Cancer Health™

Confronting Racism to Improve Cancer Care

Health equity advocate Karen Winkfield, MD, MPH, works to enroll more underserved people with cancer in lifesaving clinical trials.

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"Racism has been the major root of inequity in health care," says radiation oncologist Karen Winkfield, MD, PhD, a national expert on ways to engage communities to reduce the barriers that lead to racial disparities in cancer. Systemic race-based disenfranchisement embedded in our health care system contributes to cancer disparities, she explains.

For example, Black men who have prostate cancer are more likely to be diagnosed at a later stage than white men and more likely to die, while Black women have the same incidence of breast cancer as white women but are 40% more likely to die of the disease. "That's racism, not race," says Winkfield, executive director of the Meharry-Vanderbilt Alliance, a partnership between the historically Black Meharry Medical College and Vanderbilt University Medical College. "We have used race as a surrogate for in racism for too long."

Social determinants of health, including poverty and poor access to quality education and healthy nutrition, contribute to these racial disparities. But so do inequities within the health care system itself that keep underserved people with cancer from getting effective and timely care. "Dr. Karen," as her patients call her, discovered this in the most direct way—by talking with Black and other underserved people directly.

When she was a medical student at Duke University in the early 2000s, Winkfield cared for residents at a predominantly Black housing project directly across from the Duke Cancer Center, the major hospital where she worked. Many housing project residents with cancer couldn't get care at the center because they lacked insurance—a lack rooted in racial disenfranchisement—but the institution's outright racist history also played a role. "The Black wards in the hospital used to be in the basement," she says. While that was no longer the case at the time, the history reinforced a sense among that population that they were simply not welcome at the center, which provides state-of-the-art cancer care.

Even when insurance barriers are removed, Winkfield found, racial barriers to care persist. After earning a PhD and an MD at Duke, Winkfield moved to Boston for additional radiation training at Harvard, where she began her radiation practice and eventually became an assistant professor.

There, she discovered, it wasn't primarily insurance that kept Black people with cancer from getting the best care. While some on Medicaid could get treated only at city hospitals, many actually had private insurance—at the time, Massachusetts already had Romneycare, a model for Obamacare. "We had universal coverage—only 4% of the population was uninsured," she says. "Yet very few Blacks were going to our hospitals." Why?

"I went out and asked them," recalls Winkfield. "They didn't feel welcome. There wasn't anyone there who looked like them. It was a matter of trust too. Like Duke, Harvard hospitals also have a racist history."

When she encouraged some cancer patients to look into clinical trials—one of the best ways for people with cancer to get effective treatment—at the Harvard-affiliated Massachusetts General Hospital (MGH), "they would say, 'Harvard isn't for me. I'm not welcome there,'" says Winkfield. She recalls some of them telling her that the Harvard hospital was too far away—even though it was actually physically closer. "They would go out of their way to travel to the city hospital, where they felt comfortable," she recalls. While community hospitals can provide good cancer treatment, complex cancers can often be treated better at academic centers, such as MGH.

While at Harvard, Winkfield was co–principal investigator of a $3 million dollar grant for a cancer equity program at MGH to improve clinical access and enrollment in vulnerable populations. She worked in community outreach.

"To care for people, you have to meet them where they are," she says. "You can't enter into a clinical trial if you have trouble getting to the hospital. You might have to take two trains and a bus to get to the hospital while you're trying to hold down a job." Many in the underserved population are not salaried but wage earners, she notes, so losing a day of work means no income for that day. Helping people overcome these kinds of obstacles improves their ability to enter clinical trials.

Enlisting underrepresented populations in clinical trials has two main benefits. The first is that these trials afford patients not only the best standard of care for their specific cancer but also potential access to newer, cutting-edge treatments. "In clinical trials, there is great oversight in the course of care, so patients get the best care," she explains. "Why would you want some communities to be excluded from that?" Secondly, clinical trials help ensure that any treatments developed out of the research are actually effective in those populations. "If you look at the majority of drugs approved by the FDA [Food and Drug Administration], only about 4% of the people in the clinical trials were from underrepresented groups," says Winkfield. Encouraging more diverse populations to participate in clinical trials for cancer means the resulting treatments will be shown to work in those populations.

Winkfield continued breaking down barriers to clinical trials for people with cancer when she became an associate professor of radiation oncology at Wake Forest University in North Carolina. She also became the director of the Office of Cancer Health Equity at Wake Forest Baptist Comprehensive Cancer Center. In 2018, she joined the health equity committee of the American

Association for Cancer Research.

Now she’s working with the major cancer research fundraising organization Stand Up To Cancer (SU2C) to harness some of her hard-won insights to effect change. SU2C’s Health Equity Initiative will work directly with organizations that receive grants from SU2C. “We’ll look at your proposal, and let’s say you had a goal of including 20% representation for underserved populations but you’ve only achieved 10%. We’ll work with you to look at your strategies. We’ll hold you accountable.”

At the Meharry-Vanderbilt Alliance, Winkfield will be expanding her health equity focus to address not just cancer but many health concerns, including issues related to COVID-19. “My goal,” she says, “is to reach communities of color in a more global way.”

To read more, see “Jamie Foxx Encourages At-Risk Minorities to Get Screened for Colorectal Cancer” and “Persistent Poverty Linked to Increased Risk of Dying from Cancer”.
