Dr. Ruth Adewuy...: Hello. You're listening to Stanford Medcast, Stanford's series podcast, where we bring you insights from the world's leading physicians and scientists. If you're new here, consider subscribing to listen to more free episodes coming your way. I am your host, Dr. Ruth Adewuya. This episode is part of the Hot Topics Mini Series and today we are talking about the importance of culturally sensitive and accessible care. I am joined by Doctors Amy Filsoof and Baldeep Singh, who are the medical co-directors of Pacific Free Clinic, a Stanford Cardinal Clinic. Dr. Amy Filsoof is a clinical assistant professor of primary care and population health at Stanford Medicine. Prior to her co-director role, she was chief resident in the Stanford Internal Medicine Residency Program from 2019 to 2020. Dr. Baldeep Singh is a clinical professor, as well as the clinical chief in internal medicine in the division of Primary Care And Population Health. As a clinician educator for over 25 years, his primary focus has been on healthcare delivery, medical education, underserved populations, and he has held several leadership roles related to this. Thank you both for joining me today.

Dr. Amy Filsoof...: Thanks for having us.

Dr. Baldeep Sin...: Thank you for having us. We're happy to be here.

Dr. Ruth Adewuy...: I'm curious to hear from you, what began your interest in working with underserved patient populations?

Dr. Baldeep Sin...: When I started my career in the safety net, I came out of residency, was trying to be clear to myself that primary care was going to be my specialty, but really wanted to devote some of my career to underserved populations. So at that time I was in Los Angeles and I joined a clinic in northern Los Angeles that was primarily a homeless and underserved clinic for two years. And then brought that experience back with me to UCLA, where I was on faculty for 14 years. I tried to continue that area of expertise and interests during my time there and then since I've moved to Stanford.

Dr. Amy Filsoof...: I'll share a story with you about how I first got interested in working with this kind of population and then to be totally honest, it's not a story I'm proud of, but I think it's something that happens a lot and I think can be learned from. I got interested with working with this population when I was actually in college, an undergrad before going in medical school and becoming a doctor and I knew that that's where I wanted to go, wanted to get involved and see what I could do to help, and actually got involved with an organization that would organize these medical trips to other countries to help provide medical care to underserved populations there. It involved going to this rural part of Honduras, setting up a mobile clinic. We'd bring our own physicians, medicines and provide care. And I remember at the end of it feeling, honestly, like icky about the whole thing and feeling like, "Did we really provide good care here?"

We dropped in to this community that we didn't know anything about. We're there for one week. I felt like we blurred patients from different parts of the

country to come see us, and then didn't really have the infrastructure or tools to provide high quality care. And it just felt like all this preparation and fundraising and recruitment, medicines, all this effort, the plane tickets that it took us to get there, all that... Was that really a great use of resources? Did we benefit more than the people we were serving? And so that experience really cemented this obsession of mine, which is to take care of this population, but not just to do it however, nilly willy way, but to really be mindful about it and to make sure that we're using resources appropriately, that whatever care we're providing is high quality, that it's sustainable. Things like that. Just from that actually negative experience is how I got involved in this line of work.

Dr. Ruth Adewuy...: What stands out to me from what you both said is this intentionality about how you pursued your medical journey into this space. In order to level set the rest of the conversation, I think it's important for us to maybe choose some definitions or at least understand from both of your perspectives, what cultural sensitivity, cultural competency, and accessibility, what does that mean to you?

Dr. Amy Filsoof...: I just want to say that I, in no way, consider myself an expert in these topics. I think to be an expert, you really have to be doing research and spending a significant portion of your time studying these topics, but I'm happy to share my lived experience and just what I've noticed living and being a primary care provider and trying to work with populations of all different backgrounds. Providing care that involves being culturally sensitive and having that in mind means that your patients, regardless of their age, or sex or gender identity, cultural background, however they identify that any patient you see is going to feel comfortable sharing what they're concerned about and their experiences, and is also going to leave feeling understood. That's a hallmark of providing culturally sensitive care. And I'm saying that might look different for different people of different backgrounds, but as long as those things are common, that's culturally sensitive to me.

Dr. Baldeep Sin...: In the context of us as primary care physicians in the context of our own Stanford Primary Care, but also as medical educators that help run and guide the free clinics, we've grappled with these issues. We're not experts and we've turned often to our experts to help us educate our learners. I think being aware of cultural differences and similarities without assigning value, positive or negative, medicines had to take a very hard look at ourselves. Thankfully, Stanford has done a little better job of this in the last year or two, but I think has not done a great job prior to that of really paying attention to one's own prejudices and biases, really listening to the patients, asking questions rather than making assumptions and just cultivating knowledge. We do this in medical school, a little bit of a haphazard way. We do give medical schools credit that they have spent a lot more time on this topic of then when I was in training.

Cultural sensitivity and literacy training and bias training are all things that are now part of the curriculum for medical schools that did not exist 10, 20, 30 years ago. And so I'm very encouraged by that. You can't obviously turn on the

TV and not see that this is affecting society on an everyday basis and understand that while we have made some progress over the last 30 years since I started, we still have a long way to go.

Dr. Amy Filsoof...: I was lucky to be a part of a generation of medical training where it was increasingly recognized that the huge element to any care of any patient is understanding the cultural context that their health takes place in. They were just starting to formalize it and make it intentional and so we would have certain classes. My medical school called it Health And Society, where you learn skills to understand and weigh these things in your overall care. I will say it was still lacking, even then. I think what was missing when I was there was this recognition that physicians themselves are coming from a cultural background and just acknowledging your own biases or ways that you make assumptions as all humans do that you can at least acknowledge it and then work around it, I think was a piece that was missing, but hopefully is becoming more and more intentionally incorporated in [inaudible 00:07:37].

Dr. Ruth Adewuy...: I'm curious to hear from you how you think the cultural backgrounds of your patients intersect with the social determinants of health. The pandemic has forced us to take a deeper and harder look at how the social determinants of health of a patient impact their overall wellbeing.

Dr. Baldeep Sin...: I would say the focus on social determinants of health as being critical to the care of patients has also evolved. In fact, our own division teaches now a course at Stanford Medical School on this topic on social determinants of health. So what we did a number of years ago was we started a questionnaire within the clinic because the students really felt like we needed to do a better job of social determinants of health evaluation for our patients. And then really do an assessment of where the gaps were in our own patient population. The data was fascinating in that different populations have different kinds of needs. For example, we had done a lot of work with Second Harvest for food insecurity, thinking that this might be a really big issue in our own clinic and attendance in our particular patient population, being less of an issue than difficulty say, at getting medication.

Transportation is always an issue. That's why we've tried to locate our clinics closer to the populations in need. We have one in east Menlo Park, which is going to be moved to Sydney and then one in San Jose to try to account for that, the free clinics. They developed 30 years ago in response to medical students' concerns that they were not necessarily seeing all kinds of patients at Stanford Hospital. Number one and number two, they felt there was a need in the community that was not being addressed regarding trying to help underserved and under insured and uninsured patients. And over 30 years, this has evolved with really a dual mission. Number one, provide the best care we can, what we call transitional care. That is a care where we stabilize the patient and either get them back to their home country, if they're international patients or to a

primary care clinic that is devoted to the treatment of under-insured or low-income patients in their communities.

And the second part of that, our mission is really to provide education to the students about these communities. When the students are actually doing the work both as undergrads and medical students, and as residents, they learn a lot about what it's like to provide care to this community and how challenging it can be, given all of the issues around social determinants of health, lack of access to transportation and housing, but also the fact that many of them just have not seen doctors in a long, long time and then rope them into the system and then get them placed in the appropriate setting.

We have spent a lot of time engaging our social workers about what we can do, resource-wise to offer different kinds of resources based on the social needs screening that we're doing. This is almost like a standard question that we would do in medicine around past medical history or socia history. Your social determinates of health have now become a critical part of that intake that we do with patients, particularly vulnerable populations, in order to really adequately take care of them because so many of these factors impact their ability to follow through on our recommendations.

Dr. Ruth Adewuy...: I think it's interesting that you state that scenario where you surveyed your population, you have that data, and then you take action. The next question that I had was, if you felt like it was the responsibility of clinicians or clinic organizations to quote unquote treat those social determinants of health and it sounds like from what you just said, your answer is yes.

Dr. Baldeep Sin...: I would just say that somewhat depending on the population. So for example, in our regular patient population, which is fairly heterogeneous at Stanford, we may do a little less of this than say at the county hospital or federally qualified health center. And certainly that's why we've [inaudible 00:11:40] the free clinics because we're trying to mimic what's done at the county and federally qualified health center level. Over and over when we look at outcomes, the patients outcomes are 100% determined about whether they can get to appointments or referrals. What is their issues or barriers to food insecurity? What are their racial or cultural barriers in society? What are their issues around housing? So all of these things are critical factors that enable better health. For us to ignore those, I think, does our patients a huge disservice.

Dr. Amy Filsoof...: I completely agree 100% that it is a clinician's responsibility to address social determinants of health and I think if our goal as healthcare providers is to maintain wellness and to treat disease, then absolutely we have to. It is well-established in the literature that social determinants of health have health and wellness impacts. So to not address them and not treat them, the clinician would be in complete care. To add to that, I think as a physician, you also have to understand your own limitations and where your education's strengths are and acknowledge that maybe me as a clinician that maybe, I don't know every

available low-income housing resource in the county, for example. So I think you just have to acknowledge that medicine is a team-based sport and knowing when to recruit other teammates who have expertise that maybe you don't have. So that's where we work really closely with our social workers, with our case managers, with pharmacists, with nurses and the whole team has to work together to provide a complete picture of care that does address these social determinants.

And so as a clinician, your job is to be aware of these things so that you can pick up when patients need a specific treatment, whether that's a social worker or a case manager, whatever resource, and make sure that you're recruiting and deploying the appropriate team member to address it.

Dr. Baldeep Sin...: I would just like to highlight Amy's point, which is that primary care, because we're the frontline where the patients sometimes will interact with the healthcare system has become a team-based sport. We need to expand that at Stanford in general, but we've tried to also improve at the free clinics, although it's much harder which is integrated to behavioral health, because so much of mental health plays into physical health, often this is undiagnosed and the social determinants of health play into that in a very complex way. We have now integrated social work, behavioral health into our primary care teams, and now they've become integral members of our team.

Dr. Amy Filsoof...: We're conditioned in medical education to pretend like we have all the answers all the time. Med students and undergrads all the way through are told that you have to know everything. And if you're asked a question, you need to know the answer. You can never say, "I don't know." And I think when you get into the real world, there's a bit of unlearning that happens with that. And so you're fighting these instincts when patients are telling you about their food insecurity or about their housing, about this feeling that the provider has that they have to have all the answers. I need to know where every food bank is. So that almost leads providers not to seek out teammates and ask for that help and get that expertise of maybe someone who actually could be more helpful on those issues. There's a definite shift that needs to happen and how we train providers and future doctors to think about knowing their limitations.

Dr. Ruth Adewuy...: A tangible gap within medical school curriculum. I wanted to address peripherally what's happening during this pandemic around vaccine hesitancy. And this whole area has highlighted the reality of people's distressed in the medical system in general, or even the fact that some patients have cultural beliefs that don't align with them reaching out to health professionals. How do you connect with those patients that may harbor that distress in the medical system, or even who have cultural beliefs that don't make it easy for them to accept health advice from clinicians?

Dr. Baldeep Sin...: That, I think is one of the biggest challenges. We see this a lot in primary care, given that we live in a very heterogeneous community in the Bay Area, which is

one of the joys and the vibrancy of this community, people will bring many different viewpoints about health that we in Western medicine may or may not share. And certainly given the historical lack of trust in certain communities, we have to bend over backwards to try to understand and accept that. And so I think we all go into these interactions trying to meet patients where they are, try to ask a lot of questions, listen to their answers, and then try to find common ground where appropriate. Why we don't fully understand, say certain kinds of alternative medicine, for example, so long as we don't think it's harmful for the patient, we may agree that we want to work as a complimentary adjunct to their other care.

We also need to be humble about our understanding of all types of healthcare issues and be willing to accept that people may have different ideas about what may work or not work for a medical set of diseases that we may not agree with. So I think meeting people where they are, trying to ask questions to try to see where the barriers are. Often we try to enlist family members or people that they trust, maybe parents or children, community leaders. We have a whole social media campaign at Stanford now to try to address this in different communities. Say with regards specifically to the vaccine, for example, but it is a challenge. It is a challenge when you know in the case of the vaccines to use an example, how important this is, but if you come on too strong or too hard with the patient, I think you can really heighten that distress and make them even more defensive and then push them away. And then you're not doing them a service at all.

Dr. Amy Filsoof...: There's maybe three categories of things that I think about when people have expressed a distress in the health care system. One is to acknowledge and validate the very real ways that the healthcare system has let people down. There are very good examples of this. The responsibility of providers to be educated on those and to acknowledge that those are real and to validate. That goes from everything, from things like the Tuskegee syphilis experiments. I think an infamous example, but even in more recent history, Dr. Singh and I were just in a lecture learning about the equations we use to calculate kidney function. We've been using two different ones for people who are African-American versus non African-American. And really, that doesn't make a lot of sense based on race as a social construct. And so even things like that I think are still pervasive in our system.

So just acknowledging that's a very real thing and that people's mistrust is on a lot of cases. So there's this addressing, acknowledging the systemic factors as one, and then two, understanding someone's individual experience and really just trying to learn, ask individually, how have you been affected? What of your experiences that have led you to harbor mistrust and understanding an individual's understanding and experience in that just to learn and understand and also validate.

And then a third, I think harder one is trying to separate some of those very real and pervasive issues from this new age of misinformation, where there is a lot of misinformation and maybe mistrust that doesn't need to be there. And so trying to parsing those out and then doing what you can to educate on the misinformation and provide evidence-based and scientific fact and blending all that together. It's a tough, tall order, but important.

Dr. Ruth Adewuy...: Yeah. Thank you for sharing that. And I'm actually curious if both of you spent significant amount of time around that misinformation piece and debunking things in your practice?

Dr. Baldeep Sin...: Yeah, absolutely. But again, you have to do it in a way that's non-confrontational and doesn't insult the patient in any kind of way. Often people are being duped into information that we can't blame them for necessarily hearing the wrong information. So I think in a calm and just passionate and empathetic way, you're trying to hear what they're saying and trying to slowly systematically break down why that is disinformation, what the science is and why you think they should appeal to the therapeutics we recommend. And I will say one interesting thing that we noticed in primary care in particular is that because people have longitudinal experiences with us, often over years to decades, their level of trust can sometimes change. So my ability to get someone to engage with something maybe at their first visit is very different than someone I've taken care of for a decade who now, because we've seen them through thick and thin over many, many years, and they've grown to trust us, will now take our advice.

One of the key factors that make primary care so important is building that trust that they may really not have with any other healthcare professional in order to then start to get them to make some lifestyle changes or therapeutic changes that will really improve their health.

Dr. Ruth Adewuy...: I thought I could ask for some examples of when you were unable to connect with a patient, whether because of a different background, cultural difference or whatnot, why you think the connection wasn't established or hard to be established, and what would you change, looking back?

Dr. Amy Filsoof...: I actually had a patient not too long ago, who was young, thirties, pretty healthy, coming in just for some routine screening things. The patient grew up in a country where the standard of care for what is a routine screenings is very different from what we provide here. And this happens a lot where maybe someone comes where it's more routine to get full body MRIs or more labs or whatever it is. But so this patient really wanted to make sure that they were up to date with cancer screening. And so I explained what age appropriate cancer screening we can offer and wanting to make sure that they were up to date. And at the end of it, the patient still really wanted me to order imaging for a cancer screening and didn't have necessarily symptoms that would warrant it or other things like that.

And I spent a lot of time explaining the data and why we have these recommendations and that I didn't think imaging was appropriate. And we really just couldn't find common ground. And she just kept wanting the imaging and wanting the imaging. And so we had to leave it as, "Okay, well, we're going to have to agree to disagree on this." And I think in retrospect, what would have been a better use of our time and more relationship strengthening and building was rather than me try to convince her of my viewpoint and my data and my facts or whatever it is, which is to understand why are you so preoccupied with getting cancer screening? Did you have an experience where a family member had cancer that you had to witness, or do you have some symptoms and maybe you're not comfortable sharing with me and may do warrant some imaging. Just understanding, where is this preoccupation with cancer coming from, rather than let me just convince you of what's quote unquote, right.

So I think it gets back to this theme that keeps coming up of just understanding and having patients feel understood should be your first instinct rather than convincing.

Dr. Baldeep Sin...: In some cultures, the issue of dying is very difficult for families to want to talk about with patients. One of the things I think about we value in Western medicine is the idea of transparency with patients. There used to be a very paternalistic approach. Over many years, we've tried to become partners with patients and transparency is a key feature of this, but it has been difficult for me in that some cultures, particularly Asian cultures, and I'm not making a judgment here, but just have tried to not have me bring up the fact that there's a cancer diagnosis with typically an elderly patient who doesn't speak English and trying to keep that information from them. So here we have an Eastern value in conflict with a Western value. Many physicians have struggled with this.

We try our best to convince the families that when patients know their cancer diagnosis, it allows them closure and it allows them to engage with the family in a different way. But often I've had to concede and just express my concern with that family member not knowing their diagnosis, while I don't feel a hundred percent perfect about it, not wanting to upset the cultural background and the family and the patient.

Dr. Ruth Adewuy...: You've both referenced that it's important for clinicians to recognize their own cultural background and how that shows up when they talk to patients. But also as they take in those cultural differences that they need to keep an open mind about the different perspectives of the patient. How do you do that? What are some things that have worked for you?

Dr. Baldeep Sin...: It takes work. We have a set of teaching called motivational interviewing where you advise them on what you think they need to do. You try to get them to link what you're asking of them with something that is meaningful to them. So let's take the example of asthma that you're saying that by not smoking, their asthma will get better. So you're linking something that you're trying to change

say, quitting smoking to something, a disease they have, or to their children's health. Your smoking is now really affecting your children's health. Sometimes you have to sit with that for awhile. The patient will sit with it and sit with it. And again, getting back to this idea of the continuity and primary care, patients will come back and they say, "I really thought about what you've been telling me over years," and because I didn't pressure them when they're ready to make the change, there'll be in a much better space in their head to take that on.

If you want to talk to me about X, Y, and Z issue, I'm available to you. Make yourself available and then be repetitive. I think half the job of primary care is being really [inaudible 00:26:18] and that I bring up the health care behaviors that we need to change or adapt at every visit so they know that I wouldn't be putting this effort in if I didn't think it was important.

Dr. Amy Filsoof...: I think a place where this comes to a head a lot, and I grapple with this all the time, and I don't know what the answer is, but with mental health, I think there's a lot of variation in how different cultures view mental health and what is diseases of mental health, depression, anxiety, et cetera. It's really hard to balance what someone's understanding of those things are with what I think increasingly is the medical communities understanding, which is that depression, anxiety is a disease, much like hypothyroidism, cancer is a disease and therefore, should and can be treated. And I don't want to invalidate someone's understanding of mental health and their cultural context, but at the same time, I don't want that to prevent them from getting treatment that I know may help them and may help them feel better and function better.

And so running that needle of how can I bring my understanding of depression as a disease and blend that with your cultural understanding of depression and where can we meet halfway so that the outcome that we get is mutually agreed is good, and that you're better and whatever better means to you. What better is again, is going to be different to different people, but understanding what is better to you and how can I help you get to that is the basic principle that I use.

Dr. Ruth Adewuy...: What do you think are some key takeaways for clinicians, health care professionals and what can they do in their practice to provide culturally sensitive and accessible care to their patients?

Dr. Amy Filsoof...: I would say your first role as a provider is to understand, not to convince. I would say another pearl is what we mentioned about medicine being a team sport. Understanding your expertise and when you bring in the expertise of others to provide the most complete care and probably a third is that these principles and providing culturally sensitive care applies to 100% of your patient encounters. Every single patient has a culture, has a context, has social determinants of health. This is not unique to one population or the other and that 100% of your patients should be approached with this frame.

Dr. Baldeep Sin...: Gives us a few examples, things that we've done both at Stanford, but also at the free clinics. One is that we've provided very robust interpretive services. We really want the patients to feel comfortable who don't speak English. We have a huge population that doesn't speak English in both sets of clinics, our own Stanford clinics and at the free clinics. And in fact, we recruit students from our undergrad campus to be interpreters in the free clinics in the top four languages that we see the most. The second of course, which we've spent a lot of time thinking about what we need to still do a much better job is, recruit and retain both faculty and staff that look like our patient population so they feel comfortable. So we really want African-American, Latino, Latinex, Asian staff and faculty that mirrors our patient population. We've thought a lot about this in the free clinics and we've really tried to recruit managers and students to help patients feel more relaxed in the clinics by mimicking the ethnic diversity that they see in their communities.

The third thing which we're doing, and I think, again, we still need to do more, we recently did this with LGBT rights in the free clinics is to do trainings that are really focused on being more culturally aware to gain the knowledge and skills that you need in both the context of cultural competency, but also LGBT and other kinds of skillsets that both the faculty and the students and our staff need in order to not show biases, to be culturally competent, to be open-minded, many of the things that we've discussed in this podcast today. And then use our larger team, as Amy was alluding to earlier, community health workers, social workers, other kinds of health promotion tools that are culturally specific and appropriate to round that out so people feel that the whole [inaudible 00:30:43] you is supportive and culturally aware and thoughtful for patients in really every aspect from top to bottom.

Dr. Ruth Adewuy...: Excellent. Thank you for joining me today and talking to me about this topic and sharing your insights. It's been an excellent conversation and we appreciate you being here today.

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