



RACIAL INEQUITIES IN INTEGRATIVE HEALTHCARE

A Policy Statement from Northwestern Health Sciences University

Racism causes health disparities

A complex legacy of racism in the United States continues to create health inequities among people of color. Systemic biases in education, employment, housing, healthcare, access to food, accumulation of wealth, and the legal system contribute to poorer health among communities of color. These social determinants of health are driving factors behind the “weathering hypothesis”, where chronic exposure to discrimination and disadvantage lead to accelerated decline in health outcomes, particularly among Black individuals.¹ Black Americans experience greater rates of disease in nearly every major indicator of physical health as compared to other racial and ethnic groups in the United States.² Infant mortality among African Americans is twice the national average, and the life expectancy for Black men and women is consistently shorter than their White counterparts.^{3,4}

While this report focuses primarily on Black communities and other persons of color, we acknowledge many groups similarly face discrimination based on gender identity, sexual orientation, social class, and ability. The intersection of these characteristics with the identification as a Black person often amplifies inequities, and contributes to variability in health experiences within communities of color.⁵

While knowledge about racial inequities in healthcare is not new, progress toward a more equitable system and greater health for Black communities has been slow.² The

disproportionate impact of COVID-19 on Black individuals, coupled with cases of police brutality against the Black community, has rightfully brought the issue of racial discrimination in healthcare to the forefront.⁶ Northwestern Health Sciences University is committed to improving the health and wellbeing of all communities through integrative healthcare solutions. The purpose of this paper is to address issues of racial disparities specifically in complementary and integrative healthcare (CIH). We will also present several pathways for the integrative care community to create more equitable health and wellbeing for Black individuals and communities of color.

Race and diversity in integrative healthcare

Racial minority groups utilize CIH less frequently than non-Hispanic Whites. Those who do report greater perceived benefit in terms of stress reduction, emotional health, better sleep, and greater sense of control over health having received CIH services, compared to their White counterparts.⁷ Immigrants also report lower use of CIH compared to citizens, and increased utilization with citizenship. Non-US citizens report primarily using CIH for preventive health care. Cost and accessibility of care, as well as knowledge about CIH, have been identified as barriers to engagement and utilization.⁸

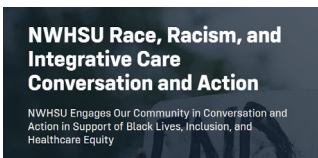
As with most healthcare disciplines, minority groups are underrepresented within CIH professions. For example, Black professionals represent only 1.6% of chiropractors,⁹ 0.8%



* “Folk back home aren’t talking about these boutique services. Not something they would think of or think they could afford.”

-Dr. Charles Watson

To hear more from Dr. Watson, click the icon below:



of acupuncturists,¹⁰ and 12% of massage therapists.¹¹ For reference, 5% of physicians¹² and 6.2% of nurses identify as Black.¹³ The most recent census data reports 13.4% of the U.S. population identify as Black.¹⁴ This segment of the US population is clearly underrepresented in healthcare generally, and especially among CIH professions.

Pathways to increase the number of underrepresented minorities (URMs) in health professions have been well articulated by others. Multi-faceted solutions have been proposed to address the cost of education; lack of academic preparation, including advising and mentorship from K-12 through professional education; limited exposure to the range of healthcare careers; stereotyping and cultural barriers in academia and healthcare; and societal constructs that reinforce bias.¹⁵

Black Mistrust of the Healthcare Community

The challenge of addressing health disparities is exacerbated by the distrust of the healthcare system that exists within communities of color. The Tuskegee Study is one of the most noteworthy examples in a long history of systemic bias and racism in healthcare.^{16,17} Beginning in 1932, hundreds of Black men with syphilis were passively monitored to study the progression of the disease, without their consent. Not only was this a breach of respect for persons, but these research subjects were not offered penicillin when it became the drug of choice for syphilis, a violation of beneficence. The study was eventually halted in 1972 and is frequently cited as an important source for mistrust in medical research and care by Blacks.

Other sources for distrust in healthcare include growth in managed and for-profit care, other examples of unethical medical research, as well as fraud and abuse.¹⁸ This mistrust, coupled with systemic differences in the medical treatment of Black individuals, contribute to a negative cycle of worse health outcomes among communities of color. Recent examples of racism within the healthcare system includes the systematic under treatment of Blacks for pain^{19,20} variable use of

preventive health services,^{21,22} and disparities in maternal and obstetric care.^{23,24}

Traditional healthcare is generally available in most communities, although often focuses on emergency and acute care, and the management of chronic conditions. In contrast, CIH practices and services are generally not commonly accessible in some communities of color. This is the result of economic barriers for both patients to receive care, and providers to establish financially viable practices in economically depressed areas. There is also a lack of knowledge about CIH within some communities of color, where CIH is viewed as ‘boutique healthcare’*. As a consequence, CIH is not often considered as part of the solution to improving health and wellbeing. This is unfortunate, principally because of the focus CIH has toward whole person, lifestyle-oriented health and wellbeing is often missed in care of communities of color.

Unique Potential for CIH Providers to Address Health Disparities

Black individuals and Black communities are often the targets of physical, psychological and generational trauma, which may manifest as poor health and disease. Trauma informed healthcare, a niche within CIH, delivers care through the lens of empathy and compassion. It acknowledges the persistent effects of past trauma on current health, and creates an environment for healing and recovery that is mindful not to re-traumatize. CIH providers typically spend more time with their patients than what is possible within the conventional medical system, often over a series of visits and in private practice settings. This provides CIH providers greater opportunity to listen to patients of color, build trust, and deepen therapeutic relationships.

Internalized racism may lead communities to feel that indigenous healing practices are inferior to modern medicine, further alienating an individual from their cultural community. CIH honors many ways of knowing and understanding health and disease, and is grounded in philosophy similar to many traditional healing practices, valuing vitalistic

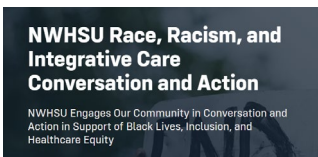


over reductionist conceptualizations of wellbeing. In contrast to the transactional and specialized nature of conventional healthcare, CIH providers typically and intentionally focus attention on whole person care and primarily utilize conservative, nonpharmacological therapies that carry lower risk of harm. This empowers individuals to have greater agency over their health, and less negative impact on their community. CIH fundamentally respects a diversity of healthcare approaches, goals and perspectives, and aligns with community values and wisdom about health and wellbeing.

* “As clinicians, we have to develop the skill to be able to see life through the eyes of patient we are treating. Fully enough that we can understand what it might be like in their lived experience.”

-Dr. Michele Renee

To hear more from Dr. Renee, click the icon below:



Call to action

However complex and difficult, confronting racism in healthcare is important and timely, particularly as it relates to the health and wellbeing of the Black community. What follows is a series of responses to be considered by the CIH community, as we contend with racism in healthcare.

1. Build trust

Trust is foundational to all other steps. It includes an openness to inquiry, listening to understand the values, experiences and beliefs among persons of color. Central to this is taking what is said by patients of color at face value, recognizing how one’s own bias may enter into the therapeutic relationship, and choosing to prioritize care over judging the individual or the situation. Genuine communication is predicated on empathy and compassion, cornerstones of all healing practices.

2. Community Driven CIH Programs

CIH providers and organizations should partner with communities of color to advance the health and wellbeing of diverse groups, increase training opportunities, and improve access to CIH services. Whether designing research projects or creating business plans for a community-based clinic, planning should consider a shift of focus away from the majority, and toward a “centering at the margins” of healthcare.²⁹ This intentionality to think of the ‘other’ refocuses the point of view to consider, involve, and promote those who are marginalized.

3. Serve Communities of Color

CIH providers must recognize that health goes beyond individual responsibility, to include the complex contributions of social structure and societal (dis)advantages. Every community has a unique set of social determinants that influence the health of its citizens. Authentically guiding an individual along a healthcare journey can only be achieved if the provider journeys alongside the community that individual identifies with. For patients who identify as Black or as a person of color, this may include seeking to understand community norms and infrastructure through relationships with cultural advocacy groups, elders or influencers. CIH providers may become strong allies of communities of color, to improve and enhance investment in social services, and direct patients toward a supportive network of resources if needed.

4. Improve cultural competence

CIH providers must demonstrate the knowledge, skills and attitudes necessary to effectively care for communities of color. The United States Department of Health and Human Services defines culturally competent programs as those that, “... maintain a set of perspectives, behaviors and policies ... that promote positive and effective interactions with diverse cultures.”²⁵

The first step toward improved cultural competence is learning about, understanding, and accepting that structural racism is inherent in the United States. Toward that end, CIH disciplines should explore how racism historically shaped our professions’ histories, and how it continues to explicitly and implicitly influence us today.

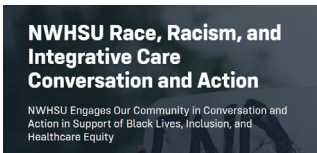
With that background in mind, CIH academic institutions and programs should develop and implement curriculum and clinical experiences addressing the domains of **cultural competence***. Organizations that accredit CIH academic institutions and programs should define and implement cross-cultural educational standards that can serve to guide this work. We have examined the educational standards for CIH programs and find them lacking in requirements for curriculum content,



* “When a Black patient sees I’m a Black doctor, they immediately get excited. And then they say I’m much more comfortable in this space. That in itself is the beginning of the healing process.”

–Dr. Stephen Thompson

To hear more from Dr. Thompson, click the icon below:



including in areas such as empathy, respect and other core cross-cultural issues, and assessment measures aimed at evaluating cultural competence similar to those found in other healthcare professions.²⁶

5. Elevate Professionals of Color

The composition of leadership within CIH professions, including academic institutions and affiliated organizations, professional associations, regulatory and licensing boards, should reflect a diverse citizenry, and consider efforts to ensure equity and diversity a central tenant of their responsibility. Organizations may wish to review their history to identify instances where they have been complicit in racial injustice, and commit to periodic audits of current policies and procedures to ensure racial equity and justice. They may also benefit from seeking out opportunities for learning, listening, and partnering with external stakeholders, with shared goals of social justice.

6. Increase CIH workforce diversity

An important strategy to advance healthcare among communities of color is to actively recruit members from these communities to enter CIH professions. First, **CIH professionals of color*** may relate to the sensitivities, perspectives and values of the community they culturally identify with in a way not achievable by others. This intimacy fosters trust and understanding in the patient-provider relationship. Second, professionals of color often chose to work in and focus on the health of their communities; persons of color may in turn encourage more individuals of color to join the CIH professions. Finally, recruiting students of color recognizes that ability is present across all segments of a population; soliciting talent from diverse groups ensures that capable individuals are not overlooked due to race.

7. Inclusive Educational Environments

CIH educational institutions should be purposeful in creating welcoming, supportive environments to support Black and other students of color. This includes measures to ensure that neither explicit nor implicit racial bias is exhibited by faculty and administrators, and is not tolerated from anyone within the campus community. Curricula on disease and disease management should reflect their impact on Black persons, to include images in learning materials, case studies, and variations in presentation to accurately reflect the experiences among diverse races and genders. The creation of health and wellbeing should be taught to consider the unique bio-psycho-social influences experienced by an individual, including those from Black communities. Black students should feel represented among their school’s faculty, administration, board, clinical supervisors and mentors, and support services should be designed to accommodate their needs.

8. Dedicated curriculum

Curriculum in our CIH educational institutions, as well as continuing education for professionals, should correctly identify race as a social construct, and seek to dispel beliefs about biological or intrinsic differences between races.²⁷ Students should be guided to identify their own biases, and the ways in which their own biases may influence healthcare interactions and decision making. CIH educational programs should model civil discourse around racial bias, exploring the moral imperative of all healthcare providers to address social determinants of health and promote equitable healthcare within their spheres of influence.²⁸ These discussions should be conducted in safe learning environments, with faculty who are equipped to constructively address elitist and pejorative attitudes pervasive in healthcare. Treating all individuals with empathy and compassion are critical competencies that must be intentionally and actively cultivated among students and within healthcare teams.

Accountability to Action

CIH bears the ethical and social responsibility to meaningfully engage in steps to address racial inequities in healthcare. While this has been a topic of discussion and effort for many, now is the time to hold one another accountable to action. At Northwestern Health Sciences University, our mission is to prepare the next generation of healthcare professionals to deliver and advance health care. Central to the success of this mission is a sustained collaborative relationship with the communities we seek to serve and more purposeful engagement to decrease racial inequities within integrative healthcare.

To demonstrate our commitment to this issue, Northwestern Health Sciences University publicly commits to the following:

- Respond to current needs of local Black communities in crisis by listening to lived experiences, establishing enduring partnerships with community leaders, and expanding health and wellness through integrative care.
- Undertake curricular mapping to ensure equity, diversity and inclusion competencies are reflected across programs and throughout the curricula.
- Review student recruitment strategies and staffing policies to cultivate an equitable, inclusive and diverse campus community.
- Support individuals from under-represented groups through diversity scholarships, to enable careers in integrative care and increase the presence of integrative care in communities in need.
- Create a digital library of storytelling to educate students, faculty, and clinicians about diverse local populations, and their relationship to integrative care.
- Develop systems to measure our progress with these commitments through metrics on our University dashboard.

Creating health equity must become more than another box to check or an appendage to our core work. Health equity is built through a relentless daily commitment to community building, cross-cultural collaboration, and ensuring access to integrative care for every person and family.

From the Center for Health Healthcare Innovation and Policy

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