



Ensuring Both Accessibility and Usability of Breast Cancer Care

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Breast cancer has long been one of the prime investigative subjects under the expansive umbrella of “health disparities.” While the impact of race and ethnic identity on breast cancer has been repeatedly shown to span across the disease process, the exact mechanism through which it affects epidemiology, diagnosis and treatment, and oncology outcomes remains convoluted.¹ Similarly, disparities findings have been corroborated with breast reconstruction in the field of plastic surgery as well.

Thus, it behooves us to examine at which critical juncture the disparities manifest themselves during the delivery of breast cancer care. Whether it stems from differential barriers to access, perioperative risk factors, or postoperative clinical outcomes,² each mandates its own careful analysis, which can then lead to problem-specific solutions.

The critical issue of accessibility in breast cancer care has recently been highlighted by discordant immediate breast reconstruction rates based on race, insurance status, and geographic access to plastic surgeons.³ Although the Women’s Health and Cancer Rights Act of 1998 has resulted in greater prevalence in patients undergoing immediate breast reconstruction (IBR), the benefits were not equitably shared: privately insured Caucasian women saw a near eightfold increase (46%) when compared with publicly insured African American and Asian women (6%). An even more staggering finding was within the greater patient cohort with private insurance, where women of color had significantly lower IBR rates than their white counterparts.

Hassan et al. further expands on this discussion by addressing community-level drivers of breast cancer health outcomes in their highlighted article.⁴ Their new insights unveil the role of neighborhood-level social determinants of health (SDoH) in postmastectomy patient-reported outcomes. Their cross-sectional survey study utilized area deprivation index (ADI), a validated composite scale measuring area-level socioeconomic risk, and revealed high deprivation groups to be associated not only with lower SF-12 physical and BREAST-Q psychosocial well-being scores, but also higher median BMI and African American patients. Even through a metric that holistically captures multiple proxies (such as race, income, employment, housing, etc.) it was evident that cancer patients’ well-being and quality of life are closely linked to one’s social risk factors.

Their efforts are to be commended, as they underscore one of the ultimate endpoints of breast cancer care as a whole: to ensure both equitable clinical and quality-of-life satisfaction. By challenging us to define patients’ well-being and health in both the individual and societal domains, they suggest that not only accessibility but also usability must be harnessed at each policy initiative and legislative change. As the authors suggest (and we agree), whether patients are equipped to reap beneficial improvements in clinical outcome and subjective well-being may be as pivotal as whether they have access to oncological and reconstructive treatments.

Tim Brown, the president of IDEO, a leading innovation consulting firm, popularized the concept of design thinking, a problem-solving approach that puts “people first”.⁵ Such a human-centered design process starts with vigorous research in user experience on the basis of direct observation and aims to gain insight into user-specific unarticulated needs. This in turn ensures the final product to be useful, usable, and desirable, and it (or an adapted version) of course is no stranger to the field of healthcare innovation.

The authors conclude their article by encouraging readers to adopt a similar empathic mindset in contextualizing the complex associations among the various SDoH outcomes.

From the deep-rooted “sequelae of policies and practices that have perpetuated racial inequalities”,⁶ to unrealistic patient expectations following breast cancer surgery and poor general satisfaction with preoperative informed decision making, a greater understanding in the experiences of our breast cancer patients (especially of those residing in marginalized neighborhoods) will guide us into identifying their unique needs and challenges. This will serve as an important foundational blueprint to align the goals of patients and surgeons in pursuing mitigation strategies targeting specific modifiable factors (e.g., at the level of patient education, legislation, or academic medical institution).

Bridging the health disparity gap is no small undertaking, but as Dr. Paul Farmer eloquently stated, “in a world riven by inequity, medicine [can] be viewed as social justice work”.⁷ It is an imperative that both the oncology and surgical communities examine each intersection at which inequity rears its ugly head. Accessibility and usability must go hand in hand as we collectively strive for value-based and personalized care for all of our breast cancer patients.

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