

## African American Cancer Disparities and Compassion

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### Abstract

African American patients tend to have worse overall rates of cancer survival compared to white patients due to racial disparities in screening, diagnosis, and treatment management. In this paper, I explore this issue by looking at the racial disparities that emerge in screening, diagnosing, and treating various types of cancer. The implicit bias that is present when healthcare clinicians interact with African American patients influences the cancer survival rate for this population. One possible solution to address this problem would be to establish and practice medicine with an emphasis on compassion. A compassion-based model of medicine will allow for healthcare clinicians to prioritize their patients' needs, setting aside their own assumptions and healthcare system priorities in the process. I advocate for two policy implications related to using a compassion-based model of medicine: 1) teaching and training healthcare clinicians the importance of compassionate care early on in medical education, and 2) implementation of guidelines for those already practicing to help them move toward compassionate care.

## Introduction

In 2016, National Public Radio released a story explaining how breast cancer death rates have decreased over the years, but racial disparities still persist. Shute (2016), points out that, although women as a whole are less likely to die from breast cancer than they were a decade ago, close to 50% of African American women receive less than optimal care for breast cancer, whether it is during diagnosis, screening, or treatment. From reviewing the literature, I found that African American patients tend to have worse overall rates of cancer survival when compared to white patients due to racial disparities in screening, diagnosis, and treatment management. The racial disparities that emerge in screening, diagnosis, and treatment significantly impact how African American patients address health issues. Although this trend is seen among all types of cancer, I will focus on breast, colorectal, and lung cancer. I chose these three types of cancers because according to the literature, there is a higher prevalence of these three cancers among African American patients when compared to white patients.

One solution I propose is for healthcare clinicians to practice a more compassion-based model of medicine. By following this model of medicine, the quality of medical care can increase. In order to establish such a model, medical education needs to change its current instruction to accommodate this model. Along with this, hospitals and other healthcare setting should implement changes in their system to accomplish a compassion-based model of medicine. Lastly, I will argue that the Schwartz Center can help healthcare clinicians and healthcare settings to make the changes necessary to accomplish this goal. By using compassion, it is possible to decrease disparities in screening, diagnosis, and treatment to increase African American cancer survival rates, helping reach towards the ultimate goal is for racial disparities in cancer survival rates to disappear.

## Racial Disparities in Cancer

In order to understand African American cancer disparities, I will discuss the research trends that emerge from looking at cancer as a whole as well as individually examining breast, colorectal, and lung cancer. Freeman and Chu (2005), consider various cancer inequalities with regards to cancer screening, diagnoses, and treatment; one of the main disparities they found was race. Race, in and of itself, is a determinant of the level of healthcare received. According to Freeman and Chu, “racial profiling may lead to errors in diagnosis and treatment, to false assumptions that result in serious harm intentional or unintentional to individuals.” (2005) Those errors are harmful for African-American patients in that they contribute to the lower cancer survival rates. The Institute of Medicine determined that African Americans are less likely to receive standard treatments for cancer even at the same insurance and economic status (Freeman & Chu, 2005). Evidence suggests that race does play a role in the delivery of medical

care. The inappropriate use of racial and ethnic classifications leads to misjudgments in screening, diagnosing, and treatment decisions.

Virnig et al. (2009), agree that the lower cancer survival rates that African American patients experience is caused by race. In their research, the authors compared the stages at which cancer is diagnosed and survival rates between African Americans and white patients. According to Virnig et al., “Inequity in overall cancer survival by race is recognized and attributed to differences in the stage at which cancer is diagnosed, its treatment, and, to a lesser extent, in the aggressiveness of tumors.” (2009) The authors mentioned that the prognostic impact of late-stage diagnosis is so strongly related to poorer survival that increasing the percentage of cancers diagnosed at an early stage is a prominent goal of the National Cancer Institute (NCI) (Virnig et al., 2009). Racial disparities in cancer stage at diagnosis have been reported for a variety of cancers, including female breast, colorectal, and prostate. For cancers for which there are effective screening tests (e.g., female breast, cervix, and colorectal), disparities in stage at diagnosis have been attributed to differences in use of screening technologies (Virnig et al., 2009). The disparities found in screening and diagnosing African American patients negatively impacts the outcome of the cancer. Virnig et al. (2009), conducted a study where they examined the thirty-four most common solid tumors affecting adults. They compared age and sex-adjusted stage at diagnosis and survival. The results of the study show that African Americans patients were more likely than white patients to be unstaged – not assigned a stage at diagnosis due to lack of information – (7.34 percent versus 5.50 percent;  $p < 0.0001$ ). African American patients were also shown to be less likely to have in situ disease – meaning the cancer has not spread from its initial site – than white patients (6.22 percent versus 8.75 percent;  $p < 0.0001$ ) (Virnig et al., 2009). African American patients were diagnosed at more advanced stages than white patients for all four cancers with widely recommended screening procedures, and African Americans were also diagnosed at more advanced stages than whites for eleven of thirteen cancers (Virnig et al., 2009). This study show that African Americans patients are treated differently by health care providers than white patients.

If we are to increase the cancer survival rates of African Americans, we must address the role of racial disparities in patient care. Provider education is one strategy for improving the general quality of care.

### Breast Cancer, Colorectal Cancer, and Lung Cancer Trends

General cancer screening, diagnosis, and treatment management trends for cancer suggest that racial disparities play a role in African American patients having lower cancer survival rates when compared to white patients. These trends persist when analyzing breast cancer, colorectal cancer, and lung cancer individually.

In regard to breast cancer, Geiger states that “African American and Hispanic women are first seen for treatment when they already have

advanced disease and they have a worse prognosis and shorter survival times when compared to whites.” (2003) Even when universal access to medical care is assured, there are still racial disparities in breast cancer diagnosis and treatment. It was also found that elderly African American women had significantly lower experience of regular cancer preventative services such as mammograms, pap screens, and clinical breast examinations (Geiger, 2003). The last trend that Geiger (2003) found was that African American patients experience significantly different care from white patients on four to ten treatment procedures. Even when universal access to medical care is assured, there are still racial disparities in breast cancer screening, diagnosing, and treatment management. A literature review conducted by Shavers and Brown (2002), also found disparities in the receipt of breast cancer treatment. According to Shavers and Brown, “African Americans were less likely than whites to receive breast-conserving surgery and radiation therapy instead of mastectomy... and African Americans were two times more likely than whites not to receive radiation therapy after breast-conserving surgery.” (2002) The racial disparity that encompass breast cancer treatment management contribute to the lower cancer survival rate that the African American population experiences. If screening, diagnosing, and treating African American women with breast cancer can be done earlier and more thoroughly, these trends can be lowered.

When analyzing colorectal cancer similar conclusions are found. When looking at colorectal cancer, African American patients were treated less aggressively than white patients with similar disease, even after adjusting for insurance coverage, hospital type, and co-morbidities (Geiger, 2003). Along with that, Geiger found that, “African Americans were from 27 to 41 percent less likely (depending on tumor stage) to undergo major procedures such as colon resection and cholecystectomy.” (2003) Shavers and Brown (2002), also found differences in treatment between African American patients and white patients. According to Shavers and Brown’s conclusions, “African Americans were less likely than whites with similar disease to receive a major colorectal cancer therapeutic procedure, cancer-directed surgery, and sphincter-sparing surgery.” (2002) African Americans also were less likely than whites to receive adjuvant therapy for stage III colon cancer and resection for advanced colon cancer (Shavers & Brown, 2002). When looking at the trends that surround colorectal cancer, the major differences involve treatment strategies and management. The differences in how healthcare clinicians treat African American patients relative to white patients for these cancers contribute to the lower cancer survival rate observed in this population. A physician's perception of patients is influenced by nonclinical characteristics, which could manifest as differences in patient referral patterns and treatment recommendations (Shavers & Brown, 2002). This is the issue that needs to be addressed in order to help decrease racial disparities in medicine.

Finally, the trends that are found for lung cancer treatment among the African American population are similar. According to Geiger, “a striking difference in treatment has been found for early stage non-small-cell lung cancer, a condition treatable by surgery that can substantially increase the likelihood of surviving for five years or longer.” (2003) After controlling for age, sex, stage of disease, co-morbidity, marital status, and income, African Americans were only about half as likely as whites to undergo surgery (Geiger, 2003). The absence of a physician’s recommendation for surgery was more frequent for African Americans than for white patients, and patients’ refusal of surgery or contraindications for surgery were uncommon. Shavers and Brown (2002), found similar results: African Americans less frequently received surgical resection, radiation therapy chemotherapy, or any definitive treatment for their lung cancer. The lack of treatment options presented and performed by healthcare clinicians is alarming. African American patients are not given the same recommendations in regards to screening and treatment causing their likelihood of survival to decrease. Introducing compassion into the way healthcare clinicians practice may lead to a smaller gap in these differences. Equal treatment may yield improved outcomes for African American patients.

### Possible Solutions and Policy Implications

According to Burgess, van Ryn, Dovidio, & Saha, there is significant evidence that health care providers hold stereotypes, including ones based on patient race, that influence their interpretation of patient behaviors and symptoms, and “application of such stereotypes frequently occurs outside conscious awareness; and providers interact less effectively with minority than with white patients.” (2007) Having compassion in the medical setting often allows healthcare clinicians to look beyond the superficial aspects of a patient like their race, and recognize the common humanity in their patients. Compassion is not a single, sympathetic remark, but is rather made up of presence and engagement that spreads throughout an entire conversation or encounter. Mills and Chapman (2016), agree that compassion is more than just kindness or wanting another individual’s suffering to end. Compassion and empathy have both cognitive and affective components. The cognitive component deals with being able to consider and understand another person’s perspective or situation. Studies that ask its participants to adopt a perspective associated with another stigmatized group or situation have been shown to reduce bias towards that group (Burgess, van Ryn, Dovidio, & Saha, 2007). Those that participate in such studies have reduced bias because they are able to inhibit the activation of unconscious stereotypes and prejudices. Burgess, van Ryn, Dovidio, & Saha (2007) mentions another study in which physicians who were described as empathic or compassionate by their peers were found to have less stereotypical attitudes toward their patients. A compassion-based model of medicine allows clinicians to engage with

the patient in a sensitive manner, see the patient as a person, accept the person where they are at, address the needs of the patient, and provide the necessary support needed to allow for optimal healing. Healthcare clinicians who experience higher levels of compassion during clinical encounters may be less likely to categorize patients in terms of their racial, ethnic, or cultural group and more likely to view patients in terms of their individual attributes and ‘illness narratives.’

Healthcare clinicians should strive to follow a more compassion-based model of medicine in order to decrease racial disparities and resultantly increase cancer survival rates among the African American population. Freeman and Chu (2005), discuss the relationship between discovery, development, and delivery of cancer and cancer treatments. The authors show that there is often a disconnect between development and delivery; this disconnect is a key determinant of the unequal burden of cancer. I believe that bridging the gap between development and delivery can greatly affect the racial discrimination that may occur during cancer screening, diagnosis, and treatment. A solution to bridging this gap is a more compassion-based model of practicing medicine. Sinclair et al. (2016), states that “compassion is frequently referenced as a hallmark of quality care by patients, health care providers, health care administrators, and policy makers. Despite its importance, compassion is one of the most referenced yet poorly understood elements of quality care.” By not understanding the importance of compassion in medicine, healthcare clinicians are opening themselves for error in patient interaction. Healthcare clinicians will be more prone to making decisions based on preconceived notions rather than the patient’s illness narrative.

De Zulueta (2015) believes that healthcare professionals need to be able to respond to all the dimensions of suffering, to respect the dignity of the person, and not slide into pity and condescension. Compassion is a central and necessary element of good medical care. De Zulueta states that, “compassion views humans as interdependent and vulnerable, with autonomy textured by our milieu and relationships. It responds to, but does not generalize suffering and it connects with our better selves and what it means to be human.” (2015) By understanding the compassionate approach to medicine, it is possible to decrease neglect or suffering that African American patients experience when it comes to cancer screening, diagnosis, and treatment management.

Post (2011), discusses the value and benefits of compassionate care when practicing medicine. He states that the care of the patient is both a science and an art. It is the competent application of science; moreover, it is the art of being attentive to the patient in a manner that facilitates well-being, security, treatment adherence, and healing (Post, 2011). The author believes that the essence of this “art” is compassionate care. Post states “Every patient has a story or ‘illness narrative’ that needs to be respected; no patient is a mere biological puzzle to be ‘figured out.’ In all healthcare systems, we should aim for a culture of compassionate care in which

patients will not experience humiliating insensitivities or rudeness, but rather compassion, respect, reassuring manner (appropriate etiquette, dress, speech) hospitality & attentive listening.” (2011) The article states that there are four beneficiaries of compassionate care. The first are clinicians, nurses, residents and other staff. Second, the medical students that experience demoralization and disenchantment when they encounter a clinical environment that is dehumanizing and uncaring toward patients or themselves as learners (Post, 2011). The next beneficiaries of compassionate care are the patients themselves. Lastly, medical centers perform better when they are able to create a seamless culture of compassionate care through new employee interviews, annual training, development of expectations and reward systems for staff, and inclusion of this dimension of care in educational endeavors (Post, 2011).

By following a more compassion-based model of practicing medicine, health care providers can help African American patients feel more comfortable seeing their physicians on a more regular basis, and physicians will understand African American patients based on their ‘illness narrative’ rather than on preconceived notions. This can potentially lead to better screenings and diagnoses of cancer which in turn will allow for early treatment interventions. By understanding and practicing medicine using ‘illness narratives,’ healthcare clinicians can identify barriers, like race, that they place before the patient’s needs and that impede the delivery of proper care. Healthcare clinicians should approach their patients as people and view their health from this vantage point as well as prioritize their patient needs, setting aside assumptions and health care system priorities in the process. By following a compassion-based approach to practicing medicine, racial differences and discrimination can be reduced, which in turn can increase cancer survival rates. It is possible for a significant reduction in the gaps in screening, diagnoses, and treatment between African American and white patients.

In order for medicine to shift toward a compassion-based model of medicine, several new policies would need to be enforced in medical education and practice. First and foremost, the amount of emphasis on compassion-based medicine needs to increase in medical education. According to Ekstrom, “as [a] routine part of medical education, there should be mock sessions in which students take turns at being patients, while the acting physician systematically belittles symptoms, causes pain, and treats patients with disrespect. Other sessions ought to model more appropriate behaviors.” (2012) Such curricular programs and others, including increased patient contact earlier on in medical school training, have been implemented in recent years in medical schools across the nation (Ekstrom, 2012). If more compassion is inserted into the process of medical examination, diagnosis, and treatment, some of these problems can be solved. The more that can be done to admit people into the medical profession who are emotionally mature and sensitive, while maintaining low levels of arrogance and high levels of compassion, the better off

patients will be. It may be beneficial to evaluate students' compassion aptitude at an early stage to determine teach-ability and to develop individualized learning plans to enhance these inherent qualities over time or at the very least buffer against the erosion of these qualities over the course of health care training (Sinclair et al., 2016). Medical education is the perfect place to instill compassion and various other qualities that can help healthcare clinicians not only recognize racial disparities when they practice medicine but also be a part of the change in patients' outcomes. When presented with healthcare clinicians that are more aware of their actions, African American patients might trust their healthcare clinicians more and a decrease in racial disparities could occur, which could produce an increase in cancer survival rate among that population.

For those healthcare clinicians that are already practicing, Morris, Rhoads, Stain, & Birkmeyer (2010), suggests creating treatment plans for cancer care that are more patient-centered as well as establishing better incentives that will aid in the elimination of disparities in the clinical setting. Geiger states that "the healthcare system needs to create increased recognition among providers of the existence and processes of stereotypical bias, and their role in the differential treatment of minority patients." (2003) The two mechanisms suggested by Geiger (2003) include tracking patterns of care by patient race for quality assurance systems in organized settings of care and teaching the nature of stereotyping and bias at every level of the medical curriculum. This will allow for a cultural competency curriculum devoted to the beliefs and behaviors of different groups of patients. It will also for self-awareness and recognition of the culture of medicine itself.

By incorporating compassion into treatment, patient-centered care, and by having hospital incentives to decrease racial disparities, the level of care and compassion that African American patients receive can increase, allowing for an overall increase in cancer survival rates. The Schwartz Center, an organization that focuses on teaching and making compassionate healthcare a priority, released a document discussing the importance and significance of a more compassionate healthcare system. The points that are made in this document guide healthcare clinicians in practicing compassion-based medicine. The seven points they make to establish compassionate healthcare include commitments to compassionate healthcare leadership, rewarding compassion, supporting caregivers, involving, educating, along with learning from patients and families, build compassion into healthcare delivery, and deepening our understanding of compassion (The Schwartz Center, 2018). Although establishing all seven points in one healthcare setting is difficult, if healthcare clinicians take a portion of these points and incorporate it in their practice, compassion-based medicine can alleviate the role of racial disparities in cancer survival rates.

## Conclusion

African American patients tend to have lower overall cancer survival rates when compared to white patients due to racial disparities in screening, diagnosis, and treatment management. When analyzing trends in breast, colorectal, and lung cancer, there is an immediate need for equal screening, diagnosing, and treatment. If healthcare clinicians and various healthcare settings follow a compassion-based model of medicine, African American patients could have a better experience going to see their physicians, and physicians would be able to screen, diagnose, and treat African American patients more effectively. In order for healthcare clinicians to follow a compassion-based model of medicine, they need to be taught the necessary skills early in their medical education. For those healthcare clinicians that are already practicing, implementing policy changes and further instructing them can benefit the African American population as well as all other patients. Practicing clinicians can implement a few of the suggestions provided by The Schwartz Center to allow for more compassionate care. The healthcare system has done a disservice to African Americans in cancer screening, diagnosis, and treatment management. Through a compassion-based model of medicine, racial disparities can decrease, producing higher cancer survival rates in the African American population.

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