

# P R E S I D E N T ' S C A N C E R P A N E L

NATIONAL CANCER PROGRAM

NATIONAL CANCER INSTITUTE

NATIONAL INSTITUTES OF HEALTH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAIRMAN  
LASALLE D. LEFFALL, JR.,  
M.D., F.A.C.S.

MEMBER  
MARGARET L. KRIPKE, PH.D.

EXECUTIVE SECRETARY  
ABBY B. SANDLER, PH.D.

## **America's Demographic and Cultural Transformation: Implications for the Cancer Enterprise February 2, 2010**

The President's Cancer Panel held the fourth meeting of its 2009-2010 series, *America's Demographic and Cultural Transformation: Implications for the Cancer Enterprise*, on February 2, 2010, in Miami, Florida. During this meeting, the Panel learned about the burden of cancer experienced by specific populations as well as changes needed to improve the experiences and outcomes of minority cancer patients.

Cancer health disparities are the result of complex interplay between numerous factors. Lack of health insurance, startlingly high poverty rates, and geographic isolation make it difficult for some populations—American Indians in particular—to access quality health care in a timely fashion. In addition, cultural factors influence health behaviors. For example, Latinos are less likely to smoke and, if they do smoke, are more likely to be light smokers (1-2 cigarettes per day) than other populations. This has implications for research on cancer risk as well as development of smoking cessation interventions. Culture also plays a strong role in cancer patients' approach to treatment. Complementary and alternative medicine (CAM) is widely practiced in the U.S., with various populations exhibiting different levels and patterns of CAM use.

There is tremendous heterogeneity within racial/ethnic groups. For example, despite a common heritage, recent immigrants often exhibit different behavioral risk factors than individuals whose families have been in the U.S. for a longer period of time. Members of the same racial/ethnic group can also vary significantly with respect to genetic make-up and environmental exposures. This is illustrated by the divergent cancer incidence rates observed among American Indian/Alaska Native tribes across the nation.

Clinical experiences often differ among members of racial and ethnic minority groups. For example, African Americans are more likely than whites to feel that they would have received better health care if they were of a different race or ethnicity. This tension between minority patients and providers may be due in part to implicit, or unconscious, bias on the part of clinicians, which can influence the quality of care delivered. Many minorities also have an intrinsic distrust of the health care system. Fostering a workforce of minority researchers and clinicians would help address this issue. Another approach that has improved patient interactions with the health care system is the use of community health workers and patient navigators who can provide culturally competent guidance before and after cancer diagnosis.

The Panel heard about National Cancer Institute efforts to increase research on cancer health disparities; enhance the capacity of minority-serving institutions and communities to carry out research; conduct applied research on potential interventions; and perform outreach, dissemination, and education in underserved communities. International efforts have illustrated the importance of raising awareness about cancer as well as providing infrastructure to facilitate cancer screening and treatment. It was emphasized that both abroad and in the U.S., researchers must take care to build genuine partnerships with communities and ensure that they conduct their efforts in a culturally sensitive manner.

The Panel will summarize findings and recommendations from this meeting, along with the other meetings in the series, in its 2009-2010 Annual Report to the President of the United States.