

The Ethical Imperative to Ensure that Black Lives Matter in Health Care

The University of Colorado Center for Bioethics and Humanities' Plan for Helping Combat Systemic Racism in the Health Professions

BACKGROUND

People who identify as Black, indigenous and people of color (BIPOC) in the US experience daily the impacts of systemic racism. No city or state has been immune from these forces, but recent events have hit close to home for our campus -- the brutal death of George Floyd at the hands of police officers in Minneapolis, prompting nationwide protests, was painfully reminiscent of the death in our own University Hospital last year of Aurora's Elijah McClain.

The righteous anger provoked by police killings of black and brown people has been amplified by the COVID-19 pandemic, which is shining a floodlight on structural racism in health care by exacerbating long-standing, stark racial and ethnic disparities in health outcomes.

While most of the recent public protests haven't been about health care explicitly, they could have been. Black Lives Matter, whether they are taken by police violence or lost to the failures of the health care system we have created.

The Center for Bioethics and Humanities serves our campus, university and state, with a mission of supporting compassionate, competent, respectful and just health care. We recognize inequities as fundamental challenges to the ethics of health care and we embrace our responsibility to play a role in addressing them.

Many groups in the US are systematically subject to stigma, bigotry and harm in the health care system due to their gender or sexual orientation, race or ethnicity, disabilities, religion, geography or other factors. These have been well-documented in research on health and health care disparities, and each has a deep history with ongoing implications for today.

For the CU Center on Bioethics and Humanities, a core principle driving our work is justice - *we recognize disparities as an injustice and a challenge to the core values of health professionals.* Each of the groups above has received some degree of focused attention in our Center's research, teaching, clinical service and outreach, and all deserve more attention in our work moving forward.

In particular, health professionals who have benefitted from white supremacy in our personal and academic lives must take responsibility for redressing the structural factors that create and sustain racial and ethnic inequities in health care.

For example, the unique legacy and contemporary results of anti-Black racism in health care stem largely from notions of genetic essentialism and 'scientific' racism. For generations, American medical scientists have played leading roles in developing notions of "race" and "ethnicity," including the misleading idea that race is a purely biological phenomenon describing meaningful group differences in physiology and cognition. And medical science has played key roles in creating and cementing in place the social, economic, geographic, carceral and other structures that perpetuate today's racial and ethnic disparities in health care and outcomes.

Moreover, advancements in the health sciences have too often come at the expense of and through the direct exploitation of BIPOC individuals and communities.

Sadly, even well-meaning attempts by health professionals to address the health needs of BIPOC individuals and communities in the US and abroad have tended to reinforce racist, paternalistic norms.

We must acknowledge and teach the fact that our health care system has helped create and reinforce current social structures that give fundamental advantages to white people in the US while systematically disadvantaging BIPOC individuals and communities. These comprise the systemic racism that makes Black people in the US twice as likely to die giving birth compared to White people, as just one example. And it's why recent [data from the CDC](#) demonstrate that Latino and Hispanic people are 4 times more likely to be hospitalized for COVID-19, and Black people and Native Americans are each more than 5 times as likely to be hospitalized, compared to white people in the U.S..

Our Center is committed to being part of the solution to these injustices, recognizing that words are not enough and that entrenched and complex problems cannot be solved through working in a silo. As part of our larger University, and in working with our health systems, we must be part of coordinated and inclusive plans for education, engagement, and most importantly, action. In particular, our students, community members, University faculty and staff who have lived with these challenges every day of their lives need to be included in discussions on how to change health systems and our larger society. And we all must hold each other accountable.

ACTION ITEMS

At the University of Colorado's Center for Bioethics and Humanities, we recognize:

- That mistreatment, injustice and abuse in health care and society are still regularly faced by patients, students, faculty and staff who identify as BIPOC;
- That harms arise from the lack of racial and ethnic diversity in academia and medicine generally, and in bioethics and the health humanities more specifically including in our Center; and;
- That addressing complex systemic problems requires more than conversations and vague promises, it requires strategic, consistent, coordinated and accountable actions.

Therefore, we commit to the following actions, and we are seeking partnerships and collaborations to help us achieve them. We also seek new ideas and actions to further embody our affirmation that Black Lives Matter.

AS LEARNERS

We will continue to seek ways for the faculty, staff and students in the Center of Bioethics and Humanities to understand the challenges of racial injustice and to be more effective agents of change.

- We will listen to the voices of BIPOC people within our community partnerships and increase diversity within our Community Board, ensuring that our Board reflects the diversity of the communities we serve - in particular, the community of Aurora, CO - by 2021.
- We will ensure that all CBH faculty and staff receive anti-racist and implicit bias training, in line with the schedule to ensure all medical students have received this training by July 2021.
- We will highlight people doing work at the intersection of race, class, culture and health care, through a speaker series on these issues in 2020-21.

AS TEACHERS

We will champion the work of scholars and thought leaders in health humanities and bioethics who identify as BIPOC, to help our learners gain from their experiences and to amplify this important work.

- We will design a course on “Racism, Structural Violence, & Health Inequalities” in our Graduate Program and offer this course to students in the Colorado School of Public Health and the CU School of Medicine.
- We will design and deliver at least 6 sessions/year for learners in different programs across the Anschutz Medical Campus specifically focused on racism and the health professions, helping learners use health humanities and ethics as frames for understanding and addressing racism.
- We will decolonize all syllabi for which CBH core faculty are primary instructors (ensuring at least 30% of the readings on the relevant syllabus have BIPOC as authors and/or focus on issues of particular concern to BIPOC communities)
- We will ensure that at least 30% of speakers for CBH programs, webinars, and panels are BIPOC.
- We will ensure that at least 30% of CBH programs, webinars, and panels explicitly address systemic oppression and injustice as drivers of inequities.
- We will use our Holocaust, Genocide, & Contemporary Bioethics Program to explore the role of structural racism in driving mass atrocity, including by exploring the transition of overtly racist laws from the US to Germany prior to the Holocaust.

AS RESEARCHERS

We will partner with diverse investigators and communities to design and conduct research that seeks to illuminate, investigate, and reduce inequities in health.

- We will explicitly consider issues of equity as a potential focus in every research proposal and project
- We will assess equity implications in the design, conduct, analysis, and interpretation of every research project
- Whenever possible, we will partner with trained disparities researchers both within and outside of CU in equity related research projects
- We will commit to increasing diversity in the research workforce in our hiring practices
- We will create and utilize tested research tools (surveys, qualitative interview guides, etc.) that are sensitive to issues of equity and bias
- We will apply established tools to evaluate our own research projects through an equity lens
- We will make equity one of the key foci of our new research work in progress (WiP) meeting for the next year and ensure that every session includes a dedicated analysis via the lens of health equity
- We will engage diverse stakeholders in equity related research as partners and team members
- We will evaluate the inclusion of equity in research related endeavors every six months
- We will calculate the percentage of publications/presentations (including press interactions) from our research group that are focused around equity
- We will report our progress on these goals in the CBH Annual Report

AS ETHICS CONSULTANTS

We will continuously seek ways for our consultation service to develop a respectful and just culture that will inform the consultation process as we collaborate with multidisciplinary teams to provide an ethical framework for clinical decision-making. We will optimize our role in policymaking to advance equity in healthcare to patients and families who identify as BIPOC. In addition, we will develop processes to identify and eliminate systems and structures that further such inequities and increase transparency by tracking the quality of consultative care.

- We will collect data on the self-reported race, ethnicity and primary language of individuals involved in case consultations, and use these data to track consult metrics and quality outcomes by race, ethnicity and primary language
- Where possible, we will include information about patient and families' trust in health care systems and practitioners into our quality outcomes measurement database
- Where possible, we will include in our quality outcomes measurement database information about patients' and family's prior experiences in health care that may be attributed to individual, implicit or systemic racism
- We will task consultants to ask about possible biases in ethics consult processes and analyses.
- We will ensure that at least two consultants complete each ethics consult to increase accountability for the recognition and elimination of bias in the consultation process by intentional audit at the time of consultation
- We will retrospectively review all ethics consults for the presence of individual, implicit, or systemic racism
- We will report the consult metrics and quality outcomes specific to the above in the CBH annual report and in presentation to Clinical Effectiveness and Patient Safety committee
- We will ensure that volunteer ethics consultants who work with CBH faculty receive implicit bias and systemic racism training as part of our ongoing continuing education.



Center for Bioethics and Humanities

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