Introduction to Session III

Cancer Therapy and Survivorship

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Introduction

The problem of disparities in medical care and clinical outcomes affecting people of color and those living in poverty is convincingly documented by a growing body of evidence from many fields of medicine (1). Cancer care is no exception (2, 3). An often neglected question is what academic health centers can and should do to correct this problem. Clearly, the academic centers are not immune to the issue. We pride ourselves on providing the latest and best treatments for patients who come to our clinics and participate in clinical trials. However, we collectively accrue few minority patients to clinical trials, often because of the low percentage of minorities treated in our hospitals and clinics. Thus, disadvantaged minorities are the last people to have access to the fruits of our research. We have also been noticeably ineffective in improving minority participation in research, despite increasing attention to problems of minority access to care. At the Dana-Farber/Harvard Cancer Center, 7% of our patient population are minorities, although the population of the Boston metropolitan area has 12% African-Americans and Hispanics. These figures have remained stable over the past 5 years despite our awareness of the problem. The diverse obstacles to care and participation in research faced by minority patients are described in the following chapters: (a) cultural, linguistic, and logistical barriers; (b) the patients’ fear of an unknown and unfriendly institution; and (c) socioeconomic factors that mitigate against seeking care outside their neighborhoods. Unfortunately, minority participation in research has its own history of deception and betrayal of African-Americans that intrudes on the relationship between minority patients and the research establishment (4).

The issue of disparities in cancer outcomes can be approached on several levels. It is most certainly a financial problem that results from poverty, lack of health insurance, and the high costs of care. It is also a problem of cultural discord, in which persons from underserved communities lack information about cancer and view illness and medical care in different contexts. Concepts of prevention and early diagnosis may have little appeal and may even conflict with cultural perceptions of health and illness. Another problem is institutional estrangement, in which underserved patients feel unwelcome in a system that reflects the culture and values of a predominantly Caucasian and middle class society with doctors and nurses who are not of their color and background. There are also biological issues, as exemplified by the high incidence and mortality of prostate cancer within the African-American population. But most importantly, it is a problem that costs lives and places an unequal cancer burden on a segment of society least able to absorb its impact. The disparate cancer experiences of communities of color and poverty demand a societal response. Research can be an important component of that response by providing effective interventions: ways of disseminating information that convince people to change (a) their diet; (b) their attitude toward smoking; and (c) their preventive behaviors. At the same time, medical care systems must change to accommodate and comfort patients who currently have no home in the American health care landscape.

What can be done to change this inequitable situation? Both the academic health centers and community need to jointly seek solutions. Attitudes and cultures must change in both the community and medical centers. Economic incentives that discourage care must be addressed. One-sided proposals that attempt to fix problems in the hospital setting, but fail to reach into the community, simply will not work. Hiring minority physicians, nurses, and other professionals will help, but only if their careers are sustained and only if they are promoted to leadership roles in the hospital and community. The communities represented by patient and care provider must both commit to solutions. We can only hope that the next conference on this subject will present new approaches and tangible progress.

Raising awareness of the problem, as exemplified by this conference, is only a beginning. What steps must we take to bridge the cultural gap and provide information, access, and effective care? The following two speakers, one a professor of nursing (Dr. Sandra Millon Underwood) and the other a distinguished government scientist and leader in cancer clinical trials (Dr. Michael Christian), will examine the themes of building bridges for medical care across cultures and implementing change through clinical research. Their perspectives are worthy of our consideration as we seek direction on this journey toward equality in medical care.

References