SPECIAL FEATURE: URBAN BIOETHICS

Bioethics in the Urban Context

Alan R. Fleischman, Betty Wolder Levin,
and Sharon Abele Meekin

The health and well-being of urban populations has been the recent focus of the New York Academy of Medicine. In 1998, the Academy created the Center for Urban Bioethics to engage in research, educational activities, and program development to address the ethical issues inherent in the density and diversity of culture, race, ethnicity, religion, and socioeconomic status that characterize the urban environment—home to many vulnerable, underserved, and disenfranchised individuals. The center joins other research efforts of the Academy that emphasize the critical nature of social and behavioral determinants of health for underserved and marginalized populations.

Over 75% of the American population now lives in an urban center or environs surrounding it. These urban settings are distinguished from rural ones by the density and diversity of people and institutions. The human congestion and heterogeneity in cities has always been an ironic interplay of extremes, with areas of substantial wealth bordering on slums, state-of-the-art health care institutions adjacent to communities with preventable and serious diseases, and powerful Brahmin families amid recently arrived immigrants. These obvious disparities and inequities create many important factors that have an impact on health.

The determinants of health, illness, and injury include social, environmental, biologic, and behavioral factors. Frequently, the complexity of the urban environment exacerbates these determinants, concentrating adverse factors and resulting in poorer health status for many of the urban dwellers. Socioeconomic factors account for much of the variation in health status and health outcomes in urban areas.¹ The observation that the socioeconomic level of individuals is associated with their present and future health has been documented for decades. Even for diseases for which there is no direct association between incidence and poverty, survival is worse among those with lower socioeconomic status. And, even for populations with access to similar health care services, variation in social status is associated with differential outcomes.²

In addition to the impact of socioeconomic status on individual and population

Drs. Fleischman and Levin and Ms. Meekin are from the Center for Urban Bioethics, New York Academy of Medicine. Dr. Fleischman is Senior Vice President of the New York Academy of Medicine and Clinical Professor of Pediatrics, Clinical Professor of Epidemiology and Social Medicine, Albert Einstein College of Medicine. Dr. Levin is Professor, Department of Health and Nutrition Sciences, Brooklyn College, New York. Ms. Meekin is Program Officer, Center for Urban Bioethics.

Correspondence: Alan R. Fleischman, Senior Vice President, New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029. (E-mail: afleischman@nyam.org)

health, an increasing body of information now indicates that the relative equity of income distribution may also be an important determinant of health.³ Internationally, countries with less disparity in income between the most well-off individuals and the poorest have better life expectancy for the entire population than those countries with greater inequity in income distribution. This relationship has also been shown for states and cities in the US. Independent of median income level or rates of poverty, the share of total household income received by the population that is the least financially well off correlates with the age-adjusted mortality rate, rate of low birth weight, and disability rate. Income inequity appears to affect the health of urban populations well beyond the impact of average income or poverty. Moreover, the level of income disparity between cities and surrounding suburban areas also predicts the health status of urban dwellers.

In addition to the correlation of poverty and inequity with health, there is mounting evidence of race/ethnicity as an independent variable in the determination of health status and access to health care.⁴ Explanations for these differences in health, health status, and outcomes among urban minorities have focused on the circumstances of poverty and differential access to care. Some clinicians have argued that poorer outcomes are related to genetic variation among racial groups or biologic differences in response to disease or treatment. But, there is little evidence to support such biologic determinism. Other observers have noted poor and late health-seeking behaviors among minority patients, inappropriately blaming patients for inadequate access to quality care.

Access to health care is insufficient to ensure quality services. Recent studies have shown that even patients with health insurance have differential access to primary and subspecialty care based on both socioeconomic and racial characteristics. For example, poorer patients with heart attacks in Ontario, Canada, where health insurance is universal, were less likely to receive specialized cardiac services such as heart catheterization or revascularization surgery and were more likely to die within the first year after the attack than marginally more affluent patients.⁵ In a recent US study of over 10,000 insured patients with early-stage lung cancer—considered amenable to cure through surgery—the rate of surgery was almost 13% lower for black patients than whites and the 5-year survival rate was close to 8% lower for blacks.⁶ These differences held despite other illnesses that might influence candidacy for surgery or survival.

Perhaps the most disturbing recent findings are reports that conclude physicians consciously or subconsciously are less likely to refer patients of color for necessary diagnostic procedures and medical and surgical treatments.^{7,8} Studies reveal that physician assessment of patient intelligence, feelings of affiliation toward the patient, estimate of likelihood of adhering to medical treatments, and specific treatment recommendations are all affected by the racial characteristics of the patients.

The Center for Urban Bioethics wants those in the multidisciplinary field of bioethics to consider these problems. In the past, bioethics traditionally has dealt with the resolution of ethical problems and value conflicts associated with the practice of medicine and the pursuit of biomedical research. There has been far less emphasis on these social concerns related to the determinants of health and the structural factors that affect health care. The range of issues that customarily concern the bioethicist has revolved around protecting individual rights and interests. Most often, this has been addressed through the invocation of principles and the development of fair and equitable processes for resolution of conflict. Much of the scholarship in the field of bioethics has focused on health care decision making,

particularly at the beginning and end of life. Ethical analysis, however, can bring a rational approach to making judgments in a broad range of areas and assist in creating processes that can resolve additional value conflicts in the field of urban health. In this venue, however, bioethics will be challenged to broaden the traditional individualistic or dyadic focus to encompass questions about the interplay and tensions among individuals and groups as well as between an individual and society.

The pluralistic nature of the city requires creative and innovative thinking about the ethical dilemmas in the urban environment. Multidisciplinary and integrative approaches are needed for analysis of the role of family, community, race, ethnicity, religion, and culture in individual choice and to study the development of moral consensus in a diverse community. As we consider the role and utility of the field of bioethics in the urban context, we need to be cognizant of the impact of culture, race, and socioeconomic status on many determinants of health and health care delivery. These factors are particularly important in the diverse urban environment. Anthropologists remind us that culture is

The complex range of beliefs, values and attitudes shared and perpetuated by members of a social group. In the context of health care, an individual's cultural heritage provides an interpretive framework for perceptions of illness and wellness and the organization of treatment modalities.^{9(p159)}

When we think about cultural diversity, we usually concentrate on issues concerning those outside the cultural mainstream—most often thinking about patients who, as a result of their ethnic and/or religious heritage, have values and/or behavior that are seen as different from those of most Americans. But, in thinking about culture, it is important to remember that all people are cultural beings. “Culture” is not only a characteristic of foreigners and recent immigrants. Everyone has a cultural heritage that influences his or her health beliefs and practices.¹⁰ Health professionals, staff, patients, and families all are affected by the values and beliefs they bring to interactions around episodes of illness.

A second area, related to but distinct from the issue of culture, is race. Unlike cultural differences, racial differences are often seen as biological. However, hardly any of the important differences we ascribe to race really are biological. Rather, race is a socially constructed category, important in US society as a focus both for individual identity and for structuring social relations.¹¹ Because of the history of economic deprivation and political oppression, often people of color come into the health care setting sicker, with more comorbidities, and later in the course of disease. In addition, attending to issues of race is important because health care institutions in urban areas typically bring together people from many racial groups who otherwise function in much more segregated settings. These individuals are forced to interact in intimate relations as health care professionals, employees of health care institutions, patients, and family members.

In addition to cultural and racial diversity, cities frequently are characterized by economic diversity, with people of strikingly different social class positions living in close proximity. Since health status is affected strongly by economic status, the health status differences in the adjoining neighborhoods in cities can be significant. For example, in 1998, in the health area on the upper east side of Manhattan where some of the wealthiest New Yorkers reside, 8% of new mothers were on Medicaid, and the infant mortality rate was 1.6 per 1,000. This can be contrasted to an area

a few blocks north, Central Harlem, where 74% of the mothers were on Medicaid, and the infant mortality rate was 11.8 per 1,000, more than a seven-fold difference.¹²

Some bioethicists have called for attention to issues of social class along with issues of race and gender. However, very little work has been done to spell out the relationships between the knowledge and power people experience in different class positions and the ethical values they apply when they enter the realm of biomedicine. Moreover, the research that exists on social class focuses primarily on the poor. But, just as gender is not something that only women have and sexual orientation is not something that only homosexuals have, social class is not something that only poor people have.

On December 2–3, 1999, the Center for Urban Bioethics convened a national symposium to consider the role of bioethics in addressing these concerns. The articles in this issue of the *Journal* are a sample of the rich and exciting contributions that were provided during that symposium. We are grateful to the authors and the other participants in the symposium for their help in defining and elucidating the field of urban bioethics. We concluded that some of the areas of inquiry for urban bioethics will include racial disparities in health care delivery; the values that motivate and provide the rationale for public health practice; justification of the need for universal access to health care; the methods to ensure quality and availability of services to the indigent; the education of professionals about respect for difference and development of the ability to elicit the values, preferences, and concerns of individual patients from varying cultures that may have an impact on decisions concerning their health and well-being; and the creation of strategies for effective and reasonable interventions for marginalized populations who risk the health of others, such as those with communicable diseases and mental illness and those who use illicit substances.

We look forward to continuing work and discussion regarding this interesting and important aspect of urban health.

REFERENCES

1. Link B, Phelan J. Social conditions as fundamental causes of disease. *J Health Soc Behav.* 1995;spec no:80–94.
2. Williams DR, Collins C. US socioeconomic and racial differences in health: patterns and explanations. *Annu Rev Sociol.* 1995;21:349–386.
3. Lynch JW, Kaplan GA, Pamuk ER, et al. Income inequality and mortality in metropolitan areas of the United States. *Am J Public Health.* 1998;88(7):1074–1080.
4. Henry J. Kaiser Family Foundation. *A Synthesis of the Literature on Racial and Ethnic Differences in Access to Medical Care.* Menlo Park, CA: Henry J. Kaiser Family Foundation; October 1999.
5. Alter D, Naylor C, Austin P, Tu J. Effects of socioeconomic status on access to invasive cardiac procedures and on mortality after acute myocardial infarction. *N Engl J Med.* 1999;341:1359–1367.
6. Bach P, Cramer L, Warren J, Begg C. Racial differences in the treatment of early-stage lung cancer. *N Engl J Med.* 1999;341:1198–1205.
7. Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med.* 1999;340:618–626.
8. Van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. *Soc Sci Med.* 2000;50:813–828.

9. Orr RD, Marshall PA, Osborn J. Cross-cultural considerations in clinical ethics consultations. *Arch Fam Med*. February 1995;4:159–164.
10. Groce NE, Zola I. Multiculturalism, chronic illness and disability. *Pediatrics*. May 1993; 91(5):1048–1055.
11. Williams DR, Collins C. US socioeconomic and racial differences in health: patterns and explanations. Reprinted in: Brown P, ed. *Perspectives in Medical Sociology*. Prospect Heights, IL: Waveland Press; 1996:5–43.
12. New York City Department of Health. Summary of Vital Statistics 1998: The City of New York. New York, NY: New York City Department of Health, Office of Vital Statistics; 1998:24.