

# Unequal Burden: Understanding the Roots of Health Disparities in Cancer Care



## CMEO Podcast Transcript

### **Karen Peterson:**

Good evening. Hello. I am Karen Peterson. And on behalf of the CME Outfitters, I'd like to welcome you to today's educational activity, titled "Unequal Burden: Understanding the Roots of Health Disparities in Cancer Care." Today's program is supported by an educational grant from Bristol Myers Squibb and Merck, Sharp, & Dohme Corporation. Today's activity is brought to you by the CME Outfitters, an award-winning, jointly accredited provider of continuing education for clinicians worldwide. I want to also encourage everyone to join us today at CME Outfitters. Let me first introduce myself again. My name is Karen Peterson. I'm the founder and chief patient advocate of Karen's Club. It's a grassroots non-profit organization where we educate and support patients of color around all things clinical trials. And I'd like to introduce our first faculty member, Dr. Bradley Carthon, associate professor in GU medical oncology at Winship Cancer Institute, Emory University Hospital in Atlanta, Georgia. Welcome Dr. Carthon.

### **Bradley Carthon:**

Thank you, Karen. Thanks so much for having me.

### **Karen Peterson:**

Thank you so much for being with us today. In addition to that, we have Dr. Patel, assistant professor, division of oncology at Stanford, California, and staff oncologist at the VA Palo Alto Health Care System in Palo Alto, California. Hi, Dr. Patel. It's so nice to see you.

### **Manali Patel:**

Nice to see you too. Thanks for having me.

### **Karen Peterson:**

Thank you so much. The learning objective for tonight's activity is to recognize factors contributing to health disparities in the cancer care continuum and their impact on patient care. Of course, let's just start with the stats and what we actually do know and the top leading cancer cases and deaths. We're all seeing what's going on and what the most common and lethal cancers sorted by male and female cancers, breast and prostate are the most common in women and men followed by lung and colorectal. In terms of lethal, lung cancer kills most people each year followed by breast, prostate, and colorectal.

And so the AACR puts out a report every year. It's called the "Cancer Disparities Progress Report." And the last one they put out was in June on June 8th. And here's a slide that represents some interesting stats in regards to cancer burden disparities for racial and ethnic minority groups in the United States. If we look deeper into the data, we can see that the incidences of and mortality from each cancer type varies by ethnicity and in some cases quite widely. And when I look at this and I look at this last column all the way to the right, and I look at the stats

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for non-Hispanic/Blacks, we lead across categories in mortality rates, except for liver, bile, and kidney and renal. And those are some interesting stats. Dr. Carthon, you've looked at the data extensively. What do you think about the ethnic differences?

## **Bradley Carthon:**

Well, I think it highlights a pervasive and prominent problem across the country. It is one thing when you have one type of cancer that disparately affects a group, but when you have so many different sites of cancer affecting people of color, it really makes you think about things that are common across all of those sites. And indeed, there are really a number of things that play a role in this. It's not just biology, but also access, insurance coverage, implicit bias, care relationships. It really highlights a pervasive problem. And I think that it's bigger than just one thing or another. And interestingly, when we look at examples, for example, prostate cancer, with the most common type of cancer in men, we see that Black men are almost two times as likely to die from this disease and 5% higher rate of a diagnosis when you look at all of the patients involved in that. And that is one out of six for Black men, one out of eight for white men, but that's greater than 2,500 extra deaths a year for Black men that are diagnosed.

And so we think about this, well, what are the reasons why this happens? Is it because of just worse biology in certain groups? Is it because of care availability? And I think a part of it really is early portions, early portions of things such as screening. What this slide is showing here is that there are certain groups that just don't do as well when you look at screening. Young folks tend to not follow those screening recommendations. African American or Black and Hispanic patients have less issues or less access to screening. And then when we look at education, that seems to play a role in gaps with screening. And so undoubtedly, this plays a role and we have data on when the PSA screening test for prostate cancer was brought forth, that it makes a difference in the number of patients that are diagnosed and how they do. It's not just prostate cancer. What about breast cancer screening with mammograms?

We see that there are indeed certain groups, younger patients, patients that actually are of Asian and Hispanic ethnicity, have decreased rates. Interestingly, Black women have gotten the word out and they do mammography screening, but education plays a role. And those that have less schooling, have lower rates of screening for breast cancer. This is a problem that is pervasive and ways to think about that can help. Including colorectal cancer, once again, young folks are not doing the screening as recommended. And once again, we see differences with Blacks and with Hispanic patients and those with less education. These are all things that we need to consider when thinking about that. What are some ways that this may be looked at with regards to lung cancer?

Well, we know that screening works. And so just like changes with prostate cancer, mortality are decreased with screening, even with lung cancer screening. And this is a trial looking at racial differences for lung cancer-specific mortality in patients undergoing low-dose CT scans. And it was shown that the risk of death was higher in Black patients, almost twice the risk younger patients. The Black patients were younger. They had more comorbidities and were less educated and that utilizing the screening modality, decreased death, but regular chest x-rays did not. And so it highlights the importance of good access to health care screening and care.

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## **Karen Peterson:**

Thank you so much for that, Dr. Carthon. And there's a question that came in and I think it's pretty relevant and it says: Are there biologic or environmental factors such as toxin exposures that lead to cancer subtype differences between the ethnic populations?

## **Bradley Carthon:**

Well, we have some good data on that. And the key point is that all the cancer diagnoses are so different. Some things are clearly related to exposure, for example, smoking. We know that smoking is risk factor for a number of cancers, including lung cancer and bladder cancer. And we know that folks that are exposed either directly or secondhand have higher rates, but it's not just that. You can look at all types of backgrounds in a racial demographic, but those with the exposures often will have higher rates. It's always been interesting to me, for example, with prostate cancer, which is my specialty, in that patients from certain areas of the world have markedly lower rates of prostate cancer. But when patients of that ethnic group move to Western society, such as Europe or the United States, their risk increases to that of the demographic that already exists there. Indeed diet, exercise, and exposures through daily living play a role in that.

## **Karen Peterson:**

It's not just about screening when we talk about the differences in participation, is it? When we think about participation in clinical trials, there's been a lot of talk and a lot of initiatives in regards to clinical trial participation amongst people of color and underserved communities, and the fact that there is a huge gap. Dr. Carthon, what do you think about that?

## **Bradley Carthon:**

Yes, there's just so much data on this. And when you look at the population and you look at the rates of participation in trials, it's pretty striking. For example, with prostate cancer patients, African American men make up about 15% of those patients, a little bit more than the general population, but in trials, whether they be pharmaceutical-sponsored trials or cooperative group trials, where different institutions around the country work together to find answers to these problems, there's a marked difference. 15% of the population African American and prostate cancer, about 4% of those patients in pharmaceutical-sponsored trials, maybe about 10% with cooperative group trials. And then for example, with breast cancer, patients of African American background make up about 12% of those patients, but only make up about three to 4% of those patients in pharmaceutical-sponsored trials, about seven to 8% of the patients in cooperative group trials.

We see a difference and that's very notable and likely plays a role in outcomes that are not as optimal. It's interesting. Different groups have been surveyed asking patients and their families what are reasons and things that might prohibit or preclude you from taking part in trials? And mistrust is a small part of things. It's not the only thing, but the risk, the perceived harms, cost, getting back and forth to appointments, not understanding exactly what a clinical trial is, and even the concerns and fears of family members, these are all things that can cause a problem with clinical trial enrollment.

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## **Karen Peterson:**

Dr. Carthon, thank you so much for breaking that down because a lot of times researchers and clinicians are often, they really don't understand or aware of what the patients are actually going through in regards to barriers and trying to access clinical research. But I noticed here that they didn't have on this particular chart, something that I think is really important. And as a patient, as a founder of a nonprofit organization, I had to think about that. And I was like, you know what, I'm going to speak up and really have a conversation about it. I need to spotlight inherent medical bias. And so I know what that's like. I know what it's like to be on the wrong side of things and what it is to be on the right side of things. I know what it's like. And I talk to patients. I talk to other non-profit advocates and the conversation is often that you don't feel valued.

I know what that's like. Or you're not being heard or there isn't active listening taking place. And I know exactly what that's like. I can remember being diagnosed with stage four triple negative breast cancer and going to my original team and asking for genomic testing and thinking about tumor mutational burden and wondering whether or not I could get into a clinical trial. My life was on the line and literally my team shut the door. They didn't want to give me access. But luckily, at the same time, I also had researchers queued up who were willing. And they were educators, not only were they doctors, but they were educators. And they taught me about tumor-infiltrating lymphocytes. And they heard my plea of wanting to make an informed decision and understood how important that was to get access to the tools in order to be able to make those informed decisions. And so when I didn't see medical bias up here, I'm like, it's a huge factor. It really is in regards to care. I feel like it weighs just as heavily as those social determinants. Dr. Patel, what do you think about that?

## **Manali Patel:**

Yeah. Lots of studies have just come out saying that perhaps people are not participating because they aren't asked, that we are not doing our jobs as clinicians, as clinical teams to ask people equitably, if they want to participate. And if we have an under-representation problem, we need to overrepresent certain patient populations. That is our job. I think the other interesting factor is that there's a lot that's on the health systems level in terms of the... The whole concept of trust makes me question, well, what are we in institutions doing to engender that trust? It's on us. It's not on the patient. I think for years we've been downstream thinking about blaming the patient. I always like to think about the biology aspect of, well, the biology is one piece of it, but it's not the whole reason. And if you look at preventable cancers in the United States, I would argue that 80% of our cancers are preventable.

And that means that it's not a biological difference. Yes, there are biological differences that play a role, but perhaps it's these upstream factors like do you live next to major freeways that's causing you to have environmental toxins or do you work in migrant farm worker fields in our farm worker organizations and are exposed to pesticides and that's leading to epigenetic factors and changes in the biology that are due to upstream changes due to structural issues? I'm going to focus on this slide that looks at the fact that there are so many other factors that we talked about: environmental factors, social factors, and these clinical factors in terms of access to health care and quality of health care that we just described. I think one important factor is social factors. And I think if you look back at one of the fundamental reasons for disparities, not only in cancer, but across many conditions, it's poverty.

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And income clearly plays a role in terms of whether or not you can access the treatments, whether or not you live in the right neighborhood so that you aren't inhaling toxins from particular environmental factors. It also impacts whether or not you can attain and achieve employment and whether or not you have to stay employed while you're getting cancer treatment. We just did a study that talked to people and found out that they were continuing to have cancer related burden and symptoms, but had to keep their jobs in order to keep their insurance to pay for their treatment. We know that there's this one to one association with poverty and accelerated cancer death. If you look at the United States, you see that the counties that have the highest poverty rates, guess what? They have the highest death rates from cancer. That association is clear to me. And I think that this graphic representation of what's happening across the United States shows that to be here. Like we talked about, and I think that question asked was the environmental factors, I call it, can I be honest here, white roads through Black neighborhoods.

**Karen Peterson:**

Thank you for your honesty. There was another question that came in and I think it's pretty relevant to the conversation since we're still talking about barriers. It says, what is the contribution of individual social determinants of health to cancer incidents and outcomes?

**Manali Patel:**

Very high contribution. You're talking to someone that feels very strongly about the fact that these self complications from social determinants of health are really the key factor that's underlying why we see that mortality paradox. Why are people dying from cancers that are preventable? And if you look at this particular picture, you can also see representations of our structural barriers. Meaning what is our built neighborhood? Do you have access to healthy foods? Do you have safe environments to be able to conduct physical activity? Again, thinking about the behavioral aspects that contribute to cancer, but then also thinking about what the structural neighborhoods, the structural environment does to inhibit people from engaging in very healthy behaviors. We've looked at where people live. And we've also seen that where you live determines how you do. Social determinants of health, I think, are one of the number one factors for why we see disparities.

**Karen Peterson:**

I also think it's interesting that when you think about participating in clinical trials, 75% of most people who are of color get their treatment from their local clinic. But it seems as if most of the clinical trials are at teaching institutions or at places where it's difficult or how can I say it? It's not as user friendly to go to if you're a patient of color and you've been treated in your community and that's where your trust factor is. And I'm just wondering, is there a way in which we can think heavily about investing in the communities and investing in bringing research into the communities instead of asking and putting the burden on the patient, always asking them to come out of their communities in order to receive top-level care?

**Manali Patel:**

That's a really good question, one that we've been trying to tackle where we are creating mini Karen's, I call them. Karen's all over the place in small communities, one community at a time, and working with community health

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workers, training community health workers, such that the burden is not on the patient, but that then the community health workers that are from the communities know exactly what the problems may be in the communities and are able to help to say to a patient, "Look, there's a clinical trial that would be perfect for you at Winship. You should go there. Here's Dr. Carthon. I'm going to tell you should talk with him and here's what you should ask.

And here are the list of questions that you should ask" and it's culturally tailored, but also in patient's languages, in language preference here. I think that's a big piece. I don't like the idea that equity is local, but it is, and the solutions are local. It's a big policy problem, but it's also a little policy problem and solutions need to be held in the communities with the communities by the communities led by the communities. Not led by us researchers. We don't know what the problems are when we're in our ivory towers, not really stepping foot and may not even live in the same neighborhoods of where our patients are coming from.

## **Karen Peterson:**

Exactly. I think it's time for a polling question if I'm correct. I'd like to explore the issues of why disparities are higher among poor rural states a little more, but right now we are going to deal with our polling question, this interactive question where we can get the audience involved. Here's the question. From 2010 to 2022, what has been the change in the number of rural hospitals in the US? Has it been increased by more than 100, increased by 25 to 100, stayed about the same, decreased between 25 and 100, decreased by more than 100, or I'm not sure. Take a few moments. Think about the question. Look at the opportunities, the answers, and see what happens. It seems as if there are 38% of you that feel that it's decreased by 25 to 100 and the actual answer is close. It is decreased by more than 100. And that affects and has affected some patients. That's real information. Let's move along. Barriers to cancer care among rural communities. Dr. Patel.

## **Manali Patel:**

Yeah. This slide says it all. It just shows how many practices have closed. What's happening to patients? Where are they supposed to go? And then you see that, sadly, the further you live away from a hospital, the worse your outcomes are.

## **Karen Peterson:**

Yeah. I've talked to patients who have gone across the country to stay alive and participate in a clinical trial. And they were so happy to be able to find the same amount of care that was equal, I'll say, on the east coast. And it took the burden off of them and their families. And so it's a hard choice to make. It's a difficult choice to make. And this sometimes discourages patients from participating in clinical trials. It's just the tip of the iceberg though. There are so many other determinants that are just, it can become overwhelming when you think about all of the things, access to health care, liquor stores, bad schools, crime, prison, access to nutritional food, neighborhood quality, education, racism. All these things are social determinants, deciding whether or not a person has access to health care. Here's another question that's come in. And it says, what can faith-based organizations play in increasing diversity in clinical trial enrollment? Dr. Carthon, what do you think about that?

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## **Bradley Carthon:**

Well, we have quite a number of small studies that highlight the partnerships that help with outcomes. And it's really interesting. Whenever we want something approved, we do a large, randomized phase three study. That's the gold standard. But it's really interesting that a lot of the solutions to problems are locally based. Here in Atlanta, we actually work with various institutions and churches and community groups to get the word out, not only about screening, but also about clinical trials and how to navigate a cancer diagnosis. We recently just did a program where we went to the barber shop of a local church, and there were numerous men that were survivors, elected officials, some sports athletes, and the conversation really carried a little bit more weight when people from your own background can speak of these things.

And so maybe this is an opportunity to think about things a little bit differently, and to think from what you would call grassroots or local-based approaches versus the top-down approach that might not work as well in Georgia as it works in Oregon or in Connecticut or Florida. And so we know that the church plays a huge role in the life and culture of many groups. Working together is one way to try to get that word out about screening trials and health in general.

## **Karen Peterson:**

I love that. And I love the fact that it sounds like people were just having an open and honest conversation and to have you there with them where they're at. You met them, where they were at. And that's really important, because again, a lot of times it can be extremely overwhelming to go into an environment and especially if you're under pressure and you're really not understanding, and you're not health literate and to try and go someplace where you've never been treated before. And here you are presenting yourself to researchers and hoping and trying to gather information, it can be really difficult. Again, I think that approach of going into the communities and stepping away sometimes from that top-down approach, it sounds about right. Let's see. Health equity is defined as everyone having a fair and just opportunity to be as healthy as possible, ethical and human rights principles that motivates us to eliminate health disparities. Health disparities are the results of structural racism and marginalization.

If left unaddressed will continue to reinforce social and economic inequities, bias and poor outcomes that affect the society. The current state of affairs for oncology patients of color. And it brings me to the point of the AACR's COVID 19 impact report that was published in February. And it talked about how--And because of the pandemic, there was nearly 10 million missed screenings from January to July 2020. And so when you think about that and they gathered all the information up, the last thing that they said was racial and ethnic minorities and other medically underserved populations, not only shoulder a disproportionate burden of COVID 19, but have also been more affected by pandemic-related disruptions to the cancer care continuum. We were already suffering and we were already having inequities, but then you add COVID on top of it and missed screenings and it's just a startling and difficult situation. Let's talk about solutions. Let's talk about solutions. Dr. Carthon, talk about your therapeutic efficacy for Black patients with prostate cancer in standardized care environments.



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## Bradley Carthon:

And I think the key word there that you highlighted is standardized care and the long and short of it is that if people have similar access, similar support mechanisms, they do just as well. This is a busy slide, but the take home is that each of those lines is a different study and whether it is chemotherapy, whether it is a pill that works on the hormonal levels, if you're talking about immunotherapy, certain types of the immunotherapy using the immune system for prostate cancer, and then even things such as what we call radiopharmaceuticals, where they can take something like a calcium molecule, attach a little bit of radiation to it to go kill cells. All of those agents show similar, if not better, effect in African American patients when given in the same environment. These are studies where they take 50 Black patients, 50 white patients in their office, treat them and see how they do.

Or they take Black patients, white patients, look at them in the VA where things are pretty even and African American and Black patients do just as well, if not better. And so a lot of this really is about making sure that the opportunity is there, standard approaches. We're not going to talk about clinical trials just yet. And we can even talk about things such as biopsies and workups. We know that sometimes there's a gap, meaning people may understand something's wrong, but trying to get in for a biopsy, trying to get in for imaging or things such as that, these are small local solutions that perhaps paint a picture of the way to go. This is a study that was done in Boston, where they looked at same-day biopsies. They noticed that women would have something abnormal on a mammogram, but somehow get lost in the shuffle. And then later on show up in serious trouble.

And so they instituted a same-day biopsy program where patients were able to come in, have imaging if something was abnormal, go ahead and get that situated right then and there, and eliminate a lot of the back and forth, getting back and forth to appointments. It's not just breast cancer. Other ways in which this was addressed, looked at colorectal cancer screening where patients in South Carolina were within a gap. They didn't quite fit for free care, didn't quite have enough for insurance, but patients in that gap were given the opportunity to have a screening and polyps and other diagnoses related to colon cancer were picked up just by making sure that access was there. These are the different counties that highlighted those areas. And once again, making access available for screening can make a difference. We know that looking at interventions and using this evidence to take that to the other parts of the country.

It may work in one area. Having the access in other states can likely have an effect as well. And it's not just prostate cancer. It's not just colorectal cancer. This is another program looking at people that fell into a gap of screening and analyzing follow up for lung cancer screening and how you're able to make a difference in their outcomes. And so these small studies really do show that things can be slightly different based on that. And we know that, if offered the opportunity, people take part in these things. We talked about some of the barriers for clinical trials, but we also know that in looking at a number of different studies, almost 10,000 patients, that if people were offered, they were willing to take part. And some of those same hurdles for not taking part were there. But once again, being a part of a trusting care environment and care relationship with your provider makes all the difference.

And lastly, as we think about ways to improve things, we know that clinical trials help people. We know that people have more opportunities for life-saving tools as part of these trials. I often tell my patients, I say, "I'm starting here with you and we're going to talk about your toolbox. We're going to talk about all of the things that we can use and think of it this way. If I have five tools, but I use them all, then we're in a little bit of a challenging



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situation. But if I can add tools to our toolbox in the context of clinical trials, we have more opportunities to fight this battle." And so people have realized that when people have to travel or when people aren't presented with options or when people have other things that are hurdles clinical trial participation is a problem. The concept of decentralized trials has come forth during this pandemic.

In many cases, patients are asked to drive in to the big hospital to pay for parking, to take off from work, to do all of these steps, but is it possible that some of those steps can be done locally? They can do labs, they can do a check in, they can do imaging locally without having that burden of traveling in. And this is a way of doing trials that really has been shown to be feasible during the COVID pandemic. It's been shown to be more patient-centered, to have increased patient diversity. People are willing to partake when they have that extra level of convenience and it can promote patient retention. Just a few things that may help with this problem of care and making sure that there's equitable access.

## **Karen Peterson:**

Wonderful. And those are wonderful ideas and it really decreases the missed opportunities and presents opportunities. And that's what I like. I like that most of it that you presented is so solutions-driven. Dr. Patel, what do you feel should be our priorities as we try to improve the care we give to patients?

## **Manali Patel:**

Yeah. I think we can start by really thinking about health equity. That moves us from just describing. I think that decades after decades of just describing the problems. We know what the problems are and they are the same in every cancer type. We also know that the solutions, I think there was a question about, well, we know in prostate cancer, equitable care, guideline-based care leads to better outcomes. That's the same in every single cancer diagnosis. We looked almost a decade ago at multiple cancer diagnoses, acute leukemia, colorectal cancer, lung cancer, you name it. If you get the treatment, your outcomes will be better. And perhaps that mortality burden will decrease, but how can we do that? Well, it is a multi-level problem. We need policy solutions. We need health care provider solutions. We need clinic solutions. We need grassroots solutions at the community.

We need to think about our care in the clinic from a clinician standpoint about how to ensure that our patients are going to get the equitable care that's in our toolbox. But then we need to work with communities to make sure that there are ways and opportunities to get that care delivered. That may mean working with payer organizations, foundation organizations, community-based resources, to think about how to deliver the highest value care. That means the best possible care without unnecessary expenses. How to advocate for policies and procedures to ensure that care is delivered and that the care is delivered in an appropriate manner. And then also to think about how as researchers, we can take what we're learning and we can take the barriers we're seeing in our clinics and implement solutions. If we know that clinical trial and distance to our centers is a big problem for why people are not participating in clinical trials, then we need to get out and advocate.

If we know that COVID 19 is disproportionately impacting our Black and brown communities, then we need to advocate for procedures that don't continue this disproportionate impact. Now, many of you know, I feel strongly about masking. I will be fine. I'm vaccinated, I'm boosted. I think I'll be fine. But the continued impact on our Black and brown communities by policies that are made to enforce actions that have direct impact on our Black

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and brown communities, not only from COVID, but then the downstream effect from cancer disparities, we are going to seed a widening gap in disparities, and we know simple solutions in our toolbox that can impact that. We also know simple solutions in our toolbox to impact the disparate access to cancer screening and cancer treatment.

## **Karen Peterson:**

Thank you, Dr. Patel. You made me smile. Thank you. Smart goals. Let's talk about smart goals quickly. Specific, measurable, attainable, relevant, and timely. Individual patient interaction. Each person is unique, not simply a representative of some racial ethnic group. Practice patient-centered communication skills, active listening, active listening, practice that. Create a sense of common in group identity. Increase treatment standardization like Dr. Carthon talked about. Become aware of where disparity is at its greatest early stage. And encourage social media discussions. I think we have a few moments for questions. Let's see here. I'm going to start with the top. If I'm a different race than my patient, how and where do I start to bridge the ethnic or cultural divide? I'll leave it up to whoever wants to answer that.

## **Bradley Carthon:**

Well, I think just statistically, I am different than many of my patients. There are not many Black male oncologists. There are not many Black male providers. I really do try to just be aware of cultural differences and that could be people from different parts of the state, the country, people from different countries in general. Even understanding that the way people grew up, they may have comfort levels. If I could tell you, sometimes I walk in the room and the eyes on the patient lights up when they see me, but I want people to feel comfortable.

And I understand that people are going to feel comfortable. Conversation, talking with close confidantes that may be very diverse and reading, learning about cultural norms. All of these really can play a role that I think we have to adapt and realize all patients are not the same and all patients are definitely not of our own backgrounds, not even the patients that may look like us. They may have a different twist to things. I think that's one start and just having that interest and eagerness to really understand where patients are coming from, each patient is coming from.

## **Karen Peterson:**

Thank you so much. I think we've got, oh doctor, please chime in. Please.

## **Manali Patel:**

I was going to say, I treat patients in the VA and so I look very different than my patient population and they do, they raise their eyebrows and say, "When's the doctor going to come in you? Oh, you look like the student. When's the doctor going to come in?" And I always think, okay, so let's talk about what my role is. My role is to be as honest and to be there as an advocate and to be a steward of information and to present it in a way that is understandable and acceptable and then to ask questions. And to understand, just like Dr. Carthon described so eloquently, is to really understand what the patient in front of me may be concerned about, what they may be worried about, and to help to establish that trust between me and that patient.

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That's my number one goal is to go in and say, we all have our perceived biases. And sadly, when we look at people, because it's inherent in how our structures have been set up in society to look at people by race, ethnicity, and what they look like, what their appearance is. It should not play a role in terms of the kind of care that the patient feels they will receive from me or the kind of care that I am supposed to be able to impart on the patient.

## **Karen Peterson:**

Again, I really appreciate the fact that you understand how important that is to be heard and be valued as a patient because oftentimes we are faced in an environment where it can be hostile to find providers, those providers who want to be educators and educate and listen and help us reach our goals. It's really important because every patient, especially patients of color, from any community, all they want is the opportunity to make an informed decision and have options. Just give us the option, work with us. I really appreciate that.

## **Manali Patel:**

But also for me to be educated. We have humility. I want to know what's going on with the patient. I don't know from the patient's perspective. I know from being the daughter of two parents with cancer, but that's my own individual experience. And I want to know what the patient in front of me is worried about, concerned about, and how can I help. And if the information that's coming across is medical jargon, I want the patient to feel comfortable enough to ask that. And for me, for my job to be able to empower, and I hate it. I don't like the word "empower" because it means that there's a power differential, but for the patient to be able to feel comfortable asking questions and to get that extra support that they may need outside of the clinic in case I didn't do my job of engendering trust.

## **Karen Peterson:**

I'm glad you recognize that power dynamic, but we can talk about that all night, but we are running out of time. I just wanted to mention that to receive credit for the CMECE credit for this activity, participants must complete the post test and evaluation online. Participants will be able to download and print their certificate immediately upon completion. Also, please visit the Oncology Hub, the CME Outfitters, visit the Oncology Hub, free resources and education to educate health care providers and patients on oncology. We are out of time. Thank you so much to the medical providers, Dr. Carthon and Dr. Patel. Thank you so much for this very interesting discussion. Before we leave, I just wanted to thank you on behalf of the CME Outfitters. And I wanted to thank you on behalf of all the patients and all of the participants in today's activity. We really appreciate you taking the time to help do this. Thank you.