

Addressing Bias and Disparities in the Care of Patients with HIV: A Call-to-Action for Associates



CMEO Podcast Transcript

Dr. Monica Peek:

Hello and welcome to a very special CMEO Snack activity that is part of a series I am leading on Diversity, Equity, and Inclusivity with CME Outfitters. Today's CMEO Snack is entitled, Addressing Bias and Disparities in HIV Care: A Call-to-Action for Associates. Today's program is supported by an educational grant from Walmart Incorporated. I'm Dr. Monica Peek, and I'm the Ellen H. Block Professor of Medicine in the section of General Internal Medicine. I'm also the Associate Director at the Chicago Center for Diabetes Translational Research and the Director of Research at the MacLean Center for Clinical Medical Ethics, all at the University of Chicago. I've been practicing medicine for over 20 years, and I'm delighted to be a part of this series. I'm also happy to be joined today by my distinguished colleagues, Jake Collins and Dr. Carlos E. Rodriguez-Diaz. Jake and Carlos, would you mind introducing yourselves to the audience?

Dr. Jake Collins:

Absolutely. Hello, and thank you, Dr. Peek. I'm Jake Collins. I'm a Physician Assistant at Dr. V Medical in Los Angeles, California. We are an internal medicine practice geared toward serving the LGBT community. We do a lot of HIV treatment and prevention, as well as general primary care. Since Los Angeles is such a global city, we have a very diverse patient community, which we welcome and celebrate. I've been practicing as a PA for three years.

Dr. Monica Peek:

Thanks, Jake. Carlos, happy to have you as well.

Dr. Carlos Rodriguez-Diaz:

Thank you, Monica. It is my pleasure to join you. My name is Carlos Rodriguez-Diaz. I'm a health educator by training and a scientist, and currently I'm Associate Professor and Vice Chair of the Department of Prevention and Community Health at the George Washington University Milken Institute School of Public Health. I'm a Latino, I'm from Puerto Rico, and I do research with primary health care centers, and we focus on Latino health, people affected by HIV, and LGBTQ people.

Dr. Monica Peek:

Thank you so much for joining us. Your expertise, both of you, is going to be so important for our session today. Before we get started, I want to make sure that we have a historical lens that we approach our session through. And that is the legacy of both racism and homophobia within medicine, and how it impacts the way that patients are treated not just in the past, but also today, and the kind of care that they receive.

And so, we know that there is medical mistrust and historical rationale for it, that patients aren't just paranoid. We know that historically, racialized minorities have had a long history of mistreatment and discrimination within society as far as redlining and racial segregation, but also within health care as far as differential treatment and

Addressing Bias and Disparities in the Care of Patients with HIV: A Call-to-Action for Associates



unethical experimentation. And the same is also true as far as sexual orientation. Homosexuality used to be labelled as a mental disease in psychiatry. And so, we have come a long way in how we think about the LGBT community within health care, but there are still a lot of stigma within our profession that we have to overcome, there's still a lot of racism within our profession that we need to address. And so, when we are particularly addressing persons of color who are a part of the LGBT community, it's an additional challenge. And so, that has impacted how we have dealt with the AIDS crisis and some of the disparities that we see even today in HIV prevalence, and how it's managed and treated.

So, when I was training in the 80s, it was at the height of the AIDS crisis, and many hospitals and health care providers would refuse care for people who were living with HIV and AIDS. I was trained at Johns Hopkins and so we were on the forefront of a treating hospital and we provided a lot of care and people were very sick. But it was during that time that, between medical schools on to residency, where I dealt with San Francisco, that it transitioned from being primarily an in-patient death sentence to a primarily outpatient chronic disease because of some of the research and medications that became available. But, it was because of the activism on the part of patients with HIV, and then forcing the government to acknowledge that this was a crisis that we had to move more quickly on that pushed the research forward that made some of the breakthroughs possible, and that forced us to acknowledge that we could not continue to marginalize a population's health because of their social identity. That made it possible, years, decades and decades later, that AIDS is now a chronic disease, like diabetes or hypertension, no longer a death sentence like cancer, or many cancers. And so, it's important for us to sort of have that historical framing before we begin our discussion. And so, I'm going to see if Carlos, if there's anything that you want to add, before I turn it over to Jake.

Dr. Carlos Rodriguez-Diaz:

Thank you for providing that important historic context in the response to the HIV epidemic. I will only add that, indeed, LGBT communities, particularly gay men, lesbian women, and transgender people of color, were in the frontline in the response to the HIV epidemic, advocating for important changes. And while that is important to know, not only for historic purposes, it's also an important factor of why our health care system is the way it is nowadays, in terms of the provision of HIV care, but most importantly, we all have a role in the response to HIV epidemic. So, we should not leave to LGBTQ people or people who are living with HIV, the activism and the response to the epidemic. We all, everybody, has a role in helping and preventing and providing services to people affected by HIV.

Dr. Monica Peek:

Absolutely, absolutely. Jake, do you want to take it from here and talk about social determinants of health? What are they? And how do they impact those living with HIV?

Dr. Jake Collins:

Absolutely. So, as we can see here, the social determinants of health, there's a few of them listed, but in general, what we're thinking about is all of the non-medical factors that can influence someone's health outcomes. So shown here, some examples include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. So, you can kind of imagine how

Addressing Bias and Disparities in the Care of Patients with HIV: A Call-to-Action for Associates



deficiencies in any of these areas may lead a person to have worsened health outcomes, and that's definitely what we see with HIV patients. I like to compare it to running a race. People with more hurdles to overcome are less likely to reach the finish line.

Dr. Monica Peek:

That's an excellent analogy. And when they do reach the finish line, they're more likely to reach it more slowly. Carlos, two other things that impact those living with HIV are myths and stigmas. What are some of the myths and stigma surrounding HIV?

Dr. Carlos Rodriguez-Diaz:

First of all, you better know that HIV stigma and discrimination kills people. As we discriminate with people, we are pushing them away from services, and that's the worst we can do.

So, some of the general myths are related to HIV transmission, and HIV is transmitted predominantly in the United States via sexual contact, and there is also a significant amount of new cases that are reported among people who inject drugs and some cases of mother-to-child transmission. That transmission can be prevented with medication, and if we provide syringes or other products for safe use of drugs is another way of preventing HIV. And for the prevention of sexual transmission of the virus, we have condoms, and also pre-exposure prophylaxis or a medication that can be used regularly to reduce the likelihood of getting infected with HIV.

So, it is important to remember that HIV is not COVID, it cannot be transmitted just to be near a person with an infection and, for the most part, we will not know when a person with HIV is around us because a person with HIV, when in treatment, will look healthy like most of us.

Dr. Monica Peek:

Absolutely. Jake, anything you want to add to that?

Dr. Jake Collins:

Yeah, I think that some of the most harmful stigma around HIV is assigning morality to an HIV diagnosis. I've heard people express beliefs that people with HIV are bad or that they deserve it, and these beliefs can be very damaging to both people with and without HIV, as it can lead to feelings of isolation and shame in the people living with HIV, but also a fear of seeking treatment and disclosing HIV status to sexual partners, which can put HIV negative people at further risk of HIV infection.

Dr. Monica Peek:

Absolutely. One of the things I think is important for everyone to know is that the health care encounter begins with the first person who greets them. And so, this is something that people at Walmart probably know because you guys have Walmart greeters. And so, the same thing is true at the doctor's office. And so, way before the patient gets into see me, they've had multiple contacts. And so, how they experience their care is impacted by all of those people they've seen before they get to see me. And if they have been made to feel less than because

Addressing Bias and Disparities in the Care of Patients with HIV: A Call-to-Action for Associates



they have HIV, if they have been looked down on or discriminated against, then that affects their whole mood that they're in by the time they get to see me.

How much of the information I'm giving them that they can actually hear, if they're in a funk, it affects whether or not they'll be able to come back to see me, if it's the first time meeting me, they may feel like this is not a good place or a safe place for them to receive their care. And so, it's not just about the care that I can deliver, it's about the care that my entire team can deliver. And so, that's why it's really important for the whole team to be on board with the idea of delivering equal care to all of our patients, particularly those who may have a stigmatizing illness like HIV. Carlos, do you want to comment on this or add anything else?

Dr. Carlos Rodriguez-Diaz:

Yes, absolutely, because many people who are affected by HIV are also members of the LGBTQ community, it is important to acknowledge that pronouns matter and referring to people in their preferred way, not only from the pronouns but the preferred name, is extremely important. If you're listening and watching this video, it's because very likely you interact with people, and perhaps you've seen how often people change their facial expression when you say good morning or good afternoon or when you know somebody's name, and you greet them by name. So, the same happens when you use the correct pronouns and the correct name of the people that you are interacting with. So, it's not that difficult, it is not something that would make your interaction more difficult.

And if you make a mistake, just acknowledge your mistake. We all make a mistake, but by acknowledging, we are providing a message of respect to the other person, and that's something very powerful that we can do in the context of making people feel comfortable and welcome where we are.

Dr. Monica Peek:

Absolutely, absolutely. So, we need to recognize that we all have to examine our own biases and there's a wonderful tool that's been developed by Harvard, and it's called the Implicit Association Test, or the IAT. And it's an assessment tool that can be found in many places, but also at our CMEO Diversity Hub. And so, you can take your own test and what it does is show you how many implicit biases you may have against a number of issues. And so, it's helpful for your own self-assessment, so you can level set and have a better understanding of areas that you may need to have some work on.

We know that there are issues with equitable care for patients of color with HIV, and I'd like to ask each of you to share examples of how bias that you may have seen in practice has impacted your patients and their care. Jake, I'll start with you.

Dr. Jake Collins:

Sure. So, this kind of links back to the social determinants of health with the whole race analogy. But, patients of color often experience more hurdles in accessing and staying in care, so even just getting through the door is one of their big barriers. But, something that I've experienced and something that I've heard from patients of color is that there's also a psychological aspect. There are some mental barriers to getting care such as fear of discrimination in a health care setting, if they come from a culture with a history of mistrust of health care, or

Addressing Bias and Disparities in the Care of Patients with HIV: A Call-to-Action for Associates



even discomfort from not seeing their own racial or ethnic identity represented in the health care staff. All of those factors can play a role that causes more of a mental barrier for patients in achieving or in receiving health care. And one of my HIV patients who was also a person of color, who needed a referral for specialty care made it clear that they would only go to see the specialist if the specialist was of their same race. And the patient had had so many negative experiences in the past with dismissive providers and felt that it was due to their race, and they really just lost trust in the system.

Dr. Monica Peek:

Yeah, and a lot of times, it's hard to find providers of color, particularly in subspecialists, and so I hope they found one, but it's more of a challenge, and particularly when you're in rural communities or, you know, certain kinds of neighborhoods that have fewer physicians in general. Carlos, any stories that you want to share?

Dr. Carlos Rodriguez-Diaz:

Yes, I would like to share the experience that one of our participants shared with me once about why they were not accessing care. And it was because the first time that they got an HIV test at a clinic, the nurse who was providing the test, after conducting an assessment and asking the participant about his sexual practices, and the sex of their sexual partner, basically blamed the person for the risk. And after the result came negative, the nurse shared with them a Bible and started praying. And that was not consistent with the assumed religious values and practices of the patient. And the patient after that experience felt that whenever they would reach to services, they will get that kind of experience, that is very judgmental, and of course, it was imposing an ideology. And we can all have our ideologies and we can practice however we want to practice those ideologies. However, those should not mediate in the interaction that we have with patients, and that definitely would be a gatekeeper, or it will keep the doors open if we have good interactions with providers and our patients.

Dr. Monica Peek:

Absolutely. Now, if you have a patient who is, as someone who has expressed to you that they use their Christian faith as a motivation, or as a way to help them deal with the loss of their loved one, and that then you guys want to say a prayer about something, then that's something that's concordant with their beliefs, if that's your belief system also. But you never want to have discordance with what your patient believes and what you're trying to push on them, and particularly if it's in a judgmental way, because that breaks that patient-provider alliance and bond and makes them less likely to adhere to care, makes them less likely to return to care and again, the stakes are so high for patients with HIV that they stay in treatment, they can have become virally negative, they fall out of treatment, they can die of AIDS defining illnesses. And so, it's so important that we prioritize having them feel like they're in an emotionally safe and physically safe environment and supported, and that they have all the resources that they need.

Thank you so much for sharing those stories. We have some patient voices, some quotes that we have here on the screen. Jake, I'm going to come back to you as someone who interacts with patients on a daily basis, and ask you just to maybe pick one of these quotes and talk about why it's important to be mindful of the patient voice and the impact of race and ethnicity on the lives of patients with HIV.

Addressing Bias and Disparities in the Care of Patients with HIV: A Call-to-Action for Associates



Dr. Jake Collins:

Sure, and I really love all of these quotes, but I'm just going to read one of them and that's the bottom one.

The patient says "I face a lot of stigma because I am gay. Being a gay Latino man is very unaccepted in my community. I was not even offered PREP because it is such a secretive topic. I wouldn't tell my doctor about my sexual history. That impacts so many people around me."

Now, I think all of these quotes really show a diversity of perspectives and experiences that HIV positive patients have, and it really shows how dependent patient experience can be based on what barriers they face and which hurdles they have to overcome to get high-quality health care.

It also emphasizes the importance of meeting each patient where they are, getting to know them as a person, and tailoring our approach to meet their needs. Some patients may need more support or encouragement, especially at the beginning. Patients of color may need additional support due to whichever cultural issues complicate their relationship with health care, if any, but the most important thing is to be sensitive to those possibilities and offer a safe space for the patient. As we keep saying over and over, it's so important that the patient feels safe. The patient doesn't expect you to know every single thing about your culture if it's not their culture, but just being open and letting them know that they're safe and that they're in a judgement-free environment is huge.

Dr. Monica Peek:

Absolutely. Jake and Carlos, thank you both so much for your wonderful insight on how we all as human beings can impact the lives and health of those around us.

I want to recap the main takeaways from today's program. One, think and reflect about your own biases and how your behavior may impact the people around you. Two, understand the myths and facts around HIV. Three, respect each person's story, and how racism and homophobia has impacted their lives. And last, I will ask that you check out these resources to learn more about what we discussed today during this activity. I would also ask that you complete the online evaluation because we really do want to hear from you, and find out what you liked, how we can improve, and what additional topics you want us to address. Also, you can also participate in our other D&I activities. Thank you so much for your commitment to education on Diversity, Equity, and Inclusivity. When we know better, we do better. Thank you for being a good human.