

Cancer and AAPIs

Cancer is the second leading cause of death in the US. In 2003, an estimated 1,334,100 people in the US are expected to be diagnosed with cancer, and 556,500 are expected to die from cancer. (American Cancer Society, 2003). One-half of new cancer cases occur in people aged 65 years and over. (US DHHS, 2000).

Between 1990 and 1996, the lung and bronchus, prostate, female breast, and colon and rectum were the most common cancer sites for all racial and ethnic populations in the US. Together, they accounted for approximately 54% of all newly diagnosed cancers. (US DHHS, 2000).

To many, cancer embodies the fear of pain, suffering, and death (Sontag, 1977). Prevention and early detection are key elements in control, but unlike other chronic diseases such as heart disease and diabetes, cancer evokes a fear that creates barriers to the utilization of health care services. Successful cancer prevention and treatment efforts must be tailored to address the distinct health beliefs and behaviors of different cultural groups.

Although the specific causes of most cancers are not well understood, **cancer is thought to be caused by three factors: environmental exposure, viral agents, and genetic predisposition.**

Environmental factors include lifestyle behaviors such as cigarette smoking and improper diet. Smoking has been linked to cancer of the lung, mouth, bladder, and other organs. Diets high in fat and low in fiber have been linked to cancer of the colon. Excess alcohol intake has been associated with cancer of the esophagus, tongue, and pharynx. (Metzlin, 1992).

Viral infections have been implicated in a growing number of cancers. The human papillomavirus is thought to play a causal role in the development of cancer of the cervix. Those who carry the hepatitis B virus have a greatly increased risk of liver cancer. *Helicobacter pylori* has been shown to be related to stomach cancer, and the Epstein-Barr virus is related to cancer of the nasopharynx. (Nomura et al., 1991).

The third cause, genetic predisposition, appears to account for only 2% of the cancer incidence. (Desmond, 1987).

Recommendation

Help your clients modify their behavior to:

- Eliminate cigarette smoking
- Modify diet and alcohol intake
- Avoid exposure to other environmental or occupational carcinogens
- Prevent exposure to hepatitis B virus
- Undergo testing to detect early-stage cancer and maximize positive treatment outcomes
- Report symptoms of cancer for which there are no screening tests

(Jenkins and Kagawa-Singer, 1994).

Adherence Factors

Communication

- **Medical information can be overwhelming.** Giving too much medical information at once can cause misunderstanding and possibly nonadherence to treatment advice.

Suggestion

Pace the delivery of information. As with all patients, try to avoid overwhelming your AAPI patients with too much information. Assess the individual's ability to take in information, and decide how much to present at one time. (Yu, 1999).

- **Use of interpreters.** Providers working through interpreters should be aware that patients may be reluctant to discuss sensitive topics in the presence of friends or relatives. Professionally certified medical interpreters may have their own culturally based biases. (Yu, 1999).
- **Indirect communication is common.** Many AAPIs use indirect or nonverbal communication rather than simply asking for what they want. Ideally, from an AAPI point of view, needs are met without having to ask directly or confront. Physicians who expect their patients to speak up and say what is on their minds often miss the substance of what is being communicated. (Yu, 1999).

Suggestion

Try to listen carefully and observe the indirect or nonverbal communication of your AAPI patients. This will help you understand any concerns that may interfere with their adherence to the recommended treatment.

- **Deference to authority and nonadherence.** Most AAPI cultures value deference to authority, which is shown by smiling or nodding. Patients may appear to be compliant just to please the provider, even if they disagree with what the provider is saying. The desire to please the provider can prevent patients from self-advocating, raising concerns, or fully examining their options. This can result in nonadherence. (Yu, 1999).
- **Reluctance to ask questions.** Some AAPIs may not be comfortable asking questions if they do not understand the provider's explanations or instructions, making it difficult to follow the provider's recommendations.

Suggestion

Have the patient explain in his or her own words what you have said. Ask the patient what help he or she might need to adhere to the recommended treatment. Provide handouts that the patient can refer to at home.

Other Factors

- Compared with whites, **all AAPI populations are less likely to undergo screening procedures**, including Pap smear, breast exam, mammography, rectal exam, and stool blood test. (Jenkins and Kagawa-Singer, 1994).
- **Reluctance to disrobe**, especially among Vietnamese women, and physician deference to a patient's modesty may act as barriers to some cancer screening procedures. (Jenkins and Kagawa-Singer, 1994).
- **Fatalism.** Illness and death may be attributed to bad luck. Thus, the outcome of an individual's disease may be perceived fatalistically. Fatalism and other cultural beliefs can cause some patients to be passive about their health care. (Yu, 1999).

References and Resources

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