

## Guest editorial

# The social determinants of cardiovascular disease: time for a focus on racism

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## Introduction

Race, or more accurately racism (systemic, institutional and individual/everyday discrimination based on race), is well known as one of the social determinants of health (SDOH). Numerous studies show that racism-related stress is a powerful predictor of health and social outcomes. In this editorial we describe how racism and colonialism are strong determinants of cardiovascular disease. We include a discussion of inter-generational trauma transmission as a core antecedent of racism-related stress among racialised peoples. The editorial concludes with anti-racist strategies for tackling this pressing professional practice and public policy concern. Although we focus on Aboriginal and African Canadian peoples, who in themselves have very distinct histories, we believe that the concepts are applicable across many racialised communities.

## Racism and colonialism as SDOH

Racialised peoples, including Aboriginal and African Canadians, have persistently worse health outcomes across the lifecourse, including significantly increased rates of depression, diabetes, coronary artery disease, breast cancer and prostate cancer, and the list goes on (Assembly of First Nations, 2007; Maliski *et al*, 2006; Quan *et al*, 2006; Taylor *et al*, 2007). In cardiovascular health, race is an excellent predictor of whether or not a patient is referred to a cardiologist or other specialty cardiac care, such as cardiac catheterisation (LaVeist *et al*, 2003). Opportunities for access to assessment, intervention and follow-up treatment are also strongly related to race (McGibbon and Etowa, 2009). These

troubling statistics persist, even after controlling for socio-economic status and insurance coverage. Findings cut across many areas of practice, including cancer, geriatric, maternity and palliative care, and community, mental health and women's health services, to name a few.

Despite notable exceptions, racism has not been taken up in the mainstream thinking or political agenda of clinicians or policy makers in the health fields. Racism, the SDOH and cardiovascular health are related in ways that have barely begun to be examined. Instead, we focus on genetics and individual lifestyle 'choices' as the best predictors of health, despite much evidence that oppressions, and their intersections, create persistent historical and present-day inequities in SDOH. The 'isms' (e.g. ableism, ageism, classism, racism, sexism, heterosexism) intersect with the SDOH (e.g. education, income and its equitable distribution, food and housing security, social safety nets, social exclusion) to deepen inequities in health outcomes (McGibbon, 2012). When one also considers the geographical or spatial contexts of oppression, it is clear that these structural or systemic inequities happen together to produce a complex synergy of material and social disadvantage (McGibbon and McPherson, 2011). Here the term 'structural' refers to the economic, social and political structures of society, and the moral and cultural systems that underpin them.

It is important to emphasise that obesity, lack of exercise and poor educational achievement are intertwined when we try to understand the structural reasons for increased heart disease prevalence in racialised communities. Income insecurity and poverty

lead to residence in low-income and unsafe neighbourhoods with lack of access to healthy foods, affordable fitness programmes, green space and recreational activities, all of which have a strong impact on overall health and thus cardiovascular health. Yes, obesity causes heart disease, but why is obesity so prevalent among Aboriginal and African Canadians? Yes, exercise and lifestyle are part of the story, but what are the root, or structural, causes? Colonialism and racism-related stress are at the forefront, although you will not likely find this aetiology in health-related textbooks or in clinical procedures or practices.

Colonialism is a spiritual, psychic and physical assault on the minds and bodies of the colonised, resulting in the privileging of Euro-Western peoples and cultures, and consequently the devaluing of non-European peoples and cultures in every sector of society. Colonialist ideologies of racial superiority and inferiority are used to legitimise the oppression and dominance of racialised peoples. These processes unfold in many ways, including the imposition of Euro-Western ideologies, values and world views on racialised peoples, the imbuing of negative traits on these peoples, and the subjugation and marginalisation of indigenous cultures, traditions, knowledge, languages and practices within education, art, the media, popular culture and healthcare. Consequently, understanding the historical and present-day impact of colonialism allows us to interrogate how deeply 'relations of power and privilege' permeate, and are embedded in, post-colonial societies and institutions (Waldron, 2012).

These historical processes are central to atrocities such as the murder and neglect of Aboriginal children in Canada's Indian Residential Schools. Over 50 000 children died in these schools, and Canadians have only recently begun a truth and reconciliation process about the torture and other inhumanities that took place in the schools at the hands of church and state. African peoples of the diaspora in Canada (e.g. African Nova Scotians, Caribbean peoples, continental Africans) have also been subject to the brutalities of colonial imperialism, including the suppressed history of Canada's slave trade and the experience of segregated education in Nova Scotia, where past and present-day schooling has left an indelible mark, creating high rates of unemployment and incarceration, low educational achievement and poor health. This colonial context illuminates why and how inequality is produced and reproduced within each successive generation (Waldron, 2012).

## Intergenerational trauma and cardiovascular disease

Given these sequelae of colonialism, cardiovascular disease is an all too logical result of the stark realities of long-term racism-related stress and intergenerational trauma. Colonialism continues; it does not somehow go away because we think these atrocities happened in the past. Generational family trauma transmission continues because adults' traumatic experiences and their impacts become transmitted within family and community systems across generations (Wesley-Esquimaux and Smolewski, 2004). There is remarkably little literature about the ways in which oppression-based trauma becomes threaded through generations of oppressed peoples. Intergenerational stress, and collective grief and loss related to the centuries-old legacy of colonisation and re-colonisation, create an oppression that inscribes deep physical, spiritual and psychological wounds. Multigenerational transmission of structural and social violence creates extreme social disparities, all of which underpin racism as a social determinant of cardiovascular disease.

Aboriginal peoples in Canada have survived over five centuries of colonisation. These centuries of physical brutality, cultural dispossession and cultural genocide, including loss of indigenous languages, are embedded in the Aboriginal psyche (Battiste and Youngblood Henderson, 2012). Social and health problems of Aboriginal people have their roots in extensive historic trauma that was never properly represented:

The meta-narrative of the Western world simply did not include the entire Aboriginal story of loss and impermanence. Collectively, one may refer to Aboriginal people as the 'bereaved': those who have been deprived of something dear—their cultural identity and their social self.

(Wesley-Esquimaux and Smolewski, 2004, p. 53)

Colonialism has had a rippling effect in that its ramifications are still felt today in Aboriginal and African Canadian communities, exemplified most clearly by internalised forms of racism, family breakdown, educational underachievement, unemployment and underemployment, poverty and other social ills that affect health. Gump (2010) discusses intergenerational trauma transmission in African Americans, noting that few psychoanalytic theories accord social, political and cultural realities a role in the development of the psyche:

This silence distorts and constricts our understanding of all subjects, but is particularly pernicious for the non-dominant, as it renders significant aspects of their subjectivities invisible. African American subjectivity is an instance of such omission. The trauma of slavery critically shaped our subjectivity, yet this impact is rarely acknowledged. In fact, the subjugation, cruelties, and deprivations

of slavery have given a traumatic cast to African American subjectivity. Through the intergenerational transmission of trauma this wounding has endured.

(Gump, 2010, abstract)

When combined with everyday racism, the ongoing and intergenerational stress of colonialism, including slavery and genocide, creates an enduring burden on spiritual, physical and mental health. The stress of racism is enough to cause significant cardiovascular disease, even in the absence of other risk factors. The body's physiological stress-handling systems eventually become overtaxed, and cardiovascular disease is a central result. Stress and stress-related diseases such as diabetes, depression, cancer and obesity (Varcarolis and Halter, 2013) are embedded in the historical, systemic, institutional and everyday structures of, and relationships in, society. Health clinicians, including nurses and public health practitioners, have had scant opportunity to learn about how colonialism has shaped our countries and our professions, despite the fact that colonialism is a potent influence on citizen health and on our practice. Clinicians have an ethical imperative to confront these root causes of hypertension, heart failure and myocardial infarction. Our persistent focus on lifestyle and obesity is outdated and ethically unsound. These 'root causes of the causes' have been neglected, and a dedicated professional practice and public policy-driven approach to addressing them is long overdue.

## Moving forward with anti-racist health and social care practice

Colonial relationships of power and privilege still permeate education, practice, research and policy making. Anti-racist healthcare practice involves an understanding of the impact of these relationships on racialised communities over time and over many geographies. Health and social care professionals may then move beyond 'scientific' conceptualisations of illness that are embraced by Euro-Western medical knowledge and healthcare systems to an understanding that illness is also the culmination of persistent racial abuse. Accurate assessments, diagnoses and treatment of racialised peoples require not only that healthcare providers begin to interrogate the hegemonic character of Euro-Western thought within medical knowledge, but also that they be able to distinguish between illnesses that result from racism and other structural factors (SDOH) and those that originate internally (genetic) (Waldron, 2010).

Strategies for clinicians include self-reflexive practice through examining White privilege and the ways in which social hierarchies of race and colonialism are

embedded in the clinician–patient relationship. Public health practitioners, nurses, physicians, and other health and social care practitioners can and should take action to address the devaluing of indigenous health knowledge and the persistence of colonialism's influence on health field cultures and the epistemologies that drive professional knowledge development. Basic and continuing education can be strengthened with the inclusion of a critical understanding of racism and the SDOH – one that is grounded in an anti-racist, anti-oppressive interrogation of power, privilege and ruling relationships that create and sustain local and global injustices in health.

Policy changes in professional practice and in public policy, as well as targeted funding, can address systemic racism and racism at the point of care, where lack of cultural safety remains a significant barrier to safe ethical care. Policy makers (e.g. in individual organisations such as community centres and hospitals, in professional practice licensing, and in the public health and social policy sectors) have the responsibility to take a leadership role. Strategic directions could include cross-sectoral examination of policy through an anti-racist, anti-oppressive policy lens, and working towards policy change to promote social justice across intersecting oppressions such as race, gender and social class. Turning away from these challenges is inaction in the face of this need. Silence is assent.

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