Fireside Chat with Dr. Wayne A.I. Frederick

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Sarah Dash:

Good afternoon and welcome to the keynote portion of our Advancing Patient Centered Cancer Care Summit. As we've already heard today, there is a deep need to improve the way that cancer care is delivered and that patients are centered throughout their care journeys. With us today to underscore the importance of patients centeredness and illuminate its connection to health equity, medical practice and policy, is Dr. Wayne AI Frederick, the President of Howard University. In addition to serving as President of the University, Dr. Frederick is also the Distinguished Charles R Drew Professor of Surgery. Dr. Frederick has advanced Howard University's commitment to student opportunity, academic innovation, public service, and fiscal stability.

He has also overseen a series of reform efforts across the university to support students, faculty, and staff. Dr. Frederick received his BS and MD from Howard University and held post-doctoral research and surgical oncology fellowships at the University of Texas MD Anderson Cancer Center, before beginning his academic career as Associate Director of the Cancer Center at University of Connecticut. He is a widely recognized expert on disparities in healthcare and medical education and his medical research focuses on narrowing racial, ethnic, and gender disparities in cancer care outcomes, especially pertaining to gastrointestinal cancers. We're so grateful to have Dr. Frederick here with us today to share his insights and expertise. Dr. Frederick, welcome.

Dr. Wayne A.I. Frederick:

Yeah, thanks for having me. It's always a pleasure to join you.

Sarah Dash:

Wonderful to have you here. So, and I'd like to begin by asking you a question, health disparities, health equity has been receiving a lot of attention this year, certainly as a result of the COVID pandemic and the clear racial inequities in this country. What has your research shown about disparities in cancer care? And what are we learning about whether or not COVID-19 and the after effects of the pandemic have exacerbated these inequities, particularly as it comes to cancer care?

Dr. Wayne A.I. Frederick:

Yeah. You know, very important issue. What we've learned so far is that the disparities are wide. You look right here in DC, as an example, you just look at life expectancy, overall. A white woman in DC who lives in ward three has the largest life expectancy, but almost 20 years less for a black man living in ward eight. And think of how small DC is, just 600,000 citizens. You would think that access, et cetera, wouldn't be an issue. The COVID-19 pandemic has exacerbated that, in my opinion. I can tell you, anecdotally, I'm seeing patients with more advanced disease. This coming Saturday morning I'll be operating on a patient with a pancreatic tumor.

And unfortunately she waited awhile because of the hesitation to go to the hospital, which we rightly shut down during the pandemic. But the residual impact of that is that people were still apprehensive to come out, even after vaccinations and so on. And so I think we're going to see a lot of missed screenings, that has been documented already. I believe screenings in underrepresented minorities for some cancers were down as much as 80%. So you think already that people that weren't accessing screenings and now they did it even less. So they're going to present with more advanced

cancers. And I think that that's going to be problematic and we'll start seeing that impacting life expectancy rates, probably within the next two to five years after we've made lots of progress over the past two decades.

Sarah Dash:

So is there anything that can be done right now to sort of stem the tide? I mean, obviously there's to do about the pandemic to sort of make that go away a little faster, but just in terms of specifically focusing on cancer and cancer care disparities, are there immediate actions that could be taken to improve the situation?

Dr. Wayne A.I. Frederick:

Yeah. There are lots of things that I think can be done. I would prioritize them probably in this order. First is we need a national effort to get screenings back on track. So we need public service announcements in the same way that we encourage people to take vaccines. As our vaccination rate has increased and COVID decreases, we need to move some of our public service announcements and our public health messaging to encouraging people to get to screenings to close that gap. Second, we need to have a focus on underrepresented minorities because of the gap that does exist, existed before, that has only wide. So we need to be out in those communities, taking the message to them. We need to look at our infrastructure. We need to look at where we have ambulatory care centers, where some of the screenings could be done. We need to look at mobile vans where you can do mammograms for instance, and we need to be deploying them where you have underrepresented minorities.

And the third thing is more of a longer intermediate to longer term strategy. We have to start filling the pipeline of diverse healthcare professionals who are culturally competent and will go into some of these neighborhoods and support the work that must be done. And that work must be done immediately. So if we start focusing on that now, we should be able to improve the number of healthcare providers who are willing to work in those neighborhoods, come from those neighborhoods and are able to reach those patients within the next five to seven years. That's an intermediary step, but can go a long way in having an impact for decades beyond.

Sarah Dash:

Thank you. Thank you so much. And I have to ask this and then I really, we're going to talk a lot about patient centeredness and equity and how they intersect. There has been so much conversation around both access, structural access challenges as a result of the pandemic, and then trust in the medical system or lack of trust that sort of has been earned by the medical system, unfortunately. And you talk about really getting the message that people need to kind of come in for their screenings or the screenings need to come to them. Are there any lessons that we've learned over the last couple of years about enhancing or building trust in the system among people who sort of rightfully have distrusted the system?

Dr. Wayne A.I. Frederick:

Well, the pandemic has taught us a couple of things. One is that there is a general misunderstanding in our society about where that mistrust and distrust comes from. I think during the pandemic, if you did a survey, if you went out on the street and you were asking the average person to tell you what happened in the Tuskegee experiment, I think one of the things that we learned is that that Tuskegee tragedy is misunderstood. People do not necessarily see it as a withdrawal or withholding of treatment, et cetera. People aren't quite sure who participated in it. What was the extent? And as a result, they don't

understand what safety measures are in place now to prevent it from ever happening again. And so it's almost, we almost need a bit of a reeducation around some of these issues and a willingness to talk openly about it. Pushing it aside is not going to make people's distrust go away. Diminishing it is not going to make people's distrust go away.

What we need to do is to say, yes, this happened. It is unacceptable that it was able to happen and we've put things in place for it to never happen again. I think the second thing is we have to believe in our trusted messengers. And we know that our trusted messengers do not only exist in our healthcare systems, but they exist in our churches. They exist in our homes and our community centers. They exist in our corner stores and groceries. And so we have to go into the community more and partner with trusted messengers. Because when we had to get word out about the vaccinations, it was those trusted messengers who showed up, who were able to convince their neighbors and their brothers and sisters and their parents. More so than physicians. Trusted messengers were important. At Howard University, we were able to go into the community and do testing.

We were able to go into the community and give vaccines. We were able to go into the community and convince people to talk to other people and to come to us and be vaccinated. So we had a tremendous amount of success with overcoming vaccine hesitancy early on. But what it also involved was talking to people, meeting them where they are, not avoiding their questions, but really offering ourselves up for that. And I think that's what we have to continue to do. My woman's volleyball team was about 50% vaccinated at one point. And so they wanted to meet with me. And so I got on the Zoom call and they had some very, very good questions. Because here ar 17 to 21 year olds who were being asked to take a vaccine messenger RNA, and one of them posed a question, is this vaccine going to get incorporated into my DNA and affect my fertility?

It's a great question. It gave me an opportunity to explain what messenger RNA was versus what DNA is, and then to also talk about how it wourked so that they can understand why it wasn't incorporated. And so I think the ability to do that was helpful. The team is now a hundred percent vaccinated. I won't say it's strictly because of my conversation, but I got some feedback from them that just taking the time, the willingness to explain what seems like a very complicated, scientific issue in a laymans term from somebody that hopefully they have developed some relationship with over time and trust, was meaningful. And so I do think that that's something that we have to continue to do to change our perspective about the medical communities.

Sarah Dash:

Thank you so much for sharing that example. Because I think it's such a great example of in some ways kind of the burden that we place on people and patients to understand really complicated, complex topics, to make complicated, complex decisions and to navigate a really complicated system. And in that vein, I'm curious to hear your thoughts on, why do you think patient centeredness is such an important concept? Do you think it's such an important concept? And do you think it is in and of itself a tool that can be used to reduce health disparities?

Dr. Wayne A.I. Frederick:

You know, my mentor, Dr. LaSalle Leffall, who passed away a couple years ago, had a saying that the patient is the object of our affection and should be the object of our obsession. And I think if you look at our healthcare system, the center of our healthcare system for too long has been the physician. And getting back to putting the patient at the center of our healthcare system is important. Now, that is not patient centeredness completely, but just the fact that if we look at the whole ecosystem around the

patient, the pharmacist, the physician, the nurse, the occupational therapist, we all are working like spokes on a wheel with the patient at the center. That's where it begins.

That empowers the patient, it reminds the patient that we are there for them and not for ourselves. It reminds the patient that no question is an unnecessary question. Every question and concern, that we are here to help them. And empowering that patient to be able to take control of their destiny around their healthcare, I think is critical in decreasing disparities and bringing health equity, but also in increasing the, I would say the quality of the relationship with the medical establishment. Because it means that we have to come with some humility about what we do, the role that we play and the ultimate impact that we can have.

Sarah Dash:

Yeah. Thank you. And patient centeredness in some ways, the way you describe it, is so individual. It's really about answering the individual's questions, making sure that their concerns are addressed, really building their trust one on one. And then when it comes to both patient centeredness and health equity, there's some real structural issues, systemic issues. How do you view that in your role as a leader? What are some of the structural challenges that would need to be addressed to make it possible for cancer care to be more patient centered?

Dr. Wayne A.I. Frederick:

Yeah, it's a great question. You know, and it's also that kind of $64,000 question, right? But what I do think is we need more collaboration. We are training physicians here at Howard to recognize that healthcare is not only about what they provide. So in my case, I'm a cancer surgeon, I'm going to do a pancreatic operation this weekend. So it's not only about me knowing the anatomy, doing a technically good operation. That's probably the most minor part of that patient's care. What we are beginning to realize is that the social environment that patient is in. So I've met with that patient, her husband, her brother, her sister, at every meeting that I've met that patient. Her sister lives out of town. She's been on FaceTime. So I recognize even just the ecosystem around her in terms of how I view the patient support system, what can potentially happen postoperatively, et cetera.

And I think that's what we have to look at. You talk about nutrition. This was a patient that was losing weight. But then I also have to be take into consideration, where do you shop for groceries, right? Not just what do you eat, but where do you shop? Do you have options that are close by? In the past, have those options been good? Do you have to go travel a larger distance? So that when you start looking at those things holistically, it means that to build a system, especially around communities, we need to be sitting with legislators, as physicians. We need to be sitting with community organizers, as physicians. We need to be sitting with city planners, as physicians.

We need to have a seat at the table to advocate for the things that are necessary. And right now that does not happen. And when was the last time a city planner knocked on the door of the president of a university that has a medical system and said, listen, now we want to do some things in this neighborhood, but we'd like to get your input, right? We are concerned about kids crossing the street and car accidents. We are concerned about pollution and we want to, and so that's not happening right now in our society. But we can't just point fingers, we need to participate. We need to show up as good community citizens and participate. And that's what we've been trying to do at Howard. We've been trying to make an argument that we need a seat at the table as well, because we want the holistic system.

Sarah Dash:

Thank you so much. And that's a perfect lead in. So when you have that seat at the table, what do you see as the best opportunities in the policy environment to improve patient centeredness in cancer care as well as post-cancer care. And what is it that you wish a policy audience would take away from this conversation today?

Dr. Wayne A.I. Frederick:

Yeah, another great question. I think one of the things that we have to look at is what are we providing for people where they are? Sometimes we look and we say, for instance in DC, you've three academic medical centers as it were. And so we say, man, for a population of 600,000 people, you've got a lot of people. But when you look in ward seven and eight, nobody has a presence there of magnitude. So right there, you have a desert, a healthcare desert. So that's an example where you get a seat at the table, you have to say, listen, how can we fix this? You know, what do we do? But in that same place, you also only have two groceries serving 180,000 people. You have far more corner stores, right? So our clinical nutrition science students for instance, are in those corner stores talking to the proprietors about shelving.

Where do you put certain items? What are you thinking about in terms of the health? We don't want to hurt your bottom line, but your bottom line could still be great while you do provide a service to the community. And so when we sit at a table, that's what we are hoping to do to, to let people see that it's an interrelated system. And that we all recognize, again, that if we are concerned about putting the patient at the center, we are very serious about prevention rather than cure, then we should be acting appropriately. So even as a cancer surgeon, I want to put myself out the business, right? I want people to not have to come see me and therefore I have to be working on the prevention side as well.

Sarah Dash:

Thank you. So what I'm hearing really strongly coming out of this conversation with you is if we want to make cancer care more patient centered, reduce health disparities, and really reduce cancer disparities, we have to focus on the environment in which people live. What sometimes people call the social determinants of health, that medical providers in the medical profession need to have an expanded role within that. And that, by the way, you're sitting right here, you need the city planners to come to you. You need the private sector to come to you so when they're making investments in these communities, it's not just about the one grocery store. It's really this broader ecosystem that is being impacted. And what I'm hearing from you is that's going to make your job as a cancer surgeon easier in a way because you'll have more resources to sort of offer the patient, their family, their ecosystem, but also at some point this is also about improving health outcomes. Did I sum that up?

Dr. Wayne A.I. Frederick:

Yeah. I think you summed it up beautifully because ultimately, think of the statistic. What distance does the average citizen have to travel to get a mammogram? Just think of if in the public health sector we had data like that? How far does a patient have to go to get a colonoscopy, on average? And you just use that, just from a transportation planning point of view, and you start looking at things like that. I think all of those things are contributing in a very different way to the outcomes.

Sarah Dash:

Very much so. Well, thank you so much, Dr. Frederick. Unfortunately, that's all the time we have right now, but we are about to hear a policy panel that is going to further illuminate some of these questions.

You've been really generous with your time and insights, best of luck to you. And thank you so, so much for joining us today at this Advancing Patient Centered Cancer Care Summit.

Dr. Wayne A.I. Frederick:

Thanks for having me. It's been a pleasure.

Sarah Dash:

Thank you.