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

DR. ADAM STRIKER (HOST):
Welcome to another episode of Central Line. I'm Dr. Adam Striker, your host and editor. Today, we welcome Dr. Gunisha Kaur to the show. Dr. Kaur is Assistant Professor of Anesthesiology and Co-Medical Director at Weill Cornell Center for Human Rights.

She's going to talk with us about global health and human rights. Her article, Serving the Health Care Needs of Vulnerable Populations, is appearing in the February issue of The Monitor. Welcome to the show, Dr. Kaur.

DR. GUNISHA KAUR:
Thanks so much for having me.

DR. STRIKER:
Why don't we start off, if you don't mind telling us a little bit about yourself and the journey that landed you in your current role?

DR. KAUR:
Sure. So I'm an anesthesiologist and a human rights researcher, which is an atypical combination. My family came to this country not through a refugee program, but as refugees. And I had decided that I wanted to dedicate my life to the service of that population. So through med school and residency training, I focused on the health care needs of refugees and asylum seekers. And now I spend a majority of my time, about 80 percent of my time, doing human rights research. My particular area of focus is chronic pain in refugee torture survivors.
DR. STRIKER:

Before we start to get into the broader conversation, I want to make sure our listeners understand the difference between global health and international health. Do you mind explaining to our listeners the difference and maybe also explain why that's important?

DR. KAUR:

Sure. So the concept of global health has really come about in the past few years as we recognize that health is not restricted by boundaries and borders, that diseases, people, plants, animals, travel cross boundaries and carry with them those diseases as well. And so international health is really focused on health care of populations abroad in other countries, not in our own country. Global health is more the concept of health care for all, that, the health of an individual in West Africa is related to my own health. It's related to the health of my patients. And in that way, global health is really about the community of patients, the global community of patients, not just serving people abroad. It's a, it's a unique concept, I think, a really powerful concept. And it brings the focus together for people in all different fields about how to bring justice into human rights, work and health care.

DR. STRIKER:

Let's start before the pandemic. In your experience, do health care workers and providers, have they had a solid understanding of that? And if so, did they have a, shall we say, an awareness that may not have been as, as it currently is?

DR. KAUR:

Certainly, I think pandemics, natural disasters, these sorts of things, really indicate and highlight our shared humanity. It's so much easier to think of cancer or a non-communicable disease as a problem of another country. But what we've seen through the Ebola pandemic in West Africa, through the Zika virus outbreak, through COVID is that the health of the global community of patients really relates to our individual health, that trans national boundaries are crossed by people, by diseases, every single day. And you can't confine individuals or diseases by borders and, and walls and boundaries. And so I think definitely COVID has brought into our consciousness more how the health of people that we don't see, that maybe it's hard to relate to because they're in another country, practice a different faith, or have a different culture, how their health might relate to ours.

DR. STRIKER:
Well, let's talk a little bit about the experience during the pandemic, then. Can you give us a little bit of insight into what we might take for granted in this country or in a first world nation as opposed to perhaps other nations?

DR. KAUR:

So pandemics, I think natural disasters, reveal fault lines in social, economic, health infrastructure. And we're definitely seeing that in this pandemic. I know all of us have found it really hard to isolate and wear masks and the hand washing that we've had to do. But seeing how that is really a privilege, we have the privilege to do that. In many of the areas where we work in refugee camps, where there's open air tents, people are living on the ground or sleeping on rocks. You know, there's not a possibility of social distancing. Wearing a mask is, is just not, they, they don't have access to masks, hand washing for people who may have access to clean water once a week or once every two weeks. It's just not practical.

And so we're really seeing the differences in how communities have access to things that allow for better health. I mean, I know we've, we've seen this in vulnerable populations in the US, in minority populations, we've seen COVID reveal how striking health care disparities can be. So we know that in Black and Latin-X communities, COVID spread has been worse, morbidity and mortality has been worse. But I think we don't even have the numbers to capture that in the most vulnerable communities. In our most vulnerable populations and patients, there is not good evidence or tracking of COVID transmission or long-term effects in refugee populations. And what we know is that the trauma, and stress, and strain of migration in these populations transmits through generation. We've demonstrated that, that, that there are multigenerational impacts of the physical and psychological trauma that displaced populations experience. So when you overlay a disaster like COVID or a natural disaster on top of that, it really destroys whatever stability these communities have. So, however challenging COVID has been for all of us, the experiences that we've had, it is substantially amplified in these vulnerable populations.

DR. STRIKER:

A bit of an aside, do you think that if more of the population of, let's just say this country, was aware of the disparities in global health in, in different nations, would they appreciate the efficacy, more of the simple measures we've been told to, to implement here over almost the past year now, social distancing, hand washing, mask wearing. It's not, not very exciting because it's not a vaccine, it's not a chemical that can prevent you from getting sick. They’re, they’re simple measures, and so we often get the impression that a lot of people just don't think it's that big of a deal to do. But do you think if people
had that insight all of a sudden those measures would become more interesting, more exciting to be able to implement?

DR. KAUR:

Absolutely. I don't have data to show that, but I absolutely think you're right there, that anything that builds understanding and empathy towards other communities and an understanding of what we have, I think can only better our own practices, our own communities. I've seen it with a training program that we run at Cornell, where we really educate and train our residents who are on a global health track about what it means to be vulnerable, what it means to be part of a vulnerable population, what it means to have no access to resources.

And you can see over the course of our six week curriculum, people shifting and really getting it and understanding. And their practices, changing practices that you might never anticipate would be related to understanding foreign born patients. For example, people become more conscious about their use of supplies in the OR. I mean, it's an amazing thing to see and it's been really exciting for us what sort of the, the secondary effects are of understanding other populations.

You know, one of the things that we teach in our global health curriculum is that a substantial part of the world's population, you know, a billion people lives on less than two dollars a day, lives in poverty. And to have our residents think about what they spend two dollars a day on, it's just this moment of understanding of themselves in a broader culture, a broader society, a global humanity, that is priceless. And what they gain out of that is, is, I think, immeasurable.

DR. STRIKER:

Well, let's talk a little bit about culture. We know culture plays an important role in establishing trust in a doctor patient relationship, something that we've talked about on a recent podcast episodes. I'd like to get your thoughts on this specifically if you think culture has been an afterthought in medicine and if it has, is that changing?

DR. KAUR:

I think we've, in medicine, we've done a really great job of understanding disease on a very basic science level. You know, we can, we can talk to each other about risk factors for COVID-19 transmission, about how it plays out in the lungs and the heart, what the impact is years down the line. We can talk about subsequent cardiac disease and, and who's at risk and why patients who present with later disease do worse. I mean, we can talk about that from a medical perspective, but I think what we've done
not a good enough job at, what we really need to be thinking about in terms of advancing health care, advancing science and caring for our patients is thinking about what are the factors that influence health beyond the medicine. What are, what we call the biosocial factors? How do socioeconomics play into it? How does an individual's cultural or religious background or language barriers, how do those things play into health? I think there's a lot of work to be done there. I think what our community is starting to think about these things and focus on them and understand that those factors can play as big of a role as the medicine itself. But I think we're a far way from actually understanding how to incorporate that into our practice.

DR. STRIKER:

Do you have any specific examples that you can share on difference in culture from your experience?

DR. KAUR:

Sure, I mean, so, it's not specific to COVID, but in our patient populations abroad, there's very different relationships between doctors and patients than we have in the US. In the US, there is a lot of patient autonomy. There's an understanding that a health care provider will discuss options with a patient of how to treat their medical condition. There's HIPAA, there's consent forms. Those things are not the same in the developing world, in other countries where we work, in other developed countries where we work.

For example, in some of our sites abroad, of course there's no HIPAA, but also patients' health information their age, their diagnosis complications is posted on a dry erase board above their head in a unit that is completely open. So there's not this idea of, and nobody feels disenfranchised by that, nobody feels awful about that, that it's just a difference in culture. We'll see, for example, patients where there are five, ten, twenty family members around a bedside providing home cooked food and therapy in terms of really rich conversations, and love, and connections. Meanwhile, in the US, our system is much more about restricting number of visitors and having visiting hours. Those things are really different.

So when patients who are foreign born come to the US, their experiences of course, are shaped by their histories, their cultures, their languages, their religions, all of those biosocial aspects. So we can't ask a patient where it's not in their culture for there to be consent in the same way. We can't ask that, that person to take as active as a role as a US born patient who understands our consent processes or the role of patient autonomy.

We're actually doing a big disservice to those patients who are foreign born by imposing our standards and our structure, rather than recognizing theirs and incorporating it into
our system of practice. I think that's where we really need to get better. If we could do a better job of understanding our patients, connecting with them, empathizing with them, I believe that the overall health care for that individual and for the community around them would be better and would be stronger. It's really hard to do. I mean, I experienced as much as anyone else the rush of getting cases started and the frustration of having to get a translator on the phone. I mean, I empathize with all of that, but I think we've become, we've maybe neglected the importance of those factors on how much they influence health itself.

DR. STRIKER:

And do you think that it is doable despite the difficulties within constraints of health care organizations, or regulations?

DR. KAUR:

I definitely think it's doable. We may need to innovate and recreate our structures. Maybe we have providers who are really focusing on just that aspect. I think in our current structure, it's, it is quite challenging to incorporate, you know, all of these additional factors in. But there's ways we can do it. You know, maybe we reduce the digital load of all of the applications we need to log into and paper forms we need to sign and all of those things, and that gives us more time to talk to our patients.

How to fix this is not my specialty, thankfully and unfortunately. But, but there, there, have to be systems that we can create that, that make it possible to do this. I mean, we've really transformed, I think, from a place where the physician's role was to connect to a patient and provide overall improvement in health, to a hyper-specialized, let's get done the checkboxes of exactly what we need, to do in order to say that we've, we've met our end points and our criteria. And I think that's a disservice to our patients.

DR. STRIKER:

Are there things within curriculum that can be implemented to help providers build trust with communities that are outside of their own culture?

DR. KAUR:

I believe so. We've, we've done this at Cornell, where we've looked at the effectiveness of, of global health and human rights curriculum on our residents’ ability to care for foreign-born patients. And when I say foreign-born patients, I mean patients who are abroad, of course, but also patients who are presenting to our medical centers in the US...
who are not born in the US. Can we create more empathy and more connection and more understanding in our providers? And I think we can.

In our curriculum at Cornell, what we do is teach way beyond medicine. So we teach things like environmental influences on health, human rights and human rights violations, how that might play into health. Displacement, refugee patients and populations, language barriers, maternal fetal health in developing countries, I mean, we look at really a holistic understanding of what patients might experience, what services might look like, what access might look like outside of the US. And I think understanding those things and there's so many, sort of, examples that you can get into there of how healthcare might be different abroad and how that, that understanding can help you serve your foreign born patients in the US.

DR. STRIKER:

What were the results like?

DR. KAUR:

It was amazing, I mean, when we did this in our residents, and we looked at case based simulations, we found that people were indeed more competent at caring for foreign-born patients. It was a study that was funded through FAER, through the Foundation for Anesthesia, Education and Research. And I didn't know that we would find what we found. I mean, really, I was very pleasantly surprised to find that we could actually teach this as sort of a core competency of their residency curriculum.

DR. STRIKER:

Do you think that engaging in this curriculum can actually improve the general doctor patient relationship with, within their own culture?

DR. KAUR:

Yes. So I think anything that helps you connect to your patients will do that. So whether it's this curriculum, or reading a book about the community that you tend to serve, or listening to a podcast about how to make yourself a more conscious and aware provider, any of those things, I think, lead to better outcomes in these patients.

All of us have biosocial factors that influence our health, right? We have different education, training, different life experiences, family experiences. If we went to another country, we would want those to be considered in our healthcare and I think that's what
we're trying to figure out, how can we get our providers here to do that for foreign born patients?

DR. STRIKER:

Let's shift gears just a little bit and comment specifically on the role of anesthesiologists in global health. What is our role?

DR. KAUR:

Well, I can't say for the entire specialty what, what our rules should be. What I can say is that I think over the course of, you know, the history of the specialty, we've become increasingly specialized and well-trained. I would never want to do the job of a pediatric anesthesiologist. It terrifies me even to think about it. I can't imagine doing the job of a peds cardiac person. I mean, there's a reason that we specialize and hyper-specialized.

But in terms of global health and human rights, I think anesthesiologists have an incredibly important, vital role to play. We are perioperative physicians. We are intensivists. I think we see the whole patient in a way that most providers do not. And I think that access to patient health makes us the ideal advocates for global health and human rights. I think we are physicians first and anesthesiologists second. I think we can lend our expertise not just in terms of knowing patients, understanding patients, but also in terms of sort of triaging important, versus not important things. I think anesthesiologists are incredibly good at figuring out what is critical, what is urgent, what is, what needs to get done, and separating it out from the noise. And our training in that way, I think is, is really invaluable to global health and human rights work.

DR. STRIKER:

Well, let's talk a little bit specifically about the articles coming out in the next ASA Monitor issue for February. Do you mind just quickly summarizing the articles?

DR. KAUR:

Sure. So this, this set of articles was really fun for me to, to help out with and, and to do, and to be an editor for the section. You know, the goal with these articles was to highlight that incredibly important and valuable role that anesthesiologists can play. To really demonstrate, to show off what people in our specialty have done, how they've done it, and how they've really made an impact. And it's really to take people out of the traditional realm of service work or mission work abroad and look at what the possibilities are for leadership in global health and anesthesiology.
So these articles span working with NGOs in Rwanda, in refugee camps, to creating curricula, education and training, to working in the United States in disadvantaged and vulnerable populations. It's really, I think, a beautiful set of pieces that highlights some of the rising stars in anesthesiology and global health, some of the programs that I think we'll look back in a handful of years and say, we're so proud of this. We took a leadership role and these were the people that led it. And it's just, you know, the experience of a couple of people, a few people who have made a major impact and, and who've really dedicated their lives and their careers to global health and human rights.

There are many other programs and many other people. And I think we are starting, as a specialty, to take ownership in that leadership role in global health and human rights.

DR. STRIKER:

Well, let's talk a little bit about solutions. How do we get more anesthesiologists and institutions like medical schools involved in global health justice? I'm wondering what's being done, for instance, at Cornell?

DR. KAUR:

Cornell, I think, is a, a really unique place. The way that we've approached global health and human rights work is really from a science angle. So we're not focused on program development or work abroad or projects abroad, as much. What we're really focused on through our work with refugees and asylum seeking populations is taking a rigorous scientific approach. So the folks that work, the faculty that work, in our global health and human rights division have pretty typical grants that one might expect in basic science research, so grants from the NIH or FAER to do this work. And I think that is a really powerful way to do global health work. It's definitely not the only way to do it. It's definitely not the best way to do it necessarily. I think for us, we have found it to be a very successful way to build out a program, have it be self-sustaining in terms of funding, and to set us up for future funding and success. It allows us to invest in research in global health and human rights in a way that we would not be able to if we didn't have a constant stream of funding.

So I'll give you an example. My research in particular focuses on chronic pain in refugee torture survivors. And what we're looking at is separating out PTSD and depression and psycho somatization from pain syndromes and somatic pain that is chronic and debilitating in our refugee patients. My initial funding was from FAER, then I went to a KL2 award from the NIH, and now I'm on an NIH K23. That pathway has allowed me to create stability in the research program and to bring on additional partners who can do that work.
That's not to say that programs abroad aren't sustainable, but it's just a different, it's a different way to approach it. And I think for us, we've found a lot of success in it because this is the metric by which medical colleges and universities rank their own success. If you have federal funding for your programs and your research, there is a level of support that I think it allows you to have, and security in the stability and sustainability of your projects. So we have found it to be really successful. And I, I think it's a really unique, great pathway to take global health and human rights work. I really think we, we don't do it enough, probably in anesthesia. And, and I think that's, I wish we were doing more of it.

DR. STRIKER:

Can you comment on how many med schools, generally, and, and not a specific number, incorporate curriculum that address global health or methods methodology, I should say, that perhaps garners more support for global health? Or is this, is it unusual?

DR. KAUR:

Well, I think there's a lot of programs that offer global health opportunities. We're realizing as a specialty, I think, medical schools realized this probably a decade before anesthesiology or any other medical specialty, that physicians, that medical students, that trainees are really interested in global health work.

I think it's a, it's a generational shift. It's an amazing shift that's happening where people are valuing the ability to do global health work and human rights work and, and contribute to a cause greater than themselves. And while I think a lot of programs have global health opportunities, I'm not sure how rich those opportunities are in terms of deep connections to the communities and partners with which they're working, research opportunities, opportunities for bilateral exchange, bidirectional education. I think we're, we're not, we have not reached our potential. We are starting to understand the importance in terms of providing education for our trainees. But I think in a vast majority of situations, what I see is that global health and human rights work is more of a, it's thought of more as charity work or service work or, or humanitarian work. And while that may work in some contexts, what we've seen in our institution, I think, is that there is a whole different level of engagement that you can have when you, when you deepen that and you take it into research, partnerships, academic partnerships, sustained partnerships on the ground.

DR. STRIKER:
That leads me to my next question, which is, I, I know there's this opinion out there that, you know, medical schools should just focus on the science and making sure physicians coming out of medical school understand pathophysiology and biochemistry and possess the ability to provide an adequate differential diagnosis. And then these other things, yeah, that can be, those are things you can do on your own, but that, that shouldn't be part of the fundamental core curriculum. What would you say to that opinion?

DR. KAUR:

I would try not to get upset. You know, I think it's just such a misinformed perspective. I, I, I try to be pretty open minded about the potential truth in different perspectives. But I think it's, it's so ill informed to think that a person's culture and background don't play into health.

For example, if you don't understand the concept of structural violence, which is how economic or social or political forces play into health, you will never understand the health of your patients. Structural violence describes and really creates an understanding of situations such as deep poverty leading to worse spread of tuberculosis or to worse spread of COVID. Structural violence leads to an understanding of why people may be delayed in seeking health care because they're fearful of providers. They're fearful of being deported or detained.

You know, you can't really understand your patients without understanding the global context. I mean, I think it's just such a narrow minded, shortsighted view. It, it would be like saying I don't have to deal with Ebola, I don't have to know anything about Ebola because that is not a disease of the US. What a misinformed perspective, considering what happened in the, the most recent West Africa Ebola outbreak. You know, these are just, it's just, it's, I think the concept of international health makes it really easy to neglect this global population of patients. But when you really think of it in the context of global health and your neighbor, who is from a different place, you know, you just can't, it cannot be something that is confined to a hobby or an activity that, that happens after hours.

You know, I think that is the typical way that global health has played out in anesthesia, that there's the work that you do during the day as an anesthesiologist, and then you do this global health work in the afternoons, in the evenings and on weekends, you know, and, and, unfortunately, I think that perspective has to change. I, I think that perspective has to change not just for us to really take a leadership role in, in global health, but because we're doing a disservice to our specialty and to our patients.
There is, for example, a major lack of anesthesiologists providing care to women in child labor. And people, I think don't recognize that if we don't fill that role, somebody else does, somebody else comes in and fills that role and they provide anesthesia. And they provide anesthesia, and anesthesia care, but, but not as safely as an anesthesiologist would, or with as much attention to all of the factors that play into the care of that individual from the anesthesia perspective.

So I think it's just really misinformed to think about global health as a activity for nights and weekends. Having said that, I think that's the reason that we consider it to be a hobby or a side activity is because of the way that we've typically done it. I think it's, it's really hard for organizations to really figure out the finances around medical mission trips. I think that's, that's really challenging. And I empathize with that. I think shifting the perspective and making it more about sustained programming and research that's funded makes it much easier for us to play an active role and for us to play a role that brings it into our careers rather than having it be a supplement or a complement on the side, something that we do for fun or as a hobby.

DR. STRIKER:

Well, Dr. Kaur, thank you so much for joining us today. I really appreciate the time. And I hope that many, many people get the opportunity to, to listen to this podcast and take a glance at the ASA Monitor issue for February. I think it's some, some exciting work being done, and, and I hope we get to as many people as possible.

DR. KAUR:

Thank you so much. Thanks for having me.

DR. STRIKER:

Well, this is Adam Striker thanking everyone for joining us on this episode of Central Line. Please tune in again next time. Thank you.

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VOICEOVER:

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