On the Cover

Equity Rx
As a pediatric hematologist specializing in sickle cell anemia, Stephen Nelson, MD, never considered racial bias a problem for him. After all, nearly all of his patients at his Minneapolis Children’s Hospital clinic were African American and genetically prone to the blood disorder.

Yet in 2008, when Nelson attended a conference session on white privilege and racism, he was mortified. “I was embarrassed that I had never thought about the issues of privilege and whiteness and racism in this country,” he recalls. And he began to wonder if the overwhelming whiteness of his staff—94 percent at the time—was affecting the care his patients received.

Nelson surveyed patients, families and staff, and found a majority of patients and families said race negatively affected their care and their relationships with caregivers; most of the nearly all-

Physicians confront the state’s serious disparities in order to promote the best health for all.

BY GAYLE GOLDEN
white staff also perceived unequal treatment in the inpatient setting.

The problem was not the result of any deliberate action. Rather, it was caused by unconscious biases built into our assumptions and systems—black patients waiting longer than white patients to be called to exam rooms, or feeling that physicians don’t spend as much time with them as they do with white patients. Sometimes, the perception is rooted in what the clinic doesn’t do. Offering free parking is nice for patients who have cars, for example, but many of the clinic’s African-American families need to take the bus at times. “We don’t pay for that,” Nelson says. “The intention may not be to cause harm, but the perception—and that’s the reality—is that patients know they’re being treated differently.”

Such inequities were already in the national spotlight. Five years earlier, an Institute of Medicine report made it clear that minority patients in the United States consistently received a lower level of care, even after controlling for factors such as access, and that the result was overall poorer health outcomes.

By then Minnesota’s demographics were changing, and health inequities around race and ethnicity were developing. The state’s inequities are now some of the most marked in the nation. Last year, Minnesota was in the top 25 percent of states for good health outcomes in its overall population, according to the most recent National Healthcare Quality and Disparities report. Yet, when it comes to health equality for blacks, Hispanics and Asians, the state is in the bottom quartile.

When Nelson’s survey findings were published as the cover article in Pediatric Blood Cancer in 2013, an accompanying editorial lit a fire under him. “It basically said, OK, we know this exists,” he says. “So what are we going to do about it?”

For Nelson, it marked the start of a new path in his medical career. Today, while he still maintains a practice, he also teaches physicians and other health care providers about structural racism (the way public policies, institutional practices, cultural representations and other norms perpetuate inequities) and how it can affect care. Nelson has led three-session workshops at Children’s and elsewhere where he focuses on issues such as: What is race and its social construction? What are the structural systems of race? What is whiteness?

Although he hopes to expand the sessions to more clinics across the state and country, he acknowledges there is “a lot of resistance” from administrators and doctors to spending time and resources on such training, most of which is aimed simply at raising awareness. “The first elephant in the room is that it [structural racism] exists, that it’s a problem,” he says. “The second elephant is that we as health care providers are part of the problem.”

Grim reality

Nelson’s personal transformation reflects a growing awareness that Minnesota’s reputation as one of the nation’s healthiest states is marred by serious inequities.

The data are striking. The state’s African-American and American Indian babies die at twice the rate of white babies. The highest rates of obesity afflict American Indian, Hispanic/Latino and African-American children. Breast cancer is more often diagnosed in later, less treatable stages among African-American and Hispanic/Latino women than among whites.

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“It’s hard to convince people that there’s a problem because we are No. 1, or in the Top 5, on many national health outcomes—if you’re a white Minnesotan,” Nelson says. “When you show the data, it’s hard to convince people that there’s a problem because we are No. 1, or in the Top 5, on many national health outcomes—if you’re a white Minnesotan.”

–STEPHEN NELSON, MD
Socioeconomic factors create a cascade of stresses that affect the well-being of the poor: not being able to eat well or get adequate rest or exercise because they lack access to or can’t afford healthful food or adequate shelter in a safe neighborhood. “If you can’t walk in your neighborhood because it’s not safe, that works against preventing diabetes and hypertension,” Vincent says. Poverty also leads to depression and other mental illnesses, making it even harder for patients to take care of their medical needs.
Lydia Caros, DO, helped start the Native American Clinic in Minneapolis 12 years ago with the goal of addressing health issues among American Indians, including the rising diabetes rates that have resulted from generations of poor access to healthful food. She says she has watched how decades of generational poverty and systemic obstacles have eroded her patients’ capacities. “I can’t tell you how many people come in and say their insurance is turned off because they didn’t get some paper back in time,” she says.

“It sounds like a little thing, but it’s huge. So people aren’t getting their medicine, they’re confused, they’re frustrated. To them, it’s one more thing the system is doing to them.”

When Caros sees pediatric patients, she spends a lot of time talking with their parents about basic nutrition or trying to convince them to seek help for depression or anxiety. Yet their lives are often chaotic, she says, so they have trouble following through with recommendations. “The health care system is what needs the work and the money,” she says. “Eliminating barriers to insurance, transportation, getting medicine, safe housing—all of those things we take for granted, they can’t get past. So they don’t get better.”

Maria Veronica Svetaz, MD, MPH, agrees. She moved to the Twin Cities from Argentina in 1998, just as waves of Latino immigrants began moving into northern states such as Minnesota. Many of them were isolated, poor and struggling with high rates of teenage pregnancy and adolescent depression. “The community made me realize that when you are made vulnerable by the social situation, you actually have special needs,” she says. “I remember saying there’s no difference between a medical condition we treat in the clinic and a chronic condition like poverty.”

**Culture and care**

Svetaz was one of the first area physicians to receive a state health disparities grant to address the special needs of Latino youth. She started Aquí Para Ti (“Here for You”) in 2002. The program takes a holistic approach to care, offering both medical and mental health services and connecting patients to resources in their communities. Teens are welcomed by Spanish-speaking staff at Hennepin County Medical Center’s Whittier Clinic, where the program is located. “We have cultural competence. We speak the same language. There’s no judgment,” Svetaz says. “The patients don’t need to explain much because we understand them.”

Indeed, within the past two decades, awareness of how important language and culture are to clinical care has grown among clinicians who serve certain populations throughout the Twin Cities. When Vincent joined the People’s Center staff full time in 1992, it had for years served mostly white students and social activists in the area. But soon waves of East African immigrants arrived, and the clinic initially struggled to meet their needs.

“I don’t think it was a mindset. The staff has always been big-hearted here, generous, welcoming to all,” Vincent says. “It was language. You just couldn’t get things scheduled. You couldn’t correctly explain things.”

Now, in the light, airy waiting room decorated with African artwork, patients schedule appointments and receive instructions in Somali and other languages. Likewise, across Interstate 94, at the University of Minnesota’s Community-University Health Care Center (CUHCC), more than half the staff speak one or more of the seven languages most spoken by their patients, including Somali, Spanish and Hmong.

Christopher Reif, MD, MPH, CUHCC’s director of clinical services, says language is just the starting point with immigrants. Doctors must be sensitive to the patient’s broader circumstances. “This means asking, When did you come to the U.S.? How did you get here? Are there any obstacles to your health care?” he says. “And being sensitive to cultural issues, including religion.”

Such sensitivity can make or break a patient’s ability to follow doctors’ orders. Daily prescription medication doses can, for instance, conflict with fasting practices for many East African patients. Campaigns for colorectal cancer screening among American Indians are more successful if framed as a benefit to the community rather than the individual. At HealthEast’s Rice Street Clinic in St. Paul, cultural factors play a role in the diagnosis of late-stage cervical cancer among Hmong patients, says Laurel M. Ries, MD, who practices family medicine with obstetrics at the clinic.

“It’s not a part of their culture to have a Pap smear, so it feels very foreign to them,” says Ries, who grew up in the Wisconsin farming town of Viola (population 365), a community whose residents remind her of the hard-working, independent-minded yet often poorly educated immigrants she treats. “I have to really start on a basic level and explain how Pap smears keep them healthy even though they don’t feel sick.”

Equally important, says CUHCC’s Reif, are connections clinics make with communities. CUHCC does this in a number of ways. On the outside of the facility, a mural depicts the multicultural staff and patients with words describing the meaning of community in eight languages including Hmong, Swahili and Anishinaabe. Inside, the clinic employs nine care coordinators who reflect the demographics of the population it serves. The coordinators help patients navigate challenges such as finding a pharmacy with staff who speak their language, remind patients about appointments, advise on transportation to specialty clinics or even help those with diabetes find culturally acceptable ways to exercise in their neighborhoods.
ON THE COVER

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–MARIA VERONICA SUETAZ, MD, MPH

Training the workforce

Also important to reducing inequities is having a culturally diverse, culturally sensitive medical staff, Reif says. Each year, CUHCC trains more than 200 medical students, residents and others from the University of Minnesota, which statistically has one of the whitest student bodies of all medical schools in the country. Yet Reif says today’s students, regardless of race, make him optimistic. “They are all asking, ‘Can you teach me how to be a doctor in a diverse world?’” he says. “We try to model that here. We have interpreters and a diverse staff show them how to do a good history, how to pay attention to the cultural issues of each patient.”

At Broadway Family Clinic in North Minneapolis, where 80 percent of patients are American-born blacks who have some of the state’s worst health outcomes, Renee Crichlow, MD, thinks a lot about how to expand the skills and reach of the 30 residents from North Memorial Medical Center who train there. Her approach: Don’t just treat the symptoms of illnesses such as hypertension or diabetes. Look upstream for the causes, which include poor food access, a failing educational system and lack of transportation that makes it difficult for many to hold jobs.

In order to learn to be upstream doctors, the residents attend seminars on poverty and regularly participate in Community Health and Advocacy Talks (CHAT) with neighborhood residents. They join The Ladder, a mentorship program in which college undergraduates, medical students and physicians meet monthly with north Minneapolis middle and high school students interested in health care careers. They also help organize a weekly farmer’s market, where families in the neighborhood can buy fresh fruits and vegetables with tokens provided in food-education workshops offered at the nearby Northpoint Clinic.

Such programs focus on long-term goals and build on small progressions: a mentored middle-schooler who makes it through a year with no suspensions can become a high-schooler with college aspirations and eventually a medical student who will one day move back to the neighborhood as a physician.

“We play small ball and long game,” Crichlow says. “Every detail counts, but you’ve got to be aiming for a long-term intervention because these are complex, systemic problems. And you have to build complex, systemic responses in order to address them.”

Community solutions

The key, Crichlow and others argue, is empowering communities to solve their own health problems. Shana Sniffen, MD, who did her residency at North Memorial, has helped the state’s newest immigrants, Karen refugees do just that.

Three years ago, Sniffen was struggling to help Karen patients suffering from substance abuse—an all-too-frequent response to post-traumatic stress disorder caused by their refugee experiences near the Thai-Myanmar border. Treatment centers often refused to take them because of the language barrier. Even when they were admitted with an interpreter, Karen patients often would become confused while going through treatment.

“They’re coming from a place that has no public health system. Even the concept of addiction as something to get treated was foreign to many of them,” she says. “They’d think, while in a treatment group, ‘Why are we all sitting in this room?’ There was no awareness of how the treatment process works.”

With a grant from the Bush Foundation, Sniffen began helping Karen leaders craft their own treatment model at HealthEast’s Roselawn Clinic in St. Paul. The model, which the clinic plans to begin using by the end of the year, involves family, community, faith leaders, interpreters and public education.

Moral obligation

Creating culturally sensitive approaches to care will become even more necessary in the future. By 2035, 25 percent of Minnesotans are expected to be people of color, which is double from 2005. Today, 35 percent of children in the state are nonwhite. Nelson, the hematologist who teaches about structural racism, says those numbers require all doctors to take stock of their personal biases if they want to offer good patient care.

Minnesota Commissioner of Health Ed Ehlinger, MD, MSPH, argues that if they don’t, the state will see its health ranking continue to fall. He points out that in 1992, the United Health Foundation listed Minnesota as No. 1 in its state health ranking. Last year, the state fell to No. 6.

“We’re going in the wrong direction, and we’ve been steadily going in the wrong direction,” Ehlinger told a gathering of public health professionals in August. Evoking the philosopher John Dewey, he argues doctors have a moral obligation to address the problem. “If we’re going to be a healthy state, we have to identify the things that are really intolerable. I think the disparities we have in this state are intolerable.” MM

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