

September 2021



# Commentary

## Confronting Delayed Cancer Screening and Cancer Disparities During the COVID-19 Pandemic

By Chyke A. Doubeni, MBBS, MPH



*Chyke A. Doubeni, MBBS, MPH, is director of the Center for Health Equity and Engagement Research and directs community outreach and engagement at the Mayo Clinic Cancer Center.*

### Commentary Overview

- While delays in cancer screening can affect all populations, the impact is felt most keenly in populations that are underserved in health care, particularly among people from racial and ethnic minority groups and in rural communities.
- Disparities are embedded in all aspects of cancer prevention and screening, from the risk of cancer and who gets screened to the quality of screening and timeliness of diagnosis and treatment.
- Promoting health equity using a model that blends community engagement with evidence-to-policy translational science will ensure that screening, prevention and treatment are equitably available to all Americans.

**Earlier this month, U.S. Senator Amy Klobuchar (D-MN), announced that she had undergone treatment for breast cancer. Senator Klobuchar shared that she delayed her mammogram due to the challenges of the COVID-19 pandemic and she urged others not to postpone “routine health checkups.”**

“[M]ore than one in three adults reported delaying or forgoing health care because of coronavirus-related concerns,” Sen Klobuchar wrote. “Studies have found that thousands of people who missed their mammogram due to the pandemic may be living with undetected breast cancer. Over and over, doctors are seeing patients who are being treated for more serious conditions that could have been caught earlier.”

Sen. Klobuchar received her successful cancer treatment in her home state of Minnesota at the Mayo Clinic Cancer Center. I extend my deep appreciation to the senator for highlighting the value of timely, routine cancer screening, and I’d like to take this opportunity to describe some important work in this area.

During the height of the pandemic, in spring and summer of 2020, there was a steep drop in the use of cancer screenings as noted by the National Cancer Institute (NCI) Director, Dr. Norman E. Sharpless. While some studies show that this gap in participation is now closing, there remains a significant screening deficit in communities that are underserved in health care. Millions of patients are missing needed screenings and, as a result, many cancer cases are being diagnosed at later stages.

While delays in cancer screening can affect all populations, the impact is felt most keenly in populations that are underserved in health care, particularly among people from racial and ethnic minority groups and in rural communities. These disparities have likely been exacerbated by the devastating health and social effects of the pandemic. We can do something about this problem, but our approach has to be intentional and evidence-based.

I have dedicated my career to understanding and mitigating health inequities, with a particular focus on research to reduce disparities in the rates of death from cancer among Black/African American people and other racial and ethnic minority groups with funding from the NCI.

**Before the COVID-19 pandemic, cancer was the second leading cause of preventable death in the United States.** Research I have conducted with colleagues shows that screening is highly effective at preventing death from cancer and that most preventable deaths from cancer occur in populations affected by social injustices. Gaps or disparities are embedded in all aspects of cancer prevention and screening, from the risk of cancer and who gets screened to the quality of screening and timeliness of diagnosis and treatment. For example, Black people are less likely than White people to undergo screening for colorectal cancer, a highly preventable cause of cancer death. We have also found that Black people are more likely to get colonoscopies from less-experienced physicians--and even when they get colonoscopies from comparably higher-skilled physicians, the outcomes are worse when compared to White people.

### The Foundations of Preventive Care

I am privileged to be a member of the US Preventive Services Task Force (USPSTF), where I also serve as chair of the Race and Racism Workgroup. The USPSTF is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine that is congressionally mandated to make evidence-based recommendations about clinical preventive services to improve the health of people nationwide. Congress has mandated that USPSTF recommendations with an A or B letter grade should be covered by insurance without cost-sharing. This includes recommendations related to screening and prevention for breast, cervical, colorectal and lung cancers as well as several other conditions, including mental health conditions and cardiovascular disease. This means that these lifesaving services can be received at no cost.

In a January 2021 [article](#) in the *Journal of the American Medical Association*, the task force noted that “when making recommendations, the USPSTF often finds substantial data that potential lifesaving benefits of recommended services are not equitably available to Black, Indigenous, and Hispanic/Latino people.” It is a tragedy that many people die for no other reasons than due to the social and economic circumstances in which they live and because the health care available tend not to be designed for their needs. These circumstances have worsened during the COVID-19 pandemic and many people have delayed or avoided care or have been unable to access care because of the digital divide. The evidence is clear: disparities are avoidable, unfair and unjust, and are a manifestation of societal inequities.

I currently serve as the enterprise director of the Mayo Clinic Center for Health Equity and Community Engagement Research and direct community outreach and engagement activities at the Mayo Clinic Cancer Center. I also serve as a principal investigator in the Community Engagement Alliance Against COVID-19 Disparities (CEAL), which is funded by the National Institutes of Health. Within the CEAL initiative, my colleagues and I have had the unique privilege and honor of working with many community leaders to address critical unmet needs from COVID-19, including delays in care. Promoting health equity using a model that blends community engagement with evidence-to-policy translational science will ensure that screening, prevention and treatment are equitably available to all Americans.

*On Thursday, October 21, Dr. Doubeni will participate in a panel discussion on cancer health disparities, as part of the 2021 AACI/CCAF Annual Meeting. He will be joined by **Dr. Lucile***

**Adams-Campbell**, associate director, minority health & health disparities research, Georgetown Lombardi Comprehensive Cancer Center; **Dr. Chanita Hughes-Halbert**, associate director for cancer equity, USC Norris Comprehensive Cancer Center; and session moderator **Dr. Robert A. Winn**, Director, VCU Massey Cancer Center, and AACI's vice-president/president-elect.

[View the Full Program](#)

[Register for the 2021 AACI/CCAF Annual Meeting](#)

## Our Mission

Representing 103 of North America's premier academic and freestanding cancer centers, the Association of American Cancer Institutes is accelerating progress against cancer by empowering North America's leading cancer centers in their shared mission to alleviate suffering.

## About AACI Commentary

To promote the work of its members, AACI publishes *Commentary*, a monthly editorial series focusing on major issues of common interest to North American cancer centers, authored by cancer center leaders and subject matter experts.



Copyright 2021 | Association of American Cancer Institutes