

# Taking on racial and ethnic disparities in cancer care

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Editor

**R**isk is stratified in cancer patients. Based on decades of data available on cancer patients, we oncology practitioners can provide a clinical and actuarial assessment of a patient's risk of complications, relapse, or death from cancer or cancer treatment. This capability to learn from the experience has enhanced our ability to predict outcome and to mitigate the likelihood of negative outcomes in cancer patients. We have developed a clearer understanding of how age, stage, performance status, ethnicity, availability of insurance, and tumor and treatment characteristics might influence patient outcomes. This experience and the remarkable technology available to us have provided us with abundant insight into many aspects of cancer treatment. Though more work remains, we have already come so far.

April is Minority Cancer Awareness Month. While we fight and win many battles in the war on cancer, have we made equal progress in serving our minority patients? There are special considerations among minorities that pose unique challenges to effective cancer management. The burden of morbidity and mortality from cancer is disproportionately higher in racial and ethnic minority populations.<sup>1</sup> There are race-based disparities in obtaining timely access to state-of-the-art care that can have an impact on outcomes. For example, Bach and colleagues reported that in patients with lung cancer, black patients were 12.7% less likely than were white patients to have surgical intervention and their 5-year survival was lower, whereas among patients with appropriate surgical management, survival was similar for the 2 racial groups.<sup>2</sup>

In some cases, cancer treatments can have a different profile of efficacy or toxicity based on physiologic changes that can alter drug metabolism owing to genetic polymorphisms that alter activation or clearance. Understanding these differences in cancer among minorities can be challenging because recruitment in clinical trials is disproportionately lower for minorities.<sup>3</sup> This means that when a new

therapeutic intervention is tested to evaluate its efficacy and toxicity, data on the therapy's behavior within a minority population may not be robust. Facilitating enrollment of minorities in clinical trials remains a daunting challenge that we have yet to overcome.



Compliance with cancer screening is substantially lower among minorities.<sup>4</sup> By not having more optimal screening, the stage distribution among minority patients is unfavorable compared with that in non-minority patients. Obviously what follows from this higher stage at presentation of illness is a greater need for more aggressive therapeutic intervention and higher morbidity and mortality from cancer. Mammography screening rates improved across all racial and ethnic groups during the 1990s, contributing to earlier diagnosis of disease, but the effect was still smaller among African American women.<sup>4</sup>

In patients with colorectal cancer, differences in screening rates are thought to contribute to half of the mortality variance seen between ethnicities.<sup>5</sup>

## How can we do better?

Obviously the causes of racial and ethnic disparities among cancer patients and how those disparities can be mitigated is a complex issue, both social and medical, but as community practitioners, we can be strong advocates for prevention in our communities. We can be facilitators of breast, cervical, and colon cancer screening in our communities. We can encourage the reduction of tobacco exposure by diminishing smoking initiation and prompting cessation through education and treatment. Among patients who have had a large burden of tobacco exposure from smoking, lung cancer mortality can be reduced by screening with CT scans that can lead to early diagnosis and timely appropriate treatment.<sup>6</sup> We can try to reduce barriers to screening and appropriate treatment by working in our communities to increase access to care.

Times are tough for community oncologists. The

Community Oncology Alliance has estimated a 20% increase in oncology clinic closings and their consolidation into hospitals as a result of policy changes and financial pressures.<sup>7</sup> In this time of adversity and challenges to our very existence, we need to continue to do what we do well – to educate, to facilitate, to prevent, to palliate, and to heal. In the words of Martin Luther King, Jr, “The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy.”

## References

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