

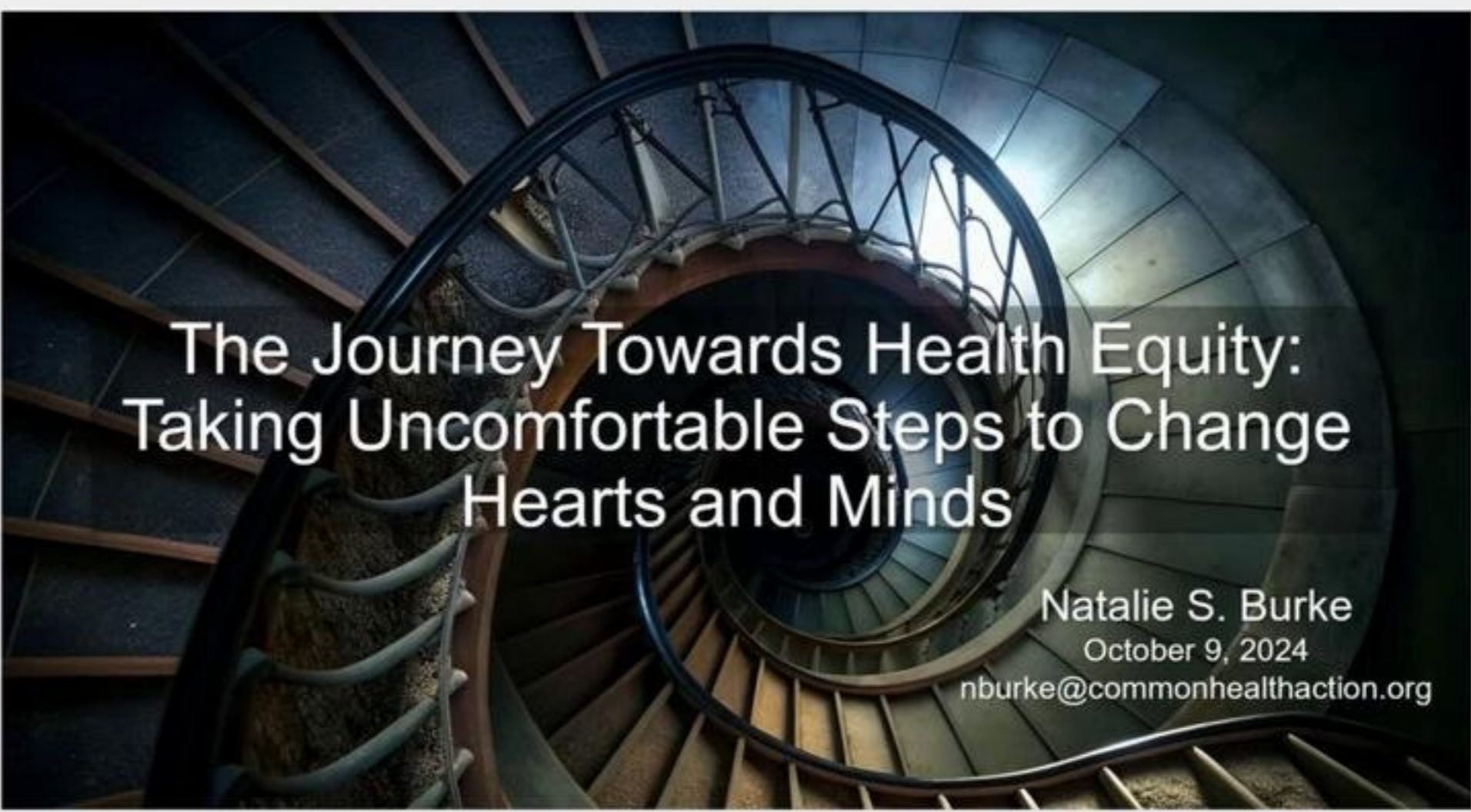
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- Example Slides
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PERSPECTIVE TRANSFORMATION

Head

- Logic
- Data
- Facts

- Fairness
- Justice
- Meaning

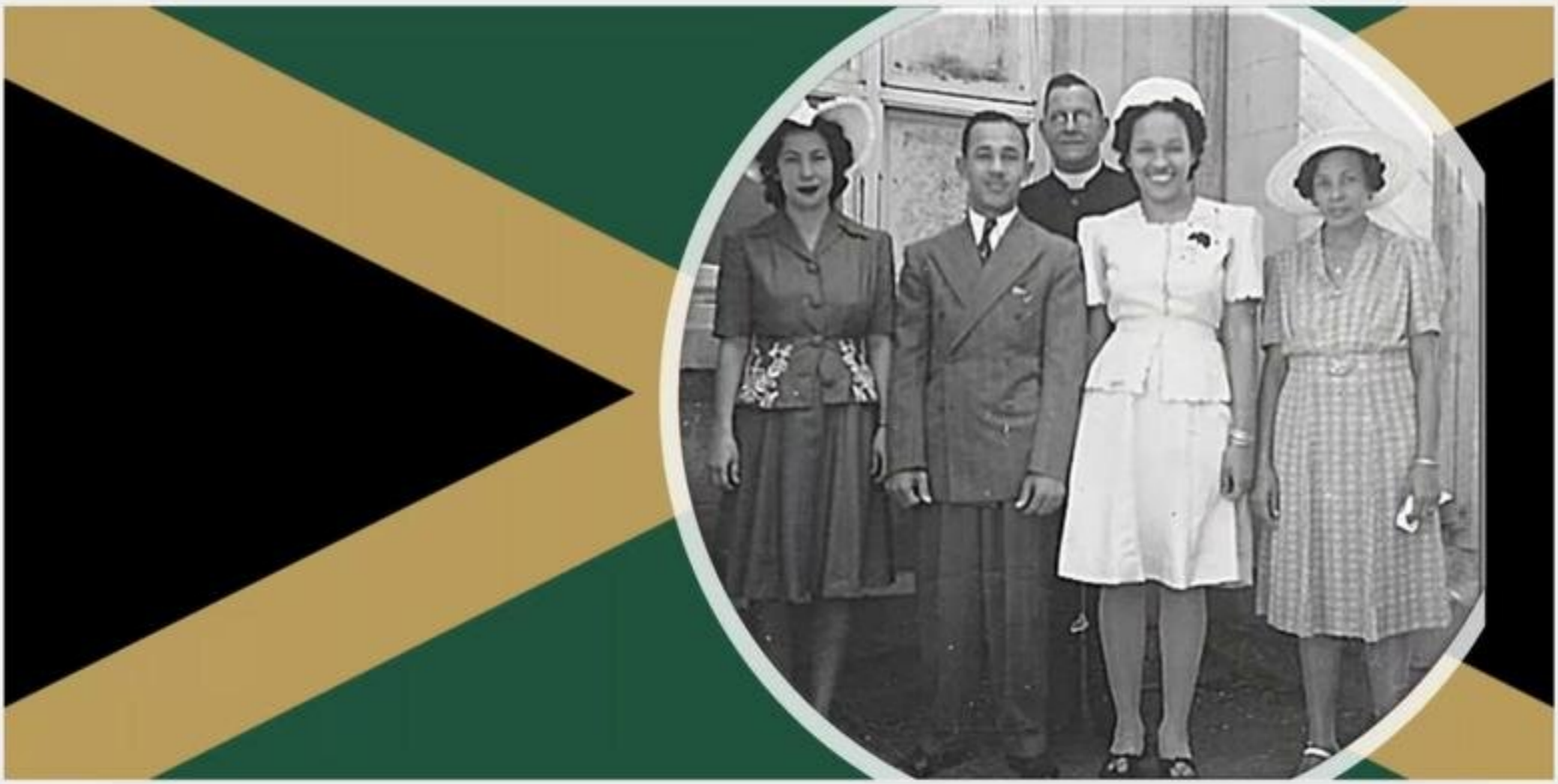
Heart

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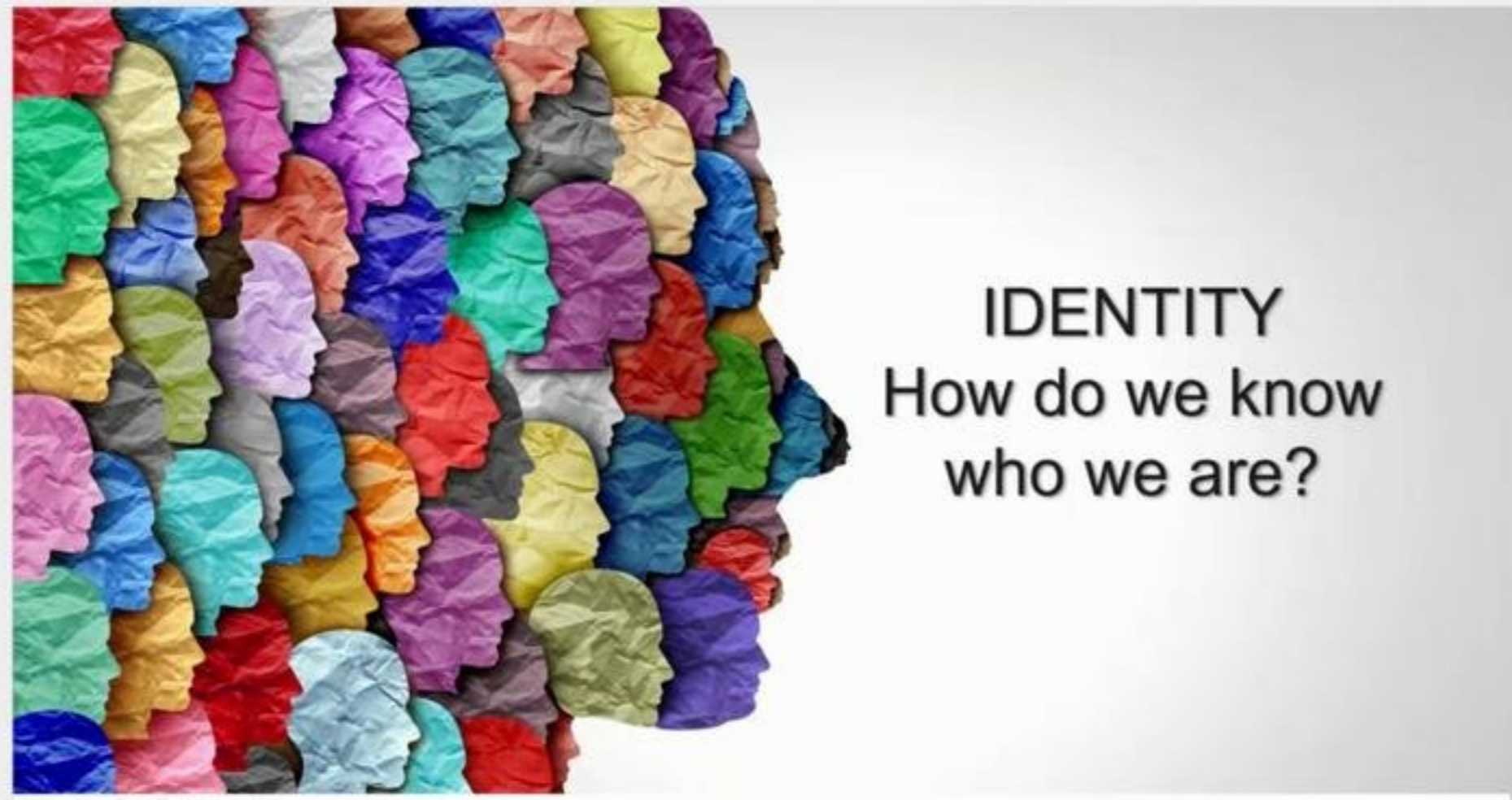
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SOCIAL IDENTITIES

Social Categorization: The process by which we organize individuals into social groups in order to understand the social world—how we are in relationship.

Social Identification: The process of identifying as a group member. This leads individuals to behave in the way they believe members of that group should behave.

Social Comparison: The process by which people compare their group to other groups in terms of **prestige** and social standing. To maintain self-esteem, we perceive our in-group as having a **higher social standing** than another, out-group.

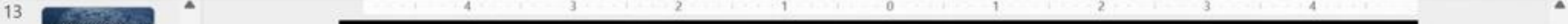
Tajfel, Henri, and John Turner. "An Integrative Theory of Intergroup Conflict." The Social Psychology of Intergroup Relations, edited by William G. August and Stephen Worchel, Brooks/Cole, 1979, pp. 33-47.

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PRIVILEGE + OPPRESSION

PRIVILEGE: When one group has something of value that is denied to others simply because of the groups to which they belong rather than because of anything they have done or failed to do.

OPPRESSION: The systematic targeting or marginalization of one group by a more powerful group for the social, economic, and political benefit of the more powerful group.

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SOCIAL ADVANTAGE / SOCIAL DISADVANTAGE

Personal circumstances and interactions based on:

- social and cultural norms
- social mobility/immobility
- social inclusion/exclusion
- implicit bias/in-group bias

1. Social advantage and disadvantage lead to positive or negative life experiences for an individual or group.
2. Although social advantage/disadvantage may lead to a person feeling +/- privileged/oppressed – the forces of privilege and oppression are still at work in their lives.

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Intersectionality

The interaction between gender, race, and other social identities in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power (Davis, 2008).



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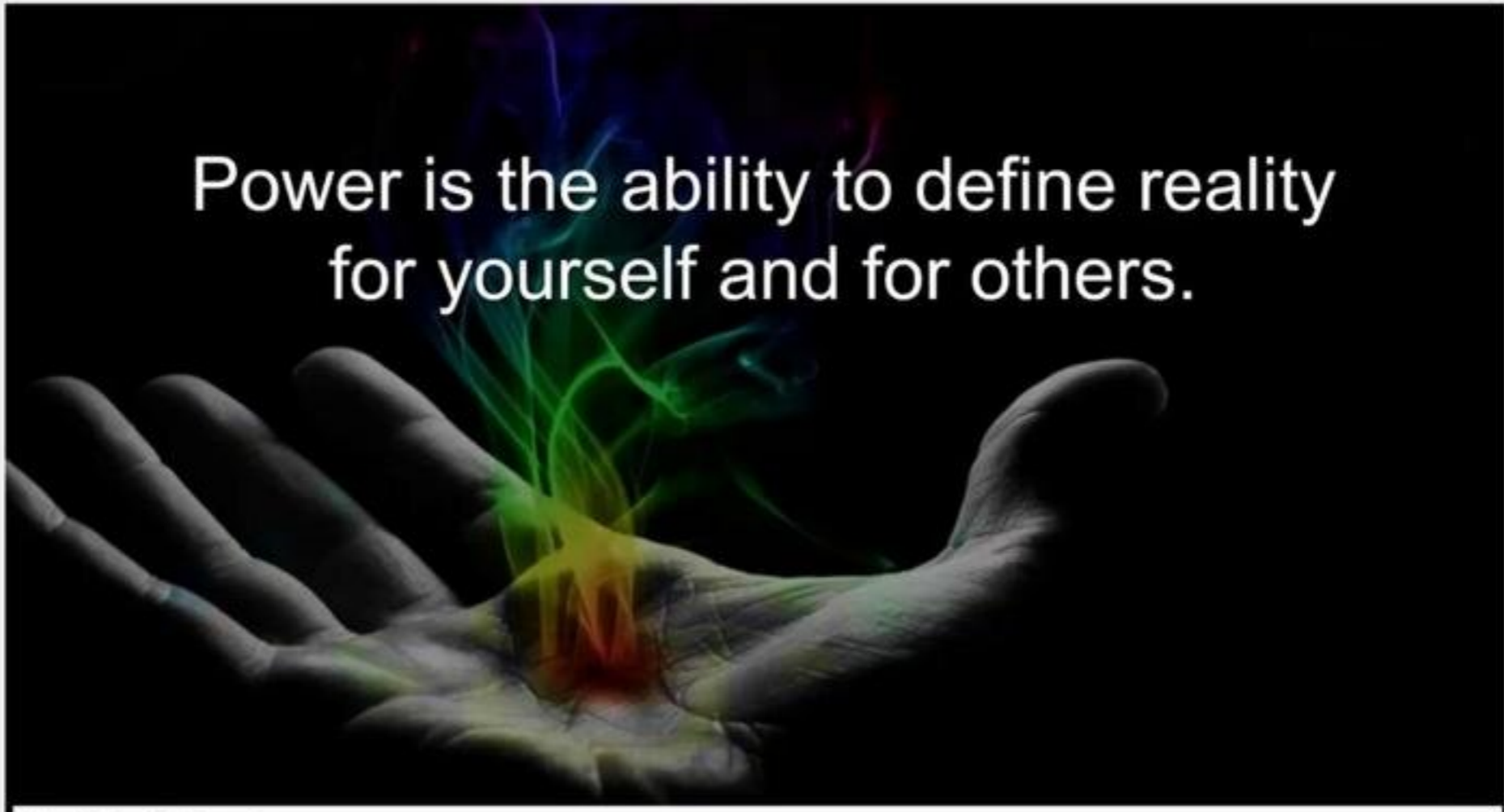
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(Health) DISPARITY

Differences in health status or outcomes between groups of people.

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(Health) INEQUITY

Disparities that are a result of systemic, preventable, avoidable, and unjust social and economic policies and practices that create barriers to opportunity.

(Adapted from National Cancer Institute)

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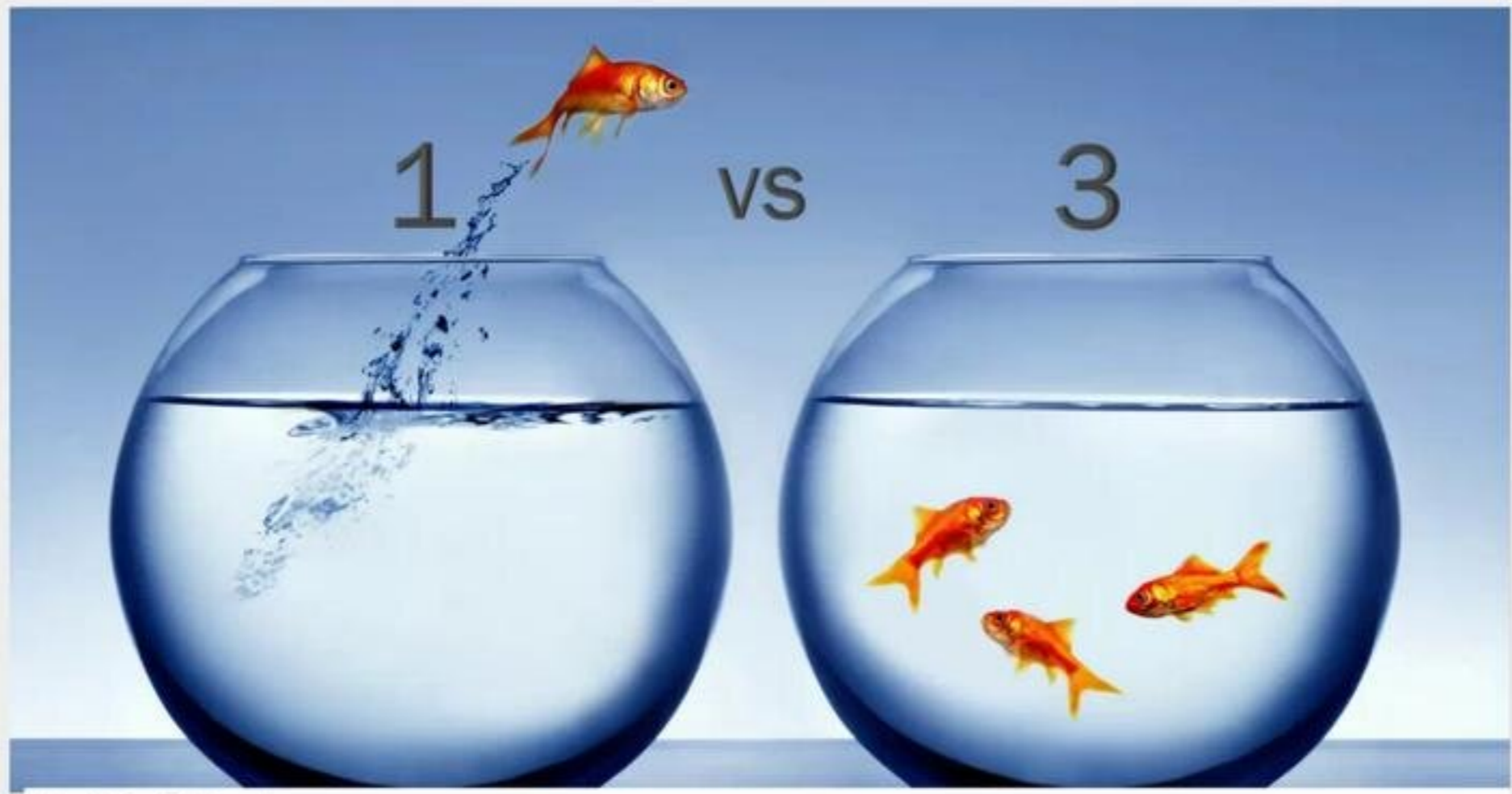
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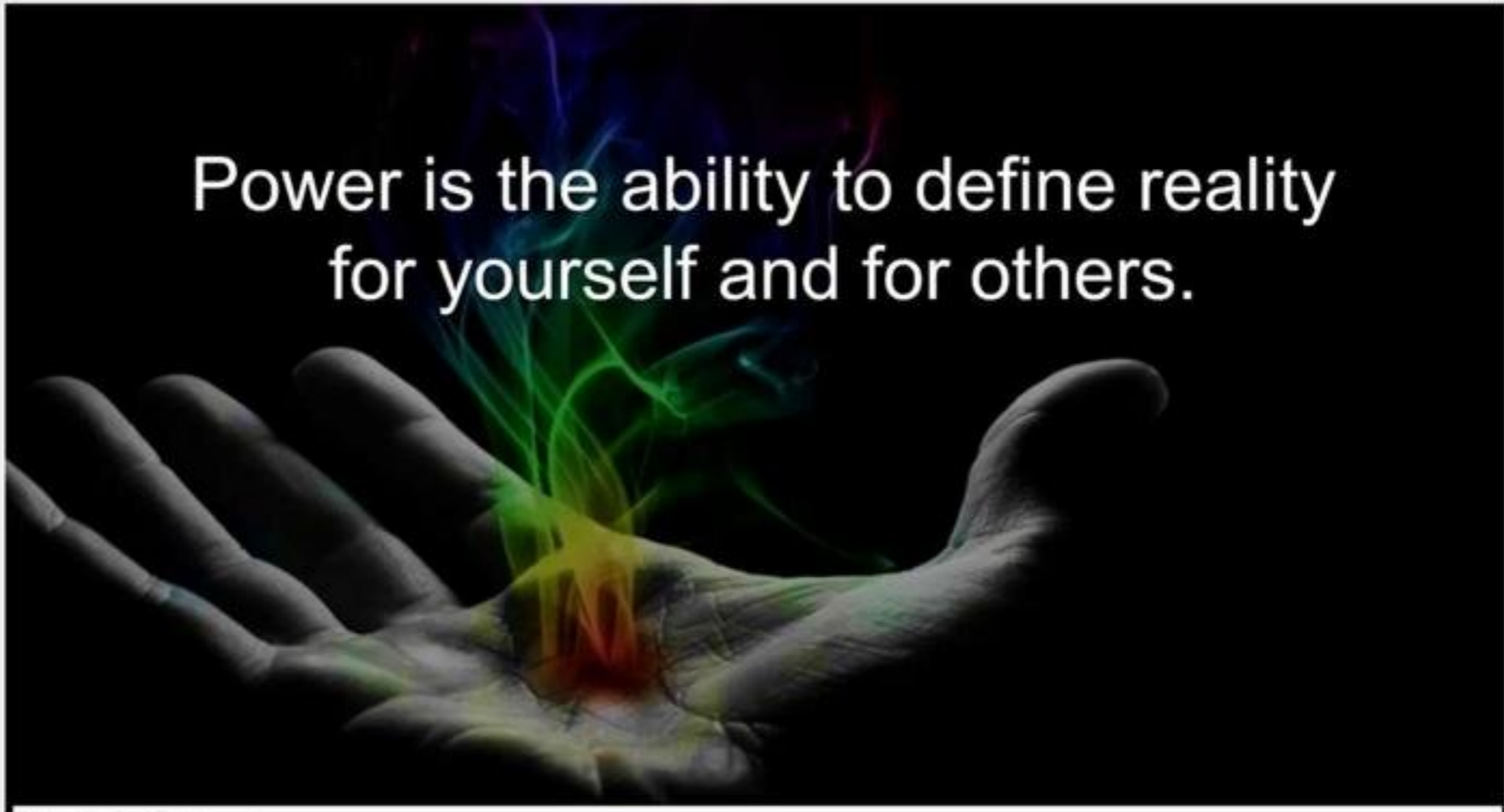


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THE CONNECTION TO HEALTHCARE



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Moral Distress occurs when someone knows the ethical action to take but is powerless to act on it due to internal or external factors.

It is a prominent phenomenon among **healthcare workers (HCWs)** that has been in nursing, but it is not isolated to clinicians.

In general, HCWs are individuals who actively engage in the protection and the improvement of the health of society.

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Structural Stigma
How inequity and discrimination toward structurally vulnerable groups is enacted through policies and practices.

↓

Moral Distress
The tension and conflict that healthcare workers experience when they are unable to fulfill their duties due to circumstances outside of their control such as structural inequity and discrimination.

↓

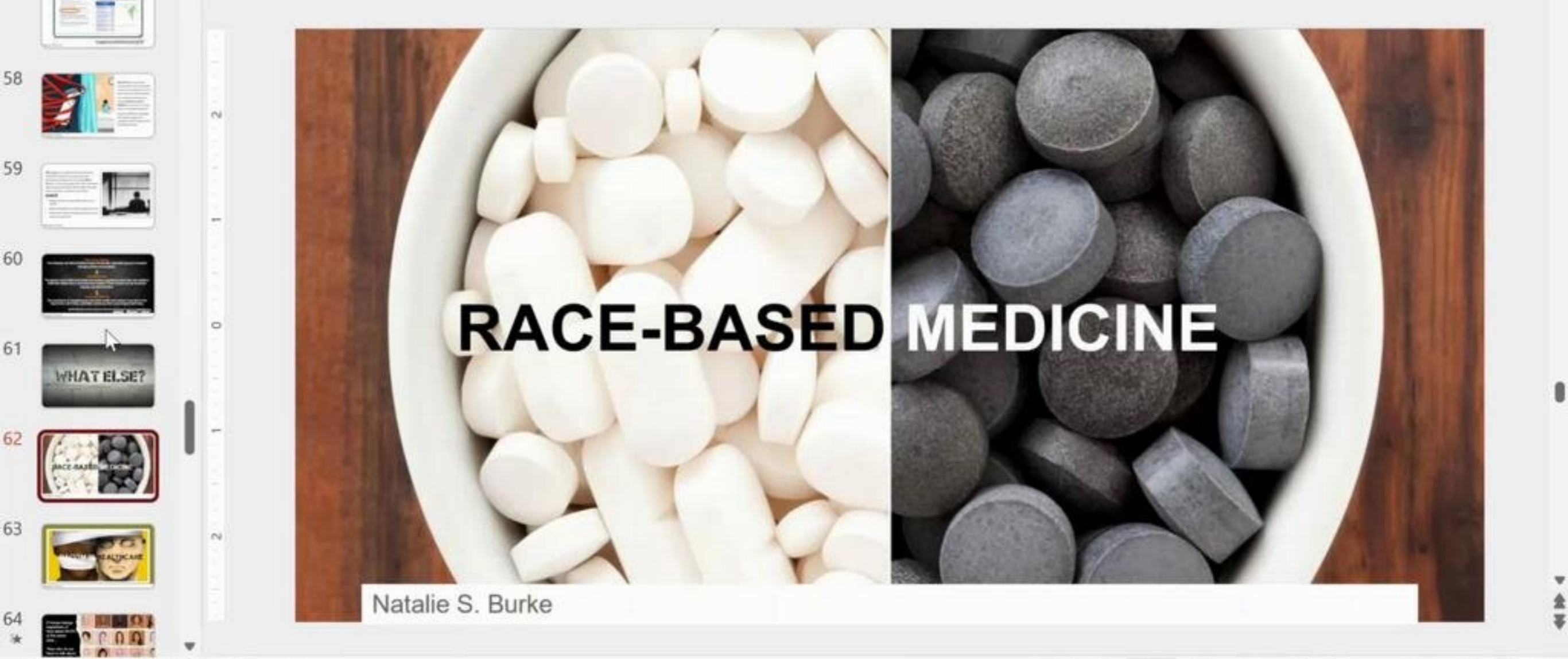
Structural Distress
The experience of powerlessness that leads healthcare workers to go above and beyond the call of duty, potentially worsening their psychological well-being

ADAPTED FROM: Structural distress: experiences of moral distress related to structural stigma during the COVID-19 pandemic
Javeed Sukhera,¹ Chetana Kulkarni,² and Teryn Taylor³

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- In the 1840s, J. Marion Sims developed a treatment for fistulas.
- Sims spent years experimenting on enslaved Black women, without anesthesia.
- After perfecting the procedures, he offered the procedure to White women but with anesthesia.

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The notion that Black lungs are inherently inferior dates back to 1785, when the US President Thomas Jefferson described "a difference of structure in the pulmonary apparatus" between slaves and White Americans.⁴

A century later, the US physician and slaveholder, Samuel Cartwright, quantified a 20% difference in lung capacity between Black and White people, establishing race as an important factor influencing lung function. In the 1920s eugenics era, race differences were included in clinician handbooks, while occupational effects and other social conditions were ignored.⁵

In 1999, a study using the National Health and Nutrition Examination Survey established the modern race and ethnicity-specific standards on which correction factors are now based.⁶

They noted lung capacity differences between Mexican Americans, Blacks, and Whites potentially related to body build. Following this study, in addition to adjusting for age, sex, and height, race-adjustment was routinely built into the software of modern spirometers, under the assumption of innate biological differences. Clinicians might miss this diagnosis if lower lung capacity measures are considered normal for minority populations. [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30571-3/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30571-3/fulltext)

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Racism in Medical Software

Algorithm that managed healthcare for 200MM people in the US systematically discriminated against Black people by giving them lower risk scores than their white counterparts--leading to fewer referrals for medical care.

(Science, 2019)
<https://www.science.org/doi/abs/10.1126/science.aax2342>

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Myths about how people experience pain based on their race continues to affect the way Black and Latino people are treated by clinicians—failure to adequately manage pain because they can supposedly tolerate more #pain than W/ ...see more



Racial disparities seen in how doctors treat pain, even among children



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How False Beliefs in Physical Racial Difference Still Live in Medicine Today

The Pain of Identity

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