

Re: Structural racism and inequity in cancer clinical trial participation: time for solutions

Craig Underhill , FRACP^{*,1,2,3}, Sabe Sabesan , FRACP⁴, Monica Green , PhD¹

¹Border Medical Oncology Research Unit, Albury Wodonga Regional Cancer Centre, Albury, NSW 2640, Australia

²University of NSW School of Clinical Medicine, Rural Clinical Campus, Albury, NSW 2640, Australia

³John Richards Centre for Rural Ageing Research, Latrobe University, Wodonga, VIC 3690, Australia

⁴James Cook University Clinical School, Townsville University Hospital, Townsville, QLD 4810, Australia

*Corresponding author: Craig Underhill, FRACP, Border Medical Oncology Research Unit, Albury-Wodonga Regional Cancer Centre, 201 Borella Road, Albury, NSW 2640, Australia (craig.underhill@bmoresearch.org).

We welcome the editorial by Pal et al.¹ accompanying a report by Guamendez et al.² describing the relationship between social determinants of health and clinical trial participation in Black and Latinx people with cancer in the United States. This is an important discussion to start to address inequity, improve access to clinical trials, and improve health outcomes. Pal et al. divided practical solutions into two categories—cancer center trial site and trial sponsor—but we suggest some additional practical strategies and believe that a third category could be added: community-based strategies. Further, the acknowledgment of First Nations people as a distinct group requiring tailored strategies is critical in any discussion of structural racism and inequities in cancer clinical trial participation.

Possibly the most impactful center-level strategy to support improved access to clinical trials especially for rural patients, not addressed explicitly in the editorial, is the use of telehealth. Models of care using telehealth to conduct clinical trials, called teletrials or decentralized clinical trials, are well described and supported by special societies and US Food and Drug Administration (FDA) guidance.^{3,4} They are an important tool in improving access to clinical trials for underserved populations.⁵

An additional practical solution at a trial sponsor level could be to formally incorporate teletrials in protocols and set quotas for the recruitment of rural or socioeconomic disadvantaged populations to clinical trials. Although policies (such an FDA diversity plan for clinical trials) encourage improved access, government agencies could go a step further and set mandated quotas as part of funding mechanisms for clinical trials.

Pal et al. refer to trial centers investing in community engagement, but we suggest going further and including a third important category for addressing clinical trial participation: community-based initiatives. Work conducted in Australia and Aotearoa/New Zealand has highlighted the importance of engaging First Nations populations in a culturally safe way, and these principles are likely to apply to other populations.^{6,7} Alongside community engagement, important initiatives/steps include co-design of clinical trials, community education and promotion of the benefits of participation, investment in the relationship between the team and community, support for the

local team, and addressing data sovereignty concerns. Following a strengths-based approach would require a shift in thinking from sponsors—for example, by privileging Indigenous methodologies during co-design and adopting culturally appropriate ways of working. This could include community visits to raise awareness and build relationships of trust and safety as important first steps.

As stated in the editorial, studies on barriers to participation among First Nations populations in Australia and Aotearoa/New Zealand highlight the need to remove strict trial recruitment requirements from trial protocols, such as allowing investigators to “judge” participants’ suitability to participate, match trials with prevalent tumor types, plus the importance of telehealth. Partnering with community, especially underserved groups, to co-design solutions to structural racism and inequity in cancer trial participation is fundamental, as is making change at cancer center and sponsor level. The journal and the authors are to be congratulated for highlighting this important issue.

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Conflicts of interest

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Data availability

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