Ms. S is a 42-year-old Russian woman who immigrated to the United States two years ago; she recently was diagnosed with stage III-A breast cancer. She underwent a partial mastectomy six weeks ago and was scheduled to begin adjuvant chemotherapy with doxorubicin and cyclophosphamide. Ms. S neither speaks nor understands English, and throughout her diagnosis and initial treatment, she appeared anxious and overwhelmed, wringing her hands or grabbing her sister's arm for reassurance. Her major and only support system is her sister, who works as a live-in housekeeper for a family. The women have friends but they did not feel comfortable asking them for any help.

During initial consultation and treatment work-up, the sister translated for both the physician and the nurse practitioner (NP) managing Ms. S’s care and treatment plan. Via translation, the physician and NP educated the patient about her diagnosis, the treatment plan, and the possible or expected side effects of the chemotherapeutic regimen. She was given prescriptions for antiemetic medications (i.e., lorazepam, prochlorperazine, and granisetron) and instructed on their use and possible side effects.

Ms. S arrived unaccompanied to the treatment center to receive her first cycle of chemotherapy. The oncologist and NP were present in the clinic but were seeing other patients. The chemotherapy nurse scheduled to begin treatment for Ms. S sought out the NP to report that the patient had arrived without an interpreter, and thus she felt she could not treat the patient without a way to validate informed consent. The NP immediately enlisted the services of a hospital interpreter, who relayed that the patient neither was aware of her diagnosis nor did she know that she was about to receive chemotherapy. Ms. S was under the impression that she had a rare infection of her breast and would require antibiotic treatment every three weeks. She had not taken the prescribed prechemotherapy antiemetics because she could not read the English instructions.

The NP contacted Ms. S’s sister, who informed her that she did not want Ms. S to know about her diagnosis. She was afraid that if Ms. S understood that she had cancer she would “give up.” Ms. S’s sister expressed that in the Russian culture, a diagnosis of cancer is a death sentence, and she was insistent that her sister not be told the truth. She also explained that her sister often was anxious and overwhelmed and knowing the truth may make her unable to carry out life-saving treatments. The sister explained that she was not able to be present for her sister’s treatments because she was afraid she would lose her job. As the time passed for the interdisciplinary staff to make a decision, Ms. S became more anxious as evidenced by wringing her hands and pacing the floor. She told the interpreter that she just wanted to take the bus and go back home.

K. Faysman, RN, BSN
Oncology Nurse II
Bone Marrow Transplant Unit
University of California, Los Angeles
UCLA Medical Center
Los Angeles, CA

Clinical Problem Solving

Responding to this clinical challenge are Karolina Faysman, RN, BSN, and Denise Oseguera, RN, MSN, FNP. Faysman is a nurse on the bone marrow transplant unit at the UCLA Medical Center and is completing the master’s oncology NP program at UCLA. Oseguera is an oncology NP in the department of hematology and oncology at UCLA.

As Ms. S appeared to be anxious and overwhelmed throughout her treatment ordeal, what were the cultural implications that may have exacerbated her anxious mood and what assessment criteria were you able to identify to support your interventions?

K. Faysman: Appropriate nursing assessment begins with the knowledge that culture and socialization influences the experience and expression of different emotions, in this case, anxiety. For Ms. S, a major source of stress was her inability to communicate because of the language barrier. The patient’s ability to express her personal feelings and needs to the healthcare team was limited. Some of her behaviors (e.g., wringing her hands) were indicative of her anxiety. Her nonverbal communication (e.g., her facial expressions reflecting worry and apprehension) and other behaviors (e.g., clinging to her sister’s arm) conveyed feelings of being overwhelmed. Ms. S must have been overwhelmed by the large medical center environment and the proposed treatment regimen.

She had been in the United States only two years and had not been to a physician until she discovered the breast lump.

What specific ethnic and cultural beliefs may have influenced Ms. S’s sister to avoid informing Ms. S about her cancer diagnosis?

K. Faysman: Generally in Russian culture, patients with serious or terminal illnesses are not told their conditions or prognoses by family members (Evanikoff, 1996). Ms. S’s sister expressed this belief when she told the NP that if her sister knew she had cancer then she would give up. Family members do not want patients to worry or be anxious about terminal illness. By protecting their loved ones from the truth, they believe patients will be more at peace so that their physical and emotional condition will not worsen by the additional burden of worry (Evanikoff). Russians have strong family bonds, and they provide strength and support for one another, especially during illness (Evanikoff). The protective behavior of Ms. S’s sister was understandable when assessed within a cultural context. The apprehension and anxiety of Ms. S’s sister should have been assessed and addressed prior to using her as the primary