age of 60 years emigrated from Pakistan to the United States. In 1995, it was estimated that there were a total of 3998 Pakistani elders with the elderly women (52.1%) slightly out numbering the men (47.9). About 95.9 % of the Pakistani elders were foreign-born (Young & Gu, 1995). The immigration of the Pakistani elders since then has continued at a brisk pace.

### B. Background

The Islamic Republic of 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 world's earliest civilizations (the Indus valley civilization of Mohenjo Daro and Harappa) rivaling those of ancient Egypt and Mesopotamia.

Pakistan emerged on the world map 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. 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 as 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 and China.

Urdu (derived mainly from Arabic and Persian vocabulary and adopting indigenous words and idioms) is the national language of Pakistan. Urdu has a similar vocabulary to Hindi, spoken widely in India. Pakistan has a population of more than 135 million people, about 95% of who are Moslem. The current population growth rate of 3.0 per cent is one of the highest among the nine most populous countries of the world. The population was estimated to be 150 million in 2000.

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<sup>1</sup> Much of the information in the module is taken from the sources on the reference list and not cited to specific references.

## **II. Patterns of Health Risk:**

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 risk compared to their American counterparts. Other health problems that are prevalent include tuberculosis, hypertension, oral sub-mucous fibrosis (often secondary to chewing *paan* which is tobacco and betel quid with a lot of added spices) and cancer (especially patients with sub-mucous fibrosis who also smoke are at high risk for oral cancers). Pakistani and Indian immigrant women in the U.S. are higher risk for breast cancer compared to their counterparts in India and Pakistan.

High risk health behaviors include poor nutrition, which may include foods high in saturated fats, higher prevalence of smoking and chewing tobacco in men, and a sedentary life style. Also a recent study in the United Kingdom (Gibbons, 1993) showed that about 55% of Pakistani marriages were between first cousins. This may put them at a higher risk for certain diseases, such as thalassemias.

## **III. Culturally Appropriate Geriatric Care: Fund of Knowledge**

### **A. Traditional Health Beliefs**

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 of 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.

*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: health, disease, and 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.

Religious Moslems may wear the *taawiz*, an amulet containing verses from the holy Koran (the Moslem Bible) when ill. The *taawizes* 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* (holymen) 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.

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 (with the exceptions of children, pregnant women, and *Al-Harim* or the severely debilitated or demented elderly) 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*. In the evening following the *iftar* it is customary for Muslims to visit with friends and family. The fast is resumed the next morning and continues for the whole month of Ramadan. Although the fast may be beneficial for health, it is regarded spiritually as a method of self-purification. This obviously has tremendous implications for the frail elderly and people with diabetes.

*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*.

*Wudu* is the ceremonial washing that is done before prayer and debilitated patients may need help with performing *wudu*. Providers should take care to preserve the cleanliness of the patient's clothes and covers as much as possible from urine 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 *Tayamu* 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.

#### **IV. Culturally Appropriate Geriatric Care: Assessment**

##### **A. Important Cultural Issues**

- Old age is respected in Pakistan. Elders should be treated with utmost courtesy and respect.
- Same sex care providers are usually preferred.
- Most, but not all, elders from Pakistan are Muslim. Religious preference should be asked rather than assumed.
- Elders 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. But 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.
- Elderly Pakistanis may wear religious paraphernalia e.g.: *taawiz* (amulet) or *topi* (religious cap). These should not be removed without the permission of the owner.
- **Sensitive issues:** Questions about sexuality are considered as extremely delicate and personal issues. Therefore, questions about sexuality should be asked with extreme sensitivity. Asking a widowed woman about her 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 needed.

##### **B. 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.

- **What do you call the problem?**

- **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.)
- **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.)
- **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 done.
- **How** do you think the sickness should be treated (what alternative therapies are you using currently), **How** do want us to help you? This question should be addressed sensitively so as to not 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.
- **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.

## **V. Culturally Appropriate Geriatric Care: Treatment**

### **A. Decision Making and Disclosure**

Many older Pakistani women may prefer to defer decision making to their sons or daughters.

Some families may ask the health care providers not to tell the patient about the diagnosis, especially when it involves cancer. When faced with this situation, the clinician should verify that the patient is comfortable with letting the family makes 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 as such. Autonomy is the right to choose, and so patients have the right to choose to remain ignorant about their diagnosis.

If the elder has cancer, treatment options can be discussed with him or her, but it is recommended that the word "cancer" not be used.

## **B. Advance Directives and End of Life Issues**

Active end of life care planning is an unfamiliar concept to most Pakistani elders. Care providers who have discussions about advance directives and advance care planning should remember that the elders might be reluctant to participate in these discussions, as they may believe that talking about death may make it a reality. Worse, the elders may believe that the physician is subtly implying that they (the elder) 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 a professional interpreter if possible.

Also, in Islam, withholding food is forbidden. So providers should be very sensitive to issues regarding withdrawal of tube feedings.

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

Moslem elders have extensive death rituals, including ceremonial washing of the body with holy waters, directional positioning of the body towards the Holy Land of Mecca, and recitation of the Holy Koran by the *Fakirs*. 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. 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 possible will go a long way in alleviating distress of a Moslem family who may be intensely grieving the loss of their loved ones.

## INSTRUCTIONAL STRATEGIES

### 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 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.*

*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 pickup your car phone to call your wife you cannot help wonder about Mrs. P. and Mohammed and their sudden departure.....*

### Questions for Discussion:

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?

### Case of Mr. M.

*Mr. M., a 76 years 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. Mr. M. 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 should 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. 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.*

Topics for discussion:

Communication about the diagnosis

Autonomy vs. family decision making

Patient's wishes vs. cultural norms

Advance directives

## STUDENT EVALUATION

### QUESTIONS:

**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. You want to talk to her about end-of-life issues today. You should:**

- 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 request 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:**

- 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 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:**

- 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?**

- 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.

**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?**

- 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.

**ANSWERS:**

- 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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