

Abstract

Hispanics are the fastest growing minority in the United States, and breast cancer is the most common type of cancer in Latina women (Lopez-Class, M. 2011). A review of literature and an interview with a bilingual nurse who regularly converses with Hispanic patients were done to look deeper into this multi-faceted problem. This review and interview were conducted because of the negative effects that cross-lingual and cross-cultural care has on patient satisfaction and outcomes. Additionally, multiple interventions were suggested in order to determine successful methods for overcoming linguistic and cultural differences that affect the care of Latina women with breast cancer. From the literature review, it was concluded that more research needs to be done. Future intervention studies can be conducted, including one in which interpreters are permanent members of the healthcare team. Furthermore, the means of evaluation should be focused on increasing patient satisfaction rates and decreasing medical errors.

Keywords: communication, breast cancer, Latina, language barriers, Spanish, Hispanic, women, interpreter

Foreword

During my last two years as a nursing student, I have witnessed multiple cases of Spanish-speaking patients receiving inadequate care due to language and cultural barriers. I have seen Hispanic patients suffer from isolation, confusion, and fear. In these circumstances, nurses tend to do everything for the patient while an interpreter is present on the floor. When interpreters are not present, the health care personnel tend to avoid interacting with the patient, perhaps in order to avoid encountering the language barrier. I recognize that consolidating care is a perceived time-saver; however, for the remainder of the day, it leaves the patient isolated. Combining the limited amount of time of the health care personnel with the inability to understand English, it is understandable that Hispanics would have a lower satisfaction rating of their stay in hospitals than English-speaking patients (Khan, 2013). I have also witnessed a health care provider attempt to converse with a patient while the patient nodded along with him. This is one of the many examples in which cultural practice can inhibit quality health care. In an interview with Mimi Alvarez, a Cuban-born nurse and therapist, she commented on this behavior, stating that it is a cultural practice among certain Hispanics to nod as a means of encouraging what the health care provider is saying. She stated that it is a way of showing respect even though they may not understand what is happening. In the circumstance that I witnessed, it appeared that the patient had understood the provider entirely. However, after asking the patient about his interaction in his native tongue, he confessed that he had not comprehended a word of his own plan of care. I found these instances to be troubling, especially considering the multiple resources at UNC Hospital to assist with communication. These instances spurred my interest in what specific language, cultural, and socioeconomic limitations are faced by Hispanic patients in the healthcare setting. After learning that breast cancer is the

most common cancer among Latinas, I decided that that demographic would be my focus due to their frequent interactions with healthcare providers during screening and treatment. I also wanted to investigate how these limitations affect the quality of care received and the overall experience of Latinas with breast cancer. It is my hope that this paper will establish the groundwork for a future intervention that will promote awareness and increase the quality of care received by Spanish-preferred patients.

Caring Across Language Barriers:

A Review of Literature Concerning Hispanic Women with Breast Cancer

Latinos are the largest minority group in the United States, accounting for 14% of the population, with an annual growth rate of 3.5%, three times higher than the U.S national average. (Jimenez, 2010). In North Carolina, the Latino population accounts for 8.7% of the population. In addition, over 34 million people (11.36% of the population) in the United States speak Spanish, making Spanish the second most commonly spoken language in the United States (U.S. Census Bureau, 2010). Naturally, because of the significant proportion, this language barrier is frequently encountered in the healthcare setting.

Language barriers have been linked to health disparities. They have been shown to increase length of hospital stay, contribute to poor understanding of medications and adverse effects, promote poorer compliance with medications, increase medical errors and misdiagnoses, limit access to preventative care, and greater dissatisfaction with care (Khan, 2013). One study found that errors in medical interpretation average 31 per medical encounter (Flores et al. 2003). Another study found that Spanish-speaking patients were twice as likely to experience critical medical events than patients with no language barriers (Cohen, 2005). Breast cancer also affects Latin women living in the United States disproportionately and is the main cause of cancer-related deaths in this population. The five-year survivorship rate is 83% for Latinas in the United States and 89% for Caucasians (Juarez, G. 2013). Since breast cancer is the most common, these patients come in contact with the healthcare system more frequently. This paper will attempt to answer the question, “How do lingual and cultural differences affect the care and health of Hispanic patients, particularly with women with breast cancer, and what interventions can be done to improve their health care experiences?” Because of the high proportion of the

population, the lower satisfaction ratings among Latinos, and additional health risks when communicating across language barriers, it is apparent that this is a significant problem. Because breast cancer is the leading cancer among Latinas in the United States (Lopez-Class et al. 2011), they will be the demographic of focus.

Background

Many studies have been done to observe the effect that lingual and cultural barriers have on Latina women. (Medina-Shepherd, 2012; Juarez et al, 2013; Gammon, et al. 2011; Cintron and Morrison 2006; Campesino, 2012) These studies focus on patient care across a spectrum from diagnosis to treatment. Breast cancer is the focus of this paper because it is the most common cancer in Latinas (Lopez-Class, 2011).

For Latina women with breast cancer, data reveals that they are more frequently diagnosed at advanced stages than non-Latina white women. This disparity is particularly concerning for Latina women with BRCA 1 and 2 mutations. According to Medina-Shepherd, (2012) BRCA1 and 2 mutations account for as many cases of breast and ovarian cancer in Latino populations as in non-Latino whites. However, data from this study indicates that certain BRCA 1 and 2 mutations are more prevalent in Latino subgroups than in other racial/ethnic populations (Medina-Shepherd, 2012). Having a higher prevalence of the BRCA mutation should instead cause a more thorough screening process and education in Latinas. Mimi Alvarez, a Cuban-born nurse and therapist who often works with Spanish speaking patients offered her opinion on this study, “ I believe it has to do with access to care...It could be because of fear of being discovered or a lack of education.” Ms. Alvarez also commented on the prevalence of religion in many Hispanic cultures. She stated, “While many seem to be moving away from religion, Spanish-speaking people in general are moving towards it, specifically Catholicism. This belief plays a

big part in seeking medical attention". It was noted that it is common practice for Hispanics to initially turn to their faith for answers and then later seek medical attention. Although this is one possible reason for the delay in of diagnoses, Ms. Alvarez commented that the problem is much more multi-dimensional, and that spirituality is only a small part of the answer (personal communication, February 25, 2014). In a study by Juarez et al, (2013) the group of Latina breast cancer survivors cited religion as the foundation for coping with breast cancer. This statement was supported by findings that Latina breast cancer survivors with high levels of spirituality feel closer to and find comfort in God, use prayer as a coping strategy, and believe that their faith is the key to recovering and coping (Juarez et al, 2013).

Additional research supports that the issue is not as simple as overcoming the language barrier. There are also personal beliefs, such as fear, as well as socioeconomic factors among the Hispanic population that can result in poor health care. Ms. Alvarez commented that many of the patients she sees are illegal immigrants and that they are often hesitant to disclose information about themselves for fear of their citizenship status being discovered (personal communication, February 25, 2014). This includes information relative to their health and well-being that is never being discussed with the provider. Also, in the United States, socioeconomic status (SES) varies drastically by race with Hispanic persons disproportionately represented among the lower SES, and SES affects health because of its association with the ability to access health care. (National Center for Health Statistics, 2012).

Another study of awareness, interest, and perceptions regarding genetic testing for breast cancer predisposition was done among 48 Hispanics, each with a spouse or family member with breast cancer. The study found that 83% of participants knew almost nothing about genetic testing, yet interest was high (81%). The study conducted also found a significant difference in

level of awareness of BRCA testing between whites and Latinas. 34.8% of whites were unaware of the availability of genetic testing while 56.9% of Latinas were unaware (Gammon, et al. 2011). This study also provides information that show that Latinos are less likely to have health insurance than non-Latino whites, have lower incomes and mean levels of education, and utilize preventative healthcare options such as cancer screening less frequently (Gammon, et al. 2011). Having a low level of awareness and regarding preventative screening leads negatively affects the care of Hispanic patients because it leads to a later diagnosis and poorer prognosis.

An important aspect of providing care is pain management. According to a study by Cintron and Morrison (2006), Hispanic patients with cancer were more likely to receive inadequate analgesia compared to Caucasians. Reasons for underutilization were inadequate pain assessment, patient reluctance to report pain, and concerns about addiction to opioid medication. Ms. Alvarez was asked for her opinion on Hispanics being undertreated for cancer-related pain, she responded, “It could be because of their own fears about addiction, or it could be because they are not advocating themselves (personal communication, February 25, 2014). Not advocating for themselves could be a result of the language barrier.

Another important stage of care to look into more closely is the surgical treatment options of breast cancer. Breast-conserving surgery (lumpectomy) alone or combined with radiation is often regarded as the treatment of choice for early-stage breast cancer. This is based on studies that reveal no differences in long-term survival rates for early-stage breast cancer treated with total mastectomy versus lumpectomy (Campesino, 2012). The study revealed that Spanish-speaking Latinas were more likely to opt for the physician-recommended lumpectomy, perhaps indicating that not all options were clear. The study revealed that when compared to Caucasian women, Latinas were more likely to view breast cancer as life threatening, experience more

emotional distress, and more often allow the physicians to make the treatment decision. According to Ms. Alvarez, “In some cultures, physicians and nurses assume a position of power so they [Latinos] do not often advocate for themselves” (personal communication, February 25, 2014). In this study, high rates of mastectomy were noted for early-stage treatment. Among the participants diagnosed with early-stage breast cancer, the majority of English-speaking Latinas and African American women received a mastectomy. However, the majority of the Spanish-speaking Latina group received breast-conserving surgery. Four factors influenced the choice of mastectomy instead of lumpectomy across the three groups: clinical indicators, fear of recurrence, avoidance of adjuvant side effects, and perceived favorable survival outcomes. Spanish-speaking Latinas were more likely to rely on physician treatment recommendations, while the other two groups used a shared decision-making style (Campesino, 2012).

One study conducted an interview of Latina breast cancer survivors. When asked about their initial diagnosis, a common feeling experienced was isolation and loneliness. These feelings were perpetuated by both the women’s immigration status in addition to their experiences with breast cancer. The women interviewed explained that breast cancer surgeries caused them to feel self-conscious, and they also felt less social because they did not want to answer questions about their illness. Separation from family is a significant stressor for many immigrants, and the results indicate that a breast cancer diagnosis, along with language barriers and changes in social habits, may exacerbate this stressor for some Latina survivors. Latina breast cancer survivors, particularly immigrant survivors, face additional challenges within an already complex system, including language and health literacy barriers that make medical information even more difficult to navigate. Some Latina women reported feelings of shame and secrecy related to their breast cancer and/or sexual functioning—feelings that at times extended to

partners of patients, perhaps in part due to Latino machismo--- an exaggerated sense or display of masculinity. These added feelings related to cultural and lingual barriers not only inhibit care provided to Latinas by inhibiting communication because they feel embarrassed or ashamed with breast cancer, but they also negatively affect their health by adding more stress to an already intense situation. (Lopez-Class, 2011)

Methods

In order to obtain the literature needed, a search was made on three databases: Pubmed, CINAHL, and the UNC Libraries Website. The key words used in these searches were: communication barriers, cultural barriers, Hispanics or Latinos, nurse-patient relations, patient satisfaction, language, Spanish or Spanish-speaking. After refining the search, 57 articles remained. At this point, a target population was selected in order to tailor the search. In addition to those previously listed, the terms women, Latinas, and breast cancer were used. The final result was 20 articles. These articles were then divided into two groups based on the information gleaned: background information and possible interventions.

In addition to the articles, an interview was conducted with Mimi Alvarez and her experiences with oncology patients in addition to her comments on the reviewed articles. She was asked for her insight into communicating with Hispanic patients. The interview occurred on UNC hospital property in a secure location. The interview lasted approximately an hour, and the conversation was recorded. The statements cited were transcribed from the recorded interview.

Interventions

Six articles studying various interventions that promote care to Hispanics were reviewed. The interventions include methods to educate nursing students in Spanish language, improving quality of life among breast cancer survivors, promoting awareness regarding screening for

breast cancer, as well as the use of interpreters to alleviate the language barrier. The articles discussed below are suggestions for what can be done to improve the health care experiences of Latina women affected by or at risk for breast cancer. Below are the results from each article.

Amerson's (2005) study implemented an introduction to Spanish for nursing students. This was done prior to lectures by nursing school faculty, and students were offered extra credit on examinations for learning Spanish medical phrases. The results showed a total of 82.6% of the students received the extra credit on their exams. This study suggests that one possible method for improving communication would be implementing required Spanish courses in Nursing schools instead of the typical elective courses. (Amerson, 2005; De Pheils and Saul, 2009) established an elective course at the University of California, San Francisco, School of Nursing, to teach Spanish and cultural competency skills to nursing students.

Of the students that responded to the final evaluation survey, 78% stated that they had worked with Spanish-speaking patients and used their language skills on their job after graduation. For 57% of the graduating students, the course significantly or moderately affected their decision and/or their ability to work with Spanish-speaking patients. The study also concluded that the most successful outcomes for educating the nursing students resulted from a small class size, high interactivity, and incorporating clinical experiences (De Pheils and Saul, 2009)

A study was also reviewed that pertains to promoting awareness and screening practices for breast cancer among Latina women. Ramirez (2013) conducted a study to determine if general-market messages versus Latina-targeted Pap smear and mammogram public service announcements were more effective. The author concluded that ethnically targeted messages are more effective for Latinas, and may not be less effective for non-Latina women (Ramirez, 2013).

Another intervention by Juarez, et al. (2013) used a program called Nueva Luz. Nueva Luz is an individualized, bilingual quality of life program that was designed to give culturally and linguistically appropriate information to Latina breast cancer survivors. The focus of the information given is quality of life concerns and coping strategies. The study divided the breast cancer survivors randomly into two groups and completed measures of quality of life, uncertainty, distress, and acculturation at baseline. They also were followed up at three and six months post intervention. The study found that overall quality of life increased slightly or remained unchanged in the two groups without significant group-by-time interaction. The social and psychological well-being subscales had the lowest scores (2013).

According to Fernandez (2004), the use and effect of interpreters reveal that patients with limited English proficiency often believe that interpreters should be used more than they are currently. However, even when interpreters are used; Spanish-speaking Latinos are less satisfied with their care than their English-speaking counterparts and are less likely to rate their provider as respectful and concerned about them” (Fernandez, 2004). “Interpretation has been described as an imperfect solution for patients experiencing language discordance with providers, potentially due to inadequate interpersonal care, lower patient satisfaction, or poorer perception of the quality of care received. The importance of employing culturally and linguistically appropriate tactics in patient-provider interactions, clinical care, and the health education of minority populations remains a strong focus” This same study also concludes that all the Spanish-speaking participants in the study preferred a Spanish-speaking provider regardless of their knowledge of English or effectiveness of an interpreter (Simon, et al. 2013). Also, revisiting the Campesino study, women in the Spanish-speaking Latina group reported to have understood their treatment options, 10 stated that they would have preferred a Spanish-speaking

physician to improve communication and access to information. This study indicates that some of the conversation was lost even though an interpreter was used (2012).

Discussion

Looking more closely at the Amerson study, it has been concluded that Hispanic patients report a more positive healthcare experience when their provider speaks Spanish (2005).

However, one of this study's shortcomings is that there is no data on how this Spanish class affected patient care. The author states that patients and patients' families expressed positive attitudes toward the students attempting to communicate, but no specific instances or satisfactory ratings were recorded (Amerson, 2005). A suggestion would be a follow up study should be done on the patients that the students cared for, particularly Latina women affected by breast cancer, before and after the study to see how quality of care would be affected. Additionally, this study taught nursing students Spanish phrases in a classroom setting. A possible future study would be to teach students Spanish in the clinical setting and seeing how that impacted patient care. This study is innovative in that it offered a very tangible reward (extra-credit) to nursing students instead of simply offering an elective course to students (Amerson, 2005). The phrases taught were also very pertinent to the clinical setting such as, "I am going to listen to your heart and lungs". As mentioned before, Hispanics prefer communicating with Spanish-speaking health care personnel instead of interpreters, so educating nursing students would lessen the need for the middle-man and foster a closer relationship between nurse and patient. (Simon, et al. 2013)

De Pheils and Saul. (2009) performed a similar intervention in which an entire Spanish course was offered to nursing students. This study gives more conclusive data stating that 78% of participants had used the Spanish they had learned with their patients. The article concludes that "Language development within the cultural context becomes an imperative in the education

of health care providers serving Spanish-speaking populations in the United States.” Without language development and cultural competency, patient-provider communication is impaired and optimal patient outcomes are limited. (2009)

If another method of teaching nursing students Spanish were implemented, it should be offered in a course similar to the one discussed in De Pheils study (2009) however, instead of asking the students about their application of Spanish to the health care setting, an alternative study would be to investigate the patient’s opinions on their newly learned Spanish. Important questions would be, “Did their basic knowledge of Spanish make communicating easier?” and “Did you understand them and feel like you were understood?” as well as “Would you have preferred that an interpreter be present during your interactions?” It is important for nurses to be able to communicate their patients, but for these studies, it is necessary to determine the impact a basic knowledge of Spanish had on the patient’s experience.

The implications of the Juarez study (2013) found that Latina breast cancer survivors have multiple survivorship issues that can put them at risk for poorer quality of life, especially when compared to Caucasian breast cancer survivors. This study offers directions for the development of culturally and linguistically tailored quality of life interventions. Information, support, and resources can aid Latina breast cancer survivors in managing symptoms and quality of life issues. However, more culturally congruent intervention research is needed to help improve outcomes of Latina breast cancer survivors. Also, the intervention should be tested among larger samples for greater statistical significance.

The Ramirez article (2013) is applicable to nursing practice because it emphasizes that ethnic targeting, when done well, is more effective than a non-targeted message. Although this study was investigating the effectiveness of public service announcements, being ethnically and

culturally sensitive is also crucial when caring for patients in the healthcare setting.

According to the interview with Spanish-speaking nurse and counselor, Mimi Alvarez, “Using an interpreter is very one dimensional. Some do not interpret the intent or meaning of the words and can be very literal so nuances are completely missed.” Ms. Alvarez also stated, “We all have our prejudices and biases and I don’t think interpreters are immune to that.” An interesting idea Ms. Alvarez presented about interpreters was making them a permanent part of a health care team. “What may work better is having interpreters in service lines where they can form a relationship with the provider and with the patients...to be almost like a point-person”. After attempting to find studies that supported this idea, it has been determined that more research is needed to conclude if this would be an effective intervention. (M. Alvarez, personal communication, February 25, 2014)

Another communication barrier that Ms. Alvarez discussed that is experienced by interpreters and medical personnel alike is the constant nodding that can be misleading. Ms. Alvarez spoke about her accounts with Hispanic patients who will continue to nod along when a nurse, physician, or interpreter is talking with them. “I do not think they understand what’s going on. It is about empowerment or living in fear...sometimes they do not understand and do not want to feel stupid, sometimes it is being in a state of denial I think it’s multi-faceted.” Ms. Alvarez was then asked for advice about how nurses can mitigate the confusion. She responded with, “Trying to understand their experience and advocating for their needs always helps.” For health care personnel it is important to understand that this trait is not always indicative of understanding. Patients may also be reluctant to admit that they do not understand. Ms. Alvarez emphasized that importance of establishing a trusting and open relationship (personal communication, February 25, 2014).

Conclusion

These findings indicate what is in the most current literature as well as the need for more information on intervention studies. Based on the findings reviewed, a study should be conducted that measures the effectiveness of educating nurses in Spanish. The effectiveness should be determined by the satisfaction ratings of Latina patients with breast cancer.

The articles reviewed as well as the interview indicate that useful interventions would be educating nurses in basic medical Spanish, advocating when the interpreter appears to be omitting details, and educating oneself on the patient's history (level of education, citizenship status, etc.). It would also be interesting to test Ms. Alvarez's idea of having an interpreter as a member of the health care team. This intervention would be measured by the satisfactory ratings of Hispanic patients before implementation of an interpreter as a permanent member of a team and after the interpreter had been on the team and established a relationship with the other members. Hopefully, by instating an interpreter in a permanent position, his or her strengths and weaknesses could be learned and helped managed by the rest of the team and more effective care could ensue. From the information gleaned from the reviewed articles as well as the interview with Ms. Alvarez, more culturally and linguistically sensitive interventions can be done in the future to improve the health care experiences of Latina women affected by breast cancer.

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