

Education

Starting the Conversation About Healthcare Disparities

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Abstract

Description

The Accreditation Council for Graduate Medical Education (ACGME) put forth institutional requirements to implement healthcare disparity education in resident and fellow curricula in an effort to decrease these inequities. Healthcare disparities stem from many different factors. These may include access to care, insurance status, socioeconomic status, health literacy, language barriers, and the way healthcare systems function. These factors may have interactions that lead to poor health outcomes. As researchers and educators, we need to find a way to research these issues in more depth as well as teach these concepts to our resident physicians. Here, we discuss El Paso, Texas, a city located on the United States-Mexico border, which is predominately Latinx. We also discuss increased rates of diabetes, sexually transmitted diseases, and liver, stomach, and cervical cancers. Common obstacles to healthcare include language and literacy barriers, lack of transportation, and lack of healthcare professionals. We outline 4 strategies for change to address these disparities. By implementing these strategies in ACGME education for residents, healthcare disparities in the El Paso community can be addressed and eliminated.

Keywords

Accreditation Council for Graduate Medical Education; ACGME; healthcare disparities; health inequities; health status disparities; Hispanics; Latinos; Latinx

Introduction

Starting the Conversation About Healthcare Disparities

The Accreditation Council for Graduate Medical Education (ACGME) put forth institutional requirements July 1, 2020, to implement healthcare disparity education in resident and fellow curriculum in an effort to decrease healthcare inequities.¹The ACGME uses the Clinical Learning Environment Review (CLER) to evaluate institutions on their commitment to develop a culture of patient safety and improving healthcare disparities. These Clinical Learning Environments (CLEs) are judged by identifying communities in need of support and potential causes of healthcare disparities. Unfortunately, the CLER report of 2018 found that not all

participating institutions implement systemic strategies to address healthcare disparities in their population. The feedback provided by these CLEs in cultural competency and healthcare disparities was broad and not specific to the populations being treated. Therefore, influencing the role of resident physicians is important in combating healthcare inequities.²

The authors have the privilege of reviewing our ACGME surveys every year. For the past two years, all our programs have consistently rated our training in healthcare disparities as “very low.” How do we ensure we are providing an inclusive environment? El Paso, Texas, is located at the western tip of Texas, along the borders of Mexico and New Mexico. We thought to ourselves, how do the residents not see that they

are working and living in an area with glaring healthcare disparities? How do they not see what we are dealing with on a daily basis? Is it so ingrained in us that we take these disparities for granted? Or, are we so desensitized to these healthcare disparities that they have now become normalized? When we reviewed our didactic schedule for the past year, we realized that while we may have a couple of sessions on the topic, for instance, maternal health disparities in Texas, we have not been incorporating the topic of healthcare disparities into the daily aspects of resident education. This myopic view does not lend itself toward combating the health inequities in our population.

A 2019 study conducted by the University of California at San Francisco looked at taking healthcare disparities for granted by medical students in their fourth year of medical school (MS4s). A survey was conducted on MS4s' perceptions of healthcare disparities; what researchers found was healthcare disparities were all around: the way patients with little to no insurance were treated versus patients with private insurance and jobs, obese patients not given proper care, Black patients being perceived as drug-seeking even if they were not, attendings labeling Hispanic women with "Hispanic panic", and not using proper language interpreter services. The medical students observed that there was no place for them to speak out about their experiences and that they felt residents and attendings were already short on time and resources and too burned out physically and mentally to try and change the system. In a sense, these experiences were normalized for the medical students.³ While this study was performed on medical students, we did not find a study that was conducted on resident physicians. We can extrapolate that many MS4s' perceptions would be similar to the physician role models they had on a daily basis.

Based on our ACGME survey results and perceived normalization of healthcare disparities by our resident physicians in El Paso, we presented this information to the residents as part of our healthcare disparities lectures. We wanted to highlight the unique challenges El Paso experiences, as many have become numb to these health disparities.

According to the National Institutes of Health (NIH), healthcare disparities "are the result of differences in and interplay among numerous determinants of health, including biological factors, the environment, health behaviors, sociocultural factors, and the way healthcare systems interact through complex multilevel pathways".⁴ These factors can often have complex interactions and lead to poor health outcomes. Researchers are challenged to identify and develop interventions that may lead to reductions in these healthcare disparities and aim to improve healthcare overall.

El Paso, is a predominately Latinx city, with 83% of the population being Latinx (mainly Mexican American) and about 25% being foreign born. Nearly 70% of El Paso speaks Spanish, making it one of 22 American cities with more Spanish speakers than English speakers.⁵ We also serve Fort Bliss, the second-largest Army base in the United States (U.S.). We often see Army patients and their dependents and we work alongside Army or former armed services physicians.

The population in El Paso County, Texas, was 833 592 per American Community Survey data for 2012-2016. The median age is 31.6, with a median household income of \$42 075. The median home value is \$114 700. In the county, 77% have a high school diploma or higher, while 23.5% have a bachelor's degree compared to 31.8% in the U.S.⁵

Discussion

Medical Conditions That Affect Our Community

Our predominately Latinx population develops diabetes at 2 to 3 times the general population. Our population has increased rates of liver, stomach, and cervical cancers. We have higher rates of liver disease, likely due to increased rates of hepatitis C and higher levels of alcohol use.^{6,7} Our rates of sexually transmitted diseases, such as gonorrhea, chlamydia, and syphilis, have been rising over the past 10 years. Texas ranks 23rd of the 50 states for sexually transmitted infections, which is not as high as other states, but, nonetheless, we should be aware of these rates and screen our population appropriately.⁸ On the bright side, El Paso has one

of the highest rates of COVID-19 vaccination. We now boast a 90% adult COVID vaccination rate.⁹

A study conducted by the University of Texas, El Paso (UTEP) surveyed 1002 Mexican American households in the El Paso area in 2009-2010, where people were able to identify their barriers to care and the resulting increase in co-morbidities for cardiovascular and metabolic diseases.¹⁰ In El Paso, we have patients who have language and literacy barriers as well as a lack of transportation. There is an overall shortage of healthcare professionals, and many people in the community feel they are treated without respect by the medical community.¹⁰

Texas has the highest rate of uninsured people in the U.S. In Texas, 17-25% of adults and 12% of children are not insured.¹¹ El Paso County has similar numbers as the statewide rate.¹² Observational studies and studies of other wealthy nations show that having insurance is associated with lower mortality rates.¹³ Texas did not take the Medicaid expansion through the Affordable Care Act of 2009 and rejected it again this past year. Studies have shown that states with Medicaid expansion were able to decrease their rates of uninsured citizens and increase access to care.¹⁴

Areas known as "colonias" are a particular challenge. Colonias are areas where people live, but which are not zoned for residential use. These areas tend to have no running water, electricity, plumbing, or sanitary services.⁷ Approximately 72 000 people live in over 200 colonias in El Paso County.¹⁵ We may encounter patients from these areas, or our patients may have family that live there, or we may work with someone who comes from these communities. Health problems in colonia residents tend to be widespread. According to the University of Texas System's Texas-New Mexico Border Health Office, for every 70 residents per 100 000 in the colonia population, the following viral diseases were reported: hepatitis A: 43.9%; salmonellosis: 21.3%; shigellosis: 18.0%; tuberculosis: 28.1%.¹⁶

Racial Disparities

On August 3, 2019, a young man walked armed into a Walmart in El Paso. This man drove all

the way from Dallas to El Paso specifically to target Mexicans. He posted a manifesto about Mexicans infiltrating Texas, drove 12 hours to get here, then opened fire on a Walmart with the primary intent to kill Mexicans. Twenty-three people were killed and many more were sent to the hospital for treatment of their wounds.¹⁷ They were sent primarily to Del Sol Medical Center, an HCA Healthcare, Level 2 trauma center, and University Medical Center of El Paso, a community-owned, non-profit, Level 1 trauma center. Our resident physicians helped take care of these patients and their families on the medical wards and the ICU. The slogan "El Paso Strong" was created following the August 3 massacre.

El Paso made national headlines again in fall 2020 when we became "Ground Zero" for COVID-19 infections, our hospitals and morgues became overwhelmed, and FEMA and the National Guard were called in. It has been documented that COVID-19 disproportionately infects Latinx communities such as ours; Latinx people are 3-5 times more likely to become infected.^{18,19} At our peak during the surge, we had about 2000 COVID-positive cases a day and roughly 2700 total deaths due to COVID. Many more were hospitalized, and nearly everyone here knows someone who was very ill in the hospital or who died.

Hand washing is considered to be essential to combat COVID-19. In our colonias and poorer neighborhoods, how did people access water to wash their hands without proper indoor plumbing and running water? Many in the community are "essential workers" such as meat processors, in the cleaning industry, or delivery personnel, and their jobs did not allow them to work from home.¹⁸ COVID-19 has affected our patients' health every day, and some have residual effects, from loss of smell or taste to having small for gestational age babies during pregnancy. Some have severe anxiety and depression, especially in our elder and younger populations when we kept people at home and away from schools and social centers. This has had a significant impact on our population.

El Paso, Texas, has experienced tragedy and this has increased our healthcare disparities. In order for a community to flourish, these

inequities need to be addressed in a systemic manner and strategies to combat this need to be implemented.

Conclusion

Strategies for Change

The question remains, how do we improve our healthcare disparity training? First and foremost, it is important to address these topics at each and every opportunity. Before any didactic or lecture, faculty have been instructed to address healthcare disparities in our community as it pertains to the subject matter. Incorporating healthcare disparities in teaching during rounds, in the operating room and the clinic, and through journal clubs is of utmost importance in reinforcing these concepts. Faculty development becomes the backbone in addressing this issue, as many faculty may not be aware of these health inequities.

Second, implementing an advocacy curriculum tailored to the population in question will educate residents and fellows in current healthcare inequities. For example, the American College of Obstetricians and Gynecologists has an excellent resource for building an advocacy curriculum. Our goal is to provide a monthly healthcare disparity lecture as it pertains to advocacy during didactics as part of this curriculum, which can be presented by residents and faculty.²⁰ They can include ongoing updates from local legislation and how to reach out to our legislatures. In order to provide continuity, we will consider assigning an advocacy resident chief to assign these lectures with faculty oversight.

Third, social determinants of healthcare are real. We need to take a moment to remember what our patients are dealing with in their personal lives and how we can perhaps reword instructions, or have a little more empathy. They may be struggling to get water, let alone get a ride to come see us. They may need to choose between paying for medications and feeding their children. We can avoid using the common patient descriptor “non-complaint,” which can be judgmental and stigmatizing. We should remember to use proper translation services. Physician burnout, especially under trying circumstances, is real. As physicians, we should remember to have patience and empathy with

not only our patients but also our fellow healthcare workers.

Lastly, encouraging research in healthcare disparities is valuable. Feeling the pulse of the community by doing research in healthcare literacy is crucial in determining where changes need to occur. It is critical to engage the community directly through interactive methodology that includes both researchers and participants. Among the methods that could be of use is quality improvement in both inpatient and outpatient settings to create an immediate opportunity to influence the closing of gaps that contribute to health disparities. Another useful tool is engaging patients with qualitative methodologies that explore their experiences and apply those experiences to existing theory concerning a condition or a barrier to care. This is performed with the intent of gathering a more nuanced and complete understanding of patients’ determinants of health. This could further make medical staff aware of health disparities while also allowing for new and innovative interventions. The value of the proposed methods lie in their ability to engage the patient as a participant rather than a subject, further humanizing the patient populations we encounter. Through quality improvement and qualitative research, residents can focus more on the unique perspectives that come from our patients, their evocative impact, rich description of their experiences over that of prejudiced abstraction, and an openness to emerging data.²¹

By implementing these strategies in ACGME education, healthcare disparities in the community can be addressed and eliminated. It is a lofty goal but one worth pursuing.

Conflicts of Interest

The authors declare they have no conflicts of interest.

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