

Accountability and Best Practices for clinic volunteers
Phoenix Allies for Community Health Orientation (PACH)
By Leah Jo Carnine

Creating this presentation has been a collaborative process. The content is compiled from the experience and wisdom of many community organizers, scholars, and grassroots experts.

Please see the reference list for an extensive listing of further relevant resources and research.

Phoenix Allies for Community Health
Mission & Vision

THE MISSION of PACH is to provide health care with respect and dignity to underserved and underinsured people with the help of medical volunteers and staff.

THE VISION: We envision a society that recognizes the right of all people to accessible health care and the knowledge it takes to prevent illness. We envision a community that supports a holistic approach to health care that encompasses the social, environmental, economic, and spiritual aspects of health.

Objectives

- 1) Define terms such as privilege & oppression.
- 2) Discuss health disparities and causes.
- 3) Analyze our own social position, and those of our patients through an intersectional framework.
- 4) Perform a self-assessment.
- 5) Identify some 'best practices'.
- 6) Take steps towards integrating new knowledge and 'best practices' into our work as clinicians and students

Why does this matter?

As clinicians and students, we are entrusted to care for our patients, many of whom come from very different backgrounds than our own. Understanding the potential difference in our experience and backgrounds from many of our patients is important in order to cultivate a trusting and healing clinician-patient relationship. Individuals in societies learn cultural and societal norms- including biases and stereotypes that we might not even be aware of.

Health care providers can unconsciously contribute to health disparities by creating clinical relationships that maintain the biases that are learned in society.

For example, A study at Massachusetts general hospital revealed that physicians held unconscious subtle stereotypes and repeatedly were more likely to prescribe life -saving drugs during patient heart attacks if they believed the patient was white, and were less likely to prescribe the drugs to Black patients. These physicians were horrified when they learned about their discrepancies of treatment, implying the potential harm of unconscious bias.

This presentation aims to help us develop a better understanding and incorporate skills to begin to challenge the biases we might not even know that we have. Challenging unconscious bias, educating ourselves about social, cultural and economic barriers to health, and developing quality communication practices can allow us to provide better and more culturally relevant care for our patients.

Points to consider

As we learn about bias and inequity, defensiveness, guilt, anger, and shame are emotions that many people experience. These feelings are a normal response when learning about these issues. If you experience any of these, consider taking some time to sit with the discomfort and reflect on why these feelings are arising. There are many resources available beyond this presentation.

Definitions

Just like any field of study, this presentation has a lot of terminology that you may or may not be familiar with. We will be defining terms and concepts in this section to help build a shared language around these issues. The goal of this section is not to memorize definitions, but to try to understand how these issues affect us, our patients, and our patient interactions.

PRIVILEGE:

An often invisible right, advantage, or immunity granted or available only to one person or group of people.

Source: Merriam Webster Dictionary.

OPPRESSION:

Society operates within a socially constructed hierarchy of difference where some people are valued and privileged and others are marginalized and exploited

Source: Rainbow Network

Some examples of oppression in this country

Migrants to this country are not allowed access to voting, social services or social respect despite their contributions to this country

African Americans are incarcerated at approximately six times the rate of whites

Source: NAACP Fact Sheet

RACISM: irrational race prejudice that is often caused by, and reflected in, institutional power.

Institutional racism leads to disproportionate unemployment, incarceration, homelessness, and poverty in communities of color.

White Person: A term used to describe people of European descent, developed in the U.S. in the 17th century.

Person of Color/People of Color: A term used to positively define ethnic and racial minorities

Racism, sexism, heterosexism, ableism, and classism can be systems of advantage or oppression- depending on your social position

White people experience privilege within racism.

Examples of white privilege

I can go shopping anywhere I want and be pretty sure I won't be followed, profiled, or harassed.

I can be confident that if I need medical treatment, bank loans, or legal help, my race will not work against me.

I can easily find posters, movies, TV shows, picture books, greeting cards, dolls, toys and children's magazines featuring people of my race.

If a police officer pulls me over I can be sure I haven't been singled out and targeted because of my race.

SEXISM: A system of advantage based on gender. The subordination of femininity by masculinity. Source: People's Institute.

Examples of male privilege (Source: Everyday Feminism)

If I have a bad day or am in a bad mood, people aren't going to blame it on my sex (or PMS).

I can walk alone at night without, or with less, fear of being raped or otherwise harmed.

If I choose to raise children, I will be praised for caring for my children, instead of being expected to be the full-time caretaker.

I can choose to not care about my appearance without worrying about being criticized at work or in social situations.

HETEROSEXISM: is a social system that gives privilege and power to heterosexuals at the expense of LGBTQ peoples

*LGBTQ = Lesbian, gay, bisexual, trans & queer individuals

TRANSGENDER or TRANS: an umbrella term for persons whose gender identity does not conform to the sex to which they were assigned at birth.

Gender identity = a person's sense of and personal experience of being feminine, masculine or both

A recent survey conducted in California said, 85% of trans people had reported verbal abuse simply because of their gender identity and gender presentation. This is a result of transphobia.

CISGENDER: means having a biological sex that matches your gender identity and expression, resulting in other people accurately perceiving your gender.

Source: Everyday Feminism Heterosexual and cisgender people experience privilege within heterosexism and transphobia.

Examples of cisgender privilege

I can use public restrooms without fear of verbal abuse, physical intimidation, or arrest. Strangers don't assume they can ask me what my genitals look like, how I have sex, or personal information about my body.

If I end up in the emergency room, I do not have to worry that my gender will keep me from receiving appropriate treatment, or that all of my health issues will be seen as a result of my gender.

How to be a Trans* Ally:

Transphobic Words:

Calling someone a tranny or too butch to be a girl, etc. demeans and trivializes the wide variety of experiences held by those who identify as transgender. If you see this type of transphobic language being used, challenge it.

Coming Out: A gender identity is personal. If someone chooses to come out to you as trans* this means they trust you. Make sure to honor that trust by checking with them before telling anyone else as they may not want others to know.

Real Name?

Asking someone what their 'real' name is implies that their chosen name is in some way invalid or not 'real'. In the same way, asking someone what their 'real' gender is disrespects their own gender identity.

Just Ask!

It is important to respect the names and pronouns that people prefer. If you are unsure, simply ask, What are your preferred pronouns?.

Show Your Support!

Make sure to show your support for your trans* friends by challenging transphobia when you see it.

Gender Identity is not Sexual Identity

Remember that, no matter how someone identifies their own gender, they may still identify with any sexual identity. Everyone has a sexual and a gender identity, and they are separate and distinct from each other.

Source: SOC Trinity LGBT.

ABLEISM: discrimination or prejudice against individuals with disabilities.

Able bodied: individuals not living with a physically disabled, chronically ill, severely obese or any other physically limiting experience.

FAT PHOBIA: the systematic oppression and devaluing of people based on their weight and body size.

The Fat Phobia scale was developed to study and measure fat phobic attitudes, fat prejudice and stigmatization on behalf of individuals, including medical providers.

Take a moment to take the survey:

http://www.yaleruddcenter.org/resources/bias_toolkit/toolkit/Module-1/1-08-SelfAssessmentTools/1-0808-FatPhobia.pdf

Fat Phobia Scale

Listed below are 14 pairs of adjectives sometimes used to describe obese or fat people.

For

each adjective pair, please place an X on the line closest to the adjective that you feel best

describes your feelings and beliefs.

1. lazy _____ industrious

5 4 3 2 1

2. no will power _____ has will power

5 4 3 2 1

3. attractive _____ unattractive

5 4 3 2 1

4. good self-control _____ poor self-control

5 4 3 2 1

5. fast _____ slow

5 4 3 2 1

6. having endurance _____ having no endurance

5 4 3 2 1

7. active _____ inactive

5 4 3 2 1

8. weak _____ strong

5 4 3 2 1

9. self-indulgent _____ self-sacrificing

5 4 3 2 1

10. dislikes food _____ likes food

5 4 3 2 1

11. shapeless _____ shapely

5 4 3 2 1

12. undereats _____ overeats

5 4 3 2 1

13. insecure _____ secure

5 4 3 2 1

14. low self-esteem _____ high self-esteem

5 4 3 2 1

Scoring

1) For items 3, 4, 5, 6, 7, 10, and 12: score as 1 2 3 4 5

2) For items 1, 2, 8, 9, 11, 13, and 14: score as 5 4 3 2 1
3) Add up the score for each item to get the total score. Then divide by 14 (or the number of items answered, whichever is less). The range of scores is 1, 5.
High scores = more fat phobia. Low scores = less fat phobia.

For more information on the Fat Phobia Scale (short form):
Bacon JG, Scheltema KE, Robinson BE. Fat phobia scale revisited: the short form. International Journal of Obesity. 2001; 25: 252-257.
preventing weight bias helping without harming in clinical practice the rudd center for food policy and obesity yale university.

Able-bodied people experience privilege within ableism.
Examples of able-bodied privilege:
Others don't get frustrated with me in public spaces for needing special accommodations or holding up lines
Public access to friends' houses, doctor offices, parks, taxis and restaurants is easy for me
My ability or body size isn't the butt of jokes in TV shows, radio shows and movies.

CLASSISM: The systematic assignment of worth based on social class; policies and practices set up to benefit more class-privileged people at the expense of the less class-privileged people, resulting in drastic income and wealth inequality and causing basic human needs to go unmet.

Source: Class Action.

People with class privilege experience class privilege within classism

Examples of class privilege:

I was taught the difference between healthy and unhealthy food, and can easily access and choose to eat the foods that I think are most healthy for me.

I can talk with my mouth full and dress in wrinkled clothes and not have people attribute this to the uncivilized nature of my social class.

In the case of a medical emergency, I won't have to decide against visiting a doctor or the hospital due to economic reasons.

Racism, sexism, heterosexism, ableism, and classism can be systems of advantage or oppression- depending on your social position.

Intersections of oppression & privilege

People don't belong to just one identity group or social location.

Our identities are complex, fluid and multi-layered.

As a result we can simultaneously be both victims and benefactors of systems of oppression.

Some examples of intersections of privilege and oppression due to one's social position include:

A white woman may experience white skin privilege as a white person, and oppression because of her female gender.

A migrant woman from Mexico might experience oppression as a woman, as a person without legal documentation, and as a person of color.

A disabled white transgender man might experience white privilege, and oppression due to ableism and transphobia in society

A gay Latino male might experience oppression as a gay person and as a person of color, and privilege as a male

All of these 'isms' play out in very tangible, though sometimes invisible ways

They lead to negative stereotypes of identity groups based on skin color, class, sexual orientation, gender identity and ability.

Even if we think we don't buy into stereotypes, we often unconsciously do.

Understanding these forms of oppression helps us identify stereotypes and biases so we can better challenge them in clinical practice.

One thing to consider with all of these definitions is that there are many ways that people self-identify. For example, some people who originate from Mexico, Central, or South America identify as Hispanic, and others identify as Latino, and others yet as Chicano. Also, some people whose families originate from Africa identify as African Americans, and others as Blacks. Further, some people identify as Lesbians, others as Queer and others as bisexual. The most important thing is we cannot tell how someone self-identifies by looking at them, and it's best to mirror the language that they use to define themselves.

CULTURE: is a way of life. Culture is passed on from generation to generation through institutions, groups, interpersonal and individual behavior. To individuals, culture provides a sense of identity, belonging, purpose and world view. In a society, culture provides the basic values, assumptions, ways of thinking, styles of learning, language, ways of relating to each other, and basic world view.

Source: People's Institute.

How do you define your culture?

What do we learn from American culture?

CULTURAL COMPETENCY: Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situation.

Source: Office on Minority Health

*Beyond just competency, we are striving for cultural respect and anti-oppression in our health care work!

ANTI-OPPRESSION: A perspective and life approach dedicated to recognizing and challenging institutional and personal forms of oppression.

HEALTH DISPARITIES: a particular type of difference in health outcomes that are closely linked with social, economic, and/or environmental disadvantage, historically linked to discrimination or exclusion

Source: Healthy People 2020

Health disparities adversely affect: People of color, Lesbian, gay, bisexual, transgender & queer people, People with disabilities, People who live in poverty.

More examples of communities who have historically been marginalized by the medical system:

Migrants

Drug users

People with mental health illnesses

People who work in the sex trade

There are many, many examples of health disparities, just a few include:

Infant mortality with African American populations is nearly twice the national average.

Source: CDC

Mexican migrants are over four times more likely to have not received medical care in the past 2 years than whites

Source: Health disparities amongst Mexican Immigrants Fact Sheet.

Latina women are approximately three times as likely to have diabetes than white women.

Source: CDC

Incidence of asthma is roughly twice as high in African American, Puerto Rican and Latino youth than white youth.

Source: CDC

Over 50% of Mexican migrants are without insurance or a source of health care, leading to disproportionate rates of preventable cancer deaths and other illnesses.

People with disabilities are more than twice as likely to have diabetes than able-bodied people.

Institutional health disparities by race: Health disparities along racial lines demonstrates the way that racism- not biological differences between people of different skin colors- affects health outcomes.

(graphic of person with caption 'racism makes me sick it affects my blood pressure and creates anxiety and depression'. Source: <http://antar.org.au>)

An article published in 2013 in Psychology today lays out 6 major pathways where racism impacts health outcomes:

1) Neighborhood segregation and zoning

Segregation determines the quality of education and employment opportunities.

Segregation contributes to the creation of pathogenic neighborhoods and housing conditions.

Conditions linked to segregation can constrain healthy behaviors and encourage unhealthy ones.

Segregation can adversely affect access to high-quality health care.

Source: Psychology Today

2) Institutional discrimination

Does the stress of living in a white-dominated society make African Americans get sick and die younger than their white counterparts? Apparently, yes.

After decades of research, Arline Geronimus concludes that the long-term stress of living in a white-dominated society 'weathers' blacks, making them age faster than their white counterparts.

Read more: Racism's Hidden Toll.

<http://www.psmag.com/health/racisms-hidden-toll-3643/>

Melissa Perry Harris show:

<http://www.nbcnews.com/id/46979745/vp/51123883#51123883>

3) Unconscious bias

Alexander Green at Massachusetts General Hospital once conducted a study. He had physicians evaluate patients and some of the physicians thought they were evaluating a white patient. And some of them thought they were evaluating a black patient. And what Greene found is that the higher the levels of subtle unconscious stereotypes the physicians held, the more likely they were to not prescribe the black patient with clot-busting drugs for a heart attack.

The physicians didn't act in ways that were driven by animosity. In fact, when they saw the results, they were horrified. They weren't trying to treat the black patients badly.

What was happening really, is someone complains of chest pain and you're having to judge: Is this person suffering from indigestion or about to have a heart attack? And in that kind of situation - where you're not completely sure - your biases can help play a very powerful role.

Read more: <http://wlrn.org/post/how-fight-racial-bias-when-its-silent-and-subtle>

4) Internalized Racism

Internalized racism is the conscious or subconscious acceptance of the dominant society's racist views, stereotypes and biases of one's ethnic group.

It gives rise to patterns of thinking and behaving that can result in invalidating and hating oneself while simultaneously valuing the dominant culture.

Internalized racism can result in negative health outcomes.

5) Psycho-social Stressors

In 2011, researchers found that African Americans who reported experiences of racial discrimination had higher odds of suffering from generalized anxiety disorder (GAD). An article on PsychCentral termed the phenomenon as "racial battle fatigue, saying that "exposure to racial discrimination is analogous to the constant pressure soldiers face on the battlefield.

-Changes in DSM-5: Racism Can Cause PTSD Similar To That Of Soldiers After War.,
Medical Daily News

Read more: <http://www.medicaldaily.com/articles/15855/20130523/dsm5-racism-racial-trauma-post-traumatic-stress-disorder.htm>

6) Racism and the Environment

People of color and Indigenous people disproportionately live on land or in parts of cities where air, water, and food are contaminated because of uranium mining, nuclear testing, highways, refineries, etc.

Watch Unnatural Causes trailer: http://www.unnaturalcauses.org/video_clips_detail.php?res_id=80

http://www.unnaturalcauses.org/video_clips_detail.php?res_id=80

Health Disparities: Poverty

Poverty is both a cause and a consequence of poor health. Poverty increases the chances of poor health. Poor health in turn traps communities in poverty.

For example, diabetes rates are twice as high amongst people living in poverty as those with high incomes. Source: CDC.

A 23-year study on the impacts of crack cocaine on gestation

concludes with clear proof that poverty is a more powerful influence on the outcome of inner-city children than gestational exposure to cocaine.

Read more: http://articles.philly.com/2013-07-22/news/40709969_1_hallam-hurt-so-called-crack-babies-funded-study

Health Disparities: LGBTQ communities

Lesbian, gay, bisexual, transgender and queer (LGBTQ) communities often provide social support and positive personal and group identities for members of the communities, but LGBTQ health is still affected by transphobia and heterosexism.

Violence and threats of violence, isolation, invisibility and discrimination contribute to LGBTQ communities experiencing:

Higher levels of depression and suicide

Higher rates of alcohol, tobacco and other drug use

Greater risks for sexually transmitted infections

Additionally, because of discrimination, LGBTQ communities often receive less quality health care

The 'Cost of Gender'

50% of transgender/gender-fluid Americans reported having to teach their medical providers about transgender care.

19% have been refused medical care because of their gender identity. Source: National Transgender Discrimination Survey.

Watch this short film project produced by the Common Language project

<http://www.youtube.com/watch?v=B16lhJwTez0>

Health Disparities: Disability

According to Healthy People 2020, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need
- Not have had an annual dental visit
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities
- Have high blood pressure and/or diabetes
- Experience symptoms of psychological distress
- Receive less social-emotional support
- Have lower employment rates

An image of a chart compares the prevalence of health issues for various marginalized groups showing that people with disabilities are at a higher risk for diabetes, stroke, and heart attack, and are in 'fair' or 'poor' health at almost double the rate of the other marginalized groups presented, which includes Hispanic, Black, Asian, and Native American populations.

All of this information on health disparities can be overwhelming. Part of understanding allows us to better identify and strive for health equity, where all people and communities, regardless of social position, have the opportunity to develop and maintain health.

If you would like to take a break, now is a great time. Next comes developing best practices and incorporating what we've learned into case studies.

Conduct a self-assessment

Do a self inventory:

- 1) Work to understand some of the dynamics at play in society and how you are affected or benefit from them
- 2) Honestly explore values, beliefs, and attitudes about your culture and cultures different from your own
- 3) Non-defensively engage other students, clinicians, and the larger community in this self-assessment

In what ways do you experience privilege, in what ways do you experience oppression?

Do you have privilege:

As a white person?

As a person with economic and class privilege?

As an English speaker?

As a U.S. citizen?

As a person without a disability (able-bodied privilege)?

As a male?

As a cisgendered person?

1) What privileges do we as clinicians and students have as a group?

2) How do these privileges affect our interactions with patients from different backgrounds in the clinic setting?

3) What social and economic contexts do our patients come from?

4) In what ways do these privileges and different experiences create a power dynamic in patient interactions?

Developing Best Practices

1) Consider power dynamics inherent in clinician-patient interactions.

Power dynamics: refers to ways that power is exercised in specific interactions.

For example, have you ever gone to a doctor's office and had him/her tower above you without making eye

contact? That is one example of how power can work in a specific setting.

When we work across differences of privilege and oppression, there are numerous power dynamics that can

impede our patient's access to receiving comfortable and respectful care.

How can you counter those power dynamics in patient-interactions?

Introduce yourself by name and role at clinic (student, nurse, PA).

Maintain eye contact.

Sit at same level as patient.

Ask for consent before all physical contact.

Ask for consent before discussing personal health information.

Ask for consent before giving advice.

If applicable, use interpreters appropriately and speak directly to the patient not the interpreter.

Be aware of the number of students, clinicians, and interpreters in the room with a patient at a time, and how lots of medical people can be overpowering.

2) Support patients in empowering themselves.

Do not pity the patients you interact with.

Challenge paternalistic or condescending notions of saving them.

Respect people for their courageous and resilient acts of survival.

Respect people's choices for how they take care of themselves and their families, often with limited resources and support.

Do not expect a pat on the back for your volunteer work.

3) Value culture.

Create an environment where people feel safe to express values, perceptions and experiences from their culture.

Respect the leadership of people from the community that we are serving.

Honor dietary choices, health practices, traditions, beliefs from the culture of the patient.

4) Meet people where they are at, use motivational interviewing

Respect people's health choices and behaviors.

Acknowledge that the conditions of peoples lives are complex, and making healthy changes might not always be possible for them.

Don't tell people what to do, what to eat, that they have to quit smoking, etc.

Do use motivational interviewing to find out what healthy changes are realistic and possible for the patient and ask them how you can support them in making those changes.

Motivational interviewing refers to a client-centered counseling technique that non-judgmentally engages a patient's intrinsic motivation and strength in order to support them to change their behaviors.

Watch this video on motivational interviewing in the primary care setting: <https://www.youtube.com/watch?v=0MbEYPzgDWw>

5) Learn about harm reduction.

Harm reduction focuses on promoting scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors while respecting people's choices to engage in these behaviors, examples include:

Needle exchanges to provide clean needles for IV drug users to reduce risk of transmitting blood-borne infections.

Providing condoms for workers within the sex trade to reduce the risk of acquiring STI's. This approach can be applied more broadly for health care providers working to meet patients where they are at.

6) Understand how historical and political differences between cultural groups impact relationships and experiences.

Read, ask questions, and be open to learning about the culture and experiences of patients you are interacting with.

For example, why do migrants come to the U.S.? Learn about NAFTA and global policies that displace people from their native countries.

7) Check your assumptions.

We are taught many assumptions about people based on the color of their skin, the way they dress, their income level, their body size, their language, culture, gender, etc.

Challenge assumptions you might make, for example:

Do not assume that if someone is overweight they are unhealthy or lazy.

Do not assume that because someone is from a community that suffers from disproportionate rates of illness, that they have an illness.

Do not assume that because someone is a migrant that he or she does not also speak English.

Do not assume, ask!

Check your assumptions!

Chart graphic shows a green circle demonstrating What You can Tell By Looking at a Fat Person. The different assumptions are color coded and only one is green, indicating that only one assumption is true and that is Fat people are fat. The other options are represented by colors not present in the circle, and those are:

What they eat

How much they exercise

How healthy they are

If they have an eating disorder

8) Honor the knowledge, experience and expertise of people from the community.

People from the communities we are trying to serve are the best positioned and most equipped to support the health and wellness of their community.

The majority of the patients at PACH are undocumented migrants.

PACH works in partnership with the Promotoras para el Bienestar, a group of mostly migrant women promoting health through community empowerment and organizing. The Promotoras are an incredible resource for many patients at the clinic.

Support the Promotoras:

Ask them questions about their work.

Volunteer with their health outreach project.

Let patients know about the Promotoras as a resource for grassroots health and community empowerment.

An image shows a group of people who are

Promotoras para el Bienestar conducting a neighborhood survey about health needs in the Garfield district.

Case Study #1

Jasmin, a 27 y.o. transgender female presents with lower back pain. She hasn't had a check-up in seven years because she works part time and doesn't have insurance. PMH reveals she has been taking estradiol IM for the past 5 years, has hypertension and is otherwise healthy.

Reflection questions

What barriers to health might this person experience?

What assumptions might we as clinicians and students make about this person?

What bias might we have interacting with this patient?

How can we best intercept those assumptions and biases to provide quality care?

Incorporating best practices

Do not refer to her as the sex she was assigned at birth, do respect her preferred pronoun.

Do not insist on knowing or using her birth name, do use the name she provides at today's visit.

Do follow her lead with what language she chooses to use about her gender and body parts.

Do check your assumptions about her sexual practices, sexual orientation, health needs, etc.

Do respect her privacy around the sex she was assigned at birth and whether or not she has had sex re-assignment surgery.

Only ask questions or perform physical exam techniques that are pertinent to her health, not to your curiosity!

Graphic says: How to be an ally to the Transgender Community

Certainly Do: Get to know me!

Educate yourself!

Use preferred pronouns!
And learn my 'real' name!

Please Don't:

out me as trans without my permission, ask what my name was 'before,' make assumptions about my sexual orientation, ask me about my genitalia.

<http://www.thegenderbook.com> Transgender Foundation of America.

Case study #2

Miguel, a 47 y.o. undocumented day laborer, hasn't had consistent employment or health care since he came to the U.S. 15 yrs ago. He has been having intermittent chest pain for 6 mos. His friend was deported from the hospital 2 years prior, and he is afraid if he seeks health services he will be turned over to immigration enforcement.

Reflection questions

What barriers to health might this person experience?

What assumptions might we as clinicians and students make about this person?

What bias might we have interacting with this patient?

How can we best intercept those assumptions and biases to provide quality care?

Incorporating best practices

Do not ask about his documentation status.

Do not use derogatory terms like illegal to describe the patient (to them or other volunteers).

Do not make assumptions that affect the quality of care you provide, for example denying him pain medications because he is assumed to be a drug seeker.

Starting him on a medication instead of offering him a trial of MNT/lifestyle modification because you assume he is unable to take care of himself.

Do keep his documentation/immigration status confidential and assure him of such

Do provide him with the same quality of care and services you would if he had health insurance

If he doesn't speak English, use interpreters appropriately to perform a comprehensive H & P

Case study #3

Rena, a 74 y.o. female Navajo elder presents with progressive osteoarthritis. She has been advised to have total knee arthroplasty, but does not want the surgery because of mistrust of western medical ways. She says none of the providers she's spoken with have respected her community healing practices or ceremony.

Reflection questions

What barriers to health might this person experience?

What assumptions might we as clinicians and students make about this person?

What bias might we have interacting with this patient?

How can we best intercept those assumptions and biases to provide quality care?

Incorporating best practices

Do not dismiss her concerns or questions about the western medical treatment approach.

Do honor her traditional healing practices (but do not assume what she does and does not practice), and work with her to incorporate them into her medical treatment, including:

Traditional healers/medicine men.

Natural or herbal remedies.

Ceremony and prayer.

Try to understand the role of elders in traditional Navajo culture.

Do honor the role of community and family in health and decision making in different cultures (which is different from individualism in U.S. dominant culture).

Case study #4

Maria, a 34 y.o. female presents for a routine check up. Her BMI is 34.1, BP 128/90, and fasting BG is 183 on today's visit. She has no current health complaints, but wanted to check her blood sugar because her father has diabetes.

Reflection questions

What barriers to health might this person experience?

What assumptions might we as clinicians and students make about this person?

What bias might we have interacting with this patient?

How can we best intercept those assumptions and biases to provide quality care?

Incorporating best practices

Do not degrade or belittle her because of her body weight.

Do not assume that her elevated blood glucose is due to her weight, or that she eats unhealthy food, or that she does not exercise.

Do not tell her to lose weight. as a substitution for necessary medical testing or treatment.

Do challenge the idea that people get diabetes solely because of their dietary and exercise choices.

Do think about how health disparities due to racism, sexism and poverty contribute to diabetes.

Do ask questions about her diet and exercise, and use motivational interviewing to support her in making choices that are realistic and desirable for her.

Case Study #5

Denise, a 60 y.o. old woman with cerebral palsy presents for a routine physical exam. She has been turned away from several other providers who claimed they were not equipped to deal with her disability.

Watch her story here:

<http://dredf.org/healthcare-stories/2013/02/19/denise-sherer-jacobson/>

Reflection questions

What barriers to health might this person experience?

What assumptions might we as clinicians and students make about this person?

What bias might we have interacting with this patient?
How can we best intercept those assumptions and biases to provide quality care?

Incorporating best practices

Do not speak to the patient's companion or care giver.

Do speak directly to the patient.

Do ask how you can best help them, and respect their answers.

Do treat the whole person, not her condition or disability.

Do allow time for history taking and a thorough physical exam.

Do respect the patient's privacy, and ask for consent at all steps of the history and physical exam.

Do work on making your health facility accessible to people with wheel chairs and different levels of mobility (ramps, elevators, etc.).

Thank you for completing the PACH Accountability and best practices training!
Please take a few more minutes to complete the post-training assessment quiz:
Please copy and paste the following link into your browser to complete the assessment:
<http://bit.ly/12BMDrS>

References & Resources

Rainbow Health Network: <http://www.rainbowhealthnetwork.ca/files/SDOH%20Pamphlet.pdf>

CDC 2011 report on health disparities

<http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>

How racism is bad for our health

<http://www.theatlantic.com/health/archive/2013/03/how-racism-is-bad-for-our-bodies/273911/>

<http://www.rainbowhealthontario.ca/about/mission.cfm>

Fat Phobia Scale: http://www.yaleruddcenter.org/resources/bias_toolkit/toolkit/Module-1/1-08-SelfAssessmentTools/1-0808-FatPhobia.pdf

Poverty is worse on health than crack: http://articles.philly.com/2013-07-22/news/40709969_1_hallam-hurt-so-called-crack-babies-funded-study

Racisms hidden toll:

<http://www.psmag.com/health/racisms-hidden-toll-3643/>

Melissa Harris-Perry show on racial health disparities:

<http://www.nbcnews.com/id/46979745/vp/51123883#51123883>

Healthy People 2020:

<http://www.healthypeople.gov/2020/>

<http://prezi.com/6-ebu4kxnvfr/racism-intersectionality-allyship/>

<http://www.healthpovertyaction.org/policy-and-resources/the-cycle-of-poverty-and-poor-health/the-cycle-of-poverty-and-poor-health1/>

Health Service Disparities among Mexican Immigrants, UC Davis:

<http://agcenter.ucdavis.edu/AgDoc/healthServiceDisparities.pdf>

Access to Medical Care for Individuals with Mobility Disabilities
Class Action:

<http://www.classism.org/about-class/class-definitions>

NAACP Criminal Justice Fact Sheet: <http://www.naacp.org/pages/criminal-justice-fact-sheet>

People's Institute (of survival and beyond):

<http://www.pisab.org/>

Peggy McIntosh 'Unpacking the invisible knapsack'

Healthcare stories: Disability Rights Education and Defense fund: <http://dredf.org/healthcare-stories/2013/02/19/denise-sherer-jacobson/>

Xion's story (image)

http://wamu.org/programs/metro_connection/12/09/21/

[xions story transgender woman tells of life on the streets](#)

Social Work Helper:

<http://www.socialworkhelper.com/2012/12/20/anti-oppressive-social-work-practice-in-mental-health/>

American Public Health Association, the problem with the phrase women and minorities.:

<http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2012.300750>

NCHCH: what is harm reduction? <http://www.nchrc.org/harm-reduction/what-is-harm-reduction/>

Everyday Feminism:

<http://everydayfeminism.com/2012/11/30-examples-of-class-privilege/>

<http://everydayfeminism.com/2012/12/30-examples-of-male-privilege/>

<http://everydayfeminism.com/2012/09/30-examples-of-cisgender-privilege/>

<http://everydayfeminism.com/2013/03/19-examples-of-ability-privilege/>