

Review Article

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A Review of Disparities in Oncology Care for Patients with Limited Access and Minorities, in an Oncology Setting, an Unmet Need for this Group of Patients to Experimental Therapies

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ABSTRACT

It is expected that half of the population in the US by 2045 are expected to be non Hispanic white, per US census Bureau projections.

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Also it is established fact that there is remarkable imbalance in clinical trial participants based on race; evident at FDA 2018 drug trial report. Minorities, and African Americans in particular are at higher risk for incidence of certain types of cancer and further access to certain therapies are challenged by racist discriminatory roadblocks [1]. For example presence of BRCA gene is more prevalent and carries higher risk of death in Black population. Especially, recent statistics indicate that age-adjusted breast cancer mortality rates are higher among black than white women and in black population [2]. (Figure 2)

Also Asian Americans have in general proven to be at higher risk for immune challenging infections, complications from cancer and death as a result [3,4]. Prisoners also lack adequate preventive measures that is required for an effective preventive oncology program [5,6].

In this study we retrospectively review a snap shot of patients' access to a preventive and complimentary program and review the barriers created for each social or ethnic group and recommend some further steps to overcome such barriers in the future. We conclude that it is imperative that clinicians' experiences be incorporated in public policy makings related to such predisposed patients.

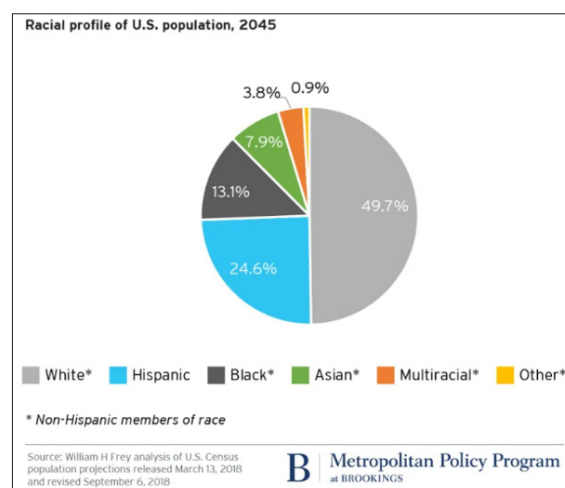


Figure 1

Incidence and Mortality Rates (by Gender and Race), United States, 2011				
	Males		Females	
	White	Black	White	Black
Incidence rates				
Breast	121.9	114.6
Lung & bronchus	84.3	103.5	57.0	51.8
Colon & rectum	56.1	67.2	41.4	50.7
Mortality rates				
Breast	23.4	32.4
Lung & bronchus	68.3	87.5	41.6	39.6
Colon & rectum	20.6	30.5	14.4	21.0

Figure 2

Background

A health-care system is evaluated by various metrics: one is how it cares for its most vulnerable patients. The United States spends far more on health care than any nation in the world, yet access to high-quality oncology services remains elusive to certain minority populations—none more so than men and women with advanced cancer serving time in our nation's prison system [7,8].

Cancer affects all population groups in the United States, but due to social, environmental, and economic disadvantages, certain groups bear a disproportionate burden of cancer compared with other groups. Cancer disparities differences in cancer measures such as

- Incidence (new cases)
- Prevalence (all existing cases)
- Mortality (deaths)
- Survival (how long people survive after diagnosis)
- Morbidity (cancer-related health complications)
- Survivorship (including quality of life after cancer treatment)
- financial burden of cancer or related health conditions
- Screening rates

Stage at Diagnosis

Some evidence suggests that there are differences in the genetics, tumor biology, and immune environment of triple-negative breast, colorectal, and prostate cancers that arise in African Americans compared with those that arise in people of other racial/ethnic groups. These differences may contribute to disparities in incidence, aggressiveness, and response to treatment of these cancers [9-12].

Also the harsh conditions that people endured during the Holocaust may be at the root of increased cancer risks found later in life. One study examined more than 142,000 Holocaust survivors found that survivors of the Holocaust had higher rates of lung and colorectal cancer. The study found the strongest correlation between male Holocaust survivors and colorectal or lung cancer. A number of environmental factors contributed to this, such as smoking habits and exposure to harsh chemicals for those who developed lung cancer, and poor diet and lack of calories for those who went on to have colon cancer [13-16]. Researchers looked at four groups of survivors in Israel, all of whom had follow ups between 55 and 59 years from the war. The first group (Group A; 81,927 people) included people who applied for and were granted compensation under the 1957 "Victims of Nazi Persecution Act." These people were recognized as "stateless refugees under the direct occupation of the Nazi Germany." They likely faced being in a ghetto, a concentration camp or escaped by using a fake identity. In this group, 22 percent of individuals had cancer. The next group (Group B; 46,491 people) were in a concentration or work camp for six or more months or were living in hiding and using a false identity for at least 18 months. During World War II. Twenty-one percent of individuals in Group B had cancer. The third group was composed of disabled war veterans who served in the allied armies, partisans or Red Army between the years of 1939 and 1945, and had at least a 10 percent health disability per the Israeli government. The veteran group — 95 percent of whom were men — had the highest percentage (27 percent) of cancer incidences [17-20].

US has the highest incarceration rates. (incarceration and social death). By 2030, more than one-third of prisoners in the United States will be older than 55 years of age. Although the system has seen compassion among health-care providers in the prison system, far too many inmates with life-threatening illnesses such as cancer are either ignored or receive substandard care due, in

part, possibly to cost issues and the limitations of the challenging environment of providing care in a correctional setting. A 2009 first-ever study published in the American Journal of Public Health examined the health standards of all prison and jail inmates nationwide, finding high rates of serious illness and poor access to care. Studies indicate that inmates with symptoms of possible cancer, such as localized pain, weight loss, or bloody stools, are often inadequately evaluated. Multiple studies and advocacy initiatives have shown that cancer care in the prison population is substandard and pain management for inmates with advanced cancer is appalling [21-24].

Methods

We studied a randomized retrospective review of the target population, evaluated at our clinic; defined as limited access groups of patients with predisposition factors, for suboptimal access to care and higher than normal disease burden. The therapy consisted of research based epigenetic therapies, multi targeted epigenetic therapy (MTET). The group consisted of 281 subjects with 57 subjects qualified for the study. The rest (224) were used as control. Interested subjects consisted of 24 patients with Asian ethnicity, 6 Jewish relatives from survivors from Holocaust, 17 Hispanic Americans and 10 African Americans. The study focused on access to care as main variable and personal interviews and clinician experiences were used for scoring 1-5. Patients who were interviewed all had been diagnosed with cancer with proven biopsy and had either failed or refused standard of care. All studied subjects were educated about their options for care and had been consented.

Results

There was a significant difference between the studied group (57 subjects) and the control (224 subjects). Limited access group had significant barrier to accessing therapies to address their cancer and quality of life. The experiences reported by the clinician in interested population, showed an average score of 2 compared to 4 in control group, in accessing therapies aimed at improving quality of life and patient response. The extreme cases were found in Asian American patients and minors, with failure to convince their practitioner to "allow" any other modality of care to be provided. The examples included several cases with scoring of 0 in ability to access adequate care, preferred by physician's recommendation, patients' family or per patient's choice.

Discussion

Access to care in patients with cancer, suffering from discrimination secondary to their ethnicity, color, religious background or minorities, in general has raised social awareness and more importantly medical alarm to proactively address this unmet need in this class of society. Furthermore, when it comes to access to experimental therapies, the need becomes more obvious, as the gap between the defined limited access group and the rest of the society is even larger. Interestingly but sadly, the standard of care approach to treat the patients in this class of society (minorities), has less success than average person outside the category. For example the risk of metastatic disease is higher in African Americans than in White population, and so is the dismal prognosis when diagnosed with advanced cancer. The more aggressive the disease certainly, there is less expected survival predicted from standard of care and the more need to further apply experimental therapies, such as the one presented here, as epigenetic therapies.

Our study here not only puts light on the existence of such difference but rather generates hypothesis on potential ways to address the need by educating the providers in the field and giving

them insight about what other options of care exist, for patients with advanced cancer and their choices. The real challenge remains however to be able to adopt and accommodate new policies in the medical system to universally improve the practical access for susceptible group of patients. The barriers could still be a wide range of financial, cultural and most importantly resistance from the medical providers.

Conclusion

Limited access to epigenetic therapies in oncology care aiming at improving quality of life is more common in patients suffering from social discriminations and disparities. These groups include minorities, patients with different ethnicities and prisoners. It is imperative that clinicians' experiences be incorporated in public policy makings related to predisposed patients, with limited access to care and overcome such challenges to improve their survival, specially when a patient is in need for research based therapies, clinical trials or has failed standard of care measures in his/ her treatment options.

References

1. Shavers VL, Brown ML (2002) Racial and ethnic disparities in the receipt of cancer treatment. *J Natl Cancer Inst* 94: 334-357.
2. Siegel R, Ward E, Brawley O, Jemal A (2011) Cancer statistics, 2011: the impact of eliminating socioeconomic and racial disparities on premature cancer deaths. *CA Cancer J Clin* 61: 212-236.
3. Kagawa-Singer M, Kho C (2015) Asian-American Health and Disease: An Overview. In: Huff RM, Kline MV, Peterson DV, editors. *Health Promotion in Multicultural Populations*. Third Sage Publications; Washington <https://psycnet.apa.org/record/2014-20479-012>.
4. McCracken M, Olsen M, Chen MS Jr, Jemal A, Thun M, et al. (2007) Cancer incidence, mortality, and associated risk factors among Asian Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese ethnicities. *CA Cancer J Clin* 57: 190-205.
5. Chettiar I, Gupta V (2018) Why are we spending so much to lock up elderly prisoners who pose little threat? ACLU. Available at www.aclu.org/blog/smart-justice/why-are-we-spending-so-much-lock-elderly-prisoners-who-pose-little-threat.
6. ACLU (2012) At America's expense: The mass incarceration of the elderly. Available at www.aclu.org/files/assets/elderlyprisonreport_20120613_1.pdf.
7. Wilper AP, Woolhandler S, Boyd JW, Lasser KE (2009) The health and health care of US prisoners. *Am J Public Health* 99: 666-672.
8. Lyckholm LJ, Glancey CL (2016) Ethical issues in caring for prison inmates with advanced cancer. *J Hosp Palliat Nurs* 18: 7-12.
9. Siegel RL, Miller KD, Jemal A (2020) Cancer statistics, 2020. *Ca. Cancer J. Clin* 70: 7-30.
10. Ward E, Jemal A, Cokkinides V, Singh GK, Cardinez C, et al. (2004) Cancer disparities by race/ethnicity and socioeconomic status. *Ca. Cancer J. Clin* 54: 78-93.
11. Shavers VL (2002) Racial and ethnic disparities in the receipt of cancer treatment. *CancerSpectrum Knowl. Environ* 94: 334-357.
12. Ellis L, Canchola AJ, Spiegel D, Ladabaum U, Haile R, et al. (2018) Racial and ethnic disparities in cancer survival: the contribution of tumor, sociodemographic, institutional, and neighborhood characteristics. *J. Clin. Oncol* 36: 25-33.
13. Olsen MH, Nielsen H, Dalton SO, Johansen C (2015) Cancer incidence and mortality among members of the Danish resistance movement deported to German concentration camps: 65-Year follow-up. *Int J Cancer* 136: 2476-2480.
14. Bogeisky YA (2013) historic review of the term "Holocaust Survivor." Tel Aviv, Israel: Knesset Research and Information Center. Available at: <http://www.knesset.gov.il/mmm/data/pdf/m03154.pdf>.
15. Committee for Immigration, Absorption and Diaspora Affairs, Permanent Committee of The Knesset (state of Israel). Holocaust Survivor Benefit Bill of 2005, MK Yuri Stern. Protocol from the meeting of the Committee for Immigration, Absorption and Diaspora Affairs [in Hebrew]. Issued August 6, 2006, Jerusalem.
16. Fishler Y, Chetrit A, Brachana M, Modan B (2003) Assessment of the completeness of the Israel Cancer Registry database-methods and findings [in Hebrew]. Ramat Gan, Israel: Israel Center for Disease Control, Ministry of Health; 2003. Available at: <http://bit.ly/1nvgtfQ>.
17. Sharon A, Levav I, Brodsky J, Shemesh AA, Kohn R (2009) Psychiatric disorders and other health dimensions among Holocaust survivors 6 decades later. *Br J Psychiatry* 195: 331- 335.
18. Stessman J, Cohen A, Hammerman-Rozenberg R, Bursztyn M, Azoulay D, et al. (2008) Holocaust survivors in old age: the Jerusalem Longitudinal Study. *J Am Geriatr Soc* 56: 470- 477.
19. Joffe C, Brodaty H, Luscombe G, Ehrlich F (2003) The Sydney Holocaust study: posttraumatic stress disorder and other psychosocial morbidity in an aged community sample. *J Trauma Stress* 16: 39- 47.
20. Keinan-Boker L, Shasha-Lavsky H, Eilat-Zanani S, Edri-Shur A, Shasha SM (2015) Chronic health conditions in Jewish Holocaust survivors born during World War II. *Isr Med Assoc J* 17: 206- 212.
21. Maschi T, Aday R (2014) The social determinants of health and justice and the aging in prison crisis: A call to action. *International Journal of Social Work* 1: 1-15.
22. Williams B, Rothman A, Ahalt C (2017) For Seriously Ill Prisoners, Consider Evidence-Based Compassionate Release Policies. *Health Affairs* 10.1377/hblog20170206.058614.
23. Supporting America's Aging Prison Population (Opportunities and Challenges for Area Agencies on Aging, from the National Association of Area Agencies on Aging (n4a) [https://www.usaging.org/Files/n4a_AgingPrisoners_23Feb2017REV%20\(2\).pdf](https://www.usaging.org/Files/n4a_AgingPrisoners_23Feb2017REV%20(2).pdf).
24. Ageing prisoners (2016) An Introduction to Geriatric Health-Care Challenges in Correctional Facilities, from the International Committee of the Red Cross <https://international-review.icrc.org/sites/default/files/irrc-903-12.pdf>.

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