Religious Diversity in Health Care

Promoting Health Equity and Inclusion

Group on Diversity and Inclusion
November 2, 2012
San Francisco
Moderator:
Ann-Christine Nyquist, M.D., M.S.P.H.
Associate Dean for Diversity and Inclusion
University of Colorado School of Medicine

Speakers:
Mark E. Fowler
Managing Director of Programs
Tanenbaum Center for Interreligious Understanding

Joseph Betancourt, M.D., M.P.H.
Associate Professor of Medicine
Massachusetts General Hospital
Objectives

1. Understand why religio-cultural competency must be addressed in a health care setting as it relates to the quality and equality of patient care.

2. Demonstrate the intersection of religion and health care in areas such as conscience rules, modesty, end-of-life and reproductive health.

3. Identify key strategies for improving the education and training of health care professionals around religio-cultural competence.
Religious Diversity in Health Care

Mark E. Fowler
Managing Director of Programs
Tanenbaum Center for Interreligious Understanding
Objectives

• WHY does religio-cultural competence need to be addressed in a health care setting?
• WHEN do religion and health care intersect?
• HOW can we improve the education and training of health care professionals around religio-cultural competence?
I always treat people of other religious faiths with respect.

People of other religious faiths always treat me with respect.
AWARENESS:
Why is Religion Important?
Cultural Competence

- Sexual Orientation
- National Origin
- Language Access
- Ethnicity
- Race
- Gender
- Socio-Economic Status
- RELIGION
U.S. Immigration Trends

Health Care Workforce Trends

• **22%** of U.S. health care workers are foreign-born, compared to **13%** of the U.S. workforce overall:
  - Physicians: 28%
  - Registered Nurses: 15%

• **25%** of today’s foreign-born health care workers immigrated to the U.S. after the year 2000.

Religiosity in the U.S.

According to a 2010 Gallup Poll:

- **92%**: I believe in God.

- **80%**: Religion is very important/fairly important in my life.

- **65%**: Religion is an important part of daily life.

- **58%**: I believe that religion can answer all or most of today’s problems.

Gallup Poll 2010: http://www.gallup.com/poll/1690/religion.aspx#1
How Many Religions?

Atheism  Shinto  Agnostic  Russian Orthodox  Santeria
Wiccan  Buddhism  Shi’a Muslim  Southern Baptist  Unitarianism
Rastafarianism  Eastern Orthodox  Evangelical Christian  Protestant  Paganism
Jainism  Sikhism  Orthodox Judaism  Baha’i  Mormonism
Voudon  Lutheran  Pentecostal  Jehovah’s Witness  Methodist
Taoism  Alaska Native  Catholic  Orthodox Judaism  Seventh Day Adventist
Zoroastrianism  Confucianism  Candomble  Hasidic  Hasidic
Presbyterianism  Reform Judaism  Spiritual  Conservative Judaism  Spiritual
Mahayana  American Indian  Seventh Day Adventist  Spiritual  Spiritual
Religious Diversity in the U.S.

- Catholic: 24%
- Athiest, Agnostic, and Unaffiliated: 16%
- Evangelical Baptist: 11%
- Non-Christian Faiths: 6%

What do patients want?

- 41% of patients want to discuss religious concerns.
- Only half report having such a discussion.
- Only 8% have this discussion with a doctor.
- 41% of patients can think of a time when religious beliefs influence a health care decision they make.

What are doctors doing?

• **91%** of physicians agree that it is appropriate to discuss religious issues when the patient brings them up.

• **55%** feel it is appropriate to proactively address a patient’s religious concerns.

However…

• Only **10%** of physicians report doing so on a regular basis.

Accreditation Standards

Liaison Committee on Medical Education:

Educational Objective: ED-21

“The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.”

KNOWLEDGE:
When do Religion & Health Care Intersect?
Trigger Topics

Dietary Requirements

Traditional and Alternative remedies

Acceptance of Drugs & Procedures

Dress & Modesty

Organ Transplants and Donations

Blood and Blood Products

Hygiene

Reproductive Health

Conscience Rules

Informed Consent

Pregnancy & Birth

Prayer with Patients

Observance of Holy Days and Rituals

End-of-Life

Proselytizing
Trigger Topics:

• **Dress & Modesty:** A hospital in Maine discovers that Muslim women are not coming in for care due to the immodest gowns.

• **End-of-Life:** A young Jewish girl is declared brain dead but the parents refuse to withdraw care. They do not view brain stem death as death.

• **Dietary Requirements:** A son is horrified to discover that his mother, a Hindu and life-long vegetarian who suffers from dementia, was served (and ate) a non-vegetarian meal.

• **Reproductive Health:** A Catholic mother refuses to consider allowing her daughter to use birth-control pill as a treatment option for endometriosis.

• **Conscience Rules:** An Evangelical Christian physician refuses to provide fertility treatment for a lesbian couple.
CHALLENGES & OPPORTUNITIES:

Religio-Cultural Competence in Medical Education
Religious Diversity in Health Care

Joseph Betancourt, M.D., M.P.H.
Associate Professor of Medicine
Massachusetts General Hospital
What do medical trainees tell us?
Residents Preparedness to Care for Diverse Populations
JAMA 2005

• Residents located in programs affiliated with 160 academic health center hospitals

• Final year of training

• N=2047 (RR=60%)

• Seven Specialties
  1) Emergency Med (EM)    2) Family Med (FM)
  3) Internal Med (IM)     4) OB/GYN
  5) Pediatrics (Ped)     6) Psychiatry (PSY)
  7) General Surgery (Surg)
97% of residents feel that it is “moderately” or “very important” for physicians in their specialty “to consider the patient’s culture when providing care”.
... and, Residents Perceive Consequences for the Health Care System & Patients

<table>
<thead>
<tr>
<th>% of Residents Who Said Cross-Cultural Patient Issues Resulted “Often” in the following consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longer than average visits</td>
</tr>
<tr>
<td>Non-compliance w/ treatment</td>
</tr>
<tr>
<td>Delays obtaining consent</td>
</tr>
<tr>
<td>Unnecessary visits</td>
</tr>
<tr>
<td>Unnecessary tests</td>
</tr>
<tr>
<td>Unnecessary hospitalization</td>
</tr>
</tbody>
</table>
# Many Residents Feel Unprepared to Deliver Specific Components of Cross-Cultural Care

"How prepared do you feel to care for [following types of] patients (or pediatric patients’ families)…?"

<table>
<thead>
<tr>
<th></th>
<th>% Very or Somewhat Unprepared</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td>Culture different from own</td>
<td>8%</td>
</tr>
<tr>
<td>Racial/ethnic minority</td>
<td>4.6%</td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td></td>
</tr>
<tr>
<td>Health beliefs at odds w/ Western medicine</td>
<td>25%</td>
</tr>
<tr>
<td>With distrust of U.S. health system</td>
<td>28%</td>
</tr>
<tr>
<td>Limited English proficiency</td>
<td>21%</td>
</tr>
<tr>
<td>New immigrants</td>
<td>25%</td>
</tr>
<tr>
<td>Whose religious beliefs affect treatment</td>
<td>19%</td>
</tr>
<tr>
<td>Who use alternative/complementary medicine</td>
<td>26%</td>
</tr>
</tbody>
</table>
## Training Matters: Residents with Little Instruction During Residency Much More Likely to Perceive Low Skill Levels

### % of Residents with Low Perceived Skill Levels (1,2) by amount of instruction

<table>
<thead>
<tr>
<th>Skill Level Activity</th>
<th>None/ Vy Little Instruct’n</th>
<th>Lot of Instruct’n</th>
</tr>
</thead>
<tbody>
<tr>
<td>How patients want to be addressed</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td>Assess understanding of illness</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>Identify relevant religious beliefs</td>
<td>40%</td>
<td>2%</td>
</tr>
<tr>
<td>Identify relevant cultural customs</td>
<td>38%</td>
<td>5%</td>
</tr>
<tr>
<td>Work with interpreter</td>
<td>18%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

1. 2012 AAMC Annual Meeting
Problems when Delivering Cross-Cultural Care

Percent Saying Each Was a Problem When Delivering Cross-Cultural Care

- Lack Experience: 19 (2), 14 (2)
- Lack Time: 42 (14), 5 (5)
- Inadequate Training: 26 (7), 13 (4)
- Lack Role Models: 24 (7)
- Dismissive Attitudes of Attendings: 13 (4)

Legend:
- Mod. problem
- Big problem

2012 AAMC Annual Meeting
So what does this all mean?

Trainees want to do the right thing, and understand that if they don’t it impacts quality, but…

- They don’t want to be lectured with the assumption they are broken and need to be fixed
- They often view cultural competence as:
  - Something that just increases visit time, not a skill set
  - Soft-science without an evidence-based
- Sometimes they want “just the facts” about cultures
- Training matters
Success is all in the pitch...

Cultural competence needs to be framed as…

• A skill set, like a review of systems, or checklist, that can help you with challenging cases

• Practical, actionable, and time-efficient

It needs to be taught…

• In a case-based fashion, creating clinical challenges

• With a link to EBG and Peer-Reviewed Literature

• And leave you with a set of tools and skills
Model for Cross-Cultural Care: A Patient-Based Approach

Awareness of Cultural and Social Factors → Elicit Factors → Negotiate Models → Implement Management Strategies

Avoid stereotypes and build trust

Tools and skills necessary to provide quality care to any patient we see, regardless of race, ethnicity, culture, class or language proficiency.
Case Example and Key Lessons

- Quality Interactions Cross-Cultural Training mandatory for 3rd yr at HMS
- Case-based, interactive, uses adult-learning theory and creates teachable moments; links to evidence-based guidelines and the peer-reviewed literature
- More than 88% said program increased awareness of issues, would improve care they provide to patients, and would recommend to colleagues; average pretest score 51%, posttest score 83%

1. Available at: http://www.qualityinteractions.org/prod_overview/clinical_program_features.html.
MOVING FORWARD:
Recommendations for Better Practices
Challenges to Cross-Cultural Education: An Uphill Battle Learners, Teachers and Integration

Learner

• “Soft”, marginalized issues requiring buy-in
• Desire for categorical approach
• Time constraints

*Resistance varies across the continuum

Teacher

• Varying fundamental approaches and teaching methodologies
• Limited time, funding, institutional support
Strategies for Integration: Five Lessons from the Field

1. “Buy-In” is critical
   - Link to quality; curriculum will *assist you*

2. Focus on cases
   - Straight didactics quickly forgotten

3. Address demand for “categorical approach”
   - Emphasize pitfalls; development of framework similar to those used in the clinical encounter
Strategies for Integration: Five Lessons from the Field

4. Think longitudinally
   • Development of attitudes, knowledge and skills over time, respecting stage of development

5. Integrate when possible
   • Identify natural synergies and allies; consider competing interests
Institutionalization

Secure buy-in
Assess needs
Develop curricular tools
Implement/Integrate
Evaluate efficacy
Adjust & Improve
Reinforce/Institutionalize
Key Players

Medical School
- Dean, Diversity & Inclusion
- Course Directors
- Dean, Medical Education
- Dean, Medical School

Hospital System
- Clinical Staff
- Director of Patient Experience
- Director of Pastoral Care
- Director of Cultural Competence/Diversity
- Hospital CEO
Save the Dates!

GDI Professional Development Conference
May 16-19, 2013
Fairmont Royal York Hotel
Toronto, Canada

GSA/GDI/OSR National Meeting
April 26-29, 2014
Hilton Bayfront Hotel
San Diego, California