Racial disparity in New Orleans: A faith-based approach to an age-old problem

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Recently in the United States, health care reform has become a central focus of heated debate and controversy. Sweeping legislation was introduced and passed by the Obama administration in an attempt to achieve universal health care with the intent of providing equal access to care through national policy. Although a laudable goal, this policy does not ensure equivalent quality of care delivered to the most vulnerable communities in our nation. Historically, racial disparity in health care delivery results in delay in diagnosis, and often inferior patient outcomes at a substantial increase in cost of care.1-5 In the same stride, strong criticism has turned to the mounting and unsustainable costs of health care on the national budget. Despite the best intentions, current proposed changes in policy and infrastructure development, national health care policy may be woefully inadequate. Health care in certain socioeconomic groups, regions, or individual institutions function well and provide excellent care. Other regions or even individual institutions struggle under their community’s payor mix to provide adequate care. Governmental support in the form of disproportionate share has been applied to decrease this financial disparity. Unfortunately, this gap is often wider than perceived and inner-city institutions absorb the sickest and most complex patients with the least primary care associated with the lowest payor mix. This self-fulfilling prophecy leads rise to multiple at-risk populations facing substantial racial disparity based on their own community location.

As physicians, we too are responsible for this disparity by our own misunderstanding or unawareness of our own patients’ competitive interests or requisite for mutual trust. In an era of ever-evolving financial hardship, a more substantial portion of society has become either the “working poor” or unemployed. These previously complex patients become more complicated as they often become victims of being under- or uninsured. Often these members of society do not have the essential resources for childcare, the ability to take time off from work to visit the doctor, or even the resources to reach the doctor’s office. Survival of the family often takes precedence over primary or preventative or health care. Indeed, patients may have to decide between food or making a copayment for a visit or medications. This same situation often leads medical conditions to fester until the neglected disorder triggers a more costly emergency room visit or a prolonged hospitalization. Even with the option of community clinics and an inner-city hospital, these members of our society most often rely on an underfunded, understaffed, and unfortunately fragmented public health system to meet their needs.

Charity Hospital in New Orleans has been staffed historically by the Louisiana State University and Tulane University schools of medicine and was built and maintained as a beacon of hope for the poor and disenfranchised of New Orleans. Over decades, “Charity” served the poor of New Orleans. Despite the challenges of a convoluted and often frustrating system, Charity offered the community a home. Unfortunately with Hurricane Katrina, Charity hospital was destroyed, leaving health care in inner-city New Orleans fragmented. Tulane University hospital flooded causing it to close its doors temporarily.
and Charity moved into a dramatically smaller outlying hospital, closing the doors to “big Charity.” As the water receded and the people of New Orleans returned, the 2 medical schools and the city government sought to develop a primary care system. The system of primary care clinics known as the 504 network, the area code for New Orleans, arose to try to meet the needs of the underserved. These community clinics with the aid of a governmental “Beacon grant” continue to establish linkage of electronic medical records among these fragmented clinics throughout the city.

Despite these efforts at delivering primary health care, the unfortunate reality is that the same at-risk populations do not access these clinics. This situation creates a void in health care in the community, ranging from gaps in knowledge, lack of early cancer screening, to even early cancer diagnosis for the people in the inner city of New Orleans. This problem was quite evident in a retrospective review of patients with head and neck cancer cared for at the Tulane University between 2005 and 2008. African-American patients afflicted with head and neck cancer presented with more advanced disease than their non–African-American counterparts. A subsequent analysis of Louisiana SEER data confirmed that African Americans throughout the state—not only inner-city New Orleans—had twice the incidence of advanced cancer head and neck cancer at presentation than observed in Caucasians.

In 2010 in an effort to bridge this gap, Dr Friedlander, a head and neck surgeon, developed Healing Hands Across the Divide to affect social change. This grassroots effort focuses on faith-based and community-based partnership with concerned physicians. This approach led to physicians being welcomed into the community and eating and spending evenings with religious and community leaders in their community centers and churches. Eventually, a mutual respect and trust evolved, allowing both the medical community to address its concerns and the community to allay its concerns, fears, needs, and frustrations. It was realized quickly that both parties would require compassion, trust, and education, but the health care providers and religious leaders were committed firmly to address this inequity. Healing Hands Across the Divide was formed and its mission established to identify and eradicate cancer health disparity in the inner city of New Orleans.

Our collaboration chose the path of open dialogue, stressing information in the setting of compassion, decency, and trust. Monthly focus groups continue, addressing the stigma that cancer holds in the African-American community and possible reasons behind presentation with advanced disease and/or outcomes. This approach has required health care providers to become students and to listen and be educated by their patients. Although many of us had worked in the inner city for decades, we realized quickly that our understanding of the African-American community was limited. We touted our community clinics and clinical trials, but also realized that these academic accolades had little or no relevance for the resident of the inner city. Uniformly, the community described access to clinics and the public hospitals as difficult, leaving many African-American patients leery of the health care system. The community often associates their hospital experience with cultural incompetence, long waits, and dehumanizing conditions. Often, patients assess their experience, as “I spent all day in the hospital sent from one place to another and didn’t get anywhere” and “you took me for a fool once but never again.” And when we talk of clinical trials, the “Tuskegee” syphilis experiments were recalled all too commonly. This feedback led us to realize that, if we were to overcome these obstacles, we must work as a team (health care providers and local leaders) to listen to the community that we treat, to earn their trust and work together for solutions.

Our initial attempt at inner-city health care began with an invitation by Reverend Norwood Thompson (New Orleans City Council Chaplain and President of the New Orleans Branch of the Southern Christian Leadership Council) to hold a cancer screening at the Martin Luther King Monument during the annual Martin Luther King parade. Our team arrived in the Tulane Mobile Health Unit anticipating that we would be delivering health care to the inner city. Our unit was parked 2 blocks from the Martin Luther King statue, and we were prepared to screen a hundred patients. Being physicians, we arrived way too early giving us the opportunity to visit with several of the early civil rights activists who were happy to share their life stories and struggles. These were mostly men in their 80s who had lived in New Orleans during these tumultuous times. Their memories were not ones of violence, but ones of fraternity, where they individually took risks, but supported the cause that they loved. We learned that New Orleans was one of the centers of the civil rights movement. One year after Martin Luther King, Jr, had organized the year-long boycott of segregated buses, he met with several local civil rights leaders in Central City New Orleans. The Southern
Christian Leadership Council was established, and King was elected president.

The parade passed, and we were able to return back to the Mobile Unit in hopes of performing cancer screening. To our surprise, very few people came to our unit to have health care delivered. This instance proved to be a learning lesson when one of the reverends (a founder of Healing Hands Across the Divide) gave us some practical tips. He kindly told us that we may be outstanding physicians, but we did not know how to work the crowd. We had thousands of people 2 blocks away, but no one was coming to be screened. “You need music and you need refreshments.” The reverend realized that these doctors really needed help, but pledged that he would ensure that our efforts were going to be successful.

During our next meetings, we discussed the Martin Luther King event and its failure as a screening event. Our team of ministers discussed our goals for screening and designed our screening platform. We have used this during the past 2 years and feel it has been quite successful. We would like to share our tips.

**SCREENING EVENTS SHOULD BE JOYOUS**

These should be celebrations of life and not events of fear. Our current screening events are coordinated with either church or community events. In conjunction with the preacher or leader, we have a 10- to 20-minute awareness discussion. This discussion is followed by the screening event and is performed on site in an area designated by the church or community center. We typically have local musicians performing for entertainment and have refreshments. What we have noticed is that the screening is performed as the backdrop of a social event where friends and family can meet. Typically, our levels of participation have proven to be very high.

**SCREENING EVENTS SHOULD BE COMMUNITY BASED**

Through a partnership with the preachers and reverends of inner-city New Orleans, our group has established outreach locations in community churches chosen by the community leaders. These locations have been utilized for education, serologic testing, and clinical screening for cancer. This faith-based approach utilizes community resources to support patients and their families, provide child care, minimize travel, and lend emotional support to diminish mistrust. Our approach attempts to improve health care at multiple levels by empowering the community itself and hopefully to eliminate health care disparity itself.

**SCREENING EVENTS SHOULD SERVE AS A DIALOGUE BETWEEN HEALTH CARE PROVIDERS AND THE COMMUNITY THAT THEY INTEND TO HELP**

We have achieved consensus that one of the major barriers to early cancer detection is a lack of trust between members of the inner city and the health care system. We try to use these screening events to earn trust. Our health care team is not only at these events to provide medical information, but is also actively seeking input from the community on barriers to health care and how we (as health care providers) can do a better job. Our cancer awareness is a discussion in which we disseminate medical information, but also allow the community to discuss their feelings about cancer and challenges of early detection. We offer institutional review board-approved surveys to participants to see if they would like to share information anonymously concerning potential barriers to healthcare. We feel that we learn more by simply listening.

**OUR FAITH-BASED PROGRAM**

Our current collaboration is based on education, screening, and advanced cancer detection directed through faith-based leadership. Strategically located churches identified by the community were selected as locations to deliver care. These church-based events and the identification of patients in need are orchestrated by church leaders and trained health care workers from the church community. Screening events lead to patient identification and referral to definitive tertiary cancer care through a navigator system and linkage of electronic medical records afforded by the Beacon grant.

**HAVE WE BEEN SUCCESSFUL?**

To date, we have opened the dialogue and screened hundreds of members of the community for hepatitis and head and neck cancer finding multiple patients needing referral for health care. To date, we have held >20 events in local churches and community centers to build trust and initiate a dialogue with the community that we are trying to serve. Our success will be determined partially by our own volition and partially by the willingness of members of the inner city to embark on a journey for change. More important metrics of success will be the willingness of the surgery community to
become involved in the inner city. Many of us have forgotten that the public health service in the United States has relied historically on the action of surgeons. The US public health service began in 1798, when Congress established the US Marine Hospital service care for injured merchant seamen. In 1870, this service was recognized as a national hospital system administered under the Surgeon General. Under the leadership of the surgeon general, national programs were established to battle major epidemics such as smallpox, yellow fever, and cholera, as well as developing systems of sanitation, clean water, and sewage disposal.

The pertinent question now is will we, as surgeons, resume our role in addressing the public health needs of our communities? Will we resume our historic role of leaders in public health or will we rely on others to do this work? Will we enter the community with humility and learn from our patients their perception of health by developing the mutual trust required to intervene in this population to achieve improved outcomes at a substantial cost savings? The answer to these questions will determine our ultimate success.

REFERENCES