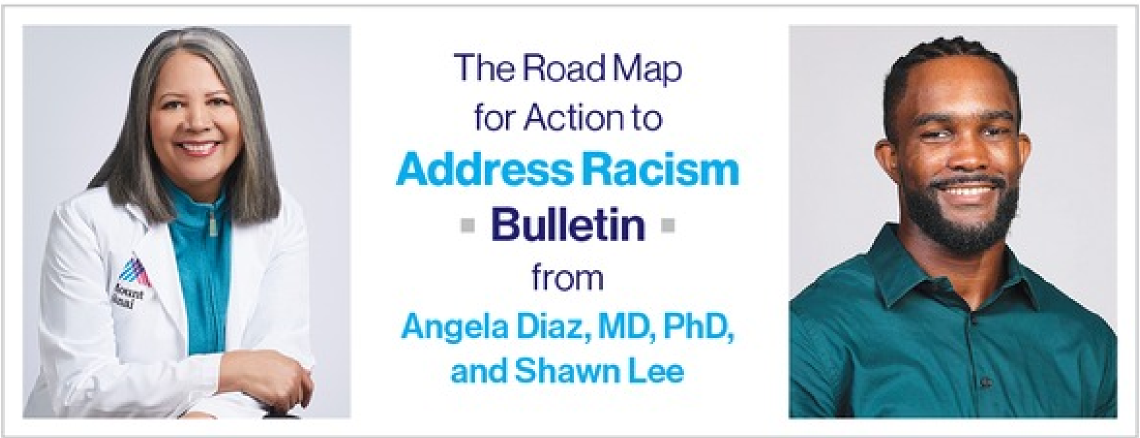

October 27, 2022

Addressing Disparities in Cancer Care—Q&A with Dr. Cardinale Smith

Happy Thursday, Mount Sinai Community–

This week, we're highlighting the latest report from the American Association for Cancer Research (AACR), which found that as cancer continues to claim more than 600,000 lives in the United States each year, disparities in who gets cancer—and who gets access to the best care—remain "a pervasive public health problem."

To dissect this report and better understand both these findings and how cancer researchers, including those here at Mount Sinai, are working to address disparities, we spoke with Cardinale Smith, MD, PhD, who was just appointed Chief Medical Officer for the Tisch Cancer Hospital and Vice President for Cancer Clinical Affairs.

Dr. Smith also serves as Chief Quality Officer for Cancer, Mount Sinai Health System; Associate Director, Community, Outreach and Engagement, The Tisch Cancer Institute; and Professor of Medicine (Hematology and Medical Oncology), and Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Below is an edited Q&A from our conversation:

Q: The AACR annual report notes that progress in reducing cancer mortality is uneven among populations, with minority groups not seeing the same benefits from therapeutic advances. Racial and ethnic minorities and medically underserved population groups in the United States continue to shoulder a disproportionate burden of cancer. Does this ring true to what you've seen in your work treating patients at Mount Sinai?

A: To some extent, yes. We see that racial and ethnic minorities are diagnosed with cancer at later stages, where the disease has had more time to progress, and therefore they face higher rates of morbidity and mortality. This is particularly true for Black men with prostate and lung cancer in New York City, but we also see it across a range of cancers. One cause is a lack of access to early screening in these communities.

Q: Social determinants of health, such as lack of housing, income differences, lack of educational equity, and inadequate or lack of health coverage, all serve as barriers to receiving the best available care. What steps can be taken to address these barriers? Are there any Mount Sinai initiatives or programs focused on these barriers you would like to highlight?

A: The social determinants of health are pervasive and certainly contribute to differences in cancer outcomes. One critical step we can take is screening for social determinants of health. If we can identify these issues early, then we can partner with community-based organizations to assist patients with their needs. Patient navigators—who can provide more one-to-one communication and education for patients and/or their caregivers—help us do this. At Mount Sinai, we routinely screen patients on treatment for cancer for social determinants of health at regular intervals and have a navigation program to help them overcome some of these barriers. We also ensure that every patient starting treatment has a visit with a social worker to further identify any psychosocial needs and barriers to care.

Q: The report also highlighted passage of laws to improve diversity in clinical trials, including the DIVERSE Act to improve enrollment of minority populations in clinical trials, and the DEPICT Act, which requires the Food and Drug Administration (FDA) to issue rules for drug sponsors to meet enrollment targets that match the population of the disease the therapy will treat. Can you speak to how these laws will help to shape equitable cancer care and reduce disparities?

A: The frequent visits and monitoring required for clinical trials is often a barrier among patients in underserved racial minority groups and those in rural populations due to the cost of transportation and the fact that few states allow pharmaceutical companies to reimburse patients for those costs. This financial reality often limits who can participate in trials. In response, the DEPICT Act would allow remote collection and assessment of data from patients enrolled in clinical trials—for example, using telemedicine or phone calls—to give patients across a wider range of demographics the ability to participate.

The DIVERSE Act would mandate that pharmaceutical companies applying for drug approval report to the FDA on clinical trial enrollment by demographic subgroup and require them to develop a Diversity Action Plan that details outreach and engagement strategies to meet these targets. Currently, most clinical trials occur at major National Cancer Institute-designated centers. (The Tisch Cancer Institute is one National Cancer Institute-designated center.) However, only a small number of patients receive their cancer care in these settings. The hope is that the DIVERSE Act will ensure clinical trials expand beyond these centers and into more communities.

Q: Is there anything else you can say about Mount Sinai's efforts to address disparities in cancer care and treatment?

A: Mount Sinai is engaged in community outreach efforts to provide cancer care in ways that are culturally responsive and tailored to specific needs. In addition, we have high rates of enrollment among racial minority communities in clinical trials, with about 35 percent of all of our enrolled patients identifying as Black and/or Hispanic. We are intentional at increasing enrollment of this population. (For more, head over to this Q&A about Mount Sinai researchers receiving a $6 million grant from Stand Up To Cancer to lead a team of New York institutions devoted to health equity in cancer research).

We want to thank Dr. Smith for this informative conversation.

We also want to wish everyone at Mount Sinai who celebrates, a Happy Diwali. May divine light shine within you, bringing health, prosperity, peace, and joy. For reflections from employees who celebrate Diwali, please click here and here on Mount Sinai Daily.

All the best,

Angela and Shawn

Join Us for an Upcoming Event

Chats for Change—On the Fence: Exploring the “Not-Racist” Category––Chats for Change is a production of the Icahn School of Medicine’s Racism and Bias Initiative. Aren’t we all striving to be “Not Racist”? How did “Not Racist” become a disparaging term? What’s so bad about it, and what are the alternatives? Join facilitators **David Muller, MD,** and **Ann-Gel Palermo, DrPH,** on **Tuesday, November 1, from noon-1 pm** to explore how language is used, why it matters, and what the difference is between racist, not racist, and anti-racist. Register on Zoom.

Road Map for Action

Past Bulletins