Cultural Aspects of Communication in Cancer Care

A. Surbone

Recent Results in Cancer Research, Vol. 168
© Springer-Verlag Berlin Heidelberg 2006

Summary
Cancer is increasing in incidence and prevalence worldwide, and the WHO has recently included cancer and its treatments as a health priority in developed and developing countries. The cultural diversity of oncology patients is bound to increase, and cultural sensitivity and competence are now required of all oncology professionals. A culturally competent cancer care leads to improved therapeutic outcome and it may decrease disparities in medical care. Cultural competence in medicine is a complex multilayered accomplishment, requiring knowledge, skills and attitudes whose acquisition is needed for effective cross-cultural negotiation in the clinical setting. Effective cultural competence is based on knowledge of the notion of culture; on awareness of possible biases and prejudices related to stereotyping, racism, classism, sexism; on nurturing appreciation for differences in health care values; and on fostering the attitudes of humility, empathy, curiosity, respect, sensitivity and awareness. Cultural competence in healthcare relates to individual professionals, but also to organizations and systems. A culturally competent healthcare system must consider in their separateness and yet in there reciprocal influences social, racial and cultural factors. By providing a framework of reference to interpret the external world and relate to it, culture affects patients’ perceptions of disease, disability and suffering; degrees and expressions of concern about them; their responses to treatments and their relationship to individual physicians and to the healthcare system. Culture also influences the interpretation of ethical norms and principles, and especially of individual autonomy, which can be perceived either as synonymous with freedom or with isolation depending on the cultural context. This, in turn, determines the variability of truth-telling attitudes and practices worldwide as well as the different roles of family in the information and decision-making process of the cancer patient. Finally, culture affects individual views of the patient–doctor relationship in different contexts.

9.1 Introduction
The existence of major healthcare disparities in Western countries due to racial and socioeconomic factors and the presence of major differences in diverse groups with respect to key issues in healthcare have stirred intense debate and action in the medical, sociological and bioethical worlds. As a result, the notions of cultural sensitivity and of cultural competence have developed and have been increasingly applied to clinical medicine (Gostin1995; Kalnins 1997; Zweifler and Gonzalez 1998; Seibert et al. 2002). The acquisition of knowledge and skills in delivering culturally sensitive care became a requirement in medical schools in highly multiethnic societies such as the USA, where demographic projections estimate that minorities will grow from 29% in 2001 to almost 50% in 2050 (Seibert et al. 2002).

Delivering culturally sensitive cancer care is a priority for oncologists who are increasingly facing many ethical dilemmas arising from cross-cultural differences in their daily practices. Ethical issues in oncology are magnified by several
factors: the severity of the illness and the negative metaphorical value of a cancer diagnosis; the physical and psychological suffering of the patient, at times extreme at the end of life; the impact of different degrees of social stigmatization and discrimination; the uncertainty related to the cancer prognosis and to the outcome and potential toxicity of experimental treatments; the side effects of many standard cancer therapies; and finally, the difficult balance between patients' desire to be involved in their care and their increased vulnerability due to the complex reality of cancer.

While the need for cultural competence may appear to be less acute in relatively more homogeneous societies and in countries with socialized healthcare systems, culture has profound implications in almost all contemporary societies because multiethnicity is increasingly common and because different cultures always co-exist within main cultures, as exemplified by the differences between North and South in many countries. Moreover, to the extent that both the patient and the physician always engage in an asymmetric yet reciprocal relationship, carrying their own personal and cultural identity, every clinical encounter and every patient–doctor relationship is an exercise in cultural competence (Surbone and Lowenstein 2003; Surbone 2004b).

Cultural differences between patients and healthcare professionals often give rise to some common bedside misunderstandings and conflicts with respect to truth telling, end-of-life choices, prevention and screening, and involvement in clinical trials. An example of the importance of cultural sensitivity in cancer care is the notion of “offering the truth” to cancer patients (Freeman 1993). This notion, based on allowing individual patients to choose their own paths and rhythm, was proposed as an effective means to respecting patients' autonomy to follow their own cultural norms.

In this chapter, I make frequent use of cross-cultural differences in truth telling as an illustration of the role of cultural competence in communication with cancer patients. In any patient–doctor relationship there is an inherent problem of what philosophers call act/object ambiguity, i.e. the fact that the truth of an assertion may refer either to the content or to the assertion of the content. This is especially true when the appropriateness of an assertion needs to be evaluated in the context of particular circumstances, when a person may be right in what she says and may not be right in saying it in a given moment or in a given cultural context (Surbone 2002b). Giving blunt bad news to an uninformed cancer patient whose family has requested the physician not to do so is an example often encountered in multicultural oncology practices.

9.2 Culture and Medicine: Understanding

9.2.1 Culture

Culture is defined as the sum of the integrated patterns of knowledge, beliefs and behaviours of a given community (Olweny 1994). Cultural groups share thoughts, communication styles, ways of interacting, views of roles and relationships, values, practices, customs (Betancourt 2003). Culture is related to race and to ethnicity, and yet their domains are not superimposable. In essence, culture refers predominantly to the social, while race and ethnicity refer to the sociobiological domains (Betancourt et al. 2003; Kagawa-Singer 2003). We all belong simultaneously to multiple cultures, expressing themselves through specific languages, such as the medical one. Medicine is a culture that involves a specific language and is associated with a specific power position in most societies. As an example, both the patient and the doctor bring their culture(s) and language(s) to every clinical encounter (Surbone 2004b).

Factors such as socioeconomic status, educational level, spoken language, geographic areas, urban versus rural contexts, religion, gender, sexual orientation, occupation and disability define culture as well. All these nested elements of culture integrate as the woven threads of a tapestry to perform integrative and prescriptive functions, whose ultimate goal is to ensure the survival and well-being of its individual members (Kagawa-Singer 2003).

Culture contributes to our identity by providing a reference framework to interpret the ex-