

Exploring Perceptions of Cancer Care Delivery Among Older Mexican American Adults

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Significant disparities exist among racial and ethnic minority groups with regard to cancer screening rates, primary therapy, conservative surgical treatment, adjuvant therapies, and treatment follow-up (Shavers & Brown, 2002). The differences exist independent of stage of cancer, patient treatment preference, and other clinical factors. System-level healthcare discrimination and healthcare provider bias have received increased focus as possible contributory factors to health disparities. Exploration of effects of perceived discrimination in cancer care among Latinos is an important area of study because, as the largest ethnic group in the United States, they experience disproportionate cancer morbidity and mortality rates. Although Latinos have lower overall incidence rates of cancer, compared to other groups such as African Americans, they present at more advanced stages of disease and have poorer survival rates for certain types of cancer, such as prostate and cervical cancer (National Cancer Institute, 2008).

Patients with language barriers are particularly vulnerable to health disparities (Robert Wood Johnson Foundation, 2005) and are more likely to perceive unsatisfactory healthcare delivery (Morales, Cunningham, Brown, Liu, & Hays, 1999). A national study of Anglo Americans, African Americans, Asians, and Latinos found that minorities were significantly more likely than Anglos to perceive disrespect and unfair medical treatment and were less likely to engage in health screening and follow recommended treatment because of those perceptions (Blanchard & Lurie, 2004). Other studies have found that Spanish-speaking Latinos are less likely to rate their providers as respectful and concerned than Anglos or their English-speaking Latino counterparts, even when interpreters are available (Fernandez et al., 2004).

Patient Perspectives of Discrimination in Cancer Care

Healthcare research examining perceived discrimination in cancer care is lacking. A comprehensive review of

Purpose/Objectives: To investigate older Mexican Americans' perceptions of cancer care delivery, specifically regarding perceived discrimination.

Research Approach: Qualitative.

Setting: Senior centers and participants' homes.

Participants: 5 older Mexican American cancer survivors.

Methodologic Approach: The sample included five Spanish-speaking Mexican Americans with low incomes who were previously diagnosed with cancer. Ages ranged from 68–86 years ($\bar{X} = 76.4$). Participants were recruited through several community-based agencies and resources. Interviews were conducted and recorded on audiotape in participants' homes or at a senior center. A demographic questionnaire and the Mini Mental State Exam were administered in English or Spanish.

Main Research Variables: Perceptions of healthcare delivery.

Findings: Three themes emerged from the interview data: (a) emotional responses to cancer diagnosis, (b) relationship with healthcare providers, and (c) use of spiritual resources in coping with cancer. Participants denied experiencing any discrimination in health care related to race, ethnicity, income, or language spoken. Perceptions of good and poor-quality health care are described.

Conclusions: Participants were satisfied with the cancer care they received, with a few exceptions. The role of age and education level in perceived discrimination needs further exploration.

Interpretation: Replication of this study with larger, culturally diverse samples is needed to increase understanding of the role of perceived discrimination in cancer care and to develop culturally responsive, evidence-based healthcare interventions for patients and families coping with cancer.

32 nursing research studies on breast cancer care among African American women over the previous decade (Underwood et al., 2005) revealed no studies addressing perceived racism or discrimination in cancer care. The few studies that have been conducted among racial and ethnic minorities diagnosed with cancer indicate that healthcare bias is an issue for some patients. Perceived bias in cancer care influenced beliefs and behaviors about cancer treatment among minority patients with

low incomes (Cain & Kington, 2003) and determined satisfaction with care more than the actual treatment received (Karlsen & Nazroo, 2002). Spanish-speaking Latinas with breast cancer reported less satisfaction with care and had delays of three months or more from diagnosis to surgical treatment compared to other minorities, including English-speaking Latinas (Katz et al., 2005).

Although the studies have been important in documenting the existence of perceived discrimination in healthcare delivery, they do not provide a clear understanding of the social and cultural processes involved in the phenomenon of racial and ethnic discrimination in health care. Furthermore, most disparity studies have been conducted from the perspectives of providers and researchers, rather than from patients' perspectives. Older Latinos are particularly under-represented in cancer behavioral research. Therefore, the aim of this pilot study was to explore perceptions of cancer care delivery, specifically regarding the presence of perceived racial and ethnic discrimination, among older Mexican American cancer survivors.

Methods

Given the lack of in-depth research on Latino patients' perspectives on cancer care delivery, a qualitative design was used to address the research aim. The institutional review board of the university sponsoring the research project approved all study procedures and materials. Study materials were translated into Spanish, assessed for linguistic accuracy and cultural equivalence, and then back-translated to English with established backward and forward translation procedures (Canales, Ganz, & Coscarelli, 1995; Phillips, Luna de Hernandez, & Torres de Ardon, 1994).

Setting, Sample, and Procedures

Participants were recruited from a community health center, senior centers, and referrals from a local Hispanic nursing organization in the southwestern United States. Participants were told that the purpose of the project was to explore their perceptions and experiences in receiving cancer care. The researcher emphasized that the principal investigator (PI) was not employed by or connected with their healthcare providers and that pseudonyms would be used in the transcript data to ensure confidentiality.

Mexican American cancer survivors who had at least three healthcare visits in the previous year and were bilingual or monolingual Spanish speakers were recruited. Exclusion criterion was significant cognitive impairment, as measured by the Mini Mental State Exam (MMSE) (Folstein, Folstein, & McHugh, 1975), which could interfere with the ability to recall and articulate their cancer care experiences. The PI administered the MMSE to establish cognitive functioning.

A demographic questionnaire also was administered to measure social background and acculturation, and it included questions on country of origin, language preferences, religious practices, and access to health care. In addition, two questions were devised to assess beliefs about discrimination toward minority groups. On a four-point Likert scale ranging from 1 (strongly agree) to 4 (strongly disagree), participants responded to the statement, "Most people in the United States receive the same quality of health care regardless of their racial background or language spoken." Participants also responded to the question, "How much discrimination against minorities do you feel there is in the United States today?" with a four-point Likert scale (4 = a lot, 3 = some, 2 = just a little, and 1 = none at all). Responses were compared with interview data in the analytic phase.

One semistructured, audiorecorded interview that required 30–45 minutes was conducted with each participant in the person's preferred language and at the location of his or her choice. Three of the interviews took place in participants' homes and two were at a senior center. After participants had the opportunity to fully describe cancer care experiences, they were asked specific questions related to perceptions of discrimination via questions adapted from Chen, Fryer, Phillips, Wilson, and Pathman (2005) and Blanchard and Lurie (2004). Examples included

- In thinking about all of the experiences you have had with cancer care visits, can you describe any times when you felt that the doctor, nurse, or other staff treated you unfairly or with disrespect because of your racial or ethnic background? Because of your need to speak Spanish?
- What sorts of things happen that make you feel disrespected or respected?

They also were asked to describe what helped them cope with receiving a cancer diagnosis and questions related to follow-up care. Participants received a \$20 gift card to a local retailer after completion of the study interview.

Analytic Process

The PI completed data analysis using content and thematic analysis methodologies (Mayring, 2004; Morse, 1994). Interviews were transcribed verbatim, and the PI checked for accuracy against audiorecordings. The one interview conducted in Spanish was transcribed and translated into English. Accuracy of the Spanish transcript and English translation was ensured by a bilingual Mexican American nurse researcher. The analytic process occurred in two phases. The first phase, a content analysis of transcripts, was done by coding individual lines in the transcripts and identifying key phrases regarding overall perceptions of and experiences with cancer care. Codes were sorted into categories to identify themes

within each participant interview. Comparison of similarities and differences in themes across participants was completed.

Because identifying perceived racial and ethnic discrimination in health care was a specific aim of this project, the second phase of analysis consisted of returning to identified codes and key phrases within each interview that related specifically to experiences of discrimination or dissatisfaction with health care. The data were compared with responses from the two discrimination items in the demographic questionnaire. To ensure consideration of contextual factors that could influence participants' experiences, data related to perceptions of discrimination were examined in relation to participants' reported income, education, and access to healthcare.

Results

All participants had acceptable scores on the MMSE and were able to complete the demographic questionnaire in the presence of the PI. All participants had a family income of less than \$10,000 per year and were enrolled in Medicare as well as the state's healthcare insurance plan for families with low incomes. Four participants were second-generation Mexican Americans who spoke Spanish in the home "most of the time" or "always" but preferred English when discussing medical issues. One male participant, a first-generation transnational migrant who maintained homes in the United States and Mexico, was the only participant who completed the questionnaires and interview in Spanish. More detailed sample characteristics are provided in Table 1.

All participants had visited a primary care physician (PCP) in the two months before the interview date. Cancer sites were breast, prostate, kidney, ovary, and mouth. All had received surgical intervention, and one woman with ovarian cancer was treated with surgery and radiation. None was currently receiving treatment for cancer, but all were receiving follow-up care from a PCP or oncologist. The participants could not identify the stage of cancer at time of diagnosis; however, based on their treatment histories and reported states of health, no advanced-stage tumors had been present. None of the participants had an oncologist who was Latino or spoke Spanish.

Perceptions About Discrimination

As described in the "Methods" section of this article, the researcher asked participants specific questions to elicit any perceptions of or experiences with discrimination in health care. Sociodemographic data also were used to assess for patterns in participants' perceptions about racial and ethnic discrimination. Participants' re-

Table 1. Sample Characteristics

Variable	n
Age (years)	
\bar{X} = 76.4	—
Range = 68–86	—
Education	
\bar{X} = 7th grade	—
Range = 3rd–12th grade	—
Gender	
Female	3
Male	2
Religious denomination	
Catholic	4
Jehovah's witness	1
Frequency of attending religious services	
More than once per week	—
Once per week	2
One or two times per month	1
Three or four times per year	1
Once per year	1
Almost never	—
Frequency of speaking Spanish in home	
Always	2
Most of the time	2
Occasionally	—
Rarely	—
Never	1
Years since diagnosis	
2	1
3	1
4	1
5	1
11	1
Frequency of healthcare visits in previous year	
Every three months	3
Every six months	2
N = 5	

sponses to the questionnaire item, "Most people in the United States receive the same quality of health care regardless of their racial background or language spoken," had a mean score of 1.6 (between strongly agree and somewhat agree). The scores for that item were consistent with interview data. Two participants, who strongly agreed with that statement, reported receiving high-quality health care with no incidents of poor-quality care. The remaining participants somewhat agreed with the statement, and each described at least one incident of feeling unsatisfied with healthcare delivery. However, they did not attribute the incidents to race, ethnicity, or language preference. Only one of those participants stated that she had heard of other people who received poorer-quality health care because "they were on welfare," but she had not had such experiences.

The item, "How much discrimination against minorities do you feel there is in the United States today?" had a mean score of 2.4 (between "some" and "just a little"). The degree of perceived discrimination increased with level of education. Two participants who believed

that no discrimination existed had the lowest levels of education (third and fourth grades, respectively). Two participants with eighth-grade educations believed that “some” discrimination occurs. The participant with a 12th-grade education believed that “a lot” of racial and ethnic discrimination exists in the United States. Yet none of the participants described perceived discrimination in a healthcare delivery context. Interestingly, one participant stated that two of her daughters, both nurses, believed that they had experienced racial and ethnic discrimination from other nurses in the workplace. She told her daughter, however, “It’s not because you’re Latino, I don’t believe it. . . . It’s because she’s a very good nurse, she’s very knowledgeable, she’s very bright, and so I think that some of those nurses get a little intimidated.” She believed that racial and ethnic discrimination exists at the broad, group level but denied it at the personal level.

All of the participants recalled their cancer care experiences quite well, including one woman who had been diagnosed 11 years earlier. There was no hesitation noted when participants shared their thoughts and feelings about their cancer journeys. Three major themes were identified from the interview data: (a) emotional responses to cancer diagnosis, (b) relationship with healthcare providers, and (c) use of spiritual resources in coping with cancer. Subthemes within the major thematic categories represent the range of experiences across participants.

Theme 1: Emotional Responses to Cancer Diagnosis

Participants were asked to describe their experiences with cancer care, beginning with the initial diagnosis or treatment, or as far back as they could remember. The experiences, described largely in terms of emotional reactions ranging from denial to acceptance to equanimity, were described vividly. All participants had at least one family member who was involved in their care, accompanied them to healthcare appointments, and who had been in communication with the oncologist or surgeon.

Denial: Some participants used denial to cope with the cancer diagnosis, which was, in at least one case, fueled by protective family members. An 86-year-old woman began the interview recounting how her husband, son, and physician had not told her the reason for removal of her breast in 1996. She chuckled as she recounted the following incident.

Then, when they operate me . . . they take me home and he didn’t tell me nothing . . . then, when I had to go to my doctor, [he] was on vacation, there was another doctor, and this doctor said, “Do you know what they operate you from?” and I said, “No.” . . . He said, “Cancer,” . . . and I told my husband, “Why you didn’t tell me it was cancer?” [chuckling]

Interviewer: Did you get mad at your husband when he didn’t tell you, when you found out?

No. My doctor got mad at the other doctor ‘cause he told him I wasn’t supposed to know. [chuckles]

Interviewer: I’m curious, who decided that you should not know?

My son and my husband.

Later in the interview, she was asked about the reaction to her mastectomy.

Interviewer: For some women, it’s a big shock when they see their body change so much, when the breast is gone. How did you feel about that, when the breast was gone?

I just, I just gotta face it, that’s all there is, and try and forget about it. If I got to live that way, it doesn’t bother me; I’m all right.

Another participant, a 79-year-old woman, also described a reaction of denial. She stated she had symptoms of bleeding for a year or more prior to the diagnosis of ovarian cancer in 2004. She did not want her family to be upset or disturbed regarding her diagnosis.

You know, I didn’t it take serious. Well, yes, I did take serious, but it didn’t bother me to go.

Interviewer: It didn’t bother you to go to the doctor?

When they told me I had cancer, well, I did get a little nervous, and my niece was with me . . . and she got too nervous and she started calling the family. And I said, “It’s okay, don’t bother the family.” “Oh, they have to know,” she said. But, I was just like nothing had happened.

She received six weeks of radiation treatment, which made her feel “a little nervous, but nothing serious.” She explained that her coping style was to “let things go” that she felt should perhaps be taken more seriously. She described feeling uncomfortable when her sister asked the doctor questions during healthcare visits, even though she knows “it’s good” to ask questions instead of “just letting it go.” At the time of cancer diagnosis and medical decision-making, she said, “I just left it up to the doctor, to do what he say.”

A 73-year-old man described a mixture of denial and a restrictive type of coping. At the time of diagnosis of mouth cancer in 2006, he said it was not what he was expecting and that he “felt real bad” as it prompted him to recall the experience of losing his wife to cancer four years prior.

When they first told me . . . you know I had cancer, I felt so bad inside. When he said the results came back and they’re not good and my heart went poof . . . I started to think about my wife. And it had been

some time, and now me, and I felt real bad. I started praying . . . praying. That's about all I can do. At one time [I said], "I don't care what came," you know. You say you don't care, but when it really comes to it, you do.

He repeatedly said that he felt "real bad" about his diagnosis, but he "held it all inside." The difficulty in expressing feelings about a potentially life-threatening illness was highlighted in his response to his wife's terminal illness. During that time, one of the nurses encouraged him to discuss the terminal condition with his wife.

She didn't want to talk about it, so why should I? You know, she was feeling sick. Why should I make her? Because I actually thought at that time if she didn't want to talk about it, I didn't want to talk about it.

He recalled that during the dying process at home, his wife had asked one of the nurses whether she was getting better.

The nurse said, "You're not gonna get any better." . . . just like that, you know. And when she started to leave, I followed her outside and told her, "Don't tell her that she's not gonna get any better." Everybody knows she's not, but I mean, you don't have to discourage her like that. . . . Next thing you know, she won't want to eat and get depressed.

Acceptance: In contrast to the other participants, a 68-year-old Spanish-speaking Mexican American man described an accepting attitude toward his diagnosis of prostate cancer in 2002. His belief in God's will seemed to allay fears and shape a response of equanimity.

Well, I didn't feel too much fear. . . . I thought I was going to be scared when I was to be operated . . . [but] no, nothing. God decides for us, and that's why one has to be satisfied and not be like, "Holy cow!" . . . this and that . . . "I have this," . . . no, no it shouldn't be like that. He knows why, and one has to be at peace with him . . . and satisfied anyway. . . . I feel good.

That participant spoke frequently in the interview about reliance on his faith, which provided a foundation of security and comfort in adjusting to life's challenges, specifically during the time of cancer diagnosis. Some of the other participants described earlier seemed to use denial at the time of cancer diagnosis, while relying on their faith during later stages of their cancer experience (e.g., post-treatment).

A 76-year-old woman described a range of emotional reactions to her diagnosis of kidney cancer in 2003, discovered while she was hospitalized for gall bladder surgery. When told of the kidney cancer, she felt "shocked and worried" and then relieved when informed that she

would need no further treatment beyond removal of the kidney. Having had one brother and several friends die from cancer, she "knew what it could do." Because she had no symptoms associated with the kidney tumor, she felt it was "a blessing" that she had had the gall bladder problem and subsequent hospitalization.

That's why I said it was a blessing in disguise because I didn't have no pain, no symptoms [of kidney cancer] . . . then it probably would've been, you know, too late by the time they would've had caught it. Yes, well, I've been one blessed person.

Theme 2: Relationship With Healthcare Providers

The predominant sentiment expressed by the participants was satisfaction with and appreciation for their healthcare providers. Although there were some incidents of negative encounters with providers, all of the people in this study believed that they had received good health care that included trusting and caring relationships.

Characteristics of high-quality care: When asked to describe what "good care" is like for them, many participants had similar comments, such as "the way they treat me, like somebody in the family," "they treated me like anybody else," "they serve us well and they talk to us with good manners," "to be patient and get along with me." One woman said of her relationship with her PCP, "We're like a family. He tells me what's wrong and what I should do. I just listen and go do it."

Another participant described a relationship of mutuality and warmth with his PCP, who was from Columbia. The PCP always greeted him with a hug, spent more time than other providers talking with him in English and Spanish, and communicated genuineness. Participants also noted the provision of physical care as a measure of quality, such as providers spending time reviewing their charts, giving them medical tests, and asking them questions. Most of their focus was on physician providers, but the participants were, in general, equally satisfied with nursing personnel and office staff, such as receptionists.

Characteristics of poor-quality care: Participants were asked to describe what constitutes poor-quality health care and what would make them feel disrespected. Most comments pertained to the interpersonal realm of care: "To be kept waiting a long time after I got there or if they didn't act interested or go through my charts, I would feel like they were discriminating," "If they were not nice," "If they ignored me." All of the patients felt that a low-level income did not affect the quality of health care received, based on their own experiences. One of the participants stated that she had heard other people complain of poor care because they were "on welfare," but this had not been her experience.

Potential differences in quality of care related to gender, race or ethnicity, and language also were explored. None of the participants described perceptions of or experiences with discrimination in healthcare delivery related to those socially constructed categories. A participant who spoke Spanish exclusively was the only one who required a translator while receiving health care in the United States. He admitted that using translators made communicating with providers more difficult. He seemed aware of the “English only” political rhetoric that was prevalent in the city.

Well, it makes you feel a little . . . I feel a little bad . . . but it's too late . . . too late to easily learn [English]. . . . We were already very old when we came here to the United States . . . and we couldn't learn. Everybody [providers] has always treated me very well. I don't have anything to say about them . . . that they say something wrong to me . . . , “Why don't you speak English,” or something, . . . no never.

There were a few incidents of perceived poor-quality health care. One woman felt chastised by her oncologist when she was scolded for not going to the correct laboratory for blood draws. She did not return to that provider and stated that he never made follow-up inquiries regarding her care. One of the men related an incident of poor pain management when his wife was hospitalized with advanced-stage breast cancer. The family was reportedly told by one of the nurses that, “There's not a damn thing that can be done,” and he said, “I wanted to choke her.” An 86-year-old woman described with great animation a time when she was hospitalized and heard the patient in the next bed having breathing difficulties.

I pulled the button and I call the nurse and the nurse said, “What you want?” and I said, “Listen here, I don't want nothing, but the lady next to me is making funny noise. . . . You come and see her.” . . . [She was swallowing her teeth] and they were running with the machine pretty soon. After they got finished, she came to me [nurse apologizing], and I said, “You'd be in trouble right now 'cause I was going to tell them that I call you and you never listen to me.”

When asked to complete evaluation paperwork at the time of discharge, she told them, “I don't have to fill it. I tell you right in your face, I don't like your hospital, I don't like your nurses. They didn't take care of me and the lady.”

Theme 3: Use of Spiritual Resources in Coping With Cancer

The third prominent theme in the interviews was the use of spiritual resources in coping with cancer. Most of the participants used prayer to allay fears, to petition

for positive outcomes in surgery, and to pray for other family members. One woman said that she prayed at home most of the time.

I just pray to God, and I'm very grateful for what he did for me, I mean that I'm well, and I pray for my family. I'm not a devoted Catholic. I wish I'd be more but, I'm not. But I do pray.

One of the men said prayer helped him cope with both his wife's illness and his own diagnosis. “I prayed all the time for her and I prayed when I got through my experience, but when she was sicker, I used to pray for her every day.”

The Mexican transnational participant was most descriptive about the role of faith in coping with his illness. He stated that he “thanks God” every morning and evening for help he's received and carries his prayers to God in his wallet. Although he believes that “God decides” what his health outcomes will be, he did not demonstrate a passive approach to health care. Self-responsibility and determination were important values for him, as he repeatedly remarked that “you have to try to help yourself” to receive help from God. “*Dice un dicho que dijo Dios, 'Ayúdate que yo te ayudaré.'*” (“There's a saying that God said, ‘Help yourself and I will help you.’”) He sought health care in Mexico (through herbs and natural medicine) as well as conventional medicine at the community health center near his U.S. home. “I take the herbs, I feel good with the herbs. . . . I feel good with the natural medicine . . . and then I come back here [United States] and they heal me in another way. . . . I'm good.”

Discussion

Very little is known about the perceptions of cancer care delivery among Mexican Americans, particularly older adults, who represent a vulnerable population with specific needs. This exploratory study provided the opportunity for five bilingual and Spanish-speaking Mexican American older adult survivors of cancer with low incomes to voice their experiences with and perceptions of health care. Although the number of participants was small, this pilot study is important because the sample is severely under-represented in behavioral oncology research.

All participants in this study denied experiencing discrimination in health care related to race, ethnicity, income, or language spoken. Two participants believed that no discrimination exists at all against minorities in the United States. Among the three participants who described experiences of poor-quality health care, none of the incidents was attributed to racial or ethnic discrimination. Each incident of perceived poor-quality health care was characterized by rudeness, uncaring attitudes, or neglect by a physician or nurse. Only one

participant perceived “a lot” of racial or ethnic discrimination against minorities in the United States. Yet her perception pertained to the broad group level, rather than the personal level, because she denied personally experiencing any discrimination. In addition, she reframed her daughters’ complaints of racial and ethnic discrimination in their healthcare employment setting by attributing it to professional jealousy. Relegating experiences of discrimination to the group, rather than the personal level, has been described as an unconscious strategy that may be used to protect self-esteem (McCoy & Major, 2003).

The vast majority of studies examining effects of perceived racial and ethnic discrimination in cancer-related medical care have focused on cancer screening behaviors (Crawley, Ahn, & Winkleby, 2008), rather than experiences in receiving cancer treatment. Findings from a qualitative study of 26 Latina breast cancer survivors reported that some women perceived differential cancer treatment based on their ethnicity, insurance, and immigration status, although perceived discrimination was not a focus of the study (Ashing-Giwa, Padilla, Bohórquez, Tejero, & Garcia, 2006). The study did not report how prevalent the perceptions were, the proportion of foreign- versus U.S.-born participants, or Latino subgroup identities (e.g., Mexican American, Cuban). Immigration status was a factor in perceptions of unfair treatment by clinic staff among 15 Mexican or Mexican American patients with cancer with low incomes and low education levels (Im, Guevara, & Chee, 2007). Age also may have been a factor in perceived discrimination, because participants in the aforementioned study had a mean age of 50 years, compared to 76 years in the current study. No studies were found that explored perceptions of and experiences in cancer care delivery among older Mexican Americans, making these findings a first step in future studies on the topic.

The participants were eager to discuss their overall healthcare experiences as cancer survivors. One participant, an 11-year survivor of breast cancer, said this was the first opportunity she had to “tell her story.”

All participants described feeling satisfied with the health care they received for cancer treatment as well as with their current PCPs. They conceptualized high-quality health care as reflective of physical care and interpersonal factors. Providers who displayed warmth, patience, and kindness were perceived to be “like a family member” by participants, and this engendered trust. Only one participant had a Latino PCP who spoke Spanish, and he viewed the relationship as exceptional because of the sense of mutuality and warmth that had been established. Even with high-quality and trusting relationships, none of the participants felt the need to ask questions of the providers. They all accepted whatever treatment recommendations were

given at the time of their cancer diagnoses. Respect for authority is common among older people and also is a Latino cultural value, so age and culture likely had an influence on this type of treatment decision-making among the sample.

Participants used spiritual resources in coping with cancer. Four of the five participants identified themselves as Catholic, but church attendance, which varied from once weekly to a few times a year, was not mentioned as a significant coping strategy. All participants, however, described a reliance on personal prayer and a relation-

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ship with God at some point during their experiences with cancer. For some, this was expressed as gratitude for a successful surgical outcome and current health. For others, prayer and trust in a benevolent relationship with God provided comfort and an enduring freedom from worry about illness. One participant in particular spoke in detail about his reliance on “God’s will” as the ultimate determining factor in his remaining healthy and feeling good. Yet such attitudes did not interfere with participants seeking cancer treatment and follow-up care or in maintaining health care with PCPs.

Findings from this study have several implications for clinical and research oncology nurses. The emotional impact of the diagnostic phase may have enduring effects among long-term survivors, as evidenced by participants in this study vividly recalling their feelings many years after cancer treatment was completed. Providers need to be particularly sensitive to how patients are informed of a cancer diagnosis and reassess coping throughout post-treatment phases. Although no experiences of racial or ethnic healthcare discrimination were described, participants reported unsatisfactory healthcare delivery, which pertained to the interpersonal realm of care. The Latino cultural value of *personalismo* highlights the importance of providers taking time to develop rapport and communicate warmth with Latino patients. Future research exploring the phenomenon of racial and ethnic discrimination in cancer care delivery is needed to determine the role of sociodemographic variables in patients’ perceptions, including age, education, and access to health care.

This study had several limitations. The sample size was small, which may decrease relevancy of findings to other cancer populations. Because this was an exploratory pilot study with funding constraints, only one interview was conducted with a limited number of participants. Multiple interviews may have elicited richer data regarding experiences in cancer care. In addition,

although the researcher emphasized that she was not associated with the participants' healthcare providers and that all information would be kept confidential, some participants could have felt inhibited in sharing negative experiences of healthcare delivery.

Conclusion

This study reveals experiences and perceptions of older Mexican American cancer survivors, a group whose voices are rarely represented in health science research. Although several national studies have reported that perceived racial and ethnic discrimination in healthcare delivery is an issue for some patients, this sample denied any such experiences or perceptions. Overall, participants were satisfied with the health care they received, with a few exceptions. The role of age and education in perceived discrimination should be examined more closely with a larger group of racial and

ethnic minority patients. Replication of this study with a larger and culturally diverse sample of cancer survivors is under way. Increasing the understanding of the role of perceived discrimination in cancer care is an important step in the development of culturally responsive, evidence-based healthcare interventions for patients and families coping and living with cancer.

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