Diversity and Inclusion Within AAPL

Barry W. Wall, MD, and Elie G. Aoun, MD

J Am Acad Psychiatry Law 47:274–77, 2019. DOI:10.29158/JAAPL.003870-19

The medical profession is well known to lack diversity. Recent estimates indicate that 4.1 percent of U.S. physicians are African-American while 12.3 percent of the U.S. population is African-American; further, the number of African-American male medical students peaked in 1978 and has been falling ever since. The percentage of U.S. physicians who are Latinx is 4.4, while 12.5 percent of the U.S. population is Latinx. Native Americans compose .4 percent of U.S. physicians, while 2 percent of the U.S. population is Native American. The 35 percent of U.S. physicians who are female are generally concentrated in specialties such as family practice, pediatrics, obstetrics, and gynecology. A 2017 Gallup poll concluded that 4.5 percent of adult Americans identified as LGBT, which breaks down to 5.1 percent of women and 3.9 percent of men identifying as LGBT. Yet there are few LGBTQ physicians, and many keep their orientation a secret to protect themselves from patients and co-workers.[1,2] Sexual and gender minorities are concentrated in the specialties of psychiatry, family medicine, pediatrics, and internal medicine.[3]

Having diversity in the medical profession improves health care disparities of patients[4,5] and reduces the impact of implicit biases defined as "attitudes or stereotypes that affect our understanding, actions, and decisions unconsciously" (Ref. 6, p 2). Patients from diverse backgrounds usually seek and are more satisfied with doctors who have the same background. Emerging data from national surveys indicate that, compared with white Americans, patients from racial and ethnic minorities face more barriers in health care delivery, including reporting communication barriers with physicians and feeling disrespected.[7] In their encounters with physicians, minority patients often report perceiving that they do not understand the doctor's opinion and recommendations, that doctors were not listening to their complaints, and that they did not have enough time with their doctors. Further, minority patients also admitted that, even when they had questions for their doctors, they did not always ask them.[7] Consequently, minority patients are more likely to report poor satisfaction in the quality of health care services they receive and have less confidence in their health care providers.

In contrast, physician–patient minority status concordance seems to be associated with higher patient satisfaction[8–10] and often better clinical outcomes.[11] Similarly, cultural competency training (including implicit bias awareness for the health care workforce) can lead to similar outcomes.[12,13] Fostering diversity and cultural competence among physicians and other health care providers is an important step for addressing disparities in health delivery and clinical outcomes among minority and majority populations.

In psychiatry, factors relating to patients' diversity are often a cause of stress that can lead to or worsen psychopathology. For patients belonging to minority or underrepresented groups, bullying, racism, or adjusting to and accepting one's differences are important factors contributing to disease burden. Indeed, disparities in care in mental health services are often

Dr. Wall is Clinical Professor of Psychiatry, Department of Psychiatry and Human Behavior, Alpert Medical School of Brown University, Providence, Rhode Island, and Director, Forensic Service, Eleanor Slater Hospital, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, Cranston, Rhode Island. Dr. Aoun is Clinical Instructor of Psychiatry at New York University and a Forensic Psychiatry Research Fellow at Columbia University, New York, New York. Address correspondence to: Barry W. Wall, MD, 196 Waterman St., Providence, RI 02906. E-mail: barrywwall@gmail.com.

The views expressed in this article reflect those of the authors, not necessarily the institutions to which these individuals belong.

Disclosures of financial or other potential conflicts of interest: None.

reflective of true or perceived poor communication between the minority patient and the psychiatrist. Additionally, numerous studies demonstrate that different diagnostic conclusions can be reached when persons of different groups present with similar symptoms. For example, African Americans are more likely to have undiagnosed depressive disorders, and they are overdiagnosed with primary psychotic illnesses, leading to an excessive use and dosing of antipsychotic medication and the underprescription of mood-stabilizing medications.[14–16] Similarly, LGBTQ persons are more likely to be diagnosed with borderline or other cluster B personality disorders than persons in the general population with a similar presentation.[17–19] Findings such as those described above suggest that implicit biases and heuristics are major contributors to the health disparities in discordant patient–doctor interactions.

Having a diverse pool of psychiatrists can improve the quality of care delivered to all patients as well as clinical outcomes. Several studies have reported that patient–physician concordance is associated with improved communication, treatment compliance, and mental health outcomes.[20–22] A diverse workforce reflective of the diversity in the patient population can improve the cultural competency of majority members by raising culturally diverse perspectives and enriching academic discourse. This can foster innovation, promote self-awareness of one's own biases, and further a fact-driven rather than a heuristically-driven clinical evaluation and treatment process.

It should be clear from the above data that there is a need to develop strategies leading to the thoughtful and deliberate diversification of the psychiatric workforce. To address such diagnostic variability and health care disparities, organizations like the American Psychiatric Association (APA) have implemented a structural reorganization plan with inclusivity, diversity, and effectiveness as guiding principles.[23] The APA also highlighted elements of the cultural formulation in the Diagnostic and Statistical Manual, Fifth Edition,[24] for psychiatric evaluations and added a Cultural Competence webpage to its website.[23]

It is important to have a diversity of psychiatrists trained to treat the diverse psychiatric population. It is similarly important to have a diversity of forensic psychiatrists, and AAPL has begun to focus on the lack of diversity within our specialty. Having a more diverse pool of forensic psychiatrists to assess and treat persons in forensic settings will likely improve health care disparities. In settings like state forensic hospitals and in corrections, disparate assessment of risk for minority persons, lack of awareness of risks of victimization for certain minority groups, cultural factors that could mistakenly suggest malingering, and law enforcement biases may be observed. There is also concern that inmates in nondominant groups receive poorer quality care than inmates in dominant groups.[25,26] There is a disproportionate number of persons of color in correctional facilities, and there is a disproportionate risk of violence for persons of color, women, and LGTBQ persons, especially trans persons.[27,28] The concept of intersectionality applies especially to the forensic population. This sociological theory describes how discrimination can be layered when an individual's identities overlap with several minority classes, such as race, gender, age, ethnicity, and other characteristics. Often, intersectional experiences demonstrate that existing laws and policies are stacked against people with multiple minority identities. The additive effects of multiple nondominant identities increase vulnerability within prisons and jails.[29]

We searched every issue of the AAPL Newsletter since January 2011 for any mentions of "diversity" or "minority." We did not find any articles on the value of diversity among forensic psychiatry; we did identify a handful of articles discussing efforts by other organizations to promote diversity or discuss the disparate impact of psychiatric and legal topics on minority populations. Similarly, out of 509 papers published in JAAPL containing the word "diversity," only 10 addressed the importance of diversity and cultural competency in forensic psychiatry (four of which are papers honoring AAPL leaders of diverse backgrounds).

At its last annual meeting, the following questions were discussed in a workshop[30] by a diverse panel of experts:

> Do African-American psychiatrists have a sense of belonging to AAPL?
>
> Do African-American psychiatrists feel welcomed by other AAPL members?
>
> How does Asian-American and Latinx background influence correctional and forensic work?

Can persons with Asian-American and Latinx backgrounds call AAPL a home association?

What has AAPL done to promote inclusion and disclosure for its LGBTQ members?

How does disclosure of sexual orientation influence correctional and forensic work?

Does AAPL as a group believe minority members belong?

How does AAPL demonstrate that?

While there may not be definitive answers to these questions, the discussion sheds light on the lack of diversity within our organization, the need to address it, and the challenges faced in achieving that goal. In thinking about why diversity in forensic psychiatry is necessary, we highlight the different and culturally relevant perspectives that minority members can bring forward. This can inform majority colleagues and can focus attention on maintaining perspective to improve every forensic psychiatrist's ability to understand and appreciate the nuances in working with minority evaluees. We note, however, that unlike clinical practice, where doctor–patient concordance is known to improve outcomes, more research is needed in forensic psychiatry to understand whether evaluator–evaluee concordance increases or decreases the credibility and the validity of the forensic opinion.

Although there are no definitive data on the extent of AAPL's diversity in its membership, it appears that it has fewer women and fewer racial, ethic, gender, and sexual minorities than other psychiatric subspecialty organizations. AAPL's relatively small size compared with other medical professional organizations affects its ability to institute initiatives to foster diversity. Moreover, the relative lack of diversity within the organization is reflective of the relative lack of diversity among forensic psychiatrists practicing in the community; as such, although we write about diversity and inclusion within the context of AAPL, this is truly a problem with the pipeline of forensic psychiatrists being trained by programs across the nation.

AAPL's leadership is committed to addressing diversity and inclusion and to promoting leadership as well as mentorship opportunities for minority members, consistent with what other medical professional organizations are doing to focus on diversity and inclusion. The AAPL Council made two recent additions to its structure to be more formally welcoming. It formed a Diversity Committee, whose main charge is to create a nurturing and accepting environment for all minority and underrepresented persons. It also recently voted to include a minority/underrepresented seat on the Council as well as a women's seat on the Council to increase representation of minority groups and to open pathways to leadership.

In addition to the structural changes that AAPL has made, we believe that increasing diversity must occur on a personal level as well. Paying attention to diversity may bring more members of minority/underrepresented groups into the organization, but inclusion makes people feel welcomed. AAPL members should also focus on recruiting a diverse pool of members at the entry points by forging personal relationships with medical students and psychiatry residents who are members of nondominant groups. Encourage them to apply to forensic fellowships. Introduce them to your colleagues at AAPL meetings. Individual interactions with a new member can foster feelings of being welcomed or inadvertently excluded. Minority/underrepresented AAPL members express optimism that focusing on diversity and inclusion will help new members feel less isolated and develop a sense of belonging. They can fully embrace AAPL as a home association and can relax, be themselves, and aspire to leadership positions.

References

1. Eliason MJ, Dibble SL, Robertson PA: Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace. J Homosex 58:1355–71, 2011
2. Newport F: In U.S., estimate of LGBT populations rises to 4.5%. Gallup, May 22, 2018. Available at: https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx. Accessed June 19, 2019
3. Sitkin NA, Pachankis JE: Specialty choice among sexual and gender minorities in medicine: the role of specialty prestige, perceived inclusion, and medical school climate. LGBT Health 3:451–60, 2016
4. Phelan SM, Burke SE, Hardeman RR, *et al*: Medical school factors associated with changes in implicit and explicit bias against gay and lesbian people among 3492 graduating medical students. J Gen Intern Med 32:1193–201, 2017
5. Garg T, Antar A, Taylor JM: Urologic oncology workforce diversity: a first step in reducing cancer disparities. Urol Oncol, published online May 16, 2019. Available at: https://doi.org/10.1016/j.urolonc.2019.04.025. Accessed July 6, 2019.
6. Elliott AM, Alexander SC, Mescher CA, *et al*: Differences in physicians' verbal and nonverbal communication with black and white patients at the end of life. J Pain Sympt Manage 51:1–8, 2016
7. Collins KS, Hughes DL, Doty MM, *et al*: Diverse communities, common concerns: assessing health care quality for minority Americans. The Commonwealth Fund, 2002. Available at: http://

longtermscorecard.org/~/media/files/publications/fund-report/2002/mar/diverse-communities–common-concerns–assessing-health-care-quality-for-minority-americans/collins_diversecommun_523-pdf.pdf. Accessed June 19, 2019
8. Wiltshire J, Allison JJ, Brown R, Elder K: African-American women perceptions of physician trustworthiness: a factorial survey analysis of physician race, gender and age. AIMS Public Health 5:122–34, 2018
9. Kumar D, Schlundt DG, Wallston KA: Patient-physician race concordance and its relationship to perceived health outcomes. Ethn Dis. 19:345–51, 2009
10. Cooper LA, Roter DL, Johnson RL, *et al*: Patient-centered communication, ratings of care, and concordance of patient and physician race. Ann Intern Med 139:907–15, 2003
11. Greenwood BN, Carnahan S, Huang L: Patient-physician gender concordance and increased mortality among female heart attack patients. Proc Natl Acad Sci U S A 115:8569–74, 2018
12. Avant ND, Gillespie GL: Pushing for health equity through structural competency and implicit bias education: a qualitative evaluation of a racial/ethnic health disparities elective course for pharmacy learners. Curr Pharm Teach Learn 11:382–93, 2019
13. Shepherd SM: Cultural awareness workshops: limitations and practical consequences. BMC Med Educ 19:14, 2019
14. Vega WA, Rumbaut RG: Ethnic minorities and mental health. Annu Rev Sociol 17:351–83, 1991
15. Schwartz RC, Blankenship DM: Racial disparities in psychotic disorder diagnosis: a review of empirical literature. World J Psychiatry 4:133–40, 2014
16. Gara MA, Minsky S, Silverstein SM, *et al*: A naturalistic study of racial disparities in diagnoses at an outpatient behavioral health clinic. Psychiatr Serv 70:130–34, 2019
17. Khachikian J: Diagnostic accuracy of borderline personality disorder in the gay population: how gay cultural norms and clinician bias may impact diagnosis. Ann Arbor, MI: Alliant International University, ProQuest Dissertations Publishing, 2013
18. Barker MJ: Depression and/or oppression? Bisexuality and mental health. J Bisexuality 15:369–84, 2015
19. Cassels BW: HPD: examining the histrionic personality from the intersection of gender politics, masculinity, and the DSM. Ann Arbor, MI: Pacifica Graduate Institute, ProQuest Dissertations Publishing, 2018
20. Cooper LA, Roter DL, Johnson RL, *et al*: Patient-centered communication, ratings of care, and concordance of patient and physician race. Ann Intern Med 139:907–15, 2003
21. Cooper-Patrick L, Gallo JJ, Gonzales JJ, *et al*: Race, gender, and partnership in the patient-physician relationship. JAMA 282: 583–89, 1999
22. LaVeist TA, Nuru-Jeter A: Is doctor-patient race concordance associated with greater satisfaction with care? J Health Soc Behav 43:296–306, 2002
23. American Psychiatric Association: Diversity and health equity. Available at: https://www.psychiatry.org/psychiatrists/cultural-competency. Accessed June 20, 2019
24. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA: American Psychiatric Association, 2013
25. Borysova ME, Mitchell O, Sultan DH, Williams AR: Racial and ethnic health disparities in incarcerated populations. J Health Dispar Res Pract 5:92–100, 2012
26. Jackson JE: Race and correctional officers' punitive attitudes toward treatment programs for inmates. J Crim Just 24:153–66, 1996
27. Glezer A, McNiel DE, Binder RL: Transgendered and incarcerated: a review of the literature, current policies and laws, and ethics. J Am Acad Psychiatry Law 41:551–59, 2013
28. Brown GR, McDuffie E: Health care policies addressing transgender inmates in prison systems in the United States. J Correctional Health Care 15:280–91, 2009
29. Romero M: Introducing intersectionality. Malden, MA: Polity Press, 2017, pp 38–9, 59–60
30. Michaelsen K, Kapoor R, Dike C, *et al*: The face of AAPL: diversity matters. Presented at the 49th Annual Meeting of the American Academy of Psychiatry and the Law, Austin, Texas, October 2018