
# The shocking influence of skin color on health care

*Dispatcher: 911, what's your emergency?*

*Caller: America's healthcare system is broken and people are dying! (ambulance siren)*

Welcome to **Code WACK!,** where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

(music)

This time on **Code WACK!** This time on Code WACK! Why do Black women have a 5-year mortality risk from endometrial cancer that's 90 percent higher than White women? Is it about race or racism – and what can we do about it? To find out, we spoke to **Dr. Diljeet Singh,** a women's health advocate and integrative gynecologic oncologist who has practiced for nearly 25 years. She's also the vice president of **Physicians for a National Health Program**, which advocates for single-payer Medicare for All.

***Welcome back to Code WACK! Dr. Singh***

**Singh:** Thanks so much for having me back.

***Q: So before we start out, can you tell us what you do as a gynecologic oncologist?***

**Singh:** So I take care of women who have endometrial cervical ovary, vulva, or vaginal cancer. And then I see a certain number of people who might have cancer and are being evaluated because there's that possibility. And I also take care of people with some precancerous of all of those things. And people who have inherited predispositions to ovarian, you know, and endometrial cancer. Those are the biggest ones that we have identified that have inherited predispositions. And so for all of those things, we do lifestyle modification for people who have cancer and if strong risks. We sometimes do surgery, sometimes do radiation, sometimes do chemo, sometimes do immunotherapies or hormone therapies. There's <inaudible> combinations of things. And as a gynecologic oncologist, I kind of get to use all those tools for women and hopefully offer them a chance of potentially getting rid of their cancer forever, living with their cancer, dealing with all the issues that come along with that.

***Q: Endometrial cancer is the most common gynecologic cancer. And Black women have a five year mortality risk that is 90% higher than White women. 90 is a startling number. Does this mesh with what you're seeing with your patients?***

**Singh:** Absolutely. There's not only the disparity, but there's increasing incidents of endometrial cancer in general. And the disparity between White and Black women is getting bigger. And so absolutely we see that in the office. The cancer I take care of most often and it absolutely makes sense in a lot of ways. You know, we know that endometrial cancer is closely related to hormones. And as we think about exposure to hormones, both in our environment, in our food, and our own hormones, and for women, one of the more important ones when it comes to cancer risk is perimenopausal and postmenopause, our body will take fat cells, adipose tissue and convert it into a weak form of estrogen. And so as the rates of obesity and overweight have gone up in America, we kind of see parallel increases in the rates of endometrial cancer because we're seeing that extra estrogen being around stimulating the lining of the uterus leading to pre-cancerous and cancers.

And so part of this increasing incidence we think is related to that. And then there's other protective factors that might be around a little bit less. The issue of racial disparity, of course, is tied up in all that stuff. And it's tied up in lots of things. And I think the research in cancer is actually a little bit more clear than in maternal mortality and infant mortality because we can break up the pieces, so to speak. And there is good research sort of saying like, okay, if there's a higher mortality, how many of these people had just a more aggressive kind of cancer? Okay, that's a piece of it. And then how many people had advanced stages when they came to us? And so that might not be connected to anything other than lack

of access to healthcare. Right? And then we see treatment differences of like in the same hospital at the same stage, how many women got surgery that were eligible and how many women weren't offered surgery?

How many women got minimally invasive surgery? How many women didn't? How many women should have been offered chemotherapy and didn't get chemotherapy? And in all of those ways, the data says Black women are less likely to get a biopsy done when they came into the office and had abnormal bleeding. So somebody didn't adhere to standard medical protocols when they took care of them. And then once they had cancer, it may be more advanced because they didn't have health insurance. It took 'em longer, it was harder to get to a specialist. Unfortunately, it is not surprising that we see this difference.

***Q: Why?***

**Singh:** We know there's racism and misogyny in medicine that when women complain about period problems, like ‘well, periods are just bad. So you know, you just need to live with that, dear.’ ‘It's hard to be a woman, isn't it?’ Same as we don't listen to people in pain. I've been having this pain in my side. ‘Well, you know, you're probably not exercising enough. Or maybe you're getting older and you've gained some weight maybe’ as opposed to like, ‘no, maybe you have an increasingly enlarged uterus.’

So the way we talk to women, the way we listen to their symptoms, the way we ignore them in our own society, let's talk about body dysmorphia. You know, I take care of a lot of people who notice changes in their health, but they think it's just cuz they're not exercising enough, they're getting fat, they're getting old, right? They're less likely to report symptoms and get things and then when they get in and actually report the symptom, they're less likely to be heard.

You know, we're talking about endometrial cancer, but certainly with ovarian cancer it's really clear that women have symptoms. You know, when I grew up in medicine, you know, I finished my training in 99. We used to say, oh, ovarian cancer is a whisper. Well now there's a whole bunch of data that women have symptoms for a year to a year and a half before they get to a gynecologic oncologist and get an ovarian cancer diagnosis. It's not a whisper, it's just that we ignore symptoms when women report them. And women themselves are trained and taught to minimize their own physical symptoms, especially when they're female oriented. Mm-Hmm.

***Q: I got it. Okay, thank you. A 2020 study in the American Journal of Obstetrics and Gynecology found that the greater mortality rate for Black women from endometrial cancer can be partly attributed to genetic markers. But the study also found that Black women are less likely to receive the proper care for this disease than White women. They're less likely to receive necessary surgery at every stage of endometrial cancer and are more likely to be diagnosed at an advanced stage of the disease. What do you think is behind these differences?***

**Singh:** Let's like clear the air on that. Like let's make it Black and White to people. That doesn't mean Black women have a higher risk of getting cancer when they're born based on the color of their skin. It doesn't mean that genetic markers in cancers or gen molecular markers in cancers are the changes that happen to the body cells over time that lead those cells to develop cancer. And those guys, right? They can be from all kinds of things. They can be from the environment, they can be from stress, they can be from diet, they can be from smoking, they can be from all of those things that lead to – they can be from chance. You know, like we don't understand all of them, but this discussion that racism is what is contributing to higher rates of cancer as well as worse quality of care at multiple levels.

Both of those are absolutely accurate. And we have to think about ways of fixing those. If we're going to decrease the likelihood of somebody of African-American descent dying of endometrial cancer, we're going to have to like look to healthcare providers, look to the system, figure out how to fix that. We're going to have to give everybody health care universally regardless of, you know, background regardless of their job, regardless of their age, et cetera. And then we're gonna have to figure out how to improve the environment that people live in, whether it's the food they have access to, the kinds of exercise and stress management they have access to, whether they're living close to a landfill, whether they're in jobs where they're exposed to more environmental risk factors, all of those things of the things that that feed into those genetic changes that ultimately become cancers and potentially more aggressive cancers that we see in Black women.

***Q: Got it. So when they talk about genetic markers, they're not talking about the genes people are born with?***

**Singh:** So when they say molecular and genetic markers, they're talking about now I'm looking at that cancer and I'm looking at the genes of the cancer, not the person I see. Relatively few uterine cancers – there are uterine cancers that are inherently predisposed to, and it's about the genes you were born with, but most

endometrial cancers are about the genetic changes that happen to your body over time and why genetic mistakes happen and accumulate over time has to do with how we live, which how we live obviously influenced by what the color of our skin is in America.

***Got it. Thank you for explaining that. That was super helpful.***

**Singh:** Yeah, yeah, absolutely. So I did actually send you a study that I think kind of tried to look at this really specifically by looking at this adherence to treatment protocol as like a way to try to say like, okay, for a lot of these cancers, no offense to me and my colleagues, like it's not rocket science.

Like it's pretty clear if someone has this, these are the treatment options and based on who they are, this is what you offer them and you know what you do, right? That's how we write. National Comprehensive Cancer Center and the NCCN, the National Comprehensive Cancer Network, I think are some of the best cancer guidelines for gynecologic cancer – really well thought out, you know, revised every year. Anyway, these guidelines, so what they tried to look at was like how often do we adhere to those guidelines when we treat people and consistently Black women did not get treatment that matched these guidelines, right?

And there have been numerous studies that kind of speak to that. And then going back even before you get to cancer, thinking about the American College of OBGYN and how we're taught to take care of women who have abnormal bleeding and when do we do a biopsy to go looking for cancer and pre-cancer, that all of those things also warned were consistently not adhered to.

And so we can think of like, what are those things a measure of once you're in the system, then they're a measure of how you're being treated. And when it's consistent that we see something different in Black women, then it's about racism. Right? Now there's parts of that that are about access to healthcare, right? There's, I'm having abnormal bleeding and I'm having it for a couple years and I went through menopause two or three years ago, but I'm not quite 65, so I don't actually have health insurance right this second. You know, that's a separate thing. And that's also right. Black women are less likely to have health insurance and are more likely to be uninsured or underinsured. You know, underinsured being you, you have insurance, but it's only like if you show up in the ER after a car crash, not for prevention, right? Like there's all kinds of like, problems with how, you know, insurance works, that even when you have insurance, it's not necessarily going to serve you in the way you want it to.

***Q: Mm-Hmm. Right. And that leads us to our next question. What impact could Medicare for all have on these deeply concerning racial disparities?***

**Singh:** You know, I think say some of the impacts are similar to what we talked about as we talked about, you know, maternal mortality and infant mortality cancer is interesting from the perspective, although I guess obstetric care is the same in that those are outcomes of a lifetime of healthcare and a lifetime of exposures and a lifetime of having things addressed. Right? Having polycystic ovarian syndrome increases your likelihood of getting endometrial cancer because of hormone imbalance, but it's completely preventable by being on the pill or having a progesterone IUD, right? And so, you know, having insurance could have made the difference there, right? And the way our healthcare system is structured and how we listen to people of course influence that is that. But if you start at the very basics that you don't even have a chance to sit with a healthcare provider and talk about what's going on.

So clearly if everybody was the same and everybody had access to care, we could change these things if people didn't wait because they had to make a decision. Like were they going to like buy food or buy their medication or go see a doctor? Right? If they weren't making those decisions, could we prevent cancer? Yes. Could we identify cancers earlier when they're treatable? Yes. Once you're getting treatment, are you more likely to be able to like stay on protocol and get all access to the best things you need? Yes. So absolutely in a multitude of ways we could prevent cancer and treat cancer better and help people who have cancer live better if they had health insurance. But I will say it's not just having health insurance, it's taking that for-profit motive out of things. It's clearing up those trust relationships that we've talked about. How if you're not sure, you know where your providers are coming from in terms of the recommendations they make, so you don't know if you should trust them.

It’s the “are you going to get a test because your insurance approved it or not approved it?” And then like weeks go by and it doesn't quite get approved. And so like, you know, you got diagnosed with cervical cancer today and you didn't get treated for eight weeks because that's how long it took in your community to get an MRI and a PET scan for somebody to be able to decide like how to do your radiation treatment. Like it's not just having insurance, but it's taking the profit motive out. That's going to really impact cancer prevention, cancer outcomes, best quality of life with cancer.

***Q: Great, and Medicare for All would take out the profit motive, correct?***

**Singh:** Absolutely. Medicare for All would take out the profit motive.

***Thank you Dr. Diljeet Singh of Physicians for a National Health Program.***

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