Is There a Black Doctor in the House?

PSYCHIATRY GRAND ROUNDS
02/12/15
Damon Tweedy, M.D.
Objectives

• List 3 ways in which demographic data reveal patient/provider discrepancies on county, state, and national levels

• Identify at least 3 racial/ethnic health differences in diagnosis and treatment of common mental health disorders

• List at least 3 ways in which black doctors provide a larger volume and potentially differing quality of care to black patients
Reluctant Speaker

• Race is Divisive

• Race is Limiting
Why talk about race?

– Continues to dominate national discussion (episodically)
  • Medical metaphors (wound, virus, cancer)

– Continues to frame how many people see the world

– Medicine is inevitably influenced by surrounding society
Disclaimer

- The views expressed today are mine alone and do not necessarily reflect those of:

- Duke University
- Department of Psychiatry and Behavioral Sciences
- Durham Veterans Affairs Medical Center
- “Black people”
Esteemed Guests

- Past speakers – “Top 10” Black American Psychiatrists
  - Rahn Bailey, M.D.
  - Annelle Primm, M.D., M.P.H.
  - William B. Lawson, M.D., Ph.D.
A Common Scenario

• A 50-year old black man is referred to a mental health clinic by a general medical provider

• Referral for “stress” or “anxiety” or “depression”

• Requests a “black doctor”
What would/should you do?

A) Inquire into why patient wants a black provider

B) Rx “race-neutral” medication for patient’s symptoms

C) Find a black doctor for the patient if possible
What is it like to be on the other end?

• Accept
  • “I’m happy to see this patient.”

• Acquiesce
  • Other doctors (women, Spanish-speaking, LGBT) face similar requests and this is just life.
    • “Okay (sigh).”
Other Potential Responses

• Resist/decline
  • “My clinic is full. I’m not taking new patients.”
  • “I want more self-pay or well-insured patients, not all Medicaid or Medicare patients.”

• Ask more questions
  • Does the patient really want this?
  • Or is the provider making that assumption?
Why Do I Keep Getting These Requests?
Race/Ethnicity Demographics – Patient Pool


<table>
<thead>
<tr>
<th></th>
<th>US</th>
<th>NC</th>
<th>Durham</th>
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</thead>
<tbody>
<tr>
<td>Caucasian/White</td>
<td>63.7</td>
<td>65.3</td>
<td>42.1</td>
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<td>Black</td>
<td>12.6</td>
<td>21.5</td>
<td>38.7</td>
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<td>Hispanic/Latino</td>
<td>16.3</td>
<td>8.4</td>
<td>13.0</td>
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<td>Asian</td>
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<td>4.6</td>
</tr>
<tr>
<td>Native American</td>
<td>0.9</td>
<td>1.3</td>
<td>0.5</td>
</tr>
<tr>
<td>Two or more races</td>
<td>2.4</td>
<td>2.0</td>
<td>2.3</td>
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</table>
Race Ethnicity Demographics, Patient Pool, II
Additional NC County Data - % black pop.
Race/Ethnicity Demographics – Patient Pool, Ill

Percentage African-American Population
(National Average ~ 13%)

- Johns Hopkins (Baltimore) 64%
- Emory (Atlanta) 54%
- Wash U. (St. Louis) 49%
- U. Penn (Philadelphia) 43%
- **Duke (Durham)** 38%
- Yale (New Haven) 35%
- Columbia/Cornell (New York) 25%
- Harvard (Boston) 24%

Source: http://quickfacts.census.gov/qfd/states
# Race/Ethnicity Demographics - Physicians

Source: - AAMC, Diversity in the Physician Workforce: Facts and Figures 2014

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
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</thead>
<tbody>
<tr>
<td>Caucasian/White</td>
<td>69.1</td>
<td>79.9</td>
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<tr>
<td>Asian</td>
<td>17.8</td>
<td>8.4</td>
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<tr>
<td><strong>African-American/Black</strong></td>
<td><strong>6.0</strong></td>
<td><strong>8.4</strong></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>6.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Native American</td>
<td>0.5</td>
<td>0.7</td>
</tr>
</tbody>
</table>

- Limitations of data:
  - Race of physician “unknown/not reported” in 30% of U.S. data; 24% of NC data
  - Does not include residents and fellows
Race/Ethnicity Demographics - Psychiatry


<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>US</th>
<th>NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>69.5</td>
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<tr>
<td>Asian</td>
<td>18.5</td>
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<td><strong>Black</strong></td>
<td><strong>4.9</strong></td>
<td><strong>7.2</strong></td>
</tr>
<tr>
<td>Native-American</td>
<td>0.2</td>
<td>0.3</td>
</tr>
</tbody>
</table>

- Limitations of data
  - Similar to prior data set, race of physician “unknown/not reported” in 20% of sample.
  - Excludes residents and federal practitioners
Race/Ethnicity Demographics – Non-MD Mental Health Providers

Source: SAMHSA, Mental Health, United States, 2010.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Percent Black Providers</th>
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<tbody>
<tr>
<td>Psychology</td>
<td>2</td>
</tr>
<tr>
<td>Master’s-level Social Work (MSW)</td>
<td>6</td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>2</td>
</tr>
<tr>
<td>Advance Practice Nursing (NP)</td>
<td>3</td>
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</table>

Limitations of data

- Data drawn from multiple sources with different methodologies
- 10-20% of subjects did not report race
- MSW data in report does not specify the number holding clinical licenses
“So what?” – Why all the data about race?

- Blacks are considered a “special population” in U.S.
- Most disadvantaged on social/economic measures
- Worse in health measures too
- Differences termed “health disparities”
Health Disparities – Causes

– Subject is now an academic/health policy cottage industry

– System-based

– Individual/cultural

– Doctor-patient***
Health Disparities – Mental Health

• Blacks more likely diagnosed w/schizophrenia than mood d/o w/similar symptoms. Gara et al. Arch Gen Psychiatry 2012; 69:593-600.

• Blacks are 40-50 percent less likely to receive psychiatric treatment as whites for disorders of comparable prevalence and severity. Kessler et al. NEJM 2005; 352:2515-2523; Manuseau and Case. Psych Services 2014; 65:59-67.
Mental Health Disparities, Con’t

• Duration of psychiatric outpatient visits 4.5 minutes shorter for blacks than for whites. Olfson et al. Arch Gen Psych 2009; 66: 214-221.

• Blacks more likely to use emergency services, higher lifetime prevalence of psychiatric hospitalization, more likely to be involuntarily hospitalized. Snowden et al. Psych Services 2009; 60:779.
What about in real life?

• Two cases during residency at same hospital

• Patient A
  – 28-year-old white male
  – Professional degree, dad/brother also post-grad
  – 1-year history of psychiatric symptoms
  – Socially withdrawn, “strange behavior,” lost job
  – Initially treated as outpatient
Patient A, Con’t

• More History
  – Initial diagnosis major depressive episode, Rx SSRI
  
  – Extensive outpatient medical work-up (Brain MRI, Copper/ceruloplasmin, urinary porphyrins, etc.)
  
  – Second opinion, diagnosed with bipolar disorder, prescribed Lithium
Further history

- Later admitted to hospital for “manic episode”

- At hospital, severe paranoia, bizarre delusions, responding to internal stimuli

- Symptoms present for several months, progressive

- Reluctantly diagnosed with schizophrenia
In Contrast

• Patient B
  – 45-year-old black man
  – Unemployed, sporadic work history
  – Alcohol use disorder
  – Admitted to hospital for “mood swings” and SI
Patient B, Con’t

• More History
  – Limited/sporadic treatment history
  – Once Rx Carbamazepine during detox admission
  – Described as “helped with my mood swings.”
  – He requested that we restart this medication
Patient B, Con’t

• Further History

  – We declined to start Carbamazepine

  – Diagnosed him with substance-induced mood d/o

  – Discharged him over his objections after 3 days
Patient B, Con’t

• Outcome
  – Patient B readmitted a few weeks later
  – Collateral from wife and daughter suggested history consistent with bipolar disorder
  – Started on Carbamazepine as previously helpful
  – Attending asked: “Why were we at first so against the idea that he could have bipolar disorder?”
Health Disparities – Remedies

• System-based changes

• Individual/cultural-level strategies

• **Doctor-patient relationship**
  – Cultural-competency education
  – Increasing number of underrepresented minority doctors
What is the case for more black doctors?

Improved access to care

– Black doctors served black patients at six times the rate as other physicians

– Black physicians were far more likely to treat patients covered by Medicaid

– The supply of physicians was lowest in areas with higher numbers of black and Hispanic patients

Do black doctors provide better care to black patients?
What do the data suggest?

Positive Results

– Study reported that black patients have more positive interactions with black physicians. “More participatory decision-making.” Cooper-Patrick et al. JAMA 1999; 282:583-589.

– Black patients more likely to rate black physicians as excellent and to describe feeling that their preventive care and other health needs had been met. Saha et al. Arch Intern Med 1999; 159: 997-1004.

– Same-race appointments were longer in duration and rated by black patients as more satisfying. Cooper et al. Ann Intern Med 2003; 139:907-915.
Black Doctors/Black Patients, Con’t

• Studies with mixed/negative data

  – A 2008 study of depressed primary care patients found that black physicians were no more likely than white physicians to discuss depression sx with black patients. Ghods et al. J Gen Intern Med 2008; 23:600-606.

What about in mental health?
Meta-analysis Findings

• 2011 review of client preferences, perceptions, and treatment outcomes (154 studies)

• Of all groups, African Americans most strongly:
  – preferred to be matched with African American therapists
  – tended to evaluate such therapists more favorably
  – had “mildly better” outcomes when matched

• Source: Smith & Cabral. J. Couns Psychol. 2011; 58:537
VA Systematic Review

“Studies suggest that black veterans may derive benefit from”

- Having a black clinician
- Being in a treatment group with other black veterans

Source: Saha 2007; Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review
Personal Experience

• A Piece of My Mind Article – Tweedy 2012
San Francisco General Hospital
Ethnic Focus Units

• Asian Focus (1980) – SF population 33% Asian

• Latino Focus (1983) – SF population 14% Hispanic

• Women’s Focus (1983)

• Black Focus (1985) – SF population 6% black

• LGBT and HIV/AIDS Focus (1992)
Logistics in Brief

• Public hospital (uninsured, Medi-Cal, Medicare)

• Most patients involuntary admits

• Units not “segregated” per se
  – white patients distributed across all units
  – bed space considerations also a factor

• Staff (MD, Ph.D., SW, RN, etc.) often matched composition of unit focus
Outcomes

• Variable depending upon unit focus

• Asian and Latino focus had better results than Black focus unit as far as acceptance of post-discharge care

• Black patients with multiple admissions were more likely to be treated on the black unit. Sicker patients.

Trainee Perspective

- Two former psychiatry residents at UCSF
- “When it worked, it worked very well”
- “Mixed feelings”

Postscript – Focus units closed in 2009 due to financial factors, consolidated into one general unit
Take Home Points

• Patient-provider mismatch with race inherent.

• Try to understand setting/history of the community in which you are practicing/training.

• Be curious/open-minded to learning about different people, seek commonality wherever possible.
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Last But Not Least