Central Line
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Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER:

Welcome to Center Line and to the New Year. I'm Dr. Adam Striker, your editor and host. And welcoming back to the show today a good friend, Dr. Lalitha Sundararaman. And we're going to discuss diversity and inclusivity today. We've tackle these topics here before in the past, but not quite like this. As the guest editor of the February Monitor, which comes at the topic of diversity from a variety of angles, Dr. Sundararaman has some fresh ideas and perspectives to share. So welcome back to the show.

DR. LALITHA SUNDARARAMAN:

Thank you, Adam. I am very excited and happy to be here.

DR. STRIKER:

Well, let's start this off with a Dr. Martin Luther King Jr. quote, which you share in your editorial. "We may have all come on different ships, but we are in the same boat now." What does that quote obviously uttered? Many years ago mean to you today?

DR. SUNDARARAMAN:

Well, Adam, I think Dr. Martin Luther King Jr. could not have been more of a seer in that statement because diversity is even more important today than ever. We aim to live in a society with pluralistic conditions, but the truth is that we live in a polarized world. And it's really important that we realize that diversity is our strength. Diversity is what makes America strong. And we should recognize that and encourage that. As health care persona, we have a special ability to do so and a special duty to do so. And that's what I hope to discuss today.

DR. STRIKER:

Well, I want to talk about some of the many ways health care inequities are are being addressed. But let's focus first how they impact patients. We've certainly talked about this on the show before, but let's start off just kind of giving a little brief overview to our listeners about an example of what health care disparities look like, how do they harm patients, etc..

DR. SUNDARARAMAN:

Health care disparities should not exist right? In a top tier health care system like the United States has. But the unfortunate truth is that it does exist. 70% of our health care facilities are actually in urban areas, so hence, rural areas already suffer a setback and many patients in rural areas don't have access to cutting edge health care services that the rest of the population does. That being said, race and ethnicity also play a very important prominent role in health care disparities.

The factors playing a role in bringing about the inequities in health care are actually very, very complex. Of course, our socioeconomic characteristics play a very crucial role. Many of these populations grew up in underprivileged areas with less governmental and structural support to their health care, whereas they also grew up in sometimes racially stigmatized societies. And many of them drop out to earn livings when they are actually much younger and have less access to economic growth and higher technologies and health care.

But that being said, a lot of health care disparities are also contributed to by patients' cultural perceptions and providers' cultural perceptions. Let me explain. For example, pain is a common symptom, which is one of the most common symptoms which is treated all across the health care system. Hispanics report acute pain with high expressivity, but they actually underreport chronic pain. Hispanic patients in America recognize that chronic pain, according to an article in the Journal of Pain in 2016, is prevalent as a common feature amongst their communities, and hence they accept it and they underreported it.

Views on utilization of opioids also differ amongst different cultures. Many patients from Muslim cultures, there's an underlying fear that opioids will interfere with their sense of self, and hence they gravitate away from opioids. And sometimes the sphere extends to non-opioid pain medications as well. Many of them also have a fear that it may not be compatible with their religious beliefs and hence avoid opioids and undertreat their pain.

Cultural and ethnic differences in also affect from the provider aspect how pain is treated or assessed. A 2007 study found that physicians are twice as likely to underestimate pain in African American patients compared to other ethnicities. And a more recent 2019 study found that pain was less readily recognized on the faces of African American patients compared to Caucasian patients. Racial biases can directly affect treatment recommendations. For example, there was a greater predilection to recognize drug seeking behavior in certain ethnicities as compared to others. All this actually affects the health care treatment and induces disparities in it in many levels.

Understanding our own implicit bias and helping to destroy that, or at least overcome by understanding it, and hence ensuring a greater level of equity in health care and treatment is really crucial for us.

DR. STRIKER:

Well, we'll touch a little bit on possible ways to address these disparities. It's such a large topic and it's impossible to cover this all in a short period of time because it's such an important issue. But before we just touch on some of the solutions or some of the possible interventions to help, let's talk about another aspect of this disparity, which is language discordance. Language discordance can pose a threat to safe, high quality care. So many languages are spoken in the United States, and it certainly can be challenging for good patient, physician communication across the continuum of care and potentially even dangerous at times. So do you mind talking a little bit about this disparity and how this is harming patients?

DR. SUNDARARAMAN:

Yes, Adam. Thank you. This is actually a topic close to my heart because we are a land of immigrants and communication is crucial in every stage of health care and its administration. We need every patient to be heard and to be feeling that they're actually being listened to. And we can't do that without understanding and attempting to understand exactly what they're trying to communicate.

It has been found out that many immigrant populations in the country have a hesitancy to actually contact health care services when they have an emergency or an urgent situation because they feel that they may not be properly understood. This is something which we have to overcome. One of the times, actually, my mom was admitted here and at that time I was at work and she was trying to communicate to the physician that she had a cough which was not preexisting, but she couldn't communicate that in English really well. And she kept trying to say that cough now, cough now. And and, you know, the doctor kept saying, yeah, I understand that you have, but I believe you've had it

before. And, you know, there's some gaps in communication which can definitely be reduced with adequate technology and also to make sure we can make sure that we have use all the solutions which we have at hand to overcome this particular problem.

Technological solutions are actually present at every point along the perioperative continuum, but there are certain lapses. For example, one of the most important things is that we do have interpretive facilities available at the preoperative area in the recovery area, but many times they are noticeably absent at the time of induction inside the operating room when the patient has some questions to say or in the last minute they want some something to ask, something to allay the anxiety. They want to ask you a question. Many times we don't understand because at that point there is a lack of interpreter facilities available or the ability to understand what they're asking. So hence making sure that the language barrier is overcome right from the time before they enter the hospital to the time they get discharged and they follow up for good post-operative care. It is our responsibility to ensure that this continuum is well maintained using whatever technology or whatever human resources we may have had.

DR. STRIKER:

You know, I want to press on and talk about other aspects that we're planning on discussing tonight. But just to touch on a couple of things you brought up, because this is so, so much a part of our daily practice. Two questions I want to follow up on. Number one, the language discordance. Do you think that it is amplified within the anesthesia practice because we have such a short time with our patients, or is it actually easier because we only have a limited number of items to discuss as opposed to, let's say, a primary care visit.

DR. SUNDARARAMAN:

Is a very good question. You know, it's actually a bit of both. Definitely. We have a less diverse number of questions to ask the patient. We actually have a crucial number of questions to ask, but we are not contending with the fact that the patient is extremely anxious is has these certain questions which he wants to be answered, in which he wants to communicate. And he's probably like not really remembering everything else or has a time to remember all the relevant and pertinent history at that point. And we are bombarding him with questions which are relevant to us, but may seem overwhelming to him at that point. So it is difficult even in the anesthesia setting. And, you know, this is really important and crucial that we overcome this barrier with all the technological and human resources available.

DR. STRIKER:

The other question I wanted to ask is about the technological solutions. I assume that means having had devices, telephones, the communication availability, that we can reach interpreters for a variety of languages a lot quicker and a lot more conveniently. Assuming that's what we're talking about, do you think that it is creating another layer of impersonal ability or another barrier in communication, even though it's even though it's there, but not having a live person there to help to sort of contextualize what we're talking about? Does that make it more difficult to communicate with our patients? And I'm not arguing that maybe the overall benefits are greater because of the access to the communication, but I'm just wondering what you think about that.

DR. SUNDARARAMAN:

I agree, Adam. Nothing beats a person actually speaking your language, your lingo, right in front of you, and reassuring you and talking to you in the way that you understand. But that being said, it's not always possible in every setting. So I think sometimes when we have our iPad like devices or maybe even our Google Translate or even a real time pixel earbuds, which can do that on a real time basis, all of these do actually try to bring about a little bit of the patient's ethnicity also into play when they're translating. So you can choose different types of dialects as well. And while I agree, we may not get an adequate, full, accurate translation, but sometimes it does help to allay patient anxieties when human resources are not available.

DR. STRIKER:

Well, let's talk about gender disparities as well. It's another set of challenges. Norms around gender are certainly changing. They're evolving quickly. And in 2021, for example, the designation of non-binary was recognized by the government and added to passports. Are we as health care providers keeping up? I imagine this is probably a question at large for the populace, as you know, there's a wide variety of age groups that are used to different norms and whatnot. But as health care providers, what do we need to know? So we're prepared to provide safe and sensitive care to the transgender community.

DR. SUNDARARAMAN:

This is a great question. I think it's a super pertinent question, which is of increasing importance now. In 2016, a national survey of the transgender community estimated that there are 1.4 million adults in the United States who identify as transgender, representing 100% growth from 15 years ago. I think it's because more people are now comfortable identifying themselves as transgender. And that being said, it's now really

important that we start to recognize this more because many health care problems are unique to this subset.

According to the Trevor survey of transgender patients and especially teenagers, it is found that almost up to 70% of teenagers exhibit some form of anxiety or depression in their behavior -- transgender teenagers. And also, increasingly, it has been found out that many patients are seeking help for their procedures and for their ailments as compared to before, which is a really good thing. And this is what should be encouraged by the health care community, by overcoming whatever implicit bias that we might have, and being, accepting cultural humility, accepting also what they might need and putting it before our needs, and also understanding what they want and treating them with respect and humility.

And then according to the Trevor Project, also, as I said, more than 70% of patients experience anxiety and other mental issues. But what is also more important, and this is kind of serious, is that according to a 2016 transgender survey, 33% of individuals reported at least one negative experience with a health care worker. Either via verbal harassment or even refusal of treatment. And this is where we can easily change ourselves. Healthcare providers must recognize that this represents a significant disparity problem, confront whatever personal biases they might have, and use their position and privilege to make necessary changes to serve this community. That is crucial. And now it has also been found out in the American Journal of Psychiatry that gender affirming surgeries, when patients undergo them, after that, they're much less likely to have mental health issues. And more and more states are also now accepting insurance for gender reaffirming surgeries. And hence, it's even more important that we know how to treat these patients and how to make sure that all their concerns are addressed in the health care setting.

DR. STRIKER:

I do want to ask you about the background of care providers. How does that matter? What is the connection between the makeup of providers and the care patients receive? And that's a big topic. Before we do that, why don't we go ahead and take a short patient safety break? So please stay with us. We'll be right back.

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DR. KEITH RUSKIN:

Hi this is Dr. Keith Ruskin with the ASA Patient Safety Editorial Board.

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VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafety22.

DR. STRIKER:

Okay we're back with Dr. Sundararaman. I just want to ask you about the background of care providers, because I think that's that's a big topic. The background of every physician, for instance, is going to make a big difference in how we perceive treatment and how we perceive our patients and whatnot. What is the connection between the provider makeup and the care the patients receive?

DR. SUNDARARAMAN:

Well, thank you for the question, Adam. It has been well established that many patients often seek out providers, especially primary care providers, with whom they identify on a personal basis. And this is really important because that's like the primary link when a provider sets up a relationship with a patient. That's also important because there's something called race conscious professionalism, which Dr. McDade, who is the head of DEI at ACGME, very well points out in his article. What is race conscious professions? It seems like a paradox, doesn't it? But it's actually somebody who comes from minoritized background tries to give back to this minoritzed background when he graduates from medical school and accepts responsibilities as a physician. This is because he has a sense of duty, belongingness and inclusion to that particular community and tries to better that community. So hence it has been found out, when they did the American Medical Colleges Matriculating Student questionnaire that nearly

65% of black, 57% of indigenous and 50% of Latinx students report that they want to serve their underserved individual communities as part of the future practices. And this is great because it helps the patient identify better with the provider. And the provider also has a special sense of belongingness to improve that community. And he also knows what the cultural expectancies and what the practices are in that community that's serving that community better. So it's really important, that physician workforce diversity is of utmost importance.

DR. STRIKER:

Can you explain to our listeners what cultural humility is and what role it plays and how important it is for us to be intentional about it?

DR. SUNDARARAMAN:

Yes. Cultural immunity is a practice of subjugating one's own cultural norms, one's beliefs and practices, in favor of careful listening and respect for those of the patient one is serving. It means not imposing one's own values onto the patient or expecting assimilation of compliance with cultural practices that are known to him, the provider, but instead listening and accepting what the patient feels and wants. It means not devaluing their beliefs because they are of a different community or culture. And that's really important. Be it for the transgender community, be it for somebody of a different religion, be it of somebody from a different community. If a health care provider wants to establish that he is giving a standard, equitable treatment for a patient, then it has to be with cultural humility.

DR. STRIKER:

Let's talk about women in the anesthesia workforce. Women represent 33% of the anesthesia workforce currently. But I certainly understand implicit bias is still a problem for women in the workplace. Do you mind talking a little bit about that or what does it look like? How can we improve it?

DR. SUNDARARAMAN:

Yes. You know, like how many times I walk into the perioperative setting, I can be assured that at least maybe about 20 to 30% of the times people will assume that I'm a nurse or I'm a PA or any other health care provider other than a doctor. It may be the fact that I'm a woman, and it also may be the color of my skin, but every time I do sometimes meet also, sometimes with the look of surprise from a patient when I introduce myself as their physician anesthesiologist. But this is not an experience which

is unique to me. It in fact it's happened to many female colleagues of mine. And this is an implicit bias that we face every day from a patients. And unfortunately, this is also something which we face in a different way from our colleagues. It has been known that promotions are much less common amongst women, and many women are overlooked for promotions in the health care field and in other fields. In fact, this disparity is even deeper for women of color, and it has been found that out of the 9,553 faculty anesthesiologists in academic centers all across the country, only 37 are African American women above the rank or at the rank of associate professor, which is kind of definitely depressing. And we should make more efforts to reduce this disparity and make sure that women and people of different minorities are all accepted and given equal opportunities for promotion and betterment.

DR. STRIKER:

What can be done at an organizational level?

DR. SUNDARARAMAN:

Dr. Villani and others actually pointed out really well that at the organization level, this actually comes at multiple stages, an effort to correct the disparity and how can it be done at the recruitment level. We should also bring about, in mind diversity and inclusivity, even when we are selecting applicants and then create a better work environment for them so that they tend to stay. Because many times we find that there are good efforts at diversity and inclusivity in the application process, but not so much in creating a work environment wherein they are accepted, they feel a sense of belonging, and they tend to stay. So hence, retention is also a problem in many of these places, and many times in order to like create a better inclusive program, people have different buddy systems. For example, the University of Minnesota also has a buddy system where and they can call upon somebody else for other for any mental health issues, for support issues and so on. And this is just one system. Many systems can be adapted according to the workplace, according to the region, and I think this will definitely help in creating a better retention. And then promotions, also, we should consider diversity when we are considering people for promotions because that actually inspires more people of racial and ethnic minorities to aim for better and to achieve their dreams.

DR. STRIKER:

Well, earlier I mentioned we would touch on solutions and we've covered a number of aspects of this very broad topic, you know, to the lay people out there that are listening to this and and are genuinely trying to maybe look at their own practices and biases and

look at opportunities to to improve or optimize their patient interactions, what are some simple suggestions, if you have any, that they could tackle right off the bat?

DR. SUNDARARAMAN:

That's a great question. I think one of the easiest solutions is to listen, right? Introduce yourself and then try to listen and look at the patient, see how the patient is feeling. Are they anxious? A smile always helps, and then it kind of puts people at ease in the beginning after introducing yourself and then let the patient initiate the conversation, see how they feel, and then bring in your opinions and everything and always keep a measure of cultural humility. Understand that your personal beliefs and practices might be different. Ask the patient what they need and assess what they need. And then always make at least an attempt to know the right pronouns, how they like to be addressed, how they like to be treated. And make sure that communication barriers are sorted out at every step along the perioperative continuum. Make sure that you allay their anxieties and that you listen to them at every step. And I think this will definitely help to bring about a better and safer healthcare environment.

DR. STRIKER:

Well, one final question before I let you go. The February Monitor comes at this topic from a number of angles. We've touched on some, but certainly not all here in our conversation tonight. What do you hope listeners and readers will do with this information? And also what is different about this article and this approach than than when we previously tackled this topic?

DR. SUNDARARAMAN:

I think this is different because we've actually tried to tackle diversity and inclusivity and equity from a diverse number of angles, and through a diverse number of media. We actually have online exclusive articles, we have this podcast, we have articles in print. You can choose whatever media outlet you prefer. The only thing we ask is that you choose it. Go ahead. Have a listen. These are easy enough topics to assimilate. They're not like super anaesthesia heavy topics, but they can make a change in your practice and they can make a change in the way you deal with the patient and probably how much satisfied the patient is at the end of the day. And that's all we ask, because even if it be a small change in the way you practice, it can be a big change in the patient's life and his experiences. And that's always important.

DR. STRIKER:

Well, powerful words, simple suggestion. Let's end it there, because I think that's that's great advice. I just want to thank you so much for your time today and sharing your experiences and your insights. I certainly look forward to the February Monitor and to continue reading about this very important topic. And as you stated, hopefully we can provide enough resources for our membership to pick and choose what they think is most helpful to them and hopefully help optimize their own communications interactions with patients. So thank you so much for joining us today.

DR. SUNDARARAMAN:

Thank you. Thank you for having me. Appreciate it.

DR. STRIKER:

Absolutely. And thank you to our our listeners for listening to this episode of Central Line. Tell a colleague or a friend about this podcast series, if you find it interesting or if you find it useful, or please share that information, please leave us a review on your favorite podcast platform and don't forget to tune in next time. Take care.

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