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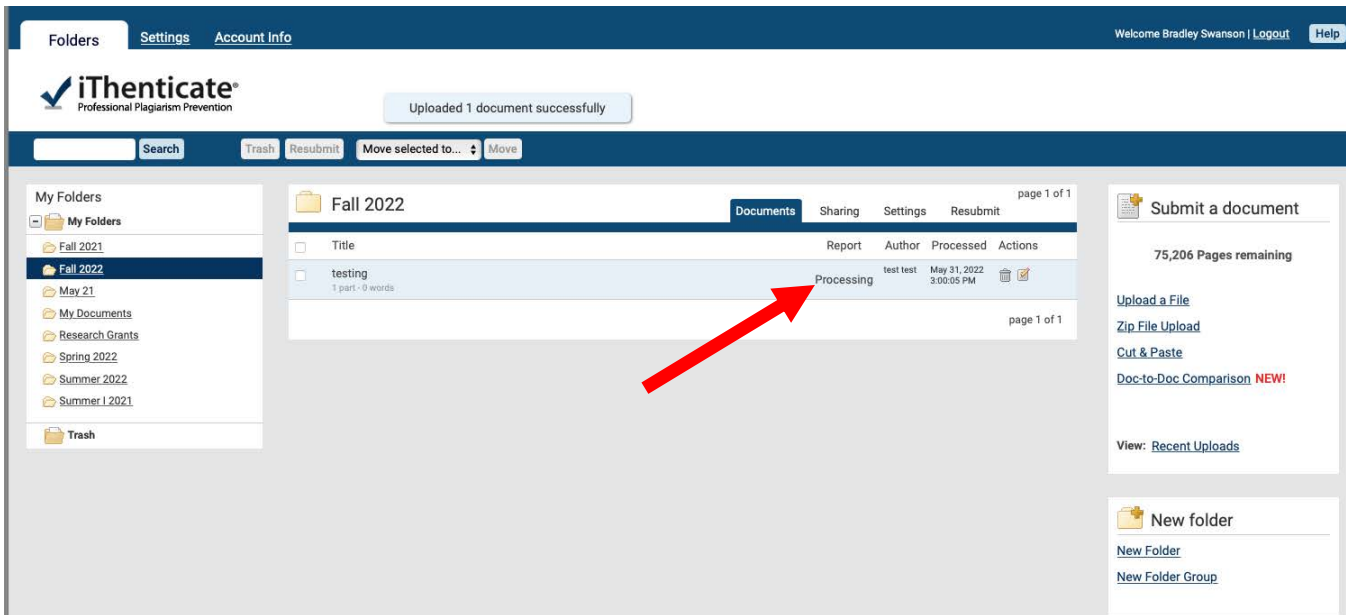
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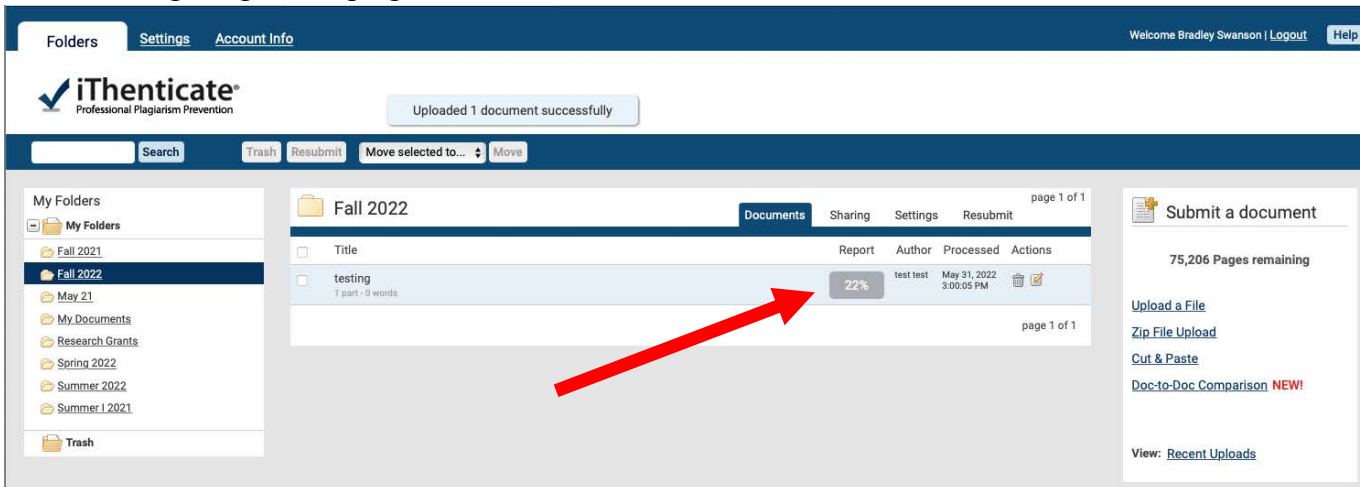
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Examples of things which would not be considered plagiarism by the OGS.

adults to participate successfully in the economy and modern society of the 21st century (Hogan et al., 2016; PIAAC, 2009). The study assessed the new labor force's essential adult skills, that is, necessary adult literacy skills in the modern labor force. PIAAC also measured individuals' ability to use computer and web applications to find, gather, and use the information and communicate with others (Hogan et al., 2016; OECD, 2019). The PIAAC used a "Job Requirements Approach" to ask employed adults about the types and levels of several specific skills used in the workplace (OECD, 2019; PIAAC, 2009). These skills included literacy skills on the job, as well as physical skills, people skills, and information technology skills (National Research Council, 2012; OECD, 2009; OECD, 2013; PIAAC, 2009). PIAAC inquired about the adult participants' main job requirements regarding the intensity and frequency of using cognitive skills (PIAAC, 2009). PIAAC also implemented laptop computers to administer an international assessment, however, some adult participants used the paper-pencil version of the evaluation if they were unable or refused to take the computer assessment (Holzer & Herman, 2015; Kanter, 2009).

In this study, as mentioned earlier the author uses the PIAAC and Survey of Adult Skills interchangeably. As such, the Survey of Adult Skills is a derivative of the Program for International Student Assessment (PISA) (Kirsch & Lennon, 2017; Kocor & Worek, 2016; National Research Council, 2012; OECD, 2009; OECD, 2013; Patterson & Paulson; 2016; PIAAC, 2009; Ruhose et al., 2019). However, the PISA and the Survey of Adult Skills use different pedagogies. For instance, PISA focuses on assessing 15-year-old school pupils' scholastic performances specifically in mathematics, science, and reading (NCES, 2019; OECD, 2009; OECD, 2013). Also, PISA explores how pupils can improve their learning, how teachers can improve their teaching, and how the schools can improve their operations (OECD, 2013). The Survey of Adult Skills (which constitutes the focus of this paper) pertains to how adults develop literacy skills, how adults use literacy skills, and how adults gain knowledge and experience using literacy skills (Kirsch & Lennon, 2017;

racial/ethnic groups, with non-Hispanic Whites more likely to be enrolled in clinical trials than African Americans and Hispanics. Moreover, Duma et al. (2018) observed a decrease in African American and Hispanic enrollment compared with data from 1996.

To address these disparities, the NIH Revitalization Act of 1993 (National Institutes of Health (NIH), n.d.) mandated the inclusion of women and minorities along with a plan for outreach and recruitment on all NIH-sponsored clinical trial sites. However, only 2% of National Cancer Institute trials had enough minority subjects to meet the Act's requirements. Additionally, only 13.4% of these studies reported results by race or ethnicity, which shows that NIH regulations and congressional mandates failed to significantly improve enrollment or reporting of race-related outcomes (Chen et al., 2014).

In response to the failure of the NIH regulations to improve enrollment and reporting, the Food and Drug Administration Modernization Act of 1997 (FDAMA) sought to address the reporting aspect by requiring trial registration in a public portal so that the organizers of the trials could be held accountable for upholding the required equity standards (Jackson, 2009). More specifically, the National Institutes of Health (NIH) was mandated under Section 113 of FDAMA to provide a public information portal on certain FDA-regulated clinical trials. FDAMA 113 mandated that the register include information concerning clinical studies that were nationally or privately funded.

In response to the failure of the 1993 NIH Revitalization Act, the FDA attempted to address the demographic aspect of the problem with its 2014 Action Plan to improve demographic data collection and dissemination in clinical trials. However, despite this Action Plan, fewer than 2% of more than 10,000 cancer clinical trials funded by the National Cancer Institute focused on a racial/ethnic minority (Nazha, 2019). One central issue is that the NIH Revitalization Act of 1993 only regulates NIH-funded trials. Clinical Trials can be sponsored by the pharmaceutical industry, academic medical centers, specialized volunteer groups,

Hispanics/Latinos, Asians/Pacific Islanders, and African Americans. This emphasizes the importance of racial/ethnic minority involvement in therapeutic trials for liver cancer.

Statement of the Problem

Liver cancer is highly fatal, and rates of liver cancer deaths in the U.S. are increasing faster than any other kind of cancer, having doubled since the mid-1980s (Islami et al., 2017). In 2017, it was approximated that liver cancer accounted for 29,000 cancer deaths and 41,000 new cancer cases in the U.S. (Islami et al., 2017). Furthermore, there are disparities in liver cancer occurrence and mortality rates according to race in the United States. For example, according to Muhimpundu et al. (2021), liver cancer incidence rates are higher among African Americans at 10.2 per 100,000 persons compared to Whites at 6.3 per 100,000 persons. Salvatore et al. (2019) added that in the United States, non-Hispanic Whites have the lowest occurrence rate of liver cancer among all racial/ethnic groups.

In general, racial/ethnic minority groups in the United States are underrepresented in clinical trials (Ailawadhi et al., 2018; Duma et al., 2018; Loree et al., 2019; Nazha et al., 2019; Regnante et al., 2019). Evidence suggests that among the 2,896 patients enrolled over the past twenty-plus years, only 18% were non-White (Ailawadhi et al., 2018), and African American patients constituted less than 4% of all the patients enrolled across multiple clinical trials (Loree et al., 2019; Nazha et al., 2019). Loree et al. (2019) evaluated proportional race representation in landmark trials supporting U.S. Food and Drug Administration (FDA) oncology drug approvals, and found that among the 230 trials with 112,293 participants, African Americans and Hispanics were underrepresented compared to Whites. Duma et al. (2018) explored the representation of racial/ethnic minorities in cancer clinical trials by analyzing the enrollment data from all therapeutic trials reported as completed in ClinicalTrials.gov from 2003 to 2016. They found that of 1,012 clinical trials, 31% reported ethnicity with a total of 55,689 enrollees, and participation varied significantly across

researchers focused on populations commonly identified and referred to as racial/ethnic minorities in the United States, including African Americans, American Indians, Alaska Natives, Asians, Native Hawaiians, and other Pacific Islanders and Hispanics/Latinos. Zavala et al. (2021) claimed that despite substantial progress in understanding the factors underlying cancer health disparities, marked inequalities persist. They provided a review of the cancer disparities experienced by rural racial/ethnic minority groups. In this review, there were several recommendations made to advance research and reduce cancer health disparities. Namely, this included developing and sustaining diverse groups that aid in collecting data used for future clinical trials. The researchers also recommended implementing changes to healthcare coverage to ensure equity in access for all minorities and utilizing culturally appropriate community outreach programs to increase cancer screening, among others. Additionally, Zahnd et al. (2021) found that rural African Americans and American Indian/Alaskan Native populations experienced greater poverty and lack of access to care, which put them at a greater risk of developing cancer and experiencing poorer cancer outcomes in terms of treatment and survival. Poverty was further linked to potential factors of lung cancer incidence and mortality, including genetic, epigenetic, and second-hand smoke exposure for racial/ethnic disparities. The authors referenced a 2018 study on second-hand smoke, which was found common among blacks and persons living below the poverty line, in that study's results.

A study conducted by Zahnd et al. (2021) observed that rural minorities, including African Americans and American Indians, face greater poverty and lack of access to care, making them vulnerable to developing cancer and experiencing poorer cancer outcomes in treatment and eventually survival. They experience a greater risk of cancer and encounter poor cancer treatments and outcomes, as well as low rates of survival. Based on the study finding, the authors recommend that it is imperative to develop and implement policies at all

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the efficacy of countries in developing literacy skills through successive generations. The gains made in some countries illustrate the pace of progress that is achievable (Coben & Alkema, 2017; Holzer & Lerman, 2015; Kanter, 2009; Kirsch & Lennon, 2017; Kocor & Worek, 2016; National Research Council, 2012; OECD, 2009; OECD, 2013). For example, Korea is among the three lowest-performing countries when comparing the skills proficiency of 55–65-year-olds; however, compared to 16–24-year-olds, Korea ranks second only to Japan (National Research Council, 2012). Similarly, older Finns perform at around the average among the countries taking part in the Survey of Adult Skills while younger Finns are, together with young adults from Japan, Korea, and the Netherlands, today's top performers (OECD, 2013). However, this progress has been highly uneven across countries. For example, In England/Northern Ireland (UK) and the United States, improvements between younger and older generations are barely apparent (OECD, 2013). Young people in these countries are entering a much more demanding labor market and are less prepared than retiring adults (OECD, 2013). England/ Northern Ireland (UK), on the other hand, is among the three highest-performing countries in literacy when comparing 55–65-year-olds; but England/ Northern Ireland (UK) is among the bottom three countries when comparing literacy proficiency among 16–24-year-olds (OECD, 2019). Innumeracy, the United States performs around the average when comparing the ability of 55–65-year-olds but is lowest in numeracy among all participating countries when comparing 16–24-year-olds (OECD, 2013; Yu et al., 2019). Of course, the survey data are results from a cross-culture of populations, not cohorts, so some of the observed differences across generations are attributable to changes in the composition of people, such as increased social diversity, income inequality or migration, or to different rates with which skills depreciate with age (OECD, 2013). At the same time, the fact that socio-economic patterns explain part of the observed changes is little consolation to countries whose economic success depends on the quality of their actual labor force, not the hypothetical labor force that they might have had in a different context (National Research Council, 2012; OECD, 2009; OECD, 2013; Kirsch & Lennon, 2017).

the data does not show any relationship between a country's average literacy skills and the impact of social background on those skills, thereby, suggesting that high average proficiency does not need to come at the expense of social inequities (OECD, 2019). Japan, and to a lesser extent Australia, the Netherlands, Norway, and Sweden, combine above-average performance with a high level of equity (OECD, 2013). Besides, France, Germany, Poland, and the United States all show both below-average performance and large social disparities (OECD, 2013). The fact that countries with the most significant social inequities in the OECD Program for International Student Assessment (PISA) are also those with low rates of social mobility, as observed in the Survey of Adult Skills (Kirsch & Lennon, 2017; Kocor & Worek, 2016; National Research Council, 2012; OECD, 2009; OECD, 2013). More specifically, according to reports, in Korea and the United States, the relationship between socio-economic background and skills proficiency is much weaker among younger adults than among older adults (National Research Council, 2012; OECD, 2009; OECD, 2013). Also, the relationship between parents' education and skills proficiency varies across generations (National Research Council, 2012; OECD, 2009; OECD, 2013; PIAAC, 2009). For example, in Korea and the United States, the relationship between socio-economic background and skills proficiency is much weaker among younger adults as compared to amongst the older adults (OECD, 2013), and in contrast, for Australia and the Slovak Republic, the reverse is true (OECD, 2019). In some countries, improvements in access to and the quality of education for individuals from disadvantaged backgrounds have weakened the relationship between socio-economic background and skills proficiency among younger adults (Kirsch & Lennon, 2017; Kocor & Worek, 2016; National Research Council, 2012; OECD, 2009; OECD, 2013; PIAAC, 2009; Rammstedt et al., 2017). In other countries, reportedly, how skills are developed and used later in life may reinforce initial social disparities (OECD, 2013; PIAAC, 2009). For example, in some contexts, access to school may be closely related to social background. Simultaneously, following skills development may primarily reflect an individual's ability, irrespective of their

Ailawadhi et al. (2018) conducted a study that examined the link between clinical trial participation and cancer outcomes for minorities. These researchers evaluated the impact of patient race and ethnicity in pooled data from nine large national cooperative group clinical trials in patients with newly diagnosed multiple myeloma. Multiple myeloma is an incurable hematologic malignancy with disparities in outcomes noted among racial/ethnic subgroups due to disparities in access to effective treatment modalities. The authors found that among 2,896 patients enrolled for more than 20 years, only 18% were non-White, and enrollment of minorities decreased from 2002 to 2011. The study also revealed that African Americans with myeloma were typically younger and exhibited higher risk factors, including anemia and increased lactate dehydrogenase. Hispanics also had the smallest proportion of patients in trials utilizing novel therapeutic agents. The study concluded that while there are significant disparities in multiple myeloma incidence and outcomes among patients of different racial/ethnic groups, this disparity could be mitigated by access to appropriate therapeutic options provided by clinical trials.

The work of Nazhan et al. (2019) provides another example of this. These researchers examined the impact of the disparity in clinical trial participation by minority patients receiving cancer immunotherapy. The authors revealed that enrollment in pivotal trials leading to the United States' regulatory approval of immune checkpoint inhibitors showed a poor representation of racial/ethnic minority groups. Specifically, African American patients constituted less than 4% of all patients enrolled across multiple trials that supported the approval of immune checkpoint inhibitors for lung cancer treatment. The study also found similar underrepresentation for trials conducted on renal cell carcinoma and other tumor types. The authors recommended using predictive biomarkers to track disease progression in order to identify responders and new strategies to expand the benefit to a more significant subset of patients. Results of the study also suggest that the inadequate representation of

the diet during the study. The study included controls with non-diabetic people in the normal range for HbA1c (e.g., non-hypoglycemic) and normal weight and BMI ranges. The non-diabetic participants would not likely experience a significant decline in Hb1Ac after weight loss. The healthy individuals had well-controlled blood sugar due to normal pancreatic function and gluconeogenesis by the liver during fasting. [These opposing processes maintain blood sugar in healthy ranges for people under conditions other than starvation (Hatting et al., 2018).] Thus, typical healthy regulation of blood sugar can remain in a much tighter range for non-diabetic participants than for T2DM patients, which supports the finding that weight loss for T2DM patients likely contributes to the significant lowering of HbA1c.

Lincoln et al. (2014) used multinomial logistic regression and data from the National Survey of American Life to examine the relationships between race, ethnicity, and sociodemographic factors to the joint classification of body mass index categories and depression among African Americans, Caribbean Blacks, and non-Hispanic Whites. The National Survey of American Life data included a national household probability sample of 3,570 African Americans, 1,621 Caribbean Blacks, and 891 non-Hispanic Whites recruited between February 2001 and June 2003. The results of the study indicate African Americans (35.42%) were more likely to be obese than Caribbean Blacks (25.13%) and non-Hispanic whites (26.69%). In addition, women were more likely than men to be obese (35.37% vs. 25.48%); however, if not obese, men are more likely than women to be overweight (40.19% vs. 26.47%).

Mirabelli et al. (2019) studied the relevance of obesity and weight management related to T2DM. In their study, Mirabelli et al. sampled 40 Italians in southern Italy who had diabetes and

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