

CROSS-CULTURAL EFFECTS ON CANCER PATIENT-DOCTOR COMMUNICATION

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ABSTRACT

At no other point in time have so many different people and cultures come into contact with one another. This means that medical practitioners will come into contact with patients from all over the world from many different cultural backgrounds. Therefore, it is important to have an understanding of how culture affects doctor-patient communication.

There is a growing body of research that indicates that the cultural and ethnic differences between patients and practitioners play an important role in the patient-doctor partnership and have an impact on effective and open communication. The aim of this paper is to explore whether a patient's culture, race and language influence the quality of the patient-doctor communication and relationship.

As the findings of this journal indicate, there are many factors that influence doctor-patient communication. For example, if a patient who is not able to speak or read English visits a doctor in an English-speaking country; they may not be able to express what is wrong and how they feel. Those patients may even avoid visiting a doctor all together as they are not able to communicate effectively with the doctor. Culture also plays an important role in doctor-patient communication, as due to cultural factors some patients cannot or do not feel comfortable talking about their illness and may not seek help outside their immediate family. Additionally, some patients from minority groups may not be well educated and may not have much knowledge about the illness that they are diagnosed with or understand some basic medical terminology. Practitioners therefore need to have an understanding of cultural difference and take culture into consideration when dealing with patients from minority groups. If medical professionals fail to take culture seriously, they will fail to understand the value systems held by those patients with different backgrounds. They will also fail to understand how to effectively communicate with their patients and that in some cultures truth-telling is either not done directly or at all.

Keywords: doctor-patient relationship, doctor-patient communication, truth-telling, cross-cultural effects on communication

Introduction

Most of the existing research that has been done on cross-cultural factors and their effects on patient-doctor communication has been limited and is mainly focused on the United States (US). The research that has been conducted so far on doctor-patient communication indicates that a patient from a minority group may not be able to effectively communicate with their doctor due to language problems (Roberts, 2001; Tchen et al., 2003). Additionally, patients may not want to convey all necessary information to their doctor because they feel embarrassed or ashamed, they may not trust the medical industry or they may be not educated enough to understand the medical language used by their doctor. Vazquez (2007) finds that older and less educated African-American patients are afraid of medicine and do not trust medical practitioners, which makes treating those patients difficult. A patient's culturally influenced views of medicine and medical practitioners may have a negative impact on effectiveness of the doctor-patient relationship.

Effective doctor-patient communication has not been researched in detail. However, published studies indicate there is considerable evidence that improving communication can improve outcome measures such as patient's adherence to treatment, patient satisfaction and disease outcomes (Rosenberg, Lussier and Beaudoin, 1997; Geiger, 1998).

Apart from an occasional reference to socioeconomic status, the literature has not studied patients' cultural backgrounds and its effects on doctor-patient communication. The cultural difference between practitioners and patients needs to be addressed and it needs to take into consideration that cultural difference does influence doctor-patient communication effectiveness.

Methodology

This journal article is an academic literature review on the cross-cultural effects on cancer patient-doctor communication. It was conducted by searching the PubMed, MEDLINE and EBSCO databases as well as Google scholar for the following keywords: *cultural influences on health, race/ethnicity and cancer, culture and medical decision-making, patient satisfaction, minority health, cultural barriers, multicultural health, doctor-patient communication, language and the doctor-patient relationship, truth-telling*, both alone and in combination. Only publications that specifically addressed the effects of cross-cultural issues on cancer patient-doctor communication were included in this review. Searches were limited to articles published in English; however, as the research into patient-doctor communications is limited there was no year limit set.

What is culture?

The culture of an individual is dependent on the region and society where the individual grows up, as well as other factors that influence and affect daily life. Each individual's experiences are different and they all contribute into a definition of 'culture'. Hence, a culture cannot be summarised and limited into one single characterisation, because its meaning is diverse and different for each individual, society and area of application.

Although a culture is made up of individuals who are different, nevertheless culture influences behaviour and provides explanations on how a group of people with the same cultural background communicate and filter information.

Culture fundamentally shapes the way people understand their world and therefore it strongly affects how patients make meaning of their illness and suffering. Consequently, it also strongly influences their medical decision-making (Kagawa-Singer and Blackhall, 2001).

Kagawa-Singer et al. (2001) state that if medical professionals fail to take culture seriously, they will fail to

understand the value systems held by those patients with a different background to that of the doctor. This lack of cultural understanding will lead to misperceptions, which in turn can lead to poor interaction with patients and their doctor as well as unwanted or inappropriate clinical outcomes (Paul, 1955; Muller and Desmond, 1992). Hence, culture plays an important role in doctor-patient communication and it should not be ignored.

Patient-doctor communication

There is a growing body of research which indicates that the cultural and ethnic differences between patients and practitioners play an important role in the patient-doctor partnership and have an impact on effective and open communication (Cooper-Patrick, Gallo, Gonzales, Vu, Powe, Nelson and Ford, 1999). Cultural barriers such as ethnicity and race have been cited (Roter and Hall, 1992; Betancourt, 2003; Cooper-Patrick et al., 1999) as having an important impact on patient-doctor communication. For example, a doctor may lack an understanding of a patient's cultural background and how direct or indirect the patient is when explaining the symptoms that he/she is suffering from. The patient may not be able to explain all of their symptoms in detail due to language difficulties, low health literacy and/or educational status (Kai, Beavan and Faull, 2011). Some practitioners may integrate racial bias, for example cultural stereotypes, when interpreting patient symptoms or a doctor may believe that he/she has an idea of what medical decisions the patient will make and how the patient will behave when diagnosed with a serious illness such as cancer. Those cultural differences often lead to communication issues between the patient and the treating doctor (Roter and Hall, 1992; Cooper-Patrick et al., 1999). For example, in a country like Australia where due to Australia's diversity, over 200 languages are spoken in the community (Australian Bureau of Statistics, 2013), a patient may not speak English well enough (or not speak English at all) to adequately and effectively communicate with their doctor.

Baker, Hayes and Fortier (1998) conducted a study in which they surveyed 467 minority patients from three groups. The first group were patients that were interviewed in English, the second group were interviewed with an ad-hoc interpreter and the third group were interviewed with no interpreter despite patients not speaking English well and reporting that they need an interpreter. Patients who used ad-hoc interpreters and patients who spoke English well and had no need for an interpreter indicated that practitioners were not friendly or respectful. For patients who needed an interpreter but did not use one, these findings were even more magnified. The third group recorded the worse medical outcomes, reporting that they were not at all satisfied with the time spent by the provider with them or with the interpersonal aspects of care. A further emergency room study with paediatric patients demonstrated that children with parents who had poor English skills had longer, more costly visits than with more testing than those who spoke English well due to the inability to communicate effectively and efficiently with parents (Hampers, Cha, Gutglass, Binn, Krug, 1999). A study conducted by Perez-Stable, Napoles-Springer and Miramontes (1997) on Latino and Caucasian diabetes patients finds a correlation between the primary care doctor speaking the same language as the patient and the patient having a better physical function and well-being.

According to Betancourt (2003), if physicians do not take into account patients' cultural backgrounds, they may start to stereotype patients. It is important for the treating practitioners to understand their patients and to do that the doctor needs to have knowledge of the patient's cultural and socioeconomic background. Having this knowledge will guide the doctor in how to best communicate with their patient. Research indicates that communication between the patient and their physician has a strong influence on the patient as poor communication means that the patient is more likely to have poor adherence and be dissatisfied with their doctor, which will have a negative impact on health outcomes (Flores, 2000; Gornick, 2000; Colman-Miller 2000; Eisenberg, 1979). Nevertheless, despite the demonstrated importance of cross-cultural factors on patient-doctor communication, this area has not been researched extensively (Cooper-Patrick et al., 1999).

According to Jones (2007), there is not sufficient published data that indicates the need for professional translators or family involvement in interpreting for patients who do not speak (for example) English well but live in an English-speaking country. However, studies that examine the use of professional interpreters indicate that patients who have limited English skills believe that interpreters should be used more than they are currently (Baker, Parker, William, Coates and Pitkin, 1996). Additionally, if the doctor cannot understand the patient well or if the patient does not follow doctor's medical advice because they cannot understand the doctor, the doctor may start stereotyping the patient. Patient stereotyping increases when the doctor is frustrated by differences in language, culture or communication style (Roberts et al, 2005). Minority patients are also less likely than majority patients to establish rapport with the treating doctor, less likely to be encouraged to take part in medical decision-making and less likely to receive sufficient information, especially if their English is not proficient (Manson, 1988; Ferguson and Candib 2002). These factors may explain why patients from minority groups often will look for a doctor who belongs to the same ethnic group or race. As they share the same culture, the patient feels that the doctor can better understand them (Pendleton, 1980; Cooper-Patrick et al., 1999) and will be familiar with or have knowledge of their values and belief system. They may even share the same language, so the patient can communicate more effectively with the doctor and often communicate more freely as well, as they do not think that the doctor is judging them or stereotyping them. According to Gray and Stoddard's (1997) research, minority patients are more likely to have minority doctors. For example, (when available) Africa-Americans and Hispanic patients favour carers and doctors from the same race as them due to language and personal preference (Saha, et al 2000). Patients also trust practitioners who are from the same cultural background more than doctors from outside their racial or ethnic group, which is an important distinction as the doctor-patient relationship is highly dependent upon trust (Eisenberg, 1972; Thom, 2001; Cooper-Patrick et al., 1999). According to LaVeist and Nuru-Jeter (2002), patients report greater satisfaction with doctors from their own race.

Socioeconomic levels and low education levels

Communication between doctors and patients is not only verbal - it can also be written. Kilbridge et al. (2009) studied African-American patients who used low-income clinics in the US. They found that most of those patients had a reading level of between a fourth and sixth grader. Due to their limited education, only 5 per cent of men in their sample understood the term 'incontinence' and many did not recognise common terms such as 'erection'. This research suggests that having low levels of knowledge about prostate cancer can be a barrier to some patients' understanding what treatment options they have, how the treatments work and the treatment's side effects (Kilbridge et al., 2009). Practitioners should always double-check if patients understand the language and medical terms that are used and always try to explain information to patients in simple and straightforward terms. However, the situation is often a paradoxical one, where the patients that need the most information receive the least. A US study highlights that doctors usually spend more time and provide more information and better explanations to patients who seem more intelligent, better educated and speak English well (Levy, 1985).

Rasheed (2012) notes that there has not been much research done using diverse cultural samples and so knowledge in the field is limited. However, the existing research on cross-culture and cancer suggests that low socioeconomic levels and low education levels will lead to poor health literacy and poor knowledge and understanding of the illness and treatment options. Researchers such as Kudadije-Gyamfi et al. (2006) find that socioeconomic status plays a major role in the disparities between minority and the majority groups in levels of education and knowledge. However, socioeconomic status is not the only factor related to the level of cancer knowledge. Age, ethnical and racial background and level of education play major roles as well as the patient's cultural background. This is why it is vital that the differences in beliefs and attitudes common to particular ethnic groups be studied (Meyerowitz et al., 1999). Research suggests that good communication between doctors and patients leads to good doctor-patient relationships and there are aspects of the doctor-patient relationship that make important contributions to compliance, satisfaction, and recovery (Korsch et al., 1968; Hulka et al., 1975; Ley et al., 1976; Steward et al., 1978).

Truth-telling about potentially fatal illnesses

According to researchers such as Ersek, Kagawa-Singer, Barnes, Blackhall and Koenig (1998), unlike in the US and many Western countries, telling a patient the truth about a potentially fatal illness like cancer is not standard practice in many countries around the world. For example, in Eastern Europe, France, Italy, Central and South America as well as Asia, most medical practitioners and patients believe that in the case of a potentially fatal illness, withholding medical information (not truth-telling) is much more humane and ethical than honesty/blunt honesty (Surbone, 2000; Thomsen, Wulff, Martin, 1993; Hern, Koenig, Moore, Marshall, 1998; Dalla-Vorgia, Katsouyanni, Garanis, Touloumi, Dragarri, Koutselinis, 1992). Surbone (2000) notes that a report by an Italian oncologist described that in Italy the patients are protected from 'bad news' by both the patient's doctor and the family. The majority of Greeks also do not believe that a patient suffering of a terminal illness should be told the truth (Ersek et al., 1998). Dalla-Vorgia et al. (1992) notes that older and less educated patients are, the less likely they are to want to be told the truth if they are diagnosed with a terminal illness. Telling the truth to a patient can be potentially harmful both mentally and psychologically to the patient, so withholding information about a diagnosis or prognosis is much more humane. Muller (1992) and Beyene (1992) note that Chinese and Ethiopian families like to shield patients from the truth about their diagnoses as they believe that the sick individual should not suffer future unnecessary emotional and physical distress.

Blackhall et al. (1995) surveyed a group of Mexican American patients. Fifty-three per cent of patients stated that they believed the truth about diagnosis should not be told to a patient if the illness is terminal. Within the same ethnic group, older, less educated patients and patients from a lower socioeconomic background preferred less truth-telling. Bach, Cramer, Warren and Begg (1999) used ethnographic interviews with Korean patients who reside in the US to determine that in the case of a terminal diagnosis or prognosis, the patient should never be told the truth as their interview data indicates that it could hastens death.

However, there are many more complex factors involved with this issue than simply not telling the truth. Individuals from Middle Eastern and Asian cultures such as Chinese, Japanese and Koreans may want to know what their diagnoses and prognoses are but wish to be told this information delicately and indirectly (Tong, 1994; Ishii, 1984). In Middle Eastern and Far Eastern Asian cultures, saving face is important, hence indirect communication is used so that the a individual is never put in the position of embarrassment or put down when spoken to.

In Arab culture, saving face, honour, harmony, consensus, social solidarity, family and tribe comes before the individual (Cerimagic, 2013) and in Asian cultures saving face is about preserving family and community honour more than individual honour. Avoiding questions that are potentially sensitive should be done where possible and indirect communication should be chosen when communicating with patients from those cultural backgrounds. Ambiguity saves face and it also allows for possible hope, hence indirect or nonverbal communication is most likely favoured by individuals from those cultures (Uba, 1994; Kim, 1996; Kagawa-Singer et al., 2001).

If doctors take those cultural factors into consideration, the doctor-patient relationship will be stronger and patients will be able to freely and clearly communicate with their doctor. This too will help with better and more effective treatment, greater patient satisfaction and better treatment outcomes. Additionally, it will encourage patients from minority groups not to only look for a doctor who belongs to the same ethnic group as commonly occurs now, therefore increasing patients' access to doctors (Pendleton, 1980; Cooper-Patrick et al., 1999).

Conclusion

As this academic literature review indicates, the communication between doctor and patient is of utmost importance if patients are to be treated successfully. The quality of the doctor-patient relationship is positively correlated with improved health outcomes.

Medical practitioners need to understand that factors such as culture, race, age, education level and socioeconomic influences will play a major role on how patients communicate and how much information they convey to the doctor. Additionally, doctors need to make sure that the information they provide to patients, both verbal and written, is understood by the patient.

Additionally, to gain patients' trust and compliance, doctors should understand and take into consideration patients' cultural backgrounds. If patients see that their doctor understands them and does not judge their decisions, they will be more willing to convey information and follow medical advice, which will lead to better medical outcomes. This cultural knowledge will also help doctors to be more sensitive towards patients and respect their wishes, for example using the culturally appropriate level of truth-telling to a terminally ill patient.

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