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Guiding Change: A Multidisciplinary Framework For Interventions Addressing Systemic Racism In Healthcare

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Guiding Change: A Multidisciplinary, Industrywide, Healthcare Intervention, Addressing Systemic Racism

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Abstract

The relationship between systemic and institutional racism in the U.S., and health outcomes in people of the African Diaspora have been well documented (Bailey et al., 2017). Distrust in the healthcare system is the result of generational trauma compounded by an ongoing issue that has yet to be fully addressed (Scharff et al., 2015). For decades people of African descent have expressed concern about negative experiences with the U.S. healthcare system. Often the encounters leave them feeling, mistreated, unheard and or criminalized. These feelings result in trepidation over using the healthcare system which often further compounds health issues (Washington, 2008). Within recent decades there have been both localized and national efforts to address the problem. The efforts have been wide ranging from simple community programs designed to build trust, to hospital staff trainings in cultural competency, and national policies designed to improve the equity of care (Maina et al., 2018). The failure of such projects to decrease systemic racism may be due in part to poor developmental frameworks. Many of which were designed to decrease the appearance of rather than end systemic racism (Danis, 2021). Despite efforts Black people continue to have worsening health outcomes. Some outcomes such as infant mortality are shown to be worse than during antebellum slavery (Owens et al., 2019). The project reviewed qualitative, quantitative, and cross-sectional studies exploring the historical patterns of inequity, and the complex layers of systemic and structural racism in healthcare. The resulting intervention addresses the ways in which policy can drive industrywide change by creating cohesion between multiple systemic tiers using a multidisciplinary approach.

Keywords: Systemic Racism, Institutional Racism, African Diaspora, Black people, multitiered, multidisciplinary, equity, cultural competency

Introduction

Over the past decade, a heightened racial climate in the U.S. has given rise to many organizations examining racial inequity and the social determinants of health as defined by the World Health Organization (WHO 2010). Over the past four years, as White citizens of the U.S. have become more aware of racism via viewings of hostile treatment and murders of Blacks, systemic and structural racism, have become a routine part of social and political discourse (Cole, 2020). Hence, in 2020 the American College of Physician's Health (ACP) and Public Policy Committee prepared a policy statement on racism against Black people including disparities in healthcare (Serchen et al., 2020). The policy statement as with many other statements prepared by organizations around the time condemned and opposed racist policies and included recommendations to confront and eliminate discrimination, bias, and racism in healthcare. A common trend in efforts to address racism has been to design policy and create programming addressing issues in targeted areas with the hope of creating change (Maina et al., 2018). However, these ideas fail to provide enough disruption at the necessary leverage points within systemic racism to provide the desired ripple effect that would result in the dismantling of the system (Bailey et al., 2017).

Literature Review

In the United States racism is a highly structured system. It is connected to many institutions shaping and defining each systems hierarchy, frequently using policy to enforce principles (Williams et al., 2019). Both qualitative and quantitative studies link racial attitudes to

the development of antiblack policies in the areas of education, welfare, crime, and healthcare. Often those who support these policies mask racist views as moral principles (Cole, 2020).

There is evidence of a direct connection between polices supporting systemic racial discrimination and racial disparities in healthcare (Williams et al. 2019).

These disparities still exist despite controlling for variables such as socioeconomic status and education. According to a Center for Disease Control vital signs report, Black people not only have a lower life expectancy than Whites, but have higher disease rates with earlier onset, more aggressive disease progression, and lower survival rate. The 2015 report equates these conditions to inequity and systemic racism (CDC 2015). Such data provided ample evidence of the need for a succinct analysis of systemic racism as a public health issue, with specific focus given to its impact upon the healthcare industry and those of the African Diaspora. Hence, in 2021 began the work of Dr. Medina Agenor of the Center for Health Promotion and Health Equity at Brown University. With a team of academics and legal scholars, Agenor developed a database of structural racism related state laws for health equity research and practice in the United States. The resulting research identified the implementation of 843 structurally racist laws between 2010 and 2013 in all fifty states. Researchers simultaneously discovered that during the same three-year time frame no laws protecting against racial discrimination were enacted in any of the states (Agenor et al., 2021). The racist laws that were implemented had extensive health impact in several areas. These implementations alone, impacted mental health, cancer screenings and physical activity. Many of the resulting conditions bore the potential to increase illness and accelerate disease progression. Other laws such as the stand your ground law affected mortality rates by selectively allowing a Black person to be killed in self- defense even if there was no actual threat presented. (Agenor et al.,2021).

Of all academic fields, social science literature provides the most accurate and thorough conceptualization of systemic and institutional racism as key factors that drive inequalities in healthcare. Unfortunately, literature in the field of social science is not adequately integrated with literature in the medical field (Bailey et al. 2017.) With little interconnection between these two fields of study, it is difficult for some healthcare workers to make the connection between the country's capitalists roots in slavery, and issues with systemic racism in healthcare today (Washington, 2008). However, many of the advances in the field of medical science occurred while conducting research on Black bodies, beginning as early as the mid 1700's during slavery in the United States . It is because of systemic racism within the field of medicine that the contributions made by Black people to medical science are not more commonly known. It is social science however that not only brings the contributions to light,but provides evidence of the generational trauma caused by contributions stemming from medical abuse. (Washington, 2008). The evidence is supported by findings from multivariate analysis of Black patients, linking fear connected to trauma and the perception of racism, to mistrust of the medical care system, and less satisfaction with care (LaVeist et al., 2000). Whether labeled as mistrust or distrust, Black fear of the healthcare system can be traced to the racial bias and false beliefs of White healthcare workers stemming from slavery but present in discriminatory thinking today. An included study revealed that white healthcare workers used racial biases and false beliefs about biological differences between Blacks and Whites to assess and make recommendations for pain when treating Black patients (Hoffman et al., 2016)

The Center for Disease Control (CDC) defines Social Science research as the study of the effects of not only attitudes and behaviors on the public's health, but also social factors including race, ethnicity, class, family structure, and community integration (CDC 2006). Unlike

the field of medicine, for decades social science has openly researched the correlation between racism and health outcomes for the purpose of identifying and reducing related health disparities (CDC 2006). Because of this, it is easier for social science, than the field of medicine, to explain how race-based discrimination is not an issue that is in the past, but a problem that is ongoing and continues to negatively impact Black people (Mahabir et al., 2021).

Herein is an exploration of the potentiality for changes made at the policy level to not only address the standard of healthcare received by Black people in the U. S., but to reimagine a robust healthcare system, with policy acting as the directive for industrywide change. This is achievable through the design of a new framework called Guiding Change (GC). Guiding Change is designed to guide interventions that seek to address systemic racism by assisting in the building of a new system with many unified structures. By combining the expertise of many fields with particular attention to social science, GC addresses the many facets of systemic racism employing many disciplines. This strong framework addresses not only systemic racism, but the social determinants of health, including health outcomes such as maternal and infant mortality which place low U.S. rankings among third world countries. The considerations explored view policy as the key to a gradual redefining of the healthcare system over time, while simultaneously addressing factors that acknowledge that policy in the current state is a part of the systemic problem. Thus, governments, businesses, profit, and nonprofit organizations in conjunction with communities must begin some changes before policy changes can begin.

While reforming policy may be a demanding effort it is likely the most straightforward process to assist in making industrywide changes (Baker et al., 2018). Presently there are policies effecting health care at every level beginning with marketing which in turn affects minority relationships with the pharmaceutical industry (Randolph 2020). An impact on the relationship

between pharmaceutical companies and the Black population directly impacts that populations relationship with health providers. This in turn has a direct impact on both access to pharmaceuticals and quality of care received by these patients (Fleck, 2020). The previously stated factors result in the current statistical data noting disproportionate rates of chronic illness and morbidity in the Black population when compared to the White population (CDC 2015). While the CDC data is specific to African Americans this paper includes all members of the African diaspora. For this reason immigrants in this review will be referred to as Black due to the impact of systemic racism on all those of African decent living in the United States including Black immigrants. Because immigration has historically been racialized, many policies related to immigration are particularly discriminatory (Misra et al, 2021). Included are studies related to best practices, racism, and cultural challenges, experienced by all Black people residing in the United States, including immigrants.

Methods

This project included a systematic search and review of relevant literature using scholarly databases. It additionally examined empirical qualitative, quantitative, and cross-sectional studies along with frameworks, programs and interventions attempting to address racism. Also included is the autoethnographic experience of the researcher which uniquely qualifies the researcher to identify gaps within the healthcare system that promote systemic racism. To support the policy focus of the framework, the research added a review of Brown University's database for structural racism related laws. The collective research explores a variety of factors, including the historical connection between capitalism, current policies, and the social determinants of health. There is in-depth examination of attempted interventions that fell short of fully addressing health

inequity albeit having somewhat addressed cultural competencies, culturally appropriate care, access to respectful, high quality skilled care, and common viewpoints or stressors associated with clinical care. From the completed examination, the integrated framework Guiding Change was developed for the purpose of guiding potential interventions with an interest in dismantling systemic racism in health care. The framework however is conducive to building strong interventions in any industry where applied.

Key word searches included

For the purpose of extrapolating the effects of the most recent policies related to systemic racism, searches were limited to decades from 2000 to 2021. While this time frame only narrowly begins to address factors related to systemic racism it draws attention to several key economic, social and health related policies as well as changes within the penal system that largely effect black populations.

It has been noted that there may be confusion with the use of the word Black which has historically been used to refer to those born in the U.S. who are descendants of slaves. In other countries specifically those within the U.K., the term Black is used to refer to any person who is not white. To improve the quantity of data regarding the experiences of Black immigrants, the term Black and Minority Ethnics (BAME) was added to the search profile. While the term BAME also has research limitations, at very least it separates all people of African descent from all other ethnic minorities allowing some opportunities to view studies exclusive to Blacks. In later research, the term traditional birth attendant was added to the terms midwife and doula. It was found that within the wide range of ethnic variations of Black women in the field of maternal health, there exists birth attendants who are neither midwife nor doula with specific best practices and techniques exclusive to their culture.

The search terms included: [systemic racism] AND [health care*] AND [Black People] AND [Black Immigrants] AND[African Americans][structural racism] AND [health] [policy reform] {Black health outcomes]AND United States {morbidity rates]"Impact*"of policy reform and health outcomes on African Americans United States[racial discrimination] AND [healthcare][Structural racism] AND [healthcare] "Impact*" of midwives, doulas, traditional birth attendants on morbidity United States [midwives] [doulas] [traditional birth attendants] Infant mortality rate.

Databases

The following health and social science resources were accessed: PubMed, Scopus, Cochrane Humanities Source, SocINDEX, CINAHL. Databases offering studies that included medical research were selected to meet the need for data driven by chronic conditions and or mortality rates. Databases from the humanities and social science categories were selected for the purpose of collecting information regarding how current policy affected Black trust of the healthcare system, emotional choices including the desire to access opportunities related to health and wellness, and the feeling of being invisible, unheard, or disregarded by clinical staff, which is demonstrative of experiences related to systemic racism in the healthcare industry (Goode, 2014). In total 48 independent research studies were reviewed.

Discussion

From the selected studies there were three emerging themes, access to care, the pharmaceutical industry, and quality of care. Each theme touched upon a crucial issue within health care connected to the overarching theme of capitalism. In general, there is ample research creating a clear path between the U.S. foundation built upon capitalism and slavery and historic, accounts of Black trauma at the hands of the healthcare industry. Despite the evidence, political agendas and connected policies consistently reflect a disregard for the need

to address the issue of systemic racism in healthcare. There are a consistent influx of systemically racist policies generated near annually (Agenor et al.2021).

Access to Care

Access to care and cultural complexity comprise the first theme due to the breadth of ethnicities the term Black embraces. While Blacks from different ethnic backgrounds face similar kinds of racial injustice, Black people are not a monolith. Black immigrants face different challenges than U.S. born Blacks and despite their societal lumping together as one community, are culturally different. This can be noted in the comfortability that mothers born outside of the U.S. have giving birth outside of the hospital with the support of a midwife. In contrast the vast majority of U.S. born women have over time grown comfortable with the medicalization of childbirth introduced to them by male dominated U.S. obstetrics (Roberts, 1997). During the research it was determined that for women born outside of the U.S. there are many kinds of health workers to support with infant and maternal health. In fact, the term traditional birth attendant was added to the terms midwife and doula during research. It was found that within the wide range of ethnic variations of Black women in the field of maternal health, there exists birth attendants who are neither midwife nor doula with specific best practices and techniques exclusive to their culture. These care givers are with both mother and infant from pregnancy beyond the infants first year of life. This is not consistent with practices in U.S. obstetrics where a mother typically visits one practitioner until six weeks after the birth of the child, after which time she will see the practitioner no more. In general, only wealthy mothers in the U.S. would experience the level of care that is the norm for Black women born outside of the U.S.
(Ross et al., 2017)

In addition to differences in basic access to care that some immigrants may be accustomed to, there are many languages and a myriad of traditions, norms and values that differ from U.S. born Blacks. Further complicating things are the differences in second and third generation

children of immigrants, many of whom experience feelings of representing both the U.S. and the country of their parents (Washington, 2008).

Potential problems arising from these complexities need to be addressed in any efforts to combat systemic racism in healthcare.

The Pharmaceutical Industry

The second theme details the nuanced relationship between the pharmaceutical industry and Black people and the impact that segregated and targeted marketing has upon health education, preventive care, and mortality rates. The racialization of pharmaceuticals has been deceptive. In one example, the company Nitro Med hired athlete Shaquille O'Neal in 2019 to market the heart medication BiDil, despite O'Neal not having a heart condition (Murch, 2019). To add insult to injury, researchers discovered that the medication was pushed for use in Black patients despite being rejected by the FDA in 1997, after studies reflected it was not useful to heart patients. The drug was being marketed by the athlete solely for pharma's capital gain more than a decade after this discovery (Murch, 2019). This would not be the only time the industry would be guilty of racialized capitalism. The opioid crisis is one of the most egregious examples. The Pharmaceutical industry aggressively began marketing Oxycotin to states with largely White populations, to avoid the stigma of being associated with Black drug users. In doing so, they created the present-day opioid crisis. The industry continues to push racially bifurcated ideas about addiction by ignoring rising opioid overdose rates in Blacks while maintaining a singular focus on the suffering of Whites (Murch, 2019).

Quality of Care

The third theme addresses systemic racism and quality of care. Here, there is examination of the effect of bias upon health outcomes. It has been documented that systemic racism creates a snowballing affect upon both healthcare providers and patients. Health care workers who

receive training based upon outdated medical ideology, reinforce structural bias, and ensure the continuation of patterns of inequity (Hoffman et al.,2016). Such is evident in a study that revealed that in 2014, many health professionals in the U.S. were still treating Black patients based upon an outdated belief that Black patients experience pain differently or less severely than White patients (Oliver et al.,). The effects of systemic racism on patient interaction leave patients of the African Diaspora feeling trepidation over using the system, concerned that they will receive a lower quality of care (Scarff et al., 2015). Additionally, patients experience feeling unheard, mistreated, or criminalized with both feelings of mistrust and distrust. All experiences result in generational trauma (Scarff et al., 2015). In each study where quality of care was mentioned patient accounts revealed that many health care facilities fell short of fully addressing patients concerns over health inequity or cultural competencies. Even fewer attempted to provide culturally appropriate care, which resulted in patients feeling they had no access to respectful, high quality skilled care. While the studies reviewed explore a variety of factors, such as the historical connection between capitalism, current policies, and the social determinants of health the researcher observed none as blatantly ignored as patient viewpoints regarding stressors associated with clinical care.

Recommendations

Policy is the most straightforward way to begin addressing access to care. When healthcare is viewed through the lens of policy it permits the issue of access to be addressed on several fronts where discrimination has played a key role in building an inequitable healthcare system with poor access. A key role that policy plays in access to care is by proliferating the social determinants of health for Black people.

This project designed the guiding Change framework by examining the ideology behind five existing public health frameworks that operate at different systemic levels. Each framework

appeared to be missing the goal of ending systemic racism completely. The Guiding Change framework made this the goal from the outset. It was also imperative that there be the addition of a high-quality comprehensive checks and balances system at each level to ensure continuity and consistency of any intervention designed using the framework

The first is the Danaher Framework which is community centered, and places focus on reducing disparities and improving population health. Community building and policy advocacy are key to the success of this framework.

The second, Bay Area Regional Health Inequities Initiative (BARHII) centers around living conditions, including physical, social and economic environments. This framework also focuses on the service environment which includes healthcare, education and social services. The third is Cooperative Extension's national framework for health and wellness (ECOP) . This framework promotes health equity as a core systemwide value. The fourth framework is The Adapted Human Resources for Action Framework designed by the World Health Organization (WHO). This framework is particularly impressive with a goal of increasing access to health workers that includes a conceptual framework for measuring results. With the exception of the WHO framework, each smaller framework focuses on the needs of a specific institution within a larger system which inadvertently leaves the region as a whole beyond their capacity and unchanged. The first WHO framework is not designed to account for the standards of a capitalist country such as the U.S. while the fifth framework also designed by WHO, considers social cohesion and social capital. What all frameworks share is a focus on policy with the 5th framework focusing on three areas of policy which include macroeconomic, social, and public policy. In the Guiding Change framework, policy is the driving force at every level of the system and all people are empowered to design equity.

Current policies address healthcare via sex, race, ethnicity, economic status, environment, and even immigration status. Through policy these categories compound oppression as laws are created to favor some, while discriminating against others. These laws affect poor Blacks by allow redistricting, redlining and divestment in communities while permitting pollution, low green space, inadequate living conditions, and less attention to safe infrastructure repairs while simultaneously aiding the growth and marketing of toxic businesses and industries known to promote products and activity that lead to illness and decreased lifespan. Guiding Change addresses all concerns with a strong focus on equity and environment, policy would be generated that prevented redlining, redistricting and toxic businesses from creating an unhealthy environment. These businesses would not be permitted in their present numbers.

In the present system, Blacks are affected when policy does nothing to address the healthcare industries insistence upon the continued use of antiquated disproven ideology around how Black patients are treated. Moreover, extraordinarily little has been done to address the racism that causes healthcare workers to make automatic assumptions about Black patients resulting in poor care. This directly aligns with several noticeable statistics in infant and maternal health. These statistics state that Black women with more financial stability and education fair worse than poorer less educated Black women. Presently The U.S. provides the highest number of cesarean sections, drug induced labors and hysterectomies of all developed nations with the bulk of these going to Black women. Despite the high number of surgeries Black women have the worst health outcomes regarding pregnancy, childbirth and general gynecological health. Current research suggests that the use of midwives, doulas and culturally congruent health workers improves the odds for Black women. Guiding Change produces policy providing access to training for birth workers as well as mandating their use in all health facilities. This would have positive impact on

both infant and maternal mortality rates for all women particularly those of the African Diaspora who suffer the greatest threats.

There is a clear connection between economic stability, social community, access to quality education and environment (Baker et al., 2018). To create a system that is both robust and equitable, attention must be given to all areas of the social determinants of health. There must also be a simultaneous shift away from treatment of symptoms and illness or "sick care" as the primary focus to making preventive healthcare the dominant focus and sick care secondary. The present systems current focus upon treating illness is not conducive to a healthy population as it addresses the state of health only when one is unhealthy. Moreover, many normal conditions such as pregnancy and aging have largely become medicalized by the healthcare industry resulting in unnecessary hospitalization and exposure to medications and medical procedures where none are needed. Guiding Change has a strong focus on preventive healthcare options which would include services such as gym memberships, health foods, farmers markets, and tools for mental health and self-care. While these options are seldom marketed to those in the African Diaspora, the multibillion-dollar, junk food, alcohol and tobacco industries invest heartily within this group. Ensuring that ads are placed strategically to ensure maximum viewership by the target market. Unfortunately, there are communities where there is great access to these products and little or no access to healthy foods for miles. Strong health policy around preventive care will address these issues by ensuring that markets in all communities provide greater access to foods and products that contribute to good health and prohibit specific types of advertising in areas that cater to school children and families. Preventive care policies can place a moratorium on the number of specific kinds of markets in communities, while increasing health centers that provide education and increase access to healthcare. An increase in

produce markets and healthcare centers combined with a simultaneous decrease in liquor stores, smoke shops and fast-food chains increases access to care while simultaneously addressing economic stability, environment, and education. Current policy does not thoroughly support a healthcare system with culturally complex needs. An effective system requires many culturally congruent health care workers and an education system that generates such a workforce. Many states have begun to adopt programs that train healthcare workers while in high school, allowing students to begin internships their junior year. A policy making such programming the standard rather than the exception would address poverty as a social determinant of health while simultaneously addressing the need for stable, well-paying jobs and access to more culturally congruent health educators and healthcare workers.

Adjustments to policy can move a step further by designing laws that prohibit any kind of care including the marketing, administering, or proscribing of a pharmaceutical used to medicalize a condition that is not a medical condition or simply not the standard treatment for an existing condition. Far too often people of the African diaspora are directed to medications or surgeries when education around lifestyle changes or less invasive treatments may be the best alternative.

Conclusion

The gaps indicated within this project are addressed by using the Guiding Change framework to create intervention through policy. This framework crosses multiple tiers within systemic racism with a multidisciplinary approach that combines legislation, social science and medicine at its core while offering enough fluidity to be used within multiple other fields. As systemic racism is the product of capitalism established at the origin of the country, it is necessary to define systemic and structural racism for those who mistakenly think it does not

exist, while simultaneously ending it for those who have endured it for generations. Guiding Change addresses the issues within systemic and structural racism and gives a particularly strong foundation to the field of healthcare, repairing the social determinants of health. The recommendations for organizations and institutions are concise, using current data as reason for both urgency and fluidity in the implementation of the intervention as each system within the framework is designed to achieve distinct goals. It is pertinent that those of the African Diaspora are heavily involved in meaningful and effective ways throughout the use of Guiding Change to ensure the success of any intervention's implementation. The proposed will not only result in the effectual dismantling of systemic and structural racism in the United States but change the entire trajectory of health and morbidity rates for those of the African Diaspora.

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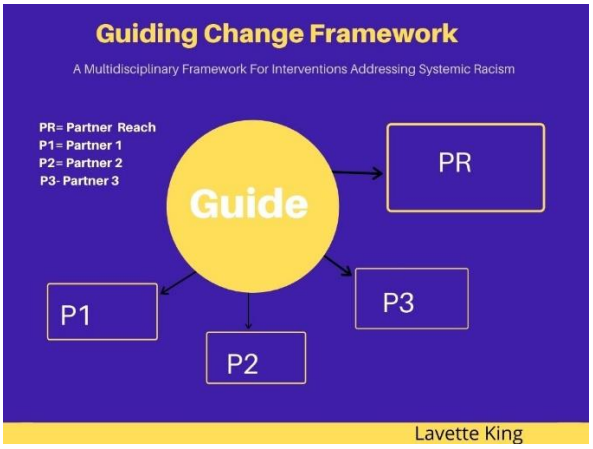
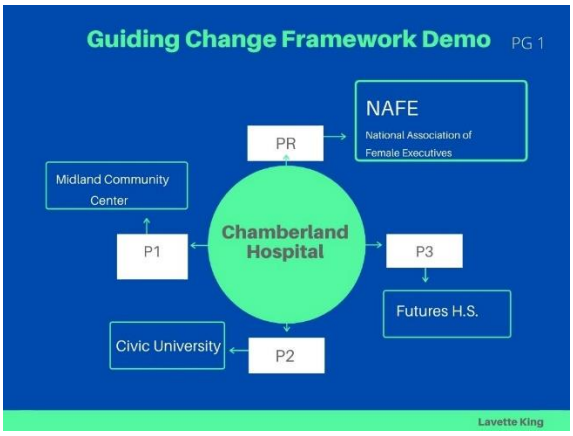
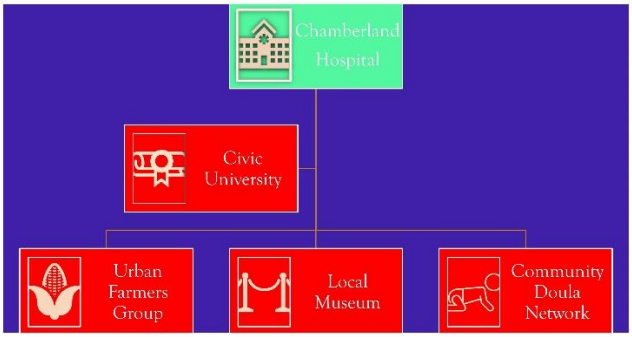
Appendix A. Guiding Change Framework



Appendix B. Demo of Framework Page 1



Appendix C. Demo of Framework Page 2



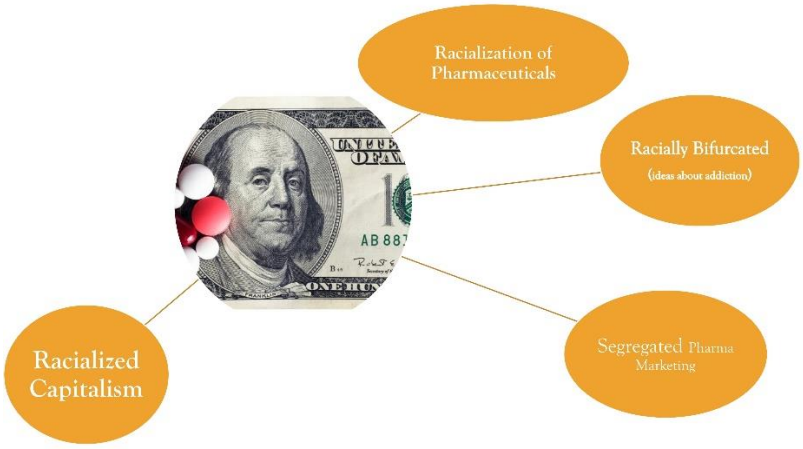
Appendix D. Radial Evidence Graph

Racialization of Pharmaceuticals
In 2005 NitroMed markets BiDil to Blacks as a heart failure med despite it being rejected by FDA in 1997.

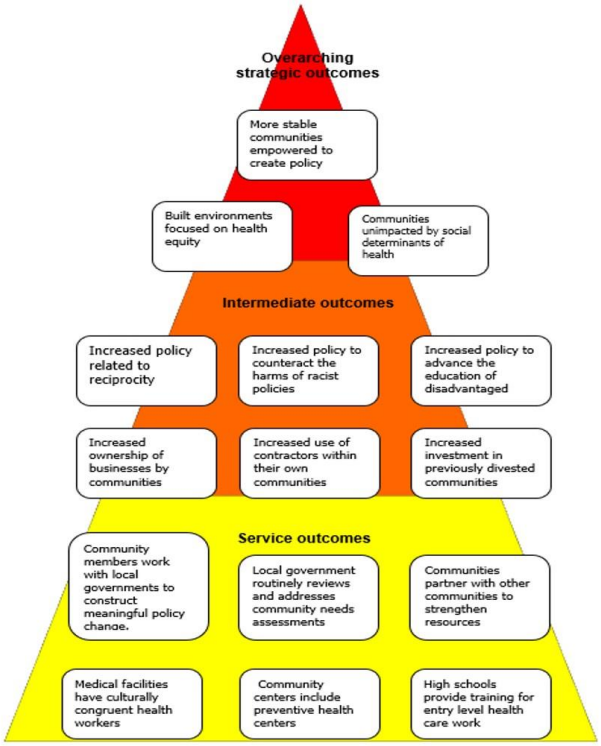
Racially Bifurcation There are rising Opioid overdose rates in Blacks however Pharma and public health maintain a singular focus on White suffering

Racialization of Pharmaceuticals 2019 Shaquille O'Neal Is hired to market the drug to improve sales, although he has no heart condition.

Racialized Capitalism To avoid the stigma associated with Black drug users Purdue aggressively markets Oxycotin in states with largely White populations

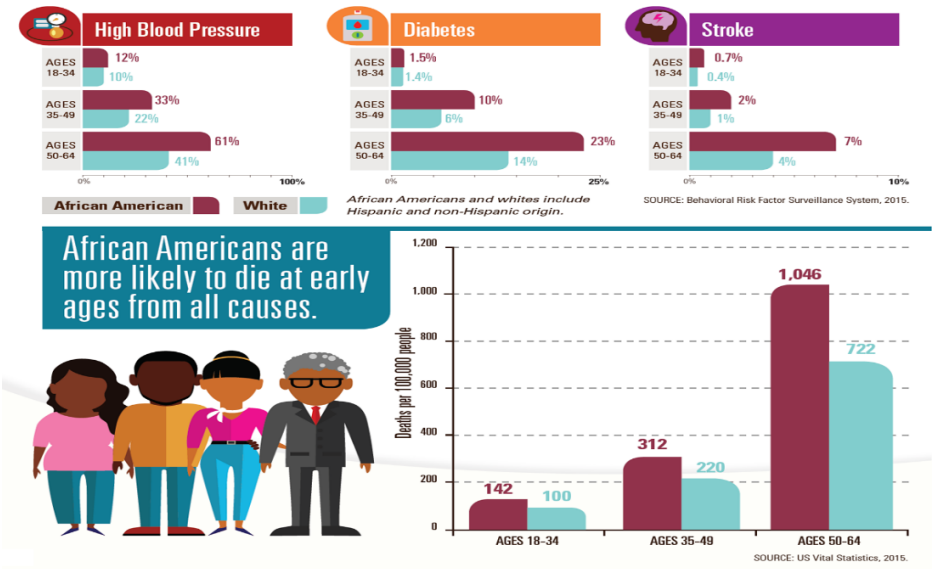


Segregated Marketing Consumers targeted solely through Black community spaces such as churches, community centers or radio.

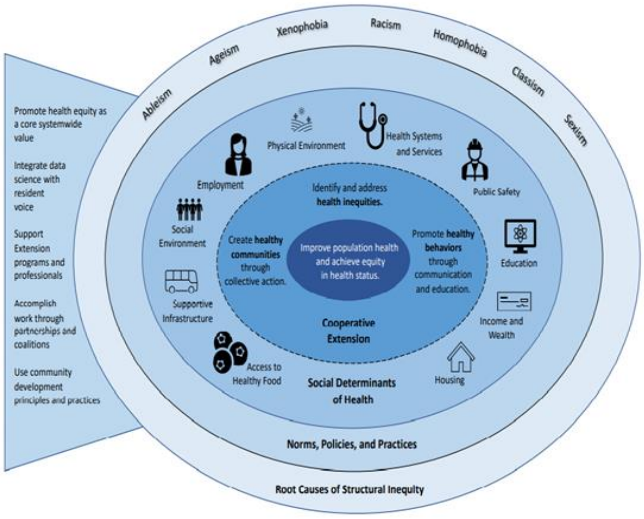


Appendix E. Outcome Triangle

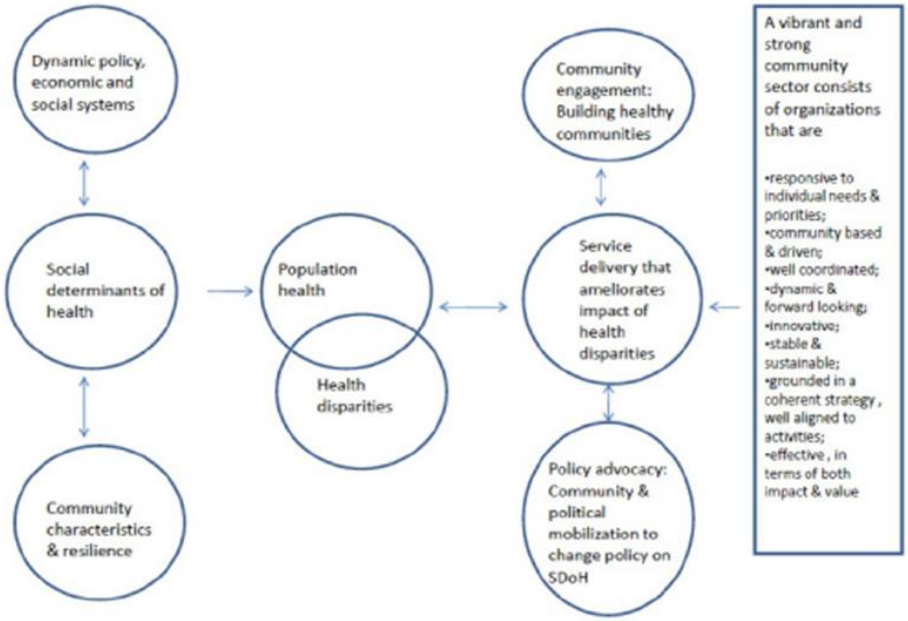
Appendix F. African American Americans Morbidity Rates



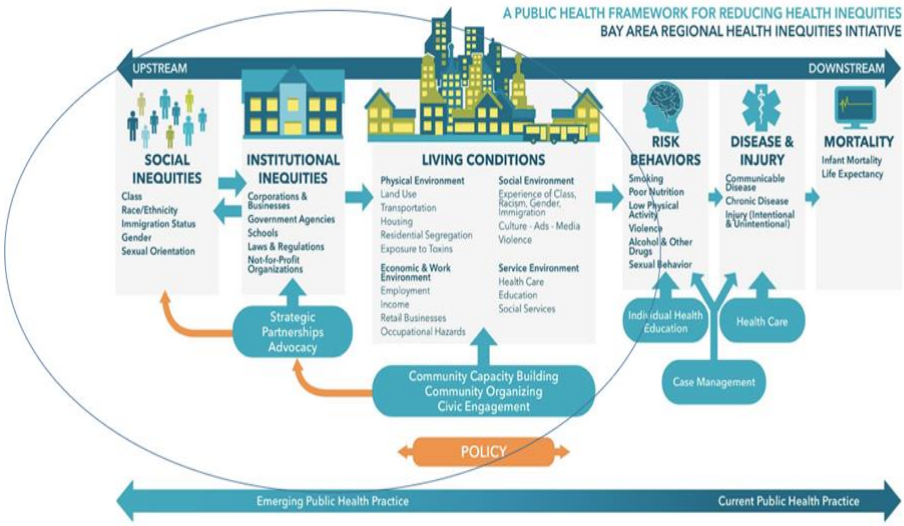
Appendix G. Cooperative Extension's national framework for health and wellness.



Appendix H. Danaher framework



Appendix I. BARHII (Bay Area Regional Health Inequities Initiative). framework for reducing health inequities



Appendix J. Final form of the CSDH conceptual framework