Understanding Poverty and Privilege to Teach Professionalism in Graduate Medical Education

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This teaching is dedicated to the children and families struggling to survive in a life of poverty in the United States on the 52nd Anniversary of the War on Poverty.

The War on Poverty is the unofficial name for legislation first introduced by President Lyndon B. Johnson January 8, 1964.
I have no meaningful disclosures
Overall Goal:
To promote professionalism of health care professionals, especially physicians, who may come from experiences of privilege and may be unfamiliar with experiences and learned behaviors common to living in poverty in the United States.
Objectives:

At the end of this presentation participants will be able to:

• **define** the diversity aspect of the ACGME **Professionalism** competency as it relates to preparing residents for the future

• **name** 2 factors which may contribute to the negative attitudes and gap in understanding between trainees and patients living in poverty

• **identify** at least 2 teaching exercises to promote professionalism in medical/graduate medical education
Why is this important to teach?
Identified Core Competencies Needed for Health Care Professionals:

• Provide patient-centered care - identify, respect, and care about patients’ differences, values, preferences and expressed needs...

• Providing patient-centered care is particularly important in light of the ethnic and cultural diversity that increasingly characterizes much of the United States.
Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care identified the need to:

- strengthen the stability of the patient-clinician relationships in publically funded health plans

- provide cross-cultural* training and education for health care clinicians to increase awareness

  *includes socioeconomic diversity

How do we provide this training?

Graduate Medical Education:

Six Core Competencies:

• Patient Care
• Medical Knowledge
• Professionalism
• Problem-Based Learning and Improvement
• System-Based Practice
• Interpersonal & Communication Skills
Psychiatry: Professionalism
Psychiatry: *Professionalism*

**Thread A: Compassion, reflection, sensitivity to diversity**

**Level 2**
**Milestone example:** Demonstrates *capacity for self-reflection, empathy, and curiosity about and openness to different beliefs and points of view, and respect for diversity*.

**Level 4**
**Milestone example:** Discusses own cultural background and beliefs and the ways in which these affect interactions with patients.

**Level 5**
**Milestone example:** Serves as a *role model and teacher of compassion, integrity, respect for others, and sensitivity to diverse patient populations*.
Internal Medicine:  
*Interpersonal & Communication Skills*

Communicates effectively with patients and caregivers

**Example Milestone:** Quickly establishes a therapeutic relationship with patients and caregivers, including persons of different socioeconomic and cultural backgrounds
Family Medicine: *Professionalism*

Health care should be responsive to the needs of diverse populations.

Demonstrates humanism and cultural proficiency

**Milestone Examples:** Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model

Identifies own cultural framework that may impact patient interactions and decision-making
Pediatrics: *Interpersonal & Communication Skills*
Pediatrics: *Interpersonal & Communication Skills*

Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.

**Milestone example:** Uses the interview to effectively establish rapport; is able to mitigate physical, cultural, psychological, and social barriers in most situations.

**Milestone example:** Uses communication to establish and maintain a therapeutic alliance; sees beyond stereotypes and works to tailor communication to the individual.
Milestone example: Communicates effectively with patients and families across a broad range of socioeconomic and cultural backgrounds.
Emergency Medicine: Interpersonal & Communication Skills

Demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with patients and their families.

Milestone example: Effectively communicates with vulnerable populations, including both patients at risk and their families.
Professionalism = Respect
My Definition of Professionalism

Possessing and exhibiting unconditional *respect* for the life experiences and the knowledge held by all health care team members, patients, and families, regardless of their particular identifiers, and particularly, when identifiers and experiences differ from our own.

*Level 5* Modeling all the above and teaching others to do the same
Social scientists define *socioeconomic background* status as a combination of 3 main elements:

- parental *income*
- parental *education*
- parental *occupation*
Medical Education and Privilege

Most medical students are children of parents with high levels of education.

- Approx. 1/2 of medical students’ fathers have a graduate degree (compared with 12% of the men in the U.S.)

- Approx. 1/3 of medical students’ mothers have a graduate degree (compared with 10% women in the U.S.)

Analysis in Brief. Association of American Medical Colleges, Vol. 9, No. 10 August 2010
Medical Education and Privilege

Using U.S. Census data, divide the population of U.S. households into fifths (quintile) by family income (AAMC data collection began in 1987)

• The percentage of students entering med school from the top quintile is consistently between 48% and 57%

• More than 75% of medical students came from families in the top two quintiles of family income

• The skew toward top quintile family is more pronounced in private verse public medical schools

The systemic skewing toward children of upper-income families is increasing with the rising cost of medical education.

With debt increasing much more rapidly than physician incomes, a continued increase in medical students from the top quintile families is to be expected.

Medical Student who is privileged

The Gap:
Parental experience
Resources
Education
Opportunities
Living conditions
Food quality and access
Leisure / Recreation
Safety issues
Healthcare access/ quality
Stress level

Patient who is underserved (poor)
What does privilege have to do with professionalism in health care education?

- People who do not experience poverty do not have an opportunity to understand the life experiences of those in poverty

- Where there is ignorance, then stereotypes flourish and can negatively impact:
  - (1) the patient–clinician relationship and
  - (2) health care policies

- This gap in knowledge (ignorance) contributes to disparities in care and ultimately leads to poor outcomes
Medical Students’ Attitudes Toward Providing Care for the Underserved: Are We Training Socially Responsible Physicians?

*JAMA 1993.* Sonia Crandall and colleagues, University of Oklahoma Health Sciences Center, Oklahoma City

The purpose of this study was to explore medical students’ attitudes toward providing care for “medically indigent” populations.

Surveyed all students M1-M4 at a state medical school in Southwestern U.S.

Demographically (age, gender, race) the students were “representative of all medical schools in the U.S.” except higher % Native American students in M-1.
Medical Students’ Attitudes Toward Providing Care for the Underserved: Are We Training Socially Responsible Physicians?

Developed a 57-item questionnaire- 4 basic themes:

- Personal roles and responsibilities
- Physicians’ roles and responsibilities
- Institutions’ roles and responsibilities
- General issues regarding access to care

Attempts to answer the question: “Whose responsibility is it?”
3 Categories combined for Total Score:

1. **Demographic items** that students indicated to what extent each item influenced **access to medical care** (e.g. age, income level, race/ethnicity, gender, insurance, urban/rural residence)

2. **Attitude Scale**- asked about access to healthcare by medically indigent (example: Society is responsible for providing medical care to medically indigent...)

3. **Service Scale**- asked to rate various treatments which patients should have access to “regardless of their ability to pay” (included preventative and basic care to expensive critical care)
M-1 class (67% male, 33% female)
M-4 class (73% male, 27% female*)

Cross sectional analysis comparing attitudes of M-1 students with attitudes of M-4 students

Results:
• The Attitude Scale and the Overall Total Score was lower for the M-4 class compared to M-1 class (especially for males)
• The M-4 class also had significantly lower rates for approval of expensive treatment (Service Scale) compared to M-1 class

Attitudes toward poor patients become less positive during medical school
*lower than national average
Medical Students’ Attitudes Toward Providing Care for the Underserved: Are We Training Socially Responsible Physicians?

These findings were consistent with previous studies:

• Female medical students express greater sense of personal responsibility toward caring for medically indigent (poor) and are more inclined to do so.

• Gender accounts for more variability in attitudes toward the poor than medical specialty or age of physician.
Residents’ Attitudes and Behaviors Regarding Care for Underserved Patients: a Multi-Institutional Study

Background:
Resident physicians are often on the front lines of care for underserved patients but we know little about their attitudes and behaviors regarding these populations.

Objective:
To measure
(1) resident attitudes regarding topics relevant to medically underserved patients
(2) resident behaviors with underserved patients (behaviors=volunteerism)
(3) the association between attitude and behaviors
• Surveyed 18 residency programs in U.S., 10 institutions, 7 specialties (psychiatry was not included)
• 52% response rate, n= 498
• Age: majority < 30, 54% male and 46% female, 70% Caucasian (white) and 30% non-white (no details), 80% primary care

Attitude Assessment (15 items)*:
• Measured attitude toward topics relevant to medically underserved patients (access to healthcare, disparities in care, etc.)
• Residents rated each item as “Very, somewhat, or not important”

*designed with review of literature and expert panel
Behavior Assessment:
Measured resident’s own perceived behavior (self-report) specifically, volunteerism with underserved patients in
• the past (med school)
• the present (during residency)
• prediction for the future (while in practice)

Residents rated each in time (hours/week): 0, 1-3, 4-7, 8-10, more than 10
Results:

**Attitude Scores** were similar across (specialty) groups

- 58% considered issues of medically underserved to be very important
- 39% considered them somewhat important
- Female residents had more favorable attitudes compared to male residents across all 15 attitude survey items

Behavior Assessment:

- Higher rates of positive behavior (volunteerism) in non-white residents
Summary:
Women and underrepresented minority physicians (and trainees) have more favorable attitudes and behaviors toward underserved (poor) patients and they serve these communities at significantly higher rates than their (white male) peers.
How do we meet the competency requirements to prepare “privileged learners” to effectively care for our nation’s diverse populations?
Sample Curriculum to fill the gap:

*Let’s talk about poverty*
Poverty

• This is a sensitive topic in the United States.

• To really understand poverty in the U.S., one has to acknowledge our shared history (including racism, sexism, discrimination and other practices of oppression).

• This topic can become a “political tug-of-war” with a lot of wasted energy but no progress to move us forward.

• Clinicians need to make an honest self-assessment in order to engage in a meaningful discussion of poverty and health.
Poverty: important concepts

• Poverty is relative (poverty in the U.S. verses global poverty)

• Poverty occurs in all races/ ethnic groups/ ages in the U.S. (although some groups are over-represented)

• “Socioeconomic class” is on a continuum rather than clearly divided

• Living slightly above the government threshold for poverty is still living in poor conditions

• Many people (including families) cycle in and out of poverty
Who are America’s Poor?
Stereotypes about poor people in the U.S.

Poor people are lazy. Poor people are homeless.
Poor people are bums.

Poor people don’t want to work.

Poor people are criminally-minded. Poor people are alcoholic and drug addicts.
Poor people are mentally ill.

Poor people would rather receive a “handout” than work.

Most poor people live in the inner city (the ghetto, the hood, el barrio).

Poor people live better than people who work.
Poor people have too many kids!

Most poor people are African American/ Black.
Most poor people are Puerto Rican.
Most poor people are Mexican.
Most poor people are immigrants.
Most poor people are ________ (non-white).
What fuels these stereotypes?
The truth about poverty in the United States
Female head of household (unmarried/uncoupled) is the major common risk factor for poverty.

Mothers and children make up the vast majority of those in poverty.
The Facts: demographics of poverty in the United States

• Over 46 million people live in poverty in the U.S.

• Poverty exists in urban areas, small towns, rural communities and suburbs

• Poverty rate in metropolitan areas (14.5%)
• Poverty rate in rural areas (17.7%)

• Poverty rate for people living with a disability is 28.4%

http://www.povertyusa.org/the-state-of-poverty/poverty-facts/
Appalachian poverty is among the worst in the nation.
The Facts: demographics of poverty in the United States

- People of color/certain ethnic minorities *are* over represented statistically.

- However, the majority of those living in poverty and who receive “welfare” (SNAP = food stamps and Medicaid) are European-Americans (White/Caucasian).

- Most people living in poverty are employed but do not have stable employment at wages that can sustain their needs/family needs.

- The poverty rate for *children* is higher than for any other age group in the U.S.
Pear of Wisdom: Avoid thinking “you people” ... or “those people” are all___________.

No characteristics should be generalized to an entire group of people without considering the uniqueness of an individual and their personal experience.

Don’t automatically “assume” the experience of a person by their appearance, their name, their accent, their education or their economic situation, etc.

Simply ask the person.
What is “poverty income” for a family of 4?
Terms used to Define Poverty

Poverty is defined as approx. $24,000 or less for a family of 4 (a couple with 2 children). (1)

Research consistently shows that, on average, families need an income of about twice the federal poverty level to make ends meet. ($48,000). This is termed “low income”. (2)

(1) Federal Poverty Income Guideline 2013
(2) National Center for Children in Poverty Mailman School of Public Health Columbia University
Terms Used to Define Poverty

**Deep (extreme) poverty** is having an income less than half the poverty level (income is 50% of poverty income)

- Example: $12,000 for a family of 4 (a couple with two children)
- Nearly 9 million Americans live in **extreme poverty**
- **Deep (extreme) poverty** rates among:
  - African Americans = 13.5%
  - Hispanic/Latino Americans = 10.9%
  - European Americans = 4.3%

U.S. Census 2009
North Carolina Counties and Poverty

Poverty remains stubborn to economic recovery, with rates varying considerably across the state.

Source: 2013 Poverty Estimates, Census Bureau, SAIPE
The Hidden Rules: 
*Could You survive?*

A Framework for Understanding Poverty

By Ruby Payne
The Hidden Rules (and Skills) of Class (Culture)

“Hidden rules” relate to patterns of thought, social interactions, cognitive strategies, etc. that reflect a cultural norm.

Each individual brings with them knowledge of the hidden rules (skills) of the class (culture) in which she/he was raised.

The knowledge and practice of hidden rules continue when one enters another socioeconomic class (culture).

In general, institutions such as public education and health care assume an understanding of middle class “hidden rules”.

A Framework for Understanding Poverty by Ruby K. Payne, Ph.D.
What Skills Do You Have?  
*Could You Survive?*

- Identify skills which *reflect* you
- Identify skills which are *unknown* to you
- Which skills are a reflection of your upbringing?
- Have you learned any skills unknown to your family?
- How does one expand their skills?
- What skills may patients have that you don’t have?
*Culture of Poverty* is based on the learned behaviors for survival in a life of poverty.

The reality of living in poverty brings out a survival mentality and turns attention away from opportunities taken for granted by people in middle and upper classes.
Generational Poverty - occurs with 2 or more generations of poverty. It is not sudden in onset. One is “born into” generational poverty.

If one leaves poverty, one will maintain their knowledge, skills and values, social connections and view of the future with them.
Movie Club:
Generational Poverty and Learned Helplessness

• Residents choose a movie to watch (Precious or Winter’s Bone)

• Discuss examples of learned helplessness in the movie

• Identify the strengths of each main character as well as their challenges
Movie: *Precious*

- Financial
- Emotional
- Mental
- Spiritual
- Physical
- Support Systems
- Relationships/Role Models
- Knowledge of Hidden Rules
Small Group Exercises in Problem-Based Learning

• Residents in small groups are given a clinical vignette which includes a patient/family in financial need (underserved) with a healthcare need

• The vignettes encourage the participants to look beyond financial resources and to place value on other resources (such as “social capital”)

• The participants get a sense of the challenges in making good health care choices when facing challenges in meeting basic needs
The “science” behind simulation games

Sociologists have used games or simulations to stimulate critical thinking and to introduce social stratification in education
Monopoly New Rules

• players are randomly assigned one of 5 levels reflecting income distribution in the United States (several players can become a family)

• the highest quintile income player (family) start out with more money, multiple properties, and receives large “salary” compared to others every time he/she passes go

• the lowest quintile player (family) starts out with a meager amount, no property, and receives limited “salary” every time he/she passes go

Monopoly with Healthcare Simulation

*Community Chest* and *Chance* cards are replaced with new scenarios:

- Financial benefits such as an inheritance or financial loss due to such situations has factory closing or divorce.
- Healthcare issues such as excellent health report in recent physical exam or untreated symptoms of depression causing decline in work attendance (must pay back wages).
• When learners from relatively privileged backgrounds “experience” a temporary bout of unfairness in a simulated game, it creates the opportunity to change their perspective.

• This can lessen a learner’s social distance from marginalized groups (in a real-world situation).
Self-Reflection Writing

Our role as physicians, and just being those who were luckier in life, is to help those in need to improve their lives as much as we can without prejudice and to the best of our ability.

PGY 1 resident
Self-Reflection Writing

“It seems that those (clinicians) who have lived in poverty or at least in different environments with different groups of people have an advantage over those of us who have not. I have never really thought about this before but, in certain ways, my privilege puts me at a disadvantage.”

PGY 3 resident
Thank you!
Resources:
AAMC MedEdPORTAL  course #192 *Elective Course in Culture and Diversity*


Liaison Committee on Medical Education (LCME). *Functions and Structure of a Medical School: Standards for Accreditation of Medical Programs Leading to the M.D. Degree.* Washington, DC, and Chicago: Liaison Committee on Medical Education. 2002.


The Urban Institute. [http://www.urban.org](http://www.urban.org)

Poverty USA
Resources

