Closing the Gap

Researchers believe specially designed cancer care programs could prevent Black patients from being lost to care.

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When African Americans receive bad treatment from the staff at a doctor's office, they are often unsure whether it's because the staff is uncaring or racist. But conscious or unconscious biases against people of color can help to drive disparities in care that result in worse outcomes for minorities. Experts have been aware of this problem for 20 to 30 years, according to Samuel Cykert, MD, a professor of medicine at the University of North Carolina Chapel Hill School of Medicine, which is why he decided to team with the Greensboro Health Disparities Collaborative to conduct research on how to ensure Black patients are given the same quality care as their white counterparts.

Cykert chose to study non-small-cell lung cancer, the most common form of the disease and a notorious killer that claims a disproportionate number of African-American lives. "If a patient isn't treated for lung cancer, then—even if it's early-stage lung cancer—about a third of those patients die within a year, and everyone dies within four years," he says. "So people better have a really good reason not to get treated."

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Previous studies on black-white bias accounted only for insurance status, age, comorbidities (illnesses that occur with other conditions) and income in their data, says Cykert. "Even with all those factors controlled for, Black patients were still getting less treatment than white patients," Cykert says. "That kind of bothered me. I really wanted to get at some of the true components of why there were still racial differences despite controlling all those other things."

According to the annual National Healthcare Quality and Disparities Reports, persistent racial and ethnic disparities may be the result of various factors, including unequal systems of health care between states, medical providers and clinicians. None of these factors bode well for the health outcomes of minorities.

In health care settings, implicit bias occurs when medical professionals make judgments and decisions based on stereotypical beliefs they've internalized about their patients. "Implicit bias exists, and it's something that we all have to be aware of in our decision-making when we're taking care of patients who aren't necessarily like us," Cykert says.

For his study, Cykert and his research team enrolled almost 300 Black and white patients ages 18 to 85 with early-stage breast or lung cancer in an intervention program. Patients were recruited at two cancer centers between April 2013 and March 2015.

The scientists organized a registry from electronic health records that delivered alerts about appointments missed, recommended tests and surgeries not completed, and radiation and chemotherapy treatments not received for each person.

Nurse navigators trained in standard health care procedures were assigned to half the patients in the intervention group. Another group of nurse navigators who had attended racial sensitivity training supervised the other half of participants.

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When the system flagged nurses about patients experiencing different issues with their therapy plans, these navigators would redirect them to care.

For example, some patients feared the cost of cancer care so much that they dropped out of treatment.

“That’s when the real-time registry basically tells the care team that the patient disappeared and needs to be reengaged,” Cykert says. “Then the navigator is prepared to deal with the patient on financial issues and figure out ways through the system so that person’s cancer care is covered.”

Sometimes, care providers failed to initiate or intensify therapy when indicated. “For these kinds of situations, the real-time registry also had programmed warnings about missed milestones of care so that these issues could be addressed through enhanced awareness of the clinical team,” Cykert says.

When nurse navigators used the intervention tools that identified patients who needed assistance to complete their treatment regimens, both groups performed equally well.

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In addition to the nurse navigators, the study also included physician champions, local oncologists who acted as liaisons between patients’ doctors and their nurse navigators to address conflicts that affected care.

“Obviously, when you have a doctor dealing with a nurse, sometimes you run into issues of authority and power,” Cykert explains. “But by having the physician champion on board, the nurse navigator had the support to go ahead and bring those issues forward without any kind of negative thought.”

When the study ended, results showed that almost 89% of Black patients participating in the intervention completed treatment compared with African Americans in two control groups. Just

80% of those in one group finished their cancer therapy, and only about 83% of those in the second set of patients with Stage I or II breast and lung cancer completed treatment.

Realistically, eliminating or minimizing bias in health care begins with the training doctors receive in school.

“Although medical schools are doing a much better job telling students about health disparities, especially in early courses and when people are doing classroom work, they aren’t as good at pointing it out during the years when students are doing their clinical rotations,” Cykert says. “I think there really has to be some faculty development where the teachers are also aware of implicit bias and pointing it out where it might be occurring.”

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Established organizations such as the American Medical Association and others are encouraging physicians to consider how they can address the problem in their own practices.

Some medical institutions offer doctors a health disparities tool kit that features interviews with both health providers and patients as well as information on, for example, cultural competency and literacy to help physicians work alongside other medical professionals and patients to end racial and ethnic disparities.

Cykert’s goal is to eventually launch racially and culturally sensitive intervention programs in cancer care systems around the country. He believes the first step is to convince health systems to conduct assessments to determine whether patients of color are receiving the same care as white patients.

“As doctors, we tend to be idealistic, and we assume that we are blind to issues of color,” he says. “But even though we are idealistic, we have to understand that, historically, institutions don’t work as well for Black patients, who are starting from a point that’s behind white patients.”

Cykert says that because cancer care centers often don’t break down their data according to race, these institutions are largely unaware of potential inequities. In addition, their electronic health record systems aren’t programmed to provide information that could help follow patients closely enough to keep them from slipping out of treatment. “You have to know what you want to program and spend the money because electronic health records are generally primitive,” he observes.

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Cykert is optimistic that cancer centers will implement these types of strategies as long as they’re supported by grants. “Most of the centers that have participated are now taking active steps to build our registry into their systems,” he says.

“There hasn’t been any overt resistance to doing this kind of work,” Cykert continues. He explains

that, despite competing priorities and interests in health care at this moment in time, providers are putting effective cancer intervention programs such as the one that was the focus of his study at the top of their list of things they need to do to optimize care.

Some Good Advice

If you don’t smoke, don’t start.

According to the American Cancer Society, an estimated 25,390 cases of lung cancer are expected to be newly diagnosed among Black people in 2019. The illness is the leading cause of cancer death among African-American men and women, and most individuals first learn they have the disease at more advanced stages, when survival rates are much lower.

Lung cancer is most often caused by smoking. If you smoke around family members, they can also develop lung cancer from secondhand smoke.

But the good news is that your risk for lung cancer decreases when you quit smoking, no matter how long you’ve smoked.

If caught in its early stages, lung cancer can often be treated or even cured with surgery and medications. This is why screening is extremely beneficial.

Preliminary examinations for lung cancer may include chest X-rays and saliva tests.

These exams help folks to avoid more invasive tests, such as biopsies.

A screening technology called low-dose computerized tomography (CT) may benefit those who are at high risk for lung cancer. Experts recommend annual CT screening for people ages 55 to 80 who are current or former heavy smokers.

Many African Americans are unaware of CT scans, but public health nurses can play a key role in increasing community awareness about this effective method of screening.
