Episode: *Author Interview: "How Should Clinicians Own Their Roles as Past and Present Exacerbators of Health Inequity and as Present and Future Contributors to Health Equity?"*

Guest: Lisa M. Lee, PhD, MA, MS
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[bright theme music]

TIM HOFF: Welcome to another episode of the *Author Interview series* from the *American Medical Association Journal of Ethics*. I'm your host, Tim Hoff. This series provides an alternative format for accessing the interesting and important work being done by Journal contributors each month. Joining me on this episode is Dr Lisa Lee, a bioethicist and epidemiologist who is currently Associate Vice President for Research and Innovation and the Director for the Division of Scholarly Integrity and Research Compliance, as well as a Professor of Public Health at Virginia Tech in Blacksburg. She's here to discuss her article, coauthored with Dr Anita Allen, *How Should Clinicians Own Their Roles as Past and Present Exacerbators of Health Inequity and as Present and Future Contributors to Health Equity?*, in the December 2022 issue of the Journal, *With Stillness and Solidarity*. Dr Lee, thank you so much for being on the podcast today. [music fades out]

DR LISA LEE: Thanks, Tim. I'm happy to be here.

HOFF: So, what's the main ethics point that you and Dr Allen are making in this article?

LEE: Yeah. Well, Dr Allen and I were presented with a case describing a physician researcher whose recent findings on the relationship between race and cardiac health were unflattering to their academic health center, and who was reflecting on the role of cardiology in perpetuating racial health disparities. This researcher was unsure about whether to share their findings, and in considering next steps, was concerned about reprisals for tarnishing the hospital's image in the community on the one hand, and on the other hand, a real sense of urgency and responsibility to share the data in order to respond justly to the many patients of color in the community. So, this case presents many ethical dimensions, and we chose to really connect the themes of the issue, of this issue of the Journal, that is stillness and solidarity, to really focus the question of how this cardiologist should act thoughtfully and deliberately to be part of the long-term solution to the problem of health inequities, to which medicine itself has contributed and continues to perpetuate.

So, we argue in the paper that between group solidarity, or what we call standing with, and others have called standing with others, is essential for motivating this type of pro-social action, where health care providers, and they are people with power and privilege, work to reconstruct oppressive systems because they recognize that, the health care providers that is, recognize the worth of all human flourishing. So, the question for us was how do we nurture this between-group solidarity among health care providers? And we propose in the article that it will take what we're calling intentional stillness, which will give rise to empathy. Empathy is a critically important vehicle through which we can build the necessary solidarity. And we see solidarity as a moral duty requiring between-group recognition of common humanity whereby people with power and privilege invest in changing systems even when they themselves do not stand to benefit from these changes.

So, in the article, we define intentional stillness as virtuous quietude and thoughtfulness. And we differentiate this from stillness when it is of might, for example, when we do nothing, which amounts to complicity or complacency. So, we also recognize that busy practice days filled with chaotic schedules are not particularly conducive to stillness, hence the importance of the intentional part. This means, of course, that health systems have to recognize the essential role of critical reflection and allow time and space for health care providers to realize these intentions.

We really think that intentional stillness asks all health care providers to decenter their own experience and make room for what others have called critical reflexivity. And that really is to think critically about moral intuitions and help gain a fuller understanding of the lives of the patients whose lived experiences are different from their own, and sometimes dramatically different than their own. And we think this critical reflection is, when it's conducted with intention and openness has, we know that it's been shown to foster empathy. And we all define empathy as this deeper understanding of emotional engagement with other people. And as I stated earlier, then that empathy can induce solidarity and pro-social action. So, fundamentally, we argue that intentional stillness will lead to empathy, which will lead to solidarity, which will motivate change to reduce health disparities.

HOFF: And what do you see as the most important thing for health professions students and trainees to take from your article?

LEE: It's a great question. I think health professions students and trainees get really good training on their obligations to provide care according to the needs of the individual patient that's sitting across from them. But after hundreds of years of building and maintaining an inequitable health care system in the US, it's pretty clear that even when we focus on the best care for the person sitting across from us, systemic biases, which are really bigger than any one of us, obviously, continue to perpetuate what are deadly health disparities in this country for people of color and other represented communities. And it is, we believe, and we say in the article, incumbent upon all of us in health, science, and technology sectors to really work to dismantle the system and the structures that propagate health inequities and mistrust. So, we think we must move forward together honoring connectedness, our connectedness with other human beings, and bring up the bottom in addition to moving the top forward. We know that health care providers, as people with power and/or proximity to power, must use all the levers available to them to right these, what we see as chronic injustices.

HOFF: And finally, if you could add a point to your article that you didn't have the time or space to fully explore, what would that be?

LEE: Hmm. Well, when I've talked with health care providers about these ideas, many respond that there are just no opportunities for stillness available to them in their work day. [chuckles] Many physicians say, for example, that they haven't felt stillness at work since they were first-year medical students. So, we know that while empathy is a vocational virtue for health care professionals of all types, it does, empathy does require stillness. And when we remove opportunities for that stillness, I worry that we might be actually decreasing empathy and getting further away from the solidarity we need to motivate real systemic change and ultimately, limit health disparities, eliminate them. I would love to work on a convincing business case for health care systems to value intentional stillness, to further develop empathy, and foster solidarity among health care teams and between

health care teams and their patients. [theme music returns] I really think this type of support will be essential if we're going to move the needle on this at all.

HOFF: Dr. Lee, thank you so much for being on the podcast with me today. And thanks to you and Dr Allen for your contribution to the Journal this month.

LEE: It was our pleasure. Thanks for having me, Tim.

HOFF: To read the full article as well as the rest of the December 2022 issue for free, visit our site, JournalofEthics.org. We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics.*