AN INTERVIEW WITH...

Lee Kirksey, MD, MBA

Dr. Kirksey discusses his efforts to address health care disparities throughout the pandemic and generally in vascular care, needs for future trials studying complex peripheral artery disease, plans for the Center for Multicultural Cardiovascular Care at Cleveland Clinic, and more.

What led you to choose vascular surgery as your specialty, and what is your favorite aspect of it?

In a word, "serendipity." As a medical student at The Ohio State University, vascular surgery was my elective rotation during general surgery clerkships and then ultimately my first rotation as a general surgery intern. I had really good mentors: Drs. Mark Mantell, Michael Weingarten, Charles C. Wolferth, and Dan Woody. All of them had an infectious enthusiasm for blood vessels and were of the "see one, do one" training era. Dr. Alex d'Audiffret was my chief resident. He was going into vascular surgery and gave me a lot of early opportunities and confidence. Most of my peers probably agree that vascular surgery isn't for everyone, but for those who find it to be a "calling" of sorts, it's tremendously rewarding.

I was fortunate enough to train with Dr. Bruce Brener in the pre-FDA approval era of endovascular aneurysm repair when we were using the Talent endograft (Medtronic) on Dr. Michael Marin's investigational device exemption. Dr. Marin was obviously the right guy at the right time to transition from a basic scientist and help usher in this new endovascular era with innovation.

I've also been fortunate to find mentors, sponsors, and allies personified in Drs. Michael Golden, Ron Fairman, Dan Clair, and Vince Rowe. I'd like to say it's a combination of luck and being prepared when opportunities present themselves.

It sounds cliché, but I'll say it anyway. Vascular surgery has such a broad spectrum of procedures and patient presentations that I find very few days are not clinically stimulating. Endo, open, hybrid—figuring out how to match the solution to the patient substrate, including their physiology and anatomy, is something I never tire of.

In this current phase of my career, I'm discovering opportunities to look at the systems that surround the care of the vascular surgery population. It was fortuitous to find a medical career that has clinical and academic opportunities that far exceed what I could have predicted when I first held a "Castro" needle holder.

Your research within the vascular space is varied in terms of anatomies, diseases, and procedures, and you've recently studied and published on nonvascular COVID-19 concerns and health care disparities. What can you tell us about the challenge of shifting from predominantly vascular disease research to the impact of COVID-19?

There is no doubt that in so many ways, the COVID pandemic has been a horrible experience for everyone. I tried to find a silver lining amid the distress we witnessed.

Early on, it was very clear to me that the same people and communities who are disproportionately impacted by chronic health conditions and health care disparities (generally and concerning vascular disease) were being specifically overwhelmed with the consequences of COVID. Those communities were disproportionately low income; socially, geographically, and economically isolated; and minority communities. I felt it was important for the public to tie the historic and long-standing health and health care inequities to the pandemic in a way that made people realize what I and many others have been talking about for decades: By most estimates, > 50% of health outcomes are determined by social and economic factors and are "baked in" before a patient ever enters the health care system.

We have been able to shift people's focus to the health disparities topic in a way that, if we are strategic and relentless, might have an enduring impact. As an example, how do we increase the pipeline of physicians who come from and represent the most underresourced communities? Whether it is Appalachia, the rural south, a Native American reservation, or a Barrio of Texas, if a physician comes from that community, they are more likely to return and more likely to understand and solve

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the unique health care challenges of that community if given the proper resources and support.

The role of digital technology will increasingly play a role in the delivery of health care to underresourced communities, provided we can enhance equitable access to broadband (see the Affordable Connectivity Program). The COVID pandemic accelerated the acceptance of virtual visit technology from the glacial pace at which it was evolving. We now must support our professional societies as they lobby government legislatures and public and private payors to appropriately reimburse for this care. There is absolutely no reason that we cannot figure out how to create more equitable enrollment.

Also, the pandemic was an opportunity to attempt to reengage with the communities we serve and help them grapple with the challenges of public health messaging during a time in which the message was fluid and everchanging—frankly, in a way that was unsettling even to health care providers. I saw it as an opportunity to invest in and earn the trust of our most vulnerable communities. One of the slogans of the Society for Vascular Surgery (SVS) is "More than a surgeon." I think that is accurate for the role vascular surgeons play in the communities we serve.

And, regarding disparities in vascular care, what are the most pressing priorities you plan or hope to see addressed in the next few years?

The big opportunity is for vascular care providers to be institutional and community leaders in population care. In whatever part of the country that my vascular care colleagues practice, a vulnerable community of patients exists. Not only does that group of patients have relatively worse cardiovascular health outcomes but those patients are also responsible for a disproportionately high health care spend. When we can combine excellent outcomes by intervening when appropriate and more importantly *not* intervening when the evidence is lacking (eg, mild intermittent claudication, small abdominal aortic aneurysm), we can impact the value-based care variable across a large population. With all of our appropriateness data from SVS and the Vascular Quality Initiative, vascular surgeons, vascular medicine specialists, and cardiologists should be leading the way on this. At the core of this conceptual paradigm is equitable health care for our communities.

Our vascular care community should also lead the way in advocating for equity within clinical trial enrollment. The rate of enrollment for minorities and women in disease areas that disproportionately impact these groups should be mirrored in clinical trials. This proposition only seems fair if the medical device and pharmaceutical industry would like us to extrapolate trial results to "real-world" clinical practice in these groups.

I realize that this is a multifaceted problem that is not as simple as a federal mandate. To accomplish this, we need more diversity among trial design and steering teams in gender, race/ethnicity, practice background, and practice geographic location. Culturally competent and, when possible, concordant teams must approach patients with appropriate educational material and not with a preconceived notion based on unfounded historical myths of minority resistance. My cardiology colleague Dr. Aruna Pradhan, a clinical trialist at Brigham and Women's Hospital, conducted a small survey within a small Boston community. She found that one of the top reasons minority patients have not participated in clinical trials heretofore is that they have not been asked. I'm confident that our vascular care community can push this forward.

I'm also very proud to be a member of the Society of Black Vascular Surgeons. This organization, mostly comprising SVS members, was founded in the midst of the pandemic and functions with an agenda identical to SVS, focusing on issues germane to the community of Black American vascular surgeons and the patients they serve. Our hope is that as the organization evolves, the collaboration will actually enhance the pace of identifying and achieving mutually beneficial goals.

Many medical societies in recent years have made commitments to diversity, equity, and inclusion (DEI) efforts, including the formation of the DEI Committee you co-lead at Midwestern Vascular Surgical Society (MWVS). When it comes to DEI issues within the field of vascular surgery, what are the immediate and long-term solutions you would like to see? What are your goals for the MWVS committee?

The focus on broad and inclusive equity is another important outcome of the social unrest seen during COVID. The MWVS DEI Committee is chaired by Dr. Bernadette Aulivola, who has done a fantastic job of championing inclusion over the years. Through her efforts and those of countless other women leaders in vascular surgery, we have a template of how we create equitable and meaningful representation in regional and national societies.

MWVS has done a fantastic job of finding out what people enjoy doing and reaching out to those individuals to better distribute opportunities to be active members. We must always remember that professional

societies exist to serve their volunteer members, and we seek a membership that is representative of the culturally, gender, racially, and ethnically diverse group of patients we serve.

What would you like to see from future trials studying patients with complex peripheral artery disease (PAD)?

We must collaborate with and assist trial-sponsoring and regulatory entities (ie, FDA and our industry partners) on the critical importance of equity in medical device and pharmaceutical trials. This equity should be across socioeconomic lines, as well as race, ethnicity, and gender. It is ridiculous to have PAD trials with < 10% Black, Indigenous American, and Latinx populations when we accept that these groups bear a disproportionate burden of disease with poor clinical outcomes.

Industry and regulatory agencies must share what they believe to be the economic, logistic, and policy barriers that prevent equitable enrollment. However, we should understand that changing a longstanding paradigm does not occur without a will to make that change. It just makes sense that if our goal is to provide safe, clinically effective, cost-effective care to the broadest spectrum of patients, the study population must mirror the clinical practice group.

Hopefully, we can extrapolate unique learnings from COVID about virtual digital technology in health care to reduce some of the time and cost constraints that prevent certain demographic groups from agreeing to participate in clinical trials.

Inserting community health workers into the process of recruitment and enrollee retention is a novel way of addressing how to make patients and families more comfortable with clinical trials. As an example, just think of our absolutely abysmal historical performance with enrolling Native Americans in PAD trials. We know that the Native American community has a burden of PAD that is underdiagnosed and undertreated and, as a consequence, has startlingly high rates of amputation, similar to Black Americans.

There is no doubt in my mind that historically, the medical industry bore a burden of a cost premium to conduct studies in these settings. However, I firmly believe that technology can mitigate these economic obstacles and that there is a significant return on investment in these communities with an underdiagnosed, undertreated chronic condition.

Finally, it is profoundly short sighted by all of us as vascular providers if we fail to recall that one of the greatest *proven* benefits of identifying a patient with newly diagnosed PAD is the ability to reduce their overall cardiovascular and cerebrovascular adverse event rate via proven guideline-directed medical therapy. Not proven (and seemingly disproven by way of recent data) is the application of prophylactic peripheral infrainguinal interventions in patients with mild intermittent claudication.

What does your role as Co-Director of the Center for Multicultural Cardiovascular Care at the Cleveland Clinic involve, and how would you describe the mission of the Center?

As our former Chief Executive Officer (CEO) Dr. Toby Cosgrove, a practicing cardiac surgeon, would remind us during his tenure: The Cleveland Clinic is a *clinically oriented* academic medical center. To that extent, most days begin with patient care and operations. The Multicultural Center was the brainchild of Dr. Lars Svensson, who recognized a need to house our focus on care of a diverse patient population under a single umbrella, akin to our disease-based institute model.

I wrote a paper over a decade ago about a culturally competent organization, and it is important to emphasize that organizational changes in equity don't occur without the whole-hearted endorsement by leadership.[1] Dr. Sean Lyden, my Chairman, has been supportive of the time and effort that I commit to these efforts, and my endowment provides the resource support that makes it possible. Similarly, I saw firsthand how committed Dr. Ron Dalman, Immediate Past President of SVS, was to diversity and inclusion by his presidential address, invited keynotes, and the Vascular Annual Meeting program focus that he set forth. That's all to say that we must be strategic and intentional by building diversity and inclusion into the DNA of the organizational culture. That is what we strive to do within our Heart and Vascular Center at The Cleveland Clinic.

One program I'm very excited about right now involves an effort to develop a cultural competence curriculum for our providers. It would be great if all patients could have demographically concordant care interactions, but that is not possible. The demographics of cardiovascular care dictate that we as providers treat patients every day who do not look like us and come from different cultural and socioeconomic backgrounds. Frankly, I think our lives and those of our patients are richer because of these interactions. However, the interaction is undermined when we begin to have negative stereotypes based on prior interactions that we extrapolate to the patient in front of us—many times, just because it is expedient. We must all accept and identify our implicit biases and learn how

to manage them. That's just one example of cultural competence. I believe every department, institute, and hospital should have a continuous curriculum for providers. A failure to deliver this type of individualized care ultimately reduces quality and increases the overall costs of health care in the form of medical errors, lengths of stay, and readmissions. Candidly, it adversely impacts the patient experience.

The second issue I'm spending a lot of time with is helping design sustainable physician pipelines. How do we support the near-term and deep pipeline for scientists and physicians coming from underrepresented communities? It is a huge problem that extremely talented individuals are not exposed to potential STEM (science, technology, engineering, and mathematics)–related careers and for that reason miss the opportunity to realize their individual potential. Childhood education research suggests that, on average, children "turn on" or "turn off" to math and science around fourth grade. We are working with the likes of Meharry Medical College, Morehouse School of Medicine, and University of Florida at Gainesville to develop easily accessed visiting clinical and research rotations that are subsidized for undergraduate and medical students. For our local Cleveland community, we are extending our most valuable asset, our provider intellectual capital and content expertise, to step into the community and provide structured programs. For me, the most important goal is to make this sustainable beyond the efforts of one individual.

Finally, I am working with The Presidents' Council of Cleveland, which is a consortium of Black American CEOs in Ohio. Social and economic determinants of health are at the heart of many health disparities. This group recognizes the critical role they play in employing members of underrepresented communities with a living wage, health care benefits, and retirement. When they understand the importance of lobbying for issues like equitable access to broadband or a full-service, affordable grocery store in certain residential communities, they fundamentally impact health care from a population perspective.

You have a strong connection to Cleveland and are invested in its health, as evidenced by several pieces with Cleveland.com directed at health concerns for the Black community in the city. How would you explain the importance of this community connection for physicians, and do you have any advice for other physicians who want to become more engaged in their communities?

Throughout the COVID pandemic, I wrote some pieces that articulated the dynamics that existed. In one instance, I laid out a framework for providing access to COVID testing and admonishing the public health system for not doing more to provide equitable care.[2] In another, I criticized our Black communities' overreliance on faith-based organizations to fulfill every role and provide every solution in a crisis (a role they have historically embraced and with which they have had much success).[3] The pieces were widely read, and I received positive feedback.

I guess I found it to be my opportunity to say things that I thought to be true and potentially helpful to further a necessary and sometimes uncomfortable dialogue in a time of crisis. That's what we do as vascular surgeons, right? We're the metaphoric firefighters who try to help in a crisis. ■

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