

Transcript Details

This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/clinical-practice/general-medicine-and-primary-care/conversations-access-care-disparities/12904/>

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Conversations in Access-to-Care Disparities

Announcer:

Welcome to ReachMD. This activity, entitled "Conversations in Access-to-Care Disparities" is provided by Prova Education.

Ms. Venable:

One of the things that concerns me is regional bias, which is bias based on where people live and the treatment options that they are offered based on their geographical location. That could be city, or it could be state or beyond.

Dr. Vega:

This is ReachMD, and I'm Dr. Chuck Vega.

Ms. Venable:

And I'm Sateria Venable.

Dr. Vega:

I really want to hear more about this concept of regional disparities, and how does that affect broader issues and access to care?

Ms. Venable:

Regional disparities come up time and time again when we are doing our advocacy work at the Fibroid Foundation or when we're doing research studies. Most recently, in the COMPARE-UF national fibroid research study, we discovered that women in the Southeast United States were offered hysterectomy far more often than women in other areas of the country. Not only were they recommended, they underwent the procedure, and that's very concerning. We also discovered that many women in rural areas of the United States have very limited access to care providers and care in general.

Dr. Vega:

I think that in America, we've just gotten used to this concept of regional disparities, and, well, that's just the way things are. But we know when you think about the most important outcome overall we consider in healthcare, which is mortality, mortality rates can be substantially different based on a short car ride. Mortality data can be remarkably different, just comparing two different neighborhoods in the same city. And while you mentioned the Southeast, there's data from central New Jersey, from Baltimore, Maryland, from Oakland and Alameda, California. And it's amazing to see that a short car ride or a short bus ride can make a difference of years in terms of average life expectancies.

Ms. Venable:

I completely agree with what you said. Oftentimes, we see patients receiving a higher level of care if they're not intimidated by the medical sphere and if they have the confidence to seek out care and to ask questions of their medical providers.

Last year, Dr. Erica Marsh at University of Michigan talked about the disparities and the length of time that it takes to be diagnosed. So there's a lot that we can uncover, and insurance is definitely one. It's just really upsetting to me to have patients reach out to us who are suffering and don't have any access to insurance providers or care to be able to be treated.

Dr. Vega:

Right, and so certainly there's a lot of systems at play here. Systems of inequity, which you highlighted, but there's also just the fact that we as providers have biases, just like everybody does.

We come into our patient care settings with our own biases, and it's really key to try to identify those biases and act upon them. And

they can shift a little bit, even during the day. For example, just this morning when I was seeing patients, towards the end of the session when I know schedule's tight and my staff is trying to go to lunch and I'm still kind of working away, it's natural to feel like I want to be more short with patients and maybe not quite as empathic as I normally am. But I really have to actively recognize that as that pressure kind of building in myself and then say, okay, no, we're going to go ahead and treat the patient as they should be treated. And just taking that moment to be mindful of that change even in my own practice during the session is important and I think yields better outcomes, better satisfaction for patients in terms of a visit, and better health outcomes, as well, in terms of their overall care.

Ms. Venable:

I think you highlighted something really important, which is that physicians are people, too, and they have emotions and bad days and bad parts of the day, and that may impact the way that they interact with a patient. And I think that it's good for your colleagues to hear that and to also recognize that it's important to note that the patient has waited, maybe in some instances, months to see you, so to try as best you can, even if you're having a challenging day, to greet them with the enthusiasm with which they are expecting to interact with you and be open to them educating you on their body and it being kind of a two-way street, rather than it being a circumstance where it's a physician telling a patient what they recommend based on their expertise, without the patient input. I learned in my advocacy work that menstrual pain is the only pain that is described as "normal" in the medical sphere, and I think sometimes it's minimized, and it oftentimes can be very pervasive and overwhelming and really impact many body systems.

Dr. Vega:

Yeah, Sateria, it's amazing to consider, and I never actually reflected on the fact that menstrual pain is just regarded as normal when no other pain is. That's remarkable to think about.

I just have to go back to the very first patient I saw. It was in my third year of medical school, and they had gotten up at 2:00 in the morning to drive down to our big medical center in Madison, Wisconsin. It was 6:30, I was the only one available to see them, and they told me their story. They got up that early and were driving through the night to reach us for a problem they couldn't solve at home, and it just was very impactful, like, wow. I just really respect that effort. So those kinds of things I hold on to and I try to re-engage with at moments when I feel stressed or when my bias may be acting out.

What other practical things as clinicians should we be getting involved with, like larger efforts at policies that reduce disparities and help us better act on our biases?

Ms. Venable:

I'm a people person – I'll tell a quick story. I had had a myomectomy. And the day after my – open myomectomy, so I was in a lot of pain. The nurse came in, and I said, "I haven't seen the doctor today." And she said, "He's waiting until the end of the day to talk to you because he knows you're going to have a lot of questions, and he wants to make sure he's not rushed." And it made me giggle because we had to work to get to that place, where we could have a more involved conversation. And so to answer your question, I think one of the things is just think of your patient as developing a relationship, where you're getting to know one another, and trying to develop a customized approach to their specific goals based on your expertise. And I think that that will go a long way to kind of reframing the patient-physician dynamic.

Another thing we do is we host fibroid talks, where we have a reception where patients and clinicians can interact in a social setting, and it kind of takes the pressure off of the clinic visit. So I think your point of going maybe outside of the clinic and maybe interacting with patients in a social setting can maybe uncover some things that clinicians may not have been aware of previously.

Dr. Vega:

It's great from a knowledge perspective, and it's also great motivation and inspiration to continue the practice, because you do see more of the patient as a human being as opposed to another case that you have to get through to move through your day. So I agree with that; that's important.

For those of you who are just tuning in, you're listening to ReachMD. I'm Dr. Chuck Vega, and with me today is Sateria Venable who's a true expert in access to care disparities.

So, Sateria, what steps can our listeners begin to take right now? Are there specific behaviors or actions you'd like to encourage them to take starting with their next patient or in terms of broader policy issues?

Ms. Venable:

There's a lot that can be done, and I believe that everyone can make a difference. One of the things that clinicians can do to support legislation efforts is to write their own personal representative. When representatives hear from a healthcare professional, it carries a lot of weight. What the legislators want to know is who in my state and city will benefit from legislation that I vote positively on. And that's the question that we're asked whenever we walk into an office. So the more people they hear from in various parts of the country, the

more impactful it will be and the faster the legislation will come to fruition.

Dr. Vega:

I agree very much in systems of practice. So I think it starts with us as clinicians, understanding our own biases, be they based on race and ethnicity or gender or sexual orientation. There's a million ways to cut those lines of diversity, but we really want to be trying to practice our best level and provide the care that patients deserve, no matter who they are or what their background, and honor their values first. I think part of that is using evidence-based tools. I know some clinicians really don't love algorithms, but especially when treatment management plans or diagnostic algorithms are developed with a diverse input, they get really valuable, because when you stray from those algorithms, that might be your bias at play.

We all need to use clinical gestalt. We need to be able to create shortcuts cognitively so we can see the number of patients we do and provide good care. That's natural, but do understand that it's that gestalt and where you're operating off of the algorithm grid. That's where your bias can really have an impact, where it's really unchecked and therefore potentially harmful to patients. So I think that's, in addition, decision support tools, where those algorithms come into play. Using your EMR, if it's done in a smart way, is also a really good way to practice.

And then I would just close by saying we can all be advocates. We're placed on a pedestal as healthcare providers, whether that's deserved or not, but we have it. We have a mouthpiece, and we can use it. So we can use it at our local level, in our clinical settings, in our practice, in our hospitals. But we can also use it in the community, so really be pro-patient and be anti-racism, for example, I think is very important, and getting involved with efforts at legislation like you're promoting, Sateria.

Ms. Venable:

I think the algorithm conversation that you just touched on is incredibly important. Having come from the architecture and design industry, and now working in the nonprofit medical industry, I've noticed that, as many people do when they are around folks, their peers that are in the same profession, there's a certain conversation that takes place, and there are assumptions that take place that are familiar to them in that workplace setting. And when you then incorporate the patient voice, you're going to have a different conversation, but I promise you it will be a more productive one because you'll get those insights. So it requires being open to not having the algorithm necessarily make sense or the data being in place, but to just try to take that feedback and create a new path forward that incorporates the data with the patient voice.

Dr. Vega:

Yeah, absolutely, and I think that's a great way to close our session. Sateria, thank you very much for these tremendous insights. I found it really both informative but also inspiring in terms of providing care for my next clinic session coming up. And thank you to our audience as well. Thank you and be well.

Announcer:

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