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CANCER PATIENT'S EXPERIENCE CROSSING THE HEALTH CULTURE

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Abstract

Cognitive anthropology does not predict human behavior, but tries to access principles that rule behavior. Cross-cultural communication is a skill acquired through a learning process, and it can improve doctor-patient relationship and enhance the outcomes of care. The unfulfilled expectations of a patient may influence the patient self-esteem and his perceived role in the society. For some patients living with cancer, it was found as an unforeseen benefit of learning to be closer to God. Based on a narrative communication, we tried to underline cross-cultural differences in cancer patients from different countries with various backgrounds. We described the patient reactions, his way of interpreting the things that happened to him, and his actions regarding adaptive changes in behavior. The originality of the study resides in understanding cross-cultural patterns of cancer patients. The innovative element is the use of qualitative research and its application in health care.

Introduction

In most countries, either we speak about America, Asia (Chiang et al., 2010), Australia or about European (Ferlay et al., 2013) regions, the health care system is facing an increased financial burden that switched from acute care to chronic diseases as hypertension, diabetes and cancer (WHO, 2014; Luengo-Fernandez et al., 2013). GLOBOCAN statistics show a higher incidence rate in men than in women at almost 25 percent. Europe is among the top positions in the world for colorectal and prostate cancer (WHO, 2012). The incidence of cancer and the mortality rate are likely to have an ascending trend in the next years. Although breast cancer incidence keeps a highest rank in more developed countries compared with Africa, mortality registers much higher levels in low-income countries most likely explained by late diagnosis or by lack of curative treatment options.

Cognitive Anthropology

Cognitive anthropology does not make predictions about most or less likely human behavior, but its role is to access principles that conduct behavior.

The developing of cancer may lead to death in a very short period of time, or may become a chronic disease, or the patient can be cured and survive to this condition.

Narrative communication is the form that brings out the principles that rule patient's behavior.

Cultural Competencies

The term of "cultural competence" was stipulated as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (Ngo-Metzger et al., 2006).

The Influence of Cultural Diversities on Individual Preferences

Culture is an instrument that engraves specific meanings upon perceiving illness, suffering and dying (Kagawa-Singer & Blackhall, 2001). As population grows older worldwide and increases in diversity, as it is in the United States, the various backgrounds augment the risk of misunderstanding terminal care. In the doctor-patient relationship, the physician, family and the patient, regardless if he/she is an African American or a Chinese-American, intersect their own cultural beliefs, values, and practices.

In an American study, the emphasis was on disparities between minorities and whites, the latter being more involved in decision-making (Ngo-Metzger et al., 2006). The minority population and those with a low socioeconomic status declare more often a lack of mutual trust and they also perceive when the physician doesn't take into consideration their personal beliefs and preferences. This attitude may influence the patient self-esteem and his perceived role in the society (Collins et al., 2002).

Patients' Healthcare-Seeking Behavior

A study performed in Taiwan shows that doctor shopping behavior refers to the compulsion of a patient, who finds out that he/she has cancer for the first time, to consult several physicians in order to try to live longer (Li et al., 2013).

It is more prone to exist in the first two weeks in newly diagnosed cancer patients (Li et al., 2013).

Most studies that report factors that explain the tendency of doctor shopping behavior were related to a frequent change of primary care physician. The influencing conditions are patient gender and residence, patient dissatisfaction with or distrust, hospital reputation and location (Graugaard et al., 2003; Bronstein et al., 2000), doctor's affiliation with a medical or scientific group, other people recommendations or medical fees (Wolinsky & Steiber, 1982), patient health status (Harris, 2003), and patient educational background (Sato et al., 1999).

Expectations

Expectations are a personal opinion about future disease-related events (Olson et al., 1996) and may influence the appraisal on philosophy of life and future hope (Winterling, 2007).

In the Cancer Care Outcomes Research and Surveillance (CanCORS) study, there were enrolled over 10,000 patients with lung cancer and colorectal cancer during three years (Catalano et al., 2013).

The awareness of the prognosis was more accurately estimated by patients who discussed life expectancy with their "most important doctor" (in whom they translated autonomy for decision making) than those who differed the truth disclosure (Liu et al., 2014).

Unfulfilled expectations may turn towards a positive direction when the patient finds himself/herself "different than expected", or the patient may not be satisfied and he/she may feel "worse than expected".

Cross-cultural differences in cancer patients

Societies are facing increases in rates of migration of population from various parts of the world, forming multicultural diversities with different ways of understanding health and social care, and of perceiving their quality of life and ageing phenomenon.

Racial/ethnic disparities as well as the elderly have their own diversity regarding illness experience, inequity in dying or health care.

In Cambodian population, culture values dictate indirect communication style without yielding to emotions or any hostility, the patient waiting to be asked if he/she needs pain killer medication (Mahloch et al., 1999). In African countries like Somalia, bioethics and the concept of autonomy are unknown, and the patient will wait to be asked if he/she is in pain (Countries and Their Cultures, 2012).

Spirituality

Cancer patients may experience emotional and spiritual distress at the moment when the diagnosis of

cancer is revealed, while health status changes as the cancer advances in evolution. The state of mind tends to fluctuate while the cancer progresses or when it can no longer be cured translating the patient into palliative care.

Patients' spiritual needs include demanding help and hope, and understanding the sense of pain and suffering they experience (Schulz, 2008).

Spiritual and religious interventions may support patients and offer answers to their psychological struggles. The Cicely Saunders Institute conducted a research to review the death in this research area (Candy et al. 2012).

A study on people from sub-Saharan Africa revealed the importance of "feeling at peace" and of "feeling that life is worthwhile" in screening spiritual distress (Selman et al. 2011a) and measuring spiritual outcomes (Selman et al. 2011b). Spiritual and religious resources, and family are found to support some people to cope with their physical illness and psychological changes after the diagnosis and prognosis were disclosed to them (Koffman et al., 2012).

A study conducted on Muslim Iranian patients revealed items like "talking with God", "doing religious activities", "having a deep relationship with God" and "offering support and love to others" (Rahnama et al., 2012). Thus, the cancer is perceived as unforeseen benefit of learning to be closer to God and strengthening the God-patient relationship. God is associated to a necessity for truth. Patients describe the support they feel coming from divinity using their own words: "trust in God" and being in a good "relationship with God" (Rahnama et al., 2012).

Relying on spiritual and religious beliefs helps cancer patients to cope with their illness in a more active style, accepting and dealing with it in a positive manner (Weaver & Flannelly, 2004).

Cross-Cultural Communication

An important aspect of cross-cultural communication is reflected by doctor-patient ways of share or exchange information.

Patients may want to be involved in decision making, but they play a small or an important role depending on cultural beliefs and values, or on patient personality and need for control.

Breaking bad news represents a difficult task, involving discussing prognosis and advanced directives, and it needs to maintain a good balance between biomedical knowledge cancer-related and communication skills (Searight & Gafford, 2005).

Instrument of Research

First developed in Sweden in pedagogy, the phenomenography – the Greek term for "what happens" – focuses on perceptions rather than the objective truth (Marton, 1981).

The fundamental of qualitative research, which is done by face-to face or phone interviews, is the narrative communication. The interview comprising open

questions is usually performed by a skilled person who can build a trusty interviewer-patient relationship and a good interaction in a short period of time. The interviews must be recorded, and afterwards verbatim typed, coded and analyzed by the researcher.

Discussion

From the west to the east part of the world, bioethics experienced a sequential launch and development. Although nowadays bioethics is part of the integrated educational teaching in medical schools worldwide, its clinical application is still underused.

Sometimes we encountered differences between the answers about patient's preferences and his actual play role in doctor-patient discussion.

Cross-cultural understanding and the use of communication techniques in the physician's "skilled hands" enhance both the healthcare outcomes and the fulfilling of patient's expectations and his/her satisfaction perception. Cross-cultural care should be able to manage the complex relationship between patient, family, and clinician that intersect on different cultural beliefs, values, and practices.

The patient can build an interactive relationship with the physician, modelling health care during the illness experience in the shape of his/her spirituality, beliefs, values and culture.

The innovative element is the use of qualitative research and its application in health care. Narrative communication can underline cross-cultural differences in cancer patients from different countries with various backgrounds. The originality of the study resides in understanding cross-cultural patterns of cancer patients.

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References:

1. Bronstein, B. H., Marcus, D., & Cassidy, W. (2000). Choosing a doctor: an exploratory study of factors influencing patients' choice of a primary care doctor. *J Eval in Clin Pract*, 6:255–262.
2. Candy, B., Jones, L., Varagunam, M., Speck, P., Tookman, A., King, M. (2012). Spiritual and religious interventions for well-being of adults in the terminal phase of disease. *Cochrane Database Syst Rev*, 16(5): CD007544.
3. Catalano, P. J., Ayanian, J. Z., Weeks, J. C., Kahn, K. L., Landrum, M. B., Zaslavsky, A. M., Lee, J., Pendergast, J., & Harrington, D. P., for the Cancer Care Outcomes Research and Surveillance Consortium. (2013). Representativeness of

- Participants in the Cancer Care Outcomes Research and Surveillance (CanCORS) Consortium Relative to the Surveillance, Epidemiology and End Results (SEER) Program. *Med Care*, 51(2): e9–15. doi: 10.1097/MLR.0b013e318222a711.
4. Chiang, C. J., Chen, Y. C., Chen, C. J., You, S. L., Lai, M. S.; Taiwan Cancer Registry Task Force (2010). Cancer trends in Taiwan. *Japanese Journal of Clinical Oncology*, 40(10):897-904.
 5. Collins, K. S., Hughes, D., Doty, M. M., et al. (2002). *Diverse Communities, Common Concerns: Assessing the Health Quality for Minority Americans*. New York: The Commonwealth Fund.
 6. Countries and Their Cultures. (2012), 2012, from <http://www.everyculture.com>.
 7. Ferlay, J., Steliarova-Foucher, E., Lortet-Tieulent, J., Rosso, S., Coebergh, J. W., Comber, H., Forman, D., Bray, F. (2013). Cancer incidence and mortality patterns in Europe: estimates for 40 countries in 2012. *European Journal of Cancer*, 49:1374-403.
 8. Graugaard, P. K., Eide, H., Finset, A. (2003). Interaction analysis of physician-patient communication: the influence of trait anxiety on communication and outcome. *Soc Sci Med*, 49:149-56.
 9. Harris, K. M. (2003). How do patients choose physicians? Evidence from a national survey of enrollers in employment-related health plans. *Health Serv Res*, 38:711–732.
 10. Kagawa-Singer, M., Blackhall, L. J. (2001) Negotiating cross-cultural issues at the end of life: "You got to go where he lives". *JAMA*, 19:286(23):2993-3001.
 11. Koffman, J., Morgan, M., Edmonds, P. M., Speck, P., Higginson, I. J. (2012). 'The greatest thing in the world is the family': the meaning of social support among black Caribbean and white British patients living with advanced cancer. *Psychooncology* 21(4): 400–8.
 12. Li, H.- C., Hsiao, Y.- L., Tang, C.- H., Jian, W.- S., Nae-Fang Miao, N.- F. (2013). Doctor Shopping Behavior Among Cancer Patients: A Nationwide Population-based Study in Taiwan. *Journal of Experimental and Clinical Medicine*, 5(5):172-176.
 13. Liu, P.-H., Landrum, M. B., Weeks, J. C., Huskamp, H. A., Kahn, K. L., He, Y., Mack, J. W., & Keating, N. L. (2014). *Journal of Palliative Medicine*, 17(6): 673-682. doi:10.1089/jpm.2013.0460.
 14. Luengo-Fernandez, R., Leal, J., Gray, A., & Sullivan, R. (2013). Economic burden of cancer across the European Union: a population-based cost analysis. *Lancet Oncology*, 14:1165-74.
 15. Mahloch, J., Jackson, C., Chitnarong, K., Sam, R., Ngo, L., & Taylor, V. (1999). Bridging cultures through the development of a cervical cancer screening video for Cambodian women in the United States. *Journal of Cancer Education*, 14(2), 109-114.
 16. Marton, F. (1981). Phenomenography- describing conceptions of the world around us. *Instructional Science* 10, 177-200.
 17. Ngo-Metzger, Q., Telfair, J., Sorkin, D. H., Weidmer, B., Weech-Maldonado, R., Hurtado, M., & Hays, R. D. (2006). Cultural Competency and Quality of Care: Obtaining the Patient's Perspective. Commonwealth Fund pub. no. 963. www.cmwf.org
 18. Olson, J., Roese, N., & Zanna, M. (1996). Expectancies. In: Higgins, E., Kruglanski, A. (Eds.), *Social Psychology: Handbook of Basic Principles*, Guilford, New York, pp. 211-238.
 19. Rahnama, M., Khoshknab, M. F., Maddah, S. S. B., & Ahmadi, F. (2012). Iranian cancer patients' perception of spirituality: a qualitative content analysis study. *Bio Med Central Nursing*, 11:19. <http://www.biomedcentral.com/1472-6955/11/19>
 20. Sato, T., Takeichi, M., Hara, T., and Koizumi, S. (1999). Second opinion behavior among Japanese primary care patients. *Brit J Gen Pract*, 49:546–550.
 21. Schulz, E., Holt, C. L., Caplan, L., Blake, V., Southward, P., Buckner, A., & Lawrence, H. (2008). Role of spirituality in cancer coping among African American: A qualitative examination. *Journal of Cancer Survivorship*, 2(2):104–115.
 22. Searight, H.R. & Gafford, J. (2005). "It's like playing with your destiny": Bosnian immigrants' views of advance directives and end-of-life decision-making. *J Immigr Health*, 7(3):195–203.
 23. Selman L, Harding R, Gysels MH, Speck P, Higginson IJ (2011a). The measurement of spirituality in palliative care and the content of tools validated cross-culturally: a systematic review. *J Pain Symptom Manage* 41(4): 728–53.
 24. Selman L, Higginson IJ, Agupio G, Dinat N, Downing J, Gwyther L, Mashao T, Mmoledi K, Moll T, Sebuyira LM, Ikin B, Harding R (2011b). Quality of life among patients receiving palliative care in South Africa and Uganda: a multi-centred study. *Health Qual Life Outcomes* 2011; 9: 21.
 25. Weaver, A. J., & Flannelly, K. J. (2004). The role of religion/spirituality for cancer patients and their caregivers. *Southern Medical Journal*, 97(12), 1210-4.
 26. Winterling, J. (2007). Hope and Despair. Philosophy of life, expectations and optimism in cancer patients and their spouses. Acta Universitatis Upsaliensis. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* 228. 67 pp. Uppsala.
 27. Wolinsky, F. D., & Steiber, S. R. (1982). Salient issues in choosing a new doctor. *Soc Sci Med*, 16:759–767.
 28. World Health Organization. International Agency for Research on Cancer: GLOBOCAN 2012

- (IARC), Section of Cancer Surveillance. Available at: <http://globocan.iarc.fr/>; (accessed 4/10/2014)
29. World Health Organization. WHO methods and data sources for country-level causes of death 2000-2012. Department of Health Statistics and Information Systems WHO, Geneva. May 2014. www.who.int/healthinfo/global_burden_disease/GlobalCOD_method_2000_2012.pdf.

