

2nd Annual Prostate Cancer Forum  
An Educational Initiative

**Ask the Experts**  
**Panel Discussion: Audience Q&A**

**Jean Bonhomme, MD, MPH**  
**Isaac Powell, MD**  
**Robert Chapman, MD**

**I. Define Disparity**

**Jean Bonhomme, MD, MPH**

Health disparity is defined as different demographic groups having different outcomes in terms of the incidence or prevalence of disease and/or different outcomes.

**II. Questions**

**1. Urodynamic Study**

**Participant**

I am taking Lupron, and I have trouble sleeping at night because I am getting up 15 times a night to go to the bathroom. I want to know if I will eventually end up with a colostomy bag.

**Panelist**

A colostomy bag pertains to the intestinal system so you shouldn't need a colostomy for your urinary system. Treatment can prevent you from getting up and night. Perhaps you need a urodynamic study to find out why you are getting up at night.

**III. Medical Societies**

**Participant**

What is the Black Medical Society doing to address the issue of disparity?

**Panelist**

There are a lot of different groups that are trying to raise prostate cancer awareness including the National Prostate Cancer Coalition. We like working through the church, and there are a lot of church groups in the City of Atlanta who are holding health fairs for men. We are also holding health screenings that are independent of the church. More needs to be done.

**Panelist**

In the early nineties, I started a group known as the Detroit Education and Early Detection Program, and we went to 51 churches to educate men about prostate cancer and screen them. That study was written up, and we published it. I also led a group within the National Medical Association to recruit families who had prostate cancer within their family called the African American Hereditary Prostate Cancer Study Group. We looked at the genetics of the families. The National Medical Association has a urological group, and individuals within that group have done a lot in terms of communities throughout the country.

**Panelist**

The African American National Medical Group was formed at a time when African American physicians were not permitted to join the American Medical Association. It continues as a multi-specialty national medical association. We have had something we call the Faith-Based Initiative where primarily but not exclusively African American physicians from Henry Ford have gone to over 30 churches in the metropolitan area and had multiple educational sessions on many health issues.

**Mr. Simons**

At The Prostate Net we have several programs that are designed to try to get people involved. We have one called our Crowns project where we go into a city to the top three or four African American churches. For a month leading up to an event we promote healthcare awareness in the churches, and on the day of the "fashion show" the women from the church dress up in their finest with their finest crowns. They have a fashion show and judging, and they strut their stuff. For every man that the woman brings with her, she gets a point. For every man who gets screened, she gets five points. The woman with the most points wins \$1,000 for her church's health ministry and \$1,000 for a new set of crowns. We have another project where we get local community barbers to work with medical centers and public health agencies to use the barbershop as a conduit of information and education. We have another program called "Gentlemen Check Your Engines" that we do in conjunction with Harley Davidson. We go into the Harley Davidson showroom and hold a health fair.

**Participant**

Several weeks ago I heard that several agencies want to be a part of the churches' conventions to promote prostate cancer awareness, but they are not being permitted to go in and give out any information. They have to pay, but they're not selling anything.

**Panelist**

It costs money to put on events, and the fee to get in defers the cost. Housing the conventions is very expensive, and that is why they charge.

**IV. PSA**

**Participant**

I am with the American Cancer Society, and we went through extensive revamping of our prostate cancer guidelines. Our recommendation is that a man should have both the PSA and the digital rectal exam, but they also have to have a relationship with their doctor. What is being done to promote the educational process in addition to the screenings?

**Mr. Simons**

I was the only patient on the panel of the American Cancer Society that wrote that recommendation, and I had a great deal of argument with the rest of the panel from the standpoint that, one, not everyone out there has a family doctor. Two, much of the argument that was being made about the prostate cancer-screening test obviated the true problem. It's not the test; it's what is done after the test. We have a system that rushes to money, and we have too many situations where an "abnormal" PSA level automatically dictates that a biopsy should be done. Until we change our system from one that compensates doctors for treating illness to one that promotes wellness and the delivering of education, the problems will continue.

**Panelist**

There is a lot of controversy surrounding the PSA test because they say that some individuals with a low PSA have cancer and some individuals with a high PSA don't. The PSA test is constantly being refined, and I personally don't buy the argument against the PSA. It at least gives us an idea of who needs to be watched. Tests don't prolong life. They detect disease. We need to work on the treatments.

**Panelist**

There have been three major screening studies done worldwide on PSA testing, and the best study was the one conducted in Sweden, which found a 44% decrease in deaths in men who got a PSA. Screening for PSA does reduce mortality. There is evidence for that, and we need to get that education out to the medical community and the general community. What the American Cancer Society has put in their guidelines is not practical; it is ideal.

## **V. Media**

### **Participant**

Have you had any exposure to national media campaigns that have used short announcements as opposed to press releases as an effective and creative way to reach people, as it relates to prostate cancer?

### **Panelist**

Because the message is so clouded and there is so much confusion about what the message should be, it is difficult to develop a short statement about what should be done about prostate cancer screening.

## **VI. Political Landscape**

### **Panelist**

There are seven federal offices and agencies devoted to women's health, there are five agencies devoted to children's health, but there is only one agency devoted to men's health. That is part of the Indian Health Service. One of the things we are advocating for is the institution of an Office of Men's Health as part of federal bureaucracy to focus attention on the totality of men's health.

### **Elisabeth Heath, MD**

One of the issues that we see a lot with national recommendations is there is no thought to the practical implications for the physician in the office. Secondly, we can't seem to agree on a message.

### **Mr. Simons**

We have a situation of self-referral where we are seeing many urologists around the country who are leasing out equipment/space to independent radiologists who will give patients a second opinion. Another problem I am concerned about is the rise of "acceptable care organizations" that are designed to bring primary care physicians together into a group who will refer their patients to the established group of specialists that form the acceptable care organization. When you are looking for informed decision-making, there is a monetary issue in the background.

### **Dr. Chapman**

Whenever we talk about an approach to a disease, there are three categories of approach. The least powerful is treatment. In between is early detection, and far and away the most powerful approach is prevention. PSA is what we have, and the fact of the matter is it is useful most of the time.

Accountable care organizations are an element in the healthcare act, and they are set up to save Medicare money. That being said, I don't know that you solve any problems if the organization you set up can't sustain itself because it operates in the red. The big problem with healthcare legislation is that in 2014 there will be a lot of people who suddenly qualify for insurance that currently don't have

insurance, and the challenge is we don't have the primary care people to take care of 30 million more patients. How we are going to meet that challenge is a huge issue that I have not heard any national discussion on.

**Participant**

I've been involved in healthcare for a long time, but I don't hear a healthcare policy being articulated at any level of society that really speaks to what people need by way of the range of care, who should deliver it and how it should be paid for.

**Panelist**

The problem is much more broad. We live in a free market, and you are talking about regulating the healthcare market. There should probably be some movement in that direction, but I don't know how you do it.

**Participant**

When we brought men together in a circle, had one health expert in that circle and allowed them to speak on their health issues, we couldn't get them out of the room. We need to work on developing an environment that makes it okay and comfortable for a man to address his health issues.

**Jean Bonhomme, MD, MPH**

A lot of the things that we are doing in men's health are kind of grassroots. The key is we need to get a federal office of men's health, and we need somebody in Washington, DC to coordinate efforts. Everybody's health is interconnected, but people don't know what the issues are. Next, some people are threatened. They think if you do something for men, you are taking away from women and children when exactly the opposite is true.

**Panelist**

Too few people have heard what Dr. Bonhomme has told us today.

**Participant**

Women know how to take care of themselves because they learned it as little girls, and mothers need to start teaching their sons the same way as they do their daughters. They want their little boys to be as healthy as their little girls.

**Jean Bonhomme, MD, MPH**

Women can assist in this time of transition. They must understand that they will benefit if men are healthier. They can assist because women have the baseline health knowledge more so than men do. Ultimately, men have to take responsibility for their own health, but right now it is not their fault because they haven't been taught.

### **Participant**

We recently held a gala, "That Certain Pink Dress, That Dashing Blue Tie," which is bringing emphasis to breast cancer and prostate cancer. We married them together, and we are trying to get the fraternities and churches more involved. We are going to promote awareness all year long.

### **Panelist**

In the early nineties we did a study to examine why Black men don't come in specifically, and we learned at that time that women had the greatest influence on men's healthcare. Men who are more educated are more independent, and they will control their health. Those who are less educated depend on others to control their health such as their wives, doctors or ministers, so we started educating women about prostate cancer so they would bring their men in. That is what has to happen. Another big barrier is the fear of the diagnosis. Men were not aware that cancer could be cured, and to them a cancer diagnosis was a death sentence. They didn't want to know.

### **Participant**

Is there any focus being given to teenagers and young adults to promote health awareness?

### **Jean Bonhomme, MD, MPH**

Teenagers feel very far removed from mortality, but the disparity in mortality is something that I just found out about a few years ago. This is something that we are only beginning to become aware of in terms of the mortality of the genders relative to each other.

### **Participant**

If you want to address health disparities, it really needs to start in the teen years because that is where smoking begins. There is nothing that would affect public health as much as smoking prevention. That is where dietary training takes place as well, and we need to promote awareness before they adopt habits that we know will cut their lives short.

### **Jean Bonhomme, MD, MPH**

The smoking habit is being pushed on young people, as they are being targeted by the tobacco companies, and that is an issue that needs to be addressed.

### **Participant**

There has been a move in the last year to address childhood obesity, and if we can handle that, we can reduce diabetes, high blood pressure, and cardiac disease. That is a beginning, and if we can continue to focus on childhood obesity, we will make a big dent in the problem.

**Jean Bonhomme, MD, MPH**

The leading cause of death between the ages of 1 and 38 is injuries. If you want to narrow the gap in that age group, we need to focus on injury prevention. The other things that are being talked about, however, will prevent disease down the road.

**Participant**

There is another public health issue that I haven't heard anybody mention, and that is the amount of uranium 235 that is littering the ground around the world right now thanks to bombing. That has contaminated an enormous portion of the world's population and is resulting in an increase in a variety of cancers. We need to stop war.

**VII. Healthcare Providers**

**Panelist**

As a prostate cancer survivor of 14 years, it is very important to follow up on patients. Patients have to take charge of their health. They can't trust that the doctor is going to do everything for them. They have to ask questions and demand appropriate health care.

**Elisabeth Heath, MD**

Men are living longer and longer, and treatments are getting better. We don't know where to actually see them. Do they keep coming back to the cancer clinics 6, 7, 8, or 14 years later? Do they show up at primary care? There are actually guidelines that are available for primary care physicians.

**Kristen Kingzett, MD**

The onus falls primarily on the primary care providers, and they need to be educated on long-term treatment and long-term surveillance.

**Participant**

I have been to dozens of these types of conferences, and I want to know if it is getting more difficult to get patients to look at certain treatments because they see direct-to-consumer advertisements that impact their decisions?

**Panelist**

With the Internet, we are seeing more patients who are more informed about their disease, their care and their treatment. The more educated the patient is, the more they will be aware of the treatments that are out there.

**Panelist**

I have seen more and more patients informed and misinformed because they don't know how to interpret and use the information that they pick up. As often as I am pointing out how a new technology may benefit a patient, I am pointing out how a new technology in their particular case isn't really relevant. At least it initiates a discussion, and as a secondary benefit it probably helps build trust in the relationship between the doctor and the patient.

**VIII. Rates of Prostate Cancer**

**Participant**

Could you comment on states, races or ethnic minorities that have a lower rate of prostate cancer occurrence?

**Panelist**

Asians in Asia have the lowest incidence of prostate cancer, but when they come to this country their diets change and that impacts the incidence of prostate cancer. I'm not sure which state has the lowest incidence, but American Indians have a low incidence of prostate cancer as well.

**Panelist**

Louisiana had the lowest incidence of prostate cancer as of four years ago.

**Participant**

I came here two years ago from the Southwest, and I took care of a lot of Native Americans. I saw a lot of prostate cancer; the problem was that you saw it in a much more advanced stage.

**Jean Bonhomme, MD, MPH**

You have to be careful when you talk about cancer in poor populations.

**Panelist**

When the PSA test became available, the incidence of prostate cancer spiked across the country. Obviously there wasn't more prostate cancer, but we began seeing it more. A major issue with Native Americans is simply access to tests and facilities.