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Reducing the Rate of Late Stage Breast Cancer Through Effective Health Communication: An Opinion Piece

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Abstract

Purpose: Health and illness are traditionally characterized and treated differently across various ethnic groups, which encourages American health systems serving these diverse populations to explore culturally competent and safe ways to effectively reduce illness within such populations. Certain ethnic groups of women in the United States (US) bear greater risk of late stage breast cancer because of various circumstances, which include but are not limited to a lack of insurance or underinsurance and discomfort with and/or resentment toward the US healthcare system. The dominant culture and the social aspects of the modern American health system often and most favorably serve the European American population as compared to the non-European American population. When non-European American female patients are given the opportunity to understand, afford, and adhere to breast cancer prevention techniques, as a result of culturally competent and safe health communication, there is greater potential to control healthcare spending and costs, improve breast cancer outcomes and risks, and produce healthier female populations. This narrative explores communication routes that practice cultural sensitivity and foster cultural safety whilst providing healthcare to non-European American populations, so as to help reduce the rate of late-stage female breast cancer in the US.

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ABSTRACT

Purpose: Health and illness are traditionally characterized and treated differently across various ethnic groups, which encourages American health systems serving these diverse populations to explore culturally competent and safe ways to effectively reduce illness within such populations. Certain ethnic groups of women in the United States (US) bear greater risk of late stage breast cancer because of various circumstances, which include but are not limited to a lack of insurance or underinsurance and discomfort with and/or resentment toward the US healthcare system. The dominant culture and the social aspects of the modern American health system often and most favorably serve the European American population as compared to the non-European American population. When non-European American female patients are given the opportunity to understand, afford, and adhere to breast cancer prevention techniques, as a result of culturally competent and safe health communication, there is greater potential to control healthcare spending and costs, improve breast cancer outcomes and risks, and produce healthier female populations. This narrative explores communication routes that practice cultural sensitivity and foster cultural safety whilst providing healthcare to non-European American populations, so as to help reduce the rate of late-stage female breast cancer in the US.

INTRODUCTION

Cultural competence can be defined as the use of verbal and nonverbal communication, interpersonal skills, commitment, and professionalism that is aligned with a particular patient's or patient population's cultural beliefs.^{1,2} Cultural safety can also be defined as a practice and concept that takes into account social issues that have caused an imbalance of societal power against African Americans, which have altogether resulted in, and continue to contribute to, a myriad of health disparities within various communities.^{1,2} The term "cultural safety" was further developed in addition to the term "cultural competence" as an alternative concept that emphasizes and acknowledges the long-term societal impacts of "power imbalances, institutional discrimination, colonization and colonial relationships" in both society and the healthcare system, and how these impacts continue to effect populations and their subsequent generations.¹

Health and illness are traditionally characterized and treated differently among various ethnic groups, which include but are not limited to Hispanics/Latinos, Asian/Pacific Islanders, Black/African Americans, and American Indians/Alaskan Natives. These characterizations and treatment methods are deeply rooted in traditional healthcare methods that have existed for centuries. They existed prior to the advent of modern healthcare which emerged and became popular, primarily used, and backed by public policy in the US around the mid-20th century.² The modern healthcare system is known to consider traditional or cultural health remedies as lesser than, ineffective, and/or primitive in comparison to modern healthcare approaches against illness. However, given the growing limitations to and unfavorable outcomes associated with modern healthcare, individuals within the US health system are engaging in an ironic and tertiary shift away from the sole practice of both modern, science-based healthcare and cultural/traditional healthcare methods. Notwithstanding the benefits provided over the past century as a result of modern healthcare technology and health policy reform, discontent with the modern health system revolves around the growing opinion that modern healthcare has become largely unaffordable, ridden with excess and waste, questionable in quality, and at times insensitive toward individuals of varying cultures and ethnicities.

Various health disparities exist within the aforementioned racial/ethnic groups, who are negatively and disproportionately affected by the spiraling cost and quality of modern healthcare in the US. In the discussion below, and through systematic review of various scholarly sources, the topic of breast cancer prevention communication in the specialized field of health science policy is presented below in sections covering the Hispanic/Latino, Asian/Pacific Islander, Black/African American (not Hispanic/Latino), and American Indian/Alaskan Native, in comparison to European American (not Hispanic/Latino) patient populations, in that respective order.² The conclusion summarizes the value of personalized breast cancer prevention communication and the value-added practice of providing high-quality breast cancer prevention communication techniques within these populations. Lastly, in consideration of the information provided and discussed herein, an overall recommendation is provided.

Discussion

Breast cancer continues to plague various racial/ethnic groups of women in the US, despite the fact that breast cancer risk decreases when preventative measures are taken. In 2013, breast cancer was reported to be the second largest cause of cancer death among women in the US.³ Data on the rate of late-stage breast cancer occurrence in 2011 are reported in Table 1.⁴

Table 1. Late Stage Breast Cancer Rates per Racial/Ethnic Group, Year 2011⁴

Racial/Ethnic Group	Late Stage Breast Cancer ^a
Hispanics/Latinos	35.0
Asians/Pacific Islanders	30.3
Blacks/African Americans, not Hispanic/Latino	51.6
American Indians/Alaskan Natives	26.9
White/ European American, not Hispanic/Latino	41.8

Note: ^a Number of cases per 100,000 population

The European American female population held the second highest rate of late-stage breast cancer in the US in 2011, however, the dominant culture and social aspects of the modern American health system relates to, and thus more favorably serves, women holding the dominant European American culture.

It is important to explore culturally competent communication and education techniques, as interventional studies to date have demonstrated that greater levels of patient education foster healthier communities across a variety of illnesses and geographic areas of varying socioeconomic status.^{5,6} This exploration is particularly important for Black/African American female populations, who hold the highest rate of late-stage breast cancer in the US. Breast cancer prevention can be partially achieved by addressing known behavioral and environmental risk factors for late-stage breast cancer, which include but are not limited to low to no alcohol consumption, a diet rich in fruits and vegetables, and exercise (see Table 2). Other protective factors include breast-feeding, child-bearing during young adult years (<35 years of age), and regular mammograms.^{2,3,7}

Behavioral Risk Factors	Environmental Risk Factors
<ul style="list-style-type: none"> - Delayed mammograms and/or medical examinations - Alcohol consumption - Absence of self-breast examinations - Lack of exercise and physical activity - Diet low in fruit and vegetables - Cultural conflicts against modern gynecological care 	<ul style="list-style-type: none"> - Lack of physical access to routine gynecological care - Inability to schedule routine gynecological care due to time conflicts and work demands - Diet low in fruit and vegetables - Lack of access to (breast) health and family planning education - Lack of transportation to routine gynecological care - Cultural conflicts against modern gynecological care - Income level - Underinsurance or lack of health insurance

Proper prevention of late-stage breast cancer, and subsequently a decreased rate of late-stage breast cancer, has a greater chance of success when culturally competent communication is disseminated among the various racial/ethnic groups. The next sections discuss mechanisms through which culturally competent breast cancer prevention communication may be achieved in

female Hispanic/Latino, Asian/Pacific Islander, Black/African American (not Hispanic/Latino), and American Indian/Alaskan Native populations.

Hispanics/Latinos

According to Table 1, Hispanic/Latino women held the third highest rate of late-stage breast cancer in the US in 2011. A significant percentage of Hispanic/Latino women are uniquely challenged with navigating the modern American health system. Challenges include but are not limited to language barriers, misalignment with time orientation, and access to care via affordable health insurance coverage.²

Such challenges should be considered in the process of structuring and creating communication that seeks to effectively reduce the rate of late-stage breast cancer in Hispanic/Latino women. Language barriers can be overcome by obtaining appropriately trained Spanish bilingual translators who are also health educators, health system navigators, and/or dietitians who can personally provide dietary and lifestyle education to Hispanic women who may not speak English.⁸ Mammogram screening facilities with flexible hours may be opened in predominantly Hispanic communities in order to accommodate women who may or may not be able to adhere to strict appointments, so as to accommodate individuals with relaxed or non-strict time orientation.

Recent health policy changes and initiatives provide low-income Hispanic/Latino women with greater access to health insurance coverage, mainly via Medicaid expansion and subsidized health insurance via the Marketplace.⁹ For example, large populations of Hispanics/Latinos reside in New York, New Jersey, Florida, Texas, and California.² Of those states, California, New York, and New Jersey adopted the Medicaid expansion under the Affordable Care Act of 2010, allowing women in these states to gain affordable access to breast cancer screening and care.¹⁰ As such, bilingual-English/Spanish health educators and health system navigators in these states may provide healthcare assistance to Spanish-speaking women wishing to obtain free or affordable insurance coverage and assistance with local health provider navigation.

Moreover, Hispanic culture tends to be matriarchal; Hispanic female members, such as mothers, grandmothers, and daughters, often advise their Hispanic family members on health-related matters that could prove to be advantageous for purposes of breast cancer prevention communication in this group. For example, as more Hispanic women are educated and coached on preventative lifestyle habits, there is greater likelihood that those women will communicate this information to other female (and male) family members and friends within their community and across generations. Therefore, this culturally competent and safe communication strategy harbors great potential toward effectively reducing late-stage breast cancer long-term.

Asians/Pacific Islanders

Table 1 illustrates that Asian/Pacific Islander women faced the second lowest rate of late-stage breast cancer in the US in the year 2011. Asian/Pacific Islander women, particularly those who speak very limited English and who reside in crowded, poverty-stricken areas, face enormous challenges with accessing modern American healthcare. Cultural dissonance also causes these women to avoid the Western health system entirely. Health disparities in the Asian/Pacific Islander population are largely attributed to the poor working and crowded living conditions faced by some members of this population. Also, many individuals in the poorer subset of this population cannot affordably gain access to preventative healthcare, and thus preventative breast cancer screenings. Therefore, it is important to explore culturally competent and safe strategies that would grant this population of women ways in which they can personally reduce their risk of breast cancer.

The traditional culture and practice of Asian/Pacific Islander medicine revolves around illness prevention. As such, lifestyle factors that prevent late-stage breast cancer may resonate well within this population. In addition, currently existing lifestyle preferences and habits within many female Asian/Pacific Islander populations, such as breastfeeding, are favorable to breast cancer prevention. A recent qualitative study that sought to examine the impact of cancer on Chinese family relationships discovered that family members share "equal suffering" with other family members suffering from cancer.¹¹ Therefore, culturally competent breast cancer prevention education may be most effective if the practice of "equal suffering" can be reversed into a message and practice of "shared prevention" as it relates to breast cancer prevention.

Spector highlights a relatively favorable feature of Asian/Pacific Islander representation in the modern American health system. In 2010, the Asian population comprised nearly six percent of the nursing workforce.² The Asian resident population in the US during that same year was nearly five percent.² This descriptive feature demonstrates demographic parity between Asian US residents and nurses, which harbors great importance since nurses are often front line medical communicators and educators, and are also more likely to directly deliver compassionate, competent, and safe care to patients. Currently, states with the seemingly largest Asian populations are California, Hawaii, and Washington; fortunately all three of these states elected to participate in the Medicaid expansion program under the Affordable Care Act.¹⁰ Therefore, Medicaid expansion under the Affordable Care Act also provides Asian women, enrolled under Medicaid, with greater access to preventative breast cancer

screening. Given the demographic parity between Asian resident populations and Asian nurses, culturally competent gynecological care may be promoted.

Black/African Americans

The Office of Disease Prevention and Health Promotion provides that in 2014, the number of overall cancer deaths (age adjusted, and per 100,000 persons) within the African American/Black (Not Hispanic or Latino) population was 190.2, which was the highest rate of cancer deaths during that year.⁴ Per Table 1, African American/Black women held the highest rate of late-stage breast cancer in the US during 2011. Given the cultural and historical implications within the African American/Black population, it is important to explore how cultural competence can help reduce the rate of late-stage breast cancer within the African American/Black female population.

As a result of historical, widespread, and overt abuse, discrimination, and systemic oppression, certain populations of African Americans/Blacks within the US distrust the US healthcare system. For example, a small 1997 focus group was conducted at Grady Memorial Hospital in Atlanta, GA by Corbie-Smith, Thomas, Williams, and Moody-Ayers.¹² At that time, the hospital served a population comprised of 89% African Americans. The researchers sought to determine the reason for low African American/Black participation in clinical research trials. The researchers discovered among the participants, who were between the ages of 20-78 years (70% women), a consensus of distrust and suspicion toward the medical community. The participants expressed feelings of fear of harm and suspicion of medical necessity. Interestingly, the focus group participants favored medical research only if they could be assured that the medical research study would not expose the participants to or inoculate the participants with an “unknown virus” such as the Acquired Immune Deficiency Syndrome (AIDS) virus. The focus group participants used the controversial Tuskegee Syphilis Study, which was conducted by the US Public Health Service and also their belief that the AIDS epidemic occurred as a result of a government-sponsored clinical study “gone wrong” as validation of their mistrust against the US medical community. Another cross-sectional survey conducted in 2003 by Brandon, Isaac, and LaVeist among 277 African Americans between the ages of 19-93 years obtained similar yet slightly contrasted results.¹³ The researchers discovered that African American/Black mistrust against the medical community was not the result of the Tuskegee Syphilis Study, but rather from broader and personal experiences of injustice and racial discrimination. Given the long and perhaps continuing history in the US of racial discrimination against Blacks/African Americans, the sincere practice of cultural safety when providing healthcare services and health education to this population is of the utmost importance.

Similar to Hispanic/Latino culture, African American/Black culture tends to be matriarchal. Informal caregivers of the African American/Black community are often women, which may result in these women neglecting or foregoing their own preventative medical care and needs in order to care for and attend to that of their families or communities. Because of historical and social oppression and racial discrimination in the US, a significant number of African American/Black women are often poor and unable to afford and/or obtain access to preventative health services and education. Medicaid expansion under the Affordable Care Act allows low-income African American/Black women to obtain greater access to preventative breast cancer screening, education, and care. In 2010, close to half of the African American/Black population resided in New York City, Los Angeles, and Miami.² Of these states, New York and California elected to participate in the Medicaid expansion program under the Affordable Care Act, making access to preventative breast cancer screening, education, and care more feasible for qualifying populations of African American/Black women residing in these states.¹⁰

Urban and poverty stricken African American/Black communities often have an abundant array of unhealthy food options and are thus considered to be food deserts.¹⁴ Food deserts make healthy breast cancer-preventative food/eating/dining options especially difficult within these communities. As an alternative to help combat this issue, urban farming and gardening initiatives have proven to be beneficial in these communities regarding increased fruit and vegetable intake.^{2,15} Urban gardening in poor urban communities, coupled with greater access to preventative healthcare via Medicaid expansion, renders large potential to controlling and reduce the rate of late-stage breast cancer in the African American/Black population. In addition, since the African American/Black culture tends to be matriarchal, healthy eating habits and gardening techniques can be shared and communicated among African American/Black women, their children, and families within their communities, which could lead to multi-generational wellness and education in this population.

American Indians/Alaskan Natives

American Indian/Alaskan Native women faced the lowest rate of late-stage breast cancer in the US during 2011. Like other members of relatively poorer communities, affordable access to preventative healthcare and preventative breast cancer screenings is vital to ensuring a lower rate of late-stage breast cancer in this population of women. Lifestyle modifications in the form of healthy eating and drinking habits may also ensure lower rates of late-stage breast cancer in American Indian/Alaskan Native women. Therefore, it is important to explore culturally competent and safe strategies that would help to achieve and/or sustain lower rates of late-stage breast cancer within American Indian/Alaskan Native women.

Several authors and public health researchers acknowledge the high rate of alcohol abuse within the American Indian/Alaskan Native population, which has led to drastically high rates of fetal alcohol syndrome in this population. Alcoholism is the most widespread and severe epidemic in the American Indian/Alaskan Native community. Several studies have linked alcohol abuse to increased risk of breast cancer in women of no specific race. For American Indian/Alaskan Native women, the combination of alcoholism and a lack of access to preventative breast cancer education places this population of women at uniquely higher risk of late-stage breast cancer.^{16,17,18}

Like the African American/Black population, American Indians/Alaskan Natives suffer from the consequences of historical oppression and domination by the White European population and culture in the US. Spector notes that anecdotal experiences by the American Indians/Alaskan Native population tend to discourage this population from obtaining modern healthcare; it is a common belief among American Indians/Alaskan Natives that their health will suffer should they come into contact with modern healthcare providers of White/European descent.¹ Therefore, from a health policy perspective, greater access to care through Medicaid expansion under the Affordable Care Act may not be entirely effective in this population as it relates to breast cancer prevention communication. As such, proper breast cancer prevention communication must circumvent or surpass deep-rooted American Indian/Alaskan Native reluctance to modern American healthcare. The sincere practice of cultural safety in this population is of the utmost importance.

A large portion of the American Indian/Alaskan Native population continues to rely on their traditional medicine men and women for their primary healthcare. Therefore, great opportunity lies in utilizing this existing route of medical communication to help American Indian/Alaskan Native women understand the risk factors associated with breast cancer. Medicine women could become educated by trusted members of their non-American Indian/Alaskan Native community or via internet sources on breast cancer risk factors and lifestyle habits. In turn, these medicine women may relay this education to women in their American Indian/Alaskan Native communities as part of any effort to control and reduce the rate of alcoholism and the subsequent risk of breast cancer.

Conclusion

Modern healthcare is not only largely unaffordable and unattainable for many members of the general population, which includes the Hispanic/Latino, Asian/Pacific Islander, Black/African American, and American Indian/Alaskan populations, but it is also undesired by several members of the general population. Fear of cultural or even financial bias and/or insensitivity by medical providers is one of the many dissuading factors that may prevent vulnerable members of the general female population from receiving the preventative or acute treatment they may require. The value of personalized care and education that embraces the practice of cultural competence and safety renders great potential in the battle against late-stage breast. When modern American healthcare professionals become educated on how to provide culturally competent and safe care across diverse American populations of women and families, there is an even greater potential to reduce the overall rate of late-stage breast cancer in the US.

Recommendation

When patients are given the opportunity to understand, afford, and adhere to breast cancer prevention techniques, there is a greater potential to control healthcare spending and costs, improve breast cancer outcomes, and produce healthier populations of women. The cost of late-stage cancer treatment, which includes patient productivity loss as contributing workers in society and patient morbidity, challenges the health system to explore and embrace the true value of breast cancer prevention techniques. It is recommended that healthcare providers fully consider the holistic effects of traditional and complementary medicine, diet, and lifestyle, as they interrelate with traditional geography, culture, and ethnicity, and have demonstrated efficacy against the onset of breast cancer.

In addition to patient education, health profession education on cultural competence is also an effective channel toward eliminating breast cancer disparities. In order to realize the benefits and value of cultural competence in breast cancer prevention and care, it is important to understand the value of effective educational planning for skilled training programs centered on patient interaction. Skilled healthcare professionals who work to eliminate or reduce late-stage breast cancer disparities are better equipped to deliver culturally competent care and co-create safe spaces that foster sensitive and unbiased patient-provider communication when they fully understand the personal values and history of the patient population they serve. Health promotion programs centered on breast cancer control and prevention should develop comprehensive and tailored lessons and learning exercises for their team of healthcare professionals. It is recommended that they utilize case studies that demonstrate the value, concepts, successful practice, cultural competence, and the understanding of cultural safety in breast cancer prevention and care. Through didactic instruction, training, and/or continuing medical education, curricula focused on the practice of cultural competence must be delivered and administered either in-person, electronically, or virtually based on the preferences and

schedule demands of instructors, professionals, and students serving vulnerable female populations at risk of late-stage breast cancer.

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