

**No Longer Suffering in Silence: How Medical Racism Affects Cancer Patients, and How It  
Can Be Combated**

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**Alexandra Julia Rashid**

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On my honor as a University Student, I have neither given nor received unauthorized aid on this  
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Advisor

Kent Wayland, Assistant Professor, Department of Engineering and Society

## **Introduction**

While incredible strides have been made to combat racism in the society of the U.S., many issues remain unsolved. The issue of medical racism is involved in any field of medical treatment one can think of. A famous case involves legendary tennis athlete Serena Williams who nearly died while giving birth to her daughter in 2018 (*Vascular Cures*, 2018). She spoke up during her labor and informed her nurse and doctor that she had a history of pulmonary embolisms (small blood clots in the lungs). Her nurse did not believe her pain, insisted that Williams was confused due to the pain medication, and did not immediately administer the CT scan and blood thinner that she requested. After her further insistence multiple times, they finally gave Williams a CT scan and discovered the blood clots that would have ended her life. If one of the most famous and well-known athletes is ignored when she is in pain, what chance do all minorities have at receiving great medical treatment?

## **Background**

The American Dream has been considered a core belief of the United States since the term was coined in 1931 by James Truslow Adams (Wills, 2015). This belief encompasses the ideals of democracy, rights, liberty, opportunity, and equality among all citizens. Equality has been one of the most elusive components, which can be seen in events like the fight for women's right to vote in 1920 or the work to emancipate slaves in 1863. Currently, in the U.S. access to superior medical care is not equal; inequities can correlate with race, sex, and other demographics. Medical racism has been defined as “the systematic and wide-spread racism against people of color within the medical system. It includes both the racism in our society that makes Black people less healthy, the disparity in health coverage by race, and the biases held by healthcare workers against people of color in their care” (Bronson, 2021). Esnaola and Ford

(2012) found that the cancer mortality rates among black people in the U.S. are on average 8.54% higher than among whites. Based on skin color alone, one could be nearly 10% more likely to die from a scientifically nondiscriminatory disease. This problem existed more obviously before and during the civil rights movement, but has remained pervasive throughout our modern society.

In a disease that has nothing to do with race, black and brown patients are dying at significantly higher rates than white patients with the same disease. The National Center for Health Statistics, Centers for Disease Control and Prevention gathered data on the rate of death for black and white cancer patients (Figure 1). This information was collected in patients with lung and bronchus, colon and rectum, prostate, and breast cancer and then summed to create general trends across all cancer sites. Across both gender and race, cancer death rates have been decreasing since the mid 1970's due to the technological advancements made in the medical field. Although these advancements have been made, there is still a noticeable difference between both the black and white death rates for both men and women. This is undoubtedly an issue and until that gap is closed, the cancer treatment that is offered to minorities in the United States will not be of the exceptional quality that should be accessible to all people.

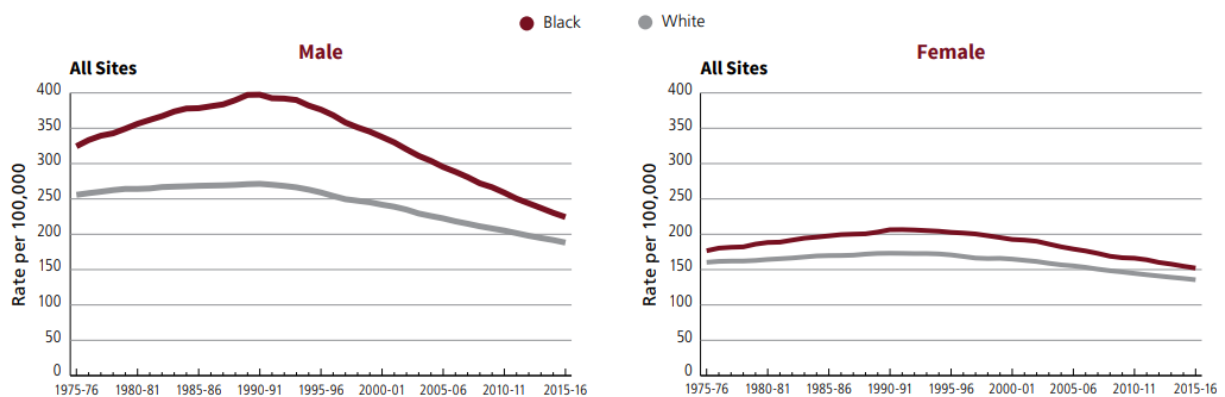


Figure 1. Trends in Death Rates for Selected Cancer Sites among Blacks and Whites, US, 1975-2016 (Street, n.d.)

## **Why it Matters**

The consequences of this inequality remaining unaddressed are clear for minority citizens who will inevitably require medical treatment of some kind and receive an inferior level of care compared to their Caucasian counterparts. Additionally, the belief of America as an equal society is irrevocably destroyed if medical racism is not focused on, assessed, and eventually dismantled. If emphasis is only placed on the technological advancement of medicines and not the ways in which society can affect treatment, the overall care of cancer patients will never be comprehensively addressed.

## **Research Question**

The main problem that this analysis aims to address is the unequal treatment and care of minority cancer patients. In order to do so, the various advocacy groups and their related organizations will be investigated to determine what it is that they do to alleviate the cancer health inequalities that minority groups in the U.S. have faced. The general work among these groups has been inventing innovative methods that can be used in various medical settings to ensure the wholly antiracist treatment of these minorities. This analysis will discuss the current approaches being executed, as well as their effectiveness and options for further improvement to procure the highest quality of treatment for everyone.

## **Methods of Research**

When conducting an analysis of these treatment systems, it is vital to assess the methods used for data collection for their rigor and validity. I plan to utilize individual case studies and examples that are representative of the general population that I am trying to address. These will be collected from reputable sources that are well-trusted to ensure that the stories are factual. For example, the Serena Williams story was found on [vascularcures.org](http://vascularcures.org) and her direct interview was

conducted by Vogue Magazine which is a very well-known source. For each of the three examples of advocacy work being done to minimize the discrepancies in cancer treatment of minorities, multiple examples will be found and each will be examined for generalizability.

Additionally, the data was procured via searches through various databases, reputable news sites, and the websites of national institutes. The main ones used were the Web of Science database and the National Cancer Database. This paper will be supplemented by primary-source documents. Any of the evidence of individual cancer patients and what they have done to improve the treatment of other minorities is inherently primary-source as it is a first-hand account of their experience and/or beliefs. The general facts and figures that show the effect of the advocacy groups on the treatment of minority cancer patients are found via secondary sources since they are journal articles, reviews, and other academic sources.

## **Discussion and Analysis**

Research on the steps required for antiracist treatment of Black, Indigenous, People of Color (BIPOC) adolescent and young adults (AYA) and adults has been conducted. The term BIPOC is complicated, due to its perception as an amalgam that ignores the differences between the people it describes (Grady, 2020). BIPOC is used in this analysis because it is the category described by some of the research, but the controversy and oversimplification of the term must be addressed.

There are three participant categories that play a large role in the alleviation of cancer health inequalities in the U.S.: cancer minority advocacy organizations, the medical professionals who work with them, and minority cancer patients themselves. However, it is not the organizations themselves that must be analyzed, but rather the work that they are doing to improve the treatment of these minority patients. The main three ways in which these groups do

so are by raising awareness of minorities facing cancer, by improving minority involvement in cancer research, and by creating innovative programs to place direct focus on the experiences of these patients. The analysis will thus be structured according to these three approaches, with examples of each that have been executed by multiple types of participants.

### *Raising Awareness*

Before large improvements in cancer treatments can be made, the medical professionals and general population must be made aware of both the general existence of cancer in minority populations and the disparities that exist. The first step is generating cohesive and comprehensive data on the instances of cancer among minority populations. There has been research into the cancer surveillance systems implemented in the U.S. which strive to collect more comprehensive data on cancer occurrences across races to develop more representative information. This information can then be applied towards the creation and improvement of meaningful programs and general research on cancer treatments. The Intercultural Cancer Council (ICC) works to connect minority communities with these systems (Wingo et al., 2005). This allows for the education of these communities who may be medically underserved, so that they may better understand the truth of medical trends concerning cancer and their population.

Additionally, the relevant data collected by these cancer surveillance systems can be provided to medical professionals so they can be better equipped to treat minorities. For example, if doctors are under the false belief that black women are affected by breast cancer less than white women simply because the doctors have seen less incidences, they may be less likely to screen a black woman than a white woman. Early detection is one of the ways to provide the best cancer treatment possible, and educating medical practitioners could result in this improving and thus saving the lives of countless minority patients.

Another prominent organization, the African American Breast Cancer Alliance (AABCA), was formed in 1990 by six female African American cancer patients (AABCA, n.d.). In a press release with CBS Minnesota, co-founder and president Reona Berry said that “the AABCA learned facts about black women and breast cancer could not be found in a brochure, so they created one. It is now used nationally and internationally” (Chapman, 2013). This is invaluable work, as some of the experiences faced by black women with cancer are not consistent with those of other races. Being able to find information that is directly relevant to one’s experience with cancer is something that should be available for all people, not just Caucasians.

This organization has three main programs: education, support, and survivorship which aim to create a safe space where patients and survivors can learn, connect, and survive. Their education program specifically raises awareness by providing free resources that are tailored to black, LGBT, and impaired women (*Education*, n.d.). These resources include general information on signs and symptoms, as well as videos that teach Breast Self-Exams (BSE). This shows how organizations such as the AABCA are able to further the awareness of not only the general population, but also the specific minority communities who may be looking for pertinent and accessible information about the disease they are fighting. Ensuring that organizations with similar resources and goals remain prominent in our society is vital to the continued improvement of the awareness of the general population, minority patient population, and medical population.

### *Improving Minority Involvement*

Even if the general and medical population are made more aware about the truth of minority cancer patients, the lack of BIPOC in leadership roles in the field of research poses a challenge. Until thirty years ago, there were no requirements for minority involvement in clinical

research studies. This resulted in a large number of studies on cancer and other diseases being conducted only on white men. The NIH Revitalization Act of 1993 established guidelines to require more diverse sampling, which has been very influential in ensuring that the research conducted is applicable to people of all races and ethnicities (*Online Survey*, n.d.).

Minority cancer patients are also trying to eradicate the health disparities they face due to this issue. Survivor Ricki Fairley started her own nonprofit organization (Touch: The Black Breast Cancer Alliance) and has said “until we get more Black women to participate in research, we really don’t know if the therapies are going to work on our bodies... we have a lot of work to do” (Gilead, 2021). If therapies and medicines have only been tested with Caucasian patients, how can someone of another race place their full trust in the research that has been conducted? Sheila McGlown is another breast cancer patient who is speaking out about issues she faces. She stated, “I’ve never known a black woman who has been on a clinical trial until I got on one” (Ciitizen, 2020).

These are two examples of work that is striving to increase the involvement of people of color in the research for the treatment that will directly affect them, and the importance of this work cannot be overstated. From 1999 to 2019, there was an increase from 14% to 25% involvement of minorities in the NCI (National Cancer Institute)’s NCTN (National Clinical Trials Network) and NCORP (NCI Community Oncology Research Program) clinical trials of all phases (*Participation by Minority Racial, Ethnic Groups in NCI-Funded Trials Nearly Doubles in 20 Years*, 2020). While this is still lower than the percentage of the population that is minority, and therefore is yet to be representative, it is a marked improvement across the years. If work like the NIH Revitalization Act and individuals speaking out about their experiences with



minority cancer research can prompt change of this nature, more focused must be placed on them to ensure they continue to do so.

### *Creating Innovative Programs*

There are a large variety of ground-breaking programs that have been created to try and tackle the problem of minority cancer health disparities. Black, Indigenous, People of Color (BIPOC) adolescent and young adults (AYA) have been historically marginalized and lied to or ignored by their healthcare systems, so they often have trouble learning to trust the medical professionals who work with them. The Patient-Centered Outcomes Research Institute (PCORI) recommends that programs avoid tokenizing the BIPOC AYAs and instead follow a “transparency-honesty-trust” model (Cheung et al., 2021). This allows for genuine patient engagement by showing the BIPOC patients that their well-being is the sole focus of the medical work. Being entirely open with them about the state of their health and treatments has allowed for this model to be successful in producing and maintaining the trust of the patients.

A very interesting example of innovative programs is found in a study on four distinct groups of Americans; Native Americans, Alaskan Natives, Pacific Islanders, and Puerto Ricans. This study showcases how they focus on culturally-specific comprehensive cancer control (CCC) for disparities that exist in their communities (Weinberg et al., 2010). Each of these groups enacted starkly different CCC programs, but one example was completed by the Native Americans and Alaskan Natives. Since lung cancer is the leading cause of death among these groups, they implemented cultural-specific initiatives to reduce the use of tobacco. This included a tobacco-free policy for tribal government facilities, smoking cessation classes, and media campaigns like “Honor Tradition, Not Tobacco” which included prominent citizens that the community trusts and relates to. This resulted in decreases in the incidence of lung cancer,

increases in cancer screening (from 27.7% in 2005 to 37.5% in 2007), and increases in earliest stage diagnoses (from 1% in 1997 to 4% in 2004). Increasing the number of community-specific programs aimed to reduce cancer in minorities would certainly be promising and could prompt change similar to that seen in the Native American and Alaskan Native groups.

The Greensboro Health Disparities Collaborative's (GHDC) agenda is to "empower and facilitate communities in defining and resolving issues related to disparities in health" (GHDC, n.d.). They accomplish this via The Partnership Project which includes a variety of equity workshops and training sessions that examine narratives of racial disparities and illustrate the systemic nature of racism to the individuals and groups that attend the sessions. These are available online, which makes it more accessible to the general public. More programs should follow this method, as it would allow for a much broader global impact.

Medical professionals often carry out the programs envisioned by these cancer minority advocacy organizations. For example, the GHDC partners with the Wesley Long Cancer Center and the Hillman Cancer Center to run the Accountability for Cancer Care Through Undoing Racism and Equity (ACCURE) program (UNC, n.d.). ACCURE studied the completion of treatments by black and white cancer patients and found that black patients were ~6% less likely to complete treatment. To attend to these disparities, the staff at both cancer centers was trained by the Racial Equity Institute (REI) and patients were interviewed to ascertain where the treatment failed. Many black women stated that their diagnoses were not explained and there was a lack of support when complications arose, so they felt it simpler to stop receiving treatment. Afterwards, ACCURE-trained nurses worked with them to "ensure patients understood their treatment options" (Hostetter & Klein, 2018) and began following up with patients if they missed an appointment or treatment milestone. This follow up alone has proved to be significantly

effective in helping patients continue their treatment, as it places the work of reaching out on the medical providers and not the cancer patients. If more medical centers were able have programs similar to ACCURE, they would be much better equipped to provide exemplary treatment to their minority patients. Having nurses that are specifically trained to be attentive to the issues of minority patients being non-responsive to follow ups or feeling inadequately informed would result in the increased quality of treatment of minority cancer patients.

## **Conclusion**

Many hospitals and medical treatment centers in the U.S. today are providing insufficient quality of treatment to minority cancer patients. There are certainly institutions (some of which were outlined in this paper) that have completed impressive work to eliminate or lessen the disparities in treatment. In order to address these disparities completely, a multifactorial approach is undoubtedly necessary. When it comes to improving the overall treatment of cancer patients, the changes needed in the medical facilities can be prompted by both cancer minority advocacy organizations and community outreach programs.

Organizations that raise awareness of the qualitative experiences of minority cancer patients and quantitative facts about their incidences must be expanded upon and implemented nation-wide. The cancer surveillance systems that work to provide accurate data about the cancer rates in minority communities should continue their work, and more organizations resembling the ICC should be founded to better connect local minority communities to these resources. Additionally, organizations like the AABCA must continue to provide more resources that are specific to minority experiences with cancer in order for the communities to learn more about the possibilities concerning this disease as well as to ensure that they do not feel alone in their battle.

Secondly, a large focus should be placed on cultivating the minority involvement in cancer research that is conducted in the U.S. While the rates have increased over the previous years, they are still far from being representative of the general population. If the minority patients are to trust the medical advice that they are given concerning their cancer treatment, it should be based on research that is conducted on their fellow minority patients. A continuing push for minorities and BIPOC on clinical trials and leadership roles within the cancer research community must occur if the rates of involvement in research are ever to be representative. This can be done by further legislation resembling the NIH Revitalization Act, or by more informal methods similar to how Sheila McGlown has spoken out.

Finally, innovative programs must continue to be developed and maintained. The transparency-honesty-trust model recommended by PCORI and equity workshops/training sessions should be made available in medical facilities across the U.S. This would allow for the medical professionals treating minority patients to be much more aware of how to provide the best treatment. The same can be said of the ACCURE program which reflects upon shortcomings in the medical facility and actively works to train the staff on how to remedy them.

Designing culturally specific comprehensive cancer control programs (like that of the Native Americans and Alaskan Natives) would allow for more relevant programs for each minority group. What works best to improve the cancer treatment of African Americans may not work best for Asian Americans, and vice versa. Being able to target these groups with individual projects that are impactful to them seems the most effective way to enact change. The respective individuals know what would be best for their communities, so the power for change in the medical sphere of cancer treatment should be given to them. More programs similar to these

being implemented in the majority of hospitals across the country would be a fantastic step in reducing the cancer treatment disparities that are faced by these minority communities.

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