Cultural competence: Why?

This issue of *Annals of Oncology* features an original article by De Lorenzo et al. [1], reporting the results of a randomized study of different communication tools in cancer patients in Italy. The impact of oral, written and video information on psychological distress and on quality of life was evaluated in 300 consecutive Italian patients, who had agreed to “receive more information on the disease and the treatment.” With respect to the perceived quality of information, patients rated oral information as best, when the oncologist had dedicated enough time to the patient. The authors emphasize the established therapeutic role of adequate and effective communication in oncology. They, however, point out that “information is still a sensitive subject in Italy” in contrast with “the most developed countries”, where “the majority of cancer patients require as much information as possible and want to be involved in all aspects of their healthcare”.

The attitudes and practices of Italian patients and physicians toward information and communication have changed in recent years. Until the 1990s, it was common practice in Italy to withhold the truth from cancer patients in order to protect them and to maintain their hope [2–7]. In the Italian family and community-centered culture individual autonomy was perceived as synonymous with isolation [3]. In the past decade the Italian culture has substantially evolved toward increasing self governance in life and also in medicine. Informed consent is now a legal and deontological requirement in Italy, and patients expect and receive more complete information and are progressively more involved in their medical care [8]. Still, partial or non-disclosure of diagnosis and prognosis exist in Italy, as well as in many European and Asian countries where a similar evolution has been reported [9–12]. A comprehensive review of this subject will be published elsewhere. This Editorial focuses rather on culture and cultural competence in medicine.

In the USA, cross-cultural encounters in the clinic are reported as an increasingly frequent source of ethical dilemma. Cross-cultural curricula are now a requirement for undergraduate medical students [13, 14]. In oncology, different cultural attitudes toward truth telling and end-of-life decisions are common sources of major dilemmas. Moreover, cultural factors play a role in the existing major disparities in access to health care and research for minority and/or underprivileged cancer patients [15, 16]. Cultural competence has thus become essential for oncologists practising in a highly multiethnic and multicultural society such as the USA. The American Society of Clinical Oncology isdevoting considerable efforts to increase oncologists’ awareness in this field.

At first glance, the need for cultural competence may be perceived as less acute in relatively more homogeneous societies and in countries with socialized health-care systems. A closer look, however, reveals that there are important lessons for all oncologists to learn. First, because multi-ethnicity is increasingly common. As an example, Italy has a population of over 57 million inhabitants [17]. Second, different cultures always co-exist within cultures, as exemplified by the differences between north and south in many countries. Third, because culture has profound implications in every patient–doctor relationship.

Culture is defined as the sum of the integrated patterns of knowledge, beliefs and behaviors of a given community [18]. Cultural groups share thoughts, communication styles, ways of interacting, views of roles and relationships, values, practices and customs [13]. Culture is related to race and to ethnicity, and yet their domains are not superimposable. Different anthropological, sociological and medical definitions have been provided [11, 14]. In essence, culture refers predominantly to the social, while race and ethnicity refer to the sociobiological domains [15, 19]. Factors such as socioeconomic status, educational level, spoken language, geographical areas, urban versus rural contexts, religion, gender, sexual orientation, occupation and disability define culture as well [13, 20].

We all belong simultaneously to multiple cultures, expressing themselves through specific languages. As an example, medicine is a culture, which involves a specific language and is associated with a specific power position in most societies. Both the patient and the doctor bring their culture(s) and language(s) to every clinical encounter. It is well established that language goes far beyond semantics to reflect different peoples’ ways of life, which are in turn based on different meanings and values. In acquiring language skills as children (but also as medical students) we, in fact, learn about the truth-value of different assertions in a specific cultural context [21]. In the end, all the different nested elements of culture(s) 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 individual members [22].

Culture contributes to our identity in three main ways. First, it provides us with a reference framework to interpret the external world and to relate to it. How we perceive disease, disability and suffering; how we express our concerns about them; how we relate to individual physicians and to the health-care system are deeply influenced by culture. The patient and the physician must negotiate between their different views of illness and of health, as well as their different perceptions of the patient–doctor relationship, in order to achieve their common therapeutic goal [22, 23].

Second, culture helps us make sense of what is happening to us. Making sense of the suffering, of the loss of control and of the many uncertainties that accompany their illness is essential to cancer patients. Third, culture acts as a facilitator at special times...
of trial, when we intensely need to rely on our sense of self and of connectedness. The experience of cancer is one such trial in the patient’s life.

The importance of cultural influences on our personal identity, however, should not be conceived in a deterministic way, as this only reinforces prejudicial and stereotypical attitudes that inevitably culminate in more or less overt forms of discrimination. There is constant redefinition of cultural identity. Cultures are dynamic, interdependent and fluid, and they evolve from within as well as under the reciprocal influence of other cultures. Individual persons or groups do not always conform to their own culture. Dissent has always been present in different cultures, and it has greatly contributed to the progress of humankind. Members of different racial, ethnic and cultural groups undergo assimilation and acculturation [22]. Both the progressive exposure to global communication and the increasing demographic mobility are contributing to profound cultural changes in contemporary societies. This raises fundamental questions of dominance, vis-à-vis the prevailing western influence throughout the world. Yet, it would be a mistake to ignore the fact that cultural identity today goes well beyond geographical and ethnic boundaries [23]. As an example, we can now find striking cross-cultural similarities in the approach of cancer patients to the salient moments in the course of their illness [18, 23]. When we speak in terms of more or less developed countries—as we often do in medicine and bioethics—we are making generalizations that are not fully substantiated by evidence and can be misleading and dangerous. Furthermore, by generalizing we fail to recognize that cultural identity is not a substitute for personal identity. Personal and cultural identities do not coincide, and allowing for the two to collapse is also misleading. Personal identity is shaped by culture, but it is primarily grounded in one’s own experiences in life as well as in universal human values. Each person thus deserves to be respected and valued in her uniqueness and this applies also to the clinical setting, where personal and cultural sensitivity are equally needed.

Cultural competence in medicine is a complex multilayered accomplishment. It requires knowledge, skills and attitudes whose acquisition is needed for effective cross-cultural negotiation in the clinical setting [13, 20, 25]. This, in turn, leads to improved therapeutic outcome and decreased disparities in medical care [14, 26, 27]. There are different methods for teaching cultural competence [13, 15, 22]. The multicultural approach focuses on providing relevant information about different cultures with respect to different health issues. (Via exemplar, cultural competence in oncology entails a basic knowledge of different cultural practices of truth telling throughout the world.) The cross-culturally based systems approach focuses on the individual patient as a teacher and on the multiple variables involved in the process of communication. It presupposes the physician’s awareness of his/her own cultural beliefs and values, and it aims at the development of attitudes and clinical skills. Effective cultural competence is based on increasing physicians’ knowledge of the concept of culture as well as of the key notions related to culture (such as stereotyping, racism, classism, sexism); on nurturing appreciation for differences in health-care values; and finally on fostering the attitudes of humility, empathy, curiosity, respect, sensitivity and awareness. These attitudes, however, are in no way confined to cross-cultural clinical encounters. 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 [28].

There are important and timely lessons to learn from a deeper understanding of the complexities and subtleties of culture and of cultural competence, and these can help us improve our therapeutic relationships with cancer patients. An additional lesson for all of us as individuals—likely the most fundamental—is that we do not stand alone in this world. We are always connected to others in a cultural and social context. In the language of moral philosophy, our moral agency is increasingly viewed as situated and relational. In the language of medical ethics, individual autonomy is replaced by relational autonomy and considerations of care, trust and justice acquire a vital role in medicine. In the language of clinical practice, respect for relational autonomy entails seeing individual patients as situated in their familial, social and cultural context [29]. Considerable dedication and time are needed to acquire the knowledge, skills and attitudes that define cultural competence. The insight gained from a better understanding of our patients and us as part of a social and cultural context is, however, worth the effort. Finally, in the Italian language, ‘autonomia’ and ‘isolamento’ no longer need to be synonymous for the cancer patient. Truth telling and respect for the patient’s autonomy can and should inform clinical practice in today’s Italy (and equally in other countries), not because this is the western way, or the most economical one, but because this is the most respectful and also the most rewarding way to care. As oncologists, we always find ourselves on the front line.

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References


17. Available online at www.istat.it


