

LiveWell Interview, Carol Mangione Pt 2

Tue, Oct 10, 2023 12:10PM 19:48

SUMMARY KEYWORDS

screening, evidence, task force, topic, recommendation, podcast, implicit bias, work, people, groups, population, women, country, studies, sleep, live, day, benefit, gap, screening tests

SPEAKERS

Dr. Wendy Slusser, Dr. Carol Mangione

Dr. Carol Mangione 00:02

And so you know, it is on the backs of groups like the task force and others to come up with a clear communication strategy. Be clear about where the recommendations come from our methods are on the web, to have tools that people who might have 10th Grade Science aptitude, don't have any trouble understanding what you're saying.

Dr. Wendy Slusser 00:28

Hi, everyone. Welcome back to The Live Well podcast and to part two of Dr. Carroll man Gianni's deep dive into the US Preventive Task Force. For those just tuning in, I recommend going back and listening to last week's part one episode with Carol about the role the task force plays in the medical world. Today, in part two, Carol tells us how the task force carefully is strategically chooses the 15 to 17 topics that works on annually. And she also discusses how to combat implicit bias and evidence gaps in research. So you've given a lot of good examples of how you might come to a decision, maybe you could step us through, like how do you find the topic you're gonna study in the first place,

Dr. Carol Mangione 01:17

the US Preventive Services Task Force has the website, and we have a page where anybody in the country can nominate a topic. And we basically think about the topics in terms of relevance to an impact prevention, primary care and public health. So you know, there might be a topic that for a very small segment of the population, could be helpful. But when we think broadly about everybody who comes to primary care, that it applies to so few people that it might not get elevated high enough on the prioritization list to be a topic that we end up taking on task force at any given moment is working on 15 to 17 topics at a time in smaller groups. We also re review topics, especially when there's new evidence, but almost everything gets reviewed on about a five to six year cycle, what we do is we partner with evidence they centers in the United States, and we create a research plan, where they will have a contract for the federal government and follow a very strict method to synthesize the evidence for the task force. So a

recent one was in 2018, for the first time, the taskforce put out a recommendation for use of prep in HIV. So you know, PrEP is of very good preventive medicine to decrease transmission of HIV. You know, we took on PrEP as a topic, because there were a number of clinical trials. And because we could tell that there was a good possibility, prep might be a great recommendation, the highest recommendation because it saves lives. But we really look at quality of life outcomes, we look at mortality, and we looked at morbidity from conditions. And that's how we decide on whether something is beneficial. So one of our screening tests, it's a great a is cervical cancer screening, when you think about cervical cancer screening, saving lives, the getting the test by itself doesn't save one life, right? You've got to have a pathway to benefit. So this was another big change that we did. While I was one of the leaders of the task force was right below the recommendations, we now have a statement describing what the pathway to benefit has to be. So you know, if it's a great a recommendation, like cervical cancer screening, then women with health insurance should get it for free. Once you screen positive, what has to happen next, you've got to have a biopsy, right? You have to have good access to pathology. And then once you have the diagnosis, you have to have great access to state of the art treatment. So he dies of of cervical cancer in our country, rural women, low income women and minority women. So when you think about that pathway to benefit, there is a step off. At every stage. There are studies that show that there's a reason why cervical cancer mortality is so focused in those health disparity populations and It's not that the free screening test doesn't work in those groups is that everything subsequently, that happens after that has a little bit of an access decrement, a little bit of a quality decrement. And by the time you get to that end of the pathway, you've had much higher mortality in certain groups. So once we've made that research plan, with the Evidence Based Practice Center, it's posted on our website for four weeks, and we invite public stakeholders. But again, anybody could get on the website, and can make comments and suggestions to strengthen that recommendation. We, you know, really look at the public participation in our work, looking toward an eye to how can we make things more equitable? How can we strengthen our recommendations? And so it is a real iterative process with the public.

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Dr. Wendy Slusser 05:55

Yeah, that I think makes it more inclusive. And you mentioned this sort of disparity potentially, with the example you gave for the cervical exam in terms of those that live in rural areas or minority groups of women. There's also, you've mentioned in the past and conversations that we've had about this whole concept of implicit bias or racism, that has happened a lot and research Overall, I'd like to understand well, for our listeners, if you could define what implicit bias means. But also, what is this mean? Or what does it tell us we need to do as we move forward in our research plan?

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Dr. Carol Mangione 06:40

Absolutely. So implicit bias is really a bias that is happening. But somebody isn't deliberately trying to rig the study to make something. So I'm going to be explicit bias, right, if you had a belief that certain groups should be excluded from studies that would be explicit. But what we have in the clinical trial base, which is an enormous problem for the task force, and creates an enormous evidence gap, is that most clinical trials in our country and in Europe, had been done on middle class or higher, predominantly white persons. So now let's think about the types of conditions that the task force has screening tests for, so we can go back to breast cancer

screening. So what do we know about breast cancer screening that doing mammography saves lives, okay. But we have this really enduring an intractable survival differential for breast cancer. So black women in this country have a 40% higher mortality from breast cancer than white women do. And we also know that black women, on average, in the national data, get more mammograms than white women, it's very hard to take a foundational evidence base, and to create a grade and to create a screening strategy with a starting age and a stopping age and interval for how often you screen when the women in the country who have the worst morbidity and the worst mortality. We're not in any of those studies in sufficient numbers to say anything about whether they should actually have a different screening strategy, either a more aggressive one, or with different supplemental tests. We don't know that. That's a massive evidence gap. So what do we do? We have no reason to believe that breast cancer screening wouldn't work in this group. So we extrapolate from studies that people weren't included in and to including them for the screening tests. And, you know, sometimes those extrapolations will be right. But I bet if we looked, and if we did more research, sometimes we would find that that Rob, that same problem applies to lung cancer screening, where black men have the highest rate of mortality, and we're not represented very well in the screening trials. That same problem goes for screening for diabetes, for screening for prostate cancer. So this is you know, these are massive evidence gaps. And what's happening is our populations that have the worst health disparities and get these conditions more frequently than other people aren't in the preventive evidence base. And so you know, when we in test first world, think about evidence gaps, there are evidence gaps that we would love to have filled. And certainly screening for young children, infants, for autism, we have a big evidence gap there. And so we're on an eye for kids under 18 months, because we don't really have very good studies. So that's one type of evidence gap.

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Dr. Wendy Slusser 10:22

In the past few years, and specifically, the pandemic, we've seen so much about how politics and specifically the political divide in science communications are related. How do you think this has impacted scientists and the general population? This kind of division and sort of skepticism of science these days? How is that harming our population?

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Dr. Carol Mangione 10:50

Yeah, so I think I mean, I think what you're driving at is really a lack of trust, there are certain entities in our country that have had long standing trust by the population. So one of those entities would be the Centers for Disease Control. And I think that two forces were simultaneously at play. And anytime a topic gets politicized, invariably, it's hard to get the voice of unbiased evidence base out there in front. So anytime there's a group that has a way to benefit from an alternative narrative, you're going to run into trouble with trust in the population, with the advent of the Internet, with the absolute swamp of uncurated information, and with a public that is getting less training in scientific method, and less skills, to how to evaluate information coming at them. What we're finding is that, you know, there's almost a 50% segment of our population that during COVID really felt like the information out there about the effectiveness of the vaccine, the information out there about whether the pandemic was a problem, just was a very politicized and muddled story, because there are all of these other communication channels. And because there are people who benefit from the discourse, not you know, being more confrontational, benefit, politically benefit economically, you know,

we end up where we are today. And so I think that changing narrative coming out of some of the trusted entities made people stop trusting them. You know, this reminded me a lot of are going to be in the AIDS epidemic, where, you know, the way we thought things were working, we would find out a year later, they actually weren't working that way. You know, and I think anytime you have a new disease, and especially if it's a politicized disease, that that, you know, you get this big erosion of trust. And so you know, it is on the backs of groups like the task force, and others to come up with a clear communication strategy. Be clear about where the recommendations come from our methods are on the web, to have tools that people who might have 10th Grade Science, aptitude, don't have any trouble understanding what you're saying, I feel like, that's our best way to combat this problem. But honestly, there there's so much money and stakeholders invested in the false narratives, that it's hard to see how we're going to get out of this situation at this point, which is tragic, because at the end of the day, it's all about lives.

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Dr. Wendy Slusser 14:07

Yeah. Communication is so critical. And now there's so many routes for communication and getting people's attention as well. You know, the the work you do Carol, in your day job and then in these volunteer positions is really something that is inspirational and also bring so much confidence to I think those that are delivering medicine, returning back to the individual and you the last question that we usually ask our podcast guests is what does it mean for you to live well?

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Dr. Carol Mangione 14:46

Oh, wow. That's a good question. You know, I'm pretty evidence based. practice what I preach them so you know, I think for me to live well, I'm I'm pretty profoundly influenced by the importance of sleep. You know, I think that there is a growing body of evidence that people, especially in my age group, who get less than seven hours of sleep a night are probably hurting their cognition in the future. And, you know, I think none of us want to hurt our cognition, that's for sure. And so, you know, I think I really prioritize making sure I'm getting enough sleep. And, and I can kind of point to a date and a time I was about 2017, when I realized I just needed to make a major life transformation to make that happen. I really believe quite strongly in physical activity. I'm, I'm a privileged person. So I live about two miles from my job. And since 2001, I've been able to walk to and from work every day. So the CDC calls me a utilitarian exerciser, because I use my feet to get to my job and back to my house every day. And you know, that gets me four miles a day. And then I try to add on a few more after that. And I'm also a firm believer in doing some isometric exercise. And I do do that about three or four hours a week too. And, you know, I think, in my own lived experience that really has helped me in terms of my energy level, in terms of minimizing joint pain, things like that. So yeah, sleep, exercise, having fun. So I think there's a growing body of evidence that loneliness is really dangerous for people's health. And so, you know, I try hard to make sure that I'm seeing friends and that I'm, you know, doing things that are enjoyable for me, whether it's going to theater, going to the movies, or making a good dinner, you know, I think that those three things are important then again, you know, healthy eating, you know, what we eat every day, you know, I'm not like radical about that. But I'm, I'm a big, you know, fruit and vegetable person and believe in a lot of variety in my diet, you know, so So I think those are, those are like my big four principles, and I do pretty much live by those.

D Dr. Wendy Slusser 17:19

I think that practicing what you preach is such an important aspect of your life. And I agree with you sleep is totally underrated, rated. I mean, it's so underrated. And all those other parts, you know, physical activity, I love your utilitarian exerciser.

D Dr. Carol Mangione 17:38

That's fantastic.

D Dr. Wendy Slusser 17:40

Well, I just want to say thank you so much for this tremendous conversation. And I'm sure we'll want to have you come back and talk about maybe some other topic in the future. And so thank you for your generosity, giving your time today and we'll have to go see a play together. Thank you again.

D Dr. Carol Mangione 18:02

Thank you, Wendy for the opportunity. And yes, I look forward to talking to you next time. Take care, okay.

D Dr. Wendy Slusser 18:11

I really hope this was just as informative and inspiring to you. As it was to me. This podcast is an awesome resource to share with medical students or anyone interested in public health as a whole. Thanks again to Carol for her time teaching us about her work and her service in the Preventive Service Task Force. We are so glad you joined us today in this conversation. To learn more about today's guest, and to explore the entire podcast archive, visit our website at healthy.ucla.edu and find the podcast page under the media tab. If you enjoy this episode, the best way to support the show is to subscribe on Spotify and Apple podcasts. And if you can leave a review or share on social media even better. If you have any guests suggestions, visit our website for the submission form or email us live.well@ucla.edu or direct message us on Instagram at healthy UCLA. Visit the show notes on our website or on whatever platform you're currently listening to and check out organizations ideas or people mentioned in this episode. Thanks for being on this journey with us. This episode has been brought to you by the Seminole healthy campus initiative Center at UCLA