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Addressing Racial Inequity in Cancer Care: Self-Awareness Among Oncology Professionals

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Extensive studies over many years have documented disparities in cancer care and cancer outcomes related to race and ethnicity. Multiple factors have been identified that contribute to these disparities, including social determinants of health, insurance status, and disease biology, as well as explicit and implicit racial bias. These factors have also been shown to influence accrual to cancer clinical trials, in which racial minorities continue to be underrepresented. The report by Schatz et al,¹ in this issue of the journal, sheds new light on how these disparities are perceived by patients, caregivers, and oncology professionals.

Although interventions aimed at reducing disparities have been described—with varying levels of success—for several decades, attention on racial disparities has been heightened in the past few years by 2 major events: COVID-19 pandemic's disproportionate effect on minority populations, and the death of George Floyd.

These events not only brought renewed focus to racial disparities in cancer care but also drew increased attention to the issues of diversity, equity, and inclusion across healthcare systems, including at cancer centers, and elevated awareness of our shortcomings in promoting equal representation of minorities among staff and providers. Many organizations have increased their efforts to promote equity and inclusion in their workforce and leadership, and have established enhanced training to increase awareness of issues of equity as well as explicit and implicit bias.

Of the strategies that have been shown to reduce or eliminate outcome disparities, adoption of guideline-concordant cancer care and recruitment to cancer clinical trials are probably the best documented. Inequitable access to these approaches persists between White and non-White racial groups,² although evidence is emerging that barriers to access can be overcome and this can result in equivalent cancer outcomes for all racial groups.³

Much of the published literature on disparities has addressed the multiple systemic, logistic, financial, and insurance barriers that minority populations face in navigating cancer care. Few studies have specifically addressed the perceptions and perspectives of patients, and even fewer have explored those of cancer care providers, regarding quality and delivery of care depending on race and ethnicity. The results of the surveys published by Schatz et al¹ are particularly significant, and in some respects, disturbing. The 2 national surveys, conducted by the Elevating Cancer Equity initiative (a collaboration among the American Cancer Society Cancer Action Network, NCCN, and National Minority Quality Forum), addressed the perceptions of patients and caregivers, and oncology providers, respectively.

In many respects, the results of the first survey are not surprising; namely, that patients and caregivers who identify as either African American/Black or Hispanic/Latino were more likely to report negative experiences during their cancer care and more likely to report that they were treated unfairly based on race and ethnicity. A closer look at these high-level conclusions shows a common theme of inadequate communication and lack of empathy across all racial groups (including White patients), but minority



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populations more frequently reported that they received poorer-quality care based on race and ethnicity and that the care team made assumptions about their wishes and financial status.

The survey of oncology providers turned up more surprises. First, only about half of the surveyed oncologists (who predominantly identified as White) reported that the health-care system treats people unfairly based on race and ethnicity. Given the extensive literature on racial disparities, this seems extraordinary. Perhaps even more puzzling is that almost two-thirds of the oncologists agreed that non-White patients received poorer-quality care than White patients and have worse outcomes. Personally, I find these apparently conflicting findings difficult to resolve. The authors suggest that this may reflect a belief among providers that social determinants are overriding the “equivalent” healthcare delivery among different racial groups, but 2 additional findings from the survey suggest that other factors may be at play. First, most oncologists reported believing that White and non-White patients receive equivalent communication from providers regarding their cancer. Second, and most disconcerting of all, 56% of surveyed oncologists reported that there was no possibility that unintentional racial bias was influencing their treatment of non-White patients and 54% reported that there was no possibility they have ever allowed this to happen.

Without intending to overinterpret the findings of these surveys, I think it is possible that many oncology providers believe racial disparities are a problem of the healthcare system and society in general and that as individuals, we have no influence on these and no capacity to change them. However, previous studies suggest otherwise. It has been well documented that healthcare professionals as a whole exhibit bias at comparable frequency to the rest of the population.⁴ Evidence exists of explicit and implicit bias and racial stereotyping among clinicians and clinical research staff involved in cancer trial recruitment that adversely affects minority accrual.⁵ Previous studies have also shown that healthcare providers communicate less effectively with minority patients.

As Schatz et al¹ suggest, quick fixes to the challenges presented by racial disparities do not exist. Increased efforts to increase the diversity of the oncology workforce are key interventions, as are improved navigation and support services

for underserved minority populations. In the shorter term, however, these survey results demonstrate the need and potential benefit of enhanced educational opportunities for oncology providers. Recent studies involving other minority groups, including the LGBTQ+ community, have shown the willingness and openness of oncology professionals to understanding more about the needs of underserved populations.⁶

The response of many organizations to the need for improved awareness of unconscious bias has been to introduce mandatory online training modules for their workforces. As someone with no expertise in the effectiveness of this approach, I can only comment from a personal perspective that the modules I have experienced have been informative, although perhaps not impactful on my own self-awareness regarding bias. In contrast, I have had the benefit of more focused and intensive training in unconscious bias as is required for members of search committees by many healthcare organizations. This more personalized and focused training has certainly helped me to understand my own misconceptions and false assumptions, recognize this bias, and develop strategies to adjust my thinking. Although many cancer center leaders and oncology providers may be concerned that more intensive training could be too time-consuming and expensive, results from the survey suggest that more resources need to be directed toward these efforts and that the return on the investment could be a significant step toward improving the care and outcomes for our patients.

The Elevating Cancer Equity initiative and Schatz et al¹ have drawn attention to a significant potential contributor to racial disparities in cancer care. Although ample evidence exists that explicit bias in healthcare has declined in recent years, implicit bias persists, as does an apparent lack of awareness. Importantly, unlike many of the factors that contribute to inequity in cancer care, this is one that oncologists and other cancer care professionals can and must impact at an individual level.

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