Promoting Cultural Sensibility Through Lifelong Learning

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During our time together...

- Barriers to eliminating health disparities
- Culture of health professions
- Challenges of cross-cultural communication in healthcare
- Barriers amenable to intervention
- Self-reflection about one's own beliefs

Disparities Exist for Alzheimer’s Disease

- Older African-Americans (2X) & Hispanics (1.5X) are more likely to have Alzheimer’s Disease or other dementias than older Whites.
- Missed diagnosis of Alzheimer’s and other dementias are more common among older African-Americans & Hispanics than among older whites.
- African-Americans & Hispanics are typically diagnosed in later stages of the disease resulting in higher use of health care services & substantially higher costs.


LGBT & Dementia

- LGBT older adults also are more likely to have diabetes and high blood pressure
- LGBT have disproportionately high levels of social isolation and stigmatization as they age, making it difficult to find support
- LGBT caregivers often have fewer financial resources and other support networks to help them when providing care. They may also be caring for a parent who does not accept their identity, relationship or gender expression


Why do these disparities exist?

- Genetic differences do not appear to account for large prevalence differences
- Higher rates of cardiovascular disease and diabetes which are associated with an increased risk for Alzheimer’s and other dementias
- Lower levels of education, higher rates of poverty, and greater exposure to early life adversity and discrimination increase risk

Persistence of disparities

Need to rethink approaches to addressing health disparities

Interventions and initiatives targeting upstream social determinants of health are likely most effective for improving health equity

“Fragmented care systems, care transitions, lack of care coordination, and inadequate planning often add to the suffering and illness burden. Individuals with ... late-stage dementia suffer physically, emotionally, and socially across all stages of illness and frequently do not have conversations with their health professionals about their care goals, values, and preferences.”


Framework for understanding the relationship between Hispanic/Latino ethnicity and health

SOURCE: Carter-Pokras & Bethune, 2009

Recommendations to achieve health equity

- Individuals and communications can:
  - advocate for political, social and economic policies and programs that will improve health for the most vulnerable populations, their families and communities and policies that support health advancement of multicultural populations.
  - understand their legal rights and the obligations to uphold the civil rights laws and disability laws.
  - advocate for enforcement of civil rights and disability laws.

- Federal, state and local governments can: adopt a “health in all polices approach” to assure that health issues are addressed broadly especially when considering social policies which affect vulnerable populations

SOURCE: APHA Draft Policy D2 - Achieving Health Equity in the United States, 2018

Education on diversity in the context of patient care

AIMS: IMPROVE COMMUNICATION (E.G. AGENDA-SETTING, INFORMATION GATHERING, NEGOTIATING TREATMENT), RELATIONSHIPS (E.G. PATIENT EXPERIENCES OF CARE, EMPATHY, SELF-AWARENESS, KNOWLEDGE/UNDERSTANDING OF DIFFERENCES), AND REDUCE HEALTH DISPARITIES

TERMS: CULTURAL COMPETENCE, CULTURAL SAFETY, CULTURAL COMPETENCY, CULTURAL SENSITIVITY, CULTURAL HUMILITY, MULTICULTURAL TRAINING, STRUCTURAL COMPETENCY & CRITICAL CONSCIOUSNESS

National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care

Principal Standard:
- Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

SOURCE: HHS Office of Minority Health
Continuing Need to Improve Health Professional Education

- Cultural competency increasingly recognized as essential for eliminating health disparities
- 1 of 4 medical school graduates report no voluntary cultural competence experience (AAMC, 2018)
- Gaps in cc education (e.g., health disparities, community strategies, bias/stereotyping)
- Limited patient involvement & evaluation in cc/hl education (especially long-term)
  — Narrative medicine/humility (DasGupta S, 2006;2008)

Cultural competency

Ability of health organizations and practitioners to recognize individuals' cultural beliefs, values, attitudes, traditions, language preferences, and health practices and apply this knowledge to influence positive health outcomes.

Health Literacy

Degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Include Health Literacy in Cross-Cultural Clinical Skills ToolBox

INTERVIEW WITH DR. ANNA MARIA IZQUIERDO-PORRERA

[Dropbox link]

“Without cultural humility in each clinical encounter among health care professionals, patients, and their family members, dementia may be treated to some extent, but the patient’s deeper needs and fears may not be well understood.”

XinQi Dong and E-shien Chang. Lost in Translation: To Our Chinese Patient, Alzheimer's Meant 'Crazy And Catatonic' Health Affairs, 2014
Cultural Sensibility

Sensibility (openness to emotional impressions, susceptibility and sensitiveness) relates to a person’s moral, emotional or aesthetic ideas or standards. Thus, cultural sensibility is interactional: if one is open to outside experience, one might reflect and change because of that experience.

**Implicit Association Test (IAT)**

- Unconscious negative evaluation of one group and its members relative to another
- Does not equal discrimination
- Is “potentially malleable, changing in response to situational cues & norms” (Blair, 2011).

**Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare**

Source: Gomes and McGuire, 2001

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<table>
<thead>
<tr>
<th>Educational content</th>
<th>Cultural expertise</th>
<th>Cultural sensibility</th>
</tr>
</thead>
<tbody>
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<td>- Knowledge is localized such that new knowledge builds on pre-existing knowledge; increasingly complex and abstract</td>
<td>- Knowledge is articulated and refined for practical use or problem solving</td>
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<td>Focus on depth</td>
<td>Focus on breadth</td>
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<td>- Students learn about others</td>
<td>- Students learn about others</td>
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<tr>
<th>Component</th>
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<tr>
<td>Recognition (attitude)</td>
<td>Knowledge is independent of context</td>
<td>Knowledge depends on context</td>
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<td>Nature of knowledge</td>
<td>People are categorized into groups in terms of key characteristics of groups</td>
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<tr>
<th>Type of categorization</th>
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<th>Categorization is useless</th>
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<tr>
<td>Perception of reality</td>
<td>Reflection might be hampered</td>
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Growing evidence that providers hold implicit racial biases* which harm patients

- Poorer communication by providers (Cooper 2012; Penner, 2010; Hagiwara, 2013)
- Lower patient satisfaction (Blair, 2013; Cooper 2012)
- Suboptimal clinical decision-making in some but not all vignette studies (Green, 2007; Haider, 2011; Oliver, 2014; Sabin, 2012)

*Implicit biases assessed using Implicit Association Test (IAT) www.implicit.harvard.edu/implicit/

Reflective Learning can:
- Lead to a deeper of understanding of one's unconscious thoughts, attitudes, and biases
- Promote self awareness, confidence, and growth
- Serve as a tool to elicit ongoing change and improvements in clinical effectiveness and quality service
- Build on a developmental process of reflective learning from everyday experiences

Paired Audience Reflection Exercise

- **Step 1 – Self – Reflection (5-10 minutes)**
  - Our unconscious biases as providers can negatively impact patient outcomes (potential biases include: racial/ethnic, gender, obesity, disability, agism, sexual orientation, religion, language ability)
- **Step 2: Giving and receiving feedback on the Reflection**
- For large group sharing: What did you learn from this paired exercise?

1. Early, promising results for interventions based on “social-cognitive approach” (often incorporating IAT)

- Goals include promoting knowledge, self-awareness, reflection, empathy, skill-building & application of strategies
- Evaluation in early stages but some promising results:
  - Improvements in knowledge, attitudes & self-awareness (Van Schalk, 2014; Gill, 2010; Hausmann, 2014)
  - Identification of strategies for identifying & managing biases (Teal, 2010)
  - Reported applying strategies in clinical/administrative practice (Hausmann, 2014)
- Need to examine outcomes related to patient care

See review by Teal et al, 2012
2. Take steps to avoid unintended consequences

Among whites, under certain conditions taking a race IAT has been shown to result in:
- Increased implicit racial bias when test is believed to be diagnostic of racism (Frantz, 2004)
- Poorer communication when interacting with Aboriginal partners (Voraurer, 2012)
- Consistent with research showing fear of being racist can lead whites to distance themselves from blacks (Goff, 2008)

Avoiding unintended consequences:

a. Deeply consider the learner’s perspective

- Variation in beliefs about inequality/bias -> affects message acceptance versus resistance (RWJ, 2010, Gollust)
- *EMPOWER study: How to frame disparities messages for providers with different inequality beliefs to increase
  - Message acceptance versus resistance
  - Motivation to change behavior/adopt new strategies


b. Emphasize growth versus fixed mindset

- Less interracial anxiety
- Greater willingness to engage in interracial interactions and learning activities to promote racial diversity
- Less physical distancing from blacks (Carr, 2012; Goff, 2008)

3. Emphasize strategies not based on suppression

- Emphasize common identities (e.g., partnership)
- Counter-stereotyping
- Perspective taking
- Individuation (e.g., eliciting the patient’s story)

(For reviews see Burgess, 2007; Stone, 2011)