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Communities Conquering Cancer: Exploring Global Oncology Trends

Dr. Sands:
Welcome to *Project Oncology* on ReachMD. I'm Dr. Jacob Sands, and on this program, we welcome back our guest, Dr. Lawrence Shulman, to continue our conversation about global oncology trends. Dr. Shulman holds many leadership roles in the oncology field worldwide, including senior oncology advisor to Partners In Health.

Now Dr. Shulman, there's a saying that it wasn't fish that discovered water, which is to say that we don't tend to recognize or notice something that completely surrounds us. So, in all international work, I expect that there are things that you notice there that really provide some perspective about the culture of health, and the health care system within the U.S. What are some of the lessons that you've learned from being in other cultures about our current health care system? And on top of that, I know that you've had some high leadership positions around health care within the U.S. as well, and so the follow-up then is how some of your international perspective has led to some of your ongoing work within the U.S.

Dr. Shulman:
You know, that's a really good question, and there are some things that have become much, much more clear to me. You know, I have lived a relatively privileged life. I spent most of my career in the Harvard Medical system in Boston, which is a wonderful place to live, and now I'm in Philadelphia. Though in both of those areas, we have pockets of poverty and patients who are not well-served by the health care establishment, but, it's not always so clear, really, what's happening. What we learned when we went to Rwanda and Haiti was that there were tremendous obstacles to care – poverty probably being the greatest one. And we have a philosophy that poverty should not be an obstacle to receiving health care that you deserve and has great potential to keep you healthy and alive. But in the U.S., that's not always the case. And we don't always reach out to our patients where poverty is a problem, and you think about, well, why is that? Well, in rural Alabama, for instance, you know, when somebody has to worry more about how to raise their children, how to make a few dollars each week to be able to put food on the table, and aren't gonna take the day off to go get their mammogram screening or seek care because they have a new pain or they've lost weight, or something else isn't right. They can't afford it. And it's not so much that they don't have the money, or they don't have insurance. They can't afford to take the time off. They can't afford to miss a day at work. They can't afford to figure out how to put food on their table. And that's true in Rwanda, as well, and so there, we've gone to great lengths to try to overcome that, and parts of that are things like trying to overcome food insecurity and we help to feed our patients in Rwanda. We help to make sure that they're well-nourished. We make sure that they can concentrate on their healthcare, and they have to worry at least temporarily less about the food they put on the table. We don't do that in the U.S. so well. And we need to think about how to overcome what we now call "social determinants of health." And we've spent a lot of time in this past year thinking about those issues. They've been brought to light by a number of the tragedies that have occurred in this country, but we still actually, probably, are doing less of a good job in the U.S. than we are in Rwanda, or frankly, in Haiti. And one of the things that we have studied in the U.S. – I've studied in others – is just looking at the Affordable Care Act, Obamacare if you will and Medicaid expansion, which helps to provide healthcare for the underserved. And some states have adopted that and some states haven't. And so in the U.S., we can see the effects of not helping people, and the effects on their cancer diagnoses – they come in with more advanced cancers, they do less well, they have a higher mortality rate – so I think that a lot of the things we've done very purposefully, in places like Rwanda and Haiti, we need to think more about in the U.S. as well.

Dr. Sands:
What are some of the things that we can do in the U.S. to address some of these very significant disparities that are really providing such different health care outcomes between different communities?

Dr. Shulman:

So, you know, there are lots of answers to that, but I'll give you one example. So, one of the biggest barriers to health care in Rwanda, aside from poverty, is transportation. People have a hard time getting to the hospital. It takes some of our patients in Rwanda two days to get from their home to our hospital. If you ask the people from West Philadelphia, where I live and I work, what the biggest obstacle for them receiving good health care is transportation. It's hard for them to get in, it's particularly hard if they're sick, it's hard if they're coming in and getting chemotherapy or radiation and don't feel well. And so, what we've established at Penn – this got a little bit derailed with COVID, because of obvious reasons – is arrangements with the ride services, like Uber and Lyft, to help with philanthropic dollars and other operational dollars to fund transportation services for our patients. And it's made a huge difference. They come in when they're supposed to. They get the treatments on schedule. They don't miss appointments, and their likelihood of doing well is much greater. And it may be something that you and I take for granted. You know, I can hop in my car and drive down to the hospital at the University of Pennsylvania, and I have a parking spot, you know, and so on. But for our patients, it's an ordeal. And sometimes for them, it's a prohibitive ordeal. Just one small thing, but it makes a difference in how patients access health care and what their ultimate outcomes are.

Dr. Sands:
Yeah, so you've highlighted some really important things, and I appreciate all the discussion about international work, and then also how taking what you've learned from doing that international work, and how to then help communities in the U.S. that have really suffered as well. So, for those interested in a career path including international work, what are some of the ways that people can get involved? And then maybe as a follow-up, or a second part to that question, what are some of the things that everybody can do that would be helpful around the globe and within their communities?

Dr. Shulman:
It's a great question. So, there was a time when none of us were thinking about international medicine. And Paul Farmer, I think, was one of the people who changed that, and he became quite well known and helped many of us to think about the fact that part of our obligation to humanity should be to use our skills and use our resources to bring healthcare to people who didn't have access to that healthcare, whether it's in Rwanda or Haiti or rural Alabama. And I will say that Partners In Health, Paul Farmer's organization, works in the Navajo nation, and other parts of the U.S. as well as working in places like Haiti and Rwanda. So that's become more front of mind for many, many people, and particularly for our students, and one of my jobs is to help students, either undergraduates or medical students at the University of Pennsylvania, to think about global health care as an important aspect of our career, something to think about, places that we could make contributions to. And so we have a very active medical student group that's interested in global cancer medicine that I helped to oversee. Before COVID, one of the more common expressions that I seem to use these days, we sent medical students on a regular basis to Rwanda and Botswana and Haiti. We sent them every summer, and then some of them went for an entire gap year. And I think that's critical because unless you go and spend time in these settings, you never really understand what the problem is. And I tell students that I'm really not willing to work with them to think about global cancer medicine unless they've had the experience of working on the ground. And that was true for me, too. The first time I went to Rwanda, I had all kinds of ideas about what it was like, or what it would be like, and what we could do, and I learned over the years, that one, it wasn't my country – I was an invited guest, and there really only at the invitation of my colleagues there. But also, the context of care was entirely different, and unless you really understood the context of care and the context of the culture that you were living in, you could not constructively work there. And it's amazing how many people don't understand that. They think they're smart, and they oughta know – be able to figure this stuff out. You can't figure it out without going and being there. I think one of the problems, sometimes, we have in world health is that many people who are in policy making decisions have, in fact, never worked in the poorer sectors of the world, don't really, truly understand what it's like to try to provide health care in these environments. So I have students who are going over, I have residents, I now have faculty members who are involved, and the American Society of Clinical Oncology, a year or two ago, formed a task force on how to develop an academic track, if you will, for patients. For people – students – who are interested in global cancer medicine. And we spent a year developing those guidelines, and we published them this last year, and that's a road map for my medical students, for my residents, for my young faculty who want to pursue global medicine as a career. We've helped to sort it out. We've worked with the national accreditation organization so that this is viewed as a credible academic track, and so now there's a path for these people to follow, if that's what they're interested in.

Dr. Sands:
As we round out this discussion, I just want to highlight that I think it's overwhelmingly important what you just stated, that people must go to that country or spend time in that community, to better understand the needs of that community, and that the local individuals there actually have very good insights on to what they truly need and the challenges they're truly facing. And until you spend time with them, you can't really define what these people know, what they're facing.

Dr. Shulman:

There's one other thing I would say, which is, I think, critical. And again, I didn't invent this, it's other people, in fact, a mantra, if you will, of Paul Farmer is you can't be helpful if you bounce in and bounce out. You know, if you show up for a week, you know, give a couple of lectures and leave, you know, and show up a year later and give a couple lectures, nothing gets better. Nothing really happens. So we've engaged on an ongoing basis. I've been in Rwanda for a decade. I've been there more times than I can count. I know the people there. They're friends, we go to each other's weddings. You know, and we've developed trust in our relationship, and because of that, we can work together to build a better cancer program there. Without that, without that sort of longitudinal support, accompaniment without the relationships, it doesn't work, and so I think for people who are interested in this, you have to look at the long game. You have to realize that this is, you know, you go in and drop in for a week, you may pat yourself on the back and feel better, but really it only matters if you're there on an ongoing basis, and they know that.

Dr. Sands:
That's a great way to wrap up our discussion, and I want to thank my guest, Dr. Lawrence Shulman, for joining me today. Dr. Shulman, absolute pleasure having you on the program.

Dr. Shulman:
Thanks so much for having me and for highlighting what I think are these really, really important issues and opportunities for us all. So thank you very much.

Dr. Sands:
I'm Dr. Jacob Sands. To access this and episodes in our series, visit reachmd.com/projectoncology, where you can Be Part of the Knowledge. Thanks for listening.