Transcript Details
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Conversations in Health Equity: Examining the Provider Needs of Latino Populations

Announcer:
Welcome to ReachMD. This activity, entitled “Conversations in Health Equity: Examining the Provider Needs of Latino Populations” is provided by Prova Education.

Dr. Galvis:
I was recently consulted as a pediatric infectious disease specialist on a 14-year-old Hispanic male with no significant past medical history. He didn’t speak English, and initially had been presented with his mom with 10 days of fever. He was admitted to the hospital initially, because his CBC had atypical lymphocytes and the bone biopsy at the time was negative for leukemic malignancies. Unfortunately, this male was discharged home and was supposed to follow up within approximately 3 months. However, he was lost to follow-up. Then, when I was consulted, this male presented, now a year later, as a 15-year-old Hispanic male with generalized weight loss and malaise, had fungus in his tongue, had multiple subcutaneous skin infections, and my laboratory workup showed that he actually was in full-blown AIDS.

Dr. Vega:
That’s a really powerful story of a missed diagnosis and its really difficult consequences. And it’s clear from that story that we need to do better.

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

Dr. Galvis:
And I’m Dr. Alvaro Galvis.

Dr. Vega:
Dr. Galvis and I know each other fairly well. He was a student in our program in medical education for the Latino community here at the University of California at Irvine, where I serve as director of that program.

So, Alvaro, pitching it back to you, I think that this is a good story about maybe being more culturally responsive could have yielded a diagnosis earlier, particularly in getting a good sexual history certainly would have changed the case very early on. Can you tell us about some specific needs when addressing Latino patients that you find are helpful?

Dr. Galvis:
Well, let’s first talk about what it is to address Latinos. So let’s talk about cultural responsiveness and what does that mean in this context? I think of cultural responsiveness as having the ability to understand cultural differences, recognize potential biases, and to look beyond those differences to work productively with the patient for a better outcome.

In in this particular case, the way I like to think about it is we have a male Latino who doesn’t speak English, who probably has not come out to his mother, and therefore we’re not able to discuss his sexual preferences or his sexual behavior. So breaking those barriers down one at a time will help us understand how to help this patient. So how are we going to do that? First, having the right translator to be able to speak to the patients and the family. Second, we know he is a male in the Latino community where being gay is not well looked upon, in most cases. And therefore, taking the sexual history should not be happening in front of the mom. That would have helped define him as being a homosexual male who’s at higher risk of having male-to-male sex and therefore higher risk for HIV. And we would have found out, from this particular case, that this male had actually had multiple sexual contacts at any given time. In fact, when I talked to him separately, he had had too many sexual partners to count and didn’t know how to keep track of them. And that would have helped

us to understand, and if we could have captured him earlier, we could have avoided AIDS. Now, what are the cultural needs for this male? Well, he was afraid of coming out to his parents, rather than what would have been his actual diagnosis.

Dr. Vega:
That's really powerful. A very scary diagnosis like HIV/AIDS might be more scary than actually just talking to your family about your sexual orientation. It's hard enough for healthcare professionals to do a good sexual history. Patients feel reticent. The healthcare professional feels reticent, and so there's some barriers there. But then you add in the Latino community. And certainly if you're gay or lesbian, bisexual, that that taboo really increases because there is such a stigma in that community. And you can see – unfortunately, you know, I see exactly how this case happened, but it's still mindboggling that it can happen.

So it brings up the concept of maybe exploring a little bit further why Latinos are more likely to develop HIV and AIDS. Is this tied to mistrust of the healthcare system, and what are some of the other factors at play here?

Dr. Galvis:
I think the biggest player, Chuck, to talk about is why is there mistrust in the healthcare system?

So if we look at some of more recent literature on Latinos and healthcare outcomes, what we understand is that consistent theme is that healthcare mistrust is really related to perceived racial discrimination. And racial discrimination being both because of linguistic issues and also because you are a vulnerable, new immigrant population. The closer you are to first-generation Latino or you yourself are just a migrant to a region, you are less likely to seek out health and primary care physicians or when you're sick even go to the ER because of this mistrust. You've already been discriminated in the workforce, you're not well understood, and therefore you think that that's going to be the same type of interaction when you go speak with a doctor.

Dr. Vega:
And so it starts with there's a million reasons they think we see this mistrust, but you're right. Systemic racism is built into our healthcare system as it is into our society as a whole, and particularly when English is not your first language, maybe you have limited educational proficiency, you're coming from poverty, you may or may not have adequate health insurance. These are all barriers that I see in my patients, every single day. And there is a clear through-line to those higher rates of chronic illnesses, acute illnesses, early mortality that's unnecessary, and a lot of suffering.

And so let's turn that around a little bit and think about, okay, so if we have this systemic racism and we have this mistrust, what can we do as clinicians to ameliorate that? How do we make things better?

Dr. Galvis:
Well, there's very simple things we can do, Chuck. For example, we can change our own environment to be a welcoming environment to this patient population. So that can start from the get-go, or our first interactions having, for example, staff that looks like the community, have people that speak the language within the healthcare workforce. Because the more you look like the community you're serving, the more you feel safer to be able to have open conversations and ability to really break down what is going on in that patient. We can talk about, think about this migrant populations, think about the poverty label, and how our EMRs are not well spoken for this population. We talk about, oh, well, we communicate to our patients via email reminders. Well, that's not going to help if you are Latino, if you're immigrant, and you don't have internet access at home. So a phone call might be a way, with a Latino-speaking staff member calling them.

And also, the other big thing is, time is very important to these patients. How do we maximize that time and not just try to rush through a checklist to get done through that visit would be helpful, but having eye-to-eye contact, time to let the patient break down what's going on and let them focus on what's making them willing to come in to see you in the office. Those interactions help limit the perceived power struggle differences between the physician and the patient and rather make them both as equal partners for a better healthcare outcome.

Dr. Vega:
So what I heard was that you're used to using a lot of good patient care techniques: let the patient speak, use active listening, they're heard, address their chief complaint and their top concerns, and make it clear what your opinions and what your recommendations are and negotiate a plan of care.

For those of you who are just tuning in, you're listening to ReachMD. I'm Dr. Chuck Vega, and here with me today is Dr. Alvaro Galvis. He is delving deeper into overcoming practical barriers to care for diverse patient populations, particularly the Latino population.

Alvaro, can you provide some insight on practical barriers for patients who don't have documentation and how this is tied to training our students, our residents, and fellows?

Dr. Galvis:
So, Chuck, I was part of that PRIME-LC [Program in Medical Education for the Latino Community] program, and part of that training as a medical student, actually coming up through the ranks, I think one of the eye-opening aspects of this training was to be able to identify Latino communities as a specific group of people and specific need to treat and manage these patients, beyond just the square-box diagnosis that we may have for them. And what I always think about cultural responsiveness is the thought of not treating the disease but really treating the patient, and go beyond the patient and think about how we treat the community as a whole. And that holistic approach, I think, is what is going to take us into changing and hopefully overcoming the disparities of healthcare outcomes for the Latino community.

Dr. Vega:
A good percentage of my practice are undocumented individuals. And what I found is that, again, there's a huge need there, and you really have to create a sense of trust, because otherwise patients may not be coming back. We're a big clinic, we got the official University of California seal out front, and it looks pretty official. But we've also made a lot of steps inside to make it a much more welcoming environment and a place where patients can feel safe and feel not just that, you know, we're going to take care of their health needs, but we're actually their advocates as well. And so we've become actively involved in advocating for health, regardless of documentation status, at more of a higher level, at a policy level, but at the same time, it starts and it's inspired by those individual patients whom we see every day, who get, I think, a ton of great service for folks who are paying out of pocket. For all the things we can offer in our federally qualified health center, we could do some great things. The bad part is when they have to escalate to your levels, when they have a complicated infection, say, and need more specialized treatments and generally that means more expense and cost, and that could be a real challenge.

Dr. Galvis:
I agree with you, Chuck, but even at my level, I am reminded of why I got into serving underserved populations, really, because as a specialist, I have so much more ability to deal with these underlying conditions.

As an individual, what keeps me going every day is the ability to look at my patients and not just deal with their particular infectious disease question, but also I take it upon myself to really come up with that plan, because the poor parents are not able to have the medical ability and knowledge to understand everything that's happening. And I think that's part of the training, and I think that's part of what we have to do with this population: be an advocate for our patients and hopefully be able to change the system slowly by being that one advocate and example for all the other specialists.

Dr. Vega:
Yeah. So, Alvaro, we're almost out of time. Any take-home messages for our audience today?

Dr. Galvis:
I think the take-home message is that cultural responsiveness is not just understanding the one particular culture, the reason why they came in, but really trying to look at this individual as a compass of the community. What brought them in? What is the medical distrust? And take the time, be it either at that one particular instance, that interaction with the patient, or in the background, as we talked about, being able to advocate for them down the line by talking to their specialist and coordinating care.

Dr. Vega:
I think it's career-sustaining to have these kinds of challenges but also successes. I see a lot of successes, and I could understand that it's daunting in thinking about, gosh, this is going to take more time; I'm going to have to do more listening. But trust me, if you do it at the outset, and you develop that trust with your patient, everything else over time flows a lot easier, and you and your patient together will make better choices, which creates a great efficiency in care, especially when I'm managing chronic illnesses and doing preventive care, that really pays off in the end. So that trusting relationship, it takes a little time investment at the outset, as you mentioned, to get to know patients and know the community a little bit, but the dividends are huge for patient and for our healthcare professionals as well.

Unfortunately, that's all the time we have today. I want to thank our audience for listening in. I know that you're all very busy, so it means a lot that you took the time to listen to us today.

Dr. Galvis:
Thank you for having us.

Dr. Vega:
I always feel a lot more confident about the future, and very inspired when I get the chance to talk to you.

Announcer:
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