

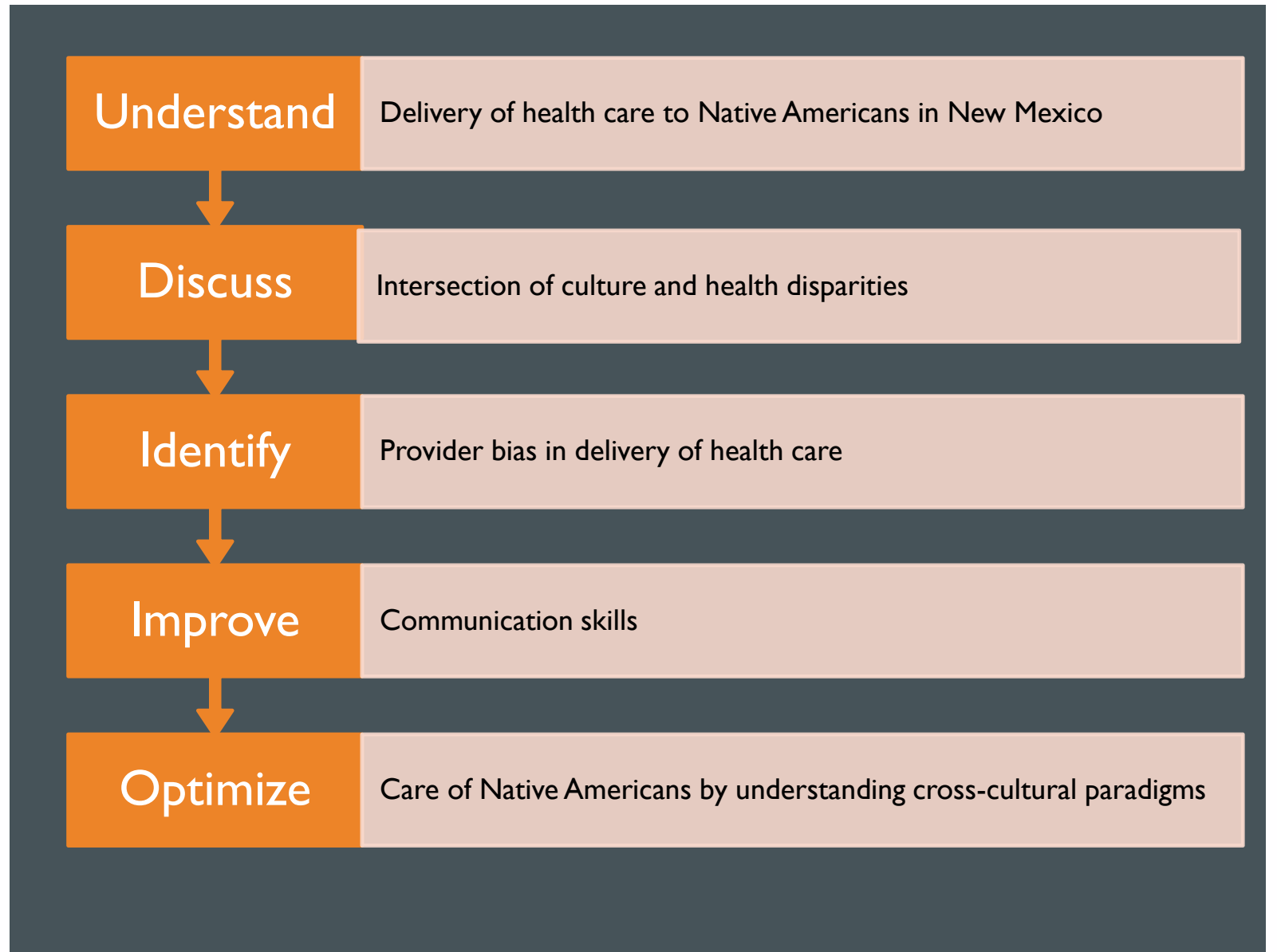


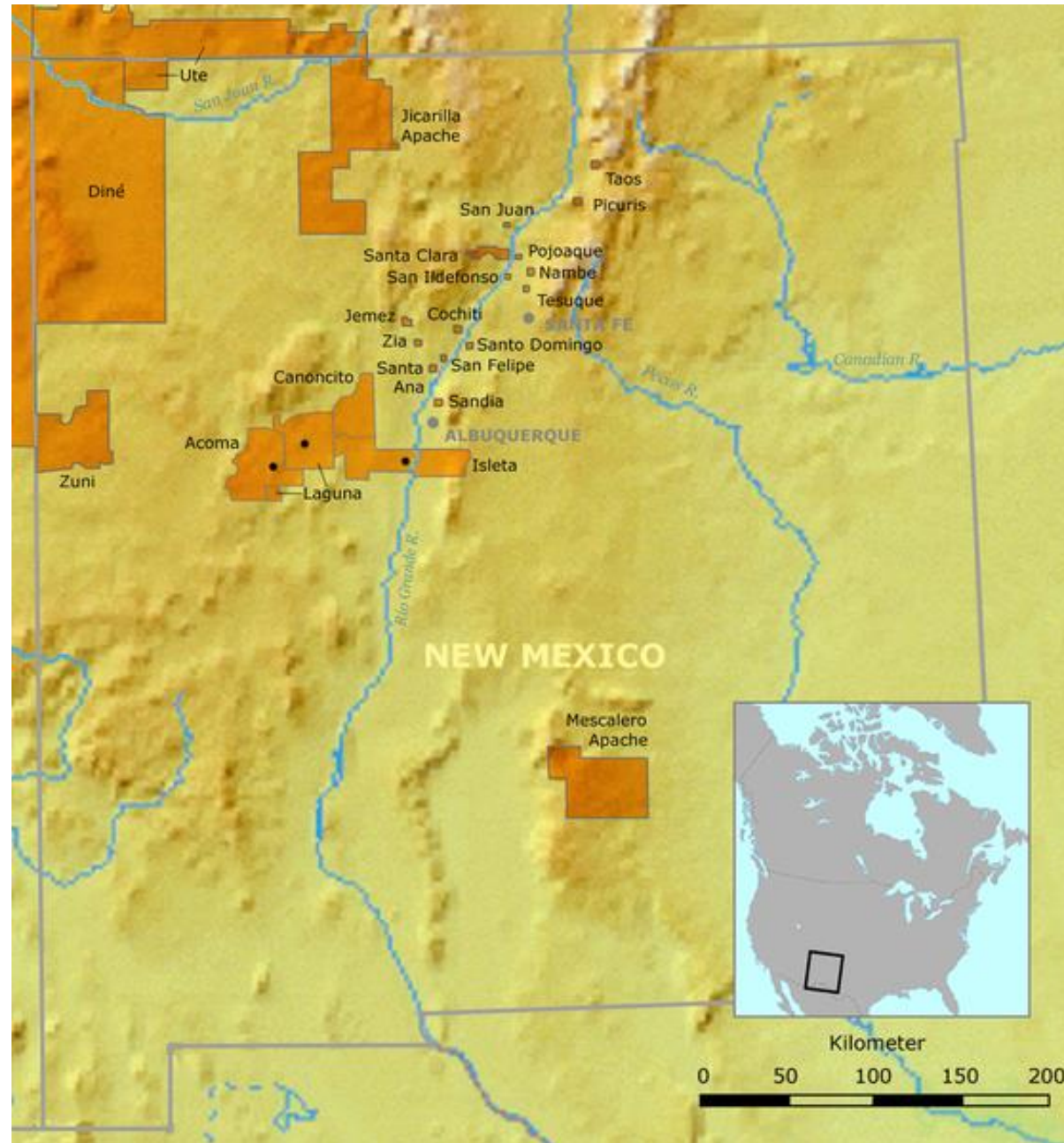
CULTURALLY SENSITIVE CARE FOR NATIVE AMERICANS

ROBERT J. SURAWSKI, MD



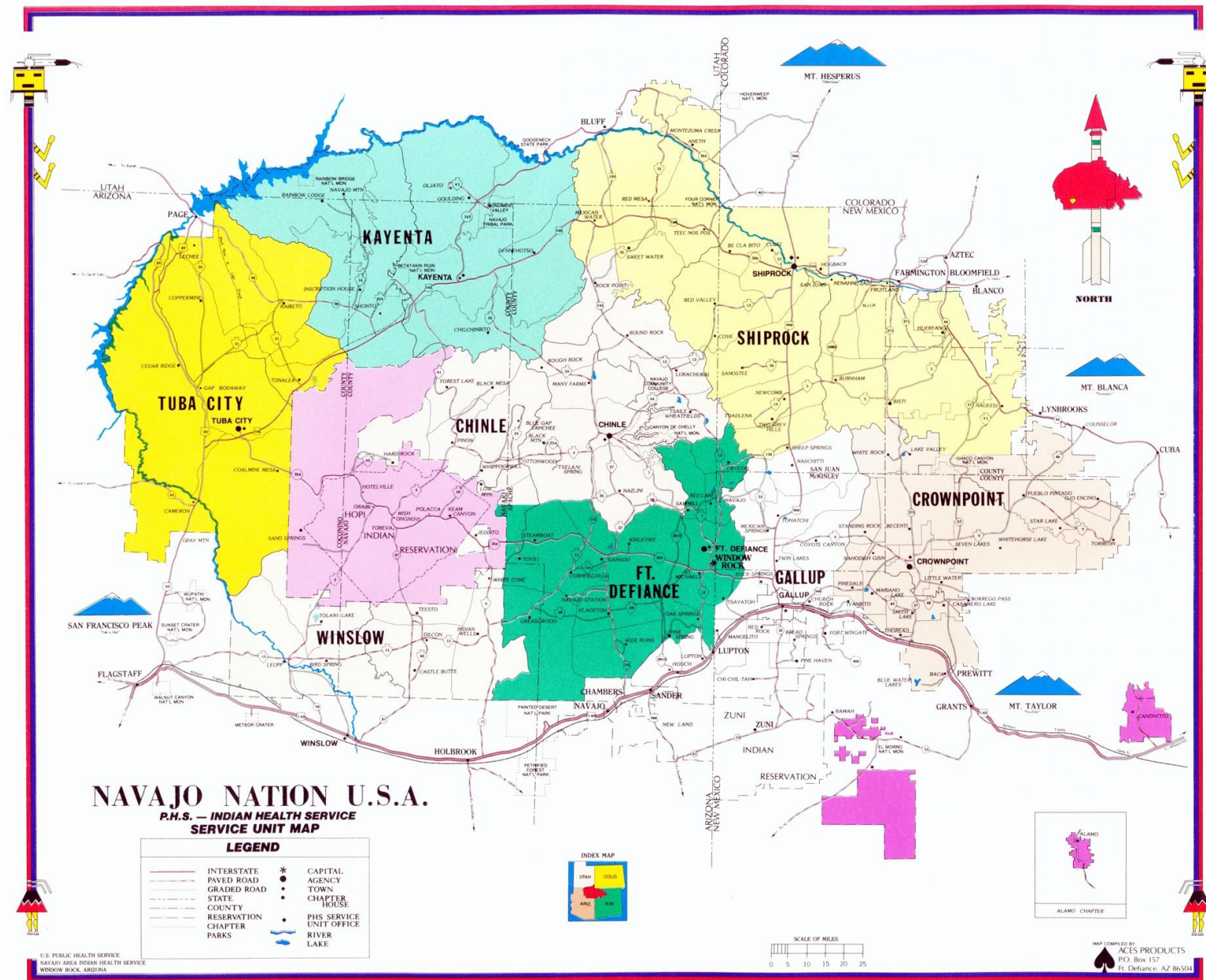
OBJECTIVES





Source: Nikater, *Map of Pueblos in New Mexico*,
Original work submitted to public domain using
Demis, March 26, 2007

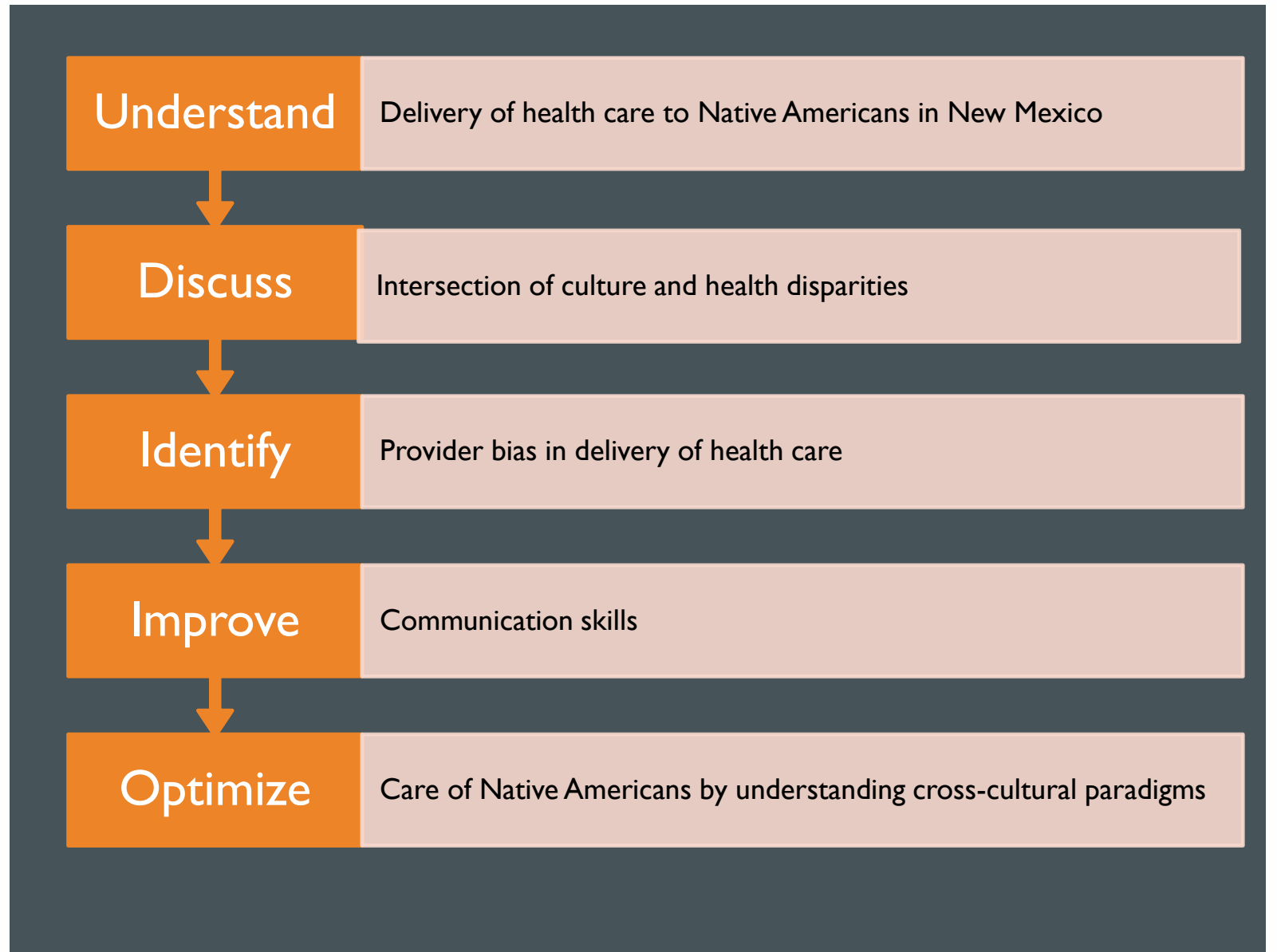




ALTERNATIVE FUNDED CLINICS



OBJECTIVES



CULTURE AND HEALTH DISPARITIES

Reservation

Ceremonies

Genocide

Historical
Trauma



Health Disparities

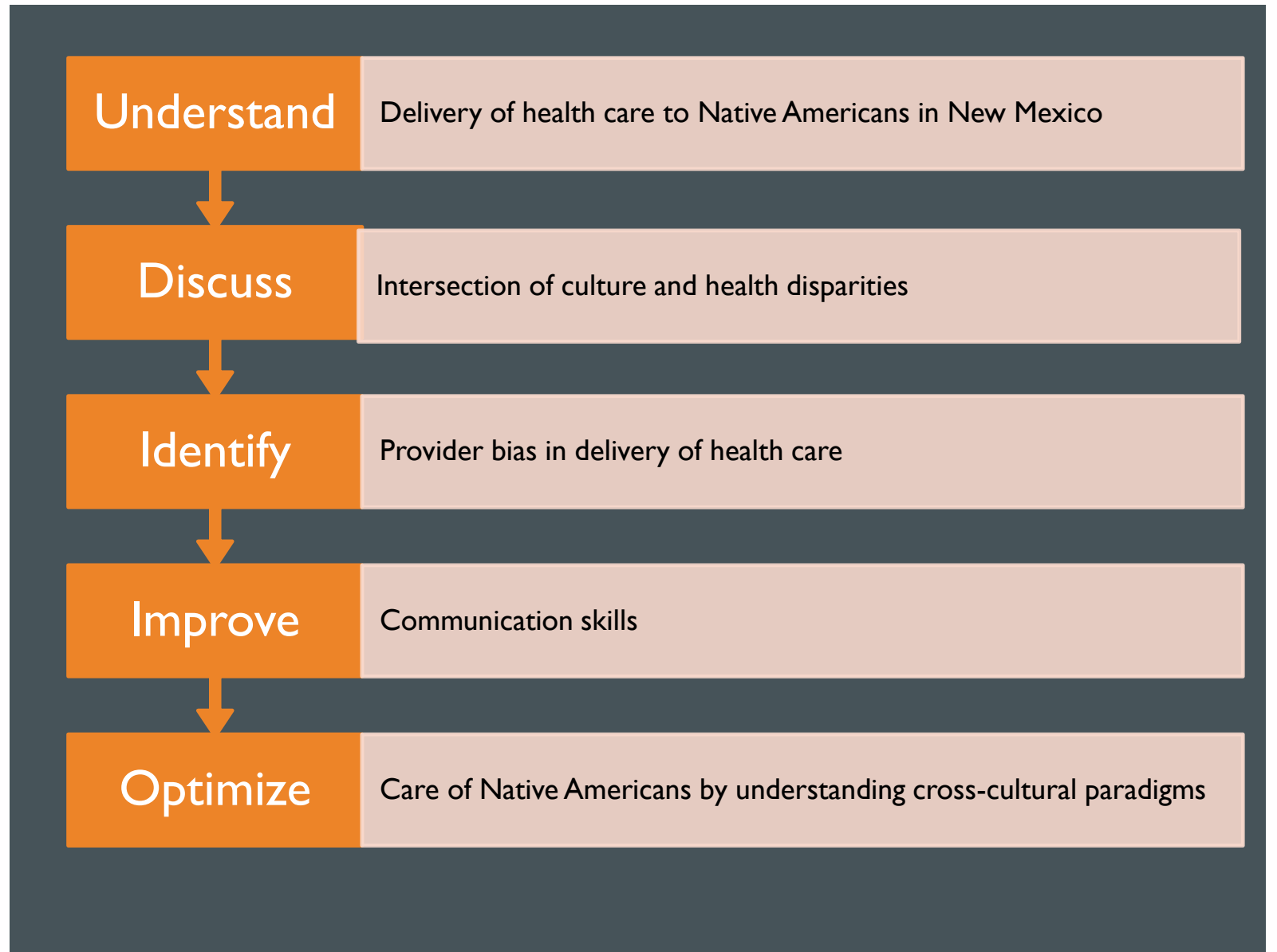
Culture
Preservation

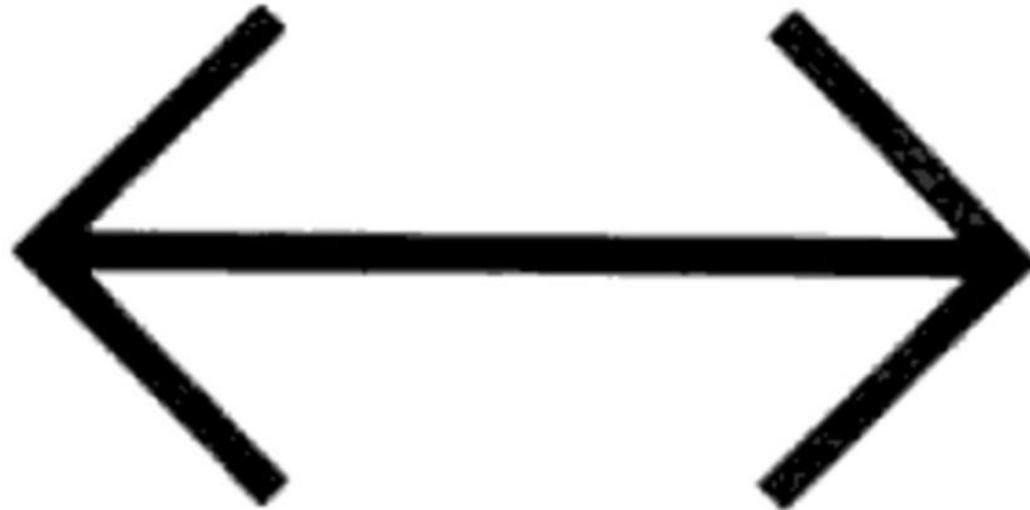
Family

Broken Treaties

Traditional
Medicine

OBJECTIVES





WHAT IS PROVIDER BIAS?

Implicit bias: associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender

ARTICLE IN PRESS

NEW ENGLAND SURGICAL SOCIETY ARTICLE

Impact of Race on the Surgical Management of Adhesive Small Bowel Obstruction

Alexander S Chiu, MD, Raymond A Jean, MD, Kimberly A Davis, MD, MBA, FACS, Kevin Y Pei, MD, FACS

BACKGROUND: Small bowel obstruction (SBO) represents roughly 15% of admissions by general surgeons. Management of SBO relies heavily on provider judgment, including decisions on how long to try nonsurgical management and whether to use a laparoscopic or open approach when surgery is needed. Given the subjective nature of these decisions, it is unknown if patient race influences management of SBO.

STUDY DESIGN: The National Surgical Quality Improvement Program was used to identify patients who underwent adhesiolysis or small bowel resection for adhesive SBO between 2010 and 2015 (n = 13,896). Adjusted logistic regression models incorporating patient comorbidity, American Society of Anesthesiologists (ASA) class, and emergency status were used to analyze odds of receiving surgery after 5 days from hospital admission (Eastern Association for the Surgery of Trauma guidelines) and of undergoing an open operation.

RESULTS: Patients who waited more than 5 days for a procedure had greater adjusted odds of postoperative complication (odds ratio [OR] 1.56 95% CI 1.37 to 1.79) compared with those waiting 5 days or less. Similarly, open procedures had higher odds of complication compared with laparoscopic (OR 2.31 95% CI 2.00 to 2.68). Regression analysis demonstrated that black patients were significantly more likely than white patients to wait more than 5 days for surgery (OR 1.31 95% CI [1.13–1.53]) and undergo open surgery (OR 1.56, 95% CI 1.36 to 1.79). There was no statistical difference for Hispanics patients waiting more than 5 days (OR 0.98, 95% CI 0.73 to 1.31) or receiving open surgery (OR 0.84, 95% CI 0.70 to 1.01) compared with white patients.

CONCLUSIONS: Clinical decisions regarding SBO management differ based on patient race. Future studies focusing on the surgical decision-making process and the influence of bias are needed. (J Am Coll Surg 2017;■:1–9. Published by Elsevier Inc. on behalf of the American College of Surgeons.)

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

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Black Americans are systematically undertreated for pain relative to white Americans. We examine whether this racial bias is related to false beliefs about biological differences between blacks and whites (e.g., “black people’s skin is thicker than white people’s skin”). Study 1 documented these beliefs among white laypersons and revealed that participants who more strongly endorsed false beliefs about biological differences reported lower pain ratings for a black (vs. white) target. Study 2 extended these findings to the medical context and found that half of a sample of white medical students and residents endorsed these beliefs. Moreover, participants who endorsed these beliefs rated the black (vs. white) patient’s pain as lower and made less accurate treatment recommendations. Participants who did not endorse these beliefs rated the black (vs. white) patient’s pain as higher, but showed no bias in treatment recommendations. These findings suggest that individuals with at least some medical training hold and may use false beliefs about biological differences between blacks and whites to inform medical judgments, which may contribute to racial disparities in pain assessment and treatment.

racial bias | pain perception | health care disparities | pain treatment

A young man goes to the doctor complaining of severe pain in his back. He expects and trusts that a medical expert, his physician, will assess his pain and prescribe the appropriate treatment to reduce his suffering. After all, a primary goal of health care is to reduce pain and suffering. Whether he receives the standard of care that he expects, however, is likely contingent on his race/ethnicity. Prior research suggests that if he is black, then his pain will likely be underestimated and undertreated compared with if he is white (1–10). The present work investigates one potential factor associated with this racial bias

These disparities in pain treatment could reflect an overprescription of medications for white patients, underprescription of medications for black patients, or, more likely, both. Indeed, there is evidence that overprescription is an issue, but there is also clear evidence that the underprescription of pain medications for black patients is a real, documented phenomenon (1, 4). For example, a study examining pain management among patients with metastatic or recurrent cancer found that only 35% of racial minority patients received the appropriate prescriptions—as established by the World Health Organization guidelines—compared with 50% of nonminority patients (4).

Broadly speaking, there are two potential ways by which racial disparities in pain management could arise. The first possibility is that physicians recognize black patients’ pain, but do not treat it, perhaps due to concerns about noncompliance or access to health care (7, 8). The second possibility is that physicians do not recognize black patients’ pain in the first place, and thus cannot treat it. In fact, recent work suggests that racial bias in pain treatment may stem, in part, from racial bias in perceptions of others’ pain. This research has shown that people assume a priori that blacks feel less pain than do whites (11–17). In a study by Staton et al. (14), for instance, patients were asked to report how much pain they were experiencing, and physicians were asked to rate how much pain they thought the patients were experiencing. Physicians were more likely to underestimate the pain of black patients (47%) relative to nonblack patients (33.5%). Of note,

Significance

The present work examines beliefs associated with racial bias in pain management, a critical health care domain with well-documented racial disparities.

Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients

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CONTEXT: Studies documenting racial/ethnic disparities in health care frequently implicate physicians’ unconscious biases. No study to date has measured physicians’ unconscious racial bias to test whether this predicts physicians’ clinical decisions.

OBJECTIVE: To test whether physicians show implicit race bias and whether the magnitude of such bias predicts thrombolysis recommendations for black and white patients with acute coronary syndromes.

DESIGN, SETTING, AND PARTICIPANTS: An internet-based tool comprising a clinical vignette of a patient presenting to the emergency department with an acute coronary syndrome, followed by a questionnaire and three Implicit Association Tests (IATs). Study invitations were e-mailed to all internal medicine and emergency medicine residents at four academic medical centers in Atlanta and Boston; 287 completed the study, met inclusion criteria, and were randomized to either a black or white vignette patient.

MAIN OUTCOME MEASURES: IAT scores (normal continuous variable) measuring physicians’ implicit race preference and perceptions of cooperativeness. Physicians’ attribution of symptoms to coronary artery disease

CONCLUSIONS: This study represents the first evidence of unconscious (implicit) race bias among physicians, its dissociation from conscious (explicit) bias, and its predictive validity. Results suggest that physicians’ unconscious biases may contribute to racial/ethnic disparities in use of medical procedures such as thrombolysis for myocardial infarction.

KEY WORDS: unconscious bias; thrombolysis; race; clinical decisions; disparities.
DOI: 10.1007/s11606-007-0258-5
© 2007 Society of General Internal Medicine 2007;22:1231–1238

BACKGROUND

Widely documented racial/ethnic disparities are particularly striking in the treatment of cardiovascular disease,^{1,2} with whites up to twice as likely as blacks to receive thrombolytic therapy for myocardial infarction.^{3–7} Whether health professionals’ biases contribute to such disparities in care has been a subject of speculation and study.^{1,8–14} For example, physicians might believe that black patients are less likely to adhere to treatment recommendations than whites, and thus offer treatment less often.¹²



Project Implicit®

LOG IN TAKE A TEST ABOUT US EDUCATION BLOG HELP CONTACT US DONATE

Arab-Muslim IAT

Arab-Muslim ('Arab Muslim - Other People' IAT). This IAT requires the ability to distinguish names that are likely to belong to Arab-Muslims versus people of other nationalities or religions.

Disability IAT

Disability ('Disabled - Abled' IAT). This IAT requires the ability to recognize symbols representing abled and disabled individuals.

Weapons IAT

Weapons ('Weapons - Harmless Objects' IAT). This IAT requires the ability to recognize White and Black faces, and images of weapons or harmless objects.

Presidents IAT

Presidents ('Presidential Popularity' IAT). This IAT requires the ability to recognize photos of Donald Trump and one or more previous presidents.

Weight IAT

Weight ('Fat - Thin' IAT). This IAT requires the ability to distinguish faces of people who are obese and people who are thin. It often reveals an automatic preference for thin people relative to fat people.

Race IAT

Race ('Black - White' IAT). This IAT requires the ability to distinguish faces of European and African origin. It indicates that most Americans have an automatic preference for white over black.

Gender-Career IAT

Gender - Career. This IAT often reveals a relative link between family and females and between career and males.

Gender-Science IAT

Gender - Science. This IAT often reveals a relative link between liberal arts and females and between science and males.

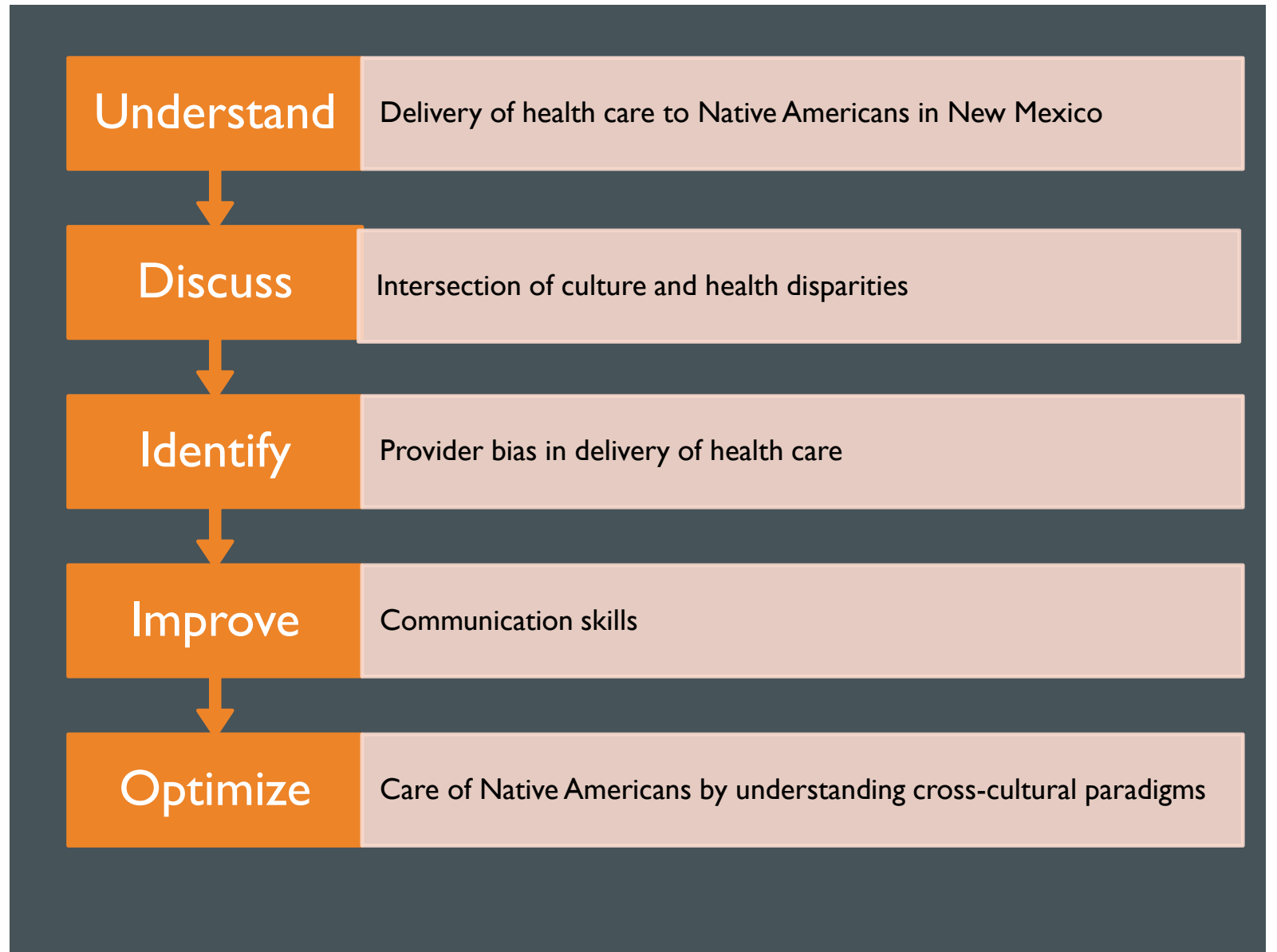
Skin-tone IAT

Skin-tone ('Light Skin - Dark Skin' IAT). This IAT requires the ability to recognize light and dark-skinned faces. It often reveals an automatic preference for light-skin relative to dark-skin.

HOW TO OVERCOME PROVIDER BIAS



OBJECTIVES





Verbal

- Let the patient tell their story
- Interrupting can be extremely rude
- Allow for silence
- Use humor!
- Consider discussing certain outcomes or side effects in the third person

Non-Verbal

- Physical distance: follow patient's lead
- Consider limiting or avoiding eye contact (always better to ask first)
- Emotional expressiveness may be limited (except for humor)
- Avoid pointing

GETTING THE PATIENT'S PERSPECTIVE

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you call it?
- What do you think your sickness does to your body?
- How do your traditional treatments work?
- Is there anyone else (family, friend) that we should talk to about this?

USING CULTURALLY SENSITIVE HANDOUTS

Diabetes Information for You and Your Family
How To Get Started Walking

Why walk?
Our bodies are meant to get up and walk—to the mailbox, down the road, around the neighborhood.

Walking can help you stay healthy and live longer to you can:

- Be there for your children, grandchildren, and other family members.
- Be an active and helpful member of your community.
- Serve as an Elder and share your wisdom.

All you need is a sturdy pair of shoes, a few minutes, and a safe place to walk. Give walking a try!

How does walking help?
Walking helps your mind, body, spirit, and emotions. It can help you:

- Have more energy by keeping your blood sugar, blood pressure, cholesterol, and weight in good ranges.
- Stay active and prevent injuries by keeping your muscles and bones strong.
- Feel calmer and less stressed by lifting your spirits.

Is walking right for you?
Walking is right for most people. If you are not sure that walking is right for you, ask your health care provider:

- Is walking right for me?
- How much walking is right for me?
- Do I need to check my blood sugar before and/or after I walk?

How can you get started?
Start slowly. You may be able to walk only a few minutes at first. That's okay. Try these tips for getting started:

- Walk at your own pace.
- Walk up and down your driveway or around your home.
- Walk around while you watch TV or talk on the phone.
- Walk a little farther from the store.

Try to build up to walking 3 to 5 minutes, 2 or 3 times a day. With time, you may be able to walk farther and go faster. Keep track of the minutes you walk. You may even find that you feel better and stronger.



"I started walking so I will be healthier and less stressed. I want to be there for my family for a long time."
Doris Arnes, Kikapoo/Gimowok Tribe, Oklahoma

Produced by the IHS Division of Diabetes Treatment and Prevention. For more diabetes information and resources, visit www.gov/indian/diabetes. 102017

Chronic Kidney Disease

What Does it Mean for Me?



NKDEP
National Kidney Disease Education Program

Tribal Health Service
Division of Diabetes
TREATMENT & PREVENTION

Eating Issues and Nutrition Tips for Educators Using
MY NATIVE PLATE

My Native Plate provides a visual guide to help your clients and patients eat balanced meals of reasonable portion sizes. Use it as a starting point for nutrition education, a daily reminder, and a way to introduce healthy eating to family members of all ages. Read the following five Issues to Consider prior to using My Native Plate. Download and distribute Two Tips to a Great Plate® when your clients are ready for more information.



Issues to Consider

Understanding a few issues that affect people's eating habits can help you introduce My Native Plate to your clients. Keep these points in mind and discuss them in a positive, supportive way.

- Emotions and stress can impact your clients' food selection and portion sizes.** The reasons why people eat certain foods, and why they overeat, are often linked to depression, anxiety and stress.
 - Ask your clients what they are eating, how much and possible reasons why.
 - Refer them to other health care professionals, spiritual leaders or counselors if needed.
- Not consistently having enough money to buy good-quality food will affect your clients' eating habits.** Food insecurity can cause your clients to overeat available foods, skip meals and/or choose unhealthy foods that are less expensive.
 - Find out if your clients have consistent access to nutritious foods and are getting enough nutrition from the foods they usually eat.
 - Refer them to community food resource program if needed.
- Family and social gatherings are important to your clients and can affect healthy eating.** Not eating foods brought to gatherings, potlaches and potlucks can be considered rude. Suggest ways your clients can enjoy social eating while using My Native Plate as a guide.
 - Explain how a small portion of several dishes from one food group (corn, pasta salad, potatoes) can be combined to make up one My Native Plate quadrant (quadrants).
 - Talk about the importance of sharing food no higher than 1-1 1/2 inches.
- Incorporating traditional foods into the plate can help your clients eat healthier.**
 - Talk about traditional foods and how they fit into the plate.
 - Consider copying the design of My Native Plate using traditional foods from your region and providing this version to your clients.
- Eating out at fast food restaurants and convenience stores may be common and can make up a large percentage of what your clients eat.**
 - Ask your clients how often they eat out and the types of foods they eat.
 - Suggest ways to use My Native Plate when eating at places with very limited menus.
 - Keep in mind that healthier menu options are often more expensive and encourage your clients to ask that their choices be prepared in healthier ways.

Two Tips to a Great Plate

Some clients may be ready for additional nutrition information. Two Tips to a Great Plate® provides tips on how to limit portion sizes, foods to avoid and foods to eat more often.

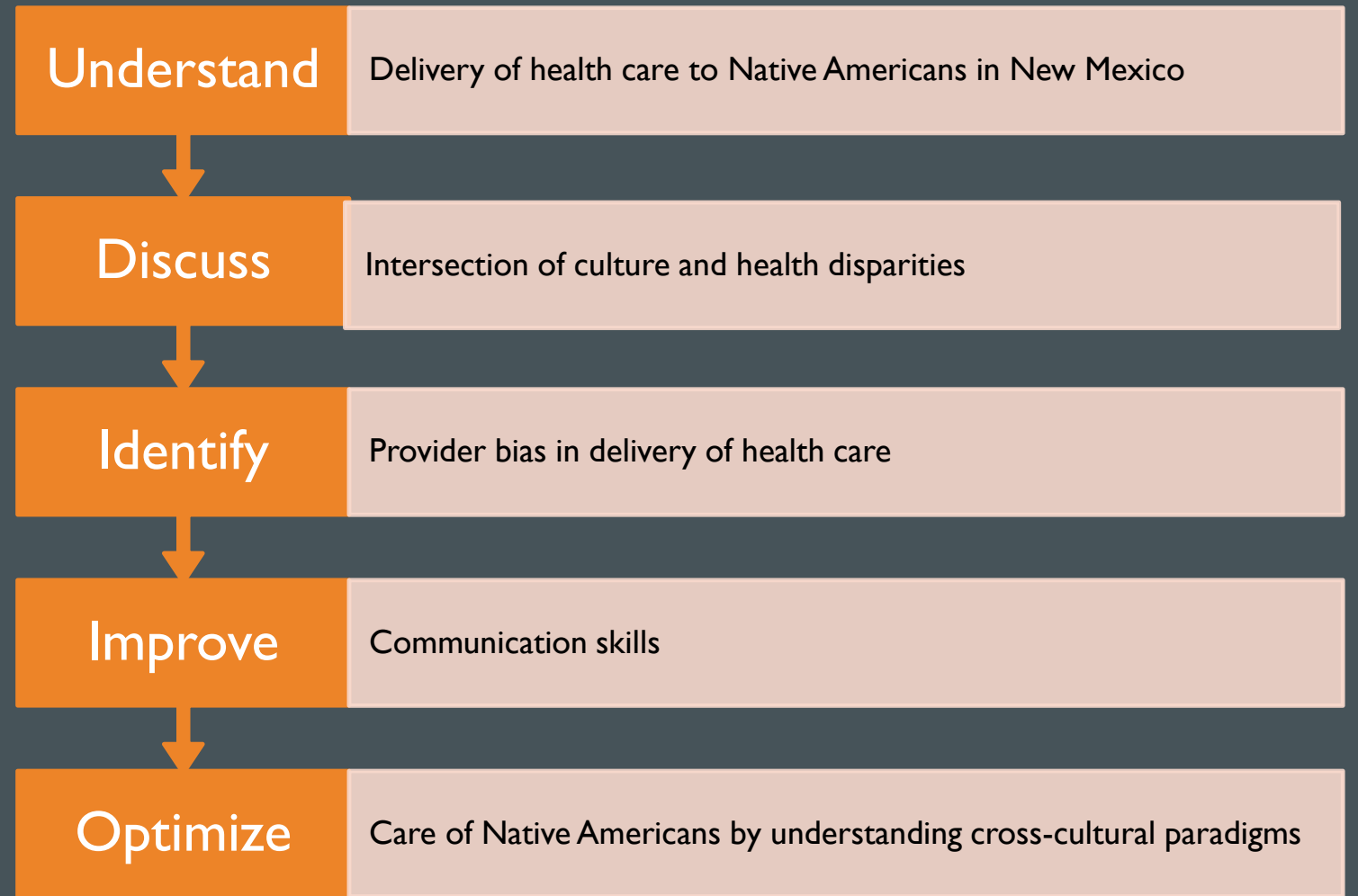
- Download it at www.ChooseMyPlate.gov and give to your clients.



Produced by the IHS Division of Diabetes Treatment and Prevention, in 2013. To print go to www.diabetes.gov/indian/PrintableMaterials.

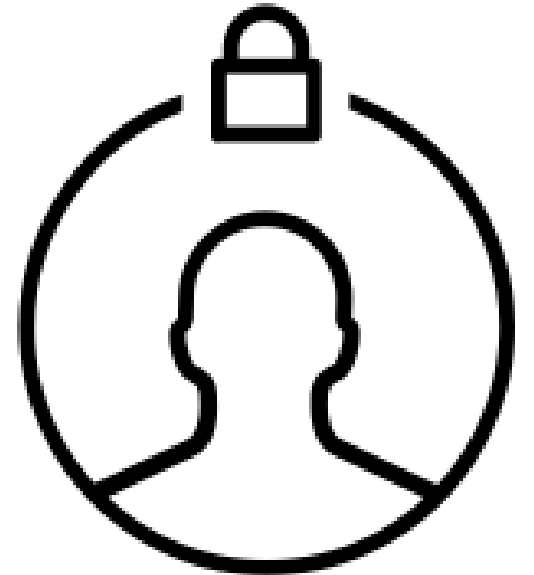
<https://www.ihs.gov/forproviders/patiented/>

OBJECTIVES



CASE I

During a busy urgent care day, a 55 yo Zuni female presents as a walk-in for UTI. Chart review reveals that her A1c was $> 14\%$ when checked 8 months ago. She was prescribed metformin (only picked up from the pharmacy once) and hasn't been seen since that time. In addition to her UTI she has been losing weight, feels fatigued, having recurrent headaches and muscle cramps.



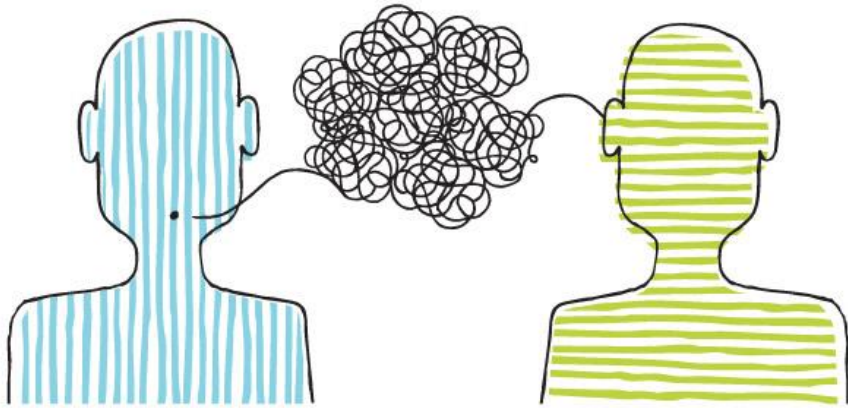
CASE 2

36 yo primigravida Navajo woman who presents for first prenatal visit. She has a history of congenital aortic insufficiency status post valve replacement shortly after birth. Her most recent echocardiogram (2 years ago) shows a failing artificial valve. She also has preexisting diabetes (Hb A1c 8.2%) and chronic hypertension (taking lisinopril and atorvastatin at time of conception). Her mother tried talking her out of this appointment.



CASE 3

66 yo Navajo male who has a history of metastatic thyroid carcinoma with known metastases to his ribs and back. He is Navajo speaking only. He is here to establish care with a new provider to manage the high dose of narcotics that he is currently taking for his pain. He does not request early refills and his PMP report is clean. When asked how he takes his medications he says he has been, “giving them to the ones that comes to visit me at night.” When asked to clarify he says that there are, “3 or 4 different women who come to my house. I have to give them a pill.”



CONCLUSIONS

Listened to

Cared for

Understood

Diagnosed
appropriately

Given instructions

- Honor story telling
- Allow silence and don't interrupt
- Focus on the present

- Honor traditions
- Use culturally sensitive handouts
- Acknowledge family members

- Remember strengths of culture
- Remember historical trauma
- Conceptualize paradigms of disease

- Minimize implicit bias
- Establish rapport before giving advice
- Use culturally sensitive handouts

- Give written summary
- Know patient's funding source, what can and can't be done with IHS

REFERENCES

- Nikater, *Map of Pueblos in New Mexico*, Original work submitted to public domain using Demis, March 26, 2007
- U.S. Department of Housing and Urban Development, *Native Americans in the Military*, September 19, 2011
- Chiu, Alexander, et al, "Impact of Race on the Surgical Management of Adhesive Small Bowel Obstruction." *New England Surgical Society*, November 2, 2017
- Hoffman, K, et al, "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites," *Proceedings of the National Academy of Science*, August 2015
- Green, AR, et al, "Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients," *Journal of General Internal Medicine*, Volume 22, Issue 9, September 2007
- Fitzgerald, C and Hurst S, "Implicit bias in health care professionals: a systematic review." *BMC Med Ethics*, volume 18, issue 19, March 1, 2017
- Blair, IV, et al, "Unconscious (implicit) bias and health disparities: where do we go from here?" *The Permanente Journal*, volume 15, issue 2, Spring 2011
- The Joint Commission, Division of Health Care Improvement, "Implicit bias in health care," *The Joint Commission Assets*, Issue 23, April 2016
- Dembrosky, A, "Can health be cured of racial bias?" heard on *All Things Considered*, NPR, August 20, 2015
- Project Implicit, Online Implicit Association Test" <https://implicit.harvard.edu/implicit/taketest.html>
- McNeil, J, et al, "A cultural competency model for American Indians, Alaska Natives, and Native Hawaiians," *National Minority AIDS Education and Training Center*, Howard University, 2006
- Substance Abuse and Mental Health Services Administration, "Culture Card: American Indian and Alaska Native," Published March, 2009
- American Indian and Alaska Native Health (website) <https://americanindianhealth.nlm.nih.gov/subtopic/1/Health-Conditions/31/General>, US National Library of Medicine, first published July 12, 2012, last update January 8, 2018