Transcript Details
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Exploring the Impacts of Race & Bias in Cancer Treatment

Dr. Sands:
The fact that a patient's home zip code is a better predictor of health than blood pressure, cholesterol, or even genetics highlights significant disparities that urgently need to be addressed. And that starts by asking some of the tough questions like, "How much does systemic racism contribute to these disparities" and "What can we do now to make a difference?"

Welcome to *Project Oncology* on ReachMD. I'm Dr. Jacob Sands, and joining me to discuss the impact of race in medicine is Dr. Christopher Lathan, Associate Medical Director of the Dana Farber Cancer Institute Network and subject matter expert in racial disparities in lung cancer treatment. Dr. Lathan, welcome to the program.

Dr. Lathan:
Thank you very much. Happy to be here.

Dr. Sands:
First, Dr. Lathan, race is often discussed with common categories. So, let's start with defining race and ethnicity. Is there an objective method for classifying race into those categories?

Dr. Lathan:
So, the short answer is, no, race is a social construct. It really didn't even exist in the ancient world, people defined themselves where they came from. You were a Athenian, you were a Spartan, you were a Carthaginian. Yes, they described your characteristics, but there wasn't race. It was in the Renaissance with the idea of going towards a scientific categorization where people started trying to divide humans into racial categories and the truth is, it was really this idea of white and black. And this idea of the white race and a black race really didn't develop until slavery in the U.S. where they used the term to really differentiate between indentured European servants who were poor and the slavery trade, and they wanted to make sure those two groups did not unite. And that's when you really had race defined. Ethnicity is a little more complicated. A lot of folks have customs in ethnicity and sometimes that can be language based, sometimes it's culture based, but that's separate from what we talk about as racial categorizations.

Dr. Sands:
So, with that, there are an overwhelming number of studies showing significantly worse outcomes for black patients in the U.S. From higher maternal mortality among black women, and this is accounting for various possible confounders to marked differences in pain management, but of course this carries into cancer treatment and outcomes as well. This includes fewer black people undergoing surgery for early-stage cancer that's when the cancer is at a stage that it can be cured, as well as less treatment for those with metastatic disease. So, can you tell us more about the disparities seen in cancer treatment, Dr. Lathan?

Dr. Lathan:
Absolutely. You know, unfortunately, those racial categories that we just described as being social construct, they do carry with them this indicator of exclusion and a history of oppression. And in 2002, the institute of medicine commissions this report and it's called "Unequal Treatment," and they really looked at exactly what you describe, Jacob. All these different areas in medicine and they tried to figure out, you know, what are these barriers and what's causing some of these differences in mortality rate? And certainly there's huge black and white mortality rate differences, and what they found is that the barriers seem to be multifactorial and multilevel. And by that I mean it's not just a decision-making individual, you know, a poor decision or poor choice of what they want to do, or excluding somebody intentionally. These are really socioeconomic barriers that have been put into the system that keep people from getting the care that they need, and also an accumulation of damage, you know, whether that's diet, exercise, all these other things that are affected by your social determinates. So, there's a lot of reasons why you see those differences and most of them have to do with where you live, how

much money you make, and the history, and the ability of your family to get good care and good nutrition.

Dr. Sands:
So, one of the tough things about this is that having biases is a natural part of being human, but I think within medicine we think of health decisions as being guided by objective data. Can you speak to some of the differences that have been demonstrated in cancer care and provide some of the background as to why these may exist?

Dr. Lathan:
We like to think, right, as clinicians and as, you know, agents of change and healing that all of our decisions are based on objective data and, very specifically, when I started doing lung cancer work and looking at who gets surgery for lung cancer, because of course that's how you can cure someone, we started seeing these disparities that we knew existed. And when you talk to the surgeons, they'd say "Look, anybody who comes into my office, I treat them, so I don't know where this is coming from. This is coming from that other guy, or that other woman, or that other place," and you really had to convince people that the disparities even existed. But, what we found is that it's not overt denial of care at this point. It was really subtle things. We found that when you actually looked at the criteria for surgery and folks were healthy and they actually made their way to a treatment Center of Excellence, they tended to get surgery about the same as their white counterparts whether you're black or white. But, it was in the places where they felt people had low social support, right, when they felt that there were other factors that didn't really make its way into the medical chart, that's when you saw the disparity widen. So, Jacob, I really think that some of these things have to do with true access to care, can you get there, do you lose money when you go see your doctor, do you have social supports with you, do you have somebody advocating for you? All of those softer things seem to really impact who got surgery for lung cancer, on top of course, what kind of insurance you had and whether or not you were healthy enough to undergo surgery, those things were an accumulation of problems but even beyond insurance and access, some of these other things really had to do with these things that we're seeing that we don't really document. And those are the things that I think really show us where these biases are kind of baked in. They're not necessarily something people are doing overtly.

Dr. Sands:
For those of you just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Jacob Sands, and I'm speaking with Dr. Christopher Lathan about the impact of race in medicine, and in particular, cancer care. Dr. Lathan, you just discussed some of the data around health care decision making that's impacted by the patient's defined or identified race. At the same time, health care outcomes as a whole are impacted by many factors, as you've also outlined. Can you speak more to the concept of systemic racism including impacts in cancer care and the health care setting as a whole?

Dr. Lathan:
Yeah, absolutely. So, I think when people hear this term systemic racism, they look around and they don't really know what that means if you're not a historically oppressed person in the U.S. And I think what I'll do is, specifically, is talk about the experience of black Americans in the U.S. If you go back and you think about the transition from chattel slavery to Jim Crow, there were obviously people who were not treated like humans, and by that specifically I mean medical procedures. A lot of the GYN surgical procedures that were developed at that time were practiced on African-American women without anesthesia due to the belief that they did not have pain receptors. And, so, as you move forward through Jim Crow and you move forward into the 1960s, you still have this remnant of black people being a different group of people, not necessarily folks who are able to get access to care and not deserving of care. Also, don't forget that the idea of eugenics in different racial groups still trying to be proven. That happened all the way through up into the 60s. So, there was a lot of emphasis on different types of care, and black folks not really having opportunities to get medical care and being treated differently. Then you look at specific regulations, and I think the G.I. Bill's a good example of something where everybody thinks of it as a great way that wealth was redistributed in the United States, and it was. Unfortunately, black veterans were really not able to utilize the G.I. Bill because of the way that Jim Crow laws were enforced. Many times they could not use those credits to go to school because they were excluded from the school or schools. You couldn't really use it to get loans because they were excluded from getting loans. And these weren't just random bad people making decisions; this was codified into the way that the laws worked in the individual states and counties. And that goes for redlining as well, which is the process of defining which neighborhoods that black people could live in, and if you happened to buy a house in a white neighborhood, everybody else would move out. So, you look at those things that were codified into law, the accumulation of over hundreds of years, it's not surprising that you have communities that have been excluded and are unable to really move up the same way as some other immigrant groups who experienced some oppression when they first got here, but generally by the second or third generation they were able to move forward. This is what systemic racism is. This is a whole series of laws and patterns that have really been generated in the United States over hundreds of years with the specific purpose of trying to keep black folks from moving up or moving on. And, it didn't just stop with the Civil Rights Act. It actually, you know, continues on because those things are baked into our processes. This is a hard thing to admit for black folks, for white folks, for anybody. It just feels awful. But that is actually what systemic racism's all about. It's really not about individual acts; it's something that is

in the society as a whole.

Dr. Sands:
Yeah, that's such an important point. Dr. Lathan any final words on that?

Dr. Lathan:
We were all taught in medical school you treat everybody the same, right? Everybody's the same and we thought that our intellectual ability would shield us from racism, discrimination, and sexism. But the truth is, human beings have a tendency to do these things and so we need to do more than think "I treat everyone the same." Actually you don't. We really don't. What we need to do is recognize how we need to treat people, we need to reach out to people who are not like us, we need to understand cultural humility, not just confidence, and recognize how the things that we do impact people. And I think that that is the first step in multiple conversations to really try to use the full power of medicine to heal beyond, you know, just those people who have the power to get to our doorstep. And in cancer in particular, that's extremely important, so it's our job as shepherds of this to be taught better, to train others better, and to initiate these difficult conversations.

Dr. Sands:
Thank you for those really important points and that round-out to the conversation. I want to thank my guest, Dr. Christopher Lathan, for joining me to discuss this really important topic. Dr. Lathan, it was absolutely wonderful having you on the program.

Dr. Lathan:
Thank you very much. It was great to be here.

Dr. Sands:
That was Dr. Christopher Lathan from the Dana Farber Cancer Institute Network talking about racial disparities in oncology. For ReachMD, I'm Dr. Jacob Sands. To hear more insights from Dr. Lathan on racial disparities in oncology and to access other episodes in our series, visit ReachMD.com/ProjectOncology where you can Be Part of the Knowledge. Thank you for listening.