Enhancing our Cultural Dexterity: The Next Step in Reducing Disparities & Providing Patient-Centered Surgical Care

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• Howard University (Adjunct Faculty)
Propose **Cultural Dexterity Training of Clinicians** as a means to reducing health care disparities and providing patient-centered care
EQUALITY IS THE CORNERSTONE OF MEDICINE
Surgical Disparities

Documented Differences in Outcomes associated with:

• Race
• Gender
• Sexual Orientation
• Age
• Obesity Status
• Geography

Emergency Departments are “the great equalizers”
Odds of mortality after trauma

<table>
<thead>
<tr>
<th></th>
<th>Adjusted Odds of Death</th>
<th>95% Confidence Intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td>White*</td>
<td>1.00</td>
<td>1.08 - 1.33</td>
</tr>
<tr>
<td>Black</td>
<td>1.20</td>
<td>1.36 - 1.69</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.51</td>
<td>1.46 - 1.64</td>
</tr>
<tr>
<td>White (Insured)</td>
<td>1.55</td>
<td>1.65 - 1.90</td>
</tr>
<tr>
<td>Black</td>
<td>1.78</td>
<td>2.13 - 2.49</td>
</tr>
<tr>
<td>Hispanic (Uninsured)</td>
<td>2.30</td>
<td></td>
</tr>
</tbody>
</table>

*Reference group

Public Health Approach

1. Identify the Problem and Create Awareness
2. Understand the Mechanisms that Lead to the Issue and Engage Stakeholders
3. Create Solutions and Disseminate them
Public Health Approach

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Surgeons ? Existence of Disparities

• > 50% believe evidence is weak
• Even those who believe evidence is strong:
  – 24% in their Hospital/Clinic
  – 11% in Personal Practice
  – 90% believe cause is patient factors

Britton VB...Haider AH. Awareness of racial/ethnic disparities in surgical outcomes and care: factors affecting acknowledgement and action. AJS 2015.
Public Health Approach

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2. Understand the Mechanisms that Lead to the Issue
3. Engage Stakeholders
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Surgical Disparities

- Provider Factors
  - Volume
  - Provider training
  - Unconscious bias
  - Trauma center & hospital quality
  - Demographics: race, ethnicity, gender, background

- Patient Factors
- Post-op Care and Rehab
- Clinical Care and Quality
- Systemic and Access Issues
Do we Treat Patients Differently Based on Race?
Teen Hit in Police Shootout

A 17 year old woman was shot during a hostage situation in East Baltimore. The young woman was walking in front of a convenience store in the early evening when an alleged drug dealer who was fleeing from police pointed a gun at her and motioned for her to move into the store. The BPD and the alleged perpetrator were then involved in a fire fight in which both the young woman and the perpetrator were injured. They were immediately transported to Johns Hopkins Hospital one after the other. Apparently both have life threatening injuries and were rushed to surgery by trauma surgeons at Johns Hopkins.
Hypothesis

Unconscious or Implicit Biases may lead us to unknowingly treat patients differently.
Race Implicit Association Test

Computer-based test of social cognition

Measures time it takes to match representatives of social groups with good and bad attributes

Test-takers with an implicit preference for whites would pair white with pleasure faster then they would with Blacks

https://implicit.harvard.edu/implicit
Race IAT Results from General Pop (>1 million responders)

- Strong preference for White people: 27%
- Moderate preference for White people: 27%
- Slight preference for White people: 16%
- Little to no automatic preference: 17%
- Slight preference for Black people: 6%
- Moderate preference for Black people: 4%
- Strong preference for Black people: 2%
Does Unconscious Bias impact how we treat patients?

Multiple Medical Studies Suggest that is does
Trauma Surgeons may be prone....

• Cognitive processing capacity taxed by:
  – Fatigue
  – Under pressure
  – Cognitive overload

It takes cognitive luxury to override implicit biases
IAT Scores: Black vs. White

Haider, AH et al. Association of Unconscious Race and Social Class Bias with Vignette Based Clinical Assessments by Medical Student. JAMA 2011; 306:942-951

CENTRAL FOR SURGERY AND PUBLIC HEALTH
Patient Assessment by Race

Haider, AH et al. Association of Unconscious Race and Social Class Bias with Vignette Based Clinical Assessments by Medical Student. JAMA 2011; 306:942-951

CENTER FOR SURGERY AND PUBLIC HEALTH
Bias in Residents

Bias in Nurses


CENTER FOR SURGERY AND PUBLIC HEALTH
In group favoritism...

“...is plausibly more significant as a basis for discrimination in contemporary American society than is out group-directed hostility”

• Small favors can have a big impact
• Often not considered an act of discrimination
• Difficult to regulate, natural tendency

Public Health Problem Solving

1. Identify the Problem and Create Awareness
2. Understand the Mechanisms that Lead to the Issue
3. Engage Stakeholders
4. Create Solutions and Disseminate them
Committee on Health Care Disparities

ACS Statement: There Is No Quality Without Access

Access to surgical care is impacted by socioeconomic status, age, gender, level of education, race, ethnicity, health care availability, and geographic distance. While insurance status proves to be the most reliable surrogate for prediction of outcome differences, underuse, and delay of surgery, rural location, and limited access to high volume hospitals are additional mechanisms that lead to inequities in surgical outcomes. Despite these factors, several studies have shown that where access to care is equal, outcome disparities become indiscernible.
### Search on provider factors:

#### Racial disparities in ovarian cancer surgical care: a population-based analysis. 14

<table>
<thead>
<tr>
<th>TITLE</th>
<th>LINK</th>
<th>YEAR</th>
<th>THEME</th>
<th>SURGICAL FIELD</th>
<th>FIRST AUTHOR</th>
<th>LOCATION</th>
<th>SYNOPSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racial disparities in ovarian cancer surgical care: a population-based analysis. 14</td>
<td>PubMed</td>
<td>2011</td>
<td>Patient and Provider Factors</td>
<td>Surgical Oncology</td>
<td>Bristow RE</td>
<td>Maryland</td>
<td>The authors conducted a retrospective analysis to investigate racial disparities in the surgical management of ovarian cancer. Using data from the Maryland Health Services Cost Review Commission database and performing multivariate logistic regression, they found that African-American racial classification was associated with a statistically significant and independent lower likelihood of hysterectomy, colon resection, lymphadenectomy and surgery by a high-volume surgeon.</td>
</tr>
<tr>
<td>Racial and ethnic differences in treatment and survival among adults with primary extremity soft tissue sarcoma.</td>
<td>PubMed</td>
<td>2008</td>
<td>Provider and Patient Factors</td>
<td>Surgical Oncology</td>
<td>Martinez SR</td>
<td>California, nationwide</td>
<td>The authors conducted a retrospective analytical study to assess racial/ethnic differences in patient- and tumor-specific characteristics, treatment, and disease-specific survival in a population of adults with ESSS (Extremely soft tissue sarcoma). They used data from the Surveillance, Epidemiology, and End Results (SEER) database between 1988 and 2003. On analysis, it was found that relative to whites, blacks received lower rates of adjuvant radiation with surgery while Hispanics received significantly lower rates of limb-sparing surgery.</td>
</tr>
<tr>
<td>Racial and ethnic disparities in kidney transplantation.</td>
<td>PubMed</td>
<td>2011</td>
<td>Patient and Provider Factors</td>
<td>Transplant Surgery</td>
<td>Malek SK</td>
<td>Massachusetts</td>
<td>In this review articles the authors have highlighted possible reasons for disparities that affect outcomes of kidney transplantation. They have provided insight into social and biological factors that may impede success of the transplant outcome. Moreover, the authors have penned down their recommendations for further research into this issue.</td>
</tr>
<tr>
<td>Racial and ethnic disparities in outcomes and appropriateness of carotid endarterectomy: impact of patient and provider factors.</td>
<td>PubMed</td>
<td>2009</td>
<td>Patient/Host Factors and Provider</td>
<td>Vascular Surgery</td>
<td>Halm EA</td>
<td></td>
<td>The authors conducted a population-based cohort study to determine disparities in in outcomes and of carotid endarterectomy for stroke. Using regional data, their population included Medicare beneficiaries who underwent the procedure. On analysis they found that Rates of 30-day death/stroke were higher in Hispanics and blacks than white patients. They also noted that minorities had higher rates of inappropriate surgery largely due to higher comorbidity. The authors concluded that minorities had worse outcomes and higher rates of inappropriate surgery.</td>
</tr>
<tr>
<td>Factors associated with decisions to undergo surgery among patients with newly diagnosed early-stage lung cancer.</td>
<td>PubMed</td>
<td>2010</td>
<td>Provider and Patient/Host Factors</td>
<td>Surgical Oncology</td>
<td>Cykert S</td>
<td>North Carolina</td>
<td>The authors conducted a prospective cohort study to determine disparities in surgical resection for stage I or II non-small cell cancer. The authors identified the relevant patients from 5 different communities from 2005-2008. Their main outcome measure was Lung cancer surgery within 4 months of diagnosis. On analysis, the authors found that the surgical rate was higher for White patients than Black patients. Moreover, surgical rates for blacks were particularly low when they had 2 or more comorbid illnesses. The authors also looked into perceptions of patient-physician communication and noted that negative perception of 1-year prognosis post surgery were associated with decisions against surgery.</td>
</tr>
<tr>
<td>Determinants of racial and ethnic disparities in surgical care.</td>
<td>PubMed</td>
<td>2008</td>
<td>Access Issues and Provider Factors</td>
<td></td>
<td>Ayarjan JZ</td>
<td>MA</td>
<td>The authors have highlighted racial disparities in cardiovascular care and outcomes.</td>
</tr>
</tbody>
</table>
Health care disparities (differential access, care, and outcomes owing to factors such as race/ethnicity) are widely established. Compared with other groups, African American individuals have an increased mortality risk across multiple surgical procedures. Gender, sexual orientation, age, and geographic disparities are also well documented. Further research is needed to mitigate these inequities. To do so, the American College of Surgeons and the National Institutes of Health–National Institute of Minority Health and Disparities convened a research summit to develop a national surgical disparities research agenda and funding priorities. Sixty leading researchers and clinicians gathered in May 2015 for a 2-day summit. First, literature on surgical disparities was presented within 5 themes: (1) clinician, (2) patient, (3) systemic/access, (4) clinical quality, and (5) postoperative care and rehabilitation-related factors. These themes were identified via an exhaustive preconference literature review and guided the summit and its interactive consensus-building exercises. After individual thematic presentations, attendees contributed research priorities for each
5 Research Priorities

1. Improve patient-clinician communication through culturally dexterous care
2. Use of Technology for engagement and community outreach to optimize patient education, literacy, and shared decision-making
3. Improve quality of care at facilities with a high proportion of minority patients
4. Evaluate interventions such as rehab support on functional outcomes and quality of life
5. Improve Patient Centeredness by engaging patients to identify expectations for recovery and palliative care
“The NIMHD is pleased to inform you that Surgical Disparities has been made a priority during our recent visioning process..... Funding announcements will be posted this summer”

Statement @ NIH/ACS Surgical Disparities Research Agenda launch webinar on 3/16/2016
Research Priorities

1. Improve patient-provider communication through culturally dexterous care
Cultural Dexterity

“Understanding the importance of social and cultural influences on patients’ health beliefs and behaviors...Considering how these factors interact at multiple levels”

Betancourt et al. 2003

Adept use of mental and physical skills to understand and adapt to each unique patient in order to provide patient centered care
Provider Awareness and Cultural Dexterity Toolkit for Surgeons PACTS
Developing the PACTS Curriculum

Milestones

**May 2015**: First Co-Investigator Meeting

**June 2015**: Launch of provider recruitment

**August 2015**: Completion of In-depth Interviews with surgical residents and faculty (n=31)

**September 2015**: Completion of qualitative analysis of provider interviews

**October 2015**: Curriculum Development Workshop

**Summer 2016**: Program Grant for Trial

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**Phase 1**: Qualitative in-depth interviews to ascertain barriers to equitable provision of culturally competent surgical care

**Phase 2**: Curriculum Development Workshop discussing findings and objectives

**Phase 3**: Apply for R01/PCORI funding for a multicenter trial to be conducted at Harvard teaching hospitals
“We are just blind to this wall with the patient... We think that the patient is not compliant or just not willing to communicate but we are actually not understanding their problem... because we don’t even know how to ask”

Female White Resident

Curriculum Learning Goals

1. Build trust and rapport with patients from diverse sociocultural backgrounds
Curriculum Learning Goals

1. **Build trust** and **rapport** with patients from diverse sociocultural backgrounds

- Be curious about culture and background
- Cooperative/shared decision-making, not paternalistic
- Hear patient's perspective, negotiate, achieve agreement rather than compliance
- Recognize mistrust
- Meet patients where they are
“...even with a good interpreter there’s something lost, you know, having a conversation kind of directly with the patient.”

Female White Attending

Curriculum Learning Goals

2. Communicate effectively and efficiently with patients who have limited English proficiency
Curriculum Learning Goals

2. **Communicate** effectively and efficiently with patients who have **limited English proficiency**

- Clear concise language
- Pause frequently
- Check meaning
- Allow interpreter to do more than just interpret
- Don’t assume literacy – diagrams, videos
“Certain patients handle pain a certain way.”

Male Asian Attending

“...if I’m going to take someone to the OR for... [abdominal pain]...it depends on how much pain you’re having...”

Male White Attending

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**Curriculum Learning Goals**

3. Assess and manage pain effectively for patients from diverse sociocultural backgrounds.
3. Assess and manage pain effectively for patients from diverse sociocultural backgrounds.

- Stoic vs. emotive
- Validated pain scales
- Ask about goals for pain management
- Alternative pain therapies
“...sometimes you can get the patient to sign the form very easily, but if you don’t get their feedback... don’t get them involved in the management of the disease they will just agree with what you are offering...”

*Female Asian Resident*

**Curriculum Learning Goals**

4. Lead meaningful informed consent discussions and negotiate treatment options with patients whose sociocultural and linguistic backgrounds may impact care.
Curriculum Learning Goals

4. Lead meaningful informed consent discussions

- Explore patients’ conceptualizations of illness
- Working knowledge of important values, customs and health beliefs
- Recognize mistrust
- Acknowledge differences in autonomy, authority and family in decision-making
1. Design a new curriculum based on interviews, specifically tailored to surgery
2. Implement at Harvard Teaching Hospitals
   – Resident curriculum and system-level changes
3. National expansion through the ACS and Society of University Surgeons
Curriculum Format

- E-learning to prep sessions
- 4-1 hour in-person sessions
  - Discussion
  - Teaching OSCE with Expert Patient Evaluator
- Assignments to reflect on clinical experiences
“Often times we get so caught up... we forget about patient care and the fact that cultural competency is a component of optimizing patient care...

...if you can optimize your cultural competency you can add another component to your ability to provide quality patient care”

Male Black Resident
“Care that is responsive to patients’ preferences, needs, and values, and ensuring that patient values guide all clinical decisions”

Patient Centered Care as defined by the Institute of Medicine (IOM)
Patient-Physician Communication

• Top Cause of Patient Non-Compliance
• Most important factor in Malpractice Suits
• Number 1 Predictor of Press Ganey Scores for Surgeons
What You Can Do ....

1. Be Aware of the Unequal Outcomes
2. Participate / Create a Program
   (call me 443-845-4590 or ahhaider@partners.org)
3. Advocate For Policy Change

Together we can Eradicate Surgical Disparities
Thank You!
@adilhaiderMD