Cultural humility and working with underserved communities

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Objectives

- Explore the role of health disparities and unconscious bias in health delivery
- Discuss several best practices that we can utilize to overcome communication barriers and build trust with our patients
- Utilize interactive case studies to put into practice some of the outlined best practices

We have a responsibility to care for our patients, who are often from different backgrounds than our own
- Provider bias and systems of inequity create barriers to underserved communities achieving health and wellness
- With the ACA, providers are more accountable to patient outcomes
- Implementation of lifestyle changes and ultimate health outcomes must come from patients
- Understanding social conditions, health disparities, and eliminating provider bias can lead to better trust between patient and provider
- Trust and healing patient-provider relationships are key in motivating patients to make life choices to improve health
Who are we talking about when we say “underserved” communities?

- Examples of underserved communities:
  - People of color
  - People living in poverty
  - Immigrants and non-English speakers
  - Lesbian, gay, bisexual and transgender people
  - People with disabilities

Certain communities are underserved because of broader societal systems of oppression and inequity.
Systems of oppression

- Socially constructed hierarchy of difference where some people receive advantages and privilege and others experience marginalization and oppression depending on one's social position.
  - Racism
  - Sexism
  - Ableism
  - Transphobia & heterosexism
  - Classism

Systems of oppression

- Systems of oppression and inequity privilege some communities of society at the expense of other communities
  - Within the system of racism, white people experience privilege and people of color experience oppression
  - Within the system of sexism, men experience privilege and women experience oppression
  - Within the system of ableism, non-disabled people experience privilege and people with disabilities experience oppression
  - Within the systems of heterosexism and transphobia, heterosexual people experience privilege and LGBTQ people experience oppression

Systems of oppression

- Systems of oppression and inequity are upheld by:
  - Institutions in society, for example:
    - Criminal justice system, banks & mortgage companies, health care institutions, school funding
  - Individual acts of discrimination and unconscious bias
Our identities are complex and multiple. Most individuals experience intersecting forms of privilege and oppression.

Intersections of oppression & privilege

A disabled white transgender man might experience white privilege, and oppression due to ableism and transphobia in society.

Intersections of oppression & privilege

An immigrant woman from Mexico might experience oppression as a woman, a person without legal documentation, and as a person of color.
**Intersections of oppression & privilege**

- A white woman may experience white skin privilege as a white person, and oppression because of her female gender.

**Impacts on health**

- These systems of inequity and oppression can lead to conditions of:
  - Poor nutrition
  - Lack of safe housing
  - Poor educational opportunities
  - Limited employment opportunities
- Together, these factors create health disparities between communities who experience various forms of oppression, and communities who experience advantage or privilege within these systems.

**Health disparities**

- “A particular type of health difference that is closely linked with social, economic and/or environmental disadvantage, historically linked to discrimination or exclusion” - Healthy People 2020.

Photo credit: Barni Quassim
Health disparities adversely affect underserved communities

Some examples:
- Infant mortality with African Americans nearly twice national average (CDC 2011)
- Incidence of asthma twice as high in African American, Puerto Rican and Latina/o youth than white youth
- Diabetes rates twice as high amongst people living in poverty as those with high incomes
- Native Americans die at higher rates than any other Americans from DM II, chronic liver disease and chronic respiratory disease (HHS disparity fact sheet 2012)

Systems of oppression affect health through numerous pathways, including:
- Neighborhood segregation
- Institutional discrimination in employment, housing, education
- Internalized oppression
- Unconscious bias
- Psychosocial stressors
- Environmental factors

http://theinspirationroom.com/daily/2008/racism-makes-me-sick/in-australia/
Neighborhood segregation

- Neighborhood segregation along racial and economic division
- Segregation determines
  - Quality of education and employment opportunities
  - Creation of pathogenic neighborhoods and housing conditions
- Conditions linked to segregation can constrain healthy behaviors and encourage unhealthy ones

Psychosocial stressors

- Systems of oppression lead to discrimination.
- Discrimination -> increase in stress hormones -> contributes to poor health
- For example, research links discrimination to higher rates of hypertension and diabetes in communities of color

Unconscious bias

- "isms" play out in tangible, sometimes invisible ways
- Negative stereotypes of identity groups based on:
  - body size, skin color, dress, gender presentation, etc.
- Often unconscious and unintentional
- Study at Mass General Hospital (Green et al, 2007)
Internalized oppression

- Internalized oppression is conscious or subconscious acceptance of dominant society’s views, stereotypes and biases of one’s marginalized identity group
- Gives rise to patterns of thinking and behaving that can result in invalidating and hating oneself
- Internalized oppression can contribute to negative health outcomes

Oppression and the environment

- People of color, Indigenous people and poor people disproportionately live on land or in parts of cities where air, water, and food are contaminated because of:
  - uranium mining
  - nuclear testing
  - highways
  - refineries
  - etc.

Best Practices
Conduct a self-assessment

- Because schools and the media generally reflect majority norms, people who come from dominant/privileged groups include
  - White
  - Christian
  - Middle class
  - Heterosexual

- Members of dominant/privileged groups taught to see ways they act as normal, and see other ways of acting as abnormal, strange, or unhealthy (Fontes, 2008)

The dominant culture is pervasive and can be taken for granted, so it is especially important that members from dominant/privileged groups be self reflective and respectful when working with people who may have a different set of values, experiences and practices (Fontes, 2008)

Self-assessment

- Reflect on systems of inequity and oppression and how you are affected or benefit from them
- Identify areas where you experience privilege and your patient might experience oppression
  - As an English as first language speaker working with non-English speaking patients
  - As a heterosexual person working with LGBTQ patients
  - As a well educated professional working with illiterate or under-educated patients
  - As a white provider working with a person of color
Consider power dynamics

- Identify ways that different experiences can create power dynamics in patient-healthcare provider interactions.

The bigger picture

- “Lifestyle choices” that affect health are complex.
- In medicine, underserved individuals are often blamed for poor health outcomes due to lifestyle choices.

Better outcomes

- Understanding of oppression, health disparities, and barriers to health access can help us be more effective healthcare providers by:
  1. Reducing blame placed on patients for lifestyle choices.
  2. Creating better understanding and rapport with patients.
  3. Better empowering and supporting patients in achieving health and wellness through lifestyle changes.
Practicing cultural humility

- Creating environment where people feel safe to express values, perspectives, experiences from their culture
- Respecting leadership from communities we are providing care to
- Honoring dietary choices, health practices, traditions and beliefs from the culture of each patient
- If suggesting lifestyle changes involving traditional foods or practices, start from a place of respect and understanding

Support patients in empowering themselves

- Practicing active listening
- Practicing motivational interviewing
- Valuing the knowledge and insights of patients on their bodies and health
- Working with patients to support their health goals in addition to encouraging them to achieve goals you set as their health care provider
- Communicating clearly and explaining in simple terms medical information

Check assumptions

- We are taught to make assumptions based on one’s skin color, dress, body size, music choices, gender presentation, etc.
- Work to identify assumptions and unconscious bias
- Challenge assumptions as they arise, for example:
  - Not assuming that someone is unhealthy or lazy if they are overweight
  - Not assuming that a poor person or person of color in pain is a “drug seeker”
Case Studies

Case study questions

1. What barriers to health might this person experience?

2. What assumptions or unconscious biases might we as health care providers have about this person?

3. How can we best intercept those assumptions and biases to provide excellent quality health care to this individual?

Case Study #1

Jasmin, a 27 y.o. transgender female presents with lower back pain. She hasn’t had a “check-up” in seven years because she works part time and doesn’t have insurance. PMH reveals she has been taking estradiol IM for the past 5 years, has hypertension and is otherwise healthy.

http://wamu.org/programs/metro_connection/12/09/21/xions_story_transgender_woman_tells_of_life_on_the_streets
Incorporating best practices: transgender people

- Become knowledgeable about transgender health care
- Welcome transgender patients into your practice
- Treat transgender individuals as you would want to be treated
- Remember to refer to transgender people by the name and pronoun that corresponds with their gender identity

If you are unsure about something, ask politely

- Do not ask patients about their genital/surgical status unless it is relevant to their care
- Keep the focus on the patients care, not your curiosity

(Silvia Rivera Law Project)

Health pearl:
Ask transgender patients, “what is your current gender identity?” and “what sex were you assigned at birth?” to provide health care that is both anatomy appropriate and gender affirming
Case Study #2

Miguel, a 47 y.o. undocumented day laborer, hasn’t had consistent employment or health care since he came to the U.S. 15 yrs ago. He has been having intermittent chest pain for 6 mos. His friend was deported from the hospital 2 years prior, and he is afraid if he seeks health services he will be turned over to immigration enforcement.

Undocumented immigrants: barriers to health

- Over 11 million undocumented immigrants living in U.S., most economic refugees working in food production, construction and other low skilled, physically demanding low-wage jobs.
- Undocumented immigrants are ineligible for publicly funded insurance programs (including people qualifying for DACA).
- Access to medically appropriate diagnostics, treatment and care beyond the scope of emergency treatment is severely limited.
- Emergency room care is recognized as an expensive and medically problematic way to treat chronic disease.
Working with undocumented individuals or families means carefully taking into account immigration status, language requirement, and eligibility criteria for healthcare and other services

(Berlinger, 2014)

Incorporating best practices: undocumented immigrants

- Avoid derogatory terms like "illegal" to describe the patient
- Avoid asking about documentation status unless medically necessary, if you do, do so discreetly and respectfully
- Keep documentation/immigration status confidential and assure them as such
- Health care providers are not under any legal obligation to enforce immigration! Clinics and hospitals are not immigration agencies

Incorporating best practices: language barriers

- If patient is monolingual non-English speaker
  - Seek quality interpretation
  - Use interpreters appropriately
    - Sit in a triangle position with interpreter and patient
    - Talk directly to patient, not the interpreter
Health pearl:
Become familiar with resources that exist locally for people without legal documentation, and be able to refer them as necessary (for example free clinics that serve undocumented immigrants)

Case study #3
Rena, a 74 y.o. female Navajo elder presents with progressive osteoarthritis. She has been advised to have total knee arthroplasty, but does not want the surgery because of mistrust of western medical ways. She says none of the providers she’s spoken with have respected her community healing practices or ceremony

Incorporating best practices: Native Americans
- Learn about the history, traditional beliefs, culture, and healing practices of the tribe you are working with
- Show respect to the culture by honoring those practices and traditions (i.e. ways of greeting, eye contact, etc.)
- Identify and validate potential concerns or questions patients might have about Western medicine and allopathic approaches
Incorporating best practices: 
Native Americans

- Clearly explain any recommended medication or treatment.
- Honor traditional healing practices, work with patients to incorporate them into allopathic medical treatment if patient is interested.
- Be aware of the ways that centuries of genocide and forced displacement affect the health of Native American communities.

Case Study #4

Maria, a 34 y.o. female presents for a routine check up. Her BMI is 34.1, BP 128/90, and fasting BG is 123 on today’s visit. She has no current health complaints, but wanted to check her blood sugar because her father has diabetes.

Incorporating best practices: 
challenging fat phobia

- Do not shame or belittle a patient because of their body weight. Shaming people for being fat does not reliably help them lose weight but does induce eating disorders (Neumark-Sztainer, 2007).
- Do not assume that someone eats too much, eats unhealthy food, or does not exercise based on their weight.
- Do not tell patients to “lose weight” as a substitution for necessary medical testing or treatment.
Incorporating best practices: challenging fat phobia

- Motivational interviewing to support patients in making choices that are realistic and desirable for them
- Be aware of how health disparities due to racism, sexism and poverty lead to limited access to healthy foods and other resources
- Work to challenge fat phobia in yourself and your medical practice

Health pearl:
Twice as many premature deaths may be attributable to lack of physical activity compared to obesity
(Medscape)

Case Study #5

Denise, a 60 y.o. old woman with cerebral palsy presents for a routine physical exam. She has been turned away from several other providers who claimed they were not equipped to deal with her disability.
Barriers to health: disability

- Barriers to health include
  - Physical/architectural barriers
  - Attitudinal barriers
  - Communication barriers
  - Social and economic barriers
- (Access to Medical Care Training, 2012)

Incorporating best practices: disability

- Speak directly to patient, not their companion or caregiver
- Ask how you can best help a patient with a disability, respect their answers
- Treat the whole person, not solely their disability
- Allow extra time for history taking and a thorough physical exam

Incorporating best practices: disability

- Respect patient’s privacy, ask for consent at all steps of the visit
- Work on making health facility accessible to people with wheel chairs and different levels of mobility (ramps, elevators, etc.)
- Check accessibility when referring patients to diagnostics and specialty clinics
- Be aware of the way that ableism in society creates health disparities for people living with disabilities, and work to challenge ableism individually and systemically in your practice
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