Minoritized racial and ethnic populations, including American Indian and Alaska Native, Asian and Pacific Islander, Black, and Hispanic communities, endure complex and persistent inequities in breast cancer outcomes. Socioeconomic factors, limited health care access, cultural and linguistic barriers, along with environmental factors, all contribute to disparities in breast cancer prevention, screening, treatment, and survivorship. Although disparities in breast cancer treatment have been well documented, the associations among race and ethnicity, declining recommended primary treatment (including surgery, radiation, chemotherapy and hormone therapy), and disparity in survival outcomes have been relatively understudied. In the field of pharmacoepidemiology, declining to initiate treatment as recommended by a health care practitioner is referred to as primary nonadherence. Most observational studies of adherence to recommended cancer treatments are limited by their focus on patients who initiate therapy and the outcome of whether patients continue the treatment as directed or discontinue prematurely (ie, secondary nonadherence). The gap in knowledge on primary nonadherence to breast cancer treatment leaves health care practitioners and policymakers with more questions than answers as they attempt to explain why patients from historically marginalized groups, such as racial and ethnic minority groups, are less likely to initiate guideline concordant cancer care.

This study by Freeman et al is uniquely positioned to deepen our understanding of racial and ethnic differences in declination of recommended breast cancer treatment using the National Cancer Database. Freeman et al examined racial and ethnic disparities in treatment declination among patients diagnosed with breast cancer between 2004 and 2020 and the association of treatment declination with overall survival. Multivariable models were used to test for associations of race and ethnicity with declining breast cancer treatment with chemotherapy, hormone therapy, radiotherapy, and surgery when these treatments were recommended and consistent with standard of care. Importantly, the analysis accounted for potential confounding by clinical factors and measured social and structural determinants of health known to impact guideline-concordant cancer care, including type of health insurance, area-level household income, rurality, and type of treatment facility. Freeman et al found that the treatment declination rate was highest for chemotherapy and lowest for surgery, with a significantly increasing trend from 2004 to 2020. American Indian and Alaska Native, Asian and Pacific Islander, and Black patients were more likely to decline chemotherapy, radiotherapy, or surgery but less likely to decline hormone therapy than non-Hispanic White patients. Moreover, racial and ethnic disparities in overall survival differed by treatment decision. Black patients who declined chemotherapy had a higher mortality risk than White patients, while there were no overall survival differences between Black and White patients who declined hormone therapy or radiotherapy.

Patients may decline recommended treatment due to fear, lack of understanding of treatment benefits, cultural beliefs, mistrust in the health care system engendered by a history of mistreatment, or financial or other resource constraints. In an analysis of data from the Surveillance, Epidemiology and End Results Program registries, patients with cancer from racial and ethnic minoritized groups, those living in less affluent areas, and unmarried individuals were more likely to decline recommended curative surgery or radiation therapy. Inequities in access to health care also contribute to lower likelihood of receipt of guideline-concordant cancer treatment for patients from...
historically marginalized groups. Those individuals may face a wide range of barriers to accessing timely and appropriate cancer-related services, including fewer geographically accessible cancer treatment facilities, transportation and language barriers, lack of adequate health insurance and social support, and the financial burden of out-of-pocket expenses and lost wages due to time away from work for diagnostic and treatment visits. The same structural barriers leading to inequities in access to care may also increase the likelihood of declining treatment when it is recommended. The study by Freeman et al\textsuperscript{3} provides important data that expand our knowledge of the root causes of racial and ethnic disparities in treatment declination and overall survival outcomes. The findings suggest that equity-focused interventions are essential to address disparities in treatment and in overall survival among racially and ethnically minoritized individuals with breast cancer. Such interventions could include culturally tailored patient education on treatment benefits, improved patient-clinician communication, and shared decision-making.

Understanding why certain patients decline recommended cancer care is a health equity imperative but presents several challenges. Ethical considerations arise because patients have the right to refuse treatment, making it difficult to explore their reasons without infringing on their autonomy. Factors such as patients' beliefs, values and emotions, cultural norms, social networks, and financial circumstances play significant roles in decision-making, but capturing and analyzing these factors objectively can be complex.\textsuperscript{4} Data availability is another hurdle, as cancer care is often fragmented and delivered across multiple health care settings, with limited systematic collection and integration of patients' treatment decisions and outcomes. Bias and stigma experienced by patients diagnosed with cancer who decline treatment may also discourage their participation in research or disclosure of their reasons for declining recommended treatment.\textsuperscript{6} Furthermore, the sample size and generalizability of findings may be limited, making it challenging to draw conclusions applicable to other populations or contexts. Freeman et al\textsuperscript{3} overcame several of these challenges in their analysis of contemporary data from a nationwide sample of patients with breast cancer, and the findings from this study should spur further research to close this knowledge gap.

These data from the National Cancer Database confirm an association between adverse social determinants of health and declination of recommended breast cancer treatment. Freeman et al\textsuperscript{1} found that patients who lacked health insurance coverage and those with Medicaid coverage were consistently more likely to decline all 4 recommended breast cancer treatment modalities compared with privately insured patients or those with managed care coverage. Consistent with that finding, patients living in areas with lower median household income were also more likely to decline recommended treatment with chemotherapy, radiotherapy and surgery. Policies that may reduce declination while ensuring patient autonomy are essential to address racial and ethnic disparities in breast cancer treatment. To encourage patients to accept recommended cancer care, policies to reduce financial and logistical barriers, such as paid sick leave and universal health insurance with low cost-sharing for financially toxic diagnoses, could be implemented.\textsuperscript{7} These policies would enable patients to choose treatment rather than being forced to forgo care due to financial or logistical barriers to comprehensive cancer care. Culturally sensitive patient education on treatment benefits, improved patient-clinician communication, and shared decision-making should also be prioritized to ensure that all patients, regardless of race or ethnicity, feel empowered to make informed decisions about their care. Ultimately, addressing racial and ethnic disparities in breast cancer treatment declination requires a comprehensive and equitable approach that addresses the social and structural determinants of health that impact access and engagement with cancer care.

This pivotal study by Freeman et al\textsuperscript{3} examining the associations of breast cancer treatment declination, racial and ethnic inequities, and overall survival highlights another paradigm through which underrepresentation in biomedical research limits our understanding of the specific needs, preferences, and barriers across racial and ethnic groups. Overcoming these challenges requires multilevel approaches, ranging from culturally sensitive equity-centered clinical practices to federal and state policies that address the structural barriers faced by historically marginalized groups in accessing and engaging with recommended cancer care.
REFERENCES


