Structural Justice Ethics in Health Care

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INTRODUCTION

The age-adjusted COVID-19 mortality rate among Black Americans is twice as high as White Americans.[1] This shocking evidence of health disparities, coincident to a public reckoning with the history of racism in the US, highlights the inverse relationship between race and health. Public sentiment may now favor addressing these pressing public health issues, but the sprawling healthcare system largely focuses on clinical care; it lacks tools to influence the social determinants of health at the point of the healthcare institution. Reinvigorating organizational ethics, sometimes called institutional ethics, may provide such a tool.

BACKGROUND

Organizational ethics became part of the healthcare system during the upheavals in financing and organization of health care in the 1990s. Yet organizational ethics in a medical setting must be more than simple business ethics.[2] Just as health care professionals are granted special privileges in society in exchange for adherence to a code of medical ethics and duties, healthcare organizations and systems also must now adhere to ethical requirements in exchange for their privileged position that includes the right to provide, and be reimbursed for, health care.[3]

In the 1990s, ethicists began to discuss how clinical ethics committees might develop an understanding of business ethics in order to provide comprehensive organizational ethics reviews.[4] Some bioethicists even believed that the challenges of integrating business and medical care would compel ethics committees to look outward, engaging in public advocacy around ethical issues in health care.[5] To fulfill the mission of maintaining organizational ethics standards within the healthcare system, ethics committees would need to advocate for patients in the public sphere. Ethics committees might even take positions at odds with those of the healthcare institutions in which they work.

Organizational ethics committees might have served as watchdogs, ensuring that healthcare organizations fulfill their fiduciary duties to their patients and communities. Bioethicists soon realized that the vision of a robust ethics committee involving administrators, bioethicists, and medical staff advising multiple divisions of large organizations and policy makers would fall short.[6] The two ethical systems remained separate: most organizations developed a combination of a clinical ethics committee adjunct to the medical staff with a compliance department to oversee organizational ethics. However, organizational ethics really goes beyond compliance; it “cannot be addressed by focusing narrowly on business matters or by quasi-legal mechanisms to assure that behavior conforms to pre-established codes or rules.”[7] As a result, there is no centralized entity with power in each healthcare institution that can treat healthcare inequities as an institutional *ethical* failure that must be addressed.

Current research on specific inequitable outcomes due to bias in clinical care includes specialties

such as maternal care,[8]cardiac care,[9] pain management, and technology.[10] Implicit bias and racist clinical interactions, once identified, may be addressed through staff training and other interventions. Yet the ethics of clinical care requires little attention to the social determinants of health such as high levels of police surveillance in the community which may cause increased rates of hypertension,[11] pre-term birth,[12] and may affect mental health. Leaving these problems to the public health realm disconnects health practitioners and institutions from the ability to remedy some of the causes of health problems in their patients. Simply treating the effects of racism in the practice of medicine is not curative – it is really palliative care.[13]

ANALYSIS

The term "organizational ethics" is too limited to encompass the scope of change needed to address structural racism and the social determinants of health in today's healthcare institutions. Structural Justice Ethics[14] better describes a plan and a process that requires the healthcare system and professionals to look both inward and outward to take on the structural causes of racism and health disparities. Building on organizational and clinical ethics, Structural Justice Ethics could amplify the research on systemic issues such as the effects of social determinants of health, racism in clinical care, and necessary advocacy with the local community. To be effective and complete, organizations should recognize duties to patients that arrive at their doorstep, damaged by generations of subordination and racism. To ethically treat patients who have experienced racism, the system and health practitioners must acknowledge and work to reduce the inequities in society that cause harm to their health in the clinical setting. Accreditation companies such as The Joint Commission could amend their standards to require top-rated healthcare organizations to form new Structural Justice Ethics committees in their organizations, taking affirmative steps to acknowledge the ethical implications of racism and the social determinants of health.

Many bioethicists have already called for the field of bioethics to address racism as an ethical issue in healthcare, some even calling for a new Black Bioethics.[15] This frustration with the profession of bioethics has developed in other areas, such as disability ethics and feminist ethics, and reflects a belief that mainstream bioethics is a rigidly principlist endeavor. The education of new bioethicists is grounded in practical philosophy graduate programs, entwined with academia's history of exclusivity. As a relatively young academic subject, bioethics has the potential to expand and grow into a more practical and justice-oriented tool, learning how to counter the overly individualistic bioethics that has roots in our racist and Protestant-dominant history.[16] Expanding organizational ethics into Structural Justice Ethics in health care could bring Black bioethicists into the center of healthcare ethics and provide the tools to implement changes needed to address racism in health care.

Healthcare organizations should not expect Black healthcare practitioners to take on these Structural Justice Ethics roles as "extra" work. Too often, people of color are expected to bear the burden of explaining racism and working to eradicate it.[17]The Structural Justice Ethics committee should be a new model, centered in ethics and policy, with professional-level staffing that reflects the racial and ethnic makeup of the community it serves. Calling on bioethicists as moral agents in the world, and particularly within the medical system, to act as social justice advocates against systemic injustice in a system where they have privilege and power seems logical and surprisingly necessary. "Going forward, bioethics needs to engage with the nuances of race with the same vigor that it has approached discussions of moral theories and biotechnologies."[18] Graduate-level bioethics programs have expanded significantly in recent years, with 45 current master's level programs,[19] and there should be a wealth of professionals ready to oversee the role of encouraging and monitoring justice in the system. These programs focus primarily if not

exclusively on the dominant paradigm of bioethics, yet as *ethics* programs, they should be able to course-correct and embrace greater diversity in people and thought. Structural Justice Ethicists can guide healthcare organizations to become learning institutions open to the idea that bias and inequity are ethical harms that they can and should address.

Some may question whether such close attention to Black health care needs amounts to reparations or "reverse" discrimination, a controversial topic in our political discussions. However, when posed as an ethical duty of health *care*, there is no option to continue to treat Black people unethically. Of course, healthcare systems will have to balance competing budgetary interests; even with unlimited funding, disparities in health care would not disappear overnight.[20] In a fair process where decisionmakers must weigh the demands of stakeholders, the ethical obligation to address the social determinants of health must have an advocate. Moreover, setting high ethical standards is not the same as government spending to make reparations for past harms. In fact, Structural Justice Ethics does not look to the past at all but looks to the needs of subordinated communities of patients as they exist today. *Any* community that is harmed by structural injustice in health care can be the focus of a Structural Justice Ethics review.

The Joint Commission and other accrediting organizations can require healthcare organizations to meet the challenges of health inequities by adopting new Structural Justice Ethics committees, just as The Joint Commission added organizational ethics to its requirements in 1995. Admittedly, Structural Justice Ethics is an amorphous concept and its role within healthcare institutions needs to be refined and assigned specific tasks. However, there is substantial research on the social determinants of health; the challenge for the Structural Justice Ethics is to recommend systemic changes from within, rather than beginning this research anew. The Joint Commission's Center for Transforming Healthcare, as a data-driven and process-oriented patient safety organization, is well-primed to take on this task. The Center can collaborate with existing academic and governmental health equity researchers to set short- and long-term goals for Structural Justice Ethics committees. To begin with, a Structural Justice Ethics committee can pose the question of "how is racism operating here" and:

a. connect with current research on specific inequitable outcomes due to bias in medicine and bring best practices to the attention of medical staff.

b. work with human resources and medical staff to support and increase diverse populations in the workforce.

c. ensure that implicit bias and other trainings are properly provided to all staff, as well as expanding the scope of such trainings to address developing areas such as epistemic harm, or the harm of one's own physical experience being discounted by medical professionals.[21] The health care workforce should also be trained in Title VI law.[22]

d. evaluate research data on the organization's own potential disparate outcomes due to race, to determine areas for improvement both within and outside of the organization.

e. invite the local community to come in for listening and learning sessions, to better understand the community's concerns and perspective on health equity.

f. improve advocacy on behalf of community members to state and local authorities, effectively taking a stand for health care equity for local stakeholders. Dr. Camara P. Jones describes a collaborative endeavor like this as critical to anti-racist work and likens it to adopting a community health center model where the health facility takes responsibility for the health and well-being of

the local community.[23] AMA policy already encourages this type of effort in opinion 8.11 of the AMA Code, which states that, alongside diagnosis and treatment, "physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community."[24]

A theoretical framework and concrete plan for radical improvement in the ethics of the healthcare system will help *all* healthcare professionals. Some healthcare practitioners may not recognize their own biases and need training to meet best practices standards in light of health inequities. Other healthcare practitioners may feel disillusioned because they know they face individual patients suffering the effects of structural racism, yet they can treat only the illness.[25] The scope of the problem may overwhelm practitioners, and without a belief that the system is committed to improvement, practitioners may become numb to the suffering, a trauma reaction that affects both the practitioners and their patients. Unfortunately, when current medical students ask the question, "what can I do to fight systemic racism?" the answer is usually "call it out." But putting the onus on newly minted individual practitioners to call out racism in an established structure is unrealistic, unfair, and destined to be unsuccessful. Just as we should not expect subordinated individuals to "overcome" their social determinants of health, we should not expect health professionals to make this change individually. Addressing injustices in the institution and adjusting medical ethics accordingly can alleviate the burden of these ethical dilemmas.

CONCLUSION

Structural Justice Ethics must be woven into the ethics committees at the institutional level. Organizational ethics committees can evaluate healthcare organizations by their integrity, i.e., how well their actions fulfill the moral obligations they have undertaken.[26] Our healthcare system has avoided the moral obligation to address racism and the social determinants of health by focusing on clinical ethics, leaving public health to academics and the government. Expanding organizational ethics to take on the issues of structural injustice within each healthcare institution will help organizations better measure, change, and ultimately fulfill their moral obligations to their patients and communities.

[1] "Color of Coronavirus: COVID-19 Deaths Analyzed by Race and Ethnicity," APM Research Lab, accessed June 1, 2021, https://www.apmresearchlab.org/covid/deaths-by-race.

[2] M. Constantinescu, "Seeing the Forest beyond the Trees: A Holistic Approach to Health-Care Organizational Ethics," in *Contemporary Debates in Bioethics: European Perspectives*, 2018, 86–96, https://doi.org/10.2478/9783110571219-009.

[3] See Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008) at 219.

[4] Elizabeth Heitman and Ruth Ellen Bulger, "The Healthcare Ethics Committee in the Structural Transformation of Health Care: Administrative and Organizational Ethics in Changing Times," *HEC Forum* 10, no. 2 (June 1, 1998): 152–76, 162, https://doi.org/10.1023/A:1008865603499.

[5] Cohen, Cynthia B. "Ethics Committees as Corporate and Public Policy Advocates." The Hastings Center Report 20, no. 5 (1990): 36+. Gale Academic OneFile (accessed May 6, 2021). https://link.gale.com/apps/doc/A8998890/AONE?u=nysl_oweb&sid=AONE&xid=84a1cade.

[6] Linda L. Emanuel, "Ethics and the Structures of Healthcare Special Section: Issues in Organization Ethics and Healthcare," *Cambridge Quarterly of Healthcare Ethics* 9, no. 2 (2000):

151–68, 166.

[7] George Khushf and Rosemarie Tong, “Setting Organizational Ethics within a Broader Social and Legal Context,” *HEC Forum* 14, no. 2 (June 2002): 77–85, 78.

[8] Olivia Pham, Usha Ranji Published: Nov 10, and 2020, “Racial Disparities in Maternal and Infant Health: An Overview - Issue Brief,” *KFF* (blog), November 10, 2020, https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/.

[9] Eberly Lauren A. et al., “Identification of Racial Inequities in Access to Specialized Inpatient Heart Failure Care at an Academic Medical Center,” *Circulation: Heart Failure* 12, no. 11 (November 1, 2019): e006214, https://doi.org/10.1161/CIRCHEARTFAILURE.119.006214.

[10] Michael W. Sjoding et al., “Racial Bias in Pulse Oximetry Measurement,” *New England Journal of Medicine* 383, no. 25 (December 17, 2020): 2477–78, https://doi.org/10.1056/NEJMc2029240.

[11] Alyasah Ali Sewell et al., “Illness Spillovers of Lethal Police Violence: The Significance of Gendered Marginalization,” *Ethnic and Racial Studies* 44, no. 7 (July 22, 2020): 1–26, https://doi.org/10.1080/01419870.2020.1781913.

[12] Brad N. Greenwood et al., “Physician–Patient Racial Concordance and Disparities in Birthing Mortality for Newborns,” *Proceedings of the National Academy of Sciences* 117, no. 35 (September 1, 2020): 21194–200, https://doi.org/10.1073/pnas.1913405117.

[13] The term “palliative care” as applied to patients suffering from the social determinants of health was used by Dr. Michelle Morse at a webinar entitled “Medical Stereotypes: Confronting Racism and Disparities in US Health Care: A Health Policy and Bioethics Consortium” presented by the Harvard Petrie-Flom Center on February 12, 2021.

[14] Linda L. Emanuel coined the term “Structural Ethics” in 2000. This term did not seem to generate much interest from the bioethics community at the time. Her explanation of this term is consistent with my thinking, although I expand it to address the health system as an entity, and focus on improving health equity.

[15] Keisha Shantel Ray, “Black Bioethics and How the Failures of the Profession Paved the Way for Its Existence | Bioethics.Net,” *www.bioethics.net*, August 6, 2020, http://www.bioethics.net/2020/08/black-bioethics-and-how-the-failures-of-the-profession-paved-the-way-for-its-existence/; Yolonda Y. Wilson, “Racial Injustice and Meaning Well: A Challenge for Bioethics,” *The American Journal of Bioethics* 21, no. 2 (February 1, 2021): 1–3, https://doi.org/10.1080/15265161.2020.1866875.

[16] See Catherine Myser, “Differences from Somewhere: The Normativity of Whiteness in Bioethics in the United States,” *The American Journal of Bioethics* 3, no. 2 (May 2003): 1–11, https://doi.org/10.1162/152651603766436072.

[17] Ushe Blackstock, “Why Black Doctors like Me Are Leaving Academic Medicine,” *STAT* (blog), January 16, 2020, https://www.statnews.com/2020/01/16/black-doctors-leaving-faculty-positions-academic-medical-centers/.

[18] Zamina Mithani, Jane Cooper, and Boyd J. Wesley, “Race, Power, and COVID-19: A Call for

Advocacy within Bioethics," *The American Journal of Bioethics*21, no. 2 (2021): 11–18, 13 https://doi.org/10.1080/15265161.2020.1851810.

[19] "Graduate Programs," The Hastings Center, accessed 2 June, 2021, https://www.thehastingscenter.org/publications-resources/bioethics-careers-education/graduate-programs-2/.

[20] Norman Daniels, *Just Health: Meeting Health Needs Fairly,* at 299.

[21] Ian James Kidd and Havi Carel, "Epistemic Injustice and Illness," *Journal of Applied Philosophy* 34, no. 2 (2017): 172–90, https://doi.org/10.1111/japp.12172.

[22] Ruqaiijah Yearby, "Sick and Tired of Being Sick and Tired: Putting an End to Separate and Unequal Health Care in the United States 50 Years after the Civil Rights Act of 1964," *Health Matrix* 25, no. 1 (January 1, 2015): 1–33, at 11.

[23] Jones CP, Maybank A, Nolen L, Fields N, Ogunwole M, Onuoha C, Williams J, Tsai J, Paul D, Essien UR, Khazanchi, R. "Episode 5: Racism, Power, and Policy: Building the Antiracist Health Systems of the Future." The Clinical Problem Solvers Podcast. https://clinicalproblemsolving.com /episodes. January 19, 2021.

[24] Sienna Moriarty, "AMA Policies and Code of Medical Ethics' Opinions Related to Health Promotion and Community Development," *AMA Journal of Ethics* 21, no. 3 (March 1, 2019): 259–61, https://doi.org/10.1001/amajethics.2019.259.

[25] Constantinescu, "Seeing the Forest beyond the Trees," at 92.

[26] Ana Smith Iltis, "Organizational Ethics: Moral Obligation and Integrity," in *Institutional Integrity in Health Care*, ed. Ana Smith Iltis, Philosophy and Medicine (Dordrecht: Springer Netherlands, 2003), 175–82, https://doi.org/10.1007/978-94-017-0153-2_10.