Cancer Disparities Symposium Issues Call to Action

The need to move from awareness to action, from documenting inequities to addressing them, reverberated across the 8th Annual Cancer Disparities Symposium, held virtually on April 23.

The event's focus on lung cancer disparities was particularly timely given that it came just days after the conclusion of a nationally watched trial involving the constriction of a Black man's ability to breath. "Whether we are undergoing lung cancer treatment or living in neighborhoods where air quality monitoring is subpar, or if our airways are being compressed by another human being, they all result in our inability to enjoy respiratory health," said Karen Burns White, deputy associate director of the Initiative to Eliminate Cancer Disparities, in her opening remarks. "We are in an era where we must not only pay attention to social injustices, we must take definitive action."

The steps that individuals and organizations can take to end disparities in lung cancer carried into panel discussions on prevention and treatment and into the keynote speech by Ray Osarogiagbon, MBBS, FACP, chief scientist at Baptist Memorial Health Care Corporation and director of the Multidisciplinary Thoracic Oncology Program at the Baptist Cancer Center in Memphis.

Osarogiagbon's talk dealt with one of the prime paradoxes of the U.S. health care system as it relates to the delivery of lung cancer care. Known as Tudor Hart's inverse care law (for the Welsh physician who proposed it), it states that the availability of good medical care varies inversely with the need for it in the population served. Poor and marginalized groups, who suffer disproportionately from many health disorders, often face the greatest obstacles to quality treatment.

"In my definition, disparities are avoidable differences in incidence, care, and outcomes of disease," Osarogiagbon said. "In my observation, they often emerge or worsen with discovery: As long as we don't know what treatment works, everybody has a similar outcome. The moment something is found to be of benefit, it's the usual people who seem to be able to get it before everybody else."

The traditional, descriptive focus of health disparities research – identifying groups who fare worse than others – is useful but tends to create an "atmosphere of victim blame," Osarogiagbon continued. The thinking seems to be, "We know what works, there must be something wrong with you. Why can't you gain access to it?"

In place of demoralizing the very groups that most need help, Osarogiagbon advocated for an approach that deals with the institutional and social determinants of health care. Borrowing a Biblical phrase, he asserted, "We need to get past faith and get to works. We need to focus more on interventions. For this, we need more understanding of why disparities happen and at what levels they happen so we can overcome them."

With a series of examples, he showed that social and institutional factors account for a far greater portion of cancer disparities than individual factors do – and therefore have the most potential for relieving those disparities. He and his colleagues at Baptist Cancer Center used a national database to study outcomes in patients who had undergone surgery for lung cancer. They found that regardless of patients' differences, those treated at academic medical centers had better results than those treated at community hospitals.

In another study, Osarogiagbon's group compared outcomes in patients treated in rural and urban hospitals in Baptist Memorial's service area of the deep- and mid-South. "We found that receiving care at a rural hospital led to significantly worse outcomes than receiving care at an urban hospital, irrespective of whether patients resided in a rural or urban area," he said. "It's not about the individual; there's something that providers' health care systems are doing that drives care and outcome disparities."

Knowing the source of disparities can inform decisions of how to remedy them, he continued, citing an example from Baptist Memorial. Beginning in 2015, the organization launched a lung cancer screening program in the metro Memphis area and

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simultaneously began an "incidental lung nodule program," in which patients who'd had a CT scan for any reason and were found to have a cancerous or potentially cancerous growth would be monitored and tracked.

"Over the last five years, the number of patients coming through the nodule program was three times the number for cancer screening," Osarogiagbon said. Even more striking, "the screening program has identified 140 patients with lung cancer in the last five years, while the nodule program has identified about 700. For every one identified in the screening program, we've found five through the nodule program."

The Institute's cancer disparities symposium is held each year in the third week of April, which is National Minority Cancer Awareness Week. It is sponsored by Dana-Farber's Cancer Care Equity Program and the Dana-Farber/Harvard Cancer Center Initiative to Eliminate Cancer Disparities.

This year's symposium, held at a time of national reckoning with racial issues, gained significance in the context of that reckoning, said Dana-Farber's Christopher Lathan, MD, MS, MPH, faculty director for the Cancer Care Equity Program, who introduced Osarogiagbon. "The collective unveiling of the structural racism and the socioeconomic caste system that impacts cancer care for marginalized communities has allowed others to see clearly truths that have been hazy before," he said. "These problems won't go away with good science and nice thoughts but will instead require definitive action and will over time to correct."

— by Robert Levy