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Racism and Cancer Care

Disparities in Cancer Care and the Asian American Population

Richard J. Lee [a], Ravi A. Madan [b], Jayoung Kim [c,d,e], Edwin M. Posadas [e], Evan Y. Yu [f]

[a]Harvard Medical School and Massachusetts General Hospital Cancer Center, Boston, Massachusetts, USA; [b]Genitourinary Malignancies Branch, Center for Cancer Research, National Cancer Institute, National Institutes of Health, Bethesda, Maryland, USA; Departments of [c]Surgery; [d]Biomedical Sciences; [e]Samuel Oschin Comprehensive Cancer Institute, Cedars-Sinai Medical Center, California, Los Angeles, USA; [f]University of Washington and Fred Hutchinson Cancer Research Center, Seattle, Washington, USA

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Abstract

Asian Americans are the only racial/ethnic group in the U.S. for whom cancer is the leading cause of death in men and women, unlike heart disease for all other groups. Asian Americans face a confluence of cancer risks, with high rates of cancers endemic to their countries of origin due to infectious and cultural reasons, as well as increasing rates of "Western" cancers that are due in part to assimilation to the American diet and lifestyle. Despite the clear mortality risk, Asian Americans are screened for cancers at lower rates than the majority of Americans. Solutions to eliminate the disparity in cancer care are complicated by language and cultural concerns of this very heterogeneous group. This review addresses the disparities in cancer screening, the historical causes, the potential contribution of racism, the importance of cultural perceptions of health care, and potential strategies to address a very complicated problem. Noting that the health care disparities faced by Asian Americans may be less conspicuous than the structural racism that has inflicted significant damage to the health of Black Americans over more than four centuries, this review is meant to raise awareness and to compel the medical establishment to recognize the urgent need to eliminate health disparities for all. ***The Oncologist*** 2021;26:453–460

Implications for Practice: Cancer is the leading cause of death in Asian Americans, who face cancers endemic to their native countries, perhaps because of infectious and cultural factors, as well as those faced by all Americans, perhaps because of "Westernization" in terms of diet and lifestyle. Despite the mortality rates, Asian Americans have less cancer screening than other Americans. This review highlights the need to educate Asian Americans to improve cancer literacy and health care providers to understand the important cancer risks of the fastest-growing racial/ethnic group in the U.S. Eliminating disparities is critical to achieving an equitable society for all Americans.

Introduction

In 2020, the confluence of the COVID-19 pandemic and the outrage about the disproportionate number of deaths of Black Americans in police custody—among other egregious affronts to Black lives—exposed critical disparities in health care and structural racism faced by Black and Latinx Americans. In support of eliminating health disparities for *all* Americans, this review examines disparities in the delivery of cancer care for Asian Americans.

The broad brushstrokes illustrate the need to evaluate disparities in this population. Asian Americans are the fastest-growing racial/ethnic group in the U.S. Unlike *every* other group, for whom heart disease leads the way, cancer is the leading cause of death in male and female Asian Americans [1, 2]. By some measures, Asian Americans have greater exposures to environmental carcinogens [3]. Despite these risks, Asian Americans have lower cancer screening rates than other groups [1, 4–7]. Taken together, there is a clear need to ensure equitable access to screening and cancer care in this vulnerable population.

The Asian American Population

Who are Asian Americans? In the broad terms "people of color" and "underrepresented minority," Asian Americans

Correspondence: Richard J. Lee, M.D., Ph.D., Department of Medicine, Harvard Medical School, Massachusetts General Hospital Cancer Center, 55 Fruit Street, Yawkey 7E, Boston, Massachusetts 02114, USA. Telephone: 617-724-4000; e-mail: rjlee@mgh.harvard.edu Received February 1, 2021; accepted for publication February 16, 2021; published Online First on March 20, 2021. http://dx.doi.org/10.1002/onco.13748
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are not typically included. Asian Americans comprise 6% of the U.S. population but are not a monolith. By the current definition used by the U.S. Census Bureau (established in 1997 by the Office of Management and Budget [https://www.census.gov/topics/population/race/about.html]), the term ''Asian'' includes people who can trace their origin to more than 20 countries in East Asia (e.g., China, Japan, Korea), Southeast Asia (e.g., Cambodia, Philippines, Thailand, Vietnam), and the Indian subcontinent (e.g., Bangladesh, India, Pakistan) [5, 8]. As of 2015, of the more than 20 million Asian Americans, 23% were from China, 19% from India, 18% from the Philippines, 9% from Vietnam and Korea, and 7% from Japan, with the remaining 15% from all other countries [8]. Asian Americans are sometimes grouped with people with roots in the Pacific Islands (e.g., native to Hawaii, Marshall Islands). The number of countries belies the significant ethnic diversity in this heterogeneous group, with 200 languages or dialects. As such, aggregate data of ''Asian Americans'' often fail to capture the broad range of experience in this group.

Asian Americans are the fastest-growing racial/ethnic group in the U.S., with 72% growth between 2000 and 2015, compared with 60% for the second-fastest-growing population (Latinx Americans). Most Asian Americans (59%) were born in another country. Since 1965, one-fourth of all immigrants to the U.S. have come from Asia. Asian immigrants comprise 13% of the 11.1 million undocumented immigrants in the U.S. [8].

Social determinants of health are defined by the Centers for Disease Control and Prevention as ''conditions in the places where people live, learn, work, and play'' that ''affect a wide range of health risks and outcomes'' [9]. Asian Americans frequently settle in either central city locations or near cities [3]. Overall, the home ownership rate among Asian Americans is lower than for the U.S. overall (57% compared with 63%), with only Vietnamese and Japanese households at or above the U.S. rate [8]. More Asian Americans live in multigenerational households (26%) compared with all U.S. households (19%) [8].

Aggregate data indicate that Asian Americans fare well based on measures of economic well-being, including median household income ($73,600 compared with $53,600 for all U.S. households) and poverty rates (12.1% compared with 15.1%) [8]. However, disaggregated data describe a broad range among subgroups, including highest compared with lowest median household incomes ($100,000 for Indian compared with $36,000 for Burmese) and lowest compared with highest poverty rates (7.5% for Filipino and Indian groups compared with 35% for Burmese). In terms of education, 51% of Asian Americans over age 25 have a bachelor's degree, compared with 30% of all Americans; however, there is a wide range among subgroups, from 9% among Bhutanese to 72% among Indians [8].

Notably, the demographics and data indicate that Asian Americans and other minority groups face different challenges related to disparities, and therefore any proposed solutions for minority groups are necessarily population specific. In addition to the wealth and poverty rates above, other measures of social inequities favor Asian Americans over White, Black, Latinx, and Native/Indigenous Americans, including incarceration rates, health insurance rates, infant mortality, and diabetes- and heart disease–related mortality [10]. Self-reported issues such as discrimination and stress are subject to reporting bias and are less readily comparable. In terms of representation in medicine, Asians are an overrepresented minority, comprising 11.2% of U.S. primary care physicians (PCPs), compared with 6.8% Black and 5.9% Latinx PCPs [11]. By comparison, the entire U.S. population is 6% Asian, 13% Black, and 18% Latinx. Of all active U.S. physicians, 17.1% identify as Asian, with 5.0% Black and 5.8% Latinx [12]. Similar trends exist in other areas of health care requiring advanced degrees, including pharmacists (17.9% vs. 5.9% vs 3.7%, for Asian, Black, and Latinx, respectively), dentists (14.3% vs. 3.0% vs. 6.1%), and optometrists (13.7% vs. 1.8% vs. 3.9%) [13].

The ''Model Minority'' Myth

Given their relatively small fraction of the U.S. population, why are Asian Americans not typically clustered with other minority populations, and how does this affect their health care? In part, this may relate to the aforementioned metrics of economic well-being, in that populations that are doing well in aggregate may receive less attention. In part, this may also relate to Asians being labeled a ''model minority,'' a label that has impacts that may be considered positive and negative.

The U.S. has a long history of anti-Asian discrimination, including the Chinese Exclusion Act of 1882 (which was extended in 1892 as the Geary Act and then made permanent in 1902), the Immigration Act of 1917 (the Barred Zone Act), the Johnson-Reed Act (1924), and the Japanese American internment under Executive Order 9066 during World War II. The Immigration and Naturalization Act of 1965 significantly shifted the immigration barriers from Asia posed by the prior acts by lifting a national-origins quota system and allowing immigrants who were relatives of U.S. citizens or permanent residents, or those with skills that were considered useful (with a preference for those with professional degrees), or refugees of unrest. This act led to hundreds of thousands of Asians immigrating to America, with a high concentration of highly skilled and educated professionals from India and the Philippines [14]. As such, this wave of immigrants included a significant proportion fluent in English who were poised for success in the U.S.

Around the same time, the ''model minority'' term was coined in 1966, in two lay articles about Japanese and Chinese Americans achieving success despite the long history of anti-Asian discrimination [15, 16]. During the Civil Rights era, the portrayal of Asians as a successful minority group was used in stark contrast with the portrayal of Black Americans. The articles described how these Asian Americans overcame the above immigration policies and racism to achieve success and avoid delinquency, positing that Asian attributes such as work ethic, emphasis on education, family stability, and assimilation overcame language and other cultural barriers [3, 14]. The corollary, then, is that failures of other non-Asian minority groups are due to their lack of

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such positive attributes. It was asserted that Asians historically faced even greater prejudice than Black Americans [16]. The argument as illustrated by the model minority stereotype is that opportunities are equally available and that success is achievable by anyone. Furthermore, acceptance of this stereotype undermined the perceived need to assist disadvantaged minority populations [3].

This argument must be considered a myth, given the known reinforcing structural disadvantages placed over 400 years to hinder Black American success. The Immigration Act of 1965 may have had benign motives, but the increase in skilled or professional workers with English fluency from Asia added to the established population touted as the model minority, allowing policymakers to accept a myth that America is a nonracist society and ignore the needs of Black Americans.

What are the consequences of Asian American success and this model minority stereotype? In society in general, Asian Americans are not generally considered "threatening." In the labor market, given their high numbers in professional occupations, Asian job-seekers are not considered minority applicants. In higher education, Asian applicants for college/university are not considered an underrepresented minority and in fact may face admission quotas at certain schools. It is arguable whether this represents progress, and at its worst, this may drive a wedge between Asian Americans and other minority groups.

There are clear health care consequences from combining this model minority myth with aggregate assumptions of Asian Americans. Given economic indicators of success relative to the overall population, Asian Americans may be assumed to have similar disease risk profiles to the majority White American population. By aggregating Asian Americans in population studies, the heterogeneity of subpopulations with genetic and cultural contributions to disease risk can be masked [3]. By acceptance of the advantages of the model minority label, Asian Americans may be reluctant to disclose, or may not advocate for, their own physical or mental health concerns and needs [6]. Taken together, the consequences of this myth may lead to poor understanding of significant medical issues faced by Asian Americans and misguided policies. Poor understanding or inattention to the fastest-growing racial/ethnic group in the U.S. must be remedied to avert a significant number of cancer deaths.

Cancer Is the Leading Cause of Death for Asian Americans

There is no question that cancer should be a significant concern for Asian Americans and their primary care providers. Cancer has been the leading cause of death for Asian Americans since 2000, with most recent data from 2017 [1, 2]. In contrast, heart disease (including coronary artery disease, arrhythmias, congestive heart failure, valvular heart disease) is the leading cause of death for all other groups in the U.S. In a study that aggregated Asian Americans, native Hawai'ians, and Pacific Islanders (AANHPIs), the leading cancer causes of death in men were lung (27%), liver (14%), and colorectum (11%), and in women, they were lung (21%), breast (14%), and colorectum (11%). By comparison, the leading causes of cancer death in all Americans in the same year were lung (27%), prostate (8%), and colorectum (8%) in men and lung (26%), breast (14%), and colorectum (8%) in women [17]. The 5-year cancer-specific survival for AANHPI men was lower compared with non-Latinx White American men (62% compared with 68%, respectively), whereas rates were similar for women (70% compared with 68%) [1]. These statistics persist despite Asian Americans having higher median household income and education levels compared with other groups [8], arguing that social determinants of health do not fully explain this disparity in the most critical outcome of survival but that it may result from the high incidence of specific malignancies in this population, such as liver and stomach cancers.

Cancer Propensity in Asian Americans

Although some of the leading cancer causes of death among Asian Americans are shared with the overall American population, understanding different cancer propensities may help eliminate disparities in outcomes.

Infectious Etiologies

Asian Americans have higher rates than most racial/ethnic group for cancers with infectious etiologies, including liver (hepatitis B virus [HBV]), uterine cervix (human papillomavirus [HPV]), nasopharynx (Epstein-Barr virus [EBV]), and stomach (*Helicobacter pylori*) [1, 5]. For liver cancer, chronic HBV infection among Asian Americans can be attributed to high HBV prevalence in country of origin, recent immigration, and vertical transmission [1]. The HBV infection and cancer rates vary among Asian American subpopulations. Liver cancer rates were highest among Vietnamese men and Korean women [5]. By contrast, the rising liver cancer incidence among other Americans is attributed to hepatitis C and nonalcoholic fatty liver disease [1, 18].

The cervical cancer incidence rate is slightly lower among Asian American women overall compared with non-Latinx White Americans, although rates among Cambodian Americans and Vietnamese Americans are 40%–87% higher [1]. These rates may reflect HPV prevalence in country of origin, recent immigration, and less screening with the Papanicolaou test, which may relate to health insurance status, access to care, and awareness.

Although rates of nasopharyngeal carcinoma are low in the U.S., the incidence among AANHPIs is five- to sixfold higher than among non-Latinx White Americans. Risk factors that may account for higher rates include EBV infection (with 98% of cases related to EBV), habits such as smoking, and culture-specific carcinogen exposures such as the high nitrosamine content in Cantonese salted fish [1].

Stomach cancer is the sixth and seventh leading cancer causes of death in Asian American men and women, respectively, but does not reach the top ten for Americans overall [1, 17]. Asian American men had the highest incidence and mortality from stomach cancer in the U.S. from 2010 to 2014 [18]. Incidence among Asian subpopulations is highest among Koreans followed by Japanese and Vietnamese, reflecting in part that worldwide stomach cancer rates are highest in Korea [1]. Risk factors for stomach cancer include

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H. pylori infection, smoking, and ingestion of salt-preserved foods [1, 19]. The prevalence of *H. pylori* infection is higher in Asia and South America than the U.S. An estimated 89% of stomach cancers that originate outside of the gastric cardia are attributed to *H. pylori*. A study assessing racial/ethnic differences found that 35.6% of cases in White Americans originate in the cardia, as opposed to 10% for Asian Americans, 15% for Latinx Americans, and 11% for Black Americans. Most cases in Asian Americans (31.4%) occurred in the pyloric antrum, compared with 19.6% for all patients [20]. Consistent with the possibility that endemic infection and cultural factors contribute to risk, several studies have shown that migration from high- to low-incidence regions such as from Japan to the U.S. is associated with decreased risk of developing stomach cancer [19, 20].

Carcinogen Exposure

Lung cancer is the leading cause of cancer-specific death in Asian Americans [1]. Although smoking is the primary risk factor for developing lung cancer, Asian Americans' cigarette use rates from 2010 to 2013 were lower (10.9%) compared with those of White Americans (24.9%), Black Americans (24.9%), and Latinx Americans (19.9%) [21]. Among Asian subpopulations, the range was broad, from Chinese and Indian Americans (7.6%) to Koreans (20.0%) [21]. That tobacco use is not more prevalent despite the increased lung cancer risk is perhaps not surprising. Whereas in the U.S., approximately 10% of patients with lung cancer are never-smokers, in Asia, >30% of patients are never-smokers, including more than half of female patients with lung cancer [22]. In this case, the biology of the disease clearly differs, with a markedly increased rate of epidermal growth factor receptor–mutant lung cancer in Asian female nonsmokers. Nonetheless, tobacco cessation remains an important recommendation to diminish cancer risk. Among smokers, only one-third of Asian Americans reported being counseled to quit smoking, compared with half of all other Americans [5].

Environmental hazards pose important, underreported health risks (e.g., heart disease, stroke, respiratory disease, cancer), most commonly for low-income and minority populations, including Asian Americans. In a national study of carcinogenic hazardous air pollutants (HAPs) based on census tracts and other available epidemiological data, Asian Americans ranked second after Black Americans for mean excess cancer incidence attributed to ambient HAP exposure, with Latinx Americans in third place [3]. When disaggregated by subpopulations, Chinese and Korean Americans had greater risks than Black Americans. Nonrace factors associated with higher cancer incidence included population density, urban setting, and renter-occupancy status (as opposed to home ownership). The byproduct of the model minority label, the authors state, is that Asian Americans are less often included in studies of environmental health disparities "based on the conventional presumption that they would have similar risk profiles to Whites." Biologic factors may also play a role, as population differences in *CYP* gene expression, which affects activation of carcinogens and metabolism of drugs, could contribute to cancer risk [23].

Changing Risks with Migration and Westernization

As described above for stomach cancers, migration can affect cancer risk. Asian Americans cancer rates align with national rates within 10 years of immigration [24]. Cancer incidence patterns have been demonstrated to change among immigrants from China, Japan, Korea, and the Philippines. For example, for Korean immigrants in the U.S., incidence rates of prostate, breast, and colorectal cancers have risen compared with native South Koreans, whereas rates of stomach, liver, and gallbladder cancers have declined [25]. Rates of infection with cancer-associated viruses (HBV, HPV, EBV) or bacteria (*H. pylori*) change as a result of migration, vaccination availability and practices, health insurance availability, cancer screening, and cultural changes such as diet and lifestyle. Dietary changes (e.g., red meat consumption), more sedentary lifestyle, and consequent body composition changes (rates of overweight and obesity) may contribute to the rising rates of colorectal cancer [5]. Breast cancer incidence rates have risen fastest for Asian Americans among racial/ethnic groups, at 1.5% per year between 2012 to 2016 [26]. An understanding of the changing nature of cancer risk among Asian Americans is critical for delivery of appropriate cancer screening and care.

Cancer Screening Disparities and Solutions

President Barack Obama signed Executive Order 13515 in October 2009, to address issues concerning the Asian American and Pacific Islander community, including strategies to reduce health disparities and improve the health of this community. Despite more than a decade since that order, significant disparities persist.

With cancer as the leading cause of death for Asian Americans, screening is of paramount importance to identify cancer cases at early, curable stages. However, screening occurs at *lower* rates for Asian Americans, the only racial/ethnic group for which cancer screening disparities compared with White Americans is not well explained by socioeconomic factors such as income, education, and access to health care [4]. This disparity holds true for each Asian subpopulation; not one group is expected to reach the national screening targets such as those in Healthy People 2020 [4].

Studies of different databases describe similar screening disparity trends [1, 5–7]. Compared with Americans overall, Asian American screening rates are lower for cervical cancer (75.4% vs. 83.0%), breast cancer (64.1% vs. 72.4%), and colorectal cancer (46.9% vs. 58.6%) [6]. These results are consistent with racial minorities receiving less provider recommendation for colon cancer screening [27]. In examining colorectal cancer screening rates among Asians in California (where approximately one-third of Asian Americans live) compared with White Americans, disparities have narrowed over time but have not been eliminated [28].

Inadequate screening is not limited to cancer. Diabetes prevalence among Asian Americans is 21%, nearly double that of White Americans, despite a lower mean body mass

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index. In a survey study from 2012 to 2014, Asian Americans had a 34% lower adjusted odds of receiving the recommended diabetes screening compared with White Americans (adjusted odds ratio [AOR], 0.66; 95% confidence interval [CI], 0.60–0.73), a difference that persisted despite age and body mass index cutoffs. In perhaps a rare example of minority groups receiving *more* screening, the adjusted odds of receiving appropriate diabetes screening was significantly higher for Black Americans (AOR, 1.20; 95% CI, 1.16–1.25) and Latinx Americans (AOR, 1.36; 95% CI, 1.29–1.44) compared with White Americans [29].

The disparity in screening for diseases like cancer and diabetes and the fact that fewer Asians are counseled to quit smoking raise important questions about potential barriers to eliminating disparities and improving cancer survival. In contrast to Black and Latinx Americans, it is clear that workforce disparities are not at issue, given the overrepresentation of Asian Americans in medicine compared with the overall population, as described above [11, 12].

The challenges of evaluating Asians in aggregate are obvious: there are differences among subpopulations in language, culture, education, income, insurance, and health-seeking behaviors, to name a few. Although some barriers are similar to other racial/ethnic groups, a barrier such as language may be more readily overcome for Latinx Americans given the common Spanish language (dialects notwithstanding), whereas interpreters and translated documents may be required for each language among the many countries of origin for Asian Americans. Asian Americans in aggregate may be less information-seeking than other groups [4]. They may be less forthcoming about symptoms or concerns, including mental health concerns, and less accepting of screening for disease given absence of symptoms. Indeed, statistics indicate that they are least likely among all racial/ethnic groups to have seen a physician in the prior 12 months [5].

Numerous studies have evaluated interventions that may increase acceptance and performance of screening. Importantly, the heterogeneity of the Asian American population makes a single strategy unlikely to address the unique cancer burden of this population and fix the disparity issue, and necessitates culturally appropriate interventions to target subpopulations or communities [24]. For example, a randomized study of a community-based approach involving Korean church-based organizations in the Philadelphia–New Jersey region increased colorectal cancer screening from 16% in the control group (n = 455) to 69% in the intervention group (n = 470) [7]. The multifaceted intervention included educational resources, health system navigation, and fecal immunochemical tests. Similarly, a study of Korean Americans identified through local community outreach in the Los Angeles Koreatown area randomized participants (n = 100) to educational brochures in Korean and English about colorectal cancer (control group) or the same brochures coupled with a short educational seminar (intervention group) [30]. The outcome was awareness of colorectal cancer screening assessed by questionnaire, with the intervention group having significantly greater awareness of screening methods. Importantly, the intervention group was also more willing to undergo screening in the following 6 months (88% vs. 8%). These specific studies highlight the importance of targeted intervention: colorectal cancer is now the most common cancer among Korean Americans, yet Korean Americans over age 50 have the lowest rate of colorectal cancer screening compared with other Asian American groups [31, 32].

Care navigation can significantly improve cancer screening rates. A randomized controlled trial employing lay navigators was performed in Moloka'i, Hawai'i, to address knowledge gaps about cancer, educate about the benefits of screening, secure insurance, facilitate health care management, provide transportation to appointments, and encourage self-advocacy [33]. The population included 45% native Hawai'ian, 35% Filipino, 11% Japanese, and 8% other. Compared with the control group (n = 246), the intervention group (n = 242) had significantly increased cervical cancer screening (57.0% vs. 26.4%), breast cancer screening (61.7% vs. 42.4%), prostate cancer screening (by prostate-specific antigen testing; 54.5% vs. 36.0%), and colorectal cancer screening (43.0% vs. 27.2%).

The absence of national guidelines for screening certain cancers that occur at higher rates in Asian Americans is a barrier to improving outcomes. Liver and stomach cancers clearly occur at higher rates in this population, with significant mortality consequences as described above. Although Asians are only 6% of the total U.S. population, an understanding of these cancer risks by primary care providers will be important for appropriate recommendations regarding smoking cessation, HBV vaccination, *H. pylori* testing and eradication, and referrals for screening of high-risk individuals [34].

Cultural Perceptions of Medical Care

An important variation among Asian Americans and in contrast with other American cultures is the general attitude toward health care. Such cultural perceptions may drive patient health care decisions more than American providers realize. For example, the simple term "cancer" has been found to carry a stigma in many Asian cultures. Some of these negative associations are derived from the belief that cancer is possibly attributable to some form of fortune (e.g., luck, transgressions in a previous lifetime, or the will of a supreme power). Therefore, it is not surprising that in a survey of 94 doctors in Singapore used euphemisms for cancer such as "lump" or "growth" [35, 36]. These findings highlight that clinicians in the U.S. may need to better understand the cultural perceptions of cancer before they can even broach the subject of screening.

Even among first-generation Asian Americans from China, a study of 45 women from varied socioeconomic backgrounds and professions demonstrated common culture-based perceptions that influenced breast screening. Although these women largely understood the significant health care implications of breast cancer, there was common sentiment among the women that because they were Chinese, the risks were low. Other barriers to screening included a fatalistic view toward a cancer diagnosis and faith in traditional Chinese remedies [37]. Specific barriers to cancer screening for pelvic and breast malignancies may

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be influenced by cultural perceptions of modesty among women. A parallel problem exists for Asian men faced with concerns about prostate cancer and colon cancer screening that is interlaced with concerns about preserving masculinity and sexual function.

Another key difference between western medicine and the Asian culture is the focus of the health care discussions once a diagnosis has been made. As opposed to a western emphasis on patient-centric care, many Asian cultures prefer a family-centric model where health care decisions must often be discussed with the family before decisions can be made. These attitudes often persist generations after migration to western societies [38]. It is also common for Asians who have migrated to the west to choose to shield their older relatives from a cancer diagnosis with a poor prognosis, perhaps related to cultural beliefs that the stress could lead to worse outcomes [39]. For these reasons, extra time may be required to accommodate the scheduling of multiple family members with the patient and implement a plan of care that is in keeping with their expectations while also appropriate for the patient.

For Asian Americans who do not choose a family-centric model, cultural stoicism and a desire to limit cost expenditures on health care may lead to patients deferring care or not sharing a cancer diagnosis (or poor prognosis) with family, perhaps contributing to poor outcomes [35, 37]. It is possible that even end-of-life care is affected by these cultural perceptions. Hospice use among Asian Americans has been found to be less than among other subpopulations and is possibly influenced by a combination of patient attitudes and perceptions that are not adequately addressed by hospice care as it is generally implemented [40, 41].

Conclusion

Asian Americans face a unique cancer challenge. As the fastest-growing racial/ethnic group in the U.S. and the only group with cancer as the leading cause of death, there is an urgent need to improve cancer screening for the Asian American population. To do so, health care providers will need to be aware of these facts, including the profile of cancer risks among different Asian subpopulations, and have the necessary tools to communicate cancer risks and benefits of screening. Asian Americans will need to be educated and encouraged to be advocates for their health, which includes improving access to insurance and health care resources.

Is This Racism?

The health care disparities faced by Asian Americans are not remotely comparable to the structural racism faced by Black Americans forged over more than four centuries [10]. By no means should this call to action imply that the needs of Asian Americans supersede those of any other group. However, disparities do exist for Asian Americans, and this may be surprising to health care providers. Therefore, the reason to raise awareness is to compel the medical establishment to recognize the urgent need to eliminate health disparities for all.

When evaluating Asian Americans in aggregate, the measures of economic and educational status, the numbers of Asian health professionals in the U.S., and the model minority label contribute to the implicit bias that Asian Americans have similar disease risk profiles to the majority White American population. Acceptance of the advantages of the model minority label (e.g., less discrimination compared with other racial/ethnic groups) may cause some Asian Americans to embody the myth of the docile, hard-working citizen who will not complain or "rock the boat"—which, when applied to health care, may lead to less information- or care-seeking for physical and mental health care needs. This acceptance by patients and providers of a stereotype leads to less advocacy, less understanding of differing disease risk profiles whether diabetes mellitus or mental health or cancer, and less screening. Hence, the disadvantages of the model minority myth, conceived in the Civil Rights era to drive a wedge between Asians and other racial/ethnic groups, *do* implicate racism as an indirect contributor to contemporary cancer disparities for Asian Americans.

Self-advocacy will be an important antidote to disparities. Past and contemporary history point to the fickle nature of public opinion and politics with respect to Asian Americans' standing in U.S. society. For over 150 years, Asians faced discrimination in laws and immigration practice as the "Yellow Peril," culminating in the ignominious internment of Japanese Americans during World War II. Only with the Civil Rights era, as an affront to Black Americans, were Asian Americans dubbed a "model minority." The death of Vincent Chin in 1982 and the Los Angeles riots of 1992 made clear that this label indeed was a myth. Even the 9/11 terrorist attacks by Al-Qaeda turned South Asian Americans, by virtue of the color of their skin and for some, their religion, into perceived threats. Finally, the COVID-19 pandemic's emergence in China and increase in racially motivated hate crimes against Asian Americans point to the potential for political rhetoric to unearth deep-seated racism [42].

Recommendations

Elimination of cancer disparities for all racial/ethnic groups involves (a) education for patients and providers of the existence of the disparity and (b) improved access to care [4]. For Asian Americans, perhaps more so than other groups, the many languages spoken by the subpopulations necessitate the availability of cancer information and screening in all languages. Medical interpreter services are critical for accurate information delivery, as opposed to translation by a family member or friend, given the complexity of medical terminology and description of risk, as well as potential cultural barriers to using terms such as "cancer." Given the time pressures of contemporary medical practice, the additional time and effort of employing medical interpreter services may contribute to fewer recommendations for appropriate screening. Therefore, it is important that providers receive education about the specific cancer risks faced by Asian Americans, including higher mortality, to spend the time to appropriately discuss cancer screening, smoking cessation, and vaccination for HBV and HPV.

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Educational campaigns reaching Asian Americans in their communities (grocery stores, places of worship, community centers, print media, direct mail, Internet) have proven effective [24]. Engagement of English-proficient community members such as younger generations may help steer older Asian Americans to advocate for cancer screening.

Improved access to care is a straightforward recommendation with difficult implementation. Culturally appropriate, community-based interventions that meet the Asian American populations where they live are likely to be the most effective at improving access to and education about health care [24]. Lay navigators can significantly improve awareness of cancer issues, access to care, and cancer screening in a culturally sensitive and impactful fashion [33]. Access to care and encouragement for self-advocacy can normalize seeing primary care providers for routine care and screening, in a population that is least likely to have seen a physician in the prior year [5]. Partnership of major cancer centers with community health centers will align the goals of seamlessly moving patients from screening and diagnosis to appropriate oncology care and access to clinical trials. At the national level, governmental funding to focus on and eliminate disparities among Asian Americans should be expanded [43]. Improving cancer literacy and access to care will contribute to narrowing cancer disparities and improving cancer care for Asian Americans.

Author Contributions

Conception/design: Richard J. Lee
Data analysis and interpretation: Richard J. Lee, Ravi A. Madan, Jayoung Kim, Edwin M. Posadas, Evan Y. Yu
Manuscript writing: Richard J. Lee, Ravi A. Madan, Jayoung Kim, Edwin M. Posadas, Evan Y. Yu
Final approval of manuscript: Richard J. Lee, Ravi A. Madan, Jayoung Kim, Edwin M. Posadas, Evan Y. Yu

Disclosures

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