Walking in Their Shoes- My Journey as a Patient Searching for Equity

Tochi Iroku-Malize MD MPH MBA FAAFP

Disclosure

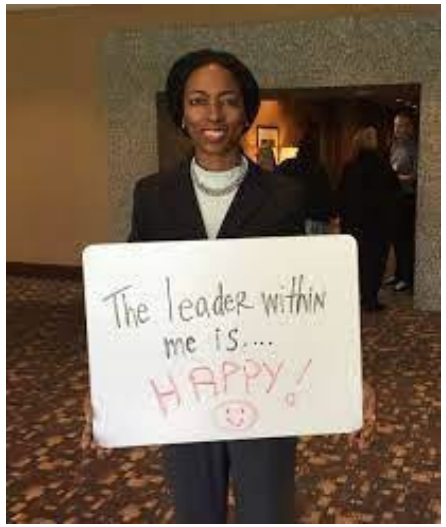
President American Academy of Family Physicians (AAFP)

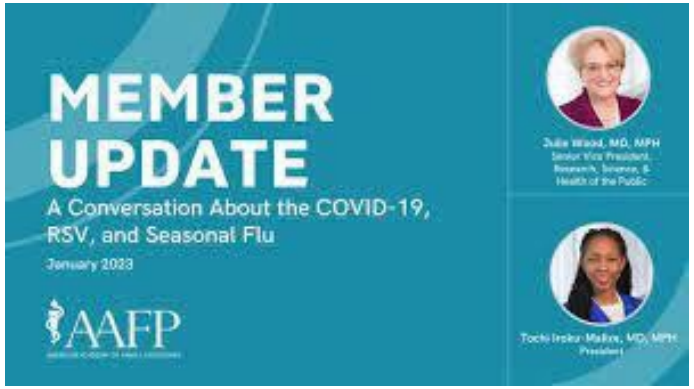
Employee Northwell Health

Board Member National Quality Forum (NQF)

Objectives

Describe	Describe at least 3 ways that the experience of a physician leaders as a patient is different than that of a non-patient physician leader
Articulate	Articulate at least 3 lessons learned from my experience on how to handle this “role reversal”
Commit	Commit to at least one positive thing to do this year based on your own experience and reflection


The leader within
me is....
HAPPY!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UPDATE
A Conversation About the COVID-19,
RSV, and Seasonal Flu
January 2023
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Julie Wood, MD, MPH
Tochi Iroku-Malize, MD, MPH
President


CONGRESS
OF DELEGATES


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Tochi Iroku-Malize
MD, FAAFP
"As I begin my term as president, I remain
committed to strengthening primary care by
encouraging our members to be change agents
in their communities and throughout the health
care system, by advocating for better health
care policies and payment, and by emphasizing
the importance of physician well-being."
AAFP

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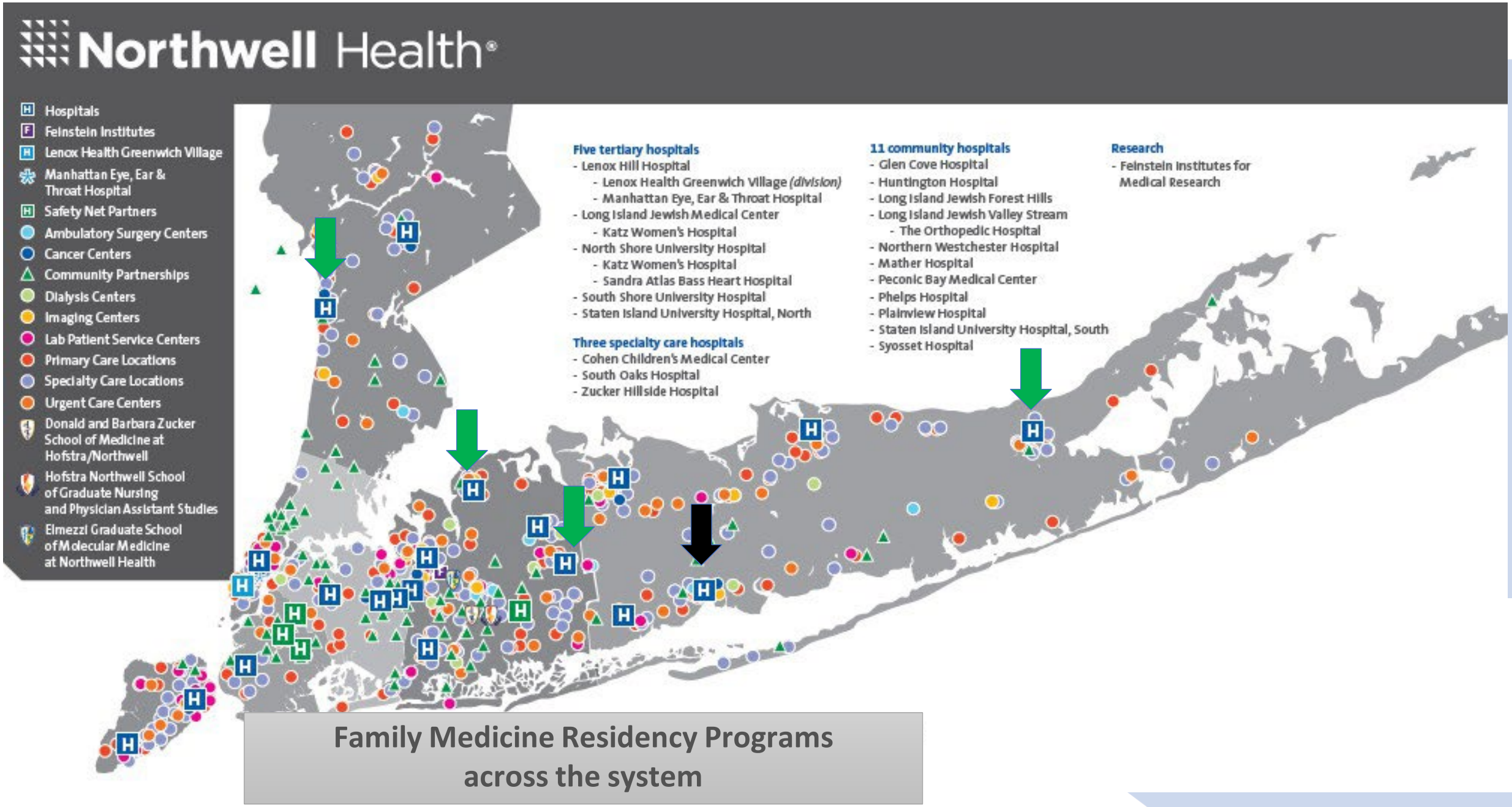

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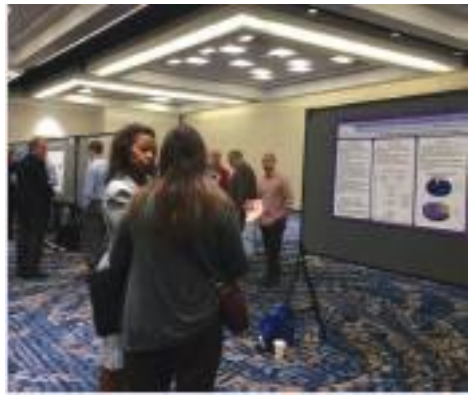

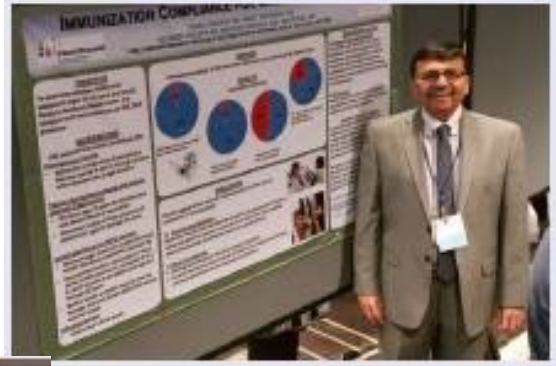

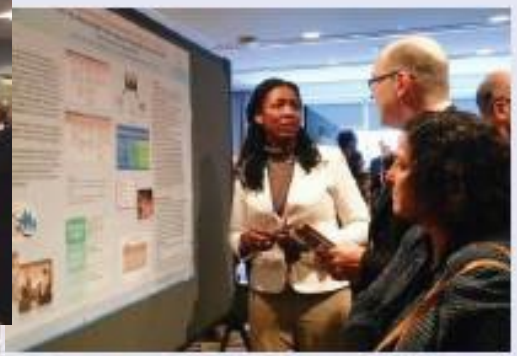

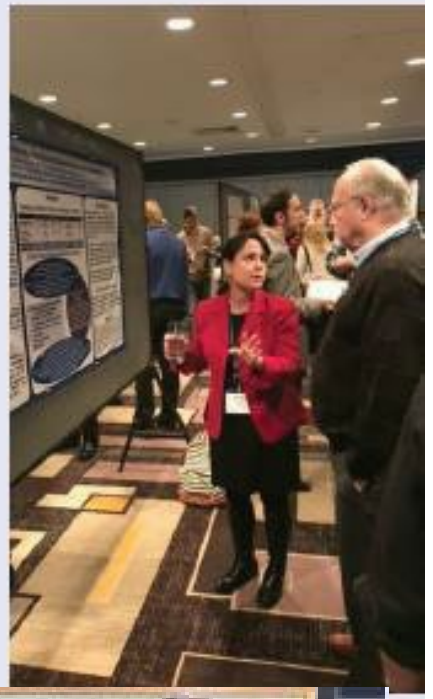

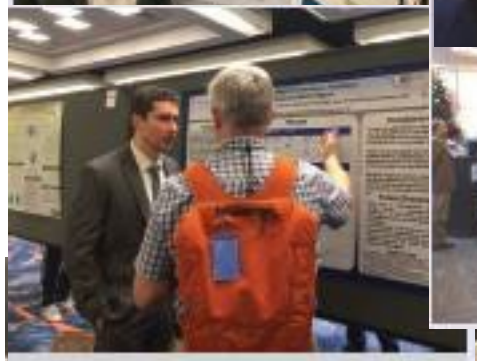

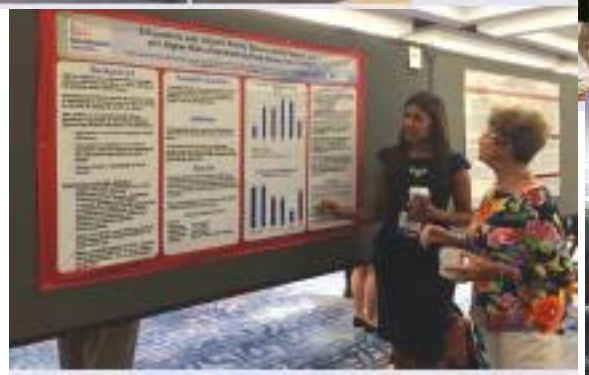

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THE JOURNAL OF FAMILY PRACTICE

Tochi Iroku-Malize, MD, MPH, MBA; Maureen Grissom, PhD
Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, Hempstead, NY

The agitated patient: Steps to take, how to stay safe

he patient is agitated and not interested in answering ny questions. He's begun pacing the room. How would u respond?

ANNALS OF FAMILY MEDICINE
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From the Association of Departments of Family Medicine
INFLUENCING STUDENT SPECIALTY CHOICE: THE 4 PILLARS FOR PRIMARY CARE PHYSICIAN WORKFORCE DEVELOPMENT

CTICE MMENDATIONS
are of signs of
n and use verbal
tion and envi-
l modifications
possible. (B)
group-based
dent debrief-
ained provider
natic event. (B)

CASE ▶ A 40-year-old man came to o
He had an acute illness that was mir
was not interested in answering my
physical exam. The more I tried to
more agitated he became—pacin
ing eye contact. I was uncomfort
tion could quickly escalate if it
What steps would you tak

The scene described
but more recently,
area was affected b

BRIEF REPORTS

FP Essent. 2016 Jun;445:11-6.
Eye Conditions in Older Adults: Open-Angle Glaucoma.
Iroku-Malize T1, Kirsch S1.
Author information
Abstract
Glaucoma is the leading cause of irreversible vision loss in the United States, affecting 1.9% of individuals older than 40 years. The prevalence of the most common form, open-angle glaucoma, increases with age and is higher in non-Hispanic minorities. The progressive loss of peripheral vision in glaucoma often leads to difficulty with driving, particularly at night, and can increase the risk of falls and subsequent fractures. Although glaucoma usually is characterized by chronically elevated intraocular pressure, it is more accurately defined as an optic neuropathy. Typically, there are no warning signs or symptoms, and extensive and permanent optic nerve damage can occur before the patient is aware of visual field loss. A cup to disc ratio greater than 0.6 on ophthalmoscopy is suspicious for glaucoma, and visual field testing results show a characteristic peripheral loss. Medical and surgical treatments are aimed at decreasing intraocular pressure by decreasing production of aqueous humor and increasing its outflow. Drugs for glaucoma treatment include prostaglandin analogs, beta blockers, alpha2-adrenergic agonists, and carbonic anhydrase inhibitors. Surgical or laser treatment is indicated if medical management is unsuccessful. Alternative therapies are less effective and have more adverse effects than standard treatments.

Mapping Residency Global Health Experiences to the ACGME Family Medicine Milestones
Maureen O. Grissom, PhD; Tochi Iroku-Malize, MD, MPH, MBA; Rita Peila, PhD; Marco Perez, MD; Neubert Philippe, MD


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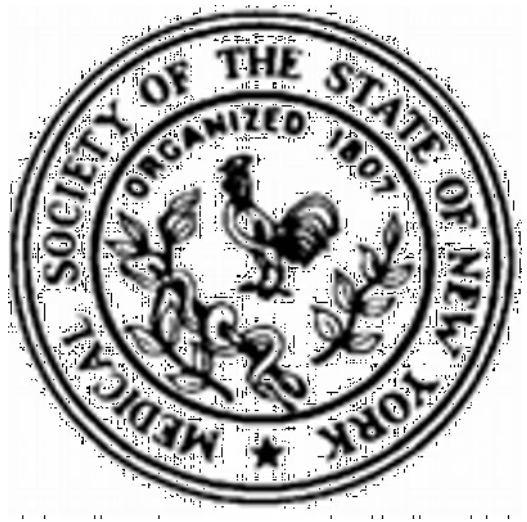
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ASSOCIATION

FM in the Media

COVID-19 Event at Kindergartners at P.S 41M

On January 29, 2021 **Dr. Santhosh Paulus** spoke with the kindergartners at P.S. 41M about ways to help prevent the spread of the COVID-19 virus in their school and at home.

A Fifth of COVID Patients With Diabetes Die Within 1 Month of Hospitalization

On February 18, 2021, **Dr. Barbara Keber** spoke with U.S. News & World Report about the effects the COVID-19 virus has had on individuals diagnosed with Diabetes. View full article **here**.

Putting on the pounds during the pandemic a problem for some

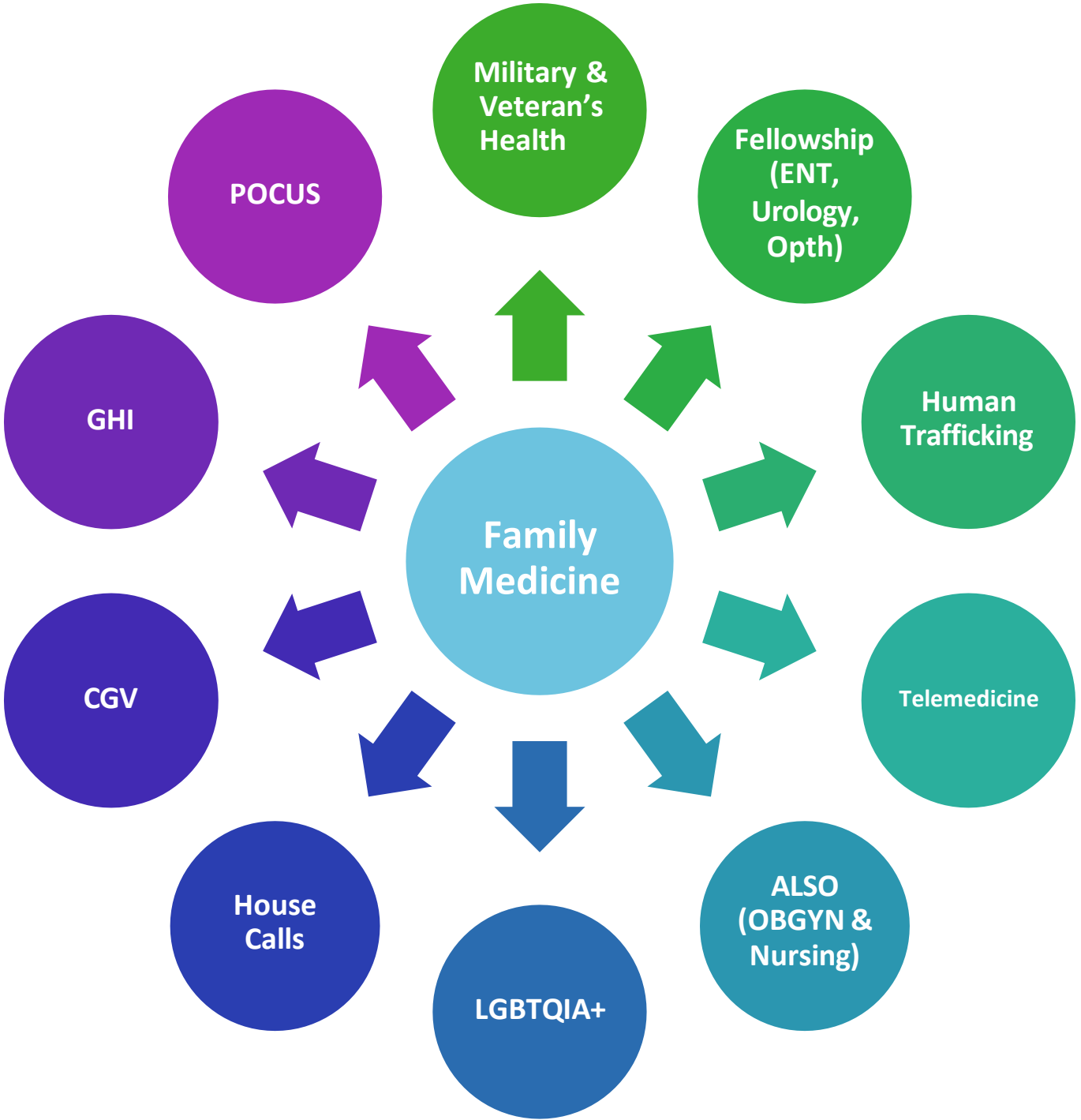
Learn more about the COVID-19 pandemic, and it's affect on obesity from **Dr. Marc Schechter.**

Doctors Report Small Number of COVID-19 Patients Develop Severe Psychotic Symptoms—Here's What to Know

On December 30, 2020 **Dr. Mason Chacko** was interviewed by Health.com about the COVID-19 pandemic and its' affects on patient's with severe psychotic symptoms. To read Dr. Chacko's interview, **click here.**

Northwell Health

Current Projects: Collaborations



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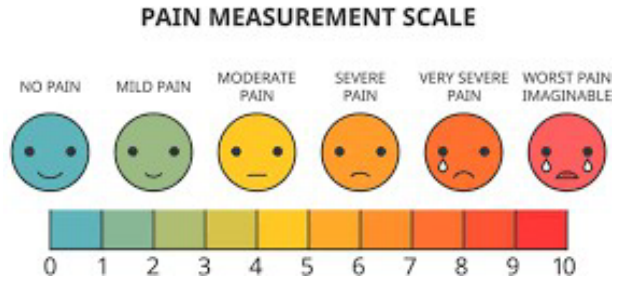
SPRING 2019


EMERGENCY


Time To
Go Home


HELP


PAIN MEASUREMENT SCALE
NO PAIN
MILD PAIN
MODERATE PAIN
SEVERE PAIN
VERY SEVERE PAIN
WORST PAIN IMAGINABLE
0 1 2 3 4 5 6 7 8 9 10

Pain Medicine, 22(1), 2021, 75–90
doi: 10.1093/pm/pnaa427
Advance Access Publication Date: 23 December 2020
Review Article

OXFORD

Racial and Ethnic Disparities in the Treatment of Chronic Pain

Mary E. Morales, MD and R. Jason Yong, MD, MBA

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Correspondence to: Mary E. Morales, MD, Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115, USA. Tel: 617-732-8210; Fax: 617-582-6131; E-mail: mmorales@bwh.harvard.edu.

Funding sources: Neither of the authors had any direct or indirect funding in support of this study.

Conflicts of interest: Mary E. Morales, MD, has no conflicts of interest to disclose. R. Jason Yong, MD, MBA, is a consultant for Endo Pharmaceuticals.

Abstract

Objective. To summarize the current literature on disparities in the treatment of chronic pain. **Methods.** We focused on studies conducted in the United States and published from 2000 and onward. Studies of cross-sectional, longitudinal, and interventional designs were included. **Results.** A review of the current literature revealed that an adverse association between non-White race and treatment of chronic pain is well supported. Studies have also shown that racial differences exist in the long-term monitoring for opioid misuse among patients suffering from chronic pain. In addition, a patient's sociodemographic profile appears to influence the relationship between chronic pain and quality of life. Results from interventional studies were mixed. **Conclusions.** Disparities exist within the treatment of chronic pain. Currently, it is unclear how to best combat these disparities. Further work is needed to understand why disparities exist and to identify points in patients' treatment when they are most vulnerable to unequal care. Such work will help guide the development and implementation of effective interventions.

Key words: Chronic Pain; Disparities; Opioids; Pain Management

› J Am Osteopath Assoc. 2007 Sep;107(9 Suppl 5):ES17-20.

Eliminating disparities in pain management

Margaret R Paulson [1], Anthony H Dekker, Sergio Aguilar-Gaxiola

Affiliations + expand

PMID: 17908826

Abstract

Not all patients are treated equally for their pain with some therefore being undertreated.
t in the way physicians treat special populations of patients such as racial
d substance abusers. All healthcare providers need to be aware of the not so
arities resulting from stereotyping, bias, ageism, and socioeconomic
ians can best provide appropriate and equal care by following pain
es; however, they may receive contradictory information and be apprehensive
bids, especially to substance abusers. In this "refreshed" article, the authors
unters with patients of color and offer some goals for removing inequality and
settings.

JAMA Network | Open

Invited Commentary | Diversity, Equity, and Inclusion

Looking Beneath the Surface: Racial Bias in the Treatment and Management of Pain

Antoinette Schoenthaler, EdD; Natasha Williams, EdD

Research has consistently documented inequities in the quality of care experienced by Black patients, with negative downstream effects on patient outcomes. Chronic pain is an area where substantial racial and ethnic differences in the management and treatment of Black individuals' pain have been well-documented. While previous research posits that the patient-physician relationship is a primary mechanism for these disparities, little empirical research has examined this association. The study by Licciardone et al[1] aims to fill this gap in the evidence-base by evaluating whether the quality of the patient-physician relationship serves as a mediator between patient race and pain and physical function outcomes among adults with chronic low back pain. This cross-sectional study included 1177 Black and White adults recruited from the University of North Texas Health Center's Pain Registry for Epidemiological, Clinical, and Interventional Studies and Innovation from 2016 to 2021. The quality of the patient-physician relationship was assessed using 3 self-report measures, which were completed by the study participants at registry enrollment: participant's perception of physician communication was assessed with the Communication Behavior Questionnaire; perceived physician empathy was measured with the Consultation and Relational Empathy scale; and perceived satisfaction with medical care was assessed with the Patient Satisfaction Questionnaire. All were linearly transformed to create a score ranging from 0 to 100 to facilitate direct comparison of the measures. Intensity of chronic low back pain was measured as the average pain level over the 7 days prior to registry enrollment using a 0 (no pain) to 10 (worst pain) scale. The Roland-Morris Disability Questionnaire was also administered at registry enrollment to assess the perceived adverse impact of low back pain on physical function.

+ Related article

Author affiliations and article information are listed at the end of this article.

AMA Journal of Ethics

March 2015, Volume 17, Number 3: 221-228

MEDICAL EDUCATION

Education to Identify and Combat Racial Bias in Pain Treatment

Brian B. Drwecki, PhD

Reducing racial bias in pain treatment is a laudable and feasible goal that requires attention to and management of health care professionals' self-concept; an interdisciplinary approach to research that bridges knowledge and expertise across multiple fields; and a medical education system primed to take advantage of its unique position at the heart of health care professional formation and development. This paper provides support for a more complex understanding of the social and psychological factors driving racial bias in medicine and pain treatment, presents evidence that reducing racial biases is possible, and considers medical education's role in doing so.

AAMC

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INSIGHTS

How we fail black patients in pain

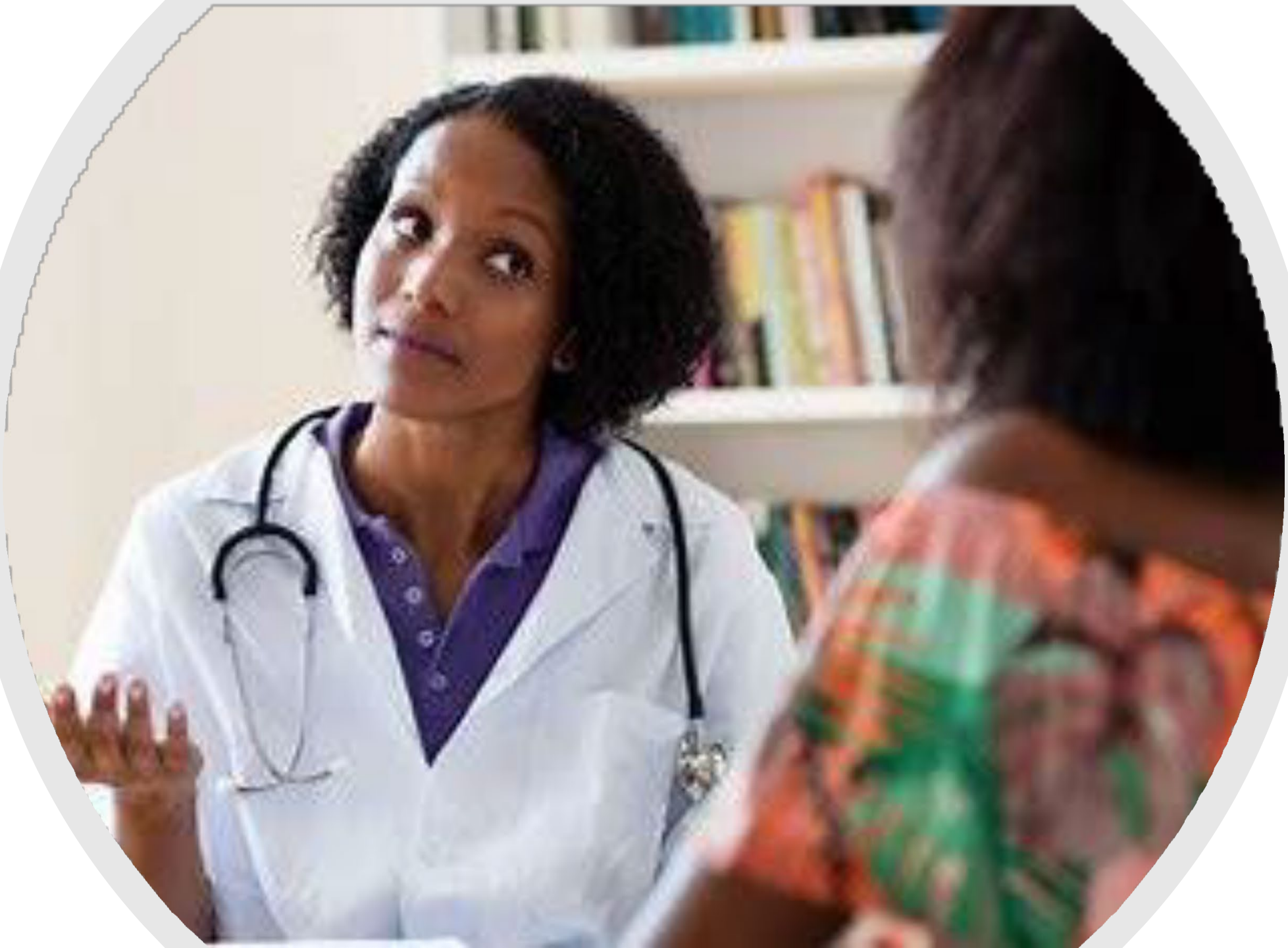
Half of white medical trainees believe such myths as black people have thicker skin or less sensitive nerve endings than white people. An expert looks at how false notions and hidden biases fuel inadequate treatment of minorities' pain.

By Janice A. Sabin, PhD, MSW

January 6, 2020

Leader Voices Blog

A Forum for AAFP Leaders and Members

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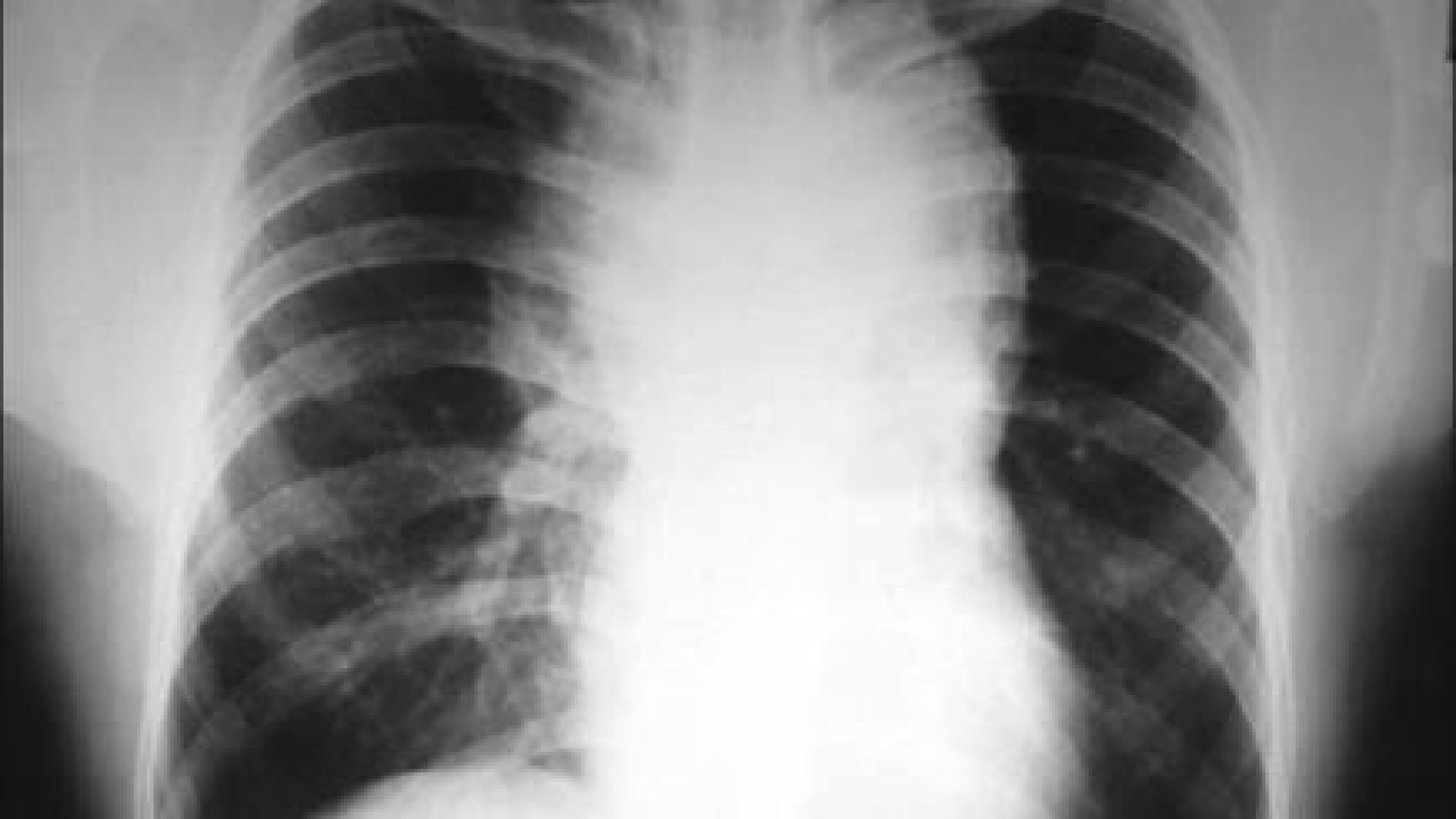

"Just shup up and take the lollipop."

Are There Errors in Your Medical Records?

JANUARY 22ND, 2019 • DOCTOR ERRORS, FAILURE TO DIAGNOSE, MISDIAGNOSIS, PATIENT SAFETY

Medical errors are the th
found more than 250,00
third-leading cause of de
be higher than 400,000 d

Inaccurate medical reco
mistake for example, car
billing. Though electroni
information, mistakes st

In the event of a medica
and why the healthcare
a healthcare professiona
or their family files a clai

JAMA Network | Open

Original Investigation | Health Informatics

Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes

Sigall K. Bell, MD; Tom Delbanco, MD; Joann G. Elmore, MD, MPH; Patricia S. Fitzgerald, MSc; Alan Foss
Thomas H. Payne, MD; Rebecca A. Stametz, DEd, MPH; Jan Walker, RN, MBA; Catherine M. DesRoches

Abstract

IMPORTANCE As health information transparency increases, patients more often seek th
data. More than 44 million patients in the US can now readily access their ambulatory visit
online, and the practice is increasing abroad. Few studies have assessed documentation er
patients identify in their notes and how these may inform patient engagement and safety s

OBJECTIVE To assess the frequency and types of errors identified by patients who read o
ambulatory visit notes.

DESIGN, SETTING, AND PARTICIPANTS In this survey study, a total of 136 815 patients at
health care organizations with open notes, including 79 academic and community ambulat
practices, received invitations to an online survey from June 5 to October 20, 2017. Patient
at least 1 ambulatory note and had logged onto the portal at least once in the past 12 mont
included. Data analysis was performed from July 3, 2018, to April 27, 2020.

RESEARCH ARTICLE | HEALTH EQUITY

HEALTH AFFAIRS > VOL. 41, NO. 2: RACISM & HEALTH

Negative Patient Descriptors: Documenting Racial Bias In The Electronic Health Record

Michael Sun, Tomasz Oliwa, Monica E. Peek, and Elizabeth L. Tung

AFFILIATIONS

PUBLISHED: JANUARY 19, 2022 Open Access https://doi.org/10.1377/hlthaff.2021.01423

SECTIONS VIEW ARTICLE PERMISSIONS SHARE TOOLS

Abstract

Little is known about how racism and bias may be communicated in the medical record. This study used machine learning to analyze electronic health records (EHRs) from an urban academic medical center and to investigate whether providers' use of negative patient descriptors varied by patient race or ethnicity. We analyzed a sample of 40,113 history and


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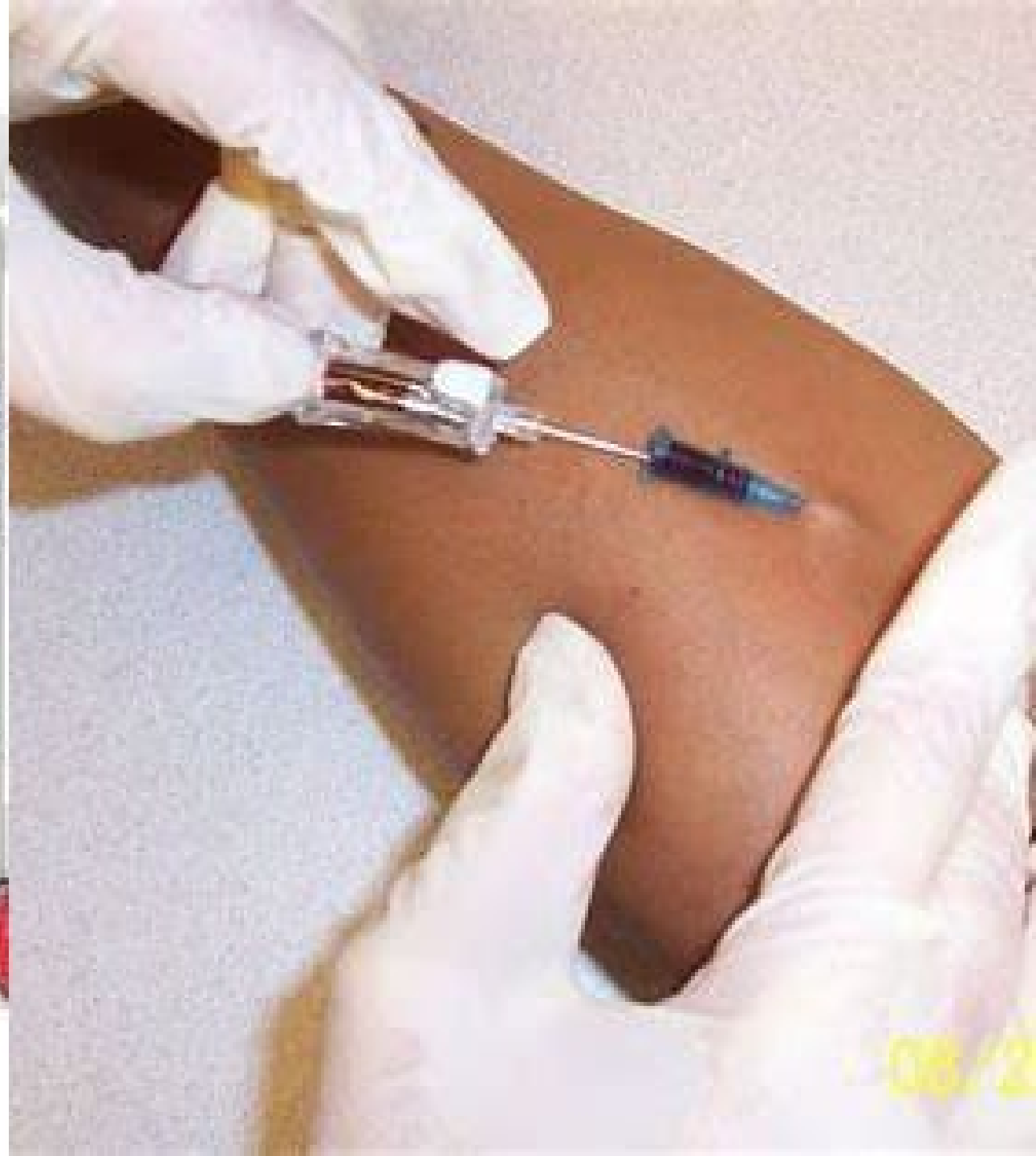


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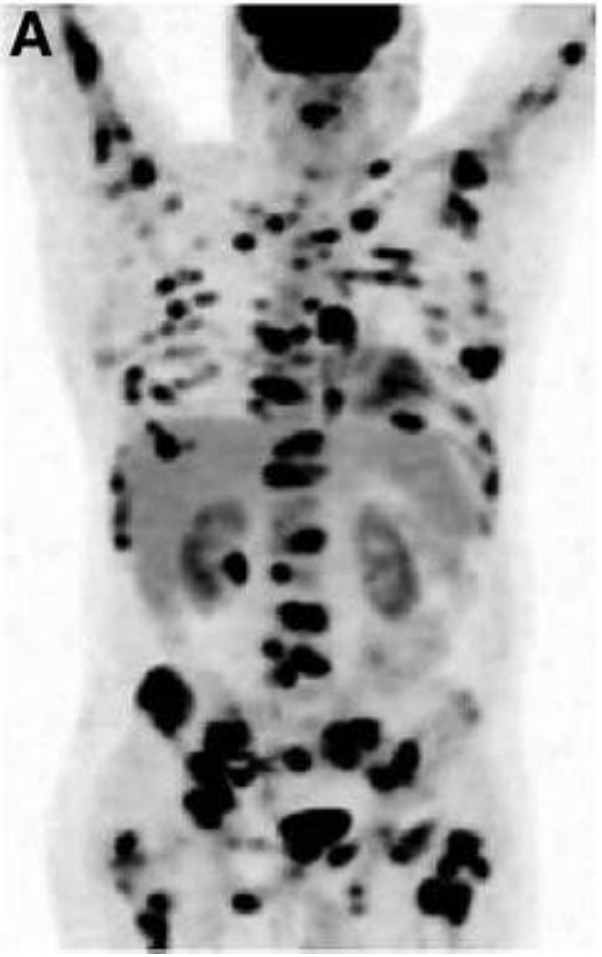
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Author manuscript
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About author manuscripts | Submit a manuscript

J Hosp Med. Author manuscript; available in PMC 2012 Oct 1.
Published in final edited form as:
J Hosp Med. 2011 Oct; 6(8): 448–456.
doi: 10.1002/jhm.919

PMCID: PMC3201712
NIHMSID: NIHMS278600
PMID: 21990173

Rethinking Resident Supervision to Impr
Interprofessional Models

Michal Tamuz, PhD,[1] Traber Davis Giardina, MA, MSW,[2]
Hardeep Singh, MD MPH[2]

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The publisher's final edited version of this article is ava

Abstract

Background

Inadequate supervision is a significant contribu

Author Manuscript

Original Investigation

July 2018

Effect of Increased Inpatient Attending Physician Supervision on Medical Errors, Patient Safety, and Resident Education

A Randomized Clinical Trial

Kathleen M. Finn, MD[1]; Joshua P. Metlay, MD, PhD[1]; Yuchiao Chang, PhD[1]; et al

» Author Affiliations | Article Information

JAMA Intern Med. 2018;178(7):952-959. doi:10.1001/jamainternmed.2018.124

AMA Journal of Ethics®
Illuminating the Art of Medicine

CASE AND COMMENTARY
FEB 2015

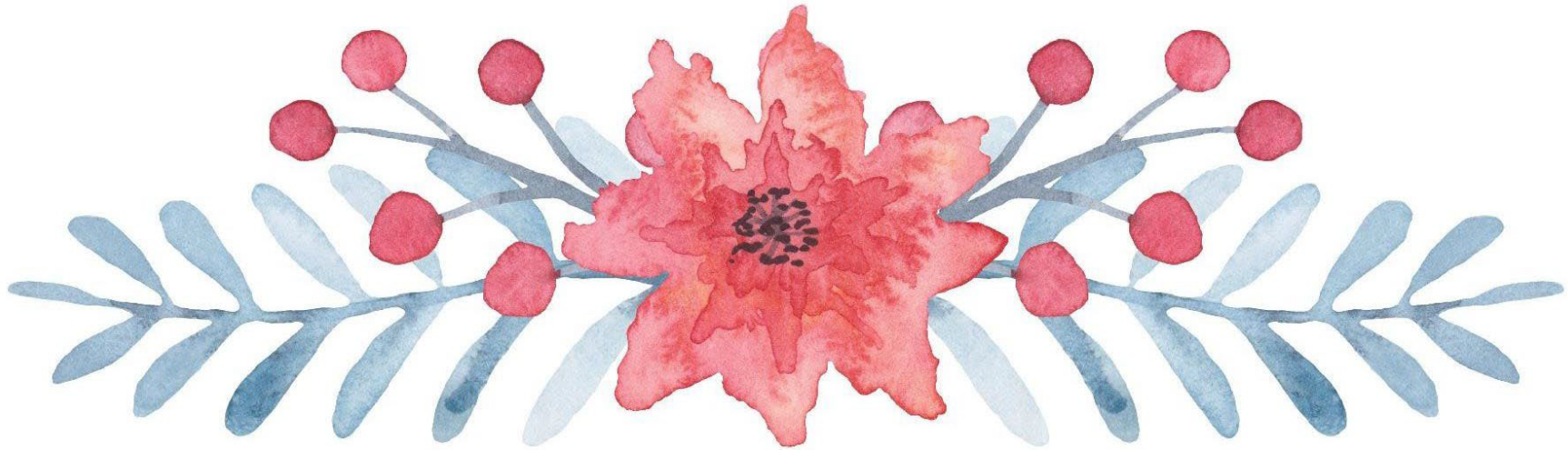
Balancing Supervision and Independence in Residency Training

Amy H. Buchanan, MD and Aaron J. Michelfelder, MD

Citation | PDF | Altmetric

Case

Chad is in his first year of residency in emergency medicine. He is working a night shift when a woman brings in her four-year-old daughter suffering from a high fever and ear pain. Chad decides to give the girl ibuprofen, start her on a course of antibiotics, and keep her under observation. Over the next couple of



September

2019

Approach to Making a Differential for Altered Mental Status

Altered mental status

Neurologic

Stroke
Cerebral hypoxia
Cerebral hemorrhage
Seizure
Trauma
TBI
Tumor
Vasculitis/Encephalitis

Metabolic

Electrolyte disturbance
Uremia
Hepatic encephalopathy
Hypoglycemia
Hypercarbia
Vitamin deficiency
Thyroid disease

Infectious

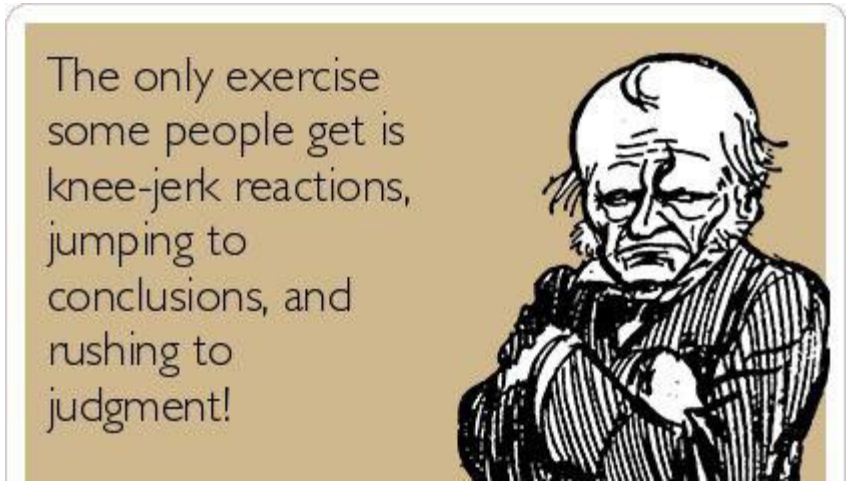
UTI
Pneumonia
Sepsis
Meningitis
Encephalitis
Abscess

Toxic

Medications
Alcohol
Recreational drugs
Toxic ingestions

Other

Insomnia
HTN, PRES
Pain
Constipation
Delirium



Perspective: OOPS! Why do doctors make diagnostic errors?

By Charles A. Pilcher MD FACEP

American Medical News published an informative essay by Kevin B. O'Reilly on December 13, 2010, about errors in diagnosis and why doctors make them. According to Gordon Schiff, MD, associate director of the Center for Patient S
Hospital, "The problem of diagnostic errors
movement." The article focused on "thinkin
both refreshingly honest and depressingly t

None of us is without error. We all make mi
the "system," but most often we have only o
"What happened that I made that error for
something about ourselves as physicians – a

But I'll get to that in a moment.

People Who Jump to Conclusions Show Other Kinds of Thinking Errors

Belief in conspiracy theories and overconfidence are two tendencies linked to hasty thinking

By Carmen Sanchez, David Dunning

AUTHORS

Carmen Sanchez is an assistant professor at the University of Illinois at Urbana-Champaign's Gies College of Business. She studies the development of misbeliefs, decision-making and overconfidence. *Credit: Nick Higgins*

David Dunning is a social psychologist and a professor of psychology at the University of Michigan. His research focuses on the

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Perspective

Tackling Implicit Bias in Health Care

Janice A. Sabin, Ph.D., M.S.W.

Article Metrics

5 References 4 Citing Articles

IMPLICIT AND EXPLICIT BIASES ARE AMONG MANY FACTORS THAT CONTRIBUTE TO disparities in health and health care.[1] Explicit biases, the attitudes and assumptions that we acknowledge as part of our personal belief systems, can be assessed directly by means of self-report. Explicit, overtly racist, sexist, and homophobic attitudes often underpin discriminatory actions. Implicit biases, by contrast, are attitudes and beliefs about race, ethnicity, age, ability, gender, or other characteristics that operate outside our conscious awareness and can be measured only indirectly. Implicit biases surreptitiously influence judgment and can, without intent, contribute to discriminatory behavior.[2] A person can hold explicit egalitarian beliefs while harboring implicit attitudes and stereotypes that contradict their conscious beliefs.

October

2019

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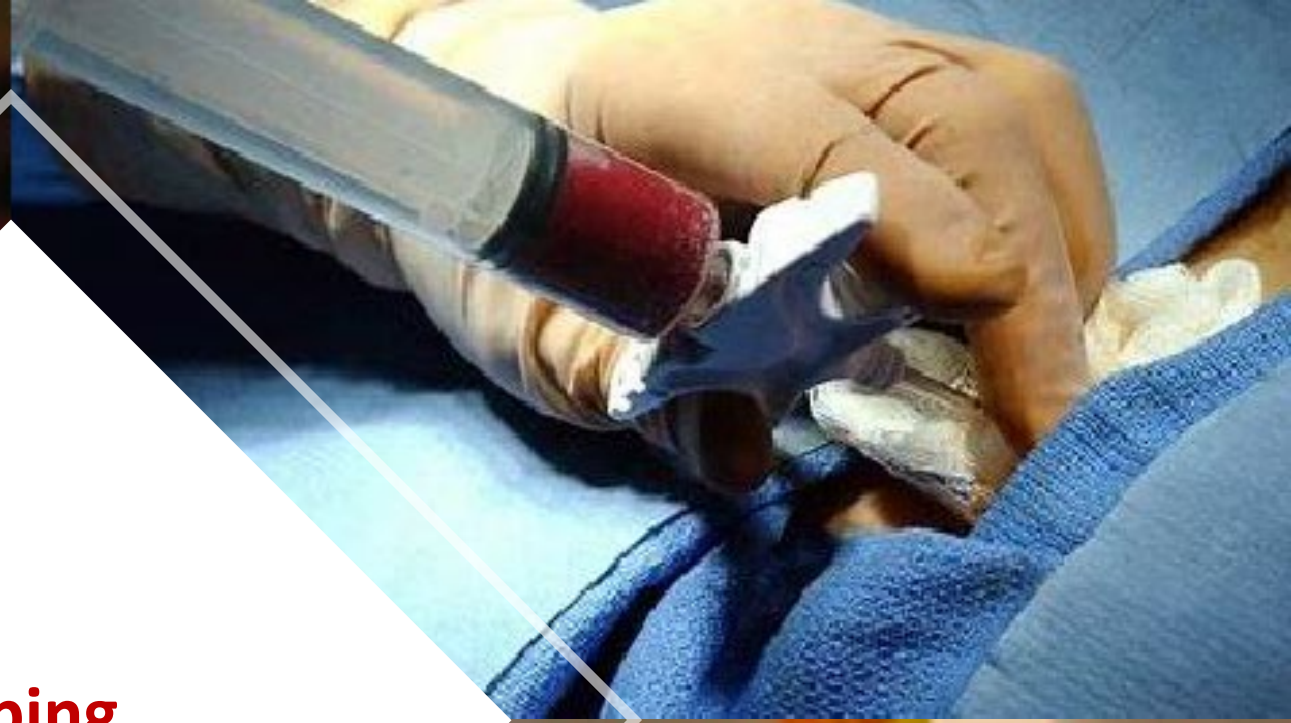

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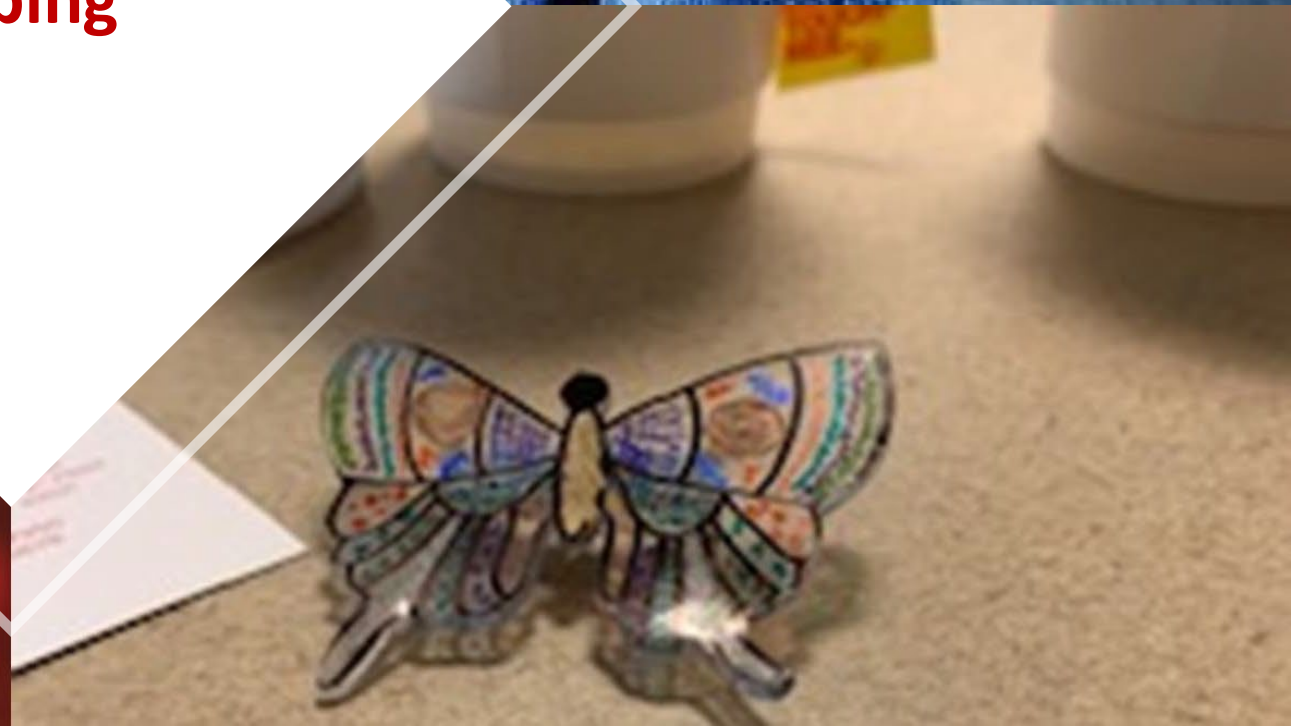

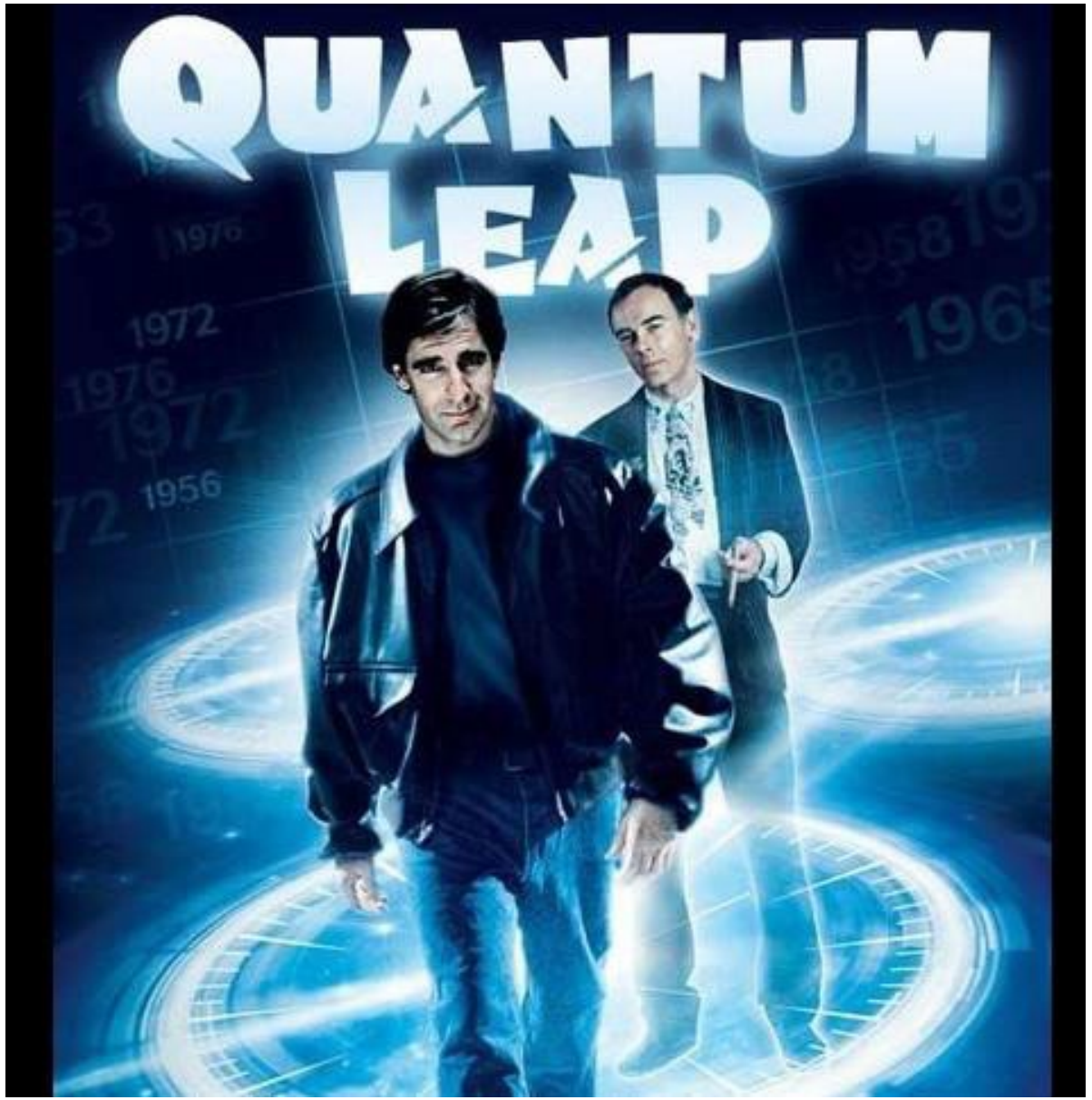
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Nurs Open. 2020 Mar; 7(2): 650–659.
Published online 2019 Dec 19. doi: 10.1002/nop2.436
PMCID: P
PMI

Barriers to practicing patient advocacy in healthcare setting

Comfort Nsiah,[1] Mate Siakwa,[1] and Jerry P. K. Ninnoni[1]

Abstract

Aim

To explore barriers to practicing pa

Design

This study used a qualitative resea

Patient Educ Couns. 2011 Dec;85(3):369-74. doi: 10.1016/j.pec.2011.01.028. Epub 2011 Feb 18.

The importance of physician listening from the patients' perspective: enhancing diagnosis, healing, and the doctor-patient relationship

Justin Jagosh [1], Joseph Donald Boudreau, Yvonne Steinert, Mary Ellen Macdonald, Lois Ingram

Affiliations + expand

PMID: 21334160 DOI: 10.1016

Abstract

Objective: The research finding
physician listening according to

Methods: Fifty-eight patients o
qualitative, interpretive design a

Results: Patients explained why
into three themes: (a) listening a

Using Active Listening to Understand Patient Needs

Apr 23 - Written By Wilesker Dias


2020


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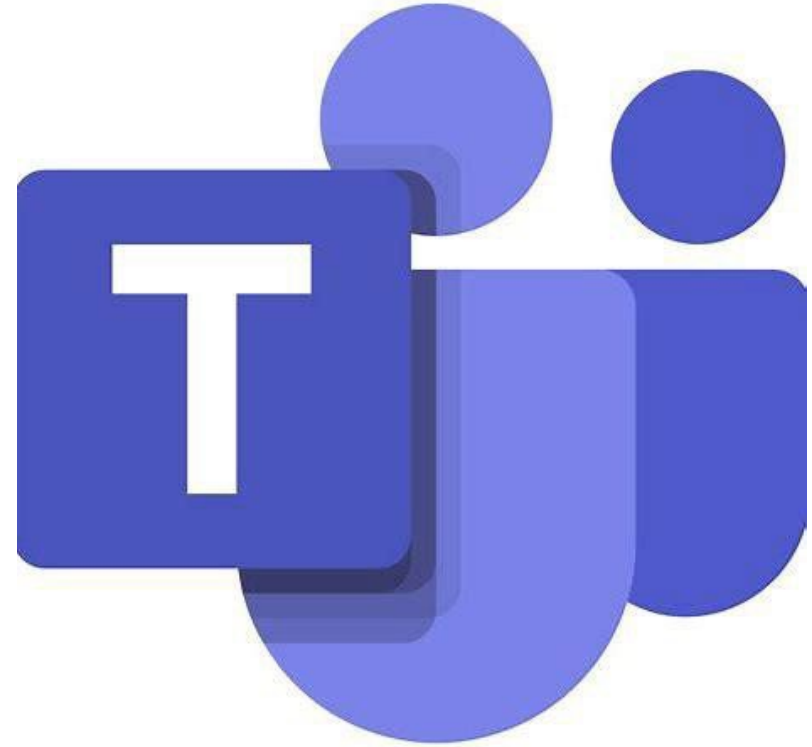


zoom

Physician Heal Thyself

Well Physician Leader

- Position of authority
- EBM statistics rule
- Priority is the many
- Long term mindset
- Mind over matter
- Deadlines

Unwell Physician Leader

- Relinquishes some authority
- Statistics suck
- Priority is the few
- Short term mindset
- Matter fights mind
- Milestones

Lessons Learned

- Use adversity to fulfill your mission
- Have a succession plan
- Delegate
- Tell your story so others know they are not alone
- **Use your experiences to advance patient care!!!!!!!**
- Be kind to yourself
- You are unique – how you handle your situation depends on you
- Continue to inspire others
- Laugh often


What is YOUR
MISSION?

Commitment

What <u>one positive thing</u> will you do **this year** based on your own experience and reflection?

Thank You

@tilimd

#YouveGotThis