Black Lives Do Matter

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In this issue of Circulation, Mehta and colleagues1 provide additional information on the state of cardiovascular care for the black population in the United States and, once again, the results remain mixed in our ability to optimize care for all. Their data remain consistent with findings from Bridges et al2 in 2000 in identifying race as an adverse factor for mortality for coronary artery bypass grafting and from Konety et al3 in 2005 who found that the differences in morbidity and mortality outcomes worsened significantly over a 365-day period between blacks and whites in the data set. With advancements in care both medically and operatively for multivessel coronary disease over the past 30 years, there has been a steady improvement in the operative outcomes for all patients undergoing coronary bypass surgery, but there continues to be a persistent disparity in morbidity and mortality between blacks and whites across cardiovascular centers in this country with a direct relationship to these differences based on our definitions of race. Despite a cardiovascular care network that is extensive with modern resources available throughout our systems of care, we are still searching for answers to these differences: solutions that are a mixture of medical and societal ills.

Below are 3 goals on which to concentrate our efforts to help narrow this gap.

1. At 48.9% for women and 44.4% for men, blacks have a significantly higher percentage of both adult men and women who are at risk for coronary artery disease and have overt manifestations of coronary artery disease in comparison with the total population.4 In Mehta’s analysis, the risk factors of hypertension, hyperlipidemia, obesity, diabetes mellitus, and tobacco use are prevalent within the study population. This is not a surprise given the need for the procedure performed; this need is statistically higher for blacks versus whites in the group evaluated. The data set does show the promising news that these risk factors are being aggressively addressed, particularly with a greater degree of adherence by blacks in relation to the comparative population in the use of thienopyridines and angiotensin-converting enzyme medical therapies postprocedure. Present in the data is a significant spread in baseline ejection fraction showing no remarkable differences. Despite this, the outcomes with surgery are worse in blacks and not entirely explained by access to care and comorbidities. A point that stands out in the conclusions from the investigators is that being black in this country by itself is a significant risk factor for an increase in morbidity and mortality with coronary artery bypass grafting. What would be helpful to better inform these data is a detailed assessment of the economic and social status of the patients studied, but those details may not be available in the database evaluated. Overall, it is a troubling assessment that bears the need for a deeper dive into the medical, economic, social, and societal barriers that has led to a difference in outcomes.

Disparity in outcomes in cardiovascular care is not a new issue and has been discussed with the power of an editorial in the very pages of this journal in the past with a call to arms to address the issues of disparity in care.5 Active research looking for subtle genetic differences that may have an impact on presentation and help in personalizing medical care and maximizing outcomes is an area of real interest. Examples of differences in platelet reactivity and a greater propensity for thrombosis and etiologies for heart failure are 2 interesting areas of focus.6 Although, as Lewontin’s landmark article in 1972 details, this is with the realization that the genetic variability is actually less among a group defined as a race than between groups.5 These variations maybe helpful in specializing care for individuals and families who may be afflicted, but it would be a mistake to put the persistent differences in the results of these studies for a whole population in this bucket. Numbers from the National Center of Health Statistics from 2013 show the percentage of blacks more likely not to have health insurance was 18.9% in comparison with whites at 10.6%.7 The persistent difference in rates of unemployment between blacks and whites (9.5% versus 4.5%, respectively) ties directly to the ability to access care.8 Socioeconomic factors of access to care along with opportunities for early prevention, identification of risk factors, and aggressive risk reduction before a sentinel event must play a greater role in our efforts to obliterate these differences in life-altering events between populations that should not be present in 2015. How, as providers whom patients trust with helping make these significant decisions in their care, can we better understand and take these issues under closer consideration and close this gap – how to address these issues head on and make a difference? Below are 3 goals on which to concentrate our efforts to help in narrowing this gap.
Go Where the Patients Are, Understand and Be a Part of the Fabric of Our Patients’ Lives

The traditions of asking our patients to come and meet us where we live, at the level of the caregiver’s understanding of their disease and how they can effectively access care must evolve. In the areas of highest risk, there may be limited resources to address ongoing medical needs and risk reduction for cardiovascular diseases and events. Innovations are needed to get greater access and adherence to care for prevention and ongoing cardiovascular therapy to blacks; meeting all where they live and work to understand and resolve the barriers to care that are not only geographic, but also emotional and economic. Working together to shatter these barriers includes promoting the concepts and solutions that enhance cultural competency for physicians – knowing the language and important nuances of local culture is vital in understanding how we meet our patients in the social and economic environments in which they live and improve outcomes.

Initiatives sponsored by the American Heart Association through the Diversity Leadership Committee like Empowered to Serve are being structured to address these issues head on. Empowered to Serve is working to partner with the large religious communities throughout the country in their local parishes, churches, and synagogues, to increase understanding for the need to identify members who are at risk for coronary artery disease, work to put in place plans for goals of therapy with their local church groups and medical communities for improved compliance and adherence to therapy, and promote initiatives to inculcate healthy living and eating strategies into their daily lives. These types of initiatives have a potential to make a significant impact by leveling the medical playing field for care before the need for revascularization, hopefully decreasing the need for this therapy and lessening the chances of complications from the procedure because of poorer premorbid status.

Level the Playing Field

The data from this study and from others over the past 15 years show differences in the capabilities and outcomes for institutions providing cardiac surgical care for the population. This may be explained by the issues of lower volumes, experience with the procedure, and the ability to provide perioperative care that is at the same standard of the highest-ranked facilities with the lowest morbidity and mortality. Best practice standards that allow institutions to understand and achieve the appropriate highest levels of care should be in place, with the caveat that those who are unable to meet these standards should work toward establishing relationships with associate institutions that are in the highest quartile and where their patients can get the level of care required to maximize outcomes.

Advance the Science

If there are differences in presentation and care that on rigorous scientific assessment are identified and lead to personalizing preoperative, operative, and postoperative care that is touched on by the authors, we should look on this as an opportunity to advance the science and care continuum. The multicenter Strategically Focus Research Initiatives grants now being put in place by the American Heart Association that looks to better understand and solve the issues of hypertension, heart failure, and coronary artery disease in the population is an opportunity to foment a dramatic change on how we treat these diseases within populations that is vital in our quest to change these statistics outlined by Mehta’s group – differences that have not changed since the beginnings of bypass surgery as a therapeutic pathway for ischemic cardiovascular disease.

We live in turbulent times. The acknowledgment that there are concrete differences between how lives are led and the impact of these differences in both the quality and quantity of those lives cannot and should not be ignored. The data and conclusions from this study in this issue of Circulation again bear witness to what our responsibilities are as providers for all the patients that we have the privilege to serve. It is our challenge to understand the issues that are the causes of these differences and our responsibility to find solutions.

Disclosures

None.

References


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