

Beyond the Manuscript: Perspectives of Community Partners Involved in an Academic Training to Address Clinicians' Implicit Bias

Emma Tumilty, Jennifer Tjia, and Leopoldo Negrón-Cruz

Welcome to *Progress in Community Health Partnerships*' latest episode of our Beyond the Manuscript podcast. In each volume of the Journal, the editors select one article for our Beyond the Manuscript post-study interview with the authors. Beyond the Manuscript provides authors the opportunity to tell listeners what they would want to know about the project beyond what went into the final manuscript.

In this episode of Beyond the Manuscript, Associate Editor, Emma Tumilty, interviews Jennifer Tjia and Leopoldo Negrón-Cruz, authors of "Perspectives of Community Partners Involved in an Academic Training to Address Clinicians' Implicit Bias." The transcript has been edited for clarity and accuracy.

Emma Tumilty: Great. Okay. Welcome, everyone, to this episode of *Beyond the Manuscript* for *The Journal of Progress in Community Health Partnerships*. I have the great privilege today of talking to two people involved with a paper that will be coming out in Volume 17, Issue 2 of our journal. We'll speak to some community partners involved in academic training to address clinicians' implicit bias. Those wonderful people are Dr. Jennifer Tjia and Leopoldo Negrón-Cruz. I'll let them now introduce themselves.

Jennifer Tjia: Well, thank you so much for having us here. I am Dr. Jennifer Tjia. I am a physician and a researcher at UMass Chan Medical School in Worcester, Massachusetts, and my research focuses on improving care for vulnerable populations, including older adults and persons from historically marginalized groups, including minoritized populations and immigrants. I'm also the daughter of immigrants myself, and what this means is that I've seen, witnessed and experienced firsthand both implicit bias and racism in some way, shape or form my entire life. So the point is ensuring this that the motivation for this project, which underlies this paper, is that I understand that racism and bias happen and when these happen in medicine. There are huge consequences, and that's what led us to do the project, which underlies this paper, which I'll tell you about after we meet our great partner here, Leo. But I'm going to let Leo introduce himself.

Leopoldo Negrón-Cruz: Likewise. Thank you very much for the invite. I'm Leo Negron Cruz. I'm a community member. I work actually at a community health center in the city of Worcester, the Community Mental Health Center in Worcester. I was raised and born in Puerto Rico, and then I'm not technically an immigrant. I just migrated from the U.S. territory to the United States. And then I grew up speaking Spanish, and then I know what it means to go to a doctor with not knowing English or limited English language skills. And then that's why these type of projects always excite me to work with medical providers. I do work with medical providers all day long, but it's really in a different capacity. And that's why this project was so exciting for me.

Emma Tumilty:

Great, thank you. I really encourage people to read the paper, because its focus is some qualitative work with the community members who actually take part in the program. But I wonder if you could start off and explain to us sort of the origins of the program and what it looks like.

Jennifer Tjia:

Yeah. I'm thrilled to do so. The program underlying this is a training program for medical residents and nurse-practitioner students at our academic medical center. And the goal of the project was to increase their ability to recognize and manage their own implicit bias in their medical encounters with patients. And the crux of this program was to work with standardized patients, which are patient actors, for those who aren't familiar, to then bring in those situations that might occur in, for example, hypertension management but have the opportunity for these learners to practice these bias-recognition and mitigation skills in simulated clinical settings in a simulation lab at the medical school.

And what we thought was super critical in trying to learn how to do this was to bring in folks from the community who had lived experiences of, let's say, less-than-optimal care but also had real personal reactions to how these clinician learners were interacting with them. So that's the premise for the project that we did, but it's also important to understand that embedded in the culture of UMass, where I work, is that this whole notion—this practicing concept of working with a community is baked into the research culture of some of the departments, including the department I work at. And so, when this project was just a glimmer in our eye seven years ago, it was critical that we have the community at the table from the beginning. And so that's always been baked into this project.

Emma Tumilty:

Yeah, and, Leo, I wonder if you could talk to that a bit, because, reading the paper, I mean, it seems like community are embedded from the beginning even in thinking about what those standardized patients are going to look like, not just acting out patients but really being partners in designing what the interactions are going to be. Is that right?

Leopoldo Negrón-Cruz:

Yeah, I think that's a piece that I really like about this project versus all those that I have participated in is that the standardized patient, which is a community member, was thought of, at least it seems to me, as a real, very important part of the full process, from the—I mean, once the grant came in but how to implement from that point on. There were community members involved as partners, not as someone that I need like a token, so to speak. Then I think that and that validated the participation of all of us in the process, because we were able to really be more invested. We're not doing you a favor. We are doing a project with you. Then in this case with Dr Tjia and the team, then we were really—I think that for me was really key.

Many of my colleagues are standardized patients, which was one of the pieces that I play in this process, where—recruited for different, other community-based organizations that have been involved that were part of other projects within UMass Chan. And that's what I really like. It was like the project understood that the community piece was important, but it was important from the get-go until the end. And we participated in the design of the cases, of the four or so different patients that were part of it, but also in some of the tools that will be used with the learners and throughout the process. And then that, I think, validates our expertise in different levels, not only in the acting, which probably was the least of all.

[Laughter]

Emma Tumilty:

I mean, that sounds exactly how we want community partnerships to work, right, not just a form of tokenism but sort of true collaboration and a degree of power-sharing. I think you said then Dr Tjia

that it's been going for seven years, and I wonder if there's been any kind of noticeable evolution in that partnership or anything that you've really seen sort of change over time in those interactions and how they work.

Jennifer Tjia:

Yeah, that's a great question. It's interesting. When we started out to do the project, we didn't set out to write this paper, right? The project was really about, how do we build a better clinician, and how do we do that in equal partnership with the community? Over time it really came out that we were learning a lot of things really in two buckets. One was, how do you work with clinicians, and how do you really teach them how to recognize bias in management? So, we were also in parallel learning this whole second, huge bucket of learnings, which were, how do you really partner with a community? How do you recruit them? How do you bring them in, and how do you maintain that relationship?

And so, what do I mean? When we set out to do this, we learned that recruiting was really actually hard. Even though we had this great tradition of working with a community, recruiting was really embedded in trust, and it was embedded in trust with our community partner. So one lesson for somebody who might be listening to this is, if you want to do this work, you either have to have trust with the community yourself, or work with somebody, a community partner or community-based organization who has trust with the community. And I think Leo can probably speak to a little bit about despite our grand notions about what we wanted to do, I think a lotta people came to the project, because they trusted our community partner. So that was sort of one thing.

But then another thing that sort of evolved over time was we realized that we worked really hard at building trust with folks like Leo and all of our community partners. But what we didn't sort of envision was how to hand that trust off or how to build the bridge to trust within the medical institution, within the academic institution, the simulation center. And let's just say that there were some stumbling blocks when folks went into the institution who weren't as aware of power dynamics or leveling power dynamics and who were much more baked into the hierarchy which just exists in academic medicine, and that created some challenges, where some of our community partners went into the setting and felt very disrespected, actually.

And that created a lot of work for us within the institution to think about how do we as an institution and our subcultures within the institution learn how to look at ourselves and look at how we work with the community. And so that over seven years really evolved from a big, very—almost—it really was a crisis at some point. We had to get the chancellor of diversity and inclusion involved to really unpack a lot of really implicit bias within our own institution and how we work with each other. And we had to learn how to get past that and create trainings within our staff, within our institution so that we could go forward and do this project, but not just go forward and do this project but then have the spillover effects for the rest of our work with the community, which extends to other standardized-patient projects and just many, many other things that we do in academic medicine. So that's one of the things that evolved over time, right?

Emma Tumilty:

I really appreciate that commentary. I think our audience will as well, because I think many of us working in this space think solely about those sort of individualized relationships of building trust. But how do we make these things that we're doing sustainable when people will change places? People's places will change in certain organizations, and so how do we do that on a grander scale to make it more effective and impactful, because if it only even relies on individual people, it's necessarily always going to be limited.

Maybe if we move to some of the benefits of this work and the challenges, then we can start with Leo this time as well. So from the community side, what are some of the benefits of doing this work beyond the obvious?

Leopoldo Negrón-Cruz: Yeah, I think the benefits overall I think for us was the satisfaction to be able to participate in training medical providers, medical clinicians. I think that is a very good piece for a sense of empowerment, right? I was the teacher of the doctor, of the nurse practitioner, so to speak, right, but also I think in—but also on a more personal level as well, I think there was a shared sentiment among many of us was that it made us look at ourselves also as patients. The project was to be a better clinician, but I think it helped at least the 12 or so of us to be better patients. And I think that was the common sense that I think we realized or I realized, in that sense, that I could be a much better patient when dealing with a provider. And in a sense also check my own biases about the provider that I'm seeing. And then it makes one look more into learning more about blood pressure, because that was kind of the condition that we were dealing with in this project. I think there were people that were already diagnosed with having blood pressure, and probably some of us like me might be going towards that direction. It makes you realize what it is and what can happen.

Again, I think that being able to provide feedback, that is how I like to be treated, but also how other people like me might need to be treated. And exchanging the feedback and comments with the learners was really, really powerful. And seeing how we talk about—I realized this. I think that for me was one of the good benefits. But also in the design kind of the project, I think, as I mentioned earlier, we validated about that your expertise is not like I'm—I look like this patient that I'm going to be portraying, but also there are many things that I could contribute to it. And it helped build a stronger relationship, I would say, with the university and the school about it. I came to the project at a community organization that I have done some work, and—the Center for Health Impact is the name of the organization, as Dr. Tjia was saying, a place that I feel comfortable, that I have the work, and I like. I trust those individuals when they approached me.

It's almost like, how you say—no, but also then once you get to the project itself, then it was a continuation of whatever relationship one has with the community-based organization. The university, the team make you feel in the same. Then that's the benefits. Many times we don't—I mean, this was in a clinical trial—did we say that? But we don't trust these medical research projects in general. As I say, this also gave us a light on, yeah, you should participate, because your input is important, and your input could shape what happens next. And then that I think for me perhaps as a community benefit, I think that's for me the benefit is really that I could speak to other people to, “Hey, you're invited to participate in this sort of program. Yeah, make sure that you have these elements. But, yeah, it's a benefit to you but also a benefit to the larger community.”

Emma Tumilty: I really love that you're describing sort of the whole range of direct and indirect benefits. As I was reading the paper, I was really struck by those around sort of the standardized-patient descriptions and the new knowledge of blood pressure and the new knowledge of ways of being a patient that might be more effective for them. That was really interesting to me, because you don't necessarily start off this kind of project thinking about that as an outcome of the community's involvement, right? You might think about those things like empowerment and what you are saying and the sort of effect of being able to spread through the community the layers of trust, but those really direct outcomes were really fascinating to me as well. Dr. Tjia, did you want to add anything to those sort of benefit discussions?

- Jennifer Tjia:* Well, it's hard to add to that, but I think the major benefits—so one is I actually have great relationships with these folks, and I feel—my life feels very enriched at true civil-rights leaders in the community just—it's like touching history to have relationships with these people, which is just a gift, right? And the second is one of our partners who—I have such a hard time figuring out who to invite, but one of our partners is an older African-American woman who is a nurse, and almost—not every time, but she's said it frequently: This project was so important, because she's seen so much disrespect in her clinical work, from physicians to patients. And she felt like she was waiting her entire life for a project like this to come along to help fix it, and it was really important for her to be part of that. I mean, I didn't set out to do that, but when somebody says like that, that's a gift to me, and it makes me just want to continue to try and keep doing this work. Yeah, the number of immeasurable benefits I've had is just tremendous.
- Emma Tumilty:* That's fantastic, and I think it's so important for people to recognize the personal benefits of doing good work, not just the academic or even health-outcome ones. Doing work with people collaboratively in a respectful way is just really good for us. It's nourishing, right?
- Jennifer Tjia:* Right, exactly. I mean, that's why we wrote this paper is, wow, this is just good.
- Emma Tumilty:* [Laughter] What were some of the challenges? What were some of the things that—if you were trying to help other people set this stuff up—I mean, you touched on them a little bit, I think around your organization, Dr. Tjia, but maybe some other ones, maybe something very practical. Anyone could start.
- Jennifer Tjia:* I don't know, Leo, if you want to start, or if I should start.
- Leopoldo Negrón-Cruz:* I don't know if this is the right but sometimes I think one of the challenges in these simulations is that they're as good as you believe they are the real thing, and I think many times I think some of the learners might have not seemed to be taking it as it was. But then as the simulation progressed, they get into it. And I think it's even maybe the same for some of us, the standardized patients, much as you believe you are that. I mean, that's to be part of the acting, right, but you're acting, but at the same time you are observing to be able to provide feedback at the end. But I think that was obvious, but we were trained on how to—not to act but how to act and observe at the same time to be able to provide feedback.
- And then we were able to develop, I would say, good tools for us to do that feedback. But I think in general that is always a challenge when you're doing simulation role-plays that you need to believe it that you're in the real situation. And if I remember some of the feedback—sometimes at the end of the session we have a group session. Some of the standardized patients would say, “I don't think my learner was into the role—” but that's really one individual, and—but at the end, people will get the feedback that they needed to hear, reality view. Believe this was real. You got the feedback that you needed, or we gave the feedback that we thought the person needed.
- Jennifer Tjia:* Yeah, our training program, the—we had two levels of challenges. We had what Leo is referring to, the level of challenges of just the intervention, the training program itself, which—it was not the focus of this paper, but it was significant, meaning that—bringing learners in to talk about difficult issues like bias and racism and then asking them to receive feedback about these difficult issues from actors was a whole bundle of challenges itself. And one of those challenges we refer to in the paper,

again, had to do with the hierarchy of medicine. Even though we as a team really believed in equal partnership and equal power and equal value to the voice of what people were saying, our learners really just were looking to what the faculty said and sometime would not, let's say, take the feedback from the community as piece—to heart as much. And so that was a challenge.

And then there's a whole other set of challenges at just the community-engagement level from bringing people on and hiring them—our hiring process at the medical schools, like any big, huge organization, was just very bureaucratic and big and difficult. And we had some very real issues that we had to think about in terms of how to negotiate that. And then I think just the challenges of time—it actually just takes a lot of time and resources to do this well, which is why I think, as a lot of research calls for more stakeholder or community involvement, there's the real—well, I don't think researchers to into this not wanting to do it well, but I think there's a maybe—the challenge of how much time and energy and money it takes to actually slow down and get the feedback you need to do this in a really egalitarian, bidirectional way. And so those are, I think, real challenges for people who are really thinking about using this approach in their work.

Emma Tumilty:

Absolutely. I think that comes through a lot, right, the mismatch between organizational processes and maybe even philosophies and the relationship with that to doing community work, both at the research and teaching levels. That's really great. We're running short on time, and I don't want to sort of abuse my privilege of getting to talk to you, but maybe if we wrap up with, what's the future of this work? What're you hoping to do next, either in research or for the program itself? Where is it going?

Jennifer Tjia:

Yeah, so I really appreciate that question. Actually, as a result of this work, the relationships we built, my team was able to get a new grant off the grant, and that new grant also is community-engaged, where we are actually looking at the measuring and understanding the impact of structural racism and discrimination on how family caregivers are engaged in the hospital and how that affects the health outcomes for people with serious illness. So, we've just been able to build on these relationships and this momentum to take it to the next level of not just training but what's actually happening in the hospital, and how can we fix that?

Emma Tumilty:

Fantastic. And, Leo, will you be continuing as a standardized patient and helping design how these programs go?

Leopoldo Negrón-Cruz:

Definitely. I think it was a really good experience, but I think I could repeat it. I could be a repeat offender, if you will, and—yeah, because I think it's important. I think one thing that—I mean, I think I probably knew that before, but this reaffirmed it—is the importance of collaborating between higher-education institutions, community-based institutions, and community members and to improve the care that we all receive. Sometimes institutions look at changing the written policy but not looking at the practice. And I think a project like this, it looks at the practice, how you put all of that into action, so—if you want to use that terminology. But, yeah, then I do like it, and that I think—but also looking at how one involves community, not just think of us as an add-on but really think of us as a real partner that has many contributions to the development and execution and evaluation of the project. Yeah, it was a really satisfying experience, and that—it could be repeated.

Emma Tumilty: Fantastic. I mean, it sounds like you have lots of exciting and really important work ahead, and we hope to sometimes maybe see it in the journal in the future with the new grant and how the program evolves. But otherwise, thank you so much for providing us with your time and this extra insight into your paper.

Jennifer Tjia: Well, thank you for inviting us.

Leopoldo Negrón-Cruz: Thank you.

Jennifer Tjia: Yeah, we're really grateful.

Emma Tumilty: Thank you.

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