LET’S TALK: RACIAL AWARENESS AND RESPONSIBILITY IN PSYCHIATRY

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Disclosures

- No financial conflicts of interest to disclose.
Objectives

- Create a shared language when discussing implicit bias and racial disparities.
- Communicate an informed approach to navigating cultural identity with patients and fostering responsiveness to concerns of inequity voiced by patients.
- Examine the experience of racial discrimination as a provider and discuss associated ethical considerations when providing care.
- Recognize how racial bias can impede the delivery of equitable psychiatric services.
- Discuss opportunities to label and mitigate racial disparities in a multi-disciplinary forum, as both individual providers and functioning teams within a healthcare system.
1. Discuss the language of bias and why implicit bias matters.
2. Review a clinical case of a patient who voices an experience of discriminatory care.
3. Discuss the ethical considerations of being a provider experiencing racial discrimination.
4. Understand the implications of bias in the delivery of psychiatric services.
5. What can we do about it?
The Language of Bias

- Schemas
- Attitudes
- Stereotypes
- Bias
- Explicit Bias
- Implicit Bias
  - Often used interchangeably with implicit social cognition, unconscious bias

- Micro/Macroinequities
- Racial anxiety
- Stereotype threat
- Stereotype replacement* (will discuss later)

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UCLA Equity, Diversity and Inclusion Video Series – Implicit Bias
Project Implicit – Implicit Association Test
Agenda

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Clinical Case:

- 26 y/o self-identified biracial male with a history of schizoaffective disorder who was BIBA for disorganized thoughts and aggression in the setting of medication non-adherence following a recent hospital stay.

Previous Hospitalization ➔ Father’s House ➔ Current Hospitalization

- Treatment team’s experience of providing care and interpretation of needs
- Patient’s experience of his care and communicating his needs
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Providers who experience racial discrimination

- It is not uncommon for providers to experience racial discrimination.
- It is not uncommon for minority communities to feel isolated in medicine.
- There are numerous ethical considerations.
- There are few guidelines to managing patient prejudice.


Discriminatory Scenarios Used in Interviews

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
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<tbody>
<tr>
<td>Scenario 1. Race</td>
<td>When an African American junior resident walked into a newly admitted Caucasian infant’s hospital room the child’s mother, also Caucasian, stood and blocked the resident’s path to the child. The mother did not move and told the resident, “I want someone else to examine my child; I do not want your kind to touch her.” The mother went on to say that she did not want a “diversity quota doctor” to take care of the child but someone who was &quot;actually smart&quot; and could treat her daughter's illness.</td>
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<td>Scenario 2. Gender</td>
<td>A male medical student walks into an OB/GYN clinic room and introduces himself to an adolescent patient and her mother. The mother asks if she can step outside with him. Once they are in the hallway the mother tells the student that she does not want a male practitioner examining her young daughter. “She’s never had a pelvic exam before. I’m worried the experience will be worse for her with a man involved.”</td>
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<td>Scenario 3. Religion</td>
<td>An intern working in the Emergency Department returned to a toddler’s exam room after presenting the child’s case to her attending. She explained to the parents that she was calling a consultant for a surgical evaluation. The patient’s father pointed to the intern’s badge and asked if her last name was Jewish. She replied, “No,” and the father then asked if the surgeon was Jewish. “I don’t want a Jewish doctor,” the father said, “I’m from Palestine.”</td>
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*Adapted from McDade W. Through the physician’s eyes: The racist parent. Virtual Mentor. September 2001;3(9).*

Participant-Recommended Approaches to a Discriminatory Patient or Family

<table>
<thead>
<tr>
<th>Theme</th>
<th>Acceptable responses</th>
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<tbody>
<tr>
<td>Assess Illness acuity</td>
<td>- How sick is the patient? Is there time to safely transfer care?</td>
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<td>- Is finding another provider at your institution an option?</td>
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<td>- Do you need to consider court order or Child Protective Services involvement?</td>
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<tr>
<td>Cultivate a therapeutic alliance</td>
<td>- Build rapport</td>
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<td>- Explore biases without the intention of changing the family’s mind</td>
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<tr>
<td>- Redirect the conversation to focus on the child’s medical care. “I'm very worried about your child. Let's focus on how we can help him/her.”</td>
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<td>- Educate the family on the team structure: “If you’re here in the teaching facility, everybody participates and that’s part of the bargain of having access to the expertise and participation of multiple people.”</td>
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<td>Depersonalize the event</td>
<td>- Remember discrimination is often motivated by patients’ fears and anxiety about the unknown</td>
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<td>- Acknowledge that discrimination may be coming from family’s lack of control</td>
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<td>- Name the behavior: “Are you discriminating against this physician because of his name/skin color/gender/religion?”</td>
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<tr>
<td>Ensure a safe learning environment for trainees</td>
<td>- Provide support and assurance of trainee competence: “I would trust this physician to take care of my own children”; “I agree with this physician. What other questions may I answer?”</td>
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<td>- Speak to Risk Management</td>
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<td>- Escalate to hospital administration and/or training director</td>
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<td>- Empower the trainee to come up with next steps</td>
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### Participant-Recommended Strategies for Trainee and Faculty Development

#### Strategies for faculty and trainee development

| Case discussions | Use real-life or simulated encounters to generate discussion and explore the range of potential responses |
| Cultural competency and implicit bias education | Help providers identify their own biases and cultural attitudes to facilitate more constructive patient-provider interactions |
| Set up expectations early in training | Explain that this type of mistreatment could happen to anyone |
| | Give permission to walk away |
| | Discuss mistreatment during intern orientation and at transitions into more supervisory roles |
| Share the chain of command for escalation | Educate faculty on institutional policies regarding faculty and trainee mistreatment and whom to contact when the situation must be escalated |
| | Explain the system for documentation and tracking of mistreatment; emphasize confidentiality |

#### Strategies for frontline faculty

| Debrief with team in the moment or shortly thereafter | State importance of trainee safety and well-being |
| | Set expectations for responding in similar situations |
| | Articulate standards of care and what is tolerated by the hospital and academic institution |
| Personal reflection | Reflect on encounter in written or verbal form to identify personal boundaries, biases, and triggers |
| | Seek support and mentorship from colleagues |

#### Strategies for institution

| Task force | Build a multidisciplinary group of physicians, nurses, social workers, and risk managers to spearhead educational efforts and policy changes |
| Trainee mistreatment survey | Implement confidential annual mistreatment survey for longitudinal tracking and intervention |
| Identify point people across the continuum of education | Identify one or several individuals in UME/GME to alert programs and departments when events occur |

Abbreviations: GME indicates graduate medical education; UME, undergraduate medical education.
- No tolerance policy for cultural and religious discrimination.
- Offer frameworks for trainees and faculty to discuss racial discrimination – be careful not to simply retreat to a protocol.
  - *Set up expectations early in training*
- Training about how to facilitate dialogue to productively challenge the behavior.
  - *Case discussions*
  - *Cultural competency and implicit bias education, transference/countertransference*
  - *Debrief with one another when an unexpected event happens*
  - *Routine team debriefs*
  - *Personal reflection*
- Know the point people you can reach out to.
  - *Create support networks*
  - *Share the chain of command for escalation, policies, documentation and tracking mistreatment*
- Measure the response.
  - *Task force*
  - *Trainee mistreatment surveys*


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Implicit Bias in Psychiatry

The field of psychiatry and mental health population are vulnerable to implicit biases, which affects delivery of equitable services across the mental health care continuum (access, clinical screening and diagnosis, treatment processes, crisis response, criminal justice). (Merino et al., 2018)

Examples include:

- Overpredicting violence risk of non-whites and underpredicting violence of whites (Campinha-Bacote, 2017)
- **African-Americans are more likely to be diagnosed with primary thought disorders** (Coleman et al., 2016)
- **African-Americans are less likely to be prescribed SGA** (Cook et al., 2015) (Herbeck et al, 2004)
- Excessive dosing of FGA in African-American patients with schizophrenia (Diaz and De Leon, 2002)
- **Ethnic minorities are less likely to be treated with newer antipsychotics in the outpatient setting** (Puyat et al., 2013)
- **Lowest rates of antidepressant pharmacotherapy and/or psychotherapy have been documented in non-Hispanic Blacks and Hispanics** (Sclar et al., 2012)
- **African-American patients receive poorer quality of care across multiple fields** (Godsil and Johnson, 2013)
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What can we do?

**Cultivate a shared starting point.**
- Be humble. We are all vulnerable to biases.
- Biases do not make us bad people.
- We have the capacity to override them.

**Create a shared language.**
- Assume good intention. Do not question the intention, question the impact.
- Listen, speak up and not over.
- When you make a mistake, work to repair it.
- Realize racial bias is a construct of disproportionate power.
Revitalize the role of narrative in racial healing.

- Storytelling as a fundamental aspect of human experience.
- Challenge dominant narratives.
- Honor the complexity of the past to forge a more equitable future.
- Showcase a monthly narrative, interact with socially dissimilar groups.
- “How do you identify?”

Let your schema be challenged.

- Diversify your experiences.

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Do the work.
- Promote self-awareness.
- Be mindful, slow down.
- Do not forget to bring yourself along and bring your patient along.
- You must be internally motivated.

Decoupling.
- Understand structural racialization.
- Review system practices.
Debiasing.

- Seek counter-examples and counter-messaging.
- Remain vigilant, resist stereotypical associations.
- Stereotype replacement.
- Identify risk areas where biases may affect behavior, implement procedures to assist with decision-making.

Research.

- Investigate how marginalized populations differentially experience implicit bias.
- Measure how implicit attitudes affect the provision of services and treatment.
- Evaluate how structural inequities perpetuate bias.
- There is a care continuum that needs intervention research.
- Many more opportunities!

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Clinical Case: Application

- Cultural identities and cultural practices
- Paranoia: pathology vs. narrative-based?
- Identify de-escalation techniques before they’re needed. Collaborate with the patient.
- The power of “tell me more.”
- “How do you identify?”
- Working to recognize, name, and understand attitudes experienced by the patient.
- Be mindful of privilege and power differential.
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References

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