COLLABORATIVE HEALTHCARE

INTERPROFESSIONAL PRACTICE, EDUCATION, AND EVALUATION

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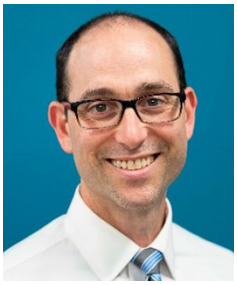
Jefferson Center for Interprofessional Practice and Education

How Structural Competency Can Help Dismantle Structural Racism



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On the afternoon of Friday, September 19, 2008, Brian Sinclair maneuvered his wheelchair to a community health center in Winnipeg, Manitoba. Center staff were familiar with Mr. Sinclair, a 45-year-old First Nations (Canadian indigenous) man and double amputee with chronic illnesses. He complained of pain and requested assistance with the catheter bag he used. A physician and nurse examined him and recommended that he go to a nearby acute care hospital to have his catheter changed in a sterile environment. Mr. Sinclair agreed. The physician gave him a letter to share with the emergency department explaining the reason for his visit, which he placed in his pocket (Brian Sinclair Working Group, 2017).

When Mr. Sinclair arrived at the emergency department, an aide greeted him and inquired about his illness but, for some reason, did not enter his case into the triage system. Mr. Sinclair sat quietly in the waiting room as his symptoms worsened. At 4:00 am Saturday, a nurse noticed the sleeping Mr. Sinclair. She checked his wrist, and, not seeing a wristband, assumed he had been discharged and was waiting for a ride or was a homeless person seeking shelter. Mr. Sinclair was still in the waiting room Saturday afternoon when other patients alerted a guard that he had vomited. Environmental services staff cleaned up the vomit, but no one informed the health professionals (Brian Sinclair Working Group, 2017).

At midnight on Saturday, a patient approached the guard concerned that Mr. Sinclair had not moved in hours. The guard said he was probably intoxicated. The patient insisted, so the guard went over to Mr. Sinclair and discovered that he was unresponsive. He wheeled Mr. Sinclair to the nursing staff, who declared him dead, the letter from the physician still in his pocket. Seventeen staff members had observed Mr. Sinclair during the 34 hours he waited for care, but none offered to help. An autopsy revealed a bladder infection had led to sepsis. It found no drugs or alcohol in his system (Puxley, 2014).

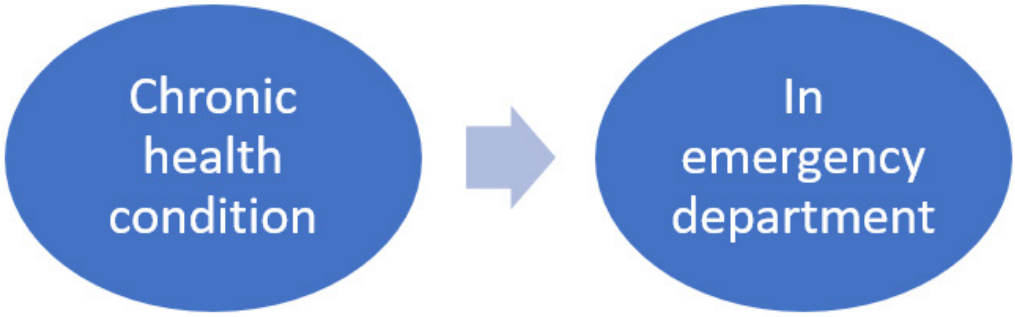
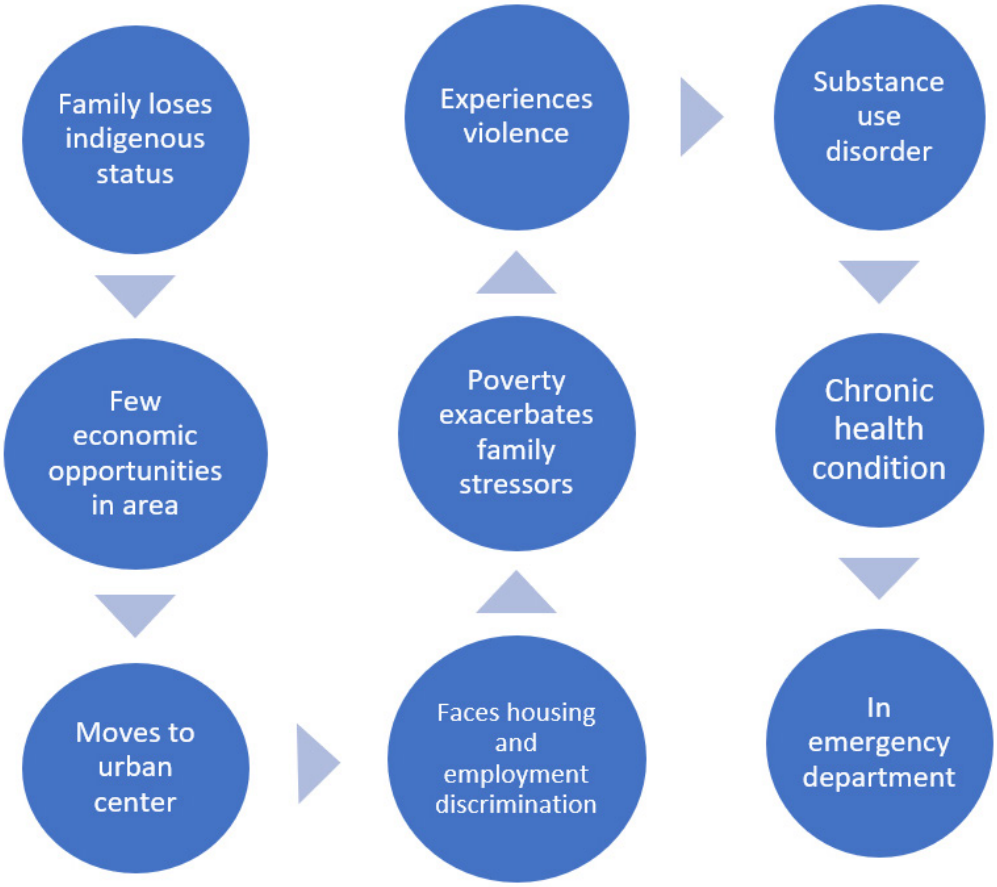


Figure 1

In the case of Mr. Sinclair, any proponent of interprofessional collaborative practice could identify lapses in team performance. Failures in communication prevented crucial information from reaching the appropriate health professionals. Some members of the hospital staff may not have fully understood

Figure 2



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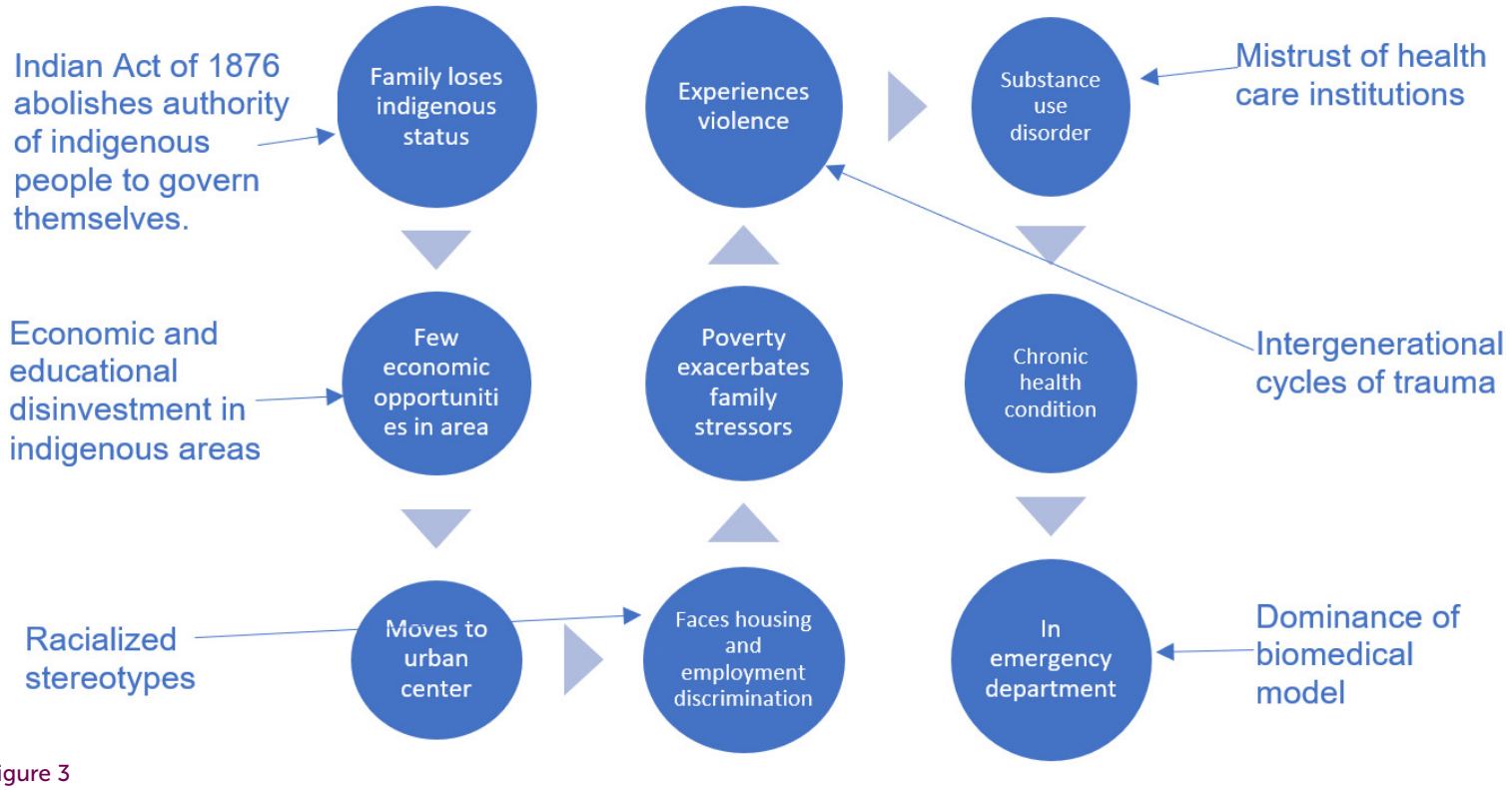

Figure 3

the scope of their and their colleagues' roles. Fellow patients exhibited more respect for Mr. Sinclair's dignity than the clinicians who encountered Mr. Sinclair.

But if health professions educators focus on fixing just the aspects of team dynamics, they still allow the underlying effects of structural racism to persist, which conditioned most of the people who encountered Mr. Sinclair to see him as someone unworthy of care. I use "structural racism" specifically to avoid judging the mindset of any individual health professional (Hardeman et al., 2016). All the staff in the emergency department may have been free of personal animus toward indigenous peoples; yet, they inhabited a structure, built up over time and continuously reinforced, that caused them all to judge Mr. Sinclair in the same way: undeserving.

For interprofessional education to meet its ultimate goal of improving wellbeing, it needs to be attentive to the adverse impacts of structural racism on health. Structural competency asks the clinician to consider not just the person presenting in front of them, but also the historic, social, economic, and environmental context in which they are embedded (Metzl & Hansen, 2014). Take Mr. Sinclair for example. A standard health history for his case would look like Figure 1 on the previous page.

A more complete health history would widen the lens to include the full trajectory that brought him to the emergency department that Friday afternoon. These are not immediately visible to the clinicians but can be solicited through more in-depth interviewing. A simplified version of Mr. Sinclair's story might look like Figure 2 on the previous page.

Finally, the external structures that shaped his life would appear. These forces are harder to see and may not be apparent even to Mr. Sinclair (Neff et al., 2020). (See Figure 3).

The benefit of structural competence is that it reorients health care away from treating patients' symptoms after they become sick to identifying root causes that prevent sustainable health (Bourgois et al., 2017). This is not to say that Mr. Sinclair bears no responsibility for the decisions he made before arriving in the emergency department, only that he inhabited a world that constrained his choices. As an analogy, think of currency: we are free to attempt to pay for retail items in the United States with euros, but customs, policies, and rules of exchange make that option unreasonable. In the same way, the rules of structural racism are not written down, but they still determine how resources and opportunities are distributed.

Interprofessional collaborative practice can be particularly helpful in building the structural competence needed to dismantle structural racism. Health professionals engaged in effective teamwork are already attuned to systems-level dynamics. They know how to identify underlying barriers in communication, hierarchy, and role clarity to put the patient and family at the center of care. Interprofessional collaborative practice has not embraced anti-racism as an explicit focus, but it takes only a widening of the lens to perceive how structural forces like racism negatively impact the health of the patient. For instance, one emergency department confronted a dispiriting roster of patients with substance use disorder in acute distress. They would admit them, stabilize their condition, and then release them back into the community only for the cycle to repeat (Messac et al., 2013). A sustainable intervention would require interprofessional coordination at multiple levels: strengthening the coordination between intensive care and outpatient social services to connect patients to resources before they need emergency care, establishing an institutional partnership with legal services to help patients qualify for housing assistance and career development programs, and leveraging multiple professional associations to lobby for more public investment in treating substance use disorders.

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A coordinated team alone cannot be expected to counteract hundreds of years of ingrained disadvantages, but team members can use their interprofessional voices to conceive and advocate for more equitable systems. Seeing systems is a strength of interprofessional collaborative practice, though traditionally the analysis has been limited to the clinical environment. To promote more lasting health that takes into account the full context of people's lives, interprofessional teams will need to consider how to extend their roles into community and policy arenas. The sheer scope of structural flaws that need to be repaired may overwhelm a clinical team already fully occupied with patient care. Fortunately, the first step toward incorporating an anti-racist orientation into interprofessional collaborative practice involves only a shift in outlook. Too often, health care team members see "frequent flyers" like Mr. Sinclair as solely responsible for the condition of their health. Nurturing a deeper understanding of the structures that shape patients before they present themselves in a clinical setting helps counteract the blame-the-victim mentality. Structural competence highlights that we all exist in a web of social and historical forces, giving impetus to interprofessional teams to use their collaborative skills to address the pernicious effects of structural racism on health.

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