

Cultural differences in breast health: Helping all ethnocultural groups to get screened for cancer

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Few things are more emotional than the Citizenship Ceremony - a congregation of people coming from many different countries bringing to Canada their incredibly rich heritage, life experience and willingness to improve the quality of life for all Canadians. It is a new start that implies a burden of new information and the need to prioritize. Learning the language, getting a job are obvious first steps. However, while access to health care is available, knowledge and utilization of the new resources is lacking. With so many new priorities, sometimes self-care is overlooked 1-2.

As Health Care providers, one of the challenges is to let new immigrants know about resources (i.e. screening programs, psychosocial support) that are available in Canada 3-4.

But informing the individual is often not enough. We must also promote the utilization of these tools that, because they are often unfamiliar to them, may otherwise be disregarded. Moreover, these tools may be in opposition to their customs. Breast health is a particularly sensitive area, where religious, cultural, and personal barriers may be difficult to overcome 5-9.

Many of us have identified situations that highlight these barriers, not only coming from the patients but also from our peers, health care practitioners who have seen the impact of these barriers first hand. This has led to this multidisciplinary effort to raise awareness on this issue.

Some Cases and Comments

The situations below are based on real cases, but all personal information has been modified to protect confidentiality.

Mariah is a 48-year-old woman that emigrated from Pakistan 15 years ago. During the last year she had menopausal symptoms and requested a change from a male to a female family doctor. She did not disclose having a mass in her breast until it became large and painful. She was diagnosed with an advanced breast cancer that had evolved over 2 years. She had not mentioned it to her prior or current family doctors (despite the latter being female and having dealt with gynecologic issues). Her annual physical exams/new patient physical exam had not included the breasts.

Mariah's case highlights the fact that our current evidence-informed guidelines do not include the breast exam. The Periodic Health Exam/new patient physical exam are based on the assumption that the patient will seek advice as soon as they notice an abnormality. These guidelines do not seem appropriate for patients with strong cultural barriers to address breast health issues. Also, we should not assume that patients that have lived in Canada for a long time will adopt our approach to health care.

Anna is a 40 year old woman who moved from the Congo to Canada 6 years ago. She described to her family doctor having nipple pruritus for 4 months. On exam she was found to have a large nodule in the breast and enlarged lymph nodes in her axilla. She mentioned knowing about the nodule for some time, but she first consulted friends that urged her to go to her physician.

Anna, like Mariah, was below the age that we recommend screening all women for breast cancer. As a result, the only way for her family doctor to know she had concerns about her breast was for the patient to initiate the dialogue. She first seeks the advice from friends and was recommended to go to a doctor. Talking about issues involving sensitive areas of the body is hard for a lot of people for cultural, religious, or personal reasons.

Canadian physicians need to be aware that even when asked directly about breast or sexual health, patients may not disclose concerns, unless questions are framed in private and in a culturally sensitive way. Often, immigrants prefer moving to communities with neighbors from the same country and if some resources are foreign to all of them, such as cancer screening programs, they may be collectively under-informed about availability and potential benefits of those resources. Physicians give advice, but acculturation (the cultural modification of an individual or group by adapting to or borrowing traits from another culture) takes time and is mainly led by the social environment.

DISCUSSION

The concept of "early detection/screening" (the detection of asymptomatic/silent/not evident disease) assumes that the population that is not target of this strategy will consult a physician if they notice an abnormality. This may not be applicable in our multicultural milieu. The preventive approach, including cancer screening, may be foreign to people coming from countries that focus mainly on treatment. Patient's barriers to cancer screening include, but are not limited to, language, gender, preference not to bother families for transportation, financial strain, lack of awareness of programs and locations.

Developing specific guidelines and policies that take into account cultural differences is an important endeavor. It will take time. It needs to aim not only to increase screening but also early detection. We may be able to have a direct impact in the quality of life and health care of our patients if we take a minute to think and identify those patients that may have cultural barriers in the screening process. An enhanced opportunity exists if we pause to reflect about ourselves, our own practice, and our relationship with patients and friends who come from different backgrounds.

In this multicultural health care context, the constant variable is our professional commitment and humanism.

RESOURCES AVAILABLE FOR HEALTH CARE PROVIDERS

- A list of screening locations is available by calling Screening Programs at 1-866-727-3926 or at <https://screeningforlife.ca/where-to-get-screened/>
- Cancer Screening Status Report on Netcare: this is a one stop snap-shot of how up to date clients are for breast, cervical and colorectal cancer screening. Find out more at www.screeningforlife.ca/cancer-screening-status-reports/
- Breast screening resources, including posters, brochures and flyers, are available at no cost at www.screeningforlife.ca/healthcare-providers-resources

Both authors are members of the "Creating Health Equity in Cancer Screening (CHECS) Advisory Committee" that is a multidisciplinary team working to reduce cultural differences and health inequities.



Dr. Gloria Roldan Urgoiti is a Medical Oncologist. As an immigrant and International Medical Graduate she is particularly interested in Cultural Differences that may influence screening, diagnoses and treatment of patients with cancer.



Dr. Christine Gibson is a family physician who works in health equity, social innovation, and global capacity building for care.

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