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COMMENTARY

# Can We Talk? The Role of Organized Psychiatry in Addressing Structural Racism to Achieve Diversity and Inclusion in Psychiatric Workforce Development

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Organized psychiatry today is in a space reflected by two relevant quotes: The words of George Santayana, "Those who forget the past are condemned to repeat it," and those of James Baldwin, "Not everything that is faced can be changed, but nothing can be changed until it is faced," describe our current situation and indicate a path forward.

Fifty years ago, in May 1969, a group of Black psychiatrists, led by Chester Pierce, M.D., entered an APA Board of Trustees meeting and demanded change [1]. Subsequently, many hoped that organized psychiatry would acknowledge and remedy the effects of racism in American psychiatry and rectify the mental health disparities created in communities of color. The long history of our profession's problems with race has been chronicled elsewhere [2]. Our inflection point for this commentary begins with the publication of an *American Journal of Psychiatry* special section on racism in 1970, inspired by the action of Dr. Pierce and his colleagues. In their article "Dimensions of Institutional Racism in Psychiatry," Sabshin, Diesenhaus, and Wilkerson [3] issued a call for "white psychiatrists to change the racist practices of their organizations and institutions" that displayed a lack of "realistic concern, until recently, for the Black American." They called for reform of community mental health, residency training and psychiatric research, and the appointment of an APA task force to "point out the presence of racist practices..., suggest means to eliminate them..., [and] provide leadership and report the successes or failures.. . to the profession." The intent of this section of the Journal was to inspire a course correction in 1970; yet here we are in 2020, still struggling with the problem of racism throughout psychiatry, including academic departments and professional organizations.

Despite stated mandates and mission statements regarding diversity, equity, and inclusion, the structures that govern and organize our efforts in the areas of clinical care, education, and research require a fundamental redesign in order to arrive in 2070 with significantly more progress made toward such goals. As former leaders of organizations important to assuring the development of the psychiatric workforce, we have joined together to make a case for what we believe the field can and must do to create a welcoming environment that would ensure a more diverse and inclusive future for the profession and better mental health outcomes for all. Our most junior colleagues enter the profession with a strong sense of responsibility for framing health care as a social justice issue and see health equity as the outcome of that approach. If we are not successful in our efforts to increase diversity and meaningful inclusion, we risk cynicism and despair in this group resulting in more psychiatrists from URM and ally groups abandoning academia and organized psychiatry.

We start with what we learn from some mistakes of the past to design a better path to the future. Let us start with the "structures" that support structural racism. We rely on academic medical centers, regulatory bodies, professional associations, health systems, and the like to help frame the work we do. Even if unintended, these structures include practices and policies which have contributed to the lack of progress toward the goal of diversity and inclusion and thus require reform.

First, we often prioritize diversity at the entry point without considering meaningful inclusion, advancement, and the well-being of the diverse colleagues we recruit into our profession. The failure of psychiatric systems to create a welcoming environment that embraces diversity and is truly inclusive stems from several sources. Inherent structural racism is an obvious target. There has been a general lack of recognition and

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acknowledgment of how embedded the ethos that "different is deficient" is in medicine. Ample evidence—from biases in how we diagnose and treat patients [4], to our methods for evaluation and selection of trainees, to lack of sponsorship for advancement in leadership for URM faculty and organizations—illustrates our continual failure to meaningfully change our structures. Organized psychiatry must provide a remedy that avoids the trap of continuing to devalue individuals who aspire to leadership and who care for our patients [5]. Pipeline programs, although useful, will be less meaningful and likely not bring about needed change if not accompanied by meaningful inclusion strategies.

We must bring a strong sense of cultural appropriateness and humility as we evaluate our systems. Change will require more than educational mandates. The barriers that race has constructed within the profession will not be dismantled solely with lifelong learning and new curricula. We believe that work to change our structures must begin with the acknowledgment of the actions in which we have been complicit since the start of psychiatry as a profession in the USA. The early history of psychiatry chronicles the fact that the founders made race-based decisions about the practices they supported as they organized [2]. Many of today's disparities and inequities have derived from those early decisions. Like our colleagues in the American Medical Association, we believe that we must offer an apology for past wrongs before we can move forward with a repair. To begin this process, we need to understand and acknowledge the hurt, intentional or not. Such a process is hindered by a number of obstacles including our desire to be "the good guys" hampering honest reflection on the racism in the history of organized psychiatry.

Repair requires listening to the pain experienced by our colleagues and patients and acknowledging it without defensiveness, qualification, or challenge. As we work with future psychiatrists from underrepresented groups, we must understand the toll that a constant sense of not belonging and being judged differently has on their development. We must listen to them without requiring evidence that their experience qualifies as a "real" act of racism. When such experiences occur during training, it is the responsibility of the program director to listen and respond with support within the limits of the program. It also requires, however, that an additional level of response be available to repair the situation at the institutional level. For example, some health systems now have system-wide diversity, equity, and inclusion employment standards which prohibit certain behaviors by faculty and employees to address just such issues from a systemwide human resources perspective. This puts the responsibility to collect and assess evidence on the institution, along with recommendations for remediation and corrective action as indicated. Such a supportive framework is essential to creating the welcoming environment downstream for a department or program to promote inclusion and address structural racism in the healthcare workforce.

This "listening to repair" requires acknowledgment of how our behavior perpetuates a sense of being an imposter in our colleagues from diverse groups. We define this as the "devaluing of persons who achieve accomplishments but who always wonder if others are asking if they have the right to be there." The burden for those not in the dominant group in academic and professional leadership (dominant being cisgendered, heterosexual, white, and male) is to expect the legitimacy of their presence to be questioned. When such lack of legitimacy becomes internalized and exists in the absence of a supportive, encouraging, and welcoming environment, it results in the expenditure of time, mental energy, and emotional reserve in self-doubt and potential decrements in performance. Multiple studies link this stereotype threat and imposter syndrome to poor performance [6, 7] and perceived stress [8] in URMs in academic environments. URM trainees are burdened by the metacognitive load of self-scrutiny, constantly second guessing themselves in what can best be described as the "unspoken, unwelcoming environment" of their training. And what a waste it is in these talented people. They are distracted by wondering about the right to be in our departments, clinics, and organizations, wasting much needed talent because of the lack of meaningful inclusivity in our systems. As a result, we may lose those who could most substantially contribute to help us fix what is broken. Our inability to stop and listen, to embrace a different way of training and promotion into leadership those members of diverse groups, may narrow the field of those who seek to have more than a seat at the table and limits our options for growth and innovation. This must change.

Another barrier to our failure to progress is the "white fragility of organizations" (Robert Rohrbaugh, personal communication 2020). Race paralyzes our natural inclination to ask certain questions and listen to the answers that follow. The inability to have honest, albeit difficult, conversations that lead to change is endemic. For example, systems may fail to protect persons of color who complain of verbal assaults by patients or even other staff. There may even be an undercurrent of resentment for raising such issues instead of the warranted response of zero-tolerance for abuse. A lack of protective structures and the failure to take seriously the victimization of our colleagues and students then contributes to the perception that the commitment to diversity, equity, and inclusion is meaningless. Continual promulgation of myths about race in teaching students and residents must be stopped [9]. Professional societies must frame standards for the learning and working environments much as they do codes of ethics and include protection from discriminatory practices of all types. Trainees are just developing confidence in their abilities and integrating a sense of professional identity so the psychological burden placed by the lack of a safe environment is even more critical and saps the enthusiasm and vitality of talented future leaders. There should be mandated education

for all about the pernicious effects of racism and what it means to be antiracist, just as we educate about sexual harassment in our systems. Teaching the racial practices in the history of our profession as a part of the history of psychiatry should be required. Curricula about how to promote health equity and justice and ongoing advocacy training (e.g., [10]) should be mandated in continuing medical education. We also cannot ignore that our profession's challenges are superimposed on the pain resulting from the onslaught of current events which must be carried disproportionately by individuals underrepresented in psychiatry and the rest of medicine. Organizational acknowledgment of such events and the commitment of resources to process them must occur.

What would it look like to create different structures? Such a process requires the examination of organizational practices, mission, and policies. All staff would be fully responsible for incorporating diversity principles, policies, and practices and solicited for ideas for making policy, program, and practice changes. Energy, commitment, and resources applied to diversity, equity, and inclusion must be equal to efforts in other areas of innovation in program and practice. Training would include new curricula and teaching formats, as listed above. Evaluation metrics and acceptable standards would be consistent with the needs of an increasingly diverse workforce and patient population; for example, incorporating holistic review of applications and not relying on standardized tests as the sole screening tool for admission to medical school or residency because this practice disadvantages URM applicants [11]. Advocating for other evaluation methods to assess ability to independently practice, such as entrustable professional activities that may be certified during residency, would provide a more holistic approach to certification of the endpoints of training. Until the current method of using USMLE examinations for state licensure and the ABPN examination for board certification changes, however, we would mandate comprehensive supports for test-taking strategies and training in biases that disadvantage URM applicants in narrative evaluations to rectify pervasive educational inequities [12]. Accreditation and certification requirements would encompass the needs of the community served, including important social justice and social determinant supports [13] and strong anti-racist training. Lack of equal access to participation in research for URM patients [14] must be rectified. Such standards would be adopted across all professional medical organizations, as limiting access to inclusion and advancement limits opportunities for URMs full participation in the entire house of medicine.

From here, principles of quality improvement may develop a continuous cycle of examining outcomes and barriers to achieving a welcoming environment for a diverse community of psychiatrists. This is how the structures that support "structural racism" will no longer prevent our goals and mission from being accomplished, instead of when the process is "worked around" to avoid dealing with such structural barriers. Systems must encourage diverse groups to be part of the organization from the start. Groups must welcome individuals with a seat at the table and full participation in the organization at every stage of their development, eliciting feedback and adjusting as required. Finally, organizations must offer sponsorship to elevate diverse individuals as part of an intentional and continuing advancement process. These are not issues that can be considered "one and done" or tokenism is the likely outcome. The fragility of white organizations, the deeply embedded barriers and beliefs, and the ensuing paralysis and cynicism when progress stalls may undo all our good work and efforts without a sustained commitment.

Navigating these "tough waters" will not be easy, but we believe that psychiatry is uniquely positioned to steer the ship. Ours is the specialty that is most skilled at dealing with issues regarding health-related communication, relationships, and the challenging conversations in offering a repair for mistakes. Self-reflection in the service of learning about the experience of another is a key component of psychotherapy. Helping individuals change fixed false beliefs is day-to-day work for many of us. We are the specialty that considers understanding systems as vital toward helping others. These skills could powerfully contribute to a transformation of our institutions, if there is the will to do so. We owe it to the future of the profession to not allow racist structures and behaviors to work against our future workforce and the health of all our patients.

## Compliance with Ethical Standards

**Conflict of Interest** On behalf of both authors, the corresponding author states that there is no conflict of interest.

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