Bridging the Gap: Disparities in Health Care for Marginalized Patients and Employees

Contributed by Valerie Pitaluga, M.S. CCC-SLP & Rebecca Brown M.S.,CCC-SLP,CNT

Primary Objective

The purpose of this document is to highlight disparities in health care service delivery for racially or ethnically marginalized patients and the underrepresentation of these marginalized populations in the field of speech-language pathology. Techniques for starting conversations about diversity and inclusion as well as feasible action steps that members can take will be discussed.

Introduction

Disparities in health care access, practice patterns, and outcomes for marginalized patients in the United States are well-documented in studies that controlled well for confounding and covariate effects. They include such wide-ranging examples as less pain management for Black and Hispanic patients than for white patients presenting to an emergency room with long bone fractures (Todd, et al., 1993), reduced rates of surgical treatment and subsequent survival for Black than for white patients with small cell lung cancer (Bach et al., 1999), lower rates of referral for Black than white patients for renal transplantation (Ayanian et al., 1999), and, most recently, disproportionately higher rates of COVID-19 infections and higher instances of mortality associated with the disease (Robeznieks, 2020). Together, these studies span decades and tell a story we need to hear. While a complete iteration of every study's findings is beyond this resource's scope, the following studies and related data were selected to support and present some of the key themes that may warrant medical professionals' attention and consideration in service delivery.

Prenatal Care and Childbirth

A 2018 study by Howell et al., found that morbidity and mortality rates were higher in Black and Hispanic very preterm births as compared to their white counterparts. In 2012, Dr. Wayne Riley noted that infant mortality rate for Black babies remains nearly 2.5 times higher than for white babies. This data highlights the fact that poor performance at hospitals where Black and Hispanic mothers deliver is an important and modifiable cause of racial disparities in neonatal outcomes and that socio-economic status cannot be undermined as a social determinant of health.

Routine care and emergency care

The root of the problem begins with disparities in routine and emergency care for marginalized populations. In fact, the Heckler Report released by the U.S. Department of Health and Human Services' Office of Minority Health noted that 45% of deaths up to the age of 70 years in the Black population would have been avoidable if better evaluation, detection, and treatment had been available.

Differences in emergency care and pain management approaches were noted in a 1993 study by Todd, et al., where Hispanics with isolated long-bone fractures were twice as likely as non-Hispanic whites to receive no pain medication in the UCLA Emergency Medicine Center. Similarly, in a subsequent study, Todd et al. (2000) found that Black patients with isolated long-bone fractures were also significantly less likely than white patients to receive ED analgesics despite similar records of pain complaints in the medical record. Finally, in a 1993 study, Johnson et al. also found that, in Black patients presenting to the ED with acute chest pain, the rate of hospital admission, likelihood of being triaged to the coronary care unit, and likelihood of undergoing coronary artery bypass procedures were all lower among Black patients than among white patients.

Care for the chronically and/or terminally ill

Research also suggests that disparities don't end in the ED. For example, in a population-based study to estimate the disparity in the rates of surgical treatment of early stage, non-small-cell lung cancer and to evaluate the extent to which racial disparities are associated with differences in overall survival, both of these measures were significantly lower for Black patients than they were for white patients (Bach et al., 1999). The researchers concluded that the lower survival rate among Black patients as compared with white patients is largely explained by the lower rate of surgical treatment among Black patients. Additionally, in a retrospective sample using inpatient Medicare data for years 2003-2006 of all beneficiaries who underwent major lower extremity amputation, Black amputees were significantly less likely than whites to undergo attempts at limb salvage, including revascularization, limb-related admission, or wound debridement, prior to amputation. These differences in care were not accounted for by regional differences in where Black and white patients received care. Finally, Crepaz et al. found, in 2014, that when compared with white patients, a lower percentage of Black patients diagnosed with HIV were prescribed antiretroviral therapy and a lower percentage of Black patients had suppressed viral loads compared to Hispanic and white patients.

Underrepresentation of Marginalized Persons Employed in Healthcare

In addition to the aforementioned healthcare disparities, marginalized individuals are underrepresented in the medical field and, more specifically, within the field of speech-language pathology. For example:

- Minority enrollment for the 2018-2019 academic year was 29.5% for speech-language pathology programs (ASHA, 2020).
- 8.4% of ASHA members and affiliates identify as racial minorities. (ASHA, 2020)
- According to the AAMC's Diversity in Medicine: Facts & Figures 2019, 56.2% of all active U.S. physicians are white, 5% are Black, and 5.8% are Hispanic or Latino.
- These figures should be compared to the U.S. Census data, which is as follows: of the U.S. population, 72.2% of respondents are white alone and 12.7% are Black alone. These figures do not include individuals of two or more races. Hispanic or Latino origin is measured independent of race and is reported to be 18.3% of the U.S. population.
- Native Americans, Blacks, and Hispanics account for one third of the U.S. population yet only constitute 9% of practicing physicians (Osseo-Asare, et al., 2018)

Change Attitudes, Change Behavior

Given the large and growing literature on racial disparities in healthcare provision for marginalized patients and the underrepresentation of racially and ethnically marginalized persons employed in healthcare, individuals should be motivated to act. To take action, one must first change personal attitudes and behaviors.
Individual's beliefs and emotions about issues, in turn, affect their behavior. Attitudes may be present implicitly or explicitly. Individuals are aware of explicit attitudes as they consciously affect decision-making. Implicit attitudes are not consciously present to the individual but still may affect decision making. Further investigation of what affects attitudes is necessary to create a positive change in behavior toward marginalized persons.

Attitudes can be shaped by:

1. Experience: what individuals themselves have experienced in their daily lives.
2. Social norms: behavior that is considered socially acceptable in cultures.
3. Learning: acquiring new knowledge and skills through teaching or individual study.
4. Conditioning: training individuals to respond or behave in a certain way.
5. Observation: individuals attentively notice the world around them.

It is the responsibility of the clinician to adjust their attitude and create change. After the change has been created on an individual basis, the clinician is more likely to influence the peer-group.

Creating Feasible Action Steps Within the Workplace, Community, State, and Nation:

Many SLPs do not engage in conversations about race and ethnicity in the workplace. Some employees do not like to feel uncomfortable while others may not recognize that there is room to grow and change. However, given the unique background of the speech-language pathologist in communication, listening, and counseling, these providers are in an important place to initiate conversations that are worthwhile regarding this subject. SLPs can individually, and as a profession, move towards anti-racism by:

1. **Listening**: Giving our marginalized patients and colleagues a voice to express their feelings and their needs. As a listener, it is paramount to remain objective, empathetic, and to not seek a posture of defensiveness. It is important to recognize that our patients and colleagues may feel righteous indignation and that their tone may rightfully come across as angry or resentful.

2. **Recognize microaggressions:** Microaggressions are defined as "everyday, subtle, intentional, and oftentimes unintentional interactions or behaviors that communicate some sort of bias toward historically marginalized groups" (Nadal, 2020). As best-selling author Ijeoma Oluo said on the ASHA Voices podcast (Gray, 2020) "it's really important to recognize that things are called microaggressions, but it doesn't mean the impact of them is small." Reflecting on this behavior internally and externally with white colleagues will promote an inclusive workplace with decreased hostility.

3. **Be aware of the policies in place:** Many facilities have policies and position statements on racial and ethnic inclusion. Being aware of their location in the employee handbook and the penalties for not adhering to those policies is of utmost importance. If your facility does not have such policies or position statements in place, SLPs are in a position to respectfully yet pointedly suggest that such policies or statements be adopted using all available research to demonstrate why this is of the utmost importance.

4. **Be familiar with the law and advocate for marginalized populations**: Ensure that your patients have access to an interpreter if they don't speak English; ask them what they understood from their conversation with other healthcare professionals and ask those professionals to come back and clarify if there are any misunderstandings; and stay in the room until nursing provides pain medication for any/all patients who complain of pain, but especially if they are Black or Hispanic because research suggests these populations are less likely to receive adequate access to pain management. Do not hesitate to ask physicians their rationale when their plans of care for marginalized patients differ from your organization's norm. Share the above resources with physicians at your facility if appropriate.

5. **Follow the chain of command:** Witnessing racism in the workplace toward patients and employees happens more frequently than many realize. As an ally, when handing a situation in a one-on-one setting is not possible, it may be necessary to escalate these concerns to supervisors. Keeping written record of events witnessed and escalating conversations beyond direct supervisors may be necessary if the direct supervisor is not taking the initial complaint seriously.

6. **Consider intersectionality**: Intersectionality, a term coined by Kimberlé Crenshaw in 2016, refers to how race, class, gender, and other individual characteristics intersect with one another and overlap in a framework that often seeks to erase the lived experiences of marginalized communities. Consider how an acquired injury, for example, compounds racial disparities in healthcare for Black and Latinx patients or how LGBTQIA+ patients and healthcare professionals are treated in the workplace. Advocate for all oppressed groups, not just racial minorities.

7. **Write a letter to Universities** advocating for reform of admission criteria, highlighting the need for more cultural and linguistic sensitivity training, and encouraging them to offer scholarships for BILAPOC students as well as explicitly seeking to recruit more diverse students. Specific suggestions include: no longer requiring or considering GRE scores as part of graduate application materials due to the racial, ethnic, and cultural biases inherent in standardized testing, establishing a procedure that would allow for application fees to be waived for individuals who are Black, Indigenous, or People of Color, evaluating all new and existing course materials for overt and covert biases, developing programs to support students of color and ensure their academic success. For a strong position statement on Justice, Equity, and Anti-Racism, please see: https://cla.umn.edu/slhs/news-events/story/striving-justice-equity-and-anti-racism

8. **Join or start a professional diversity committee** within your state speech-language and hearing association.

9. **Support marginalized-owned businesses** within the speech-language pathology community.

10. **Join American Speech-Language-Hearing Association Special Interest Group 14: Cultural and Linguistic Diversity.**

11. **Attend conference calls within the Medical SLP Collective diversity committee.**

12. **Increase knowledge** of political candidates running for office at the local, state, and national level.

13. **Complete the Harvard Implicit Bias Test** to reflect on inherent biases that are impeding your ability to become an ally (https://implicit.harvard.edu/implicit/takeatest.html). This assessment measures attitudes and beliefs individuals may be unaware of or unwilling to report.

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