Ann Surg Oncol (2022) 29:2136–2137
https://doi.org/10.1245/s10434-021-11095-7

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

EDITORIAL – GLOBAL HEALTH SERVICES RESEARCH

Disparities in Cancer Care: Educational Initiatives

Monica Morrow, MD[1,2], and Lisa A. Newman, MD, MPH[1,2]

[1]Memorial Sloan Kettering Cancer Center, New York, NY; [2]Weill Cornell Medicine, New York, NY

Disparities in cancer outcomes on the basis of race and ethnicity are well recognized. Socioeconomic status is an important cause of these disparities, but it is far from the only one. Although race is a social construct rather than a biologic one, genetic differences attributable to common ancestry do exist among racial groups. For example, African American women have a higher proportion of triple-negative breast cancers than white or Hispanic/Latina women, accounting for some but not all of the higher rate for breast cancer mortality in this population.[1] In contrast, Latina women often carry a genetic variant protective against breast cancer development, potentially explaining, at least in part, the lower rate of mortality in this group, which shares with African Americans a disproportionate burden of poverty.[2] Variations in screening quality and receipt of state-of-the-art treatment on the basis of race also occur, but even when treatment differences are eliminated through participation in clinical trials, higher death rates for African Americans persist for some but not all cancers.[3]

The primary factor underpinning disparities in cancer care, which physicians as a group have been slow to acknowledge, is racism. Although structural racism due to segregated neighborhoods, poor schools, mortgage redlining, and income inequality is a difficult problem for surgeons to tackle directly, other areas exist that can and should be addressed. Implicit bias, common among surgeons and other physicians, has been largely ignored until very recently. The surgical workforce is overwhelmingly white and male, with only 7 % of the academic surgical faculty in 2018 comprising underrepresented minorities.[4] Similar underrepresentation of minorities is seen present in medical schools and surgical residency programs, suggesting that diversity in the surgical workforce is unlikely to increase in any meaningful way in the near future.[5]

In recognition of the need for adequate representation of racial and ethnic minorities and women among the leadership and committee structure of the Society of Surgical Oncology (SSO), a Diversity and Inclusion Advisory Board was created in 2018. The Advisory Board's role initially was fairly narrow and centered around assessing the racial/ethnic and gender composition of the SSO and determining whether committee and leadership representation was proportional. However, the widely-publicized tragic murders of several men and women of color in 2019 and 2020 in the hands of law enforcement as well as race-related disparities in COVID-19 severity heightened overall awareness of systemic racism, making it clear to the Board that a more comprehensive approach was needed.

A statement on Racism, Diversity, and Cancer Care was developed (https://www.surgonc.org/about-sso/society-of-surgical-oncology-statement-on-racism-diversity-and-cancer-care/). The statement acknowledges racism as an underpinning of health disparities and calls for SSO members to be accountable for diversity, inclusion, and social justice throughout the cancer care community, in addition to providing the best cancer care to individual patients regardless of race, ethnicity, gender, sexual orientation, or socioeconomic status.

To facilitate provision of the best cancer care across the spectrum of our diverse patient population, the Diversity and Inclusion Advisory Board is developing a series of educational initiatives. The first initiative was a virtual Disparities Tumor Board covering breast cancer risk and screening of transgender persons[6] as well as colorectal cancer disparities among African Americans,[7] which are the subject of articles in this issue of *Annals of Surgical Oncology*.

First Received: 3 November 2021
Accepted: 4 November 2021;
Published Online: 31 January 2022

L. A. Newman, MD, MPH
e-mail: Lan4002@med.cornell.edu

Medical journals have been a primary mechanism for disseminating information regarding patient care since the middle of the 17th century. Surgical oncology is no exception, and as the official journal for the SSO, *Annals of Surgical Oncology* has served as a major source of peer review and publication of cancer surgery advances during the past several decades. It is therefore appropriate for *Annals of Surgical Oncology* to contribute to the groundswell of energy currently being leveraged against the impact of systemic racism on cancer care. These contributions are being formalized through the power of the journal in education, research, and career development. Editor-in-Chief Kelly McMasters, MD, PhD has pledged commitment of journal resources across all these domains.

The cancer community relies on *Annals of Surgical Oncology* for education with regard to innovations in operative management of malignant disease. Optimal delivery of surgical cancer care is compromised by disparities in health care access and also is influenced by variations in cancer burden between different population subsets. *Annals of Surgical Oncology* recently launched the "Landmark Series" of review articles designed to educate surgical oncologists regarding topics that have historic relevance to the field as well as issues that are subjects of substantive contemporary discourse. Efforts to achieve health equity by combatting systemic racism clearly fall into both of these categories. *Annals of Surgical Oncology* has therefore commissioned a sequence of disparities-related manuscripts that will be included in the Landmark Series. Some of these articles will focus on disease-specific differences in cancer risk and outcome, such as race/ethnicity-associated variation in colorectal and breast cancer. Others will address novel translational research in disparities, such as the study of allostatic load and ancestry informative markers. Still others will promote important strategies to heighten awareness of how implicit biases and microaggressions weaken our profession, such as the case-based Cultural Complications curriculum.[8]

Annals of Surgical Oncology recognizes that race/ethnicity is relevant to nearly all aspects of cancer research, as a function of access to care, variation in disease burden, or potential differences in treatment response. The journal has therefore extended its author instructions with a requirement to report race/ethnicity in the demographics description for any research involving human subjects and undergoing peer review for possible publication in the journal. Studies that fail to include these data must provide an explanation for the deficiency. This specification represents an advance over the current reporting requirements of Consolidated Standards of Reporting Trials (CONSORT), which mandate inclusion of "baseline demographic and clinical characteristics" for a study population, but this loosely written requirement can be met by inclusion of age and gender alone.

Annals of Surgical Oncology furthermore acknowledges the value of diverse perspectives in the peer review process itself. To this end, additional experts with a variety of backgrounds have been included in the cadre of reviewers for each category of its Editorial Board. It is anticipated that several of these reviewers will ascend the editorial leadership ladder, thereby strengthening the journal with an infusion of novel viewpoints while also contributing to the career development of diverse young surgical oncologists.

REFERENCES

1. DeSantis CE, Ma J, Goding Sauer A, Newman LA, Jemal A. Breast cancer statistics, 2017, racial disparity in mortality by state. *CA Cancer J Clin*. 2017;67:439–48.
2. Fejerman L, Ahmadiyeh N, Hu D, et al. Genome-wide association study of breast cancer in Latinas identifies novel protective variants on 6q25. *Nat Commun.* 2014;5:5260.5.
3. Albain KS, Unger JM, Crowley JJ, Coltman CA Jr, Hershman DL. Racial disparities in cancer survival among randomized clinical trials patients of the Southwest oncology group. *J Natl Cancer Inst*. 2009;101:984–92.
4. Valenzuela F, Romero Arenas MA. Underrepresented in surgery: (lack of) diversity in academic surgery faculty. *J Surg Res*. 2020;254:170–4.
5. Abelson JS, Symer MM, Yeo HL, et al. Surgical time out: our counts are still short on racial diversity in academic surgery. *Am J Surg*. 2018;215:542–8.
6. Clarke CN, Cortina CS, Fayanju OM, Dossett LA, Johnston FM, Wong SL. Breast cancer risk and screening in transgender persons: a call for inclusive care. *Ann Surg Oncol.* 2021. https://doi.org/10.1245/s10434-021-10217-5.
7. Johnston FM, Yeo HL, Clarke C, Stewart JH. Bias issues in colorectal cancer management: a review. *Ann Surg Oncol.* 2021. https://doi.org/10.1245/s10434-021-10232-6.
8. Harris CA, Dimick JB, Dossett LA. Cultural complications: a novel strategy to build a more inclusive culture. *Ann Surg*. 2021;273:e97–9.