

# CROSS-CULTURAL in the Treatment of Cancer



**C**ultural differences, including language and variations in the expression and tolerance of pain, impact a patient's experience and perception of pain<sup>1,2,3</sup> and make pain assessment a challenge. A diagnosis of cancer can still evoke considerable fear and feelings of isolation, making cultural sensitivity all the more important.

Cancer care providers bring their own cultural identity, beliefs, and attitudes into their communications, perceptions, and assessments of patients. In addition to becoming aware of a patient's cultural background, health care providers must recognize that they can, and often do, unwittingly impose their cultural attitudes and beliefs on their patients.

Strategies to improve cross-cultural communication depend on a strong knowledge base and curiosity about the values, beliefs, and behaviors, both verbal and non-verbal, of various cultures in the community or practice setting. In order to avoid stereotyping, this basic knowledge is expanded and/or corrected through an individual/family assessment that takes in additional factors such as acculturation and generational differences. From

this knowledge and understanding emerges a cultural competence that fosters a holistic approach to treating pain in all patient populations.

## THE EXTENT OF THE PROBLEM

A 1997 study by Cleeland and colleagues<sup>4</sup> showed that 65 percent of minority patients received inadequate analgesic prescriptions compared to 50 percent of patients from nonminority cultures. The 216 study patients included 106 African Americans, 94 Hispanics, and 16 people of other minority ethnicities. More minority patients had the severity of their pain underestimated by their physicians, reported that they needed stronger pain medication, and felt that they needed to take more analgesics than their physicians had prescribed.

The Cleeland study also found variations in concerns expressed by specific minority groups regarding pain treatment.<sup>4</sup> Hispanics reported less adequate pain relief than African Americans, but Hispanics were more worried about side effects and taking too many analgesics than African Americans, which may have made them more reluctant to report pain. Overall, Hispanic patients were found to receive less adequate pain relief than African-American patients.<sup>4</sup> If minority patients fear and avoid particular therapies or fail to seek treatment, the care gap between minority and nonminority patients widens even farther.<sup>4</sup>

Research has found the following reasons for cultural disparities in pain management:<sup>4</sup>

- The difficulty minorities face in accessing care
- Health care provider concerns about drug abuse and addiction
- Lack of resources to pay for analgesics, and difficulty filling analgesic prescriptions
- Language barriers and cultural differences.

A study by Anderson and colleagues<sup>5</sup> surveyed African-American and Hispanic patients about pain intensity, pain interventions, and attitudes toward analgesic medications. The patients' physicians also rated their patients' pain as well as the adequacy of their current analgesics. Results indicated that 28 percent of the Hispanics and 31 percent of the African Americans received analgesics that were not strong enough to manage their pain. Even though the majority of African-American and Hispanic study participants received appropriate analgesics, 65 percent still reported severe pain. Physicians underestimated pain severity for 64 percent of the Hispanics and 74 percent of the African Americans, and were more likely to underestimate pain in women than men. The study concluded that inadequate pain assessment, patient reluctance to report



# ISSUES

## Pain

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pain, and lack of staff time were all barriers to adequate pain management.<sup>5</sup>

A study of pain treatment in emergency rooms<sup>6</sup> revealed that African-American patients with long bone fractures were undertreated for pain when compared to Caucasian patients with similar injuries. Of the 217 patients seen in the ER, 127 were African American and 90 were Caucasian. Forty-three percent of the African-American patients received no pain medication compared to 26 percent of the Caucasian patients. Knox Todd, M.D., lead author of the study, concluded that a patient's ethnicity affected medical decision-making, independent of clinical criteria.<sup>6</sup>

A study by Morrison and colleagues found that only 25 percent of pharmacies in predominantly non-white neighborhoods had an adequate stock of opioid medications, compared to 72 percent of the pharmacies in predominantly Caucasian neighborhoods.<sup>7</sup>

The study reported that more than 50 percent of the New York pharmacies that were randomly sampled did not stock adequate medication for the treatment of severe pain.<sup>7</sup> Reasons reported by the pharmacists were disposal regulations, worry about illicit use and fraud, low demand, and fear of theft. Also mentioned was the paperwork required by state and federal drug enforcement agencies, regulatory oversight and monitoring, and fear of penalties by state and federal agencies.

### CULTURAL VARIABLES

Although language barriers can be bridged using professional translators, health care colleagues, and "language lines" of native speakers, nonprofessional translators (i.e., family members or untrained staff members) can cause problems. Medical information is easily mistranslated. Family members may filter or change information for a variety of reasons, including an effort to protect the patient or because cultural taboos preclude the discussion of private matters. Clinicians may not know what is actually being communicated when family members act as translators.<sup>2,8</sup>

Nonverbal communication also varies from culture to culture and is easily misinterpreted. A patient who is nodding may be doing so to be polite or to show respect and may not be responding to a question in the affirmative. Cancer care practitioners need to translate non-verbal communication into words that must then be affirmed or corrected by the patient. Using patient feedback, practitioners must ascertain the patient's understanding of the information. Questions need to be phrased simply so translation is easy.<sup>2,9</sup>

Pain is multidimensional and has emotional, cogni-

tive, spiritual, and physical components. Culture shapes the perception and expression of pain, and that expression can range from the stoic (Hindu and Japanese patients)<sup>3,11</sup> to the dramatic (Italian patients) and even to denial of pain (Irish patients). People can respond to pain passively, appearing quiet and helpless, or actively moan and cry out.<sup>9,10</sup>

Ethnic variations in response to opioids<sup>12</sup> is another aspect of pain that is being explored and that may, over time, add research data to the differences in pain behavior and response to treatment observed between cultures.

Pain and even the medications prescribed to relieve pain may have symbolic meaning for members of certain religions or cultural groups. Pain can be seen as a punishment from God, or something that must be endured.<sup>9</sup> Because opioid medications are often associated with addiction, adverse side effects, and death, a patient may be reluctant to report pain or to take opioid medications as prescribed.<sup>4,9</sup>

### CONCLUSION

Cultural competence is vital when practitioners treat pain in a culturally diverse society. Culture impacts the perception, expression, and assessment of pain, and cancer care providers need to be aware of the cultural background of the patients they serve and understand how their own cultural attitudes and beliefs influence clinical decision-making. Generalizations about ethnic groups do not predict individual behavior and are only to be used against a background of ongoing assessment that acknowledges and seeks to understand individual patient and family differences, generational influences, and acculturation. ❏

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## Two Case Studies

**RW** was a 39-year-old African-American woman diagnosed with inoperable lung cancer. A single parent with three young children, she was referred to the Pain and Palliative Care Team by her oncologist for the management of intractable pain. The oncologist reported that he had told the patient her life expectancy was short and he had recommended referral to hospice.

RW was reluctant to take her pain medication, and often waited until the pain was unbearable before she would call for the nurse. She became upset and physically shaken in response to discussions regarding prognosis and treatment decisions. On several occasions, RW threatened to sign out “against medical advice.” In exploring the patient’s distress and behavior, RW told the social worker that she feared becoming addicted to morphine and that her mother was also worried because her brother was a “drug addict.” RW said she thought her cancer and her pain were a punishment from God. When she was having discomfort, RW could be overheard crying out, “God what have I done to deserve this?”

When the pain team understood RW’s fears and beliefs, they offered her information about the medical use of opioids and instituted ongoing assessments and contacts with the family, which helped RW and her mother feel safe and allayed their fears about addiction. The chaplain was able to help RW in her spiritual struggle. Eventually, RW agreed to a DNR order and signed onto a hospice program. The social worker continued a relationship with the patient and family, collaborating with the hospice team until the patient’s death.

**LM** was a 52-year-old married Muslim man with a diagnosis of advanced prostate cancer metastatic to the bones. He was admitted to the hospital with severe, intractable pain. The attending physician, an internist, referred the patient to the Pain and Palliative Care Team to be evaluated for a PCA pump.

LM’s wife, attired in full Muslim dress, and his

daughter sat by the bedside as the pain management physician attempted to discuss the various interventions available to treat his pain, including the use of the PCA pump. The patient declined to make any decisions regarding his care, including pain, and deferred all discussions about his treatment to his nephew. LM’s wife and daughter remained silent, politely declining the physician’s offer to explain the treatment options.

The physician was puzzled and concerned because the patient’s prognosis was poor and end-of-life decisions had not been made. If the patient did not want to make decisions, the wife was the legal “next of kin.” The social worker also attempted discussion with the patient about his illness and wishes regarding treatment. The patient again deferred to his nephew.

The social worker contacted the pastoral care department for information about the Islamic religion and discovered that in that faith it is customary for the closest male relative to make all health care decisions about serious illness. Patient autonomy and the concept of informed consent is a European-American model that reflects Western values and the right of the *individual* to self-determination.<sup>13,14,15,16,17</sup> Many cultures do not work from a model of individual autonomy and individual decision-making. Western medicine is a culture in itself, based on the same Western values. The team’s initial assessment was in keeping with these Western values.

One solution in this kind of situation is to create the opportunity for “informed refusal.” Health care professionals offer the *option* of information, with the patient deciding whether to receive the information directly or to have the information given to a designated representative.<sup>14</sup> The patient who delegates decisions to another person retains autonomy through that delegation because the decision is consistent with the patient’s values and beliefs.

Traditional Islam teaches the sanctity and the preservation of life at any cost. Hospice can be viewed as being at odds with faith in Allah to heal. With this understanding, the team became comfortable working with the nephew. The use of opioids is allowed by the Islamic faith only in cases of severe pain, and the patient was placed on a PCA pump. ☐

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<sup>9</sup>Steeffel L. Treat pain in any culture. *Nurs Spectrum-Career Fitness Online*. November 19, 2001. Available at: <http://community.nursingspectrum.com>. Accessed June 24, 2002.

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<sup>16</sup>Vanchieri C. Cultural gaps leave patients angry, doctors confused. *J Natl Cancer Inst*. 1995;87(21):1576-1577.

<sup>17</sup>Crawley L, Payne R, Bolden J, et al. Palliative and end-of-life care in the African American Community. *JAMA*. 2000;284(19):2518-2521.