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Cultural Proficiency 101: New Skills for Providers

MEDICAL DISPARITIES IN OUR MINORITY GROUPS IN THE UNITED STATES

Medical disparities are seen more and more in our minority groups in the United States. Do we have any answer? What are we going to do about it? I am your host, Dr. Maurice PICKARD: and today my guest is Dr. James Webster, Professor of Medicine at the Northwestern University Feinberg School of Medicine, the Executive Director of the Institute of Medicine of Chicago and President of the Chicago Board of Health.

DR. MAURICE PICKARD:

Thank you very much for joining us.

DR. JAMES WEBSTER:

My pleasure. Thank you very much for the invitation. Glad to be here.

DR. MAURICE PICKARD:

Dr. Webster, to begin with, what is the problem? Why are we spending so much time talking about medical disparities in our minority groups in the United States?

DR. JAMES WEBSTER:

The problem is that there is lots of data that indicates that minority groups get much worse quality of care. This is due to multiple factors but the reality comes that there outcomes are likely to be substantially worse, in fact they are substantially worse in many areas of care, and if we want to improve the overall care of our country this is low hanging fruit. If we improve the quality of care we give minorities the overall level will go up in the country as well as the patients will be beneficiaries of this.

DR. MAURICE PICKARD:

Initially, I would respond by saying that the reason this exist is that they are uninsured or that they are in the lower part of the socioeconomic part of our country. But New England Journal had reported in 2004 when I looked this up that this wasn't the case, that people in the upper middle class and upperly mobile part of our minorities groups still had trouble getting non-emergency admissions, seeing a specialist in getting diagnostic imaging tests done. Why is this exist then if we eliminate what I thought would be a ready answer?

DR. JAMES WEBSTER:

Well, this is very interesting and you are absolutely correct. I had the same prejudices a few years ago the same that the big problem is that we get really insure the problem would go away, and it doesn't. Minority patients who have just as good health insurance as the general population do not get the same level of care, multiple reasons, one is even if you have insurance, either in reality or in perception, you do not have access to the best and wonderful things that our country's medical system can provide. If you live in a community where the hospitals are under resource, you are not going to get the same level of care as if you lived next to some fancy economic medical center in one of the major cities, is just not going to happen. There also are if you well historical perceptions by minorities, which gets in the way of their getting the same level of care as the general population.

DR. MAURICE PICKARD:

I think this brings up the subject of inverse care law, which I have heard you speak on?

DR. JAMES WEBSTER:

It certainly does. The inverse care law was promulgated in 1971 by a GP in Great Britain who was working in rural part of Wales where who felt he had no resources and no access to specialist and he contrasted what he was trying to do with these minorities, as compared to what happened on Harley Street in London. But certainly if you think of our experiences, we all know that there are most urban areas and other places too where specialist are bound, where physicians are competing if you will for patients, and yet at the same time there are under-resourced areas. If you go to the south or west side of my own city of Chicago, you are going to find that its very difficult to get a specialty referral in a timely manner for a patient who urgently needs one, and then its an educational issue. All the things that we take for granted, for example, the preventive intervention such as colonoscopies and mammograms, etc., these are not things that are well received by minority patients because of history, because of education.

DR. MAURICE PICKARD:

Well with minorities growing rapidly, are we adapting? Is our healthcare workforce changing to meet this need?

DR. JAMES WEBSTER:

Yes and no, how is that for wordily answer.

DR. MAURICE PICKARD:

That's good, sounds like me.

DR. JAMES WEBSTER:

The problem is that we have a workforce that is predominantly not minority. If you look nurses, physicians, mental health workers, whatever, the numbers are 7 or 8% of the health workforce, whereas in our country today, as you pointed out, about 27% of our country is now minorities, so that we have a mismatch. The graduates of our current medical and nursing schools are well equipped to deal with the sort of stuff we are talking about here. They get lots of training in cultural competency, medical sociology, etc. However, those of us who have graduated not in the recent past need a refresher course and need to really just think about what we do and recognize our own cultural background, we all have our own necessities, and we should appreciate that when we come in to the clinical situation, we bring with us our own historical background, our own biases, and its important that we face up to those and somehow wipe them out when we are trying to give the best we can to our patients.

DR. MAURICE PICKARD:

I remember personally being in a crowded elevator in a municipal hospital and looking over it a very charming child of a Hispanic mother and saying what a beautiful child you have. Shortly thereafter, the mother seemed to become agitated and it took a nurse to tell me that I had probably given the evil eye to the child by complementing the child, which is certainly something that we all do everyday. I had not touched the child. I had not reached out and said yes you have a beautiful child and touched the child. This is certainly not something that I would do in another culture. Frequently, I do not reach out, touch patients, it seems sometimes an invasion of their privacy, but in this culture it certainly was acceptable. I had missed it and was one of those older doctors who was not educated. So, how does somebody who is like myself, who is now aware of these things become somewhat self reflective about his own biases and prejudice?

DR. JAMES WEBSTER:

I love your story. <_____> **(06:47)** is a very real thing in the Latino culture and it is very tough. Certainly, my colleagues who come from other cultures have thought me a great deal. I am sure I still put my literally or figuratively sometimes probably put my foot in my mouth or don't make the right nonverbal cue, etc. I think there are things, however, that particularly if you are dealing with a Latino or an African-American population, some frank discussions with your colleagues who come from that culture are very eye-opening and are very useful. I mean, we all are used to developing trust to communicating clearly but we need to have as you pointed out, we need to have some special lessons in the specifics of these various cultures as they interact with each other and with us and there of course I think it is important to realize that for example Spanish is a language, it is not a culture. In Chicago, for example, the Hispanic culture from Mexico is very different than the Puerto Rican culture and I know what parts of the city are predominantly Mexican-Americans and which part are Puerto Rican-Americans and they have different music, they have different food. Their accents are even different and they even I can tell them apart now to listen to them talk. So, they are just the lodicules and I do not think we should expect that we are going to understand every culture all the time particularly in a multicultural city like Chicago, but I think its important that we give them the respect and dignity that they have a right to expect from us, and if we make a mistake, I just apologize, but they, yes, there are very important lessons that we can all learn and just use that as part of our armamentarium when we are dealing with patients from different cultures. It's not that hard but you have to stop and think about it and we have to realize what baggage we bring to the clinical encounter as well.

DR. MAURICE PICKARD:

If you are just joining us, you are listening to a special segment - Ethics In Medicine. I am you host, Dr. Maurice Pickard, and today our guest is Dr. James Webster, Professor of Medicine at the Northwestern University, Feinberg School of Medicine and we are talking about health disparities in minority groups.

Are there any special tools that we can learn that might help us dealing first with the Hispanic population and then may be we will talk about other special tools that we should be aware of it in the African-American population?

DR. JAMES WEBSTER:

Well, again, talking about race in our country today is a very sensitive topic. I think the important thing is the idea that A, as I mentioned you should recognize your own biases and B, we should avoid stereotyping. I am sure we all have, for example, Latino acquaintances, who are thank per I know, I do a bank president, a lawyer who is a very prominent health expert, etc., so that all Latinos are not recent immigrants to this country, etc. I think it is also important, for example, as you pointed out that we try to understand folk medicine and folk healers are still very prevalent in many first and second generation Mexicans for example and you have to ask the patient what are you doing about this or what did you have your child do about this because they may be seeing the folk healer at the same time they are seeing you. Again, as I said <_____> (**10:36**)is very important, the idea of giving respect and shaking hand, and explaining who you are, and these are all things that we should do for all patients but are particularly important, for example, for a Latino population, and the same way the African-American populations and their interactions with the medical system have not had a great history as you all know that started long before Tuskegee, but Tuskegee did not think much, but the African-American population has had so much prejudice and so much as you well neglect and abuse from the medical establishment that they are very weary, and this is one reason for example why we sometimes have problems getting them to accept the idea of a colonoscopy, I mean there is lastly good evidence that African-Americans have more colon cancer than the general population, they have more polyps certainly and yet to get them to accept the idea of a screening colonoscopy may be very difficult. Now, for that, for example, the idea of using peer groups is wonderful. In Chicago, Eric Whitaker, who was the head of the Illinois Department of Public Health that is now at the University of Chicago is famous for training barbers to give information about prostate cancer because the African-American barber shop is really a sort of a center for African-American males where they hang out and get a lot of their networking interactions and this was a terrific strategy and it did, mean that we get a lot more PSAs and get a lot more diagnosis of prostate cancer, much more than 100 lectures by yours truly whatever have done was just to get these guys talking with somebody they trusted in a peer group interaction so that this is a sort of strategy that sometimes will help with African-Americans and its important again as I said respect goes such a long way and people go ahead and disrespect to all their life and just have to remember we hopefully we do it for all our patients but its particularly important for minorities.

DR. MAURICE PICKARD:

With so few people going into primary care, who is going to provide the care to our minority groups?

DR. JAMES WEBSTER:

Well, there is good data that a patient center and medical home, where you have a team of individuals working gives better care and gives if you well the doctors on an opportunity used to things that they do best. Much of the health maintenance and preventive care and the routine care can certainly be well given by nurse practitioners and nurses and they do a much better job of it than physicians do because they will take the time and frequently the patients are more if you well willing to ask them questions and they are the physicians who still regarded as a very authoritarian figure by many minorities. The patients are more comfortable talking the things over with a nurse or a nurse practitioner or whomever. So that the physician then is left to deal with complications of the almost complex medical problems, new diagnosis, and things that physicians really do best are magnified if the care is given as part of a team of professionals.

DR. MAURICE PICKARD:

This is an answer that may help deal with the medical disparities that exist in our minority groups, and I want to thank Dr. James Webster for being our guest and we have been taking about health disparities in the United States. This has been a special segment on Ethics in Medicine.

I am Dr. Maurice Pickard, your host. To listen to our on-demand library, visit us at www.Reachmd.com. Thank you for listening.

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