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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Own Their Roles as Past and Present Exacerbators of Health Inequity and as Present and Future Contributors to Health Equity?

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Abstract

To improve health outcomes, the science and practice of medicine must move quickly in response to new information. Yet, in other important ways, health professionals must operate slowly and in a mode of intentional stillness to center empathy and light a path from empathy to solidarity. Solidarity, or standing with, prompts efforts to create circumstances in which disadvantaged communities can achieve health equity. This article argues for intentional stillness and solidarity to inspire ethical conduct and structural change. In the case presented, inaction and delay, which are neither virtuous nor antiracist forms of stillness in this context, would leave intact the status quo of disparity and inequity in cardiac medicine.

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Be still my soul the Lord is on thy side
Bear patiently the cross of grief or pain
Leave to thy God to order and provide
In every change He faithful will remain
Be still my soul thy best, thy heavenly friend
Through thorny ways leads to a joyful end
Katharina Amalia Dorothea von Schlegel[1]

For years now I have heard the word "Wait!"... There comes a time when the cup of endurance runs over and men are no longer willing to be plunged into an abyss of injustice when they experience the bleakness of corroding despair. I hope, sirs, you can understand our legitimate and unavoidable impatience.
Martin Luther King Jr[2]

Case

You are a cardiologist and researcher investigating outcomes after coronary angiography and percutaneous coronary intervention at a large academic health center (AHC) as part of a multisite, longitudinal study. Among patients who are part of a regional cohort of

patients who came to the AHC's emergency department with chest pain, many were confirmed to have elevated troponin levels, indicating myocardial infarction (MI). Several years of data consistently reveal, and now definitively confirm, that Black patients living close to the AHC are more likely than White patients to experience poorer outcomes (ie, increased mortality and hospital readmission).

You suspected your AHC's data would express racial and ethnic inequity patterns similar to those revealed throughout the country, so you are not surprised by what the final data reveal. The data's conclusiveness seems now to have new urgency for you, however, given widespread racial and ethnic health inequity throughout the country during the COVID-19 pandemic and those years' social, cultural, and political upheaval. Your impulse is to share these data with colleagues, despite your fear that a recently launched public relations campaign by your AHC could spur reprisals. You feel urgency about responding justly to your many individual patients of color; you wonder whether responding justly means sharing with those patients and the community what you know about inequitable cardiac care where you practice. You also wonder how your own cardiology practice has contributed to and continues to contribute to inequity.

You are aware of the need to act quickly, as you expect to see some of your patients during what remains of the week. You are also aware of the need to act thoughtfully and deliberately, to try to be part of a long-term solution to a long-term problem. You consider what to do next.

Commentary

The science and practice of medicine must move quickly in response to new information to improve health outcomes. Yet, in other important ways, health professionals must operate slowly and in a mode of intentional stillness to center empathy and light a path from empathy to solidarity. Solidarity, or standing with, prompts efforts to create circumstances in which disadvantaged communities can achieve fulfilling ends, including health equity and long, happy lives.

Whether one acts quickly or slowly, race is salient, as racism is a key backdrop in our changing society and a considerable social determinant of health. Local data obtained by the researcher in this case mirror national trends and outcomes in cardiac medicine that exemplify health inequities experienced by Black Americans. In particular, persistent disparities and inequities in cardiac health and health care affect Black patients of all ages.[3,4,5] Black infants are more likely to die of congenital heart diseases.[6] Compared to White people or to all other groups, Black people are 2 to 3 times more likely to die of preventable heart disease and stroke, to lack adequate access to specialized care, and to suffer kidney complications following a heart transplant.[7,8,9,10,11] Cardiac care and research—including on outcomes after coronary angiography and percutaneous coronary intervention—take place in a context of persistent race-associated health and health care inequity.[12,13] Achieving racial equity in cardiology and health care more generally will require new degrees of active collaboration among stakeholders and intentional antidiscrimination and antibias practices.[13,14]

At present, however, health research, clinical practice, and health care administration take place in contexts marked by what ethicists characterize as overlapping forms of personal, institutional, and systemic racism.[15,16,17] In 1997, the prominent philosopher Charles Mills described a centuries-old and still-prevalent "racial contract" to maintain people of color in subordinated, disadvantaged positions.[18] Scholars working in a critical

race tradition have, since the 1980s, emphasized that the interests of African Americans take a back seat to the interests of White Americans unless they happen to converge with White interests[19]; that traditional civil rights laws have not eliminated the special vulnerabilities of Black people burdened by the legacies of slavery and legally enforced segregation[20]; and that listening to the voices and stories of marginalized communities is a critical path forward in policy and practice.[21]

Recognizing that the force of history countermands unguarded optimism, we argue that virtuous intentional stillness, which can give rise to empathy and lead to prosocial action, is one vehicle through which to help build the necessary solidarity among groups and systems with proximity to power and privilege, on the one hand, and groups suffering health inequities, on the other. Empathy resulting from intentional stillness in turn generates solidarity, which can then motivate and inspire ethical conduct and structural change.

Intentional Stillness

Western philosophers since Aristotle have depicted patience, prudence, modesty, and reserve—what one might call the "stillness virtues"—as counterweights to the vice of reactive temerity inconsistent with goodness and sustainable flourishing.[22] Stillness virtues facilitate reflection, thoughtfulness, self-awareness, consultation, and planning.[22]

Stillness as a vice, however, amounts to harmful complicity or complacency. We speak of civil rights movements—confrontational strategic action—not civil rights *stillnesses*. In the context of cardiac medicine, complacent inaction and delay are neither virtuous nor antiracist forms of stillness, making it more likely that cardiac medicine will continue to contribute to persistent disparities and inequities in health and health care. However, systemic problems are not amenable to solutions dependent upon solitary efforts of single individuals, especially individuals who have been disempowered and under-resourced by an oppressive system.

It is particularly morally problematic to impose expectations of stillness on Black Americans, for whom stillness has been preached as a virtue appropriate for a submissive race of putative moral and intellectual inferiors and their superiors. In a popular hymn, a sufferer exhorts the soul to "be still" and "bear patiently the cross of grief or pain," leaving it to God "to order and provide."[1] The stillness that provides a balm for agitated souls—including Black souls—removes the pressure from society to right wrongs and exploits the vulnerabilities of people turning to patience and higher powers for their hope. This type of stillness asks the exploited and vulnerable to silently bear inequity to prevent discomfort of those who perpetuate a complex system that creates unjust outcomes. It is a failure of beneficence and justice to ask communities affected by racism, homophobia, and other inequities to be slavishly still as elites and institutions continue in stillness and complacently place self-interested priorities first, at times even falling prey to self-deception and representing that what is good for them must be good, ethical, and even God's will.

Here we define intentional stillness as quietude and thoughtfulness. For clinicians, reflection and critical thinking about moral intuitions can be a tool to help them gain a fuller understanding of the lives of patients whose lived experiences are different from their own. Critical reflection conducted with intention and openness can foster empathy, defined as a deeper understanding of and emotional engagement with others that leads to genuinely altruistic social behavior.[23,24] Intentional stillness is a practice that

decenters one's own experience to make room for critical reflexivity—which Stella Ng and colleagues define as a process of examining social structures of power, position, and embedded social structures that privilege one group over others—to better appreciate the experience of others.[25] It is an initial step toward building genuine empathy, which can mobilize people to act even when they do not stand to benefit from that action.[26]

For clinicians, intentional stillness requires a break from the rush of daily tasks as well as an openness to reflecting emotionally, intellectually, and morally on the existence of an entrenched and complex system of structural oppression, the role of medicine in perpetuating health inequity, and the profession's responsibility to contribute to a more equitable future. Intentional stillness can be an individual effort pursued through activities similar to meditation and mindfulness or a group effort with a guided version of a technique such as Schwartz Rounds®, a "slow intervention" that provides facilitated discussions for health care teams on clinicians' moral experiences and humanity in medicine.[27] Evaluations of such activities reveal gains in personal insight and empathy, resulting in prosocial behavior and organizational change.[27,28] Empathy serves as a pathway to solidarity, which is necessary for structural change.

Solidarity

Arguably one of the most highly valued prosocial behaviors undergirding social change, solidarity is an altruistic behavior that involves "standing with." Solidarity, as Jean-Jacques Rousseau described, results in common injuries (or common benefits), as "one cannot injure one of the members without attacking the body, and still less can one injure the body without the members being affected."[29] This definition aligns with Onora O'Neill's concept of "solidarity among"[30] and is based on a shared sense of *we* stemming from features that bind a group together.[30,31] In addition to Black political solidarity[32] and within-group commitments to addressing problems created by collective action or inaction,[31] we see solidarity as a moral duty requiring between-group recognition of common humanity, akin to O'Neill's "solidarity with,"[30] whereby people with power reconstruct systems in recognition of the worth of all human flourishing.

Solidarity is a vehicle for collective and individual justice, as it reflects "a basic need to stand in particularistic relationships with others" in order to achieve societal conditions necessary for individual flourishing.[33] In Felipe Santos' framing, "caring about" is rooted in empathy and generates solidarity and collective action.[26] Collective action takes several forms, including caring for, which is necessary to address needs created through faulty policy.

In sum, collective action to improve health equity can arise as a result of a strong sense of solidarity and between-group commitment to humanity stemming from empathy, which is developed through intentional stillness and critical reflexivity.

Moral Obligation to Release Study Findings

In our case scenario, a strong sense of solidarity—of standing with persons and communities whose time, efforts, and bodies made the research possible—motivates the moral responsibility to share study findings. The professional and practical implications that give the institution pause about releasing the data are understandable, but they are outweighed by at least 3 ethical motivations for sharing the data, which are revealed through reflection on ethical principles that is facilitated by intentional stillness and the sense of empathy and solidarity that result. First, there is an ethical duty to

share the knowledge because it has been gained through public sources of funding—the public pooling its resources for public benefit. Ethical principles such as reciprocity, gratitude, and accountability support the view that results of publicly funded research should be shared with the public. Second, there is a duty to share because a community's members have participated in the research. Reciprocity and respect for persons and communities as ends in themselves support the disclosure of research findings to those who took on research risks for the benefit of others. A third justification for sharing the data—supported by beneficence, nonmaleficence, justice, and solidarity—is that research results ought to be shared with all those persons and communities whose health and wellness can benefit from knowledge gained, regardless of funding sources and research participation.

Clinicians recognize the obligation to provide care according to the individual needs of each patient. After hundreds of years of building an inequitable health system in the United States that has resulted in persistent health disparities for people of color, it is clear that even with a focus on the needs of individual patients, systemic biases continue to fuel health disparities. It is incumbent on all of us in the health, science, and technology sectors to dismantle the systems and structures that propagate health inequities and mistrust. Solidarity plays a necessary, albeit insufficient, role in achieving this goal. A clinician-researcher who stands in solidarity with a community of Black research participants and patients, such as the one in the case scenario, should recognize their moral distress at the suggestion of withholding research data that could benefit Black cardiac patients, especially if the main reason for doing so is fear of bad publicity or institutional disapproval. Self-interested fear is incompatible with solidarity that stems from empathy. It is, instead, a sign of complicity and complacency. Withholding knowledge resulting from research data is a failure of scientists' social responsibilities to generate knowledge that supports human flourishing. Moreover, suppression of scientific evidence has been criticized as dishonest, lacking in respect for colleagues and the law, and a failure of good stewardship.[34]

The pace of justice, equity, and inclusion has been unjustifiably slow, as thoughtfulness of care, accountability, and deliberative community engagement by those with the power and resources to effect change have been lacking. Intentional stillness resulting in empathy that in turn ignites solidarity can help medicine begin to move toward more just and equitable care for all of us.

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