

## Unequal Cancer Treatments: *Don't Jump to Conclusions*

With demands for institutional reform now sweeping American society, the institution of medicine, too, finds itself on trial. Accusations are flying. Recently the editor of *JAMA* resigned after a subordinate dared question the assertion that American medicine is structurally racist. As this suggests, such claims are beginning to be taken not as allegations but verities. In fact, they are springing up in the medical literature itself; hence, for example, the claim in a commentary in a prominent journal that urology in the United States is guilty of “systemic racism”—an epithet used eight times in the text alone.<sup>1</sup> While the authors allege that this evil “affects our patients’ treatments and outcomes,” they offer no urological examples and do not, for some reason, discuss the profound disparity in prostate-cancer (PCa) mortality between black and white patients.

By its sheer deficiency of argument, this commentary prompts us to think more carefully and clearly about urology and race—and the risks of reckless accusation.

Black men are now about 2½ times more likely to die of PCa than whites. If American urology were racist, we might expect the literature to explain this high mortality with loose talk about biological differences. In point of fact, the emerging consensus is that regardless of biological differences (if any), the principal drivers of the high PCa mortality of black men are unequal access to care and the uneven quality and the delay or absence of care itself. By itself, the last factor—absence of care—can produce a mortality chasm. Among patients aged 60-70, untreated men with high-risk PCa die of the disease within ten years about three times more

often than those treated with surgery, and about twice as often as those treated with radiation<sup>2</sup>—numbers reminiscent of the elevated PCa mortality of black patients. Clearly, high-risk PCa not treated with curative intent can shorten life.

Among the most disturbing findings of the urological literature is that a disproportionate percentage of black PCa patients at high risk of metastasis receive no definitive treatment (that is, surgery or radiation). A 2014 study of data in a national cancer registry found, after adjusting for potential confounders, that black patients with high-risk PCa were 40% less likely than their white counterparts to undergo such treatment.<sup>3</sup> How are we to make sense of this startling figure?

If American urology were racist, we would know exactly how to make sense of it. And yet the study's authors do not cry racism. In accounting for their finding, they note that while black and white patients refused treatment at an equal rate, "it is difficult to rule out the possibility that subtle mistrust of the health-care system [on the part of black patients] led to less definitive treatment." Is it then possible for a distrustful patient to opt out of treatment without voicing a positive refusal?

Suppose the encounter goes as follows:

Patient: What are my chances?

Doctor: Without treatment you have about a 20% chance of dying of PCa within ten years.

Patient: Then I have an 80% chance of surviving ten years?

Doctor: An 80% chance of not dying of PCa.

Patient: That's good enough for me.

Doctor: With treatment, your chances are even better.

Patient: 80% is good enough for me. I'm sure.

Unless the doctor presses the need for treatment to the point where the patient bristles, the patient has not actually rejected a recommendation. By the tables, he has a risk of death markedly higher than his treated brethren (the mortality gap noted above), and yet it's also true that a man of 65 with untreated high-risk PCa still has about an 80% probability of not dying of the disease within a decade.<sup>4</sup> For a patient haunted with distrust of medicine, nontreatment—for all its risks—might well appear an attractive choice under these conditions.

Behind black distrust of medicine lies much history. But while most of us readily understand the legacy of suspicion left by a sustained atrocity like the Tuskegee Syphilis Experiment,<sup>5</sup> we err to assume that the practices viewed with suspicion are limited to studies with human subjects. They can include clinical medicine itself; hence the finding, reported in 2002, that over 40% of surveyed black patients believed their doctor might covertly use them as research subjects and expose them to harm.<sup>6</sup> For that matter, black distrust of Covid vaccination runs high at this hour,<sup>7</sup> even though black Americans suffered disproportional Covid mortality. Given both the undeniability and the historical depth of black distrust, I believe the likely explanation of racially disparate treatment of high-risk PCa is not racism on the part of white urologists but a relative reluctance on the part of black patients to be treated. A study of outright refusal of recommended treatment for PCa found double the white rate of refusal among black patients (and higher disparities among high-risk patients), with the authors suggesting only the element of distrust as a possible explanation for the difference.<sup>8</sup> A study of factors overlooked by some analyses of treatment disparities found black patients twice as

likely as whites to refuse surgery for lung cancer,<sup>9</sup> the leading cause of cancer death among black Americans.

Viewing the 40% treatment disparity in this way, we no longer confront a horror scenario in which urologists selectively deny treatment to black patients at high risk of metastasis. We confront instead patients with different dispositions and cultural inheritances who make different decisions under intense circumstances. The patient's preferences are the X factor of PCa medicine,<sup>10</sup> and being disadvantaged does not entail an incapacity to have preferences. But if distrust can account for a disparity that some will read as evidence of American medicine's endemic racism, distrust of medicine imposes a cost. In the case sketched above, the distrustful patient knowingly or unknowingly takes on an elevated risk of PCa mortality (and overall mortality). Others who may or may not benefit from treatment for PCa may have cardiovascular disease in need of treatment.

To fan distrust of medicine is to play with fire.

At this point we return to the allegation, echoing in the pages of medical journals even now, that American medicine is rife with racism. The trouble with such exaggerations is not just that they suppress counter-evidence (for example, the sharper drop in cancer deaths, including PCa deaths, among blacks than whites from 2006 to 2015),<sup>11</sup> or that they impute an evil essence, but that they can only intensify suspicion of medicine. Precisely because such suspicion can translate into an aversion to treatment, those who decry so bitterly the racism of American medicine risk reinforcing disparities of treatment and outcome by the sheer excess of their rhetoric. It's indeed a wonder any black person would entrust his or her body to the institution portrayed by certain voices of the medical left. After all, the denunciations of

medicine now appearing in medical journals do not simply remain there, out of earshot of the general public. On the contrary, such rhetoric is picked up by the press, magnified, and established by repetition, much as the editorialists cited above drive home the charge of systemic racism by using the epithet over and over. Fifteen years ago the press was already quick to jump to the preconceived conclusion that American medicine was poisoned by racism.<sup>12</sup>

With its accusations of racism, the medical left has validated a distrust of medicine that is already strong enough to deter people from getting treatment. The state of the evidence suggests that regardless of biological differences (if any), equal access to equal treatment yields comparable outcomes for black and white patients across a number of cancers. Yet comparable outcomes cannot come about if a “subtle” but corrosive suspicion of medicine as a racist institution inhibits the receipt of treatment or even the seeking of care.

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<sup>1</sup> Randy Vince, Jr., Kristen Scarpato, and Adam Klausner, “Fighting the ‘Other Pandemic’— Systemic Racism in Urology,” *Nature Reviews Urology* 18 (2021): 1-2.

<sup>2</sup> Firas Abdollah, Maxine Sun, Rodolphe Thuret et al., “A Competing-Risk Analysis of Survival After Alternative Treatment Modalities for Prostate Cancer Patients: 1988-2006,” *European Urology* 598 (2011): 88-95.

<sup>3</sup> Brandon Mahal, Ayal Aizer, David Ziehr et al., “Trends in Disparate Treatment of African American Men with Localized Prostate Cancer Across National Comprehensive Cancer Network Risk Groups,” *Urology* 84 (2014): 386-92.

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<sup>4</sup> Relative to a counterpart treated with surgery, the patient does, however, have about twice the risk of dying of other causes.

<sup>5</sup> In this abomination, some 400 black men with syphilis were given the impression that they were being treated for bad blood, though the actual purpose of the study was to chart the progress of untreated syphilis all the way to the autopsy table. Pursuant to that purpose, the subjects were denied penicillin when it became available mid-way through the “experiment,” which ran some four decades.

<sup>6</sup> Giselle Corbie-Smith, Stephen Thomas and Diane Marie St. George, “Distrust, Race, and Research,” *Archives of Internal Medicine* 162 (2002): 2458-63. Cf. Elizabeth Jacobs, Italia Rolle, Carol Estwing Ferrans et al., “Understanding African Americans’ View of the Trustworthiness of Physicians,” *Journal of General Internal Medicine* 21 (2006): 642-47.

<sup>7</sup> Simar Singh Bajaj and Fatima Cody Stanford, “Beyond Tuskegee—Vaccine Distrust and Everyday Racism,” *New England Journal of Medicine* 384 (2021): e12.

<sup>8</sup> Edward Dee, Melaku Arega, David Yang et al., “Disparities in Refusal of Locoregional Treatment for Prostate Adenocarcinoma,” *JCO Oncology Practice* 2021: OP-20. The absolute number of refusers was low.

<sup>9</sup> Joan Ryoo, Diana Ordin, Anna Liza Antonio et al., “Patient Preference and Contraindications in Measuring Quality of Care: What Do Administrative Data Miss?,” *Journal of Clinical Oncology* 31 (2013): 2718.

<sup>10</sup> Regarding disparate treatments of high-risk PCa, Wang et al. comment, “Unmeasured patient factors that vary by race, such as patient preferences and values, cultural biases, [and] perceptions . . . are probably the most influential, yet also most challenging, factors to understand.” Elyn Wang, James Yu, Robert Aboussally et al., “Disparities in Treatment of Patients with High-risk Prostate Cancer: Results from a Population-based Cohort,” *Urology* 95 (2016): 93.

<sup>11</sup> Carol DeSantis, Kimberly Miller, Ann Goding Sauer et al., “Cancer Statistics for African Americans, 2019,” *CA: A Cancer Journal for Clinicians* 69 (2019): 211-33.

<sup>12</sup> Sally Satel and Jonathan Klick, “The Institute of Medicine Report: Too Quick to Diagnose Bias,” *Perspectives in Biology and Medicine* 48 (2005): S15-S25.