

Through the lens of oncologists when communicating with non-Western migrants about cancer diagnosis, treatment, and prognosis: Results from a Dutch online survey

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ARTICLE INFO

Keywords:

Oncologist
Cancer
Non-western
Migrant
Education
Training

ABSTRACT

Objectives: With rising cancer incidence rates and a growing migrant population in Europe, understanding oncologists' challenges in communication and providing cancer care to patients with a non-Western migration (NWM) background is crucial. This study aimed to explore the perspectives and experiences of oncologists, including those in training, as they interact with such patients about their cancer diagnosis, stage, treatment, and prognosis.

Methods: Between June and September 2023, an online survey was conducted among medical oncologists and trainees (MO) and pulmonologists and trainees (PO) from university medical centers or regional hospitals in the Netherlands. The survey, hosted on LimeSurvey, included descriptive statistics, Chi-Square tests to compare the responses of MO and PO, and thematic qualitative analysis of responses to open questions.

Results: The survey included 112 oncologists, including trainees. The majority directly disclosed a cancer diagnosis to patients, often using family members as interpreters because of language barriers. When families opposed direct disclosure, most oncologists explored the patients' preferences. More than half of MO and PO were satisfied with their communication, with PO reporting higher levels of helplessness and discontent. Challenges included managing family expectations and addressing cultural differences. Qualitative analysis of open responses revealed six themes in decreasing frequency: person-centered care, cultural competence and ethics, education and research, third parties, communication, and palliative care. Nearly 80 percent of oncologists want more research to develop practical tools to optimize communication.

Conclusion: Oncologists (in training) adhere to Western care practices when communicating with patients with an NWM background, which can lead to challenges because of different expectations and cultural beliefs. Oncologists express a need for tools to optimize communication with patients with an NWM background.

Practice implications: The implementation of education and training programs can support oncologists in their daily work and promote culturally sensitive healthcare delivery in oncology.

1. Introduction

The global burden of cancer is rapidly increasing, with an estimated 19.3 million new cases and almost 10 million deaths in 2020. The global cancer burden will rise to 28.4 million cases by 2040, largely due to demographic changes, economic growth, and risk factors from globalization [1]. Migration has contributed to multicultural diversity in European countries, including the Netherlands, where nearly 26 % of the

population had a migration background in 2022 [2,3]. In the Netherlands, 'persons with a migration background' refers to both migrants and their descendants. Statistics Netherlands, the national office of the Netherlands responsible for collecting and analyzing data on various aspects of Dutch society, defines this individual as someone with at least one parent born abroad, distinguishing between Western and non-Western origin [4]. Non-Western includes Africa, South America, Asia (excluding Indonesia and Japan) and Turkey, while Indonesia and

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<https://doi.org/10.1016/j.pec.2025.108679>

Received 12 July 2024; Received in revised form 17 December 2024; Accepted 21 January 2025

Available online 27 January 2025

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Japan are considered Western due to socioeconomic and cultural similarities [5]. As of January 2022, 14 % of the population is of non-Western origin, primarily from Turkey (17 %), Morocco (16.6 %), and Suriname (14 %) [3]. In the Netherlands, historically Christian but now largely secular, nearly 6 % of the population identifies themselves as Muslim, with Moroccan and Turkish communities representing the largest Muslim migrant groups [6]. Migrants faced specific obstacles when dealing with cancer, such as understanding the local healthcare system and difficulties in communication with healthcare providers (HCPs) [7].

Cancer is a life-threatening disease, and patients from all backgrounds experience universal emotions such as fear when faced with a cancer diagnosis and treatment [8]. However, migrants may experience communication challenges due to language barriers, cultural and social differences, and assumptions made by HCPs [9,10]. These communication challenges can result in decreased patient compliance with treatment, decreased satisfaction, and poorer health outcomes [11]. A study among HCPs in 16 European countries identified several challenges in providing care to migrant populations, including language barriers, migrants' unfamiliarity with the healthcare system, cultural differences, different understandings of illness and treatment, and negative attitudes among staff and patients [12]. Studies suggest disparities in doctor-patient communication based on ethnic backgrounds, with HCPs speaking less to migrant patients using interpreters, who in turn express themselves less verbally [9,13,14]. Furthermore, oncology professionals face emotional stress, and logistic issues during communication with patients from diverse backgrounds [15–17]. Understanding the challenges of HCPs in communicating cancer care with migrant populations is crucial to addressing healthcare disparities.

A review found the absence of studies providing direct insights into how to discuss cancer diagnosis, treatment, and prognosis with the main non-Western people living in the Netherlands [18]. This study aimed to explore the perspectives and experiences of oncologists (in training) during interactions with patients with a non-Western migration (NWM) background regarding cancer diagnosis, treatment, and prognosis by conducting an online survey in the Netherlands. In this study, “oncologists” refer to both medical specialists (specifically medical oncologists and pulmonologists) and those in training. To provide further clarification, pulmonologists in the Netherlands complete two years of internal medicine and four years of lung disease, which includes oncology. This enables them to treat all forms of lung cancer. By exploring the experiences of oncologists with patients from these backgrounds, we could gain a better understanding of the barriers they face, the strategies they employ, and the areas where improvements can be made to enhance patient-centered care.

2. Materials and methods

2.1. Sample and data

The survey was conducted between June 23, 2023, and September 24, 2023. The researchers sent out invitation emails to medical oncology and pulmonary departments in Dutch university medical centers and regional hospitals. Oncologists were encouraged to share the link with their colleagues. The emails contained direct links to the questionnaires hosted on LimeSurvey. Implicit informed consent was assumed when an oncologist started with questionnaire completion. This study was approved by the medical ethics committee (METC) of Erasmus University Hospital under registration number MEC-2022–0688.

2.2. Survey instrument

In this exploratory study, we did not conduct formal psychometric testing on the survey instrument, but the research team pre-tested the survey instrument to ensure clarity. The survey instrument was developed with expert input and based on our previous review, which

identified key challenges in discussing diagnosis, treatment, and prognosis with non-Western cancer patients [18]. The first section of the survey instrument assessed the demographic and professional characteristics of the oncologists through seven questions (Table 1). The second section consisted of questions on the experiences of the oncologists (Table 1). The questionnaires primarily consisted of multiple-choice questions, with some questions allowing participants to select multiple answers using categorical categories. Additionally, each question included the option “otherwise, please specify” accompanied by an open text box for participants to provide their own responses. All questions were optional and could be skipped by the participants. All responses were processed anonymously. The responses were stored on an internal server within Erasmus University Hospital.

2.3. Statistical analysis

Data entry and analysis were carried out using the Statistical Package for Social Sciences (SPSS) Statistical Software version 28.0.1.0 2021 (142). Given the exploratory nature of this study, no minimum sample size was required. The analysis includes descriptive statistics, wherein numbers and frequencies for categorical variables were used to generate percentage distributions. Categorical answers were compared with the Chi-Square test for differences between medical oncologists and pulmonologists. In addition to the “otherwise, please specify” option each question, there was an open-ended final question where respondents could add more related comments. Thematic qualitative data analysis was performed to identify themes and patterns [19], with each response coded multiple times.

3. Results

A total of 112 oncologists participated in the online survey, which included medical oncologists ($n = 41$), medical oncologists in training ($n = 8$), pulmonologists ($n = 61$), and pulmonologists in training ($n = 2$; Table 2). Due to small sample sizes, trainees were grouped by their respective specialties. Consequently, medical oncologists and trainees will be referred to as “MO”, while pulmonologists and trainees will be referred to as “PO” throughout this article. The analysis revealed no significant differences between the characteristics of MO and PO, except for their hospital affiliations, with more MO affiliated with university medical centers, as depicted in Table 2. Additionally, the majority of oncologists reported no religious or cultural affiliation. Among 107 oncologists, all reported encounters with these patients, with 60.7 percent estimating that 6 percent to 25 percent of their patients have such backgrounds (Table 3). Below, we will provide the results for each subject addressed by the questions.

3.1. Disclosure of bad news by oncologists

As showed in Fig. 1a, the majority of MO and PO preferred to disclose the cancer diagnosis immediately. However, some, especially PO, examined patient preferences first. A small percentage avoided using the term ‘cancer’ altogether, and none informed family members before they informed patients. The replies in the ‘other’ category favored assessing the wishes of the patient and family and discussing the prognosis according to their preferences. Additionally, it was noted that younger individuals were approached directly, unless there were language barriers, a significant presence of family members, or a family member acting as a spokesperson.

In cases where the patients didn't speak Dutch, most of MO (51.1 %) and PO (60 %) communicated directly with family members (acting as interpreters) in the presence of the patient, while a small number chose to communicate with patients and engage a professional interpreter, as shown in Fig. 1b. Two approaches were identified in the replies in the ‘other’ category: either a flexible approach based on the patient's preferences or involvement of the patient, a family member and an official

Table 1

Survey questions and answer options.

Demographic questions
1. <i>What's your age?</i>
2. <i>I am religious/non-religious/undecided/prefer not to say</i>
3. <i>Are you: medical oncologists*/ medical oncologists in training/ pulmonologists*/ pulmonologists in training?</i>
4. <i>Only for questions 3*: How many years have you been working as medical oncologists or pulmonary oncologists?</i>
5. <i>Where do you work? University Medical Center/ Regional/ Other, namely</i>
6. <i>Do you have a non-Western cultural background? Yes*/ No</i>
7. <i>Only for question 6*: Which background?</i>
Research questions
Question 1: <i>do you attend to patients with a non-Western migration background at your clinic?</i>
A. Yes
B. No
<i>*Question: If yes, what percentage does this represent in relation to the total number of patients you see?</i>
Question 2: <i>what method do you use when discussing an oncological diagnosis and stage of the disease with patients with a non-Western migration background?</i>
A. Directly delivering the bad news (cancer diagnosis)
B. Not mentioning cancer, but referring to it as 'incurable disease' and/or 'serious illness'
C. Assessing whether disclosing the diagnosis is preferred. If not, exploring the possibility of discussing the diagnosis and prognosis with another family member
D. First discuss the diagnosis and prognosis with a family member, then with the patient
E. Other, please specify
Question 3: <i>with whom do you communicate the diagnosis when a non-Western cancer patient does not speak Dutch?</i>
A. Patient (using an interpreter)
B. Family member (primary contact person) acting as an interpreter who is present with the patient
C. Family member (primary contact person) without the presence of the patient
D. Any individual present during the conversation who is proficient in the Dutch language
E. Other, please specify
Question 4: <i>what is your course of action if a family member opposes discussing the diagnosis/prognosis with the non-Western cancer patient?</i>
A. Proceed with discussing it with the patient (possibly through an interpreter) as part of the duty to provide information
B. Explore the patients' preferences
C. Take no action and refrain from informing patient
D. Inquire about the reasons behind the family member's objection and endeavor to persuade them of the importance
E. Other, please specify
Question 5: <i>what is your approach when a patient or their family member with a non-Western migration background insists on chemotherapy (or other systematic therapy) for the patient, while you have doubts about whether it constitutes good care?</i>
A. Proceed with the treatment
B. Providing information that the treatment may result in more suffering
C. Refer the patient to a colleague or another hospital for a second opinion
D. Discussing the option of best supportive care
E. Other, please specify
Question 6: <i>What feeling do you usually have after a bad news conversation with patients from a non-Western migration background? (multiple answers possible)</i>
A. Satisfaction; you have done your best to deliver person-centered care
B. Helplessness; it is unclear whether it has been well received, and you are unsure how else to proceed
C. Discontent; the conversation went differently than expected, and you should have maybe acted differently
D. Frustration; the conversation went differently than expected and/or due to lack of understanding from the family
E. Other, please specify
Question 7: <i>what do you do if delivering bad news to patients with a non-Western migration background did not go as desired?</i>
A. Schedule a follow-up conversation with the patient
B. Inquire about the wishes and needs of the family
C. Take no action and wait
D. Ask another colleague to share their thoughts and potentially help
E. Inform the general practitioner about the course of the conversation and the reaction of the patient and their close family
F. Other, please specify
Question 8: <i>do you experience difficulties in conversations with patients with a non-Western migration background about the non-curative aspect of their illness?</i>

Table 1 (continued)

Demographic questions
A. Yes
B. No
Question 8a: <i>what do you experience as the biggest problem? (multiple answers possible)</i>
A. The language barrier
B. Difference in cultural background
C. Other, please specify
Question 9: <i>would you like more research to be conducted on the wishes and needs of patients with a non-Western migration background in order to develop tools/methods for HCPs to apply in their daily practice?</i>
A. Yes
B. No
C. Other, please specify
Question 10: <i>do you have anything else with you would like to add to this topic?</i>

Table 2

Characteristics of 112 oncologists.

Characteristics	Total		Medical Oncologists (in training)		Pulmonologists (in training)		P-value
	n	%	n	%	n	%	
Age							
30–39	37	33.0	20	40.8	17	27.0	0.204
40–49	39	34.8	17	34.7	22	34.9	
≥ 50	36	32.1	12	24.5	24	38.1	
Specialist							
Medical Oncologists	41	36.6	N/A	N/A	N/A	N/A	N/A
Medical Oncologists in training	8	7.1	N/A	N/A	N/A	N/A	
Pulmonologists	61	54.5	N/A	N/A	N/A	N/A	
Pulmonologists in training	2	1.8	N/A	N/A	N/A	N/A	
Work experience in the oncology field							
1–5	29	25.9	11	28.2	18	29.5	0.756
6–10	21	18.8	8	20.5	13	21.3	
11–15	20	17.9	10	25.6	10	16.4	
16–19	5	4.5	1	2.6	4	6.6	
≥ 20	25	22.3	9	23.1	16	26.2	
N/A	12	10.7					
Hospital*							
University Medical Center	45	40.2	34	69.4	11	17.5	< 0.001
Regional	66	58.9	15	30.6	51	81	
Other-both	1	0.9	0	0	1	1.6	
Religious							
Yes	19	17	7	14.3	12	19.0	0.550
No	71	63.4	30	61.2	41	65.1	
Undecided	19	17	11	22.4	8	12.7	
Prefer not to say	3	2.7	1	2.0	2	3.2	
Non-Western cultural background							
Yes	8	7.1	2	4.1	6	9.5	0.462
No	104	92.9	47	95.9	57	90.5	
Which background?							
Afghan	1				1		
Aramaic	1				1		
Chinese	1				1		
Lebanese	1		1				
Persian	1				1		
Turkish	3		1		2		

* "University Medical Center" includes academic hospitals with comprehensive medical training programs, including categorical programs. Other hospitals are categorized as regional.

Table 3
Responses of oncologists to survey questions.

Responses regarding patients with a non-Western migration background in clinic							
Do you attend to patients with a non-Western migration background at your clinic?							
	Total		Medical Oncologists (in training)		Pulmonologists (in training)		P-value
	n	%	n	%	n	%	N/A
Yes*	107	95.5	47	100	60	100	
N/A	5	4.5					
<i>If yes, what percentage does this represent in relation to the total number of patients you see?</i>							
	n	%	n	%	n	%	P-value
0–5 %	14	12.5	5	10.6	9	15.0	0.574
6–25 %	68	60.7	28	59.6	40	66.7	
26–50 %	22	19.6	12	25.5	10	16.7	
51–75 %	2	1.8	1	2.1	1	1.7	
76–100 %	1	0.9	1	2.1	0	0	
N/A	5	4.5					
<i>What feeling do you usually have after a bad news conversation with patients from a non-Western migration background? (multiple answers possible)</i>							
	n	%	n	%	n	%	P-value
Satisfaction	59	56.2	24	53.3	35	58.3	0.489
Helplessness	31	29.5	9	20.0	22	36.7	0.052
Discontent	21	20.0	7	15.6	14	23.3	0.286
Frustration	19	18.1	9	20.0	10	16.7	0.727
Other	25	23.8	13	28.9	12	20.0	0.345
N/A	7	6.3					
<i>Do you experience difficulties in conversations with patients with a non-Western migration background about the non-curative aspect of their illness?</i>							
	n	%	n	%	n	%	P-value
Yes	74	66.1	29	61.7	45	75	0.148
No	33	29.5	18	38.3	15	25	
N/A	5	4.5					
<i>Would you like more research to be conducted on the wishes and needs of patients with a non-Western migration background in order to develop tools/methods for HCPs to apply in their daily practice?</i>							
	n	%	n	%	n	%	P-value
Yes	89	79.5	40	87.0	49	81.7	0.507
No	11	9.8	3	6.5	8	13.3	
Other	6	5.4	3	6.5	3	5.0	
N/A	6	5.4					

interpreter.

3.2. Oncologists' reaction to family expectations

As showed in Figs. 1c and 1d, two questions addressed the expectations of family members regarding oncologists. When a family member opposes discussing the patient's diagnosis or prognosis, 8.7 percent of MO and 10 percent of PO would still discuss it with the patient, possibly through an interpreter, due to their duty to provide information to the patient. Meanwhile, 56.5 percent of MO and 51.7 percent of PO sought to find out the patients' preferences. Both groups inquired about the reasons behind the family member's objection. The replies in the 'other' category revealed a range from deciding whether to inform the patient to understand family objections, from accepting their family decision while ensuring patient care to seeking advice from colleagues with the same cultural background as the patient. Some oncologists also mentioned that this has never occurred in their practice.

When patients or their family members with an NWM background insist on chemotherapy, 80.9 percent of MO and 73.3 percent of PO indicated they would inform them that treatment may result in more suffering, as shown in Fig. 1d. However, one MO proceeded with the treatment, while two POs referred the patient for a second opinion. In the replies to the 'other' category, some oncologists mentioned presenting all options or adding the involvement of spiritual or counseling professionals.

3.3. Emotions of oncologists

This study found that more than half of MO and PO reported being satisfied with how bad news was communicated to patients with an NWM background (Fig. 2). However, there was a group of MO respondents who predominantly experienced frustration and helplessness, and PO respondents reported more helplessness. The statistical analysis of the differences in helplessness between MO and PO revealed almost significance ($\chi^2 = 3.773$, $p = 0.052$; Table 3). Overall, the PO group exhibited higher levels of helplessness (36.7 % vs. 20 % for MO) and discontent (23.3 % vs. 15.6 % for MO). Frustration was the least frequently reported emotion among PO.

Oncologists described a combination of emotions in the replies to the

Question: what method do you use when discussing an oncological diagnosis and stage of the disease with patients with a non-Western migration background?

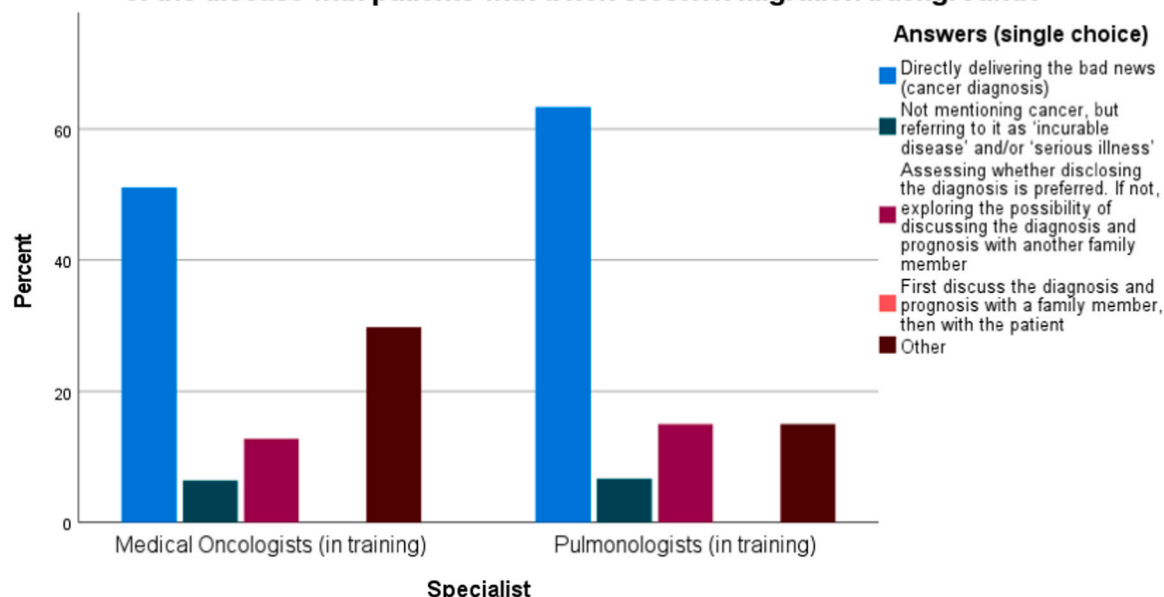


Fig. 1a. The methods of communication used by oncologists.

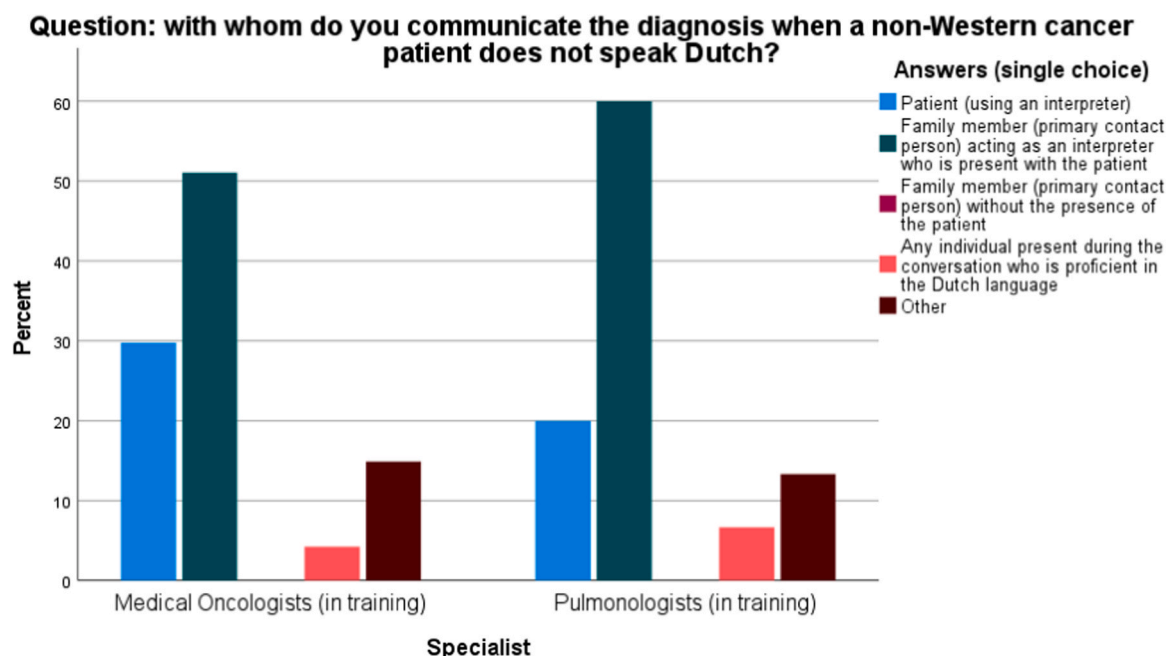


Fig. 1b. Communication of diagnosis when language barriers exist.

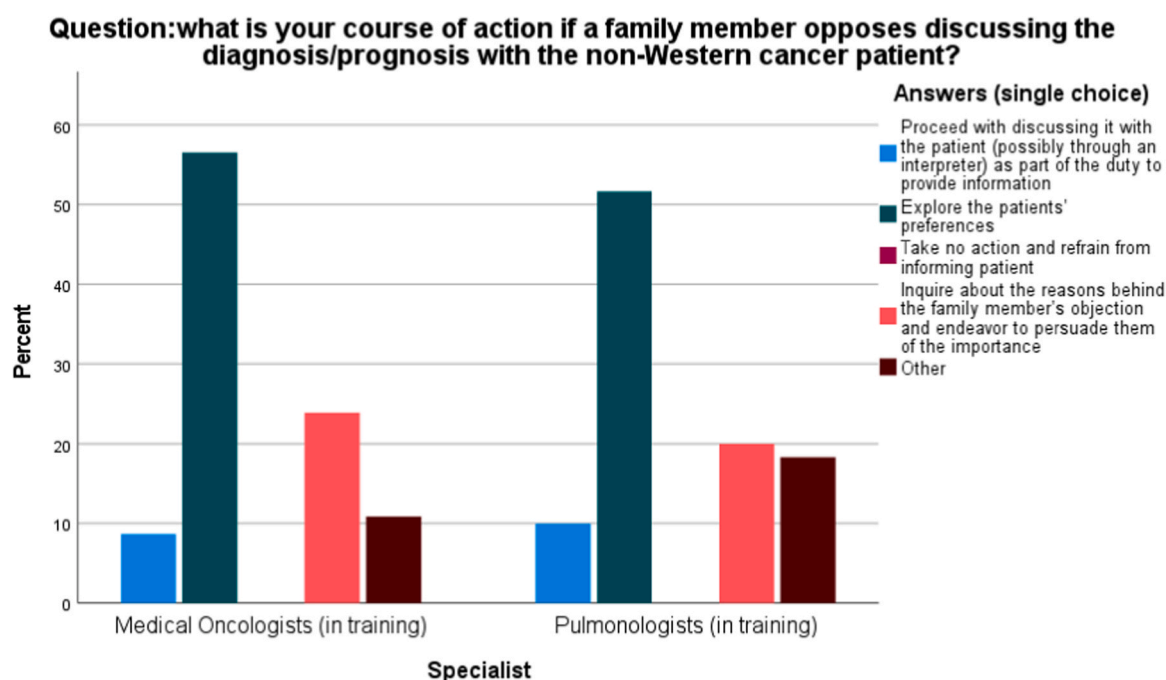


Fig. 1c. Oncologists' response to family refusal to disclose information.

'other' category. Family members may have impacted these emotions in cases where the family reacted angrily or distrustfully towards the oncologists when the patient had trouble understanding the information. Oncologists also expressed frustration with managing their time effectively due to the different expectations of patients and family members.

3.4. Practices and experiences of oncologists

Among PO, 30 percent inquire about the wishes and needs of the family, compared to 19.1 percent among MO. Additionally, both groups considered consulting the patient's general practitioner, while seeking advice from another colleague was less frequently noted. When

delivering bad news did not happen as desired, most oncologists scheduled follow-up conversations (Fig. 3a). In the replies to the 'other' category, most oncologists indicated they explored all options except the 'wait and see' policy. Many also mentioned the option of follow-up discussions, inquiring about the needs and wishes of the family, and informing the general practitioners. Consulting spiritual care providers was also noted. Some indicated they would approach the situation similarly to Western patients.

In the context of non-curative settings, Table 3 shows that PO experienced more challenges with NWM patients compared to MO. Specifically, as shown in Fig. 3b, PO faced more challenges related to cultural differences ($\chi^2 = 2.251$, $p = 0.134$). However, MO experienced

Question: what is your approach when a patient or their family member with a non-Western migration background insists on chemotherapy (or other systematic therapy) for the patient, while you have doubts about whether it constitutes good care?

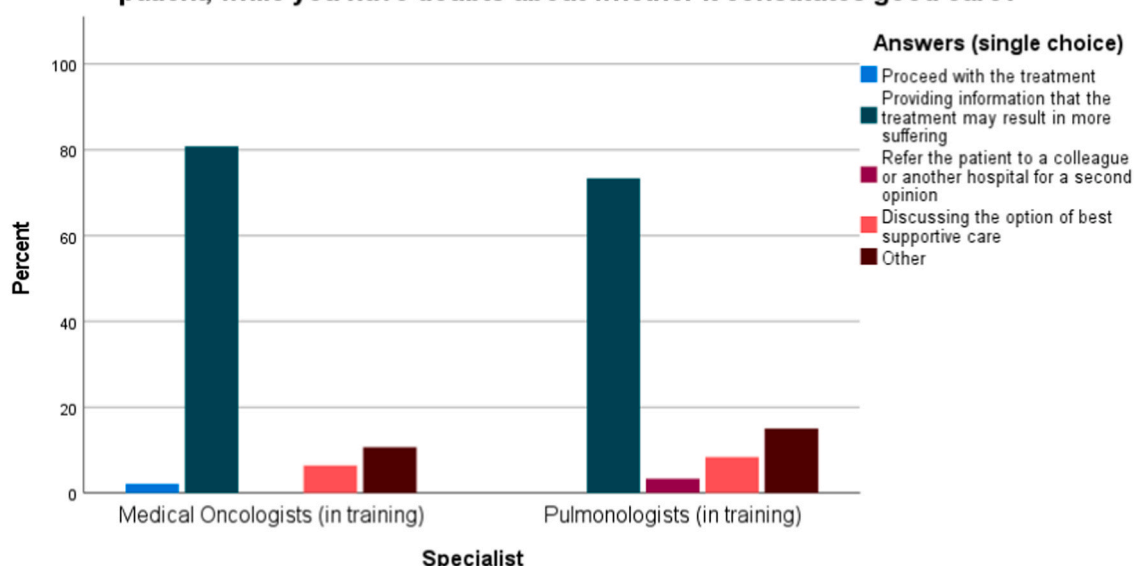


Fig. 1d. Oncologists address patients and families who insist on treatment.

Question: what feeling do you usually have after a bad news conversation with patients from a non-Western migration background?

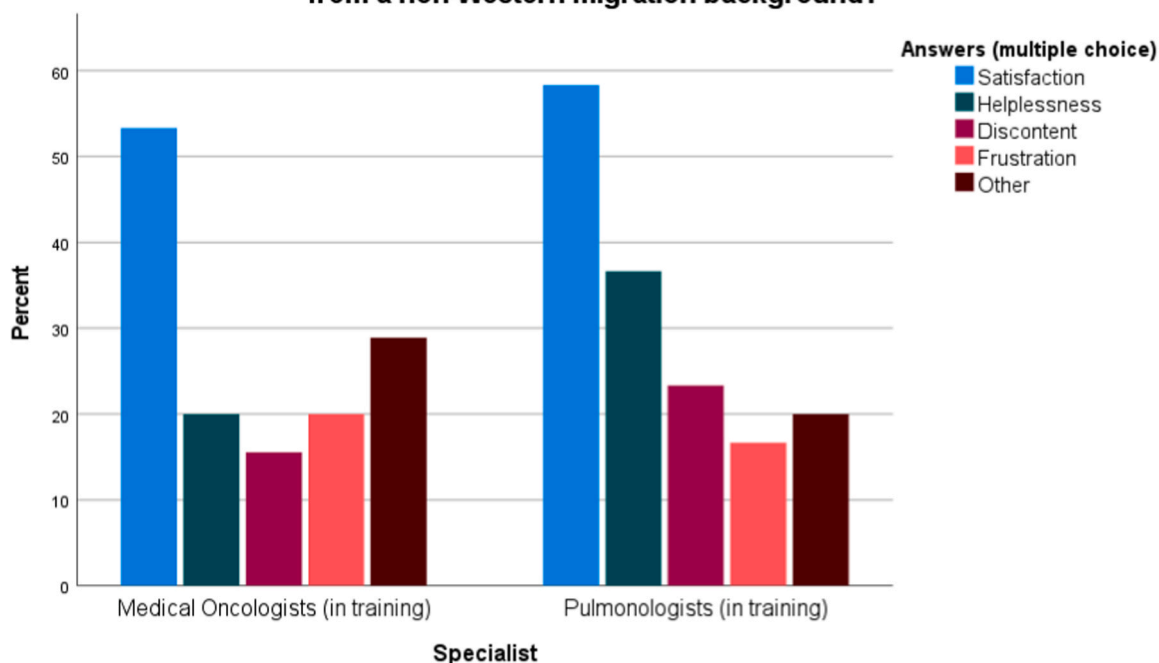


Fig. 2. Oncologists' feelings about bad news communication.

a slightly higher rate of language barriers compared to PO ($\chi^2 = 0.080$, $p = 0.778$).

The replies in the 'other' category shed light on the challenges in healthcare for patients with an NWM background arising from cultural, religious, and language differences. Communication barriers and misunderstandings may arise from cultural beliefs and language differences. There was also a difference in perception regarding the acceptance of palliative care when language barriers were absent. In addition, oncologists faced high patient expectations, disagreements with patients and families about good care, and requests for multiple second opinions in

different countries. Finally, the oncologists were aware of their own limitations in understanding diverse cultures and the preferences of patients with an NWM background.

3.5. Needs and suggestions from oncologists

Nearly 80 percent of oncologists would like more research on the wishes and needs of patients with an NWM background in order to develop practical tools or methods for HCPs to apply in their daily practice (Table 3). In the replies to the 'other' category, some saw

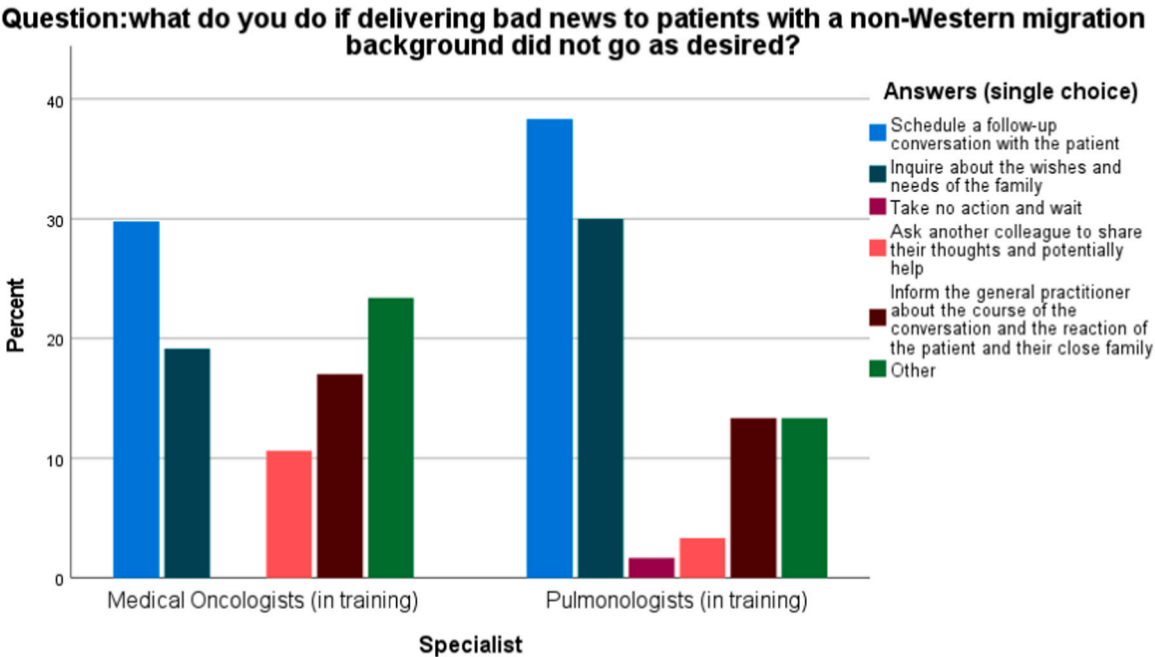


Fig. 3a. Oncologists' actions when delivering bad news did not go as desired.



Fig. 3b. The challenges faced by oncologists.

additional research as valuable for introducing alternative approaches and raising awareness among HCPs. Other oncologists believed that existing knowledge was adequate but was not always utilized due to a lack of awareness or training. Some suggested shifting focus towards alternative forms of support, like involving family members prominently.

3.6. Insights from open-ended responses

The final question was open-ended and received input from 34.7

percent of oncologists. Six distinct themes emerged from their responses. In Fig. 4, the pyramid illustrates ‘person-centered care’ as the predominant theme at the top and others descending in order of decreasing frequency of codes. In Table 4, the themes are presented along with selected quotes and key insights. Person-centered care is preferred by oncologists, with challenges lying in communication, cultural diversity, team management (e.g. involved professionals), and the feasibility of shared decision making. Some mentioned the complexity of cultural and religious differences, particularly while caring for Muslim patients, as well as the challenge of family involvement in discussions. Oncologists

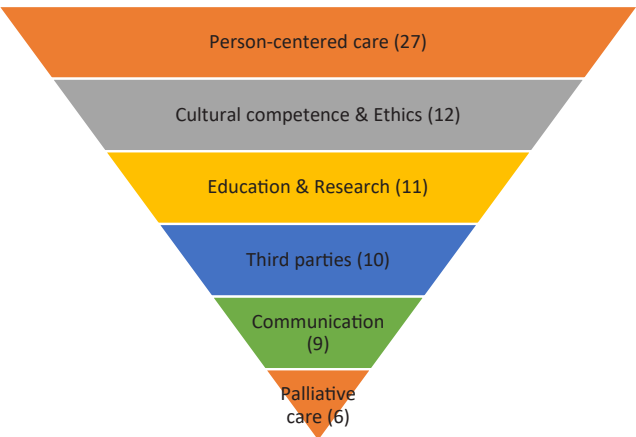


Fig. 4. Top themes mentioned by oncologists in responses to the open-ended question, based on the frequency of codes.

reported to be unable to obtain bespoke support from the healthcare system to address these challenges.

4. Discussion

This survey explored the perspectives and experiences of oncologists, including those in training, during interactions with patients with an NWM background regarding diagnosis, treatment, and prognosis. The majority of oncologists in our study preferred immediate disclosure of a cancer diagnosis, similar to Western practices. However, practices vary in Middle- Eastern countries, where disclosure may be less common. The differences may lie in the emphasis placed on the elements of the principles of biomedical ethics [20]. While Western healthcare systems prioritize patient autonomy and informed consent, many Middle-Eastern cultures prioritize non-maleficence[21]. Understanding these differences is crucial for enhancing patient autonomy in cultures with family-centered relationships and values[21], particularly in multicultural societies where oncologists are thought to provide patient-centered care. According to an Australian study, all oncologists from different ethnic and cultural backgrounds recognized the importance of delivering bad news gently and gradually [22]. Additionally, laws in the Netherlands, such as the Dutch Medical Treatment Act (WGBO Art.7:449) [23], allow patients to decline diagnosis disclosure, underscoring the need to prioritize patient preferences, particularly in multicultural settings. Therefore, it is crucial for HCPs to be sensitive to the diverse cultural preferences of their patients in order to provide truly patient-centered care. Next to cultural differences, there is often an important language barrier. In our study, family very often took on the role of interpreter. These findings align with a mixed-methods review, which indicated that oncology health workers often relied on family interpreters in cases of language barriers [15]. While family members are often preferred, a qualitative study from the Netherlands found that some family members acting as interpreters did not disclose the cancer diagnosis [24]. Our study revealed that in such cases, oncologists prioritized the preferences of patients. According to another review, using professional interpreters led to better clinical care than using ad hoc interpreters (such as family members) [25]. However, the presence of an interpreter (whether professional or ad hoc) can lead to different interactions between migrant patients and oncologists [14,26] and sometimes family members feel resistance to professional interpreters [15]. According to our study, family involvement could make oncologists feel discontent and helpless. Therefore, it is important for HCPs to understand family interactions and to consider involving family members as interpreters on aspects of quality of care and to prioritize the use of professional interpreters to get the best understanding of patients' preferences on disclosing information on diagnosis, treatment, and

Table 4
Open responses to question 10.

Theme	Subtheme	Quote	Key insights
Person-centered care	Expectations and experiences	"I believe mutual understanding should be a two-way street."	Person-centered care is preferred by oncologists, with challenges lying in communication, cultural diversity, team management, and the feasibility of shared decision making.
		"It's not the case that one size fits all."	
		"...but sometimes it's about going with the flow, sometimes it's about pushing back a little."	
Cultural competence & Ethics	Respecting cultural diversity	"The differences with native patients are minimal and seem to diminish over time."	Dealing with conflicts between the personal values and norms of the oncologists, guidelines, and the preferences of the patient with a NWM background.
		"Sometimes, a wonderful team of physicians and spiritual caregivers who share the patient's faith comes together around the patient. More often than not, this doesn't happen due to ignorance, being called in too late, or frequently time constraints on one of the parties."	
		"Because I also regularly have the same kind of difficult conversations with Dutch patient."	
Education & Research	Professional development	"Let go of your own values and norms and adapt to those of the patient."	The importance of training and education for oncologists, the necessity of comprehensive information, and the promotion of cultural awareness in healthcare.
		"Having more clarity about the legal frameworks within which a physician must operate."	
		"I have a Southeast Asian background myself and actually never experience any issues with muslim group."	
Education & Research	Information provision & technological tools	"Enhanced training for physicians and nurses on this subject"	
		"Providing patients with leaflets in their native language about cancer treatment in the Netherlands, including explanations of	

(continued on next page)

Table 4 (continued)

Theme	Subtheme	Quote	Key insights
Third parties	Family involvement & decision-making	what we consider quality of life and addressing cultural differences." "Broader and easily accessible relevant information on this subject, implementation of Google Translate-like reliable apps" "... and it's difficult to ascertain whether the patient doesn't want to know the information or if it's just the family saying so."	Family involvement complicated conversations, leading to uncertainty regarding information transfer, distrust of oncologists, and an increasing demand for foreign second opinions.
	Second opinions	"Sometimes, patients suddenly go abroad without any consultation or communication." "My experience with patients from a muslim background is that a carefully guided supportive care policy can suddenly be overridden by a male family member's decision for second opinions..."	
Communication	Information provision	"Tailored care is also effective for patients with a NWM background...."	The challenges for oncologists included: information provision, communication style, and overcoming language barriers.
	Communication style	"However, it's their culture and their way of communicating." "The method of communication is important, where emphasis is placed. For example: You can say that someone is dying from metastatic cancer, or you can say that you will help them feel better with metastatic cancer."	
	Language barrier	"Better opportunities for interpreters are needed."	
Palliative care	Coping with terminal illness	"I find that patients with a non-Western background generally show gratitude, and even if it's not always mentioned, they often realize that it's about palliative treatment."	Oncologists faced challenges in providing palliative care to patients who either preferred not to be informed or declined treatments due to cultural or religious beliefs.

Table 4 (continued)

Theme	Subtheme	Quote	Key insights
	Culturally sensitive palliative care	"In general, I notice that as long as you give patients hope, the conversations go smoothly." "...the conversation may lead to the consensus that doctors do not decide on matters of life and death, but they can and should provide all meaningful support."	

prognosis.

To our knowledge, this is the first study to explore oncologists' feelings about how they delivered bad news to patients with an NWM background. Despite the emotional nuances, there were no significant differences between MO and PO in our study. In non-curative settings, PO faced more challenges with NWM patients related to cultural differences. The majority of oncologists in our study agreed that more research is needed on patients with an NWM background to develop tools for daily practice to optimize communication with patients and their families. Most medical oncologists and pulmonologists primarily learn from on-the-job experience and have not received dedicated training on communication about cancer diagnosis, treatment, and prognosis to patients with an NWM background. Although in a study some oncology healthcare workers believed that cultural competence was a skill that had to be learned on the job, we tend to believe that with the current population of non-Western migrants, this is insufficient [17]. With the increasing diversity of populations, medical training programs should be expanded to include cultural humility training. Such training can lead to significant improvements in the culturally enriched communication skills of HCPs with patients and families from NWM backgrounds, which in turn results in enhanced satisfaction among patients and families from minority groups [27].

In the replies to 'other' category, oncologists mentioned facing challenges in non-curative settings, such as high patient expectations and disagreements over optimal care, consistent with prior findings among Dutch HCPs and incurable cancer patients with Turkish and Moroccan backgrounds [28]. Another Dutch study highlighted that patients from these groups often perceive HCPs in their countries of origin as providing better care, greater empathy, and other positive qualities, which contributes to their lack of trust in the Dutch healthcare system [29]. Additionally, our study noted that patients with an NWM background frequently seek second opinions, sometimes abroad, with Muslims specifically mentioned as seeking second opinions, having high expectations, or where communication challenges arise. These challenges may arise from HCPs' limited holistic approach and migrants' unfamiliarity with healthcare systems in host countries [12,30]. Education for HCPs and information provision to patients and their families will be crucial to bridge these gaps and improve trust in the healthcare system.

Moreover, a review found that studies predominantly focused on identifying challenges and barriers rather than exploring factors and opportunities for oncology health workers to deliver satisfactory care to ethnic minority groups [15]. The responses to our last open question show that we need to do more research to find out exactly which factors within these themes affect medical consultations and how to improve communication and care for patients from NWM backgrounds in order to find effective ways to close the gaps in cancer care.

4.1. Strengths and limitations

Some strengths and limitations of this study should be noted. Firstly, the study was conducted solely in the Netherlands, which limits its generalizability to other countries. Similar studies in other European countries would be beneficial to determine if the findings are consistent across different cultural contexts.

Secondly, the unknown response rate due to the difficulty of contacting all medical specialists in the field complicates assessing response representativeness. However, the strength of the study lies in including an 'other' option for each question and an open question at the end, allowing participants to provide additional insights beyond predefined categories.

Another strength is the anonymity of the online survey which ensured that participants felt comfortable sharing their true thoughts and opinions without fear of judgment.

Thirdly, the terms 'non-Western' and 'Western' were based on definitions used by Statistics Netherlands, which are generally used in Dutch society. These terms were not explicitly defined in the survey to allow for participants' own interpretation. While this approach may have limited clarity, only two participants asked what non-Western means, with one of them associating it with a Muslim background.

Finally, the data should be interpreted with the usual caution due to the potential for different interpretations of questions in an online survey. Nevertheless, the inclusion of an 'other' option enhanced the dataset with both quantitative and qualitative data, providing a deeper understanding of the findings.

5. Conclusion

Oncologists recognize the challenges of discussing diagnosis, treatment, and prognosis with patients and their families from NWM backgrounds. While many oncologists followed standard Western principles, such as directly informing patients of their diagnosis and prioritizing patient preferences over those of family members, they often encountered unexpected communication challenges and cultural differences. Along with the time constraints, this affects their functioning and emotions. Oncologists express a need for practical tools to optimize communication with patients from NWM backgrounds.

Funding

This work was supported by the Roparun Foundation [grant number 2022023], The Netherlands.

Practice implications

The implementation of education and training programs can support oncologists in their daily work and promote culturally sensitive healthcare delivery in oncology.

CRedit authorship contribution statement

Husson Olga: Writing – review & editing, Supervision, Investigation. **van der Graaf Winette T.A.:** Writing – review & editing, Supervision, Investigation. **van Meerten Esther:** Writing – review & editing, Supervision, Investigation. **Gedik Asiye:** Writing – review & editing, Writing – original draft, Investigation.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper

Acknowledgements

The authors would like to acknowledge Frank Santegoets from the ICT department at Erasmus MC for their assistance with LimeSurvey.

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