# Medical Professionalism And Racial Inequity

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The last 18 months have been filled with concurrent crises. The COVID-19 pandemic has been an exceptional stress on our American health care system, stretching hospitals, physicians, nurses and all health care providers to, and sometimes beyond, their limits. The death toll in excess of 650,000 has been awful in itself, but the evidence of poor outcomes for minorities and those with low incomes demonstrates in stark fashion the inequities that appear to be inherent in American health care. Along with the pandemic, the death of George Floyd, killed under a police officer's knee, and other police-related deaths of people of color brought to the fore issues of racism, injustice and structural inequality in our society.

The response of health care professionals to the sick and suffering in the coronavirus pandemic exemplified some of the best of professionalism: dedicated service at personal risk and enduring long hours to care for the critically ill. But revelations about health disparities, not only related to deaths from COVID but also other issues like maternal mortality of Black women, raise the question as to whether medicine as a profession is part of the problem of structural injustice and inequity in health care.

As a physician, I am targeting the profession of medicine and arguing that focusing on health equity, improved minority representation in the profession and dismantling structures that contribute to injustice in health care are crucial to a reconsideration of the practice of medicine. I believe this is likely true of other health care fields but feel it is best for me to comment on my own profession. The medical profession should be a powerful force for change. Reviewing recent notions of medical professionalism reveal that a focus on positive change is inherent for individual physicians and the profession as a whole. Physicians need the support of Catholic health care systems and local hospitals to create positive change that reduces inequity and racism while improving health care outcomes for minorities.

## MODELS OF MEDICINE AS A PROFESSION

Study of the profession of medicine prior to the 1990s focused more on the sociological characteristics of the profession rather than moral commitments. The classic work was Eliot Freidson's *Profession of Medicine: A Study of the Sociology of Applied Knowledge*, published originally in 1970 but incorporating previous work done by the author. Freidson characterized medicine as a profession defined by four characteristics: 1) those entering the profession underwent extensive and arduous training; 2) this training brought to physicians specialized knowledge and skills of great benefit to society by maintaining health, curing disease when possible and limiting suffering for members of the society; 3) as a consequence of the benefits to society, members of the profession are granted considerable professional autonomy; and 4) that autonomy comes with a set of societal obligations. Those obligations included acting in the patient's best interests, maintaining confidentiality (with rare legally mandated exceptions), a commitment to competence and skilled service, responsibility to the patient before personal interests, financial honesty and professional self-regulation.[1]

The final decade of the 20th century brought renewed interest in considering the role of phy-

sicians and the profession in response to several pressures. Those pressures included the introduction of managed care, the development of for-profit health care corporations and concerns about physician behavior. Managed care contracts raised potential conflicts between the needs of the patient and the financial reimbursement of physicians who were rewarded for limiting expenses. For-profit health care treats the medical management of persons as a commodity and, like managed care arrangements, unsettles traditional values of putting the treatment of vulnerable people above financial concerns. Finally, there was increased attention on physicians who made sexist and harassing comments, displayed racist attitudes and behaviors, threw temper tantrums and made insulting remarks to nurses, medical students and other staff. A number of voices presented a vision for the profession of medicine in response to these challenges. I will focus on three: the work of Dr. Edmund Pellegrino, a groundbreaking article by Matthew Wynia and others in the *New England Journal of Medicine*, and an address by Cardinal Joseph Bernardin to the American Medical Association House of Delegates.

Pellegrino was a physician, a scholar, one of the founders of American bioethics and the namesake of the bioethics center where I teach. He argued for an understanding of medicine as a distinct profession with an inherent moral core. An individual physician, by her or his oath of profession, formally promises dedicated service to the patient. The goal in every encounter is to find the right healing action in the relationship between the doctor and the patient. This right healing action is based on a four-fold good: the biomedical, the person's own good, the person's sense of her or his goods as a human being and the person's spiritual goods. The doctor works with the patient, using the knowledge, skill, compassion and competence that are essential to the doctor's role, in finding the right biomedical good that will accomplish the patient's achievable goals of care. This is what it means to act beneficently, respecting the patient autonomy to bring about the best outcome possible.[2]

It is this dedicated care of and service to the patient that is the center of professionalism. As a group, physicians constitute a moral community by their oath of service and their daily practice. But the responsibility of this moral community both encompasses the individual doctor-patient encounter and extends broadly. Pellegrino writes: "Physicians cannot be indifferent to injustice, inequality and suffering caused by our system of health care, by an institution's insurers, or by our professional self-interest. We share a collective responsibility to be strong and clear voices for a just health care system, for the competence of our fellow physicians for the rehabilitation or expulsion of those who violate the moral demands of what it means to be a physician."[3]

Wynia and his colleagues, in their 1999 *New England Journal of Medicine* article, note that professions broadly have a societal function in protecting vulnerable persons and vulnerable societal values. They argue that medicine should be

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defined by distinct moral premises. Chief among them are: devotion to providing health care that places individual and public health ahead of self-interest; a public profession of values that recognizes a shared understanding so patients can trust their physicians; and a willingness for professionals to be in dialogue with the public about shared values that are held by both the profession and the larger society. The model serves as a basis for trust for the public in the profession and a commitment by the profession to be accountable, put the patient over their own self-interest and be responsive to the needs of society in delivering health care.[4]

Cardinal Bernardin, like Pellegrino and Wynia, puts moral relationship at the heart of the medical profession. Bernardin's reflections came in the wake of being diagnosed with pancreatic cancer and his own experience of illness. His model of the profession views medicine as a covenant between the patient and the physician, with the covenant based on moral obligations, and establishes

responsibilities for the physician from this covenantal relationship. The moral obligations are to work to establish healing, to promote and restore wholeness of life and respond to those who ask for help. The individual responsibilities for physicians include putting the patient's interests first, demonstrating real caring rather than simple technical expertise in the use of medical science and technology, upholding the sanctity and dignity of life from conception to natural death and attention to the physicians' own spiritual needs as healers. In turn, the profession has three obligations to society: establishing health care as a basic human right, promoting public health in the widest possible sense and providing leadership on the protection of human life and the enhancement of human dignity while facing that health care resources are not unlimited.[5]

The sixth edition of the *Ethical and Religious Directives for Catholic Health Care Services* provides a description of the professional-patient relationship that corresponds to the models of Pellegrino, Wynia and Bernardin and extends it to the Catholic Church's commitment to human dignity. The introduction to Part Three of the *Ethical and Religious Directives* states: "A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty and appropriate confidentiality." In Catholic health care, the professional-patient relationship is rooted in our Catholic faith and its teaching: "When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. ... The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional."[6]

Revisiting medical professionalism in a time when we are becoming more aware of unjust outcomes, serious health disparities and inequity in access and care is crucial if the profession of medicine seeks to retain the moral core that has been highlighted in this article. This is true for the profession in general but is even stronger in Catholic health care, where the moral nature of the profession is in service to the healing mission of Jesus Christ.

### RESPONDING TO THE CRISIS

What are the implications for the profession of medicine when concerns about racism, inequity and structural barriers to just health care have come to the fore?

Recall Pellegrino's emphasis on the attempt to find the right healing action for a patient. This requires a deep openness between doctor and patient to explore the nature of the good for the patient and to choose the appropriate biomedical action in the pursuit of the good. Such openness is always a challenge. But differences in culture, ethnicity, suspicion and the knowledge of previous injustice can make that challenge even more daunting. This requires, in Pellegrino's words, "paying attention to building trust, being faithful to promises, and removing any basis for a suspicion of discrimination." Individual action by physicians, however, is not enough to deal with the entrenched structures of inequity in health care: "Collectively, however, health professionals have obligations through their professional associations to be advocates for removing injustices in availability, accessibility and quality of services that African American and other groups might experience. If health professionals appreciated the moral power their collective advocacy could exert, they would feel less unable to effect change."[7]

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Pellegrino's attention to individual efforts to build trust and collective action by professional organizations resonates with the assertion by Wynia and his colleagues that a key premise for medical professionalism is public profession of values that ensure respect for a moral core so that patients can have trust in the people who provide care for them. A corollary would be that a public

profession of the values of inclusion, nondiscrimination, personal respect and dialogue on areas of disparity is especially needed in this time when many minority individuals have profound skepticism and distrust about the care they receive. Likewise, the emphasis on dialogue between the profession and members of society on the shared values that should guide medical care implies, for a profession that is underrepresented in minority physicians, that minority communities must have a voice in helping the profession find its moral compass in addressing problems of discrimination and inequity.

Bernardin's description is of a covenant between the physician and patient and its emphasis on actions that promote healing and wholeness, demonstrate real caring and attend to human dignity. It highlights the importance of careful attention to the person who receives care and working to respect the person in need of healing as one made in God's image and likeness. Inherent and often unintentional bias, a lack of empathy and misunderstanding can prevent the rich covenantal relationship from being formed between physicians and minority patients. As Pellegrino noted, individual actions to listen and build trust are important, but the obligations on the entire profession that are described by Bernardin need attention. These obligations include establishing health care as a basic human right, promoting public health and leadership on protecting human life and dignity in a way that is mindful of limited resources. They take on new urgency when our eyes are opened to wide gaps in mortality, the pernicious effects of social determinants that negatively impact human health and the de facto devaluation of the value of human life and dignity for Black people and other minorities.

Institutional Catholic health care, as defined in the *Ethical and Religious Directives*, is guided by our Catholic faith and its insistence on respect for human dignity and calls for professional patient relationships that are marked by mutual respect and honesty. The defense of human life in Catholic health care appropriately is found in resistance to abortion and euthanasia. But confronted with the facts of health inequity and increased mortality in minority communities, our faith calls us to continue to assert the dignity of life and work to protect those at the beginning and end of life as well as robust efforts to emphasize the dignity of those whose health and life are imperiled and diminished by structures of exclusion, discrimination and disrespect.

### SUGGESTIONS FOR REAL CHANGE

What can the profession of medicine do, concretely, to change how we care for those whose lives are diminished by injustice and racism? More narrowly, what should physicians, management and boards of directors in Catholic health care do to allow the medical profession and other health care professionals to be faithful in their calling in ways that are articulated in the work of Pellegrino, Wynia, Bernardin and the *Ethical and Religious Directives*?

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First, the boards of Catholic health care hospitals and systems, in cooperation with management and the chief medical officer, should devise plans that focus on disparate health outcomes and consider how to improve their own institution. This means careful listening to the voices of minority patients, doctors, nurses and others so that their stories are heard. The boards then should devise actions that draw not just on good intentions but efforts to respect, build trust and act faithfully. These actions could include improvements to policies and practices for a more equitable workplace environment, recruitment of minority physicians, nurses and other providers as well as reaching out to the community to hear the experience of minority patients. There is

a need for deliberate education on the problem of poor outcomes for minority populations, enhancing awareness and reduction of inadvertent bias and the imperative for the profession of medicine to act along with the wider institution.

Second, boards can use the structures in place to track outcomes, institute changes and measure success (and the occasional failure) on the path to creating a just and inclusive healing environment. Quality Improvement subcommittees of the larger board are charged with monitoring safety and tracking measures of health care. The approach of these quality committees is often driven by listening to individual stories and then gathering data, constructing pathways for improvement and following results. Patient satisfaction and data on compliance with a variety of health measures are typically the bread and butter of meetings. These subcommittees, with the approval of the larger board, can extend the monitoring of safety and quality to look at satisfaction and outcomes for minority patients and then begin an analysis of where there are disparities, examine the causes and develop methods to improve.

Third, the chief medical officers, in conjunction with chief nursing officers, should be empowered to develop educational tools and programs that harness the moral power of the profession to encourage individual practitioners to grow in their ability to treat all patients with deep respect and care, realizing that distrust and difference will be challenges. Just as in promoting safety and quality, the emphasis should not be on blaming or accusing physicians of deliberate bias and poor behavior but a straightforward presentation of the problem and adoption of best practices for improvement.

Living through the crises of the past months has not been easy, but the pain and suffering can be the catalyst for growth, change and improvement. Just as our experiences with COVID-19 have changed patterns of practice, created innovations in care and new knowledge, so can the exposure of injustice and racism in health care lead to positive change rooted in the best traditions of the medical profession. For Catholic health care, assisting our physicians and other health care professionals to grow in their respect for the lives and dignity of our minority patients is a shared imperative requiring institutional commitment and assistance to our practitioners to enhance and move forward the healing ministry of Jesus Christ.

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**NOTES**

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2. Dr. Edmund D. Pellegrino, "Moral Choice, the Good of the Patient, and the Patient's Good," in *The Philosophy of Medicine Reborn: A Pellegrino Reader*, ed. H. Tristram Engelhardt, Jr., and Fabrice Jotterand (Notre Dame: Notre Dame University Press, 2008), 163-186.
3. Edmund D. Pellegrino, "Medical Ethics in an Era of Bioethics: Resetting the Medical Profession's Compass," *Theoretical Medicine and Bioethics* 33, no. 1 (2012): 21-24.
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7. Lawrence Prograis and Edmund D. Pellegrino, eds., *African American Bioethics: Culture, Race, and Identity*, (Washington, D.C.: Georgetown University Press, 2007), xvi.

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