Recognizing and Addressing Health Care Disparities Among Black Populations

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you ever considered whether some of your patients of color might be receiving less-than-optimal care? Have you been uncertain about how you might discuss their responses to "microaggressions" or to perceived discrimination in health care? Have you wondered whether their access to health care has been limited and how that can be remedied? Have you thought about how you might modify your practice to improve care? If you have, the following case vignette and discussion should prove useful.

CASE VIGNETTE

Mr A, a 63-year-old Nigerian immigrant who was fluent in both English (but with a Nigerian accent) and Yoruba (a major language spoken in Nigeria), was brought to the emergency department (ED) by ambulance after his family called 911 due to acute agitation. He had no prior psychiatric disturbances but had a history of hypertension. While in the ED, Mr A repeatedly claimed he was the Pope. He was restless, frequently pulled at the blood pressure cuff and his intravenous lines, and appeared confused. His blood pressure was 200/110 mm Hg, his heart rate was between 80 and 120 beats/minute, and he was afebrile. His physical examination was otherwise unremarkable. His electrocardiogram revealed a sinus tachycardia. His urine toxicology screen was negative. The ED resident and attending physician noted that Mr A was grandiose and had rapid speech, and they offered a preliminary diagnosis of bipolar I disorder. He was given haloperidol (5 mg) and lorazepam (2 mg) to reduce his agitation and hydralazine to manage his blood pressure. The psychiatry team was consulted in the ED to manage his presumed acute mania.

The junior psychiatry resident learned that Mr A was religious and served as a senior member of his church (working as a deacon and an elder and highly esteemed in the community). Mr A's wife and 1 or more family members stayed by his side throughout his ED stay. After evaluation by the psychiatry resident, admission to a psychiatric unit was recommended. Unfortunately, due to bed shortages his transfer was delayed, during which time he was confined to a gurney in a windowless room for more than 72 hours.

Once his hypertension was controlled, his mood was calm, and his speech and thought pattern became clear. However, he insisted that his status was that of the Pope. This statement was attributed to ongoing acute mania.

When the senior psychiatry resident, a Nigerian immigrant and chief resident in our psychiatry program, evaluated Mr A with the junior resident, the patient reported that he had no history of mental illness and that he was unsure why he was being admitted

Clinical Points

- Cultural humility incorporates a lifelong commitment to self-evaluation, self-critique, and addressing power imbalances in the patient-physician encounter.
- It is necessary to mitigate the negative consequences of implicit and explicit bias in health care systems.
- It is useful to incorporate social determinants of health into routine patient encounters and to optimize understanding of the social history within the electronic health record to address unmet patient needs.

to the psychiatric unit. He noted that he felt intimidated in the ED and that he was treated unkindly. He recalled having made statements such as, "At my church, I am like the Pope." He clarified that he was not claiming to be the Pope in the Vatican and that he was speaking metaphorically. According to the family, he had never previously manifest symptoms of mania, and there was no family history of bipolar disorder or a psychotic disorder. The senior psychiatry resident, who was familiar with the nuances of his language and the importance of considering language variance in the diagnostic and cultural formulation of the patient's case, refined the diagnosis.

The psychiatry team, based on the continued evaluation, determined that Mr A had not experienced an acute mania episode secondary to a primary psychiatric illness but instead due to significant hypertension. Once his blood pressure normalized, his mental status improved. Mr A and his family agreed to the plan for hospitalization because they thought they did not have a choice. However, they shared their concerns when they encountered a racially and ethnically concordant physician—the Nigerian psychiatry resident.

DISCUSSION

How Can Stigma Adversely Affect How People Feel About Themselves, Their Health Care Providers, and the Health Care Systems Where They Receive Care?

Stigma (negative attitudes, beliefs, or discriminatory behavior toward a person or a group of people based on specific characteristics, such as an illness or demographic factors, eg, race, ethnicity, or migrant status)[1] involves a process of labeling, stereotyping, separation, status loss, and discrimination in a context in which one group (the stigmatizer) exercises discriminatory power over another group (the stigmatized).[2–4] Black people, because of their race, are often stigmatized within our health care system and in society.[3,5,6] Racism, not race itself, is a social determinant of health and a fundamental cause of health inequities[7,8] and as a social construct is the primary driver of racial disparities in health.[7–9] Health care providers frequently perpetuate racial stigma and implicit bias in medicine,[10] which leads to greater mistrust of health care systems and providers,[7,10–12] increased psychological distress,[13–18] and self-defacing beliefs about oneself.[19]

Why Are Black People Stigmatized in Health Care Settings?

Unfortunately, Black people, including Black immigrants, remain highly stigmatized and experience discrimination in health care settings[6,20] (eg, Black patients seen in EDs received less effective pain management compared to White patients, and implicit bias contributes to beliefs that Black people have less sensitive nerve endings).[21–24] As such, racism is an important social determinant of health as is migrant status, which adversely affects health.[25] Longstanding public stigma toward Black people includes perceptions that they are lazy, aggressive, and unintelligent.[9,26,27] Skin tone is one of the more visible attributes about an individual and can elicit racial bias. One study[28] showed that for Black women at either end of the color continuum, skin tone was associated with delays in prenatal care. In addition, Black men may be perceived as aggressive or threatening. One study[28] showed that compared to young White men, young Black men are perceived as taller, heavier, and stronger, and even after controlling for actual body size, racial stereotypes of aggression persisted.[29] Health care professionals are influenced by public stigma, and these societal beliefs influence patient-provider interactions.[7,30]

How Can Medical Mistrust Influence the Perceptions About Care Being Delivered?

Communication among physicians and patients forms the bedrock of good medical care.[31] Medical mistrust (that results from historical injustice as well as ongoing, present-day social and economic inequities that perpetuate mistrust[32,33]) is prevalent among Black patients and when unacknowledged leads to a breakdown in physician-patient communication. Medical mistrust may be directed toward health professionals or health care systems, and it is a known barrier to engagement in health care services for the Black population.[32,33] Moreover, everyday circumstances, such as *microaggressions* (a term coined by Chester Pierce, MD, in 1970 to refer to subtle and stunning daily racial offenses that lead to deleterious effects),[30] lead to anxiety and perceived lack of control related to racism.[34,35] Perceived discriminatory experiences are linked to psychological distress and depressive symptoms.[34]

How Can Health Care Providers and Health Care Systems More Effectively Recognize Rifts in the Doctor-Patient Relationship and Create Solutions to Deliver Equitable and Respectful Care?

The National Academy of Medicine (NAM) reported that across virtually every therapeutic intervention in the United States, Black people and other minorities experienced a lower quality of care than White people.[36] The NAM concluded that implicit bias on the part of health care professionals was a likely contributor.[36] There are limited interventions that seek to reduce bias in health care professionals and the negative impact of implicit bias in real-world patient care. However, some strategies to reduce implicit and explicit bias for individual health care providers are as follows.

Engage in cultural humility. Cultural competency tends to focus on mastery of effective and respectful delivery of health care services to diverse populations; however, cultural humility incorporates a lifelong commitment to self-evaluation, self-critique, and addressing power imbalances in the patient-physician encounter.[37,38] Cultural humility is a more suitable goal, as it seeks to develop a mutually beneficial, nonpaternalistic partnership among physicians and patients.[37] Most health care training is built on the notion that one can master effective communication (through attaining cultural competency) with diverse populations and cultures.[37] Health care training models may be made more effective by incorporating an approach that is not focused on mastery. Instead, it will be more effective to focus on a lifelong commitment to approach each patient-physician encounter with a desire to listen and learn through self-evaluation, self-critique, and acknowledgment of power imbalances.[37] Physician humility has promoted better communication among health care professionals and patients and led to enhanced patient outcomes.[38]

Practice with shared decision-making. Shared decision-making is an important aspect for improving patient-provider interactions.[39] While health care professionals may be experts in the biological basis of disease, patients are experts on their cultural background and how their cultural values influence their health care decisions. Listening is a critical part of communication, and health professionals should work to approach patients as individuals, rather than place individuals into stereotyped groups that are often stigmatized.[26]

Raise awareness about implicit bias. Counteracting unconscious bias through raising awareness about racial and ethnic stereotypes can be employed to address racial stigma.[26] Exercises, such as use of the Implicit Association Test,[26] may reveal unconscious racial stereotypes and promote awareness of the social and historical context of racism in health care. For health care providers who unintentionally perpetuate racism, exercises that enhance awareness (such as the Implicit Association Test) may be a step toward self-discovery in a nonjudgmental setting.[26]

Avoid stereotype suppression. Stereotype suppression can result in increased social distancing from the stigmatized group and undermine the interpersonal relationship between the patient and the provider. Instead, it is more effective to acknowledge that stereotyping is a common tendency; however, it can be recognized and counteracted, rather than suppressed and ignored.[26]

Enhance physician wellness. The impact of stress and time constraints within health care systems can be addressed by using mindfulness techniques and Balint groups.[10,26] These techniques can promote positive patient and provider communication. Health care providers can incorporate mindfulness techniques and participate in Balint groups as part of their personal and professional development.

Become familiar with the social determinants of health. Understanding the social determinants of health that affect patient health outcomes can promote health equity.[36] Barriers to equity in health care encompass more than the health care system itself. They include aspects of patient experience related to employment, housing, income, health insurance, and education. Some strategies to address social determinants of health include the following:

- *Address social barriers in patient encounters.* The history section of the electronic health record is rarely used by health professionals.[40] Social determinants (eg, food security, housing stability, and community and religious backgrounds) may influence health outcomes. While the section on social history in the electronic health record is rarely the focus of patient visits for general medical care,[40] understanding the social context of individual patients may be critical to improving their health outcomes. Health care professionals can contribute to health equity by documentation and review of social determinants of health data within the electronic health record.[40]
- *Become familiar with community resources that may benefit individual patients.*[41] Health care professionals should become familiar with local community health resources and programs. Health systems should work toward making local community resources and programs that support patients more available where they live and work.

Physicians involved in education can contribute to efforts to build a more diverse health workforce. In a study on shared racial and ethnic identity between patients and health care providers, respondents reported that having health professionals who shared their race and ethnicity reduced their hesitancy about receiving mental health services.[11,20,42] Concordance in race and ethnicity has been associated with higher levels of trust, improved communication, and a more robust intent to adhere to health care services.[42,43] Health care providers are often involved in education mission setting within their institutions, and supporting efforts through medical school training, residency, and fellowships to recruit and retain Black medical students and physicians will enhance the quality of Black patient care. There are well-established benefits of workforce diversity in improving patient experiences and satisfaction, including but not limited to improved physician-patient communication, enhanced trust, and the benefits related to language concordance and cultural understanding of patients' backgrounds.[44]

What Happened to Mr A?

After a review of Mr A's case and consultation with the ED medical team and the attending psychiatrist, Mr A was discharged to his home in good condition with primary care physician follow-up for his hypertension. His statements that were perceived as being grandiose—given the cultural formulation of the case—did not rise to the level of being delusional or grandiose. He was informed about the risk of stroke and cardiovascular disease with uncontrolled blood

pressure and was also offered resources for mental health care.

Mr A's experience in the ED and his misdiagnosis may interfere with his willingness to seek mental health services in the future and facilitate further medical mistrust. His family's approach to the health system may also be affected by his misdiagnosis. However, interventions to address his misdiagnosis may also contribute to repairing his trust with the health care system and foster positive patient-provider communication.

CONCLUSION

Mr A, a male Nigerian immigrant with an altered mental status due to hypertension, was managed by treating his hypertension and correcting a misdiagnosis (bipolar I disorder with psychosis). Inadequate knowledge of his cultural background, racial stereotypes (such as the perception of Black people as aggressive), and language variance may have contributed to his misdiagnosis and led to a less-than-optimal diagnosis and treatment approach and undue stress for his family and caregivers. Health care professionals will benefit from developing greater awareness of their own implicit and explicit biases when delivering health care services to people from minority populations (eg, Black patients). Cultural humility was important in reevaluating Mr A's situation after a decision was made to psychiatrically hospitalize him. In addition, collateral information from Mr A's family helped to develop a more accurate formulation.

Our case vignette reinforces the need for health care systems and professionals to adopt real-time strategies to prevent stereotyping of Black people. Strategies that were applied in this case included the use of a diverse physician team, racial and ethnic concordance in the patient-physician encounter, and cultural humility on the part of the ED medicine and psychiatry consultation teams to revise the decision to admit. While an earlier intervention related to cultural understanding and formulation may have prevented misdiagnosis, identifying the error was important to prevent further adverse effects, such as treatment for bipolar I disorder with psychosis, following a misdiagnosis.

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REFERENCES

1. Corrigan PW, Morris SB, Michaels PJ, et al. Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatr Serv*. 2012;63(10):963–973.
2. Link BG, Phelan JC. Conceptualizing stigma. *Annu Rev Sociol*. 2001;27(1):363–385.
3. Dovidio JF, Penner LA, Albrecht TL, et al. Disparities and distrust: the implications of psychological processes for understanding racial disparities in health and health care. *Soc Sci Med*. 2008;67(3):478–486.
4. Maunder RD, White FA. Intergroup contact and mental health stigma: a comparative effectiveness meta-analysis. *Clin Psychol Rev*. 2019;72:101749.
5. Stangl AL, Earnshaw VA, Logie CH, et al. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Med*. 2019;17(1):31.
6. Pederson AB, Earnshaw V, Clark CT, et al. Mental health stigma among black immigrant women in an urban setting. *J Ment Health Clin Psychol*. 2021;5(2):1–7.
7. Williams DR, Lawrence JA, Davis BA. Racism and health: evidence and needed research. *Annu Rev Public Health*. 2019;40(1):105–125.
8. Williams DR. Stress and the Mental health of populations of color: advancing our understanding of race-related stressors. *J Health Soc Behav*. 2018;59(4):466–485.
9. Williams DR. Race, socioeconomic status, and health. The added effects of racism and discrimination. *Ann N Y Acad Sci*. 1999;896(1):173–188.
10. Capers Q 4th, Bond DA, Nori US. Bias and racism teaching rounds at an academic medical center. *Chest*. 2020;158(6):2688–2694.
11. Sullivan LS. Trust, risk, and race in American medicine. *Hastings Cent Rep*. 2020;50(1):18–26.
12. Jaiswal J. Whose responsibility is it to dismantle medical mistrust? future directions for researchers and health care providers. *Behav Med*. 2019;45(2):188–196.
13. Quinn DM, Earnshaw VA. Understanding concealable stigmatized identities: the role of identity in psychological, physical, and behavioral outcomes. *Soc Issues Policy Rev*. 2011;5(1):160–190.
14. Bos AER, Pryor JB, Reeder GD, et al. Stigma: advances in theory and research. *Basic Appl Soc Psych*. 2013;35(1):1–9.
15. Corrigan PW, Watson AC, Barr L. The self-stigma of mental illness: implications for self-esteem and self-efficacy. *J Soc Clin Psychol*. 2006;25(8):875–884.
16. Fox AB, Earnshaw VA, Taverna EC, et al. Conceptualizing and measuring mental illness stigma: the mental illness stigma framework and critical review of measures. *Stigma Health*. 2018;3(4):348–376.
17. Quinn DM, Earnshaw VA. Concealable stigmatized identities and psychological well-being. *Soc Personal Psychol Compass*. 2013;7(1):40–51.
18. Ritsher JB, Phelan JC. Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Res*. 2004;129(3):257–265.
19. Link BG, Cullen FT, Struening E, et al. A modified labeling theory approach to mental disorders: an empirical assessment. *Am Sociol Rev*. 1989;54(3):400–423.
20. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med*. 2013;28(11):1504–1510.
21. Heins JK, Heins A, Grammas M, et al. Disparities in analgesia and opioid prescribing practices for patients with musculoskeletal pain in the emergency department. *J Emerg Nurs*. 2006;32(3):219–224.
22. Miner J, Biros MH, Trainor A, et al. Patient and physician perceptions as risk factors for oligoanalgesia: a prospective observational study of the relief of pain in the emergency department. *Acad Emerg Med*. 2006;13(2):140–146.
23. Haq N, McMahan VM, Torres A, et al. Race, pain, and opioids among patients with chronic pain in a safety-net health system. *Drug Alcohol Depend*. 2021;222:108671.
24. Saluja B, Bryant Z. How implicit bias contributes to racial disparities in maternal morbidity and mortality in the United States. *J Womens Health (Larchmt)*. 2021;30(2):270–273.
25. Williams DR, González HM, Neighbors H, et al. Prevalence and distribution of major depressive disorder in African Americans, Caribbean Blacks, and non-Hispanic Whites: results from the National Survey of American Life. *Arch Gen Psychiatry*. 2007;64(3):305–315.
26. Burgess D, van Ryn M, Dovidio J, et al. Reducing racial bias among health care providers: lessons from social-cognitive psychology. *J Gen Intern Med*. 2007;22(6):882–887.
27. Ashley W. The angry Black woman: the impact of pejorative stereotypes on psychotherapy with Black women. *Soc Work Public Health*. 2014;29(1):27–34.
28. Slaughter-Acey JC, Sneed D, Parker L, et al. Skin tone matters: racial microaggressions and delayed prenatal care. *Am J Prev Med*. 2019;57(3):321–329.
29. Wilson JP, Hugenberg K, Rule NO. Racial bias in judgments of physical size and formidability: from size to threat. *J Pers Soc Psychol*. 2017;113(1):59–80.
30. Williams MT, Skinta MD, Martin-Willett R. After Pierce and Sue: a revised racial microaggressions taxonomy. *Perspect Psychol Sci*. 2021;16(5):991–1007.
31. Becker C, Hunziker S. The importance of communication between physicians and patients. *Ther Umsch*. 2019;76(5):231–238.
32. Powell W, Richmond J, Mohottige D, et al. Medical mistrust, racism, and delays in preventive health screening among African-American men. *Behav Med*. 2019;45(2):102–117.
33. Henderson RC, Williams P, Gabbidon J, et al; MIRIAD study group. Mistrust of mental

health services: ethnicity, hospital admission and unfair treatment. *Epidemiol Psychiatr Sci*. 2015;24(3):258–265.
34. Alegría M, NeMoyer A, Falgàs Bagué I, et al. Social determinants of mental health: where we are and where we need to go. *Curr Psychiatry Rep*. 2018;20(11):95.
35. Bleich SN, Findling MG, Casey LS, et al. Discrimination in the United States: experiences of Black Americans. *Health Serv Res*. 2019;54(suppl 2):1399–1408.
36. Williams DR, Cooper LA. Reducing racial inequities in health: using what we already know to take action. *Int J Environ Res Public Health*. 2019;16(4):606.
37. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9(2):117–125.
38. Ruberton PM, Huynh HP, Miller TA, et al. The relationship between physician humility, physician-patient communication, and patient health. *Patient Educ Couns*. 2016;99(7):1138–1145.
39. Peek ME, Odoms-Young A, Quinn MT, et al. Race and shared decision-making: perspectives of African-Americans with diabetes. *Soc Sci Med*. 2010;71(1):1–9.
40. Wang M, Pantell MS, Gottlieb LM, et al. Documentation and review of social determinants of health data in the EHR: measures and associated insights. *J Am Med Inform Assoc*. 2021;28(12):2608–2616.
41. Castillo EG, Ijadi-Maghsoodi R, Shadravan S, et al. Community interventions to promote mental health and social equity. *Curr Psychiatry Rep*. 2019;21(5):35.
42. Street RL Jr, O'Malley KJ, Cooper LA, et al. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. *Ann Fam Med*. 2008;6(3):198–205.
43. Greenwood BN, Hardeman RR, Huang L, et al. Physician-patient racial concordance and disparities in birthing mortality for newborns. *Proc Natl Acad Sci U S A*. 2020;117(35):21194–21200.
44. Ludwig S, Gruber C, Ehlers JP, et al. Diversity in medical education. *GMS J Med Educ*. 2020;37(2):Doc27.