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Geri Amori: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I'm joined by Rebekah Shiefer, a behavioral clinician and educator who focuses on the healing power of the patient-clinician relationship; Josh Hyatt, a healthcare risk manager, bioethicist, lecturer, professor, and author; and Anthony Cheng, MD, a full-spectrum family medicine physician with special interests in addiction treatment, gender-affirming care, digital health, and health equity. Welcome.

Today we're talking about The Joint Commission's new mandate to collect data on patients' social determinants of health, now called healthcare disparities, and the ethical issues surrounding this data collection. So, Josh, as an ethicist, can you talk to us in lay terms about the ethical principles of the beneficence, autonomy, and justice as they relate to healthcare disparities?

Josh Hyatt: Thank you. Well, we'll start with just the basics. Beneficence, autonomy, justice, and nonmaleficence all tie into basic bioethics principles, and we use those in terms of dealing with complex situations in our everyday structure. And beneficence refers to providing treatment that's only beneficial to the patient. Autonomy is giving the patient their choice, allowing them to make informed healthcare decisions. Nonmaleficence is tied into not performing...well, performing acts that are harmful to the patient without any real benefit. And then justice is the basic overview of equity within healthcare. So these terms have a lot of intersection. They intersect with different types of barriers to care such as racism, homophobia, transphobia, misogyny, and so forth.

And the principles are good as a frame for ethical conversation, but I think the real issue that I see expands into the values and lived experiences of others, so the values of the patient, the value of the healthcare provider, the organization, the society. Treating everyone equally without respecting the lived and collective experiences of a particular vulnerable population actually makes us blind to the real social determinants of health that individuals face kind of day to day. So, this is kind of actively seen through the lens of implicit bias and microaggressions. So, for example, there's a study that was done about 7 years ago that found that 41% of first- and second-year medical students believe that Black patients have a higher threshold for pain than White patients.

So you can extrapolate a lot out of this kind of particular study. And in fact, there's a lot of studies, I mean you can just do a good Google search and find that Black and Brown patients have less access to pain treatment, preventative screening, and testing, as well as even AI programs that are built with racial and gender-biased algorithms. So ultimately what happens is that that particular vulnerable population who are negatively impacted by the intersectional issues, they have a disturbingly negative and distrustful view of healthcare as an institution and then even with the providers at times. So then this leads to our moral distress, conflicts over powers and goals, they tend to avoid care, become combative, less compliant and you have a higher risk of harm overall. So, it's imperative that we understand the values of the patient so

that we can kind of meet them where they are and not expect them to fall in line with our approach.

Amori: Excellent. Wow. That's really a lot to swallow. I mean it's a lot to think about. We don't think about that on a day-to-day basis. Dr. Cheng, can I call you Anthony?

Anthony Cheng, MD: Absolutely.

Amori: Okay, great, thank you. Anthony, how do you see your role via an ethical lens regarding the collection of this information? And how does it interface with the physician code of ethics?

Cheng: Yeah, thanks for that question, Geri. And before I dive more specifically into that question, I just want to respond to one of the really interesting data points that Josh mentioned previously around the perceptions about pain tolerance and the racism that's implicit in that. It's a really important study, and there's some other studies that show that some of that bias in care can actually be ameliorated when providers know that they're being watched from that perspective. So, for example, there is a study that looked at the recommendations for cardiac catheterization when people present with symptoms concerning for coronary disease and there was some discrepancies in care that were present at baseline, and when there was an awareness of the bias present, of the observation, that reduced some of that bias.

So, when we talk about the collection of this healthcare disparities data, there is a potential that it could improve some things, but I also think that there's some really significant risks for unintended consequences that could be very negative. And we'll talk about that throughout this series of podcasts, but when I specifically talk about my own perspective as a provider and how I think about the physician code of ethics, it gets to the question about what's in our lane as a doctor, as a physician. Is racism in our lane? Is social determinants of health, are those in our lane? And there's some good reasons to say that we do need to be concerned about it as physicians. In the Code of Ethics, there's two elements. One is that a physician shall respect the law and recognize the responsibility to seek changes in those requirements which are contrary to the best interest of the patient. And then also, the physician shall recognize the responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

And so, both of those mandates that we have in our professional Code of Ethics instruct us to pay attention to these healthcare disparities. But I think that optimistically as a physician I think about the other role that I have as a participant in a democratic society and how a lot of these problems are really not just about healthcare. In fact, they're really about the way that we have decided to organize our country and how we decide to distribute power and economic resources. And I would hope that there's an awareness through this data that we as physicians need to engage as civic members, as participants in government, and really push on other levers outside of our professional roles and responsibilities.

Amori: Wow. That really expands the role and really does put that into perspective. Thank you. Hey, Rebekah, how do the ethics related to your role as a social worker intersect with the collection of healthcare disparities information?

Rebekah Shiefer: That's a great question, Geri, and I just want to say I really appreciate the issues and the points that both Josh and Anthony have raised. I think that there's an assumption maybe within healthcare and healthcare leaders outside of social work that the collection of this information is in line with social work values, which I think in many respects it is. But I am concerned about a few areas that relate to social work ethics specifically. So, dignity and worth of the person, the importance of human relationships, and competence. And I think social workers involved in this screening who were not attending to these principles could really risk alienating the very clients that they seek to serve.

For example, some of the questions that we ask on a social determinants of health screener, these could feel really deeply personal to a person seeking healthcare services, and this could create a situation where they might feel embarrassed or offended by the questions. There might be cultural considerations that influence the comfort in answering these questions. And although, of course, these questions are intended to help, even asking these questions could set up a person to feel disrespected in some way or worried that if they answer them honestly that they would actually introduce further bias into the relationship. And that leads me to my second point which is that these screeners are not always taking place inside of a trusting relationship. With a healthcare professional, we know that that is so important and that there are so many outcomes that are actually just tied to the quality of the relationship.

And so, this could also create the appearance of, I think, prioritizing extracting data over a relationship. And then, finally, I think the issue of competence. So, are we certain that our healthcare systems delivering these screeners are providing patients with the competent social care that they really need to help access some of these resources. And I don't think that that's always the case.

Amori: So, if I hear you right, you're saying that it's not necessarily the questions finding out the information, it's how we go about finding out that information and who's doing it, and how the patients feel about those people and those systems. That's really important. I hadn't thought about that before. You know, Josh, you come at this from a really unique perspective being both an ethicist and a healthcare risk manager, which some people see as kind of multiple sides of that coin. What do you see as the legal risk management issues around basically what Rebekah and Anthony were talking about?

Hyatt: That's really great. And I want to echo what Rebekah said. I think a lot of the approach to how questions are asked and the kind of questions and who's asking them and what the environment is, you can actually create more distrust in the relationship if you are not the right person asking the right questions. And for me, it's more about developing relationships. That kind of relationship that you have with your provider is very different. As a gay man, if somebody started asking me very personal sexual orientation questions and they're in the intake office, I'm going to be a little less than forthright because I don't think it's an appropriate place. So, I think that's definitely going to be one big issue.

I believe that the approach to this is a step in the right direction as it opens up conversations to a critical issue that's been underaddressed in healthcare for, well, forever. But unfortunately, to

many people at the administrative level, this sounds like yet another unfunded mandate. And where I see this a little differently, in my opinion, is that an unfunded mandate involves a facility performing a task that's not easily integrated into normal operations. So, you have to then create or reallocate funds. But this is really different. This is more about changing how we think about something and it's almost philosophical. It's very complex to ask an extraordinarily diverse population to be able to do this well. So, the first main issue that I see is the confusion and alignment around what does this actually mean. What is a social determinant of health? And how do you even address it? Because I believe that, based on just what I know from my colleagues, there's a lack of awareness on how to achieve this even as a measurable outcome.

So I think more direction and operational definitions would be helpful to help meet the intent of what these standards are trying to get us to. Secondly, the notion about bias around determinants of health in healthcare is not new, right? It's been around for a long time. What's different though is that it's becoming part of a conversation, both inside and outside of medicine. So what it does is that it increases awareness to everybody, which in and of itself is a double-edged sword. So for example, patients may be experiencing something that they perceive as unjust or unfair but could be clinically appropriate. So, this could really change that clinical situation from being collaborative to combative. And then this compounds things like resource allocation issues that all facilities are facing and then that increase conflict in healthcare settings. It increases risk of diagnostic and patient safety events and then burnout to our providers.

And lastly, I see this as more applicable to a patient experience more than risk because this is something that's really perceptual. So could this standard be potentially used in litigation? Possibly. But I predict that you would see these standards even used against an organization as like a causative factor if there were a large-scale event when those tend to get a lot of publicity. So what I would do is I would challenge our risk managers, quality people, and patient safety professionals out there to think about how can we utilize a vulnerable patient's status and their unique determinants of health in the processes of event investigations, adverse event investigations, grievance reviews, and RCAs, and so forth. You're, like, asking questions did the patient's status as a vulnerable person impact this outcome or event, or did the provider potentially act out of implicit bias. I think these could help guide some of those more complex questions and address more of a cultural approach.

Amori: You know, before I move on and ask Anthony my next question for him, I want to ask you your next question, Josh, because I think you're really building onto something. And basically, you're saying that we get sensitive information and we don't have the systems to address them, so we're going to have to turn to our ethics to help us make priorities because we have no other choice. So, what do you see as our method? How can we prioritize what we address first ethically?

Hyatt: It's a really difficult question because it's all circumstantial. And so, a lot of times in those circumstances when you're having to prioritize, what you're talking about is rationing. And when you start talking about rationing as the allocation of a good under the conditions of scarcity, implying that somebody who could benefit from something won't get it, it creates a lot of conflict. And there are a couple of types of rationing. There's like macro allocations where you're looking at things on a larger scale. Where you say, for example, we only do

mammography screenings for women over 50. But then there's also those micro allocations where it's more of an identifiable patient and that's often the bedside rationing.

And both of those are fraught with problems, and they need input from multiple people, and we often defer off that to the physician. And really, the physician needs the support to make these decisions, and you need ethicists and attorneys and physicians and staff and stakeholders and all of that. So, for me, first and foremost collaboration with the patient is critical. Being honest about the barriers, letting them know that you want to be their advocate, this is done by determining the values of the patient and then working together and developing a plan. So if you align your approach with their values, you've created a powerful mechanism by which you create a strong relationship. But there does need to be alignment with the values and capacity of the institution and the providers.

So, take for example writing a policy about access to ventilators when you have more patients that need ventilators than you have ventilators. And this was a topic that I dealt a lot with in 2020 in my role with a lot of facilities. So what's the bedrock on how you make this decision? Is it first come, first served? Is it the sickest, and how do you quantify that? Is it based on who has the most benefit to society? Like should you give nurses and doctors preferential treatment so that they can recover and go treat more patients? No matter what approach you take, the impact is going to impact all vulnerable patients. Beneficence, autonomy, nonmaleficence, justice, all of that's impacted because these vulnerable populations are going to be often the ones that are put in second place. And so, the trick is trying to strike a balance so that you can mitigate the amount of moral residue and distress that these decisions have on both the patients and the providers. And these decisions also then have to be transparent, if you are able to manage all of those little intricacies.

Amori: I did want to ask...we need to move to our last question, but before we do, I want to ask Anthony one pithy question before we get to the last question and, Anthony, that is, you know, you're going to be talking lots of vulnerable populations. You do, that's what you do, and you do it beautifully and we're so happy that you are engaged in that and feel that. But how do you feel that asking these maybe very personal questions, as Rebekah brought out, is going to affect your relationship with them as a physician?

Cheng: Yeah. I mean I think this is a question about imagination because the way that I approach these conversations is very much that the patient and I write a story about their life together and we come to an understanding about these very personal issues together. And there's a process of disclosure that proceeds essentially at the pace of trust, right? And so, when someone is experiencing poverty, I want them to bring that into the narrative when it's comfortable and appropriate to them. And my fear is that this is going to feel extractive. Like they're coming through a data machine that's removing things from their control, that then this information comes into the awareness of the clinician relationship in a way that the patient doesn't have control over it. I'm not sure how it's going to affect things. I tend to have a much more collaborative relationship with the patient, but I'm hopeful that this will unlock some progress. When I've been able to address social determinants of health with patients, that's really when we've had the most success and a therapeutic effect on medical issues, frankly. So, my hope is

that this will unlock some new ways of helping people, but I'm afraid that it's going to damage the relationship, and I think we'll just have to see how it goes.

Amori: I hope not. Before we close, I would like to ask our final question that I forewarned our panelists that I was going to ask each of you. I'd like to keep it pithy. So I'm going to start with you, Rebekah. If you had one thing, one important thing about the ethical issues related to collecting this data that you would like our listeners to take away, what would that be?

Shiefer: Well, it's a challenge for me to edit it down, Geri, but I'll try. I think that what's really important as we embark upon this is that we really need to be...healthcare administrators really need to be inviting clinicians and staff into these conversations about their concerns. I think oftentimes when we're told by The Joint Commission we have to do something, it's implemented. And I think that a takeaway needs to be that although this may be the right thing to do, it is complicated, and it is very much deserving of having conversations during the implementation process to really discuss the complexity and the concerns that are coming up for those of us who are working directly with patients.

Amori: Thank you. That's good points for everyone to think about as we step into this. Anthony, what is your perspective? What's the one thing you want all of our audience, not just physicians but all of our audience, to take away?

Cheng: This policy says that structural racism and poverty and other issues that are social determinants of health are in our lane as healthcare providers, but that does not mean that it decides what our role is in that conversation. It doesn't mean that we lead versus follow. It doesn't mean that we speak versus listen. It also doesn't mean that we stand in front versus alongside or even behind other folks that are actively engaged in this conversation. So we really need to be good partners with all the folks that are concerned about these issues in our professional roles and as our roles as citizens.

Amori: Thank you. That's very important to keep in mind as well. And Josh, what would you like our audience, if you have one thing for them to remember, to take away.

Hyatt: I'd build on what Anthony was saying. Collaborate. Work with people that know how to address this topic before you venture into it because it can be very detrimental if it's not done well.

Amori: Thank you very, very much to each of you. This has been a really great discussion. I want to thank our panelists for participating and I hope that you, our audience, have found this very valuable. Thank you for joining us.

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