

Comprehensive Cancer Care: Integrating Complementary and Alternative Therapies  
Race, Poverty & Cancer: Comprehensive Care for All  
Harold Freeman, MD  
June 12, 1998

Dr. Gordon: Our next speaker is Dr. Harold Freeman, Director of the Department of Surgery at Harlem Hospital Center, and Professor of Clinical Surgery at Columbia University of Physicians and Surgeons, both in New York. He's been appointed Chairman of the President's Cancer Panel by Presidents Bush and Clinton. Harold Freeman is one of the few people and things on which President Bush and President Clinton have agreed wholeheartedly.

He's also been an enormously important force in reminding us that illness and death, morbidity and mortality, do not just come from aberrant cells or wayward bacteria, but death and illness are intimately related to economics and to race and geographic location. He has been an important voice on such issues. I remember particularly a quote about men in Bangladesh, in which he noted that men in Harlem had less of a chance to live into old age than people in Bangladesh. This was from *The New England Journal of Medicine*. Dr. Freeman has been published in all of the right places, and his voice should be heard everywhere. We're hoping to amplify his perspective and bring his spirit into this conference and into all the work we do. Dr. Harold Freeman.

Dr. Freeman: Thank you very much for that introduction. I'm very honored to be here. Let me start out by saying this. Poverty should not be an offense which is punishable by death. I'm afraid that it is. Dr. Epstein mentioned the war against cancer which was declared in 1971. That war has not been fought properly on all fronts. Certainly we've had tremendous breakthroughs in some research and translation of research, but we have breakdowns in delivery.

It is my belief that we should apply what we really do know to all American people, irrespective of their ability to pay. In our country, the poor and the uninsured are treated differently. Cancer ultimately is a human condition, and therefore cancer occurs under human circumstances. And those circumstances include the physical environment, the culture of the people themselves, the social and economic condition of people, political circumstances, and also psychological and spiritual concerns. If cancer occurs under those conditions, then it's not enough to understand carcinogenesis, if we ever get to understand that – we should understand it in human circumstances and settings.

Now some people in America don't do as well when they have cancer as others. The reasons for the disparities are what I'm going to talk to you about here today. Let me first go quickly through some slides. You can see that cancer is the number two cause of death in America. In the American male, that peaking yellow line represents death due to lung cancer. In the female, lung cancer has exceeded breast cancer as a cause of death. You can see from this slide, which is very important, that the top bar represents lung cancer, which is clearly the cancer that kills more males and females, followed by breast and prostate cancer and colon cancer.

Now here is a slide that is very significant. Over several decades we see what has caused death, the death rate in males and females in America. In 1930 at the beginning of this slide, cervical cancer was the number one cause of cancer deaths in American females. The Pap smear has been put into use, and that has been a major force in reducing cancer deaths. So that line is relatively flat for females. But what happened to males is they began to smoke, and that has been a major force in peaking the line that goes upward in the males. So we can see that the things that people do with respect to lifestyle, and also tests that are discovered, both have a bearing on preserving life and promoting longevity.

Now let me go briefly to the focus of what I'm going to talk about here today. In talking about these issues, I think we're really talking about the essence of America itself. I'm going to separate the meaning of race from the meaning of poverty, and I will demonstrate how these powerful forces, race and poverty, interplay and inter-react in causing cancer death and cancer incidence. But I want to first punctuate this by showing you how I got started with these concerns in my 30 years as a surgeon in the community of Harlem.

I studied cancer of the breast in poor black women. The women who come to Harlem are poor women, so we're dealing with a poor population, a city hospital. The question is, what are the results when poor black women develop breast cancer? We looked at more than 700 patients who came to Harlem Hospital over a 22-year period with breast cancer, usually coming in through the emergency room, because they had no private doctors.

Looking at a segment of these cases we find that about half of them had no insurance. Another 30% were covered under Medicaid, and you have to be very poor to be covered under Medicaid. Half of the people who are defined as poor in America are not poor enough to receive Medicaid. You can't see this, but this is a woman who was pretty typical in those early days. Her breast has actually been replaced by cancer, and this is the way we saw her on her first visit to Harlem Hospital.

To give an overview of the findings, only 6% of these women who came to Harlem Hospital were in the early stage of breast cancer, stage one. Half of them were in stages three and four, so half of them were incurable when they came into the hospital. Now the question is, how can this occur in America, the country that has the highest technology, medically, in the world, and the richest country in the world? How can this occur? How do these pockets of tragedy occur as illustrated here? There are many similar patterns throughout the country, not

related to race. At the end of five years, only 38% of these women were alive, excluding 25% who were not treated at all because they were too advanced.

We set up screening clinics in Harlem, and I want to show you what happened there. After a 20-year experience we can say now nearly 40% of women screened in Harlem in stage one, in advance, shows something can be done. But even that is not as good as the nearly 60% of American white women on initial examination. Although screening has helped in Harlem, it hasn't completely solved the problem. There are some factors beyond access that are causing these disparities.

Now looking at race in general you see that black men do worse than anyone else with respect to mortality. Everybody is in danger of developing this disease, because nearly 40% of American people will develop cancer in their lifetimes. I'm not going to go deeply into this slide. Just take it as a picture to show that different ethnic groups have different incidences of cancer. This is from the NCI SEER data, and it shows black men and women have the highest incidence of cancer in America. There are different results with respect to mortality and survival according to race. The question is, what is the real effect of race, when we look at race, or is that the surrogate? Is that the right indicator or proxy, or must we look deeper to find the real answers, and the real variables that are causing these disparities? The latter I believe is true. Here again, if you look at different organ sites you can see that the mortality and survival is much lower in black versus white people, men and women.

But let me get to the essence of what I'm going to say here today. In order to get to the right answers to these apparent racial disparities, we need to understand the meaning of race. We need to understand the effect of racism in America, which has a rich history of racism. We need to understand the meaning of culture and the meaning of class.

The President's Cancer Panel held a very significant meeting about a year ago to look at the meaning of race in science. This would take a long time to describe, but I'm going to hit a few points of our conclusions. One conclusion is this: Race, as used in the United States of America, and really throughout the world, is a social and political construct, and is based on our nation's history, and has no basis in science or anthropology. This is a very important conclusion. This would mean that racial findings are not driven by the point that races are biological classifications. It would drive us to look for other causes of the disparity. The second conclusion: Biologically distinct races do not exist. There's no genetic basis for racial classification. But racism, which is rooted in the erroneous concept of biological race superiority, has powerful societal effects and also influences science. The bottom line: Race does not exist, but racism, based on an erroneous concept of race, does exist.

Those forces that we're describing do have meaning. Social status is affected by race, as is economic status, and health outcome. The issue then, is to disentangle the social and political meaning of race from its presumed biological meaning in order to get to solutions. If race is to be validly used in scientific research, we conclude that we must define what is being measured and for what purpose, since the clarity of definition must be made a priority for the future.

Now I'm going to shift my focus from race to poverty. 15% of American people are poor by the standard of poverty. A third of the poor are black, but blacks make up only 12% of the American population. A third of blacks are poor, and about 10% of the whites are poor. However, anyone who is poor is in similar circumstances. What does poverty mean? We need to get to the essence of this question.

Poor people tend to be unemployed, and they have less education, poorer housing, poorer nutrition, and inadequate access to medical care. They need to concentrate on day-to-day

survival, and do not plan into the future. These people are also exposed to more toxic environments. Poor people, we find, experience greater pain and suffering when they develop cancer, because of late disease. They meet many barriers in attempting to negotiate the health care system, being uninsured, and not being educated. They often make sacrifices in trying to get health care. According to firsthand testimony in hearings that we held, they very often find the educational efforts that we offer very insensitive and even irrelevant to them and their circumstances. And poor people become fatalistic.

The American Cancer Society has looked at ethnic differences in cancer. I chaired a committee in 1986 and we reported that ethnic differences in cancer survival are primarily related to economic status. We found that the overall cancer survival rate in poor people is 10 to 15% less than in other American people. Nevertheless, I want to point out that race does have meaning, and I'll get back to that in a second. At least half of the difference in cancer survival among the poor is due to late diagnosis, raising the likelihood that factors other than late diagnosis have an effect.

Now before we get to the final part of my talk, let me give a picture of what I'm trying to say here. We have a society that has separated itself off in a number of ways, according to race, according to economic status. A society that is made up of people who are diverse and culturally different. Culture is a major factor, because if you want to understand people, you need to understand their culture. What I mean by culture is that there are groups of people that may or may not be in a race, who have similar ancestors, who live in a similar social and economic environment, who communicate in the same way, who have similar traditions and believe in the same things, and have the same values, and have the same way of looking at the world. And such people then have similar lifestyle, attitude and behavior. This is cultural. This is a very

important determinant of what happens to people. It doesn't necessarily coincide with race, but it may be in some ways driven by race. Therefore, there is some confusion between race and culture.

On the other hand, poverty is different. Poverty has to do with lack of resources, lack of knowledge, poor environment, exposure to toxins, and lack of access to health care. When you put these overlapping forces together, we're dealing mainly with poverty as a driving force, seen through the mirror of culture, or acting through culture, causing certain events, and thus giving culture the opportunity to modify poverty's expected effects. So in facing solutions to these problems in America, first of all we need to translate race into its cultural meaning if it is doable, and we also need to look at economic status.

That leads me to a series of recommendations. It is really unacceptable that we have 41 million American people who have no health insurance. It is absolutely unacceptable. We are the only so-called advanced social country where this occurs, and I do not understand it. In 1994 there was a plan by the President to get universal access to care. For complicated reasons, it failed, but we cannot accept the point that there are 41 million uninsured American people. So we all must become advocates for universal access to health care for all Americans, irrespective of their race, their socioeconomic status. It doesn't matter, it's just the thing that we must do.

And since I've stressed culture here, I want to point out this recommendation. Our educational system very often is insensitive to people who are different. We need to take an anthropologic approach to public education, looking at the culture of people – who they are, how they relate, how they see things. People see things differently. People receive information differently. A Chinese philosopher put it this way: "Tell me, and I will forget. Show me, and I

will remember. Involve me, and I will understand.” In order to reach people, we have to reach them through involvement.

Another recommendation. We know that there are people in America who are living in pockets of death. In the *New England Journal of Medicine* article, we proved that a black man in Harlem has less of a chance of reaching age 65 than a male growing up in the third world country of Bangladesh. So there are zones of excess mortality, and they can be defined both geographically and culturally. We need to define these areas and then we need to direct special help – for example, culturally targeted education, social support networks, tobacco control, and improved access to prevention and treatment.

There is a great need for improved social support systems. We’ve created one in Harlem that works very well, and I will describe it briefly. It’s called “patient navigation.” The patient navigation system attempts to diminish the barriers to early diagnosis and treatment of cancer in poor people. We have people who are called patient navigators. When a person comes into Harlem and an abnormality is detected, that person speaks one-on-one to a patient navigator, whose job it is to get that patient through treatment, no matter what it takes. The patient may be uninsured. We get them covered, rapidly, or treat them when they’re uninsured. A patient may speak a different language. A patient may have children they can’t leave at home. We find a way to take care of that. For an uninsured patient who comes to Harlem Hospital with an indication of the presence of breast cancer, the average time between initial visit and biopsy is 12 days. If this happened throughout America we would save many lives. Patients need navigation, particularly when they are poor.

We offer a cancer control model that goes beyond phase one, which is an outreach phase to educate people. We educate people in a way that they would never develop cancer, never

smoke, have a proper diet. We educate people about toxic exposures that they may be subjected to, particularly in poor communities. Then when they come in with a symptom, we get them rapidly through, and that's called the navigation phase. And finally, when they are treated, we see that their quality of life is good after treatment, and that is called the rehabilitation phase. We offer this as a cancer control model.

I believe that humanity can best be measured by the way that we relate to the members of our society who are disadvantaged, including the poor and the elderly. To solve the problems that I have outlined today – increased mortality, increased incidence, and low survival rates in segments of population who are poor, disadvantaged and culturally different – what we need to do is to pare down the cultural and economic barriers to early diagnosis and treatment. We need to delineate, geographically and culturally, areas of excess mortality. We need to provide universal access to all Americans irrespective of their ability to pay. We need to understand that the cancer problem cannot be separated from poor housing and unemployment and lack of access to health care. These are all one. They do not separate out. We need to respect, as we are trying to help people, the pride, the values, and the folkways of those people we're trying to help. That is my message to you today.

The great philosopher and physicist, Albert Einstein, put it this way: “What you see depends on where you stand.” What I see depends on my background, being born black, living half of my life in legalized segregation and the other half after the Martin Luther King revolution in the mid-60's, half my life in a country whose laws are fair. But the hearts and minds of people are not necessarily equal to the change in the laws. I also come from Harlem, a community of poor black people. I've had the opportunity to study these people and through various promotions, through luck and chance, I've had the opportunity to look at the same

factors throughout the country, and I find universality of discrepancies and differences. Race is not the issue. The issue is human conditions. We need to use the filter of race to get down to real variables that cause disparities and solve these problems for all American people. Thank you very much.