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RESEARCH ARTICLE

Responsibility for Structural Racism in Medicine: Reflections and Recommendations from One Institution

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Abstract. In this article, we draw upon recent ethical arguments by Zheng and Young to explain our experience applying the social connection model of responsibility to structural racism in medicine. We propose that taking responsibility for structural racism must begin with acknowledging, studying, and learning from localized, particular instances of racism. Such practices raise personal and institutional consciousness about racism and injustice, creating a knowledge base from which effective action is possible. We describe our experiences engaging with responsibility for structural racism as a small group of scholars dedicated to learning more about our institution's history and our own agency in altering its future trajectory. Our learning and introspection were developed over multiple sessions in the 2019–2020 academic year when the authors participated in a Medical Ethics Forum Fellowship.

The Medical Ethics Forum Fellowship (the Forum) of the Medical University of South Carolina (MUSC) is composed of a diverse group of interdisciplinary faculty members, students, and practicing health professionals. The precise membership of the group changes every year, with a number of members continuing for multiple years. Each academic year the Forum focuses on a specific bioethical issue of current interest. Our focus for the academic year 2019–2020 was race and ethnicity in 21st century health care. This paper is the result of our year-long deliberations based on study of the relevant literature, monthly discussions, as well as personal presentations and discussions with nationally known scholars in this field.

Keywords. Racism, Medical Ethics, Health Care, Injustice, Responsibility, Medical Education, Interdisciplinary

Introduction

Structural racism is one type of structural injustice, a term which broadly captures inequities due to ingrained policies and institutional practices that disproportionately affect populations stratified by race, gender, sexuality, abilities, and other social group identifiers. Medical education scholars and practitioners generally focus on macro-level structures in their discussions of structural racism, foregrounding how the policies and procedures of, for example, health insurance companies, hospitals, medical centers, and health professional education institutions perpetuate racism (Bailey et al., 2017; Williams et al., 2019; Gee & Ford, 2011). As with other forms of structural injustice, structural racism perpetuates unjust systems that depend on occasionally explicit and often implicit hierarchies that rank groups preferentially and allocate social value, agency, power, and concrete resources in a manner that both reinforces and seemingly justifies the original hierarchy (Bailey et al., 2017; Williams et al., 2019).

Many calls to study structural racism in medicine focus on the need to better understand its processes and to measure its effects on disadvantaged social groups. This research is important because structural racism is a social determinant of health that is often unrecognized and, when it is acknowledged, is subsequently misunderstood. In addition to understanding, interventions are needed that address structural racism by both acknowledging its existence and ameliorating its effects. As some have noted, research on these interventions is still in its infancy yet structural racism is so corrosive of our social fabric that it is crucial not to wait for full understanding before we act to counter it (Williams et al., 2019).

Cultural competency training is an intervention that has been broadly discussed and adopted; it targets cultural racism, which has been defined as "the instillation of the ideology of inferiority in the values, language, imagery, symbols, and unstated assumptions of the larger society" (Williams et al., 2019, p. 110). Cultural competency training aims to increase clinicians' awareness of cultural variation and sensitivity so as to undermine racism in clinical encounters. It often uses vignettes that highlight the importance of culture in healthcare decision making and enable clinicians to imagine appropriate interactions. Such training has been extensively used in medical education and clinical training, though its effectiveness has been mixed (Bailey et al., 2017). While cultural competency training improves providers' attitudes and knowledge about the role of culture in clinical care, no clear effect on health outcomes has yet been reported (Williams et al., 2019).

Metzl and Hansen (2014) offer a theoretical framework termed "structural competency" that calls for institutions to move beyond cultural competency training and education. They recommend implementation of interdisciplinary pedagogical approaches and training programs in which institutional personnel examine discriminatory policies, practices, and environmental factors that shape patient interactions. In recounting our own particular experience, we build on Metzl and Hansen's approach and recommendations, arguing that a crucial dimension of interventions aimed at structural racism is the extent to which they are *particularized* and *localized*. While knowledge of structural racism and social determinants of health is critical for medical care in the United States generally, recognition of responsibility for structural racism should also occur individually, not just institutionally, and ought to include specific manifestations of structural racism within local communities. While "big picture" frameworks provide a basis for understanding macro-level systems and the practices that perpetuate them, it can be difficult for individuals to see how their choices, attitudes, and understandings are involved in these systems. Our goal is to describe how our particular experiences exploring these concepts during our year within the Forum empowered us as individuals to understand our role in perpetuating structural racism within our own institution and to act on that understanding.

In the following section, we explain the ethical underpinning of individual responsibility for structural injustice, drawing on Zheng's (2018) recent proposal of the "role ideal model" of structural

injustice, a model that builds on Young's (2011) influential social connections model, but which moves beyond it in important ways that are directly relevant to our experience. We then offer our own interdisciplinary experience with the kind of consciousness raising recommended by Zheng and Young. We reflect on the complex history of our own medical institution and what it means for providers, educators, and students to take responsibility for that history. After a brief synopsis of our educational forum, we conclude with a set of hypotheses about the fruits that similar efforts by other institutions could bear in combating structural racism in medicine.

Individual Responsibility for Structural Injustice: A Philosophical Account

Ameliorating structural racism requires that medical professionals first and foremost understand how their healthcare institutions currently and historically contribute to inequities that disproportionately affect people of color and marginalized groups. This consciousness-raising enables individuals and institutions to understand their responsibility and be spurred to act, as we explain below. This is not to say that institutions themselves are not accountable or responsible; rather, here we focus on individual responsibility to reflect more deeply on our own experience within a medical institution with a long history of injustice.

Young addresses the complicated question of how to approach individual responsibility for structural injustice in her "social connections model" of responsibility. She rejects the idea of responsibility as liability for a harm, but rather suggests a model of responsibility that derives from the social interdependence within which we pursue projects and seek benefits. She writes, "The social connection model of responsibility says that individuals bear responsibility for structural injustice because they contribute by their actions to the processes that produce unjust outcomes" (Young 2011, p. 105). Young emphasizes that, in the context of structural injustice, our contribution to injustice often emerges from our acceptance of background conditions as normal, leading us to perpetuate practices and enact policies that constitute unjust structures.

Zheng has drawn on Young's work to develop her proposal that individuals are responsible for structural injustice not as part of their general social responsibilities, but by virtue of the particular social roles they inhabit. Zheng argues that social roles carry with them specific responsibilities that do not necessarily relate to any action individuals inhabiting those roles themselves have taken. For example, faculty members might bear special responsibilities to teach diverse perspectives on a given issue, based on the recognition that they benefit from a system in which certain viewpoints have been recognized as authoritative while others have been unfairly marginalized. Similarly, clinicians might bear special responsibilities for health inequities arising from racism, even if they themselves do not actively or intentionally contribute to such inequities. Zheng argues that a privileged role in an unfair system imposes responsibility for modifying that system for the betterment of the general community.

Directly relevant to the fellowship experience we describe below, Young argues that individuals have responsibility for historic injustice, not to reproach or punish, but rather because "the past matters to the way members of the society take up responsibility for present racialized structural injustice" and "the mere unchangeability of historic injustice . . . generates a present responsibility to deal with it as memory. We are responsible in the present for how we narrate the past" (Young 2011, p. 182). This responsibility is greater for those in positions of relative privilege in the overall structure. Tying together the work of Zheng and Young, we propose that medical professionals have a unique social role in society, which generates a special responsibility to deal with the history of injustice in medicine by using it to transform their own institutions.

A major feature of the social connections model for responsibility is that all individuals who benefit from and perpetuate unjust structures bear some responsibility for making them just. This responsibility is based on individuals' active and passive support of racist and unjust practices (including epistemic practices that dictate what counts as

shared knowledge within the institution). Controversially, Young writes,

> An important corollary of the idea that responsibility in relation to structural injustice is shared among all those who contribute to the processes that produce it is that many of those properly thought to be victims of injustice nevertheless share responsibility for it. On the liability model of responsibility, blaming those who claim to be victims of injustice usually functions to absolve others of responsibility for their plight. In the social connection model, however, those who can properly be argued to be victims of structural injustice also can be called to a responsibility they share with others to engage in actions directed at transforming those structures (p. 113).

On one interpretation, Young can be seen as ignorant of the intersection of social roles and identities, such that individuals might be victims of injustice several times over (as extensions of Crenshaw's (1989) concept of intersectionality have emphasized). Young could then be criticized for further burdening victims of injustice with the responsibility for rectifying it. Nevertheless, this does not seem to be how she intended her suggestion to be interpreted. She writes,

> That we share responsibility in this way as contributors does not imply, however, that we should not distinguish degrees and kinds of responsibility in reasoning about how to take forward-looking action in discharging the responsibility. No philosophy can tell actors just what we ought to do to discharge our responsibility, nor can philosophy provide a formula for decision (p. 124).

The fact that responsibility is shared by individuals who benefit from and enact unjust social structures need not imply that it is shared equally or ought to be discharged uniformly. How this responsibility is enacted depends on a number of factors which Young details, including power, privilege, and interest. As she writes, "We who share responsibility ought to take action, but it is up to us to decide what it is reasonable for us to do, given our abilities and our particular circumstances" (Young 2011, p. 143). We understand this to mean that, since individuals are the locus for acting on their responsibility, they also have agency in determining what this action looks like. It would be inappropriate for institutions or individuals to demand or require taking responsibility for injustice through particular forms of action. Rather, individuals must retain agency in determining what an appropriate response is for them.

Putting Young's and Zheng's understandings of responsibility for structural injustice together, individuals who teach and train within academic medical centers have a duty to educate themselves, their students, and their trainees about structural injustice through the lens of their institutions' pasts and their ongoing roles perpetuating problematic structural arrangements. This conception of personal responsibility encourages individuals to recognize opportunities to address structural injustice in their own context. Such pedagogical practices raise individual and institutional consciousness about local examples of racism and other forms of injustice, creating a knowledge base from which effective action is possible. We have found this to be effective in our own institution.

Synopsis of the Fellowship Forum

The Medical Ethics Forum Fellowship followed a dynamic and shared learning plan, divided into three phases including background learning, current topics, and final outcomes. For our background and familiarization, sessions began with roughly a dozen assigned readings over the course of the fellowship. Reading discussions began in person as a group but then involved pairing up for focused discussion. Pairings were meant to group members unfamiliar with each other. Unsurprisingly, the diversity of the fellows was key to the program. Specifically, fellows represented many of the different divisions within the university and hospital system with their varying missions and included students and faculty from all ranks and all colleges (medicine, nursing, and pharmacy). Each dyad shared their unique discussion highlights with the group. We attempted in most cases to steer the conversation to personal experiences in our clinical and academic environments and to identify intersections across disciplines.

For our first session, we read excerpts from Dorothy Roberts's *Killing the Black Body* (1997), which mention MUSC specifically, alongside Mary Faith Marshall's reflection on her involvement in the Supreme Court case *Ferguson v. City of Charleston* (published in this journal, 2016), which we discuss in more detail below. Another topical discussion was based on assigned readings from Deirdre Cooper Owen's *Medical Bondage* (2017), given its relevancy to the topic and its historical roots in the South, as much of the human experimentation described took place in South Carolina.

For our second phase we brought in guest speakers who were experts in the field; alternatively, one of the fellows would present a project to the group focused on diversity in medicine. Presentations were then followed by discussion, again with a focus on personal intersections of identity within our medical community. We had planned to host a campus wide lectureship for the spring of 2020 that was unfortunately derailed by COVID-19 (Sullivan & Sade, 2021).

The third phase of the fellowship was devoted to discussion and planning for outcomes. We discussed how to disseminate information back to our home departments or classes and ways we could take action to increase awareness of diversity and decrease racial bias. We also considered possible publications, polls, and actions we or the university could consider. For instance, as a state institution in South Carolina, MUSC historically celebrates Confederate Memorial Day on Monday, May 11. Many employees have searched for a way to end this practice, and MUSC has now implemented a personal floating holiday in lieu of Confederate Memorial Day starting in 2021. Although the official fellowship would end, sustaining the discussion and expanding discourse on a broader scale has always been seen as paramount.

Localized Instances of Structural Injustice: Our Medical Center's Experience

There was much in our institution's history for our forum to learn about and discuss. As the forum progressed, our discussions often turned to news articles or stories that a member had discovered in between meetings or connections they had identified with our readings. For example, Owens (2017) deals extensively with J. Marion Sims, previously lauded as the "father of US gynecology." His experimentation on enslaved Black women has been critiqued in both public debate and scholarly research for its inherent lack of informed consent and its noteworthiness as an example of the house of medicine's collusion with the institution of slavery. Broader public knowledge of this history has resulted in the relocation of a statue of Sims from an East Harlem park and the bestowal of an alternate title, "The Mothers of Gynecology," upon the enslaved women who served as his subjects and assistants (Vernon, 2019; Zhang, 2018; Trouillot, 2017). Forum members were not all aware that J. Marion Sims once attended courses at the Medical College of South Carolina, now MUSC. Nor did we all know that Sims's legacy has long been celebrated at MUSC, with an endowed chair in OB/GYN carrying his name until 2018 and his inclusion as a famed alumnus in the medical school's white coat ceremony program as recently as 2017; both have since been discontinued.

While most of us have seen the plaque in front of the hospital in memory of the 1969 Hospital Workers Strike, we were not all informed of the details of this effort. A year after Rev. Dr. Martin Luther King, Jr.'s assassination, MUSC was the site of the 1969 Hospital Worker's Strike, in which 400 African American hospital workers, all but twelve of whom were women, went on strike against the all-white administrations of the then Medical College Hospital and Charleston County Hospital over unfair pay and termination. The strike was led by working-class Black women Mary Moultrie and Naomi White. During the Hospital Worker's Strike, which lasted over three months, over 100 medical professionals were arrested and the National Guard was used to enforce a curfew and suppress demonstrations (Debnam, 2016).

Finally, some members were surprised to learn through Roberts's groundbreaking *Killing the Black Body* that in 2001, MUSC was found in violation of the Fourth Amendment in the US Supreme Court case *Ferguson v. City of Charleston*, which focused

on a joint policy between MUSC and Charleston law enforcement to involuntarily test pregnant women suspected of drug abuse. The results were reported directly to the police department without the women's consent and resulted in the arrests of pregnant women for child neglect or endangerment, allowing some patients to be shackled during labor. While records from the time show that both white and African American maternity patients at MUSC consumed illegal drugs at equal rates, the primary focus on testing for crack cocaine in MUSC's public prenatal clinic, which served mostly black women, meant that 29 of the 30 women arrested under the policy were African American. This case was the reason ethicist Marshall, who had testified under subpoena in court that MUSC had violated the civil rights of these patients, was initially denied promotion and subsequently left MUSC after the bioethics program was cancelled due to "financial exigency" (Marshall, 2016; Perez, 2013).

Over the past year, we have been studying these issues not because we bear ill will towards our institution or desire to "air dirty laundry." On the contrary, MUSC is to be lauded for supporting this Forum, requiring diversity training for all full-time employees, supporting an independent ethics service, and acknowledging structural racism and health disparities (see Cole; *Race, Health, and Social Justice*). Rather, we assert that accepting individual responsibility for structural injustice, of which racism is one form, requires health professionals to educate themselves about their own institutions' histories of both privilege and harm, from which they benefit, explicitly or not. Fellows acknowledged that there were varying degrees of familiarity with the history of their home institution; some were Charleston natives, having trained at MUSC and with developed personal reflections on these events, while others were new to South Carolina and only familiar with a portion of the history. Many of us conceded that, even in instances where we were familiar with the history, we were unaware of how relatively recent some of these instances were, making it ever more obvious that the past is intermingled with the present. Additionally, the efforts our institution has made to acknowledge and rectify our history, such as requiring diversity training for administrators, increasing enrollment of minorities, and supporting the Medical Ethics Forum Fellowship, must be viewed through the lens of this painful history.

Reflections from the Fellowship

Some of the authors of this work, who were also Forum Fellows, have described their own experiences of this year's study and discussions below; their thoughts exemplify the benefits of this form of particularized consciousness raising. The excerpts below highlight the transformative nature of medical professionals, scholars, and students educating themselves about elements of structural injustice that directly relate to their roles within institutions.

> During my time with this group, I recognized that my focus has been solely about a patient's experience or perception of my care, but I have failed to reflect on my individual responsibility as a teacher or person with a privileged role, who has benefited professionally from a racist system. I have most certainly failed to be an instrument of change. My commitment must be more than bettering one patient's perception; it must take into account my role as teacher, attending, and admittedly reluctantly, leader for social justice. I have seen that it is my responsibility to be part of ensuring that MUSC's community messaging acknowledges our painful history, that our educational philosophy commits to educate the newest generation of healthcare providers to be more than just clinically competent, and to ensure that the projects we choose to prioritize or fund reflect our commitment for accountable and equitable health care.

> As a Charleston native, I grew up hearing stories about Black citizens' distrust of medical institutions and MUSC was not exempt from those tales. I heard oral histories of mothers, grannies, "big mamas," uncles, and friends being mistreated by the local hospitals. A cloud of suspicion and foul play shrouded MUSC in the eyes of many family and community members, but I was skeptical that the narratives I heard as a child were simply old wives' tales. However, I started to give some credence to the suspicion after our reading about once revered gynecologist Dr. J. Marion Sims. But it wasn't

until I learned about Mary Faith Marshall and her fight against MUSC's *Interagency Policy on Management of Substance Abuse During Pregnancy* that I fully considered why so many Black locals lacked faith in our medical institutions. My kinfolks weren't simply referencing painful experiences passed down from the days of slavery or Jim Crow; Marshall brought to light a problematic policy that was affecting Black women during my lifetime.

To be honest, I don't like talking about race. It is not because it makes me uncomfortable. I can handle that. It's because I'm so afraid I'll say the wrong thing and hurt or offend someone. That is a much harder pill to swallow. I would rather treat people how I'd like to be treated and be on my way. The Forum exposed the error in thinking I can get through my work and life like that. Black people are sicker and dying younger than white people because of the racist healthcare system that I am a part of and that MUSC's history has contributed to. My uninformed words cannot hurt them as much as this system does.

As a medical student who came into school with a desire to address and raise awareness of ethical issues around race and medicine, participation in this fellowship gives me both hope for the future and an enhanced sense of urgency. Healthcare professionals are finally starting to tap into the decades of research in the humanities in order to make our field more equitable and navigable for all patients, but as the disproportionate death rates in Black and brown communities during the COVID-19 pandemic show, we have a long way to go. Healthcare professional students are still learning about race as a risk factor, rather than racism, a framing that relies on pseudoscientific narratives about marginalized people's supposed innate or cultural pathology, rather than a rigorous scientific examination of the root causes behind social inequity. It will ultimately take an interprofessional, interracial coalition of concerned and knowledgeable professionals to champion thorough explications of the social determinants of health over narratives of pathology, change the racial healthcare and health disparities we see, and create a healthcare field truly worthy of marginalized patients' trust.

As a faculty member trained in research ethics, I thought I understood the historical cases underpinning concepts such as mistrust and the lack of respect for persons, especially when it comes to working with Black communities. I am embarrassed to say I never fully explored the history of my institution. I am a white researcher who partners with predominantly under-resourced Black communities. I consistently and openly partake in dialogues with my community partners regarding historical cases of scientific misconduct conducted by white research scientists on Blacks. These conversations enable us to acknowledge past examples and work collaboratively to build trust and empower community members to have a voice and role in the design, conduct, and dissemination of clinical research and to also implement processes for ensuring this does not occur in the studies we conduct together. I was remiss in not previously exploring the injustices my own institution enabled. To be part of a system of change, clinical academicians need to understand the broader contexts of race, social injustices, and the resultant health disparities faced by affected populations, but we also need to closely explore our own institutions and roles they have had in these structural injustices to begin to turn the tide. This experience not only has opened my eyes but has solidified my resolve that I have a duty to educate future clinicians and scientists on the ethics of race in medicine and to work to implement processes that protect marginalized populations.

Lessons Learned and Future Directions

As reflected in the narratives above, personal acknowledgement and education about previous and current institutional transgressions is an important component of the corrective process to redress a healthcare system afflicted by structural racism (Metzl, 2014). To address health inequities and injustices, hospitals and academic medical centers must acknowledge, accept, and reconcile historical instances of racial injustice, identify local sociocultural factors that impact clinical relationships, and develop new language and processes for discussing and teaching structural competency (Romano, 2018). Faculty, administrative staff, clinicians, and students in academic medical centers must also understand how their personal prejudices and biases—conscious and unconscious—perpetuate and propagate racist policies and practices and

recognize their roles as persons of privilege in correcting an unfair system. Individuals are the building blocks of community health care and play a key role in eradicating bias.

To educate students about health inequalities, many academic medical centers have incorporated discussions of race and health into their curricula (Coria et al., 2013). These exercises are useful in developing students' cultural sensitivity and critical thinking capacities, but instructors often use standardized examples that focus on the patient as the cause of their health problems (Hatchett et al., 2015). Further, education about structural injustice cannot be limited to students, as all professionals employed by an institution ought to know about their role in a broader historical picture of structural injustice, as our fellows' reflections show (Hardeman et al., 2016).

Instead of using generic examples, we recommend institution-specific case studies using an interdisciplinary approach, incorporating medical sociology, critical race pedagogy, and structural inequality research. Local historians can help institutions to identify narratives and strategize about how to share them. The institutional history of MUSC—South Carolina's foremost academic medical center and the oldest in the South—probably carries a heavier burden of institutional racism than most, but it is not unique. Indeed, it seems likely that every medical center in this country, if not the world, can identify such instances in their own histories, learn from them, and use them for transformative change.

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