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# Prostate Cancer Screening: Leadership Implications

Dorothy D. Zeviar, EdD

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## ABSTRACT

*The epidemiology of prostate cancer in the African American population is well-known to healthcare practitioners; prostate cancer disproportionately impacts African American men 2:1 compared to Caucasian men. The Prostate Cancer Foundation hypothesizes that the increased mortality risk may be due to delayed diagnosis, poor work-up, and less complete treatment, indicating inequitable use of the health care system. The National Cancer Institute suggests that availability of health insurance and physician contact may increase screening and thus, reduce cancer mortality. Because health behaviors and health outcomes are impacted at five different levels according to the Social Ecology Model of health – intrapersonal, interpersonal, organizational, community and social/policy levels – this report proposes that a Collaborative Leadership model based on the work of the Turning Point Leadership Development National Excellence Collaborative be applied for greatest and widest effect. In conjunction with this model is the assumption that public health facilitators and leaders espouse the values articulated by Robert Greenleaf in the theory of servant leadership – i.e., that people’s highest priority needs are being served first, and that people grow as (healthy) persons as a result of their personal involvement in issues that touch their lives. Both approaches work together to reduce health disparities and increase quality-of-life for so many people.*

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## Background

This paper presents the case for action around the public health conditions that contribute to disproportionate mortality among African American men, and uses one leadership theory and one leadership model that may help create interest in, and motivation for, improving the status quo. Prostate cancer is second only to lung cancer as the most common cause of cancer death. African American men have the highest rates of prostate cancer in the world. Moreover, they are more than twice as likely to be diagnosed with prostate cancer and have a mortality rate more than double that of American Caucasian males (UPMC Cancer Center, 2010; NCI, 2010). Data from the Centers for Disease Control and Prevention (CDC) indicate that African American men have a 20% chance of being diagnosed with prostate cancer, and a 5% chance of dying from it (CDC, 2010). Whereas the risk of developing prostate cancer begins at around age 50 for Caucasian men, “risk begins at age 40 for black men and for those who have a first-degree relative (father, brother, maternal or paternal grandfather or uncle) with prostate cancer” (UPMC Cancer Center, 2010).

Data from several credible health resources, including the CDC, prostate cancer research organizations and the U.S. Census demonstrate poorer health outcomes for people characterized as from a lower socio-economic status (SES), identified by lower income and higher rates of unemployment or under-employment, with lower educational attainment, lacking access to healthcare and health insurance, and lacking strong social support and

social networks. Lower SES is often used as a proxy for African-American men; the PCF hypothesizes that “[The] “increased mortality risk of patients of low socio-economic status is almost completely explained by delayed diagnosis, poor work-up, and less complete treatment, indicating inequitable use of the health care system. Policies ensuring a more equitable access to screening and treatment are needed to eliminate these disparities” (PCF, 2010). A recent report from the National Cancer Institute (NCI) attributes lower cancer screening behaviors to barriers such as “education, income, usual source of care, health insurance and recent physician contact” (NCI, 2010). They suggest that health interventions to overcome these barriers could reduce the mortality associated with cancer.

The Social Ecology Model (SEM) of health postulates that multiple influences affect health outcomes, including factors at the intrapersonal, interpersonal, organizational, community and social/policy levels (McLeroy, Bibeau, Steckler & Glanz, 1988). Because so many levels of influence can impact health outcomes, this author proposes that the Collaborative Leadership model sponsored by the Turning Point Leadership Development National Excellence Collaborative is the leadership model that can be applied to greatest effect to help diminish the health inequities among African American men and the mortality burdens they bear, especially relative to prostate cancer (Turning Point, 2002). Underlying the application of the Collaborative Leadership model are the beliefs and values as articulated in the theory of servant leadership by John Greenleaf (1970). Applying a

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collaborative leadership model in conjunction with values espoused in servant leadership; i.e., that people's highest priority needs are being served first, and that as a result of the collaboration, everyone grows as a (healthy) person, public health facilitators and leaders may help reduce health inequities and unequal disease burdens, and by extension, improve the quality-of-life of so many people (Greenleaf, 1970).

### Background and Significance of the Problem

How can public health practitioners help reduce health disparities and increase longevity in good health? What constitutes good health? In 1948, the World Health Organization (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." In 1977 it added "the major social goal of governments should be the attainment by all people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life" (WHO, 1948, 1977). Beyond the altruism of this goal, economists have emphasized that "health equals wealth" to all societies; therefore, it is in a government's interests to promote good health and prosperity amongst its citizens (Byrne, 2003).

How we are working towards that goal here in America is outlined in the Department of Health and Social Services Healthy People 2010 program. Two major overarching goals have been tracked and analyzed over the past decade:

- Increase quality and years of healthy life; and
- Eliminate health disparities.

Quality-of-life measures include physical and psychological health, social relationships, independence, and activity limitations. Health disparities are related to the first goal and analyzed according to race and ethnicity, among other socio-economic stratifications. A mid-term analysis of how well the *Healthy People 2010* program was attaining its goals revealed that African Americans had disparity rates over 100 percentage points higher than the best group, usually in the category of leading causes of death, especially prostate cancer mortality. Black men continue to lag behind Caucasian men in longevity and quality-of-life (Healthy People, 2005).

Epidemiologic data from the National Cancer Institute (NCI) indicate that incidence rates for prostate cancer between the years 2003-2007 were 235/100,000 African American men versus 150/100,000 Caucasian men, and death rates were 54/100,000 African American men versus

23/100,000 Caucasian men (2007). These data generate many questions: Is race/genetics a factor in assessing risk of prostate cancer? Or, are there other etiologies responsible for the disproportionate incidence of prostate cancer among African American men?

Two sets of factors are proposed as "upstream" determinants of health by public health professionals – socio-economic factors such as income and employment, education, health literacy, insurance, and social support/social cohesion; and environmental factors such as crime, social capital, civic engagement, exposure to toxic chemicals, homeownership, social and behavioral norms, stress and segregation (Coreil, 2010). However, a 2002 Institute of Medicine (IOM) report dismisses these factors as unrelated to morbidity and mortality associated with prostate cancer on the basis of insufficient research; IOM does, however, acknowledge disparities in healthcare access, utilization and quality of healthcare as determinants of health (LaVeist, 2002). Whether the reader takes the public health view of social determinants or the IOM view of disparities, one must ask: how are these non-biologic factors related to increased morbidity and mortality from prostate cancer?

It may all begin with education. The ability to read and understand health literature (paper-based or electronic-based), to analyze information and apply it to one's personal situation, and to make decisions in the face of a plethora of information, is related to health literacy. Health literacy helps one feel more self-efficacious about taking care of one's health ("knowledge is power"), and thus, increasing one's quality-of-life and longevity. Without education, young people are relegated to high-stress, low-paying jobs with little control. Low-paying jobs frequently lack health insurance, and the stress of meeting month-to-month financial obligations often supersedes the "option" of buying health insurance for oneself and/or one's family. Without insurance, routine visits to healthcare providers is an unaffordable luxury, and healthcare is often obtained at the emergency department of the local hospital or clinic when the condition becomes acute and unbearable. Persons with low-income jobs often live in run-down, high-density, high-stress, high-crime neighborhoods where social cohesion and social capital are rarely found. Once in this socio-economic environment, people find it difficult to move up and out; thus, life conditions usually remain status quo.

In a 2009 article, Marks (2009) reiterates the importance of health literacy on health outcomes. She states that there are three categories of health literacy – basic literacy or comprehension; interactive and participatory literacy; and critical literacy, i.e., the ability to critically analyze scientific data and assess its appropriateness for the individual.

She concludes that health literacy is a “significant predictor” of health outcomes. It appears evident to this author that health promotion encompasses increasing the health literacy of our clients for improved health outcomes.

Racial discrimination and institutional racism contribute stress to a person’s life, thus contributing to a physiologic environment conducive to pathologic conditions among African American men. Institutional racism restricts economic and social achievement, thus limiting income and access to quality healthcare. Health policies that address “upstream” etiologies of poor health must be legislated and enforced (Williams, 2009).

Why are genetic factors less a health determinant than SES and environmental factors, especially as related to prostate cancer incidence and mortality in African American men? What responsibility do public health professionals have to reduce socio-economic and environmental factors to help reduce morbidity and mortality associated with prostate cancer among African American men? The answer lies in leadership and values.

Anecdotally, research values that drive health professionals, the answer is invariably “I want to make a difference.” We make a difference through serving others, by helping educate them, by applying evidence-based research, by helping create community capacity, and in so doing, help increase self-efficacy and quality-of-life. These values are inherent in the theory of servant leadership as espoused by Robert Greenleaf (1970). Additionally, to help *facilitate* capacity-building and self-efficacy, public health workers must be mindful that we are not doing *for*, but we are doing *with* people in the community. The ideal model by which to accomplish this is through the collaborative leadership model which will be elaborated in a subsequent section (Turning Point, 2002).

### Factors Related to or Affecting the Problem

As previously stated, several priority factors influence higher rates of morbidity and mortality among African American men regarding prostate cancer. The first one is knowledge and health literacy, including awareness of the risks and the ability to make a clear health decision in the face of those risks. Two tests are available and used together to diagnose prostate cancer – the digital rectal exam (DRE) and the Prostate-specific Antigen (PSA) test (a blood test). The problem for any man facing a positive prostate cancer test is making a decision about follow-up care. Because no one protocol is advocated by any medical authority, nor is any one protocol right for the current or even continuing situation, a man must have the health literacy and ability to take in all the current data of his health history and, with his health provider,

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come to a consensus and resolution about how to proceed with his care (CDC, 2010).

Another factor involves men’s access to prostate cancer screening, healthcare providers, and follow-up care, if diagnosed with cancer. Often, free prostate cancer screenings are offered in neighborhood clinics, but many men fail to take advantage of these screenings for the following reasons:

- Don’t know why it’s important (awareness of risks)
- “Discussing my prostate is embarrassing”
- No insurance for follow-up care
- Don’t want to hear “bad news”
- Lack of social support, someone to “take care of me”

The relevance of bullet point 4 is two-fold: there are often few, if any, environmental cues for a man to be encouraged to get screened. Lacking a primary care doctor, he will not necessarily be reminded to get screened, unless the screening is part of a workplace or neighborhood clinic activity. Spouses and significant others often are also unaware of the risks and do not encourage screening (Hart et al., 2008).

An effective technique that is being researched and applied in many metropolitan areas of the United States is Lay Health Educators. In this program, barbers are recruited to volunteer to act as peer health educators to their clients in regards to men’s health, particularly prostate cancer health. The majority of barbers enthusiastically endorses this approach and helps counsel clients about risks, screening and follow-up care. The reason that barbershops were chosen is two-fold: first, barbershops are perceived as “the black man’s country club” where they can go and be themselves, relax, and at same time, be away without fear of reprisals or discrimination, and network with others. Second, barbers and ministers are perceived as community leaders and thus are a good source of trustworthy advice on almost any topic affecting black men (Hart et al., 2008).

In a second phase, prostate cancer education and screening programs often go to beauty shops and churches to recruit ministers and spouses/significant others to act as lay advisors as well. Education and materials are provided, coaching in discussions with men about prostate health is practiced, and information about community resources is provided. In this way, both inter-personal and community levels of the social ecologic model are enhanced and complement each other.

To enhance the organizational level of the social ecologic model, researchers often go to workplaces and clinics to work with healthcare

providers to provide them with prostate health education materials, reminders to mail to men to have annual screening, and coaching to enhance communication and sensitivity skills.

Lastly, but perhaps most importantly, the health policy level of the SES model must be addressed to meet client needs and expectations. Often grants are provided that enable free screening and fund extended clinic hours to accommodate working men's schedules, transportation is provided if needed, and additional medical assistance for follow-up consultations is provided through the grant. The last point is often the determining one in terms of the ultimate success of the program; i.e., reduction of morbidity and mortality associated with prostate cancer. Further research and grant funding are needed to meet *Healthy People 2020* goals and objectives (Hart et al, 2008). Repeating the conclusion of the 2002 IOM report and prostate cancer screening advocates, further research is needed to determine the strength of the relationship of "upstream" socio-economic determinants of health outcomes and health disparities among minorities (LaVeist, 2002).

### Implications for Leadership

Because so many social determinants of health are involved in improving the morbidity and mortality rates of prostate cancer among African American men, rather than simply genetic/organic causes, the role of public health in this issue highlights the need for a strong, clear vision of good health, as defined by the WHO, and leadership to involve all levels of the social ecologic model to make it happen. The desire to add value, to strengthen community capacity for health literacy, self-efficacy, social cohesion and capital, and improve quality-of-life is inherent in the theory of servant leadership. Servant leaders such as public health workers and educators, researchers, health providers, community leaders and health advocates help facilitate the manifestation of priorities of the communities they serve. Other principles of servant leadership include:

- Develop people and communities to bring out the best in them;
- Coach and encourage people to be the best they can be;
- Facilitate personal growth, development and self-expression;
- Listen, value people, build trust, and build the community; and
- Transform the community and quality-of-life (McCrimmon, 2008).

In conjunction with servant leadership values and principles, a public health leader must have a community orientation, as described in the bullets above. One cannot be a leader by oneself and improve health outcomes; one must be engaged with others in the community and bring all levels of the social ecology model together under a shared vision and manifestation of improved health outcomes for all stakeholders. A public health leader with a community leadership orientation helps align both the health needs and ethno-centric values of the community with the goals of *Healthy People 2020* to meet and exceed expectations at all levels of the social ecology model.

A strong and effective leadership model to accomplish the goals stated above is the collaborative leadership model espoused by Turning Point (2002). Common values bridge the collaborative leadership model with the theory of servant leadership – a spiritual and moral imperative, commitment to and caring for the community, sharing a vision of what can be, inclusiveness, commitment to collaboration *with* and not doing *for*, and mobilizing all stakeholders. With shared values, mobilizing refers to facilitating people's knowledge and growth as contributing members of the community, developing people, and collectively (synergistically) achieving the vision of improved quality-of-life for everyone.

"Collaborative leaders do not fear loss of control" (Turning Point, 2002, p. 5) because collaborative leadership is not about self-interest, but about building sustainable relationships and communities for the long-term.

This section will describe the collaborative leadership activities that are happening in many communities across the nation to help reduce the burden of prostate cancer among African American men. This section will describe the activities within each level of the social ecology model and the success each has achieved.

- Intra-personal – educational materials and videos are widely available to enhance African American men's awareness of their risks for prostate cancer, the social and network opportunities available to men to learn more about prostate cancer, and directions for where to go for further information and assistance (CDC, 2010; PCF, 2010; NCI, 2010; Prostate Health Education Network, 2010; Center for Equal Health, 2010; ZERO, 2010). This information is available and disseminated throughout African American communities through places of business, churches, civic organizations, libraries, and available online.

- Inter-personal – friends, family and significant others are encouraged to volunteer to become peer health educators, along with those in the community described below. The inter-personal level is one step closer to the individual in terms of confidentiality, trust and proximity.
- Community – some overlap between peer health educators and community leaders such as business owners and church ministers occurs at this level. Community leadership and peer health educators are volunteering to learn more about the risks to African American men and prostate cancer, to help spark men's interest in learning more about men's health, to dispel myths and misunderstandings, and to encourage men to go for annual screening. They also help build self-efficacy for making personal decisions around treatment protocols after diagnosis. Barbershops, beauty shops, and churches in African American communities are key to successful implementation at this level of the social ecology model (Luque et al., 2010; Frasier et al., 2009; Rivers, 2008).
- Organizational – churches and places of business in African American communities are key to the success of enhancing men's health at the organizational level. Again, peer educator volunteers are a key component of success, as well as an organization's willingness to participate in screening activities. In many communities, grants have been approved for free clinics (rolling clinics (buses) come into a community for a few days and provide free screening), and/or extending health facility hours and days of operation to improve access. Healthcare providers are coached on how to talk with clients about men's health issues, and reminders for screening are mailed out annually (Scripps Media, 2010).
- Social/policy – communities are developing community capacity (social capital) to advocate at county, state and national levels for improvements in health quality-of-life, such as added Medicare/Medicaid coverage for basic cancer screening, expansion of community health clinic services, and increases in funding for men's health issues. Communities are also having some successes at increasing green space, access to recreation spaces, and decreasing crime, all of which improve quality-of-life measures (NACCHO, 2010; ZERO, 2010).

## Conclusions

Byrne (2003) reminds us that "health is a productive economic factor in terms of employment, innovation and economic growth" (p. 3). He adds, "Health is a driver of prosperity" (2003, p. 3). Without health and longevity, people are not productive, cannot contribute to the Gross Domestic Product (GDP), use health resources without "giving back," and are a drain on the national economy. He challenges countries to think of healthcare as an investment in their people, rather than as an expenditure, such as is happening here in America. In working at the social/policy level, we must make arguments within the context of policymakers' worlds; that is, we must argue for the cost-benefit advantages of enhanced funding for healthcare and improved health outcomes. As new birth rates diminish and the numbers of those living with chronic conditions increases, our nation's productivity and ability to financially sustain itself is jeopardized. As public health professionals, we can help make a difference in our communities by developing leadership skills in ourselves and sustainable personal growth in our stakeholders, developing a joint vision of quality-of-life within our communities, and help facilitate collaborative goal-setting and attainment through the application of our values and public health skills.

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