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Preface: Surgical Oncology for All: Why We Must Prioritize Inclusion and Equity for Our Patients and Ourselves xiii
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Financial Toxicity and Shared Decision Making in Oncology 1
Rachel A. Greenup

Oncologists are often ill-prepared for patient-provider communication about the financial costs and burden of treatment. Several barriers to cost communication exist, including provider discomfort, lack of knowledge or access to accurate information, and background historic concerns that cost discussions may negatively impact the doctor-patient relationship. However, clear and transparent cost communication can yield cost-reducing strategies that ultimately mitigate the high costs of cancer care and risk for financial toxicity.

Barriers to Equitable Palliative Care Utilization Among Patients with Cancer 9
Gabriel D. Ivey and Fabian M. Johnston

Over the past half century, palliative care has grown to become a pillar of clinical oncology. Its practice revolves around relieving suffering and optimizing quality of life, not just dealing with end-of-life decisions. Despite evidence that palliative care has the potential to reduce health care utilization and improve advance care planning without affecting mortality, palliative care remains inequitably accessible and underutilized. Furthermore, it is still too often introduced late in the care of patients receiving surgical intervention. This article summarizes the numerous and complex barriers to equitable palliative care utilization among patients with cancer. Potential strategies for dismantling these barriers are also discussed.

Disparities in Creating a Diverse Surgical Oncology Physician Workforce: Just a Leaky Pipeline? 21
Callisia N. Clarke

Demographic shifts in the United States population highlight the growing need for a diverse physician workforce to care for communities of color and to eliminate existing disparities in cancer care and outcomes for these potentially vulnerable patients. The current surgical oncology workforce lacks adequate racial and ethnic representation, and the pool of medical students and surgical trainees who are underrepresented in medicine (URM) is scant. This review critically evaluates data, summarizes challenges in the recruitment and retention of URM surgeons to surgical oncology, and provides strategies to address these workforce deficits.
Disparities in the Management of Peritoneal Surface Malignancies
Kathleen Marulanda and Ugwuji N. Maduekwe

Peritoneal surface malignancies are a group of aggressive cancers involving the peritoneum. Cytoreductive surgery and hyperthermic intra-peritoneal chemotherapy can improve outcomes and survival in select patients. Despite significant advancements in care, racial disparities in peritoneal malignancy outcomes persist and may have even worsened over time. Poor adherence to guideline-recommended therapy introduces wide variability in patient care and often results in fewer options and suboptimal treatment of vulnerable populations. This review explores biological, sociodemographic, and environmental factors that contribute to disparities in peritoneal malignancy outcomes.

Undertreatment of Pancreatic Cancer: The Intersection of Bias, Biology, and Geography
Madeline B. Torres, Matthew E.B. Dixon, and Niraj J. Gusani

Pancreatic cancer is the third leading cause of cancer deaths in the United States. Black patients with pancreatic cancer experience higher incidence and increased mortality. Although racial biologic differences exist, socioeconomic status, insurance type, physician bias, and patient beliefs contribute to the disparities in outcomes observed among patients who are Black, indigenous, and people of color.

Disparities in Clinical Trial Participation: Multilevel Opportunities for Improvement
Brooke A. Stewart and John H. Stewart IV

Current data demonstrate ongoing inequities in surgical oncology clinical trials and understanding these disparities is vital to creating a more just and equitable health care system. Analysis of participatory patterns in cooperative group surgical oncology trials demonstrates complex relationships between race, socioeconomic status, and participation in these trials at the patient level. Further analysis reveals that provider-level implicit bias plays a significant role in access to clinical trials by minority populations. Holistic approaches to addressing disparities in clinical trial participation include creating a more robust pipeline of minority surgeon-scientists, engaging in partnerships with community advocates, and promoting public policy.

Racial Disparities in the Management of Locoregional Colorectal Cancer
Scarlett Hao, Alexander A. Parikh, and Rebecca A. Snyder

Racial disparities pervade nearly all aspects of management of locoregional colorectal cancer, including time to treatment, receipt of resection, adequacy of resection, postoperative complications, and receipt of neo-adjuvant and adjuvant multimodality therapies. Disparate gaps in treatment translate into enduring effects on survivorship, recurrence, and mortality. Efforts to reduce these gaps in care must be undertaken on a multilevel basis and focus on modifiable factors that underlie racial disparity.
Breast Cancer Disparities and the Impact of Geography 81
Samilia Obeng-Gyasi, Barnabas Obeng-Gyasi, and Willi Tarver

Neighborhood has significant implications for breast cancer screening, stage, treatment, and mortality. Patients residing in neighborhoods with high deprivation or rurality face barriers and challenges to accessing and receiving care. Consequently, they experience higher mortality rates than their financially affluent or urban counterparts. There are multiple gaps in the literature on the relationship between place of residence and the use of systemic therapies or emerging surgical strategies for disease management. As the management of breast cancer continues to evolve, additional studies are needed to understand the implications of place on the implementation and dissemination of new and emerging treatment modalities.

The Impact of Health Delivery Integration on Cancer Outcomes 91
Vishnukamal Golla and Deborah R. Kaye

Although integrated health care has largely been associated with increases in prices and static or decreased quality across many disease states, it has shown some successes in improving cancer care. However, its impact is largely equivocal, making consensus statements difficult. Critically, integration does not necessarily translate to clinical coordination, which might be the true driver behind the success of integrated health care delivery. Moving forward, it is important to establish payment models that support clinical care coordination. Shifting from a fragmented health system to a coordinated one may improve evidence-based cancer care, outcomes, and value for patients.

Disparities in Genetic Testing for Heritable Solid-Tumor Malignancies 109
Jacquelyn Dillon, Foluso O. Ademuyiwa, Megan Barrett, Haley A. Moss, Elizabeth Wignall, Carolyn Menendez, Kevin S. Hughes, and Jennifer K. Plichta

Genetic testing offers providers a potentially life saving tool for identifying and intervening in high-risk individuals. However, disparities in receipt of genetic testing have been consistently demonstrated and undoubtedly have significant implications for the populations not receiving the standard of care. If correctly used, there is the potential for genetic testing to play a role in decreasing health disparities among individuals of different races and ethnicities. However, if genetic testing continues to revolutionize cancer care while being disproportionately distributed, it also has the potential to widen the existing mortality gap between various racial and ethnic populations.