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Cultural Competency in LatinoAmerican Countries: From a Hispanic Resident Perspective

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CULTURAL COMPETENCY IN LATINOAMERICAN COUNTRIES: FROM A HISPANIC RESIDENT PERSPECTIVE

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OVERVIEW

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Hispanics are Heterogeneous

- My story:
  - Born, raised in Nicaragua
  - Medical school & residency in Nicaragua
  - Immigrated with family & became U.S. citizen
- Hispanics can vary by:
  - Immigration generation status
    - Recent immigrant from more than 20 possible countries
    - Born in U.S. – 2nd+ generation
  - Language
    - More than 20 major dialects of Spanish
    - May not speak Spanish
  - Skin color
  - Mixed race
  - Education
  - Cultural
  - Socioeconomic
  - Political

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Hispanics Underrepresented

- Hispanics estimated at:
  - 17.8% of U.S. population[1]
  - 4.4% of U.S. physicians[2]
  - 6.9% of U.S. psychiatry physicians[3]
  - 5.1% of U.S. residents[4]
  - 5.7% of U.S. psychiatry residents[4]

1.https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html
2.http://www.aamcdiversityfactsandfigures.org/section-ii-current-status-of-us-physician-workforce/index.html#fig1
3.Medscape Psychiatrist Lifestyle Report 2017: Race and Ethnicity, Bias and Burnout, Jan 11, 2017 Carol Peckham
4.Data Resource Book Academic Year 2017-2018, ACGME, Department of Applications and Data Analysis, ISSN 2473-9670

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Disparity in Care Impact on Hispanic Patients

- Hispanics are frequently undertreated compared to Caucasians[1]
- 31% of Hispanics with mental illness received care vs 48% of Caucasians[1]
- Bilingual patients are evaluated differently when evaluated in English versus Spanish[1]
- The ethnic group with highest rate of uninsurance was Hispanics at 21% compared with 7.5% for Caucasians[1]

1. American Psychiatric Association, Fact sheet, Mental Health Disparities: Diverse Populations, 2016 https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

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Hispanic Beliefs Impacting Care

- 45% of Latinos prefer home remedies to avoid medical costs[1]
- 72% of Hispanics never use prescription drugs[1]
- Only 10% of Latinos with a psychiatric disorder contact a general health care provider[2]
- Only 5% of Latinos with a psychiatric disorder contact a mental health specialist[2] (reluctant to seek help outside of intimate social networks)
- 40% of Caucasians with a probable need for mental health services reported that they would seek treatment, versus only 27% of Latinos[3]

1. 2013 Poll, commissioned by Adelante con la Salud: Latino Health Care Engagement Project and administered by Latino Decisions, queried 401 Latino/Hispanic adults living in Colorado
2. American Psychiatric Association, Fact sheet, Mental Health Disparities: Diverse Populations, 2016 https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts
3. Health Services Research, July 18, 2013, Blacks and Latinos Seek Mental Health Care Less Often, http://www.cfah.org/hbns/2013/blacks-and-latinos-seek-mental-health-care-less-often

Home Remedies:

Altami (nerves),

Hombre Grande (bites, menstrual period),

Manzanilla (nerves, insomnia),

Yerba Buena (nerves, parasites),

Romero (nerves)

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Impact on Minority Resident Physicians

- Minorities 30% more likely to withdraw from residency compared to White counterparts[1]
- Minorites 8 times more likely to take extended leaves of absence compared to White counterparts[1]
- 84% of Black residents reported training experiences characterized by pervasive discrimination, lower expectations from supervisors, harsher consequences for mistakes, and social isolation[1]
- Residents described the following 3 major themes concerning their training experiences in the workplace: (1) a daily barrage of microaggressions and bias, (2) minority residents tasked as race/ethnicity ambassadors, and (3) challenges negotiating professional and personal identity while being seen as "other." [1]

1. Aba Osseo-Asare, MD; Lilanthi Balasuriya, MD; Stephen J. Huot, MD, PhD, et al, Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace, *JAMA Network Open.* 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723

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Impact on Minority Resident Physicians

- Research among medical students has demonstrated racial/ethnic disparities in the receipt of academic awards and in the use of positive language in letters of evaluation[1]
- Numerous studies published in the last five years have found that trainee mistreatment and discrimination is a widespread phenomenon with between 17% and 95% of trainees reporting its occurrence[1]
- One meta-analysis found that verbal harassment was the most common form, with discrimination based on gender and race most prevalent, ranging from 4% to 19%, respectively[1]

1. Whitgob, Emily E. MD, Alyssa L. MSW, et al., The Discriminatory Patient and Family: Strategies to Address Discrimination Towards Trainees, Journal of the Association of Medical Colleges, November 2016, Volume 91, Issue 11, p S64-S69, doi: 10.1097/ACM.0000000000001357

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Latino Perspective of Healthcare

- **Cultural values:**
  - politeness,
  - personalness,
  - respect,
  - trust (it's not coming easily),
  - family,
  - destiny

- **Healthcare beliefs:**
  - folk illness (combination of psychiatric and somatic symptoms recognized only within the culture, "culture bound syndrome or cultural concept of distress DSM-5"),
  - supernatural causes,
  - home remedies,
  - reluctance to seek help outside of intimate social networks

Language barriers

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Microaggressions/Implicit Bias

- **Definition:** brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group[1].

1. Nadal, K. L. (2014). A Guide to responding to microaggressions. *CUNY Forum, 2,* 71-76.

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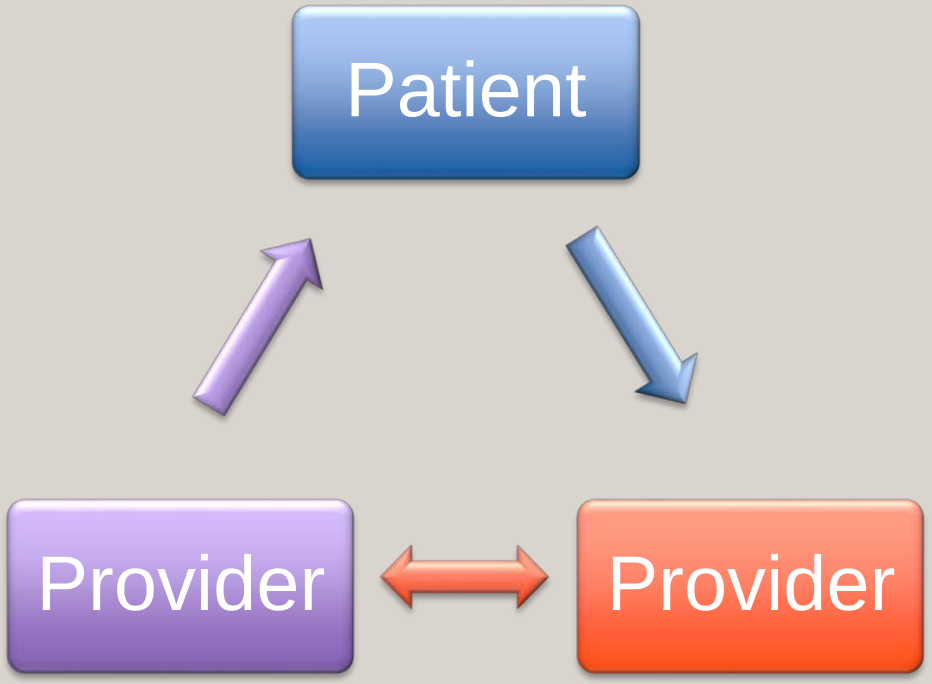
Residents Perspective of Discrimination

- **Microaggressions** on the part of providers to patients, patients to providers, and between providers.
  - Physicians have had patients refuse treatment or ask for a different clinician because they don't want to be seen by a physician of a certain ethnic background, religion or gender.
  - Health care professionals who made disparaging remarks about their ability to speak English.



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Common situations Latino residents confront[1]

- "Commonly, I'm mistaken for an assistant, janitor, secretary, nurse, student, etc., even when I have my white coat on."
- "Wow, you've really come a long way. You know, like, you know, being like a Mexican, that's just...I didn't expect somebody to be that well educated."
- "Oh you don't really look like a doctor."
- Hey, can you go fill my coffee?
- "You speak English really well" (despite being born and raised in the United States).
- "There was a situation most recently where I was with one of my program directors and we went in a room to see a patient, and the father was irate, and then he went out to the hallway and one of the things he said to the nurses was that they sent the big black guy in the room to intimidate me."

1. Aba Osseo-Asare, MD; Lilanthi Balasuriya, MD; Stephen J. Huot, MD, PhD, et al, Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace, *JAMA Network Open.* 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723

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Microaggressions/Implicit Bias

- Microaggressions go beyond race. There is both established and emerging literature that shows how microaggressions extend into other socially constructed identities that embody privilege in different ways, such as income, social capital, religion, ableness, sex, and sexual orientation[1].
- The impact that microaggressions can have on the well-being of individuals is indeed cumulative[1].

1. Roberto E. Montenegro, M.D., Ph.D., Hector Colon-Rivera, M.D., Racial/Ethnic and Sexual/Gender Minority Training Experiences in Psychiatry: Past, Present, and Future Directions to Improving Training Climate, American Journal of Psychiatry, Residents' Journal, January 2, 2016, Vol 11, Issue 1, p 2-4.

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Microaggressions/Implicit Bias

- Most of us, including people in positions of power, alternate between being the “recipient” of a microaggression and actually “committing” a microaggression[1].
- “These are microaggressions that people don’t even realize they’re putting you under.”[2]
- “With implicit bias, it’s tasteless, odorless, to everybody except the victim.” “It is related to institutional racism,”[3] and that’s something very difficult to see.

1. Roberto E. Montenegro, M.D., Ph.D., Hector Colon-Rivera, M.D., Racial/Ethnic and Sexual/Gender Minority Training Experiences in Psychiatry: Past, Present, and Future Directions to Improving Training Climate, American Journal of Psychiatry, Residents’ Journal, January 2, 2016, Vol 11, Issue 1, p 2-4.
2. Jaymie Rivera-Clemente, How training doctors in implicit bias could save the lives of black mothers, NBC News, May 11, 2018
3. Dr. Raymond Cox, How training doctors in implicit bias could save the lives of black mothers**,** NBC News, May 11, 2018

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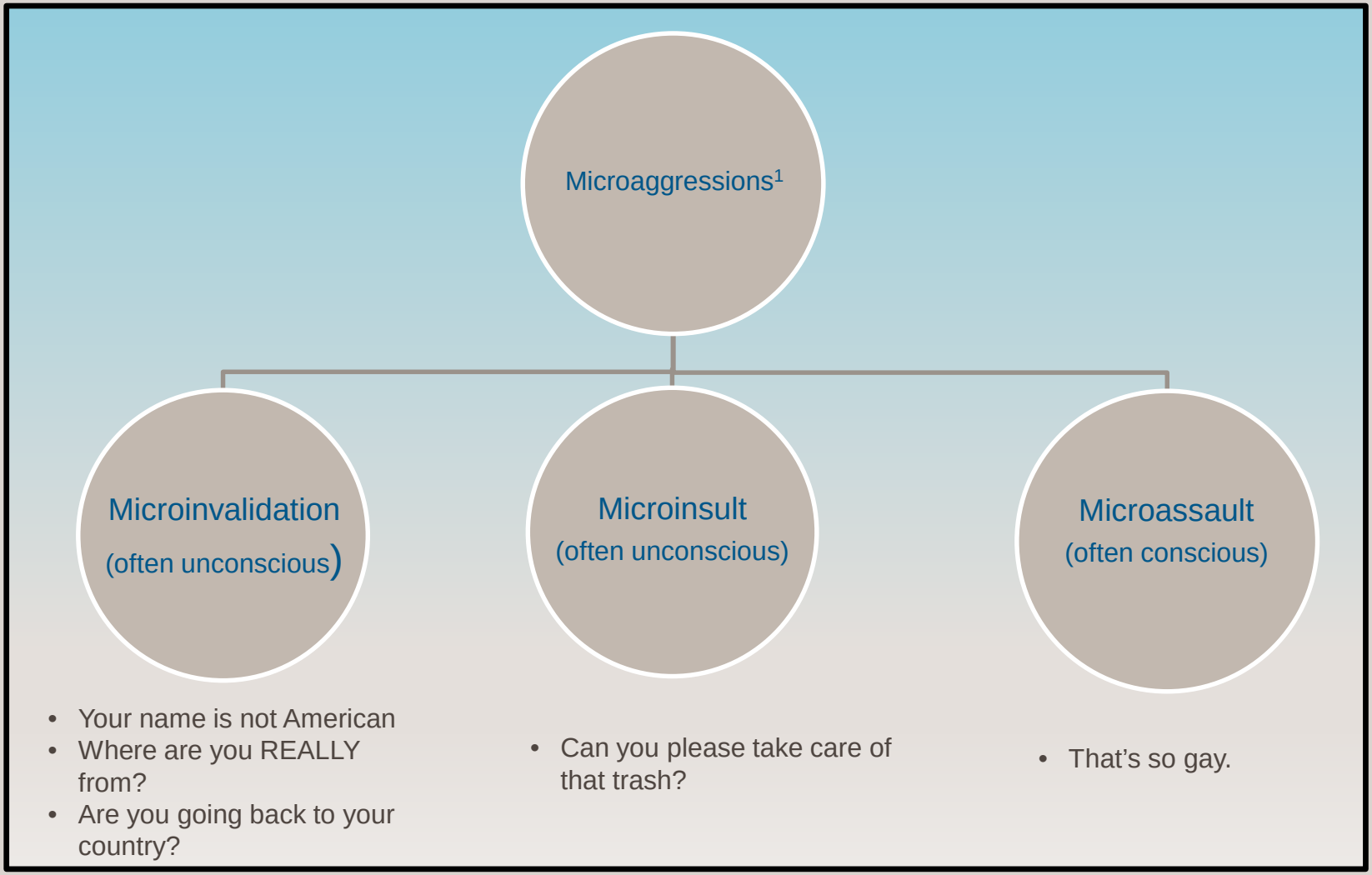
Types of Microaggressions



1. Nadal, K. L. (2014). A Guide to responding to microaggressions. *CUNY Forum, 2,* 71-76.

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Addressing Microaggressions

- If an individual is certain (or moderately certain) that a microaggression did in fact occur, she or he has to ponder the potential risks or consequences of responding or not responding[1]. Some questions include:
  - If I respond, could my physical safety be in danger?
  - If I respond, will the person become defensive and will this lead to an argument?
  - If I respond, how will this affect my relationship with this person? (e.g., coworker, family member, etc.)
  - If I don't respond, will I regret not saying something?
  - If I don't respond, does that convey that I accept the behavior or statement?

1. Nadal, K. L. (2014). A Guide to responding to microaggressions. *CUNY Forum, 2,* 71-76.

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Strategies for Addressing Microaggressions - what NOT to do

- Approach the situation in a passive-aggressive way.
  - Make a joke or a sarcastic comment as a way of communicating that you are upset or annoyed.
  - Respond by rolling your eyes or sighing .
  - Do nothing in that moment and decide to talk to others about it first, in the hopes that it will get back to the perpetrator.
- React in a proactive way.
  - Yell back.

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Strategies for Addressing Microaggressions

- Keeping the tone of such conversations non-blaming and open is important.
  - Inquiring — "What do you mean by that?"
  - Making an impact statement — "I was thinking about what you said, and it hurt me because the focus of your content had nothing to do with my presentation."
  - Reframing — "How would you feel if this happened to you?"
  - Revisiting after the fact — "Do you remember the conversation where you mentioned …?"

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Strategies for Addressing Microaggressions – what TO DO

- Act in an assertive way.
  - Calmly address the perpetrator about how it made you feel.
  - Educate the perpetrators, describing what was offensive about the microaggression.

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ACGME Response and Needs

- Updated Common Program Requirements to reflect an expectation that all residency programs promote recruitment and retention of a diverse workforce[1].
  - Goes into effect in July 2019, and residency programs will have 1 year to adjust their practices before citations will be implemented[1].
  - This approach is in line with similar diversity accreditation standards at the undergraduate medical education level, which have been in place since 2009.
- The ACGME should create benchmarks for excellence, such as bias education programming and formalized diversity committees.[2]
  - Focusing on obtaining higher numbers of minorities without addressing the specific challenges that minority residents encounter in the workplace is likely to result in continued disparities.

1. ACGME Common Program Requirements (Residency), Section I.C., ACGME approved major revision: June 10, 2018; effective: July 1, 2019
2. Aba Osseo-Asare, MD; Lilanthi Balasuriya, MD; Stephen J. Huot, MD, PhD, et al, Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace, *JAMA Network Open.* 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723

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Psychiatry's Response

- DSM-5 has tools (in the appendix) to use for a culturally sensitive psychiatric evaluation – Outline for Cultural Formulation[1]
  - Main goal is to help clinicians identify cultural contextual factors affecting the patient that are relevant to diagnosis and treatment.
  - It is intended **for any clinician with any patient**, regardless of cultural background.
  - Even patients and clinicians who appear to share the same cultural background and speak the same language may differ in ways that are relevant to care.

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Arlington, VA, American Psychiatric Association, 2013

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Program Needs[1]

- Minimize the impact of microaggressions by creating a supportive environment where residents can address and process their experiences.
- Microaggressions should be recognized, acknowledged, examined, and addressed to support an optimal training environment.
- Residency leadership and residents alike should have appropriate training in implicit bias to understand how microaggressions affect the training environment.
- Facilitate an open dialogue about diversity issues; this can create a welcoming environment where underrepresented residents are celebrated and not just tolerated.

1. Roberto E. Montenegro, M.D., Ph.D., Hector Colon-Rivera, M.D., Racial/Ethnic and Sexual/Gender Minority Training Experiences in Psychiatry: Past, Present, and Future Directions to Improving Training Climate, American Journal of Psychiatry, Residents' Journal, January 2, 2016, Vol 11, Issue 1, p 2-4.

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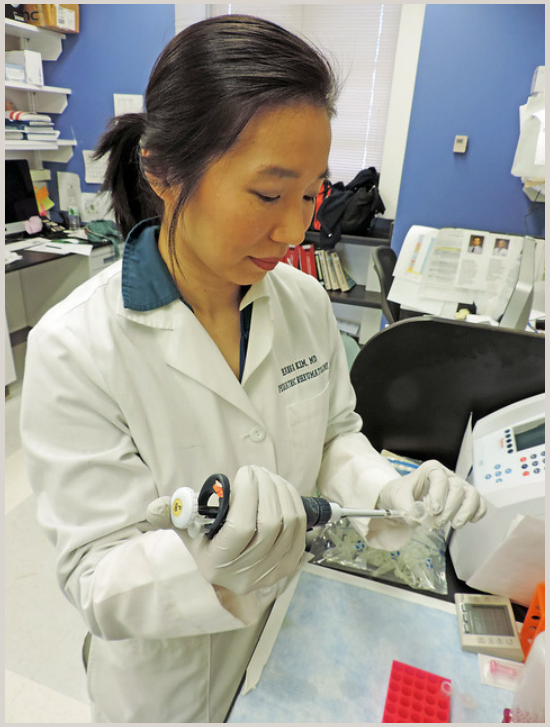
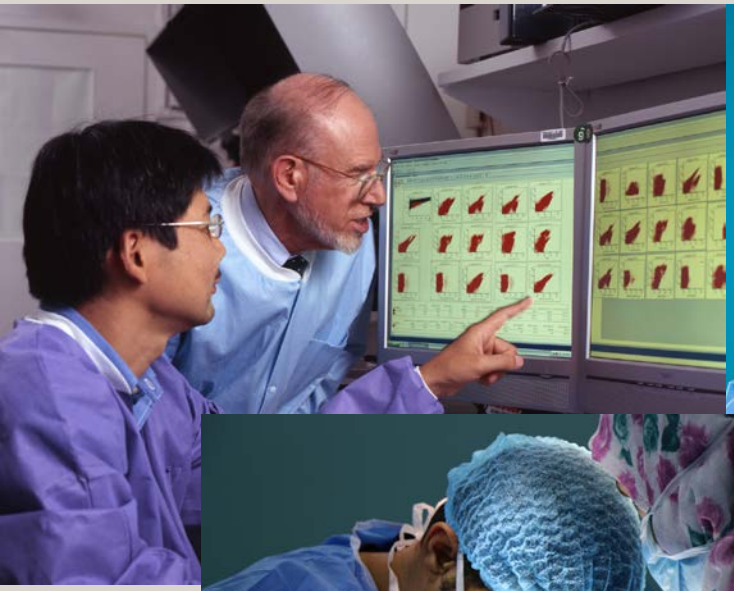


- QUESTIONS?

THANK YOU!!!!!



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