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Patient engagement and cultural sensitivity as a strategy to improve health inequities: The solutions are as simple as they are complex

The SARS-COV-2 (COVID-19) pandemic has confirmed that since the 2003 Institute of Medicine Report: *Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care*, we have made little progress in addressing health disparities for Black Americans. The Report showed that even after adjusting for the social determinants of health such as income, comorbid illness and health insurance type, health outcomes among Blacks were still worse than Whites¹. While there is no evidence that Blacks are genetically more predisposed to SARS -COV-2 infection, data from the CDC showed that during the first surge in April 2020, COVID-19 related hospitalization rates among Blacks were 3.3 times the rate of Whites².

The COVID-19 pandemic has shed a bright light on the numerous long-standing health inequities experienced by Blacks across the United States; however, the greater challenge is contrasting perception versus reality. The perception is that the impact of the COVID-19 pandemic is a result of poverty, lack of access to care, transportation challenges, social determinants of health and underlying comorbidities. But when we examine these further, other factors warrant consideration and study. Prince George's County in Maryland is one of the most affluent Black communities in the nation, yet the county had the highest death rate in the suburban Washington, D.C. area³. Another reality was seen in Brooklyn, New York. Brooklyn has a Black population exceeding 833,000, which is about 35% of the total population. The borough has thirteen hospitals (including one state and three public) and an extensive public transportation system. Despite this support system, this borough was among communities experiencing some of the highest COVID-19 associated deaths in New York City⁴.

The current pandemic highlights the need to promote the health and well-being for the Black population. Over the years, data has shown that irrespective of diagnosis (cardiac disease, HIV, cerebrovascular disease, diabetes, glaucoma), Blacks have the worst health outcomes across several disease categories (Table 1). Consequently, we must seek solutions that address structural racism and inequities. The requisite first step to decrease health care in-

equities is to increase the value of the individual. It is important to recognize and address the role of cultural sensitivity across all populations. Unfortunately, the English-speaking Black population is totally left out of the current discussions devoted to improving cultural sensitivity.

The authors recognize and propose that decreased human value, and as a result the lack of patient engagement and empathy, are critical pieces missing when conscious and unconscious biases are the drivers for the current crisis. A culturally sensitive patient engagement approach designed to value the Black population overall and Black patients individually is essential.

The history of the trials and tribulations of the aging Black population is unique and must be acknowledged. Several years ago, during an encounter by one of the authors (MB) an elderly African American female stated, "All I want when I come to a hospital is for someone to be nice to me." Another elderly African American stated in a separate encounter, "I picked cotton in the South, and I paid my dues, I don't deserve to be treated in this way." These powerful quotes are saying "Do you know me, do you know my historical background, do you understand the basis of my pain and my suffering? Do you possess the level of cultural sensitivity to comprehend who I am and what issues in my life are most important to me?" In the absence of this background context, it is difficult to understand how to express empathy and engage the patient to improve the individual's health. As health care providers, very few of us have been hospitalized and the majority who have been hospitalized are women creating life through birth, whereas many of our patients are fighting for their lives.

To address the issue of health inequities, it is important to understand that the solutions are as simple as they are complex. If we successfully solve the "simple" we may prevent problems escalating to "complex." This concept evolved from empathetic and non-judgmental conversations conducted by one of the authors (MB) over a 10-year

Table 1. African Americans & health disparities.

Disease Category	Reference	Outcome
Cardiovascular Disease	Mensah GA. Cardiovascular Diseases in African Americans: Fostering Community Partnerships to Stem the Tide. <i>Am J Kidney Dis</i> 2018 Nov; 72(5 Suppl 1): S37-S42.	Death Rates for African Americans remained 20% higher for heart disease and 40% higher for Cerebrovascular Accidents (CVA).
Cardiovascular Disease	Redberg RF Editorial Comment. Gender Race and Cardiac Care. Why the Differences? <i>J Am Coll Cardiol</i> 2005; 46(10): 1852-1854	African American patients are less likely than white patients to undergo diagnostic tests and revascularization even after controlling for socioeconomic factors.
Cardiovascular Disease	Arya S, Bonney Z, Khakharia A, Brewster L, et al. Race and Socioeconomic Status Independently Affect Risk of Major Amputation in Peripheral Artery Disease. <i>J Am Heart Assoc</i> 2018 Jan 12; 7(2): e007425.	Black race significantly increases the risk of amputation even within the same socio-economic group compared with white patients and has an independent effect on limb loss after controlling for comorbidities, severity of PAD at presentation and use of medications.
Cerebrovascular Disease	U.S. Department of Health & Human Services: Office of Minority Health 2021. https://minorityhealth.hhs.gov/omh/	African Americans are 50% more likely to have a stroke as compared to their white counterparts. Black men are 70% more likely to die from a stroke as compared to whites. African American women are twice as likely to suffer from a stroke than white women.
Infectious Diseases HIV	Sangaramoorthy T, Jamison A, Dyer T. Older African Americans, and the HIV Care Continuum: A Systematic Review of the Literature, 2003-2018. <i>AIDS Behav.</i> 2019 Apr; 23(4): 973-983.	Disparities in the HIV care continuum persist in older age groups particularly among African Americans. Older African Americans face a disproportionate risk of acquiring HIV and suffer higher morbidity and mortality than older adults of other racial and ethnic groups.
Renal Disease	Hamler T, Miller V, Petrakovitz S. Chronic Kidney Disease and Older African American Adults: How Embodiment Influences Self-Management. <i>Geriatrics</i> 2018 Sep; 3(3):52.	African Americans over 65 yrs. have death rates 15% greater than whites in the same age range.
Alzheimer's Disease	African Americans and Alzheimer's Disease: The Silent Epidemic. Alzheimer's Association. https://www.alz.org	The Age-related prevalence of dementia was 14% to 100% higher in African Americans. The cumulative risk among first degree relatives of African Americans who have Alzheimer's disease is 43.7%. There is a greater familial risk for Alzheimer's in African Americans. Genetic and environmental factors may work differently to cause Alzheimer's in African Americans.

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Table 1 (continued)

Disease Category	Reference	Outcome
Ocular Disease (Glaucoma)	Javitt J, McBean A, Nicholson G, Babish D, et al. Undertreatment of Glaucoma among Black Americans. <i>N Engl J Med</i> 1991;325 (20): 1418-1422.	Glaucoma related blindness is between 6-8 times more common among Black Americans than among white Americans. The authors studied population-based rates of incisional and laser surgery for open angle glaucoma among Blacks and whites in a 5 percent random sample of Medicare claims for 1986 through 1988. For all U.S census divisions combined, the rate of surgery for glaucoma among Black beneficiaries was 2.2 times higher than the rate of surgery among white beneficiaries. The authors calculated an expected rate of glaucoma surgery was 45 percent lower than expected which might in part account for the excess rate of blindness among black Americans. The magnitude of the difference ranged from 29 percent in the Middle Atlantic states to 50 percent in the South Atlantic States. The authors concluded that African Americans are not receiving potentially sight saving care for Open angle glaucoma at the same rate as White Americans

period with over one thousand patients in two ethnically diverse boroughs within New York City. All these exchanges occurred at the NYC Health & Hospitals/Queens, Elmhurst, and Kings. These hospitals are members of the largest public health care system in the United States.

The recognition that individuals came to our institutions and were given a diagnosis they did not want and cannot give back, is the common thread, i.e., the human experience. Once a disease is accurately diagnosed, the disease is non-negotiable and no individual, culture, economic status, race, ethnicity, or country of origin can change the circumstances. This aspect of the human experience has the potential to be unifying. Furthermore, when we accept the concept of a “non-negotiable disease diagnosis,” then empathy rather than judgmental attitudes toward all patients must be the chosen patient engagement approach.

THE PROPOSED CONCEPT

The cultural change in our health system must acknowledge the diverse background and training of our physician pool and include the diversity of Black patients. According to a December 2018 report published in *Health Care Weekly*, 29% of Physicians practicing in the U.S. were born outside of the country. Moreover, according to the 2019 American Association of Medical Colleges Report, among all physicians practicing in the U.S., only 5% identified as Black. Similarly, only 5.5% of physicians in res-

idency training across the U.S. reported as Black/ African American^{5,6}.

Patient Engagement and Cultural Sensitivity must have a Bi-Directional Approach. Therefore, we suggest the following forms of exchange:

- American born physicians engaging with American born patients who are racially / ethnically different from themselves
- American born physicians engaging with Foreign born patients
- Foreign born Medical Graduates engaging with American patients

There are essential questions which should be asked by both the physicians and the patients to develop perspectives that will enhance patient engagement. Communication includes verbal as well as body language. Most experts agree that body language accounts for up to 93% of our communication⁷. When body language is the driver, these are some of the concepts that are important to understand:

1. What is the patient not saying that the healthcare providers are not hearing?

- I am embarrassed to talk about my living arrangements.
- I have not accepted this disease.
- I do not understand what you are saying.
- I cannot afford the medications.

- I am frightened about my condition.
- I am worried about the impact of my disease on my job and finances.
- I do not trust the medical system and I am going to try home remedies.

2. What is the health care provider not saying that the patient is hearing?

- I am not smart enough to understand my disease.
- I am in the low literacy group; therefore, I have low intellectual capabilities.
- You assume that I am not going to follow your instructions.
- You people do not usually follow instructions.
- You do not see the need to value and understand my cultural beliefs.
- You do not see my life as having equivalent value to yours.

3. Language of negativity: does it reflect the absence of patient value?

- Non-compliant label without asking “why.” If it is not known why an individual did not comply with instructions and or medications, the impact can lead to poor health outcomes. The “Why” question is a clear example of the “simple” solution.
- The slang term often utilized by hospital personnel “Frequent Flyers” implies that the individual is at fault for his/her worsening health status and does not deserve comprehensive effort of the hospital team.
- How frequently are patients specifically assigned these negative labels? 10%? 20%? 50%?
- What percentage of Black patients are assigned these negative labels?
- Does the care provided to this group of patients lack empathy?
- Drug seeker is an unconscionable description often used for a patient with Sickle Cell Disease. Many individuals with Sickle Cell Disease in the U.S. are Black Americans⁸.
- These individuals experience two forms of severe pain.
 - The physical unimaginable pain associated with the sickle cell crisis
 - The mental and emotional pain when one is referred to as a “drug-seeker”

The mental and emotional pain is avoidable, but the physical pain is not, as it is a complication of the disease. The mental and emotional pain that an individual suffers while accessing care to eliminate the severity of physical

pain during a crisis episode is unwarranted, and unnecessary, and lacks compassion and empathy. It is a result of either conscious and/or unconscious bias towards this patient population.

4. The importance of the social history assessment.

A major area of concern is the social history documentation in the medical record. For example, a 70-year-old African American female who is admitted for decompensated Congestive Heart Failure due to non-compliance, with a social history significant for no alcohol, tobacco, or toxic substances is concerning. The combination of non-compliance without asking “why” coupled with “no toxic substance” to define a human being is a result of bias. That individual is no longer valued. Ironically, we are taught in medical school what should be included in the social history.

To limit who the patient is with the description related to substance abuse is unconscionable. If we know who the individual is as opposed to one’s perception of the individual, then it makes healthcare delivery more attainable with potentially better health outcomes. If one’s perception is the same as the reality, then there is an opportunity to make necessary changes, but if one’s perception is different from the reality, we run the risk of increasing disparities in care and health outcomes.

5. The role of religion to the elderly African American.

It is also critical to recognize the importance of religion in the elderly African American Community and how it influences clinical care. An 82-year-old African American during her hospitalization shared, “What I am most concerned about is that I will not be able to go to church this Sunday.” This patient had stopped eating and participating in her care. The medical team diagnosed her as being depressed and that she should have a psychiatric consultation. However, it was suggested by the care management team that her pastor should also be consulted. The pastor visited her and promised to return on Sunday to pray with the patient if she was not discharged by that date. The pastor clearly understood that from the patient’s perspective, she needed to please God. Following the Pastor’s visit, the patient was a different individual. She was no longer depressed, reverted to participating in her care and no longer had feelings of guilt because of her inability to attend church services.

THE SPOT CHECK METHODOLOGY TOOL

The Spot Check questions are designed to assist patients with issues related to identity: who they are, what are their fears, and what issues are most important to the patient and their acceptance of the diagnosis (Table 2). Equally

Table 2. Spot check methodology.

Speak to patient/family to understand the individual	Who is the individual (Married/Single/Separated/ Divorced; Mother/Wife/Grandmother/Widow; Father/Husband/Grandfather/Widower; Educational level/ Employment; Place of Birth; English speaking, non-English speaking, limited English proficiency, bi/multilingual; belief system)?
Pacify fear factors if possible	What are the fear factors that keep the individual up at night? (e.g., Am I going to die? Will the treatment make me feel worse? Can I have a normal life? Is this my fault? Did God do this to me?).
Outline what is important to the individual	Family, Work, Character, Religion/Culture/Ethnicity, Finance, Health, Fun and Recreation, Privacy, Dignity and Respect, Choices.
Take into consideration the time it takes an individual to accept the disease	Where is the individual in the acceptance of the disease? Are they in denial and how do we as health professional put forth a plan to help the individual in the acceptance of the disease?

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important is the empowerment of the patient to share vital information with the healthcare providers. When an individual is given an unexpected diagnosis that could be life threatening, there is no preparation for coping with a non-negotiable disease.

FOR THE PATIENT

Most often patients relate that they experience confusion and fear. The absence of coping mechanisms heightens anxiety and confusion. The providers must know who you are as an individual and not who they perceive you to be. The providers must understand that being a patient is merely a part of who you are as an individual and not the sum total. The importance of the questions is multifaceted. An individual’s fear and lack of acceptance of the disease can potentially drive non-compliance. Knowing the individual and what is important to the individual will open avenues for engagement, enhance compliance, and improve outcomes⁹.

FOR THE PROVIDER

Speak to the patient/family to understand the patient as an individual person. What are the fears that keep the individual up at night? (e.g., Am I going to die? Will the treatment make me feel worse? Can I have a normal life? Is this my fault? Did God do this to me?). Outline what is important to the individual: family, work, character, religion/culture/ethnicity, finance, health, fun and recreation, privacy, dignity and respect, choices. Take into consideration the time it takes an individual to accept the disease. Where is the individual in the acceptance of the disease? Are they in denial? How do we as health professionals put

forth a plan to help the individual in the acceptance of the disease⁹?

RECOMMENDATIONS

Health disparities that negatively impact the Black patient transcends socioeconomic status. We believe a culturally sensitive patient engagement approach that enhances the value of the Black population is the key. We propose that the tools discussed will enhance the necessary training on patient engagement and cultural sensitivity particularly for the English-speaking Black population.

- The application of the concept of the Common Thread: The Human Experience will create an empathetic as opposed to a judgmental delivery of health-care.
- The Spot Check Methodology to improve patient provider communication.
- Application of C.H.A.N.G.E. to Improve Health Disparities.
- Mnemonic to Improve Health Disparity
 - C-Change negative perception of patient to reality.
 - H-How can I help?
 - A-Acknowledge the atrocities that the Black elderly endured.
 - N-Never Use Non-Compliant without asking why.
 - G-Give the patient the benefit of the doubt.
 - E-Empathetic Care.

These concepts can be built into training modules for residents and faculty as well as hospital wide human

resources annual training. This will improve overall patient engagement and result in better health outcomes for the Black population.

CONCLUSION

In 1966, while addressing the Medical Committee for Human Rights, Martin Luther King expressed eloquently that “Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”

Health inequities clearly delineate the association between poor health outcomes for the Black population and conscious and unconscious bias. If the perception and reality are the same, then there is an opportunity to create an effective and sustainable needed change. If the perception is the driver and not the reality, then needed change will be ineffective.

The tools outlined above will enhance the necessary training on patient engagement and cultural sensitivity particularly for the English-speaking population.

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