U.S. Healthcare Services & Diverse Populations

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Presenter: Tasha Perkins Holmes, MOT, OTR/L

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- [Fawn] Our course today is U.S. Healthcare Services & Diverse Populations. Our presenter today is Tasha Holmes. She has a Bachelor of Arts and Sociology from the University of Maryland, Baltimore County, and a Master's Degree in Occupational Therapy from Nova Southeastern University. Tasha has been an occupational therapist for over 16 years, and has worked in a variety of settings with age groups spanning from toddlers to the elderly. She has spent over nine years providing school-based OT services, with more than six of those years using a telehealth service delivery model. Her teletherapy experience has allowed her to provide school-based OT services across the U.S. and as well as internationally. In addition to direct treatment services, she also spent time teaching in the Certified Occupational Therapy Assistant program at Central Piedmont Community College. Welcome back, Tasha. So glad to have you.

- Thank you. Thank you, everyone, for joining me for this presentation. Here is the slide with my disclosures. So feel free to take a look at that. I'd like to go into the learning outcomes for this course. After this course, you will be able to identify some of the barriers to healthcare in diverse populations. You'll be able to identify ways to be more inclusive when providing healthcare services. You'll also be able to identify ways to support coworkers in a healthcare setting. And this presentation, it's designed to help start the conversation for some and advance it for others. We're all in a different part in our journey for providing equitable services. That has a lot to do with the way that we were brought up, the current things that we have going on in our lives, our different leisure activities which allow us to maybe read and engage in different types of activities that have an effect on the way we provide healthcare services. So I want you to keep that in mind as we go through this presentation. There are limitations. It does not provide an in-depth look at intersectionality. And while I do feel that intersectionality plays a very big part in how people receive healthcare services and also affects how equitable those services are and people's experiences in healthcare services. This is not a deep dive into that. We're just beginning the conversation and advancing it, adding on information for others. This does not provide an exclusive list of historical, present-day events, laws, policies, that have caused and continue to perpetuate marginalization. So while we will look at some historical events that have had an effect on healthcare, this is not a deep dive into those events either. It does not discuss issues faced by every marginalized group. And so that certainly would be longer than a two-hour presentation in order to present all of the different issues that each marginalized group has to face when they're receiving healthcare services. And it's not an exclusive list of the issues faced by the groups discussed. And so while I will discuss some marginalized groups, and groups, their issues, this is not an exclusive list. So please keep that in mind also as we go through these slides. So U.S. healthcare.

Okay, I'd like to start out with this quote by John Lord Dalberg-Acton. It says, "The most certain test by which we judge whether a country is really free is the amount of security enjoyed by minorities." And so I'd like just to take a minute and think about how that applies to healthcare and how that applies to services provided to marginalized groups. Here's another activity that I'd like to present to have you think about, just to do some reflecting before we get into our information. Have you ever had to correct a healthcare provider regarding your preferred pronoun? So my preferred pronoun is "she." I've never had to correct a healthcare provider. I've always been referred to as such. Have you ever been concerned that your race would negatively affect how seriously you were taken by a healthcare provider? Have you ever been reluctant to seek medical care due to your sexual orientation or your sexual identity? Have you ever been concerned about there being a language barrier between you and your healthcare provider? Have you ever missed follow-up healthcare services due to financial reasons? Or have you ever experienced physical challenges that made it difficult to obtain healthcare services? So have you ever been concerned about how you're actually going to physically get inside of that building to see your healthcare provider? Okay, so I'd like you to keep this in mind while we're going through the slides as well. Okay, so I'd like to present to you a timeline activity that we will complete while we're going through the slides. And so for this timeline activity, what you will need is something to write with and something to write on. And you'll make your timeline, so you'll either make a vertical line or a horizontal line, whichever way you choose, and you're gonna put tick marks. The first one will be the year either one, where both of your parents were born, the year you were born, the year you graduated from high school. You'll put another mark for the year you graduated from college. Another mark for the year you graduated with your degree in healthcare. And then, you'll put in, your last mark will be for this year, okay? So please take a minute to add those dates into your timeline.

Okay, and the first thing I would like you to add onto your timeline after you've placed all of the other tick marks in, I'd like you to add in the date 1964. And next to that, I would like you to write, "The Civil Rights Act." So this Civil Rights Act, it outlawed discrimination on the basis of race, color, religion, sex, national origin, and it required equal access to public places and employment, and enforced desegregation of schools and provided the right to vote. Wow, that's a lot. So it sounds like the Civil Rights of 1964 probably fixed all of the issues that were going on prior to then leading up to 1964. And so at that point, we should've seen equitable care in healthcare and school, for employment. But let's think about this for a minute. How do you think this affected attitudes at newly integrated hospitals? So you go into work on Monday and it said that hospitals need to be segregated. And then you come back to work on Tuesday and the law has been signed saying, well, we are going to integrate the hospitals.

So, of course, doesn't happen overnight, not in 24 hours. So let's think about the attitudes of the people who were previously working in the segregated hospitals, and let's think of the patients who were currently being segregated in the hospitals. How do you think the attitudes may have changed from one day to the next? Or what people were thinking and feeling when they heard that the Civil Rights Act was now a law?

How do you think this affected the attitudes of professionals who were teaching future healthcare providers? So on Monday, we have segregation. And on Tuesday, it's saying that integration is what needs to happen. Do you think there were discussions about how this was going to affect the way they were gonna provide healthcare? Do you think there were discussions on how to make sure healthcare was gonna be equitable? Do you think there were action plans for how can we help these hospitals get integrated or these schools get integrated where we're going to be practicing? And how patient-centered do you think mental health care services were at the time? Do you think that they were looking at intersectionality? That they were thinking, you know, let's think about what these patients are feeling since they may have been segregated previously?

Let's just think about some of those things. So that's just for you to reflect on as we go through some of these slides. So with that being said, barriers to healthcare. There are a lot of different barriers to healthcare. We're gonna touch on a few. People may not receive care because of distrust of the healthcare system, language barriers, or the cost of missing work. That's a huge deal for some people. Racism, stigma, and systemic inequalities undermine prevention efforts, they increase levels of chronic and toxic stress, and ultimately sustain health and healthcare inequities. So that is the information that I pulled from the CDC actually regarding COVID-19, in terms of the racism, the stigma, and the systemic inequalities. Which is interesting because it's, you know, now we're in 2020 and we're looking at those types of things. But in 1964, there was a desegregation of hospitals. So that should've provided equity in healthcare, right? When we're also looking at language barriers, and we're looking at the cost of missing work, that goes along with some of that intersectionality where you're thinking about while someone may be thinking about their race, they may also be thinking about their language, or they may be in a lower socioeconomic class, another layer for them. So a language barrier is more than just inconvenient. A language barrier can be fatal if that person does not understand the medication dosage. That's a real issue that's a life-or-death issue. A patient or patient's parent or caregiver may have to take off of work without pay to attend therapy and/or doctor's appointments. That becomes a health issue as well if you don't have the money to take off of work and you can't attend your follow-up appointments, or even your primary care appointment, or your therapy appointment for you or your child, that's gonna be very detrimental to the health and wellbeing of that family.

A patient or patient's parent or caregiver may not have the money for transportation to appointments. So they may not be able to, they may not have the gas money to get to that appointment. The gas money versus maybe buying food for the week, so they're not gonna come to that appointment. That's gonna be a big, huge barrier. They're not gonna be able to, maybe they can't afford a cost-share ride to the appointment. They can't afford public transportation to get to the appointment. Or maybe they, you know, they don't have a car to get to the appointment, so it's not even a matter of the issue of having gas. That's a huge barrier to getting the necessary healthcare needed. And so, there's also been studies done that suggest the fear of discrimination and consequent delay of care are at the forefront of healthcare challenges for transgender adults. So if you really think about this, what this is saying is that the fear of being discriminated against is so strong that that person is willing to forego either a mental health treatment or a physical health treatment because of that discrimination. Or they're willing to delay care that they really need because they're afraid of that discrimination. That means that discrimination is a bigger concern than what's going on with them health-wise.

Okay, so I'd like you to add something else to your timeline. Okay, in 1972, the Tuskegee Experiment ends. Okay, and so why is that an important date? So the Tuskegee Experiment began in 1932. And you can also find more information about this if you go to the CDC website, or you can just do a general search for "the Tuskegee Experiment." But what it was, was it was an inethical research project where a group of Black men thought that they were receiving healthcare for syphilis. They were not receiving healthcare for it. So they were not being treated like they thought they were being. So it took from 1932 to 1972 for this to end. So put this on your timeline. We're creeping closer and closer to 2020. Okay, so research and diversity. Our historical notions about race have shaped our scientific research and clinical practice. For example, experimentation on Black communities and the segregation of care on the basis of race are deeply embedded in the U.S. healthcare system. So had there been more diversity in the people who were doing the research, then perhaps 1972 would not have been the end of the Tuskegee Experiment. They would've had a whistleblower prior to then. Or maybe in 1932, they would not have even experimented on this group of Black men because someone would have said that this is inethical. Okay.

So another more recent experiment was done and it took a look at racial bias and pain assessment and treatment recommendations. And there was a study published regarding this in 2016. And the title of the study is "Racial Bias and Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites". And so what they did in this study is they took a look, they were taking a look at the systemic, the pain treatments for Black Americans versus white Americans. And so what they found by doing this study and talking to medical students was that there still demonstrated the beliefs about biological differences between Blacks and whites, beliefs dating back to slavery. And that they're associated with the perception that Black people feel less pain than do white people and with inadequate treatment recommendations for Black patients' pain. And so let's keep that in mind, too, when we move a little bit further in our slides and we talk about, you know, when we're giving patient care. This is something that we're gonna need to consider that perhaps the Black patients are receiving less pain management control.

Okay, so we wanna also think about the norming of standardized tests using diverse populations. And so this is something that's important when doing research because you really wanna get a good look at how different populations are responding to whatever stimuli you're taking a look at, and when you're using that to norm. Or you start to look at things where you get tests that are more culturally biased rather than actually looking at the function or the needs of the person that you are assessing. Preventing a marginalized group from having their rights violated by researchers. So this is another reason why in healthcare research diversity is important. We really don't want a repeat of what happened with the Tuskegee Airmen. Identifying research that has not been done in areas important to diverse communities.

So as we discuss different communities and their needs, we need more diversity in research because we need to identify the things that are important to them. So we wanna look outside what the mainstream population needs and really look at different subsets of the population and what we can do to help them in healthcare. Okay, so I'd like you to take a look at this quote. "There is no such thing as a single-issue struggle because we do not live single-issue lives." And that was said by Audre Lorde. And so this discusses intersectionality, which we're not gonna take a deep dive into that, but it is something that's certainly important to consider. Because we are not single-issue people. We're a multidimensional people. We have a lot of different things that contribute to our beliefs. And we have a lot of different things that contribute to the way we provide services, as well as our patients, our patients are multidimensional as well, too. So we can't just look at one part of a person's life and make the assumption that there are not other things that are affecting that person's life as well, which affects their healthcare.

So we're gonna add something else to the timeline. In 1990, the Americans with Disabilities Act became a law. 1990. Really wasn't that long ago. Okay, and so people with disabilities constitute our nation's largest minority group. It is also the most inclusive and the most diverse. So we're really talking about intersectionality here. Because we're talking about someone who has a disability, disabilities including both genders, it's including every and any sexual orientation, it's including every age, different religions, different socioeconomic levels, and various ethnicities are all represented in this group. And so when you're looking at intersectionality and you're thinking of people as being more than just a single-issue person, we're looking at the fact that when a person comes in and they have an amputation, this person may also be of low socioeconomic level. This person also may be, you know, Muslim. This person, or you know, you may have another person who's had a stroke, but they also may be Black, or this person may also, you know, be gay. Or you may have someone who is a Spanish speaker who has diabetes, you know, who is Catholic. So you're looking at the different things that make up a person, and you're looking at the different things of where the intersection.ality part of the person that may make them a part of more than just one minority group.

Okay, so we're gonna add another date to the timeline. Okay, so this next date, we're jumping back a little bit, we're jumping to 1973, when the DSM removed homosexuality as a mental illness. So I'd like you to think for a second that in the healthcare field, if in 1972, the DSM says that homosexuality is a mental illness, but now in 1973, it's saying that it's not. Are we assuming that in 1974 that all of those people practicing in healthcare and even the general public who's familiar with the DSM, all of those people prior to, who had these ideas prior to 1973 that said, "Yes, homosexuality is a mental illness." In 1974, were they saying, "You know what? Homosexuality is not a mental illness. We should not be treating this as such. You know what? Let's just move on from here." Let's think about how attitudes may have changed or not changed after that happened. So here's some helpful information, and this is about preferred names. And this is more of thinking about if you have a transgender woman or a transgender man or if you have someone who's non-binary, which we'll take a look at these a little bit later in the slides, too, when you're thinking about name choices and you're thinking about providing equitable healthcare and you're thinking about therapeutic rapport, the use of preferred name can have a positive effect on customer service, okay? So allowing the healthcare staff to address the patient in a manner chosen by the patient, whether or not they elect to provide a preferred name.

So I know that sometimes I've worked in different places where I've read a chart and the name might say, the name is John Smith, but then when I go to the room, it says he likes to be called Al, okay? So I may not know where he got "Al" from "John," but I know that's his preferred name, so that's the name that I'm going to call him. And the patient usually appreciates that because although it doesn't say that in their chart, that's the name that they prefer to be called. The use of a preferred name for transgender patients has been identified as important in providing inclusion toward a class of patients that have historically been disenfranchised from the healthcare system. So that goes right back to being so afraid of being discriminated against that you don't want to go in and you wanna seek medical care. And you go in, and the person is using the name that's in the chart, and so that just adds another layer of angst to the person. And then when they correct them and they say, "You know, I prefer to be called by this name." And the healthcare provider says, "Okay." Can you imagine the effect that that would have just by calling someone by their preferred name?

Okay, so here's another piece of helpful information. The APA endorses the use of "they" as a singular third person pronoun in the seventh edition of the "Publication Manual of the American Psychological Association". The APA advocates for the singular "they" because it is inclusive of all people and helps writers avoid making assumptions about gender. And so for me, this really hits home because I am that person who likes to call people by their preferred name, and I also like to call people by their preferred pronoun because I do want to build that therapeutic rapport. But at the same time, I'm also that person who came from the school of thought where you don't use "they" for singular person. You either use "he" or you use "she." And so I will even say for myself this information is so very helpful and really hits home for me because I did in trying to make my email sound grammatically correct, I used "he" instead of "they" when writing an email to someone, and it really hurt their feelings. And I apologized and I felt really bad about it. But for that person, I think I probably was probably the straw that broke the camel's back. I was that last person that used the wrong pronoun after being briefed that that was the pronoun that I needed to use, and that person was like, no, thank you, don't want your services. And while I felt really, really bad because I did not, that was not my intention, I can only imagine how that person must've felt. And so, you know, in an effort not to make it about me, because I've also been on the receiving end sometimes of things that have not been so kind, and I have talked to someone and I said, "I did this, and where can I find some information so I don't make this mistake again?" And a wonderful coworker said, "You know what? Look, the APA has this information." And I read it over and over again and I internalized it, so that way I could make sure that I made that change when I'm writing my emails so that way "they" sounds correct to me versus using "he" or "she."

Okay, I'd like you to add something else to your timeline. In 1975, Education of All Handicapped Children Act guaranteed free and appropriate education. Okay, so once again I just want you to think about the impact that this had for children receiving services in schools. I want you to think about what may have happened before 1975, and what happened maybe in 1976. Do you think between 1975 and 1976 everything was in place and all of everyone had their attitudes focused on these children who were previously separated from the general education public and housed in homes and facilities are now in our school system and we're gonna welcome them with open arms, and we are gonna make sure that we are doing the best that we can for these children? You know, are our attitudes gonna be that these children certainly deserve to be here and we're gonna work our best to make sure that they feel that way? So I just want you to think about how maybe attitudes changed or may not have changed given that, okay? "If we cannot now end our differences, at least we can help make the world safe for diversity." And this is a quote from John F. Kennedy. So I want you to think about this, too. What do you feel like that means in terms of healthcare? Okay, so making the world safe for diversity. And so we already discussed some things that could be a threat to the safety of someone when they're not receiving equitable services.

Okay, I have something else for you to add to your timeline. In 2015, the Supreme Court declares that same-sex marriage is legal. Okay, so we're looking at in 2014, it was illegal. In 2015, it is now legal. Okay. The Centers for Medicare and Medicaid Services issued guidance clarifying that health insurance companies that offer spousal coverage also offer spousal coverage to same-sex spouses. So now we're thinking about the fact that more people are having access to healthcare. Because where previously a same-sex spouse may not have been able to receive services due to health insurance issues, now they may have healthcare services using their spouse's coverage. So think about attitudes in terms of providing services to that same-sex couple now. Okay, so I wanna spend some time thinking about some things that we can do to help to increase equity in healthcare. So we have all of the things on our timeline and we have those placed. And we're looking at, okay, some of these things that happened in our lifetime, and we wanna think about how long ago were they? Have the attitudes changed since then?

And so let's take a look at a few different things. So training, providing training to help providers identify their implicit biases, making sure that providers understand how these biases can affect the way they communicate with patients and how patients react. Also training both providers and administrators to understand how biases can affect their decision-making, including decisions about resources. So as we discussed previously in the slides about the Tuskegee Airmen and that research project, and also thinking about pain management, administering pain medications, when we're looking at trainings in our companies and putting together information and really looking at all of our different implicit biases, those are things that we wanna consider. We wanna consider historical things that have happened, so that way we're not in a position to repeat or continue to perpetuate ideas that are incredibly outdated. And so the tricky thing about an implicit bias is that it's not something that we're aware of a lot of times. With an implicit bias, it may be something that kind of pops up in the heat of the moment.

We're not always aware of the things that have caused us to think a certain way. And that's part of the reason why I wanted you to take a look at the timeline is because if you're practicing one day and homosexuality is, you're being told all throughout your schooling and your life that it's wrong and it's a mental illness. And then the next day the DSM is saying, "No, this is no longer a mental illness." And then a few years later, you're going in, you're practicing, and you're working with a patient who is homosexual, are you gonna continue to consider the fact, are you gonna say, you know, continue to think that that person is mentally ill? And you're gonna dismiss some of the issues that they have because they're homosexual, you're gonna dismiss that and maybe not look at the intersectionality of the fact that this person is looking for my care, they're also homosexual so there's maybe some other issues that they may be dealing with, some things that maybe I need to think about and discuss and be open to. And also thinking about decision-making for resources. Looking at what type of resources you're providing to your patients. If you're under the impression that everyone should speak English, then it's not gonna be on your list of things to do to make sure that you have a form in multiple languages, if that's your line of thinking. Think about assessments.

So when you're considering looking at facial symptoms, you know a lot of them are documented Eurocentrically. You may not see a person of color or a person with a dark complexion, they may not look flushed or pale in the face, or you may not see them with red cheeks. Some of the assessments, the visual assessments that you're looking at when you're looking at facial symptoms, they're not gonna show up the same when you're taking a look at someone who has a darker complexion. And so those are things that you also wanna think about when you're providing healthcare, too, because you may assume that something that says the person is either flushed or they're pale, their cheeks look really red, or they're getting red around their neck, or red on their chest, you may not see those things, and you may miss some symptoms that may show a reaction in your patient. So that goes along with looking at assessments and the way that they're considered when you're dealing with different populations. Also looking at, we'll go back to how assessments are normed.

So once again, really thinking about are the assessments that you're choosing, are they culturally appropriate for the person that you're assessing? Are they looking at the person's function or dysfunction versus looking at something that's very culturally-centered? Considering assessments that lend themselves more to function versus assimilation into mainstream accepted culture. And so I'm thinking of some of the things like if you're looking at something where it's based on clothing norms, and you have maybe a patient or a student that is transgender, well, they're gonna choose something different than what you may expect for them if you're looking at a clothing norm. Or if you're looking at different roles. Or if you're looking at, you know, even if you're looking at someone's culture, if you're judging a child and you're taking a look that they don't have certain motor abilities maybe at age two because they've been carried for most of their life versus here in America where we expect by the age of two that a child should certainly be up and walking around independently. Looking at different things like that. Are we looking more at the culture assimilation or are we looking more at the actual function and dysfunction in the person that we're assessing?

You also wanna consider outcome measures that lend themselves to the patient's functional needs. And so we'll look a little bit more about that in some of the other slides. But really considering outcome measures that are really looking at what that patient actually needs to do, or what that student actually needs to do, and not what we culturally or what we assume that that person should be doing. Use interviews to get a complete picture of a patient's or family's needs or wants in regards to treatments. Because once again, that's looking at equitable care in terms of providing what's culturally or patient-centered and relevant towards that patient and not what we think should be relevant to that patient.

Okay, so considerations for relaying information. So understanding that people who are not neurotypical, that they may need information presented in a different way to increase understanding. And really keeping in mind the fact that just because they are not receiving information or presenting information in what we may feel is typically appropriate doesn't mean that it's incorrect, or doesn't mean that that person is not understanding and not able to understand the information. Providing interpreters for IEP meetings and during discussions regarding healthcare. The language sometimes that we use in IEP meetings, although we are supposed to really use words that the layperson can certainly understand, sometimes we do get a little bit technical in the things that we say. It's always better to have an interpreter there to make the parents feel more comfortable and make sure that the parent is really understanding what is being said.

So, of course, the parent does have the right to refuse an interpreter, but really just making sure that things are available, because when you're discussing the health of a child or the services that you are providing, you really wanna make sure that the parent is making an informed decision and that they're understanding all of the language in their specific language where they feel comfortable. And so that also goes back with the implicit bias. You may feel like a parent really cognitively can't understand when the person is trying to speak to you in English, not realizing how amazingly articulate the person is in their first language. And so where you may just make assumptions about the home situation because of the way parent is able to our unable to articulate themselves in their second language, that could affect the way that you're providing services. We also wanna think about considering that a person may hesitate to ask for literature or information in their preferred language. And so this becomes a little tricky. So while you do want to make sure that you do have interpreters available, that you do have information available in a person's home language, you also have to realize that that person may not ask for it, or that person may refuse it. And that is just really, you know, you really wanna think about in terms of if you're constantly hearing you should speak English, and you want to really be respected in your meeting with your healthcare provider, you may forego information that you sorely need in your home language just for fear of how that healthcare worker may look at you because you're not as proficient in English as you are in your first language. Or you may be concerned about how the school may look at you as a parent because you're not as proficient in English as you are in your primary language. But you may be afraid to ask for additional assistance with the language because of attitudes towards people who do not speak English.

You also wanna think about the fact that dementia patients, they may revert back to their native language. And so that's something important to consider, too, when you're dealing with a patient that has dementia and you're trying to figure out, okay, where is this person on the cognitive continuum? And it could easily be that at that point in time that that person has reverted back to their native language. And so discussing things with them that you may have discussed with them in English previously, it may seem that they're on a cognitive, more on a cognitive decline than they actually are because they've reverted back to their native language. And so providing stimuli in their native language such as music, or someone talking to them in their native language, or them being able to maybe see words in their native language may be more appropriate at that time versus providing all of that stimuli in English. Forms. So having forms available in multiple languages. If you have on a form, and I know that it would be unreasonable to print every single language on every single form, but if you had forms where someone could pick and choose, or maybe on the front it's English and on the back it's a different language, allowing that person to be able to passively receive the information in their language without having to request it and feel uncomfortable, or without you maybe providing the information and feeling uneasy about being perceived that you're assuming the person doesn't speak English well, just having forms in multiple languages would certainly help with that, because then that way the person could choose to either read in their native language or they could choose to read it in English.

Okay, so here are some terms. So I know it kind of seems like it's jumping around. And really when I was organizing this presentation, although I said I was not going to do a deep dive into intersectionality, you really can't help it because people are so dynamic that a lot of these different issues go for more than one person. So now I'm gonna go with some familiarity with terms. So cisgender describes a person whose gender identity aligns with the sex assigned to them at birth. So I'll use myself as an example. I would be a cisgender woman because I was assigned the sex as a female at birth, and that is what I identify as. Gender dysphoria. So clinically-significant distress caused when a person's sex assigned at birth is not aligned with their gender identity. So that would be if I was assigned male at birth, but I certainly do not identify a male. If I identify as female, then that would be gender dysphoria. That would be people constantly continuing to call me a male and continually calling me "he," and me really having that internal struggle that, no, I am a female. That does not align with the identity that I'm being given. Gender identity. One's innermost sense of self as male, female, a blend of both together. A person's gender identity can be the same or different from their sex assigned at birth.

So like said, I'm cisgender. That's my gender identity. I identify as a woman. I'm labeled as a woman, so I do not have gender dysphoria because both of those two things align. Gender non-conforming. So this describes a person who does not subscribe to society's traditional expectations of gender expression or gender roles. And so these are terms that I retrieved from glaad.org, where you can certainly go and you can get additional information. So let's go to transgender now. So this describes people whose gender identity and/or gender expression is different from cultural expectations based on the sex they were assigned at birth.

Okay, so being transgender does not imply any specific sexual orientation. So what that's saying is that just because you are a transgender male, it does not also mean that you are homosexual. So does not mean, those two things do not necessarily go together. And so that's why when we're also looking at intersectionality, we're also thinking about when you're discussing LGBTQ+ issues, just because all of those are lumped in together a lot of times, people have different layers. So you're looking at someone who may be an Asian transgender woman who is homosexual. So you're looking at the different layers that that person's going through and making them a multiple minority. Okay, since some societies only recognize male or female genders, and the American Cultural Society, we only recognize, well, we recognize male or female genders, and hopefully we're moving towards being a society that does recognize more than one, especially in healthcare, just so that way we can certainly provide more equitable healthcare. But non-binary is one term people use to describe genders that don't fall into one of these two categories, male or female. And so you will find in other cultural societies that they do recognize more than just two genders, so more than just male or female.

And so that's something that you also want to think about, too, is that when we're looking at something and if we're looking at our assessments and we're basing our assessments on what we feel like a male gender role should be or a male gender answer should be, and we have a person who's non-binary, are we really, we need to really look at what are we actually assessing. Does that really have an effect on what we're looking at? Does that really have an effect on that person's healthcare needs?

We really need to think about looking at the function, the needs, and the dysfunction, and not necessarily looking at where some of these cultural, where people fall in terms of cultural norms or cultural assimilation. Okay, so on forms, something else that could be placed. A legal name on the form. Then also a spot for preferred name. And thinking of that as a source of information. So I'm sure that many of us, depending on what type of facility you've worked in. I've worked in hospitals where I might have two patients with names that are very, very similar. And so I will get the warning label, warning, name alert.

So that's warning me that, okay, I really need to make sure that I'm picking up the right chart because these names are so similar. So that's the reason why I put "as a source of information" for the spot. Because it doesn't need to be a warning. It doesn't need to be, "Joe Smith wants to be called Sarah Smith. Warning, I'm just warning you he wants to be called Sarah." There's a lot of things wrong with that statement, because maybe Sarah likes to also use the pronoun "she." So it's a source of information. It's not a warning. Because "warning" really has a negative connotation there, too, and that also implies an implicit bias of this is wrong, so we're just gonna go along with this. So it also it helps to change the attitude thinking about it as a source of information. And it's something that's really universally good for all patients where you can have your legal name on forms. Sometimes people like to be called by nicknames. It makes them feel more comfortable. So having that as a source of information on a form is really something that could be universally done and would be helpful for everyone. Putting parent one, parent two versus mother and father.

So, yes, while that is also looking at the gender roles and taking into account how a person identifies with their gender, or taking a look at maybe there's two mothers or two fathers, or maybe there's one that's, you know, one's the mother and one's non-binary. So instead of looking at those things, this is one of those things on forms that could be changed that universally would help a lot of people. Parent one, parent two. A lot of people have a lot of different situations and they have one parent guardian and then the second parent guardian. And then that's where your interviews come in where you can discuss a little bit deeper if you need to know exactly who is parenting the child, or who the exact caregiver is and what the relationship is, you know, in terms of your treatment, that's where you can get into more of that information by using those interviews. You can also put a place for preferred pronoun. Once again, that's something that can easily be put on a form that's universally helpful for everyone. So if, you know, I saw that on a form and I put "she," it really doesn't bother me to have to put "she" as my preferred pronoun. However, if I was one of those people who constantly had to explain what my preferred pronoun was, that would make a huge difference for them to just be able to put their preferred pronoun on it. It would just be up to the healthcare provider to respect that.

Okay, for reports, use a person's preferred name. I do that even when I have students who have nicknames, I'll write their first name, and then I'll put their name, the information on the top of the evaluation, and then I may use the first name, the given name first, parenthesis with their preferred name and then use their preferred name throughout. Using a person's preferred pronoun. You can do the same thing on a report, too. What I would say that if it's, and comes down to for an adult versus having a child with a nickname or an adult with a nickname, for a person's preferred name, while you can use their identifiers just because you have to use that in order to keep track of the medical records, you can note that that person's preferred name is such and that's how they will be referred to for the duration of this report. So that would be an easy way to do it. Because I do understand that we do need to make sure that our reports are able to be identified and linked to the people that we are writing reports on. Providing visuals as appropriate to assist with the understanding of the report. So this goes back to someone with a language barrier or someone who has neurotypical learning. Just because someone may not give you information in a way that you feel is the most articulate does not mean that they are not very highly capable of receiving information. So it's that expressive language versus that receptive language. And so sometimes when people have visuals, it's a lot easier for them to digest the information and a lot easier for them to understand the information that you are providing. And so when you are providing visuals, although they may not be able to expressively articulate themselves well due to whatever reason, providing visuals may help with that receptive ability to digest that information.

Choosing language that is easy to understand while not compromising the integrity of the information presented. And you know I'm sure that a lot of us do that. There are times where you definitely have to use some of those clinical terms. But when you're providing information to your student or your patient or your student or your patient's families, just choosing language that's really easy to understand, especially when you do have that language barrier or you do have someone who maybe learns differently, so that way they're able to receive the information to the best of their abilities. Okay, activities of daily living. So really taking into consideration the texture of a person's hair and their haircare needs and routines when you're looking at activities of daily living. I'm sure anybody who's worked in a skilled nursing facility or a hospital, we have all seen those little teeny combs, the little black combs with the really close teeth. I would have to say that if I was a patient and that was what someone was coming near me to do haircare, that we would not be doing haircare that day.

So really understanding that different ethnicities have different needs for their hair. And so when you're taking that into consideration and you're doing family training or you're doing patient training, sit down and ask them, "What type of comb are you using for your hair? What type of brush are you using for your hair? What type of hair products are you using? What styles are we gonna," you know, is going to be easiest for the patient to do. And then respecting when the patient doesn't want to maybe necessarily work on that. I know for myself, I would probably say let's wait until my family members come and I will let them help me with my hair. Consider if and how a patient's head or hair needs to be covered and make recommendations for adaptations. So we do, you do get patients who they do wear head coverings for cultural or for religious reasons. And so incorporating that into ADLs, because that's something that's important to that patient. That patient, that does show a level of respect for the patient, and that does help to build therapeutic rapport by discussing with the patient, okay, well what is acceptable for your head covering? When do we need to cover your head? Or what are different ways you could ask a family member to show you how to do wrappings? Or you could ask family members to assist you so that way you can help to train the patient for how they need to be covered. Considering the type of eating utensils that may be used in a home.

So some families maybe use forks, spoons, and knives, silverware. Some families may use flat bottom spoons. Some may use chopsticks. And some families may eat with their hands. So really taking into consideration those different types of ADLs when you're working on feeding, self-feeding, or when you're looking at discussing how the patient is going to go home and eat. Being able to adapt those different utensils or being able to assist the patient with getting up and down from the floor if they are used to sitting on the floor for eating, or figuring out how the patient can make adaptations to where they previously sat for eating, or what they previously used to eat their meals. Some additional activities of daily living to be included, thinking about binding as an ADL. And so for those who are not familiar, binding is the act of taking something, so you can take like ACE wrap, or some type of really taut material, and it's flattening the breast against the chest. And so you will find people that binding is part of their ADL routine. And so that may be something that right off the bat that may not be shared with you. Or, I mean, that may be something that you have to ask. And that could certainly be something that you could add into your regular routine of when you're talking to your patients, so that way your patient doesn't feel like they have to come out and say that, "I bind my breasts to flatten them against my chest as part of my ADLs." And so that's something that I will certainly say that I didn't learn as an ADL when I was in school. That was actually something that I learned as an ADL through my social circle. So really it's like when we were looking at the attitudes and we're looking at different laws and we're looking at the different ways that we look at things, looking at adding additional things into our scope of ADLs, that would be, would've been something that had it not been pointed out by my social circle that I would've not considered as an ADL. Why? Because it's not something that I do.

So those are things that we also need to look at when we're providing equitable healthcare, and that goes back to looking at things and looking at things that people in different subsets of the population, what their needs are. Identifying different areas of research. Identifying different needs for healthcare. Consideration of the way a person urinates. I do it all the time for my patients who are cisgendered. I've had older male patients where I have to say, "I understand that up unto this point you were standing to urinate. However, now, the safest thing for you to do would be to urinate sitting on the toilet." But like I said, if it was not for my social circle, I would not consider the fact that perhaps I have a patient who is transgender, and the way I assume they urinate may be something completely different. And so that's something that you also want to think about, too. And you also may need to take the extra step and make the note that where if your patient is saying that they normally stand to urinate, explaining that, okay, we're gonna sit to urinate because it's safe. Not necessarily we're gonna sit to urinate because I think that that is how you should be urinating. So when you're, if you're a physical therapist, thinking about the fact that maybe you're gonna have to work on standing balance because the person is a transgender man and they would like to work on urinating standing up, or the person is a transgender woman and maybe prefers to sit down to urinate.

So thinking about that when you're walking to the bathroom as the PT and are we gonna be standing, or thinking about that if you're the OT, and we're thinking about the toilet transfers. Also addressing same-sex intercourse. So not only just thinking about sexual intercourse between a woman and a man, thinking about same-sex intercourse as an activity of daily living. Also thinking about tucking as an ADL. And I'll say it, once again, someone who has had, you know, I've had 16 years of OT experience, but I will say, tucking as an ADL came up to me from my social circle. It didn't, not as something that in my head I thought, "You know, I probably should ask or check with my patients to see if this is an ADL that needs to be addressed." And so even with all of these different things, that's gonna require additional training. I would certainly say that I am not qualified to teach, assist a patient with binding as an ADL right now, or tucking as an ADL. So those would be things that for myself that if I decide to continue to work with adults, especially younger adults, really looking at those as ADLs and making sure that I am well-qualified to assist my patients with these ADLs because it's important to them. And so many of our assessments they're not taking into account these different ADLs. And I know we also we all consider reimbursement when we're doing therapeutic treatments. So really taking a look at the fact that these are things that are important for our patients and we need to make sure that we're still being client-centered while we're still writing our reports and working on things that will help with the outcome measures.

Okay, pain management considerations. So considering that the patient may be in too much pain due to their pain medicine dosage. And so that goes back to the study that I discussed earlier in the presentation, if it's a real thing that perhaps your patient has not received the amount of pain medicine that they need to properly manage their pain. And so really thinking about that when you're working with your patient and you're making the assumption that, "Wow, really, you know, you got pain meds. You know, you really shouldn't be in this much pain. This patient's not compliant." Just really considering other facts that may have an effect on your patient's ability to participate in their therapeutic treatments. So that's part of really being able to provide equitable healthcare. Not making assumptions that everything is face value, but really taking these other things into consideration. Understanding that Western medicine is not the only form of intervention available. So while you may have some patients who are taking their pain medicine as prescribed by their doctor, you may have other patients who use other forms of pain relief. And so, of course, as long as it's something that's safe for the facility, that may be something that you have to work on with your patient. Maybe they're using deep breathing. Maybe they are, you know, I don't want pain medicine, so I'm needing the hot packs or the cold packs. Or maybe they're used to stretching to help with pain. Maybe when they leave they're going to use acupuncture. So just considering the fact that your patient is managing their medications based on who they are as a person.

So like we talked about before, the intersectionality, there's so many different things that make up a person that we really need to take all of those things into consideration. We can't just say, "Well, just take the pain medicine and then we'll be able to do X, Y, and Z." That's not necessarily gonna work for that patient and they're probably gonna show poor carryover when they leave the facility. Religious considerations. So if you're a speech therapist, you might have to think about working on feeding techniques during a different day when your patient's not fasting. You may have a patient who celebrates Ramadan and they're fasting during the day. And so that patient's refusing to participate in feeding activities with you, and it's not because they are belligerent, it's because they're observing their faith. They're fasting. They don't want to work on feeding techniques at that point. Understanding the denial of medical procedures as a result of your faith such as transfusions. If they're a Jehovah's Witness, they do refuse blood transfusions. And so rather than making judgments on their choice of what they're choosing to receive or not receive in terms of medical care, us as healthcare professionals, we really need to just think about, how can I still be respectful of this person, of this person's religious convictions while I'm providing healthcare, and what can I do within the parameters of what I'm able to provide to provide equitable healthcare without being judgmental or allowing my biases to get in the way of my equitable care. Other things that you may have to think about when you're working with patients for their religious considerations would be adaptations for praying if the patient isn't mobile enough to do so. So that could be in terms of providing therapy, in terms of making adaptations for how the person will pray. That could be going back to trying to work the therapy times around the person's praying times. That could also go back to making sure that you're going to into the room and providing the person with what they need for praying within reason that's available to them in the facility, or giving the family a call and saying, "This person needs this in order to engage in praying while they're here at this facility," and you'll find that being respectful of that, that helps build that therapeutic rapport with a patient. Scheduling the service time around prayer if possible, discuss that.

Okay, so with pediatric considerations. So using therapeutic activities that have a diverse representation in their graphics, their objects, et cetera. So thinking about the fact that if you're working with a pediatric population, how gratifying it would be for them to see images of children that look like them, on their worksheets, in their social stories, in their handouts, or even having therapy objects that are available that look like them or look similar to them, or just having a diverse amount of treatment activities on paper or just that tangible that children can use to engage in their therapy. Children do notice differences between themselves and other people, and so that doesn't have to be a bad thing. That can certainly be celebrated. Something that I like to do with some of my students, especially the ones who have names from different cultures that I'm not familiar with, we do an all about me thing where we take a look at where that student's name is from, what it means, and different things about that culture. And I always find it interesting because I like to learn about a different culture. And it also puts the child in the driver seat where they're really being celebrated for their difference. And so you really do, that helps to build therapeutic rapport, it also helps to, helps the child internalize the things that you're doing. So when they have things that look like them or sound like them or things that are familiar to them, it helps them to internalize the other therapeutic interventions that you're trying to place for the child.

Considering what holidays are or are not celebrated in the home, as well as what a holiday may mean to a particular group. So in terms of holidays, like I said, Jehovah's Witness, if you have a Jehovah's Witness, they're not gonna be celebrating the birthdays, and the Thanksgiving, and the Halloween, and those different types of activities. So whereas you may have activities lined up that are based on those themes, it may feel uncomfortable for that child to particular in those activities. It never hurts to ask a parent or a child what they celebrate or what they don't celebrate. Or you have different holidays that are not necessarily celebrated by a group because it means something different to them.

So I mean, if you're looking at a holiday like Thanksgiving and you're working with an Indigenous family, it doesn't hurt to check to see how they feel about the holiday and should we do activities or that or not to do it. So that's once again really thinking about outside of what may be offensive to you or what may be appropriate to you, and really looking at your client or your patient or your student, and really considering something to make that centered for them versus making it about what you feel is appropriate. And something else I'll touch on for pediatrics, too, when we're discussing intersectionality. I've had students where they have had preferred names that may not be something that I've expected or that the school uses. The student may have a preferred name that that student would like to use. Or I've had students who, transgendered students who not only are, they're either on the spectrum, or they have other disabilities, but because of their struggle internally and things that are going on externally outside of them, because they are transgender, they require mental health services because of depression. And so when we're thinking about intersectionality, we also need to think about the fact that sometimes being a member of a certain minority group and being different than the majority group, it can actually cause other healthcare issues. So when you're looking at things like depression or anxiety, that can be compounded with the fact that when you're receiving healthcare, when you're constantly seeing images that are negatively showing your subset of group, or when it constantly shows an absence of your subset of group. So you might have a child that has a girl doll that he wants to put boy clothes on, or well, I'll say "boy clothes," or you might have a child that has a boy doll that he might want to put "girl clothes" on. And I say that in quotation marks because culturally in our culture we do have boy and girl clothes, which can be different than other cultures. So really looking at those things that if he wants to put the dress on the doll, the boy doll, and he feels like that's a representation of him, that that shouldn't be listed as a dysfunction. That should be, once again, a source of information.

Okay, so he feels like this doll should have this on. And what we're doing is we're just working on using both hands together by putting clothing on a doll. So that doesn't need to be corrected. Also with pediatric considerations, consider financial access when making recommendations. So thinking about when you're making recommendations of things to follow-up for at home or materials to get at home for children to be able to carryover their skills, really taking into account what that family's financial status is. Because when we're really looking at reality, we're looking at the fact that when you have a child that does have some type of disability, it's not gonna be just therapeutic cost that that patient has to incur, or just general healthcare costs that that family's incurring. They're probably incurring a whole set of other charges for things that they may not have if they have a typically-developing child. And then if you compound that with the fact that maybe the family is of a low socioeconomic level, we don't wanna make recommendations that make the family feel like they need to get certain things that they can certainly get in a low-tech way or we could find other means for them to retrieve those services or meet those needs for follow-up care at home. Collecting books and toys that can be given to the child to use at home. Just thinking about that when you're making recommendations, too. A lot of times we're cleaning out our closets as home, especially those of us who have kids. Maybe you wanna just keep a stash aside and if you see that child may not have access to certain things, just say, "You know, why don't you take this home? This is yours. You can go ahead and take this home to play with," and give the parent multiple uses of that one or two items that you're sending home, so that way there can be better follow-up at home for that child without making that a financial burden on the parent.

Okay, so I hope you have kept track of your timelines, because we finally have another thing to add onto our timeline. We're gonna go ahead and stick something else on there. Alright, we are going to stick on here the 2020 COVID-19 pandemic. And I put a little star there because it's important to note that even at the time of this presentation, it's still a health issue for us, a very big health issue. Okay, and I'd like to add this quote in. "There's a point where anecdotal evidence becomes the truth." And that's said by Temple Grandin. Okay, and so regarding COVID, despite anecdotal evidence of a spike in discriminatory behavior targeted at Asians across western countries, little empirical evidence for this "othering" hypothesis exists. Okay, so that sounds like a mouthful. So what it's saying is that although there are lots of stories that Asians are being discriminated against in western countries, there's little empirical evidence for this "othering" hypothesis. So there's not a lot of numbers to back this up. And so I'm gonna make a few points, so I wanna go back to this slide one more time and say, "There's a point where anecdotal evidence becomes truth."

Okay, so we don't always have the numbers to prove that things exist. But when you hear enough stories and you hear a lot of similar, parallel stories from certain groups, then it does at some point become the truth. And so that goes along with us talking about the fact, I'll slide back to this slide one more time, that goes also back to us discussing the fact that when we're looking at diversity in healthcare and we're looking at research, it's wonderful to really have those numbers to back up things and to really prove with numbers that certain things are really happening. But there comes a point where you actually have to listen to the public, too, and you really have to listen to stories because they do, stories do tell a lot. It just means those certain things haven't been researched. And so that's also the important part, too, when you're discussing diversity and research is to really take a look and think about the things that are affecting different minority and marginalized communities. What things are they facing that are causing barriers to healthcare? And so although, and with that being said, with the stories, I can certainly tell you that, yeah, the empirical evidence may not be there, but once again, from my social circle, I have friends who are Asian who are healthcare providers, and they're concerned. "I'm concerned about getting sick." And they're concerned about what's gonna happen if they become sick and they're Asian and they have COVID. And what are the healthcare workers going to say, or what are they're gonna do, or what's gonna happen with implicit bias? Because after all, I mean, we're all healthcare providers. But healthcare providers, we're also healthcare consumers. So we worry about the same things that some of our patients worry about.

Alright, so we're gonna add something else to our timeline. We're gonna add 2020, the Supreme Court rules that the LGBTQ+ community is protected from workplace discrimination. So congratulations, we've finally made it to this year. And so if you'll remember, we have two things on our 2020 right now. We have COVID-19, which is one thing, and then we have the Supreme Court ruling that the LGBTQ+ community is protected from workplace discrimination. A completely different issue. Or is it? Because we do have some Asian people who fall in this LGBTQ+ community. So we're looking at 2020 and we're looking at the intersectionality there. So we're looking at a group of people who was already concerned about receiving healthcare because of their sexual orientation, and now we're gonna add COVID-19 on top of that. Alright, so I really like this quote. "Don't mock a pain you haven't endured." So I'm going to assume that if you have made it this far through this presentation with me, that we can discuss some stories and that we can also discuss the fact that you not enduring something doesn't mean that it doesn't exist.

Alright, because like I said, we're healthcare providers. We provide treatment. We help people. But we also have feelings. We're also part of groups that have been and are discriminated against. We're not immune to discrimination regardless of our degree or our social class. And we're also healthcare consumers. So talk about intersectionality right there. So while in our heads we're thinking about the fact that, "Yes, I'm a healthcare provider. I need to provide equitable care." Some of us are also thinking the fact that we're also healthcare consumers. So while on one hand, I really want to think about how fair I'm being to my patients. On the other hand, I'm thinking, "Whew, how fair am I gonna be treated as a healthcare consumer?" Because once I take the badge off or I take the scrubs off, or it doesn't matter, I'm still a healthcare consumer and I'm still vulnerable. Alright, so this was kind of something neat that I had done for myself. On your piece of paper where you have your timeline, I'd like you to go ahead and do this for you, too. You can go ahead and pause it or you can do it after. But I took the Maslow's theory and I applied it to just being someone who is a healthcare worker.

Okay, and so on the bottom of Maslow's theory, you know, it's the hierarchy of needs for those of you who are not familiar. And so I won't spend too much time discussing what Maslow's theory actually entails. You can go ahead and look that up and then you can come back and make your own. But if I look at it, so it looks just like a pyramid. And so the bottom, the bottom longest part would be the physiological needs. And so I listed in terms of being a healthcare worker as the physiological needs being meeting the qualification of the healthcare job, getting hired, alright, so that's like the basic level. That's what I need in order to start my healthcare journey as a healthcare provider. I need to have all of my qualifications. I need to get myself hired. So I'm hired, got the job, got the qualifications, I'm good to go. That's the bare minimum. Alright, in terms of safety, your differences are tolerated and you know you're not going to be fired from your job due to your differences.

Now, a part of that happened in 1964. But the other part of that just happened recently when, in 2020, when it was saying that if you're in the LGBTQ+ community that you can't be fired from your job. So let's think about this for a minute. So it took up until

2020 for someone from that community to really say, okay, safety, I can't be fired from my job due to my difference, okay? My differences are being tolerated. Same for myself. I could say, alright, you know, I've a lot of times been in, where I work, that I'm usually the minority. So, hey, my differences are tolerated. I know I'm not gonna be fired. So I've hit the first two. Love and belongingness. Okay, so that's a step up from safety. So now, my ideas are being respected and my concerns are being listened to. So I really feel like I belong here because I say something and people are really respecting what I'm saying.

Okay, esteem. Moving up to the next rung. You're a part of the action plan to address concerns. Your ideas are considered and executed as appropriate. So not only do people hear my ideas and listen to me, they say, "You know what? You're right. I think we need to make some changes. Hey, do you think you could help us out with that?" And I'm, you know, "Yeah, well, that's wonderful." So that that's esteem, you know? You're listened to. Your ideas are being considered. They're being executed. You've got an action plan. So the next step is self-actualization. So you, now, you know that your ideas are important and that people are gonna listen to you, that people are gonna form action plans, they're gonna address your concerns. So I feel so comfortable right now that I know that I can advocate for others. So I'm taking it beyond myself. So I'm advocating for others. I'm spearheading policy reforms. I'm starting community programs. I'm educating my professional peers. I'm, you know, just doing all these different volunteer opportunities and helping other volunteer groups help bridge the gap for equity. So that's a way that you can think of the application of Maslow's theory for that. So if you are stuck in a point where you're only feeling safe, that, "We're gonna tolerate your difference.

Okay, fine, we'll call you by that pronoun that you want us to call you by," and everybody's rolling their eyes, or you know, "Oh gosh, if I have to hear one more time about how you were discriminated against or how someone said something to you that was just racially inappropriate, you know, alright, I'll listen," if you're stuck in that safety part, how are you, it makes it really difficult for you to kinda push through and get to the point where you can really make the most of your healthcare degree and your opportunity to help others. Now, I will say, just like Maslow says through his theory, you can move through the different stages. And sometimes you can be on more than one. And sometimes if something's not met 100%, you can still move on to the next one. But I will tell you as someone who has been able to move into the esteem part or the self-actualization part without necessarily being in the love and belongingness part, it makes it more difficult. It can be done, but it does make it more difficult. And the reason why I'm saying this is because as I said, healthcare workers are also healthcare consumers. But we also have to come to work during the day, too, and so we have this intersectionality too where, yes, we're the healthcare worker, but we also deal with some of these other things that put us into these diverse populations who were not receiving equitable treatment and equitable care.

So with workplace considerations, it's really difficult to use therapeutic use of self if you are working in a culture that promotes hiding your authentic self. So if I know that I'm gonna go to work and everyone's talking about their spouses, and I know that I probably shouldn't say anything about my spouse because I have a same-sex spouse, or I know that what I wear to work is not necessarily my preferred thing that I like to wear when I'm in my personal time. I might feel a little stifled. And, of course, we're taking into consideration the fact that, yes, there are dress codes at work. And yes, some things are, you know, that's more personal discussing your spouses and things like that. But I'm just talking about creating the atmosphere of a person who feels safe, that they can complete their job, but they can certainly not always have to pick in the back of their head about what they reveal about themselves to their coworkers. If you're afraid you're gonna lose your job or be overlooked for a promotion due to self-advocation, that can increase stress, too. So if you're worried that no one's gonna back you up when this patient is spewing xenophobic or homophobic or racial slurs at you, then that adds an additional layer of stress for you. And that's increasing stress and that's something else that you have to think of in addition to doing your job. The reason why I pointed out in 2020 looking at the fact that you can't lose your job because of your sexual orientation. For that to happen in 2020, I mean, that's one of the things that we can all who are sitting here right now, we can't say, "Oh, you're not gonna lose your job." You can't, you know, it's been a real thing for people up until 2020. If you're afraid that you won't be believed or will be perceived negatively then you may not be open about your issues. And so if you're having a workplace roundtable and you're trying to discuss, you know, how can we make this a very conducive work environment, or really safe place for our students, or what can we do to help our patients feel like they're really receiving the best level of care, or that what can we do to really encourage our students to participate and feel included and create an inclusive classroom and therapy room and pediatric ward and nursing home. If you're always feeling like the things that you know are red flags for that facility or for that type of environment are not going to be listened to, or people are gonna roll your eyes at it, it really hinders your ability to be a productive member of making sure that equitable care is being provided for the people that you serve. And also for you, I mean, it keeps you from being a productive member and helping that facility operating the best that it could be operating.

Let's see. So let's so go back and let's take a look at your timeline. Alright, so the Supreme Court rules that the LGBTQ+ community is protected from workplace discrimination, so 2020. So I know that we all certainly have been alive for this one. So I want you to go back and give yourself points for the things that happened in your lifetime, okay? So our next one is the 2020 COVID pandemic. We were all alive for that one, okay? And I'll share a little bit about my timeline and what things that I had on mine. And so when you're also thinking about being in the workplace and you're looking at what may be going on in terms of patients that you serve, you really wanna think about the fact that that person wants to go back to being a functioning member of their community as well, too. And so you really need to think about sometimes it is more than just about fixing the physical ailments that that person has. We're also needing to really look at the fact that that person may feel like they need to be at a certain physical level in order to be competitive in their workplace just because of they may not feel the same way, they may not be able to work through their Maslow pyramid without working on certain ADLs in order to be able to participate in their job. So the 2015, I certainly would say that we were probably all alive for that one, too, unless there's anyone that's less than five years old. 1975, I will say for me, being born in 1978, I was not alive for this one.

However, my father, who was born in 1954, this certainly happened in his lifetime, too. So when you think about that, too, you're having people who are in healthcare who are of an older age, they might have spent a lot of their practice not having to work with certain populations. And so when certain populations are needing care, that certainly, you know, you have to reframe your mind to be able to participate in equitable care. So that's one of the things that we also need to make sure that we do, too, that when we're looking at continuing education courses, you wanna make sure that you're not just necessarily looking at things that you're interested in, you need to make sure that you're also looking at things that are necessary. So like I said for me, for my social circle, because it has been explained to me that tucking and binding are significant ADLs in the transgender community, that for me, okay, it may not be personally, okay, well, I need to go and learn what, how exactly to teach these ADLs to my patient. But it behooves me as a healthcare provider and someone who really wants to provide equitable care that I do that. That's a necessity. That's something that I need to do. I need to identify my area of inexpertise and make a growth there. We're looking at this one, 1973. I don't know if anyone was alive for this one. But like we talked about that before. So we're going back in time, but as you can see, really these things really weren't that long ago. 1990, I hadn't graduated high school yet, but it's not incredibly far from graduation. But take a look at this, too. So you're looking at the Americans with Disabilities Act. It just became a law in 1990. These are things that a lot of us when we think in our head, and even me as an OT, I became an OT in 2004, and I work with kids, and I have to look at these things, and I have to place myself where, what was I doing in 1990? Because as an OT, I'm like, "Oh, these things have been around for so long." They really haven't. It hasn't been. And so when you think about people's trainings and their attitudes and access to care, you really wanna think about how long has this law been in place, and know that things did not change overnight. And with all of these acts, you can actually go back and look to see, okay, at what period in time did these things really start to come to fruition, like at what point did attitudes really start to change, and at what point were these things really put into action? Because just because it's a law does not mean that overnight, everyone, it makes it illegal to do certain things, but it doesn't mean being put into practice that the things are just changing right away. And we'll go back to our 1972 with the Tuskegee Experiment.

Once again, that's something that happened in my father's lifetime. And so we also wanna think about those things, too, that not only are we a product of our education, we're a product of our life experiences, we're also a product of other people's life experiences indirectly. Because if you grow up in a time where, you know, 1932 to 1972, there's an experiment, like the one on the Tuskegee Airmen, and someone's telling you, in 2020, you should go ahead and give that experimental vaccine a try for COVID-19, and you don't wanna do it, you need to think about why your patient may be afraid of that, or you might wonder why everyone comes in to stick your patient, why your patient is concerned about that, or why a parent may not, this could possibly be a reason why maybe a parent is against vaccines, alright? So we're looking at the Civil Rights of 1964, okay? So like I said, my dad was born in 1954. So in 1964, he was allowed to go to school with people, you know that schools were desegregated, so now he's allowed to go to schools that were all-white schools. And I will say, it wasn't 1964 right on the dot that they said, okay, my father went to a segregated school. They didn't say, okay, well now we're a desegregated school, so tomorrow you're gonna go to a different school. That's not how that worked. It took awhile for that to happen. So he still continued to go to a segregated school. So let's think about this. So in '19, maybe, let's think '66, you have someone who has maybe been working in the school system or practicing healthcare, like we had mentioned this before, what is it gonna look like in 1966 when all of a sudden these things are segregated?

And I say "all of a sudden" in terms of attitudes. I mean, the older we are and the longer we practiced a certain way, the longer it takes for us to change our mind about certain things, especially if you've been told for the majority of your career that things are a certain way. we really need to think about the fact that us as healthcare workers, we're in a very unique position. We have a very important position, and the fact that literally we can affect how the rest of the country runs. Because we are working with people who have jobs of various types of things, we're working with children who are becoming our next generation, and so when we're thinking about the fact that providing equitable care, now more than ever it's very important to really consider what our children need and what our older adults and middle-aged adults need from us. Otherwise, they can't go out and be effective. And so this is not to say to you that to disregard the things that make you you, because I do understand that when it comes to equitable healthcare, as healthcare providers, the easy thing to say is, "Do it." You need to be equitable. You need to identify your biases. You need to not be biased. You need to not be discriminatory. And you need to just take care of your patients. But I do appreciate the fact that we all have other things that make ourselves, make up ourselves. And so one thing that I want you to think about is, actually I'll jump back to the workplace thing first, and then I'll move on to finish that thought. But one person from one group of people is not the spokesperson for the entire group.

So I, you know, while I have all of this information, while my social circle has helped chip in, give me information and given me things that I needed to think about, I am one person from one group and I cannot be the spokesperson for all Black, Christian, cisgender, heterosexual women. I can't do it. But I can give information and speak from my experience on certain things, which probably aligns with a lot of things that other people have to say that are in one part of my intersectional group. You don't have to understand someone's circumstances to be respectful. I certainly understand, like I said, we all grow up with different things that influence who we are as people, and healthcare providers are people. And so you don't always have to understand why someone thinks something's respectful or disrespectful to either do or not do it. You know, sometimes we don't always have, it's not always on that person to explain to you why something's respectful or disrespectful. Just like the family and my really trying to correct my grammatical error. It wasn't on them to educate me. It's on me to educate myself and make sure that I don't make those mistakes again. And it also is on me the fact that I certainly, it honestly was only a grammar mistake, but it's also not on them to make me feel better because I was so worried about my grammar that I appear disrespectful in my email. I needed to just take that and say, "Okay, I don't need to do that anymore." Empathy does not save lives or create equity. There must be action.

So it's nice to feel sorry for people and it's nice to really be like, "You know, I understand what you, I'm trying to understand what you're saying, and I really have respect for your experiences." But that doesn't save lives and that doesn't create equity. We talked about having a language barrier and how that can be detrimental to someone's life. We also talked about people delaying healthcare because they're afraid of being discriminated against. So you can feel sorry and you can really want to reach out to someone, but you really need to take action in order to really promote equity. And some of those things that you can do, you can participate in forums, social media groups, events, activities, to gain insight into the needs of others different from ourselves. Read historical accounts and healthcare literature that is written from a minority point of view. And go to museums highlighting the culture of others. So these are all ways that you can really take a look at someone else's point of view and really see there's maybe some issues that you had never thought of. So like I said, my social circle has pointed out to me some of the gaps that we have in terms of activities of daily living, which I may not have thought of until I came across that one patient where this was an issue. So I would rather be prepared than be reactionary. With the reading of the historical accounts, a lot of times we will say, we have a tendency to read things and look at things from people who look like us or people who have had experiences like us. And when you're in a minority group and you're marginalized, you wanna be heard. And so your account of things that happened may be completely different than other accounts of what may have happened. And so that goes a long way for healthcare, too, because we're dynamic people. The things that happen to us in our everyday lives does affect our healthcare and it does affect the way that we are able to interact with our patients and the way that we do receive information. What else can you do? Vote. Advocate for policies that promote equity in healthcare. You see how important those things are that we put on our timeline.

So those things did not get done just because someone said, "Oh, you know, it sure would be nice if we made it equal for, we said, took," ah, sorry, I'm getting tongue-tied. There are so many different things on the slides. But it just didn't get done because someone thought it was a good idea. Volunteer your talents and expertise in underserved communities. So it's great to read about underserved communities, and it's great to read about marginalized people, and it's really nice to be empathetic and read an article and say, "Oh, okay, I understand that." But you know what? Volunteer, make friends, make connections in the professional world. That's how you get to know about people and different subsets of groups. I also put a little star next to the voting because I do want to be mindful of the fact that there are some religious groups that do not vote. Okay, they do not believe that. And like I said, we all are a combination of all of our life experiences and that makes us who we are. So if voting is not what works for you, then certainly volunteer your talents somewhere. And before I read this final quote, I also want to be conscientious of the fact, too, that a lot of people, because of your religious beliefs, it does cause implicit bias for you. And it is maybe a struggle for you in terms of equity in healthcare. And so I would also implore you to figure out what you have to do to reconcile that. For me, I reconcile that people are human beings and everybody deserves to be treated equally. And so you don't have to agree with something to advocate for someone and to ethically do your job because it is a matter of ethics. And I'll finish with this quote, it says, "It's in your hands to make a better world for all who live in it." We all became healthcare providers for a reason. We did it because we wanna help people. And the way to help people is to help everyone who is not receiving equitable care. And so as a healthcare provider, we really wanna make sure that we're doing everything we can to provide equitable, safe care for our consumers. Thank you.

- [Fawn] Thank you so much, Tasha, for a great talk today. Let me just get back to your email here. If anyone has any questions and would like to reach out to her, there's the email that you can reach her at. I hope everyone has a great rest of the day. Join us again on continued and occupationaltherapy.com. Thanks, everyone.