

Putting Anti-Racism into Practice as a Healthcare Ethics Consultant

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Marion Danis

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Events in the US in 2020 have laid bare the reality that racism and its effects continue to take a heavy toll on the lives of Black Americans. The three articles in this issue of *AJOB* each provide a reflection on these current events and call for more attention to justice and anti-racism in bioethics, albeit through differing approaches (Braddock 2021; Mithani, Cooper, and Boyd 2021; Yearby 2021).



In light of these calls, it is pertinent to point out that very little information exists about how the concept of race and the problem of racism are being addressed in the actual practice of healthcare ethics consultation. While the aspiration is there, we know little about how we are doing and the little we do know does not indicate substantial attention to racism and social justice. The ASBH Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants identifies a professional obligation “to reduce disparities, discrimination, and inequities when providing consultations... to identify and include relevant voices in the discourse, particularly marginalized voices... [and] [w]hen possible, ... identify systemic issues constraining fair outcomes in [healthcare ethics consultation]” (ASBH 2014). Yet ethics consultants seem far from delivering on this commitment. The American Society for Bioethics and Humanities Report, ‘Core Competencies for Healthcare Ethics Consultants,’ lists the typical concerns that ethics consultants must be prepared to address, and it does not include concerns about unfair treatment, discrimination or racism (ASBH 2011, 4).

There is hardly any empirical evidence of attention to racism in the published literature on clinical ethics consultation. In a paper published in 2014, Angove et al explored whether decisions related to the use of

ethics consultation or the outcome of ethics consultation were affected by race (Angove, Ngui, and Rapenshek 2014). In their systematic literature review covering more than a 20-year period (1990–2012) they found nine articles that reported empirical studies using search terms for clinical ethics consultation and race and ethnicity. The majority of studies collected information about race but did not use race as a study variable in their analysis. None of the studies addressed whether race was used or documented in relation to ethics consultations. Until recently, little other evidence seems to have been published on this topic.

However, more detailed efforts to measure the characteristics of ethics consultation practices (published in 2020) are informative. Harris and colleagues used a coding system for ethics consultation, the Armstrong Clinical Ethics Coding System (ACECS, copyrighted in 2013) to review consultations in two large hospital systems. In their review of over 700 consultations, they found that one consult pertained to discrimination and three consults pertained to social justice (Harris et al. 2020).

The events of this past year and the devastating evidence they reveal about the ongoing impact of racism on the health of Black Americans and other minorities should make us pause to consider why our consultative work is missing the mark in addressing the injustice of racism. Leaders in the field of bioethics are cognizant of the deficiency. The recent statement by the Association of Bioethics Program Directors (ABPD) specifies that directors and faculty of bioethics programs and centers across the United States and Canada are committed, among other substantial efforts, to “Ensure that ethics consultants are

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prepared to recognize and counter racism, including institutional and structural racism and their impacts, as they arise in clinical encounters and in advising on institutional policy” (ABBD 2020).

How are we going to accomplish the task?

Perhaps, as Braddock’s writing suggests, blindness to race is deterring attention to racism during our consultations (Braddock 2021). Perhaps consultations that are ostensibly triggered by concerns such as disagreements between clinicians and patients, noncompliance, difficulties with discharge planning, and resource allocation, are actually instances in which bias and structural racism are at play. If we fail to appreciate this, we will not be prepared to counter racism.

We need to consider whether we are unaware of or overlooking attitudes, behaviors, and practices that have racist consequences and if so, why and how we can change this. Is it the case that clinicians are overlooking problems related to racism and thus not bringing them to the ethics consultant’s attention? Is it that clinicians may not believe that clinical ethics consultants can help? Is it that clinical ethicists themselves may not believe there is anything they can contribute to helping reduce racism and its effects?

In addition to this kind of diagnostic assessment and reflection, what practical efforts can we pursue? If consultation requests are not forthcoming, we need to take a more proactive stance through our educational and policy-related efforts. On the educational front, ethics consultants provide substantial teaching to several audiences in their healthcare organizations—medical staff, nurses, trainees, non-clinicians, and hospital leadership. Exploring with these audiences how racism is manifest in the course of healthcare delivery—stereotyping of patients, biased decision-making, discomfort when clinician-patient pairs are discordant, unequal access to healthcare—and reviewing how inequalities in the social determinants of health lead to unequal and unfair health outcomes—should be part of our teaching portfolio.

We need to collaborate with others in our organizations to review policies that may reflect structural injustice and participate in revising these policies. We should be collaborating with organizational leaders to ask whether the mission of the organization is attentive enough to social justice and whether institutional policies are aligned with the mission. Are hospital policies, such as admissions and discharge policies, having an adverse and unfair impact on minority and disadvantaged patients? Are business practices and employment practices attentive to principles of

justice? Are efforts at community outreach effective in engaging with the community served by the organization?

We should consider other ways to join efforts in our workplace to devise solutions. Can we participate more often in multidisciplinary care meetings for patients whose compromised health and complex healthcare needs are affected by structural injustices? Should we be participating routinely in morbidity and mortality conferences and case reviews in efforts to pursue quality assurance? Can we expand our ethics committees to include, in addition to the usual array of doctors, nurses, and social workers, staff who work in interpreter services, billing office, discharge planning—those who work at key points in our hospitals where problems are most likely to be manifest? Should we confer regularly with patient representatives and patient advocates in our healthcare organizations about concerns they are hearing from patients?

Certainly, the efforts of healthcare ethicists in collaboration with other healthcare workers in the healthcare organizations where we work will only go so far in overcoming the effects of structural racism and injustice in society. We can debate whether healthcare ethicists are obliged to do more beyond their workplace, but addressing racism in the healthcare organizations where we work seems part of our responsibility.

DISCLAIMER

The views expressed here are those of the author and do not necessarily reflect the policies of the National Institutes of Health and the US Department of Health and Human Services.

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It's Time for a Black Bioethics

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There are some long-standing social issues that imperil Black Americans' relationship with health and healthcare. These issues include racial disparities in health outcomes (Barr 2014), provider bias and racism lessening their access to quality care (Sabin et al. 2009), disproportionate police killings (DeGue, Fowler, and Calkins 2016), and white supremacy and racism which encourage poor health (Williams and Mohammed 2013). Bioethics, comprised of humanities, legal, science, and medical scholars committed to ethical reasoning is *prima facie* well suited to address these problems and influence solutions in the form of policy and education. Bioethics, however, so far has shown only a minimal commitment to Black racial justice.

In a recent opinion piece, I argued that bioethics must address the issues facing Black health if it is to remain a relevant academic discipline for the 21st century and if it is to retain its reputation as a proponent of justice (Ray 2020). I questioned, however, whether bioethics, given its unyielding commitment to more "traditional" bioethics topics, is up to the task. Based on the limited amount of bioethics scholarship on the issues facing Black health and the growing size of this problem, rather than waiting for bioethics to bend toward these issues, instead, I offered the lens of Black bioethics. In this commentary, I expand upon the idea of Black bioethics.

Black bioethics loosely defined as "the exploration and interrogation of any event, ideal, technological advancement, person, or institution that directly or indirectly affects the health or well-being of black individuals or the black population" (Ray 2020). To demonstrate what Black bioethics might look like in practice, I will explore Black maternal mortality in light of the most widely-used paradigm in bioethics, the principlist perspective of Tom Beauchamp and James Childress (2013). There are, of course, other ways of doing bioethics, and Black bioethics can be congruent with all of these methodological approaches, for the key point about Black bioethics is that it is experiential. That is, so long as the Black experience is central, any method of bioethical inquiry may be used to advance Black bioethics. Here, though, I employ the principlist framework, specifically relying on the principles autonomy, beneficence, non-maleficence, and justice, simply because it is so widely known and affirmed in bioethics.

In the United States, Black women (and birthing people) are three to four times more likely to die during or soon after childbirth (Howell et al. 2016) than White women. Even when Black women have higher incomes and more education than White women, their chances of dying during or soon after childbirth are disproportionately higher (New York City

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