Promoting Cultural Sensibility Through Lifelong Learning

Olivia Carter-Pokras, PhD
Professor
University of Maryland
School of Public Health

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.

SOURCE: https://www.alz.org/media/HomeOffice/Facts%20and%20Figures/facts-and-figures.pdf; https://www.alz.org/media/Documents/lgbt-dementia-issues-brief.pdf

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

SOURCE: https://www.alz.org/media/HomeOffice/Facts%20and%20Figures/facts-and-figures.pdf

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

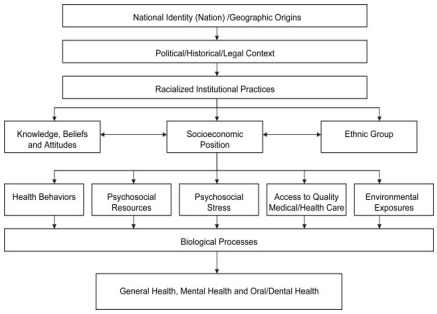
SOURCE: https://www.alz.org/media/Documents/lgbt-dementia-issues-brief.pdf

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

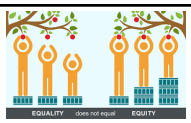
Framework for understanding the relationship between Hispanic/Latino ethnicity and health



SOURCE: Carter-Pokras & Bethune, 2009

"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."

American Public Health Association. Supporting Public Health's Role in Addressing Unmet Needs in Serious Illness and at the End of Life. 2013



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 SENSITIVITY, CULTURAL SENSIBILITY, 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.

(Nielsen-Bohlman, 2004)

Include Health Literacy in Cross-Cultural Clinical Skills ToolBox

HEALTH LITERACY IMPORTANT FOR CULTURALLY COMPETENT HEALTHCARE.

HOW PATIENTS UNDERSTAND AND USE HEALTH INFORMATION TIED TO CULTURAL ATTITUDES/BELIEFS.

PATIENT'S HEALTH LITERACY AFFECTED BY CULTURAL BELIEFS, EDUCATION & LIMITED ENGLISH PROFICIENCY.

INTERVIEW WITH DR. ANNA MARIA IZQUIERRDO-PORRERA

https://www.dropbox.com/h

"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

SOURCE: Dogra N, Carter-Pokras O. Chapter 31. Diversity in Medical Education. In: Understanding Medical Education (3rd edition). Association for the Study of Medical Education. Wiley-Blackwell. In Press.

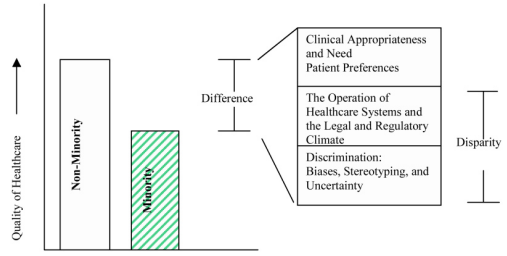
Educational philosophy	Cultural expertise	Cultural sensibility
Epistemology (what constitutes knowledge)	• Knowledge exists independent of context • Positivism	• Knowledge depends on context • Constructivism
Nature of knowledge	• People are categorised into groups • Cultural competence is based on knowledge of key characteristic of these groups	• People are not categorised into groups • Cultural competence is based on knowledge of people as individuals
Use of categorisation	Categorisation is helpful	Categorisation may be unhelpful
Conception of reality	Objective reality to be revealed or discovered	No single objective reality to be discovered
Analytical perspective	Reductionist	Holistic
Historical connection	Rooted in historical context of minority disadvantage and white domination	Steps outside of the historical context of race
Politics of institutions	Improve competence of providers and /or users to improve access to care/services	Does not work on a competence level
Relation to inequalities	Attempts to change and reduce health care inequalities	Acknowledges inequalities but as such does not directly attempt to change them
Role of teacher	Teacher sets the agenda	Teacher introduces the agenda
Role of learner	Receive information	Contribute to dialogue and actively listen

SOURCE: Dogra N, Carter-Pokras O. Chapter 31. Diversity in Medical Education. In: Understanding Medical Education (3rd edition). Association for the Study of Medical Education. Wiley-Blackwell. In Press.

Educational content	Cultural expertise	Cultural sensibility
Bernstein's Curriculum type (54)	Collection type • knowledge is hierarchical such that new knowledge builds on prior and becomes increasingly complex and abstract • focus on depth	Integrated type • knowledge is laterally linked and interrelated for practical use or problem solving • focus on breadth
Nature of content	Parochial Specific	Global Non-specific
Organisation of content	To meet local needs / demands	To maximise student self-learning
Curriculum	Fact acquisition to gain body of knowledge	Self-reflection and self-awareness of students
Teaching focus	Groups (treats people as groups) More service-centred	Individuals (views individuals as potentially parts of different groups in different contexts) More patient-centred
Focus of content	Students learn about others	Students learn as much about others as themselves

SOURCE: Dogra N, Carter-Pokras O. Chapter 31. Diversity in Medical Education. In: Understanding Medical Education (3rd edition). Association for the Study of Medical Education. Wiley-Blackwell. In Press.

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



Source: Gomes and McGuire, 2001

Implicit bias

- 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).

Implicit Association Test (IAT)

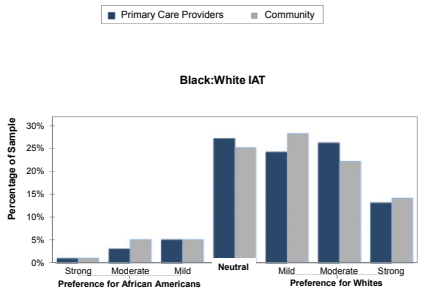
Most well known and used measure of implicit associations

Implicit bias exists among clinicians & public; may be associated with treatment recommendations

Can be used to trigger discussion

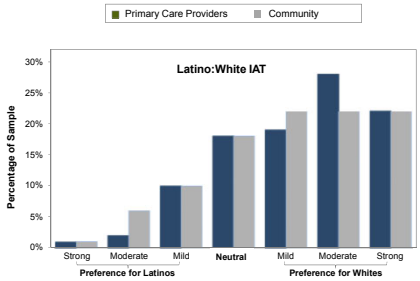
Need for debriefing after IAT
Skilled facilitators very important
Create "optimal amount of discomfort" in a safe environment

Implicit Racial/Ethnic Attitudes



SOURCE: Blair et al. (2013). Am J Public Health.

Implicit Racial/Ethnic Attitudes--II



SOURCE: Blair et al. (2013). Am J Public Health.

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/*

*Full references on handout provided.

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 Schaik, 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:

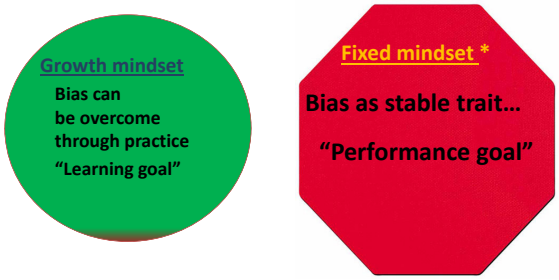
- Increased implicit racial bias when test is believed to be diagnostic of racism(Frantz, 2004)
- Poorer communication when interacting with Aboriginal partners (Vorauer, 2012)
- Consistent with research showing fear of being racist can lead whites to distance themselves from blacks (Goff, 2008)

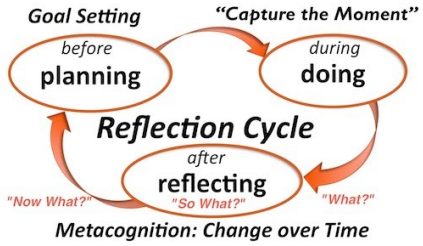
Avoiding unintended consequences:
a. Deeply consider the learner's perspective

- 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

*VA HSR&D IIR 11-328-2: Burgess, PI. Co-I's: Bokhour, Clark, Dovidio, Gollust, Gordon, Partin, Pope, Saha, Taylor, van Ryn.

Avoiding unintended consequences:
b. Emphasize growth versus fixed mindset





This model is based on the theory of ***Self-Regulated Learning***.

Abrami, P., et. al. (2008), Encouraging self-regulated learning through electronic portfolios. Canadian Journal of Learning and Technology, V34(3) Fall 2008. http://www.cjlt.ca/index.php/cjlt/article/viewArticle/507/238

Among whites, growth versus fixed mindsets lead to:

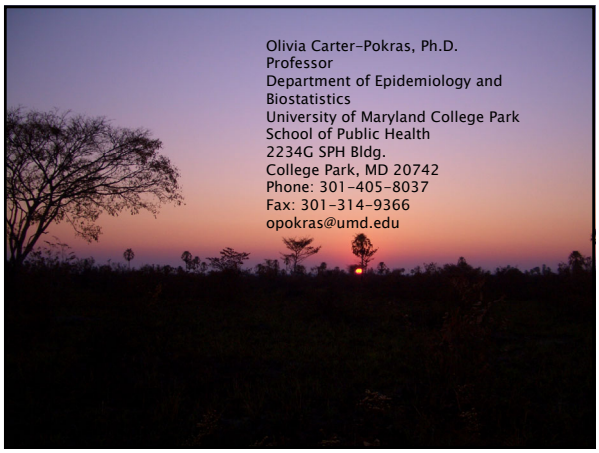
- Less interracial anxiety
- Greater willingness to engage in interracial interactions and learning activities to promote racial diversity
- Less physical distancing from blacks

(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)


Olivia Carter-Pokras, Ph.D.
Professor
Department of Epidemiology and Biostatistics
University of Maryland College Park
School of Public Health
2234G SPH Bldg.
College Park, MD 20742
Phone: 301-405-8037
Fax: 301-314-9366
opokras@umd.edu