Patients’ Cultural Beliefs in Patient-Provider Communication With African American Women and Latinas Diagnosed With Breast Cancer

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African American women and Latinas often experience suboptimal breast cancer care. This article describes providers’ self-rated skills in communication practices when working with African American women and Latinas diagnosed with breast cancer. Current literature reveals how providers are lacking in the ability to communicate with these patients and often fail to incorporate cultural beliefs into breast cancer care and treatment. This poor communication and failure to acknowledge cultural beliefs can be correlated with poor patient outcomes. In a study of providers’ perceptions of how they address the cultural beliefs of African American women and Latinas diagnosed with breast cancer, interviews with physicians, inpatient nurses, cancer clinic nurses, mammography technicians, and ultrasound technicians showed that they used the same approach for all patients, regardless of race, ethnicity, or culture but felt they practiced culturally sensitive care. Increased and improved cultural competence education is recommended for providers at all levels as a first step toward increasing culturally competent communications.

Breast cancer is the leading cause of cancer-related death among Latinas and African American women (American Cancer Society [ACS], 2012). In 2010, the U.S. population was comprised of 14.6% African American and 12.1% Hispanic/Latino people (U.S. Census Bureau, 2010). Although the age-adjusted incidence of breast cancer (per 100,000 U.S. women) was higher among Caucasian women aged 50 years and older (see Figure 1), late-stage diagnosis among African American women and Latinas was higher when compared with late-stage diagnosis in Caucasian women (ACS, 2012, 2013a) (see Figure 2). The ACS categorizes breast cancer survival by stage, showing that those diagnosed with localized disease have a 99% five-year survival rate, whereas those diagnosed with regional disease have only an 84% five-year survival rate (ACS, 2012, 2013a, 2014). Those women diagnosed with distant metastatic disease have only a 24% five-year survival rate. Therefore, African American women and Latinas are more likely to die from breast cancer than are Caucasian women (ACS, 2013b).

Review of the Literature

Current literature suggests that culture may play a role in reduced rates of breast cancer screening and delayed treatment planning for African American and Latina women following abnormal diagnostic studies (Ashing-Giwa et al., 2004; Baldwin, 2003; Campesino et al., 2012; Dreher & MacNaughton, 2002; Engebretson, Mahoney, & Carlson, 2008; Fowler, 2006; Joseph, Burke, Tuason, Barker, & Pasick, 2009; Pesquera, Yoder, & Lynk, 2008; Richer & Ezer, 2000). Such delays can result in metastatic disease being present when diagnosis is made and treatment is initiated, which often leads to shorter survival times (Gorin, Heck, Cheng, & Smith, 2006). Cultural similarities exist between African Americans and Latinos (Richer & Ezer, 2000). Both groups tend to seek professional care only in crisis situations, and the use of formal medical care is reserved for true emergencies (Purnell, 2009). Latinas tend to be ambivalent regarding screenings and follow-up care, feeling that healing should come from God instead of medical technology.
African American women who maintain control over their own health status and use professional health care sparingly are less likely to obtain initial screenings or follow recommendations for further testing (Barton-Burke, Smith, Frain, & Loggins, 2010).

Delays in Care

A study of women diagnosed with breast cancer from 2002–2006 determined that 8% of African American women and 10% of Latinas needed follow-up after obtaining an abnormal diagnostic study, with 9% and 6%, respectively, delaying obtaining further testing or treatment (Wujcik et al., 2009). In a study of 47,905 women (91% Caucasian, 6% African American, 3% Latina), Gorin et al. (2006) found that delays of greater than one month between biopsy/confirmation of diagnosis and beginning treatment were higher among African American women and Latinas than among Caucasian women (30%, 19.7%, and 18.7%, respectively). In another large study of 107,587 women who received diagnoses of breast cancer from 2004–2006, Caucasian women experienced a 90-day delay in beginning treatment of 3.6%, whereas African American women and Latinas experienced 90-day delays at rates of 6.8% and 6.9%, respectively (Fedewa, Ward, Stewart, & Edge, 2010).

Culture and Health Care

Cultural factors influence healthcare provider decision making. King et al. (2008) found a lack of understanding by providers of the impact of culture on health-seeking behaviors that contributes to providers being less likely to offer standard therapies to minorities, believing minorities will be less likely to adhere to treatment plans. Because treatment decisions are based somewhat on information obtained from patients, communication barriers can exist. If providers, the majority of whom are Caucasian, cannot understand a patient’s explanation of his or her complaint, they may treat different ethnic groups differently. A survey of 6,722 Americans of all racial and ethnic backgrounds showed that 19% of all patients reported at least one problem in communicating with their providers. Of this 19%, Caucasian patients (16%) had fewer problems than African Americans (23%) and Latinas (33%) (King et al., 2008). Culture also may influence who makes healthcare decisions for patients. Maly, Umezawa, Ratliff, and Leake (2006) found that less acculturated Latinas (63.4%) were more likely than Caucasian (30.5%) or African American women (30.2%) to defer to a specific family member to make treatment decisions.

Socioeconomic Status

Socioeconomic status (SES) factors also influence healthcare decision making by providers. Poverty has been cited as a cause of an unequal cancer burden (Battaglia, Roloff, Posner, & Freund, 2007). The outcome of failure to have screening is generally late-stage diagnosis (Blackman & Masi, 2006; Freeman, 2004). This problem extends beyond screening and treatment into survivorship, with many minority cancer survivors indicating that access to care was not adequate to meet their needs (Weaver, Rowland, Bellizzi, & Aziz, 2010). Blackman and Masi (2006) cited lack of insurance, lack of a primary care provider, and personal attitudes and beliefs as some of the primary reasons why women do not follow up on care after abnormal screening. This was supported by Virnig, Baxter, Habermann, Feldman, and Bradley (2009). African American women and Latinas who live within a low SES setting were noted to have a low return rate because of inability to afford services (Itano, 2011).

Findings

Taken together, these findings suggest that culture should be considered when determining which healthcare treatment options should be discussed. A need exists for a better understanding of the provider communication practices for African American women and Latinas diagnosed with breast cancer, particularly in terms of the degree of cultural sensitivity present in providers. The study drew from three conceptual frameworks: Leininger’s Theory of Nursing: Culture Care Diversity and Universality (Leininger, 1988), Champion’s Health Belief Model (HBM) (Champion & Scott, 1997; Rosenstock, Strecher, & Becker, 1988), and Purnell’s Model for Cultural Competence (Purnell, 2009). Based on these three models, the authors designed and conducted a study to determine if providers caring for African American women and Latinas included these patients’ cultural beliefs in education and treatment planning.

Methods

Approval for a qualitative study was obtained from the institutional review boards (IRBs) of Nashville General Hospital at Meharry (NGHM) and the University of Alabama at Birmingham. Because no patients were interviewed, both IRBs granted approval as an exempt study and indicated that written documentation of informed consent was unnecessary. Verbal informed consent was obtained at the time of each provider interview.
The study was conducted at the Metropolitan Nashville/Davidson County, TN, safety net facility. The majority of patient admissions to this facility are uninsured, with many being homeless or recent immigrants to the United States.

**Interview Tool and Process**

With the assistance of the director of clinical trials at NGHM (who also serves as the director of the clinical trials shared resources at a large academic-based institution), providers' awareness of African American women's and Latinas' cultural beliefs regarding a diagnosis of breast cancer and cancer treatment planning was determined to be the basis for question development. A series of seven questions, with some specifically targeted to certain providers, was developed related to breast cancer diagnosed in patients seen in inpatient and outpatient settings at NGHM (see Figure 3).

Letters of invitation were distributed to 20 oncology providers involved in caring for African American women and Latinas diagnosed with breast cancer. These providers included medical oncologists, surgical oncologists, RNs, advanced practice nurses (APNs), licensed practical nurses (LPNs), ultrasound technicians, and mammography technicians. The study’s principal investigator conducted all interviews in private settings. Each participant was informed that he or she could stop the interview process at any time and could decline to answer any question throughout the interview. Thirty minutes were scheduled for each interview. Actual time for interviews ranged from 8–20 minutes in length, with a mean length of time for each interview being 12.2 minutes.

**Analysis**

Following completion of all interviews, the recordings were transcribed verbatim. Data were analyzed using thematic content analysis. The purpose of this inductive analysis of qualitative data was to identify recurrent thoughts and statements in provider interviews. Coding and theme analysis then were verified by a content expert.

**Results**

Fourteen of the 20 invitees consented to participate (medical oncologists [n = 2]; surgical oncologists [n = 1]; RNs/APNs [n = 8]; LPNs [n = 1]; ultrasound technicians [n = 1]; mammography technicians [n = 1]). Gender and ethnic breakdown of providers was as follows: four males, 10 females, three African Americans, eight Caucasians, and three Latinos. Of the six who declined, four were unsure whether they could address the issue and two cited time constraints as precluding their participation. The 14 participants had a combined total of 157 years as oncology providers.

**Themes**

Themes identified focused on the extent to which providers included a patient’s cultural beliefs or practices in providing breast cancer care for African American women and Latinas. Six themes were identified: disease perception, delivering diagnosis, reactions to diagnosis, acculturation, family, and education.

**Disease perception:** Providers sought to elucidate interpretations regarding how African American women and Latinas viewed cancer as a disease based on their cultural beliefs, education, and SES. They also spoke about how acculturation and the ability to speak and comprehend English affected patients’ perceptions of cancer in general and, specifically, patients’ perceptions regarding receiving a personal diagnosis of breast cancer. A myriad of responses were given, ranging from their beliefs that patients’ perceptions of cancer were related directly to patients’ education, SES, and degree of acculturation. One provider indicated she felt that African American women perceived cancer as being curable but stated this was because the women were naïve. This same provider felt that communication problems factored into Latinas’ perceptions to a great degree, stating that hindrances exist even with the use of interpreters, and interpreters are not always present during the entire time the patient is in the clinic or hospital. Sometimes this results in fragmented communications, with some information being inadvertently omitted. Other providers felt that the lower the education level of the patient, the more the patient attributed the disease to fate, sometimes leading these women to decline treatment. One of the providers interviewed stated, “People who are not well educated do not understand cancer.”

**Delivering diagnosis:** A key question in all interviews addressed the strategies providers used to discuss a breast cancer diagnosis and treatment plan with African American women and Latinas. Findings revealed that providers focused strongly on ensuring African American women and Latinas who had been diagnosed with breast cancer were educated regarding the disease and planned treatment. When asked, however, one provider stated, “[With African American women and Latinas] once the diagnosis is given, what I see . . . is fear and uncertainty.”

**FIGURE 2. Breast Cancer Diagnosis by Stage Per 100,000 Women Aged 50 Years or Older (2006–2010)**

*Note.* Based on American Cancer Society, 2013a.
Reaction to diagnosis: Conflicting responses were given about how patients responded to receiving a diagnosis of breast cancer. Most providers felt more fear existed among Latinas than among African American women, but about 25% found no difference in the reactions between patient groups. A perception also existed that Latinas had more emotional reactions to the diagnosis than did African American women, displaying more tearfulness and fear. One provider stated, “I think [African Americans’] perception of cancer, in general, is that . . . it is very curable . . . I think they are naïve in that way.” Another stated, “[Latinas] are often reluctant to interact with providers because of [the] language barrier. I do not know if there is lack of trust per se, but I think that there is a comfort level that needs to be attained and I think the language barrier is a significant factor.

Acculturation: Other than including the use of a translator for non-English-speaking patients, all providers indicated that no variation existed in the content and delivery of the diagnosis of breast cancer and any education related to the diagnosis and treatment options. Providers acknowledged that, with immigrants, the length of time since immigration and the degree of the patient’s acculturation often indicated an increased proficiency in the use of the English language and an improved knowledge of the U.S. healthcare system. Nothing indicated, however, that the lack of acculturation was addressed in any manner other than by using translators to deliver disease- and treatment-specific information, despite findings that patient satisfaction was improved when cultural beliefs were addressed and respected (Sheppard et al., 2008). During the interview, one provider stated, “[Latinas] don’t seem to be as aware of what’s going on to them. . . . They are not comprehending what the doctors [are] telling them. They’re not registering how serious it is.”

Family: Reports also were conflicting among providers about the level of family involvement desired by each patient group. Although the majority of providers indicated that African American women were more likely to bring family with them and want to wait in making decisions until all family members are informed about the plan, others felt Latinas were more likely to arrive at appointments with a cadre of family accompanying them. One provider indicated that older women of both groups were more likely to want family involved in decision making than younger women. Regarding family involvement, one provider stated, “I think the Latinos, there is more of a family. They usually come in with other family members, and they are very protective of all their patients and don’t necessarily want them to know everything what’s going on.” Regarding African American patients and recent African immigrants, one provider stated,

A lot of times [families] don’t even tell her she has cancer. So it’s almost difficult because the families don’t want the physician to really explain what’s going on with the patient, and they expect us to treat her without her really knowing what’s going on.

Education: Providers at all levels seemed to have a standardized education format when discussing the diagnosis of breast cancer and its treatment with women of any race, nationality, educational level, or SES, and providers adhered to that format explicitly. Only one provider interviewed indicated that education needed to be based, to some degree, on the patient’s level of health literacy. The education process was described by one of the providers interviewed.

We tried to incorporate the same care to everybody. We talked about the disease and the care, their diet, their pain control, nausea control, starting to chemotherapy . . . but we try to do the same care for everybody, just maybe alter the language just a little bit, they need little more layman’s terms.

Another said,

Understanding the side effects and the medicines and make sure that they take [medications] when they are supposed to and to call if they have fever. It is more making sure that they are given the point of what we [want] them to know.

Results of this study supported the premises of all three conceptual frameworks used in study development. Leininger (1988) posited that nursing care decisions often are based on knowledge of the nuances of various cultures and providers must be competent in those nuances. The HBM addressed the four criteria required for a person to accept and initiate beneficial practices: perceived susceptibility, perceived severity or seriousness of the disease, perceived benefits of adhering to specific healthcare recommendations, and health motive to follow recommendations (Champion & Scott, 1997; Rosenstock et al., 1988). The application of the HBM in African American women and Latinas is supported by exploring the cultural characteristics of these women delineated in the Model for Cultural Competence (Purnell, 2009). Purnell sought to delineate how
Implications for Practice

- Increase awareness of cultural beliefs and practices among ethnic and racial groups and how these beliefs and practices influence health-seeking behaviors.
- Seek professional organizations’ support for incorporating health-related cultural diversity education in schools of nursing and associate-, bachelor-, and doctoral-level programs.
- Introduce health-related cultural diversity as a nursing competency for all levels of staff and in all healthcare facilities.

social context and cultural beliefs affect healthcare behavior directly and indirectly. His model stressed the importance of understanding the environment in which this population obtains care as being essential to providing care—and having this care accepted and followed.

Implications for Practice

The data from this study have shown the providers’ evaluation of communications between providers and African American women and Latinas diagnosed with breast cancer to be generic. As previously identified in a review of the literature, patients have long described how they feel providers have a certain standard of practice and they attempt to make all patients fit into this mold (Dreher & MacNaughton, 2002; Engebretson et al., 2008). Further study in this area is needed to explore practices in other facilities and regions. One major limitation of this study is its lack of ability to be replicated. A possible step to address this limitation is to interview African American women and Latinas treated for breast cancer to determine their perceptions of providers’ communication skills. Studies that capture real-time interviews would be valuable because these interviews would link actual provider communications with patients’ actions related to a diagnosis of breast cancer.

Conclusion

The literature repeatedly cited patients describing how they felt they must fit the providers’ preconceived ideas of patient behaviors and how these feelings influenced their desires to pursue treatment for breast cancer. The purpose of the project was to examine how often providers included cultural beliefs and practices when treating African American women and Latinas diagnosed with breast cancer. The issue of providers requiring patients to meet their needs rather than the providers meeting the needs of their patients is one that appears to be more widespread than most people would think.

Interviews with providers at several levels were consistent with patients’ perceptions as identified in the literature reviewed. Of the 14 providers interviewed, each indicated that education was the key to helping patients comprehend the diagnosis and treatment plan. The information obtained from these interviews also indicated that all but one provider stated he or she delivered the same information to all patients regardless of race, ethnicity, education, SES, or acculturation. Only one provider indicated that education regarding breast cancer needed to be tailored to the patient’s literacy level, but even this provider did not address the need to include cultural beliefs in the education process. An interesting premise is the possibility that further studies in patient-provider discussions related to breast cancer diagnoses and treatment planning may reveal that information provided by these interviews is different from the actual discussions between patients and their providers. This would involve the active participation of investigators in patient-provider interviews. Although the information obtained could be more accurate regarding actual content of these discussions, providers possibly still could skew the results by changing their methodology in structuring patient interviews.

To communicate effectively with patients of all ethnicities and races related to illness, particularly breast and other cancers, providers need to become more familiar with the specific health beliefs and practices of their patients. By increasing the ability to communicate with patients, providers may then have a greater impact on health-belief practices among African American women and Latinas diagnosed with breast cancer.

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