



Invisible Inequities –
Promoting Health Equity for
Patients with Psychiatric
Comorbidities

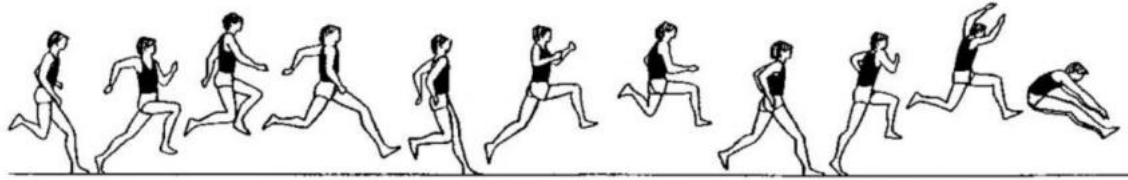
KD Dr. med. Oliver Matthes
Chief Physician PDGR

KOMPETENT UND GEMEINSAM FÜR LEBENSQUALITÄT

Where I come from ...



Triple jump



Observation

—
Describing inequities

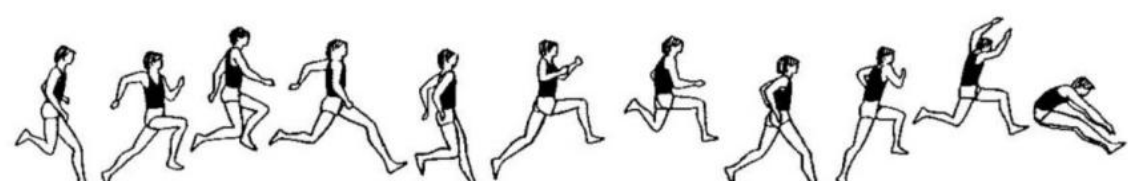
Explanation

—
Applying Ryoa Changs theory of
Structural health vulnerability
and epistemic injustice

Obligation

—
Institutional responsibilities
and Ethical imperatives

Triple jump



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Our patients are «complex medically ill»

The competency profile is intended to enable the acquisition of the necessary expertise in the psychiatric care of complex medically ill patients. This term refers to patients with:

- comorbid psychiatric and somatic conditions, whose interaction significantly complicates diagnostic and therapeutic processes,
- organic brain disorders and symptomatic mental disorders,
- somatoform and functional disorders,
- severe mental illnesses requiring treatment within an acute general hospital setting.

Postgraduate Training Programme of the SSCLPP
(Swiss Society for Consultation-Liaison Psychiatry)

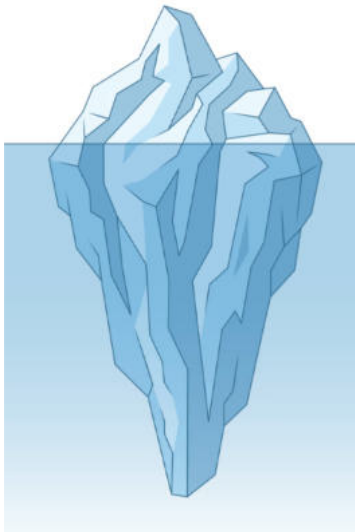


Why would you not like to have a (severe) mental disorder?

Mental health patients live 10–20 years shorter than the general population.

Tiihonen et al. 2009
Coldefy & Gandré 2018

Why Do People with Severe Mental Illness die earlier?



Suicide
Risky Behavior
Substance Use
Poor Lifestyle choices
«Difficult» Behavior / non-adherence

Barriers to healthcare (e.g. Limited access to primary care; long waiting times; lack of transportation; complex appointment systems; inadequate health insurance coverage.)

Socioeconomic Disadvantage (e.g. poverty, unemployment, unstable housing, social isolation, chronic stress, reduced health literacy)

Health System Factors (e.g. fragmentation between mental and physical healthcare)

Stigma (e.g. delayed help-seeking, reduced trust in healthcare systems)

Sidenote - «The difficult patient»: A classic view

Relevant?

Between 15 and 60% of patients are considered «difficult» by their treating physicians.

Hahn 1994; Hahn 2001; Jackson and Kroenke 1999

What exactly means «difficult» in this context?

«Difficult» patients are typically described as «those who raise negative feelings within the clinician,» presumably due to behaviors deemed «inappropriate» in a treatment setting.

Wasan 2005

What is the presumed origin?

«The difficult or frustrating patient . . . often has (unrecognized) psychiatric problems»

Haas et al. 2005

«The difficult patient»: A classic view

Groves, J. E. (1978). *“Taking Care of the Hateful Patient.”*
New England Journal of Medicine

Groves’ article describes four stereotypes of “difficult” patients, each associated with particular personality styles, defense mechanisms, coping strategies, and typical countertransference reactions in clinicians.

“**Dependent Clingers**” – histrionic, dependent traits

“**Entitled Demanders**” –narcissistic traits

“**Manipulative Help-Rejecters**” –borderline traits

“**Self-Destructive Deniers**” – antisocial traits

Concern: oversimplified?!

An Organizational Sociology Perspective: A different view

Medicine is organized around specific kinds of patients. In the cross-section of overarching biomedical narratives, international and national regulations, and guidelines and local practices, a particular kind of «ideal» patient is produced. The ideal patient embraces the larger biomedical paradigm, fits standardized diagnostic or treatment protocols, and behaves in expected and respectful ways. At the same time, its downside is created. Modern medicine’s narrow pathways create all sorts of «difficult patients». Rather than focusing on the «difficult patient» as a psychological or relational struggle for individual care professionals or patients – a common focus in medical literature and debate – this chapter approaches the «difficult patient» as a phenomenon inherent in the ways in which medicine is organized.



Misfit One: Logics of Standardization and Complex Patient Needs

Inequities – Excess Mortality is a Robust Empirical Pattern

People with severe mental illness die **10–20 years earlier**

This excess mortality is:

- observed across diagnoses
- consistent across countries and health systems
- persistent despite universal health coverage

Bottom line: The mortality gap is largely preventable — and structurally produced!

Triple jump



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Structural Health Vulnerability

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SPECIAL ISSUE

Journal of
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POLITICS

Structural health vulnerability: Health inequalities, structural and epistemic injustice

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Structural Health Vulnerability

Structural health vulnerability is a framework for understanding persistent health inequalities.

It shifts attention away from individual risk factors toward social, political, and economic structures.

Health risks emerge from systemic conditions, including:

- economic inequality,
- discrimination,
- institutional power relations.

Key claim: Health vulnerability is socially produced, not

Application: Psychiatric Comorbidity as Structural Vulnerability

Patients with psychiatric comorbidity have a higher somatic disease burden. They depend on continuous, coordinated care across services.

Structural vulnerability arises from:
fragmented care pathways
repeated transitions between institutions.

Example

A patient with severe mental illness is repeatedly admitted for acute somatic problems but receives no systematic follow-up for cardiovascular risk factors across admissions.

Take-home

Risk accumulates through fragmented systems — even when no one misinterprets symptoms.

Structural Injustice in Health

Structural injustice refers to social arrangements that systematically disadvantage certain groups, regardless of individual intentions.

These injustices are:

- embedded in everyday institutions,
- often invisible or normalized,
- reproduced over time.

In health contexts, they shape:

- exposure to risk,
- access to healthcare,
- quality of treatment and health outcomes.

Implication: Formal equality does not prevent health inequities.

Application: Structural Injustice in Somatic Hospitals
Care pathways are split between psychiatric and somatic domains. Responsibility for complex patients is diffuse and fragmented.

Example
During hospitalization, no service takes ownership of metabolic monitoring for a patient on antipsychotic medication.

Take-home
Excess risk is produced by institutional design, not by individual neglect.

Epistemic Injustice in Healthcare

Health inequalities are also sustained by **epistemic injustice** - injustices related to knowledge, understanding, and credibility.

Testimonial Injustice

Occurs when individuals are not believed or taken seriously due to epistemic injustice.

In healthcare:

- patients' reports are dismissed or underestimated
- credibility deficits align with gender, race, class, or other social factors

Hermeneutical Injustice

Occurs when people lack shared concepts to interpret their experiences.

In health contexts:

- certain forms of suffering remain unnamed or poorly understood
- dominant medical frameworks marginalize non-dominant experiences

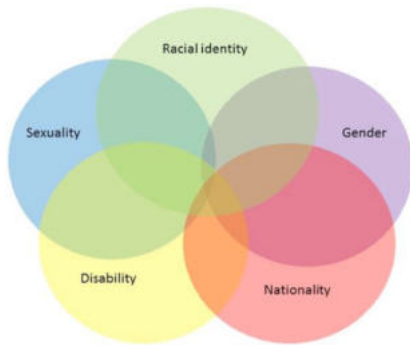
Core insight: Epistemic injustice restricts both whose voices are heard and how illness is understood.

Application: Epistemic Injustice in Somatic Care
Psychiatric labels affect credibility assessments. Somatic symptoms are psychologized or minimized. Patient narratives lose epistemic authority.

Example
Chest pain or shortness of breath in a patient with bipolar disorder is repeatedly interpreted as anxiety, delaying the diagnosis of myocardial infarction or pneumonia.

Take-home
When credibility is reduced, clinical knowledge becomes distorted.

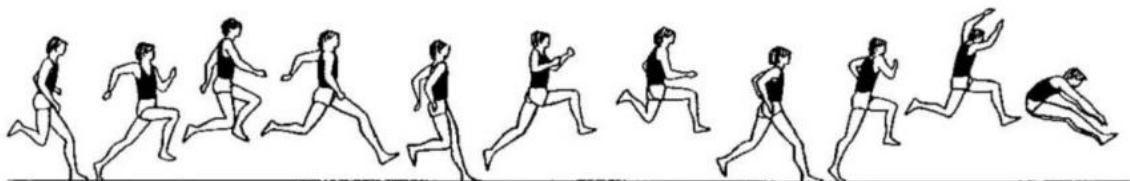
Intersectionality



Intersectionality is an analytical framework for understanding how aspects of individual and collective identity — some of which are named in the graphic — intersect and constitute different experiences and agencies within social systems. The meanings these intersections are given in conflict contexts create power relations between actors and groups.

Julia Paliemo Federer
Plenary Session «Clinical ethics and conflict resolution»
ICCEC 2025

Triple jump



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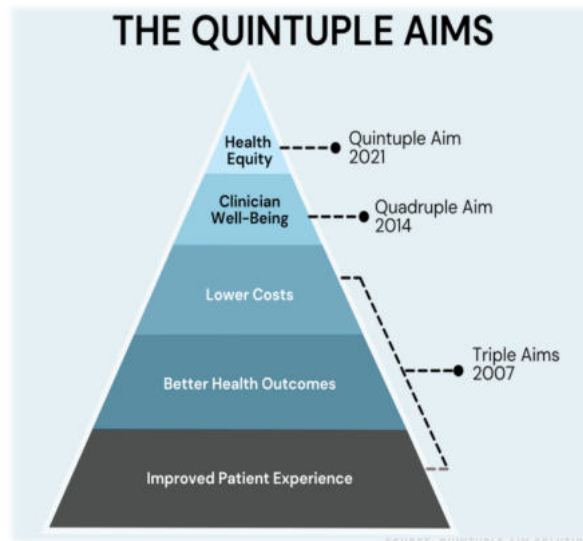
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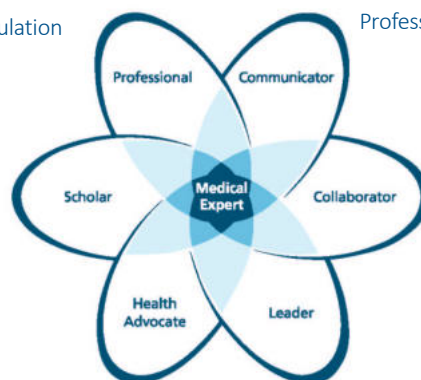
Should we bother from an ethics perspective?



Obligation or Supererogation? Physicians' moral responsibilities toward "difficult patients"

Professional
Ethical conduct
Self-reflection
Professional self-regulation

Communicator
Recognition
Respect
Professional responsibility



Collaborator
Teamwork
Interdisciplinary collaboration
Interpersonal skills
Trust

CANMEDS

Many good things in life have layers ...

Political Level
Institutional Level
Individual Level

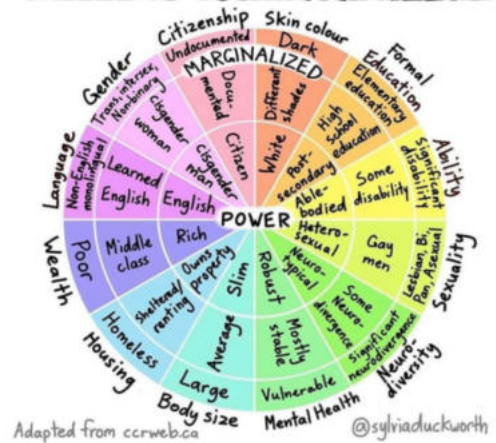


Individual Level



<https://implicit.harvard.edu/implicit/takeatest.html>

WHEEL OF POWER/PRIVILEGE



Institutional Level – Responsibility by Design


- Strengthening consultation-liaison psychiatry as core clinical infrastructure
- Protected time and resources for interdisciplinary coordination
- Embedding equity and mental health in quality indicators and accreditation



Political Level – The Conditions of Possibility

- Psychiatry and clinical ethics as advocacy actors for structurally vulnerable patients
- Patient and public involvement in policy, guideline development, and governance
- Structural and epistemic courage to name injustice and redesign systems





Thank you
so much!

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Psychiatrische
Dienste Graubünden

- ← Anmeldung / Réception
- ← Besprechungsräume / Mehrzwecksaal
- ← Cafeteria
- ← Direktion / Verwaltung
- ← Stationen
- ← Tageskliniken
- ← Wohnheim Montalin