Research Paper: Ethical Decisions in Biased Medicine

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Abstract

The realm of this paper will focus on the ethics surrounding medical institutions lacking a diverse curriculum and representation that inherently influences future medical providers' bias towards race and culture. The research surrounding the foundation of this paper is comprehensive as well as representative of the background knowledge and overall argumentation of the ethical dilemma. Background research includes defining integral terms for the argument such as, cultural competence, health disparities, and inherent racial bias. The paper nods to the origin of the ethical dilemma and its effect on minority populations by including entries from law journal and research studies. Along with the sources utilized for background knowledge, Aristotle's virtue ethics, Noddings' care ethics, and the American Medical Associations code of ethics will be analyzed to further develop the paper's argument to support the necessity of a diverse curriculum. The paper ends on a note of possible proposals that could be implemented to solve the ethical dilemma.

Introduction

In a time of great political unrest due to ongoing racial injustice conducted by systematic racism that inherently keeps minorities indigent and bound by stereotypical racial identities; more than just racial prejudice and police brutality are at stake for minority populations. Hidden from the media lies an ethical dilemma surrounding race and quality of health care which further widens the gap of health disparities amongst race. As of current, medical institutions, education and medical research does not reflect the overall diverse population of the United States which is problematic to the future of medicine for a plethora of reasons. This research paper will answer whether it is ethical to allow medical students to treat minority populations including African Americans, when higher education and medical institutes do not employ such a curriculum to properly instruct future medical providers of treating such groups. A comprehensive list of sources, Aristotle's virtue ethics, Nodding's care ethics, and the American Medical Association's code of ethics will be utilized for supporting the argument of the implementation of a diversified curriculum and racial representation to better educate medical providers and lower health disparities amongst race.

Background

The foundation of this paper is conceived of a compiled list of sources ranging from law journals, current events, scholarly articles and an insightful research study circulating cultural competency within the medical professions. Cultural competence is defined as the "integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes" (Center for Disease Control and Prevention, 2020). This is imperative to the initial understanding of racial disparities amongst race and necessary to

the support of a diverse curriculum to reflect a diverse population. Cultural incompetence in the medical field, or "the decision not to know more enables providers to define the patients' problems in terms that are fixable and that meet the need for efficiency" (Ikemoto, 2003, p. 82). In a separate source the author argues,

> "if medical schools plan to shape the practices of future physicians within the context of cultural competence, it is of vital importance for the medical profession to reassess traditionally conceived values, beliefs, and biases which may not be in agreement with current social diversity" (Kripalani, Bussey-Jones, Katz, & Genao, 2006, pp. 1117-1118).

Cultural competency thus has a direct impact on health disparities amongst race. Health disparities are defined as patterns of unequal distribution epidemiologically amongst racial groups due to unfair social factors outlined through systematics (Chae, Nuru-Jeter, Lincoln, & Francis, 2011). This impact is inherently seen "in racism—historically informed and perpetuated by institutions, and manifested in the set of assumptions, stereotypes, and biases that are attached to race, both externally and internally—positioning groups of people into relative positions of power and deprivation" (Chae et al., 2011, p. 73). It is due to the circumstances of these outcomes that have led researchers to propose alternating to the socio-psychobiological approach. This approach in medicine combats against current models to "examine racial disparities in health and emphasizes how more traditionally examined individual-level determinants of disease, including psychological, behavioral, as well as biological risk factors, are informed by racism" (Chae et al., 2011, p. 65).

In order to better examine researchers' contemporary proposals for cultural competency it is imperative to understand how the divide in health disparities amongst race began. As stated in majority of the sources utilized in this paper, disparities originated during the first historical

accounts of colonization that resulted in slavery (Pittman, 2003). However, health disparities that are both outdated yet contemporary became most apparent historically after the 'separate but equal doctrine' during Jim Crow era (Pittman, 2003). This era atones for disgusting acts of racism and segregation mainly against African American communities and other minute minorities that resulted in the death and destruction of countless lives (Pittman, 2003; Williams, 2003). Laws and segregation as forementioned began during the "separate but equal doctrine" in *Plessy V. Ferguson* (1896), this doctrine allowed for segregation of white and 'people of color' resulting in poor housing communities, indigency and poor-education for those ruled a person of color (Pittman, 2003). Health disparities have worked to maintain these stereotypes of indigency and poor-education and further stigimatize these communities to this day. One source states, "medicine continues to reflect the vestiges of unequal treatment and care of racial and ethnic minorities, with regard to access to health care and differential quality of care" (Chae et al., 2011, p. 69). It is imperative to this knoweldge that current approaches to medicine are outdated and need to adapt to the changing political and social movements of the 21st century. To combat this, few sources suggest moving towards a socio-psychobiological approach by claiming, "a socio-psychobiological approach emphasizes how social inequalities generated by racism impact health directly, as well as by shaping psychological, behavioral and biological vulnerability to disease" (Chae et al., 2011, p. 73).

Theory Application

The ethical codes that will be applied to argue the thesis of this paper will include Aristotle's virtue ethics as well as Nodding's care ethics. These specific ethics are included in the paper versus other ethics because of the similarity between the two. Both Noddings and Aristotle

outlined their individual ethics to reflect emotions and qualities of one's character rather than logic and reasoning.

Aristotle's virtue ethics acknowledges the two different types: intellectual and moral virtue ethics (Marino, 2010). However, it is imperative to define what is meant by virtue, Aristotle notes that virtue is the mean in human action and feeling which is either made up of intellectual or moral virtue (Marino, 2010). Intellectual is derived from experience and time whereas moral virtue is derived from habit (Marino, 2010). Aristotle reasons that morality lies within habitual actions, but more importantly that "virtue then, is a state of character concerned with choice lying in a mean…virtue both finds and chooses that which is intermediate" (Marino, 2010, p. 74). Aristotle's era and his philosophy are centered around the goal of human life being eudaimonia, or happiness. This concept of eudaimonia is important and applicable to the topic of the paper because happiness is a right defined by Thomas Jefferson in the *Declaration of Independence*. This notion of happiness could be argued to mean a healthy life free from discrimination and able to transcend past racial stereotypes and disparities which is the essential concept of this paper. Aristotle claims,

> "there is excess, defect and the intermediate… but to feel them at the right, with reference to the right objects, toward the right people, with the right motive, and in the right way, is what is both intermediate and best, and this is characteristic of virtue" (Marino, 2010, p. 73).

This correlates to the ethical dilemma being discussed in this paper because an individual who follows this ethical paradigm habitually will do what is morally right by aligning themselves within the intermediate of ignorance and arrogance and choose to educate themselves in these conditions. For those within medical or health related fields in which health care will be provided

to several groups of people, they should follow the intermediate in order to better educate themselves and reach eudaimonia. These actions will resonate in the quality of care seen in patients, who will also reach eudaimonia knowing that trust is mutual and quality healthcare will be provided not by the basis of their race but by the nature of their condition.

The essential paradigm of Noddings' ethics is to expand further on Aristotle's ethics by claiming that there are two additional sentiments that develop an individual's morality. Noddings claims, "the first sentiment of natural caring. There can be no ethical sentiment without the initial, enabling sentiment…the second sentiment occurs in response to a remembrance of the first…there is a transfer of feeling analogous to the transfer of learning" (Marino, 2010, pp. 425-426). The sentiments outlined by Noddings argue that along with the teachings of virtue ethics, a quality of care is not only necessary but required to drive morality. When comparing to the ethical dilemma, the first and second sentiment of Noddings should drive individuals to not only 'want' to educate themselves to provide the best quality of health care, but that they 'ought' to. Medical students studying to become providers should educate themselves further then current curriculum because all patients should be cared about, and this motive should be derived from past experiences and feelings.

Professional Code Application

The professional code that will be utilized to analyze the ethical dilemma is the code of ethics for healthcare professions outlined by the American Medical Association. This code of ethics focuses on the nine principles of ethical standards which all medical providers should uphold concerning community health, education and what is expected of physicians. The failure to implement an education that is representative of the diverse population and discusses disparities and its correlation to race and minorities directly violates four principles of the AMA

code of ethics. The first, fifth, seventh and ninth principles are the four standards that are violated by these actions, these principles outline what is expected of physicians beyond providing adequate health care.

Persuasive Arguments

In order to properly defend the argument mentioned beforehand, it is of importance to identify its unethical nature. The absence of a rigorous curriculum surrounding racial representation within the course, text materials and faculty at medical schools is unethical because it does not provide confidence to treat minority patients postdoctoral from an institute nor does it prevent students from developing inherent racial bias. This ethical issue directly impacts the principles outlined within the AMA code of ethics by allowing this ignorance to continue despite public health concerns surrounding race.

The first principle in the AMA code of ethics states, “physicians shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights” (American Medical Association, 2017). Such a principle, along with being the first of the nine principles, is the most important and encompasses the obligations of physicians’ environmental role. It is important to note that this principle encompasses both “competent” and “human dignity and rights” both of which are imperative to the ethical argument. Aristotle’s theory of eudaimonia would argue that every individual has the goal and intention for happiness, which is further defined as a natural-born right in the United States (Marino, 2010). This distinction within the AMA code of ethics supports the earlier argument that happiness may be attributed to a healthy life free from discrimination when compared to Aristotle’s theory of eudaimonia. The first principle also acknowledges “competent medical care”, this is of importance because cultural competency is necessary in order to treat patients of various races and cultures. As stated

in one of the sources, “risks that racial profiling in medicine creates are very real. They include reinforcing, and perpetuating stereotypes, failing to address ‘the underlying individual factors’ and misdiagnosing patients of color at excess rates” (Ikemoto, 2003, p. 93). It is also to be recognized, “while it is important to increase the diversity of medical schools and health care systems, minority physicians should also receive cultural competency training in order to maximize their ability to relate to patients of a different background. Cultural competence training is for everyone regardless of cultural background” (Kripalani et al., 2006, p. 1118). This distinction is important because the argument of the paper is not to isolate and educate only the majority race, but rather to expose all racial prejudices amongst all races and cultures. To further exapand, an education devoid of cultural competency within the medical field supports stereotypes and inherent racial bias when diagnosing patients which is unethical by both reason and emotion.

The fifth principle of AMA code of ethics states, “a physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation and use the talents of other health professionals when indicated” (American Medical Association, 2017). The value of knowledge is that it is infinitum, there will constantly be more knowledge to be harvested in order to adjust to the changing social and political sectors of culture and society. The principle states that physicians must consistently update their own knowledge in order to better adapt and provide the most concurrent information to patients, this encompasses the realm of health disparities and race. In order to better diagnose and treat patients of minority descent, physicians should be engaged in curriculum surrounding the differences amongst political, social and biological factors that contribute to minority health disparities. Physicians according to this

code of ethics are obligated to educate themselves not only of adequately treating these patients and disparities, but to implore this information to other colleagues and patients to further educate a new generation of physicians. The fifth principle reinforces Noddings' notion of care ethics by supporting the second sentiment in which morality is driven by "the transfer of feeling analogous to the transfer of learning" (Marino, 2010, p. 426). Physicians should uphold Noddings' feministic approach to ethics and moral education because at least 43.8% of physicians working in 2019 were considered a minority and experienced this curriculum lacking cultural competency and diversity which thus discriminated the minority group that includes them. From this experience and remembrance of the misrepresentation of being the minority population, these physicians should 'want' and 'ought' for medical schools to adapt to the social and cultural diversity as defined by Noddings' second sentiment of care ethics (Marino, 2010).

The seventh principle of the AMA code of ethics states, "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health" (American Medical Association, 2017). As stated in one source, "social inequality is the primary driver of racial disparities in health" (Chae et al., 2011, p. 66). Thus to lower racial disparities physicians should support the implementation of an overall inclusive medical education that is both culturally competent and sound. Physicians should partake in this movement because it is a public health concern, because the "issue is one of patient safety" (Page, 2020). A recent *Washington Post* article boasts of a current medical student enrolled at St. George's Medical whom has published a handbook to detect clinical signs on black and brown skin (Page, 2020). Both the student and the institution were concerned with the "methods of teaching unfairly disadvantaging and 'othering' students from black and minority ethnic groups" (Page, 2020). Leaving the medical institution to question whether "[we

were] adequately training our students to be competent health-care professionals who can detect important clinical signs in all patient groups" which would be considered a public health concern (Page, 2020). The ideals of public and community health can also be attributed to Noddings' care ethics pertaining to the first sentiment of care. The first sentiment states, "the sentiment of natural caring. There can be no ethical sentiment without the initial, enabling sentiment" (Marino, 2010, p. 425). Physicians should care about public health concerning cultural competency in education because "the impulse to act in behalf of the present other is itself innate" (Marino, 2010, p. 429). Due to the natural ability to care for others, public health should be included within the definition of the "present other" which supports Noddings' theory of twin sentiment and what an individual "ought" to do (Marino, 2010).

In the final principle this paper will examine, principle nine states, "A physician shall support access to medical care for all people" (American Medical Association, 2017). Although the principle is vague and can be attributed to either health care or accessibility to care through insurance and monetary value, the former will be the focus of this paragraph's argument. As pertaining to the argument, "all" will refer to the various races, cultures and ethnicities that constitute the minorities of the United States. Physicians should support accessibility to healthcare because it is what Noddings argues as moral according to the philosopher's care ethics. Noddings states, "For an ethic of caring, the problem of justification is not concentrated upon justified action in general. We are not "justified"—we are obligated—to do what is required to maintain and enhance caring" (Marino, 2010, p. 440). Noddings' notion to obligation thus reinforces the idea that physicians should support accessibility in healthcare, because it is a moral obligation to caring. Physicians should feel obligated to provide quality level of care to all patients within a community as outlined in the AMA principles, this "care" stems from a moral

and innate characteristic, one which Aristotle would argue is of virtue. "Caring" is one of the few virtuosic characters outlined by Aristotle philosophy which focuses on emotion driven habits, relationships and obtaining knowledge through the senses and the physical world (Marino, 2010).

Regarding solutions to the ethical dilemma in question, few researchers and institutions have relegated amongst their peers to denounce ignorance and plan for a more diverse education. In the study conducted by van Ryn et al. (2015) a little over 3,500 students participated in a longitudinal study following implicit racial bias test (IRBIAS) scores ranging from year one to year four in various medical degree programs. This study hypothesized, "medical school exposure in three domains: formal curricula, informal curricula, and interracial contact, would predict change in non-African American medical students implicit racial bias towards African Americans" (van Ryn, et al., 2015, p. 1749). Initially in first year medical students the researchers uncovered an "automatic and unconscious negative attitudes towards African Americans as compared to whites" (van Ryn, et al., 2015, p. 1748). This research followed the students who were exposed through various forms of curricula and were surveyed on questions pertaining to formal curriculum and informal curriculum of cultural competency and racial differences according to the socio-psychobiological scale, as well as interracial contact through peers and faculty (van Ryn, et al., 2015). The survey was administered a second time in the medical students' fourth and final year, the results concluded; those exposed to formal or informal curriculum had scored lower IRBIAS scores then the previous scores from year one whereas those who had little to no formal or informal curriculum and relied heavily on interracial bias had scored higher IRBIAS test scores then the previous year one scores (van Ryn, et al., 2015). The finding within the research study provides a foundation to the overall thesis and

argumentation of this paper. Individuals who were exposed to any curriculum, whether formal or informal, scored lower IRBIAS scores and reported more confident in treating minority peers outside of the institution (van Ryn, et al., 2015). This discovery supports the argument because it provides empirical data that students exposed to curriculum including cultural competency, racial and minority representation as well as resources and workshops that allow students to be exposed to diverse conditions has an improved effect of lower inherent racial bias. Whereas individuals whose institution did not have curriculum implemented relied heavily on interracial interaction which impacted the scores negatively, proving inherent racial bias and doubt in the ability to care for minority populations.

Solving the ethical dilemma surrounding culturally competent education in medical institutions will need to take a joint effort from current physicians, current students, and those planning to attend medical fields in order to garner actual change. It should be proposed to conduct more research, possibly on a larger scale, such as the study of van Ryn et al. to provide more empirical and statistical data surrounding inherent racial bias. Much like other political movements currently, petitions, protests, and walkouts could be of benefit to gather media attention and receive notice from larger institutions who have hidden from their inherent racism toward an equal comprehensive education system for far too long. Other proposals include supporting Malone Mukwende and his efforts to publish a medical handbook called, *Mind the Gap*, as well as the project and curriculum petition implemented at St. George's Medical due to his efforts (Page, 2020). Other actions include holding institutes accountable for their lack of diverse representation, education and resources to adequately educate future medical providers. This effort can be accomplished through placing phone calls and writing letters to institutions' presidents, state officials, or even government officials on the abhorrent nature of discriminatory

education almost sixty years after the passing of the Civil Rights Act. Taken together, social and physical actions such as those mentioned beforehand would be beneficial in the initial steps needed to implement a more diverse education that is reflective of the United States population.

Conclusion

Political and social tensions are currently rampant after the recent proceedings following police brutality cases leading to the realization of the ethical dilemma of this paper. With the use of background research, philosophical paradigms from Aristotle and Noddings, and the AMA code of ethics, an argument was formed on the thesis of the ethics regarding racial representation and education within the medical field. Leading to the proposed question whether it is truly ethical to refrain from delivering racially representative curriculum that focuses on cultural competency during medical education and residency; yet expect medical students to provide adequate healthcare to their future patients with the absence of racial bias. Arguments found that each principle of the AMA code of ethics is applicable to the ethical dilemma and had a strong correlation to the paradigms of Aristotle and Noddings' which focused on character and emotion. The principles of the AMA code of ethics served as separate arguments for the morality surrounding the ethical decision and the necessity for culturally diverse education as seen in the empirical data from the van Ryn et al. case study. Making culturally diverse curriculum and racial representation in medical schools a norm within society would ensure that future generations of medical providers are better equipped to provide equitable and quality medical treatment despite racial, cultural and social differences in health disparities.

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