Addressing Bias and Disparities in the Care of Patients with Cardiometabolic Disorders: A Call-to-Action for Associates

CMEO Podcast Transcript

Monica Peek, MD, MPH, MS, FACP:

Hello, and welcome to a very special CMEO Snack that is part of a series I am leading on Diversity, Equity, and Inclusivity with CME Outfitters. Today's CMEO Snack is entitled *Addressing Bias and Disparities in the Care of Patients with Cardiometabolic Disorders: A Call-to-Action for Associates*. Today's program is supported by an educational grant from Walmart Incorporated. I'm Dr. Monica Peek, and I'm the Ellen H. Block Professor of Health Justice in the Department of Medicine at the University of Chicago. There, I am also the Associate Director at the Chicago Center for Diabetes Translation Research and the Director of Research at the MacLean Center for Clinical Medical Ethics. I'm really delighted to be joined today by my friends and colleagues, Dr. Marc Cohen and Dr. Rachel Bond. Marc and Rachel, would you mind introducing yourselves to the audience today?

Marc Cohen, MD, FACC:

So, I'm Dr. Marc Cohen here. I am currently the Chairman of the Department of Medicine at Newark Beth Israel in Newark, New Jersey. And for the last 40 years, I've been an Interventional Cardiologist seeing a lot of the not-so-great outcomes related to years and years of cardiometabolic diseases, ultimately resulting in heart attack or stroke or some of the not so nice things. So, a lot of experience relating to cardiovascular.

Rachel Bond, MD, FACC:

And I am Dr. Rachel Bond. I'm the System Director of Women's Heart Health at Dignity Health in Phoenix, Arizona. I'm also the Assistant Professor of Internal Medicine for Creighton University School of Medicine. And I do sit on several leadership cardiovascular societies, one of which I'm the Co-Chair of the Women and Children's Committee for the Association of Black Cardiologists. My clinical practice focuses quite a bit on race and ethnic disparities, as well as sex and gender disparities and health equity, so I'm looking forward to our discussion today.

Monica Peek:

Thank you both. Your background and experience for both of you has such a rich meaning, so much experience for our conversation today, so I'm really, really delighted to have you. Before we start our conversation, I want to just back up and talk a little bit about structural racism and interpersonal racism, and how that impacts the way that socially marginalized patients, particularly racially minoritized patients, receive their care, interpret their care, and how that impacts their health.

Rachel Bond:

So, I would say that, when it comes to calculators, many of which we use for cardiovascular disease, what these calculators do is they help us as clinicians determine a patient's risk for experiencing a cardiovascular event. So that way, we can highly focus on primary prevention, meaning preventing something from happening before disease is actually there. So, let's use, as an example, the Pooled Cohort American College of Cardiology

(ACC)/American Heart Association (AHA) Risk Calculator. We know that that particular risk calculation has looked from a race perspective at the White race as well as the Black race. However, the limitation is, is that if we were to use this on an alternative race other than White or Black, there would be a great limitation because it hasn't been studied in that particular race.

That is why I would say that there's value in anybody who's thinking about creating these calculations that give us the opportunity to better risk stratify patients that we actually bring it out to the diverse patient population, not just from a race and ethnicity perspective, but also from different sex and genders as well, because when you look at a lot of research trials, we know that many women, at times, have a lower participation in research. Therefore, how do we know that these calculators are specific for one sex, gender, race, and ethnicity if we're not utilizing them and piloting them in a group or cohort that actually is very diverse?

So, in the cardiovascular realm, I would say that all of the calculations that we have out there, we want to be, I would say, highly focused on who was included in the background when we were creating these actual calculators and more importantly, who was studied and asked to participate in the research. And then, moving forward, as we develop more and more of these calculators that are really very helpful for us as clinicians, we just have to be more thoughtful about making sure that we are including a much more diverse group of patients.

Monica Peek:

That is only some of the baggage that we carry when we move forward into things like the pandemic and say, “Hey, our government has established a new vaccine that we would like to give to the population,” and wonder why many minorities and other communities of color are wary about these vaccines or other new medical tests or studies that are going on. And so, it's with that sort of background that we want to dive in today and talk a little bit more about the impact of racism on chronic disease, on the day-to-day experience of persons of color. So, Rachel, I'm going to turn this over to you. We know that racism impacts more than just health care, more than just access to care, and the care that is delivered once people are in the health care system. We know that racism can actually cause chronic diseases also. Can you talk a bit about this?

Rachel Bond:

With that lack of trust, there are, we know, a lot of stressors, such as racism that does disproportionately impact one's health in a negative way. When we think about racial and ethnic underserved groups, they are more often exposed to the stressors such as lower income, limited or poor access to health care, limited access to resources, discrimination, which can be both community-based, but also from a systemic level. We also know there could be exposure to unsafe environments and social disadvantages. And one thing that's relevant for us to address when it comes to these chronic exposures to toxic stress, such as racism, is that that does disproportionately impact their cardiovascular health because it leads to upregulation of their cortisol levels or hypothalamic pituitary system.

We know that also their inflammatory markers are going to be driven up, and all of that causes, unfortunately, a burden prematurely, both cognitively, but also on the cardiovascular structure. So as such, this is why these communities are having higher and higher rates of cardiovascular disease earlier and earlier on in their life course.

And I think it's important that we, as clinicians, factor in these aspects such as the systemic racism that many of these disenfranchised groups have to encounter day-to-day.

Monica Peek:

Okay Marc, now that we've touched on how racism can cause and impact chronic disease, can you tell us about what cardiometabolic risk factors are, and how we can work to prevent them from contributing to heart disease in our patients of color?

Marc Cohen:

So, cardiometabolic risk factors are those factors that predispose patients to develop myocardial infarction, heart attack, stroke, sudden cardiac death, or sudden death. In other words, diabetes will predispose you to develop a heart attack way before your neighbor who's not diabetic. Having uncontrolled high blood pressure will predispose you to having a stroke way before your neighbor has a stroke, who doesn't have high blood pressure. Obesity has multiple negative adverse effects on your cardiovascular health, including predisposing you to high blood pressure, which then predisposes you to stroke, or predisposing you to obstructive sleep apnea, which then predisposes you to atrial fibrillation and then predisposes you to stroke, etc., etc.

So, these are factors that are incredibly easy to identify, and should be, in the year 2022, relatively easy to treat and to educate the patient on how to minimize these risk factors in themselves. Just to pass along a few quick facts, these risk factors occur at a much higher rate in the African American population. So, for example, among African American women, the rate of high blood pressure is roughly 1½ times higher than among non-African American women. The likelihood of diabetes-related mortality in African American women is twice as high as a non-African American women. Obesity also twice as high in African American women. So, these are just plain and simple facts that our African American population suffers more from risk factors that then predispose them to irreversible events like stroke and heart attack and sudden death.

Monica Peek:

Excellent. Thank you for that. Rachel, can you take us a little deeper on the importance of prevention in childhood, specifically for children from racial and ethnic underserved populations?

Rachel Bond:

Yeah, absolutely. I think the reason we want to target as early as possible prevention is because although cardiovascular disease is the greatest cause of death in the United States, it is about 80% preventable. So, starting that prevention early on will hopefully lead to primordial prevention, potentially even primary prevention. So, when we think about all of the tools that we instill in our adult patients, we want to make sure that is going from basically a generational perspective, where they're also incorporating that to their family. But maybe even beginning those conversations with our pediatricians at the earliest level, where they are actually engaging with these younger children, making sure that they're limiting and monitoring screen time, exercising, eating healthy. We know that now data suggests that sitting is the new smoking, we have more and more children, right, that are sitting on those little tablets or computer games, and unfortunately they're not going out and doing things like

sports, or at least even walking around the neighborhood. And unfortunately, as a result of that, we're seeing more and more children having diagnoses of being overweight and/or obese.

Obesity is an epidemic in our younger population, specifically those that come from the Black and Brown community, and we know that obesity leads to just a series of cardiovascular potential risks such as stroke and heart attack. So, I really do think that we have to foster these conversations as early as possible, as simple and basic as explaining to them what a healthy diet looks like, what the recommendations are for exercise, which is about 150 minutes of moderate activity per week, which does include walking. But also, we have to be aware that sometimes there are limitations in our underserved communities, because they may have limited access to fresh and affordable foods, or even a safe place to exercise, and this is where I would say sometimes utilizing community centers may be key, because a lot of times they have access to those more affordable foods because they provide it to the communities complimentary, but they also may have a safe place where they could open up a gym, as an example.

So, I think that we, from a larger perspective, really do need to incorporate the community into some of these conversations when we're focusing on these more underserved populations, but it's also important that we have these conversations as earlier, as early as possible with children and their parents, so they instill, again, making it a generational change, not just an individual change.

Monica Peek:

Absolutely. Excellent, excellent point that, you know, these diseases don't pop up out of anywhere, and they start earlier in life for racially minoritized groups. So, thank you for that great explanation.

So, Marc, we also know that bias, implicit biases are ubiquitous amongst all providers. We all have them you know, against perhaps people who are overweight, or different racial and ethnic groups than our own or, you know, the literature is rich with an understanding of the kind of biases that everyone carries, particularly physicians. And so, can you talk a little bit about what kind of stigmas exist when it comes to cardiometabolic disorders, and then again, thinking … I'll never forget just the transition that you have had from doubling up medications to then going to being a person who really wants to shut the door and talk about the social determinants of health. And so, I want you to talk a little bit about your own trajectory, and how you've identified your own biases, and what you did to sort of, improve your own journey.

Marc Cohen:

So, just to give you an example, years and years ago, as a trainee or as a young doctor, my attitude was, I have a medical problem, a patient with high blood pressure, she's on a certain dose of medication, or he's on a certain dose, and the pressure is still high, so the simple thing to do is just increase the medication. Thank you, come back in three months. The attending would love it. Get the patient in, get the patient out, everybody would be happy, except for of course, we didn't exactly get to the bottom of why the patient's hypertension even exists in the first place. In the current era, I guess Marc Cohen, doc, 2.0 maybe, what I would do is ask the patient, who cooks for you? Do you cook for yourself? Do you even have time to make a healthy meal? Or are you in between two jobs or three kids, or are you taking care of your elderly aunt or parent? And the bottom line, basically, is every one of our disease states usually, especially the cardiometabolic states, can be traced back to a mechanism.

So, for example, if I sit down with a patient like I did last week, and talk to her about it being overweight, she said, "Yeah," she has a sedentary job, she's an IT person, works on computers and she sits down and she snacks all day. And believe it or not, none of her prior doctors, and this woman was like 55-56 years old, I'm sure she's seen at least 10 doctors before she came to my office, identified the fact that this is just a terrible habit. The patient actually volunteered this to me, I didn't even have to dig that hard. And I said, "Well, what do you think's going to happen if you keep doing this?" And little by little, it didn't take that long, but little by little, she came to understand that this was just, if she continued on this path, it wouldn't end well.

And so, the commitment to actually not just look at the disease, take out your prescription pad, or, you know, get on the electronic medical record, and hit double a dose of labetalol but rather to sit with the patient and listen and say, "What's going on in your day-to-day routine that may be predisposing to this?"

Monica Peek:

Absolutely. Thank you so much. So, we have some voices of the patients, and Rachel, I'm going to come back to you and ask you why it's important to be mindful of the patient voice, and what can we all do to make an impact when it comes to cardiometabolic health?

Rachel Bond:

Absolutely, I mean just with these three examples, one assumption being that because of their race and ethnicity, they're unaware of how to eat healthy or properly. Another example talking about how communities of color may not feel sometimes as comfortable having those conversations about their underlying, their own underlying medical conditions and how incorporating the community and trusted leaders into this could be impactful. And then even the other example, about how many a times, women that come from communities of color, the Black and Brown community in particular, are dismissed when they present with signs and symptoms that are concerning for cardiovascular disease, and a lot of times are thought that it's a panic attack.

So, I think that this highlights the fact that the voice of our patients is such, so powerful, and it's such an easy thing for us to listen to, because these patients, like any patient, know their body so much better than we do. And if they are telling us that something's not right, if they're asking questions, we really have to be thoughtful, and give them that time to actually listen to them and hopefully, by doing so, it's going to make our job so much easier. If we just paused and listen to our patients, we would probably be able to actually figure out what's going on with them, or at least direct us in the right way where we can actually order them for the appropriate test. So, I can't emphasize enough the patient's voice. And I would say that even examples within my own clinic, because I focus quite a bit on women and women of color, and as mentioned many a times, their voices are the ones that are silenced.

I have so many women coming to me for second opinions because they had been dismissed, they've been told that it's anxiety, they've been told that it's stress, that they maybe need to think about reassessing their personal relationships. And at the end of the day, we actually do additional testing, and we diagnose them with actual cardiovascular disease, things that went on for years, and were unfortunately mismanaged and under-diagnosed. And one thing that I do think is important to highlight is that chronic stress, those toxic stressors as we mentioned, are risk factors in and of itself for cardiovascular disease. So, if you're going to say that it's due to a

panic attack or stress, you have to acknowledge the fact that those are risk factors, and then factor in other risk factors, and then hopefully, you'll be more empathetic to actually delving deeper into what's bringing them to you as the clinician or to you as, let's say, the emergency room when they're presenting with some of these signs and symptoms that are actually concerning.

So, patient's voice is probably the top of the list when it comes to what I do as a clinician, and hopefully, what others will start to do when it comes to taking an actual detailed history.

Monica Peek:

That is beautiful. Thank you so much for re-centering the experience on the patient's voice and reminding us all what we learned when we were first a medical student, like, listen to what the patient is telling you. We start the Subjective, Objective, Assessment, and Plan (SOAP) note with the "Subjective" of a patient's experience.

So, thank you so much for that, and for both of you. I'm not sure where the time went, but we are out of it. Marc and Rachel, thank you so much for your wonderful insight on how we all, as physicians and human beings, can impact the lives and health of those around us. Providing excellent care requires a team-based approach, and everyone on the team matters. You don't have to be a physician to impact the health and the well-being and the attitude of the patients and customers that come across our way. I want to recap the main takeaways from today's program, which is to recognize the impact of racism on health and to examine your own biases, to acknowledge how social determinants of health impact patients and consumers, and then to remember that prevention is key for heart health.

I'd like to ask that you all check out these resources to learn more about what we discussed during today's activity because we couldn't get to everything, but there's so much more to learn. And then last, I'd ask that you complete the online evaluation, because we really want to hear from you. We want to know what you liked, how we can improve, and what additional topics you'd like for us to address. We also have a number of other programs in our D&I activities.

Thank you so much for your commitment to education on Diversity, Equity, and Inclusivity. When we know better, we can do better. Thank you for joining us today and for being a good human. Have a wonderful day.

