Cultural competence in oncology: where do we stand?

Demographic shifts in recent decades have rendered most of today’s industrialized countries multiethnic and multicultural. Yet cultural pluralism remains a moral and social quandary as the coexistence of multiple cultures within countries is at the same time a source of enrichment, stress and potential conflicts [1]. Tolerance, the private and public virtue of acceptance and respect for the different views of others, often clashes with the inevitable practical consequences of people holding not only diverse customs but also diverse ethical or legal standards and norms.

In 2004, I reported for Annals of Oncology on the impact of culturally different beliefs and attitudes regarding matters of health, illness and death on individual professionals and health care systems [2]. Cultural differences, compounded with socioeconomic factors, are a major determinant of unequal access to cancer prevention, screening, optimal standard care, enrollment in clinical trials, effective pain control, adequate supportive and end-of-life care, psychosocial research and interventions and survivorship care [3–7].

The notion of cultural competence—the set of knowledge and practical skills needed to properly deal with cancer patients and families belonging to different cultures—has evolved since then. Its initial focus was on providing clinical tools for the necessary negotiation of different health beliefs and values in discordant medical encounters, and its main goal was to reduce the conflicts that arise from cultural differences among patients, families and health care professionals [8]. Today, cultural competence is increasingly considered a key factor, both at individual and system levels, that may contribute to our efforts to eliminate disparities in health care and reduce the burden of unequal cancer treatment [9, 10]. The American Medical Association, National Medical Association and National Hispanic Medical Association have established a Commission to End Health Care Disparities to promote quality care for ethnic and racial minorities by bringing attention to disparities, fostering work force diversity and increasing education and training in cultural competence [11].

Teaching and training programs in culturally competent care have been developed, implemented and tested for effectiveness worldwide. They have also been made mandatory for medical students and health care workers in some countries. Outcome evaluation of their impact is ongoing [12, 13]. Guidelines for the acquisition of individuals and institutional cultural competence have been issued by major medical and specialty organizations, including oncology [14, 15]. Finally, patient-centered care has embraced the notion and application of cultural competence.

We are far from having reached the goals of setting optimal standards or exhausted the need and opportunities for research in the field of cultural competence, however. Why? Let’s examine the main unresolved issues that have a direct impact on the practice of oncology.

First, the notion of culture is extremely complex and we still lack a good definition for it since confusion persists about race, ethnicity and culture, and there is a tendency to reduce cultural issues to socioeconomic issues [16]. By contrast, cultural and socioeconomic factors, while intermingled, do not always overlap and should not be conflated. Recent studies in oncology show that, despite the increasing efforts of the oncology community and of patient advocates, unequal treatment of minorities in the United States has persisted in the past few decades and this applies also to cancer patients with access to some forms of insurance [17]. These and many other data indicate that, along with socioeconomic factors, cultural variables play a key role in the origin and perpetuation of health disparities.

Secondly, the relationship of culture to health and illness is complex, multifaceted and still poorly understood. For example, most medical literature evaluates the impact of cultural factors using Western standards for comparison, while knowledge and appreciation of non-Western cultural traditions and beliefs in promoting the health of their members are largely overlooked [18]. An inadequate comprehension of the role of culture in medicine is especially problematic in the field of oncology, where patients and professionals confront a disease highly charged not only with physical and psychosocial suffering for all patients and their families but also with dire metaphorical implications and social stigmatization in some cultures. Awareness of the negative implications of a cancer diagnosis, however, should be paralleled by knowledge of the many effective support systems offered by families and communities in those same cultures [18].

Thirdly, many unfortunate instances of racism still exist in the practice of medicine. Racism, defined as the assertion of power, ego fulfillment and status at the expense of others on the basis of real or presumed ethnic differences, is rarely an attribute of individual health care workers, whose profession is committed to alleviating the suffering of other fellow human beings and restoring their well-being [18]. Most often, it results from institutional and system attitudes and choices that create a ‘culture of discrimination’ by which health care workers are influenced. A 2009 study, however, shows that subconscious racial biases are present also among individual physicians, leading to discriminatory attitudes, first and foremost with regard to communication with patients and families of different skin color or culture [19]. In our everyday activity as members of cancer teams, we witness profound experiences of suffering, resilience, loss and grief, regardless of our patients’ race,
ethnicity, socioeconomic status or culture. Yet, we live embedded in our own culture and its prejudices, and we practice in a specific culture of medicine, which in western countries is largely on the basis of a biomedical notion of disease as opposed to a holistic one of illness. Self-awareness and knowledge of one’s own cultural background are key steps in cross-cultural medical encounters. For example, we must acknowledge that it is easiest to discuss difficult medical decisions, often involving life and death matters, with cancer patients who share our own cultural background.

Fourthly, effective communication in medical encounters is a bidirectional process that enables us to gather information and clarify it during the course of our patients’ illness, with the aim of establishing a correct diagnosis, prognosis and treatment plan and of involving patients in the decision-making process, so that they may receive not only the best care but also the one most respectful of their values and beliefs, according to their individual wishes and culture [20]. Reciprocal comprehension is necessary to effective communication, while linguistic, health literacy and cultural differences combined render mutual understanding especially difficult [21]. Language and cultural barriers can become a major source of stress for patients, families and physicians as communication among them shrinks to an exchange of simple information about the strictly medical, often technical, aspects of the patient’s cancer and its treatment. Furthermore, the attitudes or behaviors of some patients, such as the husband or male family member always replying in lieu of a female patient or the patient never looking straight into the doctor’s eyes, may elicit strong reactions of disapproval or annoyance in some oncology professionals, when in fact such actions and characteristics may be indicative of cultural patterns [15, 18].

Fifthly, inadequate communication, whether verbal or nonverbal, engenders frustration and reciprocal mistrust. Mistrust, in turn, negatively affects the quality of the care received by cancer patients, which in large part depends on an open, effective, ongoing relationship with their oncologists. Errors may occur, and their seriousness may be enhanced, if patient safety rules cannot be adequately communicated and understood [22]. Inadequate communication may also lead to bedside misunderstandings and conflicts, reduced adherence to treatments or preventive measures and limited participation in screening programs or clinical trials [10, 17]. As the therapeutic relationship has boundaries and clinical oncology is practiced under major time constraints, the help of a professional figure who is able to mediate among different languages and cultures has become essential.

This issue of *Annals of Oncology* features an article by Lubrano di Ciccone, Brown, Gueguen, Bylund and Kissane reporting their experience of teaching physicians how to interact with patients through a professional interpreter [23]. In the United States, it has been estimated that ~23 million people have limited English proficiency. This estimate includes many cancer patients and health care workers. Multilingual phone services and educational brochures, when translated into different languages with sensitivity to cultural terms and approaches, can be valuable tools for overcoming language barriers. Most importantly, professional interpreters with training in medical issues and terminology can substantially improve communication in clinical encounters, help patients navigate cancer care systems and orient them with consent forms and bureaucratic procedures.

The role of medical interpreters goes well beyond that of providing an accurate translation as they also mediate between the different cultures of patients, families and oncology professionals [23, 24]. Interpreters must be introduced to patients and family members, at the outset, to enhance the latter’s acceptance of them as members of the medical team. When their role is recognized and correctly presented, interpreters make possible effective reciprocal communication between patients and cancer care professionals, even in the absence of shared language and meanings, thus assisting them in establishing trusting relationships [24]. It is critical that oncologists be comfortable with the interpreter’s presence and that they consult with interpreters during the course of the patient’s illness and treatment to verify and improve the adequacy of the communication process. Finally, interpreters can also provide precious insight at times of difficult decision making about treatments or of transition from curative to palliative care or at the end of life [25].

In the United States, the Joint Commission is developing and promoting standards for culturally competent care that include language services as a key element of patient-centered care [20]. The Office of Minority Health calls for a universal implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health Care [26]. This attention to language is to be integrated with attention to the cultural, spiritual and religious perspectives for all patients and their families [4, 27]. Clearly, providing language services to cancer patients and increasing oncology professionals’ education and training in cultural competence require a deep ‘cultural’ and social commitment, along with adequate funding. Not all cancer facilities, however, can afford to have on-site professional interpreters or phone services offering medical translation, and not all patients and families feel comfortable with the presence of professional interpreters. As a result, we often need to rely on the translation of relatives or friends who accompany the patient. Nonprofessional translators, however, may not convey all information delivered by the oncologist, either for lack of understanding or to protect the cancer patient from painful truths. Inadequate informed consent may occur as the kind and potential extent of treatment toxic effects may not have been fully translated. At times in my clinical practice, interpreters were not available for the specific language and the patient wasn’t comfortable with phone translation. On several occasions, patients opposed the involvement of anyone other than family in discussing their cancer condition, which was culturally perceived as shameful or stigmatizing. I have also met young women accompanied only by their children, as young as 8 to 10 years old, who had the task of translating for their mothers that they had advanced cancer.

Not all communication models can be exported. Professional translation may be refused, phone or e-mail counseling, interviews or follow-up, or the use of written or audio material may not be considered appropriate means of communication in some cultures. Cultural communication strategies that are important to have as part of the team’s repertoire of culturally competent care will fail if patients or family members perceive
them as disrespectful. We must, however, make efforts to promote the involvement of professional medical interpreters in those settings where this is an affordable and appropriate option and foster their inclusion as valuable members of the oncology teams.

The acquisition of communication skills requires training through intensive interactive courses, whether residential or online, and continuing medical education courses, along with guidelines and publication of practically-oriented research, with clinical tips on making best use of individual and institutional resources to meet the needs of culturally diverse patients and their communities [14, 15, 23, 27, 28]. In addition, specific training for communication teachers is necessary [29].

Finally, after years of research and clinical work in the effort to overcome language and cultural barriers to equal treatment of cancer patients, we have learned that it is impossible to separate cultural competence and patient- and family-centered care in the clinics from health policy-making and sociopolitical considerations [30]. For example, when discriminatory attitudes against new immigrants or existing minorities are chosen by governments over tolerance, and pressures are put on physicians to act as gatekeepers for discriminatory policies, rather than as universal healers, individual efforts at practicing cultural competence in clinics and hospitals are undermined. Despite these limitations, our individual practice of cultural competence, while per se not sufficient to eliminate unequal cancer care, can improve the quality of care that we offer to all cancer patients and can also foster reciprocal understanding and tolerance in the patient–doctor–institution relationship. Ideally, these values may spill over from the clinic to other aspects of our lives and improve our societies.

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