ACP Humanism in Medicine Lecture

Providing Meaningful Care to a Diverse Patient Population

Improving one's cultural competency and removing implicit bias

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Baptist Health International

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By the end of this talk, participants should be able to:

- Identify cultural variations that may limit communication and relationship building with patients
- Identify the unconscious biases that exist within ourselves that may inadvertently limit access to high quality care
- Gain strategies to mitigate these barriers and better connect with culturally diverse patients

- Contents:
  - Explicit misunderstandings
    - Case scenarios
  - Implicit bias
    - Sources of discrimination and cognitive biases
  - Tools to address these issues
    - Address Cognitive Bias
    - Prevent Disparities
    - Optimize Outreach

Speaker Disclosures

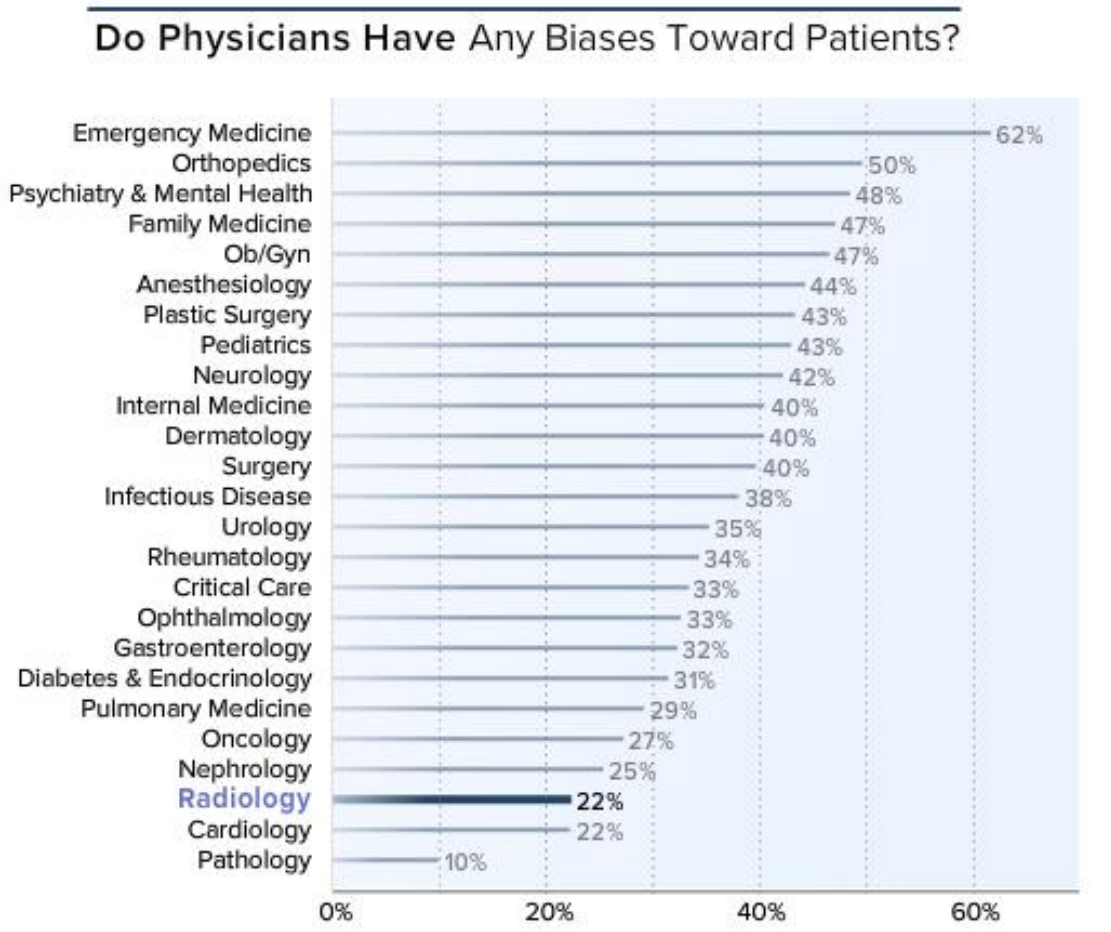
- I have no professional conflicts of interest in giving this presentation.

Did you know…

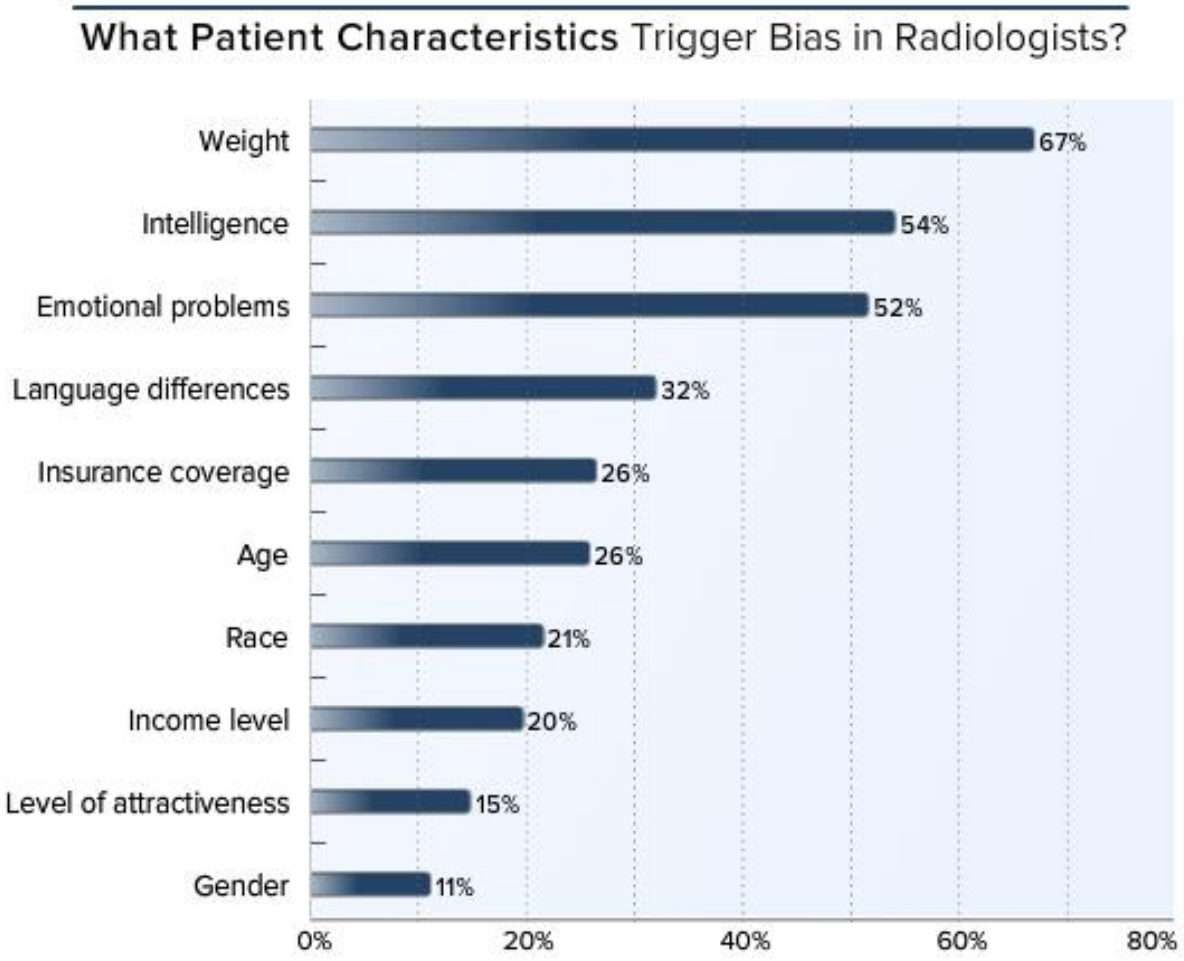
- **Providers order fewer diagnostic tests for black patients?**
  - Nationwide study of 500 hospitals: blacks less likely than whites to receive major diagnostic procedures in 1 out of 5 tests[1]
- **Minorities get fewer needed procedures than white patients?**
  - Duke University study of 12,402 patients : **Blacks 13% less likely than whites** to undergo angioplasty, and 32% less likely to undergo CABG[2]
  - Cleveland VA hospital study of 938 patients: **When decision-makers are blinded to race**, Blacks are slightly *more* likely to undergo angioplasty or bypass[3]
- **Minority patients get less needed pain medication?**
  - In teaching hospital ED, Hispanic patients with long bone fractures **two times less likely** than non-Hispanics to get pain medication[4]
  - In 1492 Medicare-certified nursing homes, black, Hispanic, Native American and Asian residents with cancer were **1.6 to 2.3 times less likely** to receive pain medication[5]

Source: 1) Harris et. al. j. Ethn Dis. 1997
2) Peterson et. al. NEJM 1997
3) Okelo et al. J Am J Cardiology 2001
4) Todd et al. JAMA 1993
5) Bernabei et al. JAMA 1998

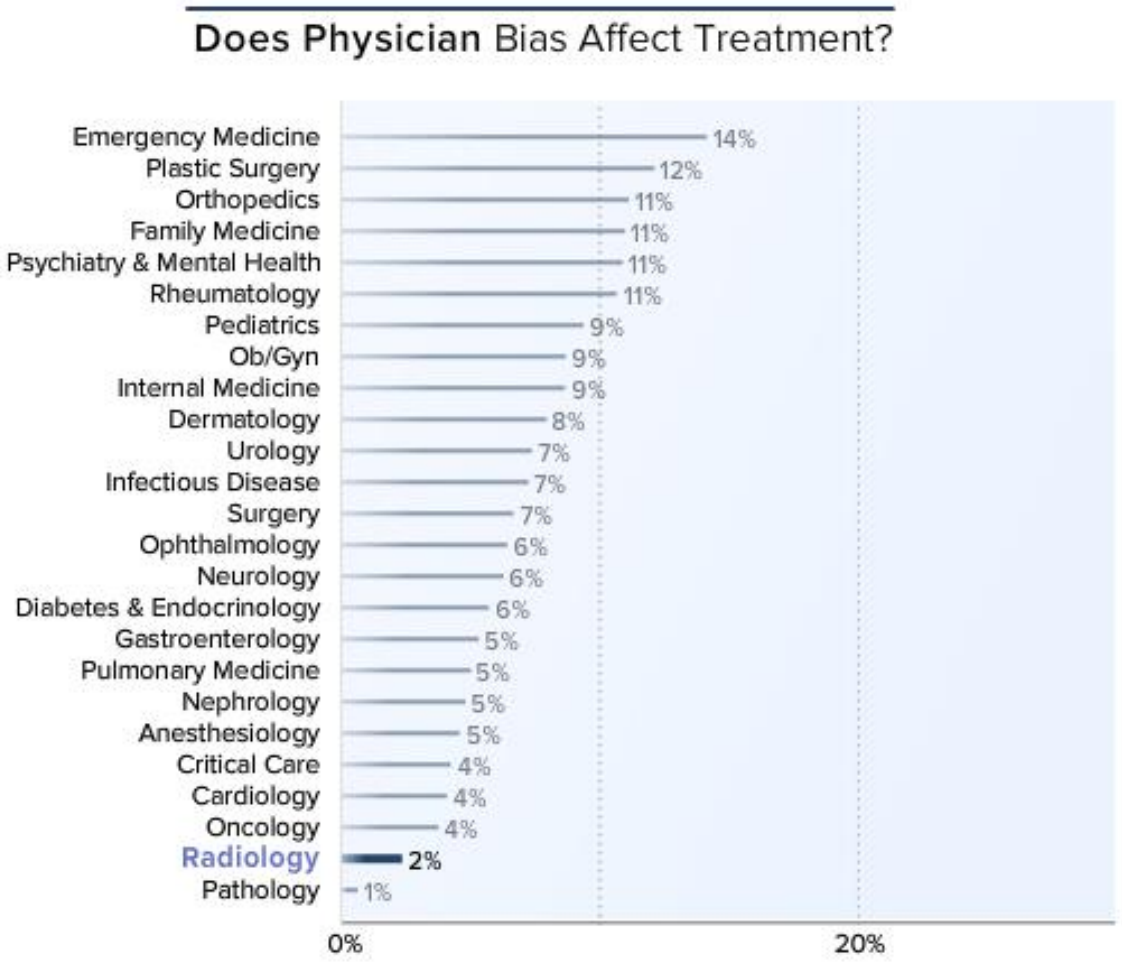
Did you know…


Do Physicians Have Any Biases Toward Patients?
Emergency Medicine 62%
Orthopedics 50%
Psychiatry & Mental Health 48%
Family Medicine 47%
Ob/Gyn 47%
Anesthesiology 44%
Plastic Surgery 43%
Pediatrics 43%
Neurology 42%
Internal Medicine 40%
Dermatology 40%
Surgery 40%
Infectious Disease 38%
Urology 35%
Rheumatology 34%
Critical Care 33%
Ophthalmology 33%
Gastroenterology 32%
Diabetes & Endocrinology 31%
Pulmonary Medicine 29%
Oncology 27%
Nephrology 25%
Radiology 22%
Cardiology 22%
Pathology 10%
0%
20%
40%
60%

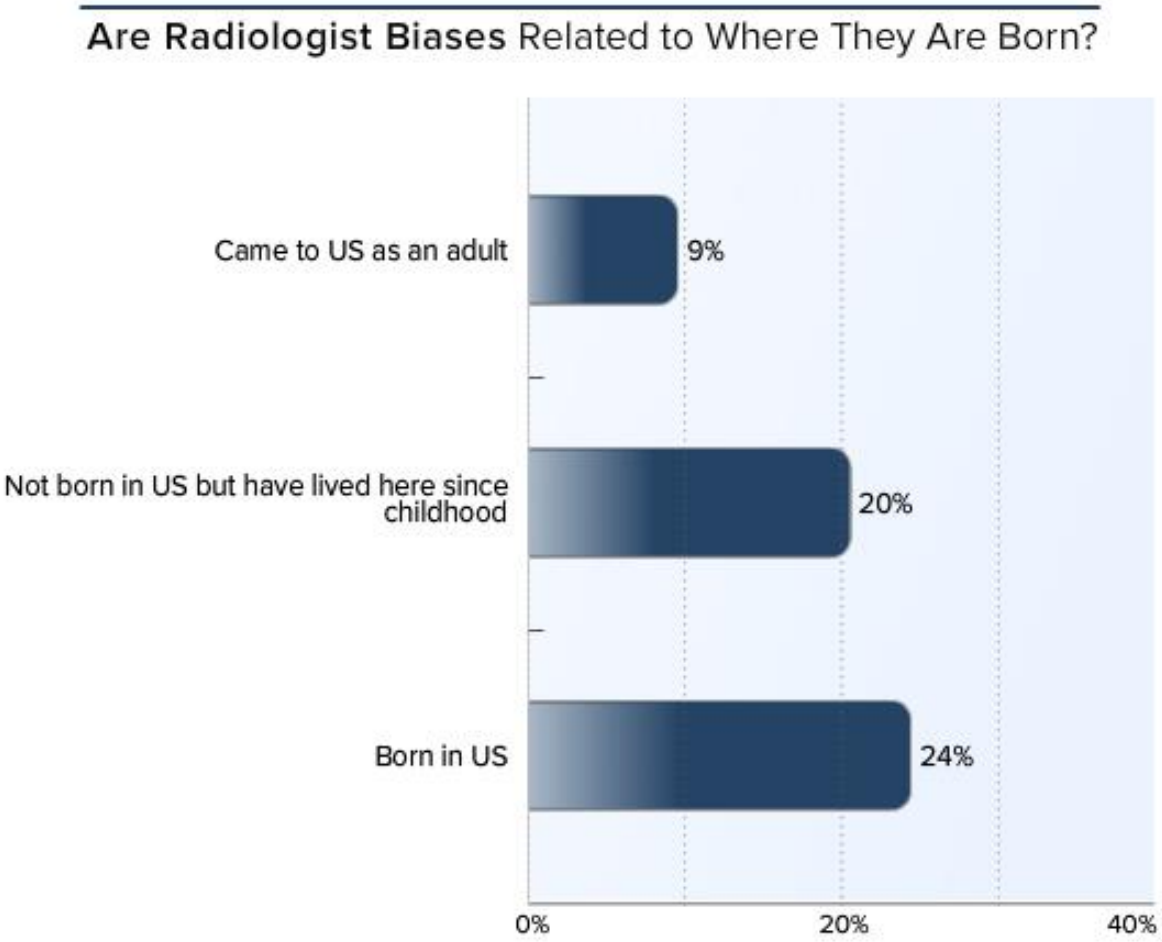
Bias…


What Patient Characteristics Trigger Bias in Radiologists?
Weight
67%
Intelligence
54%
Emotional problems
52%
Language differences
32%
Insurance coverage
26%
Age
26%
Race
21%
Income level
20%
Level of attractiveness
15%
Gender
11%
0%
20%
40%
60%
80%

Bias…

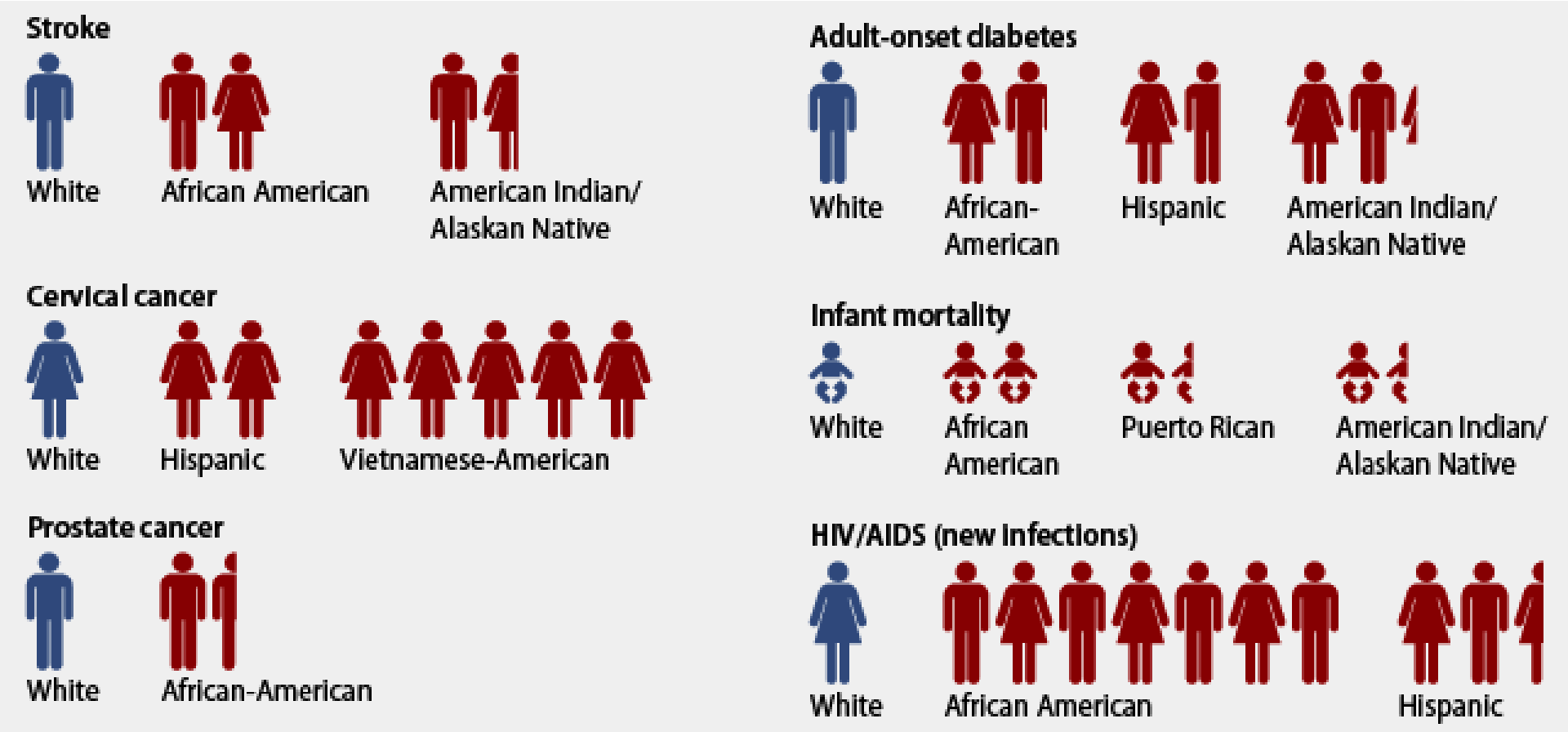

Does Physician Bias Affect Treatment?
Emergency Medicine 14%
Plastic Surgery 12%
Orthopedics 11%
Family Medicine 11%
Psychiatry & Mental Health 11%
Rheumatology 11%
Pediatrics 9%
Ob/Gyn 9%
Internal Medicine 9%
Dermatology 8%
Urology 7%
Infectious Disease 7%
Surgery 7%
Ophthalmology 6%
Neurology 6%
Diabetes & Endocrinology 6%
Gastroenterology 5%
Pulmonary Medicine 5%
Nephrology 5%
Anesthesiology 5%
Critical Care 4%
Cardiology 4%
Oncology 4%
Radiology 2%
Pathology 1%
0%
20%

Bias…


Are Radiologist Biases Related to Where They Are Born?
Came to US as an adult
9%
Not born in US but have lived here since childhood
20%
Born in US
24%
0%
20%
40%

Why are we concerned?

For every white person with this illness:



Source: Center for American Progress

Practice reflection:

- What do you think about cultural disparities in your own practice?
- Can you think of a time a patient was unfairly stereotyped due to language or cultural barriers?

Health is a cultural experience

- Various cultures perceive health and illness differently
- Understanding these differences can allow us to better serve our patients and remove barriers to care
- This can ultimately lead to reduced disparities in health outcomes

But remember…

- Culture is only one of many elements that influence our perception of disease
  - Family
  - Social environment
  - Education
  - Prior experiences with healthcare system
- Above all, remember that:
  - Cultures are dynamic and evolving
  - There is huge variation within cultures

PART ONE – EXPLICIT MISUNDERSTANDINGS

Part 1 – Explicit Misunderstandings

TERMINAL ILLNESS AND END OF LIFE CARE

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Case study 1

- A new immigrant family from India is spending their mother Amrita’ s final days at her bedside. They are often seen moaning, crying, and sobbing throughout the hospital. Amrita’s daughter has been kneeling on the ground, wailing and pounding her fists to the floor.

Practice reflection

- What are your thoughts in this situation?

Variation in end of life practices

Expression of Grief

- Some cultures are stoic; others freely express grief
- Some expect only the family to grieve, others have relatives and friends participate
- Some have a fixed period of mourning and grieving is expected to gradually decline afterwards

Organ Donation

- Some cultures believe the body should remain intact at the time of death and will refuse organ donation
- Never assume people will agree or disagree – always explore with the family

Funeral Practices

- Burials often used in cultures where body needs to remain intact for resurrection
- Cremation often preferred when body needs to be returned home or to a place of significance

Source: Hospital for Sick Children

Attitudes and beliefs

Disclosure

- Many cultures shield the seriously ill from bad news to reduce suffering and maintain hope
- Many people feel it is bad luck to talk about death. They believe what will happen is in God's hands; talking about it creates negative energy and unnecessary grief

Decision-making

- In some cultures decision-making rests with community or faith elders, or physicians, rather than family
- Some feel that discussing advanced directives "challenges hope"

Hospice care

- Some cultures need to have specific rituals at time of death (a candle to guide the spirit to heaven, a suit with no buttons to enable the soul to slip out, windows open to allow the spirit to leave) which may be seen as not possible in hospice

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Source: Hospital for Sick Children

Takeaway points

- Cultural perceptions around end of life decisions can vary significantly between groups
- Disclosures, decision-making, and location of palliative care can all be affected by cultural background
- Always ensure you ask the family regarding their own beliefs – never assume beliefs

Part 1 – Explicit Misunderstandings

CHRONIC ILLNESS

Case study 2

- 60 year old Amhara has severe rheumatoid arthritis. Recently she had a significant flare with significant swelling of her joints. Despite this, she has elected to stop taking her pain medications.

Google search image

Practice reflection

- What are your thoughts in this situation?

Pain and cultural competency

- Different expressions of pain
  - Some cultures are stoic and withhold pain information
    - Associated with North American (“no pain no gain”) , European, East Asian cultures
  - Other cultures freely express pain, allow others to react to pain
    - Associated with Hispanic, Mediterranean, Middle Eastern, South Asian cultures
- Some cultures feel that treating pain will hinder the immune system and will actively avoid pain medications

Source: Hospital for Sick Children

Practice reflection:

- In your own previous experiences with patients, do you encourage a stoic or emotive response to pain?

Assessing pain across cultures

- Ask patients and their families about their beliefs regarding pain
- Use observational and physical measures of pain (vitals, grimacing, change in skin color, limited range of movement, restricted affect, lack of focus, guarding)
- Consider cultural factors such as pain expression and language, social expectations and perceptions of the healthcare system

Google search image

Source: Hospital for Sick Children

Takeaway points

- Cultural perceptions around pain can vary significantly between groups
- Use objective measures of pain to better understand current situation
- Pain is ultimately a subjective experience. Understanding cultural background can help better assess a patient's pain experience

Cultural groups have varying beliefs regarding cause of illness: Asthma Causes

Puerto Ricans	Mexican-Americans	Mexicans	Guatemalans
Air pollution	Air pollution	Air pollution	Air pollution
Cigarette smoking	Cigarette smoking	Cigarette smoking	Cigarette smoking
Weak lungs	Weak lungs	Weak lungs	Weak lungs
Untreated cold/flu		Untreated cold/flu	Untreated cold/flu
Drafts		Drafts	Drafts
Inherited	Inherited		Inherited
Allergies	Allergies		Allergies
		Drinking cold/sweating	Drinking cold/sweating
		Virus	Virus
Being overweight			Being overweight
		No shoes on cold floor	No shoes on cold floor
		Wet/sweating	Wet/sweating
Overexertion			Overexertion
		Bath during cold/flu	Bath during cold/flu
			Lack of vitamins
Unclean house			
Strong emotions/nerves			

Source: Pachter et. al. J Asthma 2002

Use of complementary and alternative medicines

- Cultural diversity in asthma treatment among Puerto Rican Latinos
- N=117

	Have tried	Is effective		Have tried	Is effective
Pray to god	73%	75%	Vicks/Camphor	74%	62%
Baños (spiritual baths)	21%	24%	Siete jarabes	25%	21%
Azabache	15%	2%	Aloe vera	15%	19%
Pray to the Saints	12%	10%	Cod liver oil	15%	20%
Prayer candles	8%	6%	Agua maravilla	11%	10%
Azogue	2%	0%	Garlic	6%	8%
Pray to the Orishas	2%	2%	Te de eucalypto	6%	3%

Source: Pachter et. al. J Asthma 2002

Views of disease causation may influence adherence to treatment

- A person's worldview is closely linked with cultural and religious background
- Those who believe in fatalism (i.e. predetermined fate) often do not adhere to treatment as they believe medical intervention cannot alter the course of illness
- Spiritual vs physical cause to illness
- Hot-cold imbalance (Asian, Latino cultures)

Juckett G. Am Fam Phys 2005

Questions to ask

- What do you think is causing this disease?
- What types of treatments have you tried?
- What do the treatments do?
- Are they helping with your symptoms?
- What happens if the disease is not treated?

Takeaway points

- Cultural beliefs are often strong regarding chronic illness
- It is important to address these cultural roots for illness when managing patients with chronic disease
- Where possible, incorporate non-harmful complementary and alternative medicine into your treatment plan to ensure patient buy-in

Part 1 – Explicit Misunderstandings

TRANSFUSION

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Case Study 3

- Joshua McAuley, 15, was involved in a motor vehicle accident and was airlifted to hospital, having sustained significant abdominal and leg injuries. He was a devout Jehovah's Witness. While still conscious, he emphasized his wish to not receive blood transfusions, and died later that evening.

Practice reflection:

- What are the values and legal frameworks at play in this situation?

Procedures around transfusions

- Many Jehovah's witnesses carry signed and witnessed advanced directive cards refusing transfusion and releasing doctors from liability from this refusal
- Emergency treatment can be provided without consent should it be impossible to obtain consent
- Competent minors are able to make their own wishes regarding blood transfusion
- A minor's consent or refusal can be overruled by parental authority
- Doctors who administer blood in the face of a refusal by a patient may be unlawful and could lead to criminal and/or civil proceedings

Cultural beliefs around surgery and transplantation may affect decisions

- Belief around defining death: Some cultures have ambiguity around death if your organs are still alive. This may impact on transcendence to the afterlife
- “Whole body” needed for the afterlife
- Suspicion that the care team will not work hard to save you if you are an organ donor

Takeaway points

- Some religious and cultural groups refuse blood transfusion
- Administering a transfusion to a patient who competently refuses transfusion may be considered unlawful
- Honest discussion and respect for patient's wishes are important in quality patient care

Part 1 – Explicit Misunderstandings

PEDIATRIC CARE

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Case Study 4

- A family from Laos you have worked with before brings their 4 month old child in for routine immunizations. On examination you notice four red and blistered, quarter-sized areas on the child's abdomen. You have observed, from this and prior encounters, that the parents are loving and affectionate with their child. You wonder if you should mention anything to the parents around the burn marks.

Google search image

Source: Hospital for Sick Children

Practice reflection:

- What would you do in this situation?

Parenting practices vary across cultures

	Individualistic Cultures	Collectivistic Cultures
Parent-Child Bonding	• Verbal expression of love, e.g. “I love you”	• Tend to use behavior rather than words to express affection • Encourage bonding with multiple family members
Family Role	• Core parents are responsible for parenting decisions	• All members of the community are responsible for each other
Sleep	• Believe separate sleeping arrangements help children develop independence • Value parental privacy	• Regularly co-sleep • Feel that self-soothing is less important

Source: Hospital for Sick Children

Takeaway points

- Cultural practices in child rearing may differ in various cultures
- Parent-child bonding, decision-making in child rearing may be highly variable between cultures, particularly if those cultures are collectivistic vs individualistic.

Part 1 – Explicit Misunderstandings

VACCINATIONS

Case Study 5

Priya is seeing you with her son Rajiv for a 6 week postpartum visit. When you mention she is to bring Rajiv in for his 2 month vaccinations, she becomes uncomfortable and changes in her demeanor.

Google search image

Practice reflection:

- Why do you think Priya could be acting this way?

Views towards vaccination

- Most religious and cultural groups support vaccination
- Some religious groups are ambivalent regarding vaccination
  - Catholic church raises concerns on the grounds that vaccines made using cell lines from aborted fetuses
  - Christian Scientists believe many medical interventions, which may include vaccines, are unnecessary
- Some groups entirely distrust vaccines
  - Tuskegee Syphilis Study and history of racism in USA
  - “Western plot” theories: rumors of vaccines used to sterilize women

Source: History of Vaccines

Takeaway points

- Certain religious and cultural groups may have resistance to vaccination
- An open discussion with those who are against vaccination is important
- Maintaining open communication lines and ensuring continuity of care will be critical with these patients

PART TWO – IMPLICIT BIAS

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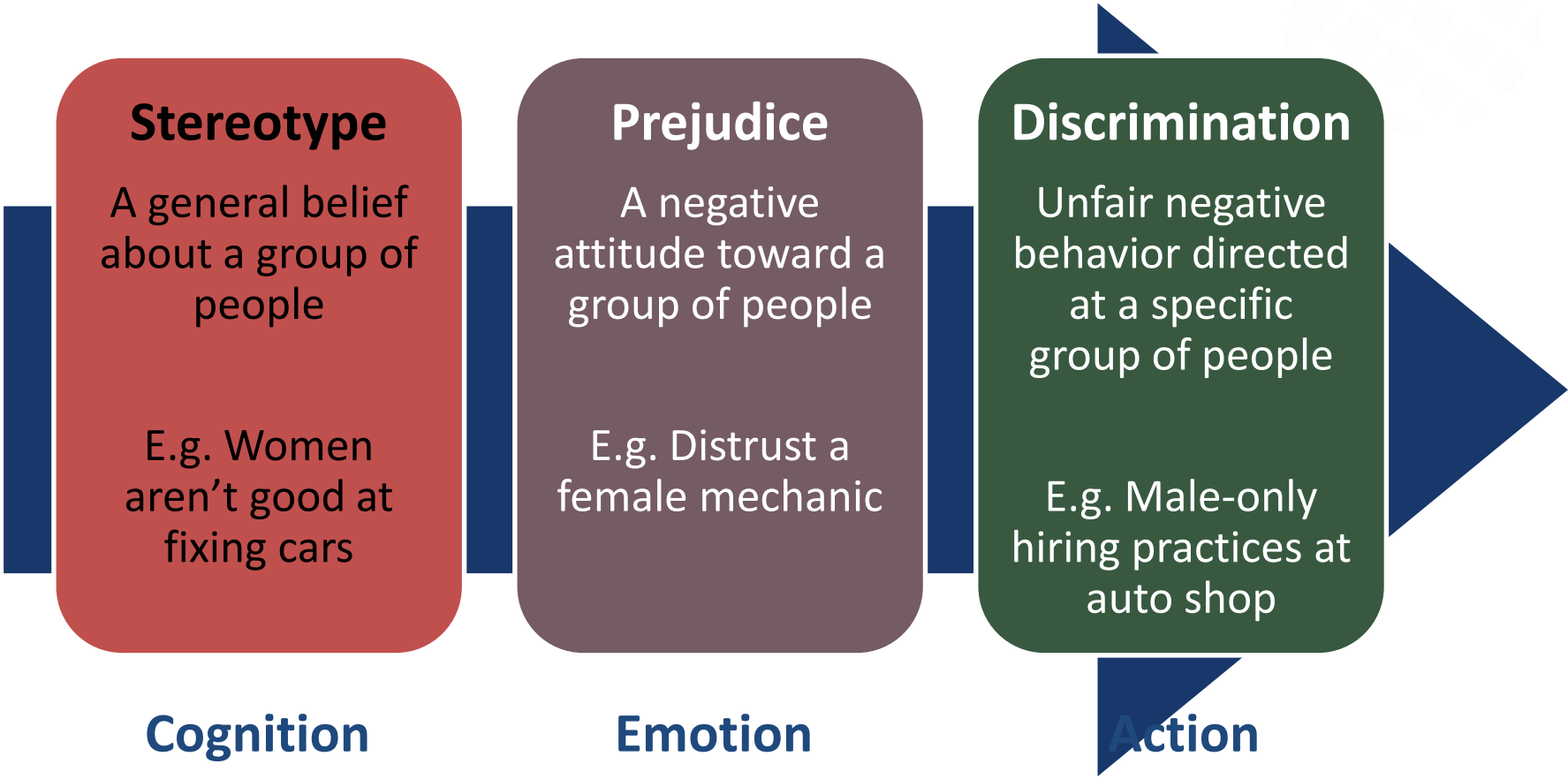
We all have our own stereotypes about others… good or bad

"Sir, our latest intel indicates we're terrible at gathering intel."

Stereotypes, prejudice, and discrimination



Unconscious bias is still bias

- Many healthcare providers who overtly identify as being "culture-conscious" still make decisions that lead to system-level discrimination
  - On rating patients for hostility-related attributes
  - On prescribing patients hydrocodone

Sources of stereotyping

Stereotyping

Social Learning

Observation of others' behavior

Cognitive Bias

Outgroup homogeneity
Ingroup favoritism

Attribution Bias

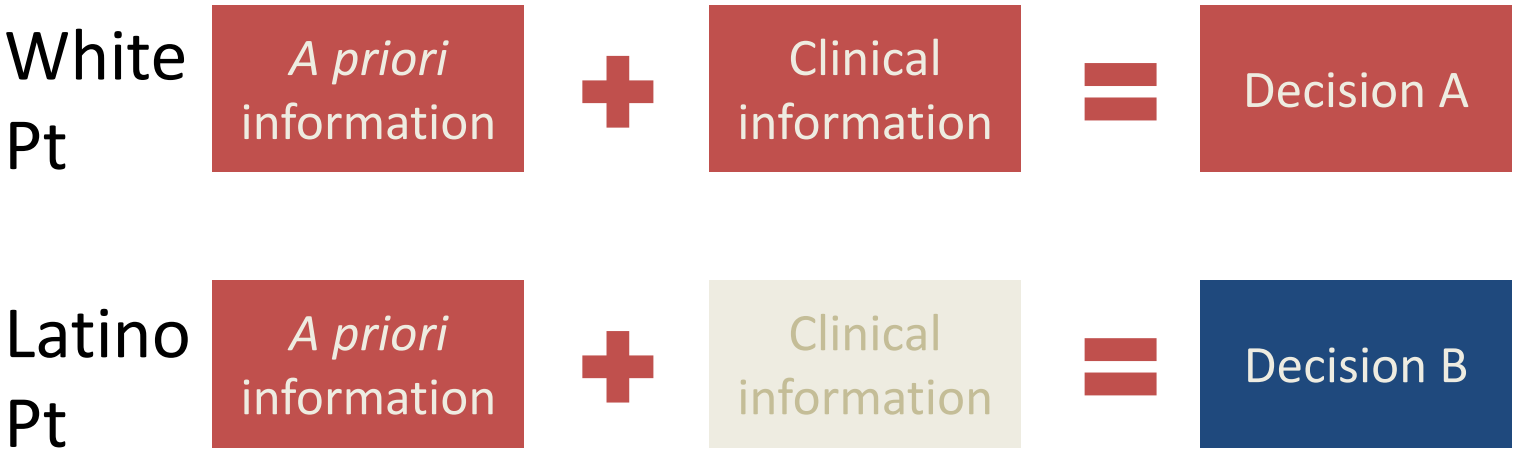
"just world" hypothesis

Sources of stereotyping: Social learning

- Attitudes in social circles strongly influence our world view
  - Colleagues
  - Friends
- Attitudes are also learned in the home
  - Parents!
  - Siblings

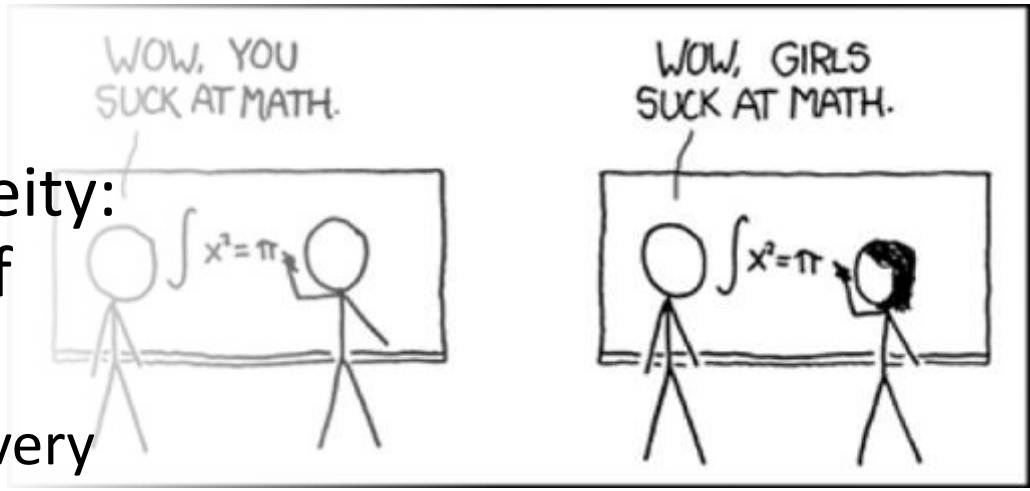
Less social learning leads to communication error, and different treatment decisions

- A white man and a Latino man go see you for chest pain…
  - Will you make the same clinical decision?



Cognitive Sources

- Social Categorization
  - Dividing people into "ingroups" and "outgroups"
  - Outgroup homogeneity: the belief that "all of them are the same"
    - Seeing outgroup as very similar
    - Seeing ingroup as very diverse

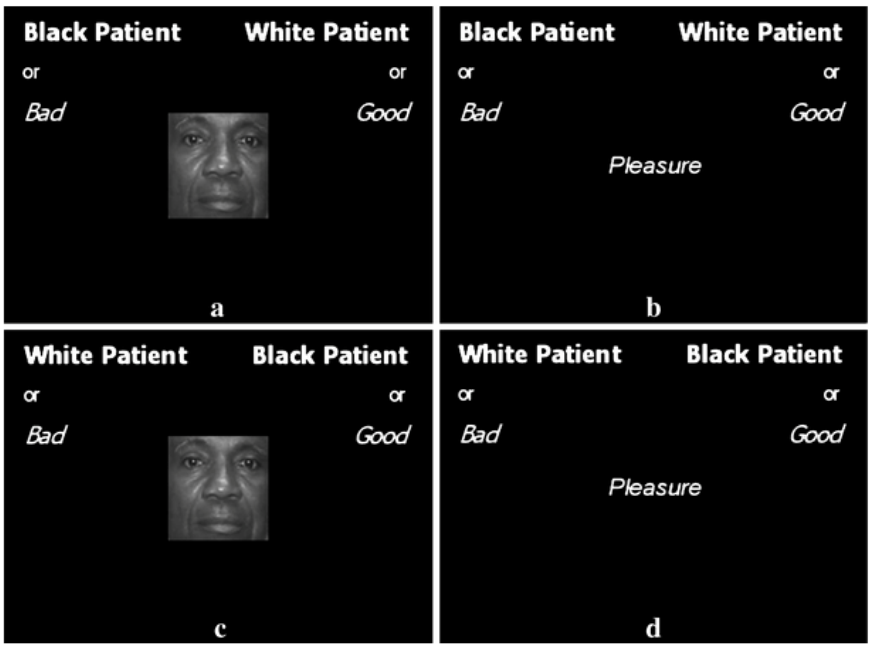


(1) Cartoon: XKCD.com

Attribution Biases

- Just-world hypothesis
  - The belief that victims of misfortune deserved what they got
  - Allows us to see the world as predictable and fair
  - “Blame the Victim” mentality
  - 10-20% of people believe rape victims are at least partially responsible for being attacked

Trying the Implicit Association Test



Google search image

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(1) Cooper-Patrick et al. 1999

Implicit Association Test

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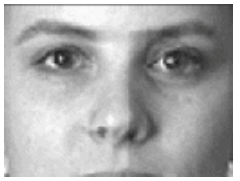
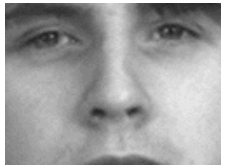
Part 1 – Face Priming

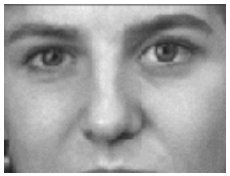
Say “Left” or “Right” on each of the image prompts

African American

European American







Part 2 – Word Priming

Say “Left” or “Right” on each of the image prompts

Agony

Glorious

Failure

Joy

Love

GOOD

BAD

Pleasure

Evil

Nasty

Terrible

Hurt

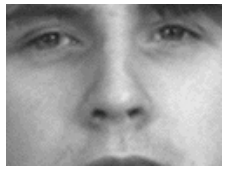
Peace

Part 3

Say “Left” or “Right” on each of the image prompts

Awful

Horrible

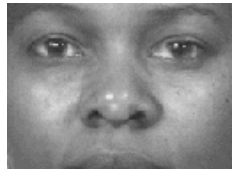


Happy

Failure

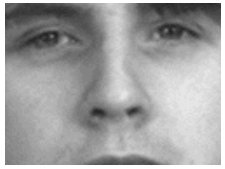
African American Or GOOD

European American Or BAD



Nasty

Wonderful

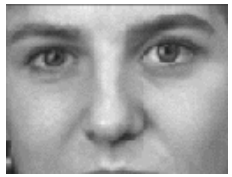


Glorious

Terrible

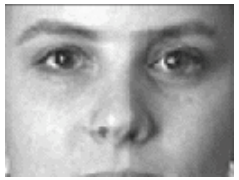
Pleasure

Love



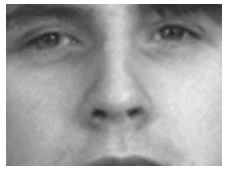
Part 4

Say “Left” or “Right” on each of the image prompts



Peace

Laughter

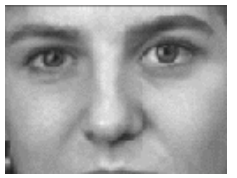


Horrible

Pleasure

African American Or BAD

European American Or GOOD

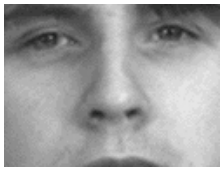


Happy

Joy

Terrible

Wonderful



Glorious

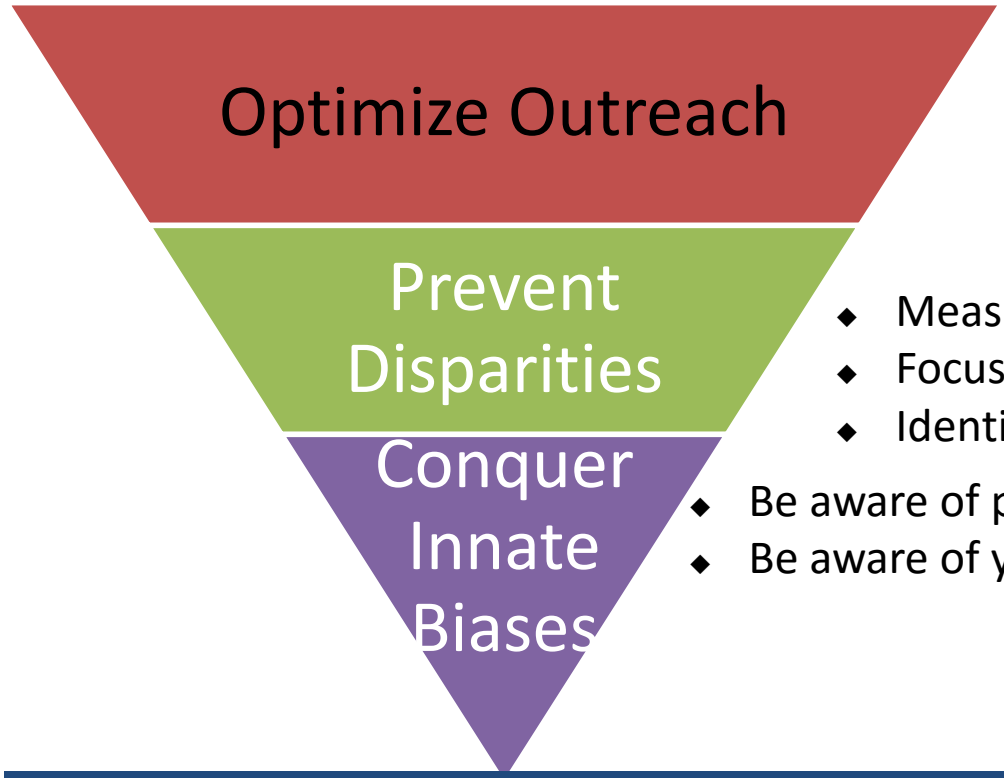
Love

Consequences of Stereotyping

- Self-fulfilling prophecy
  - A belief that causes itself to become true
  - Can lead to positive outcomes
    - How might a student perform who is told that she is “excellent”?
    - How might the same student perform if she is told she is “average”?
  - We may inadvertently promote such outcomes based on how we interact with our patients

PART THREE – TOOLS TO ADDRESS THESE BIASES

So how do we reduce discrimination?



- Strengthen continuity of care
- Implement multidisciplinary care teams
- Increase minority health professionals
- Use community health workers
- Provide language services

- Measure outcomes
- Focus on early intervention efforts
- Identify barriers to care

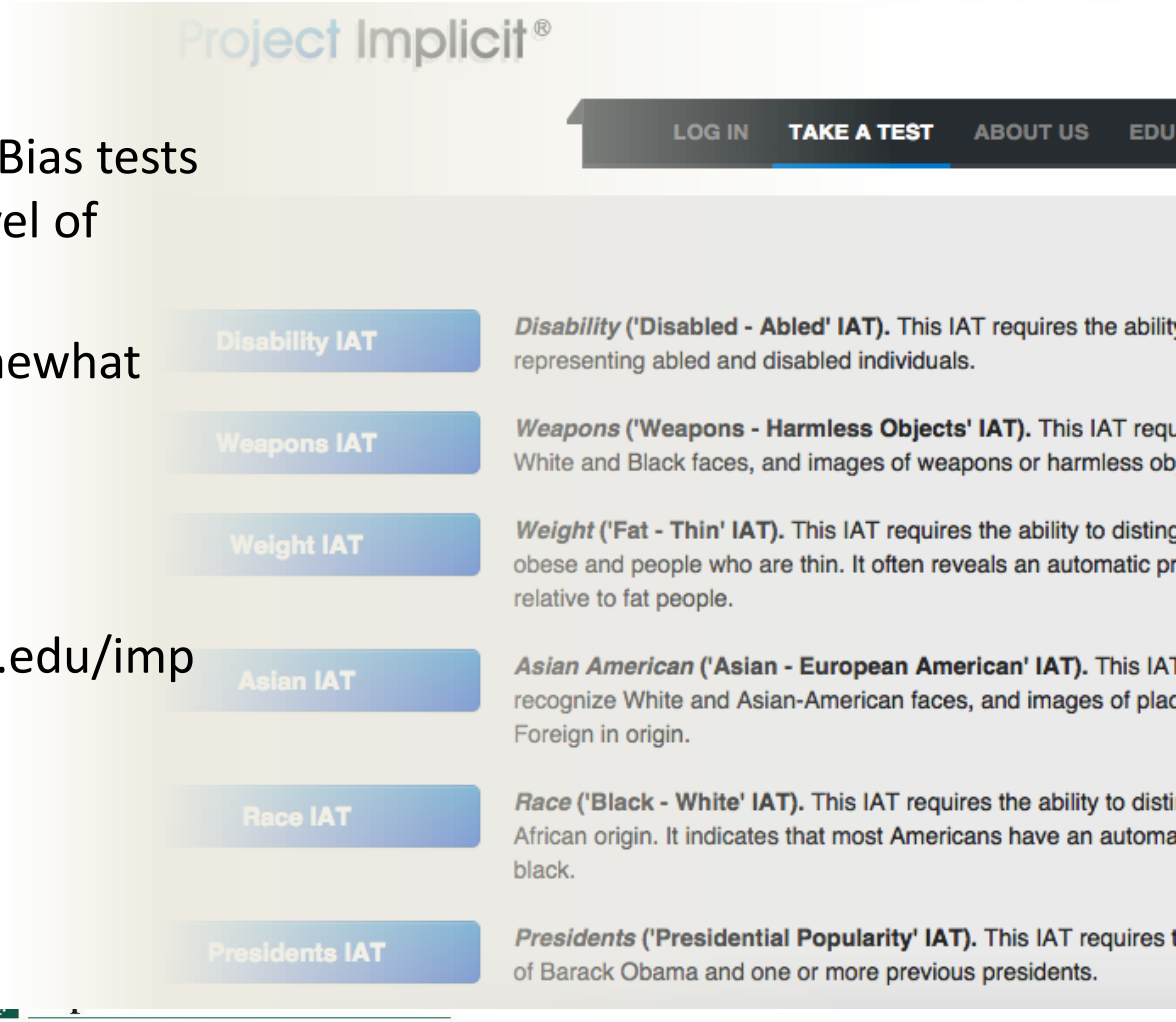
- Be aware of problems with heuristics
- Be aware of your own biases

Outcome: Reduced disparities in care

Conquer Innate Biases: Be aware of risks of rapid decision-making

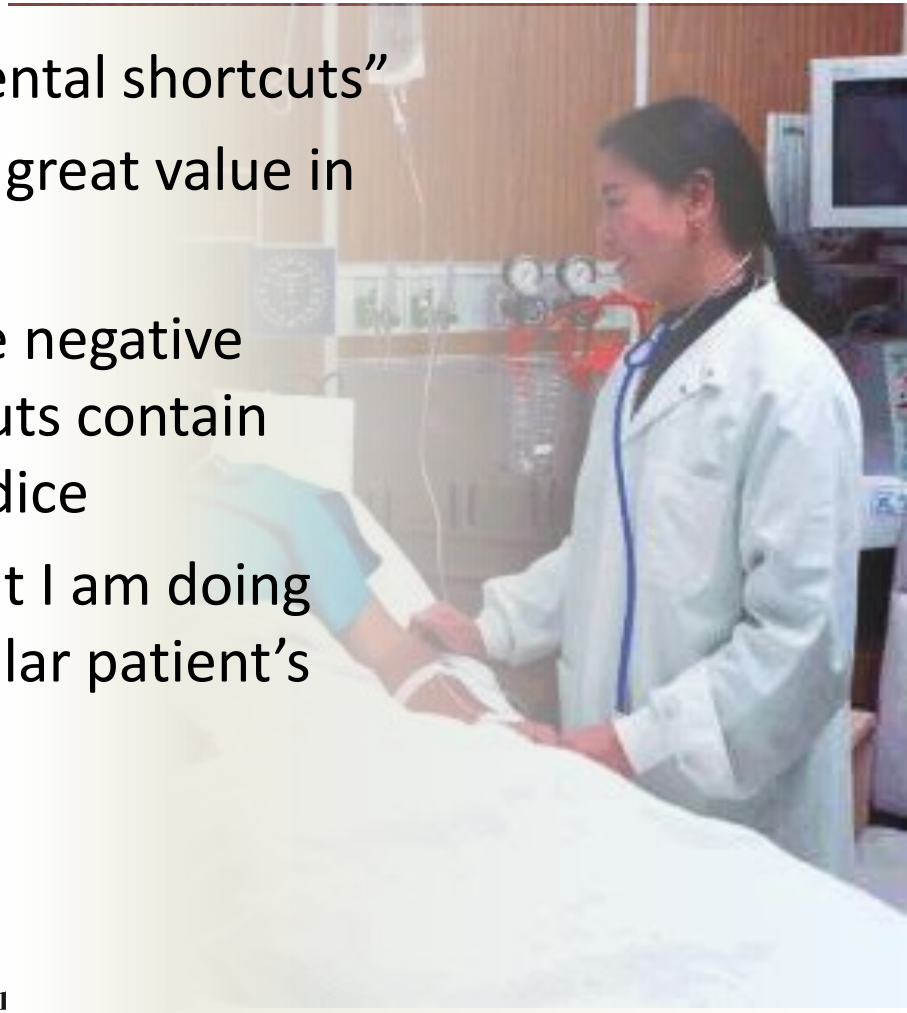
- Project Implicit:
  - Free, Online Implicit Bias tests that can test your level of implicit bias
  - Most people are somewhat implicitly biased
  - Try it out tonight

https://implicit.harvard.edu/implicit/selectatest.html



Conquer Innate Biases: Be aware of risks of rapid decision-making

- Doctors and nurses rely on “mental shortcuts”
- These cognitive shortcuts have great value in rapid decision-making
- However they also can produce negative outcomes when mental shortcuts contain intrinsic stereotypes and prejudice
- Question your thoughts: Is what I am doing actually in line with this particular patient’s function?



Conquer Innate Biases: Evidence for training programs

- Increase education programs around bias
- Telling someone about bias not nearly as effective as programs where one can experience bias
- Study: Medical students and case studies involving bias (Netherlands, 2016)

Source: Van Geene et al. Perspect Med Educ 2016

Prevent disparities: Measure outcomes

- Measure health disparities
  - Potential negative patient reaction
  - Provider buy-in

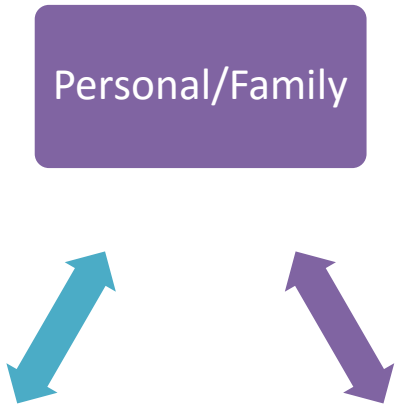
Prevent disparities: focus on early-intervention efforts

- Ensure high-risk groups are screened for diseases, for example:
  - Diabetes, hypertension
    - African Americans, Hispanics, American Indians, Asian-Americans
  - Breast cancer
    - East Asian, Filipino
  - Hepatitis B, gastric cancer
    - East Asian
- Be aware of the options facing these patient populations and ensure appropriate, early screening

BHSF photo

Prevent Disparities: Identify barriers to care

Cultural Barriers to Care



- Family involvement
- Attitudes/beliefs
- Complementary medicine
- Health behavior
- Language/Literacy

- Availability of providers
- Availability of appointments
- Transportation

- Insurance coverage
- Reimbursement levels
- Public support

Optimize Outreach: Strengthen continuity of care

- Primary care providers are a powerful source of advocacy for patients
- Consistent contact with one provider may also alleviate mistrust
- Focus on:
  - Stability of assignment to PCP, and ensured accessibility
  - Reasonable patient load per PCP
  - Reasonable time allowances for initial and follow-up visits

Google search image

Optimize Outreach: Implement multidisciplinary care teams

- Multidisciplinary teams can:
  - Enhance care
  - Enhance patient adherence through better follow-up
  - Address the multiple behavioral and social risks faced by patients
  - Save costs and improve the efficiency of care
    - Reducing need for face-to-face physician visits
    - Improve patients' self care between visits

Optimize Outreach: Support use of community health workers

- Lay health workers can improve health outcomes while reducing costs[1]
- Lay health workers have a variety of functions:
  - Act as doctor-patient liaisons
  - Organize community participation in health
  - Educate patients
  - Provide consumer advocacy and support
  - Help coordinate patient care
- Major barriers have been lack of recognition; however results are emerging within multiple areas of care

Optimize Outreach: Increase the number of minority health workers

- Racial concordance is associated with:
  - Greater patient participation in care
  - Higher patient satisfaction
  - Greater adherence to treatment[1]

- Consider doing everything possible to increase the number of underrepresented populations in healthcare, including affirmative action

Optimize Outreach: Provide language services

Language assistance best practices
1. Offer language assistance at no cost
2. Inform all patients of the availability of language assistance services in their preferred language, verbally and in writing
3. Ensure competence of those providing language assistance
4. Provide education materials/signage in the languages commonly used in the service area

(1) Dept of Health and Human Services Office of Minority Health 2001

Conclusion

- Cultural competency is critical for ensuring we deliver equitable, high-quality care to our patients
- Besides becoming culturally aware, we must also become aware of our implicit biases that may limit the quality of treatment we provide
- Active listening and learning are the best tools to fight bias

Further Resources

- Online resources
  - CultureClues tip sheet (University of Washington)
    - http://www.depts.washington.edu/pfes/cultureclues.html
  - Cultural Competence E-Learning modules (Hospital for Sick Children, Canada)
    - http://www.sickkids.ca/patient-family-resources/child-family-centred-care/Health-Equity-Cultural-Competence/Cultural-Competence-E-Learning-Module-Series/Cultural-Competence-E-Learning.html
  - EthnoMed (University of Washington)
    - http://ethnomed.org/
  - Provider's Guide to Quality and Culture (Management Sciences for Health)
    - http://erc.msh.org/

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